# Understanding medical tourism within the field of neo-institutionalism: an ethical insight


## Rossella Canestrino*

Business Management – SECS-P/08,
DISAQ – 'Parthenope' University of Naples,
Naples, 80132, Italy
Email: rossella.canestrino@uniparthenope.it
*Corresponding author

## Pierpaolo Magliocca and Claudio Nigro

Business Management – SECS-P/08,
University of Foggia,
Foggia, 71121, Italy
Email: pierpaolo.magliocca@unifg.it
Email: claudio.nigro@unifg.it



**Abstract:** Medical Tourism (MT) has increased in recent years, since a large number of patients from worldwide have travelled to other countries to receive medical cares. This tendency poses deep ethical dilemmas with reference to both the respect of human rights and the unequal distribution of healthcare resources between the rich and the poor. According to the above-mentioned considerations, our paper aims at exploring the ethical concerns of MT and of its social sustainability, as well. In doing this, the neo-institutionalist perspective has been adopted to understand the phenomenon. The proposed paper is theoretical one: it reviews relevant health and medical tourism literature, crossing it with the main contributions belonging to the neo-institutionalism. The adoption of a neo-institutional perspective provides scholars for a new framework that has never been used before, to investigate MT.



**Keywords:** medical tourism; neo-institutionalism; normative institutional framework; symbolic institutional framework; ethical insights; social sustainability.

**Reference** to this paper should be made as follows: Canestrino, R., Magliocca, P. and Nigro, C. (2016) 'Understanding medical tourism within the field of neo-institutionalism: an ethical insight', *Int. J. Environment and Health*, Vol. 8, No. 1, pp.76–99.



**Biographical notes:** Rossella Canestrino is an Assistant Professor of Management Studies at the Parthenope University of Naples (Italy), where she holds her PhD in Management and Business Administration. Her research interests include knowledge management, cross-cultural management and business ethics. Among the underlined research fields, she particularly focuses on the way cultural diversities may foster or, alternatively, limit knowledge creation and transfer, which means how culture affect firm's propensity to


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create and diffuse knowledge. Similarly, she also investigates the role of culture in shaping firms' propensity to social responsibility and to adopt sustainable practices.

Pierpaolo Magliocca is an Assistant Professor at the University of Foggia (Italy). His research interests include knowledge management, process management, international business and medical tourism. Within the field of knowledge management and firms' internationalisation process, he focused his attention on the conditions upon which intra-organisational knowledge transfer may occur and corporate learning process may be fostered. His research activities are reinforced by his involvement in several academic research projects. Actually, he is the scientific coordinator for the project 'Medical Tourism: Managerial and legal dynamics', selected for funding by the University of Foggia.

Claudio Nigro is a Full Professor of Economics and Management at the University of Foggia (Italy). He is the author of several monographic works, essays and contributions on the themes of business and organisational theories, with particular interest in the relationship between organisations, management, business innovation, tourism and territorial development. He has participated in many national and international conferences and has various contributions in international papers. He received the 2007 Highly Commended Award for Excellence from the Emerald Literati Network and, in 2014, the Best Paper Award at the International Conference HTHIC in Heritage, Tourism and Hospitality.

## 1 Introduction

Medical tourism (MT) has increased in recent years, as it is supported by the large number of people who travel abroad to get medical cares (Burns, 2014; Han and Hyun, 2014; Snyder et al., 2011; Sobo, 2009).

Even if travelling for medical cares (and well-being) has long existed, some differences are soon emerging and a 'reverse globalisation' is still arising (Connell, 2013): Not only Thailand, Singapore and Malaysia, but also India are capitalising on their reputations as the most important MT destinations in the world, by combining high-quality medical services at competitive prices with tourist packages.

In spite of its rapid diffusion, MT is a still little investigated issue within the field of management studies. The lack of resources about the topic may depend on the difficulties to define the phenomenon, as well as on the ethical controversies that arise by its spread at global level. The existing overlapping between the two different industries – health and tourism – makes the analysis even more complex, with reference to both the drivers and the consequences of MT at societal level.

According to many authors (Burns, 2015; Han and Hyun, 2014; Edelheit, 2008), patients travel to another country looking for more affordable cares, or cares that are more accessible abroad, than into the domestic country; particularly, cross-border healthcares are mainly motivated by the lower costs of procedures available abroad, and by the avoidance of long wait times 'at home' (Hopkins et al., 2010).

Not surprisingly, Thailand, Singapore, Malaysia, India and East Asia are the preferred destinations by US patients. The latter are mainly driven not only by the rising of health costs in the USA, but also by the significant reduction in the percentage of US residents with healthcare insurance (Hadi, 2009).

Additionally, patients look abroad for achieving 'extreme' procedures – stem cell therapy, surrogacy and even euthanasia – not undertaken, or not morally accepted, in their home countries. In such circumstances, MT soon develops at international level, posing strong challenges about the balance between its business opportunities and ethical concerns, which shapes its sustainability, at least.

First, MT affects the fundamental human rights – life and health – by limiting, or allowing, individuals' freedom in gaining healthcares (Adams et al., 2013; Ackerman, 2010; Sengupta, 2011). Second, it could impair the equality of healthcare resources distribution, not only between domestic and foreign countries, but also within the destination countries themselves (Chuang et al., 2014). Taking into account the mentioned considerations, we believe that the emergence of a 'dual healthcare system' in many destinations, as well as the 'morality' of some extreme procedures may, finally, mine the cornerstones of MT's sustainability.

Our paper particularly aims at improving the actual understanding of MT, mainly referring to its ethical concerns. Through an inductive approach, an extensive literary review about health and MT has been carried to gain a wide understanding of phenomenon with reference to its drivers and implications. The collected literature has been then crossed with the contributions belonging to the *Neo-institutionalism* to investigate the way both the normative and the cultural diversities may affect patients' choices to go abroad. We, particularly, support the idea that every time *Institutional Normative Frameworks*, or *Symbolic Institutional Frameworks* – as they have been defined within the *Neo-institutional* framework (Meyer and Rowan, 1977; DiMaggio and Powel, 1983) – differ from one country to another, patients look abroad for health solutions that are not available, or that are not morally accepted, in their domestic country, thus fostering the growth of MT itself.

According to our research aim, we, firstly, examine the set of the drivers that lie upon the emergence of MT with reference to the neo-institutional framework. Second, we discuss the impact that MT growth has at societal level, to exploit the ethical concerns of the phenomenon, and of its social sustainability, as well.

