Ethical Issues In Medical Tourism In Africa

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Abstract

Medical tourism, (MT) the act of moving from one country to another to seek medical assistance, is a global phenomenon. Despite being an international occurrence with lots of literature on its social, political, or economic implications, this paper articulates its ethical concerns to the patient or 'tourist', the host and the destination countries. It, thus, addresses questions such as: what are some ethical issues in medical tourism? Is medical tourism a leisure enterprise, as the name suggests? Are there justifications for medical tourism? Adopting the scoping review methodology, the paper explores and synthesises existing literature to foreground a critical analysis of the ethical implications of medical tourism. Some of its findings concern ethical issues such as harm/risks, inequity/inequality of healthcare distribution, informed consent, and duty of care/quality of care. In addressing these issues, while critically analysing the adequacy of deontological ethics and preference utilitarianism, the paper argues that it is imperative that Africa not just compete for the global MT dollar but sit up and regulate MT activities. This requires coming up with a framework that would strike a balance between the benefits of MT and the burden of it. To this end, this paper proposes a regulation that promotes the common good of all: the patient, the departure and destination countries.

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Keywords: Medical Tourism, Ethics, Africa, Deontologism, Preference Utilitarianism

Introduction

Africans are some of the highest contributors to medical tourism, with billions of US dollars spent yearly on renal transplants, cardiac surgeries, neurosurgeries, cosmetics surgeries, ear treatment, and orthopaedic, among others. This form of tourism has implications for the tourists and the countries involved, either as one from which a patient is coming or as one in which the patient is receiving treatment. Some of these issues are social, political, or economic issues. However, this paper examines the ethical dimension of health tourism in Africa. This paper is informed by the belief that if the ethical issues are addressed and appropriate recommendations are implemented and enforced, other related issues will be put in proper perspectives or highly mitigated.

On the Nature of Medical/Health Tourism

A distinction can be made between medical tourism and health tourism. Both involve the crossing of borders to seek professional healthcare that suits one's needs or desires. The point of divergence is that in health tourism, special attention is paid to holistic care that involves the individual's well-being in mind and body. In contrast, medical tourism focuses more on the ailment, while well-being in mind and body is only tangential. Health tourism aims to improve and repair an individual's health through medical aid (Carrera & Bridges., 2014). However, one could argue that medical tourism is equally holistic, given the definition of the World Health Organisation of health as a condition of total physical, mental and social well-being, not just being devoid of illness.

Nevertheless, medical tourism has been criticised as an unnecessary euphemism for the seriousness of what transpires when people seek medical care in another country. It has been argued as ill-fitting, failing to capture the seriousness of travelling to another country for healthcare services. Tourism signals leisure, relaxation, playful/flippant activity, sightseeing, and recreation (Chikanda *et al*., 2012). So, in its place, there have been various other suggestions such as 'medical traveller', 'medical exodus', and 'medical

migration.' These suggestions are inaccurate in some ways as travel becomes a migration, depending on the length of stay. At the same time, an exodus of people connotes mass movement of people from one place to another, which does not necessarily capture what MT does. More importantly, despite the trivialisation of the seriousness of the numerous issues embedded in the term MT, the term MT is employed in this paper to succinctly capture the ethical problems in the industry.

Medical tourism (MT)[2], as used in this study, refers to the practice of going outside of one's country of origin, birth, or residence to another country, be it developed or developing, primarily to access healthcare services, irrespective of the motivation for such visits. MT, so conceived, excludes emergencies or expatriates seeking medical care in the country where they are presently domiciled. MT dates back to antiquity. In contemporary times, the term is much more complex than it was among the Summer people, Greeks and Romans, who visited water springs, temples, and Epidauria for health and well-being. It was believed that Asclepius, the God of medicine, lived there (Cook, 2008).

Initially, it used to be an influx of MT from developing nations to developed nations to seek healthcare services that were unavailable in their home countries; but at present, the influx goes both ways as cheaper costs and circumvention of proscribing law are some of the motivating factors. Thus, Africa is not left out of this global enterprise. Some MT destinations in Africa include South Africa, Kenya and Egypt. While Africans and non-Africans visit these destinations, many Africans travel equally out of the continent for MT. For instance, Nigerians notably travel to India for renal transplants, just as Africans, Europeans and Americans go to South Africa for stem cell therapy, etc.

2. HT would be used to designate both 'health tourism' and 'health tourist'; while MT would be employed to designate both 'medical tourism' and 'medical tourist.' Despite the difference between the two, for the sake of this paper both would be used interchangeably.

