HELLENIC NATIONAL BIOETHICS COMMITION

R E P O R T

Medical Tourism

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1. Introduction

The development of biomedical technology coupled with the production of new knowledge from research and the increasing training of scientific staff now offers more opportunities for patients to seek cross-border health care and treatment. The term "*medical tourism*" refers to the cross-border activity of patients traveling to other countries in order to receive specific health services, such as medically assisted reproductive services or novel cell therapies. Patients are being impelled to medical tourism, mainly, to receive health services that are not available in their country of residence, or not permitted or their financial cost is higher, or there are long waiting lists, or to combine health services with recreation.

There is an ongoing debate regarding what is the most appropriate term to describe the travelling of patients or citizens to other countries to receive health services. Some argue that the term "medical tourism" transfuse the notion of leisure travel, ignoring the actual need for health restoration, and propose the term "cross-border health services".[1] In the present Report the term "medical tourism", which has prevailed, is used.

On the one hand, medical tourism offers more opportunities for citizens' health and, on the other hand, poses risks to both healthcare providers and healthcare professionals, as well as to patients themselves, while having an impact on the economies of the countries concerned. It is noteworthy that medical tourism affects both the host country that offers the medical services and the country of origin of the patients, to which they will eventually return.

This present Report aims to present statistics and scientific data on medical tourism, to identify and analyze the ethical issues arising from the reception of health services in foreign countries for all parties involved, and finally, to make specific recommendations in order to avoid the risks arising from this phenomenon. To this end, and because the notion of medical tourism includes various health services, the Report is divided into:

- **Reproductive tourism**, that is medical tourism for services of Medically Assisted Reproduction (MAR), such as *in vitro* fertilization (IVF), surrogate motherhood and gamete donation.
- Medical tourism to receive **novel treatments**, such as stem cell therapies - the so-called stem cell tourism.
- Medical tourism to undergo **plastic surgeries/aesthetic procedures**. For some, cosmetic or aesthetic procedures are not the subject of medical tourism because they aim at improving physical characteristics and not at repairing injuries, and therefore, do not fall within the context of health. However, a significant proportion of cross-border search for health services includes aesthetic procedures and therefore plastic surgeries/aesthetic procedures are the subject of this Report.
- Medical tourism to undergo **"conventional" therapies**, that is to handle medical emergencies for guests on leisure or business purposes in a foreign country, or to cover for regular therapies of chronic diseases, such as hemodialysis.

2. The Data

The cross-border search for health services is not a new phenomenon, since the 19th century there were patients traveling to other countries to benefit from the healing properties of thermal baths. In the 20th century, patients, mainly wealthy patients, traveled to more developed countries to receive high-quality health services. On the contrary, in the 21st century, the opposite phenomenon is observed, that is patients from developed countries are seeking for cheaper health services in less developed countries. The number of patients seeking host countries with low cost medical services is increasing, which is at least partly due to affordable travel but also due to the unlimited information that is now available on the internet. [1]

Nowadays, medical tourism is a growing phenomenon, which also has a significant economic impact. In spite the fact that there are no precise data on the size of the medical tourism market, the "medical tourism industry" is estimated by some at $100 billion,[2] whilst according to other estimates this number is much

smaller, that is $15-20 billion.[3] Nevertheless, the economic aspect of medical tourism is not the subject of this Report.

Medical tourism includes, and therefore affects, many parties involved:

- The patients themselves or their healthy partners (for example, regarding gamete donors or surrogate motherhood).
- The health care providers (hospitals, clinics, MAR units, diagnostic centers) and their staff (medical, nursing, laboratory and administrative) in the host country as well as in the patient's country of origin.
- The insurance organizations (public and private).
- The competent Ministries (Health and Tourism).
- The certification bodies of medical services.
- The providers of accommodation (e.g. hotels) for patients and their escorts, and the providers of transportation (e.g. airlines, local transport).
- Medical tourism' s offices/agencies.

