3 South-South and North-South Medical Tourism: The Case of South Africa
Jonathan Crush, Abel Chikanda and Belinda Maswikwa

INTRODUCTION

In November 2010, the private South African hospital group, Network Healthcare Holdings Limited (), admitted to 102 counts of fraud, serious assault and contravention of the country’s Organized Crime Act for performing illegal organ transplants at its St. Augustine’s Hospital in Durban between 2001 and 2003 (Allain, 2011). Brazilian and Romanian donors (who were paid as little as US$5,000 per kidney) were flown to South Africa for their removal. A game safari was often thrown into the bargain (Schepel-Hughes, 2011). The kidneys were sold to wealthy Israeli citizens for up to US$120,000 who travelled to South Africa at the same time for the transplant operation. In order to comply with South African laws, documents were forged to show that the recipient and donor were related. An estimated 300 operations were performed in three cities but only the St Augustine’s operation was targeted by prosecutors (Kockett, 2010).

After denying knowledge and wrongdoing for several years, Netcare made a plea bargain with the state in late 2010. The group was fined ZAR4 million (US$590,000) and forfeited the ZAR3.8 million (US$560,500) that it had supposedly made from the operations. Charges against the Netcare Chair, Dr. Richard Friedland, however, were withdrawn (Sidley, 2010). Eight people involved in the scam, including five doctors, subsequently appeared in the Durban Regional Court on charges of fraud, forgery, assault and contraventions under the Human Tissues Act (Kockett, 2010). An interpreter, Samuel Ziegler, pleaded guilty and was fined ZAR50,000. A nephrologist, Dr. Jeffrey Kallmeyer (now practicing in Toronto, Canada), pleaded guilty on 90 counts and was fined ZAR150,000. Two coordinators and four transplant surgeons await trial (in mid-2011). They claim that Netcare had full knowledge of and endorsed the program, leading the South African media to dub the case ‘kidneygate.’ Journalists from the South African Mail and Guardian newspaper have suggested that “the biggest scandal of the case is the absence from the dock of any decision-maker from Netcare” (Hassan & Sole, 2011).
The global traffic in illegal organs, of which this is only one sordid example, represents the dark side of the global medical tourism industry and has significantly tarnished South Africa’s reputation as a medical tourism destination (Budiana-Saberil & Delmonico, 2008; Scheper-Hughes, 2008). In 2009, the South African government promised a national policy on medical tourism would be crafted by the end of that year; the policy has still not appeared. This suggests that the government is still very sensitive to the negative international publicity that the case attracted and remains highly ambiguous about giving its support to the private sector-driven medical tourism industry with its focus on high-end North-South (developed to developing country) elective procedures and cosmetic surgery.

Despite the fall-out from this abuse of law and medical ethics, Netcare continues to thrive. As South Africa’s largest private hospital group, it is positioned to play a major role in South Africa’s expanding medical tourism industry. South Africa has a dual private and public health system. Rooted in the country’s apartheid past, access to the private sector is largely restricted to medically insured South Africans, who compose approximately 16 percent of the population and are more likely to be White and Asian (Ahwireng-Obeng and van Loggerenberg, 2010, p. 2). The private sector has 22 percent of all hospital beds in the country, absorbs 60 percent of all health spending and employs 73 percent of all physicians (Mortensen, 2008, pp. 11-12; American International Health Alliance [AIHA], 2011, p. 4). The standard of care in private hospitals is consequently far superior to public facilities and compares favourably to medical facilities in developed countries (McIntyre et al, 2007; Mooney & McIntyre, 2008). Most medical tourism to South Africa is to the private health sector, however the public sector is also accessed by patients from other African countries.

