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Cross-border healthcare policies and cancer care: Strategic opportunities for medical tourism in South Asia

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Abstract

The globalization of healthcare has fueled the rapid growth of cross-border medical tourism, particularly in regions with significant disparities in healthcare infrastructure. In South Asia, cancer patients increasingly seek treatment abroad due to a lack of specialized oncology services, affordability constraints, and regulatory barriers. This research critically examines the intersection of cross-border healthcare policies and cancer care, identifying key push and pull factors that influence medical travel in the region. The study employs a document analysis and case study approach to assess how national healthcare policies either facilitate or restrict access to international oncology treatment. Findings highlight the uneven distribution of cancer care resources, with countries, such as India, serving as medical hubs, while others, such as Bangladesh and Nepal face severe treatment shortages. Policy inconsistencies, visa restrictions, and healthcare agreements further complicate patient mobility. This research underscores the need for regional cooperation in standardizing medical regulations, improving patient safety measures, and streamlining healthcare policies to enhance access to timely and cost-effective cancer treatment. The study contributes to the discourse on regional health integration by proposing policy recommendations for harmonized cross-border healthcare frameworks within South Asia.

Keywords: Cross-border healthcare; Cancer care; Medical tourism; South Asia; Health policy; Regional cooperation

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1. Introduction

The globalization of healthcare services has enabled the rapid expansion of cross-border medical tourism, in which patients travel to foreign countries to receive medical treatment that is not available, costly, or of inferior quality in their countries.[1] Medical tourism has become an increasingly important sector of health care infrastructure due to factors, such as higher healthcare costs and healthcare disparities, long waiting times and innovations in the field of medicine.[2] According to the Medical Tourism Association, the global market in medical tourism is projected to exceed USD 200 billion by 2025, with a large portion of this market being achieved by patients who travel to obtain oncology treatment.[3] Cancer is a major driver of cross-border healthcare—a growing problem in countries, such as South Asia where limited oncology infrastructure compels

patients to seek advanced treatment abroad.[4] As elective procedures, such as cosmetic or dental surgery are often non-determinative, cancer treatment requires long-term strategies (surgery, chemotherapy, radiation therapy and immunotherapy), which sometimes present additional difficulties for patients who are delegated to multiple healthcare systems. Cancer is a leading cause of morbidity and mortality in South Asia. The burden of the disease is increasing due to changes in lifestyle, environment and population growth. South Asia accounts for more than one-fourth of the global cancer incidence.[5] Incidence rates are rapidly growing in India, Bangladesh, Pakistan, Sri Lanka and Nepal. Some of the most common cancer types include breast, cervical, lung, and gastrointestinal cancers. Mortality has been exacerbated by late-stage diagnosis of these cancers, compounded by limited access to high-intensity treatments.

A major challenge in South Asia is the disparity in cancer care infrastructure, with certain countries (such as India) possessing world-class oncology centers, while others face severe shortages in oncology specialists, radiotherapy units, and chemotherapy facilities.[6] India has 27 comprehensive cancer centers per 100 million people, whereas Bangladesh has only three, highlighting the uneven distribution of resources.[7] As a result, thousands of cancer patients from Bangladesh, Nepal, Afghanistan, and the Maldives travel abroad—primarily to India, Thailand, Malaysia, and Singapore—in search of timely and affordable treatment.

Cancer patients' inter-regional mobility depends largely on healthcare policies at the national and regional level, including rules on the visa regime for medical practitioners, policies governing transfer of medical insurance, trans-border remuneration and costs of cancer treatment, and international hospital accreditation. In contrast to regions with established medical patient mobility structures (e.g., European Union), South Asia lacks an established framework for cross-regional medical travel. Inconsistent visa policies, fluctuating diplomatic ties, and financial constraints often prevent patients from accessing life-saving oncology treatments.

