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# South–South medical tourism and the quest for health in Southern Africa

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ABSTRACT

Intra-regional South–South medical tourism is a vastly understudied subject despite its significance in many parts of the Global South. This paper takes issue with the conventional notion of South Africa purely as a high-end "surgeon and safari" destination for medical tourists from the Global North. It argues that South–South movement to South Africa for medical treatment is far more significant, numerically and financially, than North–South movement. The general lack of access to medical diagnosis and treatment in SADC countries has led to a growing temporary movement of people across borders to seek help at South African institutions in border towns and in the major cities. These movements are both formal (institutional) and informal (individual) in nature. In some cases, patients go to South Africa for procedures that are not offered in their own countries. In others, patients are referred by doctors and hospitals to South African facilities. But the majority of the movement is motivated by lack of access to basic healthcare at home. The high demand and large informal flow of patients from countries neighbouring South Africa has prompted the South African government to try and formalise arrangements for medical travel to its public hospitals and clinics through inter-country agreements in order to recover the cost of treating non-residents. The danger, for 'disenfranchised' medical tourists who fall outside these agreements, is that medical xenophobia in South Africa may lead to increasing exclusion and denial of treatment. Medical tourism in this region and South–South medical tourism in general are areas that require much additional research.



## 1. Introduction

Medical tourism is usually associated with the movement of affluent patients from the Global North to access treatment in dedicated private health care facilities in the Global South (Turner, 2010; Johnston et al., 2010; Chuang et al., 2014). Yet, the bulk of the world's medical tourism to destinations in the South is actually intra-regional in nature and often between countries with varying standards of care and levels of access to treatment (Ormond, 2011). India, for example, is one of the world's major medical tourism destinations, yet a large proportion of India's medical tourists are of South Asian origin. Some studies estimate that as many as 85 percent of medical tourists to India are from neighbouring countries (Connell, 2011). In the case of Malaysia, Ormond (2013) shows that nearly three-quarters of all recorded medical tourists are actually from neighbouring Indonesia. The well-known Bumrungrad International Hospital in Thailand draws most of its patients from South East Asia, but the Gulf Region is also one of its most important sources of medical tourists (Connell, 2011). Other emerging South–South medical tourism corridors include China–Taiwan (Pan and Chen, 2014), Myanmar–Thailand (Maung and Walsh, 2014) and Cambodia–Vietnam (Pocock and Phua, 2011).

South–South medical tourism falls into two general categories: first, there are medical tourists from the more affluent upper and middle-classes in many countries in the South who move across borders to access the higher quality private healthcare available in major medical tourism destinations. This appears to mimic "high-end" medical tourism from the North to the South. However, there are several important differences including the motives for travel, the distances travelled and the types of medical procedures accessed. For example, high-end South–South medical tourists are more likely to travel because facilities and forms of treatment are not available in their own countries. Distances travelled tend to be smaller since much of the movement is intra-regional in character. And the cosmetic surgery market that drives a significant portion of

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the North–South movement is not as important in South–South medical tourism. Secondly, and numerically more noteworthy, South–South medical tourism is characterised by what Roberts and Scheper-Hughes (2011: 2) call "poor and medically disenfranchised persons" who are "desperately seeking life-saving drugs and therapies and corrective surgeries that they cannot get at home." In this context, South–South medical tourism (from poorer to better resourced countries within the Global South) is not only growing rapidly but challenges conventional North–South models of the phenomenon (Connell, 2011).

Since the end of apartheid, South Africa has emerged as an important secondary hub for global medical tourism. The South African industry regularly positions itself as a cosmetic surgery destination for patients from the North offering a uniquely "African" combination of medical treatment and recuperative tourism experience (such as a wildlife safari) (Maaka, 2006; Stolk, 2009; Nicolaides, 2011; Nwafor, 2012). George (2004: 241, 243), for example, argues that "South Africa has a number of attributes that entice medical tourists. These include a wonderful climate, wildlife, spectacular scenery, a favourable exchange rate and world-class medical care … It is the provision of two desired services, surgery and safari, that prospective patients/tourists are enticed to utilise South Africa for their medical needs." The main target market for cosmetic procedures is Europe, particularly the UK and Germany. The most popular procedures are rhinoplasty, breast augmentation, liposuction, facelifts and tummy tucks (Maaka, 2006). More recently – and controversially – South Africa has become a destination for kidney and stem cell transplantation (Bass, 2005; Scheper-Hughes, 2011; Mohamed and Slabbert, 2012; Meissner-Roloff and Pepper, 2013) as well as fertility treatment and drug rehabilitation (WeDoRecover, 2011; Currie, 2013).

