

Governing medical tourism in Asia: comparative policy evidence and implications for China

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Research Article

Keywords: medical tourism, cross-border healthcare, health policy, patient protection, insurance, documentary analysis, Asia, China

Posted Date: October 19th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10896512/v1>

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Additional Declarations: No competing interests reported.

Abstract

Background

Medical tourism connects patients with providers across borders, while responsibility for care remains divided among institutions and jurisdictions. We examined how selected Asian destinations allocate these responsibilities and what their arrangements reveal about emerging international medical services in China.

Methods

We conducted a purposive comparative analysis of public documents from Japan, South Korea, Singapore, Thailand, India and China. Five destination cases informed a focused examination of Shanghai and Boao Lecheng. The revised source register records institutional responsibilities, regulatory instruments, patient pathway stages, financial arrangements and evidential limits. Dated policies, programme descriptions and reported activity were analysed separately. Academic literature contextualized the comparison; heterogeneous patient and expenditure indicators were not pooled.

Results

The documents describe different allocations of authority. Japan links patient reception to accreditation and travel coordination; South Korea combines promotion with provider registration and liability insurance. Singapore places explicit limits on public hospitals' recruitment of foreign patients. The Thai sources describe health authorities' promotional roles, wellness assessment and a hospital–insurer payment process. India coordinates tourism, health, accreditation and visa functions through a national strategy and interministerial activity. These instruments provide different forms of information and accountability, but do not establish their effects on patient trust or safety. Shanghai already specifies insurance cooperation, complaints and statistical monitoring. Its published activity figures, like those for Boao Lecheng, do not isolate inbound medical tourists or demonstrate continuity after patients return home.

Conclusions

The comparison identifies where responsibilities are assigned and where implementation evidence remains incomplete. For China, priorities include distinguishing patient populations, evaluating existing safeguards and specifying responsibility at transitions between providers, insurers and jurisdictions. Additional national promotion alone would not resolve these questions.

Background

Medical tourism involves travel outside a person's country of residence to obtain planned healthcare. It forms part of cross-border healthcare, which also includes other arrangements for treatment and reimbursement. The distinction from wellness travel matters because clinical treatment creates obligations concerning consent, complications and subsequent care [1]. In practice, official categories often combine medical treatment, screening and wellness. The population described by a policy or statistical report therefore requires examination before its claims can be interpreted.

Research on medical tourism in Asia has already established that service exports can conflict with domestic health-system priorities. Pocock and Phua's comparison of Thailand, Singapore and Malaysia linked medical tourism to regulation, financing, healthcare provision and workforce distribution [2]. Their contribution was to place destination promotion within the health system rather than treat it as an isolated tourism activity. Hanefeld and colleagues subsequently identified uncertainty about patient flows, outcomes and the implications for publicly financed care [1]. These questions remain relevant even where international patient services have expanded.

More recent studies add institutional and political detail. Xu and colleagues' bilingual review of South Korea identified a policy emphasis on industry growth alongside limited evaluation of consequences for access and equity [3]. In Malaysia, stakeholder interviews by Samsudin and colleagues found continuing tensions between medical tourism and domestic access, and examined insurance portability and accreditation [4]. These studies challenge the assumption that a mature promotional programme necessarily provides evidence of public benefit.

India illustrates why analysis must extend beyond the state's formal role. Hunter and colleagues examined private healthcare regulation in Maharashtra through interviews, witness seminars and documentary material [5]. They identified dispersed rule-making involving insurers, accreditation organizations, platforms and courts, alongside government and professional bodies. Although their study was not confined to medical tourism, it helps explain why a national strategy cannot represent the whole system governing international patients.

Patient studies address a related but different question. Brown and colleagues' analysis of online narratives about treatment in India examined affordability, service experiences and dissatisfaction [6]. Zakaria and colleagues surveyed Bangladeshi patients or relatives at an Indian visa centre and found associations between service-related factors and reported satisfaction [7]. Neither design establishes the effects of particular regulatory arrangements. A recent review of cosmetic and bariatric medical tourism likewise describes information seeking through personal accounts and social networks [8]. Institutional information competes with these other influences, so its availability should not be treated as evidence of trust.

The present study examines how destination-facing documents assign responsibility across specific stages of care. It traces who provides information, authorizes services and handles payment, with particular attention to transitions between institutions. This extends earlier work on health-system consequences by comparing the scope of the instruments through which cross-border services are

organized. Restrictions on recruitment and limits to insurance coverage are included alongside measures intended to expand access.

