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Evaluating Sharia Compliant Healthcare Standards: A Quantitative Study on Patient Satisfaction in Indonesian Hospitals

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ABSTRACT

Introduction: Management and services of Sharia hospitals require high quality institutional standards covering organization, human resources, facilities, services, and financial systems designed in accordance with Islamic Sharia principles. This study aims to empirically examine the effect of implementing these Sharia hospital standards on patient satisfaction in Indonesia, where faith based expectations significantly influence healthcare experiences.
Methods: This quantitative study employed a Structural Equation Modeling Partial Least Squares (SEM-PLS) approach based on primary data. A total of 195 respondents were selected through purposive sampling from two certified Sharia compliant hospitals in Indonesia, Tangerang City Hospital and RSI Sari Asih Serang.
Results: Bivariate analysis revealed significant relationships between all five Sharia hospital standard domains and patient satisfaction. Multivariate analysis, however, identified that only the facilities variable had a statistically significant effect, highlighting the central role of religiously congruent infrastructure.
Conclusion: This study provides new empirical insights into the implementation of Sharia hospital standards by demonstrating that certified facilities enhance patient satisfaction particularly through physical environments that align with Islamic values. These findings contribute to the development of culturally responsive healthcare policies in Muslim majority settings.

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INTRODUCTION

In recent decades, accreditation has emerged as a cornerstone of global healthcare reform, aimed at ensuring quality and patient centered care. Studies have highlighted its potential to improve safety culture, institutional accountability, and continuous quality improvement (1,2). In Iran, accreditation scores were significantly correlated with patient satisfaction, while in India, NABH accredited hospitals received more favorable feedback (3). However, not all findings are consistent some research indicates limited or no correlation between accreditation and actual patient experience (4,5) These inconsistencies underscore the need to explore contextual factors that may shape accreditation outcomes.

The debate becomes more complex in Muslim majority contexts, where healthcare quality is interpreted through both clinical performance and conformity with religious and cultural values. Patients often perceive excellence in care as inseparable from ethical integrity and spiritual fulfilment. Emerging evidence shows that alignment with Islamic principles such as gender sensitivity, halal services, and spiritual support can enhance patient trust and satisfaction (6,7). These findings point to a critical need for models of care that integrate clinical standards with Islamic ethical frameworks.

Given the salience of religious values, Indonesia has pioneered a distinct accreditation framework for Sharia compliant hospitals, developed by institutions such as MUKISI and the DSN MUI. This framework comprises five foundational components: organizational governance, facilities, human capital, patient services, and financial management all designed in alignment with Islamic jurisprudence. These standards operationalize religious principles into healthcare delivery, including gender sensitive care, halal pharmaceuticals, and spiritual services. However, despite their conceptual breadth, few empirical studies have rigorously examined how these Sharia based standards impact patient satisfaction in practice.

This study addresses a critical gap in existing healthcare quality models, which often fail to reflect the religious sensitivities of Muslim patients in Indonesia. Global models such as the Malcolm Baldrige National Quality Award (MBNQA) and the Model for Understanding Success in Quality (MUSIQ) have been widely adopted but are rooted in secular paradigms that overlook spiritual dimensions of care (8). While they focus on leadership, strategic planning, and efficiency, these frameworks rarely consider the moral, ethical, and theological expectations that are essential to many Muslim patients.

Several conceptual efforts have been undertaken to bridge healthcare with religious and spiritual dimensions. Notably, the Transformative Learning Framework (TLF) and the Triple Circle Care Model (TCCM) offer paradigms that embed spiritual needs within patient care processes (9). The Structure–Process–Outcome (SPO) model developed by Donabedian has also been extended to include religious values, offering a multidimensional framework to assess healthcare quality through ethical, clinical, and experiential lenses (10,11). Together, these frameworks provide a foundation for designing culturally sensitive healthcare systems that recognize the centrality of faith in patient satisfaction.

Informed by these conceptual models, Sharia compliant hospitals in Indonesia have adopted a comprehensive approach that infuses Islamic values across care delivery, governance, and ethical financing. Examples include gender sensitive service arrangements, financial systems free from riba (usury), and the presence of religious chaplaincy in clinical settings (12,13). However, while the normative framework is well developed, there remains a notable lack of empirical evidence on how these individual components influence patient satisfaction. This study addresses that empirical gap by examining which specific Sharia standards most significantly shape the patient experience.