The data on the exact number of patients or citizens and the countries preferred are unclear, mainly due to the difficulty in accessing data, the problems in identifying the incentives for patients' travelling and the interests of health care providers.[4] However, most studies concur to the conclusion that Asia is the most popular destination for medical tourism, with Thailand being at the top of the preference of patients worldwide, while frequent destinations are also Costa Rica, India, Israel, Malaysia, Mexico, Singapore, South Korea, Taiwan, Turkey and the United States.[5,6] There is also lack of data regarding the clinical results of the therapies, as well as the medium and long-term follow-up of patients that received treatments in a foreign country.

2.1. Reproductive tourism or tourism for Medical Assisted Reproduction (MAR) services

The current legislations, which may be wholly prohibitive or prohibitive for certain groups of patients (e.g. single women), the cost of MAR services that differs from country to country and also the long waiting lists, have as a result that not all citizens

have equal opportunities in accessing MAR. Therefore, a portion of citizens decide to resort to reproductive tourism, that is to travel and receive MAR services in another country.

The Cross-Border Reproductive Care (CBRC) Task Force of the European Society of Human Reproduction and Embryology (ESHRE) uses the term "cross-border reproductive care" that is defined as "a widespread phenomenon where infertile patients or their healthy partners (such as egg donors or surrogate mothers) cross international borders in order to obtain or provide reproductive therapies outside the borders of their country of origin".[7]

Reproductive tourism includes various health services, such as: intra-uterine insemination, *in vitro* fertilization (IVF), *in vitro* fertilization (IVF) using donor gametes, *in vitro* fertilization (IVF) using donor embryos, prenatal or preimplantation genetic testing of embryos (PGS/PGD), cryopreservation of gametes, surrogate motherhood, or combinations of the above. Patients seeking MAR services in a foreign country may be heterosexual couples, gay couples or single individuals.

2.1.1. Statistics on reproductive tourism in Europe

In Cross-border Reproductive Care (CBRC) studies in Europe, it is estimated that 24,000-30,000 *in vitro* fertilization cycles involve reproductive tourism for 11,000-14,000 patients.[8,9] Considering the total number of *in vitro* fertilization cycles, reproductive tourism corresponds to 5% of all *in vitro* fertilization cycles at a European level.[10]

In particular, a 2010 survey addressed to patients from 46 MAR clinics in Belgium, the Czech Republic, Denmark, Switzerland, Slovenia and Spain, showed that host countries recorded patients traveling from 49 countries: Italy (31.8%), Germany (14.8%), the Netherlands (12.1%), France (8.7%), Norway (5.5%), United Kingdom (4.3%) and Sweden (4.3%). Italian patients were more likely to seek MAR services in Spain and Switzerland, Germans in the Czech Republic, Dutch and French in Belgium, the British in the Czech Republic and Spain, and Swedes and Norwegians in Denmark. The services requested by the patients were intra-uterine insemination at 22.2%,

MAR at 73%, both insemination and MAR at 4.9%, while 22.8% used donor egg, 18.3% used donor sperm and 3.4% used donors embryos.[8]

Similar studies with questionnaires addressed to the staff of 16 MAR clinics in Belgium showed that France (38%), the Netherlands (29%), Italy (12%) and Germany were the countries from which most patients came (for the period 2005-2007), with a steady increase in the total number of patients resorting in medical tourism in Belgium (for the period 2003-2007). The services requested by the patients were intra-uterine insemination using donor sperm (34%), intra-uterine insemination (29%), *in vitro* fertilization (11%) and *in vitro* fertilization using donor egg (8%).[11,12]

2.1.2. Statistics on reproductive tourism in North America

Similar studies for North America showed that for Canadians, the most common reason for travelling for health reasons in another country was *in vitro* fertilization using anonymous donor egg (80%), while for American citizens it was *in vitro* fertilization (without donor gamete interference) by 41% and *in vitro* fertilization using anonymous donor egg by 52%.