China is the focal case because its current initiatives make these questions visible in two contrasting settings. Shanghai coordinates international services across public hospitals and other providers, whereas Boao Lecheng combines medical service development with access to imported medical technologies. The comparison cases are used to identify governance functions relevant to these initiatives. They are not a control group, and China is not assumed to pass through the same development stages.

Three connected questions guide the analysis. First, which institutions and instruments govern the selected destinations' international patient services? Second, how do these arrangements allocate responsibilities along the patient pathway, including the role of insurers? Third, which responsibilities and evidence needs can be identified in Shanghai and Boao Lecheng when examined through the same framework? The first question maps institutional arrangements, the second follows their operation across care transitions, and the third applies the comparison to the focal case.

Conceptual framework

We use governance to mean the allocation of authority and responsibility for organizing, regulating and accounting for cross-border care. Walt and Gilson's health policy framework directs attention to actors, content, context and process [9]. We combine that orientation with the health-system concerns identified in medical tourism research and the dispersed regulatory relationships described by Hunter and colleagues [2, 5]. Competition and service positioning remain contextual features; they do not serve as proxies for governance quality.

The patient pathway provides a second organizing device. It identifies transitions at which a patient moves between a facilitator, clinician, hospital, insurer or provider in the country of residence. Each transition raises a specific question about responsibility. A referral requires information about the receiving clinician; a payment authorization requires a defined benefit; discharge requires an identified recipient of clinical information. A portal may assist one transition without resolving the others.

We distinguish information made available to patients from the authority supporting it. A public provider listing, for example, identifies an organization. Licensing determines whether it may deliver a regulated service, whereas accreditation evaluates specified organizational standards. Insurance and complaints arrangements provide other, narrower forms of protection. We refer to these as institutional information and accountability arrangements. Their effects on trust, treatment choices and clinical outcomes remain empirical questions.

Table 1 translates this framework into extraction questions. Actors' interests are interpreted cautiously from their stated mandates and the functions described in documents. Commercial incentives and potential conflicts are discussed as analytical implications where they were not directly investigated.

Table 1
Governance framework and extraction questions

Domain	Question applied to each case	Evidence sought
Actors and authority	Who authorizes, coordinates, delivers or pays for the service?	Named institutions, mandates, allocation of duties and relevant institutional level.
Policy instruments and status	What does the document require, permit, encourage or report?	Licensing, registration, accreditation, contractual arrangements, administrative plans and reported activity.
Patient pathway	At which transition does responsibility arise, and who receives the handover?	Referral, consent and interpretation, payment authorization, discharge, complaints and follow-up.
Public accountability	What information permits scrutiny of services and domestic effects?	Defined populations, reporting requirements, limits on recruitment or capacity use, review and complaint procedures.
Evidence boundary	What can this source establish, and what requires other data?	Separate policy design, reported operation, inferred implications and outcomes not evaluated.

Analytical questions adapted from health policy and medical tourism scholarship [2, 5, 9]. They are not a validated scoring instrument.

Methods

Design and case selection

We conducted a comparative documentary policy analysis using purposively selected public materials. The design is asymmetric: five destination cases provide structured comparisons for a focused analysis of two Chinese initiatives. The unit of comparison is a governance function within a documented arrangement, rather than a national healthcare system as a whole.

The five comparison cases were retained because they illustrate contrasting arrangements relevant to the focal case. Japan provides examples of reception accreditation and travel coordination; South Korea combines active recruitment with a dedicated registration system. Singapore makes the boundary around public-sector recruitment explicit. Thailand connects private hospital services with a wider wellness sector, while India uses national coordination across ministries and industry participants. Table 2 records this rationale together with available activity and financial context [10, 11, 12, 13, 14, 15, 16]. These descriptions identify the selected arrangements, not exclusive characteristics of each country.

China's inclusion reflects the opportunity to compare municipal coordination and pilot-zone experimentation within one national setting. The other destinations differ in institutional history, financing and the composition of international patients. Those differences are part of the analysis and

preclude a ranking by maturity or success. The sample is not representative of Asia. Malaysia is an important omission, particularly for coordinated promotion, and its scholarship informs the interpretation rather than constituting an additional empirical case [4].