The remainder of this paper is formatted as follows: Section 2 points out the literary background about MT. This last one may be divided into two main categories:

- outbound MT (when patients travel away from home country)
- inbound MT (when foreign patients come for care in a given country – e.g., India, Malaysia, or Singapore).[1]

For our purpose, we investigate only the outbound MT. According to a demand/consumer perspective, the reasons why people travel to access to cross-border healthcares are also scanned in this section. Section 3 exploits the drivers of MT within the *Neo-Institutional* framework. The *Ethical* concerns of the phenomenon are, therefore, examined in Section 4. Conclusions have been finally provided in Section 5.

## 2 Theoretical background: when people travel for healthcare

Despite the large number of available papers about MT (Connell, 2013, 2006; Crooks et al., 2010; Hopkins et al., 2010), the body of research about the topic looks heterogeneous and fragmented. Not surprisingly, MT has been differently described over time according to the main issues discussed in the related papers: ethical concerns, economics dynamics, marketing or other perspectives (Woo and Schwartz, 2014).

Some scholars often define MT as a 'travel' engaged by citizens to obtain medical care (Cormany and Baloglu, 2011), without referring to the type of procedures that the patients expect to obtain.

For Cormany and Baloglu (2011), for example, MT refers to 'the act of travelling abroad to obtain medical care'. According to Kopson (2010, p.1), MT means *"travel[ing] to another country to receive medical, dental and surgical care while at the same time receiving equal to or greater care than they would have in their own country … because of affordability, better access to care or a higher level of quality of care".* Similarly, Adams et al. (2013) labelled MT as the practice of patients to travel out of the country with the intention to receive medical care. Even when the mentioned authors focus on the distinction between public and private healthcare (since medical tourists are those patients who pay for medical cares 'out of pocket'), they never distinguish among the types of procedures that the patients look for.

In reality, the range of interventions related to MT moves from yoga and massages, cosmetic surgeries, dentistry, to operations, like hip replacements and transplants, reproductive procedures and even to 'death tourism',[2] suggesting for a more punctual categorisation of the phenomenon. This is the reason why, for example, wellness tourism usually belongs to a different literary field (Smith and Puczko, 2009), and dental tourism has sometimes been excluded from the definitions of MT (Pollard, 2011; Turner, 2008). For the same reasons, MT is also distinguished by health tourism (Lunt and Carrera, 2010; Lunt et al., 2010), since the last one is mainly devoted to low-key, therapeutic and non-invasive measures, like, for example, check-ups, water-care and dentistry (Connell, 2013).

The difficulties in depicting MT also depend on the linkage that should establish between health and tourism industry under the pressure of the phenomenon: in other words, patients' healthcare needs and their enjoyment at the destination have to exist in the same time (Woo and Schwartz, 2014). In contrast with the mentioned prescription, however, Cormany and Baloglu (2011), Kopston (2010), Adam et al. (2013) and even many other authors (like, for example, Burns, 2014; Chuang et al., 2014; Crooks et al., 2010; Lunt et al., 2010) underestimated the leisure aspects of MT. This could be due to the perception that the patients/tourists have about the medical variables of MT: as Woo and Schwartz (2014) suggested, tourists perceive the quality of medical treatment as much more important than the recreation facilities.[3]

But, without ignoring the pain that is implicit in some medical procedures, as well as the desperation – that often led patients to go abroad – connotations of pleasure, relaxation and education belong to the MT, and it is supported by the scholars (Han and Hyun, 2014; Heung et al., 2010; Jagyasi, 2008; Connell, 2006; Laws, 1996).

Health tourists, therefore, take the opportunity to visit a popular travel destination, thus combining healthcare with a vacation.

In line with this perspective, Laws (1996) defined MT as a travel from home to other destination to improve one's health condition, as well as one's type of leisure. Connell (2006) described MT as popular mass culture according to which people look for cross-border medical cares, taking the opportunity to visit the host country and to enjoy local touristic attractions.

Similarly, Jagyasi (2008, p.10) referred to MT as "the set of activities in which a person travels often long distance or across the border, to avail medical services with direct or indirect engagement in leisure, business or other purposes".

The underlined perspectives include: "a vacation that involves travelling across international borders to obtain a broad range of medical services. It usually includes leisure, fun and relaxation activities, as well as wellness and health-care service" (Heung et al., 2010, p.236).

MT is viewed as being composed of two main components: the 'medical outsourcing' and the enjoyment of certain activities available at the destination by these last authors (Woo and Schwartz, 2014).

Table 1 summarises the referred literary contributions about MT, by considering the balance between the medical concerns and the leisure aspects of the phenomenon.

Defining MT is only one of the topics examined within the current literature related to MT industry. Several papers (Connell, 2006, 2013; Crook et al., 2010; Hopkins et al., 2010) have been published to summarise the magnitude, the longevity, the trend of the industry, as well as the ethical and economic issues of the phenomenon, widening both the heterogeneity and the fragmentation of the examined body of research. To fill this gap, Chuang et al. (2014) identified and illuminated the main themes and key issues amidst the MT literature, by applying the main path analysis. Their research results show the emergence of two distinctive paths that develop different themes within the field of MT. One of the paths focus on the evolution of MT and its associated problems, patients' motivations to go abroad and economic analysis. The other path concentrates more on organ transplantation, ethics, risks, regulatory pre- and post-operation-related issues. As the authors themselves recognised, these two paths eventually merge to a common node, opening to a future research trend.

In line with this lastly observation, we focus on the 'bridge' between the patients' motivation to go abroad for treatments and the ethical implications of MT. As we noted earlier, patients look for foreign destinations to gain the access at healthcares that are 'not available' in their home countries. These push factors include: high costs of care, lack of or inadequate health insurance, long waiting time and unavailability of the procedures because of technical, legal or ethical reasons (Ramamonjiarivelo et al., 2015). In other words, MT provides the patients/tourists with services otherwise unavailable, thus granting patients' right to healthcare. At the same time, however, MT poses a lot of ethical problems, mainly referring to its implications at societal level: in-equal distribution of the healthcare resources between the rich and the poor (Connell, 2013; Bristow et al., 2010; Hadi, 2009), privatisation of healthcare based on a free market principle, prevention of corruption and human rights abuse associated with the commercialisation of organ transplant (Penney et al., 2011; Merion et al., 2008;

Bramstedt and Xu, 2007; Canales et al., 2006; Bass, 2005), as well as fertility, transgender treatments and death tourism (Martin, 2014; Cohen et al., 2012; Higginbotham, 2011; Inhorn, 2011).