For patients who traveled to Canada, the main reason was *in vitro* fertilization (73%). In the USA, 4% of infertility therapies (approximately 6,000 *in vitro* fertilization cycles) were offered to patients from other countries, mainly Latin America and Europe, who traveled to the USA to receive *in vitro* fertilization by 51%.[9,13]

2.1.3. Statistics on reproductive tourism in Greece

It is estimated that approximately 1,000 patients travel annually to Greece to receive MAR therapies.[14] According to the Hellenic National Authority of Medically Assisted Reproduction, there are currently 45 licensed MAR Units.[15] The data regarding specifically reproductive tourism in Greece are limited in relation to other countries.

The study by Paraskou & George (2013) recorded data for patients coming to Greece in order to receive infertility therapies. The study was conducted with

questionnaires addressed to the staff of MAR Units, mainly in Northern Greece, and to 130 patients who traveled to Greece to receive MAR services (this is estimated to account for 13% of all reproductive tourism in Greece). The countries of origin of the patients were Italy, Germany, France, United Kingdom, Ireland, the Netherlands, the USA and other European countries. The main reason why patients were seeking MAR services in Greece was the fact that there were restrictive legal provisions in their country - especially for the Italians and the Germans - and strict eligibility criteria that entail long waiting lists - especially for the British and the French.[16]

Most patients were aged 41-45 (29.7%) and 46-50 (18.8%) and married (45.3%) or cohabiting with a partner (18.8%). The majority of patients chose a MAR center in Thessaloniki (37.5%), Athens (36.7%) and Crete, mainly in Heraklion (11.7%). The main therapies sought by patients in Greece were egg donation (38.2%), embryo donation (20.9%) and to a lesser extent *in vitro* fertilization (5.5%) and *in vitro* fertilization using donor sperm (4.5%). The factors that positively influenced patients' decision to visit Greece for reproductive tourism were, primarily, the financial cost, since Greece is highly competitive regarding the cost of various MAR services (Figure 1), access, spiritual and religious reasons, communication, the quality of services, the reputation of medical staff/clinics and the combination of therapy coupled with holidays (Figure 2). Finally, the discouraging factors to choose Greece for reproductive tourism was the lack of credentials and published data, language and accessibility (Figure 3).[16]

Country	Indicatory average treatment costs in Europe & the USA (in EUR)			
	IVF (1)	Oocyte donation (2)	Embryo donation (3)	Preimplantation Genetic Screening (4)
UK	5800	14000	7000	4000
Germany	3000	not allowed	not allowed	(partially allowed): 3500
Italy	6000	not allowed (5)	not allowed (5)	(partially allowed): 3500
Denmark (6)	2500	5000	not allowed	3500
Spain	5000	9000	6000	4500
Czech Republic	1900	5000	2000	3000
Russia	2000	8000	5000	4000
Ukraine	1800	6000	3000	2000
Greece	3500	6000	3000	3000
Cyprus	3000	6000	3000	3000
USA	2000	15000	8000	6000

Notes: Rates in local currency, converted in EUR on xe.com in August 2013.
(1) Intended is IVF with intracytoplasmic sperm injection (ICSI).
(2) Costs refer to oocyte donation using an exclusive female donor; in some countries, e.g. UK, there are shared programs (i.e., one female donor donates to more recipients, or a woman undergoing treatment herself, donates a part of her oocytes to another woman). Such programs cost less.
(3) There is a difference between embryo donation (which implies using embryos resulting from a female and a male donor) and embryo adoption (which implies the use of embryos left over from couples who do not need them any longer). Legislation in this regard varies among the countries. The costs in this table concern embryo donation.
(4) There are two methods for aneuploidy screening: The FISH method (fluorescence in situ hybridization) and CGH array (comparative genomic hybridization). This table refers to CGH array and the fees are based on an assumption of eight embryos.
(5) Legislation has meanwhile changed.
(6) Denmark does not allow donation of an embryo, only oocytes and sperm can be donated but one of the intended parents always have to be genetically related to the child.
Source(s): Compiled based on data from World Tourism Organization, *ESHRE* European Society of Human Reproduction and Embryology, *HFEA* Human Fertilization and Embryology Authority; & Connolly et al. [12]