For example, India has been developing mechanisms to facilitate international patients' access to travel, treatment, and streamlined visa regimes. However, recent diplomatic tensions have resulted in restrictions for patients from Bangladesh and Pakistan, significantly disrupting their access to cancer care. Thailand and Malaysia are, on the other hand, positioning themselves as alternative hubs for international oncology treatment by providing an easier visa process and public, that is, private partnerships in healthcare.[8] These examples suggest that medical tourism for non-oncological services is growing and warrants equal attention in regional health governance.

While cancer care continues to be a dominant driver of medical tourism in South Asia, other high-demand procedures, such as organ transplants (especially kidney and liver), cardiac surgeries, fertility treatments, and advanced diagnostics also play a pivotal role. Countries, such as India, have become popular destinations for liver transplants due to comparatively lower costs, availability of skilled surgeons, and lax regulatory enforcement. However, this expansion also raises ethical concerns around donor safety, consent, and commercial exploitation—particularly in the realm of transplant tourism. Fertility services, which are often restricted or culturally stigmatized in countries, such as Pakistan or Bangladesh, have driven demand in Indian metropolitan areas that offer *in vitro* fertilization and surrogacy options. These examples suggest that medical tourism for non-oncological services is growing and warrants equal attention in regional health governance.

2. Background and theoretical framework on healthcare regionalism

The legal and policy frameworks governing patient movement are a significant factor in determining the effectiveness of cross-border healthcare. To facilitate seamless medical travel while guaranteeing patient safety, bilateral health agreements, visa facilitation policies, and insurance interoperability are crucial. Patients may be discouraged from seeking care overseas due to disparities in accreditation standards, medical malpractice laws, and reimbursement procedures caused by South Asia's absence of a single regulatory framework for medical tourism.[9]

Access to therapy for cancer patients frequently hinges on how simple it is to get a medical visa and whether foreign medical credentials are accepted. Even though India has loosened its visa requirements for medical tourists, patients from Bangladesh and Pakistan still face administrative obstacles that prevent them from receiving timely cancer treatment.[10] In addition, patients are forced to rely on out-of-pocket payments due to the lack of a regional health insurance system, which makes it more expensive for low-income people to receive treatment overseas. The accessibility and affordability of healthcare in the area might be greatly increased by filling these gaps through cross- border insurance agreements and policy harmonization.

A solid theoretical basis for examining South Asian medical tourism and cross-border healthcare policies is offered by the Theory of Regionalism. In the healthcare industry, regionalism is the term used to describe the organized cooperation of countries to improve health

services, strengthen policy coherence, and generate mutual economic and social advantages.[11] Because it emphasizes the value of regional integration in overcoming inequalities in medical infrastructure, cost, and accessibility, this approach is especially pertinent to cross-border cancer treatment.

Regionalism in South Asia draws attention to the potential for collaboration through organizations, such as the South Asian Association for Regional Cooperation (SAARC), which can ease restrictions on medical travel, standardize treatment protocols, and facilitate healthcare agreements.[12] The hypothesis also helps explain why some nations, such as India, emerge as hubs for medical tourism due to their competitive pricing and sophisticated healthcare infrastructure, while other nations struggle with resource constraints and fragmented health policies.

In addition, regionalism in healthcare highlights the importance of bilateral agreements, transnational healthcare governance, and policy harmonization in fostering cross-border access to cancer care.[13] By using this approach, policymakers can overcome the logistical, financial, and regulatory obstacles that prevent cancer patients in the area from receiving timely, high-quality treatment.

3. Methods

This study examines medical tourism and cross-border healthcare policies in South Asia, specifically in relation to cancer care, using a comparative case study approach and document analysis. To evaluate the effects of national and regional health policies on medical tourism, the document analysis technique methodically examines policy documents, bilateral agreements, legislative frameworks, and institutional reports. In healthcare policy research, this approach is frequently used to assess governance and regulatory frameworks. The World Health Organization (WHO)-SEARO reports on cross-border healthcare, SAARC regional healthcare initiatives, and national healthcare policies are the main sources used in this analysis. With an emphasis on visa restrictions, insurance portability, and economic differences in healthcare prices, the analysis seeks to identify the major regulatory facilitators and hurdles affecting cancer patients' ability to seek treatment overseas.