**Table 1** Summary of the referred definitions of MT

| *Authors* | *Medical outsourcing* | *Balance between medical outsourcing and enjoyment* |
|---|---|---|
| Chuang et al. (2014) | | "Medical tourism combining the very polarised purposes of pleasurable travel and potentially stressful healthcare services…" |
| Burns (2014) | "International medical tourism refers to travelling outside one's country to obtain care at significantly reduced cost or …increased quality" | |
| Chuang et al. (2014) | "Medical tourists are patients who travel internationally for non-urgent medical treatments…" | |
| Woo and Schwartz (2014) | | "Medical tourism is viewed as being comprised of two major components: medical outsourcing …and the enjoyment of certain activities…" |
| Adams (2013) | "Practice of patients to travel out of country with the intention to receive medical care" | |
| Cormany and Balogu (2011) | "Travel engaged by citizens to obtain medical care" | |
| Crooks et al. (2010) | "Medical tourism is understood as travel abroad with the intention of obtaining non-emergency medical services" | |
| Lunt et al. (2010) | "Medical tourism is when consumers elect to travel across international borders with the intention of receiving some form of medical treatment. This treatment may span the full range of medical services, but most commonly includes dental care, cosmetic surgery, elective surgery, and fertility treatment" | |
| Heung et al. (2010) | | "Medical tourism is a vacation that involves travelling across international borders to obtain a broad range of medical services. It usually includes leisure, fun and relaxation activities, as well as wellness and health-care service" |

**Table 1** Summary of the referred definitions of MT (continued)

| *Authors* | *Medical outsourcing* | *Balance between medical outsourcing and enjoyment* |
|---|---|---|
| Kopson (2010) | "Travel[ing] to another country to receive medical, dental and surgical care while at the same time receiving equal to or greater care than they would have in their own country…because of affordability, better access to care or a higher level of quality of care" | |
| Jagyasi (2008) | | "Medical tourism is the set of activities in which a person travels often long distance or across the border, to avail medical services with direct or indirect engagement in leisure, business or other purposes" |
| Carrera and Bridges (2006) | | "Organised travel outside one's local environment for the maintenance, enhancement or restoration of an individual's well-being in mind and body" |
| Connell (2006) | | "Medical tourism is practiced by people who travel long distances or to overseas countries to obtain medical, dental, and surgical care, while simultaneously being a holiday-maker in the more conventional sense" |
| Laws (1996) | | "Medical tourism is a travel from home to other destination to improve one's health condition, as well as one's type of leisure" |

*Source*: Our elaboration

## 3 Understanding the drivers of MT

A lot of drivers affect the growth of MT, but, among them, the high costs of procedures and the long waiting times to access care at home are the most cited at international level (Burns, 2015; Ramamonjiarivelo et al., 2015; Pocock and Phua, 2011; Lunt and Carrera, 2010; Kopson, 2010).

The rapid growth of healthcare costs is particularly relevant in those countries, like USA, where public health systems do not exist. According to Deloitte (2008), per-capita US healthcare costs are among the highest in the world and they continue to rise. Depending on this, US patients look for healthcare abroad, mainly, in under-developed and emerging countries (e.g., not only Thailand, Malaysia and Singapore, but also Hungary, Poland, Turkey and Mediterranean countries) where the costs are substantially lower than at home.

According to Burns (2015), medical facilities in other countries offer care at significantly lower costs compared with the USA owing in part to higher volumes in their surgery centres: lean techniques, surgical specialisation and standardisation of procedures allow greater surgeon productivity and lower overhead cost per patient.[4]

According to the data provided by allmedicaltourism.com, as well as by health-tourism.com and treatmentabroad.com, US patients may save up to 85% of costs in India for an aortic or heart bypass, and up to 92% for a total disc replacement in Malaysia.

Thailand, India and Mexico are nowadays the most important international hubs, not only for medical surgeries, but also for cosmetic tourism, as well. As Kopson (2010) reported, customers move mainly from USA, Canada, the UK and other European countries, since most of the cosmetic surgeries are not covered by medical insurance in the West countries and are very expensive.

But, cost savings are not the only drivers for MT: waiting times also play an important role.

In 2010, a high number of patients in Canada, Sweden, Norway, the UK and Australia reported waiting four months or more for an elective surgery. Since excessive waiting times for non-emergency surgery often lead to stress, anxiety or pain (Sanmartin et al., 2004), a lot of patients, mainly Canadian, travel to India, Thailand, Malaysia, or to Philippines, where they can get the treatments almost immediately (Hadi, 2009).

Even if the high costs of procedures and the long waiting times are the most cited drivers for patients' decisions to look abroad for care, the presence of legal or moral restrictions may also impel patients to explore alternative countries, to get the procedures they are looking for (Connell, 2013; Crooks and Snyder, 2011; Merion et al., 2008; Reed, 2008). We particularly refer to those procedures, like not only surrogacy or organ transplant, but also trans-gender surgeries or assisted suicide, that are not allowed in some countries and permitted in other ones. In such conditions, the existing diversities in norms or values at global level have to be considered themselves as drivers for the emergence of MT.

According to these considerations, the following subsection provides for a deeper understanding of MT, by examining the drivers that affect it, within the field of *Neo-Institutionalism.*

### *3.1 The contribution of the neo-institutionalism*

According to the neo-institutionalism, key suppliers, resources and consumers, regulatory agencies and other organisations that produce similar services and products belong to an *Organisational Field*, the last one considered as a 'recognised area of institutional life' (DiMaggio and Powell, 1983), founded by the aggregation and relations among organisations.

The *Organisational Field* is animated by *Institutional Entrepreneurs* who interact with *Markets* and affect the *Institutions* through *Institutional Work.* From the neo-institutionalist perspective, *Institutions* are not only collections of structures, rules and standard operating procedures that have a partly autonomous role in political life. They are also equilibrium contracts among self-seeking, calculating individual actors or arenas for contending social forces (March and Olsen, 2005). *Institutions* are reproduced through the everyday activities of individuals. Members of organisations engage in daily practices, discover puzzles or anomalies in their work, problematise these questions and

develop answers to them by theorising them. Thanks to this kind of *Institutional Work*, new *Institutions* may arise.[5]

The dynamic interaction between *Institutional Entrepreneurs* and *Institutions* gives, particularly, rise:

1 On the one hand, to a *Normative Institutional Framework* – new laws and norms according to which both *Market* and *Organisational Field* have to conform, even '*pro tempore*'.

2 To a *Symbolic Institutional Framework*, on the other hand. The *Symbolic Institutional Framework* absorbs, socialises and transfers myths and values to the market to provide the background for the social legitimacy (Carolillo et al., 2011).