Document identification and evidential status

The revised corpus was assembled by reconciling the original source register with targeted searches, source-link checking and examination of references in relevant research. Searches combined medical tourism, medical value travel, foreign patients, international patient services, accreditation, insurance and the country names. Official health, tourism, immigration and municipal websites were prioritized. Searches in Chinese additionally used 醫療, 醫療, 醫 and 醫. Japanese and Korean programme terms were used to locate or verify the corresponding institutional materials. The revision search and verification were completed on 7 September 2026.

Eligible records had an identifiable issuer and a retrievable passage relevant to a governance function or to interpretation of the selected cases' activity. We retained older instruments where they explain continuing arrangements, alongside recent policy statements and reports. Commercial destination rankings and unsupported forecasts were excluded from the analysis. A market estimate reproduced in an official publication was retained only as explicitly labelled economic context. It was not treated as an audited revenue series.

The original register contained 30 entries: eight background or theoretical references and 22 destination-related entries. Supplementary Table S1 identifies the 26 case records used in the revised analysis, with academic and methodological literature listed separately. The accompanying Supplementary Source Register provides an editable version of Table S1, preserves the original 30-entry register and documents each retention, replacement or removal. The original summary reports 38 candidate records and eight exclusions but does not identify the excluded records individually. Those historical totals are not used as a screening denominator for the revised purposive sample, and exhaustive coverage is not claimed.

An official source was not automatically treated as evidence of implementation. A ministry's strategy establishes a stated intention; a registration guide describes an administrative requirement; a statistical release reports activity under its own definitions. Government-hosted news and hospital guidance were identified as such. The latter was used only to describe that hospital's stated payment process. Research reports and journalism supplied context where comparable primary statistics were unavailable.

Extraction and language handling

We extracted relevant policy clauses, programme descriptions and statistical statements into a source-level register. Each record summarizes the cited passages from one source, including its issuer, language, status, relevant actors, governance functions, patient pathway stages and interpretive limitations. Several clauses within one document contribute to one source record. Numerical information

retains the reporting period, population and unit. The approach follows the practical sequence of preparing documents, extracting information, analysing relationships and distilling findings described by Dalglish and colleagues [17].

Official English versions were used where available. Chinese and Japanese source passages and Korean statistical terminology were examined with AI-assisted translation into English. Institution names, dates, numbers and distinctions between obligation and encouragement were checked against the source text. Official English summaries provided an additional check where available. The Thai wellness manual was analysed in its issuer-provided English translation. The workflow did not include independent bilingual validation or independent duplicate coding. Supplementary Table S2 records translation decisions affecting the interpretation.

The original register describes initial extraction and a second source check by the same author. During revision, AI-assisted retrieval and checking updated the register. Cited passages were revisited when an interpretation exceeded a document's scope or reports used inconsistent populations. These checks did not constitute independent duplicate extraction or triangulation.

Comparative synthesis

Analysis proceeded from within-case summaries to comparison by governance function. Within each case, we identified the institutions named, their documented instruments and the boundaries of their responsibilities. Across cases, we compared arrangements for entry and referral, clinical service authorization, payment, complaints and continuity. The analysis then examined whether the Chinese documents specified analogous functions, used different instruments or left their operation undocumented.

We separated three kinds of statement during synthesis: a provision described by a source, reported activity, and an implication proposed by the analysis. A function unreported in the selected records was coded as not established by this corpus. It was not coded as absent from the country. For example, Shanghai's proposal for statistical monitoring supports a finding about policy design, but does not establish either complete implementation or the absence of other monitoring.

Patient and expenditure indicators were interpreted within their source definitions. Medical-purpose arrivals, foreign patients, visits and international service episodes were not converted into a common total. Expenditure estimates were distinguished from hospital revenue and from wider tourism spending. This treatment preserves economic context without using incompatible indicators to rank destinations.

