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MEDICAL TOURISM: A HAPPY HOLIDAY?

This article explores the nuances in medical tourism and highlights the key challenges posed in terms of ethics and application in this unregulated industry. The need for a comprehensive legal framework to balance patient safety and autonomy is imperative as markets grow and advances are made in technology.

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> Countries promoting medical tourism should have a well-developed legal system in place, one that spells out the rules and regulations for economic, political, and social behaviour.[1]

I. Introduction

1 Throughout the ages people have travelled far and wide in search of medical treatment.[2] Travelling to holy shrines in the hope of a cure for specific ailments or just generally for good health is still a prevalent practice to this day. This article is about patients travelling out of their country to a foreign one for medical, as opposed to spiritual, cure or treatment. That patients may travel abroad not only for specific treatment such as to cure lung cancer but also for non-specific, general medical check-up, is an indication of the wide range of medical tourism. An added attraction is that "distance provides anonymity".[3] Furthermore, although the bulk of this industry may concern modern medicine, there are people who will travel for traditional cures. An example is the popularity of traditional Chinese medicine ("TCM") in countries that offer it.

2 Medical tourism is a vast terrain, and each region has many deep, and sometimes divisive, issues. Abortion is one clear example. Assisted suicide is another, and so is organ transplantation. Cultural and legal differences divide proponents and opponents in such matters. Each of these have filled books and will continue to do so. Although this article is intended to examine the ever-expanding field of medical tourism in broad terms, parts of it will focus on the conflict between healthcare

1 Milica Z Bookman & Karla R Bookman, *Medical Tourism in Developing Countries* (Palgrave, 2007) at p 121.
2 John Connell, *Medical Tourism* (CABI, 2011) at p 12.
3 John Connell, *Medical Tourism* (CABI, 2011) at p 47.

and economics. Underpinning the conflict are concerns over ethical and administrative issues. I will use the terms "healthcare" and "medical treatment" to suit the context and not to draw specific distinctions. The aim here is to describe what medical tourism is and what sorts of problems it presents. As Lunt *et al* write:[4]

> Optimising quality and minimising risk are two ingredients for creating better and safer health-care services, whether they are providing services for domestic consumption or for medical travellers. This can only be accomplished through the setting up of appropriate forms of clinical governance framework within the hospital or clinic designed to assess quality, identify risk and deal with all relevant issues, and at the same time promoting a culture of remaining vigilant. At the present time, medical tourism services remain largely unregulated. Concerns over the quality and safety of the medical care provided overseas have emerged due to the lack of robust clinical governance arrangements and quality-assurance procedures in provider organisations.

3 Ultimately, legislation may be the only means to demarcate the boundaries of permissibility. A comprehensive study of the extensive terrain of medical tourism is essential but so is a clear overview of it, without which we will likely miss the forest for the trees.

4 Worldwide data is plentiful but not well co-ordinated. This is partly due to the fact that the industry has many grey sectors. Hence, regulators may allow some activities to skip over, undetected, because they appear to be regulated under other existing regulations but, in fact, are not. An example is that of the medical facilitator whose role is discussed again shortly. Another problem is that without uniform data, it is difficult to identify and follow the progress of medical tourism across the world. This is summed up by Hakkı Çılgınoğlu as follows:[5] "[T]here are many exaggerated estimated numbers and confusing descriptions in health and medical tourism research disciplines … how could we consider a country as successful if we do not know the exact numbers of global tourism?"

5 Nonetheless, Fortune Market Insights estimates: "The global medical tourism market was valued at USD 24.14 billion in 2023 and is projected to be worth USD 29.26 billion in 2024 and reach USD 137.71 billion by 2032, exhibiting a CAGR [Compound Annual Growth Rate] of 21.4% during the forecast period (2024-2032)". This was last updated as at 30 December 2024.[6] Market estimates may not

4 Neil Lunt *et al*, "Quality, Safety and Risk in Medical Tourism" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) at ch 4.

5 *Medical Tourism Market in Turkey and Reverse Innovation* (KDP Publishing, 2018).

6 "Medical Tourism Market" *Fortune Business Insights* <https://www.fortunebusinessinsights.com/industry-reports/medical-tourism-market-100681> (accessed 30 December 2024).

cover grey areas in which cosmetic surgery blends into medical surgery. Furthermore, many hospitals do not report complete data. Overall, the general picture is clear – medical tourism is big business. Lest it be forgotten, medical tourism deserves the immediate and close supervision of the law. As Nathan Cortez writes, "Yet medical tourism presently escapes most if not all of this oversight. When a patient travels to a foreign hospital – whether at the behest of an insurer, with the help of a facilitator, or simply on his own – the transaction largely occurs in a legal void".[7]

II. "Health is wealth"

6 As the object of medical procedures and treatments is to cure or alleviate medical conditions, the safe and proper administration of the treatment by qualified doctors in approved hospitals and clinics should not be objectionable; however, there are other constraints. Medical ethics may be universal, or at least, mostly universal. The problem is that in medical tourism, not only is the healthcare industry married to the hospitality industry, it has become a business model in itself, and its notions of what is ethical may differ from those that apply in the medical industry.

7 Why do people travel abroad for medical treatment? The first reason is that the treatment sought is unavailable in the patient's homeland. The second is that the treatment abroad is cheaper, and the third is that the treatment sought is illegal. These are the main reasons underlying the growth of medical tourism, but when we probe deeper into each of them, a greater assortment of problems present themselves. Many of these problems traverse more than one of the three reasons. This article identifies the principal legal, medical, sociological and ethical problems, but owing to the complexities that surround this industry, solutions may not be readily found.

8 According to the website of MedRetreat, the four main groups of North Americans most interested in medical tourism and its cost savings are: (a) 47 million uninsured Americans; (b) 250 million insured Americans with restricted coverage due to pre-existing conditions, resulting in out-of-pocket expenses; (c) 34 million Canadians receiving socialised medicine and enduring long wait lists for many popular

7 Nathan Cortez, "Into the Void: The Legal Ambiguities of an Unregulated Medical Tourism Market" in *Risks and Challenges in Medical Tourism: Understanding the Global Market for Health Services* (Jill R Hodges, Ann Marie Kimball & Leigh Turner eds) (Praeger, 2012).

surgeries; and (d) potentially 330 million Americans seeking elective cosmetic and dental surgery.[8]

9 When travelling abroad for medical treatment, there are two considerations. First, the availability of the treatment, and by implication, the competency of medical skill. Sometimes, exceptions are made; for instance, the competency of the destination country in the treatment sought may lag behind that of the home country, but the cost is significantly lower. That brings us to the second consideration – the cost of treatment. In this regard, it does not follow that where the cost of treatment in the destination country is lower than the home country, the level of the medical care is lower.