To address this gap, the present study investigates the empirical relationship between Sharia hospital standards and patient satisfaction by analyzing data from two accredited Sharia hospitals in Indonesia: Tangerang City Hospital and RSI Sari Asih Serang. Utilizing a quantitative descriptive analytic approach and Structural Equation Modeling–Partial Least Squares (SEM PLS), this study identifies which of the five Sharia compliance domains organizational governance, facilities, human capital, services, and financial management has the most significant influence on patient satisfaction.

Previous literature has indicated a positive association between faith-based service delivery and patient perceptions. Othman and Owen (2011) showed that Islamic service quality strengthens trust and satisfaction (14), while Putra and Herianingrum (2015) and Mahdalena et al. (2021) linked Sharia service attributes to increased customer loyalty and perceived quality (15,16). However, most of these studies are situated in non-clinical domains

such as Islamic banking or administrative services. This study extends that knowledge by applying Sharia service quality indicators within the context of direct hospital based patient care.

This study contributes to the growing body of Islamic healthcare literature by empirically examining how each Sharia compliance component ranging from service design to financial ethics shapes patient experience. Particular attention is given to the role of physical and spiritual infrastructure, such as gender specific wards, halal certified meals, and prayer conducive environments, in fostering patient dignity, comfort, and trust. These aspects are not peripheral, but fundamental to therapeutic efficacy within Islamic care settings.

Accordingly, this study sets out with three core objectives: (1) to examine the relationship between each of the five Sharia hospital standard domains and patient satisfaction; (2) to identify which dimension exerts the strongest influence; and (3) to formulate policy insights for enhancing culturally aligned healthcare quality. The novelty of this research lies in its empirical validation of a religiously nuanced quality assurance model one designed specifically for Muslim majority health systems. The study also aims to inform cross national discourse on faith integrated healthcare governance.

Ultimately, this study advances the discourse on culturally responsive healthcare by illustrating the pivotal role of Islamic values in shaping perceptions of care quality. It emphasizes the integration of Sharia principles not only in clinical interactions but also within institutional governance and ethical financing. This holistic, faith based approach offers the potential to elevate patient outcomes, institutional credibility, and long term loyalty thereby fostering a more inclusive, equitable, and culturally resonant health system.

METHOD

Research Type

This study employed a non-experimental, quantitative descriptive analytic design to examine the relationship between the implementation of Sharia hospital standards and patient satisfaction. This design was selected to enable a structured evaluation of the associations between five predetermined Sharia compliance dimensions organizational governance, facilities, human capital, services, and finance and the outcome variable of patient satisfaction. Structural Equation Modeling using Partial Least Squares (SEM PLS) was used as the analytical tool, due to its suitability for complex latent models, small to medium sample sizes, and non-normal data distributions (9,17).

Patient satisfaction was measured using a modified version of the SERVQUAL model developed by Parasuraman et al. (1985) (18). The five dimensions reliability, responsiveness, tangibles, assurance, and empathy were systematically adapted to reflect the Islamic healthcare context. For example, the tangibles dimension incorporated prayer room accessibility, halal certified meals, and gender specific room arrangements. The empathy domain included items related to staff sensitivity to religious obligations, such as accommodating prayer times and observing modesty norms. These modifications ensured cultural and religious relevance while preserving the original SERVQUAL structure.

All items were rated on a five point Likert scale (1 = strongly disagree, 5 = strongly agree). Before the main survey, the instrument was pilot tested with 20 participants to assess its clarity, cultural sensitivity, and preliminary psychometric reliability. Feedback from the pilot test led to revisions in item wording for greater contextual appropriateness. While the pilot data were excluded from final analysis, the process supported content validation.

