The Southern African Migration Programme

Patients Without Borders: Medical Tourism and Medical Migration in Southern Africa

Migration Policy Series No. 57

Patients Without Borders: Medical Tourism and Medical Migration in Southern Africa

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Series Editor:
Prof. Jonathan Crush

Southern African Migration Programme (SAMP)
2012

Acknowledgements

We would like to thank the International Development Research Centre (IDRC) and the Open Society Initiative (OSISA) for their support of the Southern African Migration Programme (SAMP) and Cassandra Eberhardt for her editorial and other assistance.

Published by Idasa, 6 Spin Street, Church Square, Cape Town, 8001, and Southern African Research Centre, Queen's University, Canada.

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ISBN 978-1-920409-74-6
First published 2012
Design by Bronwen Müller

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Printed by Megadigital, Cape Town

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Executive Summary

Medical tourism has become a major focus of research and policy interest in the Global South in recent years. Much of the discussion focuses on the motives and impact of Europeans and North Americans who travel to developing countries for lower-cost medical and health care. One recent overview of the global medical tourism industry identified three major hubs (Thailand, India and Singapore) and three minor hubs (Costa Rica, Hungary and South Africa) for North-South medical tourists. Medical tourism operators, facilitators and service providers generally advertise South Africa as a cosmetic tourism destination. The most popular procedures for European medical tourists are hip replacements, rhinoplasty, breast augmentation, liposuction, facelifts and tummy tucks. In other words, South Africa is seen as an archetypal medical tourism destination, combining a medical (elective) procedure with related travel and tourism activity. This paper first reviews the operation of the private sector industry in South Africa and the role of medical facilitators in particular. It shows that the industry is premised on a highly romanticised and stylised image of South Africa which stresses the quality of the country's private healthcare system and its numerous tourist attractions.

The paper shows that cosmetic surgery is only one small segment of medical tourism to South Africa. A great deal of medical tourism to South Africa is not from the North at all, but from other African countries. The number of medical migrants to South Africa increased from 327,000 in 2006 to over 500,000 in 2009. Around 4.5% of total entries were for medical treatment which, became relatively more important over time (rising from 3.9% in 2006 to 5.0% in 2010). The Global North generated a total of 281,000 medical travellers over this time period while the Global South was the source of over 2 million The South African case therefore offers an important opportunity to examine the dynamics of South-South and intra-African travel for medical treatment. Just as South-South migration has generally been ignored, there is a danger that the same will happen to South-South medical tourism. This is unfortunate as South-South medical migration is growing rapidly and challenges conventional notions of medical tourism. This paper aims to reinstate intra-African medical tourism and migration as an important topic worthy of further research and policy attention.

South-South movement to South Africa for medical treatment is far more significant, numerically and financially, than North-South movement. Two major forms of South-South medical migration (or medical travel) to South Africa from the rest of Africa are identified. The first is the growth in medical travel from East and West Africa to South Africa.

These travellers spend more in South Africa than any other traveller (including those from the North) and are generally middle-class Africans seeking specialist diagnosis and treatment. The second, making up over 80% of the total medical travel flow to South Africa, are formal and informal movements from countries neighbouring South Africa (especially Lesotho, Swaziland, Mozambique and Zimbabwe). Very little is known about this movement beyond the basic dimensions of the flow.

Public health systems in countries neighbouring South Africa are in a state of crisis, under-resourced, understaffed and overburdened. The problem is exacerbated by the ongoing brain drain of doctors and nurses to South Africa and overseas. The countries neighbouring South Africa have much worse patient to doctor and nurse ratios than South Africa or the recommended WHO minimum. Southern Africa is also the epicentre of the global HIV and AIDS pandemic, which has increased the burden of disease on health systems by increasing the demand for treatment and palliative care, imposing heavier workloads on health care workers, reducing the workforce by infecting health care workers and imposing psychological stress on health workers who have to administer palliative care, leading to low morale, burn-out and absenteeism.

The general lack of access to medical diagnosis and treatment in SADC 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. An analysis of exit survey data reveals the following about the movement:

- The proportion of medical travelers from neighbouring states as a proportion of total entries was around 6% in 2010. However, there is considerable country variation with medical travellers amounting to 17% of total entrants from Mozambique and 12% of those from Angola. The proportion for most countries neighbouring South Africa is much lower: Botswana (4%), Lesotho (4%), Zimbabwe (3%) and Swaziland (2%). This is because cross-border traffic with these countries is so large that medical travel is relatively insignificant as a proportion of the whole.
- The actual number of medical travellers is currently 300-350,000 per annum. Lesotho is the source of the greatest numbers (140,000), followed by Botswana (55,000), Swaziland (47,000), Mozambique (38,000) and Zimbabwe (17,000). The flow has been increasing fastest from Mozambique: from 8,000 in 2003 to 147,000 in 2008.

- The average length of stay for medical tourists from Europe is 8 nights. The average length of stay for medical travellers from countries neighbouring South Africa, on the other hand, is lower than 4 nights and as low as 1 night in the case of Botswana and Lesotho. This is consistent with a pattern of short-term cross-border movement to access routine medical services or treatment in South African towns close to the border between the countries.
- The total annual spend by medical travellers in South Africa amounts to over R1.5 billion. Of this, over 90% is generated by South-South medical travellers from the rest of Africa, powerfully illustrating the overall economic importance of this form of medical travel.

The high demand and large informal flow of patients from countries neighbouring South Africa has prompted the South African government to try and formalize arrangements for medical travel to its public hospitals and clinics through inter-country agreements. South Africa has entered into bilateral health agreements with eighteen African countries. Bilateral agreements can be seen as an effort to formalise and manage these movements and obtain payment from governments for the cost of treating non-residents. Some SADC governments have set up special funding mechanisms (such as the Phalala Fund in Swaziland) to pay the medical costs of patients who go to South Africa for approved treatment. However, these special funds have been plagued by corruption on both sides of the border to the detriment of patients.

Medical tourism and South-South medical travel are areas that require much additional research and policy formulation. SAMP has recently embarked on a major research project on South-South medical travel to examine the following issues:

- *Drivers of Cross-Border Medical Migration*. The reasons for the growth of medical travel to South Africa require investigation. Possible "push" factors include the crisis of detailed public health care systems in most SADC countries; lack of access of patients to diagnosis, drugs and care; inequitable distribution of health care resources that disadvantage rural populations; growth in the burden of disease and care accompanying the HIV and TB pandemics; lack of access to ART for PLHIV; and the comparative costs of treatment at home versus in South Africa. Possible "pull" factors include South Africa's better-resourced and staffed public health system; the existence of world-class medical facilities in the private system for those who can afford to pay; easier access to diagnosis, treatment and care; and greater ART coverage and accessibility.

- *Health Seeking Behaviour by Medical Migrants*. Beyond aggregate statistical information on the numbers involved, their length of stay in South Africa and their expenditure patterns, little is known about the medical reasons why residents of neighbouring countries seek treatment and care in South Africa and the ways in which they seek to access medical treatment in South Africa. What kinds of medical conditions prompt people to cross borders for treatment? Have HIV and AIDS and TB played a role in inducing more people to cross borders and, if so, what do they hope to achieve by going to South Africa? What role does the quest for maternal and child health play in prompting migration? Do people cross borders in order to access ART and how is their treatment regime affected by the fact that they have to travel regularly to access the drugs? Do medical migrants tend to go to hospitals and clinics in border towns or do they go to the larger centres? How do they decide which clinics and hospitals to attend and how do they actually get to these centres? What kinds of follow-up do they receive and, in particular, do they continue on prescribed drug regimens after leaving South Africa? This could be a crucial issue in the context of the emergence of drug-resistant strains of TB and other conditions.
- *Treatment of Medical Migrants in South Africa*. There is considerable evidence that migrants living in South Africa are regularly denied their constitutional right to medical treatment and care by personnel at hospitals and clinics. Studies of foreign residents of South Africa have clearly demonstrated the difficulties faced in getting medical attention from the public health system. Clearly, given the scale of the movement involved, medical migrants are somehow able to access treatment or they would not come. The fundamental question, then, is whether the barriers to access and human rights violations experienced by foreign residents are also experienced by medical migrants and what strategies they adopt to try and overcome these barriers. Are patients denied access to clinics and hospitals on the grounds of origin, citizenship and language? How are they treated by South African health workers and physicians? Do they receive the same kinds of care as South African patients? What kinds of payments are they asked to make for treatment? What happens to them if admission is considered medically advisable? Are they admitted and under what conditions or are they sent home?
- *Policy Responses to Medical Migration*. The 1999 SADC Health Protocol has amongst its objectives "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." Bilateral agreements can be seen as an effort to formalise these movements and obtain payment for the cost of treating non-residents who cannot afford to pay for expensive, specialised medical treatments in South Africa. Recent press reports from Botswana and Swaziland suggest that these agreements are not functioning well, to the detriment of patient care. For example, 500 Swazi cancer patients undergoing chemotherapy were recently sent home because the Swazi government had not paid their hospital bills. A critical analysis is needed of the functioning of the bilateral agreements and the extent to which they facilitate or obstruct the rights of patients.

Introduction

In November 2010, the private South African hospital group, Netcare, admitted to 109 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.[1] Poor Brazilians and Romanians were paid as little as $3,000 for a kidney and flown to South Africa for surgery and a game safari.[2] The kidneys were sold to wealthy Israeli citizens for up to $120,000 each who travelled to South Africa at the same time for the transplant operation. In order to comply with South African organ transplant laws, documents were forged to show that the recipient and donor were related.[3] After denying all knowledge and wrongdoing for several years, Netcare made a plea bargain with the State in late 2010.[4] The group was fined R4 million and forfeited the R3.8 million that it had made from the operations. Charges against the CEO of Netcare, Dr Richard Friedland, were withdrawn.[5] Eight people involved in the scam, including five doctors and surgeons, subsequently appeared in the Durban Regional Court on charges of fraud, forgery, assault and contraventions of the Human Tissues Act. A nephrologist, Dr Jeffrey Kallmeyer (now practicing in Toronto, Canada) pleaded guilty on 90 counts and was fined R150,000.

