IDENTIFYING THE PUSH AND PULL FACTORS OF A MEDICAL TOURISM DESTINATION

by

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ABSTRACT

Some tourists travel for medical reasons, and this is known as medical tourism. The growth of medical tourism is mainly spurred by globalisation and the availability of quality healthcare services in receiving countries. Once a medical need arises, a prospective medical tourist would usually search and gather information about prospective medical tourism destinations. Various push and pull factors would determine whether a destination will be selected by tourists to satisfy their medical needs. The aim of this study was thus to identify the push and pull factors of a medical tourism destination, and based on these, to measure South Africa’s performance as a medical tourism destination.

Making use of a qualitative research approach, semi-structured interviews were conducted with 13 medical tourism tour operators. Content analysis was used to analyse the data. Some of the push factors identified were the cost and lack of treatment/medical services in medical tourists’ home countries, the availability of expertise and medical facilities at the receiving destination, and the wish to avoid long waiting lists. The quality of hospitals, cost of surgery, expertise of the physicians, as well as the accessibility of destinations were indicated as the pull factors. The findings also show that medical tourists seem to be more interested in the reputation of the healthcare providers and hospitals than in typical tourist activities in medical tourism destinations. The findings of this study highlight the fact that South Africa is not known as a medical tourism destination. Hence there is a need for South Africa to be promoted by government and other stakeholders as a credible, affordable and accessible medical tourism destination. The study contributes to the available literature on medical tourism but from the perspective of medical tourism tour operators as major stakeholders in the medical tourism industry.

Keywords: Medical tourism; medical tourist; medical tourism push factors; medical tourism pull factors; medical tourism tour operators.
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DEFINITION OF KEY TERMS

**Destination**: “a place … to which someone is going” (Collin, 2005:90); OR where “tourists want to spend their time away from home” (Jafari, 2000:179)

**Health tourism**: “the attempt on the part of a tourist facility or destination to attract tourists by deliberately promoting its’ healthcare services and facilities in addition to its regular tourist amenities” (Goodrich in Boekstein & Spencer, 2013:290)

**Medical procedures**: treatments and/or surgeries performed on patients with the purpose of satisfying their health-related needs or health problems (include preventative medical services; minor surgeries, major invasive surgeries; wellness, therapeutic and rehabilitation treatments; and gender transformations (Wongkit & McKercher, 2013)

**Medical tourism**: involves people who live in one country, who travel to another or within their own country’s hospitals and clinics for medical treatments (usually motivated by affordability and access to higher level of care) in different areas of Western medicine such as cardiology, gynaecology, neurology, ophthalmology, oncology, orthopaedic, transplants, preventive medicine, artificial insemination, and complex diagnostic tests (MTA, 2019)

**Medical tourism destinations**: receiving destinations where patients go to access medical procedures/treatments

**Medical tourism intermediaries**: medical tourism companies (e.g. medical tourism facilitators, medical travel agencies, medical travel associations, medical tourism tour operators and medical tour brokers) which serve as a link between the specialists of various fields in medical tourism, and they connect these fields with the consumers/medical tourists (Ko, 2011)
Medical tourism pull factors: relate to the healthcare or medical services providers factors and the physical (tourism) external attributes in the medical tourism destinations (Adwan, 2020; John & Larke, 2016)

Medical tourism push factors: mainly related to the medical tourists’ individual characteristics and their healthcare needs, which cannot be fulfilled in their home countries, and then leads to the demand for medical tourism (Adwan, 2020; Allen in Ile & Tigu, 2017)

Medical tourist: a person who travels to the receiving country or location to receive medical and tourism services (Ahmadi, Hosseini & Jafari, 2017)

Pull factors: the “destination’s attributes or characteristics that will motivate potential travellers to visit a specific destination, such as the natural or man-made/built attractions; site attractions; event attractions” (Medlik, 2003: 168)

Push factors: “the tourists’ motivations to travel OR the needs that they have which they feel will be fulfilled through a certain kind of travel” (Lubbe, 2003:34), and these can be at an “individual or social level, or a combination of both” (Jafari, 2000:512)

Tourist: someone making a trip for vacation, holiday, business, pilgrimage, conference, visiting relatives, study, and health purposes (Jafari, 2000)

Tourist attractions: the “elements of the tourist product which attract visitors and determine the choice to visit one place rather than another” (Medlik, 2003:168)

Tour operator: “a travel agency which organises and sells package holidays or tours” (Collin, 2005: 318). They are involved in the “planning, preparing, marketing, reserving, and also the operation of the package tours” (Jafari, 2000:620)

Travel agency: company that facilitates the sale of “tours, holiday, transportation tickets, and other related products such as accommodation, car rentals, attraction tickets, and insurance to the public. The suppliers of the products sold may include “tour operators”, and others (Jafari, 2000:636)
**Wellness tourism**: travel for the pursuit of enhancing physical and mental well-being, and includes holistic and traditional medicine and therapies like Ayurveda, yoga, thermal-baths, homeopathy and acupuncture (Goodrich in Boekstein & Spencer, 2013:290; UNCTAD, 2017:72)
LIST OF ABBREVIATIONS

Listed in the table below are the descriptions of the abbreviations used throughout this document:

Table 0.1: Abbreviations used in this document

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BBL</td>
<td>Brazilian Butt Lift</td>
</tr>
<tr>
<td>BRICS</td>
<td>Brazil, Russia, India, China and South Africa</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and communication technologies</td>
</tr>
<tr>
<td>IHRC</td>
<td>International Healthcare Resource Centre</td>
</tr>
<tr>
<td>IVF</td>
<td>In vitro fertilisation</td>
</tr>
<tr>
<td>JCI</td>
<td>Joint Commission International</td>
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<tr>
<td>MTA</td>
<td>Medical Tourism Association</td>
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<tr>
<td>MTI</td>
<td>Medical Tourism Index</td>
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<td>MTSA</td>
<td>Medical Tourism South Africa</td>
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<tr>
<td>PWC</td>
<td>PricewaterhouseCoopers</td>
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<tr>
<td>SAT</td>
<td>South African Tourism</td>
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<td>StatsSA</td>
<td>Statistics South Africa</td>
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<tr>
<td>UNCTAD</td>
<td>United Nations Conference on Trade and Development</td>
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CHAPTER ONE
INTRODUCTION TO THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

According to the Collin (2005:90), a destination is “a place … to which someone is going”. As a place a destination can be regarded as a geographical area (e.g. countries, regions, cities, towns and other areas), where the main focus is on attributes such as the facilities, attractions and the services that are designed to satisfy the needs of tourists. These attributes are known as the pull factors. According to Dann (1981:191), pull factors “respond to and reinforce push factor motivation”, thus they attract tourists to travel to a specific destination, and play a role in the tourist’s selection of a destination. Pull factors determine when, where and how people travel to tourism destinations (Mill & Morrison in Cohen, Prayag & Moital, 2014; Uysal, Li & Sirakaya-Turk, 2008; Wong, Musa & Taha, 2017). Potential tourists are pushed by their internal desires and emotions, “feelings, beliefs and opinions” about the destination’s ability to provide satisfaction to their holidaying needs (Hu & Ritchie, 1993: 25). Push factors represent the reasons for and the direction of travel behaviour, and thus are used to describe the desires of typical tourists to travel, e.g. a desire to travel for escape, relaxation, and health and wellness. Push factors therefore play a major role as to whether a tourist will go on a trip or not. A tourist’s decision to visit a particular destination thus depends on its perceived appeal that motivates, attracts and pulls the tourists towards the destination. Different push and pull factors play a role in travel, and the presence of various attributes in different destinations influences the tourists’ choice of one destination over the others.

As much as there can be many attributes associated with a specific destination, these (attributes) may not necessarily have the same or equal influence on tourists’ perceptions in finding the destination that appeals to their emotions. It is therefore important for destination marketers and related stakeholders to identify the relative importance of various attributes in the destinations (as pull factors), in relation to various tourism products on offer or available in the destinations, so that when they promote destinations, emphasis is placed on the appealing effect of these attributes.
Potential tourists are likely to consider various pull factors at the same time, as long as these respond well with the push factors that they are currently experiencing. According to Klenosky (2002), it is also possible for any destination’s pull factor/s to be driven by one or more push factors, and simultaneously, a traveller may use different push reasons in balancing the same pull force. Even though much of the literature available on push and pull factors focuses on leisure tourism, it is well-known that tourists travel not only for leisure purposes, but also at times for medical reasons. As a result, the push and pull factors that attract them to a medical tourism destination will differ from the push and pull factors that draw them to a leisure destination.

Medical tourism as a tourism niche generally refers to the process whereby tourists travel across international borders to access medical care and treatment, financed mainly from their own resources and normally without any formal referral from their home-country healthcare system (Johnston, Crooks & Snyder, 2012). It should, however, be noted that medical tourism is not limited to travel across international borders. Patients are also able to travel within their own country to access medical treatments at a location other than that in their vicinity; this is known as intra-national or domestic medical tourism (Constantinides, 2017; IMTJ in Hudson & Li, 2012). Globally, the medical tourism industry has shown a steady growth in recent times with more people looking for the best treatment at competitive prices in destinations of their choice.

The need for health and well-being creates internal desires in patients that encourage them to search and find ways to satisfy their underlying need to be healthy. These internal desires created are referred to as push factors and explain the demand for medical tourism. If a way to satisfy their health needs cannot be found in their home countries or in their immediate location, then the patients will be forced or motivated to travel elsewhere for treatment. Hence push factors push patients away from the healthcare system in their most immediate or local environment as they have a pre-travel expectation that the chosen destination will offer a better alternative than the local healthcare system. Typical medical tourism push factors are the following:

i. High cost of medical treatment in home countries, especially in developed countries (Manaf, Hussin, Kassim, Alavi, Dahari, 2015a; Aydin & Karamehmet, 2017; Park, Ahn & Yoo, 2017);
ii. Unavailability of certain procedures/treatments (Drinkert & Singh, 2017; Zolfagharian, Rajamma, Naderi, & Torkzadeh, 2018);

iii. The desire to avoid long waiting lists at home (Manaf et al., 2015a; Connell, 2013; Johnston et al., 2012; Zolfagharian et al., 2018);

iv. Unaffordable or insufficient health insurance (Crooks, Kingsbury, Snyder & Johnston, 2010; Zolfagharian et al., 2018);

v. Ease of travel due to the availability/affordability of international airlines (Aydin & Karamehmet, 2017; Carrera & Bridges, 2006; Zolfagharian et al., 2018);

vi. Availability of travel intermediaries (Zolfagharian et al., 2018);

vii. Need for privacy and confidentiality when receiving treatment (Zolfagharian et al., 2018); and

viii. The possibility of combining medical treatment with a vacation (Gupta & Das, 2012; Kara, 2016).

On the other hand, the attributes at the destination play a role as pull forces to the destination. These shape the medical tourists’ decision-making processes and help them to evaluate potential destinations based on what they offer in terms of their (patients’) needs. Pull factors attract or draw medical tourists to medical tourism destinations. Typical pull factors include the following:

i. Overall physical environment (including tourists’ attractions) and the desirability of the receiving destination (Collins, Medhekar, Wong & Cobanoglu, 2019; Fetscherin & Stephano, 2016; Zolfagharian et al., 2018);

ii. Perceived high quality and accreditation of health services and facilities at the receiving destination (Chaulagain, Pizam & Wang, 2020; Collins et al., 2019; Drinkert & Singh, 2017; Rahman, 2019);

iii. Perceived expertise and reputation of medical professionals at the receiving destination (Kim, Arcodia & Kim, 2019; Wongkit & McKerchner, 2016; Rahman, 2019);

iv. Affordable medical costs at the receiving destination (Aydin & Karamehmet, 2017; Collins et al., 2019; Fisher & Sood, 2014; Park et al., 2017);

v. Prospect of shorter or no waiting period at the receiving destination (Fisher & Sood, 2014; Park et al., 2017; Wongkit & McKerchner, 2016);
vi. Impact of globalisation that has resulted in advance of technologies (Lang, 2019; Ormond & Kaspar, 2018; Tiren-Verbeet, Cetin, Alp & Doganay, 2018; Xu, Wang & Du, 2020);

vii. Ease of global travel (Aydin & Karamemhet, 2017; Xu et al., 2020);

viii. Rapid advancement in medical technologies (Chaulagain et al., 2020; Xu et al., 2020); and

ix. Interpersonal behaviour and cultural and/or familiar similarities, e.g. language and religion (Collins et al., 2019; Kim et al., 2019; Rahman, 2019; Soltani, Ghorbanian & Tham, 2020).

The relative importance of these push and pull factors may vary depending on the treatment the medical tourist is looking for and/or where they reside. According to John and Larke (2016), patients may be pushed by the nature or the type of treatment that they need at the time. For instance, where patients are in need of life-saving treatment (e.g. cancer treatment) which they cannot access at home for various factors, e.g. unavailability of the treatment or the fact that they have to wait for some time before being treated, their need for survival (push) would be more pronounced than their need to see tourism attributes (pull) at the receiving destination. In contrast, where patients are in need of less invasive treatment, e.g. dental treatment, their need to see tourism attributes at the receiving destination might be more pronounced.

Push and pull factors are also influenced by where medical tourists reside, i.e. whether they are from developed (also known as the North-South) or developing countries (also known as the South-South or cross-border). According to Khan, Chelliah, Haron and Ahmed (2017), and Abd Mutalib, Soh, Wong, Yee, Yang, Murugia and Ming (2017), medical tourists from developed countries are exposed to good quality medical facilities which offer various medical treatments and procedures. Furthermore, the cost of medical treatment in developed countries is exorbitant (Aydin & Karamemhet, 2017), and these patients generally pay out of their own pockets for medical treatments and procedures. Although patients from the developed countries may have the desire to save on costs through medical tourism, this is not the only motivating factor. According to Aydin and Karamemhet (2017), the restrictive conditions that may exist in their home countries, e.g. unavailability of procedures/treatments, or required procedures deemed illegal, the potential to receive quality treatment at the receiving
Destination plays a role in motivating patients to seek medical treatment at medical tourism destinations. Other possible motivations for these patients may be associated with their health insurance issues, such as being uninsured or underinsured (Collins et al., 2019), their desire to avoid long waiting lists before accessing treatment (Adams, Snyder, Crooks & Johnston, 2015), and their need for privacy and confidentiality when receiving medical treatment at the receiving destination (Drinkert & Singh, 2017; Zolfagharian et al., 2018). In contrast, medical tourists from developing countries usually participate in medical tourism because of the lack of, or poor healthcare systems in their own countries (Khan et al., 2017). For these patients, the cost of medical care in the receiving country is usually immaterial; their main concern is to receive medical treatment.

Both push and pull factors as the main motivators of travel behaviour and have the potential to influence the travellers’ perceptions of destinations. However, it should be noted that the internal desires (push factors) usually tend to precede the pulling effects that a destination may have on a potential tourist (Dann, 1977). This study highlights the medical tourists’ motivations (push) to travel to a specific medical tourism destination and also identifies the factors about a destination that make it more desirable than others to the medical tourist, i.e. the pull-factors.

1.2 PROBLEM STATEMENT

The use of the push-pull theory to explain travel motivation was initially proposed by Dann in 1977. Dann (1977) argued that the main reason why people travel is that they have desires or needs to satisfy, and their choice of destination is influenced by the prospect that the destination will be able to satisfy those needs. After Dann many authors have used the push-pull theory, but in different contexts (Guha, 2009; Hu & Ritchie, 1993; Lee & Chen, 2017; Lewis & D’Alessandro, 2019). Most studies that have used the push-pull theory have focused on leisure tourism, but tourists also travel for medical reasons. Some authors have looked at the role played by motivation or push factors in medical tourism, for instance, Adams et al. (2015), Aydin and Karamehmet (2017), Fisher and Sood (2014), Khan et al. (2017) and Österle, Johnson and Delgado (2013).
Various studies investigated medical tourism from a pull-factor perspective, e.g. Collins et al. (2019), Cormany and Baloglu (2011), Hanefeld, Lunt, Smith and Horsfall (2015), Lee and Fernando (2015), Moghimehfar and Nasr-Esfahani (2011) and Rahman (2019). Furthermore, other authors (Carrera & Bridges, 2006; Crooks et al., 2010; Lee & Park, 2013; Lee, Han & Lockyer, 2012) investigated the interrelationship between the push and pull factors in medical tourism, and demonstrated how both factors represent the expectations of potential medical tourists with regards to their healthcare needs.

Models or frameworks incorporating the push and pull factors have also been developed. Some of these models or frameworks focus only on the pull factors, e.g. the Medical Tourism Index (MTI), developed by the International Healthcare Resource Centre (IHRC) (Fetscherin & Stephano, 2016). The dimensions used in the MTI place emphasis on the physical attributes available at medical tourism destinations, thus the pull factors. The index does not take into consideration the treatments or procedures that medical tourists are likely to seek at the medical tourism destinations. Another study that examined the pull factors of medical tourism destinations was conducted by Shahrokh, Brojeni, Nasehifar and Kalamadi (2017). Although the main focus of this study was mostly on the physical attributes (pull factors) of medical tourism destinations, the procedures or treatments sought by medical tourists were also discussed as part of the selection of medical facilities (Shahrokh et al., 2017), and as such treatment variety forms part of this model.

Other models and frameworks incorporate both push and pull factors. For example, Smith and Forgione (2007) used a two-stage model to demonstrate medical tourists’ decisions in seeking healthcare services globally. According to Smith and Forgione (2007), the pull and push factors are considered as equally important. In addition, Heung, Kucukusta and Song (2010), designed a three-level supply-and-demand model representing the medical tourist’s decision-making process, i.e. selecting the destination country (e.g. destination attributes), the healthcare centre (e.g. the quality of healthcare facilities, accreditation) and the doctor (e.g. doctors’ expertise). According to Heung et al. (2010), there is an interaction between the demand (push) and supply (pull) factors, but even so, the authors emphasise that the patient’s
healthcare needs always play a significant role in the decision-making process, and their significance may vary from patient to patient. These authors therefore highlight that the push factors take precedence over the pull factors.

Previous research on the push and pull factors of medical tourism destinations, including the models and frameworks developed in the abovementioned studies, have shown some shortcomings. Heung et al. (2010) and Smith and Forgione (2007) for example developed conceptual models from the literature, while the main shortcoming for the multilevel model developed by Shahrokh et al. (2017) and the MTI (Fetscherin & Stephano, 2016), is the respondents that they used to test the models. Shahrokh et al. (2017) used medical tourism experts and did not specify who these experts were. Fetscherin and Stephano (2016) used the general public (not medical tourists only) and their perceptions of countries as medical tourism destinations. Ideally, the model and index should have been tested on medical tourists and people who have participated in medical tourism or who have shown themselves keen to participate in medical tourism. In addition, even though some of these models and frameworks have included types of treatment sought by medical tourists, it is still unclear how and if the push and pull factors of a destination differ based on the types of procedures undertaken at the destination.

This study thus addresses the shortcomings of previous research studies by firstly using medical tourism tour operators as participants, and secondly by identifying how the push and pull factors of a medical tourism destination differ based on the types of procedures undertaken at the destination. After identifying the push and pull factors of a medical tourism destination, and determining if these factors differ based on the types of procedures offered by the destination, the study measures South Africa’s performance as a medical tourism destination in terms of its push and pull factors. Bass (2008) and de Arellano (2007) indicated that there was evidence that people were coming to South Africa for various medical treatments while Mokoena (2015), and Haarhoff and Mokoena (2016) looked at the role played by medical tourism facilitators (medical intermediaries similar to medical tourism tour operators) in cosmetic medical surgery. Mudzanani (2016) went further to conduct a thematic analysis of newspaper articles on medical tourism in South Africa, and used the push-pull framework in his study. To date, it is still unclear what the opinions of medical
tourism tour operators as important intermediaries and gatekeepers between medical tourists and medical tourism destinations are in terms of the push and pull factors of South Africa, and also how South Africa performs in terms of its push and pull factors.