Figure 1. Comparison of the cost of MAR services in different countries. The mean value corresponds to costs reported after queries in 3-5 clinics in each country between 2011 and 2013. Source: Paraskou & George, 2017.[16]

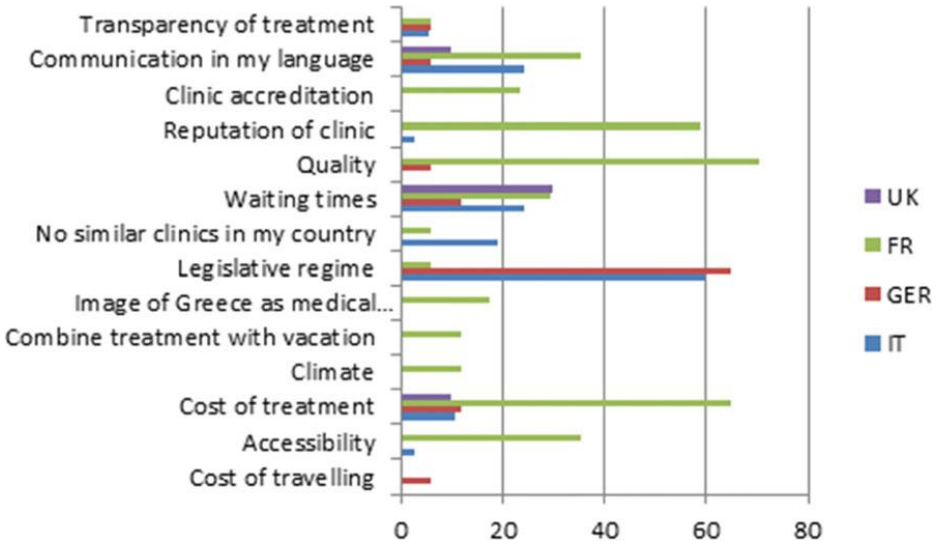

Figure 2. Encouraging factors to choose Greece as a destination for MAR treatments. Source: Paraskou & George, 2017.[16]

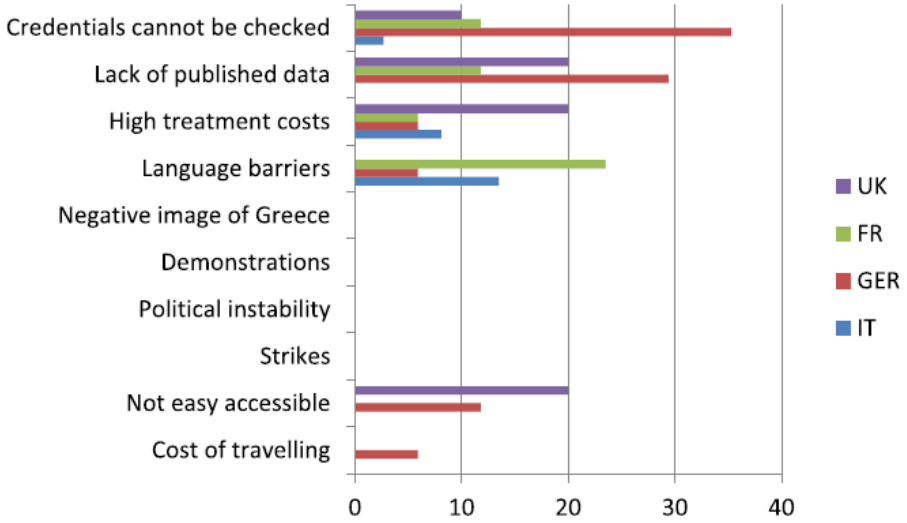

Figure 3. Discouraging factors to choose Greece as a destination for MAR treatments. Source: Paraskou & George, 2017.[16]

A second study, of Rozée Gomez and de La Rochebrochard (2013), recorded the incentives and the experience of 128 French patients who traveled to Greece (17%), Belgium (15%) and Spain (68%) for reproductive tourism.[17] It is noted, however, that the data of this study concern a single MAR center for each country, for the period 2010-2012.