Two coordinators and four transplant surgeons await trial (in mid-2011). They claim that Netcare had full knowledge of and endorsed the programme, claims that have led the South African media to dub the case "kidneygate." The Mail and Guardian has even suggested that "the biggest scandal of the case is the absence from the dock of any decision-maker from Netcare."[6] One of the accused physicians has claimed that Johannesburg's Charlotte Maxeke Academic Hospital and Garden City Hospital, and Cape Town's Chris Barnard Memorial Hospital were responsible for a further 220 illegal transplant operations.[7]

The global traffic in illegal organs, of which this is only one troubling example, represents the dark underbelly of a global medical industry in which patients from one country travel to another for treatment and medical procedures.[8] Globalization and increased human mobility have brought a dramatic increase in the numbers of people migrating across international borders for medical reasons. This phenomenon, which has grown into a multi-billion dollar global industry in the last two decades, is widely known as "medical tourism." The Netcare scandal has significantly tarnished South Africa's reputation as a medical tourism destination. At the Inaugural South African Health Tourism Congress (SAHTC) in 2009, Dr Molefi Sefularo, the South African Deputy Minister of Health noted that Government was "open-minded and would be inclined to sup-

port the formalization of this sector understanding that it would contribute to skills development and job creation. I would like to confirm our support for this area of clinical care."[9] Government promised a national policy on medical tourism would be crafted by the end of that year. The policy has still not appeared which suggests that government is very sensitive to the negative international publicity attracted by the Netcare case and remains highly ambiguous about throwing its support behind the private sector-driven medical tourism industry with its focus on high-end North-South elective procedures and cosmetic surgery.

Although the number of global medical tourism destinations is multiplying rapidly, a recent overview of the global medical tourism industry identified three major hubs (Thailand, India and Singapore) and three minor hubs (Costa Rica, Hungary and South Africa) for North-South medical tourists.[10] The competitive success of the three major hubs is attributed to a number of factors. India, for example, is the cheapest of all the hubs with prices for surgical procedures averaging only a fifth of those in the United States.[11] The country has specialist hospitals that focus on areas such as heart surgery and joint replacements and cater entirely to foreign patients. These facilities also offer procedures that are rare or unavailable in countries of origin, such as hip resurfacing. In sum, India offers "well-trained health practitioners, a large populace of good English-speaking medical staff, a good mix of allopathic and alternative systems of medicine, the availability of super-specialty centres, use of technologically advanced diagnostic equipment, and finally and more importantly, the availability of these premium services at competitive cost."[12] Thailand's two largest medical tourism destinations are the Bumrungrad and Bangkok Hospitals, which treat 400,000 and 150,000 foreign patients respectively per annum.[13] These "mega-centres" offer a full range of medical services. However, the services that most exemplify medical tourism in Thailand are elective procedures such as routine check-ups and cosmetic surgery. Singapore had 410,000 medical tourists in 2006 and the government has committed to raising the number to over one million from 2010 onwards.[14] Singapore tends to be sold internationally as a hub on the basis of highly skilled practitioners and state of the art technology.[15]

In the intensely-competitive environment of globalized medical tourism, how do minor and emerging hubs position themselves in relation to the global market and the large revenue streams at stake? With regard to South Africa, the conventional answer is its unique combination of quality medical treatment and tourist attractions:

> South Africa's strength lies in the packaging of its tours, rather than the outright price of their medical capabilities. *A cosmetic surgery package in South Africa will consist of a*

> *consultation and surgery, personal physical therapist and personal assistant during your recovery in a spa and a safari tour afterwards.* Any of these components can be found in other tourism hubs for far less and some travel agents will even bundle them, but the professionalism and polish of the South African package cannot be matched [our emphasis].[16]

Medical tourism operators, facilitators and service providers generally advertise South Africa as a cosmetic tourism destination.[17] The main target market for cosmetic procedures is Europe, particularly the UK and Germany, and the USA. The most popular procedures for European medical tourists are hip replacements, rhinoplasty, breast augmentation, liposuction, facelifts and tummy tucks.[18] In other words, South Africa is an archetypal medical tourism destination, combining a medical (elective) procedure with a related travel and tourism experience: "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."[19]

Medical tourism to South Africa by well-heeled Europeans and North Americans is viewed by critics as ethically indefensible since the industry rests upon, and reinforces, South Africa's dualistic and highly unequal health care system.[20] The criticism is largely directed at profit-seeking private sector health care providers but may increasingly be aimed at government as well, as medical tourism is not at all incompatible with the ANC's neo-liberal economic policies. Mazzaschi's recent analysis of medical tourism in South Africa is based on a limited segment of the medical tourism market – cosmetic surgery – and one company (aptly named Surgeon & Safari).[21] His critique is certainly prescient but could reinforce the popular impression that this is all there is to medical tourism in South Africa. As Turner suggests, however, to equate medical tourism with cosmetic surgery is a "serious error."[22] North-South medical tourism to South Africa is not simply about scalpel safaris and producing "valuable bodies" through cosmetic surgery.[23] It is far more heterogeneous and complex than is suggested by its popular image as an archetypal "sea, sun, sand, surgery (and safari)" destination for body sculpting.[24]

In this paper we show that the "surgeon and safari" medical tourism experience is only one small segment of the industry in South Africa. Indeed, the evidence suggests that a great deal of medical migration to South Africa is not from the North at all, but from other African countries. The South African case therefore offers an important opportunity to examine the dynamics of South-South and intra-African travel for medical treatment. Roberts and Scheper-Hughes have recently noted

that medical tourism conjures "up an image of affluent Westerners taking advantage of the health care resources of poor nations."[25] As they go on to observe, however, many medical "tourists" today are "poor and medically disenfranchised persons desperately seeking life-saving drugs and therapies and corrective surgeries that they cannot get at home." In this context, South-South movement (from poorer to better resourced countries) is becoming increasingly common. In the same way that South-South migration has generally been ignored in the migration literature, there is a danger that the same thing will happen to South-South medical tourism.[26] This is unfortunate as South-South medical tourism is growing rapidly and, at a conceptual level, challenges conventional models of the industry. This paper aims to reinstate intra-African "medical tourism" as an important topic worthy of further research and policy attention.

WHAT IS MEDICAL TOURISM?

Medical tourism has become a major focus of research and policy interest in recent years.[27] Much of the discussion on the drivers of medical tourism focuses on the motives and impact of Europeans and North Americans who travel to developing countries for lower-cost medical and health care.[28] The rapid growth of such "North-South" medical tourism in the last two decades has been enabled by the growth of high quality, low-cost private medical care in the South and various push factors in the North including patient disillusionment with the lack of accessibility to timely care in overburdened public health systems; the absence of or inaccessibility to private healthcare options; actual and experimental treatments that are not available in countries of residence; inadequate insurance or personal funds to pay for expensive procedures and the demand for cosmetic surgery.[29] As a result, "a model of profit-driven health care has been exported around the world, chiefly providing care for mobile patients who can afford to travel or who have the personal resources to borrow to do so."[30]

Two terms have emerged to describe the modern form of international medical travel, namely "health tourism" and "medical tourism." Although the two terms are often used interchangeably, they are also seen as separate and distinguishable from each other. After reviewing 149 academic papers on the subject, Carrera and Bridges define health tourism as "organized travel outside one's local environment for the maintenance, enhancement or restoration of the individual's wellbeing in mind and body."[31] The three essential components of health tourism are (a) crossing borders, (b) consumption of a health-related intervention and (c) the presence of structural facilities dedicated to offering these services. Examples include wellness resorts, holistic treatments, addiction centres and weight loss clinics.

They define medical tourism as "organized travel outside one's natural healthcare jurisdiction for the enhancement or restoration of the individual's health through medical intervention." The two central characteristics of medical tourism are (a) cross border travel and (b) the use of a health care professional's expertise to achieve or restore the desired outcome. Carrera and Bridges add two qualifiers to their definitions: travel must occur to a place that is not the patient's principle or permanent place of residence or work; and the primary purpose of travel has to be for health or medical reasons. In other words, definitions of "medical tourism" can be constructed without any interrogation of the term "tourism" and its more common usage to describe travel for leisure, recreation and sightseeing.

Attempts to disaggregate "medical tourism" have led to a proliferation of terms such as "wellbeing tourism", "dental tourism", "stem-cell tourism", "transplant tourism", "abortion tourism" and "xeno-tourism."[32] If every medical treatment is seen as a distinctive form of "medical tourism" the term itself starts to lose any analytical value. Some have questioned whether the use of the word "tourism" is applicable at all. Firstly, the term connotes "leisure and frivolity" and, secondly, it fails to capture an extremely diverse phenomenon.[33] Roberts and Scheper-Hughes, argue that it is a "vexed term" and that "there are no easy ways to capture all the divergent experiences of medical travellers or their bodies and various states of embodiment."[34] They propose, as an alternative, that any travel in pursuit of bio-medical treatment or bodily alteration should be grouped within a broader framework of "medical migrations" and that people who travel for treatment should be labelled "medical migrants."[35] In practice, however, they tend to use the terms "medical tourism", "medical travel" and "medical migration" inter-changeably.

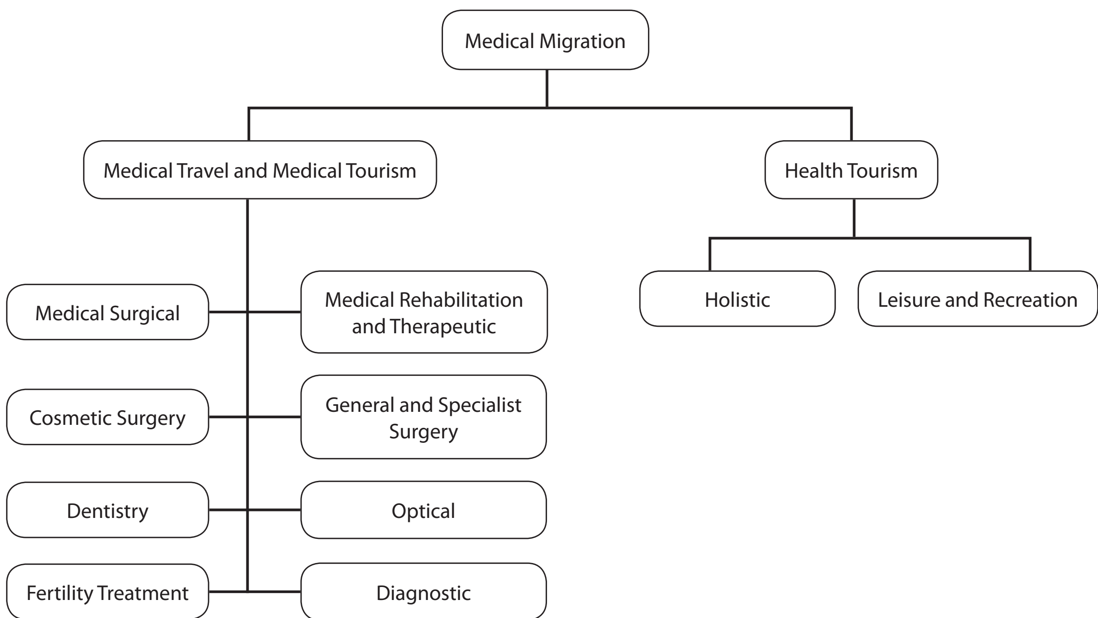
In the migration literature, the difference between travel and migration usually relates either to the length-of-stay in the destination country or to whether there is a change of residence or not. The UN, for example, defines an international migrant "as any person who changes his or her country of usual residence. Temporary travel abroad for purposes of recreation, holiday, business, medical treatment or religious pilgrimage does not entail a change in country of usual residence."[36] Here, we use the term "medical migration" as a general category to refer to all forms of cross-border movement for medical or health reasons.