1.3 RESEARCH OBJECTIVES

The main purpose of this study is to identify the push and pull factors of a medical tourism destination, and based on these factors, to measure South Africa’s performance as a medical tourism destination.

In order to achieve this purpose, the following research objectives are formulated:

• To explain the push and pull theory and its use in tourism literature;
• To provide an overview of the medical tourism industry globally and in South Africa;
• To identify the push and pull factors of a medical tourism destination;
• To determine if the push and pull factors of a medical tourism destination differ based on the type of procedure offered at the destination;
• To measure South Africa’s performance as a medical tourism destination in terms of its push and pull factors

1.4 DESCRIPTION OF RESEARCH METHODOLOGY

The interpretivism research paradigm was used in this study. According to Bryman (2016:546), interpretivism is an “epistemological position that requires the social scientists to grasp the subjective meaning of social action”. Given that there is neither a single way of knowing, nor of interpreting reality, the interpretive paradigm enables researchers to contextualise and understand knowledge as presented by various participants in research. The researcher in this regard used the participants’ experiences, perceptions and their backgrounds in the medical tourism industry to have a better understanding of the push and pull factors of a medical tourism destination.

The target population of this study is African (African and South African) and international medical tourism tour operators. According to Pearce, Saffery, Morgan
and Tulga (in Mwesiumo & Halpern, 2018), local tour operators are likely to be more knowledgeable in terms of the local environment, and may have built close relationships with local suppliers. On the other hand, international tour operators are exposed to potential tourists and this enables them to interact directly with the tourists and to design and sell desirable packages to them (Pearce et al. in Mwesiumo & Halpern, 2018). It should, however, be noted that responses from the medical tourism tour operators were not as a result of their own lived experiences, but rather as a result of their actual interactions with medical tourists through their companies.

This was a qualitative study/research. According to Polit and Beck (in Moser and Korstjens, 2017:271), qualitative research entails an “in-depth investigation of phenomena and involves the collection of extensive and elaborate data while using flexible research designs”. A qualitative research approach was followed, since the type of information required from medical tourism tour operators could only be obtained by using qualitative research techniques. While investigating the perspectives of tour operators it was not the number of responses that mattered, but rather the detail and richness of their responses. Emphasis was thus not on the number of responses or quantities but on the words used to describe the feelings and perceptions of the medical tourism tour operators in relation to the push and pull factors for medical tourism destinations, and the types of procedures performed at these destinations. Consequently, qualitative techniques are better implemented under certain conditions, such as where the wealth of information is important.

For the purpose of this study two purposive sampling strategies, i.e. criterion- and snowball sampling were used. According to Paton (in Suri, 2011:69), criterion sampling involves reviewing and studying “all cases that meet some predetermined criterion of importance in a study”. In terms of this study, participants invited to participate satisfied the criterion of being medical tourism tour operators who had been rendering services to medical tourists for a minimum of one year. Tour operators with less than a year’s experience, and those not in the medical tourism industry, were not considered. A snowball sampling strategy was also used. According to Etikan and Bala (2017) and Suri (2011), snowball sampling involves seeking information from key informants/participants and/or networks about details of other information-rich cases or potential participants in the field. Thus, snowball sampling can also be regarded as
a referral system. In this study, the initial participating medical tourism tour operators, selected using the criterion sampling, were given an opportunity to recommend other medical tourism tour operators to participate in the study. However, tour operators who were not in the medical tourism industry were not asked to participate.

Although there is no formal database for medical tourism tour operators in South Africa, the researcher managed to source 19 South African medical tourism tour operators from the internet. The Medical Tourism Review website also lists up to 231 medical travel agencies worldwide, and these include South African tour operators. The researcher invited 78 medical tourism tour operators (South African, African and international) by email for participation in the study. Of the 18 that responded, 11 accepted the invitation (3 South African, 4 African and 4 international) and 7 (5 South African and 2 international) declined. The researcher engaged with the participants who had declined the invitation through email and SMS (where possible) to persuade them to participate, but this was unsuccessful. Two of the international participants recommended two other international participants who agreed to participate, bringing the total number of participants to thirteen.

An interview schedule was developed from the literature reviewed that included questions on medical tourism push factors and destination attributes (pull factors), medical procedures and the profiles of medical tourism tour operators. The medical tourism tour operators were also asked to identify the push and pull factors for South Africa and then evaluate this country’s performance in terms of the factors identified.

The advent of the Covid-19 pandemic made it impossible to meet with the participants face-to-face, especially the South African participants as initially planned. The researcher conducted all interviews telephonically, through WhatsApp calls as this also allowed for international calls without restrictions such as roaming restrictions. Semi-structured in-depth interviews were used to collect data from all participants, and with permission from all of them, the interviews were recorded on a digital recorder. Interviews with all the qualifying participants were conducted until data saturation was reached. The final sample size consisted of thirteen participants. According to Sutton and Austin (2015), semi-structured interviews enable researchers to adapt the pre-determined questions in line with the participants’ responses, thus ensuring that rich
information is collected (Moser & Korstjens, 2018; Sutton & Austin, 2015). To ensure that the collected data was comprehensive, open-ended questions were used. The participants were therefore able to share their ideas, perspectives and perceptions freely and holistically. Most of the interviews lasted for 30 minutes, with a few going beyond (up to 45 minutes) due to connectivity problems. The recorded interviews were transcribed into text and each transcript checked against the voice recordings for accuracy; irrelevant and unnecessary parts were omitted.

For data analysis purposes, the researcher worked systematically through the participants’ transcripts to identify the frequencies of the codes so as to establish categories; this is also known as content analysis (Harding, 2019). Codes helped the researcher to categorise and contextualise the collected data. A detailed explanation of the research methodology will follow in Chapter 4.

1.5 DELIMITATIONS OF THE STUDY

The participants in this study are confined to medical tourism tour operators only. Both the medical tourists’ motives or push factors and destination attributes or pull factors play an important role in medical tourism destination choices. This study identifies the push-pull factors from the perspectives of the medical tourism tour operators, as key role players in the medical tourists’ journey to any medical tourism destination.

The study deliberately uses medical tourism tour operators as they are most likely to help make the necessary arrangements for tourists interested in seeking medical treatment at a medical tourism destination. It is assumed that they are knowledgeable about the patients’ motivations to seek healthcare outside their own countries, and the types of procedures that the patients are likely to seek. The literature consulted in this study highlights the need for privacy and confidentiality, as argued by Fisher and Sood (2014), as one of the motivating factors for patients to seek treatment beyond their usual place of residence. In order to ensure privacy, and confidentiality, this study does not involve the medical tourists directly. Tourists trust tour operators with their information. Hence medical tourists are likely to trust that the medical tourism tour operators will not divulge their details, or the types of treatments/procedures they seek,
to any unauthorised person without their permission. The medical tourism tour operators are not asked to reveal the identity of patients or to link the treatment to specific individuals.

This study focuses on medical tourism, not on the broader health tourism concept, which includes both medical and wellness tourism. In contrast to wellness tourism, which focuses on keeping healthy people healthy, medical tourism focuses on the curing of illnesses or the restoration of health through medical interventions or treatments (Carrera & Bridges, 2006; Kara, 2016). Given that the aim of medical tourism is to restore the patients' health by accessing the medical treatments, this study wants to determine if the push and pull factors of medical tourism destinations differ based on the type of procedures offered at these destinations.

Lastly, this study focuses only on medical tourism from an international perspective, thus, medical tourism tour operators are not asked about medical tourists who travel to seek medical treatment domestically, e.g. from one province to the other.

1.6 ACADEMIC VALUE AND INTENDED CONTRIBUTION OF THE STUDY

This study intends to contribute to the body of knowledge available on the push and pull factors of a medical tourism destination from the medical tourism tour operators’ perspectives, and then to measure South Africa as a medical tourism destination against these factors. The study also seeks to determine whether the push and pull factors differ based on the procedures or treatments that are sought by medical tourists in medical tourism destinations.

Even though a number of studies have been conducted highlighting the push and pull factors of a medical tourism destination, e.g. Heung et al. (2010), Smith and Forgione (2007), Shahrokh et al. (2017) and Fetscherin and Stephano (2016), they have been conceptual in nature, or they have used medical tourism experts or the general public as respondents. This study looks at medical tourism tour operators as key role players in the medical tourism industry by highlighting their perceptions in terms of the push
and pull factors relating to medical tourism destinations, and whether these factors differ based on the procedures prospective medical tourists are likely to seek in receiving destinations.

Medical tourism does take place in Africa, albeit on a small scale. For instance, medical tourists already visit South Africa and between 2015 and 2016, of all the international and domestic tourists that visited South Africa, there were only 1.9% international medical tourists (with most tourists coming from African countries) and 1% domestic medical tourists (Department of Tourism, 2017). The identification of the push and pull factors that draw medical tourists to South Africa would assist medical tourism tour operators to amplify their promotional material and develop packages that will be more attractive to prospective medical tourists. Having knowledge on the push and pull factors will also help in marketing and promoting South Africa as a medical tourism destination in order to attract more medical tourists to this country.

1.7 LAYOUT OF THE STUDY

The study consists of six chapters.

Chapter One focuses on the introduction and the background of the research topic. This includes the problem statement, research objectives, the methodology, the research delimitations, as well as the academic contribution of the study.

Chapter Two focuses on the push-pull theory and identifies the various push and pull factors as primary motivators of travel behaviour. The push and pull factors that motivate tourists to choose one destination over another are identified. The push and pull factors that motivate a tourist to visit South Africa are also identified.

Chapter Three focuses on medical tourism and discusses the push and pull factors that drive medical tourism. The push and pull factors that motivate a tourist to visit South Africa as a medical tourism destination are discussed, and the procedures that medical tourists are likely to have in South Africa are highlighted. The chapter concludes with two theoretical frameworks indicating the push factors, pull factors and procedures for any medical tourism destination and for South Africa.
Chapter Four focuses on the research design and methodology. The research approach and paradigm are explained. The sampling method and the importance of the sample selected are discussed, followed by the process followed in designing and drafting the data collection instrument used. The data collection process and the data analysis process are described in detail, to ensure validity, reliability, and transferability.

Chapter Five focuses on the interpretation of the data and the overall findings in relation to this study.

Chapter Six draws conclusions and provides industry recommendations, discusses managerial implications, and provides a basis for future research studies.

1.8 CONCLUSION

In conclusion, this chapter introduced and provided the background to the study and the main concepts, i.e. medical tourism, and push and pull factors were defined and contextualised. The problem statement was articulated in relation to the push and pull factors of a medical tourism destination. The purpose of the study, as well as the guiding research objectives, was highlighted. The research methodology and delimitations of the study were described. Lastly, the intended contribution of the study was highlighted; and the chapter lay-out was described.

The following chapter looks at the push-pull theory and identifies the various push and pull factors as primary motivators of travel behaviour. The push and pull factors that motivate a tourist to visit South Africa are also identified.
CHAPTER TWO
PUSH AND PULL THEORY

2.1 INTRODUCTION

The previous chapter discussed the background of the study and the main concepts were defined and contextualised. The research objectives that will guide the study were also identified. In this chapter, the demand for tourism will first be explained, whereafter the push-pull theory will be explored in order to illustrate the significance of push-pull factors as travel motivators for travel behaviour, and how these play a role in tourists’ choices of one destination over another. According to Whyte (2017) and Nikjoo and Ketabi (2015), combining the internal drivers or the push factors with the external factors or pull factors enables researchers to understand the tourists’ behaviour better, and also clarifies how tourists choose the destinations to which they travel.

2.2 DEMAND FOR TOURISM

Prospective tourists are attracted to destinations which they feel have elements that could satisfy their travel needs, e.g. tourism products, services, activities and facilities. Therefore, the destination’s elements create the demand for tourism. The demand for tourism explains how and why people participate in tourism, i.e.

... how they behave as tourists, why they choose to participate in certain types of tourism and not in others, what tourism means to them, and why their taste in tourism may change over time (Sharpley, 2006: 29).

According to Sharpley (2006), the demand for tourism is the consequence of the tourists’ goal-oriented motivation to travel. To understand the demand for tourism, we must identify the relationship that exists between the tourist’s need, motivation and their travel behaviour. Lubbe (2003) considers that the needs prospective tourists may be experiencing at a time may motivate them to consider taking an action (e.g. travel) in order to satisfy these needs. Motivation serves as a link between the tourist’s needs
and the action that is taken (or needs to be taken) in order to satisfy the need (Sharpley, 2006). Thus, in order to for us to understand human motivation, it is necessary to first indentify the needs of tourists and how these can be met (Lubbe, 2003). It is also necessary to understand the motivations of tourists since these connect their needs and buying behaviour.

2.2.1 Needs of humans

According to Hoyer, MacInnis and Pieters (2018:48), a need is an “internal state of tension experienced [by consumer/s] as a discrepancy between the current state and an ideal or desired state”. The tension experienced usually forces the consumer to act (e.g. eating) in order to correct the discrepancy, thus satisfying the need (i.e. hunger) as indicated in Figure 2.1. According to Hoyer et al. (2018), the following are the typical characteristics of needs:

- [they] can be internally or externally activated, i.e. although needs are generally experienced internally, they can also be externally triggered;
- Need satisfaction is dynamic, i.e. the satisfaction of a need is never permanent, and satisfaction of one need may evoke another need;
- [they] exist in a hierarchy, i.e. even though a number of needs can be activated at the same time, some may have more prominence than others;
- [they] can also clash or conflict with each other, e.g. at times an individual may find himself in a position where he has to make a choice between “two or more equally desirable options” to satisfy the same or different needs.

Taking into consideration that the needs exist in a hierarchy, as mentioned in these characteristics, it is important to note that lower level needs must be relatively fulfilled before one can proceed to higher-level needs (Lubbe, 2003) as illustrated (with arrow) in Figure 2.1.
As indicated at Figure 2.1, needs are the building blocks for motives or reasons to want to do something. According to Wilkie (1994:176), the concept ‘motive’ is used to “explain the reasons for behaviour”. People usually have various reasons or multiple motives for behaving in a particular way or doing things in certain ways. Wilkie (1994) further argues that some motives may be overt (i.e. the individuals will be aware of the reasons for their actions), and some may be hidden in the individual’s mind. As a result, individuals may not be aware of the reasons for their actions. Just like needs, motives are not constant (Lubbe, 2003). In Lubbe’s opinion, motives may change in response to certain circumstances and situational constraints experienced at the time, e.g. the availability, or lack, of time and money, family situation, healthcare needs, place and one’s social company. It is very likely that the circumstances and situational constraints that an individual may experience can significantly change over time, and the change will also have an impact on the motives for behaviour. Motivation is an “internal force which emanates from a non-satisfied need that leads an individual to perform a specific behaviour in order to fulfil the need” (Khan et al., 2017:117). In short, motivation is the main factor that arouses, directs, and integrates a person’s behaviour resulting in specific action/s, e.g. travel to satisfy a pending need (Murray in Lee,
O’Leary, Lee & Morrison, 2002). Although motivation influences behaviour, it is not its only determinant; other factors, e.g. an individual’s cultural and situational circumstances may also determine and/or influence or limit behaviour (Maslow, 1943).

2.2.2 Needs and motivations of tourists

There is no general agreement as to what motivates people to travel, even though a number of scholars, e.g. Crompton, Dann, Iso-Ahola, Pearce (in Morrison, 2019) have tried to explain what makes people decide to travel, be it for pleasure or any other reason. Various theories and approaches have also been used to explain the motivation to travel, as discussed by Maslow, Herzberg and others (in Morrison, 2019). In spite of the lack of agreement amongst scholars, the common theory and trend to analyse the motivation to travel has always been Maslow’s hierarchy of needs (Figure 2.1), i.e. the physiological/survival needs (i.e. hunger, thirst, rest, activity); safety (i.e. security, freedom from fear and anxiety); belonging and love (i.e. affection, giving and receiving love); esteem (i.e. self-esteem and esteem from others); and self-actualization (i.e. personal self-fulfilment) (Maslow, 1943; Morrison, 2019).

Pearce and colleagues (in Lubbe, 2003:32), in their endeavour to explain travel motives developed “The Travel Needs Ladder”, which is based on Maslow’s hierarchy of needs. In the ladder, the travellers’ life-cycle is also taken into consideration. In terms of the ladder (McIntosh in Lubbe, 2003), as tourists become experienced travellers, they tend to climb up the ladder. The converse of climbing up the ladder (McIntosh in Lubbe, 2003) is that as the tourists go through various lifecycles in their travel, they may come down the ladder. According to Lubbe (2003), different people have different travel needs and motives, and therefore it is possible for a single destination to attract a variety of tourists at the same time. On the other hand, travel motives for one destination may not necessarily be applicable to another. Table 2.1 illustrates the interrelationship between tourists’ needs, motives and the subsequent desires/actions based on Maslow’s hierarchy of needs and other travel literature summarised by Mill and Morrison (in Morrison, 2019).
Table 2.1: Tourists’ needs, motives and desires/actions

<table>
<thead>
<tr>
<th>Need</th>
<th>Motive</th>
<th>Desires/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiological</td>
<td>Relaxation</td>
<td>Escape; relaxation; sun-lust; physical and mental relief of tension</td>
</tr>
<tr>
<td>Safety</td>
<td>Security</td>
<td>Health; recreation; keeping oneself active and healthy for the future</td>
</tr>
<tr>
<td>Belonging</td>
<td>Love</td>
<td>Family togetherness; enhancement of kinship relationships; companionship</td>
</tr>
<tr>
<td>Esteem</td>
<td>Achievement</td>
<td>Convince oneself of one’s achievement, status, prestige and social recognition</td>
</tr>
<tr>
<td>Self-actualization</td>
<td>Be true to one’s self</td>
<td>Exploration and evaluation of nature; self-discovery; satisfaction of inner desires</td>
</tr>
<tr>
<td>To know and understand</td>
<td>Knowledge</td>
<td>Cultural education and wanderlust; interest in foreign areas</td>
</tr>
<tr>
<td>Aesthetics</td>
<td>Appreciation of beauty</td>
<td>Environmental/scenery</td>
</tr>
</tbody>
</table>


Travel motivations describe why people experience the need to travel and what they ultimately do to satisfy this need; thus they are the outcomes of the needs and they spur the demand for tourism. Different travel needs can be satisfied through different travel experiences. Tourism push factors relate to people (person-specific) who want to travel, and explain why people want to travel, while pull factors relate to destination-specific attractions, and basically explain to which destination people want to travel. Travel motivations can therefore also be explained through push and pull factors, and these work harmoniously together to explain global travel patterns.

2.3 PUSH AND PULL THEORY

The push and pull theory is the theoretical framework that will be used in this study. According to Medlik (2003), this theory was initially used in migration studies, and it indicates that people are motivated or pushed by unfavourable
circumstances/conditions (e.g. unemployment) to move from an area, and they (people) are simultaneously drawn or pulled by an alternative area providing favourable circumstances/conditions (e.g. employment prospects).