Population and Sample

The study population consisted of inpatients who had undergone surgical procedures at two officially accredited Sharia compliant hospitals in Indonesia: Tangerang City Hospital and RSI Sari Asih Serang. These hospitals were selected purposively due to their compliance with DSN MUI and MUKISI accreditation guidelines, which ensured comprehensive implementation of Islamic service standards. A total of 195 respondents were recruited using purposive sampling, targeting individuals with firsthand and recent exposure to Sharia based hospital care. This approach allowed the study to access informed perspectives on the religious dimensions of service delivery. While purposive sampling limits generalizability, it enhances contextual depth and relevance in exploratory frameworks like this.

Inclusion criteria required participants to be post operative inpatients who had recovered sufficiently to engage with the survey instrument and had been hospitalized for at least 48 hours. This ensured that participants had

substantial interaction with various hospital departments, allowing for meaningful evaluation of care quality and Sharia compliance.

Data Collection Procedures

Data were collected using a structured questionnaire adapted from the 1438H edition of the Sharia Hospital Standards and Certification Instruments developed by DSN MUI and MUKISI. This instrument encompasses five main domains: Sharia Standards for Organizational Management (SSMO), Facility Management (SSMF), Human Capital (SSMMI), Patient Services (SSPP), and Financial Management (SSMAK). Each domain was operationalized as an independent variable and measured using multiple indicators derived directly from the official compliance criteria. The adaptation process ensured alignment with validated elements from national standards, and face/content validity was reviewed by Sharia health experts.

Data Analysis

Data analysis was conducted using Structural Equation Modeling with Partial Least Squares (SEM PLS), a variance based method suitable for exploratory models with latent constructs and moderate sample sizes. SEM PLS was selected due to its robustness in handling non normal data, complex path structures, and a combination of formative and reflective measurement models (Sanıl & Eminer, 2021). Additionally, SEM PLS enables simultaneous testing of both the outer (measurement) model and the inner (structural) model, which is essential for understanding how multiple dimensions of Sharia hospital standards influence patient satisfaction (21). A schematic diagram of the model is presented in Figure 2.