10 The availability of medical treatment, and for that matter, quasi-medical treatment depends on the specific treatment sought. Some, like cancer treatment (with small differences such as the latest model of radiotherapy equipment), are available in many countries all over the world. Some may be more esoteric and experimental. Venki Ramakrishnan tells us about the investments by some billionaires into anti-aging research. In "Why We Die", Ramakrishnan, winner of the 2009 Nobel Prize in chemistry, hints that as wealth increases, more people will be like those billionaires "who made their money very young, enjoy their lifestyles, and don't want the party to end. When they were young, they want to be rich, and now they're rich, they want to be young."[9]

III. "Money talks"

11 Although patients will travel to a foreign country for medical treatment that they need but are not available in their home country, they will do so only if they can afford it. Many medical tourists travel because the treatment afforded in the destination countries are much cheaper than what they have to pay in their home countries. The costs may differ from facility to facility, and may also vary from time to time, but generally, the difference is significant. For example, a heart bypass in an American hospital may cost between S$55,000–S$130,000 but S$13,000–S$18,500 in Singapore. Similarly, a hip replacement may cost S$24,000–S$43,000 in the US but S$12,000–S$16,000 in Singapore. A spinal fusion costs S$60,000–S$63,000 in the US and S$8,000–S$10,000 in Singapore.[10]

8 *MedRetreat* <https://www.medretreat.com/> (accessed 30 December 2024).

9 Venki Ramakrishnan, *Why We Die: The New Science of Ageing and Longevity* (Hodder Press, 2024) p 210.

10 "Medical Tourism to Singapore" *health-tourism.com* <https://www.health-tourism.com/medical-tourism-singapore/> (accessed 30 December 2024).

12 The patient has to work out which facility and in which country he will optimise his cost savings. That, of course, depends on where the home country is. For North Americans, MedRetreat advises the rough guide to calculating how worthwhile it is to become a medical tourist. Under the heading "The $6,000 Rule", it states:[11]

> Medical tourists can now obtain essentially any type of medical or surgical procedure within reason. However, there is a simple rule we follow to determine if it makes financial sense to travel abroad. We call it the '$6,000 Rule'. If your procedure would cost $6,000 in the U.S., you may not realise any financial savings. Although the surgery would only cost $1500 abroad, by the time you add the airfare, post-op hotel accommodations, ground transportation, and the other essential overseas travel, you may only realise a break-even scenario. This being said, many still choose to travel abroad to achieve complete privacy and anonymity, peaceful recuperation, and the avoidance of daily hometown distractions.

13 The difference in the costs of procedure exemplified above is further complicated by the costs of travel and accommodation of accompanying friends and relatives. However, the primary question relates to what we may know about the quality of the foreign doctors and hospital facilities? They are bound to vary from country to country. Taking Singapore as an example, basic quality control comes in the form of statutory requirements for the registration of doctors (and surgeons), and even practitioners of traditional Chinese medicine require registration.[12] A patient in Singapore is also protected by medical negligence law and is entitled to claim damages in the event of medical malpractice. Most countries will have similar laws protecting patients, but the bigger question lies in the finer points – whether an overseas patient has the status to sue, and whether the relief sought is commensurate with what he might have enjoyed in his own country.

14 The healthcare within a country itself may vary widely, more so if the country is a large one like the US. How should a medical tourist evaluate quality?[13] Narrowing one's choice to accredited hospitals is one possible solution. There are not many accrediting bodies that are truly universal. One of the more prominent ones is Joint Commission International, a US-based non-profit organisation.[14]

15 The main object of such organisations is to provide sufficient information and data for a patient to evaluate the hospital or facility that

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11 *MedRetreat* <https://www.medretreat.com/> (accessed 30 December 2024).
12 Traditional Chinese Medicine Practitioners Act 2000 (2020 Rev Ed).
13 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 45.
14 Another is the International Society for Quality in Health Care (ISQua).

he might choose. One problem immediately presents itself. The types of medical procedures and the number of doctors and hospitals providing those medical services may have differing measuring standards, and many relate to very specific procedures.[15] Apart from the inherent difficulty of having a uniform standard of information disclosure across the world, mandated disclosure requirements may result in producing too much information. This may lead to what Cohen describes as the problem of bounded-rationality.[16] That arises when the costs of gathering information becomes so high that patients resort to rules of thumb in making their choices. Accrediting bodies are important because it is one of the factors that patients rely on in making their decision to be a medical tourist. According to a report by the Medical Tourism Survey, 63.3% of medical tourists say that "accreditation influenced their decision to choose their provider".[17]

IV. Glorified tour guides

16 Just as the tourism industry benefits from tour guides and agents, medical tourism nowadays is widely organised by agents, known in the industry as "facilitators". They know the appropriate hospital facilities to recommend to their patient clients. They are conversant with the procedures, both medical and administrative. They help the friends and relatives travelling with the patients to find accommodation. They are in that respect, very much like tour guides. This sector of the medical tourism industry has grown and many facilitator companies have worldwide offices. Dr Prem Medical Tourism is an example[18] and MedRetreat is another. Singapore too, has gotten into the act with Pacific Prime CXA.[19]

17 The facilitator's role resembles in part that of the travel agent, but because he is not designated as a travel agent, he may not be subject to

15 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 63.

16 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at pp 64–65.

17 *Medical Tourism Unveiled: Why Patients Travel and What Holds Them Back: A Deep Dive into the Medical Tourism Decision-Making Process* (The Medical Tourism Association & International Healthcare Research Centre, 2024) <https://www.healthcareresearchcenter.org/patient-survey> (accessed 30 December 2024).

18 *Dr Prem Medical Tourism* <https://drprem.com/medical-tourism/consultant/?gad_source=1> (accessed 30 December 2024).

