The role of trust and religious commitment in Islamic medical tourism

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The role of trust and religious commitment in Islamic medical tourism

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ABSTRACT
This study has examined the effect of trust and religiosity on Islamic medical tourists’ attitudes, and consequently, satisfaction by considering age, gender, and education as moderators. A survey was undertaken of 227 Muslim medical tourists who had been treated in Islamic hospitals in Iran, and the data were analysed using partial least squares techniques. The results showed that although trust has a significant effect on Muslim medical tourists’ attitudes, religiosity has no significant effect. The relationship between attitude and satisfaction towards the Islamic medical treatment practised by the healthcare providers is also supported. Gender and education moderate the relationship between religiosity and attitude. In addition, education moderates the relationship between trust and attitude. The results of this research can provide useful insight into the needs of Muslim medical tourists, which would be useful for Islamic hospitals to provide higher quality healthcare services.

KEYWORDS
Healthcare; Islamic medical tourism; trust; religious commitment; satisfaction

Introduction
The worldwide number of Muslims was 1.7 billion in 2014, and the number is predicted to be 2.2 billion by 2030 (Zailani, Iranmanesh, Aziz, & Kanapathy, 2017). The population growth rate for Muslims is 1.5% per year and this is double the growth rate of non-Muslim peoples (Thomson Reuters, 2014). Therefore, the fast-increasing Muslim population highlights the importance of the Islamic medical tourism industry as highly lucrative, and along with it comes the importance of paying careful attention to halal medical practices (Fathi, Zailani, Iranmanesh, & Kanapathy, 2016; Soltanian, Zailani, Iranmanesh, & Aziz, 2016).

Among the fast-developing tourism services in countries such as India and Iran, Islamic medical services have seen much success in recent years. India alone in the year 2008 attracted 1.11 million Muslim patients seeking Islamic medical treatment. They came not only from neighbouring Pakistan and Bangladesh, but also, from the Middle East and Africa (Medhekar & Haq, 2010). According to Izadi et al. (2012), the total percent of medical tourists of Iran had increased to 207.5% from 2007 to 2011.

Due to the rapid expansion in the international Islamic medical tourism market, competition has become very intense in recent years. Hence the question of how best to attract new Muslim medical tourists and motivate them to regularly and continuously use Islamic medical services is of prime interest to practitioners in this field (Han, 2013). It is important to note that retention of existing customers is five times more profitable than trying to attract new customers, according to the latest reports (Chiu, Hsu, Lai, & Chang, 2012; Kim & Gupta, 2009). Businesses have been shown to improve their profitability by increasing customer retention (Jiang & Rosenbloom, 2005). Thus, it follows that one of the most important factors determining repeat purchases by customers as well as their recommendations by word-of-mouth is customer satisfaction (Berkman & Gilson, 1986). In the Islamic medical tourism market, as well as for
any Islamic medical destination country, therefore, it is essential to be able to recognize the key factors creating a high degree of satisfaction for the Islamic medical tourists.

Much has been written about the importance of patients’ trust in medical care. Chang, Chen, and Lan (2013) found that the perception of trust amongst patients has a positive effect on their satisfaction. The factors that have been shown to increase a patient’s trust in their physician include being able to choose their physician, having a long relationship with their physician, and maintaining trust in the managed care organization (Kao, Green, Davis, Koplan, & Cleary, 1998). In the context of Islamic healthcare delivery systems, Muslim medical tourists’ trust in physicians regarding the considering of religious beliefs in their treatment, may be important in addition to trust in the physicians’ skill. Religious commitment is another factor that Muslims consider as a source for decisions and behaviour (Alam, Mohd, & Hisham, 2011; Razzaque & Chaudhry, 2013). How much a person adheres to the values, beliefs and practices of his or her religion and practices them in daily life is what constitutes religious commitment (Worthington et al., 2003).

Despite the criticality of trust and religious commitment for Muslim patients, no Islamic medical tourism research has yet examined their impacts on Muslim patients’ attitude and satisfaction. Due to this gap in the medical tourism research, the present study sought to focus on what effect trust and religious commitment have on Muslim patients’ attitude and satisfaction. With the growing numbers of Islamic medical tourists, such a study would be beneficial for healthcare providers to be aware of Muslim medical tourists’ attitudes and what factors shape them. It is necessary to be aware, however, that the medical tourists do not represent a homogenous group in terms of values and expectations they hold vis-a-vis their care providers (Choi, Lee, Kim, & Lee, 2005). Muslim medical tourists’ heterogeneity regarding age, gender, and education may cause a change in the importance of trust and religious commitment. Therefore, the effect of Muslim medical tourists’ heterogeneity was considered in determining the potential impact of trust and religious commitment on their attitude. However, greater knowledge about Muslim medical tourists’ segments is useful for healthcare providers to offer quality healthcare services that suit Muslim medical tourists’ characteristics and consequently, attract Islamic medical tourists.

The present study will provide an introduction, followed by a literature review on medical tourism, Islamic medical tourism, and patient satisfaction. Next, our proposed model on how to determine the impact of trust and religious commitment on the attitudes and satisfaction of Muslim medical tourists will be presented, followed by an empirical study to validate our proposed conceptual model. Finally, the findings will be discussed and our conclusions presented.

**Literature review**

**Medical tourism**

Medical tourism or health tourism, which has been defined as “travel with the aim of improving one’s health” (Bookman & Bookman, 2007), will be used interchangeably in this paper. This new fast-growing industry has changed over the past few decades. At first, those seeking medical treatment from developing countries travelled to countries in the developed world such as the United States or Europe. This trend was common among the affluent, who were able to afford it. Later, some people from developing countries began to travel to other parts of the developing world to access better healthcare facilities supported by more advanced technology than what existed in their home countries (Adams & Kinnon, 1998). Recently, however, a new trend has begun in which increasing numbers of patients are travelling from developed countries to less-developed countries for medical treatment (Kher, 2006). This new trend has come about alongside the former trend of patients travelling from developing countries to developed countries, thus changing the one-way traffic to a two-way highway (Horowitz & Rosensweig, 2008).