Dann (1977) is considered the pioneer of using the theory in the tourism context. He (Dann, 1977) used this theory to explain tourists’ motivation to travel based on two concepts, i.e. anomie, i.e. the desire to transcend the feeling of isolation inherent in everyday life and to simply get away from it all, and ego-enhancement, which is the need for recognition and is obtained through the status brought by travel. Anomie and ego-enhancement therefore relate to the travellers’ motivations or internal needs and desires to travel. In Dann’s (1977) opinion, anomie and ego-enhancement are responsible for inducing in tourists the internal desire to travel, in order to satisfy the travel need at the time, and therefore they can be regarded as push factors. According to Uysal et al. (2008), push factors and the tourists’ needs explain what motivates them to travel from their regular destinations to other destinations. This could be the need for escape, rest and relaxation, self-esteem, prestige or health and fitness.

In a subsequent study, Dann (1981) further argues that anomie and ego-enhancement precede or are antecedents to the pulling effect that a destination’s external or physical attributes, e.g. the sunshine and so on, may have on motivating the traveller to travel to a destination (Dann, 1981). Travellers are drawn or pulled to specific destinations by the destinations’ attributes that have the potential to satisfy their internal needs and desires to travel (Whyte, 2017). The pulling effect is therefore in response to the anomie and ego-enhancement effects. The push and pull theoretical framework thus relates to the sociopsychological (internal) motives that push people to travel, and the attributes (external) that attract individuals to a tourism destination (Dann, 1977 & 1981).

According to Cohen et al. (2014), the push-pull theory can also be used for market segmentation purposes with the objective to profile the tourists. For example, tourists can be grouped according to their travel motivations, and then classified into various categories (segmented) based on their demographic details. Given that tourists are not identical, it is necessary for the tourism industry to categorise potential tourists into
distinct groups which may have [or not] something in common, so that the industry can create strategies that accurately target specific tourist categories.

After Dann (1977) various authors have used the push-pull theory to explain the different aspects of travel contexts, with some focusing on the push or pull factors only, while others focused on both factors. Some studies focused on the push factors, e.g. Cha, McCleary and Uysal (1995) investigated the travel motivations of Japanese overseas pleasure tourists, and found that these broadly fell into three categories, i.e. sports, novelty, and family/relaxation seekers, which were mainly influenced by the tourists’ demographic factors such as education and age. Six push factors were found to have motivated these tourists, and these were the need to relax, to acquire knowledge, adventure, travel bragging, family, and sports (Cha et al., 1995). According to Cha et al. (1995), these findings highlight the difference between the push factors of Japanese tourists and those of tourists from other countries.

Klenosky (2002) conducted a means-end investigation to establish the relationship between the destination attributes (i.e. the means) and the potential tourists’ motivational forces (i.e. the end) that influences them to travel. Although this study was based on push and pull factors, the ultimate goal was to establish the role played by the pull factors in attracting tourists to destinations, and to demonstrate that it is possible for the pulling effect of the destinations’ attributes to be driven by multiple motivational forces experienced by the tourists in selecting the destination. For instance, the pulling effect of a beach at a tourism destination may attract diverse tourists. According to Klenosky (2002), while some tourists may need relaxation at the beach or any other physical destination attribute, some may want to socialise, while others may want to enjoy nature and outdoors, or simply to escape from daily mundane activities.

Other authors used the push-pull theory to investigate both push and pull factors. For example, Uysal et al. (2008) looked at the role played by push and pull factors in the tourists’ decision-making processes and how motivation influences the whole process. For tourism to take place, we need both the destination and the tourist. According to Uysal et al. (2008), the destination must have certain attributes or characteristics (supply) about which the potential tourists may have perceptions or to which they
attach meaning or value. The perceptions and/or value associated with the attributes supplied by the destination can also be regarded as a tourist’s motive to visit the destination. Thus, there is a relationship between the destination’s pull factors (supply) and the tourist’s motives or push factors (demand). Whyte (2017) conducted a study on cruise tourism destinations and also focused on the push (travel motives) and pull (destination attributes) factors, and the subsequent relationship that exists between the factors with regards to cruise tourists’ decision-making processes.

The use of the push-pull theory helps to clarify and better comprehend the sociopsychological motives (push factors) that trigger and direct the desire to travel. Using both the push and pull factors, the destination’s external attributes, in tourism research provides a basis for a clearer understanding of tourists’ decision-making processes and their tourism destination choices.

2.4 PUSH AND PULL FACTORS

Push and pull factors are useful concepts to explain travel behaviours, trends and patterns worldwide. According to Baptista, de Sousa Saldanha and Vong (2020), as internal and external factors, push and pull factors motivate one to undertake a trip from one destination to another in order to satisfy their travel needs at the time. Push factors explain why people travel, while pull factors explain where people travel to. Both can therefore be used to market and promote tourism destinations.

2.4.1 Push factors

According to Uysal et al. (2008:414), push factors can be regarded as the tourists’ “socio-psychological constructs and their environment that predispose the individual to travel”. Push factors have an influence on the tourists’ travel decisions and/or their demand to travel, and therefore motivate tourists to travel (Lubbe, 2003). In Lubbe’s (2003) opinion, motivation push factors relate to the tourists’ needs that they feel will be fulfilled through a certain kind of travel. Push factors are thus related to the tourists’ internal (intrinsic) desires or drivers (intangible) such as motives, attitudes, beliefs and intentions to travel to a destination (Whyte, 2017). The emotions experienced by the
tourist or potential tourist, motivate the tourist to travel or not. The internal desires usually develop as a result of the unavailability and absence of an individual’s desired things in a particular place. It is as a result of this absence that the individual’s desire and drive is initiated to seek the desired things elsewhere (Abd Mutalib et al., 2017). Push factors can also be directly linked to Maslow’s hierarchy of needs as indicated in Figure 2.1, i.e. the basic/physiological needs, safety needs, social needs, esteem and the self-actualisation needs that tourists may want to satisfy through travel. As indicated by Uysal et al. (2008), push factors thus predispose tourists to travel.

According to Baptista et al. (2020), push factors determine whether or not people will travel and thus explain the reasons why people travel. Typical travel push factors are: the need for rest and relaxation; the need for escape; the need for adventure; the need for prestige; the need for healthcare and fitness; and need for social interaction (Adair, 2006; Lubbe, 2003; Morrison, 2019; Uysal et al., 2008) as also indicated in Table 2.1. According to Uysal et al. (2008), push factors also include socioeconomic and demographic factors, such as the tourist’s age, gender, income, race and income.

Push factors can also be associated with the demand that can be generated for the destination, and relate to the perceived importance of attributes at the destination, e.g. attractions. Tomigova, Mendes and Pereira (2016) suggest that the perceived importance of attractions may also be influenced by situational constraints affecting tourists, e.g. costs/budget and time. This means that even if tourists perceive the destination’s attractions to be important, without critical resources such as time and money, they may not be able to satisfy their travel needs. The tourists’ experiences, actual or potential, at the destination will also determine whether or not their needs were satisfied.

2.4.2 Pull factors

According to Hu and Ritchie (1993: 25), tourism destinations evoke “feelings, beliefs, impressions and opinions” in potential tourists about the destinations’ potential to satisfy tourists’ travel needs. Tourists, actual or potential, thus create mental constructs about the destination’s physical or external features, and then imagine
these constructs satisfying their travel needs (Baptista et al., 2020; Medina-Muñoz & Medina-Muñoz, 2014). The perceptions that travellers have with regards to the attributes of the destination influence and explain their decision for its selection. Abd Mutalib et al. (2017) argue that pull factors draw individuals to particular locations and they are able to do so because of the availability of particular attributes at the destination that meet individual desires. Pull factors therefore explain where travellers travel to in order to have their needs and motivations fulfilled (Baptista et al., 2020). Pull factors relate to the destinations’ physical and tangible characteristics and contribute to the destinations’ attractiveness, i.e. the physical attributes, attractions, infrastructure, entertainment, access to the destination, information sources, interpersonal (as a result of family or friends’ influence) and structural (as a result of opportunities or cost associated with the activities) constraints (Whyte, 2017).

Buhalis (2000) points out that a tourism destination must have the following 6As in order to draw tourists: attractions, accessibility, amenities, available packages, activities and ancillary services. In Lee and King’s (2019) opinions, Buhalis’ framework demonstrates the emotional thought processes and the physical well-being aspects of the destination that the tourist considers in choosing one destination over another. For example, the available packages for visiting a particular destination may influence the tourist’s decisions with regards to the activities they may want to engage in at the destination in order to satisfy their needs, and thus they may be used to evaluate various destinations, thereby influencing their final choice of destination. In contrast to Buhalis (2000), Jafari (in Lee & King, 2019) classified the destination attributes into three interrelated and overlapping categories, i.e. tourism-oriented products, resident-oriented products, as well as background tourism elements. This means that when tourists visit a destination, they use the tourism- and resident-oriented products whilst they simultaneously experience the background tourism elements such as nature, attractions and the socio-culture of the destination.

Lubbe (2003) states that pull factors can be classified into three categories, i.e. primary, secondary, and tertiary pull factors. Primary pull factors are the physical attributes at the destination such as the scenery, cities, climate, wildlife, means of travel, as well as the historical and local cultural attractions. A typical feature of most primary pull factors is that they are unchangeable or static (Meinung, 1989).
Secondary pull factors are the man-made attractions at the destination, such as the catering, accommodation, personal attention, entertainment, sports, ease of access for tourists, the destination’s political condition, and trends or sudden changes (such as health crises) impacting the tourism industry. Unlike primary pull factors, secondary pull factors are dynamic or variable. According to Meinung (1989), the dynamic nature of these factors is such that their presence and availability can quickly change as and when the demand for tourism changes, e.g. some of them can be seasonal or may be influenced or affected by certain events or circumstances at the destination. The size, i.e. scale or quantity and quality, if they are well-maintained and/or managed of the secondary pull factors usually determine and influence their level of dynamism or attractiveness. Finally, the tertiary pull factors focus on aspects such as how a destination is marketed and the prices at the destination. According to Meinung (1989), tertiary pull factors are influenced by the marketing efforts and prices at the destination and are very likely to be unstable, e.g. if the destination is going through an economic crisis or any other crisis that affects or influences the demand for tourism in a negative manner.

The availability of the physical attributes at the destination makes the destination attractive to potential and actual tourists, thus we can conclude that the absence of attributes at the destination has the potential to lead to a decline in the perceived attractiveness of the destination. The availability of attributes also plays an important role in destination choice and influences when, how and where people travel (Prayag & Ryan, 2011). A destination without attractions will therefore find it difficult to draw or pull tourists to its shores.

2.4.3 Interrelationship between push and pull factors

Although the push factors precede the pull factors (Baptista et al., 2020; Dann, 1981), a definite relationship exists between the two concepts. According to Formica and Uysal (2006), there is a reciprocal relationship between a destination’s availability of attractions, i.e. supply, and their perceived importance to the tourist, i.e. demand. In this author’s opinion, people travel because they are motivated or pushed and/or pulled by the destination/s attributes. The presence of the tourism demand and supply
components will produce a touristic experience for travellers. According to Baptista et al. (2020) and Uysal et al. (2008), the interrelationship between these factors demonstrates how the destination’s pull factors respond to the tourist’s motivational push. Both the push and pull factors play a crucial role in the traveller’s choice of destination; therefore they can be used to successfully market tourism destinations (Prayag & Ryan, 2011; Seebaluck, Munhurrun, Naidoo & Rughoonauth, 2015). The interrelationship between the push and pull factors has also been described as a continuum (Klenosky in Lubbe, 2003), with the push factors (i.e. the intangible, needs, motivations, benefits and personal values sought by the tourist) on the one end, and the pull factors (i.e. the tangible attributes of the destination) at the other end. The interrelationship between the push and pull factors is summarised in Figure 2.2.

Figure 2.2: Interrelationship between push and pull factors

![Interrelationship between push and pull factors](image.png)

Source: Morrison (2019:486)

In terms of Figure 2.2, tourists consider various types of destination attributes (pull factors) that correspond with their motivational needs (push factors) when they decide whether or not to travel to a destination. Kirilenko, Stepchenkova and Hernandez (2019), and Morrison (2019) acknowledge that the push and pull factors may also vary from one tourist to another, depending on their individual circumstances, motivations, interests, and their psychological predispositions. Other factors are tourists’
constraints, e.g. time, financial and physical constraints; where tourists come from, i.e. their origins that include their geographical location and socio-cultural background; the prospective destination they want to visit, i.e. destination's geographical profile; the destination’s image and what the destination has to offer; connectivity and accessibility to various places and attractions at the destination; the tourism product that they want to consume; and the overall perceived benefits of undertaking the travel.

2.5 PUSH-PULL FACTORS THAT MOTIVATE A TOURIST TO VISIT SOUTH AFRICA

The end of apartheid in 1994 led to an increase in the number of visitors to South Africa. As an emerging economy, the country has positively positioned itself in the global tourism industry and is regarded as a top tourism destination on the African continent (Saayman & du Plessis, 2003), particularly to tourists who would like to experience the unique African attributes which cannot be experienced anywhere else except on the continent. These include the different landscapes, the people and their unique cultures as well as the wildlife.

Recent tourism reports issued by both the Department of Tourism (2018: 33) and Statistics South Africa (Stats SA) (2019), show that South Africa welcomed over 10 million international visitors between 2016 and 2019, although there was a decrease of 2.3% in 2019. The 2016 tourists’ figure is an improvement of about 12.8% from 2015 as indicated in Table 2.2.

<table>
<thead>
<tr>
<th>Table 2.2: Number of tourists to South Africa 2015 to 2019</th>
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<tr>
<td><strong>2015</strong></td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Difference</td>
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<tr>
<td>Increase/decrease %</td>
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Sources: Data 2015-2018 (Department of Tourism, 2018:33); data 2019 (Stats SA, 2019:23)
According to the Department of Tourism report (2018), 9 549 236 international tourists visited South Africa in 2014, thus a decline of -645 463 tourists was observed in 2015 as indicated Table 2.2. In South African Tourism’s (SAT) 2018/19 annual report, they, together with the Department of Tourism, note the efforts the country is taking to manage the challenges identified as deterrents to tourism in South Africa (South African Tourism, 2018/19). The report (SAT, 2018/19) indicates that both SAT and the Department of Tourism will implement various strategies to address the negative perceptions that tourists have about South Africa, such as safety and security, and that the visa processing/issuing challenges are being attended to find workable solutions. In addition, SAT has formed partnerships with provincial tourism authorities to work on air-access strategies. The report also states that there are plans in place to address inappropriate wildlife interaction and hunting as reported by the media.

The report further indicates that the fears created by the debate on land expropriation without compensation are being addressed, and reaffirms its commitment to promoting brand South Africa so that the destination can be a destination of choice to potential tourists. The report highlights that the water shortages experienced during the recent 2017/18 droughts in the Western Cape have been resolved. It is hoped that these developments will yield positive results for the country’s competitiveness and possibly lead to the envisaged increase in the number of tourists visiting South Africa in future.

### 2.5.1 Push factors for visiting South Africa

Tourists are motivated by various push factors to visit South Africa as a tourism destination. A number of studies have looked at tourist motivations to visit SA, e.g., Benson and Seibert (2009) conducted a study on what motivates Germans to take part in volunteer tourism in South Africa. The authors’ findings revealed that escape, enhancement, exploration and self-education (Benson & Seibert, 2009:306) were the push factors for these participants. Many authors studied the travel motives in relation to national parks, e.g. Saayman and Saayman (2009), Kruger and Saayman (2010), Slabbert and Viviers (2012), Kgote and Kotze (2013), Hermann and du Plessis (2014), Scholtz, Kruger and Saayman (2015) and Chikuta, du Plessis and Saayman (2017). The common push factors from these studies are: escape and relaxation; novelty;
nostalgia; family togetherness and enhancement of relationships; prestige; health benefits; exploration; education and learning.

Some authors looked at other types of tourism, e.g. events and festivals (Streicher & Saayman, 2010), marine tourism (van der Merwe, Slabbert & Saayman, 2011), and visits to museums (Mudzanani, 2014). The common push factors from the abovementioned studies are: socialisation; personal motivation; escape and relaxation; family togetherness and enhancement of kinship relations; novelty; nostalgia; and education. From these studies even though it is not a comprehensive list, one can concluded that escape and relaxation, exploration, nostalgia, socialisation, gaining knowledge and seeking new experiences are the typical push factors to travel to South Africa.

2.5.2 Pull factors for visiting South Africa

A multitude of attributes (pull factors) make South Africa an attractive destination. According to Saayman and du Plessis (2003), the following attributes or pull factors encourage tourists to visit South Africa.

2.5.2.1 Natural attractions
Natural attractions have their origins in the physical environment and are comprised of the following: wildlife, climate, beaches, plant-life, geographical features such as the landscapes (including the scenery), mountains and the seas. South Africa is home to various local and international natural attractions, including Table Mountain and the Kruger National Park, which is also home to the Big Five, the Garden Route, Cape Point, and others.

2.5.2.2 Man-made attractions
Man-made attractions are those that have been created by people and include among others architectural structures, monuments, parks and gardens, casinos, shops, and many more. Typical examples of South African man-made attractions are conference centres, beach resorts, and urban attractions such as the Apartheid Museum, Sun
City, Gold Reef City, Victoria and Alfred Waterfront, the Union Buildings, and many more.

2.5.2.3 Socio-cultural attractions
These are attractions that relate to the history, religion, science, arts and music, administration, economy, architecture, regional traditions, gastronomy, politics and way of life of a region, and have the potential to motivate tourists to choose a certain destination to explore the offerings of the destination first hand. Typical South African examples of socio-cultural attractions are Robben Island, Soweto (especially Vilakazi Street), battlefields such as the Blood River heritage site, and the traditional African craft centres in various provinces.

2.5.2.4 Facilities and accessibility of the destination
In a tourism destination, facilities include the infrastructure and buildings that do not necessarily generate tourism but complement it and their absence would discourage people from visiting a destination, such as accommodation facilities, restaurants, transport, retail outlets, shopping centres and other facilities. South Africa is home to many leading hotels and resorts, restaurants, and shops and it is easily accessible by various forms of transport. Accessing the facilities at the destination is crucial, and this relates to those attributes that are likely to affect aspects with which a tourist destination can be reached, for instance, the cost, speed and convenience of travelling there. Although South Africa’s geographical location is said to be far or long-haul, it has world class infrastructure, airports and roads, to cater for the needs of tourists and the general tourism industry. Government regulations and prescripts are in place to regulate services such as transport operations and visa applications. It is also reasonably affordable to reach this destination which has fully functional information and communication technologies (ICTs), making it easier for online activities such as bookings, communication, banking and other activities requiring technology.

2.5.2.5 Price
Costs are involved when one decides to visit a specific destination, such as travel costs, e.g. by air, accommodation, entrance fees to attractions, food, entertainment, and so forth. Travelling to South Africa offers an array of experiences to the tourism market and it is also value for money for most international tourists. especially those
from developed countries as the exchange rate tends to be more favourable for them due to the weakness of the rand/dollar exchange.

Studies conducted on pull factors to South Africa include that of Benson and Seibert (2009:306) who identified discovering nature and wildlife; learning and acquiring new knowledge; and meeting and interacting with African people and their cultures, as pull factors for Germans participating in volunteer tourism. Some studies that focused on national parks (Saayman, Slabbert & van der Merwe, 2009; Kgote & Kotze, 2013; Hermann & du Plessis, 2014; Chikuta et al., 2017) identified nature and beautiful scenery, leisure activities, attractions, destination and site attractiveness, trip features, photography and value for money at the destination as pull factors. These studies may not be comprehensive, but confirm the findings by Saayman and du Plessis (2003) on what pulls tourists to South Africa.