19 *Pacific Prime CXA: Simplifying Insurance* <https://www.pacificprime.sg/medical-tourism-in-singapore/> (accessed 30 December 2024).

the Travel Agents Act 1975.[20] Section 4 of this Act defines the business of a travel agent as follows:

> **4.**—(1) Subject to subsections (2) and (3), a person carries on the business of a travel agent if the person carries on, or advertises or holds himself, herself or itself out as carrying on, a business of any one or more of the following:
>
> (*a*) supplying any person a right to travel on any conveyance;
>
> (*b*) supplying any person —
>
> (i) a right to travel on any conveyance to; and
>
> (ii) a right of accommodation at a hotel or similar boarding premises at,
>
> one or more places, whether in Singapore or elsewhere;
>
> (*c*) purchasing, or reserving, for resale to any person a right to travel on any conveyance;
>
> (*d*) supplying any tour (whether or not organised by the person) to any other person;
>
> (*e*) any other similar activity that may be prescribed.

18 It can be seen the business of a medical facilitator resembles that of the activities of a person carrying on the business of a travel agent. Facilitators are thus exempt from registration and supervision under this Act, the regulation of their business requires governance for the obvious reason that they are often the first point of contact in matters relating to the health and life of their customers – the patients. One aspect that requires governance is the conflict of interests that clearly stands between the facilitator's loyalty to the medical facility that engages him, and that of the patient who depends on his contacts and facilitation. There are no clear rules that prevent a facilitator from accepting referral fees from the medical facility and at the same time, administration fees from the patient.

19 The extent of the legal obligations of a facilitator, and his liability to the patient depends also on the question of his position as an intermediary. Is he an independent contractor for which the common law deems him personally and fully liable to the patient – assuming, first, that a contract can be gleaned from his relationship with the patient. If he is merely acting as an agent, the question then arises – who is his principal? Is it the patient or the medical facility?

20 2020 Rev Ed.

20 A facilitator is more likely to engage the patient in the patient's home country than in the destination country because the very nature of medical tourism is founded on an outward-bound patient, and thus it is the home country that the facilitator will be seeking his customers. Cohen takes the view that in cases where a facilitator is being sued for the medical malpractice of the healthcare provider, "facilitators are likely to be judged under a less plaintiff-friendly standard than foreign hospitals or physicians".[21] However, Cohen seems to assume that courts are stricter with foreign healthcare providers and hold a stricter standard with them. Cohen suggests that the position of the facilitator may be akin to that of a Health Management Organisation ("HMO") in which, under US law, the HMO is not liable for the malpractice of a physician unless the physician is directly employed by the HMO.[22]

V. What is on offer?

21 Before we consider the liability of overseas healthcare providers, let us examine some of the treatments and procedures that patients travel abroad to receive. Travel for routine procedures is usually just a matter of economics, *ie*, the destination country offers considerable savings in costs. There is also the question of availability. That is, sometimes the expertise for a treatment cannot be found in the home country. In such situations, again, there is little controversy and the main issue is costs, including the question of whether the procedure is covered by insurance.

22 However, some treatments and procedures are controversial for other reasons, and they arise mainly because the treatment or procedure is not only unavailable in the home country but is also illegal there. These include abortion, transplantation of organs, stem cell procedures and assisted suicide. Telemedicine is also an area that requires consideration for regulation, but that is a separate topic that this article will return to shortly.

A. Abortion and assisted suicide

23 These two procedures are commonly referred to collectively as the two ends in the spectrum of "ending life". Assisted suicide is sometimes referred to as "euthanasia", but that name has a negative connotation in that it originates as the act of a person ending the life of another, albeit for

21 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 93.

22 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 93.

the latter's own good. On the other hand, referring to abortion as "ending life" is an argument by those who oppose abortion. This article will use the straightforward and neutral descriptions of both procedures. This article is not concerned with the legal and moral arguments concerning abortion and assisted suicide, and is only concerned about the issues relating to those procedures as part of the itinerary of medical tourism, and what, if at all, regulation is required.

24 The issues relating to abortion and assisted suicide overlap, but the legality of each may differ from country to country. Abortion as part of medical tourism depends uncontroversially with age and finance. An adult woman in Ireland, *eg*, may travel to England or any country where abortion is legal, provided that she can afford the travel. Some may not have to travel far as ships flying the flags of countries that permit abortion may anchor in international waters off the coast of Ireland. "Women on Waves" operates this sort of service.[23] In March 2024, Women on Waves, in collaboration with Aid Access[24] planned to station abortion robots (Nicknamed "Roe-bots") in Washington DC, and in front of the Supreme Court of the United States ("US Supreme Court"). These robots would dispense abortion pills, of which the drug mifepristone is a major component.[25]

25 A case was filed in the US Supreme Court concerning the registration of mifepristone. In June 2024, the US Supreme Court decided against the banning or restrictions to access of mifepristone.[26] That may mean that American women may travel to Washington for this form of abortion – surgical abortions are another matter – nonetheless, this may not resolve the legal and practical problems of abortion ships, as the 2017 Guatemala incident exemplifies. A "Women on Waves" ship was detained at a Guatemalan harbour when its purpose was made known.[27] Abortion procedures, in places where abortions are permitted, are considered "day surgery" which means that the patient can fit the procedure into part of a planned regular tourist holiday.

26 Assisted suicides are more complicated because there are not many jurisdictions that permit assisted suicide. The moral and legal

23 Women on Waves was founded in 1999 by Dr Rebecca Gomperts.

24 Also founded by Dr Rebecca Gomperts.

25 "Abortion Roe-bots dispensed abortion pills in front of the Supreme Court" *Women on Waves* <https://www.womenonwaves.org/en/page/7839/abortion-roe-bots-to-dispense-abortion-pills-in-front-of-the-supreme> (accessed 30 December 2024).

26 *Food and Drug Administration v Alliance for Hippocratic Medicine* 602 US 67 (2024).

27 The facts and commentary can be found in Jennifer Bisgaier, "Navigating Rough Seas: Women on Waves' Legal Options for Overcoming Resistant States" 20(1) *Chicago Journal of International Law* 98.

question arises as to whether the patient and his family and friends who assist him in the process may be prosecuted in the home country where assisted suicide is not permitted. Assisting suicide is an offence in Singapore.[28] It is also an offence under the UK Suicide Act 1961.[29] In neither country is attempting suicide itself an offence. The courts in the UK have thus dismissed applications seeking an exemption from prosecution for assisting a suicide. The leading case is *R (Pretty) v Director of Public Prosecutions*[30] ("*R(Pretty)*") – Dianne Pretty sought to end her life but needed her husband to assist her in the physical arrangements because of her incapacity arising from a motor neuron disease. The Director of Public Prosecutions ("DPP") declined to grant her husband immunity from prosecution, and her appeals went not only to the House of Lords but also the European Court of Human Rights.[31] The appeals were dismissed; the former on the ground that Art 8 of the European Convention on Human Rights was not wide enough to allow a person to determine his own death, and the latter on the ground that the interests of the state may be invoked to protect vulnerable people.