It is important to note why developing countries are now attracting medical tourists. Affordability is perhaps the most prominent reason, given the fact that developing countries can provide surgeries at a fraction of the cost one would have to pay in the USA or the UK (Reddy, York, & Brannon, 2010). In the developed world, medical insurance may not cover the required treatment. In addition, treatments in developing countries may be more quickly accessible in addition to the lesser cost. In Iran, for example, medical care and treatment is comparable to what is provided in the West, even with regard to state-of-the-art medical technology (Jabbari, Ferdosi, Keyvani, & Agharahimi, 2013), and yet the cost is markedly lower. Medical tourists can also avail themselves of the...
chance to be a tourist and enjoy a kind of vacation and the luxury of travel while they pursue their medical treatment (Bookman & Bookman, 2007). In taking advantage of this combination of purposes, several medical tourism companies offer an entire package trip organized for their clients, including airline ticket bookings, transport to and from the airport, and accommodation based on the kind of health treatment they will undergo, even including surgical procedures.

Iran has recently become a favourite destination for regional and Islamic medical tourists, attracting patients from neighbouring countries, such as the United Arab Emirates, Iraq, and Azerbaijan, mainly due to the advanced healthcare facilities and affordable costs of medical treatment offered (Jabbari et al., 2013). Amongst the popular treatments demanded are cardiac surgeries, cosmetic surgeries, fertility treatments, and organ transplants. These new trends highlight the importance of understanding the values and expectations of medical tourists. In Iran and elsewhere where the numbers of medical tourists seeking treatment are growing, the results of this study could greatly help healthcare practitioners to provide treatments and services which could benefit them as well as the medical tourists coming to their country.

**Islamic medical tourism**

The meaning of “Islam” is “peace” and signifies a person who has actively submitted to Allah (the one God in Arabic), the sole creator of humankind and the universe. Muslims have traditionally travelled for various purposes, including pilgrimage, leisure, business, and health, and the religion of Islam in fact encourages its followers to travel for acquiring knowledge and witnessing the glory of God. A relatively recent travel phenomenon among Muslims is Islamic medical tourism, which refers to Muslim tourists who travel for the purpose of health treatment. They choose countries where Islam is the major religion so that they can be assured that health services conform to Islamic teachings (Zailani, Ali, Iranmanesh, Moghavvemi, & Musa, 2016).

Islam enjoins its followers to abide by a set of halal dietary laws, which include any food or medicines consumed by Muslim patients (Zailani, Kanapathy, Iranmanesh, & Tieman, 2015). There are foods which are forbidden to be consumed by Muslims, including alcoholic drinks, pork and its by-products, meat of dead animals, blood and meat of animals that have not been slaughtered according to Islamic methods, amphibians (i.e. crocodiles, frogs, and turtles), undesirable insects (i.e. worms, flies, and cockroaches) and poisonous animals (i.e. rates, snakes, centipedes, and scorpions) (Mickler, 2000; Mouelhy, 1997). Medicines consumed by Muslims must be hygienic, pure, clean, and of good quality, and especially must contain only those ingredients permitted under the Shariah.

However, in certain special cases, this requirement may be relaxed, such as in the situation where no alternative medicine is available and by not consuming it the person could face danger or death (Mohezar et al., 2017). In such cases, the doctor and pharmacist involved should openly inform the patient about any forbidden ingredients contained in the medicine in question.

Hospitals which comply with Islamic principles must provide healthcare that is gender-concordant, meaning that female patients are examined and treated only by female medical staff. Such service requirements stem from the values of Islamic modesty. If this service is not available, the healthcare providers should inform patients and offer other possibilities such as requesting a female relative or staff to be present during the patient’s examination by a male healthcare provider. An additional measure to ensure the ease and comfort of Muslim patients is for doctors to announce their arrival just before entering a female patient’s room. This interval allows her to cover her entire body except for the hands and face (Deng, Jivan, & Hassan, 1994; Din, 1989), which is enjoined upon Muslim women to observe modesty. Some Islamic-compliant hospitals also accommodate nursing patients by offering single-bed occupancy, which allows for maximum privacy and night stays. If, for economic reasons, an open-ward system is in operation, the hospital should provide for full-curtain enclosure for patients’ beds as well as controlled visiting hours to ensure individual privacy. Modesty in dress is enjoined upon both males and females to ensure moral social order and to protect a person’s honour and is thus implemented by an Islamic dress code. Accordingly, female staff should wear uniforms which are neither transparent nor tight-fitting, and hair, arms, and legs must be covered. The work dress code for males is to cover their torso and upper legs.

In consideration of the Muslim obligation to pray five times a day, a clean, quiet well-maintained prayer room at the hospital premise is an important priority. For Muslims, prayer is crucial to the healing
process, so if they are interrupted while prayer, they may experience considerable discomfort. Healthcare providers in an Islamic-compliant hospital are responsible for making sure that patients’ daily activities comply with Shariah law (Mohezar et al., 2017). For example, nurses are required to help patients to perform prayers and ablutions when they may be too sick or immobile to do so unassisted. It is also encouraged to play Qur’an recitations through electronic devices so that the nursing ward would be full of these sounds for the benefit of patients. As far as the spiritual and counselling aspects of healing, some international studies recognize the role played by the Imam. He leads the Muslim prayers and in his sermon, advises the congregation on spiritual matters, which plays an important role in community health (Padela & Curlin, 2013). Another aspect of an Islamic-compliant hospital is concerns about the method of funding and financing (Mahjom, Alias, & Zulkifli, 2011), as the financing of such a hospital should comply with Shariah regulations, which means among other concerns that the owner must contribute a stated portion of his revenue to Zakat (charity). To ensure these measures are being followed, a board must be established made up of an Islamic scholar, a management staff, and a medical officer, who together act as advisors to the hospital owner to make sure that Shariah law is being followed in all operations.