Table 2
Case selection and economic context

Case and policy trajectory	Reason for inclusion	Reported activity and financial context	Interpretation limit
Japan Medical stay visa guidance and institutional reception schemes	Examine coordination between entry documentation, hospital information and accreditation.	The selected reception and visa documents do not establish a national medical-tourist count or annual receipts [10, 11, 12].	Institutional coverage is not market size. Reception schemes also serve resident foreigners.
South Korea Recruitment since 2009 and dedicated obligations from 2016	Examine recruitment regulation and routine reporting.	1.17 million foreign patients in 2024; 2.01 million in 2025. The 2026 release reports modelled 2025 medical spending of KRW 3.3 trillion and wider medical-tourism spending of KRW 12.5 trillion [18, 19].	The spending estimates are not audited hospital receipts. The wider measure includes accompanying persons and nonmedical spending.
Singapore Public-sector recruitment boundary documented in 2018	Examine explicit protection of the public service mandate.	About 18,000 foreign inpatient/day-surgery patients annually during 2019–2023, according to a media report quoting the health ministry. Comparable medical-tourism revenue was not established [20].	Excludes other outpatient care. A restricted flow measure cannot establish the whole market.
Thailand Medical hub promotion and a distinct wellness assessment scheme	Examine coordination across clinical, tourism and wellness activities.	A 2025 research report discusses an estimate of about 3 million foreign patients annually and warns of category mixing. Government reporting gives THB 107,662 average spending per medical/wellness trip [15, 21].	The flow is uncertain; the spending figure combines medical and wellness travel and is not sector revenue. No multiplication was performed.
India National strategy in 2022 with continuing interministerial coordination	Examine links among health, tourism, insurers, accreditation and visas.	The 2026 backgrounder reports 507,244 medical-purpose arrivals in 2025 and reproduces an industry market estimate of US\$8.7 billion for that year [22].	Arrivals are not unique patients. The industry estimate is not an official audited receipt total and is used only as context.

Case and policy trajectory	Reason for inclusion	Reported activity and financial context	Interpretation limit
China Shanghai pilots from 2023 and Boao Lecheng's regional experimentation	Examine two focal settings with different institutional arrangements.	Shanghai reported 4,128 foreign/Hong Kong/Macao/Taiwan inpatients in the first half of 2024. Lecheng reported 413,700 medical tourism visits in 2024. National inbound receipts were not established [23, 24].	Different periods, populations and units. Neither identifies all overseas residents travelling specifically for care.

Indicators retain their original years, currencies and populations. “Not established” means not established by the selected sources, not zero activity or proof that no data exist.

Results

Japan

Japan’s selected arrangements distribute responsibility across immigration administration, accreditation bodies, coordinating organizations and hospitals. The Ministry of Foreign Affairs’ medical stay visa guidance requires documentation of planned care and links patients to registered guarantors. Repeat visits may require a treatment plan [10]. This arrangement connects entry documentation with a proposed course of care. A guarantor’s administrative role does not establish responsibility for a clinical complication.

The Japan Medical Education Foundation operates Japan Medical Service Accreditation for International Patients (JMIP). Its assessment concerns institutions’ reception of foreign patients, including language and cultural support [11]. The published procedure combines document review with site visits and examines forms used in reception and consent [25]. JMIP addresses foreign patients broadly, including people already in Japan; it is not a measure of inbound medical tourism or comparative treatment outcomes.

Medical Excellence JAPAN operates a separate hospital information and recommendation arrangement. Its international patient guide describes indicative treatment costs, additional interpretation charges and coordination through accredited assistance companies [12]. Together, these arrangements divide pre-travel coordination and institutional assessment among several organizations. Patients may encounter a visa guarantor, a recommended hospital and an accredited reception service within one journey, although each assurance has a different scope.

South Korea

South Korea combines state-supported recruitment with requirements directed at participating institutions. Medical Korea's registration guide states that registered medical institutions serving foreign patients must hold medical malpractice liability insurance [13]. The programme's published legal extracts also distinguish institutions from attraction agencies, prohibit misleading recruitment information and identify restrictions on excessive commissions [26]. These instruments connect market participation to defined obligations and make intermediary conduct a regulatory issue.

The Ministry of Health and Welfare reported approximately 1.17 million foreign patients in 2024 and 2.01 million in 2025 [18, 19]. The later release distinguishes patient counts from approximately 2.72 million patient attendances. It also reports foreign-patient bed occupancy below 1% in tertiary and general hospitals, alongside different statutory ceilings [19]. This provides a specific capacity indicator, although it cannot establish the effects on waiting times or workforce allocation.

The programme thus couples permission to recruit with obligations toward foreign patients. Liability insurance gives this protection a defined financial component, whose operation would need to be assessed through claims and settlements. Growth and the reported capacity indicator also need to be read alongside Xu and colleagues' finding that the domestic health consequences of expansion remain insufficiently evaluated [3].

Singapore

Singapore provides a documented counterpoint to unrestricted recruitment through public hospitals. In a parliamentary reply, the Ministry of Health stated that public healthcare institutions may not actively market to foreign patients. It also reported the cessation of contracts supporting foreign-patient referrals [14]. The statement identifies a public-sector boundary; it does not prohibit all international care or describe private hospitals' recruitment practices.