2.6 CONCLUSION

As an internal force, motivation arouses, directs and integrates a person’s behaviour to take specific action/s, such as to travel, to satisfy their pending needs. Tourists evaluate and make comparisons between the attributes, i.e. pull factors of different destinations before making their final decision on a destination that offers the attributes that they deem able to satisfy their travel needs, i.e. the push factors. The end of apartheid in South Africa led to a surge in the number of tourists visiting the country. Tourists who visit South Africa are mostly motivated, i.e. pushed by their desires for enjoyment, novelty, escape and relaxation, the potential to expand their horizons in terms of knowledge, and to socialise and rekindle or enhance their relationships. In return, tourists stand to benefit, at a fraction of the cost (as indicated at 2.5.2) from the beautiful scenery, warm weather and landscapes, natural and/or man-made attractions and heritage sites, variety of activities and events in which to participate.

The following chapter looks at the push and pull factors that make any medical tourism destination appealing to potential medical tourists, and identifies the push and factors that will motivate a medical tourist to select South Africa as a medical tourism destination.
CHAPTER THREE
MEDICAL TOURISM

3.1 INTRODUCTION

As indicated in the previous chapter, various push and pull factors motivate tourists to engage in tourism, and also play an important role in the tourists’ destination choices. Push and pull factors also play a role in attracting tourists to a medical tourism destination. In medical tourism, push factors are associated with unmet healthcare needs. The attributes of medical tourism destinations play an important role in the selection of a medical tourism destination, and thus serve as pull factors.

In this chapter, the push-pull factors that determine a medical tourist’s destination choice, and the push-pull factors that will motivate medical tourists to visit South Africa as a medical tourism destination will be identified.

3.2 OVERVIEW OF MEDICAL TOURISM

Medical tourism is not a new phenomenon. According to Lang (2019), Mogaka, Mupara, Mashamba-Thompson and Tsoka-Gwegweni (2017), Pereira, Malone and Flaherty (2018) and Xu et al. (2020), globalisation has simplified the import of technology and various medical goods by developing countries, enabling these countries to develop medical infrastructure and systems. Medical tourism requires the services and expertise of highly trained and experienced physicians, high-tech medical equipment, and specialised ultra-modern medical facilities (Pereira et al., 2018; Tiren-Verbeet et al., 2018; Lang, 2019), and thus globalisation is an enabler for developing countries. As an industry, medical tourism is growing steadily globally and is driven by a number of factors, e.g.

... the changing demographic profile of aging populations in high- and middle-income countries seeking healthcare; the ease of international travel and communication; the retreat of neoliberal states in the provision of public services, and the portability of health insurance (Whittaker, Manderson & Cartwright, 2010:338).
In 2018, the medical tourism industry was estimated to be worth between $45 billion and $72 billion, with the potential to grow between 15% and 25% per year (Southern & East African Tourism update, 2018) in the near future. Despite this growth, there is still no agreement in defining the concept of medical tourism. There is, however a general agreement that patients or medical tourists do move around from their home countries or usual places of residence to access medical care in foreign destinations as well as domestically, but further from home. According to Smith and Puczko (2014), medical tourism is a combination of medical and tourism services, and involves people (also known as medical tourists) who live in one country but who travel to another or within their own country's borders to hospitals and clinics for medical treatment. Given that people have been travelling for medical treatment for centuries, some authors, such as Chia and Liao (2020) and Connell (2013) prefer the concept medical travel, or international medical travel (Chow, Pires & Rosenberger III, 2015). In this regard, medical tourism is regarded as a subcategory of medical travel, as the patients' main intent is to travel to get medical treatment.

According to Carrera and Bridges (2006), Goodrich (in Boekstein & Spencer, 2013) and Junio, Kim and Lee (2017), medical tourism is one of the two subdivisions of the broader health tourism sector. Health tourism as the main category in this regard, is defined as a tourism facility's/destination's endeavour to attract tourists by purposely promoting healthcare services to be rendered and the available facilities on top of regular tourist amenities at the receiving destination (Chia & Liao, 2020; Manaf et al., 2015b). The second subdivision is wellness tourism. According to Boekstein and Spencer (2013) and Smith and Puczko (2014), medical tourism involves sick people or patients travelling to receive surgery or medical treatment, while wellness tourism involves helping healthy people to stay healthy, both physically and mentally. Medical tourism is associated with the curing of illnesses and the restoration of health through medical intervention; therefore it takes place in hospitals/clinics, under the supervision of surgeons or physicians (Manaf et al., 2015b; Carrera & Bridges, 2006; Kara, 2016). Wellness tourism is also associated with the prevention of illness and may involve various procedures (e.g. massages, pedicures, beauty treatments, etc.) which may be performed in spas, wellness centres, etc. These do not require hospital/clinic
admission or the supervision of surgeons of physicians (Boekstein & Spencer, 2013; Kara, 2016; Manaf et al., 2015b).

In defining the concept, other authors also include the various services that medical tourists may seek in medical tourism destinations in addition to medical treatments/procedures. For instance, some medical tourists may also seek travel, financial and legal services (Park et al., 2017). Some authors even add the potential for a holiday or leisure at the destination (Gupta & Das, 2012; Kara, 2016; Lovelock & Lovelock, 2018; Wongkit & McKercher, 2013). The UNCTAD (2017) report, however, indicates that medical tourists are not a homogenous group, therefore, not all of them would seek the tourism aspect simultaneously with their medical needs, arguing that the medical need is likely to take precedence over tourism/holidaying. On the other hand, Uchida (in Lovelock and Lovelock, 2018), argues that medical tourism should rather be viewed as medical examination and treatment abroad. The reason provided by Uchida (in Lovelock & Lovelock, 2018) is also raised in the UNCTAD report (2017), i.e. medical tourists often go overseas for medical treatment or procedures rather than for a holiday (Nahai in Lovelock & Lovelock, 2018).

Patients usually seek medical treatment further from home if they feel that their healthcare needs are somehow not met at home. According to Glinos, Baeten, Helble and Maarse (2010), patients generally travel overseas in search of healthcare services (such as surgical, medical, dental care, and fertility treatment) which they are unable to access in their countries’ healthcare systems. Patients may struggle to access healthcare services at home for various reasons, for example, the healthcare services may be unavailable or very expensive at home in comparison to those of the medical tourism destination/s. According to Ahmadi et al. (2017) and Mogaka et al. (2017), medical tourists generally opt for medical treatment in the receiving countries to obtain obligatory and elective treatments. Obligatory treatment is usually immediate and unplanned, and is the treatment for dangerous diseases, such as neurosurgery, cardiovascular surgery, orthopaedics, oncology as well as reproductive treatments. Elective treatments include treatments and procedures deemed unnecessary in one’s own country, such as liposculpture, bariatric, plastic and cosmetic surgeries. Medical tourism may also be used for diagnostic treatments, such as scans, health screening
and second opinion diagnoses (Mogaka et al., 2017). The Medical Tourism Association (MTA, 2019) comprehensively summarises medical tourism as

... people who live in one country [and] travel to another country to receive medical, dental and surgical care, while at the same time receiving equal to or greater care than they would have in their own country, and are travelling for medical care because of affordability, better access to care or higher level of quality of care.

Not only does the definition by MTA look at the movement of medical tourists but it also gives context and/or reasons for these movements. This study acknowledges that medical tourism can also take place within one’s own country, at hospitals/clinics which are outside the patient’s regular place of residence, as alluded to by Smith and Puczko (2014). For the purpose of this study, the definition by MTA will be used.

The medical tourism industry is comprised of three categories, i.e. outbound, inbound and intrabound medical tourism (Gupta & Das, 2012). According to these authors (Gupta & Das, 2012), outbound medical tourism relates to the process in which patients travel out of their home countries to other countries for treatment. Inbound medical tourism, on the other hand, refers to the process whereby foreign patients travel into receiving countries for medical treatment. Lastly, intrabound medical tourism is the process whereby patients of any country travel within their own country or domestically for medical treatment. Most patients who may need treatment in a foreign location may not necessarily know where to start looking for useful information, although some may try to find information from the internet, their doctors, family members and friends (Abd Mutalib et al., 2017). Noting that medical tourists do not necessarily require a formal referral to engage in medical tourism (Khan et al., 2017; Leggat, 2015), and their possible need for privacy when receiving treatment (Gaines & Lee, 2019; Abd Mutalib et al., 2017), most patients may not even discuss their intentions with the people mentioned above. Patients are likely to find information online about medical tourism intermediaries or companies, and possibly interact with these to find out what their options are.

According to Kamassi, Manaf and Omar (2020) and Ko (2011), medical tourism intermediaries serve as a link between the specialists of various fields in medical tourism, and they connect these fields with the consumers/medical tourists. Typical examples of intermediaries include medical tourism facilitators; medical travel
agencies; medical travel associations; medical tourism tour operators; and medical
tour brokers. According to Stolley and Watson (2012), as companies, medical tourism
facilitators assist travellers in connecting with the care they are seeking, and they also
play a role as specialised travel agents. They therefore assist potential medical tourists
to find appropriate information relating to medical tourism and quality medical
treatments, and arrange the patient’s trip details, from booking accommodation to
transportation, and leisure activities (if requested) during the recuperation phase after
the medical procedure (Haarhoff & Mokoena, 2016; Stolley & Watson, 2012). According to Ko (2011), medical travel agencies provide specialised services for
overseas customers who would like to receive medical treatment, and they may also
be called medical/health travel/tourism agents, medical travel planners, medical travel
facilitators, medical travel brokers and medical expediters. Medical travel or tourism
agencies assist patients by conducting searches for the best global healthcare
available on behalf of patients, and by also providing the necessary support throughout
the patient’s medical tour. If necessary, or requested to do so, medical travel agencies
can also arrange air tickets, visas, transport and accommodation as well as food and
leisure activities on behalf of patients.

According to the health-tourism.com website (https://www.health-
tourism.com/medical-tourism/associations/), medical tourism associations came into
being as a response to the fast global growth of the medical tourism industry, and most
medical tourism destinations have their own medical tourism association or they are
affiliated to one. They are generally comprised of international hospitals, medical
providers, healthcare travel intermediaries, insurance companies, employers, patients
and other affiliated companies and members. The common objective of medical
tourism associations is to ensure that patients receive top medical treatments in top-
quality facilities globally.

According to Cook (2019), medical tour brokers offer healthcare or medical travel
benefit packages or insurance plans to patients who intend to receive medical
treatment, and this could be structured in such a way that patients can receive
treatment sponsored domestically, internationally, or through pharmaceutical
providers. The various plans offered by medical brokers are usually risk-profile
(sponsor or the patient) dependent and usually give patients an opportunity to save
substantially on medical costs without compromising the quality of treatment (Cook, 2019). Given that medical tourists generally pay for treatment from their own pockets, medical tour brokers can give potential medical tourists some form of financial relief through the insurance plans offered. Lastly, medical tourism tour operators on the other hand, serve as the main information channel between tourists and service providers and/or products (Romero & Tejada, 2019). From the descriptions given above with regards to medical tourism facilitators, medical travel agencies, medical travel associations, medical tourism tour operators and medical tour brokers as intermediaries, the common thread is that they all act as the connection between the customers (medical tourists) and tourism products (medical tourism products). Medical tourism operators will therefore be used in this study to refer to all medical tourism intermediaries.

In addition to the various intermediaries above, the success of the medical tourism industry is also reliant on other stakeholders such as the healthcare providers (hospitals/clinics, doctors, nurses and other medical professionals, especially at the receiving destinations), government agencies, accreditation and redentialising bodies, healthcare marketers, and infrastructure and facilities at the medical tourism destinations (Kamassi, et al., 2020; Lang, 2019; Yusof & Rosnan, 2020). As the main stakeholder, the medical tourist’s experience at the medical tourism destination is influenced by his/her interaction/s with any of the stakeholders mentioned above. Thus, when patients decide to visit a medical tourism destination, their experience is likely to be influenced by the quality of treatment they would receive from the treating doctors and the overall experience in the medical facility. According to Das and Mukherjee (2016), the patient’s healthcare provider experience has an impact on their perception of the medical tourism destination, therefore, the healthcare providers must ensure that their relationship with destination management organisations and agencies is in-sync in both destination marketing (and also involve healthcare marketers) and service provision to the patient. Being in-sync will assist both the healthcare providers and destination management organisations to manage the customers’ (patients’) expectations and perceptions in a meaningful way. Typical destination management organisations include intermediaries, other non-medical businesses (infrastructure and facilities) such as restaurants and hotels, as well as the locals at the medical tourism destination.
Medical tourists usually associate the quality of healthcare providers with their healthcare providers’ accreditation status. Ko (2011) and Lang (2019) argue that healthcare providers which have international accreditation from reputable bodies such as the Joint Commission International (JCI), Council for Health Services Accreditation of Southern Africa (COHSASA) and others, are perceived to render quality healthcare which meets international standards as determined by bodies such as the International Society for Quality in Healthcare (ISQua) and others. It is thus important for healthcare providers to ensure that they are accredited and also maintain a positive relationship with accrediting bodies so that these bodies can also help them to keep their services in check.

3.3 TYPES OF MEDICAL TOURISTS

Medical tourists are patients who travel to medical tourism destinations to receive healthcare services at the medical destination. According to Allen (in Ile & Tigu, 2017), medical tourists generate the demand for medical tourism, and as such they can be segmented into four categories based on their country of origin. The segments are as follows:

- medical tourists from *developed countries* that travel to *developing countries* for treatment.
- medical tourists from *developing countries* that travel to *other developing countries* for treatment, and these are also known as cross-border or South-South medical tourists.
- *wealthy* medical tourists from *developing countries* that travel to *developed countries* for treatment (also known as reverse tourism).
- *domestic* medical tourists travelling from *a city* (or province) to *another in the same country* (also known as domestic medical tourism).

The segments above illustrate that medical tourists are not homogenous, and that the motivation for one segment is very likely to be different from the other. For example, while medical tourists from developed countries may seek affordable medical treatments from developing countries due to the high cost of medical treatments in...
their own countries (Allen in Ille & Tigu, 2017; Xu, et al., 2020), the patients from developing countries with poor or no healthcare system would travel to other developing countries to access basic healthcare (Khan et al., 2017; Abd Mutalib et al., 2017). According to Marlowe and Sullivan (2007), medical tourists include the uninsured (have no healthcare insurance), underinsured (those with a limited healthcare insurance) and the uninsurable (those who cannot be insured for whatever reasons).

Ko (2011) reports that some medical tourists may travel because they need certain medical procedures/treatments (e.g. major/minor/cosmetic surgeries), while others may require some medical services (e.g. diagnostic services and alternative treatments) at the destination. Medical tourists are therefore regarded as consumers of medical tourism products and services (Ahmadi et al., 2017; Maaka, 2006; Smith & Puczko, 2014; Tham, 2018). Medical tourists may also be categorised according to their motivation for travel, e.g. for affordability and better access to care or a higher level of care in the medical tourism destination, and formal referral is not necessarily a requirement for one to do so (Ko, 2011; MTA, 2019; Najafi, Raeissi, Gorji, Ahmadi, & Haghighi, 2017). Occasionally, medical tourists combine the treatment/procedure with a vacation in the process (Cohen, 2008; Gupta & Das, 2012; Kara, 2016; Lovelock & Lovelock, 2018).

Wongkit and McKercher (2013) categorised medical tourists into four types depending on the extent to which the medical treatment influences their trip decision, i.e. the dedicated, hesitant, holidaying, and opportunistic medical tourist:

i. the **dedicated** medical tourist, i.e. someone who decided to seek treatment prior to departure to the medical tourism destination and identified seeking treatment as the main reason for his travel decision;

ii. the **hesitant** medical tourist, i.e. someone who identified seeking treatment as a main or equally important trip motive, but did not make the final decision to participate in medical tourism until arriving at the destination;

iii. the **holidaying** medical tourist, i.e. someone who identified a vacation as the main reason to travel and also pre-planned to undergo treatment at the medical tourism destination;
iv. the *opportunist* medical tourist, i.e. someone who travels to a destination primarily or mainly for a holiday and only decides to seek medical treatment once in the destination.

From these descriptions with regards to the types of medical tourists, it is evident that medical tourists are diverse. Not only does their country of origin influence their demand for medical tourism, but they are also influenced by the type of treatment that they require. From the four types above, it is clear that the dedicated and holidaying medical tourists plan beforehand to receive medical treatment at the destination. For the hesitant and opportunistic medical tourists, on the other hand, receiving medical treatment at the destination will just be slotted into an existing planned holiday. Medical tourists are therefore classified into two broad categories, i.e. those who travel solely for medical treatment, and those who combine a vacation with medical treatment (Cohen, 2008; Junio, *et al*., 2017; Wongkit & McKercher, 2013).

3.4 BENEFITS OF MEDICAL TOURISM TO THE MEDICAL TOURIST

Medical tourism involves the utilisation of medical and travel services by medical tourists, and among others, offers the following potential benefits to medical tourists.

3.4.1 Cost-saving

Saving costs is usually the main driver and benefit of medical tourism (Abubakar & Ilkan, 2016; Gaines & Lee, 2019; Kumar & Hussian, 2016; Tham, 2018). Patients in need of the lifesaving major procedures such as heart surgeries mostly prefer to receive treatment at home if they can afford the procedures, but such surgeries are very expensive, especially in developed countries (Horowitz & Rosensweig, 2007). As a result, price-conscious patients would look for treatment where they can get them at an affordable price, and usually this is in a developing country (Alleman, Luger, Reisinger, Martin, Horowitz & Cram, 2011; Xu *et al*., 2020). According to Horowitz and Rosensweig (2007), many medical tourists have to pay out of their own pocket for medical treatments such as cosmetic surgeries, dental reconstructions, gender reassignment operations and fertility treatments, as these treatments are not covered
by healthcare insurance. Although medical tourists still have to spend on airfares to and from the medical tourism destinations, accommodation, medical treatment and holidaying at these destinations, all these costs can still be perceived as affordable. Thus, if the total costs (for both the treatment, travel, accommodation, and others) to the medical tourism destination are perceived to be affordable as compared to what they (patients) would pay at home, they may serve as an incentive for medical tourists to travel elsewhere for medical treatment (Abd Mutalib et al., 2017).

Unlike developed countries, developing countries such as South Africa, Brazil, India and others can afford to charge lower fees for medical treatment as they spend less on labour costs, there is little or no third-party involvement (such as the government) in their pricing packages, and there is limited collaboration between healthcare facilities and physicians (Gill & Singh, 2011). Furthermore, service providers in developing countries tend to charge for the services rendered to patients independently, and the costs of malpractice and litigation (if any) are usually lower (Moghavvemi, Ormond, Musa, Isa, Thirumoorthi, Mustapha, Kanapathy & Chandy, 2017). People who do not have insurance or are underinsured also find getting medical treatment overseas (especially in developing countries) to be more affordable, convenient and practical (Henama, 2014; Abd Mutalib et al., 2017; Zolfagharian et al., 2018).

3.4.2 Shorter or no waiting lists

The likelihood of receiving medical treatment without having to be on a long waiting list or the possibility of waiting for a minimal period, is sufficient motivation for patients to consider engaging in medical tourism (Abubakar & Ilkan, 2016; Chia & Liao, 2020; Gaines & Lee, 2019; Kumar & Hussain, 2016; Tham, 2018). By opting to receive medical treatment in a foreign country, patients could gain faster access to medical treatment, and thus avoid having to wait before receiving treatment. According to Gill and Singh (2011) and Horowitz and Rosensweig (2007), even in countries such as the UK and Canada, where healthcare systems are intact, patients often opt to engage in medical tourism as they cannot afford to wait for their turn to receive treatment (which might be approximately between 22 and 28 weeks at times). Generally, patients feel
that it might be too late if they wait for their turn to come, as the healthcare need is usually considered urgent by the patient even if the healthcare system does not see the urgency for treatment at the time.