Halal tourist activities are very important for Islamic medical tourist destinations because apart from the facilities and treatment aspects, leisure activities should also comply with Islamic teachings. Hence there should not be any gambling, drinking, and other party activities that contradict Islamic teachings. Similarly, the hotels, restaurants, as well as the hospitals involved in Islamic medical tourism must prepare and serve halal meals which are free from any forbidden ingredients such as pork and alcohol. In addition, praying facilities and an Islamic code of conduct and dress should be implemented.

### Patient satisfaction

Patient satisfaction could be defined as an assessment recipient of care as to whether their expectations on medical treatment have been met or not (Owusu-Frimpong, Nwankwo, & Dason, 2010). This dimension is considered as a pertinent quality indicator that needs to be continuously evaluated in view of the stiff competition in the medical tourism industry (Musa, Doshi, Wong, & Thirumoorthy, 2012). Improving patient satisfaction with the healthcare service delivered has become a key concern for hospitals as this will facilitate them in attracting a large pool of medical tourists. Satisfied inbound medical tourists are likely to exhibit favourable behavioural intentions, benefiting the healthcare providers’ long-term success.

According to patient satisfaction theory, patient satisfaction can be achieved by adding together all the subjective assessments of various multidimensional attributes which are connected with the clinical experience (Linder-Pelz, 1982). In the sociological and community medical literature, various research methodologies have been used to test the determinants of patient satisfaction. The majority of them found service quality to be the main driver of patient satisfaction. The five dimensions of SERVQUAL, including tangibles, reliability, responsiveness, assurance, and empathy on patients’ satisfaction of healthcare received, were tested in previous studies (e.g. Amin & Nasharuddin, 2013; Calisir, Bayraktaroglu, Gumussoy, & Kaya, 2014; Kitapci, Akdogan, & Dortyol, 2014). Variables such as personnel quality, infrastructure, administrative process, clinical care process, social responsibility, compassion to family and friends as well as the pleasantness of the surrounding environment were amongst the other components investigated and found to determine patient satisfaction. Oon (2006) utilized the SERVQUAL framework with additional constructs, including accessibility and affordability to determine the potential drivers of medical tourist satisfaction with the healthcare experienced in Island Hospital, Malaysia. In a more recent study, Padma, Rajendran, and Sai Lokachari (2010) applied the model and found personnel quality, clinical care, hospital image, and trustworthiness as significant attributes that affect patients’ satisfaction in Indian hospitals. In Kuwait, Alhashem, Alquarini, and Chowdhury (2011) has discovered different dimensions – long waiting time and inconvenient operating hours as factors contributing to patient dissatisfaction. Whilst these models appear to be reliable and applicable to be used in measuring medical tourists’ satisfaction, management needs to be able to adjust and implement them according to the culture.

Cultural differences may affect health and medical treatment perceptions (Kushnir, Esterson, & Bachner, 2013). Whilst caring exists in all cultures, the ability of hospitals to deliver clinical experiences that are culturally relevant and incongruent with the ethnic
values could result in a more effective treatment and higher patient satisfaction (Halligan, 2006). In an earlier study, Leininger (1985), for instance, provided empirical evidence that the caring and health practices of Western and non-Western cultures are not similar. In another study, Cortis (2003) indicated a lack of congruence between patients’ expectations and caring experience received from nurses within the Pakistani immigrant context in Britain hospitals resulting in unfavourable experiences. Within the setting of Muslim medical tourists, the patients’ awareness of Islamic values and effort in promoting the halal culture in delivering the medical treatment is pertinent (Padela, Gunter, & Killawi, 2011). Whilst Islam obliges the followers to seek medical treatment when inflicted with diseases or illness, Muslims, for instance, are only allowed to consume medicines that contain ingredients permitted under the Islamic teachings (Aziz, Ibrahim, & Raof, 2014). Hence, Muslim patients that encounter healthcare treatments that are conflicting with their religious values may feel discomfort and perceive poor clinical service quality, affecting their satisfaction levels. Given these arguments, a more comprehensive medical tourist satisfaction model that incorporates Muslim medical ethics is needed to facilitate understanding the drivers of Muslim medical tourists’ attitudes and satisfaction.

Conceptual model and hypotheses development

In this study, a conceptual model of Muslim medical tourists’ attitudes and satisfaction integrating the Islamic values has been developed (Figure 1). The model identified two factors incorporating trust and religious commitment to determine Muslim medical tourists’ attitudes and satisfaction towards the Islamic medical treatment practised by the healthcare providers. Apart from these factors, the model also suggests Muslim medical tourists’ characteristics, including age, gender, and education, as moderators. Based on the conceptual model and literature reviewed, hypotheses have been articulated.

According to psychological theories, patient evaluations of various situations are influenced by their personal feelings and attitudes. Attitude may be defined as holding feelings of liking or disliking towards an object which influences a person’s behaviour (Ajzen, 1991). Within the healthcare literature, a few studies have provided empirical evidence on the importance of patients’ attitudes in influencing their satisfaction levels. Makoul, Arntson, and Schofield (1995) illustrated that patients who form a positive attitude towards the medical students’ engagement in the clinical treatment tend to demonstrate that they have had an encouraging clinical experience. Their good perceptions of the medical students’ responsibilities and practice help mould their acceptance of the healthcare provided. In another study involving the Jewish culture, Kushnir et al. (2013) reported that a negative attitude towards electronic medical record (EMR) usage during the healthcare consultation were central determinants to patients’ dissatisfaction. They perceived that the use of the EMR during the interaction may impair the communication process. Within the Islamic medical tourism setting, Muslim medical tourists who place great faith in the physician’s abilities to treat them according to Islamic medical ethics may have a positive attitude. Physicians who appear to respect the values of Muslim medical tourists may be perceived as more competent and inspire greater confidence amongst them (Padela

![Figure 1. Conceptual framework.](image-url)
Based on these arguments, it has been postulated that:

**H1.** Muslim medical tourists’ attitudes towards the Islamic medical treatment practised by the healthcare providers have a positive effect on their satisfaction.

