

Perspective

Reframing US Healthcare Globalization: From Medical Tourism to Multi-Mode Cross-Border Trade

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Abstract

This Perspective presents a framework for US hospitals treating foreign patients to reconceptualize international healthcare trade by leveraging all four modes of trade in health services under the General Agreement on Trade in Services (GATS), which include information exchange (Mode 1), patient travel/medical tourism (Mode 2), commercial presence (Mode 3), and temporary movement of healthcare personnel (Mode 4). This framework illustrates how hospitals could adopt multi-modal approaches and describes the strategic implications for hospitals and their international patient programs. Historically, US hospitals have focused primarily on international patient travel (Mode 2), but this narrow approach creates vulnerability to disruption. Mode 2 exports by US hospitals have not recovered to pre-pandemic levels, making expansion into other modes essential for maintaining competitive advantages while mitigating systemic risks. Diversification into other modes, such as digital health and telemedicine (Mode 1), co-branding and managing facilities (Mode 3) and visiting professorships (Mode 4) are single-mode approaches for diversification. Multi-country clinical trials are an example of cross-border trade that addresses all four modes of GATS. Overall, this perspective provides a new framework for US providers engaged in or considering entry into international markets that does not solely rely on Mode 2 medical tourism but instead adopts a multi-modal, cross-border health service paradigm.

Keywords: international patient programs; international medical travel; medical tourism; clinical trials; telehealth; General Agreement on Trade in Services; health travel; cross-border trade in medical services; medical services exports



Academic Editor: Francisco Epelde

Received: 28 September 2025

Revised: 12 November 2025

Accepted: 17 November 2025

Published: 21 November 2025

Citation: Ziemba, E.; Stackpole, I.; Whittier, M.L.; Johnson, T.J. Reframing US Healthcare Globalization: From Medical Tourism to Multi-Mode Cross-Border Trade. *Hospitals* **2025**, *2*, 28. <https://doi.org/10.3390/hospitals2040028>

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1. Introduction

Medical tourism, one aspect of the globalization of healthcare services, is undergoing significant transformation in the wake of the COVID-19 pandemic and changing geopolitical and economic landscapes. Historically, US hospitals and health systems have pursued revenue, brand prestige, and other monetary and non-monetary benefits from engagement in international markets primarily through international patient programs (IPPs) (General Agreement on Trade in Services [GATS] Mode 2; patients traveling to a destination for treatment, also often referred to as “medical tourism”) [1,2]. The vulnerabilities of this approach—made stark by pandemic-era border closures, travel bans, and geopolitical

shifts—necessitate a fundamental strategic reconsideration of how cross-border healthcare is defined, delivered, and leveraged by US providers.

Although rigorous and comparable data are scant, best available estimates of the global market for Mode 2 exports (medical tourism) range from \$20–30 billion USD in 2023 and are projected to reach \$115 billion in 2032 [3]. The United States has been a destination for complex medical care for decades; however, the COVID-19 pandemic caused a precipitous decline in Mode 2 exports [4]. Since 2022, this market has re-emerged with significant changes for US hospitals with IPPs, including a decline in exports to China that has likely impacted the number of patients traveling to the US for complex medical care. These market disruptions will likely continue presenting obstacles to US hospitals unless tactical and strategic changes are made.

This Perspective critically evaluates an alternative approach for cross-border trade in health services: shifting from single-mode dependence to a multi-modal strategy for medical services exports using the GATS framework. The clinical trials market is an example of diversification from Mode 2 to Modes 1, 2, 3, and 4, representing a more expansive strategic approach for US hospitals treating international patients.

GATS serves as a framework for cross-border trade in health services. Medical tourism is described as individuals traveling from one country to another country for the purpose of receiving medical care. GATS describes the modes of services imports and exports, providing a structure for US hospitals, IPPs and health systems to manage the cross-border trade in healthcare services. There are four modes in GATS of cross-border trade in health services [5,6]:

Mode 1 [Information Exchange]: Cross-border delivery of health services refers primarily to the use of electronic media, such as telemedicine where the service (e.g., information) is provided across a border, including but not limited to virtual specialist consultation, second medical opinion, teleradiology, and distance learning or skills transfer. It may also refer to the exchange of information, reports, or organic samples, including tissue and blood, via mail, email, or other forms of electronic communication.