27 After *R (Pretty)*, two other cases signalled a more empathetic view of granting immunity. In 2008, the DPP declined to prosecute Daniel James' parents who had assisted James in ending his life in the facility run by Dignitas in Switzerland. And after *R (Purdy) v Director of Public Prosecutions*,[32] when it became obvious that persons assisting a patient seeking assisted suicide would not know in advance how the prosecutorial discretion would be exercised, the DPP issued guidelines regarding the exercise of such discretion.[33] From a technical legal point of view, in the guidelines, the person seeking assisted suicide is referred to as "the victim" and the person assisting, as "the suspect".

28 The pros and cons of assisted suicide in jurisprudence and philosophy remain unresolved subjects of debate. Nonetheless, the regulation of medical tourism as an industry will not be complete without a review of this subject, given that existing case law may be behind time, and policy considerations in aging populations shift away from extreme efforts to prolonging life.[34] An assisted suicide organisation, Assisted

28 Penal Code 1871 (2020 Rev Ed) s 306.
29 Suicide Act 1961 (c 60) (UK) s 2.
30 [2002] 1 AC 800.
31 *Case of Pretty v The United Kingdom* (2002) Application No 2346/02 Eur Ct HR <https://hudoc.echr.coe.int> (accessed 30 December 2024).
32 [2010] AC 345.
33 The guidelines are reproduced in I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at pp 322–324.
34 See Daniel Sperling, *Suicide Tourism: Understanding the Legal, Philosophical, and Socio-political Dimensions* (Oxford University Press, 2019) at p 106.

Suicide Coalition, reports that between 2015 and 2018 about 233 cases of UK residents have sought assisted suicide in Switzerland.[35] Assisted Dying Coalition reported that legislation regarding assisted suicide is being tabled for discussion in the Parliament of the Republic of Ireland.[36] The question is whether abortion and assisted suicide ought to be legal (they are related but not conjoined). Hence, a country may permit or deny both, or allow one but not the other – as in the UK, where abortion is permitted but not assisted suicide – although from time to time we see campaigns for legalisation[37]).

29 The second question is one of law: Can a country criminalise acts of its citizens for offences abroad? This question is a wide one. The criminalisation of assisted suicide by the home country is discussed by I Glenn Cohen in *Medical Tourism*. One of the solutions he suggests is to have the patient request the aid of a resident of the destination country.[38] A strong case may be made for murder, but it may be complicated with the secondary question: "Is abortion murder?" The arguments relating to both policy and law on this subject will require more space than this article permits. The short point is that these are issues that lay under the umbrella of medical tourism.[39]

B. Organ transplantation

30 The first human organ transplantation was performed by Dr Joseph Murray in 1954.[40] Today, many more organs are capable of transplantation, including the heart, kidney, liver, lung, pancreas, stomach and intestine. Medical transplantation is not limited to organs;

35 Assisted Dying Coalition, "Briefing: Number of UK Citizens Going to Switzerland to Seek an Assisted Death" <https://humanists.uk/wp-content/uploads/2019-2-1-KM-Assisted-Dying-Briefing_-Number-of-UK-citizens-going-to-Switzerland-to-seek-an-assisted-death-1.pdf> (accessed 30 December 2024).

36 "Irish Assisted Dying Committee to Recommend Law Change" *Assisted Dying Coalition* (7 March 2024) <https://assisteddying.org.uk/> (accessed 30 December 2024).

37 Josie Ensor, "How Euthanasia Works in the US State That Could Inspire England" *The Times* (6 October 2024) <https://www.thetimes.com/uk/society/article/assisted-dying-oregon-bill-uk-z930x0q6w> (accessed 30 December 2024). See also, Camilla Long, "The Assisted Dying Bill is the Latest Argument of the Progress Junkie" *The Times* (5 October 2024) <https://www.thetimes.com/comment/columnists/article/the-assisted-dying-bill-is-the-latest-progress-junkie-cause-9hlxckhpq> (accessed 30 December 2024).

38 I Glenn Cohen, "Circumvention Tourism" (2012) 97 Cornell L Rev 1309 at 1334.

39 See I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at ch 8.

40 Marc A Shampo & Robert A Kyle, "Joseph E Murray – Nobel Prize for Organ Transplantation" (March 2001) 76(3) *Mayo Clinic Proceedings* 240.

soft tissues such as the cornea and heart valves can also be transplanted, as are human limbs, and even cells such as bone marrow and stem cells.

31 Given the wide range of such procedures, the limitations of expertise and facilities, and the availability of donors, organ transplantation is a major part of medical tourism, if not for the quantity, at least for the complexity and costs. Organ transplantation is legal in virtually every country that has the facilities and expertise to carry out the procedure. What creates legal and moral problems is the black market for the sale of organ parts. Organ sales are almost universally illegal. On 3 September 2008, Tang Wee Sung, a businessman, was jailed for a day and fined S$17,000 in Singapore for lying to get approval for a kidney transplant.[41]

32 Tang exemplifies the problem in studying organ transplantation – the dearth of recipients willing to discuss their cases. On the other hand, organ sellers are more ready to do so.[42]

33 Organ sales are complicated by the mixture of coercion and deception. The black-market operators produce the "organ sales version" of the facilitators discussed above, only that they are nefarious and often the seller does not get the full price promised. Even though organ sales are largely illegal, it appears to be a lucrative trade.[43] Many are medical tourists who travelled abroad for the (probably illegal) procedures, but most return to their home countries for post-transplant care.[44] When a patient returns to Singapore after an organ transplantation abroad, he creates ethical problems for the local doctors should he require aftercare.[45]

34 Like the medical tourism in abortion and assisted suicide cases, medical tourism in organ transplantation gives rise to profound ethical and legal issues that will occupy volumes. Unlike the first two, organ transplantation's black-market problems provide greater incentives for prohibition. The question is how regulations should be enacted, and what

41 "Singapore Tycoon Gets Kidney from Hanged Man" *Reuters* (10 January 2009) <https://www.reuters.com/article/lifestyle/singapore-tycoon-gets-kidney-from-hanged-man-idUSTRE5090VZ/> (accessed 30 December 2024).