According to these data, 89% of French people who traveled to Belgium were seeking a sperm donor, while 100% of French people who traveled to Greece were to make use of an egg donation, with the corresponding rate for Spain at 74% (Table 4). The majority of the French patients who resorted to Greece and Spain for an egg donation were heterosexual couples (99%) and aged <43 (65%), and therefore met the criteria for MAR using donor egg in their own country. However, motivated by the limited egg availability in France and long waiting lists, those patients traveled to Greece or Spain.[17]

The majority of patients (83%) who traveled to Spain to receive egg donation chose the MAR center following a physician's recommendation, while Greece was selected following the recommendation of a Patients Association (77%) or due to

low cost (91%). It is noteworthy that 41% of the French who traveled to another country for reproductive tourism, have sought compensation by the French social welfare system.[17]

	All patients (n = 128), 100%		Greece (n = 22), 17%		Spain (n = 87), 68%		Belgium (n = 19), 15%	
	n	%	n	%	n	%	n	%
Ooocyte donation	87	68	22	100	65	74	0	0
Sperm donation	22	17	0	0	5	6	17	89
Oocyte and sperm donation	5	4	0	0	5	6	0	0
Embryo donation	1	1	0	0	1	1	0	0
IVF	6	5	0	0	6	7	0	0
Oocyte cryopreservation	5	4	0	0	5	6	0	0
Surrogacy	2	1	0	0	0	0	2	11

Figure 4. MAR therapies that 128 French patients requested, depending on the destination. Source: Rozée Gomez and de La Rochebrochard (2013).[17]

In conclusion, from the two studies mentioned above concerning Greece, it appears that the main reason why patients visit Greece is *in vitro* fertilization using donor egg, and the relatively low treatment cost in relation to other European countries positively contributeç in this decision.

2.2. Medical tourism to undergo novel treatments

Medical tourism to receive novel treatments includes mainly the search for cell therapies, specifically with stem cells. Stem cell therapies are widely advertised through the internet, especially in countries without specific legislative framework or permissive legislative framework, such as China, Singapore, Malaysia, Japan, Thailand, India, South American countries like Mexico and Brazil and African countries.[18, 19,20] The "industry of cell therapies" is estimated at $120 billion for 2018.[18]

Cell therapies remain mostly “unproven”, that is there are still no scientific data that could prove their efficacy and safety, with the exception of only a few therapies with proven efficacy for specific hematological diseases or diseases of the immune system. The major risk of stem cell therapies derives from the fact that these therapies usually have not passed the clinical trial and approval stages so that they could be administered to patients. Thus, they are offered to patients either as “experimental therapies”, without this being absolutely clear to them, or illegally without the necessary documentation for their efficacy and safety.

In the relevant literature on stem cell medical tourism, there are plenty of cases of patients who traveled to a foreign country and received unproven cell therapies, with severe effects to their health. Typical is the case of an American patient who suffered a stroke and received a stem cell therapy in stem cell clinics in China, Argentina and Mexico. The patient developed, among others, a tumor in the spinal cord that originated from the allogeneic stem cells that were administered to him.[21] Notable is also the case of patients from New York and Canada who developed Q fever, since they had all previously traveled to Germany to receive cell therapy with non-human cells (fetal sheep).[22]

2.3. Medical tourism to undergo aesthetic procedures

A proportion of people seeking cross-border health services, travel in order to receive treatments or procedures for aesthetic-cosmetic reasons. Although this proportion cannot yet be estimated, however, there is a propensity of traveling to specific countries. For example, American citizens often travel to Mexico for aesthetic reasons, in Thailand and India for aesthetic reasons and for gender reassignment.[23] In the cases of medical tourism for aesthetic reasons, individuals themselves bear the cost of these procedures (interventional or non-interventional).[24]

According to the American Society of Plastic Surgeons (ASPS), there is an increased possibility that patients, who receive aesthetic procedures in other countries, will suffer from infections and severe complications that require expensive treatments in their country of origin. For example, the cost of the

treatment of infections and other complications for those who have received aesthetic procedures in foreign countries and returned in the USA is $1.3 billion per year.[25] In fact, the International Society of Aesthetics Plastic Surgery, (ISAPS) has issued "guidelines for plastic surgery tourists" in order to inform them about safety and the quality of provided services.[26]