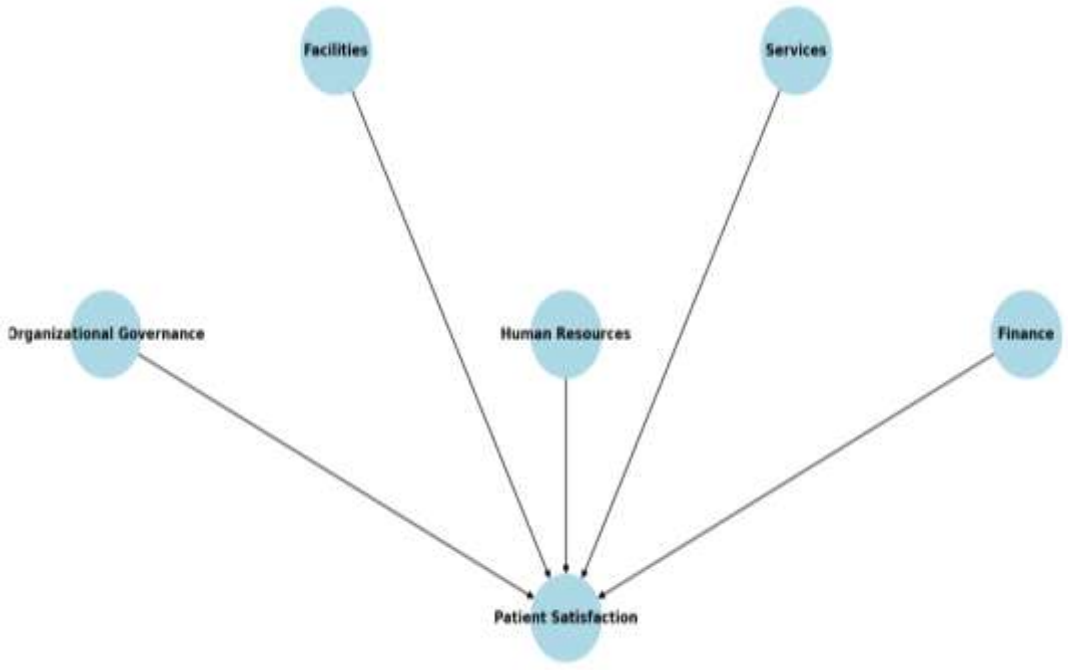

Figure 1. A schematic diagram of the model

Model evaluation followed a two-step procedure. First, the measurement model was tested for reliability and validity. Internal consistency was assessed through Composite Reliability (CR) and Cronbach's alpha, while convergent validity was established via Average Variance Extracted (AVE). Discriminant validity was verified using the Fornell Larcker criterion. In the second stage, the structural model was examined by analyzing the significance and strength of the hypothesized paths using standardized path coefficients, t values, and p values. A t value > 1.96 indicated statistical significance at the 0.05 level. All statistical outputs were generated using SmartPLS 4.0.

The final structural model indicated that among the five domains of Sharia hospital standards, the Facility Management Standard (SSMF) exerted the strongest and statistically significant effect on patient satisfaction ($t > 1.96$, $p < 0.05$). This suggests that the availability of Sharia aligned infrastructure including prayer spaces, halal certified amenities, and gender sensitive environments plays a critical role in shaping patient perceptions of care quality. Although the other four domains (organizational governance, human capital, services, and finance) exhibited positive path coefficients, none achieved statistical significance in the multivariate analysis, indicating their comparatively weaker direct impact.

To verify the robustness of the model, multicollinearity was assessed using Variance Inflation Factor (VIF), and all scores were below the threshold of 5, indicating no multicollinearity issues. Model fit was evaluated using the Standardized Root Mean Square Residual (SRMR), which fell within acceptable bounds (<0.08), confirming good model data fit. Additional fit indices such as R squared values and path significance support the structural model's adequacy.

Ethical Approval

This study received ethical approval from the Health Research Ethics Commission of the Faculty of Public Health, Muhammadiyah University of Jakarta (Protocol No. 10.389.C/KEPK FKMUMJ/XII/2023). Written informed consent was obtained from all participants prior to data collection, ensuring voluntary participation and adherence to ethical research principles.

RESULTS

The results are presented according to the five Sharia hospital standard domains: organizational governance, facilities, human resources, services, and finance. Table 1 shows that all variables were significantly associated with patient satisfaction in bivariate analysis ($p < 0.001$). However, only the 'Facilities' domain retained statistical significance in the multivariate model. In the subsections below, each variable is discussed in detail, integrating empirical findings with theoretical insights from Islamic healthcare literature.

Table 1. Results of Bivariate Analysis of Sharia Standards and Patient Satisfaction

Variable	Less Satisfied (%)	Satisfied (%)	P value	OR (95% CI)
Organization	59 (64.1%)	33 (35.9%)	<0.001	3.33 (1.85–5.99)
Facilities	59 (62.8%)	35 (37.2%)	<0.001	3.04 (1.70–5.46)
Human Resources	62 (64.6%)	34 (35.4%)	<0.001	3.65 (2.02–6.59)
Services	62 (66.7%)	31 (33.3%)	<0.001	4.18 (2.30–7.61)
Finance	63 (67.7%)	30 (32.2%)	<0.001	4.59 (2.51–8.40)

Source: primary Data

Organizational Governance. The governance structure of Sharia hospitals plays a vital role in fostering trust and ethical alignment. Patients who perceived organizational governance positively were 3.33 times more likely to report satisfaction (OR = 3.33; 95% CI = 1.85–5.99; $p < 0.001$). This aligns with prior studies (Othman & Owen, 2011; Algunmeeyn & Mrayyan, 2022) showing that Islamic ethical supervision such as structured Sharia boards, policies against unethical practices, and spiritual oversight reinforces perceived legitimacy and dignity in care delivery (6,14). Sharia governance typically integrates a supervisory board and structured policies to uphold compliance, and the presence of takmiran (prayer room administrators) and spiritual advisors further enhances patients' trust.

Facilities. Facility quality had a strong and statistically significant association with patient satisfaction in both bivariate (OR = 3.04; 95% CI = 1.70–5.46) and multivariate analysis ($t > 1.96$; $p < 0.05$). Infrastructure elements such as designated prayer areas, halal certified meals, and gender specific room arrangements were consistently cited as crucial to patients' spiritual comfort and emotional well-being. This finding is consistent with prior evidence (Ardian et al., 2024; Gashoot, 2021; Yusof, 2023), which underscores the therapeutic impact of culturally and religiously aligned environments (22–24). These facility attributes provide comfort and emotional well-being, which are core aspects of healing and satisfaction.