Furthermore, this study analyzes how various national policies influence cross-border cancer care using a comparative case study methodology. Three major nations are the subject of the study: Bangladesh, a major source country for patients traveling abroad; Nepal, another important outbound medical tourism destination; and India, a center for medical tourism. While Bangladesh and Nepal are examples of nations where a lack of domestic healthcare resources forces patients to seek treatment overseas, India is a prime case study because of its sophisticated oncology infrastructure and government-sponsored medical tourism programs. The study investigates the geographic, policy, and economic elements that affect cross-border healthcare migration by contrasting these situations.

To ensure the reliability of findings, thematic coding and triangulation are applied, identifying key themes, such as regulatory challenges, financial constraints, and policy harmonization efforts. The use of multiple data sources strengthens the validity of conclusions, aligning with established research methodologies in global health governance.

In addition to the core case studies of India, Bangladesh, and Nepal, this research acknowledges the broader South Asian context, which includes Sri Lanka, Pakistan, Bhutan, and the Maldives. Although these nations were not included as focal cases due to data limitations, their healthcare dynamics—especially in oncology—remain critical to understanding the regional picture. For instance, Pakistan and Sri Lanka possess pockets of excellence in cancer care, while the Maldives frequently refers patient abroad due to its limited tertiary care infrastructure. By recognizing the shared policy constraints an healthcare challenges across South Asia, this study offers transferable insights that extend beyond the core countries analyzed.

This study is limited by its focus on three countries—India, Bangladesh, and Nepal—selected due to the availability of policy data and prevalence of cross-border healthcare. It does not include other South Asian countries, such as Sri Lanka, Bhutan, or the Maldives, which may exhibit distinct healthcare trends. The qualitative document-based methodology also restricts patient-level insights, and reliance on secondary data may introduce institutional bias. Moreover, this study does not quantitatively assess patient outcomes or treatment success rates, which are critical to evaluating medical tourism's effectiveness. Future studies should incorporate patient interviews, cross-country quantitative analysis, and policymaker perspectives to enrich findings and enhance applicability.

4. Results and discussion

4.1. Present landscape of medical tourism in South Asia

The policy-driven measures that facilitate patient mobility are one of the main drivers of cross-border medical tourism in South Asia. As a leading center for medical

tourism, India has put in place a number of strategies to draw in international patients, such as the e-Medical Visa system, which speeds up the application procedure for a medical treatment visa. India has become a cancer care hub due to its affordable, excellent services and government-supported medical tourism programs. The number of cancer patients from nearby nations seeking treatment in Indian hospitals has dramatically increased since the creation of this visa category. Furthermore, patients from Bangladesh, Nepal, and Sri Lanka can enter India more easily due to the medical visa on arrival program.

In addition to facilitating visas, India's public-private partnerships (PPPs) in oncology care have been crucial in increasing the number of foreign patients who can receive cancer treatment. PPP models are used by renowned hospitals, such as the Apollo Cancer Institutes and the Tata Memorial Centre, which provide subsidized care for patients from low-income backgrounds while simultaneously drawing in foreign medical tourists aiming for the first-rate services. Access to cancer treatment, both before and after travel, is further made possible by means of telemedicine consultations and international partnerships with South Asian nations.

Despite India's leadership, other South Asian nations are beginning to implement similar medical tourism enablers. Bangladesh has attempted to integrate healthcare tourism incentives into its policy framework by developing private oncology centers that offer treatment to foreign patients. However, the country still lacks a robust system like India's e-Medical Visa.