2.4. Medical tourism to receive "conventional" therapies

This category of medical tourism mainly includes the provision of health services to chronically ill, such as renal patients who need regular hemodialysis and continuous monitoring. According to the Non-governmental organization Greek Medical Tourism Council (ELITOUR), there are many units in Greece that offer conventional health services, that include hemodialysis, ophthalmic services, dental care services etc.[27]

3. The ethics issues

The issue of bioethics for medical tourism has as its starting point a question about the limits of the individual right to health. Is someone free to seek medical services abroad when they are either lacking or provided under conditions that do not satisfy him/her, or - even - may be banned in his/her own country? And, by extension: from the viewpoint of the social right to health, should the state ensure especially financially - to some extent - the access of its citizens to health services provided elsewhere?

A subsequent question concerns the relationship itself between the provision of health services and the tourism industry, more specifically how we ensure that the medical services truly meet the objective of health protection and are not deductible in simple activities of economic interest. In the light of this question, for example, the issue of advertising medical services to attract patients from abroad is raised.[28]

3.1 The limits of the right to health

The freedom of the person to define itself in health matters is, in principle, subject to no restrictions. Since health is the keystone for the enjoyment of our fundamental rights - of our total autonomy – the interest of the person to protect it in every way cannot be questioned on moral terms. However, the delimitation between the right of one person's health and the fundamental rights of others is self-evident. This delimitation is perceived in the field of health resources allocation: on the basis of the necessarily finite resources available to a society for the health of its citizens, the individual right to health is relativized by the notion of justice, that is equal access for all to these resources.

Beyond this self-evident assumption, any other limitation in health care could not be easily morally grounded. Thus, health services, which - for some - are considered to be contrary to “social ethics”, such as abortion, certain methods of assisted reproduction, gender reassignment etc. - in a democratic society are legitimate, precisely insofar as they are related to the broader self-determination of the person, reassuring the background for the development of his/her personality. This observation applies to both medical services aimed at prevention or treatment of the organism as well as for medical acts of "enhancing" external characteristics or abilities, since the latter are also part of the individual’s self-determination regarding health issues.

The moral approach of “medical tourism” (or “cross - border health services”) is based precisely on this very wide freedom of the person to take care of his/her health. Indeed, this freedom justifies travelling to other countries for receiving medical services, irrespective of the reason the person concerned may invoke. Therefore, the practical enjoyment of this right justifies - and requires - the organization of cross – border provision of medical services. This organization is primarily the responsibility of the state, whether it may be about the state of dispatch of the persons concerned or the host state of those persons, and includes in particular: a) the securing of resources (health units certifications, appropriately trained staff, but also the provision of public insurance funds for the transfer of patients abroad), and b) the protection of the rights of the persons who travel.

The notion of “medical tourism” is certainly associated with a margin of freedom of choices of the person.[i] Thus, it does not fall within the scope of this concept, the case of urgent provision of health services, which requires the transition of a patient to another country, because the treatment of this incident is not provided within his/her country. In this regard, the social right to health is more binding to the state of origin of the patient, that is to provide sufficient means of ensuring the urgent transition and medical care of the patient in the host country, mainly through the social security system. Therefore, the measure of this commitment of the state - associated with criteria of fairness – does not fall within the scope of this Report.