42 As is apparent in Sallie Yea, "Trafficking in Part(s): The Commercial Kidney Market in a Manila Slum, Philippines" (2010) 10(3) *Global Social Policy* 358.

43 See I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at ch 7.

44 See Muna Canales, "Transplant Tourism: Outcomes of United States Residents Who Undergo Kidney Transplantation Overseas" (January 2007) 82(12) *Transplantation* 1658.

45 See Andrew J Aronson, "Transplant Tourism: Treating Patients when They Return to the U.S., Commentary 2" <https://journalofethics.ama-assn.org/article/transplant-tourism-treating-patients-when-they-return-us-commentary-2/2008-05> (accessed 30 December 2024).

ought to be the jurisprudential and policy basis for doing so. Although the buying and selling of human organs is prohibited in Singapore under the Human Organ Transplant Act 1987,[46] the Act permits organs from deceased persons to be removed and transplanted in approved hospitals and by approved medical officers.[47] The Act, however, is silent as to medical tourists returning from organ transplantation abroad. Many of these patients may require aftercare, either to prevent or address complications from organ rejection. The US National Organ Transplant Act[48] makes it illegal to sell human organs but permits organ donations. It also does not prohibit a US citizen to have an organ transplantation overseas.[49]

35 Medical tourism in human organ transplantation requires legislative intervention, not only specifically readdressing the ethical issues, but also comprehensively in line with all other aspects of medical tourism.[50] Where exceptions are made for legitimising organ transplantation abroad, not only would approval procedures be needed, but the terms of insurance coverage have to be reviewed, not only in respect of the transplantation but also with regard to post-surgical care, which may be problematic if doctors cannot decide if other organs fail and need treatment – will those treatments be covered by insurance or be attributed to the organ transplantation?

VI. Fertility and surrogacy tourism

36 We move from discussing the grim aspects of death and organ trafficking, to what appears to be a more felicitous situation – medical tourism relating to fertility treatment and surrogate mothers. Surrogate pregnancies are pregnancies in which a woman carries and gives birth to a baby for a person who is not able to have children on her own. Surrogacy is often regarded as commodifying the human body and thus similar considerations apply to surrogacy as with the sale of human organs, only of course, in the case of surrogacy, the transaction is more like renting than selling.

37 Nonetheless, a trade is a trade and with it comes the attendant dangers of exploitation. However, it is reported that in some surrogacy

46 (2020 Rev Ed) s 13.
47 Human Organ Transplant Act 1987 (2020 Rev Ed) s 6.
48 42 USC § 273 (1984).
49 See I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 311.
50 Many of the issues relating to the ethics of human organ sale are discussed in I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at pp 283–304.

centres in India, a surrogate mother earns US$5,000–US$6,000 for each birth.[51] Doctors who have surrogacy clinics see it differently. Dr Nayana Patel established an infertility clinic in Gujarat, India, in 1991 and now, her clinic is known as "Akanksha Hospital and Research Institute". She began surrogacy procedures in 2003[52] and by 2015, she had delivered her 1,000th surrogate baby.[53]

38 Surrogate pregnancies have two main variations. The first is where the sperm and egg come from the intended parents, making them the genetic parents, and the surrogate the gestational parent. The second is where the surrogate's own egg is impregnated by artificial insemination with the sperm of the intended parent. In this case, the surrogate is both the genetic and gestational parent. Other permutations include the use of both egg and sperm from unrelated donors with the view of having the child adopted by a third party and the pregnancy carried by a surrogate. The case of "Baby Manji" illustrates what legal obstacles intended parents may face in fertility and surrogacy tourism.[54]

39 Briefly, a Japanese couple went to India to have a surrogate birth. The sperm came from the father but the egg was from the surrogate and not the wife. The couple divorced before the baby was born. The father wanted to raise the child but the mother wanted nothing to do with it. The father could not get a Japanese passport for the child because Japanese law required the child to have an Indian passport since she was born there. But under Indian law, an Indian passport cannot be issued without the passport of the mother, who, in this case, had already disowned the child. After months of application after application, a two-step solution was found, whereby the child's paternal grandmother was given a restricted certificate and allowed her to take custody of the child in Japan for a year, after which, the father may then apply for adoption. Clearer guidelines in the form of regulations will prevent the heartaches and anxiety of uncertainty – in Singapore, surrogacy is not allowed at all.[55]

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51 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 373.

52 "Dr. Nayana H. Patel" *Akanksha* <https://www.ivf-surrogate.com/DrNayanaPatel> (accessed 30 December 2024).

53 P C Vinoj Kumar, "Giving a New Life to Many a Childless Couple and a Livelihood for Women Renting their Womb" *The Weekend Leader* (19 October 2015) <https://www.theweekendleader.com/Success/2280/joy-to-couples.html> (accessed 30 December 2024).

54 See I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 375.

55 Healthcare Services (Assisted Reproduction Service) Regulations 2023 reg 36.

40 In the case of fertility tourism, couples wishing to have the benefits of assisted reproduction such as in vitro fertilisation, will travel to where they can find suitable facilities for the procedure. In modern times, fertility clinics can offer more advance procedures such as the selection of the sex of the child. "Microsort Laboratories" offer an advance procedure for helping couples choose the sex of their child. Although it is currently carrying out this service in various countries, including Mexico, North Cyprus, Japan, Thailand, Malaysia, Cambodia and Nigeria, it has not been approved by the US Food and Drug Administration.[56]

41 Sex selection is a nebulous area in the sphere of medical ethics. A strong case may be made for it if the intended parents can show that one of them has a genetic disease carried in the "X" chromosome. Conversely, using sex selection to select a male in societies where the female gender is under-represented may lead to social imbalance. Hence, Microsort imposes conditions to counter such situations.[57] The greater concern in some countries is that the use of unregulated assisted fertilisation, especially when combined with surrogacy, permits single parents and gay parents to have children that they may claim as their genetic children or as adoptive parents. Hence, Sweden has a high proportion (43%) of single women seeking fertility treatment overseas. In France, where assisted reproduction for single and gay women is not allowed, the percentage of gay women seeking treatment abroad is 39.2%, and 16.4% for single women.[58]