4.2. Barriers and enablers of cross-border oncology care

The smooth movement of cancer patients throughout South Asia is impeded by notable obstacles, even in spite of the enabling policies.[14] The main problem is that regional nations do not recognize mutual insurance. Due to the lack of cross-border health insurance agreements, patients seeking cancer treatment in India from Bangladesh or Nepal must pay for their own care.[15] South Asia lacks a unified framework for portable medical insurance, making cross-border treatment financially burdensome—unlike the European Union's European Health Insurance Card (EHIC), which enables healthcare coverage across member states.[16]

Patient mobility is made more difficult by political sensitivities and visa restrictions. Although India offers an e-Medical Visa, patients from some areas face bureaucratic obstacles due to its strict restrictions, such as the need for a recommendation letter issued by the government.[17] Furthermore, medical travel between India and Pakistan is restricted due to diplomatic tensions, hampering Pakistani patients' access to India's cutting-edge oncology facilities.[18]

Both successful and unsuccessful initiatives at cross-border cancer care in South Asia are highlighted by a number of real-world case studies. Each year, thousands of foreign patients are admitted to hospitals, such as Apollo and Fortis, which provide them with follow-up telemedicine care, integrated treatment packages, and lodging services.[19]

Table 1 shows the comparison of cancer care infrastructure across the South Asian countries.

Table 1. Comparison of cancer care infrastructure across South Asian countries

Questions	Bhutan	Pakistan	India	Bangladesh	Sri Lanka	Nepal
Number of qualified oncologists in the country	2	125	1,500	150	18	40
Number of cancer centers in the country	1	20	27	18	6	5
Number of other hospitals treating cancer patients in the country	200	300	1,800	106	15	40
Number of new cancer patients diagnosed every year in the country	300	150,000	1,000,000	100,000	15,000	30,000
Number of medical oncology journals initiated in the country	Nil	1	5	3	Nil	Nil
Number of oncology conferences and CMEs conducted in the country every year	Only once in 2011	55	55	20	5	20
Number of radiotherapy machines currently available in working condition	Nil	25	630	19	11	15
Number of scientific societies/associations dedicated to oncology in the country	None at the moment; going to set up soon	2	5	3	1	10
Is there degree training in oncology (any branch) available in the country?	No	Yes	Yes	Yes	Yes	Yes
Is there an official national healthcare policy for cancer in the country (of any nature)?	Yes	Yes	Yes	Yes	Yes	Yes

Abbreviation: CME: Continuing medical education.

4.2.1. Problem: Restrictions on medical visas between Pakistan and India

Some of the restrictions on medical visas between Pakistan and India are summarized in the following:

(i) Pakistani cancer patients find it difficult to secure medical visas for treatment in India due to diplomatic sensitivities, which forces many of them to seek more expensive care in the Middle East or Turkey.
(ii) Pakistani patients' treatment costs are raised by the informal and costly medical facilitation networks that arise from the absence of government-backed patient referral schemes.
(iii) Due to inadequate hospital accreditation, shoddy policy implementation, and a lack of international recognition, Bangladesh's attempt to launch its own medical tourism business by drawing patients from Nepal and Myanmar was unsuccessful.

In 2023, a 52-year-old patient from Chittagong, Bangladesh, diagnosed with late-stage colorectal cancer, opted to seek treatment at Fortis Hospital in New Delhi. The patient faced a 4-week delay in local biopsy reports, prompting the family to explore foreign options. A local facilitator assisted in securing an e-Medical Visa and coordinated a treatment plan with Indian oncologists. Although the total cost exceeded USD 18,000, the family deemed it a necessary investment due to poor diagnostic services at home. Similarly, a patient from Nepal with a rare pediatric leukemia case was fast-tracked to Apollo Hospital, Chennai, after consultations through a regional non-governmental oganizations (NGO) partnership. Such stories reflect the lived experiences driving the surge in medical tourism for oncology treatment and highlight both the opportunities and disparities in cross-border healthcare access.

The findings of this study highlight the complexities of cross-border healthcare policies and cancer care in South Asia, revealing both enabling factors and persistent challenges. The discussion critically synthesizes these findings in light of existing literature and theoretical perspectives, emphasizing key policy implications and strategic opportunities for regional medical tourism.

In addition, the regulatory environment is still disjointed. Foreign medical services are subject to taxes in some nations, which raises the cost of cancer treatment overseas. For example, patients are deterred from seeking specialized care in Thailand or India by Nepal's higher taxes on international medical payments. The lack of uniform healthcare laws throughout South Asia makes cross-border cancer treatment collaboration even more challenging.