In South Africa, industry is far more heterogeneous and complex than is suggested by its popular image as an archetypal ‘sea, sun, sand, surgery’ (and safari) destination for medical travellers from Northern countries (Connell, 2006; Stolk, 2009; Mazzaschi, 2011). Over the last decade, South Africa has become a major destination for ‘medical tourists’ from the rest of Africa and therefore provides an important opportunity to examine the dynamics of South-South and intra-African travel for medical treatment. This chapter begins with an overview of the volume and various types of medical tourism to South Africa as a way of highlighting the
information and data deficiencies for medical tourism, and also highlights the differences between North-South and South-South medical travel to South Africa. In particular, we draw attention to the increasing importance of South-South medical tourism to the country. The final section examines the significance of the emergence of inter-governmental agreements on medical treatment between South Africa and other African countries. The conclusion discusses the implications of the South African case study for our understanding of South-South medical tourism.

**DIMENSIONS OF MEDICAL TOURISM TO SOUTH AFRICA**

Estimates of the number of medical tourists to South Africa vary widely. For 2003, Maaka (2006, p. 103) put the number at only 8,000 annually with an industry value of ZAR123 million (US$17.5 million). For 2006, one source placed the number of medical tourists to South Africa at 50,000 (Prasad, 2007, p. 256). For the year 2007, a different source estimated that there were 30,000 medical tourists a year, who generated approximately ZAR3 billion or US$429 million (Tourism KwaZulu Natal, 2008, p. 9). In contrast, the President of the South African Association for Plastic and Reconstructive Surgeons said that as many as 200,000 medical tourists visited South Africa in 2006, generating approximately ZAR260 million (Gilfellan, 2008, p. 65). Such widely varying estimates reflect an underlying reality that reliable and consistent data on the size of the medical tourism industry is difficult to find.

Official tourism data on travellers to South Africa is of limited use in determining the numbers of medical tourists. Although, the 2002 Immigration Act provides ‘medical permits’ only to people who intend to stay in South Africa for periods in excess of three months.² Because the vast majority of medical tourists enter the country for shorter periods, any statistics on the issue of medical permits can only capture a small proportion of the market. Entry data is also unhelpful as there is no medical ‘purpose of visit’ option on visa applications or entry and customs forms. Most people entering the country for medical purposes give ‘holiday’ as their reason for coming to South Africa, which generally entitles them to a 90 day
(renewable) stay. Therefore, medical tourists are indistinguishable in tourism statistics from other temporary entrants.

Statistics South Africa and South Africa Tourism (SAT) do, however, conduct a regular Tourism Departure Survey (Statistics South Africa [SSA], 2007). The Survey uses a stratified random sample to select respondents who are departing from both land and air ports of entry. A face to face interviewing method is used and questions are asked using a structured questionnaire. Information is collected on (a) country of residence and citizenship; (b) the main purpose of entry (‘medical/health’ being one of the options); (c) the length of stay in the country; (d) the number of nights spent in various facilities in different provinces (‘hospitals’ being an option); (e) activities engaged in (a broad range of activities are listed including medical (e.g. treatment in clinic/hospital) and health (e.g. hydro, spa, beauty centre, health farm); (f) reasons for being attracted to South Africa (includes ‘medical facilities’ as an option); (g) travel arrangements; and (h) amount spent (including on ‘medical expenses’) (SSA, 2007, p. 267-80). Raw survey data are not available but the information extracted by SAT from the survey is extremely helpful in building a general picture of medical tourism flows to South Africa.

The proportion of surveyed foreign tourists who said they had entered for medical reasons (4.5 percent on average between 2006 and 2010) is well below those who came to shop (25.1 percent), on holiday (23.8 percent), to visit family and friends (23.6 percent) and on business (17.5 percent) (see Table 3.1). However, the number of medical tourists increased from 327,000 in 2003 to 410,000 in 2009 and then fell in 2010 to 330,000 (see Figure 3.1).³ In relative terms, the proportion of medical tourists rose from 3.9 percent in 2006 to 5.0 percent in 2010.