42 Sex selection is not permitted in Singapore.[59] In *UKM v Attorney-General*,[60] the High Court, in the course of considering the application by two gay men to adopt a child born overseas by a surrogate, rendered its opinion regarding surrogacy, generally, encouraging Parliament to review the status of surrogate births. The court opined:[61]

> Having reviewed all the relevant material, we find that absent express government confirmation, we are not in a position to articulate a public policy against obtaining surrogacy services, whether in or outside Singapore. It is simply unclear from the evidence whether there is a settled public policy against surrogacy at present and, even if there is, what that policy would be. The Government's statements may be consistent with more than one reading: the ART Licensing Terms may prohibit surrogacy in Singapore because the

56 *MicroSort* <https://www.microsort.com/> (accessed 30 December 2024).
57 "Requirements" *Microsort* <https://www.microsort.com/requirements/> (accessed 30 December 2024).
58 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 383.
59 See n 50 above.
60 [2019] 3 SLR 874 at [176]–[182].
61 *UKM v Attorney-General* [2019] 3 SLR 874 at [178]–[180].

> Government is regulating surrogacy for health related reasons, or because the Government is still grappling with the ethical issues raised by surrogacy, or because of a combination of the two; alternatively, the Government may be considering these issues and adopting an interim stance against surrogacy locally but allowing specific and narrow exceptions in adoption applications. The Guardian was unable to confirm which position was a better approximation of the Government's policy.
>
> This is not to say that it would be unreasonable for public policy objections to be taken to surrogacy. Surrogacy is an ethically complex and morally fraught issue. To some, surrogacy represents a medical solution of last resort to the problem of infertility. It offers hope that the desire to procreate and raise a child may be fulfilled. But to entertain this solution, one must grapple with its profound moral and social implications.
>
> It would not be an understatement to say that legitimising surrogacy would involve a radical reconsideration of established paradigms of family, intimacy, parenthood, gender relations, sexuality and the creation of life. Surrogacy fragments the concept of motherhood by separating gamete contributor, gestational carrier and caregiver. It regards these roles as links in a supply chain for the on-demand production of human life. It interposes a third, sometimes a fourth, person into the reproductive process, neither of whom may intend to care for the child after birth. It 'promote[s] a world of private ordering' in which family relations are less a matter of circumstance and more a matter of choice: see Radhika Rao, 'Surrogacy Law in the United States: The Outcome of Ambivalence' in *Surrogate Motherhood: International Perspectives* (Rachel Cook, Shelley Day Sclater & F Kaganas, eds) (Hart Publishing, 2003) ('*Surrogate Motherhood*') ch 2 at p 33. And unlike adoption, surrogacy is designed to eliminate from the outset not only part of the child's biological heritage because he must leave his birth mother, but also part of his genetic heritage if donor gametes were used. Surrogacy prompts us to examine our values and decide which of them, if any, we are prepared to surrender if we decide to embrace technology's promise of ultimate self-determination.

43 Three other issues remain for consideration in respect of fertility treatment and surrogacy. The first is that the ubiquitous middleman and his services needs regulation, if only to ensure that all aspects of liability are covered when things go awry. The second, which is more relevant for surrogacy, is the danger of coercion, and worse, human trafficking. The third is the question concerning the best interests of the child itself. Where the intended parents, or one of them, no longer want the child; or in situations in which the law does not permit them to adopt the child, some provisions are required to ensure that the child may be brought up in the best circumstances.

44 Promulgating regulations in this area has a troublesome question not unlike that concerning abortion cases where one must consider the best interests of a child who is yet to be born, and whose nationality and citizenship are yet to be determined. In any criminalisation of surrogacy

in medical tourism, the child will be affected unless provisions are made in the home country allowing for the appointment of a guardian-to-be to speak on behalf of the child. This issue is connected to the question of granting citizenship or permanent residency to the child when the parents bring the child home, a question that becomes more difficult if one or both parents end up rejecting the child.[62]

45 Finally, fertilisation and surrogacy procedures, in so far as they involve a third-party donor or surrogate, invariably raises the issue of the legality and enforceability of the contract that binds the parties. Furthermore, as pointed out by Cohen, in some instances, the contracts may place the interests of the mother above that of the foetus.[63]

46 Conversely, if Singapore is the destination country and venue for a surrogate birth, regulation may be required to recognise the legal status of the birth and the surrogate contract so that the parents in the home country will be able to register the child more easily there.[64]

VII. Telemedicine and telehealth

47 The steady growth of surgeries and other medical procedures in medical tourism discussed above pales in comparison to the growth and potential of telemedicine and telehealth. Telemedicine is the term describing the provision of doctor-patient services by means of telecommunications. Telehealth is the broader term that covers all healthcare services that are provided by the same means. This distinction is not crucial, and many have used them interchangeably.[65] For the purposes of this article, telehealth will generally include telemedicine.

48 Medical consultation through the telephone has been practised for decades, but with the advancement in both the field of communications and diagnostic technology, telehealth has made vast progress, and it rolls on even faster during and after the COVID-19 pandemic. Hence, old

62 See Andrea Whittaker, "Cross-border Assisted Reproductive Care: Global Quests for a Child" in *Risks and Challenges in Medical Tourism: Understanding the Global Market for Health Services* (Jill R Hodges, Ann Marie Kimball & Leigh Turner eds) (Praeger, 2012) at pp 176–180.

63 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 397.

64 See also I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 405.

65 See *Telemedicine: The Computer Transformation of Healthcare* (Tanupria Choudhury *et al* eds) (Springer, 2022) at p 1. See also Larry D Jones, *The Truth about Telehealth: Why a Revolutionary Industry Has Failed To Deliver and How It Can Still Be a Game-changer for Healthcare* (CreateSpace, 2018) at p 22.

and handicapped patients in remote places can gain access to medical services more readily and conveniently. Telehealth in medical tourism is like the National Geographic of medicine – travel the world without leaving home. As Mishra *et al* explain:[66]

> Telemedicine offers independence by making it possible for many patients and people to receive medical services. Rather than wasting several hours or days commuting to a health clinic, medical advice and consultation may be accessed more locally, freeing up time and making it possible to get care.

49 Traditional medical practice is a cosy relationship between a patient and his doctor. That is a relationship built over the long term; a relationship that includes the doctor's knowledge not just of the patient's medical history but that of his family as well. That relationship enables a doctor to detect ailments in his patient even without the patient complaining about symptoms. Modern technology changes this. A patient's medical record is stored online and may be shared between his family physician and a specialist or a hospital.