It is precisely because medical tourism has this dimension of the person’s freedom of choice, that the problem of the potential conflict with the legislation of the state of origin arises, when its legal system prohibits the medical services desired by the person concerned.[ii] The problem is perceived by the latter as “bypassing the legal barriers of his/her country” in order to fulfil his/her purpose in a country where the same services are legitimate. Known examples herein are the example of women from Ireland who wished for the artificially termination of their pregnancy and due to the relative prohibition of their country's legislation, they were travelling abroad (e.g. in Britain), as well as the recent example of couples from France who wanted to have a child through the process of surrogate motherhood, and for that reason they were travelling to the USA, as for the French judiciary this method infringes the public policy clause (ordre public). In the latter case, these cases resulted in legal problems, when the parents requested the recognition of the French nationality to their children. The solution was given by two decisions of the European Court of Human Rights (ECtHR) that justified the parents and condemned France’s negation, which now calls into question the prohibition of surrogate motherhood from most national legislations across Europe.[iii]

[i] This freedom is not always absolute. For example, the case of pressure of workers by employers to conduct specific medical acts in another country (usually of the Third World), in order for the latter to accept to cover (cheaper than the country of origin) the expenses. See e.g. I. Glenn Cohen, Patients with Passports: Medical Tourism, Law, and Ethics, Oxford, N. York, Oxford U.P., 2014, in the Preface.

[ii] Glenn – Cohen, op. cit., Part Two.

[iii] ECtHR, Mennesson, Labassee v. France (2014).

From a moral point of view, the issue raised is whether the person's autonomy regarding health matters may outweigh the choices of the legislator, which presumably reflect the prevailing “social ethics”. In this dilemma, the answer is rather affirmative, at least to the extent that the interventions in the person's organism do not affect the fundamental rights of third parties. This, for example, occurs in the case of abortion, where - additionally - the continuation of an unwanted pregnancy can be considered contrary to the human value of the woman. The same could be assumed for gender reassignment surgeries or other aesthetic procedures that may encounter “moral” reactions in certain societies.

In each case, "medical tourism", through the abolishment of the frontiers in medical practice, raises a broader issue regarding the acceptance of certain “universal” values, regardless of the particularities and differentiations of the prevailing morality between national (or local) societies. This primacy of individual autonomy - in principle - does not necessarily entail the support of a person's choices on behalf of the social state. If one excludes the support provided through public insurance to urgency health services available solely abroad, the freedom of choice of such services by the person himself/herself, in the framework of self-determination, in principle, means his/her individual burden with the relevant cost. Deviation from this rule should be accepted- but still on the basis of the same principle - when the entire way of living or even the balance of one's health is likely to depend on this particular medical act. In the examples mentioned above, it would be reasonable to assume that if specific medical acts such as abortion, gender reassignment or assisted reproduction are not conducted this is likely to have an impact on the social life and even the mental health of the persons concerned. Nonetheless, the problem of how such a risk can be ascertained (to justify the assumption of costs by the welfare state, even when its legislation considers the medical act unlawful on moral grounds) is intractable.

3.2 The relation with the tourism industry

Another aspect of interest to bioethics is the relation between health services and the tourism industry. Medical tourism is based on this relation, since that being

the only way in which it can be ensured the promotion of health services to patients potentially concerned from other countries. However, the issue raised refers to the boundaries of methods of promotion - advertisement essentially - in view of the specificity of these services, which are in principle addressed to a vulnerable audience and in any case non- expert “consumers”.

It is precisely this element which differentiates medical tourism from other forms of tourism and imposes a reflection on patient information. The “promotion” of medical services is more of the nature of “informing” both the patient himself/herself and his/her physician in his/her own country. Without substituting the patient's personal information from his/her physician (taking into account that the message is addressed to a broader audience of patients with a potential interest), this information should, however, be precise and comprehensible by non-experts. Regardless of the information on facilities, staff and provided services, especially its part concerning the guaranteeing of the patient’s rights in the host country, both substantive (consensus, protection of confidentiality, sensitive data, etc.) and procedural (protection institutions – such as hospital patients’ offices, competent independent authorities, etc., any insurance coverage) is of great importance. Besides, information on the certification of the quality of the medical services provided in the host country according to internationally recognized standards, that allow comparisons of the quality of the same services in the country of origin, must be considered as a necessary piece of information. This is important especially when there are apparent divergences between national health systems (e.g. when the host country is a developing country).