3.4.3 Quality of healthcare

Chia and Liao (2020), Wu, Li and Li (2016), and Abd Mutalib et al. (2017) argue that many potential medical tourists also engage in medical tourism because of the perceived quality of healthcare with accredited medical facilities and fully qualified medical professionals in foreign countries. According to Wongkit and McKercher (2016), patients usually question the quality of the healthcare treatment that they are likely to receive in foreign countries. Given the perceived risks associated with receiving medical treatment in an unfamiliar environment, the perceived potential quality of treatment that the patients expect to receive at the medical destination is likely to be regarded as a benefit (Habibi & Ariffin, 2019). Medical tourism also has the potential to improve access to certain treatments for the local communities through improved infrastructure and medical professional expertise, thus reducing brain-drain (Henama, 2014), therefore the services which were initially developed to attract medical tourists can also be of benefit to the locals.

According to Chia and Liao (2020) and Soltani et al. (2020), clear communication is necessary for the patients to understand and interpret their legal rights, information about their flights and vacation activities, as well as the risks of a surgical procedure in a foreign country. It is for this reason that many medical tourism destinations have medical staff who speak the language commonly spoken by the patients that visit the facility, so that communication can be as smooth as possible between patients and service providers in the receiving countries. For instance, the main language spoken by medical professionals in South Africa is English, however, translators are usually available in cases where English is not the main spoken language of medical tourists (MTSA, 2014).
3.4.4 Medical treatment and vacationing

Medical tourism has made people realise that they can combine their health needs with their vacation desires (Gaines & Lee, 2019; Ghosh and Mandal, 2019; Heung et al., 2010). According to Wongkit and Mckercher (in Wongkit & Mckercher, 2016), the tendency to want to combine medical treatment and vacation is common for long-haul medical tourists, especially in Thailand, and these patients would have usually visited Thailand for the purposes of both holiday and medical treatment. Patients who have had minor treatments, e.g. dental treatment or minor surgery, are likely to want to engage in leisure, fun and relaxation activities at the destination after treatment (Heung et al., 2010; Jónás-Berki, Csapó, Pálfi & Aubert, 2015). According to Jónás-Berki et al. (2015), some patients may even seek wellness and health-care services by visiting spas for massages and beauty treatments or visit historical and cultural sites at the destination. There are various medical travel companies providing travel packages that combine tourist attractions and medical facilities and/or services in their marketing and advertising campaigns. Often, such travel packages include airfare costs, luxurious accommodation (including recovery resorts), cost of surgery, and local sightseeing opportunities, depending on the traveller's needs. However, Ko (2011) argues that medical procedures take precedence even for vacationing medical tourists, as they would usually engage in tourism activities after having the procedures.

3.4.5 Confidentiality and privacy

The need and desire for confidentiality and personal privacy can also be regarded as another benefit of participating in medical tourism (Abubakar & Ilkan, 2016; Chow et al., 2015; Zolfagharian et al., 2018). Patients worldwide are concerned about the privacy of their health information and, as a result, they must give consent for their medical information to be transferred from one healthcare provider to the next. Although many countries have legislation to ensure confidentiality, sometimes patient information still gets distributed without the patients’ consent, resulting in much distress for patients. Obtaining medical treatment domestically is mostly accompanied by significant information sharing (Zolfagharian et al., 2018), and as such, patients who are concerned about the confidentiality and privacy of their treatment, usually opt
for medical tourism, even though the privacy cannot be sustained for long. Typical treatments that patients usually want to undergo without being noticed by people they know include some cosmetic surgeries, gender reassignment and drug addiction therapy (Horowitz & Rosensweig, 2007; Ko, 2011).

3.4.6 Access to treatments inaccessible in own country

Some patients may want to undergo medical treatments which are subjected to legal, moral, cultural, and social restrictions in their own countries, and as such regarded as illegal and prosecutable (Ko, 2011; Zolfagharian et al., 2018). Examples of such treatments include abortion, fertility and reproductive treatment, stem cell therapy, euthanasia and some organ transplants. These treatments may be easily accessible in other countries without the fear of being prosecuted. According to Gaines and Lee (2019), medical tourists can also access novel or experimental treatments and/or procedures, which may also not be available in their own countries, at medical tourism destinations.

3.4.7 Benefits of medical tourism to the destination country

Various benefits for countries offering medical tourism services have also been identified by various authors. Whittaker et al. (2010) report that medical tourism has the potential to contribute to a country’s economy because it leads to the creation of employment in both the medical arena and the tourism industry in general. Medical tourism can also contribute to the generation of foreign exchange and tax revenues through its linkages with other businesses involved in tourism, such as insurance as well as food and hotel industries, as such businesses will also benefit from the spending by medical tourists. In addition to the above, Mogaka et al. (2017) argue that healthcare systems in receiving countries may be able to reverse the brain drain of medical professionals as medical tourism allows for the existence of diverse medical specialists. In the opinion of these authors medical tourism provides an opportunity for the transfer of the latest medical technology in healthcare. Not only can medical tourism be used to benchmark the local healthcare system in receiving destinations, it
also gives countries an opportunity to evaluate their own healthcare systems against others globally.

3.5 DISADVANTAGES AND RISKS OF MEDICAL TOURISM

There is no doubt that medical tourism can widen the medical tourist’s choices with regards to the choice of a destination, facility/ies and service providers. The phenomenon can, however, be complicated by legal and ethical issues. Medical tourism also has the potential to expose medical tourists to emotional challenges and risks which can affect them negatively. The reputation of medical practitioners at the receiving destination, as well as the image of the medical tourism destination, can also be affected negatively especially if the medical tourists had bad experiences. The following paragraphs describe some of the potential disadvantages associated with medical tourism.

3.5.1 Organ transplants

According to Henama (2014) and Mogaka et al. (2017), medical tourism has the potential to encourage living-donor transplants or making illegal organ transplants. Donors usually donate organs prior to their death, however, in countries such as China, India, Iran, Pakistan, Thailand, Singapore, Peru, Egypt, Turkey and Mexico, it was found that most organ donations were living-donor transplants. The reason for the fertile ground for market of illegal organ transplants is spurred by the shortage of donors worldwide in contrast to the demand for organs (Nicolaides & Smith, 2012).

3.5.2 Role of two-tier systems

Most medical tourism destinations establish two-tier systems. The impact of a two-tier system in most cases is that domestic patients are not well-catered for. In such cases, healthcare resources and personnel may sometimes be reserved for medical tourism or the private sector at the expense of the locals (Gaines & Lee, 2019; Mogaka et al., 2017; Ormond, Mun & Khoon, 2015; Whittaker et al., 2010). According to Whittaker et al. (2010), countries with two-tier healthcare systems tend to commodify healthcare
and their healthcare resources are usually unequally distributed. Such countries tend to have wide disparities between the wealthy and the poor, with technologically sophisticated hospitals catering for the wealthy medical tourists and the elite, while public hospitals remain poorly resourced.

3.5.3 Accreditation and patient protection

Although many medical facilities at most medical tourism destinations may be internationally accredited, some of these may not necessarily provide sufficient patient protection (Gaines & Lee, 2019; Henama, 2014; Abd Mutalib, Ming, Yee, Wong & Soh, 2016). This trend is very common in many developing countries as most of these countries do not have strong legal systems. The poor legal circumstances in these countries make medical tourists vulnerable should they suffer any medical malpractice as there may be no recourse. Some countries may also not be compliant with the HIPAA (Health Insurance Portability and Accountability Act) (Gan & Frederick, 2018), and as a result, patients’ privacy and confidentiality may be at risk even if it had been promised to the patients.

3.5.4 Experimental treatments

Many medical tourists participate in medical tourism for the opportunity to access novel or experimental treatments at the receiving destinations (Gaines & Lee, 2019). Often such treatments will not have been scientifically tested for effectiveness, and thus, medical tourists who opt for such treatments, will be doing so at their own risk. According to Mogaka et al. (2017) and Whittaker et al. (2010: 340), medical tourism destinations may also experience local brain-drain. The result of the brain-drain is that skilled medical professionals from the public sector are lost to the private healthcare sector, which caters for the elite and medical tourists at the expense of the local population. In many countries, the majority of the locals are likely to depend on the public healthcare system, which is usually under-resourced and underfunded.
3.5.5 Risks

Just as there are risks associated with leisure tourism, so there are various risks to which medical tourists expose themselves when they engage in medical tourism. According to Fuchs and Reichel (in Khan et al., 2017), health and medical tourists are more likely to be exposed to risk than other categories of travellers, such as leisure travellers, as they tend to be more vulnerable due to having undergone medical treatments/procedures. Below are some of the potential risks.

3.5.5.1 Risks related to health at a tourist destination
According to Chen and Wilson (2015), Leggat (2015), and Ruggeri, Zalis, Meurice, Hilton, Ly, Zupan and Hinrichs (2015), medical tourists are at risk of contracting diseases at some medical tourism destinations. This risk may be influenced by various conditions at the destination, e.g. contaminated water, unhygienic food, substandard healthcare and poor sanitation services. Medical tourists may also not be in a position to evaluate the quality of the level of care at the destination as they may lack access to the destination’s treatment quality data (Gaines & Lee, 2019; Soltani et al., 2020). Medical tourists may also not be able to evaluate the data (where available or provided) to determine its accuracy (Abd Mutalib et al., 2016).

3.5.5.2 Risks related to long-haul travel
Long-haul travel can cause various health complications and conditions for travellers. Medical tourists who travel to distant medical tourism destinations may also suffer various complications, such as thrombosis and deep vein thrombosis from lengthy air travel (Gaines & Lee, 2019; Gan & Frederick, 2018; Kumar & Hussain, 2016; Abd Mutalib et al., 2016). Infection control practices at some destinations may also not be at the same standard as in the home countries of medical tourists. Poor infection control may thus expose medical tourists to infections and/or infectious diseases, such as HIV and Hepatitis B and C after undergoing procedures (Leggat, 2015; Ruggeri et al., 2015; Soltani, et al., 2020). The medical complications experienced by medical tourists also have the potential to lead to incur further costs, e.g. having to see other physicians for corrective treatment/s and post-operative care (Gaines & Lee, 2019; Reddy, York & Brannon, 2010), possibly on their return to their home countries.
3.5.5.3 Destination-related risks

Every destination has its unique risks. As such, all travellers, medical travellers included, may be at risk of crime, robbery, abduction, racism, and physical and sexual assault (Gan & Frederick, 2018; Khan et al., 2017).

3.5.5.4 Pre-operative and recuperative risks

According to and Khan et al. (2017) and Leggat (2015), sometimes patients do not necessarily consult their local physicians before embarking on medical tourism. Not only do they risk the discontinuation of medical records at home, but this also puts them at risk of other complications. The risks and complications may range from anaesthetic recovery and healing, to possible impairment and disability as a result of the medical or surgical treatment (Chen & Wilson, 2015). Some patients may even develop psychological and emotional distress while recovering, and may not necessarily be able to access the necessary medical assistance they require from the receiving destination (Khan et al., 2017). Abd Mutalib et al. (2016), Leggat (2015) and Reddy et al. (2010) opine that medical tourists may also find it difficult to obtain follow-up care after surgery at the receiving destination as they are more likely to return to their home country soon after the treatment/procedure.

It is preferable for prospective medical tourists to consult with their physicians and travel medicine provider/s in their home country before embarking on medical tourism. However, as indicated by Crooks et al. (2010), Johnston et al. (2012), and Leggat (2015), this is not always the case. According to Gaines and Lee (2019), consulting with their physicians will empower the patients on various issues, such as the risks associated with surgery and travel; the need for using accredited healthcare providers and facilities in receiving destinations; how to assess the facilities and providers in the receiving destinations; the legal recourse available to them should they experience medical-related problems, and how to plan for follow-up care.

The types of medical tourists as well as the benefits of medical tourism to medical tourists provides the background to determine the push and pull factors that motivate a potential medical tourist to seek medical treatment in a medical destination. The disadvantages and risks associated with medical tourism will help the potential
medical tourist to make an informed decision on whether or not to engage in medical tourism.

3.6 PUSH-PULL THEORY: MEDICAL TOURISM CONTEXT

The push-pull theory will be the theoretical framework used in this study, and has been discussed in detail in the previous chapter. The push-pull theory has been used in different studies to explain the different aspects of consumer motivation in selecting one destination over another. The push-pull theory demonstrates that people are motivated or pushed by conditions or circumstances that they deem unfavourable, whilst at the same time being drawn or pulled by conditions or circumstance that they perceive to be favourable. Motivation thus plays an important role in the push-pull theory, given that people generally engage in tourism in order to satisfy their travel needs which they feel are not met at home.

3.6.1 Medical tourism push factors

As indicated in the previous chapter, motivation refers to the internal force or drive that develops from a non-satisfied need and this non-satisfied need usually leads to an individual performing a specific need-satisfying behaviour (Khan et al., 2017). According to Marlowe and Sullivan (2007), individuals or patients participating in medical tourism will have to be very motivated to travel distances (sometimes long distances) for medical treatment.

Medical tourism push factors are mainly related to the medical tourists’ individual characteristics and healthcare needs. According to Khan, Chelliah and Haron (2016), and Runnels and Carrera (2012), medical tourists are mainly pushed by the need for medical or healthcare which most of the time cannot be fulfilled in their home countries or where they are located (Horsfall, 2019), which then leads to the demand for medical tourism. Khan et al. (2016), argue that sometimes the patients may also be dissatisfied with specifics or the overall medical care in their home country, although this is not common. Hence medical tourism becomes an attractive option for them. According to Heung et al. (2010:244), the demand for medical tourism illustrates the medical needs
that motivate potential medical tourists to seek medical treatment and influences his/her selection of the doctor, hospital and the destination. The demand for medical tourism is therefore generated by medical tourists (Allen in Ile & Tigu, 2017; Horsfall, 2019). The demand aspects of medical tourism can also be referred to as the push factors. Individual sociodemographic factors, such as the medical tourists’ age, gender, and income, also play an influential role in pushing medical tourists to seek medical treatments in receiving destinations (Fetscherin & Stephano, 2016; John & Larke, 2016).

3.6.1.1 Healthcare needs of medical tourists
Patients would consider medical tourism to satisfy their healthcare needs which they feel are unmet or not considered urgent in their home country. Runnels and Carrera (2012), and Chow et al. (in Lovelock & Lovelock, 2018), argue that when individuals decide to embark on medical tourism, they tend to follow a certain pattern as follows:

- Establish what their core healthcare needs are at the time;
- Think about and weigh the available treatment options at home and/or abroad;
- Consider the cost of treatment at home and/abroad;
- Establish whether they have the time (or can make time) to travel for the treatment or wait for their turn in the local healthcare system

As soon as all the relevant comparisons have been made and all the questions they may have are satisfactorily answered, they can then decide whether or not to take the trip. The authors (Runnels & Carrera, 2012; and Chow et al. in Lovelock & Lovelock, 2018) above are also of the view that the final decision on whether or not to embark on medical tourism, is mainly dependent on whether the healthcare system at home can/cannot help satisfy the healthcare needs experienced at the time of need, versus going elsewhere for treatment.

To explain the healthcare needs, Runnels and Carrera (2012) arranged these in a hierarchy as indicated in Figure 3.1. As with Maslow’s hierarchy of needs (see Figure 2.1 on page 19), it is common for the needs at the bottom of the hierarchy to be satisfied first before individuals can move to the next or higher level needs (as indicated by the upward arrow in Figure 3.1).
Figure 3.1: Hierarchy of healthcare needs

The upward arrow in Figure 3.1 indicates that healthcare needs go beyond the examples given for basic healthcare, i.e. immunisation and preventive screenings. For basic healthcare, funding is readily available for all patients in the home destination who may require these services, and there are no restrictions or waiting period to receive them. However, most people from developing countries may not even have access to basic healthcare (Lunt, Horsfall & Hanefeld, 2016; Chikanda & Crush, 2019; Crush & Chikanda, 2015; Khan et al., 2017), and as such, they may be forced to look for basic healthcare at a receiving destination.

As the hierarchy continues, there may be patients who have a need for medically necessary treatments, e.g. acute care for sickness or injury, which may be inaccessible to patients domestically for various reasons, such as lack of or insufficient health insurance, waiting lists, or treatment may be apportioned according to its urgency. Figure 3.1 also illustrates that medical tourism considerations are most likely to begin at the medically necessary treatment level, especially for patients from developed countries. It is at this level that patients start weighing their needs against the available treatment at home or abroad depending on their circumstances, as indicated by Runnels and Carrera (2012) and Chow et al. (in Lovelock and Lovelock, 2018). Some of the considerations patients are likely to debate would be whether they can wait for their turn (which in other countries can be up to eight weeks or more), or
whether they can afford to go elsewhere to get immediate treatment. If the patient decides to go abroad for treatment, financial implications must also be considered.

Above the medically necessary treatment level in the hierarchy, healthcare needs tend to be more elective (not emergency), i.e. health enhancement and optimum health. Patients usually plan ahead for these and most instances they will be paying themselves, as these treatments are generally not covered by insurance (Lang, 2019). The cost of the procedure is not necessarily a motivating factor for the medical treatment. If patients want to undergo a publicly funded elective treatment, then they must be willing to wait as these may be subject to waiting period and are prioritised according to their level of urgency. The optimum health level in the hierarchy mostly focuses on wellness and holistic health, and these do not form part of medical tourism. Wellness and holistic health are within wellness tourism (which is a sub-category of health tourism), and these involve helping healthy people to stay healthy, both physically and mentally (Goodrich in Boekstein & Spencer, 2013; Carrera & Bridges, 2006).

3.6.1.2 Other medical tourism push factors

Medical push factors can also be categorised into: procedure-, travel-, affordability and cost-related push factors (Chow et al., 2015; Hudson & Li, 2012; Khan et al., 2016).

(i) Procedure-related push factors

These relate to the need to have a medical procedure. Patients can also be pushed by the nature/type of procedure (John & Larke, 2016) they need at the time. According to Chow et al. (2015), John and Larke (2016) and Abd Mutalib et al. (2017), when considering to get medical treatment at a medical tourism destination, the demand for such treatment would be motivated by the specific medical procedure that they need to undergo (e.g. cosmetic, dental, etc.) and the unavailability of expertise at home (Rokni et al. in Matiza & Slabbert, 2020), which is usually matched by the availability of the required expertise at the receiving destination. The patients will also consider the perceived quality and reliability of the medical care in the receiving destination in comparison to their home destination (Manaf et al., 2015b; Matiza & Slabbert, 2020). Sometimes patients may want to undergo procedures which are deemed illegal in their home countries, thus unavailable or prosecutable. Typical examples of such
procedures include organ transplants, some fertility and reproductive procedures, and stem cell therapies (Annas in Zolfagharian et al., 2018; Khan et al., 2016; Ko 2011). In this regard, patients needing such treatments (banned or unavailable), will have to go to foreign countries to receive them. Patients’ influential sources of information in decision-making include recommendations from their doctors, families and friends (Al-Maaitah, 2016). Medical tourists’ prior medical tourism experience, their need for privacy and confidentiality when getting treatment, and the cultural similarities between themselves and the medical tourism destination country, can also motivate them to consider medical tourism as an option (Al-Maaitah, 2016; John & Larke, 2016; Abd Mutalib et al, 2017).

