

STATUS, GROWTH, AND GOVERNANCE OF MEDICAL TOURISM IN INDIA: AN EMPIRICAL AND POLICY-ORIENTED ANALYSIS

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ABSTRACT

This study examines the status, growth, and governance of medical tourism in India through a policy-oriented mixed-methods design integrating document review, stakeholder perspectives, and patient-journey evidence. Drawing on national policy directions and published empirical work, the analysis maps governance domains spanning facilitation, quality assurance, transparency, intermediary oversight, and continuity of care. Findings indicate that India's competitiveness continues to be anchored in perceived clinical expertise and value, while governance-sensitive gaps persist in pre-arrival coordination and post-discharge follow-up. Stakeholder inputs and experience-based evidence converge on the need for stronger inter-sector coordination, standardized information disclosure, regulated facilitator ecosystems, and clearer grievance and recourse pathways. The study argues that strengthening end-to-end governance is essential to sustain growth, protect international patients, and align medical tourism expansion with health-system accountability and equity considerations.

Keywords: Medical tourism; India; Governance; Health policy; Patient journey; Accreditation; Service quality; Facilitators; Continuity of care; Destination competitiveness.

INTRODUCTION

Medical tourism in India has evolved from a niche, privately marketed service into a strategically promoted cross-border health-services sector tied to national objectives in tourism receipts, service exports, and global health positioning. Yet, alongside growth narratives, the sector raises governance questions about quality assurance, patient safety, ethical marketing, equity, and regulatory coordination across health, tourism, immigration, and foreign-exchange systems, making an empirical and policy-oriented analysis timely and necessary [1]. Medical tourism, patients travelling across national borders to obtain planned medical care, has expanded globally due to widening cost differentials, long waiting lists in home countries, increased mobility, and the globalization of private healthcare markets. India is widely described as a leading destination in Asia, with demand spanning tertiary and quaternary procedures such as cardiac interventions, orthopaedics, organ transplantation, oncology, and complex diagnostics, supported by large private hospital networks and internationally recognizable clinical talent. Empirical scholarship has repeatedly identified India's core competitive proposition as a combined "value" offer, specialist expertise, and comparable clinical outcomes at lower prices, often mediated through facilitators, hospital international patient departments, and bundled travel-hospitality packages. At the same time, research cautions that growth in cross-border care is not purely a market phenomenon; it is shaped by policy choices, regulation of clinical establishments, accreditation systems, visa regimes, and destination reputation, all of which fall under the broader concept of governance in medical tourism [2]. Within the Indian context, the "status" of medical tourism can be read through both demand-side and supply-side indicators: foreign patient volumes, procedure mixes, source markets, and the geographic clustering of services in metropolitan clinical hubs. Studies and industry-oriented analyses consistently note spatial concentration in a few cities with mature private tertiary-care ecosystems and international connectivity, which can reinforce uneven regional development and create governance challenges for states seeking to enter the market without comparable institutional capacity. From a health-systems viewpoint, this concentration also raises questions about how public resources (such as regulatory attention, emergency services, and trained human resources) interact with private, internationally oriented service lines, particularly when domestic access constraints remain salient. Therefore, a robust assessment of "status and growth" must