In addition, information on this content must be provided to the persons concerned in good time, i.e. before they decide to travel to the host country, so that they would have the opportunity to consult their physician in their own country. The latter has the duty to inform the patient about the possibility of provision of health services in another country, within the context of the relationship of trust, as well as the duty to cooperate and exchange information about the patient with the latter’s physicians in the host country. On the other hand, the patient, who receives therapy abroad, is morally bound to keep his/her doctor in the country of origin informed

regarding the course of the therapy, as long as he/her does not want to interrupt the medical relationship between them.

4. The relevant legislation

The travelling to and from an EU member state for receiving health services is governed by Directive 2011/14, which was implemented in our national legislation by Law 4213/2013. The Directive does not simply address medical tourism, but any transition to another country for medical purposes and includes the recognition and protection of the patients' basic rights.[iv]

For host countries that have ratified the Oviedo Convention (such as Greece), its provisions on patient rights (consensus, confidentiality, the right to be ignorant, legal representation, earlier Directives, a framework of genetic tests and genetic therapies, ban on the commercialization of the body) apply in parallel.

National legislation that has incorporated EU law (health data protection, clinical studies) is also applicable to those EU citizens who seek health services in our country.

On the contrary, a question that arises is whether other national legislation regarding medical law is applicable to foreigners, including EU citizens (e.g. the Code of Medical Conduct, legislation on assisted reproduction, legislation on transplantation, artificial termination of pregnancy etc.). In this case, the applicable law must be determined by reference to the Greek rules of International Private Law. In the matter of medical acts received by foreigners, it is more appropriate to follow the relevant provision of legal capacity, which under the Greek Law is governed by the law of the foreigner's nationality (Article 7 of the Greek Civil Code), as long as it provides the same level of capacity that the Greek Law requires (Article 9 of the Greek Civil Code).

[iv] See in. T. Vidalis, and I. Kyriakaki, Cross-border Healthcare: Directive 2011/24 and the Greek Law, European Journal of Health Law 21, 2014, p. 33 - 45.

5. Recommendations

Medical tourism, whilst offering possibilities to patients / citizens traveling to another country, nevertheless, poses potential serious risks. For this reason, all parties involved have ethical - and in many cases legal – obligations aimed to protect the person concerned. Below, a range of measures is proposed, that ought to be taken by the parties involved for the protection of health and patients' rights.

- **Patients/citizens**. Before deciding to travel to another country, patients/citizens directly concerned should receive legal advice from experts who will guide them regarding the legal implications of a health service. This is particularly crucial, for example:
  a) in the case of MAR using a surrogate mother, when surrogate motherhood is forbidden in the country of origin, where the patients will return, resulting to problems regarding the recognition of the nationality of the children, and
  b) in the case where the costs of the therapy or the treatment of complications are not covered by the national health system after the patient' s return to his/her country.
- **Physicians in the country of origin**. The attending physician of the patient in the country of origin, if requested by the latter, has the moral duty to inform him/her about the searchability of health services in another country as well as the potential risks and the quality of the services provided in the host country.
- **Health services units (and physicians) in the country of destination**. Health services units in the country of destination ought to fully inform those concerned about the safety and the potential risks of a therapy, as well as regarding which international standards or guidelines are followed in each case. Especially in the case of cell therapies, it is absolutely crucial that the patients be informed whether the therapy is proven, scientifically documented through clinical trial or experimental procedure. By all means, the information and all the relevant documents addressed to patients should be provided in a language understandable by them, such as the English language.

- **Medical/scientific societies.** The medical/scientific societies of each country should issue relevant guidelines for the protection of the safety of the patients and the quality of health services provided in other countries.
- **Greek State**. The Greek State ought to introduce a register of accredited health units for medical tourism in Greece, after having first ensured the certification of the units that provide such services in accordance to the international standards.

  In particular, regarding reproductive tourism, the Greek State with the care of the Hellenic National Authority of Medically Assisted Reproduction, should create and activate the register of donor gametes that will ensure the transparency in gamete donation and will prevent the exploitation of vulnerable and financially disadvantaged groups. This is particularly crucial for our country, since the data available so far (see 2.1.3) show that one of the main reasons that foreign patients prefer Greece is *in vitro* fertilization using donor eggs.

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