The UK was the most important source of medical tourists from the North: a total of 122,000 between 2003 and 2008 (approximately 20,000 per annum) (see Table 3.2). Next was Germany (8,000 per annum), followed by the US (6,500 per annum) and the Netherlands (3,500 per annum). Other source countries in the North included Australia, France, Canada, Italy and Sweden. Smaller numbers also entered from countries in the South including India, China and Brazil.
Table 3.1  Purpose of Visit of Tourists to South Africa 2006-2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Holiday</th>
<th>Shopping-Personal</th>
<th>Shopping-Business</th>
<th>Business</th>
<th>Medical</th>
<th>VFR*</th>
<th>Religion</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>28.6</td>
<td>11.2</td>
<td>14.5</td>
<td>16.5</td>
<td>3.9</td>
<td>22.4</td>
<td>1.9</td>
<td>2.9</td>
</tr>
<tr>
<td>2007</td>
<td>25.3</td>
<td>11.8</td>
<td>12.2</td>
<td>19.2</td>
<td>4.5</td>
<td>24.2</td>
<td>1.1</td>
<td>3.0</td>
</tr>
<tr>
<td>2008</td>
<td>20.0</td>
<td>12.6</td>
<td>13.8</td>
<td>18.1</td>
<td>4.3</td>
<td>25.1</td>
<td>0.3</td>
<td>5.7</td>
</tr>
<tr>
<td>2009</td>
<td>22.1</td>
<td>13.5</td>
<td>11.2</td>
<td>18.8</td>
<td>4.6</td>
<td>22.7</td>
<td>0.3</td>
<td>6.8</td>
</tr>
<tr>
<td>2010</td>
<td>22.9</td>
<td>13.2</td>
<td>11.3</td>
<td>18.3</td>
<td>5.0</td>
<td>23.6</td>
<td>0.6</td>
<td>5.1</td>
</tr>
<tr>
<td>2006-2010</td>
<td>23.8</td>
<td>12.5</td>
<td>12.6</td>
<td>17.5</td>
<td>4.5</td>
<td>23.6</td>
<td>0.8</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Source: Adapted from South Africa Annual Tourism Reports (SAT, 2007; 2008; 2009; 2010a; 2011)

Notes: VFR= Visiting Friends and Relatives

Figure 3.1  Number of Medical Tourists to South Africa 2006-2010

Source: Adapted from South Africa Annual Tourism Reports (SAT, 2007; 2008; 2009; 2010a; 2011)
Table 3.2  Detailed Purpose of Visit by Source Country and Region 2003-2008

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Tourists</th>
<th>Total Medical</th>
<th>Percent Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NORTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>2,849,029</td>
<td>122,000</td>
<td>4.3</td>
</tr>
<tr>
<td>Germany</td>
<td>1,496,133</td>
<td>47,000</td>
<td>3.1</td>
</tr>
<tr>
<td>USA</td>
<td>1,451,732</td>
<td>41,000</td>
<td>2.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>718,368</td>
<td>21,000</td>
<td>2.9</td>
</tr>
<tr>
<td>Australia</td>
<td>499,416</td>
<td>14,000</td>
<td>2.8</td>
</tr>
<tr>
<td>France</td>
<td>677,502</td>
<td>13,000</td>
<td>1.9</td>
</tr>
<tr>
<td>Canada</td>
<td>265,699</td>
<td>9,000</td>
<td>3.4</td>
</tr>
<tr>
<td>Italy</td>
<td>303,606</td>
<td>7,000</td>
<td>2.3</td>
</tr>
<tr>
<td>Sweden</td>
<td>207,693</td>
<td>5,000</td>
<td>2.4</td>
</tr>
<tr>
<td>Japan</td>
<td>166,622</td>
<td>2,000</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>SOUTH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>239,108</td>
<td>7,000</td>
<td>2.9</td>
</tr>
<tr>
<td>China</td>
<td>264,227</td>
<td>6,000</td>
<td>2.2</td>
</tr>
<tr>
<td>Brazil</td>
<td>150,188</td>
<td>5,300</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>AFRICA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Africa Air</td>
<td>800,000</td>
<td>38,000</td>
<td>4.7</td>
</tr>
<tr>
<td>Africa Land</td>
<td>33,200,000</td>
<td>2,158,000</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Source: Adapted from South African Tourism Country Reports (SAT, 2010b-2010p)
What is most striking, however, is that over two million medical tourists entered South Africa from the rest of Africa compared with only 300,000 from non-African countries. In other words, 85 percent of South Africa’s medical tourists are actually from other African countries, not the North. South-South medical tourism therefore dominates the South African industry. The following three sections will compare the main characteristics of North-South and South-South medical tourism to South Africa.