(ii) Affordability and cost-related push factors
These factors relate to the affordability of healthcare in the receiving country. The patient will make a cost comparison between having the procedure at home or elsewhere. These push factors may be mainly influenced by the unaffordability experienced in the home country at the time. According to Heung et al. (2010), the patients will therefore have to establish how much the procedure will cost, so that they know whether or not they will be able to afford the procedure. The potential to pay less for treatment at the receiving destination plays a huge role in motivating medical tourists to participate in medical tourism. According to John and Larke (2016), Matiza and Slabbert (2020) and Zolfagharian et al. (2018), the patients’ insurance status and coverage may also influence patients to seek medical treatment elsewhere, as some of the treatments they may need may not necessarily be covered by insurance in their home countries. If such patients were to have the procedures done at home, they would have to pay cash, and this tends to be very expensive (Al-Maaitah, 2016; Österle et al., 2013; Zarei & Maleki, 2019).

(iii) Travel-related push factors
These factors, on the other hand, relate to how easy or difficult it is to access the medical tourism destination and the frequency of flights, but may also include the cost of travel as indicated earlier as cost-related push factors.

In addition, medical tourism push factors are influenced by where the medical tourists come from. The push factors of medical tourists from developed countries will differ
from those of developing countries. Medical tourists from developed countries are pushed to travel to receiving destinations for medical treatment for various reasons, and their procedure-related factors are likely to be different from those of patients from developing countries, as their healthcare needs may also be different or influenced by different circumstances (Lunt et al., 2016). Typical examples of their reasons are: to avoid the ever-increasing costs of medical care in their own countries; to obtain treatments not covered by their insurance policies at home (Manaf et al., 2015a), and to avoid the unacceptable long waiting lists for certain procedures in their home countries (Adwan, 2020; Habibi & Ariffin, 2019; Zolfagharian et al., 2018; Wang, 2012; Zarei & Maleki, 2019). Patients may also want to have access to novel or experimental treatments and procedures prohibited and/or unavailable in their health systems (Ahmadi et al., 2017; Gill & Singh, 2011; Hudson & Li, 2012). Some patients may want to take advantage of the growing technological sophistications/innovations in receiving destinations, the potential quality and safety of treatments available overseas, the simplicity of travelling (and relative affordability of international air travel) to foreign nations, and privacy and confidentiality (John & Larke, 2016; Zolfagharian et al., 2018; Zarei & Maleki, 2019).

The motivations for medical tourists from developing countries are completely different from those who originate from developed countries. The motivation of these patients to participate in medical tourism stems from the fact that, in most cases, these countries do not have fully-functional healthcare systems (Lunt et al., 2016; Chikanda & Crush, 2019; Crush & Chikanda, 2015; Khan et al., 2017). For such patients, especially those who are poor, cost is not necessarily the motivating factor, as they may have no alternative, even for basic healthcare, in their home countries (Manaf et al., 2015a). Most governments in developing countries enter into bilateral agreements so that their citizens can access healthcare (public and private) from neighbouring countries with better healthcare systems (Chikanda & Crush, 2019; Khan et al., 2017; Ormond & Sulianti, 2017). The healthcare agreements between neighbouring countries facilitate cross-border healthcare between the countries, and also shows that medical tourism can take place within a closer geographical location or region (de la Hoz-Correa & Muñoz-Leiva, 2019).
In conclusion, medical tourism push factors illustrate that medical tourists are not a homogenous market or group, as also indicated in the UNCTAD (2017) report. As indicated by Zarei and Maleki (2019), medical tourism push factors reflect on and relate to the medical tourists and their home countries. Typical push factors include the need of medical tourists to save on costs, to avoid waiting lists, unavailability of treatments and the need for privacy when receiving treatment (Chia & Liao, 2020). Four categories of medical tourism push factors were identified, i.e. healthcare needs, procedure, cost, and travel related (Chow et al., 2015). Healthcare needs range from basic healthcare needs to optimum healthcare needs. Procedure-related push factors deal with access to treatments and may also be influenced by the extent of the procedure required, i.e. whether the procedure required is life-threatening (major) or not. The extent of the procedure needed at the time influences the patient’s decision-making process, especially with regards to where to go (i.e. locally or at the medical tourism destination) for treatment. Cost-related push factors are about the affordability of treatment which may also be influenced by the availability or lack of healthcare insurance. Cost-related push factors are also related to the travel-related push factors with regards to the affordability of international travel. Travel-related factors are also about how easy/difficult it is for patients to reach the medical tourism destination.

3.6.2 Medical tourism pull factors

Tourists are attracted to destinations which they feel have attributes or elements that can satisfy their travel needs. The attributes at the destinations are also known as pull factors, and their role is to attract inbound tourists to the destination. According to Heung et al. (2010) and Matiza and Slabbert (2020), pull factors are closely related to the supply-side of the medical tourism destination and they deal with the infrastructure, promotion, quality and communication at the destination. Pull factors thus explain where people travel, i.e. the destination choice.

According to Adwan (2020) and Zarei and Maleki (2019), medical tourism pull factors refer to factors related to the healthcare or medical services providers and the physical (tourism) external attributes in the medical tourism destinations. Healthcare provider-specific pull factors relate to the features of the healthcare or medical treatment
providers at the receiving destination which will influence patients to seek medical treatment at the destination. Destination pull factors, on the other hand, relate to the specific external features that make a destination appealing to potential medical tourists (John & Larke, 2016).

3.6.2.1 Healthcare provider pull factors
Healthcare provider-specific pull factors influence potential medical tourists’ decisions to seek medical care at a medical tourism destination. According to Ghosh and Mandal (2019), Matiza and Slabbert (2020) and Zarei and Maleki (2019), potential medical tourists are drawn or pulled towards the healthcare providers in the receiving destination if the providers are perceived to offer affordable and personalised quality medical treatment or services. Furthermore, the providers are likely to have a pulling effect if the physicians’ and other medical professionals’ expertise and reputation are perceived to be of high quality and deemed trustworthy (John & Larke, 2016). In addition, if the general quality of healthcare is perceived to be of a high standard and the medical facilities are accredited (Al-Maaitah, 2016; John & Larke, 2016), the healthcare providers will be attractive to patients. In Ghosh and Mandal’s (2019) and Iajevardi’s (in Matiza & Slabbert, 2020) opinions, healthcare providers that have advanced medical technologies, such as robotics and other artificial intelligence technologies, are likely to be very appealing to potential medical tourists.

Potential medical tourists are also drawn by the providers’ ability to offer multi-speciality medical services, such as the possibility of undergoing a procedure and also getting recuperating services at the facility (John & Larke, 2016; Österle et al., 2013). Given that most developed countries tend to subject patients to long waiting lists before they can access some of the medical treatments, the potential to be on a shorter waiting list or to access treatment faster (Adwan, 2020; Khan et al., 2016; Zolfagharian et al., 2018) will also pull potential medical tourists. Healthcare providers who are able to serve potential medical tourists in their preferred language or who are proficient in the language/s used by medical tourists have the potential to pull medical tourists (John & Larke, 2016; Shahrrokh et al., 2017; Soltani et al., 2020; Wongkit & McKercher, 2016). However, some healthcare providers do offer translation services to potential medical tourists (MTSA, 2014).
3.6.2.2 Destination-specific pull factors

Destination specific pull factors relate to the external attributes or characteristics of the medical tourism destination. According to Al-Maaitah (2016), Ghosh and Mandal (2019) and John and Larke (2016), medical tourism destinations that have a positive image (e.g. perceived to be safe, offering good quality healthcare, and welcoming to tourists) are likely to be more attractive to potential medical tourists. In addition to a positive image, medical tourism destinations with responsive healthcare-related laws (Henama in Matiza & Slabbert, 2020) and generally stable political, regulatory, social and economic circumstances (Henson, Guy & Dotson, 2015; Smith & Forgione, 2007; Shahrokh & Kalamabadi, 2016) are likely to attract potential medical tourists.

Most potential medical tourists would usually like to save costs where possible, and thus, if the destination offers them favourable exchange rates, they can easily choose that destination over others that do not have the same advantage (John & Larke, 2016). Al-Maaitah (2016) and John and Larke (2016), also argue that destinations that offer top quality public and private healthcare infrastructure, and a high standard of accommodation (e.g. hotels), are likely to be perceived as attractive by potential medical tourists. Medical tourists would most probably want to use non-medical services at their destination, such as restaurants and banks, and other medically related facilities and services, such as laboratories and ambulance services. Thus, destinations that offer top quality supplementary services infrastructure are likely to pull potential medical tourists to their shores (Wongkit & McKercher, 2016; Zarei & Maleki, 2019).

3.6.2.3 Medical Tourism Index (MTI)

According to Fetscherin and Stephano (2016), the Medical Tourism Index (MTI) is a country specific and statistical measurement instrument used as a benchmarking tool for assessing the attractiveness of a country. The index focuses on the following attributes or dimensions relating to medical tourism (receiving) destinations: i.e. the overall country environment, the destination country’s healthcare costs and tourism attractiveness, and the quality of medical facilities and services at the destination. The MTI is therefore a tool used to measure medical tourism destination pull factors.
As a tool, the MTI uses simple numbers to explain the medical tourism phenomena and trends, which cannot be effectively explained any other way (Fetscherin & Stephano, 2016). A medical tourism destination’s average score is computed using the dimensions (i.e. destination environment, medical tourism industry, and quality of facilities and services). According to Fetscherin and Stephano (2016), the dimensions are related and interdependent, i.e. the country environment (Dimension 1) provides a framework for the medical and tourism industry (Dimension 2) which subsequently impacts on the quality of medical facilities and services (Dimension 3) of the medical destination.

(i) **Dimension 1: Country environment**
According to Fetscherin and Stephano (2016), this dimension refers to the image and the overall environment of the receiving country, i.e. the medical tourism destination as perceived by the potential medical tourist. This dimension includes the political environment (e.g. low level of corruption or no corruption at all); stable economic conditions and favourable exchange rates; historical and cultural factors (including language), as well as safety and security at the destination. The country environment factors were also identified by John and Larke (2016), Smith and Forgione (2007) and Henson *et al.* (2015) as important role players in the medical tourist’s decision with regards to choosing a potential medical tourism destination.

(ii) **Dimension 2: Medical and tourism factors**
Smith and Puczko (2014) maintain that medical tourism combines medical and tourism services at the destination. This dimension therefore relates to the healthcare system and tourism industries in the receiving destination. According to Fetscherin and Stephano (2016), the medical tourism aspect in the receiving destination is comprised of low cost of treatment and healthcare, low cost of accommodation and travel, as well as the affordability of airfares as perceived by the potential medical tourist. Patients usually consider (are pushed into) medical tourism because of the higher prices that are charged at home for medical treatments, and thus lower prices (including travelling and accommodation prices) at the potential medical destination will be appealing, as also indicated by John and Larke (2016). Tourism-related items include the external and physical attributes such as the weather conditions at the receiving destination, the attractiveness of the country as a tourist destination, the availability of cultural and
natural attractions, and whether the destination is perceived as a popular or exotic destination. According to Zolfagharian et al. (2018), medical tourists also take the destination’s physical attributes into consideration when choosing a potential medical destination.

(iii) Dimension 3: Quality of facilities and services
This dimension relates to the quality of facilities or hospitals, and the service quality of the medical professionals (i.e. doctors, nurses and other professionals) in the receiving country. According to the MTA (in Fetscherin & Stephano, 2016), most medical tourists are likely to perceive a medical facility to be of good quality based on the facility, i.e. the hospitals or facilities being internationally accredited and meeting international standards as prescribed by bodies such as the International Organisation for Standards (ISO), availability of state of the art hospitals, and the reputation of the hospitals and the healthcare quality indicators (e.g. for pre- and post-operative care). According to Zolfagharian et al. (2018), destinations offering good quality facilities and services are more desirable to medical tourists than those with questionable quality features or assurance. The service quality of medical professionals, on the other hand, refers to the doctors’ and nurses’ education and training, their accreditation and expertise. The friendliness of the medical staff and doctors and the country’s medical reputation also form part of this dimension. Word of mouth plays an important role in medical tourism, and thus the recommendation of doctors and/or facilities by families or friends is very important (Abd Mutalib et al., 2017). In his study, Mokoena (2015) found that 97.03% of medical tourists deemed the quality of medical services and the accreditation status (also 97.03%) of the facility as attractive and influential in selecting a medical tourism destination. These were closely followed by the quality of medical facilities at 92.20%.

In conclusion, the medical tourism pull factors relate to the healthcare service provider and the physical attributes at the medical tourism destinations that attract potential medical tourists to a destination (Festcherin & Stephano, 2016; John & Larke, 2016; Zarei & Maleki, 2019). Typical medical tourism pull factors relating to the healthcare provider include the doctors’ expertise, reputation and training, the cost and quality of treatments in hospitals and the accreditation of the facilities (Adwan, 2020; Lang, 2019; Manaf, Hussin, Kassim, Alavi & Dahari, 2015b). Destination-specific factors, on
the other hand, include the overall destination circumstances (e.g. political, economic and regulatory) and environment, accessibility of the destination and the availability of various infrastructures at the destination. Medical tourists have various destinations from which to choose and therefore the availability of an index such as the MTI can help them (by using the scores) to compare destinations.

3.6.3 Interrelationship between push and pull factors

Figure 3.2 illustrates the interrelationship between the demand (push factors) and supply (pull factors) aspects in medical tourism.

Figure 3.2: Interrelationship between demand (push factors) and supply (pull) factors

Source: Heung et al. (2010:244)
Figure 3.2 illustrates the demand and supply for medical tourism. The demand for medical tourism is influenced or generated by the patient’s need for medical treatment which arises because such need cannot be satisfied at home, for whatever reason. As indicated earlier, motivation is the main connection between the tourist’s needs and the action that must be taken by the tourist to satisfy the need (Sharpley, 2006). Figure 3.2 thus demonstrates the processes which the potential medical tourist takes in order to satisfy his need for medical treatment. As indicated by Runnels and Carrera (2012), once a medical need arises, patients usually weigh their treatment options at home or at the medical tourism destination, consider the costs of treatment (in both locations), and then establishes whether they can wait for their turn at home for the treatment or decide to go elsewhere for treatment. The demand for medical tourism thus relates to the medical tourist’s push factors.

The demand for medical tourism as illustrated in Figure 3.2 also demonstrates the expectations of a potential medical tourist with regards to his/her specific healthcare or medical treatment needs (John & Larke, 2016), at the time. In order for the potential medical tourists to make an informed decision and choice regarding their medical treatment needs (and the extent of the treatment required), they need to be informed, and thus they will make use of any of the advertising and/or distribution channels, as indicated in the model. According to Figure 3.2, the medical tourist has a variety of information sources to choose from, such as family and friends, medical tourism intermediaries, hospital representatives and others. The potential medical tourist also needs to assess the information that he/she acquires so as to make an informed decision regarding the action needed to satisfy his pending need. According to Heung et al. (2010), the potential medical tourist needs information to select the doctor, the hospital or the destination as indicated with the bracket-arrows that originate from the distribution channels. Studies have shown that the source of information of many potential medical tourists is family doctors and friends (Al-Maaitah, 2016; Crooks et al., 2010; Johnston et al., 2012). However, even though the patients would get information from their doctors, formal referral is not necessarily a requirement for them to seek/get treatment in the medical tourism destination (Johnston et al., 2012; Leggat, 2015). The double-ended arrows between the selection of the doctor, hospital, and destination illustrate the interdependence of the three aspects.
Different patients will follow different decision-making processes, largely influenced by the medical treatment required. For instance, the needs of a patient requiring an aesthetic surgical procedure will differ greatly from the one requiring an organ transplant, therefore, the decision processes required and the prioritisation of the factors that affect decision making are likely to be different (Heung et al., 2010). Furthermore, the physician’s qualifications and expertise may be the main concern for patients in need of surgery (major or minor), but for patients in need of a life-threatening major surgery, the cost of the treatment may not necessarily matter as compared to someone in need of an aesthetic surgery (Runnels & Carrera, 2012). In making their decisions, sometimes patients have to do so because the treatment they need is unavailable and/or illegal at home (John & Larke, 2016), and thus the receiving destination that is able to satisfy their need becomes an option. At times the treatment may be available at home, but it may be unaffordable or affordable but subject to long waiting lists (Adwan, 2020; John & Larke, 2016); thus, a receiving destination where the patient can access such treatment in the shortest possible waiting time or no waiting at all, will be an option.

The supply aspects, on the other hand, relate to all the destination’s promotional efforts, facilities and services offered at the medical tourism destination. The supply aspect thus relates to pull factors. Heung et al. (2010), argue that medical tourism destinations must ensure that all the medical infrastructure (including superstructure) and the quality of medical facilities and services (hospitals and clinics) must be able to satisfy the patient’s expectations, for them to be considered attractive to potential medical tourists. The government departments in medical tourism destinations must therefore vigorously promote their medical tourism industries through national campaigns and overseas marketing strategies. Medical tourism destinations must ensure that good communication systems are in place, and at least have medical personnel who are able to speak various international languages. To measure the attractiveness of medical tourism destinations and to benchmark with other medical destinations, a medical tourism index (MTI) was developed by the International Healthcare Research Centre (IHRC) in 2016 (Fetscherin & Stephano, 2016). In their decision-making process, patients should also consider what the medical tourism destination has to offer in order to satisfy their needs. Destinations perceived to offer affordable quality treatments, which have quality facilities and where patients can
access the treatment they need as speedily as possible and without fear of prosecution, are deemed to be attractive (Zolfagharian et al., 2018). The use of the double-arrows between the demand and supply in Figure 3.2 demonstrates the interrelationship between the demand for medical services or treatments (push factors), and the supply of medical services (pull factors) at medical tourism destinations in response to the demand by medical tourists.

3.7 HOW PUSH-PULL FACTORS OF A MEDICAL TOURISM DESTINATION DIFFER BASED ON TYPE OF PROCEDURE OFFERED

Medical tourists participate in medical tourism to access various types of medical procedures and treatments from medical tourism destinations. According to Heung et al. (2010) and Wongkit and McKercher (2013), medical procedures or treatments sought by medical tourists in medical tourism destinations may vary from preventative medical services (e.g. check-ups and health screenings), and minor procedures (e.g. dental surgeries), to major invasive procedures (e.g. open-heart surgery, knee/hip replacements, and spinal fusions), and gender transformations. According to Cormany (in Ko, 2011), the procedures sought by medical tourists at a receiving destination can be categorised as follows:

- Necessary major surgeries or procedures, e.g. cardiac or heart surgeries and cancer treatments and therapies;
- Treatments/procedures unavailable or deemed illegal at home, e.g. fertility and reproductive treatments, sex changes, and euthanasia;
- Necessary minor surgeries or procedures, e.g. dental or weight-loss surgeries;
- Diagnostic services which may involve the use of radiologists and pathologists to establish the cause/s of illness;
- Alternative treatments, e.g. acupuncture or herbal treatments;
- Lifestyle or wellness treatments, e.g. stress management and other therapies
- Cosmetic surgeries, e.g. rhinoplasty, face lifts and breast augmentation surgeries

The procedure categories above can be used to distinguish between the treatment needs and decision-making influences of the medical tourists. For instance, patients...
in need of necessary lifesaving major surgeries, will be more focused on the expertise of surgeons, the quality of facilities and their recovery options (Ko, 2011). These patients could be needing medical treatment because they are unable to access it at home due to the high costs (Shahrokh & Kalamabadi, 2016; Tham, 2018), the long waiting lists before accessing such surgeries (Adwan, 2020; Gaines & Lee, 2019; Shahrokh & Kalamabadi, 2016), or lack of expertise to perform such surgeries (Rokni et al. in Matiza & Slabbert, 2020; Shahrokh & Kalamabadi, 2016). Some patients may also need diagnostic services such as health screenings, second opinion diagnoses, radiology and pathology (Mogaka et al., 2017), and thus may require access to specialised medical facilities like laboratories at the medical tourism destination. For these patients, destination tourism features and leisure at destination will not be of great importance, therefore the push factors are more important than the pull factors for these patients. Quality medical facilities and services may also be important than tourism activities for patients requiring treatments deemed illegal at home and certain cosmetic and minor surgeries (Zolfaghrarian et al., 2018).