Healthcare service regulation provides a separate function. The Ministry's account of the Healthcare Services Act describes licensing by service and accommodates different delivery models, including virtual care [27]. International marketing and service authorization should therefore be distinguished. Neither a medical tourism designation nor a commercial referral substitutes for authorization to provide the relevant healthcare service.

For economic context, a 2025 report quoting the Ministry describes an annual average of about 18,000 foreign patients in public and private inpatient and day-surgery care during 2019–2023 [20]. This measure excludes outpatient activity beyond day surgery. The case illustrates a deliberate distinction between accepting foreign patients and authorizing public institutions to recruit them, with wider licensing requirements governing the services provided.

Thailand

Thailand's selected documents distinguish medical hub promotion from the assessment of wellness services. Government reporting describes a health ministry steering committee, the Department of

Health Service Support and the Tourism Authority of Thailand as participants in the medical hub agenda [15]. Their stated activities connect healthcare, investment and tourism. These overlapping objectives create a need to identify which body is responsible for each service within a combined package.

The Thailand Wellness Awards manual assigns assessment functions to departmental, district and provincial bodies. It requires relevant licensing documentation and includes a process for responding to customer complaints [28]. This is a specified quality-development scheme with a defined scope. An award for wellness operations cannot be interpreted as evidence of the safety or efficacy of a hospital procedure.

Hospital–insurer arrangements add another form of governance. Bumrungrad’s published payment guidance describes prior authorization, final bill review and responsibility for costs outside a policy’s coverage [29]. Its example shows how clinical discharge and financial clearance can involve different decisions. It is evidence of one provider’s stated process, not a national estimate of insurance access.

A Thailand-focused research report identifies substantial uncertainty in estimates that mix medical tourists with expatriates, other resident foreigners and incidental users of healthcare [21]. That uncertainty matters for both promotion and oversight. Without separating these populations, a rise in foreign-patient visits cannot establish growth in planned medical travel or its burden on clinical capacity.

India

A 2025 parliamentary reply locates primary responsibility for tourism development and promotion with state and union territory governments, while the national ministry provides complementary support [30]. India’s national strategy places medical and wellness tourism within a coordinated promotional framework. The Ministry of Tourism describes a national board chaired by the tourism minister and support linked to accreditation by the National Accreditation Board for Hospitals and Healthcare Providers (NABH) [16]. This arrangement gives accreditation an additional role in access to promotional support, while leaving clinical regulation conceptually distinct from tourism coordination.

A subsequent parliamentary reply names hospitals, medical value travel facilitators, insurance companies and NABH among the actors involved in coordination with the health ministry [31]. It also describes medical and attendant e-visa arrangements. The visa portal requires a letter from the receiving hospital stating a tentative admission or treatment date [32]. This links entry documentation to the intended provider, without establishing insurance coverage. The parliamentary reply identifies insurers within policy coordination rather than leaving their involvement to be inferred from private healthcare provision.

The 2026 government backgrounder describes further portal development and regional medical hub proposals, alongside reported medical-purpose arrivals [22]. Proposed integration is not evidence that every patient can access a functioning pathway. In particular, the reviewed communications do not establish uniform insurer contracts, facilitator enforcement or responsibility for complications after return home.

The national agenda depends on relationships among ministries, hospitals, facilitators, accreditors and insurers. Hunter and colleagues' study of private healthcare regulation in Maharashtra offers a relevant contextual explanation: formal state coordination operates alongside other sources of regulatory influence [5]. How those relationships affect a particular medical tourism service requires examination at provider and contract level.

Responsibilities along the patient pathway

The cases identify several forms of coordination before treatment: visa documentation, hospital information, registration and indicative payment arrangements. These functions provide different kinds of assurance. Japan's travel coordination links a prospective patient to a proposed service; Korea's registration requirements attach obligations to participating providers and agencies. Neither establishes the quality of every treatment episode.

During care, consent and interpretation are organizational responsibilities that can be examined through accreditation or service standards. The Thai wellness manual, however, demonstrates why the assessment's scope must remain explicit. Standards for a recovery or wellness component do not establish responsibility for the clinical component of a package. Table 3 follows these distinctions across the pathway and identifies the information needed to examine implementation.

International insurers influence care through benefits, authorization and financial agreements. Their role can include determining whether a planned treatment is covered and whether the hospital receives direct payment. Provider liability insurance has a different purpose: it concerns liability arising from treatment. A patient's travel insurance, hospital liability cover and an agency's financial guarantee should not be described collectively as insurance interoperability. The reviewed sources do not establish a shared cross-border claims system [13, 29, 31].