We restrict the use of the term "medical tourism" to apply to the global industry that promotes medical travel as a form of "tourism."[37] The term "medical travel" is used to describe short-term movements which are motivated primarily by a desire to seek medical treatment in a country other than the country of usual residence.[38]

"Medical tourists" and "health tourists" are sub-categories of medical

migration that refer to medical patients who cross international borders for treatment and tourist activities while they are abroad (Figure 1). Medical migration can be divided into three broad categories: (a) intra-bound migration, (b) inbound migration and (c) outbound migration. Intra-bound medical migration occurs when patients move domestically to access medical care. Inbound medical migration refers to cross-border temporary movement to a foreign country for medical care and outbound medical migration to temporary movement from a foreign country to receive medical care (Heckly and Underwood, 2009:3). South-South medical migration in Africa is a form of outbound and inbound movement from one country to another.

Figure 1: Conceptualising Medical Migration



The global extent of medical migration is not known although it is clearly growing rapidly. Different agencies using different methodologies have released widely varying statistics. At one end of the spectrum are global consultancy firms such as McKinsey and Deloitte who argue that the size of the industry is grossly exaggerated.[39] According to McKinsey there are only 60,000 to 85,000 "medical tourists" globally every year, a figure that has been criticised for being US-centric and based on a flawed methodology. At the other end of the spectrum, Youngman estimated in 2009 that medical travel would be a $40-billion business in 2010, with over 780 million patients seeking care outside their principal country of residence.[40] Middle of the road estimates from industry insid-

ers such as Koncept Analytics, place the global figure at 5 million health and medical migrants every year.[41] By their own admission, however, these estimates are on the conservative side, as they are based on the lowest official government statistics and ignore countries that do not report including South Africa. For instance, the number used for India is 200,000 compared to an official government estimate of 1 million or Export Import Bank estimates of 500,000.

Medical Migration to South Africa

Dimensions of Medical Migration

Estimates of the number of medical travellers and tourists to South Africa vary widely. One study put the number of medical tourists at only 8,000 in 2003, with an industry value of R123 million.[42] Another estimated that there were 30,000 medical tourists in 2007, who generated approximately R3 billion.[43] 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, but only generated approximately R260 million.[44] As with the global industry, such widely varying estimates reflect the reality that there is an absence of reliable data on the size of the phenomenon in South Africa.

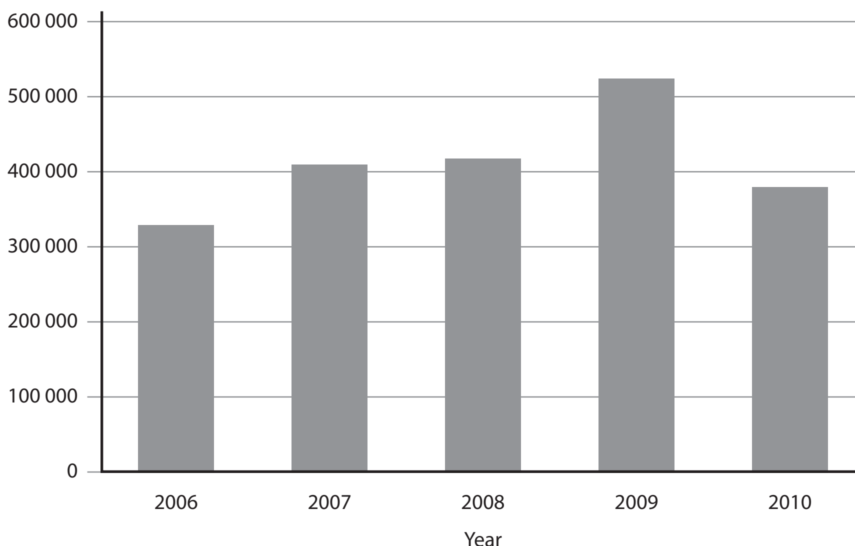
Official South African data on tourist entries is of limited use. The 2002 Immigration Act provides for the issue of "medical permits" but only to people who intend to stay in South Africa for periods in excess of three months.[45] Since the vast majority of medical tourists enter for shorter periods, any data on the issue of medical permits would only capture a small proportion of the market. Purpose of entry data is also unhelpful as there is no medical option on visa applications or entry forms. Most people entering the country for medical purposes therefore give "holiday" as their reason for coming to South Africa, which generally entitles them to a 90 day stay. They are therefore indistinguishable in tourism statistics from other temporary entrants.

Statistics South Africa (SSA) and South Africa Tourism (SAT) do, however, conduct a regular Tourism Departure Survey.[46] The Survey uses a stratified random sample to select respondents who are departing from both land border posts and airports. 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; (h) amounts spent (including on "medical expenses").[47] Raw survey data is unfortunately not available, but the information extracted by SAT from the survey is extremely helpful in building a general picture of medical migration flows to South Africa.

The number of medical migrants increased from 327,000 in 2006 to over 500,000 in 2009 but dropped again to under 400,000 in 2010, probably as a result of the global recession (Figure 2).[48] The proportion of entrants who said they had come to South Africa for medical reasons in the period 2006-10 is well below those who came to shop (25%), on holiday (24%), to visit family and friends (24%), and on business (17.5%) (Table 1). Around 4.5% of entries were for medical treatment, although this reason has become relatively more important over time (rising from 3.9% in 2006 to 5.0% in 2010). The Global North generated a total of 281,000 medical migrants over this time period while the Global South was the source of over 2 million (Table 2). In terms of the regional breakdown, Asia and Australia were the least important source of medical migrants at 29,000 (only 2.5% of total visitors) and Africa the most important at 2,196,000 (or 6.5%). What is most striking, is that 85% of South Africa's medical visitors are from other African countries. South-South medical travel therefore dominates the South African industry.

Figure 2: Number of Medical Migrants to South Africa, 2006-2010



Source: South Africa Annual Tourism Reports, 2008-2011

Table 1: Purpose of Visit of Visitors to South Africa, 2006-2010								
Year	Holiday (%)	Shopping Personal (%)	Shopping Business (%)	Business (%)	Medical (%)	VFR* (%)	Religion (%)	Other (%)
2006	28.6	11.2	14.5	16.5	3.9	22.4	1.9	2.9
2007	25.3	11.8	12.2	19.2	4.5	24.2	1.1	3.0
2008	20.0	12.6	13.8	18.1	4.3	25.1	0.3	5.7
2009	22.1	13.5	11.2	18.8	4.6	22.7	0.3	6.8
2010	22.9	13.2	11.3	18.3	5.0	23.6	0.6	5.1
2006-2010	23.8	12.5	12.6	17.5	4.5	23.6	0.8	4.7

*Source: South Africa Annual Tourism Reports, *VFR – Visiting Friends and Relatives*

Table 2: Regional Sources of Medical Migrants to South Africa, 2006-2010			
	Total Tourists	Total Medical	%
Europe	6,252,331	215,000	3.4
Asia & Australia	1,169,373	29,000	2.5
Americas	1,867,619	55,300	3.0
Africa & Middle East	34,000,000	2,196,000	6.5
Total	43,289,323	2,495,300	5.8
Global North	8,635,800	281,000	3.3
Global South	34,653,523	2,214,300	6.4

Source: South African Tourism Country Reports

The United Kingdom is the most important source of medical tourists from the North: a total of 122,000 in the six years between 2003 and 2008 (or around 20,000 per annum) (Table 3). Next came Germany (at around 8,000 per annum) followed by the USA (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 entered from non-African countries in the South including India, China and Brazil. Tourism statistics distinguish between African long-distance visitors who enter by air and short-distance visitors who enter by land. The official definition of the "African air market" refers to people from countries where more than 60% of arrivals come by air, primarily East and West Africa. The "African land market" refers to countries where less than 40% of arrivals come by air and therefore includes most of South Africa's SADC neighbours (with the exception of the DRC, Tanzania, Mauritius and the Seychelles). The African air market generated 38,000 medical migrants during this time period (less than the UK, Germany and USA). Around 86% of the total number of medical migrants to South Africa therefore originated from the short-distance African land market.

Table 3: Major Country Sources of Medical Travellers, 2003-2008			
	Total Tourists	Total Medical	Medical (%)
NORTH			
UK	2,849,029	122 000	4.3
Germany	1,496,133	47 000	3.1
USA	1,451,732	41 000	2.8
Netherlands	718,368	21 000	2.9
Australia	499,416	14 000	2.8
France	677,502	13 000	1.9
Canada	265,699	9 000	3.4
Italy	303,606	7 000	2.3
Sweden	207,693	5 000	2.4
Japan	166,622	2 000	1.2
SOUTH			
India	239,108	7 000	2.9
China	264,227	6 000	2.2
Brazil	150,188	5 300	3.5
AFRICA			
Africa Air	800,000	38,000	4.8
Africa Land	33,200,000	2,158,000	6.5
Source: South African Tourism Country Reports			

The image of South Africa as a “medical tourism” hub might suggest that those who come to the country for medical reasons also engage in tourist activities while in the country. The data shows very high levels of additional everyday activity by medical migrants: in 2010, for example, 94% said that they had shopped and 80% had experienced the “night-life.”[49] However, only 3% had engaged in more conventional tourism behaviour including cultural activities (3%), going to the beach (2%) and visiting a game park (1%). Unfortunately, country data is not available since it is likely that most of those who do fall into the “medical tourist” category and engage in tourism-related activity are from the North. The activities of medical migrants as a whole are a stark contrast to those whose main reason for coming to South Africa was to vacation: 46% of these visitors saw wildlife, 42% engaged in a cultural activity, 38% went to the beach and 13% went to a casino.