Human Resources. Patients who evaluated human resource performance positively were 3.65 times more likely to report satisfaction (OR = 3.65; 95% CI = 2.02–6.59; p < 0.001). This result emphasizes the influence of interpersonal behavior, particularly when grounded in Islamic ethical principles such as akhlakul karimah (noble character), which includes honesty, humility, empathy, and compassion. Prior research (Kumala, 2024; Alfarajat, 2022) has underscored the importance of embedding such values in staff training, and our findings validate their positive reception by patients, who consistently described feeling spiritually supported and respected (25,26). These values were confirmed in this study to resonate strongly with patients, who felt respected and spiritually reassured by staff behavior.

Service Delivery. Service delivery also emerged as a strong bivariate determinant of satisfaction, with an odds ratio of 4.18 (95% CI = 2.30–7.61; p < 0.001). Sharia aligned services such as provision of spiritual support, respectful communication, and emotional attentiveness were highly appreciated by patients. These findings affirm the argument of Alfarizi and Arifian (2023), who contend that the integration of spiritual and emotional care into clinical practice enhances patient loyalty and trust (27). The current study corroborates this by showing that patients valued care that was not only clinically competent but also spiritually resonant and culturally aware.

Among all domains, the financial dimension showed the strongest bivariate association with satisfaction (OR = 4.59; 95% CI = 2.51–8.40; p < 0.001), indicating the critical role of Islamic financial ethics in shaping patients' trust. Respondents highlighted key Sharia principles such as transparency in billing, absence of hidden charges, fairness in cost structures, and avoidance of riba. Practices like cross subsidization for underprivileged patients were viewed as equitable and socially just (28,29). These alignments with maqashid al shariah (objectives of Islamic law) contributed not only to satisfaction, but also to a perception of healthcare as morally responsible and community centered.

While bivariate results showed strong associations across all five domains, only the 'Facilities' variable remained statistically significant in the multivariate structural model (Figure 1). This suggests that infrastructure elements may have a more immediate and observable influence on patient satisfaction than systemic or administrative factors. Features such as prayer rooms, halal kitchens, and gender specific accommodations appeared to meet non-negotiable religious expectations, directly shaping patients' perception of dignity, comfort, and trust.