The weakest basis for comparison concerns care after departure. Documents describing referral or payment rarely provide outcome data on handover to clinicians in the country of residence. The present corpus therefore cannot show how often follow-up succeeds, whether complaints are resolved or who pays for delayed complications. This is a limit of the evidence, rather than proof that all destinations lack such arrangements.

Table 3
Responsibility at transitions in the patient pathway

Stage	Documented arrangements	Responsibility to examine	Evidence needed to assess operation
Search and referral	Japan's hospital information and medical stay documentation; Korea's registration and recruitment rules [10, 12, 26].	Identify the provider, the referring party and the scope of each assurance.	Provider identity checks, referral records and handling of inaccurate information.
Assessment and consent	JMIP reception assessment examines institutional documentation; Shanghai specifies multilingual services [25, 33].	Assign responsibility for clinical assessment, interpretation and consent.	Actual consent records, interpreter arrangements and procedure-specific information.
Payment and treatment	Korean liability insurance; Indian insurer coordination; a Thai hospital's authorization and bill review process [13, 29, 31].	Separate clinical decisions, benefit authorization, payment and liability.	Coverage terms, authorization decisions, exclusions and disputed-payment records.
Discharge and return	Hospital payment guidance describes discharge administration; the corpus provides little evidence on cross-border clinical handover [29].	Identify responsibility for records, medicines, review and deterioration after departure.	Receipt of discharge information, a named contact, completed follow-up and readmissions.
Complaints and public oversight	Korea's recruitment reporting channel; Shanghai's complaints and monitoring provisions; Lecheng's biomedical-technology adverse-event duties [26, 33, 34].	Identify the competent body and the route for escalation or reporting.	Complaint disposition, response times and implementation reports with defined denominators.

The third and fourth columns are questions and evaluation requirements derived from the analysis; they are not findings that these activities are universally absent.

China

Shanghai

Shanghai's pilot programme began in 2023 with 13 public hospitals. A government-hosted report describes both international service activity in the pilot hospitals and 4,128 foreign, Hong Kong, Macao and Taiwan inpatients across the city in the first half of 2024 [23]. These are different populations and institutional scopes. Neither indicator isolates people who crossed a border specifically to obtain care.

The municipal implementation opinion issued in December 2024 assigns responsibilities to health, financial, tourism and other authorities. It addresses commercial insurance cooperation, direct settlement, multilingual services, complaints and statistical monitoring [33]. The policy therefore

provides a basis for examining implementation: which institutions have adopted the specified arrangements, how responsibilities are coordinated and what results are reported.

Shanghai also has a recommended local standard for international medical services, DB31/T 1487–2024, effective from October 2024 [35]. The standard’s existence and status can be verified in the national standards register. That metadata alone does not demonstrate compliance by every pilot hospital or validate individual treatment outcomes.

Public hospital participation makes resource allocation a necessary subject of evaluation. The reviewed activity report does not establish whether international services displace domestic care, receive implicit subsidies or generate a measurable public benefit. These effects require hospital accounting, workforce and access data. They should be framed as questions for evaluation rather than as harms already demonstrated by this study.

Boao Lecheng

Boao Lecheng combines a geographically bounded policy experiment with the provision of medical services and access to imported technologies. Reporting attributed to the pilot-zone administration records 413,700 medical tourism visits and 51,400 episodes involving specially permitted drugs or devices in 2024 [24]. The figures are visits or use episodes, not counts of overseas residents travelling for treatment. They cannot be added to Shanghai’s inpatient figure to estimate a Chinese market.

Dedicated sector coordination also has its own instruments. A March 2025 joint notice from Qionghai’s municipal government and the pilot-zone administration identifies trial international medical tourism management measures and service-quality guidance [36].

The biomedical technology provisions, effective from February 2025, have a specific scope. Article 2 covers clinical research and translational application of technologies including cell therapy, gene therapy and tissue engineering; Article 12 retains the relevant national requirements where the intended product is a drug or device. Articles 3 and 19–24 allocate oversight, consent, data and adverse-event responsibilities [34]. These provisions should therefore be interpreted within their stated scope, rather than as a single authorization for every imported product or international service.

Boao Lecheng is consequently useful as a case of the boundary between service development and technology governance. Evaluation of an international service involving a new intervention would require its specific authorization, indications and evidence, alongside information about follow-up and responsibility for adverse events. These are proposed evaluation requirements; the activity totals do not establish whether they have been met.