Mode 2 [Patient Travel]: Consumption of health services abroad describes travel of individuals from one country to another country to access and consume treatment abroad (typically referred to as “medical tourism”). This Mode also includes students relocating for education, training, or up-skilling.

Mode 3 [Commercial Presence]: Foreign direct investment into the health system of a country includes the establishment of hospitals, clinics, and other health and medical organizations or institutions by foreign entities. It also describes co-branding, leasing, or other forms of contractual investment abroad.

Mode 4 [Temporary Movement of Personnel]: Temporary movement of health workers involves healthcare professionals temporarily working in another country. This mode also includes teachers or healthcare professionals temporarily relocating to deliver or provide training.

The purpose of this Perspective is to (1) examine the impact of the COVID-19 pandemic on cross-border trade in health services, specifically international patient travel to the US (Mode 2), (2) identify challenges to Mode 2 exports for the US, and (3) propose a multi-mode framework for trade in health services using clinical trials as an example.

2. The Impact of the COVID-19 Pandemic

The COVID-19 pandemic led to an unprecedented disruption in the global medical tourism market, effectively halting cross-border patient flows across the world. Early pandemic forecasts suggested that pent-up domestic demand for healthcare services would surge once travel restrictions were removed, raising concerns that US healthcare providers’

capacity could be overwhelmed [4]. In the immediate post-restriction period, hospitals prioritized the restoration of services to address the immediate needs of domestic patients. These changes led US hospitals with IPPs to re-evaluate their global market strategies and delay efforts to attract international patients for medical care.

Mode 1 services, including telemedicine, telehealth, and other digital health platforms, facilitate cross-border healthcare delivery by connecting foreign patients, providers, and their intermediaries for services such as initial consultations and second opinions. Telemedicine was forecast to become a critical channel for foreign patients to access US healthcare services following the pandemic. US regulations that had restricted physicians from treating US patients across state lines were waived during the pandemic, so that physicians could engage in interstate consultations without violating either state or Federal law, or the terms of their medical malpractice insurance. In contrast, countries competing for international medical travelers such as Malaysia and South Korea had robust telehealth services before the pandemic. These countries successfully leveraged these tools to maintain strong positions in the international global healthcare marketplace and continued to attract international patients after the pandemic [7,8].

Patients in the United States shifted to telehealth early in the pandemic. In the second quarter of 2020, 48% of Medicare beneficiaries who used healthcare during this time had at least one telemedicine service [9,10]; however, utilization steadily declined to 13% in the fourth quarter of 2023 [9,10]. The Federal waivers that allowed telemedicine to spread quickly were set to expire in December 2024 but were temporarily extended [11]. In the US, concerns about jurisdictional issues have hindered the development of this capacity, which can be a compelling feature in attracting international patients. US IPPs' use of telemedicine as a channel for cross-border health services exchange is limited due to both perceived and real legal, regulatory, and malpractice issues [12]. Additional political and legal barriers may further constrain US hospitals' IPPs. These challenges include uncertainties about National Institutes of Health funding, telemedicine regulations, and restrictive visa policies that limit mobility of patients and healthcare professionals. As of June 2025, the US had implemented full or partial visa suspensions for nationals of 19 countries, creating barriers to international patient travel from affected countries and serving as a deterrent for prospective international patients from non-restricted countries [13].

3. Changing Supply & Demand

Post-pandemic trends suggest both declining demand for US hospital services among international patients from key source countries and increased competition from hospitals outside the US for these patients. Historically, US hospitals have attracted substantial numbers of patients from the Middle East, Mexico, South America, and China. Although neither international patient volumes nor healthcare service exports are tracked at the national level, international arrivals have been used as a proxy measure for evaluating changes in international patient travel to the US [4]. While international arrivals to the US have partially recovered, arrivals from key source countries remain below pre-pandemic levels (Table 1), suggesting that medical tourism volumes have not recovered [14].