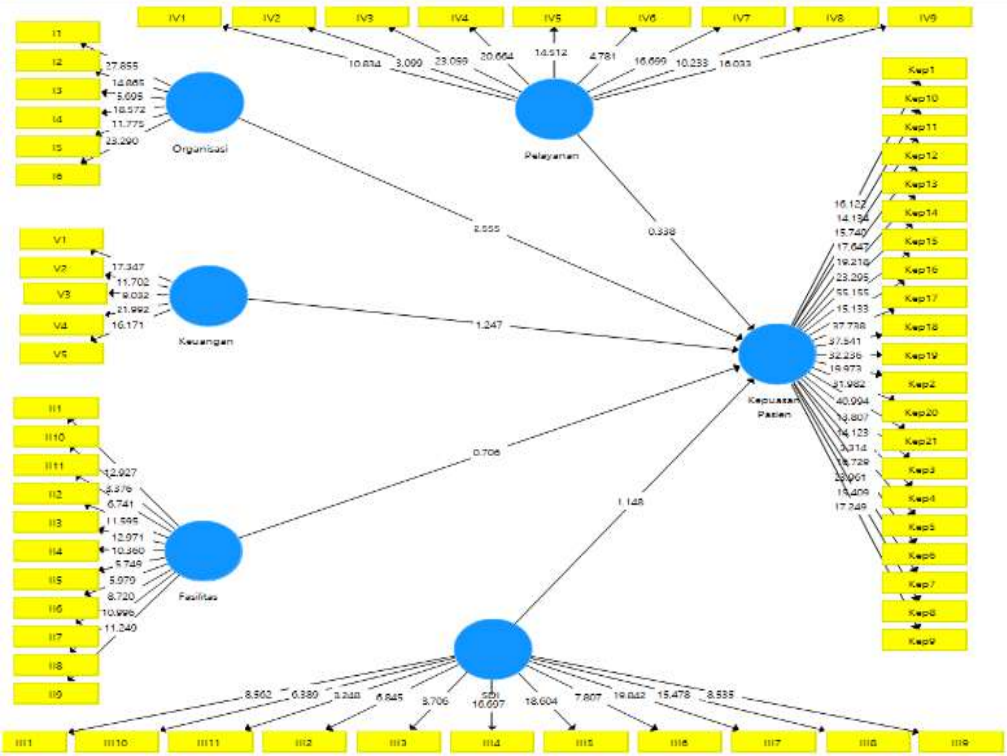

Figure 2. Multivariate Analysis Structural Model (Inner Model)

Figure 2. illustrates the structural model generated using SEM PLS, highlighting the standardized path coefficients among the five Sharia hospital domains and patient satisfaction. Among these, only the path from 'Facilities' to satisfaction exceeded the t statistic threshold (>1.96), confirming its central role in the model. This supports prior findings (30) that tangible aspects of care particularly those aligned with religious expectations are primary interfaces through which patients experience value driven healthcare (30).

The model's robustness was confirmed through multiple validity checks. Composite Reliability (CR) and Average Variance Extracted (AVE) values exceeded recommended thresholds (>0.7 and >0.5, respectively), supporting internal consistency and convergent validity. Discriminant validity, assessed via the Fornell Larcker criterion, indicated sufficient separation between constructs. Additionally, all Variance Inflation Factor (VIF) values remained below 5, indicating no multicollinearity issues.

In summary, all five Sharia hospital standard domains organization, facilities, human resources, services, and finance were significantly associated with patient satisfaction in bivariate analysis. However, only the 'Facilities' domain retained significance in the multivariate structural model. This highlights the pivotal role of religiously attuned infrastructure in shaping perceived service quality. These findings offer empirical support for prioritizing facility investments that meet Islamic values holistically spiritually, ethically, and physically.

Although the remaining domains organizational governance, human capital, services, and finance did not show statistical significance in multivariate analysis, their strong bivariate associations suggest potential indirect or complementary effects. These domains remain integral to a synergistic Sharia based care ecosystem. Therefore, future policy and managerial strategies should emphasize integration across all five domains to deliver comprehensive, culturally congruent, and ethically grounded healthcare.

DISCUSSION

This study reinforces the pivotal role of Sharia compliant hospital standards in shaping patient satisfaction within Islamic healthcare settings. In line with prior research, all five domains organizational governance, facilities, human resources, services, and financial systems showed positive associations in bivariate analysis. However, the multivariate results highlight a key nuance: only the 'Facilities' domain retained statistical significance. This suggests that visible, tangible expressions of religious alignment such as prayer rooms, halal meals, and gender separated spaces are more immediately perceived by patients compared to structural or administrative dimensions.

Cross National Comparisons and Thematic Convergence

Cross National Comparisons and Thematic Convergence. The present findings align with broader literature on Sharia compliant care in other Muslim majority countries. In Indonesia, the integration of halal services, gender segregation, and spiritual care is decentralized and often driven by institutional commitment rather than national mandate. In Malaysia, by contrast, centralized oversight through bodies like JAKIM ensures strict adherence and higher service uniformity (32). This contrast may explain why organizational governance in our study showed strong bivariate correlations, but not multivariate significance possibly due to inconsistencies in standard enforcement across Indonesian hospitals. Thus, regulatory centralization appears to influence both the consistency and perceived credibility of Sharia implementation.

Turkey provides an illustrative case where Islamic ethical values are integrated within a secular healthcare framework. Rather than institutionalizing Sharia law, the Turkish model relies on culturally sensitive service norms and patient provider trust to embed religious ethics (33). While ethical convergence exists across countries, the Turkish experience underscores how cultural harmonization rather than regulatory enforcement can also generate high satisfaction. For Indonesia, this comparison suggests a potential hybrid approach: combining institutional governance with localized cultural sensitivity to strengthen Sharia implementation without overreliance on central regulation.