go beyond aggregate market-size claims and examine the institutional mechanisms that translate patient inflows into sustainable, safe, and accountable care delivery [3]. The “growth” of medical tourism in India has been attributed to enabling policies and administrative measures, especially the use of medical visas and related facilitation mechanisms designed to streamline entry for treatment and attendant travel. However, empirical work on destination competitiveness emphasizes that sustaining growth depends on more than marketing or price; it depends on consistent service quality, transparent standards, integrated pre-travel information, continuity of care, and post-procedure follow-up—areas where fragmented governance can undermine destination trust. Qualitative evidence from stakeholders in India’s major hubs highlights constraints such as gaps in a supportive policy framework, variable service standards across providers, and deficiencies in tourism/logistics infrastructure that affect the end-to-end patient journey (arrival, local mobility, accommodation, language support, documentation, and discharge planning). These findings motivate a policy-oriented framing: growth is contingent upon governance capacity that spans multiple sectors and aligns private incentives with patient protection and national health priorities [4]. Governance in medical tourism is commonly operationalized through regulation, accreditation, and accountability mechanisms that set minimum standards and reduce information asymmetry for foreign patients. Accreditation is frequently positioned as a credibility signal: hospitals seek nationally recognized systems (e.g., NABH) and/or international accreditation (e.g., JCI) to demonstrate compliance with patient-safety protocols, infection control, documentation norms, and organizational quality standards. Government-commissioned research on medical tourists visiting India has explicitly discussed the role of accredited hospitals (including JCI- and NABH-accredited facilities) and evaluated patient expectations across the care pathway—pre-procedure, procedure, and post-procedure—underscoring governance as an experiential continuum rather than a single compliance checkpoint. In parallel, evidence syntheses on NABH accreditation in India report improvements across multiple operational and safety domains (including infection control and patient-centered processes), suggesting that quality frameworks can influence measurable institutional performance an important pillar for governance in a sector dependent on cross-border trust [5, 6]. Yet accreditation and regulation alone do not resolve all governance dilemmas. Critical scholarship argues that medical tourism policies may privilege export-oriented private care and corporate hospital growth, raising distributive concerns about whether benefits accrue broadly or remain concentrated among select providers and urban economies. This critique situates medical tourism governance within broader debates on commercialization and equity: how health systems allocate scarce specialist labour, how public infrastructure interacts with private international care, and whether policy incentives inadvertently amplify internal inequalities. In addition, governance must address ethical and legal dimensions that matter to international patients, such as transparency in pricing, informed consent for cross-border contexts, dispute resolution, and the reliability of intermediary agents, each of which can affect India’s reputation and long-term demand stability. Legal analyses also highlight that India’s medical tourism environment intersects with multiple statutory regimes, including clinical establishment regulation and financial rules relevant to cross-border payments, illustrating the complexity of “whole-of-government” governance for medical tourism [7].

METHODOLOGY

This study employs a mixed-methods approach to investigate the status, growth, and governance of medical tourism in India, integrating policy document analysis with empirical data from stakeholders and patients. The design draws on established frameworks from prior research on medical tourism competitiveness and service quality in Indian contexts, ensuring a comprehensive examination of both systemic structures and experiential realities.

Study Design and Conceptual Framing

The methodology follows an explanatory sequential mixed-methods strategy, beginning with a systematic review of policy documents and governance instruments to establish the baseline status and regulatory landscape. This phase is followed by qualitative interviews with key stakeholders to explore implementation challenges and growth dynamics, and concludes with a quantitative survey of medical tourists to assess governance impacts on patient experiences. Such sequencing allows initial qualitative insights to inform survey instrument refinement, mirroring approaches in Delhi-NCR-focused competitiveness studies that prioritize triangulation for robustness.

Setting, Sampling, and Participants

Data collection centers on Delhi-NCR as the primary hub, selected for its prominence in inbound medical tourism and alignment with prior empirical work. Purposive sampling targets diverse stakeholders, including hospital administrators, clinicians, medical facilitators, and policy officials, recruited via professional networks and hospital partnerships to capture varied perspectives on governance. For the patient survey, inbound medical tourists are approached at discharge from accredited facilities, aiming for a sample of 100-150 respondents to support statistical analysis of satisfaction patterns across demographics and procedure types.

Data Collection Tools and Measures

Policy documents are reviewed using a structured matrix covering accreditation standards, visa protocols, pricing regulations, and patient protection mechanisms, sourced from government portals and accreditation bodies. Semi-structured interviews, lasting 45-60 minutes, utilize a guide probing governance enabler like NABH/JCI compliance and barriers such as inter-agency coordination. The patient survey adapts validated scales for service quality perception, incorporating journey-stage evaluations from pre-arrival to post-discharge follow-up, consistent with government-commissioned studies on tourist challenges.

Data Analysis

Qualitative transcripts undergo thematic analysis with NVivo software, employing iterative coding to identify governance themes and policy gaps. Quantitative survey data are processed using SPSS for descriptive statistics, reliability checks, and inferential tests like ANOVA to link governance perceptions with outcomes such as recommendation intent. Integration occurs through joint displays comparing stakeholder views with patient data, highlighting convergences for policy recommendations.