In general, medical migrants tend to stay in the country for shorter periods than other visitors (Table 4). The average length-of-stay of all tourists in 2010, for example, was around 8.5 nights while medical migrants stayed for around 5.5 nights on average. The main reason for the discrepancy is that the former tend to engage in a wider variety of activities in several destinations whereas medical migration is gener-

ally restricted to a single destination and purpose. However, the average length-of-stay of medical migrants did increase from 4.5 nights in 2007 to 5.6 nights in 2010. This could be associated with a greater demand for more specialised treatment and advanced medical procedures by patients.

Table 4: Average Length of Stay in South Africa of Tourist and Medical Migrants (Nights)

	All Tourists	Medical Migrants
2006	8.2	4.7
2007	7.9	4.5
2008	8.2	5.6
2009	8.3	6.0
2010	8.5	5.6

Source: South Africa Annual Tourism Reports

North-South versus South-South Medical Migration

The survey also provides several insights into the differences between North-South and South-South medical migration to South Africa. For example, there is a significant difference in the importance of medical migration as a component of all travel. The vast majority of North-South travel to South Africa is non-medical. For example, only 0.1-0.2% of total European travel to South Africa is for health reasons. In contrast, 5-6% of South-South travel to South Africa from the rest of Africa and the Middle East is health-related. There is also considerable variation within South-South travel, with more than one in ten visitors from some African countries coming for medical reasons. These include Mozambique (17%) and Angola (12%). However, the proportion for most countries neighbouring South Africa is much lower: Botswana (4%), Lesotho (4%), Zimbabwe (3%) and Swaziland (2%). This is simply because the cross-border traffic with these countries is so large that medical travel is relatively insignificant as a proportion of the whole.

When length-of-stay data is broken down by source country, further interesting differences emerge. The average length of stay for medical tourists from Europe, for example, was 8 nights in 2010 (compared with 13 nights for all European tourists) (Table 5). The average length of stay for South-South medical travellers from countries neighbouring South Africa, on the other hand, was 4 nights and as low as 1 night in the case of Botswana and Lesotho. This is consistent with a pattern of short-term cross-border movement to access routine medical services or treatment in South African towns close to the border between the countries.

Medical migrants from African countries further away actually spend more time in South Africa than European medical tourists: for example,

20 nights for medical migrants from Angola; 14 nights for those from the DRC and 13 nights for those from Nigeria. This is not unexpected since most medical migrants from these countries come to South Africa to access advanced private sector medical treatment unavailable in their home countries. However, while European medical tourists tend to spend less time in the country than normal tourists, the opposite is true of long-distance African travellers. This is primarily because many African visitors to South Africa are not "tourists" in the conventional sense, since they come primarily on short business/shopping trips or to visit friends and relatives. In the case of countries neighbouring South Africa, tourists and medical travellers come for similar periods of time.

Table 5: Average Length of Stay in South Africa by Country of Origin, 2010 (Nights)

	All Tourists	Medical Migrants
Europe	13	8
Africa Air		
Angola	4	11
DRC	6	14
Nigeria	3	13
Other	6	9
Africa Land		
Botswana	1	1
Lesotho	1	1
Malawi	4	4
Mozambique	2	2
Namibia	3	3
Swaziland	1	3
Zimbabwe	2	4

Source: South Africa Annual Tourism Reports

In general, African visitors from SADC and from outside SADC have very different activity profiles. Non-SADC African "tourists" to South Africa do not generally engage in many of the activities associated with the South African tourism industry and with tourists from the North. For example, fewer than 10% of these African visitors go to see wildlife although 15-20% do engage in a cultural activity (Table 6).[50] SADC visitors are also far more likely to be involved in business and trade activities than conventional tourist activities. The proportion of non-SADC visitors who come for medical reasons is certainly lower (at 2-5%) than the equivalent for SADC travellers (at 6-12%).

Table 6: Main Reason for Visiting South Africa, 2010						
	Medical	Business	Trading	Wildlife	Sporting / Adventure	Cultural
Africa Air						
Angola	7	17	3	8	2	7
DRC	5	19	5	8	0	19
Kenya	2	36	3	7	2	14
Malawi	2	19	8	11	4	15
Nigeria	2	30	2	8	1	17
Africa Land						
Botswana	12	9	22	5	2	5
Lesotho	10	10	10	6	5	27
Mozambique	5	9	22	12	4	11
Namibia	6	13	1	5	6	5
Swaziland	6	10	26	10	8	4
Zimbabwe	9	14	4	9	9	8
Source: South African Tourism Country Reports						

A final point of differentiation between North-South and South-South medical migration is in expenditure patterns while in South Africa. According to the data, the total spent by all visitors in South Africa increased from R58 billion in 2005 to R71 billion in 2010 (Table 7). Direct medical expenditures are a small proportion of this total, although they, too, have increased over time (from R70 million to R1.9 billion over the same period). However, it would be incorrect to conclude that this is the total spend by medical migrants since many of them also pay for accommodation, meals and goods while in South Africa.

Table 7: Total Tourist Spend in South Africa, 2005-10 (R billion)						
	2005	2006	2007	2008	2009	2010
Accommodation	8.7	9.6	8.8	10.3	7.8	9.0
Transport	5.8	6.5	5.7	6.6	4.7	5.5
Food & Drink	5.9	6.5	6.6	8.2	7.5	8.7
Leisure & Entertainment	3.4	3.4	4.4	5.2	4.2	4.5
Shopping	31.9	30.6	30.9	35.7	29.6	37.6
Medical	1.5	1.6	1.5	1.8	1.8	1.9
Other	0.7	1.1	1.6	5.5	3.4	5.1
Total	57.9	59.3	59.5	73.3	59.0	71.3
Source: South Africa Annual Tourism Reports						

Average per capita expenditures in South Africa are the highest amongst long-distance African medical migrants (Table 8). The average expenditures by North-South medical tourists are, perhaps surprisingly, much lower: at R4,530 for those from Europe and R3,320 for those from the USA and Canada. The comparatively low figures may reflect the fact that those on tourism packages pay for airfare and accommodations before departure.[51] Also surprising is the relatively high expenditure of short-distance African travellers (at R3,910 per person). Given that most routine procedures are relatively cheap in public hospitals and that they do not tend to stay very long in South Africa, this figure includes expenditures on goods that they take back with them to their home countries. Data from three sample countries shows that medical costs amount to around two-thirds of total spend in the case of patients from Botswana and Mozambique and only a half in the case of Nigeria (Table 9). Fully a quarter of the Nigerian medical traveller spend is on shopping. The total annual spend by medical migrants in South Africa amounts to over R1.5 billion. Of this, over 90% is generated by South-South medical migrants from the rest of Africa, powerfully illustrating the overall economic importance of this form of medical travel.

Table 8: Expenditures of Medical Migrants in South Africa

	No of Medical Travellers (Annual Estimate)	Average Expenditure Per Person (R)	Total Expenditure (R million)	%
Africa Land	360,000	3910	1,407,600	85.0
Africa Air	6,500	17740	115,310	7.0
Americas	9,000	3320	29,880	1.8
Asia and Australia	4,500	6780	30,375	1.8
Europe	16,000	4530	72,480	4.4
Total	396,000	4181	1,655,645	100.0

Source: South African Tourism Country Reports (SAT, 2010b-2010p)

Table 9: Expenditures of Medical Travellers in South Africa by Country

	Medical %	Transport %	Accomm-odation %	Food %	Leisure %	Shopping %
Botswana	63	12	7	7	1	9
Mozambique	68	7	11	7	0	7
Nigeria	53	6	11	5	1	24

Source: South African Tourism Country Reports

North-South Medical Tourism

Imagining 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 the USA, with South Africa, India, Croatia and Mexico shows that advertised cosmetic surgery prices in South Africa are lower than in the USA but higher than in the other destination countries.[52] For example, a facelift, breast augmentation and rhinoplasty that would cost US$33,000 in the USA, costs $18,806 in South Africa (43% lower), $11,900 in Mexico (64%), $11,500 in India (65%) and only $9,515 in Croatia (72% lower) (Table 10). Similarly, non-elective surgery is cheaper than in the USA but more expensive than in the other destinations. A combined hip replacement and heart bypass in the USA costs on average US$194,000, compared to US$70,000 in South Africa and only US$12,200 in India (36% and 6% of the USA price respectively.)

Table 10: Price Comparison (USD)

Procedure	USA	South Africa	Mexico	Thailand	Croatia	India
Angioplasty	57,000	14,447	12,500	3,788	11,240	3,300
Breast augmentation	10,000	7,000	3,500	2,727	3,955	3,500
Face lift	15,000	6,120	4,900	3,697	4,813	4,000
Heart bypass	144,000	50,000	27,000	15,121	18,000	5,200
Heart valve replacement	170,000	40,000	18,000	21,212	21,000	5,500
Hip replacement	50,000	20,000	13,000	7,879	11,000	7,000
Knee replacement	50,000	25,000	12,000	12,297	13,000	6,200
Rhinoplasty	8,000	5,686	3,500	3,091	2,415	4,000
Spinal fusion	100,000	8,066	12,000	9,091	6,644	6,500
All Procedures	604,000	176,319	106,400	78,903	92,067	45,200

Source: Medical Tourism Association Survey, 2010; Medical tourism websites

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 (whose motto is "where smart medicine and exotic travel come together") compares several destination countries and notes that:

> South African hospital and clinics are vying to attract more international medical tourism patients from around the world. With many private, world-class medical institutions, highly skilled doctors, serene vacation settings and somewhat close proximity to Western Europe; Europeans have been traveling to South Africa for health tourism procedures for some time now. 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 tourists attractions are astounding.[53]

A common medical tourism advertising motif for medical tourism to South Africa is the combination of medical procedures, scenery and safaris:

> Popular procedures include breast augmentation and reduction, face lifts, liposuction, and nose and ear corrections. Dental surgery and tooth implants, eye surgery and laser treatments, and fertility treatments are popular with foreign visitors as well. The country boasts sunshine throughout the year, extraordinary scenery, and of course, a wide variety of wild animals in their native habitats. These attractions, combined with the lower costs for treatment are major enticements for thousands of travelers. 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.[54]

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. This is therefore the ideal time for your cosmetic surgery in Cape Town. We have arranged everything for you, from the moment you step off the plane, to the essential recovery period once your surgery is complete. 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. Contact us right now and experience the very best that Cape Town has to offer. Visit us for your surgery option and then stay to experience the magic that everyone is talking about. We will arrange your medical accommodation in Cape Town, as well as your tours, and help you to experience the greatest city in the world.[55]

While ordinary tourism advertising often stresses 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 reality, past or present, is 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. The South African Blood Transfusion Service continues to lead the field with its technology. 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.[56]

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, and the crime rate and lack of security in the country are major factors driving the "brain flight" of South African health care professionals to Europe and North America.[57]

Facilitating Medical Tourism

The South African medical tourism industry comprises a number of interlinked players (Figure 3). At the heart of the system are South Africa's private medical practitioners, clinics and hospitals who perform the vast majority of procedures. Many private practices have operating privileges at hospitals and clinics and perform surgery there. Most dental and cosmetic surgeons have their own private surgeries. Some hospitals have specialised services – such as fertility clinics or cancer clinics – which can be accessed by medical travellers, either directly or through medical tourism facilitators.