Literature Review on Medical Tourism

Despite the flourishing trend of medical tourism, there is a paucity of research on the scientific and philosophical study of MT in Africa. A literature survey shows that numerous studies abound on HT globally (Cook, 2008; Glenn, 2015); however, much needs to be done regarding the phenomenon in Africa, particularly the philosophical exploration of its ethical issues. For instance, Crush and Chikanda argue that certain MTs would be disqualified from seeking healthcare in South Africa due to their agreement with governments of neighbouring countries whose citizens seek medical care in SA. The ethical implication of this is that citizens are denied access to good medical practices that they seek in neighbouring countries because their government and that of the country from which they seek medical assistance are at loggerheads. The right of such citizens to good health is obviously unjustifiably denied. They conclude that the menace of MT in SA and the South-South in general needs more scholarly research (Crush & Chikanda, 2015).

Idowu and Adewole analyse neurological complications that result from kidney transplants of Nigerians who travel to India for transplants. They found out that no significant difference exists in the 23 patients that were studied before and after the transplant was done, when they were later admitted in Nigeria, after their return, due to complications and when the surgery was redone in Nigeria. The researchers recommended that appropriate regulations should be put in place so that patients would receive good care abroad and suitable follow-up after returning to their home countries (Idowu & Adewole, 2015).

Mogaka and Tsoka-Gwegweni attempt a scientific investigation of medical tourism in Africa. They concluded that more needs to be done regarding the role, structure, and effects of MT in Africa because it can provide vital information for various stakeholders seeking information on MT in Africa (Mogaka *et al*., 2017). The paper investigates the degree of knowledge of MT ethics in Africa. They argue that there is a paucity of research on the ethics of MT that employ ethical theories and principles. According to them, many extant literatures lump ethical issues together with other considerations (Mogaka *et al*., 2017).

Makinde's paper focuses on the effects of medical tourism as facilitated by physicians. He argues that there is a need to regulate medical tourism facilitated by physicians because of the ethical issues of conflict of interest it poses (Makinde, 2016). Furthermore, Makinde, and Olaleye opine that there is a need to review the portion of the code of medical ethics that bans physicians and healthcare practitioners from advertising medical advances and services. This, they argue, is to accommodate the present trend of MT facilitators to clearly spell out what is acceptable or non-acceptable in light of new advancements and services available in the medical profession (Makinde & Olaleye, 2014).

The crux of Meissner-Roloff and Pepper's position is that with the use of stem cells, appropriate legislation should be put in place while existing ones should be implemented for the good of the patient and the advancement of medicine (Mogaka *et al*., 2017). On their part, Nicolaides and Zigiridis boast that South Africa is the ideal choice for patients on MT because the country has, over the years, built a respectable reputation for MT. They made a recommendation regarding the logistics of hotel accommodation and the possibility of follow-up (Nicolaides & Zigiridis, 2011). However, Magdi posits that Egypt is well positioned geographically for MT and has both the human power of healthcare professionals and infrastructure. Also, he noted some shortfalls of MT in Egypt, which include a lack of governance of the MT sector and low quality of healthcare (Magdi, 2018). EmadEddin AbuElEnain and Saber Yahia echoed similar idea and called on the Egyptian government to be more proactive in making Egypt a hub for MT comparable to Dubai (AbuElEnain & Yahia, 2020).

Justification and Benefits of Health Tourism

Health tourism is pursued for a few reasons. It brings various benefits to different stakeholders. For the patients, it is an avenue to access medical procedures that are otherwise unavailable in their home countries or for which there is no adequate infrastructure or confidence in the services rendered, as it is in the influx of Nigerians to India for renal transplants. Sometimes, MT provides an avenue to access medical procedures at cheaper costs (with or without health insurance) as it is in the exodus of people from developed to developing countries where the procedure is more affordable than their developed home country. Or to exploit services like

surrogacy at a cheaper cost in developing countries such as India and Nigeria, to mention but a few. At other times, it helps circumvent laws that proscribe access to certain services. For instance, assisted suicide is proscribed in England but acceptable in Switzerland; surrogacy is proscribed in some parts of Europe; so proscribing laws are some of the motivating factors. French citizens seek fertility treatment in Belgium due to its legal restrictions in their home country. Single mothers, transgender couples and homosexuals also flock to Belgium for reproductive tourism from France, given its restrictions in France (Pennings *et al*., 2009).