In the marketing literature, trust could be defined as the confidence held by consumers that the service providers could be relied on to deliver on their promise and fulfill the obligations set forth in an exchange (Gundlach & Murphy, 1993; Sirdeshmukh, Singh, & Sabol, 2002). In the context of the healthcare industry, trust emerges as one of the pertinent dimensions owing to the heightened awareness of harm resulting from errors in the medical treatment. Hence, patients’ concerns about their safety may lead them to stop receiving treatment from a particular hospital and switch to another healthcare provider owing to the negative word-of-mouth. The quality of the interaction between physicians and patients, degree of disclosure, amount of autonomy in decision-making, continuity of service, and level of engagement are influenced by patients’ trust towards the healthcare providers (Ozawa & Sripad, 2013; Rowe & Calnan, 2006; Thom, Kravitz, Bell, Krupat, & Azari, 2002). Because healthcare services involve a high degree of uncertainty and risk, they are known as high-credence services, meaning that patients put a great deal of trust and faith in the physician’s ability to deliver proper and correct treatments (Mudarri & Fisk, 2007). In other words, patients are unable to properly evaluate medical service quality, i.e., a surgeon’s skills or a physician’s diagnostic capability. In the Islamic context, Muslim medical tourists have particular spiritual needs, which, if not met, could cause mistrust, doubt, and an overall negative attitude (Halligan, 2006). On the other hand, if the Muslim medical tourist’s needs are given attention, faith, and trust in the hospitals and healthcare service could result. Following these arguments, it has been postulated that:

**H2.** Muslim medical tourists’ trust towards the Islamic medical treatment practiced by the healthcare providers has a positive effect on their attitudes.

Religion occupies an important role in the health practices of Muslims. Religious commitment could be defined as the extent to which an individual has incorporated the tenets of a particular religion into his or her attitudes, values, and beliefs (King & Williamson, 2005). Individuals who are committed to their religions will adhere to their religious values, beliefs, and practices by integrating them into their daily life (Worthington, Hook, Davis, & McDaniel, 2011). Highly religiously committed persons tend to evaluate their world on religious dimensions and values. Religion is more important to religiously committed individuals and they may evaluate others based upon their religion. Muslims may differ with regard to what is acceptable and what is not acceptable, depending on their interpretation of their religion. A strict Muslim patient might refuse a vaccination or medical treatment that contains forbidden materials, whereas others may not (Halim, Salleh, Kashim, Ahmad, & Nordin, 2014). Another example concerns the use of different forms of birth control. Some Muslims may not accept postcoital methods of birth control, such as the morning-after pill or intrauterine devices, as these could result in the abortion of a fertilized egg. Based on these arguments, this study postulates that:

**H3.** Muslim medical tourists’ religious commitment has a positive effect on their attitudes towards the Islamic medical treatment practised by the healthcare providers.

Although patients’ attitudes towards the Islamic medical service received are expected to be influenced by religious commitment and trust, there is uncertainty about the strength of the predictive relationship. How the variables involved relate to one another may be determined by patients’ sociodemographic characteristics, e.g., gender, education, and age (Tucker & Clegg, 2002). Some studies have indicated that higher level of education is associated with being more health conscious as well as more aware of consumer rights. Persons who fall in this category are likely to ask more questions and even challenge medical advice (Naidu, 2009). They may expect the physicians to make treatment recommendations, discuss options, and allow them to participate in deciding on the treatment (Ditto, Moore, Hilton, & Kalish, 1995). Within the context of the Islamic medical practice, Muslim patients with higher educational levels might value the physicians’ practice in disclosing the derivation of non-halal substances to them more as they might be more aware of the existence of non-halal prescriptions in the market (Hoesli & Smith, 2011; Sattar, Ahmed, Majeed, & Petty, 2004). They might demand a proactive clinician and pharmacist, with the increase of product choices and current regulations which do not impose any obligation on the hospital or pharmacy department to label micro packaging of drugs (Sadeeqa & Sarriff, 2014).
addition, women and old persons tend to be more religious than men and young ones (de Vaus & McAllister, 1987; Uecker, Regnerus, & Vaaler, 2007). Therefore, it is expected that women and old persons value Islamic medical practice more than men and young persons. Following these arguments, it has been postulated that:

H2a. Gender moderates the relationship between Muslim medical tourists’ trust towards the Islamic medical treatment practised by the healthcare providers and their attitudes.

H2b. Age moderates the relationship between Muslim medical tourists’ trust towards the Islamic medical treatment practised by the healthcare providers and their attitudes.

H2c. Education moderates the relationship between Muslim medical tourists’ trust towards the Islamic medical treatment practised by the healthcare providers and their attitudes.

H3a. Gender moderates the relationship between Muslim medical tourists’ religious commitments and their attitudes towards the Islamic medical treatment practised by the healthcare providers.

H3b. Age moderates the relationship between Muslim medical tourists’ religious commitments and their attitudes towards the Islamic medical treatment practised by the healthcare providers.

H3c. Education moderates the relationship between Muslim medical tourists’ religious commitments and their attitudes towards the Islamic medical treatment practised by the healthcare providers.