Both the *Normative* and the *Symbolic Institutional Frameworks* affect the *Organisational Field* by establishing laws and standards according to which people have to adequate (laws and norms) or tend to behave (moral principles). In essence, actors and firms' behaviour are influenced by rules and norms prevailing in their own *Organisational Field*, and also by the culture, values, ideas and beliefs embedded in the social environment within which they locate.

In its original formulation, the *Neo-institutional* framework is highly embedded into the national context. It means that the *Institutional Entrepreneurs,* which belong to a given *Organisational Field*, relate with markets and other players, as well as with *Institutions* located, or acting, into the same context. It does not explain, for example, what happen when *Institutional Entrepreneurs* need to relate with actors belonging to widen *Organisational Fields*, which means with players performing at international level, as well as what happen when cross-border phenomenon – like MT – develop worldwide.

Nowadays, players – key suppliers, brokers, resource and product consumers, agencies, etc. – usually act and relate one to each other at a wider context, which overcomes the local dimension. Taking into account the extended field among which the *Institutional Entrepreneurs* perform, a *Global Organisational Field* seems to arise. But, it is not the same with reference to the *Normative* and *Symbolic Institutional Frameworks*. Without neglecting the possibility that some international norms may control 'key fields' in more than one country, in fact, laws and politics are, usually, national embedded. As a consequence, different *Normative Institutional Frameworks* may arise worldwide.

Similarly, the *Symbolic Institutional Framework* is shaped by values and beliefs that prevail in a given society, which means it is shaped by local culture. Since no universal culture really exists, what is considered *right* or *wrong* may vary from one context to another, as well as over time (Robertson, 2002; Stajkovic and Luthans, 2001). Depending on the above, different *Symbolic Institutional Frameworks* also arise at global level.

The described extended model fits with the transnational dimension of the MT.[6] Because of the worldwide spreading of the phenomenon, the *Organisational Field* acquires a global dimension, too: by moving in a global arena, the *Institutional Entrepreneurs* have to relate with the *Institutions* of both domestic and foreign countries; they co-produce the *Institutional Framework*, which means laws and rules that will control international market of healthcare products and services.

In spite of this, *Institutional Framework* maintains a local dimension, thus rules and laws differently control MT flows and procedures. Our considerations find support in the lack of international uniform norms aiming at governing MT within different countries

(Bass, 2005). This is the reason why, for example, surrogacy is illegal in Italy, but allowed in Russia and Ukraine; euthanasia is legal only in Netherlands and Belgium, or patients coming from everywhere travel to Iran to look for an organ transplant (Ghods and Savaj, 2006).

Sometimes, the *Normative Institutional Frameworks*, which belong to the different geographical contexts involved into the flow of MT, may overlap. It means that a given practice or procedure is allowed – or not – in both domestic and foreign countries and that it is similarly ruled. When the described situation prevails, MT is mainly driven by the examined diversities in the costs of procedures and in the waiting times between and among the countries.

On the contrary, when the *Normative Institutional Frameworks* significantly differ, a normative 'gap' could be established, with negative consequences for patients engaging in procedures not allowed in their own domestic country. This is the case, for example, of *reproductive* or of *transplant tourism*. As an example, Italian law prohibits surrogacy while the recourse to this practice is allowed in many other countries, like Russia or Ukraine. The mentioned 'gap' between and among destinations usually impels Italian patients to look for a foreign country to access to the procedure they are looking for.[7]

*Institutions* and *Institutional Entrepreneurs* also play an important role in shaping the *Symbolic Institutional Framework*, through legitimacy mechanisms and myths socialisation. But while laws and politics are mainly nationally defined, values and beliefs can differ within the same country, because of the emergence of sub-cultures.[8] Similarly, same values may overcome national borders to embrace similar cultural groups, making the investigation and comparison even more complex.

Culture affects not only what may be considered 'right' or 'wrong' (Canestrino, 2007), but also the hierarchy of values that prevails in a given area, and the way legitimacy may be gained, as well. When different cultures cross, therefore, legitimacy mechanisms and myths socialisation may be blocked by the existence of different moral standards, according to which individual behaviour is evaluated.[9]

Transgender treatments provide us a very important example for this issue.

As reported by the *New York Times*,[10] Serbia is becoming a transgender surgery hub, partly because genital reassignment surgery is costly, controversial and complicated and is shunned in many other European countries (including Austria, Italy, Hungary, Romania, Bulgaria and Greece and the other countries of the former Yugoslavia) and partly because its social attitudes are slowly shifting.

From our perspective, every time patients go abroad for cares, considered ethically 'wrong' in the home country, they are looking for legitimacy in the host country, since the practices they need may be morally accepted abroad, but not at home.[11] Even when a given practice is allowed at normative level, it may be morally refused, thus affecting individuals' moral intimacy.

In Italy, the matter of gender change is regulated by Law 14 April 1982 n. 164, which states "*the legislator finally showed he did no longer ignore the phenomenon of transsexuality by recognising a great principle of justice: no one can be condemned to declare throughout life a gender identity in which they do no longer recognise themselves*".

But at social level, homosexuality and transgender, as well, encounter a lot of obstacles in their legitimisation, mainly because of the role played by Catholicism in the country.[12]

It is not surprising that people feel themselves frustrated and go abroad to access to transgender procedures, even when they are available in Italy: patients going abroad usually request to be anonymous, thus intermediaries, brokers and destination managers assure their privacy. It means, in other words, that the existing gap between the *Symbolic Institutional Frameworks* at international level fosters the development of an MT flow.

Summing up the above-mentioned considerations, we may point out that the development of MT may depend on the differences between *Normative Institutional Frameworks,* on the one hand, or between *Symbolic Institutional Frameworks*, on the other hand. The adoption of a neo-institutionalist perspective allows us, in this sense, to deepen the dynamics of the phenomenon, by widening the set of drivers that lie upon its emergence at global level.

As we have already suggested, MT poses important ethical concerns mainly belonging to its sustainability. The phenomenon inevitably affects public opinion all over the world, especially referring to the access to extreme procedures.

Some questions need to be answered about MT and the ethical concerns arising under its rapid development. Without the claim to be exhaustive, the following section examines the *ethical* insights of MT, by scanning the impacts it has on tourism, health industry and equity for both developed and under-developed countries.

## 4 The ethical implications of MT: 'equity' vs. 'duality' of healthcare systems

MT may have positive and negative consequences, for both domestic (sending) and host (destination or receiving) countries.