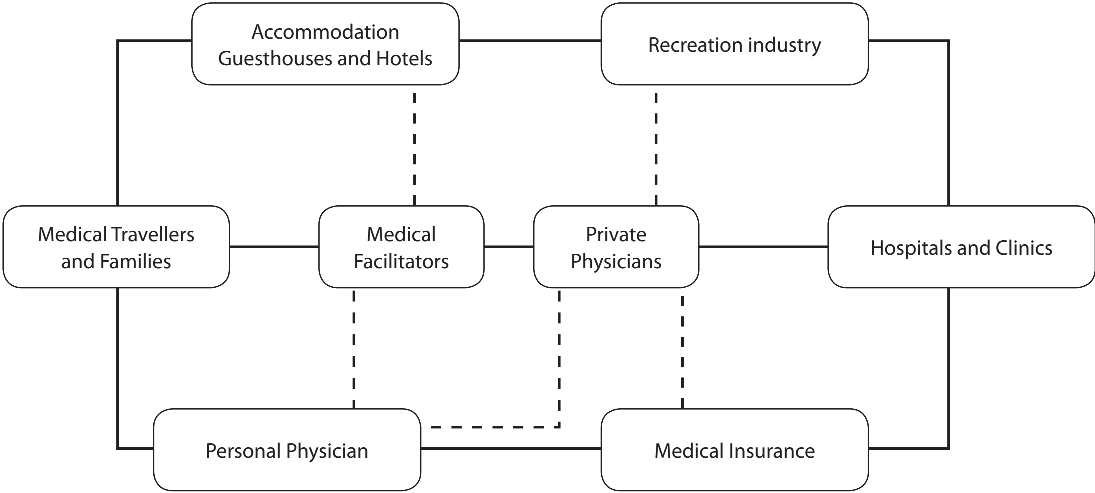
The medical tourism industry is largely driven by small-scale medical tourism facilitators, who market the country at an individual level. This contrasts with major destinations such as India and Thailand, where private hospitals, policy makers and tourism agencies work together to invest in, develop and promote the industry.[58] As a result, these other destinations are often viewed as having more established, better marketed, and better managed medical tourism industries.[59] The Asian industry includes travel agencies with medical tourism divisions such as Commonwealth Travel in Singapore; Provider Groups such as Bumrungrad in Thailand and Apollo in India which have international patient divisions; Hotel Groups such as WelcomGroup in India which have service divisions dedicated to medical facilitating; and medical travel planners, such as MedRetreat, which act as patient representatives in finding treatment abroad.[60]

South African facilitators are a mixture of travel agencies and provider groups and act as intermediaries for international patients. There are currently no industry-wide definitions, standards or accreditations of South African facilitators and a wide range of services is offered. A web search identified at least 16 South African-based medical facilitators (Appendix 1). They include firms such as Surgeon & Safari, Cape Health Destination and Surgical Bliss that cater primarily to the European and North American market and work with agents or representatives in source countries. The initial facilitators tended to focus on cosmetic surgery. Some have since broadened their activities to include a wide variety of elective and necessary surgical procedures while others – such as Dental Retreat SA, Dental Safaris, Fertility Care SA and IVF Safari – facilitate in one specialised area only. Despite their differences, all of these companies market South Africa as an integrated package for quality medical procedures and tourist activity. They also act as intermediaries between patients, the private medical system and the tourist industry. The range of services offered varies considerably but can include pre-trip consultations in the home country; connecting prospective patients with South African health facilities and surgeons; preparing detailed cost estimates; arranging medical consultations; organizing accommodation packages at hotels and company-owned guesthouses and coordinating post-surgery tourist activities including wildlife safaris.

Government regulations affect the ability of South African doctors' to directly attract international patients. Physicians in South Africa are not supposed to market or advertise their services, or to have a photograph of themselves on their website, or to make claims about the quality of their work. Many simply ignore these regulations. In addition, doctors cannot act as medical tourism facilitators. So although they might be able to refer a patient to a hotel or travel agent, they should not accept payment

for these services. South African physicians therefore build their international clientele through a combination of personal websites, working with medical facilitators, hospital referrals, referrals from colleagues abroad, and word of mouth.

Figure 3: The Medical Tourism Industry



South Africa's major private hospital groups, as well as some individual hospitals, are sufficiently interested in the potential of medical tourism to market themselves directly overseas. Netcare International, for example, uses external facilitators but also has an in-house Central Referral Office (CRO) that acts as a Group Medical Facilitator. The CRO has a foreign patient liaison officer, agreements with local guesthouses, uses an online enquiry form and markets the group's hospitals internationally. The CRO is eligible to receive a referral fee from doctors, even though it is a commercial entity, because they are able to make medical evaluations and accept medical liability. The Medi Care Group, which operates 40 private hospitals across South Africa and Namibia, has its own subsidiary, Medi-Travel International, which arranges all aspects of medical tourism for the group. The website offers copious information about the country for medical travellers who are thinking of visiting South Africa for treatment. The Cape Town Mediclinic has a Client Services Manager who deals directly with prospective patients, referring them to travel agents, assisting in arranging flights, arranging accommodation for relatives in nearby guesthouses and organizing holiday itineraries.

The overall importance of medical tourism to the operating revenue and profits of the three major hospital groups is not that significant at present. Expansion outside South Africa has proven to be a much more lucrative business strategy.[61] Netcare, for example, has opened a

private hospital network in the UK. Life Healthcare provides services to NHS patients in the UK. And Mediclinic has opened subsidiaries in the United Arab Emirates and Switzerland. The phenomenon of overseas expansion (medical tourism "in reverse" where providers go to the patients instead) may have decreased the attractiveness of medical tourism to South Africa, and may help to explain why South African hospitals are not driving the medical tourism industry, unlike their more aggressive Asian counterparts.

A new development in the South African private health industry concerns Discovery Health, the country's largest health insurance scheme. Discovery Health launched a medical scheme in the US called Destiny Health in 2000, but pulled out in 2008 after failing to capture a significant portion of the market. They later entered the UK market as a joint partnership with Prudential and currently have over 700,000 members or a market share of 11%.[62] In 2010 Discovery Health announced its plan to buy a 25% share in China's Ping An Property and Casualty Insurance. South Africa's health insurance is thus globalising and facilitators, physicians, insurers and hospitals could form 'outsourcing' partnerships similar to those developing between the American, European and Indian markets. Members would then have the option of getting surgery in South Africa.

At present, medical tourism is a sideline for hospitals, clinics and physicians in South Africa's private healthcare system. However, as the revenue-generating potential of the medical tourism industry grows, dedicated health and medical facilities are likely to be established specifically to cater for the medical tourist. One project currently on the drawing board is the Thukela Health and Wellness Centre in Kwazulu Natal (KZN). The Centre is projected to cost R3.5 billion to build and will constitute a "one-stop shop for medical tourism and health" including cosmetic and advanced surgery, an oncology unit, and a rehabilitation centre for addiction, depression, stress and eating disorders.[63] The Centre will be located on the KZN coast and provide easy access to the region's game parks, beaches and other tourism facilities and activities.

South-South Medical Migration

South-South medical travellers from the rest of Africa fall into two main groups. First, the African middle-class throughout the continent increasingly views post-apartheid South Africa as a centre of high quality and affordable medical care which is unavailable in their own countries. Public health care systems up and down the continent are in crisis, under-resourced, over-burdened and decimated by the brain drain of health professionals to the North. Private healthcare

is present in many countries but the quality of care varies considerably and none have the kind of infrastructure and hospitals that characterise the private medical sector in South Africa. Movement to South Africa for medical services is therefore motivated by such factors as quality and safety concerns about facilities at home; increasing costs of medical services in Europe and America; and tightened visa restrictions in developed countries.

Emerging Medical Tourists

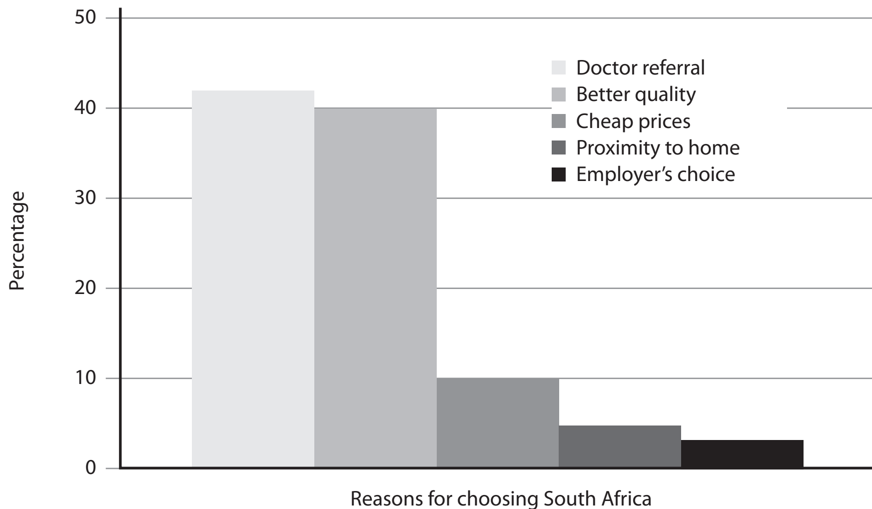
In recent years, there have been several high profile cases of African leaders and politicians going to South Africa for medical treatment, the most recent being President Robert Mugabe of Zimbabwe. Interestingly, when his spouse required treatment for a hip injury, the Mugabes headed for Singapore (at considerable government expense).[64] However, it is not only high-profile African political figures who travel to South Africa for treatment. Table 3 shows that in the period 2003-8, nearly 40,000 travellers flew from the rest of Africa to South Africa for medical reasons. These are predominantly members of the continent's growing middle-classes who can afford health insurance and the costs of travel to South Africa and feel ill-served by their own medical facilities.