Data collection

For the present study, the survey method was used based on a questionnaire to test the hypotheses of the conceptual model. A list comprising 31 hospitals that were engaged in the Islamic medical tourism industry was obtained from the Iranian Ministry of Health and Medical Education, with the majority of them being located in Tehran and Mashhad. These hospitals were contacted through telephone calls. Meeting with the hospital management was further arranged to secure permission for conducting the survey at their premises. Only nine hospitals agreed to participate in the study. The sample population was drawn from Muslim medical tourists who received inpatient services from the listed Islamic hospitals for at least one day. Since they usually communicate in Arabic, Turkish, or English, three different versions of the questionnaires were prepared. To minimize translation errors, a blind translation-back-translation method was used, which is the most commonly applied translation technique because of its consistency and accuracy (Van de Vijver & Tanzer, 2004). The translated questionnaires (Arabic and Turkish versions) were thoroughly reviewed and improved by Arabic- and Turkish-speaking academics. Trained research assistants administered the questionnaires to the Muslim medical tourists in the main entrance of hospital lobbies. Only Muslim medical tourists who actually received medical services for at least one day and were later completely discharged were asked to fill out the questionnaire. The researcher sought participant consent after thoroughly explaining the purpose and procedure of the study to them. It was also emphasized that their identity would remain anonymous, their participation voluntary, and the data collected would be only used for research purposes. Survey questionnaires were given and retrieved onsite. Out of the 350 questionnaires that were distributed, 227 were returned, yielding a response rate of 64.9%. The power of the collected 227
samples was measured using G*Power version 3.1.9.2, which had a statistical significance ($\alpha$ level) of 0.05. The power yielded was 0.999, which is higher than 0.80 (Chin, 2001), signifying that the sample had the required power to reject the null hypotheses (Faul, Erdfelder, Buchner, & Lang, 2009).

**Analysis**

In order to test the research model, the partial least squares (PLS) technique of structural equation modeling using SmartPLS Version 3.0 was used since the study was of an exploratory nature (Hair, Ringle, & Sarstedt, 2011). The two-stage analysis and interpretation of the PLS was based on Hulland’s procedure (Hulland, 1999). In stage one (which focused on testing the measurement model), validity and reliability analyses had to be done on each measure in order to make sure that only reliable and valid construct measures were being utilized in drawing conclusions about the nature of the construct relationships (e.g. Nikbin, Iranmanesh, Hyun, Baharun, & Kim, 2015; Yusof, Awang, & Iranmanesh, 2017; Zainuddin, Zailani, Govindan, Iranmanesh, & Amran, 2017). In stage two (which focused on testing the structural model), the paths between the model constructs had to be estimated in order to find the significance as well as the predictive value of the model.

**Results**

**Sample**

Out of the entire sample, 47.6% were males and 52.4% were females. The age breakdown was: 82 respondents (36.1%) were between 50 and 64 years old, 65 respondents (28.7%) were above 65 years old, 48 respondents (21.1%) were between ages 30 and 49 years, and 32 respondents (14.1%) were below 29 years old. The respondents also came from a variety of nationalities, including 63.4% from Iraq, 18.1% from Afghanistan, 9.7% from Pakistan, and 7.1% from other countries. The medical service breakdowns were as follows: a total of about 53.1% of the respondents received medical treatment; 22.6% received cosmetic services, 19.3% received surgical services, and 5.0% received other types of medical services. The educational level of the respondents were: 40.1% had a diploma, 36.1% had a bachelor degree, 16.7% were postgraduate, and 7.1% were still schooling.

**Measurement model results**

All the constructs of interest were evaluated by a measurement model, with validity and reliability tests performed based on the full measurement model which was generated (e.g. Shaharudin, Govindan, Zailani, Tan, & Iranmanesh, 2017; Weng, Zailani, Iranmanesh, & Hyun, 2017). Table 1 indicates that all constructs were of composite reliability values greater than 0.7, which is the threshold point (Hair, Ringle, & Sarstedt, 2013). Accepting items with loadings of at least 0.6 were suggested by Hair, Black, Babin, and Anderson (2010). As for the individual item reliability, the loadings associated with each scale were greater than 0.6 and hence were estimated as reasonable. In addition, the average variance extracted (AVE) from the constructs reached the cut-off point, indicating a satisfactory level of reliability.

How much items differ from one another is called discriminant validity (Campbell & Fiske, 1959). As can be noted in Table 2, the square root of the AVE was greater than the corresponding construct correlation (Fornell & Larcker, 1981). The Heterotrait-monotrait (HTMT) ratio was used to assess the discriminant validity because it is more reliable than the Fornell–Larcker criterion in detecting a lack of discriminant validity (Henseler, Ringle, & Sarstedt, 2015). The HTMT ratios were consistently lower than the most restrictive threshold of 0.85, thereby indicating satisfactory discriminant validity properties. Therefore, the measurement model results show that the validity and reliability criteria were met and that constructs developed for this measurement model are useful in testing the structural model and associated hypotheses.

**Assessment of the structural model**

Based on the results of the measurement model, a structural model was constructed, assuming that the measurement model satisfied the psychometric assessment. As far as the predictive accuracy of the model was concerned, it was evaluated in terms of the portion of the variance explained, and the results suggested that the model was capable of explaining 37% of the variance in attitude and 32.3% of the variance in satisfaction. As an additional model fit assessment, the predictive relevance developed by Stone (1974) and Geisser (1975) was included in addition to estimating the magnitude of $R^2$ (e.g. Kamal, Yusof, & Iranmanesh, 2016; Kurniawan,
The manifest indicators of each latent construct can be predicted by this technique, which represents the model adequacy. Next the Stone-Geisser $Q^2$ (cross-validated redundancy) was computed in order to examine the predictive relevance using a blindfolding procedure in the PLS. Chin (2010) has set guidelines which, if followed, can predict the model relevance if the $Q^2$ value is greater than zero. A value of 0.201 was obtained in the present study as an average cross-validated redundancy (for all endogenous variables), which was far greater than zero. Therefore, the model exhibited an acceptable fit and high predictive relevance.