The benefits of MT for sending countries have been discussed by Helble (2011). As the author pointed out, in some countries, like USA, medical travels provide an alternative way for uninsured or underinsured patients to obtain treatments. At the same time, those health systems characterised by long waiting lists may take advantage from the growth of the phenomenon, to clear backlogs without the need to expand their capacity. The higher competitiveness resulting from the downsizing of the domestic healthcare demand could, probably, bring the prices down with positive effects for local patients.

Into destination countries, MT may increase the level of foreign exchanges, as well as their balance-of-payments position (Arellano, 2007; Turner, 2007; Bookman and Bookman, 2007). It can also improve a wide economic growth, by creating new jobs and wealth in both tourist industry (hotels, restaurants, food suppliers and transport) and health systems (hospitals and pharmaceuticals) (Nguyen, 2009; Lunt et al., 2010).

Some authors, like, for example, Arellano (2011), suggested that the major income, generated by MT, has been used to develop local facilities in Cuba and to better serve local patients. Similarly, in Singapore, local authorities claim that the involvement in MT enables them to provide a broader range of medical services to the indigenous population (Lee, 2010; Lee and Hung, 2010).

Economic improvements are not the only advantages coming out from MT. Among the others, technology diffusion and knowledge progresses are the most important for the destination countries. Hospitals catering to foreign patients impel to a constant search for highly skilled professionals to raise the quality of cares and facilities, to attract new

customers. The attempt to assure international standards for cares, and to satisfy the needs of foreign patients, leads to the enhancement of local human capital, and to more investments for the development of skills and technologies (Burns, 2015; Lunt et al., 2010).

In spite of the scholars' considerations, however, the advantages of MT are not yet proven, since it is still a young phenomenon, difficult to estimate and evaluate over the time (Burns, 2015).

The potential benefits of MT are criticised in several points, especially referring to the impacts it has for the receiving countries, where the 'dream of growth' faces the challenges of social inequality and un-sustainability (Johnston et al., 2010).

First, in some destinations, a 'dual healthcare system' seems to arise, with high specialised private clinics devoted to foreigners and wealthy domestic patients, while local and public healthcare system is often inadequate to serve local and poor population even for basic needs, from the availability of clean water to the provision of appropriate primary healthcare.

According to Adams et al. (2013), the promotion of medical care to foreign patients may encourage a shift in the resources allocation, such as public finance, or human resources, from the public to the private sector.

This has prompted deep criticism of MT that has been described as an "*elite private space … inextricably linked to a beleaguered national medical program*" (Ackerman, 2010, p.403), and a '*reverse subsidy for the elite*' (Sengupta, 2011, p.312).

Singapore and Malaysia give us some evidences for the above-mentioned observations.

Private sector mainly governs care provision in Singapore and Malaysia, and it is slowly expanding its role in tertiary hospital care.

During economic growth periods, wealthier populations have emerged with demand for private providers in response to the perceived lower quality of public health system. Many investments have been soon addressed to support the development of private healthcare system, to satisfy local demand and to attract foreign patients, as well. As a consequence, the public sector has become more *pro* poor. Because of the private ownership of health facilities, the profits generated by medical tourists flows are generally re-invested in private hospital chains located in Southeast Asia. Not surprisingly, the Fortis-Parkway recently merges the second largest Indian healthcare group with the largest private Singapore-Malaysia group, thus founding the largest hospital chain in Asia (Pocock and Phua, 2011). Furthermore, in Malaysia, private health system growth is supported by government facilities, since tax incentives are available for building hospitals (industry building allowance), using medical equipment, staff training and service promotion (deductions on expenses incurred) (Chee, 2008). At the same time, public funds are insufficient to finance the building of new hospitals (Ramesh and Xun, 2008).

The emergence of the mentioned 'dual healthcare system' in many destinations is exacerbated by the migration of skilled health workers from rural and regional areas and from the public sector into the private sector (Adams et al., 2013; Lunt et al., 2010). According to Hadi (2009), MT affects the classic model of 'brain drain', according to which professionals move from under-developed and poor countries to wealthier and more developed ones, to gain new job opportunities, higher salaries and professional development. Since private hospitals look for highly skilled professionals to improve

their own reputation and quality of cares, higher salaries and lower workloads are used by private sector to attract specialists from public hospitals, as well as from neighbouring countries (Hadi, 2009).

As expected, an ‘inverse’ brain drain has been reported in Thailand. Since the higher pay offered at Bumrungrad, the major hospital in the region that treats medical tourists, a shortage of doctors in the public hospitals has been experienced in Bangkok. A similar situation is also present in Malaysia where a large public-private salaries discrepancy exists.

A related concern in Thailand is that medical education is mainly supported by public investments and private hospitals do not share the costs of such education.

The emergence of a ‘dual healthcare system’ and the ‘reverse brain drain’ phenomenon, however, seem to mine the cornerstones of *social sustainability*[13] of MT.

According to Harris (2000), a social sustainable system must achieve adequate provision of social services, gender equity, participatory and pluralistic democracy and political accountability. For the World Tourism Organisation, the *social sustainability* in tourism may be reached only by respecting the socio-cultural authenticity of host communities, and by ensuring the preservation of cultural assets and traditional community values. Additionally, *social sustainability* must take into account the dimensions that improve the quality of life of the local community, such as access to education, health, employment and dwelling. But, this does not happen with the development of MT.

Our considerations about the *social sustainability* of MT are also reinforced by the ethical debate arising with reference to some extreme procedures, to their ‘morality’ and to the impact they have at societal level. We, particularly, refer to reproductive, transplant and death tourism, which are exploited in the following sub-section.

### *4.1 Deepening the ethical concerns: from reproductive to death tourism*

As we have already noted, avoiding national restrictions or moral judgements belong to the main drivers of MT. Particularly, the mentioned drivers play a very important role in shaping reproductive, transplant and death tourism.

Reproductive tourism (RT) is “the travelling by candidate service recipients from one institution, jurisdiction or country where treatment is not available to another institution, jurisdiction or country where they can obtain the kind of medically assisted reproduction they desire” (Pennings, 2002, p.337). It refers to a practice according to which people travel across national borders, to access to reproductive technologies and services, such as in vitro fertilisation (IVF), gamete (sperm and egg) donation, sex selection, surrogacy and embryonic diagnosis (Martin, 2009). This phenomenon is not restricted to USA or Australia, but it also occurs in Europe, where patients coming from France, Germany or Italy travel to Belgium to gain treatments not available at home, like, for example, IVF treatments with oocyte or sperm donation (Pennings, 2002) or fertilisation treatments for homosexuals, lesbians or singles (not allowed in Italy, France and Germany).