These countries have also improved their local hospital capacity, making domestic healthcare services more attractive and reducing demand for US healthcare services. For example, the number of private hospital beds in China increased from 1,489,000 in 2017 to 2,207,000 in 2021, or a 48% increase [15]. Increased capacity in these source countries is an additional vulnerability and an emerging, long-term threat to international patient travel to US hospitals. For example, the Gulf Cooperation Council (GCC) countries have been a large source of patients coming to the US hospitals for complex medical care, but many GCC countries are now actively promoting themselves as "medical tourism"

destinations [16,17]. Since 2020, the Kingdom of Saudi Arabia (KSA) has significantly invested in its infrastructure, which may limit the number of residents of the KSA and from neighboring countries who travel to the US for healthcare in the future [18]. Another example of disruptions in Mode 2 exports is reduced international patient travel from Mexico and South America, regions that have historically imported medical services from the US. Recent changes to US immigration policies have led to further disruptions in the flow of patients from these countries to US hospitals, particularly those located in Florida and southeastern Texas. At the same time, increasing capacity and marketing by Colombian hospitals has reduced the number of international patients traveling to US hospitals from South American countries. Overall, these data and trends point to declining or shifting demand and increased competition for US hospital IPPs. These vulnerabilities are a threat to US IPPs and require a new strategic approach to how US hospitals engage in the international trade in health services.

Table 1. Foreign Arrivals (Thousands) to the United States from Selected Countries/Regions *.

Year	China	Middle East	Mexico	South America
2017	3174	1182	17,788	5556
2018	2992	1197	18,387	6027
2019	2830	1216	18,328	5733
2020	378	262	6809	1433
2021	192	513	10,576	3019
2022	368	861	12,436	4214
2023	1078	1035	14,367	4833
2024	1626	1102	16,990	5399

* U.S. visitor arrivals include air and sea arrival from Mexico and from all modes of transit for other countries. Source: International Trade Administration, US Department of Commerce. Non-US Resident Visitor Arrivals in the United States 2000—Present Annual Country of Residence Arrivals. Available from <https://www.trade.gov/i-94-arrivals-program> (accessed on 11 November 2025).

4. Future Directions: Multi-Mode, Multi-Partner Models and Cross-Border Clinical Trials as a Model for Strategic Reframing

Diversification is widely recognized as a strategic approach to reduce over-reliance on one form of service [19]. Before the pandemic, some large US-based hospitals were actively developing international markets. Cleveland Clinic, for example, established Cleveland Clinic Abu Dhabi in the United Arab Emirates. Mayo Clinic established its Mayo Clinic Care Network in Europe, including partnerships with Koç University Hospital and American Hospital in Turkey. Mass General Brigham has been involved in the development of Jiahui International Hospital in Shanghai.

The pandemic prompted more US hospitals to expand their cross-border strategies to engage other GATS modes beyond international patient care as well. Examples include telemedicine, virtual grand rounds, and data sharing (Mode 1); building or co-branding clinical facilities and training centers (Mode 3); and visiting professorships (Mode 4). This strategic shift reduces risks associated with international travel and may generate additional revenue streams.

Multi-country clinical trials provide an example of multi-modal engagement. Although data are limited, industry reports estimate the value of the global clinical trials market at approximately \$50.02 billion USD in 2023 and project the value to reach \$85.37 billion USD by 2032 [20]. Clinical trials can engage all four GATS modes simultaneously, reducing vulnerabilities associated with reliance on Mode 2 medical tourism.

Cross-border clinical trials may incorporate a combination of some or all GATS modes. Table 2 provides examples of how each GATS mode could be engaged in a clinical trial. The benefits from these exchanges include commercializing expertise in Modes 1, 3, and 4

as well as growing knowledge, fostering innovation, and enhancing brand and reputation. Figure 1 illustrates the shift from siloed, single-mode trade to multi-mode trade.

Table 2. Examples of Clinical Trials by GATS Mode of Trade in Health Services.