Other than the numbers involved, there is very little information on long-distance South-South medical tourism to South Africa. Anecdotal evidence suggests that middle-class African medical tourists from East and West Africa go to South Africa to access medically necessary procedures such as reconstructive surgery and chemotherapy, rather than the elective cosmetic surgery that dominates North-South medical travel. The only systematic study conducted to date was of 320 African women receiving breast cancer treatment at the Netcare Breast Care Centre of Excellence at Milpark Hospital in Johannesburg.[65] The women in the study came from 15 African countries including 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). About 70% had their expenses covered by insurance which is notable since the insurance market in Africa is very small and "only the middle to upper class take up insurance cover."[66] The rest either paid their own way (25%) or were covered by employers (3%) and government (2%).

There was little evidence of medical facilitator companies playing an intermediary role. The two critical factors in this case were physicians in their home countries and social networks. For example, 45% of the patients were directly referred to Milpark by doctors in their home countries. Another 15% came to Milpark Hospital on the recommendation of

their doctors. The remainder (40%) had Milpark recommended to them by relatives or friends because local care was of poor quality or unavailable. Two-thirds of these patients had knowledge of another person who had been treated at Milpark. Forty percent cited the quality of care in South Africa (presumably compared with that at home) but only 10% said that cost was a factor in their decision to come to Milpark (Figure 4). In other words, cost does not appear to be a major issue driving middle-class Africans to travel to South Africa for treatment. On the other hand, fully 63% of the respondents said that they intended to take recuperative holidays in South Africa after treatment. Although the study does not appear to have enquired about what kind of holiday they would take, the finding suggests that for middle-class African medical travellers, tourism may be an important element of the overall package.

Figure 4: Reasons for Choosing South Africa



Source: Ahwireng-Obeng and van Loggerenberg, "Africa's Middle Class Women"

A recent phenomenon is the emergence of medical facilitators (such as Serokolo, Afrisurg, Afri-Care Health and South Link Consulting) targeting the African market. Some are run by immigrant physicians from other countries. South Link Consulting, for example, is owned by four Nigerians, a gynaecologist based in South Africa, a specialist doctor based in Nigeria, and a family physician and his wife (who is the Chief Executive Officer). The company has offices in Lagos and Pretoria. The medical tourism process for a South Link patient consists of ten steps (Figure 5).

Figure 5: Medical Tourism Process for South Link Consulting[67]
STEP 1: Completion of the Enquiry form
Clients complete an online form detailing the procedure they need and South Link personnel send an outline of the procedure, estimate costs, recuperation period and vacation options available. A medical history form is sent to the client and his or her personal physician at home.
STEP 2: Assignment of Clients to a Medical Practitioner
The medical history form is forwarded to a physician in South Africa and South Link is made aware of the agreed terms of consultation between the client and surgeon.
STEP 3: Approval of Medical Procedure
The physician informs South Link to proceed with arrangements, once the client agrees to the terms of the medical procedure. South Link contacts the client to discuss the tourism package and confirm the financial arrangements.
STEP 4: Finalisation of the Quotation
A final quotation and itinerary will be prepared and faxed to the client. Neither the surgeon nor patient are under any obligation to undergo the procedure at this stage.
STEP 5: Confirmation of the Booking, Payment and Communication
The client returns a completed booking form and pays a non-refundable deposit (to South African bank account). South Link sends a detailed itinerary including the medical procedure, medical appointments, and accommodation and vacation details to the patient. Nigerians would need these documents to apply for a visa to enter South Africa.
STEP 6: Client Arrival
South Link personnel meet the client at Johannesburg International Airport, assists them through immigration and airport procedures if needed, and transfers clients to their hotel. A personal assistant is provided for the duration of their stay, to ensure all needs are met eg cellphones.
STEP 7: Consultation and Physician payment
The client is driven to all medical consultations with the Physician. A full medical assessment is made, the procedure explained and the initial quotation confirmed. The client signs a consent form and deposits the balance payable to the physician or medical institution's bank account.
STEP 8: Medical Procedure
Clients are taken to the clinic on the day of the surgery, and admissions details taken care of.
STEP 9: The "Care-Bubble"
The client is driven to all follow up and post-operative consultations and takes advantage of the recuperative package which may include health spa treatment, safaris, and tours to Sun City.
STEP 10: Departure and Post-Operation Contact
South Link assist with the packing and freighting of any goods bought in South Africa, takes the client to the airport and keeps in touch with clients once they return home.

MEDICAL TRAVELLERS

Public health systems in countries neighbouring South Africa are in a state of crisis, under-resourced, understaffed and overburdened.[68] The problem is exacerbated by the ongoing exodus of doctors and nurses to South Africa and overseas.[69] Southern Africa is also the epicentre of the global HIV and AIDS pandemic, which has increased the burden of

disease on health systems by increasing the demand for treatment and palliative care, imposing heavier workloads on health care workers, reducing the workforce by infecting health care workers and imposing psychological stress on the health workers who have to administer palliative care, leading to low morale, burn-out and absenteeism.[70] The countries neighbouring South Africa have much lower ratios of health-care workers to patients than South Africa or the recommended World Health Organisation (WHO) minimum (Table 11).

Table 11: Number of Health Care Workers

Country	Number of doctors per 100,000 inhabitants	Number of nurses per 100,000 inhabitants	Number of health providers per 100,000 inhabitants
Lesotho	5	63	68
Malawi	2	56	58
Mozambique	3	20	34
South Africa	74	393	468
USA	247	901	1,147
UK	222	1,170	1,552
WHO minimum standard	20	100	228

Source: Médecins Sans Frontières, "Help Wanted", p. 3

A recent analysis of private health care systems in Southern Africa suggests that although private care is touted as the answer to the regional health care crisis, little has happened in practice:

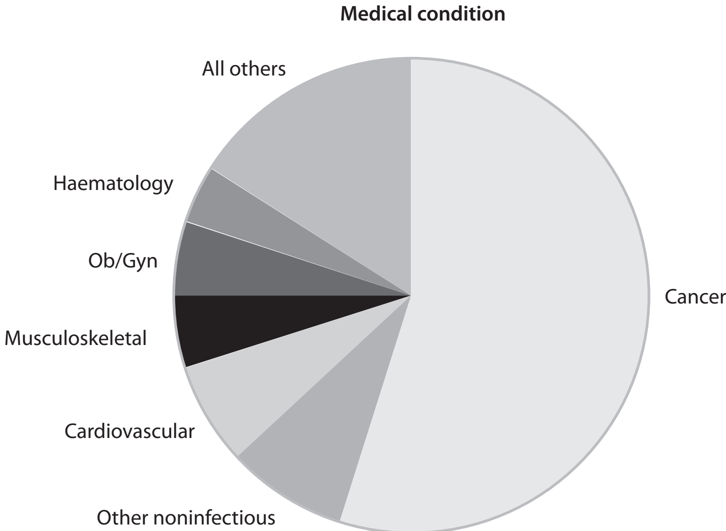
> Capital flows in the health sector in the region are relatively small, the private-for-profit health sector — where it exists — caters for a small portion of the population (typically in urban areas), and there is little evidence that the private-for-profit health sector has an interest in expanding into areas where access to health care is poor. In the absence of large private-for-profit capital flows into the health sector, and in the environment of decreased government spending on health, a huge gap exists between the services needed and the services provided, especially in poor rural areas.[71]

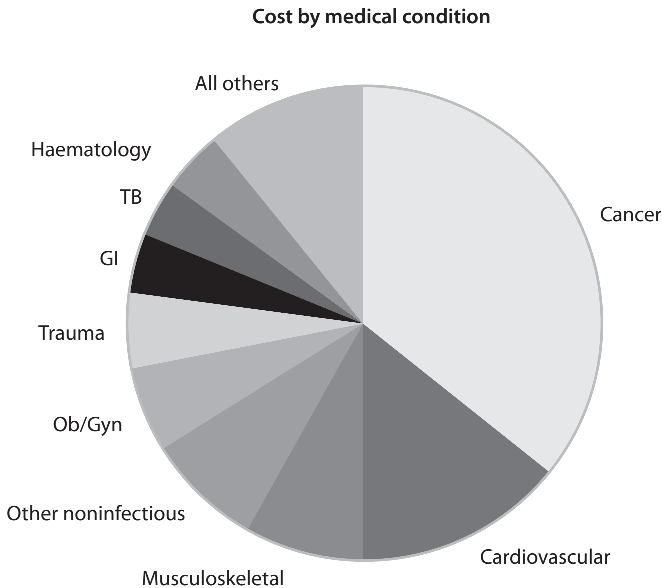
A possible harbinger of things to come in the SADC health sector are private-public partnerships (PPPs). In Lesotho, for example, the World Bank's IFC successfully promoted a private-public healthcare reform strategy for Lesotho.[72] A new PPP-financed hospital has recently been built in Maseru at an estimated capital cost of USD155 million and financing from the Lesotho Government, Development Bank of

Southern Africa (DBSA) and the World Bank. The hospital is operated by Tšepong, a PPP consortium. Tšepong comprises South African health-care group Netcare (a 40% share); a group of Basotho physicians called Excel Health (20%); a group of South African physicians called Afri'nnai (20%); D10 Investments which is the investment arm of the Lesotho Chamber of Commerce (10%); and Women's Investment Corporation, a Basotho investment company (10%).[73] The new Queen 'Mamohato Memorial Hospital opened in October 2011 and was immediately swamped by patients. It remains to be seen what kind of impact it will have on health access in Lesotho, medical travel to South Africa (as well as what kinds of profits the private partners will shift out of Lesotho).

The general lack of access to medical diagnosis and treatment in SADC has led to a growing temporary formal and informal movement of people across borders to seek help at South African institutions in border towns and major cities. In some cases, patients go to South Africa for procedures that are not offered in their own countries. For example, because South Africa has legalised abortion, women from neighbouring countries tend to go there rather than run the risks of illegal backyard abortions at home.[74] A 2002 study of patient referrals from Lesotho examined 1,048 documented referrals to hospitals in Bloemfontein.[75] The study found that by far the largest number of referrals were for cancer treatment (55% of cases and 36% of the cost to Lesotho). Referrals were also made for a wide range of other conditions requiring specialist treatment including cardiovascular disease (7% of patients and 14% of costs), musculoskeletal conditions (5% of patients and 8% of costs), non-infectious disease such as kidney and thyroid problems (8% of referrals and 8% of costs) and gynaecological conditions (5% of patients and 6% of costs).