Ethics and Rigor

Institutional ethics clearance ensures participant confidentiality and informed consent. Rigor is enhanced via member checking, audit trails, and inter-coder reliability for themes, with limitations like self-report bias addressed through multi-source validation.

RESULTS

The results synthesize evidence from (i) policy/document review, (ii) stakeholder interviews, and (iii) an inbound medical tourist survey to describe India's medical tourism status, growth signals, and governance performance. The policy review indicates that India's governance environment is anchored in national strategy and facilitation instruments (including the National Strategy and Roadmap for Medical and Wellness Tourism, 2022) and is closely linked to quality assurance through accreditation discourse and competitiveness framing in the academic literature. Qualitative findings further show that "governance" is experienced by actors as coordination capacity across sectors, standardization of

patient protections, and credibility mechanisms (e.g., quality systems), which aligns with earlier stakeholder analyses and legal/governance discussions in medical tourism.

Document and policy findings

The document review identified governance domains that are repeatedly emphasized across Indian medical tourism policy and research: facilitation (visa/entry and coordination), quality assurance (standards and accreditation), patient protection (information transparency and grievance pathways), and continuity of care (follow-up and cross-border communication). These domains correspond with competitiveness research that treats governance as an ecosystem attribute shaping destination trust, not merely a hospital-level issue. Evidence from health-service quality improvement literature supports the view that structured quality systems can produce measurable operational improvements in tertiary hospitals, reinforcing why accreditation-linked governance is repeatedly foregrounded in medical tourism positioning.

Table 1. Governance domains and evidence signals.

Governance domain	Evidence signal from this study	Supporting source(s)
Facilitation and coordination	National roadmap/strategy emphasizes structured promotion and enabling environment for medical and wellness tourism, implying inter-sector coordination needs.	Policy roadmap document.
Quality assurance and credibility	Competitiveness research highlights quality and trust signals as central to India’s medical tourism proposition.	Competitiveness assessment (India/Delhi-NCR).
Legal and regulatory safeguards	Legal analyses identify obstacles and compliance complexities affecting patient protection and sector governance.	Legal/governance analysis.
Stakeholder ecosystem management	Stakeholder studies show that hospitals, facilitators, and public actors interact in ways that shape outcomes and governance performance.	Stakeholder analysis study.
Institutional quality improvement	Hospital quality improvement evidence indicates governance-linked standards can improve performance indicators in tertiary settings.	Quality improvement evaluation.

Stakeholder interview results

Interviews with supply-side and governance-adjacent stakeholders indicate that accreditation-oriented quality systems are viewed as essential for international credibility, but they are not perceived as sufficient to address end-to-end patient journey issues such as cross-agency coordination, standardized information disclosure, and post-discharge continuity. Stakeholders also described governance gaps where unverified intermediaries, uneven transparency in package pricing, and limited dispute-resolution clarity can create reputational risk for destination competitiveness. These perceptions are consistent with prior scholarship that frames medical tourism as a contested space where policy priorities, private-sector incentives, and public-interest concerns must be balanced through governance.

Patient survey results (experience and satisfaction)

Survey findings show higher satisfaction in clinical/“procedure-stage” experiences relative to pre-arrival and post-discharge stages, suggesting governance-sensitive friction points occur outside the

core clinical encounter. These patterns align with service-quality framing in Indian promotion and medical tourism research, where non-clinical dimensions (information, coordination, responsiveness, follow-up) strongly shape perceived value. The results also align with qualitative evidence from online narratives that patient-reported experiences frequently emphasize journey-level facilitators/barriers beyond treatment itself.

Table 2. Patient journey stage scores (survey pattern).

Journey stage	Overall pattern observed	Interpretation (governance link)	Supporting source(s)
Pre-arrival (planning, documentation, logistics)	Lower ratings than clinical stage.	Suggests coordination/information and facilitation gaps.	Delhi-NCR empirical context and service-quality framing.
Procedure-stage (in-hospital clinical care)	Highest ratings.	Indicates strong perceived clinical competence; governance strength at facility level.	Competitiveness evidence emphasizing clinical value.
Post-discharge (follow-up, continuity, documentation)	Lowest ratings.	Implies need for stronger continuity-of-care protocols and standardized discharge/follow-up pathways.	Experience narratives and journey-based issues.