Mode	Clinical Trials Example
Mode 1—information exchange	Clinical and non-clinical knowledge exchange Experience and expertise in conducting clinical trials Exchange of ideas and clinical information using electronic transfer Systems-based knowledge, skills, and understanding
Mode 2—patient travel	Patients may travel to another country for the clinical trial OR may be able to access clinical trial domestically; travel may decrease due to patients receiving the trial-based intervention in their home country
Mode 3—commercial presence	In-country promotion of participation of foreign providers Licensing brand name One or more clinical trial partners may offer branded management services across trial sites located in different countries May extend to sharing medical personnel remotely (Mode 1) or in-person (Mode 4)
Mode 4—temporary placement	Relocation and employment of personnel to one or more clinical trial sites to provide trial supervision, recruitment and/or intervention services

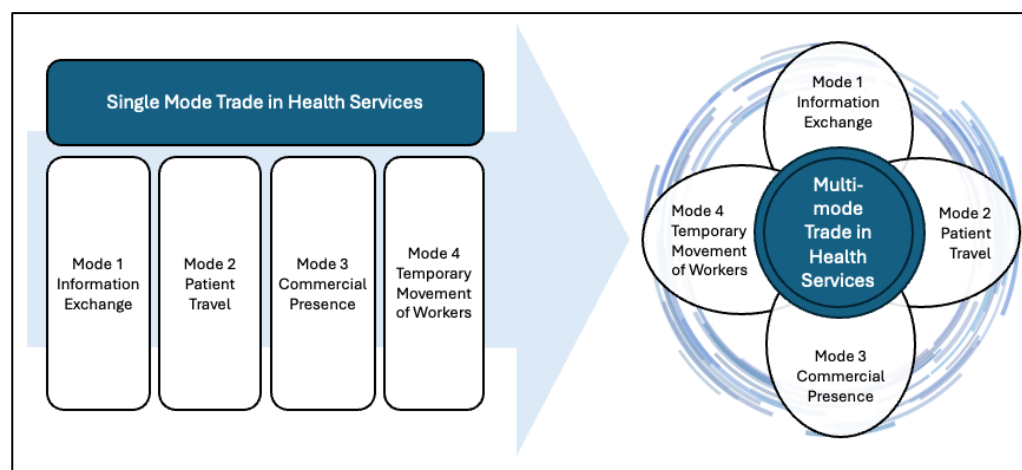


Figure 1. Framework for Multi-mode Trade in Health Services.

4.1. Global Trends in Clinical Trials

As of October 2024, the US National Library of Medicine reported 67,215 trials recruiting subjects with almost one third (23,366) recruiting patients in the United States [21]. Of that total worldwide number, 19,536 (29.1%) were focused on cancer [21].

While many clinical trials are conducted within the borders of one country, cross-border clinical trials are growing in number. For example, the EU-X-CT Cross-Border Clinical Trials Initiative in Europe is co-led by the European Forum for Good Clinical

Practice (EFGCP) and the European Federation of Pharmaceutical Industries & Associations (EFPIA). This initiative has a goal of improving access to cross-border clinical trials in Europe [22]. Patient organizations, academia, research networks, and industry are actively involved in the initiative to increase Europe’s competitiveness in the global pharmaceutical and healthcare sectors.

To evaluate the dynamics within these multi-partner, multi-modal markets, we examined clinical studies registered in ClinicalTrials.gov in eight countries that service international patients: China, Colombia, Costa Rica, Germany, Mexico, KSA, South Korea, and Turkey. China, KSA, Turkey and Costa Rica have experienced increases of 25% or more in the number of clinical trials registered on ClinicalTrials.gov between 2017–2019 versus 2021–2023, compared to an 8% increase in registered trials in the US [21]. Average planned enrollment per trial, a measure of patient reach, increased by more than 50% in Germany (from 419 to 779 per study) and South Korea (from 435 to 785 per study), compared to a decrease in the United States (from 1166 to 903 per study) [21]. Multi-country trials create or expand pathways for the US hospitals that conduct or participate in clinical trials. Successful clinical trial collaborations between and among international healthcare organizations pave the way for further expansion and variations in trade through personnel exchanges, skills transfer, and capital investment.

4.2. Motivations and Benefits for Cross-Border, Multi-Modal Clinical Trials

The motivations and benefits for engaging in cross-border, multi-modal healthcare collaborations such as clinical trials differ for hospitals, governments, and patients. The following summary of these motivations and benefits focuses on tertiary and quaternary care providers as the complexities of many cross-border projects require substantial investment of money, time, knowledge, and other assets that may represent barriers to potential partners (Table 3) [19,23–37].