Within Europe, Germany has by far one of the strictest policies regarding the uses of assisted fertility services. Germany’s Embryo Protection Act accords to embryos with the same status as born human beings, and thus regards some forms of reproductive technology as violations of the embryo’s human dignity. In Germany, egg and embryo donation are not allowed, as well as surrogacy; the Act limits the number of embryos that may be transferred to a woman’s uterus; forbids sex selection with the exception of cases

in which severe sex-linked genetic illness is to be prevented and forbids unmarried or lesbian women access to assisted fertility services. Pre-implantation genetic diagnosis and stem cell research are also prohibited.

In stark contrast to the restrictive Germany, Spain and Czech Republic are the most famous European destinations for fertility treatments. Cyprus, Russia, Ukraine, Greece, Turkey, India and Thailand belong to the main selected destinations in providing reproductive outsourcing, since surrogacy[14] and surrogate mothers are legal in these countries (Jasanoff, 2005; Robertson, 2004). With reference to RT, surrogacy seems to pose the major ethical dilemmas, mainly because it relies on the reproductive services of a woman acting as a gestational carrier (Hamilton and Devlin, 2009): the protection of human rights, as well as of the physical and psychological health of both the surrogate mothers and their children may be considered the most discussed and controversial ethical implication of the phenomenon. The uncertainty about the legal status of the child created via IVF and surrogacy raises other legal, ethical and human rights concerns. As Sharma (2008) noted, the lack of adequate control systems to ensure that unused eggs or embryos are not stored could allow an indiscriminate commercialisation to couples who want fair-skinned children or to couples who have not viable eggs/sperms.

Palattiyil et al. (2010) overviewed evidences about surrogacy in India, and discussed the extent to which proposed legislation, the Assisted Reproductive Technologies (Regulation) Bill and Rules 2009, ensures adequate protection of the interests of young Indian women engaged in surrogacy. Commercial surrogacy has been legal in India since 2002 and there are reports of exploitation of women from poorer backgrounds, where mortality and morbidity rates associated with pregnancy are high (Dolnick, 2008). Indian women who work as surrogates in commercial reproductive industry appear to have little understanding of their rights, in terms of their own health and well-being. Anecdotal evidences indicate that at least some surrogates suffer from post-partum depression and a sense of emptiness as a result of being unable to breastfeed their baby; additionally, thousands of women die each year during pregnancy and childbirth (Blyth and Auffrey, 2008).

Not surprisingly, the practice of surrogacy often reflects blatant exploitation of vulnerable women, thus fostering the debate about the morality of this practice.

In coherence with our theoretical perspective, the growth of cross-border fertility treatments (not only surrogacy, but also gamete donors and fertilisation treatments for homosexuals) may be traced back to the discussed gap between *Normative Institutional Frameworks* that establishes at international level. The existing heterogeneity among the normative frameworks – that rule reproductive treatments at global level – leads the patients/tourists to look for those destinations where the required medical practice is allowed.

Avoiding national normative restrictions is also the main driver for the transplant tourism (TT).

Currently, the World Health Organization estimates that of the 660,000 people in the world who require any form of transplant, 10% receive one each year. Of these, 10% receives their transplant through commercial TT (Watts, 2007).

The lack of donors and the rise of TT force regulatory organisms throughout the world. The European Union tried to boost organ donations by suggesting a Europe-wide donor card, and has formed a regulatory body to standardise the quality and the safety within transplantation in the effort to reduce commercial transplants. The People's Republic of China, which performs more transplants per year than any other country –

except the USA – has recently introduced tougher restrictions and penalties for commercial transplantation (Watts, 2007).

In contrast with the reported evidences, living-donor kidney transplants are performed in all the 14 Islamic countries of the Middle East, while living-donor liver transplants are performed in Turkey, Iran, Saudi Arabia, Jordan and Iraq. Among the Islamic countries, Turkey had the highest organ transplant activity, especially living-donor organ transplant. In 2013, a total of 2944 kidney transplants were performed in Turkey, including 2359 kidney transplants from living and 585 kidney transplants from deceased donors. Iran is one of the few countries in the world where a paid living donation program – mainly for kidney donation – has been established (Ghods and Savaj, 2006).

In MT literature, the interrelationship of ethical and legal dilemmas facing human transplantation is extremely complex: proper legislation may allow the recruitment of live donors under the pressure of an economic compensation, thus fostering the commercialisation of organ transplant. As Merion et al. (2008) reported, an increasing number of US patients on waiting lists turn to transplants in foreign countries, mainly in underdeveloped countries, where the trade of organs for transplantation is a common practice (Turner, 2008, 2009; Major, 2008; Cohen, 2013).

Cohen (2013) focuses on the sale of kidney, the most common subject of TT. The author reviews the available data about sellers, recipients and brokers, by three countries (Pakistan, Bangladesh and India), discussing the bioethical concerns posed by the trade, as well as the potential regulations to deal with the issue.

According to Cohen (2013), Pakistan is one of the 'largest host centres for transplant tourism' in the world, with over 2000 organs sold per year, about two-thirds of which go to foreigners (primarily from the Middle East, South Asia, Europe and North America). All the sellers are very poor or in debt.[15]

In Bangladesh, a significant growth in organ trade is registered, too. Sellers were often recruited by advertising in local newspapers; after contact, they are portrayed as living perfectly well: the surgery and selling a kidney is presented as a *win win* situation. In strict contrast with the given picture, the sellers' health profoundly deteriorates after the surgery and a lot of physical problems were experienced, like pain, weakness, weight loss and frequent illness.

In India, the sale of kidneys has been banned by a national law since 1994. All the transplant centres need an authorisation and are submitted to the control of a committee reviewing. The committee evaluates and determines if donations inspire to altruistic and not to commercial reasons. Nevertheless, a significant trade in selling kidneys persists in India (Cohen, 2013). Organ trade in the country is like other problems such as child labour and prostitution. It mainly depends on the exploitation of the poverty-stricken people, who are lured with financial gains that can meet their immediate short-term financial needs. But, unlike other similar exploitative social situations, organ donation requires an invasive surgical procedure that has both physical and psychological implications (Shroff, 2009).

The inclusion of organ transplant packages among the medical procedures sold to international patients could prompt organ brokers to increase the number of organs (not only kidneys) bought from impoverished individuals,[16] thus posing a huge dilemma about the morality of such actions, between one's right to healthcare and the respect of the inherent dignity of all other humans.