**NORTH-SOUTH MEDICAL TOURISM**

The North-South medical tourism industry to South Africa comprises a number of inter-linked players. Medical services for medical tourists in South Africa are provided by individual physicians, private medical practices, and public clinics and hospitals. Government regulations affect South African doctors’ ability to attract international patients. Physicians in South Africa are not allowed to market or advertise their services, post a photograph of themselves on their website or make claims about the quality of their work, other than that they undertake it (Otley, 2008; Stolk, 2009, p. 68). However, many ignore this rule. In addition, though some doctors offer ‘international patient services’ they cannot act as medical tourism facilitators. For example, they may refer a patient to a hotel but should not accept payment for these services. South African physicians build an international clientele through a combination of their personal websites, medical facilitators, hospital referrals, referrals from colleagues abroad and word of mouth referrals from satisfied patients. Treating these patients is not without risk according to a dental surgeon, Dr. Peter Galatis, who says that his insurers “double the premium and halve the indemnity” for overseas patients (Otley, 2008).

The industry is therefore largely driven by small-scale medical tourism facilitators working independently to market the country as a destination for foreign patients. This is in contrast with major destinations such as India and Thailand where private hospitals, policy makers and tourism agencies work together to invest in, develop and promote the industry. As a result, these other destinations are often viewed as having more established, better marketed and better managed medical tourism industries (Runckel, 2007; Stolk, 2009).
The South African medical tourism industry has two types of medical facilitator groups and is not as diverse as the Asian industry (Keckley & Underwood, 2008, p. 12). South African facilitators are a mixture of travel agencies and provider groups, acting as intermediaries for international patients and offering a wide range of services. Each company performs one or more of the following roles: international patient marketing for physicians, or acting as a travel agent and medical liaison for patients. In other words, they can act as a patient referral service for physicians, helping them to build and maintain ‘high-calibre’ or ‘repeat’ international clientele. For patients, facilitator roles range from organising flights, visas and vacations, to acting as a personal advisor on a wide variety of issues such as quality concerns or patient rights (Keckley & Underwood, 2008; Stolk, 2009). There are currently no industry-wide definitions, standards or accreditations of South African facilitators.

A web search in early 2011 revealed the existence of at least twenty South African based medical facilitators, although the industry is dominated by a smaller number who have managed to find a niche market. Surgeon and Safari, for example, focuses on the UK market and has offices on the prestigious Harley Street, London. Although Netcare uses external facilitators, they have an in-house Central Referral Office (CRO) that acts as a Provider Group Medical Facilitator. This CRO has a foreign patient liaison officer, arranges agreements with local guesthouses, uses an online enquiry form and markets the hospital internationally. The CRO is eligible to receive a referral fee from doctors because it is able to make medical evaluations and accept medical liability.

The three largest private hospital groups, Life, Medi-Clinic and Netcare, operate 165 private hospitals between them. At the same time, the overall importance of medical tourism to the operating revenue and profits of the three groups is presently not large. Corporate expansion outside South Africa has proven to be a much more lucrative business strategy (Mortensen, 2008). Netcare, for example, has opened a private hospital network in the UK; Life Healthcare provides services to NHS patients in the UK; and Medi-Clinic has opened subsidiaries in the UAE and Switzerland (Mortensen, 2008; Otley, 2008). The success of overseas expansion (medical tourism ‘in reverse’ where providers go to the patients instead) may have somewhat decreased the attractiveness of medical tourism in South Africa, and may
help to explain why private South African hospitals are not driving the expansion of the medical tourism industry, unlike their more aggressive Asian counterparts (Connell, 2011; Shetty, 2010).