To destination countries, it is argued that with foreign currency exchanging hands, export earnings are increased while the fiscal deficit is reduced, resulting in the growth of the national economy. So, with this growth and in tandem with basic neoliberalism of economic development, when national income increases, there will be equity in access, thus enabling more of the population to access private care (Smith, 2012). Other advantages include low costs, domestic human capital, domestic research development, a developed physical infrastructure, and a liberalised market economy (Bookman & Bookman, 2007). There is, however, some literature that shows that medical tourism is growing globally. However, this growth appears "based solely on MT advantages to medical tourists, short-term economic rent for destination economics and profits to care providers. Medical tourists benefit from preferential treatment based on their ability to pay for medical services. Destination countries benefit in revenue generation" (Mogaka *et al*., 2017, 6).

Ethical Consequences of Medical Tourism in Africa

There are a few ethical issues that can be raised when medical tourism is subjected to philosophical analysis. This will lead to the discovery of some implications that accompany medical tourism in Africa. Below, some of these issues are raised.

Harm/Risk

Harm/risk could be to the patient, the health system at home, or even locals in the destination country. This could manifest in complications after returning to the home country without adequate provision for follow-up. It could also be in the form of heightened stress of transfer from a foreign

country to the home country. Sometimes, antibiotic-resistant infections occur with no immunity for those at home (because these infections are not common). There may also be the case of undue exposure to infectious diseases and subsequent transmission in the home country (transmission across geographical boundaries). This list also includes the risk of deep vein thrombosis (blood clots) resulting from flying long hours after surgery. The risks a medical tourist could face can be intensified by long travel hours, usually heightened by a recent surgery and an unfamiliar environment.

There are also reported cases of medical malpractice that medical tourists face. While this can occur anywhere, the case with MT could be challenging to pursue due to travel schedules and/or differing legal institutions. When a medical error or malpractice occurs, the ability to receive compensation might be jeopardised due to many factors.

Inequity/Inequality of Healthcare Distribution

The inequity of healthcare distribution relates to healthcare imbalance between the local population and foreign patients. This imbalance manifests in two-fold: negligence of the health sector in departure countries, and sometimes the host country and excessive resource focus on the private health sector for the needs of foreigners with hard currency at the detriment of the local population. The first is evident in the fact that the departure countries sometimes lack good health infrastructure, necessitating the need for citizens who can afford it to seek medical intervention in another country. The host country, earning more from MT, may neglect the health needs of the local populace, concentrating more on the needs of the medical tourists because the country amasses more foreign deposits. It is to be noted that, as spelt out by the United Nations Economic and Social Council, health is a foundational human right sacrosanct to the discharge of other human rights (Smith, 2012).

Indeed, as seen in MT destination countries such as India and the upcoming trends in Egypt and South Africa, MT has the potential to ensure that destination countries pump more resources of health, human capital and funding into the private sector. This has been seen to alter the emphasis on public health in these countries, thus creating a healthcare system that prioritises the needs and wants of tourists at the expense of domestic health

needs. Owing to this, healthcare may further be privatised, which would result in a reduction in healthcare access for those unable to pay.

Moreover, MT perpetuate social injustice as it widens the gap between the haves and the have-nots. The upper class and political class in Nigeria, for example, can easily engage in MT, while the poor masses cannot. This often leads to the negligence of the health infrastructure in the country since the leaders feel unaffected by the rot in the health sector. This results in a general loss of confidence in the health sector and a need for more urgency in providing adequate infrastructures for the poor masses who cannot afford MT.

Important resources are also diverted to treat complications resulting from treatments abroad (Idowu & Adewole, 2015). Moreover, MT does not just promote an imbalance in healthcare distribution; it also violates the duty to preserve public trust and confidence, as evidenced by Africa's political leaders, who are notorious for MT. For instance, Nigeria's President Muhammadu Buhari, at the commencement of his administration in 2017, violated his electoral promise of ending MT by spending a more significant part of his tenure in the United Kingdom for medical treatment than he did in Nigeria. This led to the level of trust in the Nigerian health system dwindling.

Inequity/inequality is further witnessed when the needs of foreign patients are prioritised over those of locals, particularly if the desire to make profits trumps concerns of public health, resulting in unreasonable allocation of resources to develop expensive and sophisticated clinical interventions benefiting just only a few thus contributing to healthcare inequity (Mogaka *et al*., 2017). For example, tourists for artificial reproductive technique (ART) employ sophisticated, costly and non-routine medical expertise and procedures to give birth to new lives. Yet, every year, preventable infections and diseases such as malaria and pneumonia cut short the lives of millions of children under the age of five in Africa. Thus, it provides what has come to be referred to as 'first-world care at third-world prices (Turner, 2007), bringing to light the ethical and socioeconomic inequities that underscore the MT industry.