A report presented to the House Subcommittee on International Operations and Human Rights, US Congress on 27 June, 2001 states that:

> "The growth of medical tourism for transplant surgery and other advanced procedures has exacerbated older divisions between the North and South and between the haves and have-nots. In general, the flow of organs, tissues and body parts follows the modern routes of capital: from South to North, from third to first world, from poor to rich, from black and brown to white, and from female to male bodies. In the very worst instance, this market has resulted in theft and coercion, as in the case of China, to a self-serving belief in rights of the rich to the 'spare parts' of the poor, as in the case of the many transplant junkets arranged to carry affluent patients from Saudi Arabia, Israel and North America to Turkey, India, Romania and the Philippines where kidney sellers are recruited from prisons, unemployment offices and urban shantytowns."

All these reasons justify the moral debate about TT and about its social sustainability, as well.

Death tourism (DT), finally, refers to terminally ill patients from across the world who travel to countries where assisted suicide[17] or euthanasia[18] is legal (Shondell Miller and Gonzalez, 2013). It may be considered as a subset of medical and wellness tourism, in which patients travel across borders to obtain treatments and procedures. Such medically related travel is now a fast-developing part of mainstream medicine, with developments in technology and electronic communications, low-cost airlines and international commercial agreements making it easier for patients to travel abroad for medical care. While laws around the world have begun to recognise the challenges posed by medical tourism, very few have responded to the specific phenomenon of DT (Terry, 2007).

In the USA, there has been an intense debate about the ethics and legality of euthanasia and assisted suicide for more than a decade. In June 1997, the US Supreme Court unanimously ruled that there is neither a constitutional right nor a constitutional prohibition to euthanasia or assisted suicide. This allowed Oregon to legalise the latter. In the USA, euthanasia is prohibited in 50 states under homicide laws (Emanuel, 2002). However, assisted suicide is legal in the US states of Oregon, Washington and Montana.

Within Europe, several approaches to euthanasia and assisted suicide are emerging, thus fostering a huge debate about the topic. Because of the strict laws worldwide on euthanasia and assisted suicide, cases have begun to increase in countries with more liberal laws, like Switzerland, the Netherlands and Belgium.

Assisted suicide has been allowed in Switzerland since 1942 (active euthanasia remains illegal). Here, the Dignitas Association offers an organised assisted-suicide service to people who meet its criteria – including that the person must be suffering either from a terminal illness or from an incurable illness with unbearable symptoms. In any case, however, the patients have to commit the act themselves and helpers have no vested interests in their death[19]

The Netherlands and Belgium are the only other countries where laws permit euthanasia or assisted suicide. As the data show, there were 4360 patients with an explicit intention of hastening death in 2010. Among them, 310 ended their life without explicit request, 192 requested for assisted suicide and 3859 asked for euthanasia.[20] Belgium has legalised euthanasia since 2002 and it has become the first country to allow euthanasia for terminally sick children (Rodriguez, 2014).

Depending on the existing diversities among the norms at worldwide level, patients who want to seek euthanasia or other assisted suicide services travel to countries where these procedures are allowed, thus fostering the increasing of DT (Pereira, 2011). DT inevitably affects public opinion all over the world, since many controversies arise about the appropriate reasons for killing themselves, as well as the 'sustainability' of travelling abroad for 'good death'. Not surprisingly, the phenomenon poses a deep ethical debate because the individual request for euthanasia and assisted suicide is complex in origin. It includes personal, psychological, social, cultural, economic and demographic factors, thus requiring not only respect, but also a careful attention, together with an open and sensitive communication in the clinical setting. What is certain, in our perspective, is that the current trend in international travel and movement means that the moral values that lie under the restrictive national rules (that prohibit euthanasia and assisted-suicide) are weakening.

A number of jurisdictions have allowed assisted dying in a limited form in the last five years, like Washington State and Luxembourg (Steele and Worswick, 2013).

A British survey found that 75% of the population is in favour of the change in the law to permit 'some degree of assisted suicide'. A UK Royal College of Nursing (RCN) consultation suggested that 49% of the nurses who responded were in favour of assisted suicide and 40% against it (Annadurai et al., 2014).[21]

All the mentioned changes required for a novel consideration of euthanasia and assisted-suicide, as well as for a revisiting of the current provisions. From a neo-institutionalist perspective, it means, therefore, that the existing *Normative Institutional Framework* needs to change under the external pressure.

## 5 Conclusions

Understanding MT and its *social sustainability* is not easy, mainly because of the lack of official data about the healthcare flows at global level, as well as the ambiguity that prevails in defining *social sustainability* itself. Additionally, the existing overlap between the two different industries – health and tourism – makes the analysis even more complex, with reference to the drivers and to the social consequences of MT.

Taking into account the mentioned research difficulties, we aimed at exploiting MT, within the field of neo-institutionalism. A new enlarged theoretical framework – developed into a previous research – has been used to discuss the role played by both the *Normative* and the *Symbolic Institutional Frameworks* in shaping the patients' choice to go abroad for healthcare.

Particularly, every time that *Normative Institutional Frameworks* or *Symbolic Institutional Frameworks* differ from one country to another, patients look abroad for health solutions that are not available, or that are morally refused, in their own country.

According to the underlined perspective, some considerations may be pointed out:

- When both *Normative Institutional Frameworks* and *Symbolic Institutional Frameworks* do not significantly differ at international level, patients look for MT destinations, mainly because of the higher costs of procedures, or to avoid the long waiting times into their domestic countries.

- When *Normative Institutional Frameworks* differ at international level (even when *Symbolic Institutional Frameworks* do not significantly differ), patients look abroad for health solutions that are not available or are not allowed (like fertility treatments) into their home countries.
- Even when *Normative Institutional Frameworks* do not significantly differ at international level (meaning that a given procedure is allowed in both the sender and the receiver country), patients may be impelled to look for new destinations by the need for a moral legitimation. (This is the case of a gap between the *Symbolic Institutional Frameworks*).

From an ethical perspective, MT opens up to a lot of moral controversies, mainly referring to its *social sustainability* and the social impacts it has in many destinations, especially in under-developed and emerging countries, like, for example, Thailand, Singapore or Malaysia.

Particularly, the advocates of *social sustainability* usually alert against the risks and challenges of MT for global healthcare equity, claiming the necessity for a global 'governance' able to routinely monitor its growth, to develop rules for all the involved stakeholders, and to maximise the benefits for the health and the well-being of all populations. But far from being easily translated into reality, their 'prescriptions' do not explain to what extent and through what mechanisms global stakeholders, with opposing personal interests, would give up some of their 'value', to gain a more social equity.

Obviously, we do not neglect the importance of prescriptive models for the *Sustainability* of MT. In spite of that, we point out their utopist vision of the world.