Nonparametric bootstrapping was applied (Wetzels, Odekerken-Schroder, & van Oppen, 2009) with 2000 replications to test the structural model (e.g. Foroughi, Nikbin, Hyun, & Iranmanesh, 2016; Gilani, Iranmanesh, Nikbin, & Zailani, 2017). The significance of the direct effects specified by the research model was evaluated

### Table 1. Factor loadings, AVE, and composite reliability of the measurement model.

<table>
<thead>
<tr>
<th>Construct</th>
<th>Items</th>
<th>Factor loadings</th>
<th>CR</th>
<th>AVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust (TRU)</td>
<td>I trust that my doctor will follow the Muslim beliefs for my treatment.</td>
<td>0.603</td>
<td>0.929</td>
<td>0.599</td>
</tr>
<tr>
<td></td>
<td>I trust that doctors always explain about the medicine that they use.</td>
<td>0.600</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I trust the hospital doctors do their best to use the halal medicine for me.</td>
<td>0.890</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I trust that my doctors will involve me in all important decisions such as the use of vaccines that are porcine in origin.</td>
<td>0.771</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I trust that my doctors will inform me before dispensing any medicine which has any non-halal content.</td>
<td>0.883</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I trust that this hospital would not use any medicine which has any non-halal content.</td>
<td>0.677</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I trust that this hospital will take consent from the patient before dispensing any medicine which has any non-halal content.</td>
<td>0.852</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I trust that this hospital will provide only halal medicine for Muslim patients.</td>
<td>0.831</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I completely trust that this hospital is concerned about the religious beliefs of Muslim patients.</td>
<td>0.790</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious commitment (IRC)</td>
<td>I spend time trying to grow in understanding of my faith.</td>
<td>0.853</td>
<td>0.894</td>
<td>0.631</td>
</tr>
<tr>
<td></td>
<td>It is important to me to spend some periods of time in private religious thought and reflection.</td>
<td>0.645</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religious beliefs influence all my dealings in life.</td>
<td>0.891</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religion is especially important to me.</td>
<td>0.783</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I often read about my faith.</td>
<td>0.777</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude (ATT)</td>
<td>I believe that the medical team in this hospital is knowledgeable about Islamic principles in medical care.</td>
<td>0.666</td>
<td>0.897</td>
<td>0.558</td>
</tr>
<tr>
<td></td>
<td>I believe that the doctors in this hospital are aware of the presence of potentially non-halal ingredients in the medicines.</td>
<td>0.680</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I believe that the medical team in this hospital is aware of the potential haram risk in medical care.</td>
<td>0.771</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The medical team in this hospital care about my Islamic concerns.</td>
<td>0.878</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I believe I receive good Islamic healthcare in this hospital.</td>
<td>0.833</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I worry sometimes about having to pay large medical bills for Islamic treatment.</td>
<td>0.682</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The Islamic medical care I have been receiving is just about perfect.</td>
<td>0.689</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction (SAT)</td>
<td>Overall, I am satisfied with the medical care I have received from this hospital.</td>
<td>0.886</td>
<td>0.955</td>
<td>0.681</td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the explanations on halal alternatives.</td>
<td>0.759</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the Islamic healthcare practices in this hospital.</td>
<td>0.887</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied because medical doctors at this hospital are consistently courteous and respectful to me</td>
<td>0.829</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the explanations of treatment results.</td>
<td>0.855</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the Ibadah infrastructures (e.g. prayer room, signage, wudhu facilities) of this hospital.</td>
<td>0.808</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the quality and variety of halal food at this hospital.</td>
<td>0.863</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the treatment duration at this hospital.</td>
<td>0.814</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the nurses behaviour at this hospital.</td>
<td>0.784</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am satisfied with the doctors at this hospital.</td>
<td>0.753</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: CR = Composite reliability; AVE = Average variance extracted.

### Table 2. Discriminant validity.

<table>
<thead>
<tr>
<th>Mean</th>
<th>SD</th>
<th>TRU</th>
<th>IRC</th>
<th>ATT</th>
<th>SAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRU</td>
<td>3.665</td>
<td>0.310</td>
<td>0.774</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRC</td>
<td>3.525</td>
<td>0.294</td>
<td>0.323</td>
<td>0.794</td>
<td></td>
</tr>
<tr>
<td>ATT</td>
<td>3.354</td>
<td>0.318</td>
<td>0.608</td>
<td>0.207</td>
<td>0.747</td>
</tr>
<tr>
<td>SAT</td>
<td>3.652</td>
<td>0.315</td>
<td>0.599</td>
<td>0.202</td>
<td>0.568</td>
</tr>
</tbody>
</table>

Zailani, Iranmanesh, & Rajagopal, 2017; Nikbin, Hyun, Iranmanesh, Maghsoudi, & Jeong, 2016). The manifest indicators of each latent construct can be predicted by this technique, which represents the model adequacy. Next the Stone-Geisser $Q^2$ (cross-validated redundancy) was computed in order to examine the predictive relevance using a blindfolding procedure
The results indicated that the effect of patients’ trust on attitude was significant ($\beta = 0.604$, $p < .001$). Nevertheless, this study did not find sufficient support on the relationship between religious commitment and attitude ($\beta = 0.011$, $p > .05$). In addition, the effect of patients’ attitudes on satisfaction was significant ($\beta = 0.568$, $p < .001$). As such, H1 and H2 were supported; whilst H3 was rejected.

In order to test the moderating effect of socio-demographic characters on patients’ attitudes as well as religious commitment, a multi-group analysis was performed, in which the sample was split into two groups. For age, group 1 consisted of those respondents below 50 years old, whilst group 2 was made of the respondents who were 50 years old and above. For education, group 1 referred to the respondents who held diplomas and high-school certificates, whilst group 2 consisted of the respondents who possessed bachelor degrees and postgraduate education. Henseler’s nonparametric approach was used to make a statistical comparison. As indicated in Table 3, there were significant differences reported of the religious commitment on the attitude between females and males. This study, however, found insufficient support for the moderating effect of age on the relationship between patient trust and patient attitude, as well as patient religious commitment and patient attitude. Additionally, the results further reported a significant moderating effect of education on the relationship between patient trust and patient attitude, as well as patient religious commitment and patient attitude. Hence, H2a, H2b, and H3b were rejected whilst H2c, H3a, and H3c were supported.