Figure 6: Basotho Patients Referred to South Africa, 2002





Sudden health crises in source countries can also precipitate mass movements of patients across borders. The most notable recent example was in 2008 when a breakdown in Zimbabwe's water treatment system combined with the virtual collapse of the country's public health system caused one of the worst cholera outbreaks in Southern Africa.[76] Zimbabwean hospitals turned away desperate patients because there were simply no drugs. People who could make the trip travelled to neighbouring countries including South Africa, in order to seek treatment. Although initially turned away from public hospitals, trans-border cholera outbreaks in South Africa caused public health concerns. Consequently, the Minister of Health announced that South Africa would provide free treatment to all Zimbabweans with symptoms, even if they had travelled to South Africa in order to receive treatment. Some were simply given medication whilst others were hospitalized and given IVs.

A key driver of the expansion of medical travel to South Africa has been the HIV and AIDS pandemic. Swaziland, Botswana and Lesotho have the highest HIV prevalence in the world (at around a quarter of the adult population). The absolute number of People Living With HIV (PLHIV) is highest in Mozambique (nearly 1.5 million) followed by Zimbabwe, Zambia and Malawi (Table 12). The symptoms of HIV infection (such as rapid weight loss, coughing, fever, swollen glands, muscle ache, joint pain, chest infection, diarrhea, and various neurological disorders) are all likely to prompt those affected to seek treatment even without a diagnosis of HIV. As the disease progresses, the patient becomes ever-more susceptible to opportunistic infection such as pneumonia,

toxoplasmosis, bacterial and yeast infection, fever, anemia, and cancers like lymphoma and Kaposi's sarcoma. Perhaps the most common opportunistic infection is tuberculosis (TB).[77] The incidence of TB infection has grown dramatically in the countries of Southern Africa in the last two decades. The number of new cases of TB in eight SADC countries increased from 115,000 in 1995 to over 190,000 in both 2005 and 2010 (Table 13). In most countries, TB patients are now routinely tested for HIV. The number of HIV positive TB patients is large and growing. HIV prevalence in new TB cases is over 50% in the eight countries (Figure 7). HIV, opportunistic disease and the management of ART have greatly increased the burden on overstretched public health systems throughout Southern Africa.[78] They have also led to growing numbers of ill people crossing borders to seek diagnosis, drugs and ART in South Africa.

Table 12: Prevalence of HIV and ART, 2010

	No. of People Living With HIV (PLHIV)	Adult HIV Prevalence (%)	No. on ART	% ART Coverage
Botswana	320,000	24.8	145,190	45.4
Lesotho	290,000	23.6	61,736	21.3
Malawi	920,000	11.0	198,846	21.6
Mozambique	1,400,000	11.5	170,198	12.1
Namibia	180,000	13.1	70,498	39.2
Swaziland	110,000	25.9	47,241	42.9
Zambia	980,000	14.3	283,863	29.0
Zimbabwe	1,200,000	13.8	218,589	18.2
South Africa	5,600,000	13.6	971,556	17.3

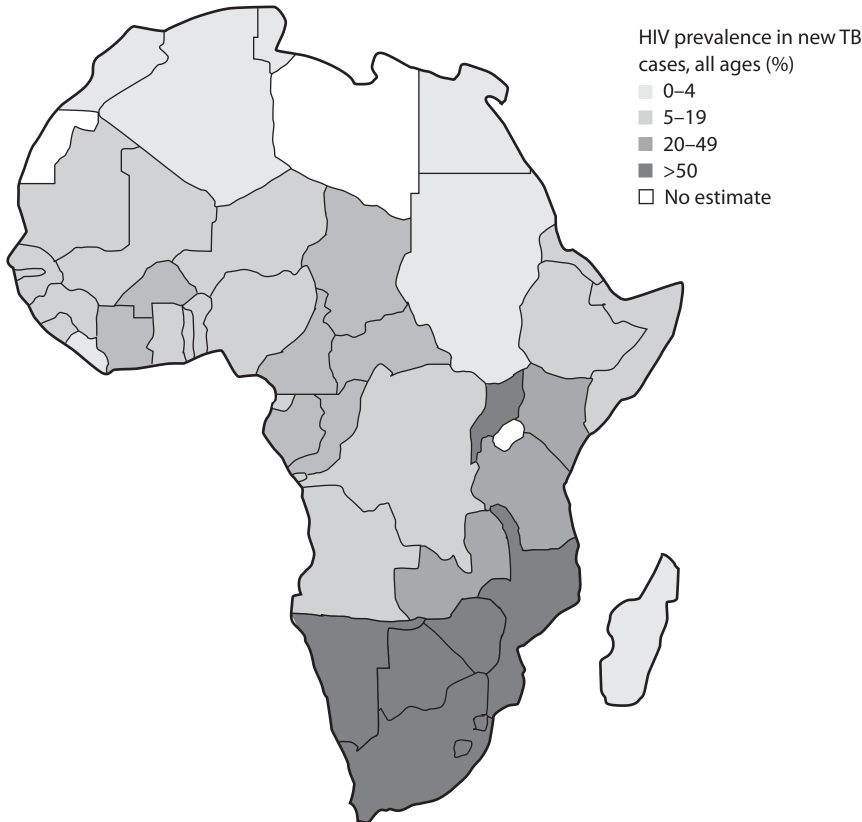
Source: UNAIDS, Global Report: UNAIDS Report on the Global AIDS Pandemic (Geneva, 2010), pp. 110-11, 181, 250, 252.

Table 13: Number of New TB Cases Reported

	1995	2000	2005	2010
Botswana	2,938	9,292	10,058	7,013
Lesotho	5,181	9,746	10,802	11,674
Malawi	19,155	23,604	25,491	21,092
Mozambique	17,882	21,158	33,231	43,558
Namibia	1,540	10,799	14,920	11,281
Swaziland	2,050	5,877	8,062	10,101
Zambia	35,958	49,806	49,576	44,154
Zimbabwe	30,831	50,855	50,454	44,209
Total	115,535	181,137	202,594	193,082

Source: WHO, Global Tuberculosis Control (Geneva, 2011), pp.131-2.

Figure 7: HIV and TB Co-Infection



Source: WHO, Global Tuberculosis Control (Geneva, 2010), p. 6

In the six years between 2003 and 2008, a total of nearly 34 million visitors crossed into South Africa from its neighbours (Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe) (Table 14). Of these 1.9 million came for medical treatment (an average of nearly 320,000 people a year). Lesotho was easily the most important source of medical travellers (averaging 142,000 per year), followed by Botswana (56,000), Swaziland (47,000), Mozambique (38,000), Zimbabwe (17,000) and Namibia (11,000). The numbers from Malawi and Zambia were much smaller (less than 3,000 a year). However, the numbers coming from every country have increased virtually every year, although they may start to decline as ART becomes more widely accessible. ART coverage currently varies considerably from country to country (from a low of 12% in Mozambique in 2010 to a high of 45% in Botswana). Although not all cross-border medical travel is HIV-related, it is interesting to compare the situation of Botswana and Mozambique. Almost half of HIV positive people in Botswana are now on ART. The

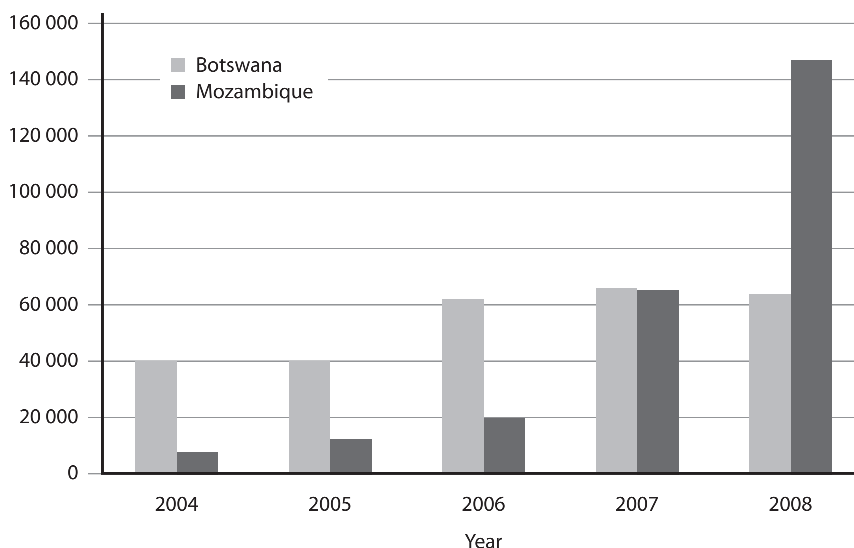
prevalence of TB has stabilised with more extensive concurrent treatment of TB. And the number of medical travellers from Botswana to South Africa has remained relatively consistent since 2003. Mozambique presents a very different scenario. Prevalence of both HIV and TB (and co-infection) are growing rapidly. ART is only available to around 1 in 10 PLHIV. The number of medical travellers from Mozambique to South Africa continues to grow (from 8,000 in 2003 to 147,000 in 2008).

Table 14: Medical Travel to South Africa

	Total Visitors	Medical Travellers	Annual Average (Est)
Botswana	4,776,000	334,320	55,700
Mozambique	4,603,000	230,150	38,400
Zimbabwe	5,061,000	101,220	16,900
Lesotho	10,660,000	852,800	142,100
Swaziland	5,678,000	283,900	47,300
Malawi	719,000	14,380	2,400
Zambia	898,000	18,000	3,000
Namibia	1,328,000	66,400	11,100
Total	33,723,000	1,901,170	316,900

Source: South African Tourism Country Reports

Figure 8: Medical Travel to South Africa from Botswana and Mozambique



Source: South African Tourism Country Reports

MANAGING MEDICAL TRAVEL

The South African Department of Home Affairs has instructed hospitals not to treat people from other countries without proper identification. Many Zimbabweans living in South Africa's major cities have found themselves excluded from accessing timely medical care in the public health system on the grounds of their "foreignness."[79] However, hospitals and clinics in smaller centres and border towns take the position that their duty is to treat anyone who requires it, irrespective of their immigration status in the country. Medical travellers from countries such as Botswana, Lesotho and Swaziland also speak South African languages and can therefore access healthcare without too many questions being asked.