Table 3. Motivations and Benefits to Engage in Clinical Trials for Hospitals, Patients, and Governments. Content highlighted in blue are the categories of motivations while the items directly below them are examples of those motivations.

Motivations and Benefits	Modes 1–4			Mode 2 Only		
	Hospital	Patient	Government	Hospital	Patient	Government
Access to Cutting Edge Treatments						
Early access to innovative therapies	P	P	P			
Enhance treatment options	P	P		S	P	S
Treatment for rare or complex conditions	P	P		S	P	
Enhance healthcare outcomes	P	P	P			
Improvement in Patient Care						
Advance patient care	P	P		S	P	S
Enhance patient monitoring	P	P				
Personalized attention		P			S	
Financial or Economic Benefits						
Funding and resources	P					
Reduction in operational costs	P					

Table 3. *Cont.*

Motivations and Benefits	Modes 1–4			Mode 2 Only		
	Hospital	Patient	Government	Hospital	Patient	Government
Revenue Generation including more patients	P	P		P	P	S
No cost or reduced cost for treatment		P			P	
Coverage of additional costs		P				
Stimulate/boost economy	S	S	P	S		P
Cost-effective public health interventions	S	S	P			
Increased foreign exchange/Investment	S		S	S		P
Reputation and Prestige						
Enhance brand & reputation	P		P	P		S
Attract talented staff	P		P	P		S
Advancement of Medical Knowledge						
Contribute to medical science	P	P	P			
Research & development opportunities	P		P			
Help future patients		P	S			
Staff Development & Training						
Professional development	P		P	S		S
Exposure to clinical research methodologies	P		P			
Capacity building across sectors	S		P			S
Global leadership & collaboration	P		P	S		S
Job creation	S		P	S		P
Improved Infrastructure						
Upgrade facilities & equipment	P		P	S		S
Enhance data management systems	P		P			
Strengthen Collaborative Networks						
Collaborate with academic institutions & industry	P		P	P		
Build research networks	P		P	S		
Patient Satisfaction & Loyalty						
Increase patient satisfaction	P	P	P		S	
Patient retention and/or attraction	P	P	S	P	S	S
Regulatory Compliance						
Strengthen ethical standards	P	S	P			
Regulatory compliance experience	P		P			
Patient Empowerment						

Table 3. *Cont.*

Motivations and Benefits	Modes 1–4			Mode 2 Only		
	Hospital	Patient	Government	Hospital	Patient	Government
Active in healthcare decisions	S	P			S	
Informed decision-making	S	P			S	
Support & follow-up (non-clinical)	S	P				
Ongoing follow-up	P	P			S	
Contributing to health equity	P	S	P			
Potential to extend life	P	P			P	
Psychological & emotional benefits	S	P			S	
Access to expertise		P			P	
Public Health Benefits						
Address unmet medical needs	S	S	P			
Strengthen health systems	P	S	P			S
Preparedness for health emergencies	S	S	P			
Increase public trust in research	S	S	P			
Boost to Tourism & Hospitality						
Synergy with tourism and hospitality services				S	S	P
Longer stays				S		P

Notes: P = primary motivation; S = secondary motivation; blank = neutral, little or no motivation.
Sources: [19,23–37].

4.3. Return on Investment in Cross-Border, Multi-Modal Clinical Trials

There are monetary and non-monetary benefits, or returns on investment, to organizations participating in the cross-border trade in healthcare services. For US hospitals treating international patients (Mode 2 medical tourism), the per-case revenue may exceed revenue from domestic patients, but the total Mode 2 revenue is a small percentage of a hospital's overall operating budget. However, the benefits to hospitals for other multi-country, multi-mode trade in health services include additional revenue through direct foreign investment from international patients or their third party payors, such as government sponsorship and private healthcare insurance; new knowledge and skills transfer for healthcare professionals working internationally; brand enhancement and projection into foreign markets; improved recruitment of physicians and other healthcare professionals; and improved retention of domestic healthcare professionals and potential repatriation of others.