In contrast, for patients in need of lifestyle and wellness treatments at the destination, tourism features (e.g. tourist attractions and the beauty of the destination) and other tourism services may rank higher than medical or healthcare facilities as they do not need these (Ko, 2011) for their treatments. Such patients may be motivated by their need for privacy when receiving treatment (Abubakar & Ilkan, 2016; Abd Mutalib et al, 2017) or the need to combine the treatment with a vacation (Heung et al., 2010; Kara, 2016). For these patients, the pull factors at the destination might be more important than the push factors for getting the treatment.

Different countries specialise in different procedures, and the responsibility of finding the right physician for specific procedures or treatments lies with the patient. In most cases, the patients would need the expertise of experts in the medical tourism industry to identify reputable physicians for the medical treatment they are interested in undertaking. Typical medical tourism experts include medical tourism tour operators and medical travel agencies and/or facilitators, hence the use of medical tourism tour operators in this study.
3.8 SOUTH AFRICA AS A MEDICAL TOURISM DESTINATION

The end of apartheid in 1994 led to an increase in the number of visitors to South Africa and a surge in medical tourists seeking medical treatment in South Africa (Chikanda & Crush, 2019). It is also well known that in 1967 Dr. Christiaan Barnard performed the world’s first human-to-human heart transplant operation at Groote Schuur Hospital in Cape Town and this led to South Africa being associated with medicine (Chikanda & Crush, 2019). According to Mudzanani (2016) and Nicolaides and Zigiriadis (2011), South African medical schools such as the University of Cape Town, the University of Free State (UFS), the University of Pretoria and the University of Witwatersrand train good quality medical professionals whose qualifications are recognised worldwide. For instance, South African-trained medical professionals (doctors and nurses) are sought throughout the world, and many of them are recruited by developed countries such as the United Kingdom (mostly nurses), Canada, and New Zealand (mostly doctors) (Mlambo, 2017).

Medical tourism is said to be slowing down in most developed countries, and gaining momentum in developing countries, and this is known as “reverse globalisation” (Dangor, Hoogendoorn & Moola, 2015: 20) or “reverse shift” (Shahrokh & Kalamabadi, 2016). According to Dangor et al. (2015) and Shahrokh and Kalamabadi (2016), this opposite movement of patients is influenced by the rapid technological and medical developments in developing countries, improved and quality medical facilities and services, as well as easy access to these countries. Matiza and Slabbert (2020) and Nicolaides and Zigiriadis (2011), argue that South Africa attracts patients from the United Kingdom, Western Europe, the Middle East and the United States of America. Patients from these countries stand to save between 25% and 40% on medical treatment costs in South Africa (Forbes Africa report in Matiza & Slabbert, 2020), and this is because of the exchange rate and the value of the rand versus the currencies of these countries. The patients will not even be subjected to waiting lists before they obtain medical treatment in South Africa (Nicolaides & Zigiriadis, 2011).

Nowadays people tend live much longer, and this puts greater pressure on many healthcare systems, as more health care is required. According to Nicolaides and
Zigiriadis (2011), as the developed countries’ global healthcare systems become overburdened, their patients look to developing countries for medical treatment. South Africa as a developing country should position itself to benefit from this movement of patients from the developed countries. South Africa has world-class facilities and good quality medical professionals, and as such it is regarded as a reputable medical tourism destination (Chikanda & Crush, 2019). South Africa is thus in a good position to offer the good quality medical treatment that these patients may require.

According to Ruggeri et al. (2015), many countries globally give estimates of the numbers of medical tourists that come to their shores. In most cases this is due to the inability of the country to collect accurate data relating to medical tourists, or where available, the data collected tends to be anecdotal or insufficient. As a result, countries tend to give estimates for the medical tourists’ numbers, and South Africa is no different. Although the Department of Home Affairs website (http://www.dha.gov.za/index.php/immigration-services/types-of-visas) indicates that they also issue a medical tourism visa, this does not seem to be helping in gathering the necessary data relating to the numbers of medical tourists coming into the country. According to Crush and Chikanda (in Chikanda & Crush, 2019), many patients, especially from the African continent, do not necessarily require a special permit to visit South Africa. On application to visit South Africa, most of these patients mention “holiday” instead of “medical purposes” (Chikanda & Crush, 2019: 329), and this makes it difficult to differentiate them from other ordinary holiday makers.

Perhaps if all medical tourists visiting South Africa made use of medical visas, the Departments of Home Affairs, Health, and Stats SA would be able to capture accurate statistics based on the information from the visas issued and processed. For example, the South African Department of Tourism State of Tourism Report, 2016/17 (2017) indicates that about 10 285 197 tourists visited South Africa in 2017, and from these, the department estimates that only 1.2% came for medical purposes. In its 2018 report, Stats SA (2018) reported that South Africa had a total of 10 472 105 tourists visiting in 2018, and only 6701 of these visitors were medical tourists. The 2018 figure for medical tourists equals 0.1% of all those who visited the country. This was a decline from the 1.2% reported in 2017. In its 2019 report, Stats SA reported that 10 288 593 tourists were received in South Africa in 2019 (Stats SA Tourism Report, 2019), and
only 6 126 of these tourists came for medical purposes. The number of these medical tourists translates to only 0.1% of all tourists that visited South Africa in 2019. According to this report, 4986 of these medical tourists were from the African continent (Stats SA Tourism report, 2019). Table 3.1 indicates the number of tourists who visited South Africa for medical purposes from 2017 to 2019:

Table 3.1: Tourists who visited South Africa for medical purposes - 2017-2019

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of tourists</td>
<td>10 285 197</td>
<td>10 472 105</td>
<td>10 288 593</td>
</tr>
<tr>
<td>Total number of medical tourists</td>
<td>(no data provided)</td>
<td>6 701</td>
<td>6 126</td>
</tr>
<tr>
<td>% of medical tourists</td>
<td>1.2%</td>
<td>0.1%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Overseas medical tourists</td>
<td>1225</td>
<td>1112</td>
<td></td>
</tr>
<tr>
<td>African medical tourists</td>
<td>5438</td>
<td>4986</td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td>38</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>


Table 3.1 indicates that there was a decline in the number of medical tourists coming to South Africa, from 1.2% in 2017 to 0.1% in both 2018 and 2019. In spite of the decline, South Africa still receives some medical tourists from the continent. The country must work harder to attract more medical tourists and to increase these numbers for it to be competitive in medical tourism. According to the 2018 Stats SA Tourism Report (2018:57), the majority of the medical tourists, i.e. 5438, were from the African continent, and 4567 of them were from the SADC region. From the 4567 medical tourists, South Africa received more than 50 patients from the following SADC countries: Botswana (1458); Zimbabwe (659); Angola (554); DRC (429); Namibia (422); Mozambique (328); Zambia (322); Tanzania (130); Malawi (122); Swaziland (82); and Mauritius (50) (Stats SA report; 2018:57-58). South Africa received more than 50 patients from the following East African countries: Kenya (116); Cameroon (101); Uganda (65); and from Ethiopia (59) (Stats SA report, 2018:58). Of these South Africa also received patients from the following countries in West Africa: Nigeria (212) and Ghana (67) (Stats SA report, 2018:58 & 59). According to the 2019 Stats SA
Tourism Report (2019:57), the majority of medical tourists were from the African continent, i.e. 4986 as also indicated in Table 3.1.

The number declined in 2019 from 5438 in 2018, as indicated in Table 3.1 and Table 3.2. From the 4986 medical tourists, 4297 were from the SADC region. South Africa received more than 50 medical tourists from the following SADC countries: Botswana (1359); Zimbabwe (621); DRC (523); Angola (498); Namibia (362); Mozambique (312); Zambia (210); Tanzania (136); Malawi (122); and Mauritius (56) (Stats SA Tourism Report, 2019:57-58). South Africa received 447 medical tourists from Eastern and Central Africa, receiving more than 50 medical tourists from the following countries: Cameroon (109); Kenya (88); Uganda (63); Ethiopia (61); and Congo (50) (Stats SA Tourism Report, 2019:58). South Africa also received 226 medical tourists from West Africa, receiving more than 50 patients from Nigeria (84) and Ghana (63) (Stats SA Tourism Report, 2019: 58-59). Table 3.2 is a summary of the African medical tourism market distribution to South Africa for 2018 and 2019.

Table 3.2: African medical tourism market distribution to South Africa - 2018 and 2019

<table>
<thead>
<tr>
<th></th>
<th>SADC</th>
<th>East &amp; Central Africa</th>
<th>West Africa</th>
<th>North Africa</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>4567</td>
<td>500</td>
<td>347</td>
<td>25</td>
<td>5438</td>
</tr>
<tr>
<td>2019</td>
<td>4297</td>
<td>447</td>
<td>226</td>
<td>16</td>
<td>4986</td>
</tr>
</tbody>
</table>


In spite of the decline in the number of the African tourists, Table 3.2 indicates that some African patients consider South Africa a destination of choice for medical treatment.

According to the 2018 Stats SA Tourism Report (2018: 53-54), South Africa received 1225 overseas medical tourists, and more than 50 medical tourists were received from the UK (370), the USA (187), The Netherlands (112) and Germany (54). In 2019, Stats SA reported that 1112 overseas medical tourists were received in South Africa (Stats SA Tourism Report, 2019: 53-54), and more than 50 medical tourists were received
from the UK (343), the USA (149), The Netherlands (116) and India (60). There was also a decline in the numbers of overseas medical tourists in 2019 (from 1225 in 2018 to 1112 in 2019), as was the case with the African medical tourists as indicated in Tables 3.1 and 3.2, with exceptions for Australasian countries and Asian countries, which saw a rise in numbers as indicated in Table 3.3, which illustrates the overseas medical tourism market distribution to South Africa for 2018 and 2019:

Table 3.3: Overseas medical tourism market distribution to South Africa - 2018 and 2019

<table>
<thead>
<tr>
<th>Region</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Europe</td>
<td>805</td>
<td>705</td>
</tr>
<tr>
<td>North America</td>
<td>213</td>
<td>180</td>
</tr>
<tr>
<td>Central &amp; South America</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>Australasia</td>
<td>45</td>
<td>47</td>
</tr>
<tr>
<td>Middle East</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>Asia</td>
<td>115</td>
<td>149</td>
</tr>
<tr>
<td>Total</td>
<td>1225</td>
<td>1112</td>
</tr>
</tbody>
</table>


Table 3.3 illustrates there was a decline in the number of overseas medical tourists who visited South Africa in 2019, with the exception of the Australasian and Asian countries. This rise in the Australasian countries is attributed to the increase in the number of medical tourists who came from Australia. From the 45 that visited South Africa for medical treatment in 2018 from Australasia, 35 were from Australia (Stats SA Tourism Report, 2018: 55), and from the 47 that visited in 2019, 44 were from Australia (Stats SA Tourism Report, 2019: 55). On the other hand, the rise in the Asian countries in 2019 can be attributed to the increase in numbers for medical tourists from, among others, India - 60 in 2019 versus 46 in 2018; China - 26 in 2019 versus 18 in 2018; Japan - 13 in 2019 versus 6 in 2018; and Pakistan - 19 in 2019 versus 9 in 2018 (Stats SA Tourism Report, 2018: 56-57; Stats SA Tourism Report, 2019: 56-57). In spite of the accolades that South Africa has in medicine, the 2018 and 2019 statistics above demonstrate that the country is not doing as well as it should be (Bizcommunity, 2017). Even though the MTA (2019) considers South Africa a “world in one destination”, due to its location and its temperate climate, the statistics above are proof that South Africa still has to do more to attract medical tourists.
South Africa has a two-tier health-system, with one being publicly-funded and the other funded and run by the private sector. The publicly-funded healthcare system in South Africa provides healthcare to the majority of the population, and as such it is usually described as being overcrowded and underfunded (Mayosi in Dangor et al., 2015), while the private healthcare system caters mainly for those who can afford it or who have private healthcare insurance. Medical tourists who come to South Africa for medical treatment, however, have access to both public and private healthcare facilities (Chikanda & Crush, 2019). According to the Medical Brief website (2019), South Africa has over 600 public healthcare facilities (https://www.medicalbrief.co.za/archives/sas-big-public-hospitals-freed-provincial-health-depts/). The Hospital Association of South Africa website lists five private healthcare groups, i.e. Life Healthcare, Mediclinic, National Hospital Network, Netcare and Independent members hospital groups as their members (https://hasa.co.za/our-members/). According to Chikanda and Crush (2019), three of these private hospital groups, i.e. the Life Healthcare, Mediclinic Southern Africa and the Netcare Group participate in medical tourism in varying degrees, with 221 hospitals between them. However, there is a perception that most private hospital groups are not fully committed to marketing South Africa as a medical tourism destination, in contrast to their counterparts in other parts of the world, e.g. India (Crush et al. in Chikanda & Crush, 2019).

Chikanda and Crush (2019) argue that this perception may be perpetuated by the fact that some private hospital groups have established hospitals internationally beyond South Africa, for instance, in the UAE, Europe, Lesotho and Botswana, and thus there is no need for them to promote medical tourism as they can still serve patients beyond South Africa. Perhaps the reason for the lack of commitment to market South African healthcare could also be attributed to the restrictive ethical rules that the South African government has in terms of medical professionals advertising or canvassing their services. For example, doctors are not allowed to “state their personal qualities, superior knowledge, quality of service or best practice as explained in the Health Professions Council of South Africa’s (HPCSA) guidelines” (2016:9). According to the HPCSA (2016:7) canvassing can be described as any conduct which

... draws attention either verbally or by means of electronic media to one’s personal qualities, superior knowledge, quality of service, professional guarantee or best practice.
This means that if a medical doctor engages in any canvassing activity as described, e.g. describing the quality of the treatment they offer to patients or their expertise, they may be found to be in contravention of the ethical guidelines (Otley in Chikanda & Crush, 2019). According to Chikanda and Crush (2019), the promotion of South Africa’s medical excellence and as a medical tourism destination, is mainly done by some private sector hospitals, through word of mouth (e.g. by patients who had treatment in South Africa) and by the various medical tourism intermediaries, such as medical tourism tour operators.

3.9 PUSH-PULL FACTORS OF SOUTH AFRICA AS A MEDICAL TOURISM DESTINATION

Medical tourists are motivated by various push and pull factors to participate in medical tourism. In spite of the statistics above with regards to the number of medical tourists who have visited South Africa, the country has the potential to attract (pulled) patients worldwide. South Africa offers various medical treatments that patients may want (pushed) to have, and these are provided in good quality facilities.

3.9.1 Medical tourism push factors: South Africa

Medical tourists are motivated by the emergence of a healthcare need which they hope will be fulfilled by undertaking medical tourism. Even though the potential medical tourists do not need a referral from their physician, they still rely on information and medical treatment/procedure recommendations from various sources, such as family doctors, relatives and friends.

Potential medical tourists to South Africa are motivated by various factors and these are influenced mainly by where they originate from, i.e. whether they are from developed or developing countries. South Africa is in a fortunate position because it is able to attract medical tourists globally, and these could be from both developed and developing countries. Medical tourists from developed countries are exposed to good quality healthcare systems at home; however, they experience various challenges in terms of accessing some treatments that they may need. For instance, patients may
want to access treatments that are not available in their own countries (e.g. may be banned) such as stem cell therapy treatments (Khan et al., 2017), and thus they will have to go to destinations where such treatments are available, such as South Africa. Other push factors for patients from developed countries are: to receive affordable quality treatments in the receiving country as healthcare is mostly expensive in their countries; to avoid long waiting lists, to combine treatment with a vacation, and for privacy when receiving treatment (Ormond & Sulianti, 2017). Thus, if patients feel that their own healthcare systems do not satisfy their healthcare need in terms of any of the push factors mentioned above, they could consider getting medical treatment in South Africa.

In contrast, patients from developing countries, such as South Africa’s neighbouring countries and others on the continent, seek medical treatment in receiving destinations because of a lack of or poor healthcare systems in their own countries. Most countries with poor healthcare systems make healthcare agreements with other countries considered to have better healthcare systems, such as South Africa. Many countries on the continent have struggling healthcare systems, and as a result, have bilateral healthcare agreements with South Africa. According to Lunt et al. (2016), South Africa has bilateral agreements with 18 countries on the continent, most of which are from Southern Africa (Chikanda & Crush, 2019). Thus, in contrast to patients from developed countries, the push factors for patients from developing countries have nothing to do with saving costs. Most of these patients come to South Africa to receive basic healthcare services which are poor or non-existent in their own countries. Medical tourists from the African continent are also referred to as the South-south cross-border patients (Chikanda & Crush, 2019).

Patients from developing countries can also be divided into two categories, i.e. the wealthy or middle class financially stable patients and the poor. Although they may reside in the same country, and be exposed to the same experiences, their economic circumstances influence their motivation to receive treatment. For instance, while most of the poor citizens would need basic healthcare in foreign countries, the wealthy can afford to look at various (expensive) treatments which may not be available at home, possibly because of lack of expertise in their home countries, such as reconstructive cosmetic surgeries and chemotherapies and other major surgeries (Chikanda &...
Crush, 2019; Ormond & Sulianti, 2017). Most of the wealthy are also likely to have healthcare insurance, and even if this does not pay for the treatment in full, they can afford to pay the difference. The poor, on the other hand, are bound by the healthcare agreements between countries and thus will have to wait until they get a referral (from their own country) to get treatment in the South African healthcare system (Chikanda & Crush, 2019), as per the healthcare agreements. It should, however, be noted that some patients from South Africa’s neighbouring countries usually access the South African healthcare system without formal referral (Ahwireng-Obeng & van Loggerenberg’s in Chikanda & Crush, 2019). In addition, all medical tourists can access both public and private healthcare facilities for medical treatment in South Africa. The push factors for patients from the developing countries therefore are: the lack of facilities at home, the lack of/shortage of medical expertise, and the bilateral healthcare agreements between the countries and South Africa.

3.9.2 Procedures offered to medical tourists in South Africa

According to the MTSA (2014), most medical tourists who choose South Africa as a medical tourism destination also stand to benefit from the affordable costs of the procedures/treatments due to the favourable exchange rate in South Africa. The South African currency is weak in comparison to major international currencies, and thus potential medical tourists can take advantage of this benefit, without compromising the healthcare quality. Typical procedures that medical tourists can undergo in South Africa are: fertility treatments, various cosmetic and reconstructive surgeries; dentistry (Henama, 2014; MTSA, 2014); audiology; stress management; holistic treatments; hair treatments; ophthalmology; dermatology; rehabilitation; general medical check-up (MTSA, 2014); obesity surgeries; heart surgeries; orthopaedic surgeries; organ transplants (Health-tourism.com); abortions (Henama, 2014); HIV & AIDS treatments (Chikanda & Crush, 2019; Ormond & Sulianti, 2017); and stem cell therapies (Slabbert, Pepper & Mahomed, 2015). The medical tourism tour operators Med-Afrique, also offer urology, neurology and gastroenterology treatments, while Surgeon and Safari offer supplementary services such as ambulance, pathology and radiology services on top of medical treatments.
According to the price comparison from the Med-Afrique website (https://med-afrique.com/medical.html#wsa), for a heart bypass procedure that costs approximately $123,000 in the United States of America, the patient is likely to pay approximately $25,806 in South Africa (see Table 3.4 below), which is a significant saving, given that in most cases, medical tourists pay out of their own pocket. Table 3.4 indicates price comparisons for various procedures offered between South Africa (in bold) versus the US and other medical tourism destinations.