What the comparison supports

The two Chinese initiatives address different institutional settings and patient populations. Shanghai specifies several service and coordination functions; Boao Lecheng adds a technology-governance dimension. A common basis for comparison is whether assigned responsibilities can be traced through

a defined service, from entry and authorization to follow-up and reporting. Their public records establish elements of that design while leaving implementation and patient populations incompletely described.

Table 4 distinguishes the observations from the policy implications. The comparison suggests questions that can be investigated within existing initiatives, including who is counted, who authorizes payment and who accepts clinical responsibility after departure. The available documents cannot determine the optimal national organizational model or the scale at which international services should expand.

Table 4
Chinese observations and bounded policy implications

Observation	What can be concluded	Proposed evaluation
Activity categories differ between Shanghai and Lecheng [23, 24].	The reported figures cannot be combined into a national inbound total.	Record residence, nationality, travel purpose and unique patients separately from episodes.
Shanghai specifies coordination, insurance, complaints and monitoring [33].	These functions are present in policy design; implementation is a separate question.	Examine institutional adoption and publish service-level results.
Lecheng’s biomedical-technology provisions assign oversight and clinical responsibilities [34].	Technology access is conditional on the relevant regulatory pathway.	Audit authorization, consent and adverse-event processes for the specific intervention.
The corpus contains no comparative hospital accounts or access outcomes.	Neither crowding out nor public benefit has been demonstrated.	Evaluate staffing, costs, revenue use and domestic waiting times within relevant specialties.

Policy implications are analytical proposals. No implementation timetable, effectiveness estimate or claim of nationwide absence is inferred.

Discussion

Contribution to the governance literature

The comparison develops an existing concern in medical tourism research: healthcare exports operate through domestic institutions but create responsibilities that extend beyond them. Pocock and Phua identified consequences for financing, provision and the workforce [2]. The present analysis adds a more specific examination of the instruments visible at transitions between institutions. Registration requirements, visa guarantees, wellness awards and payment authorizations serve distinct functions, even within the same medical tourism destination.

This distinction helps explain why a comprehensive promotional offer does not establish comprehensive accountability. Hunter and colleagues’ account of dispersed regulation makes the interests of insurers, accreditors and other intermediaries analytically relevant [5]. Our documents show some of the formal

connections between these actors. They reveal much less about negotiation, bargaining power or enforcement. Interviews and organizational records are needed to determine how these relationships operate when commercial and clinical priorities diverge.

The comparison also qualifies any simple distinction between mature and emerging destinations. Singapore's restriction on public-sector recruitment and Korea's provider obligations represent different policy choices. They cannot be placed on a single scale of increasing openness. For China, the transferable lesson is to identify the function an instrument performs and the authority needed to sustain it. Adopting a portal or accreditation label does not reproduce the surrounding institutional relationships.

Institutional information and patient trust

Documents can identify the information institutions offer, but they cannot establish how patients interpret it. Brown and colleagues' narratives and Zakaria and colleagues' survey concern experiences and perceptions in the Indian context [6, 7]. These studies show why trust-related questions require patient evidence. They do not validate a causal pathway from official information to satisfaction or treatment choice.

Nichol and colleagues' review further indicates that personal stories and social networks shape decisions about cosmetic and bariatric treatment abroad [8]. Such sources may be more accessible or persuasive than regulatory material. An institutional signal should therefore be evaluated through its recognition, interpretation and use, as well as the reliability of the underlying institution. The present study examines only the documented institutional side of that relationship.

Future research could test whether prospective patients distinguish a provider licence from voluntary accreditation or a facilitator's assurance. It could also examine whether patients understand the boundaries of insurance coverage before committing to treatment. Such studies would need to account for procedure type, prior experience, language and referral source. They would provide evidence for claims about trust that the documentary comparison cannot make.

Insurance and continuity across borders

Insurance is part of governance because financial decisions can determine access to services and responsibility for costs. The Malaysian study by Samsudin and colleagues connects insurance portability with the development of international accreditation [4]. Our comparison identifies more specific institutional relationships, including Korea's liability requirement, India's insurer participation in coordination and a Thai provider's authorization process. It does not show that these arrangements provide equivalent protection.

An evaluation should distinguish what happens before treatment from what happens after a complication. Direct settlement for an authorized admission need not resolve a later claim in another jurisdiction. For a defined service, hospitals and insurers could specify the covered intervention,

authorization process, exclusions and escalation route. Patients without coverage would require an equally clear account of likely costs and payment responsibility. These are proposed contractual and information requirements rather than findings about universal current practice.