Table 3. Structural model analysis.

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Relationship</th>
<th>Path coefficient</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct effect</td>
<td>TRU -&gt; ATT</td>
<td>0.604***</td>
<td>Supported</td>
</tr>
<tr>
<td>H2</td>
<td>IRC -&gt; ATT</td>
<td>0.011</td>
<td>Not supported</td>
</tr>
<tr>
<td>H3</td>
<td>ATT -&gt; SAT</td>
<td>0.568***</td>
<td>Supported</td>
</tr>
<tr>
<td>Moderating effect of gender</td>
<td>Male ($n = 108$)</td>
<td>Female ($n = 119$)</td>
<td>Difference</td>
</tr>
<tr>
<td>H2a</td>
<td>TRU -&gt; ATT</td>
<td>0.672***</td>
<td>0.616***</td>
</tr>
<tr>
<td>H3a</td>
<td>IRC -&gt; ATT</td>
<td>0.027</td>
<td>0.294**</td>
</tr>
<tr>
<td>Moderating effect of age</td>
<td>Less than 50 ($n = 80$)</td>
<td>Above 51 ($n = 147$)</td>
<td></td>
</tr>
<tr>
<td>H2b</td>
<td>TRU -&gt; ATT</td>
<td>0.619***</td>
<td>0.714***</td>
</tr>
<tr>
<td>H3b</td>
<td>IRC -&gt; ATT</td>
<td>0.189</td>
<td>0.034</td>
</tr>
<tr>
<td>Moderating effect of education</td>
<td>Low educated ($n = 107$)</td>
<td>High educated ($n = 120$)</td>
<td>Difference</td>
</tr>
<tr>
<td>H2c</td>
<td>TRU -&gt; ATT</td>
<td>0.777***</td>
<td>0.546***</td>
</tr>
<tr>
<td>H3c</td>
<td>IRC -&gt; ATT</td>
<td>0.290**</td>
<td>0.027</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01, ***p < .001.

**Discussion**

Researchers have long suggested the importance of patients' personal feelings and likings on healthcare practices in influencing their satisfaction levels (Kushnir et al., 2013; Makoul et al., 1995). From the perspective of theory advancement, this study provides additional empirical support that Muslim medical tourists who form favourable attitudes towards the Islamic practices demonstrated by healthcare providers tend to establish an encouraging healthcare experience. This is expected, as patient satisfaction is a cognitive approach and emotionally affected, depending on the subjective perceptions of an individual (Urden, 2002). In this study, it has been found that the Muslim medical tourists’ satisfaction is championed by their beliefs in the physicians’ abilities to understand the Islamic medical ethics and integrate them in delivering clinical treatment and medical advice. Physicians presenting guidance on the halal prescriptions, for instance, were perceived as significantly more competent, inspired greater confidence, and seen to be more satisfying to Muslim medical tourists.

Previous literature has indicated the importance of patient trust in moulding the positive attitudes towards the halal practices of healthcare providers (Ozawa & Sripad, 2013; Rowe & Calnan, 2006). Consistently, the findings of this study have confirmed earlier studies. The results showed that trust was the central determinant of Muslim medical tourists' hospital experience. Muslims who reported a higher degree of trust had an expectation that their healthcare providers would behave with goodwill towards them and...
with competence in the domain that they were entrusted, generating a positive attitude towards the hospitals. This was expected, as healthcare services are considered as high-credence services, characterized by a high degree of uncertainty and risk, leading patients to leave the treatment decisions to the physicians as they often lack the knowledge and skill to properly judge the health services provided (Mudarri & Fisk, 2007). Within the Islamic healthcare systems, Muslim medical tourists may express an approving attitude towards the hospitals if they trust that providers are aware of Islamic medical ethics and have taken the extra mile towards cultural competence by accommodating these ethics when possible (Padela et al., 2011). The results show that education moderates the relationship between trust and attitude. On the other hand, age and gender do not moderate the effect of trust on attitude. It can, therefore, be concluded that the role of Muslim medical tourists’ trust in forming their attitudes appeared to change with the introduction of the Muslim medical tourists’ level of education; whilst age and gender did not play a role. Although older Muslim medical tourists may have greater trust towards healthcare services as they may have had longer enduring patient–physician relationships than their younger counterparts, this may not translate into favourable attitudes. It might be speculated that the sample of the respondents that consisted of Muslim medical tourists may be reflected in the researchers’ findings. As medical tourists, they may not have previous experience with the same healthcare providers and utilize particular medical professionals more often. Rather, their trust and positive attitudes are formed by the host country’s characteristics. Iran, which has a large local Muslim population, assures the Muslim medical tourists of their ability to meet the religious obligations more easily. Moreover, since medical treatment is considered as a high-risk purchase with a considerable credence value (Musa et al., 2012), positive word-of-mouth from friends, relatives and others may have a great influence on Muslim medical tourists’ trust, and positive attitudes. This study, however, lacks the data that could shed light on these disparities. This possibility should be subject to future investigations. The significant effect of the level of education as a moderating variable has also reinforced the prior argument made by Naidu (2009). Less-educated Muslim medical tourists may be aware that they are not well-equipped to judge and understand unusual contents, such as medical treatment and diagnosis, and may tend to develop trust and rely more on their physicians.