As we have already noted, socially engagement in MT requires individuals to act in a manner that improves health equity and that respect the inherent dignity of all other humans. But, both the emergence of a 'dual healthcare system' in many destinations and the ethical concerns related to the 'morality' of extreme procedures undermine the cornerstones of the *Social Sustainability* of the phenomenon. More particularly, MT affects the fundamental human rights – life and health – by limiting, or allowing, individuals' freedom in gaining healthcare. In this perspective, *Social Sustainability* and MT may be only interpreted as conflicting landscapes in a common, global, field, within which everyone looks for own right to health, own actions' legitimacy and the best way to catch 'value'.

Our paper is mainly a theoretical one. It examines the main ethical issues about the MT, mainly referring to its implications for the destination countries. In doing this, a new literary framework, never used before to understand MT, has been adopted to interpret the drivers of the phenomenon, thus providing scholars with new and valuable tools for future investigations.

We recognise that a lack of empirical investigations is one of the main limits of our paper. But, we, also, believe these limits may themselves suggest future investigations about MT. One future research in the field could be to examine the way *Institutional Entrepreneurs* affect the *Normative Institutional Frameworks*' changes at global level, under the pressure of shifting values and beliefs. More focused researches about RT, TT and DT could also be developed to better understand their dynamics within the field of neo-institutionalism.

## Acknowledgements

The paper has been developed thanks to the Funds for a/the Research Project of the University of Foggia in 2014. It is the output/result of the joint collaboration of the three authors (cited in alphabetic order). Rossella Canestrino is responsible for Sections 4 and 4.1. Pierpaolo Magliocca is responsible for Sections 3, 3.1 and 5. Claudio Nigro is responsible for Sections 1 and 2.

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## Notes

[1]Kopson (2010) referred to three main categories: a) Travel away from USA (Outbound); Travel to the USA (Inbound) and c) Travel between two non-US countries (non-USA).

[2]"Medical tourists are patients who travel internationally for non-urgent medical treatments like organ transplants, stem cell treatments, reproductive services, cosmetic surgery, dental care, etc." (Chuang *et al.*, 2014, p.49).

[3]Woo and Schwartz (2014) tested a mechanism to assess the medical tourism providers' perception about the tourists' perceived important product attributes when selecting a medical tourism destination. According to their research results, the 'quality of the medical treatment' attribute scored the highest mean, with 81.5% of respondents perceiving it to be a 'very important attribute' for potential medical tourists, and 12.4% stating that it is an 'important attribute.' The 'recreation facilities for patients in the hospital' attribute had the lowest mean, with 44.4% of the respondents assigning it a neutral score and 12.7% a 'not important' one.

[4]Other drivers of cost differences in medical care are: the prevalence of insurance coverage, the tax treatment of that coverage, the types of coverage offered and the methods to reimburse providers (Burns, 2015).

[5]DiMaggio (1988, p.14): "New institutions arise when organised actors with sufficient resources (institutional entrepreneurs) see in them an opportunity to realise interests that they value highly".

[6]For a deeper understanding, see Canestrino *et al.* (2015).

[7]In the above-mentioned example, coming back home, Italian patients run the risk to be jailed up to 2 years, even if the procedure has been already allowed in the host country (Italian law n.40/2004).

[8]According to Martin and Siehl (1983), different values and beliefs may be established in a given dominant culture, thus belong to the so-called sub-culture. Sub-cultures are sources of diversity: they may support dominant culture (Martin *et al.*, 1985), or they may even disagree with it, thus opposing to the prevailing values.

[9]Moral standards may be considered as the set of principles according to which individuals' actions are evaluated, and they are deeply rooted in a given context (Donaldson and Dunfee, 1994).

[10]*Source*: Bileskyjuly (2012).

[11]The New York Times reported the choice of Daniel, a 25-year-old lawyer from St. Petersburg, Russia, to go to Belgrade for a transgender surgery. Daniel said his grandparents, both physicians, refused to accept it, saying he had a disorder of the brain. "*I came out twice, first as a lesbian, then as transsexual. That made it easier*" he said a day after having the surgery. "*Russia is extremely homophobic, and coming to Serbia was easier for me*".

[12]Petilli *et al.* (2015) examined the role played by Catholicism on the level of interiorised homophobia by catholic gay and lesbian. The interiorised homophobia may develop in a homosexual person, often associated with self-loathing, self-censure and self-censorship. As a consequence, gays and lesbians perceive a painful contradiction between their faith and sexual attitude, which increase their stress (Jones and Yarhouse, 2007) and their emotive discomfort (Beckstead and Morrow, 2004).

[13]A huge number of efforts have been made to make order within the works and Vallance *et al.* (2011) attempted to clarify the concept of *social sustainability* by organising the existing literature on the topic. They analysed the works by three authors – Sachs (1999), Godschalk (2004) and Chiu (2002, 2003) – helpful in identifying the different aspects of *social sustainability*, namely: social homogeneity, equitable incomes and access to goods, services and employment.

[14]Surrogacy utilises modern reproductive techniques to create an embryo using the egg and semen of each genetic parent (although donor egg or semen could also be used), which is then placed in the uterus of the surrogate (Palattiyil *et al.*, 2010).

[15]As Cohen reports: "Sellers were promised between $1146 and $2950 USD for their kidney, but no seller in the sample was actually paid that price. The mean amount received was instead $1377 USD with a range of $819–$1803 USD, largely because deductions were taken for the costs of the nephrectomy, hospital it came to finances, 85% said there was no improvement in their lives and they were either still in debt or had not achieved their objectives. Only 4% indicated they had paid their debt, although some had used the money for marriage, housing or business" (2013, p.270).

[16]The World Health Organization identifies Colombia, India, Pakistan and the Philippines as four of the leading global hot spots for buying and selling human organs, even the sale of organs is illegal in those countries (Turner, 2008, 2009).

[17]A doctor intentionally helping a person to commit suicide by providing drugs for self-administration, at that person's voluntary and competent request (Materstvedt *et al.*, 2003).

[18]A doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request (Materstvedt *et al.*, 2003).

[19]*Source*: Dying with Dignity Factsheet 14: A Guide to Dignitas (http://www.dwdnsw.org.au/ves/index.php/fact-sheet-14-guide-to-dignitas-vesnsw).

[20]Statline Netherland (2010).

[21]Many activists against euthanasia alert on the risk of the phenomenon. According to them, legalising euthanasia will lead to 'slippery slope' phenomenon, which leads on to more number of non-voluntary euthanasia (Annadurai *et al.*, 2014).