Operational and Systemic Challenges in Implementation

Despite strong empirical associations between Sharia standards and satisfaction, real world implementation faces several systemic hurdles. One primary barrier is the absence of a unified national framework for Sharia compliant care in Indonesia. Regional differences in interpreting Islamic principles often result in fragmented

protocols and inconsistent execution. As observed by Khairunnisa and Kusbaryanto (2023), this decentralization weakens standardization efforts and complicates quality assurance mechanisms (34). Consequently, while governance appears significant in perception based analysis, its practical impact may be diluted by institutional heterogeneity.

Economic constraints present another critical challenge in operationalizing Sharia standards. Many hospitals especially in under resourced areas struggle to allocate funds for infrastructure upgrades, religious advisory boards, or staff competency development in ethical service delivery (35). This particularly affects domains such as human capital and service quality, where ongoing training in Islamic ethics is vital (36). Additionally, recurring expenses for halal certification, segregated facilities, and religious accommodations are often not covered by public health funding, making reliance on alternative mechanisms such as zakat, waqf, or community subsidies essential.

Resistance to organizational change represents another implementation barrier. Some healthcare professionals may view Sharia standards as peripheral intended more for symbolic compliance than operational transformation (37). Embedding ethical frameworks into daily clinical practice requires not just awareness, but a paradigm shift supported by institutional alignment. Without adequate incentives, accountability systems, and structured capacity building, ethical commitments risk being rhetorical rather than actionable. These findings suggest that successful integration depends on both managerial will and professional development infrastructure.

Cultural perceptions further complicate implementation, particularly in regions where Sharia based care is unfamiliar or viewed with suspicion. This gap in public understanding can lead to limited patient engagement, despite the presence of compliant infrastructure and service offerings. To address this, hospitals should proactively invest in community based health education and culturally inclusive outreach (38). These strategies not only raise awareness but also cultivate public trust and legitimacy key factors for the broader acceptance of Sharia healthcare models.

Policy Implications for Health System Development

This study's implications extend beyond individual hospital performance and speak to broader health system policy in Muslim majority contexts. Sharia compliant care models offer a framework for improving access, fairness, and ethical governance in healthcare delivery. Mechanisms such as zakat, waqf, and sadaqah can function as complementary financing instruments particularly in resource limited settings by reducing cost burdens and supporting underserved groups (39,40). When institutionalized, these instruments can help bridge healthcare equity gaps and reinforce public trust.

Islamic ethical frameworks also align with core principles of modern quality assurance. The prohibition of riba, emphasis on transparency, and commitment to fairness establish a moral foundation for healthcare financing (28,29). Findings from this study reinforce that patients value transparent billing and equitable cost structures suggesting that ethical finance mechanisms not only satisfy religious expectations but also enhance systemic credibility and institutional trust.

Finally, Sharia aligned financing and governance models may enhance health system resilience. During crises, instruments like zakat and community based religious donations can rapidly mobilize support and fill gaps where conventional mechanisms fall short (41). However, the integration of religious frameworks into public health policy requires careful calibration ensuring that inclusivity, pluralism, and legal neutrality are preserved to avoid unintended exclusion or politicization of care models.

Revisiting Measurement and Theoretical Models

The divergence between bivariate and multivariate results highlights the multifaceted nature of satisfaction within Sharia based healthcare. While all five domains showed strong bivariate relationships, only 'Facilities' retained significance in the multivariate model suggesting that patients' immediate perceptions are most influenced by tangible, observable components. This aligns with Donabedian's Structure–Process–Outcome (SPO) model, which emphasizes that structural quality (e.g., facility design) is a prerequisite for process quality (e.g., service delivery) and ultimately outcome quality (e.g., satisfaction) (10). These findings reaffirm the foundational role of visible religious alignment in patient trust and perceived care excellence.

These results also point to the need for culturally sensitive measurement instruments. While SERVQUAL remains a popular tool, its original dimensions tangibles, reliability, responsiveness, assurance, and empathy may not

fully encompass the moral spiritual nuances emphasized in Islamic care. Scholars have proposed integrating constructs such as religious observance, ethical integrity, and spiritual resonance into new models. Future research should explore developing or refining patient satisfaction instruments that account for Islamic epistemologies of health and healing.