50 Hence, previously, telemedicine was localised with the home country – it helps, for instance, a farmer in the rural Midwest US to communicate with a heart specialist in Chicago. Nowadays, that same patient, should he be on holiday in France, can communicate with the same doctor through e-mail, voice call or Zoom. Conversely, that means that the doctor is not restricted to staying in Chicago. He may be on holiday in France, and the farmer patient can, similarly, reach him. This means that the doctor can be reached by patients all over the world.

51 Radiologic services are another medical service that can benefit from medical tourism. X-rays can be despatched by e-mail and reported by radiologists in countries where their services are less expensive. Technology also enables other diagnostic tests to be conducted and reported remotely. However, technology has its limits. Perhaps one day, it may produce machines that can be as discerning as the human eye and mind where lines are blurred and collected data produces only a fuzzy picture. In the meantime, it can only be hoped that doctors and laboratory professionals do not grow complacent and be overly dependent on the machine to make medical decisions for them. One way to prevent this over-dependence is to maintain the traditional doctor-patient relationship.

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66 Sudhanshu Mishra *et al*, "Telemedicine: The Immediate and Long-Term Functionality Contributing to Treatment and Patient Guidance" in *Telemedicine: The Computer Transformation of Healthcare* (Tanupriya Choudhury *et al* eds) (Springer, 2022) at p 275.

52 Other examples of the extent of telehealth applications include "gastroenterologist-led teleproctoring using simple video technologies to allow a surgeon to conduct sclerotherapy for haemostasis"[67] in the setting of a variceal bleed. Some other case reports identified the transfer of smartphone images from surgical trainees to an attending physician to make a real-time decision about a potentially problematic liver acquisition, which took place 545km away from the university hospital.

53 What requires regulation, so far as medical tourism by means of telehealth is concerned, is the issue of licensing and the recognition of foreign medical and healthcare expertise. Should diagnostic tests and procedures such as X-rays and scans taken in Singapore be reviewed by radiologists in India, and *vice versa*? What regulations, if any, are needed if a patient purchases a blood and urine test kit in the US and takes the test in the UK but sends the results for reporting from Singapore to a laboratory or specialist in the US?

VIII. Liability

54 In medical treatments (strictly in the context of the private home), the outcome of a legal claim may not always be predictable, but the laws and procedures are more certain. In medical tourism, the laws and procedures relating to liability claims, whether in contract or tort, are not uniform, and the results of legal claims are even less predictable. Pain and suffering, a standard item for claims in common law jurisdictions, is not a recognised head of claim in some countries, such as Thailand.[68] The amount of compensation can also differ widely. It is not possible to compare every country, but generally, there will be countries that award much higher compensation in medical malpractice cases than some other countries.[69]

55 In some jurisdictions, the failure to succeed in malpractice cases can be attributed to the jurisdiction's juridical attitude to exemption and waiver clauses. Some advocate a ban of such clauses, but others may advocate the use of arbitration to avoid the prohibition of such clauses.[70]

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67 David Hailey, Risto Roine & Arto Ohinmaa, "A Systematic Review of Evidence for the Benefits of Telemedicine" (2002) 8(1) J Telemed Telecare 1, referred to in *Telemedicine: The Computer Transformation of Healthcare* (Tanupriya Choudhury *et al* eds) (Springer, 2022) at p 275.

68 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 87.

69 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 83.

70 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at pp 102–105.

The third solution is through medical malpractice insurance. Obviously, apart from the ease with which claims can be made under such policies, the policies must necessarily and explicitly cover medical treatment abroad.[71] In some cases, the patient may be able to sue his home physician for negligent referral. This may be his only recourse in the event that he has difficulty suing in the destination country or finds it difficult to enforce the foreign judgment.

56 Another aspect of liability that has to be addressed concerns the liability of a home country healthcare provider who provides aftercare services to a patient who has received medical treatment abroad. The fundamental question is whether the home physician may decline to provide aftercare services in such cases, and the second usually involves, not just the question of whether there is a legitimate basis for liability, but also the difficult question of causation. This may be due, in part, to the difficulty of obtaining the disclosure of records from the destination country, and the equally daunting one of getting the destination healthcare providers to testify.

57 As they say, "Prevention is better than cure". This axiom is not only taken from the context of medicine but applies directly in it, none less so than in medical tourism because there is the tension between those in the industry who are concerned with selling medical procedures and the patients and consumers they want to sell to. In this regard, the aim of full disclosure and clear informed consent are the high gates to the dangers of medical malpractice and fraudulent selling of medical products and services.[72]

IX. Health touring in Singapore

58 According to Wong Kee Mun and Ghazali Musa, medical tourism in 2008 worldwide is an industry worth US$60b. In Asia it is estimated at US$4.4b:[73] "Medical treatment in Asia costs six to 33 per cent less compared to what it would have cost in the United States".[74] Wong and Ghazali cite various reports indicating that Singapore is

71 I Glenn Cohen, *Patients with Passports: Medical Tourism, Law, and Ethics* (Oxford University Press, 2015) at p 107.

72 Leigh Turner, "Medical Travel and Global Health Services Marketplace: Identifying Risks to Patients, Public Health, and Health Systems" in *Risks and Challenges in Medical Tourism: Understanding the Global Market for Health Services* (Jill R Hodges, Ann Marie Kimball & Leigh Turner eds) (Praeger, 2012) pp 256–259.

73 Wong Kee Mun & Ghazali Musa, "Medical Tourism in Asia" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) ch 15, at p 167.

74 Wong Kee Mun & Ghazali Musa, "Medical Tourism in Asia" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) ch 15, at p 170.

one of the top destinations in Asia for medical tourism.[75] With a small population, it is important that Singapore attracts foreign patients to sustain a high quality medical and healthcare industry. The reports state that "Singapore prefers to compete on high quality medical services instead of price".[76] Where price is concerned, Malaysian medical tourism has a big advantage because of its exchange rate.[77] Compared to Malaysia, Wong and Ghazali report that the "only drawback of Singapore compared to other countries … is that its medical services are the most expensive."[78]

59 A multi-agency government programme was launched in 2003, with the Singapore Tourism Board one of the leading agencies, to promote medical tourism in Singapore. Some years later, a report in Travel Weekly Asia[79] reported that travel agents found the effort not lucrative enough for them because "the healthcare providers such as the hospitals … stand to make higher margins". Travel agents today are a profession in decline, or, at least, changing their scope of practice. They may well find a strong partner in technology to reinvent themselves in the sphere of medical tourism. Without medical tourists, the local market may not be sufficient to grow in terms of getting the best doctors, and other healthcare providers, and the most up-to-date medical equipment, all of which tend to be expensive.