A new development in the South African industry concerns Discovery Health, the country’s largest health insurance scheme. Discovery Health launched a medical insurance company in the US called ‘Destiny Health’ in the year 2000 but pulled out in 2008 after failing to capture a significant portion of the market (Discovery, 2012). Discovery Health also entered the UK market as PruHealth, a joint partnership with Prudential, a large multi-purpose insurance company. PruHealth currently has over 700,000 members or a market share of 11 percent (PR Newswire, 2010). In 2009, Discovery Health announced its plan to buy a 25 percent stake in China’s ‘Ping An Property and Casualty Insurance.’ South Africa’s health insurance is also globalising and facilitators, physicians, insurers and hospitals could form ‘outsourcing’ partnerships similar to those developing between the American, European and Indian markets. The difference is that members in countries served by such outsourced partners would have the option of getting surgery in South Africa.

South Africa certainly cannot compete with most other medical tourist destinations on price alone. A survey of the cost of different procedures in South Africa, compared to India, Thailand and Mexico shows that advertised non-elective surgery prices in South Africa are, on average, higher than in the other three destination countries (Keckly & Underwood, 2008, p. 6). For example, a knee replacement surgery costing US$50,000 in the US would cost US$25,000 in South Africa but only US$14,000 in Thailand, US$11,500 in Mexico and US$9,000 in India (see Table 2.1 in Chapter 2 of this volume). Similarly, a combined hip replacement and heart bypass in the US costs on average US$187,000, compared to US$34,900 in South Africa and only US$20,000 in India.

MARKETING SOUTH AFRICA

Advertising for South Africa as a medical tourism destination situates the country as an authentic ‘medical tourism’ experience combining a medical procedure with the opportunity for a recuperative vacation in idyllic surroundings. MedRetreat (the motto is “where smart
medicine and exotic travel come together”) compares several destination countries and notes that:

“South African hospitals and clinics are vying to attract more international medical tourism patients from around the world. ... Although the cost of medical treatment is not as price competitive as many of the other popular medical travel destinations, the quality of treatment is world-class and available tourist attractions are astounding (MedRetreat, 2012).

A very common advertising motif for medical tourism to South Africa is the combination of medical procedures and game safaris. Indeed, many websites advertising medical tourism contain gratuitous photo images of wild animals:

“The country boasts sunshine throughout the year, extraordinary scenery, and of course, a wide variety of wild animals in their native habitats. ... Many healthcare providers and private clinics in South Africa have realized that their country’s natural wonders can have a positive impact on the recovery process for their patients and encourage both post-operative relaxation and exploration (Discover Medical Tourism, 2011).

The city of Cape Town, in particular, is portrayed as the ideal location to combine cosmetic surgery with twenty-four hour ‘pampering’:

“The water breaks on the shores of Camps Bay on yet another perfect morning in Cape Town. Medical tourism in South Africa is booming – not only due to the prevailing sunshine that beats down on the country, but thanks in no small part to events such as the FIFA World Cup lighting up the continent with a glow that has enveloped each and every one. ... Take the time to browse our many options of things to do and enjoy your all-encompassing trip to Cape Town...Our skilled team of surgeons is only matched by the endless help that our tourism, accommodation and safari specialists that we have on beck and call (Surgical Bliss, 2008).

While ordinary tourism advertising places great stress on the country’s history and the opportunity to visit iconic landmarks, townships and learn more about anti-apartheid struggles, this is almost completely absent from medical tourism advertising where escapism rather than harsh realities, past or present, are paramount. At the same time, advertisers and promoters
are only too aware of the bad press generated by the country’s crime rate and its place at the epicentre of the global HIV and AIDS pandemic. These issues are either ignored by promoters or attempts are made to reassure the hesitant.