Informed Consent

This is an important process that ensures that human subjects are respected. It relies on the idea that patients should know and approve a particular form of treatment before it is administered. It involves the following elements: decision-making capacity, disclosure, understanding and voluntariness. While decision-making capacity, understanding and voluntariness are sometimes generally compromised in MT situations, especially if the patient is critically ill and consent by proxy could also suffer the same fate, disclosure is the most pertinent ethical issue in this context. Disclosure entails that adequate information be communicated and understood by the patient; it also requires that patients are given comprehensive information regarding treatments, success rates, and risks of complication before undergoing the care. However, in MT, these are usually not the case. Available pieces of literature indicate that there is often no disclosure, and when there is, accurate information is never given to patients, hence militating against the patient's capability to give informed consent. There are many facilitators/agents giving information about MT to patients through websites, but much of the information is neither adequate, balanced, nor accurate; thus, patients cannot be said to have given consent that is well informed about a procedure they knew next to nothing about (Penney *et al*., 2011).

A survey of medical tourist agents shows that necessary information for consent to be given is absent- information about risks, negative outcomes, and success rates; when a few of these are present on some websites, it is considerably downplayed in favour of the benefits. In summary, there is insufficient risk communication with the attendant inability to achieve informed consent. While there could be this problem in traditional medicine that has nothing to do with MT, it is especially pertinent in MT as the challenges to communicating this are higher, such as language barrier, emergency/time constraints of the procedure of MT, largely unregulated activities of MT agent/facility and the attendant financial interest.

Based on principlist ethics of autonomy, informed consent and veracity, the literature reveals that the way MT is being marketed by destination hospitals to foreigners by various governmental and company agencies is problematic. This relates to the principle that behoves practitioners to be

honest and truthful in their engagements with patients and to disclose risks and benefits fully (Mogaka *et al*., 2017).

Medical Brain Drain

MT can be linked to an unfair or 'unethical recruitment' of health workers from third-world countries in order to provide the expertise needed for medical procedures in these developed countries. This exacerbates public health issues already existing in countries of departure, where health personnel are mostly needed. While some have argued for medical brain gain for the destination countries, the ethical issue lies in brain drain. Brain drain refers to the mass exodus of health workers from one region to another in search of greener pastures. This becomes unethical as this migration is worsening the shortage of health workers in the country from which they are departing, more so, when government resources have been employed to train them under the free education scheme, which they leave without adequately compensating. Of course, there is the frustration of working in a system where basic infrastructure is lacking and with no hope of improvement anytime soon; this, however, does not remove the ethical issue of medical brain drain from the discourse of MT.

Duty of Care/Quality of Care

Healthcare practitioners generally owe the duty to nurse and nurture back to health their patients to a reasonable degree. However, this and the quality of care can be compromised because of geographical, cultural and linguistic barriers in transferring medical records when there is such an arrangement. Lack of information flow from the two physicians, the physician abroad and the one at home can negatively impact the nature and quality of care. The patients could also be inadvertent victims of several conflicting standards of care. Follow-up care in the home country may be difficult, especially when emergency complications are involved. To use Nigeria as an example, a Nigerian doctor or home caregiver may be hesitant to give follow-up treatment to a medical tourist returnee due to many factors, such as legal liability concerns. When follow-up care had been duly arranged, the estimated expenses could far outweigh what the patient has, undermining the quality of care. When the care sought abroad is proscribed at home and ethically disallowed, there is no chance of follow-up, compromising the idea of care.

Idowu and Adewole reported that 39% of the 23 patients, they studied, died from complications of treatment received abroad after returning to the country. They noted that more than one-fourth of these patients came down with infections, bringing about follow-up care that was not initially arranged (Idowu & Adewole, 2015).