Continuity also depends on clinical responsibility. A translated discharge summary is useful only if it reaches an appropriate recipient and the patient can obtain necessary care. Digital consultation can support follow-up, but the existence of a platform does not establish authorization to practise across borders or permission to transfer records. Service-specific agreements need to identify the treating team, the receiving clinician where available, and the response to deterioration. Their effectiveness should be assessed through completed handovers and subsequent care, not portal availability.

Implications for China and domestic health-system stewardship

Evaluation of existing arrangements is the immediate priority suggested by the Chinese cases. Shanghai's provisions identify relevant functions, while the two initiatives' statistics describe different populations. A common reporting specification could distinguish residence, nationality, travel purpose, service episodes and unique patients. It would make local results interpretable without requiring every jurisdiction to adopt an identical service model.

Evaluation of public hospital pilots should compare international activity with domestic access and resource use over time. Useful measures include clinician time, waiting times within relevant specialties, treatment costs and the allocation of international-service revenue. Private provision also requires scrutiny because staffing and investment can affect the wider system. Ownership alone cannot demonstrate either protection from, or exposure to, displacement. This follows the concerns raised in the Asian health-system literature rather than an effect established by our documents [2, 3].

For Boao Lecheng, evaluation should remain intervention-specific. Regulatory permission to provide a technology does not establish that it is suitable for all prospective patients. Traditional medicine, rehabilitation and advanced biomedical interventions also require different kinds of evidence. A destination-wide claim of quality would obscure those distinctions. The same principle applies when clinical treatment and wellness services are sold together.

These considerations support a practical approach to policy development. Existing pilots can test a small set of defined service pathways, publish the responsibilities attached to them and report what happens after discharge. Expansion decisions can then incorporate evidence on patient protection and domestic access. The timing and scale of expansion would also require a separate assessment of resources.

Conclusions

The selected Asian cases show how international patient services are organized through different combinations of public authority, institutional assessment and contractual coordination. These arrangements should be examined according to their responsibilities and scope. Their existence does not establish that patients receive continuous or accountable care across borders.

Shanghai and Boao Lecheng provide specific settings in which these responsibilities can be evaluated. Priorities include distinguishing the patients represented in activity reports, testing the implementation of existing safeguards and documenting responsibility after departure. Evidence from that evaluation would provide a firmer basis for policy decisions than destination rankings or aggregate growth claims.

Limitations

This study draws on a purposive sample of public documents that primarily describe formal governance arrangements. The more detailed examination of the Chinese initiatives limits the symmetry of cross-country coverage; the findings therefore concern selected governance functions within the settings examined. The absence of independent duplicate coding may also affect the consistency of interpretation, particularly for multilingual materials and legal terminology.

Differences in patient definitions and the limited availability of comparable financial data constrain comparisons of market size and revenue. The documentary design does not establish how the identified arrangements operate in practice or affect patient and health-system outcomes. Future research combining documentary analysis with interviews and service-level audits could examine implementation and its implications for patients.

Abbreviations

JMIP, Japan Medical Service Accreditation for International Patients; NABH, National Accreditation Board for Hospitals and Healthcare Providers.

Declarations

Ethics approval and consent to participate

Not applicable. The study used publicly available documents, statistics, published research and reports. It involved no human participants or identifiable individual-level data.

Consent for publication

Not applicable.

Availability of data and materials

The materials used in the analysis are identified in the references and Supplementary Tables S1–S3. The supplementary document records source locations, extracted observations, translation decisions and limitations. The accompanying Supplementary Source Register provides an editable version of Table S1 and documents how the original 30-entry register relates to the revised sources. No individual-level dataset was generated.

Competing interests

The authors declare that they have no competing interests.

Funding

This research was supported by the Chinese Academy of Engineering Science and Technology Strategic Consulting Project (Grant No. 2025-PP-14), the National Natural Science Foundation of China (Grant Nos. J2324020 and 72571170), and the Shanghai University Faculty Industry-Academia-Research Practice Program.

Authors' contributions

Y.Z. and C.M. conceptualized the study, developed the methodology, and conducted the investigation. D.X. and Y.R. extracted the documentary evidence, verified the sources, and prepared the original draft. Y.Z. analyzed the data and critically revised the manuscript for important intellectual content.

Acknowledgements

Not applicable.

AI assistance statement

Not applicable.

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