Interpretation of Key Findings

This study reveals that while all five dimensions of Sharia hospital standards organizational governance, facilities, human resources, services, and finance were positively associated with patient satisfaction in bivariate analysis, only 'Facilities' retained significance in the multivariate structural equation model. This underscores the salience of tangible and observable elements such as prayer spaces, halal certified meals, and gender sensitive wards, which directly fulfill patients' religious and emotional expectations. The unique visibility and physical immediacy of facilities may explain their dominant influence. Although other dimensions lacked multivariate significance, their consistent bivariate correlations suggest indirect or latent contributions that merit inclusion in future holistic service models.

Comparison with Previous Studies

These findings resonate with and enrich prior research in both regional and global contexts. For example, Othman and Owen (2011) and Algunmeeyn and Mrayyan (2022) found that Islamic service values, especially ethical governance and spiritual alignment, are key drivers of trust and satisfaction (6,14). Comparative evidence from Malaysia and Turkey further supports this, although implementation varies. Malaysia enforces Sharia compliance through centralized regulatory bodies like JAKIM, while Turkey emphasizes culturally infused professionalism without overt religious institutionalization. Our study complements these insights by highlighting the dominant influence of facility based Sharia compliance in Indonesia indicating a sociocultural dynamic where visible religious symbols may carry more weight than policy frameworks. This suggests that models for Sharia compliant healthcare must be tailored to the specific legal, cultural, and institutional landscape of each country.

Limitations and Cautions

This study's findings must be interpreted with certain limitations in mind. While the data affirm the value of Sharia compliant standards in enhancing satisfaction, the research design cross sectional and self reported limits causal inference. Moreover, contextual barriers such as fragmented regulatory frameworks, funding constraints, and cultural resistance may impede uniform implementation. These constraints highlight the importance of adapting Sharia healthcare models to local conditions, while future integration into national health systems will require robust governance, sustained financing, and inclusive public engagement.

Recommendations for Future Research

Future research should address several gaps identified in this study. First, structural equation modeling could be expanded to explore mediation or moderation effects such as the role of trust, religiosity, or perceived fairness as latent pathways between standards and satisfaction. Second, qualitative studies are needed to capture interpretive dimensions of care that may not be fully explained by survey instruments. Third, longitudinal designs would enable tracking of patient experiences and behavioral loyalty over time. Lastly, integrating analytical frameworks like the Transformative Learning Framework (TLF) or Triple Circle Care Model (TCCM) may help theorize how religiously aligned care is cognitively and emotionally processed by patients.

CONCLUSION

This study concludes that Sharia hospital standards particularly when implemented comprehensively have a meaningful impact on patient satisfaction. All five domains (organizational, facilities, human resources, services, and finance) showed significant bivariate associations with satisfaction. However, multivariate analysis revealed that only the 'Facilities' domain exerted a direct and statistically significant effect. This finding reinforces the importance of physical infrastructure aligned with Islamic values as a key determinant of perceived care quality. To enhance satisfaction in Sharia hospitals, investment must prioritize not only tangible facilities but also the holistic integration

of religious, ethical, and operational standards across all service dimensions. These results contribute empirically to the growing discourse on culturally and spiritually responsive healthcare models, particularly in Muslim majority health systems.

AUTHOR'S CONTRIBUTION STATEMENT

All authors contributed substantially to the conception, design, analysis, and writing of this manuscript. Fini Fajriani led the conceptual framework and data collection process, Arif Sumantri conducted statistical analysis and interpreted the results, and Nur Hidayah developed the literature review and integrated the discussion with existing theoretical models. All authors critically revised the manuscript for intellectual content and approved the final version for publication.

CONFLICTS OF INTEREST

The authors declare that there is no conflict of interest regarding the publication of this paper.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

The authors used generative AI-based tools (such as grammar and style improvement software) solely to assist in language editing and writing clarity. The research ideas, analysis, interpretation, and conclusions were entirely generated by the authors without reliance on AI for substantive content generation.

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