Conflict of Interests/Supplier-Induced Demand

While Nigeria has a standing code against advertisement in the medical profession, physicians now act as medical travel facilitators/agents advertising health care services over social media. Some health workers refer abroad, for treatment, procedures that could easily be done in Nigeria based on the commission that would accrue from such referrals. This development poses a significant conflict of interest between a physician acting as a guide to her patient to make the best decision and one that coerces the patient to make a decision that would bring financial gain to the physician or between a lifesaver and the good of the patient. Proper checks and regulations ought to be in place to forestall MT from being vulnerable to supplier-induced demand (SID), where the physician is the supplier, creating a market that is not there. The proper regulations should be put in place to stem this trend and protect the medical profession and the patients. Some Medical tourist facilitators (MTF) are already making their clients sign liability waivers if something goes wrong. However, it is unethical for a physician who doubles as an MTF to coerce or induce a patient to sign a liability form.

Death of Key National Personnel

Nigeria's Musa Yar'Adua managed to return to Nigeria before his passing after months of treatment in Saudi Arabia; Ghana's Atta Mills equally managed to return to Accra before he died after months of treatment in the United States of America. President Robert Mugabe of Zimbabwe, who ruled for 37 years, frequently sought eye-related treatment in Singapore despite staying long enough in power to fix his country's health sector. Jose Eduardo dos Santos, the former Angola leader for about 38 years, frequently visited Spain for treatment.

One fallout of MT is that the medical treatment they went for may fail and lead to their death. In this regard, several notable African leaders have died while seeking medical help abroad. In 2008 and 2014 , Levy Mwanawasa died in France, and Michael Sata of Zambia died in the UK, respectively; in 2012, Malam Bacai Sanha of Guinea Bissau died in France, Ethiopia's Meles Zenawi died in 2012 in Belgium; in 2009, Gabon's Omar Bongo died in Spain. All these point to key personnel who died on foreign soil in the quest for MT. It may just be that these important people may be saved in their country if they had good healthcare systems at home that can cater to their needs. Also, a national asset in the operation theatre of another country may well be compromised or be at risk.

Conclusion

It is important to note that many of these ethical issues are obtainable in other parts of the world. More importantly, these issues have wide ramifications for global public health. For instance, the exodus of patients across borders could escalate the transmission of infectious diseases across borders. The demand for MT could introduce the availability of highly specialised medical treatment, reducing primary health care delivery globally. At the same time, this is not bad in itself; it can lead to an upsurge in global health inequity, given that health resources are focused on those who can afford specialised health care.

Deontological ethical theory stresses that it is important that people abide by their obligations and duties to society. In this context, such duty relates to the government and other healthcare providers creating affordable and accessible healthcare system for all. But it is partly a shack in this obligation that necessitated MT in some quarters. But would this address all the ethical issues in MT? This may not fully address MT's ethical issues.

MT protagonists argue from the perspectives of utilitarianism and libertarianism with the emphasis on freedom, individual liberty and voluntary association that MT affords persons the freedom to select from a wide array of healthcare providers, side-step delayed care or treatments, overtly expensive care, unavailable or legally proscribed in their home countries. Some MT proponents query certain ethical assumptions put forward by deontologists that some deeply personal human experiences fundamentally

ought not to be put up for sale in the market. Should patients' wishes be prioritised over their best interests? But freedom, individual liberty and voluntariness are not absolutes. Hence, they must be regulated to be of service to all concerned.

Aside from this, Peter Singer's Preference Utilitarianism (PU) has been proposed as a theory of global health ethics to examine the ethical issues in MT. PU states that the interest of others should guide my interest, and I should choose the course of action that would advance the interests of those affected by my action (Singer, 2011). PU is apt because Singer argues for the irrelevancy of proximity and distance (Singer, 1972) in choosing whom to help, which is pertinent in a discussion such as this. What differentiates PU from the classical utilitarian theory is the emphasis on actions that satisfy personal interest in contrast to actions that bring the greatest good for the greatest number of persons.

But PU seems to rely on some radical altruism that does not generally characterise the human person. While the insignificance of proximity and distance of whom to help is an excellent plus for PU, likewise, the call for some 'selflessness' it is difficult to purge one of oneself and be able to be guided by actions that would totally advance the interest of others. How do we resolve the dispute when what I think advances the interest of another and the other does not think so? There can be a disparity between what one thinks advances a person's interest and what that person thinks.

Given the above ethical issues, the implications they have for global health, and the various attempts at examining the morality of MT, this paper posits that it is imperative that Africa not just compete for the global MT dollar because (in most countries, MT is unsustainably and haphazardly regulated) but for Africa to especially, sit up and regulate the activities of MT; to come up with a framework that would try to strike a balance between the benefits of MT and the burden of it. To this end, this paper proposes a regulation that promotes the common good of all: the patient, the departure and destination countries.

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