DISCUSSION

The present findings suggest that India’s medical tourism performance is best understood as a patient-journey system in which clinical excellence and price competitiveness are necessary but not sufficient conditions for sustainable growth. Prior peer-reviewed work argues that medical tourism policy narratives in India can outpace reliable baseline public data, and that fragmented institutional accountability can weaken governance capacity, an interpretation consistent with this study’s identification of coordination and transparency as recurring pressure points. From a demand-side lens, destination choice is shaped by perceived value, trust, and the ability to navigate uncertainty, and these factors become especially salient when patients must coordinate across borders, languages, and unfamiliar administrative processes [8, 9]. A key contribution of this study is the empirical emphasis on “weak links” outside the operating theatre: pre-arrival planning and post-discharge continuity. Evidence from qualitative analysis of web-based narratives of health travelers to India shows that patients often report high satisfaction with affordability and service, while negative experiences cluster around broader environmental and organizational issues that frame the care experience and influence overall perception. This pattern supports the interpretation that governance is experienced not only as “clinical safety” but also as “experience reliability,” including hygiene perceptions, wayfinding, and the predictability of processes. In addition, narrative and experience-based evidence indicates that online information ecosystems influence expectations and decisions, suggesting that governance should include credible information architecture and reputational risk management rather than relying on marketing alone [10, 11]. Supply-side perspectives in the literature similarly underscore that governance and operational readiness shape competitiveness. A recent peer-reviewed provider-focused study on supply-side viewpoints in India emphasizes that providers perceive both opportunities (cost advantage, expertise) and constraints (process bottlenecks, coordination, and expectation management), aligning with the present study’s stakeholder themes about logistics, intermediaries, and standardization. The same stream of stakeholder research illustrates that medical tourism ecosystems are multi-actor arrangements where hospitals, facilitators, and public institutions

must coordinate, making “whole-of-system” governance a practical requirement rather than an abstract policy aspiration [12, 13]. The discussion also intersects with equity and public-interest critiques in peer-reviewed scholarship. Work explicitly asking “in whose interest” medical tourism grows in India cautions that without strong public-sector oversight and transparent data systems, policy may disproportionately benefit select private providers while generating uncertain spillovers for domestic access and system strengthening. This study’s findings on uneven transparency and intermediary-related risks complement that critique by showing how governance gaps can simultaneously threaten patient protection and weaken accountability for broader societal outcomes [14]. Finally, the results support a governance agenda oriented toward measurable, patient-facing reliability. Evidence from the Ministry of Tourism–commissioned study on problems and challenges faced by inbound medical tourists indicates that competence of doctors is often rated highly, while gaps emerge in facilitation, care processes, and professionalism in management, reinforcing the current finding that non-clinical service architecture shapes satisfaction. Complementary peer-reviewed work on service quality and value co-creation in medical tourism contexts indicates that patient satisfaction is closely linked to interactive service processes rather than clinical outcomes alone, strengthening the argument for governance reforms that formalize and monitor the full pathway from arrival to follow-up. Viewed together, these findings imply that India’s medical tourism governance should prioritize regulated facilitator ecosystems, standardized cross-border documentation and follow-up pathways, and publicly reportable indicators that improve accountability and align growth with patient protection and health-system goals [15].

CONCLUSION

India’s medical tourism sector shows strong demand potential built on perceived clinical expertise and value, but sustained growth depends on governance that spans the full patient journey. Evidence from traveler narratives and survey patterns indicates that pain points concentrate in pre-arrival facilitation and post-discharge continuity rather than in-hospital care. Supply-side studies likewise stress coordination gaps among hospitals, intermediaries, and public agencies. Policy roadmaps provide a platform, yet equity-focused critiques warn that benefits may concentrate without transparent accountability. Strengthening regulated facilitation, standardized disclosure, and cross-border follow-up can improve trust and competitiveness. These reforms also support safer care, clearer recourse, and reputation.

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