Studies concerning religious commitment have considered religiosity as a predictor for patients’ attitudes towards healthcare delivery (Halim et al., 2014). Patients who are devoted to religion may incorporate these beliefs and values into their daily life (Worthington et al., 2003). Yet, the finding of this study is surprising as the relationship between religious commitment and patients’ attitudes was insignificant. Since the concerns of Islamic faith and practices in treating Muslim medical tourists are often common in Muslim countries such as Iran, it is possible that forming a positive attitude towards the Islamic medical treatment practised by the country’s healthcare providers is easier regardless of the religiosity levels. Additionally, the researchers further examined the moderating effect of the respondents’ socio-demographics on the relationship between religious commitment and Muslim medical tourists’ attitudes. The findings indicate that Muslim medical tourists’ religious commitment in developing constructive attitudes is more significant in samples that consist of female respondents who had higher levels of education. This was expected as Muslim medical tourists with higher levels of education might be more health conscious and aware of Islamic practices, and thus, may have demonstrated a more holistic view of medical treatment that was aligned with the Shari’ah law, influenced by their personal religious beliefs.

Conclusion and implications

In summary, given the fact that Islamic medical tourism is a fast-growing market, it is crucial to analyse the factors that influence Islamic medical tourists’ attitudes and satisfaction. This study examined the effect of trust and religious commitment on Muslim medical tourists’ attitudes and satisfaction by considering age, gender, and education as moderators. The results showed that trust has a significant effect on Muslim medical tourists’ attitudes towards the Islamic medical treatment practised by the healthcare providers. In addition, the relationship between trust and attitude is moderated by education only. The relationship between religious commitment and attitude is moderated by gender and education.

The findings of this study might be helpful for industry practitioners. The study provides new insights on how trust, religiosity, and the socio-demographics
of Muslim medical tourists may interact with each other in forming a positive attitude and satisfaction towards the medical treatment received in the Islamic context. Whilst Iran has various potentials in entering the Islamic medical tourism market, there are personal and cultural variations that may lead to difficulties in delivering the medical practice that tailors to all Muslim medical tourists. This study implies that healthcare providers could improve Muslim medical tourists’ satisfaction, by forming good perceptions towards the Islamic practice of the healthcare providers. Muslim medical tourists have great trust if the physicians and hospitals are able to treat them in accordance to Islamic medical ethics. Following this trait, the improvement on the healthcare services not only requires a good hospital atmosphere and the existence of well-trained physicians as in conventional healthcare settings, but the hospitals also may need to employ good certified medical personnel who are able to understand Islam as a way of life and incorporate these elements into their work practice. Physicians who appear to respect the values of Muslim medical tourists may be perceived as more competent and inspire greater confidence amongst patients. Notwithstanding this, healthcare providers need to be sensitive towards these medical tourists’ needs and should work towards cultural competence by accommodating these values when possible. A lack of their attention to these needs may compromise the provision of quality service. For instance, hospitals’ management efforts in establishing guidelines that incorporate Islamic principles for healthcare staff and providing religious officers who visit Muslim medical tourists on a daily basis to facilitate them in performing worship might help in instilling trust and developing a constructive attitude, leading to higher satisfaction amongst Muslim medical tourists. The healthcare providers may need to reflect their clinical practice and comprehend how and under what circumstance they could reinforce trust amongst their Muslim medical patients. Some changes in hospital operations and the delivery of medical services in place might have the potential to increase trust, strikingly, leading to improved Muslim medical tourists’ satisfaction.

The study indicates that since Iran is an Islamic country, the nation is at a great advantage to offer Shari’ah-compliant medical treatment as another medical tourism product to Muslim medical tourists. Yet, as purchasing healthcare treatment involves considerable risks, there is a need to provide excellent services which are right the first time. This approach may facilitate in generating positive word-of-mouth and reducing patients’ concerns about their safety, which could lead them in switching to another Islamic healthcare provider in other Muslim countries. The development and promotion of this service may need to be intensified to enhance the awareness of such product offerings in the region amongst prospective Muslim medical tourists.

This study offers theoretical and practical contributions by demonstrating how Muslim medical tourists view the Islamic medical treatment received from Iranian hospitals. In terms of the theoretical contribution, this research offers a theoretical view to improve the knowledge of Islamic medical practice by uncovering the impacts of trust and religious commitment on Muslim medical tourists’ attitudes and satisfaction. In addition, the study has shown the impact of Muslim medical tourists’ characteristics, including age, gender, and education, on the effect of trust and religious commitment on their attitudes. To the best of the researchers’ knowledge, these have not been empirically tested before. In terms of the practical contribution, understanding the interaction effect of trust, religiosity, and socio-demographics of Muslim medical tourists on their attitudes and consequently, satisfaction may create a greater opportunity for the healthcare providers and policy-makers to position the country as a popular medical tourism destination that could attract other Muslim medical tourists who are seeking first world healthcare at an affordable price. For all healthcare providers, it is very important to understand and articulate how they can tailor the delivery of service to meet the needs of this group, which stands today as the second largest religious group in the world.

Despite that this study expands prior research on the medical tourism area, the present research has some limitations. The data were only confined to the voices of those Muslim medical tourists who received treatment at Iranian hospitals with the majority of them being located in Tehran and Mashhad. Hence, the findings may not be generalized as representative of Muslim medical tourists in Iran. Nevertheless, this work represents a first approximation to better understand inbound Muslim medical tourists’ values and needs in Iran. This research examined the satisfaction of Islamic medical services from the perspective of Muslim medical tourists as patients. In the future, it would be beneficial to explore this issue from the point of view of the various actors involved, including
nurses, physicians, and healthcare administrators, as each has the capacity to create different experiences. Yet, it is hoped that this paper has succeeded in providing empirical evidence of medical tourism in the Iranian setting from an Islamic perspective. Insights gleaned from this study could facilitate industry practitioners in improving cultural competence and providing good healthcare experiences to these culturally sensitive market segments, leading to a growing market size.

**Disclosure statement**

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**References**