Cross-border cancer care is heavily affected by the absence of interoperable health insurance systems in South Asia. Patients from Nepal or Bangladesh traveling to India must pay fully out-of-pocket, often leading to exorbitant expenditures. Unlike the European Union's EHIC model, South Asia lacks a regional insurance portability mechanism. Incorporating such a model through SAARC could dramatically increase access to cross-border care, reduce the financial burden on patients, and enable governments to monitor healthcare migration patterns more systematically.

Cross-border cancer care is greatly impacted by stakeholder attitudes on regulatory to guarantee that patients from other countries receive certified care, India's National Accreditation Board for Hospitals and Healthcare Providers (NABH) has been instrumental in standardizing quality control and assurance of cancer services.[20] When seeking care at foreign institutions, patients frequently express worries about accountability, post-treatment follow-ups, and treatment quality.

However, a number of stakeholders contend that differences in treatment quality are caused by South Asia's absence of unified patient rights policies. For instance, it is challenging to handle medical malpractice cases in Bangladesh and Nepal, as these countries do not offer complete legal safeguards for patients seeking care outside.[21] The lack of a regional medical oversight authority makes matters worse because there is no formal system in place to settle conflicts, standardize oncology procedures, or control international healthcare collaborations.[22]

Trust in healthcare services also plays a crucial role in cross-border medical tourism. A study highlights that many South Asian patients rely on word-of-mouth recommendations and informal social networks when choosing hospitals abroad.[23] The lack of official referral systems on government-endorsed medical travel programs increases reliance on private medical facilitators, which often charge high service fees without ensuring transparency in hospital selection.[24]

The institutional gap in regional healthcare governance is one of the main conclusions. There is no regional policy framework in South Asia to support cross-border cancer treatment, in contrast to the European Union's cross-border healthcare regulation, which offers a structured legal framework for medical tourism. An unregulated medical tourism sector results from the lack of an SAARC-wide health policy, which hinders unified legislation, insurance portability, and quality control measures.

To bridge these institutional gaps, experts suggest forming a South Asian Medical Tourism Council under SAARC to develop standardized policies for:

- Accrediting oncology hospitals for international patients
- Facilitating cross-border health insurance schemes

- Implementing patient safety and malpractice resolution protocols.

Successful examples of regional healthcare cooperation can be found in ASEAN, where mutual recognition agreements for healthcare professionals enable oncologists to practice across member states.[25] A similar approach in South Asia could improve access to specialized oncology care and reduce reliance on informal medical networks.

Figure 1 illustrates that India dominates the region in terms of cancer-related medical tourism, followed by growing hubs, such as Thailand and Malaysia, in other specialties

4.3. Policy interventions to improve patient access

To operationalize cross-border cancer care in South Asia, a phased and concrete policy roadmap is necessary. This roadmap should be grounded in regional cooperation mechanisms and modeled after successful international frameworks, such as the European Union's Cross-Border Healthcare Directive and the ASEAN's Mutual Recognition Agreements. The following phased interventions are proposed to enable practical implementation:

4.3.1. Short-term (1–2 years): Policy design and stakeholder alignment

4.3.1.1. Key activities

(i) Conduct a SAARC-led regional needs assessment to identify disparities in oncology infrastructure and patient mobility patterns.
(ii) Form a South Asian Task Force on Cross-Border Oncology Care comprising representatives from national health ministries, SAARC, private hospital networks, patient advocacy groups, and regional insurance bodies.
(iii) Initiate a Regional Cancer Patient Registry to improve transparency and facilitate data sharing on treatment access and patient outcomes.