A recent critical analysis of medical tourism in South Africa focuses on one segment of the medical tourism market (cosmetic surgery) and one company (Surgeon & Safari) (Mazzaschi, 2011). In the context of a two-tier and highly inequitable health system, the critique is certainly prescient but could reinforce the popular impression that this is all there is to medical tourism in the country. As Turner (2007:307) suggests, to equate medical tourism with cosmetic surgery is a serious error. Medical tourism to South Africa is not simply about scalpel safaris and producing "valuable bodies" through cosmetic surgery (Mazzaschi, 2011). It is far more heterogeneous and complex than its popular image as an archetypal "sea, sun, sand, surgery (and safari)" destination for body sculpting might suggest (Connell, 2006; Stolk, 2009). In this paper we argue that cosmetic medical tourism from the North is only one small segment of the industry in South Africa and that the private health care system is only one provider. The evidence presented in this paper suggests that the vast majority of medical tourism to South Africa is not from the North at all, but rather from other African countries. The South African case therefore offers an important opportunity to examine the dynamics of South–South medical tourism and to instate intra-African medical tourism as an important topic worthy of further research and policy attention.

## 2. Data sources

Estimates of the number of medical tourists to South Africa vary widely. Published estimates for 2006, for example, vary between 50,000 (Prasad, 2012) and 200,000 (Gilfellan, 2008). Such widely varying figures reflect the fact that there is a paucity of reliable data on the size of the phenomenon in South Africa. South Africa's 2002 Immigration Act provides for the issue of 'medical permits' but only to people who intend to stay in South Africa for periods in excess of three months. Since the vast majority of medical tourists enter for much shorter periods, any data on the issue of medical permits only captures a small proportion of the market. In 2012, for example, only 1870 medical permits were issued (Statistics South Africa, 2013: 14). Most people entering South Africa for medical purposes enter on visitor's permits which generally entitle them to a stay of up to 90 days. This makes medical tourists indistinguishable from other temporary entrants in immigration statistics.

The main source of official data on medical tourism is collected by Statistics South Africa (SSA) and South Africa Tourism (SAT) who conduct a regular Tourism Departure Survey (TDS) (SAT, 2012a, 2012b: 143). A stratified random sample is drawn from people leaving South Africa through land border posts and airports. Information collected in the TDS includes country of citizenship and residence, the main purpose for visiting South Africa ('medical/health' being one of the options), length of stay in the country, activities engaged in and amounts spent. Two sets of data on medical tourism flows can be extracted from the published TDS statistics in South African Tourism's (SAT) Annual Tourism Reports:

- Series A: includes all tourists who made use of medical and health facilities while in South Africa. The data set covers the period between 2003 and 2008 and includes three groups: (a) tourists whose main purpose of entry was medical (Series B below); (b) those for whom medical treatment was one of a number of reasons for going to South Africa but who specified a non-medical reason as their main purpose; and (c) non-medical tourists who obtained medical attention while in South Africa. Unfortunately, the TDS data does not distinguish between these three groups for the period concerned.
- Series B: records the number of tourists who described their main purpose of entry to South Africa as "medical." These individuals classify as "medical tourists" proper but the data set excludes those whose secondary purpose was medical and those who obtained medical treatment having entered for a non-medical reason. This data set covers the period from 2007 to 2012 and is disaggregated by year and source region and country of origin.

In the case of some source countries, the difference between Series A and Series B statistics is relatively significant. With reference to the United Kingdom, for example, Hanefeld et al. (2013) use the United Kingdom International Passenger Survey (IPS) to calculate that the average annual number of UK medical tourists to South Africa between 2000 and 2010 was in the range 1500–5000. Yet, Series A data shows that the number of UK tourists who engaged in a medical or health-related activity in South Africa was closer to 20,000 per annum between 2003 and 2008. Thus, approximately three-quarters of UK visitors who received medical treatment in South Africa either did so after falling ill or went for medical treatment but did not specify this as their main reason when leaving the UK. There is therefore a strong likelihood that the IPS does not accurately capture the full extent of medical tourism between the UK and South Africa.

In the case of medical tourists from South Africa's neighbouring countries, by contrast, the difference between Series A and Series B is relatively slight. In effect, the vast majority of those who went to South Africa to access medical treatment gave this as their primary reason on exit and the number who fell ill and sought treatment or went primarily for another reason was relatively small. Although the average annual figures cover different periods, the general difference between all visitors who engaged in a health-related activity (Series A) and medical tourists whose primary reason for entry was medical (Series B) is only 34,000 per annum. This suggests that nearly 90 percent of those who accessed medical services in South Africa entered with this as their primary purpose.

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