A common perception of South Africa for foreign travelers is the fear of giving or taking blood in a country so broadcasted for its HIV and AIDS scares. South Africa has one of the most stringent guidelines for blood donation and acquisition in the whole world. … Another perception of South Africa is the crime rates and random power cuts. There is a lack of information being given to the consumer about the world class medical expertise and tourism benefits the country has to offer (Johnson, 2009).

These are major image obstacles to overcome, especially when studies show that contracting HIV at work is a major fear of South African health care providers themselves (Shisana, Hall, Maluleke, Chauveau & Schwabe, 2004; Zelnick & O’Donnell, 2005) and the crime rate and lack of security in the country is driving the ‘brain flight’ of South African health care professionals to Europe and North America (Crush & Pendleton, 2010).

SOUTH-SOUTH MEDICAL TRAVEL

In recent years, there have been several high profile cases of African leaders and politicians going to South Africa for medical treatment, the most recent being President Robert Mugabe of Zimbabwe (Mathuthu, 2009; Zhangazha, 2011). Interestingly, when his spouse required treatment for a hip injury, the Mugabes, at the government’s expense, headed for Singapore. However, it is not only high-profile African political figures who head to South Africa for treatment. Table 3.2 shows that in the period between 2003 and 2008, 38,000 medical travellers flew from the rest of Africa to South Africa and over two million medical travellers entered South Africa from neighbouring countries.

Other than the numbers involved, there is very little information on South-South tourism to South Africa and much more research is urgently needed. Anecdotal evidence suggests that middle-class African medical travellers from non-Southern African Development Community (SADC) countries travel to South Africa mainly to obtain medically necessary
procedures such as reconstructive surgery and chemotherapy. Fairly typical are the 320 African women receiving breast cancer treatment at the Netcare Breast Care Centre of Excellence at Milpark Hospital in Johannesburg who were interviewed in a recent study (Ahwireng-Obeng & Van Loggerenberg, 2010). The two primary reasons for coming to South Africa were doctor referral and quality of treatment. Cost was not a significant factor.

In recent years, the high demand and large informal flow of patients from neighbouring countries has prompted the South African government to try and formalize arrangements for medical travel to South Africa’s public hospitals and clinics through inter-country agreements. South Africa has now entered into twenty bilateral health agreements with eighteen countries in Sub-Saharan Africa. It is difficult to obtain precise details about many of these health agreements, as the majority are tied to general health protocols and larger economic investment agreements. Nevertheless, agreements with Swaziland, Lesotho, Mozambique and Burundi do have specific medical travel provisions (see Table 3.3).

Patients from these countries can be referred to South African public hospitals for specialised medical care mostly for cancer treatments, reconstructive surgery and cardiovascular disease. They are admitted in the same way as South African patients, in that they are allowed to access treatment without paying in full in advance (Khumalo, 2010). Any upfront payments required are assessed according to the user fee schedule for South Africans.
Table 3.3 Sample Bilateral Health Agreements

<table>
<thead>
<tr>
<th>Country</th>
<th>Name of Agreement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swaziland</td>
<td>Agreement between the Government of the Republic of South Africa and the Government of the Kingdom of Swaziland on Cooperation in the Field of Health. Effective: 10 May 2010</td>
<td>Swazi citizens may be referred to Government of South African public hospitals for specialised medical treatment. Swazis have to bring their own donors for organ transplants. They can pay the same price that South Africans pay for public health access.</td>
</tr>
<tr>
<td>Malawi</td>
<td>Agreement between the Republic of South Africa and the Government of the Republic of Malawi in the Field of Health. Effective: 12 February 2009</td>
<td>Malawians may be admitted to South African public hospitals at subsidized fees (pay the same price that South Africans pay). Will provide specialised medical treatment not available in Malawi.</td>
</tr>
</tbody>
</table>

Source: Adapted from Department of Cooperation and International Affairs (2011).