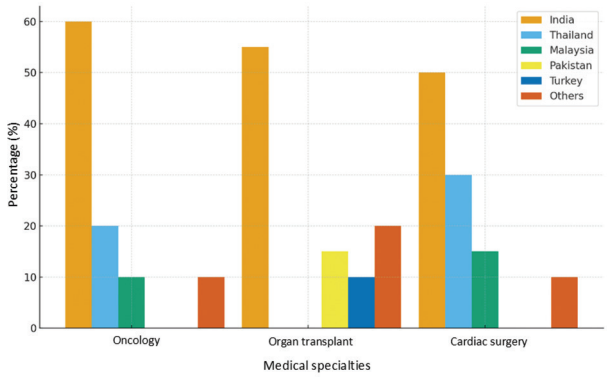

Figure 1. Top medical tourism destinations in South Asia by specialty in 2023

4.3.1.2. Key stakeholders

SAARC Secretariat, Ministries of Health (India, Bangladesh, Nepal, Pakistan), WHO-SEARO, national oncology centers, private hospital consortia, and medical visa authorities.

4.3.2. Medium-term (2–5 years): Legal harmonization and access facilitation

4.3.2.1. Key activities

(i) Develop mutual recognition agreements for hospital accreditation and oncology care standards, modeled on NABH and Joint Commission International frameworks.
(ii) Launch a regional medical visa agreement with standardized application procedures, visa-on-arrival options for oncology patients, and emergency fast-tracking mechanisms.
(iii) Pilot a regional health insurance portability scheme allowing patients to use public or private insurance for cross-border cancer treatment in designated facilities.

4.3.2.2. Key stakeholders

Ministries of Foreign Affairs and Interior, national insurance regulators, hospital accreditation agencies, private insurers, and patient support NGOs.

4.3.2.3. Policy tools

Model health legislation, electronic medical visa platforms, bilateral and multilateral memorandums of understanding.

4.3.3. Long-term (5–10 years): Institutionalization and technological integration

4.3.3.1. Key activities

(i) Establish a South Asia Medical Tourism Authority under SAARC to monitor standards, resolve disputes, and ensure ethical medical facilitation practices.
(ii) Deploy regional telemedicine platforms for pre-treatment consultations, second opinions, and post-treatment follow-ups to reduce unnecessary travel.
(iii) Develop training and exchange programs for oncology professionals and healthcare administrators to address skill gaps and foster shared learning.

4.3.3.2. Key stakeholders

Regional health councils, medical universities, digital health startups, public-private research bodies, and SAARC technical committees.

4.3.3.3. Policy tools

Digital health protocols, oncology certification programs, and transnational legal agreements.

This roadmap not only identifies the tools needed to implement a regional oncology policy but also lays out clear sequencing and stakeholder responsibilities. By embedding oncology care in structured regional mechanisms, South Asian countries can offer a reliable, ethical, and patient-centric model for cross-border medical tourism. Existing research supports the idea that regional cooperation in healthcare can drive economic and social benefits. However, achieving policy alignment will require overcoming institutional inefficiencies and geopolitical barriers that have historically hindered SAARC's effectiveness.

5. Conclusion and future research

5.1. Policy fragmentation and the need for harmonization

This study highlights the uneven access to cancer treatment across South Asia, driven by disparities in oncology infrastructure, fragmented healthcare policies, and inconsistent visa and insurance frameworks. While India has emerged as a leading destination for medical tourism due to its advanced facilities and favorable policy environment, neighboring countries, such as Bangladesh and Nepal continue to struggle with insufficient cancer care resources, prompting thousands of patients to seek treatment abroad.[25]

The absence of a harmonized regional policy on medical travel and cancer treatment poses a significant barrier to equitable healthcare access.[26] Findings from this work suggest that structured regional cooperation—particularly through SAARC—can play a critical role in standardizing oncology protocols, enhancing insurance portability, and streamlining visa policies for patients requiring urgent cross-border care.

Future research should explore the economic impact of outbound medical tourism on source countries, including household-level financial burdens and health system strain. Comparative studies of successful cross-border healthcare models from other regions, such as the European Union or ASEAN, can also offer valuable insights for South Asia. In addition, longitudinal studies that track patient experiences across regulatory systems, and policy simulations that test regional agreements, will be crucial in designing a more inclusive and sustainable framework for cross-border cancer care.

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Conflict of interest

The authors declare that they have no competing interests.

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Availability of data

Data are available from the corresponding author upon reasonable request.

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