The high demand and large informal flow of patients from countries neighbouring South Africa has prompted the South African government to try and formalize arrangements for medical travel to its public hospitals and clinics through inter-country agreements. The 1999 SADC Health Protocol has amongst its objectives "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."[80] South Africa has entered into bilateral health agreements with eighteen countries in Sub-Saharan Africa (Table 15).[81] Bilateral agreements can be seen as an effort to formalise these movements and obtain payment for the cost of treating non-residents who cannot afford to pay for expensive, specialised medical treatments in South Africa.

The bilateral health agreements are significant because non-resident foreigners are normally charged for the full costs at the maximum treatment rate, and are required to pay the entire bill upfront. Under some of these agreements, patients 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.[82] Any pre-payments are assessed according to the same user fee schedule as South Africans. According to the Department of Health, the all-inclusive, fully subsidized rate for all treatments is currently R39 or $6 for an outpatient or R194 ($28) for up to 30 days admission in a public hospital. The respective governments are then billed for the full costs of treatment and hospitalisation, as well as patient travel and accommodation expenses.[83] The governments are sent one medical bill for all citizens treated over a specific time period.

Governments in neighbouring countries also arrange the transfer of

patients from their own hospitals to private South African hospitals for complex procedures. In Botswana, for example, the Ministry of Health pays private South African hospitals around R100 million a year to treat patients from that country. In March 2011, however, Botswana accused the hospitals of padding bills and charging for unnecessary procedures and medications. Although the hospitals have refuted such claims, Botswana initiated an investigation of private-clinic bills. In response, South African clinicians have been highly critical of Botswana. One retorted that it takes up to 18 months to get paid by the government and that patients arrive in "extreme conditions of neglect" and with minimal documentation about their treatment regime in Botswana.[84]

This conflict pales in comparison with the scandal-plagued Phalala Medical Referral Fund in Swaziland. The Fund was established in 2001 by government to pay for the treatment of Swazi patients at South African hospitals. In 2005, a Commission of Enquiry found that the fund had disbursed R80 million in four years and had another R15 million in outstanding bills. The Commission noted that the fund had never been audited and recommended tighter regulation. One of the problems that emerged, and continued thereafter, was overcharging by South African physicians and hospitals.[85] The Swaziland Minister of Health recently claimed that inflated invoices were commonplace and that the Fund had even received and paid invoices for gynaecological treatment for male patients and in one case an amount of R8million to a South African doctor for bandaging a Swazi patient.[86] According to the Minister, South African doctors and hospitals regarded the fund as a "blank cheque."[87] The fund was further depleted by corruption in Swaziland. Phalala funds were misappropriated when people would fake illnesses and be referred to non-existent South African private clinics. Government reportedly paid fake bills for hundreds of patients and the money was used to build a lodge in South Africa.[88] In early 2010, Phalala lost another R1 million when Standard Bank employees, including a Bank Manager, colluded with a local businessman to cash fake cheques and draw money from the Fund's account.[89] By early 2011, the Phalala Fund was virtually broke. In January, hundreds of Swazi patients were denied chemotherapy in South Africa because of unpaid medical bills for previous patients. Around 300 cancer patients already on chemotherapy were reportedly "blacklisted" by hospitals and sent back to Swaziland.[90] In mid-2011, the government settled R17 million worth of outstanding bills and 500 patients resumed their treatment in South Africa.[91] The management of the Fund has since been overhauled and an arrangement concluded with only one Pretoria hospital.[92]

Table 15: Sample Bilateral Health Agreements		
Country	Name of Agreement	Details
Swaziland	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	Swazi citizens may be referred to 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.
Malawi	Agreement between the Republic of South Africa and the Government of the Republic of Malawi in the Field of Health Effective: 12 February 2009	Malawians may be admitted to South African public hospitals at subsidized fees (pay the same price that South Africans pay). Will continue to provide specialised medical treatment not available in Malawi.
Burundi	Agreement between the Government of the Republic of South Africa and the Government of the Republic of Burundi on Cooperation in the Field of Health Matters. Effective: 16 September 2008	Provision for the referral of Burundians to South African public hospitals for medical treatment. Under consideration: request for Burundians to access public sector treatment at the same price that South Africans pay.
Lesotho	Declaration of Intent on Cooperation in the field of Health. Memorandum of Understanding on Co-operation in the Field of Health. Effective: 3 May 2002	Facilitate cross border transfer of patients from Lesotho to South Africa for specialised medical treatment not available in Lesotho.
Mozambique	Agreement on Health Matters Effective: 8 December 2005	Agreement formalising the treatment of Mozambicans in public health facilities in South Africa (particularly border areas) and the implementation of a coordinated patient referral system. Mozambique will be billed for citizens treated in South Africa
Source: Department of Co-operation and International Affairs South Africa		

Conclusion

South Africa has become a significant medical tourism destination since the collapse of apartheid in 1994. Medical tourism is often associated with elective cosmetic surgery and the South African private health sector markets the country as the ideal destination for scalpel safaris. The majority of these medical tourists come from the UK, Germany and the USA. 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 the body sculpting message. Important as this form of elective medical travel is, this paper has demonstrated that medical tourism is much more complex and varied than this image suggests. A growing proportion of the North-South medical tourism to South Africa is for non-elective procedures as patients seek treatment that is unavailable or they have to wait inordinate periods for at home. The result is that more patients in the North who require diagnosis, procedures and surgery are turning South in desperation.

The term "medical tourism" seems inappropriate to describe the other form of non-elective medical travel described here. This is 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 elites and middle-classes as a place where high quality private care is available for non-elective treatments such as surgery after accidents, heart surgery and cancer treatment. However, the greatest growth in medical migration to South Africa in recent years is from neighbouring countries whose public health care 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. Intra-African health travel is a form of South-South medical migration that can also be seen increasingly in Asia and the Middle East. However, very little is known about the drivers and impacts of this form of medically-inspired movement.

In order to better understand the dimensions and impact of medical migration, SAMP has embarked on a major project to study the phenomenon. This overview paper has investigated the current "state of knowledge" from secondary sources and grey literature and identified research gaps that need to be addressed. These include the following:

- *Drivers of Cross-Border Medical Migration*. Medical migration within Southern Africa has increased dramatically over the last decade. The reasons for the growth of this phenomenon need much further investigation. Possible "push" factors driving this movement include the crisis of public health care systems in most SADC countries; lack of access of patients to diagnosis,

drugs and care; inequitable distribution of health care resources that disadvantage rural populations; the growth in the burden of disease and care accompanying the HIV and TB pandemics; lack of access to ART for PLHIV; and the comparative costs of treatment at home versus in South Africa. Possible "pull" factors include South Africa's better-resourced and staffed public health system; the existence of world-class medical facilities in the private system for those who can afford to pay; easier access to diagnosis, treatment and care; and greater ART coverage and accessibility. There is evidence that South Africa's own public healthcare system is in a state of crisis too, but these problems clearly pale in comparison to those in neighbouring countries.

- *Health Seeking Behaviour by Medical Migrants*. Beyond aggregate statistical information on the numbers involved, their length of stay in South Africa and their expenditure patterns, little is known about the medical reasons why residents of neighbouring countries seek treatment and care in South Africa and the ways in which they seek to access medical treatment in South Africa. What kinds of medical conditions prompt people to cross borders for treatment? Have HIV and AIDS and TB played a role in inducing more people to cross borders and, if so, what do they hope to achieve by going to South Africa? What role does the quest for maternal and child health play in prompting migration? Do people cross borders in order to access ART and how is their treatment regime affected by the fact that they have to travel regularly to access the drugs? Do medical migrants tend to go to hospitals and clinics in border towns or do they go to the larger centres? How do they decide which clinics and hospitals to attend and how do they actually get to these centres? What kinds of follow-up do they receive and, in particular, do they continue on prescribed drug regimens after leaving South Africa? This could be a crucial issue in the context of the emergence of drug-resistant strains of TB and other conditions. These are all key questions about which very little is currently known.
- *Treatment of Medical Migrants in South Africa*. There is considerable evidence that migrants living in South Africa are regularly denied their constitutional right to medical treatment and care by personnel at hospitals and clinics. Studies of Zimbabweans and refugees in South Africa have clearly demonstrated the difficulties faced in getting medical attention from the public health system.[93] Clearly, given the scale of the movement involved, medical migrants are somehow able to access treatment or they would not come. The fundamental question, then, is whether the barriers to

access and human rights violations experienced by foreign residents are also experienced by medical migrants and what strategies they adopt to try and overcome these barriers. Are patients denied access to clinics and hospitals on the grounds of origin, citizenship and language? How are they treated by South African health workers and physicians? Do they receive the same kinds of care as South African patients? What kinds of payments are they asked to make for treatment? What happens to them if admission is considered medically advisable? Are they admitted and under what conditions or are they sent home?

- *Policy Responses to SADC Medical Migration.* The 1999 SADC Health Protocol has amongst its objectives "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."[94] In recent years, the high demand and large informal flow of patients from countries neighbouring South Africa has prompted governments to try and formalize arrangements for medical travel to its public hospitals and clinics through inter-country agreements. South Africa has entered into twenty bilateral health agreements with eighteen countries in Sub-Saharan Africa.[95] Bilateral agreements can be seen as an effort to formalise these movements and obtain payment for the cost of treating non-residents who cannot afford to pay for expensive, specialised medical treatments in South Africa. Recent press reports from Botswana and Swaziland suggest that these agreements are not functioning well, to the detriment of patient care. A critical analysis is needed of the functioning of the bilateral agreements and the extent to which they facilitate or obstruct the rights of patients.

Appendix:
List of South African based Medical Tourism Facilitators

1. Serokolo
http://www.serokolo.co.za

2. Surgeon and Safari
http://www.surgeon-and-safari.co.za

3. Cape Health Destination
http://www.capehealth.co.za/home.html?page=2

4. Nu Look Surgery
http://www.nulooksurgery.com

5. Afrisurg
http://www.afrisurg.com

6. Surgical Bliss
http://www.surgicalbliss.com

7. Afri-Care Health
http://www.africarehealth.co.za

8. Surgical Attractions
http://www.surgicalattractions.com

9. Dental Retreat SA
http://www.dentalretreat-sa.com

10. Dental Safaris
http://www.dentalsafaris.com

11. Medi-Travel International (subsidiary of Mediclinic)
http://www.meditravel.co.za/tourism.htm

12. South Link Consulting
http://www.southlink.co.za

13. ETI Health and Leisure
http://ehlcc.com/ehlcc/

14. Fertility Care SA
http://www.fertilitycaresa.com

15. Surgeon Assist
http://www.surgeonassist.co.za

16. IVF Safari
http://www.ivf-safari.com/Default.aspx

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