According to the Department of Health, the all-inclusive, fully subsidized rate for all treatments is currently ZAR39 (US$6) for an outpatient or ZAR194 (US$28) for up to 30 days admission in a public hospital. Their respective governments are then billed for the full costs of treatment and hospitalisation, as well as patient travel and accommodation expenses (Department Of Health, 2005).7
The South African policy of concluding bilateral agreements with other African countries can also be seen as an example of health diplomacy. This usually refers to a government’s purposeful efforts to incorporate health as a foreign policy tool and has been defined as any “political change activity that meets the dual goals of improving global health and maintaining and improving international relations, particularly in conflict areas and resource-poor environments” (Novotny & Adams, 2007, p. 1). South Africa’s health diplomacy efforts are focused in Africa and are generally guided by the 1999 SADC Health Protocol. The protocol’s most important objectives are “to facilitate the establishment of a mechanism for the referral of patients for tertiary care” and “to coordinate regional efforts on epidemic preparedness, mapping, prevention, control and where possible the eradication of communicable and non-communicable diseases” (Department of International Relations and Cooperation, 2011).

CONCLUSION

South Africa has become a significant medical tourism destination since the collapse of apartheid in 2004. Medical tourism is often associated with elective cosmetic surgery and South Africa markets itself as an ideal destination for combining such surgery with tourist activities such as game safaris. The majority of these medical tourists come from the UK, Germany and the US. The evidence shows that they are attracted by the ‘total tourist experience’ offered by the industry. Even the names of prominent cosmetic surgery facilitators – such as Surgeon and Safari, Surgical Bliss and Nulook Surgery – convey this message. Important as this form of elective medical travel is, this chapter has attempted to demonstrate that medical tourism is much more complex and varied than these images suggest.

The term ‘medical tourism’ seems inappropriate to describe the other form of medical travel outlined in this chapter: the rapid growth in travel from other African countries to South Africa to seek medical diagnosis and treatment. South Africa is increasingly looked to by the continent’s elite and middle-class as a country where high quality private care is available for treatments such as surgery after accidents, heart surgery and cancer treatment. However, the greatest growth in medical travel to South Africa in recent years is from neighbouring countries.
whose public healthcare systems are in a state of crisis. South Africa’s own public healthcare system is itself overburdened and under-resourced but it can still deliver a quality of treatment that is often unavailable at home.

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1 Netcare is the largest hospital group in South Africa consisting of 56 hospitals with 9,546 registered beds, and more than 1 million admissions per year. It operates 86 pharmacies and the largest private emergency service, Netcare 911, with 7.5 million members and a fleet of 264 vehicles, three helicopters and two fixed-wing air ambulances transporting 175,600 patients per year. Through the primary care networks, Medicross and Primecure, a combined 3.5 million patients are treated per year. Netcare employs nearly 20,000 people in South Africa and yearly South African revenue reached R 8,869 million in 2007 (Mortensen, 2008).


3 The fall in 2010 reflects a change in the methodology used for collecting data on foreign tourist arrivals. This changed in 2010 to bring South Africa in line with the guidelines of the World Tourism Organization. Prior to 2010, the reported figures for tourist arrivals were synonymous with the total number of foreign arrivals which included day visitors and people who engage in remunerated activities in South Africa (SAT, 2011, p. 2).

4 The Africa air market in Table 3.2 refers to countries where more than 60 percent of arrivals come by air. It also includes Middle East countries, namely Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syria, UAE, and Yemen (SAT, 2010b, p. 6).

5 Various surgeons provide an industry price range on their websites. These prices represent the mean of the high and low estimate.

6 The women were from Botswana (152), Malawi (36), Ethiopia (32), Zambia (28), Mozambique (16), Zimbabwe (12), Angola (8), Namibia (8), Ghana (4), Mauritius (4), Nigeria (4), Senegal (4), Swaziland (4), Tanzania (4) and Uganda (4) (Ahwireng-Obeng & Van Loggerenberg, 2010, p. 12).

7 Such intergovernmental arrangements for cross-border treatment in public facilities are not, by conventional definition, medical tourism, but represent another aspect of the globalization of health care.

REFERENCES


Sidley, P. (2010). Hospital group admits that its premises were used for illegal transplantations. *British Medical Journal, 341*, c6543.