Additionally, cross-border clinical trials can result in research that is more representative of the global population with the diseases being targeted while also addressing issues of equity and inclusion [27]. Diversity among subjects from expanded multi-country clinical trials may improve clinical treatments and outcomes, particularly for rare diseases that face distinctive challenges in recruiting a sufficient number of patients [38,39]. For rare diseases, multi-country clinical trials may be the only way to enroll enough subjects to achieve sufficient statistical power. Multi-country clinical trials may also reduce research

costs. Traditionally, the hospital conducting the clinical trial brings patients from other geographic locations to its facility [Mode 2] at a high cost for the funder and/or the patients and their families. Cross-border collaborations leverage Modes 1–4 to create a larger pool of potential subjects who could receive care domestically, reducing costs for the hospitals and benefiting the patients and their families, who remain in familiar surroundings with their existing local support systems. Additionally, recruitment targets may be met more quickly, ultimately decreasing the time required for treatment approvals or new therapeutic discoveries.

Cross-border clinical trials benefit from trade in multiple GATS modes. For example, trial communications can take place electronically (Mode 1) and in-person, either through patients traveling to another destination (Mode 2) or clinical trials staff working abroad (Mode 4). Partner hospitals in resource-constrained environments may lack the in-house systems and processes to manage the complexities of clinical trials, creating opportunities for working with US hospitals to improve their infrastructure and technology while building capacity among their healthcare professionals and other clinical trial personnel. The cross-border collaboration may require that a hospital, or a third-party, be hired to manage the clinical trial taking place in the second hospital [Modes 3 & 4]. A clinical research organization may be a partner in the cross-border clinical trial collaboration, providing services to expedite trial recruitment and other processes.

5. Conclusions

Pandemic-related shocks to the US healthcare system, potential cuts to the US National Institutes of Health [40], and the competitive pressures facing IPPs underscore the need to diversify strategies for cross-border trade in health services. By expanding international initiatives beyond GATS Mode 2 to include Modes 1, 3, and 4, US hospitals and IPPs can improve their resilience and competitive advantage. Cross-border clinical trials are one example of how US hospitals can leverage all four modes of trade in health services that may be more sustainable forms of cross-border trade in medical services.

However, several important considerations merit discussion. First, hospitals may hesitate to share cutting-edge knowledge and innovations across borders that may create international competition, particularly in clinical trials involving therapeutics or treatments that have not yet been brought to market. Yet in reality, the US is already a hub for disseminating healthcare innovations through training of international medical graduates and recruiting physicians from other countries to fill shortages. Moreover, recent legislation has been proposed to reduce US training requirements for physicians who have been trained outside of the country [41]. Second, multi-country clinical trials may not be viable for all US hospitals, despite their value to strategic diversification. For US IPPs, traditional diversification strategies have focused on marketing to international patients from multiple countries and geographic regions to reduce fluctuations from local disruptions. However, the COVID-19 pandemic has demonstrated how global events can impact international patient travel and medical tourism across the world, providing evidence for the need to diversify across GATS modes rather than relying primarily on patient travel. Finally, this Perspective highlights ways in which hospitals can pursue multi-country clinical trials that address each of the four GATS modes at the strategic level. Future work should examine the operational aspects of how each GATS mode contributes to multi-country clinical trials.

Author Contributions: Conceptualization, E.Z., I.S. and T.J.J.; methodology, E.Z., I.S. and T.J.J.; investigation, E.Z., I.S., M.L.W. and T.J.J.; data curation, E.Z., I.S., M.L.W. and T.J.J.; writing—original draft preparation, E.Z., I.S. and T.J.J.; writing—review and editing, E.Z., I.S., M.L.W. and T.J.J. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Data Availability Statement: Data are provided in this publication or are publicly available.

Conflicts of Interest: Elizabeth Ziemba is President and Founder of Medical Tourism Training, which provides training and consultation services related to medical tourism. Irving Stackpole is the President of Stackpole & Associates, which provides consultation related to medical tourism. Millan Whittier and Tricia Johnson have no conflicts of interest to declare. Publicly available data reported in this manuscript were reviewed by E.Z., I.S., and T.J.J.

Abbreviations

The following abbreviations are used in this manuscript:

GATS	General Agreement on Trade in Services
GCC	Gulf Cooperation Council
IPPs	International patient programs
KSA	Kingdom of Saudi Arabia
NIH	National Institutes of Health

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