60 Increasing the demand for medical tourists in Singapore may require having more hospital beds available. This may have to incur co-operation between developers and hospitals as well as capitalists. The area that may not require too much real estate space is telemedicine and online medical advice in conjunction with laboratory tests. However, these have issues that require closer attention. The Ministry of Health recently revoked the licence of a telemedicine clinic group for improper practice. The complaints include short consultations, the issuing of multiple medical certificates over a short period of time, and questionable and poor documentation of patient records.[80]

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75 Wong Kee Mun & Ghazali Musa, "Medical Tourism in Asia" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) ch 15, at p 173.

76 Wong Kee Mun & Ghazali Musa, "Medical Tourism in Asia" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) ch 15, at p 173.

77 Wong Kee Mun & Ghazali Musa, "Medical Tourism in Asia" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) ch 15, at pp 169 and 175–177.

78 Wong Kee Mun & Ghazali Musa, "Medical Tourism in Asia" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) ch 15, at p 174.

79 "Agents not taking well to Singapore Medicine" *Travel Weekly Asia* (15 August 2006) <https://www.travelweekly-asia.com/Travel-News/Agents-not-taking-well-to-SingaporeMedicine-2147468813> (accessed 30 December 2024).

80 "Regulatory Action Against MaNaDr Clinic and Doctors Involved in Potential Professional Misconduct" *Ministry of Health Singapore* (24 October 2024) <https://

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X. Future journeys

61 Medical tourism will continue to increase not only in numbers but in variety. It is an area in which we can see technology running ahead of the law. By sheer convenience and availability, patients will get access to many forms of healthcare whether there is regulation or not. For example, Patient X who is a resident of Chicago may consult his doctor through telemedia and then getting a second opinion from another specialist, also by telemedia, in Berlin. Then he gets his prescription drugs more cheaply from New Delhi or arranges for surgery there or somewhere less expensive. The surgeon from the destination country (who may well be qualified to perform the surgery) may also link up with the patient's home consultant via video). There are many other forms in which a patient may travel abroad virtually or physically, or a combination of both, for medical care.

62 A fundamental problem for the medical tourist is that, as Hall points out, "without a passport or identity card, travel is not sanctioned. There is no 'right' to engage in international travel", hence, Hall concludes that "[g]iven the lack of specific international law providing access to other countries, the rights of travellers outside their normal jurisdiction have been mainly conferred in the area of consumer rights".[81] The law that overseas medical tourism will, by necessity be a mix of public and private laws. In addition to licensing regulations, the rights and liabilities of the tourist patient and the healthcare provider will be governed by business and property laws.[82]

63 The breadth and scope of medical tourism prompt a need to have a comprehensive strategy so that the law can keep up and ensure that healthcare in the technological age can develop and the best practices are followed. But because of the diverse strands and peripheral businesses involved, the first question is whether regulation should be specific or comprehensive. An effort to embark on the latter is ideal, but will be a daunting task. Even the seemingly unconnected matter of the immigration visa affects medical tourism. The ease of obtaining an entry visa and the length of time the tourist may remain are as important as the reason for the visit.

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www.moh.gov.sg/newsroom/regulatory-action-against-manadr-clinic-and-doctors-involved-in-potential-professional-misconduct> (accessed 30 December 2024).

81 C Michael Hall, "The Contested Futures and Spaces of Medical Tourism" in *Medical Tourism* (C Michael Hall ed) (Routledge, 2013) at p 205.

82 See Milica Z Bookman & Karla R Bookman, *Medical Tourism in Developing Countries* (Palgrave, 2007) at p 122.

64 With the ever-increasing utility of digital technology, medical tourism becomes faster and more efficient, but conventional travel is still crucial to many. In this regard, the merging of hospital and hotel services and facilities has vast potential. An example of a hotel-hospital resort facility is covered in *Future Trends in Medical Tourism and Wellness: Club Med or Club Medic?*[83] An interesting study is that of "The Grand Resort Bad Ragaz", which is a resort facility with musculoskeletal rehabilitation, internal medicine rehabilitation and psychosomatic rehabilitation, as well as an entire suite of medical consultation and diagnostic services covering aspects of health involving rheumatology, dermatology, gynaecology and ophthalmology.[84]

65 Many countries, Singapore included, face an aging population, and many without the counterbalance of increasing childbirth. There is therefore much scope for a subset of medical tourism – the elderly medical tourist. It is also noted that the elderly are already increasing participants in social travel by reason of the fact that they are retired and have a higher life expectancy than previous generations. "As Bakir and Çakır observed:[85]

> At the same time, elderly tourists constitute a segment of society with motives such as keeping the quality of life high, paying attention to their psychological and physical health, and showing interests in subjects such as healthy living, balanced nutrition, turning to preventive health services, supplements and medicines. It is known that touristic activities and travelling have positive effects on the mental and physical health of individuals and therefore their quality of life.

66 In every sector of medical tourism, the law should at least take into account: (a) the questions regarding the recognition and accreditation of the healthcare provider and the middle-man facilitator; (b) the question of jurisdictional control in respect of ethical conduct; the application of the law regarding liability – both as to the right to sue and the remedies available; clear statements of law regarding the rules of conflicting private law; (c) the collection and sharing of patient data;

83 Frederick J Demicco, Erfan Rezvani & Jingyan Wang, *Future Trends in Medical Tourism and Wellness: Club Med or Club Medic?* (Apple Academic Press, 2017) at pp 231–232.

84 Frederick J Demicco, Erfan Rezvani & Jingyan Wang, *Future Trends in Medical Tourism and Wellness: Club Med or Club Medic?* (Apple Academic Press, 2017) at pp 281–286.

85 Ugur Bakir & Sinem Yegel Çakır, "Elderly Tourism Market: Elderly Consumers as a Target Group in Health Tourism" in *Global Perspectives on the Opportunities and Future Directions of Health Tourism* (Oğuz Doğan ed) (IGI Global, 2023) at p 51.

and (d) with unambiguous explication as to public policy where relevant. Many countries are vying to be "The Club Medic". The race is on.