**Table 3.4: Price comparisons (US dollars) for some medical treatments/procedures between South Africa and selected destinations**

<table>
<thead>
<tr>
<th>Medical treatments or procedures</th>
<th>South Africa</th>
<th>USA</th>
<th>Costa Rica</th>
<th>South Korea</th>
<th>Mexico</th>
<th>Israel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart bypass</td>
<td>$25,806</td>
<td>$123,000</td>
<td>$27,000</td>
<td>$26,000</td>
<td>$27,000</td>
<td>$28,000</td>
</tr>
<tr>
<td>Heart replacement valve</td>
<td>$22,497</td>
<td>$123,000</td>
<td>$170,000</td>
<td>$30,000</td>
<td>$28,200</td>
<td>$28,500</td>
</tr>
<tr>
<td>Hip replacement</td>
<td>$10,365</td>
<td>$40,364</td>
<td>$13,600</td>
<td>$21,000</td>
<td>$13,500</td>
<td>$36,000</td>
</tr>
<tr>
<td>Knee replacement</td>
<td>$10,365</td>
<td>$35,000</td>
<td>$12,500</td>
<td>$17,500</td>
<td>$12,900</td>
<td>$25,000</td>
</tr>
<tr>
<td>Gastric bypass</td>
<td>$6,286</td>
<td>$25,000</td>
<td>$12,900</td>
<td>$10,900</td>
<td>$11,500</td>
<td>$24,000</td>
</tr>
<tr>
<td>IVF treatment</td>
<td>$523</td>
<td>$12,400</td>
<td>N/A</td>
<td>$7,900</td>
<td>$5,000</td>
<td>$5,500</td>
</tr>
</tbody>
</table>


3.9.3 Medical tourism pull factors: South Africa

South Africa has various attributes or characteristics that have the potential to make it an attractive medical destination, and these can be divided into two main categories, i.e. healthcare provider and destination related factors. These attributes are referred to as pull factors. According to Gan and Frederick (2011), healthcare provider-related factors tend to be more specific to the medical tourists or consumers, while the
destination related factors focus mainly on the medical tourism destination or country, thus country-specific.

3.9.3.1 Healthcare-provider pull factors

Medical tourists are likely to choose a medical tourism destination based on their perceptions that the destination is well resourced and has top quality healthcare providers and services. South Africa is an attractive medical tourism destination because of the healthcare provider factors presented in the following sections.

(i) South Africa has high quality medical facilities and services that meet international standards, such as hospitals and clinics, and offers other supplementary services, such as ambulance, pathology and radiological services. Some of these facilities are public while others are private. Medical tourists can access any of these facilities for treatments required (Chikanda & Crush, 2019; Pillay, 2017).

(ii) South Africa has the state-of-the-art advanced medical technological healthcare system, and thus it can compete with the best in the world (Chikanda & Crush, 2019; Lajevardi in Matiza & Slabbert, 2020).

(iii) Provides top quality medical care, and specialises in various procedures such as fertility treatments, cosmetic surgery, dentistry and stress management (MTSA, 2014). All treatments offered are available immediately on request, thus patients will not be subjected to waiting lists (Henama, 2014).

(iv) South Africa offers lower medical costs for medical treatments and procedures, especially for patients from developed countries, such as the UK and the US where most of the medical treatments and procedures are expensive (Caboz, 2017; Chikanda & Crush, 2019; Henama, 2014).

(v) Medical practitioners (physicians and nurses) are well trained, experienced, highly reputable and internationally recognised, thus patients will be given good quality medical care (Chikanda & Crush, 2019)
(vi) English is widely spoken in South Africa, and most medical staff speak this language. This makes it easier for the staff to communicate with foreign patients. If patients are non-English speakers, arrangements for translators can be made so that the patients can be comfortable when being treated. According to Bacus (2010; MTSA, 2014), South Africa also has many Afrikaans-speaking medical professionals, and as such has the potential to attract the Dutch medical tourists.

(vii) South Africa offers easy access to specialised medical treatments, e.g. fertility treatment, abortion and others, without the possibility or fear of being prosecuted (Henama, 2014; Ormond & Sulianti, 2017; Pillay, 2017).


The marketing of South Africa as a medical tourism destination is mainly through word of mouth and medical tourism intermediaries or companies (Chikanda & Crush, 2019), which include medical tourism facilitators, medical travel agencies, medical tourism tour operators, and medical tour brokers. According to Haarhoff and Mokoena (2016) and Ko (2011), all the concepts above can be used to describe medical tourism intermediaries. Tourism intermediaries serve as a connection between demand (push factors) and supply (pull factors), and therefore they are tourism product facilitators (da Silva, Costa & Moreira, 2018), for both local and international travel (Picazo & Moreno-Gil, 2018). The role of the intermediaries in medical tourism is to provide specialised services to potential medical tourists, such as identifying suitable hospitals, arranging treatment, transportation, and lodging during recuperation.

As indicated earlier (in 3.2), medical tourism tour operators will be used to identify medical tourism intermediaries. Typical examples of medical tourism tour operators include Med-Afrique, Surgeon and Safari, and South African Medical Traveller (SAMT). According to Chan and Tay (2016), and Romero and Tejada (2019), tour operators are the main information distribution channel between the tourists and the producers/providers at the destination. The medical tourism tour operators as intermediaries serve as sources of information and a link between the medical tourists.
and healthcare providers. Just as regular tourism intermediaries can sell or customise packages according to potential tourists’ needs (Chan & Tay, 2016; da Silva et al., 2018), so can medical tourism tour operators customise packages according to individual potential medical tourists’ needs (MTSA, 2014). Medical tourism packages may include the treatment, transportation, accommodation, excursions, and they can even recommend specialists to patients when requested to do so.

3.9.3.2 Destination-related pull factors

Destination-related pull factors are the attributes at a destination that make it attractive to potential medical tourists. South Africa as a destination (and a medical tourism destination) is well-known for its various attractive attributes as indicated below:

- Beautiful scenery: South Africa has breath-taking landscapes such as beaches, wildlife, and mountains (Caboz, 2017; Henama, 2014);
- Lovely climate/weather conditions; there is lot of sunshine in South Africa (Nwafor, 2012);
- South Africa has top quality infrastructure, such as banks (with international banking systems), hotels, shopping centres, airports and travel agencies (Henama, 2014);
- Favourable exchange rate; this is due to the weakness of the currency as compared to the US dollar and the Euro, thus making air travel and medical procedures to South Africa very affordable (Haarhoff & Mokoena, 2016);
- Food and accommodation facilities (Chikanda & Crush, 2019);
- Social and cultural familiarities with many developed countries, e.g. English is widely spoken in South Africa (Haarhoff & Mokoena, 2016).

Although South Africa is regarded as an attractive emerging medical tourism destination, reports by Stats SA (2018/2019) and the State of the Tourism Report (2016/2017) show the contrary. Nevertheless, according to Chikanda and Crush (2019), South Africa is the only country on the African continent that has been ranked among the 30 leading medical tourism destinations, and this has been the case since 2014. For instance, the Forbes Africa report (in Matiza & Slabbert, 2020: 338), has ranked South Africa as a “top 20 medical tourism destination”. According to Matiza and Slabbert (2020) this ranking is said to have been influenced by the perceived
affordability or potential to save between 25% and 40% on medical costs in South Africa. The latest (2020-2021) global MTI rankings from the MTA (2020) (https://www.medicaltourism.com/destinations/south-africa), ranks the country 22nd out of 46 destinations. The MTI ranking also illustrates that South Africa’s ranking has improved in the BRICS (Brazil, Russia, India, China & South Africa) category by moving from fourth position in the previous (2016/2017) ranking to second position after India. The second position was previously held by Brazil (currently ranking 28th on the MTI). In Africa, South Africa remains the top destination, followed by Egypt (26th), Morocco (31st) and Tunisia (38th). According to the 2017 PricewaterhouseCoopers (PWC) report on the BRICS countries (PWC Report, 2017), there has been a steady increase of support for South African tourism in general and medical tourism in particular, by the Chinese who chose South Africa for medical treatments such as cosmetic surgeries. According to the PWC report, the reason for Chinese patients accessing medical treatment in South Africa could stem from the perceived value for money of the country’s medical treatment and the state-of-the-art medical facilities. In support of the PWC report, Govender (2018) also states that Chinese medical tourists are also likely to stay in the country for much longer (at times for over two months) until they are fully recovered from their procedures in various leisure settings, such as going on a safari, and shopping.

Table 3.5 demonstrates South Africa’s ranking as a medical tourism destination according to the MTI rankings (MTA, 2020) in Africa, BRICS, and globally, as well as on the Forbes Africa report (Matiza & Slabbert, 2020). Table 3.5 also confirms that South Africa has been ranked among the 30 leading destinations (Chikanda & Crush, 2019).

Table 3.5: South Africa’s ranking as a medical tourism destination

<table>
<thead>
<tr>
<th>Africa</th>
<th>BRICS</th>
<th>Globally</th>
<th>Forbes Africa Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>22</td>
<td>20</td>
</tr>
</tbody>
</table>


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The global MTI rankings measure medical destinations using three dimensions, i.e. destination environment, medical tourism industry, and quality of facility and services. These dimensions relate to the physical attributes at the medical destinations and the MTA (2020) improved ranking also confirms that the physical attributes contribute to the country’s popularity as a medical tourism destination. In 2019 the MTA described South Africa as “a world in one destination” and this description was also based on the country’s attributes. Globally, the most preferred top 10 destinations according to the 2020-2021 MTI rankings are Canada, Singapore, Japan, Spain, The United Kingdom, Dubai, Costa Rica, Israel, Abu Dhabi, and India. Given that the index measures the attractiveness of medical tourism destinations, it is most encouraging to see that South Africa has improved, and this shows the potential that South Africa has as a medical tourism destination. Table 3.6 illustrates South Africa’s 2016/2017 and 2020/2021 MTI rankings.

Table 3.6: South Africa’s 2016/2017 and 2020/2021 rankings as a medical tourism destination

<table>
<thead>
<tr>
<th>MTI Dimensions</th>
<th>2016/2017 Rank</th>
<th>Tot no of countries</th>
<th>Score</th>
<th>2020/2021 Rank</th>
<th>Tot no of countries</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Destination environment</td>
<td>26</td>
<td>41</td>
<td>22</td>
<td>46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical tourism industry</td>
<td>30</td>
<td>41</td>
<td>28</td>
<td>46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of facilities and services</td>
<td>25</td>
<td>41</td>
<td>20</td>
<td>46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Global Ranking</td>
<td>27</td>
<td>41</td>
<td>62.2</td>
<td>22</td>
<td>46</td>
<td>65.82</td>
</tr>
</tbody>
</table>


The rankings information in Table 3.6 demonstrates that South Africa has improved from the previous ranking on all the dimensions used on MTI, hence the improvement on its global ranking. The 2020/2021 ranking is a great improvement (ranking 22nd).
from the previous ranking (2016/2017) where the country ranked 27th out of 41 destinations globally. According to the MTA (2020) website, South Africa is a popular destination not only for its cultural diversity and temperate climate throughout the country, but also for its geographical extremes that range from wildlife, panoramic views, lush subtropical costs to snow-capped mountain ranges.

Figure 3.3 summarises the literature and illustrates the conceptual framework with the factors (constructs) that were measured in the empirical phase. The conceptual framework demonstrates the interrelationships between the procedures and the push-pull factors. Central to the interrelationship are patients who need medical treatment or procedures. On realising that they have an ailment that needs to be treated, the patient will try to access treatment in their most immediate healthcare system at home.

If patients are able to access treatment at home, they will have no reason to consider alternative ways to get treatment. However, if they cannot access treatment (for whatever reason) they will weigh the options available to them (Horsfall, 2019). Among the options they may have will be to wait for their turn (if the reason for no access is the long waiting list), or to look for alternative ways to access the treatment quicker. If the patient decides to receive medical treatment at home, there will be no need to travel elsewhere for treatment, thus no medical tourism. The access (or not) to medical treatment determines whether the patient will be pushed to seek treatment elsewhere or not. Push factors therefore push patients away from their most immediate healthcare system, and force them to seek alternative destinations where they will be able to get treatments. Patients will then have to find a destination which will be offering better alternative/s than their local healthcare system. Medical tourism destinations provide (supply) medical treatments to patients in need of treatment and thus when patients make a decision regarding the destination, they compare the healthcare providers of the receiving destinations against their own, e.g. facilities, doctors’ expertise and other factors at the destination.

Medical tourism destinations are represented by the pull factors in Figure 3.3 and they attract potential medical tourists by, among others, offering affordable quality treatments with less or no waiting period before one can access treatment. The use of double-arrows thus indicates the interrelationship between procedures and push
factors (e.g. the inability to access procedures will push the patients away from the home healthcare system). Push factors thus explain why there is demand for medical tourism. The availability and access to quality treatment at the medical tourism destination makes patients confident that their healthcare needs will be satisfied at the destination. The use of the double-arrows between the procedures and the pull factors illustrates the relationship between the procedures sought by patients and the potential to access these at the medical tourism destination. The double arrows between the push and pull factors show that the patient is exposed to both the home and the receiving destinations, and that the patient makes a comparison between the two when making a decision on getting treatment. The medical tourism destination that provides what the patient perceives as being able to satisfy their healthcare need at the time is likely to be chosen against others that are not perceived in the same way. If treatment can be accessed at home, the patient will not be pushed to seek treatment elsewhere; thus, they will not be pulled away from home.
3.10 CONCLUSION

In conclusion, both the push and pull factors play an important role for the decisions of potential medical tourists to visit or not visit specific medical tourism destinations. The main purpose of travel for medical tourists is to receive medical treatment or a procedure at the destination. In contrast to consumers of other forms of tourism, in their decision-making when choosing a receiving destination, potential medical tourists focus primarily on their healthcare needs and issues rather than on the actual destination features or attributes; these are secondary. Various push factors drive medical tourists to seek medical treatment in receiving destinations, such as the high
medical costs in their home countries; perceived affordable healthcare costs in the receiving destinations; long waiting periods before accessing medical treatment in their home countries; unavailability of certain procedures at home; lack of basic healthcare services; and many more.

Destination attributes that serve as pull factors at medical tourism destinations include, among others, the availability of high-quality health services and facilities; accreditation of the healthcare system; the expertise and reputation of medical professionals; and the fact that the healthcare system is internationally accredited. South Africa is an emerging medical tourism destination, and medical tourists who come to South Africa can benefit from receiving high quality medical treatment at affordable prices. South Africa offers a wide range of medical procedures and patients will not be subjected to waiting lists or risk prosecution.

The next chapter focuses on the research methodology used in this study.
CHAPTER FOUR
RESEARCH METHODOLOGY

4.1 INTRODUCTION

The research methodology section describes the strategy, approach and steps that are followed in conducting this study. This chapter begins by discussing the research paradigm used in this study, distinguishes between quantitative and qualitative research methodologies, discusses the research design, target population, sampling, data collection, data analysis, methods used and the ethical considerations of research.

4.2 RESEARCH PARADIGM

According to Ponterotto (in Williams & Morrow, 2009: 577), a research paradigm is:

... an umbrella which embraces the researcher’s views about the nature of reality, the relationship between the researcher and the participant, the researcher’s research viewpoint and stance in terms of his subjectivity/objectivity; the researcher’s values in the research process; the research process in general; as well as the language that the researcher will be using to communicate the research processes and findings to the relevant research stakeholders and audience.

A research paradigm is comprised of the following:

- ontology (i.e. the study of being or views about the nature of reality);
- epistemology (i.e. the nature and form of knowledge or views about ways of inquiring about the nature of the world);
- methodology (i.e. strategy or form of action); and
- methods (i.e. specific techniques and procedures used to collect and analyse data) (Crotty, 1998; Ponterotto, 2005; Scotland, 2012).

Not only do research paradigms outline the researcher’s assumptions about knowledge and the truth, but they also demonstrate the influence that such assumptions may have about his/her belief’s and how they view the world around them.
(Crotty, 1998; Ponterotto, 2005). According to Scotland (2012), the researcher’s assumptions also play a role in the selection of the methodology to be used in the research, thus helping researchers to put research in context.

Researchers have a variety of research paradigms to choose from, e.g. positivism, post-positivism, constructivism-interpretivism and critical theory (Ponterotto, 2005). For the purpose of this study the interpretivism paradigm was used. According to Blaikie and Priest (2019:107 & 288), in interpretivism, social reality is regarded as
... a product of its inhabitants [i.e. social actors or participants], and it is [also] a world that is constituted from the meanings [the] participants produce and reproduce as a necessary part of their everyday activities together.

This definition relates accurately to the participants in this study, who interpreted their interactions with the medical tourists the way they saw it, and thus their medical tourism experiences have multiple interpretations, hence the use of interpretivism in this study. The participants thus acted in accordance with the interpretations of their surroundings and experiences. The ontology applicable to interpretivism is known as relativism.

In terms of relativism, social reality differs from person to person, and thus it is subjective (Guba & Lincoln in Scotland, 2012). The researcher’s objective should be to make sense or interpret the meanings the participants have about the phenomenon being studied (Creswell & Creswell, 2018). In the process of researchers trying to make sense of the participants’ behaviour and/or the phenomenon, they are likely to gain more insights and knowledge with regards to the participants and how they interact with their surroundings (Scotland, 2012). In this study, the medical tourism tour operators described what they had observed, learnt and experienced as push and pull factors from their interactions and engagements with medical tourists. Rich data as expressed by the different medical tourism tour operators was collected by the researcher, and interpreted as presented to her.

Epistemological assumptions in interpretivism operate from the point of view that access to any social world has to be through the language used by the participants as they describe their social reality and/or experiences (Blaikie & Priest, 2019).
Researchers should therefore not impose their views and ideologies, or influence the participants’ expression of their experiences in the phenomenon or their interpretation of their surroundings. Crotty (1998) states that participants use language to develop and formulate knowledge and meaning as they contextualise their social reality and the world. In Scotland’s (2012) opinion, when researchers use the interpretive paradigm, they must be cognisant of and accept participants' views and ideologies as they are, regardless of how they (researchers) may feel about such views and/or the phenomenon. In this study, all information provided by the medical tourism tour operators with regards to push-pull factors, including the various procedures, was accepted as is. Although some information was acquired through literature, the researcher refrained from expressing her own point of view, accepting what medical tourism tour operators stated.

4.3 DIFFERENCE BETWEEN QUALITATIVE AND QUANTITATIVE RESEARCH

According to Bryman (2016), during data collection and analysis, qualitative researchers put greater emphasis on words than on quantifying the collected data as done by quantitative researchers. As highlighted by Austin and Sutton (2014), data can also be collected about people who portray certain attitudes, opinions, feelings and perceptions about a certain phenomenon in a quantitative study. In the final analysis of the data, it is the number of people and responses that matters. According to Bryman (2016), quantitative research tends to be more deductive in nature, i.e. it usually begins with a hypothesis, and is aimed at testing theory. Quantitative research is also objective, i.e. it is absolute, descriptive and factual (Scotland, 2012), and as a result, the phenomenon being studied and its intricate meanings is independent of the participants (Bryman, 2016).

In contrast to quantitative research, qualitative researchers want to establish the reasons why people are portraying the feelings, attitudes, opinions and perceptions about the phenomenon being studied (Austin & Sutton, 2014), and to do so, they rely on the words used by the participants. According to Bryman (2016), qualitative research tends to be inductivist (i.e. relates to the generating of theory from the
research data), constructionist and subjective (i.e. social reality and meaning are constructed by the participants), and interpretivist (i.e. reality is socially constructed and done through language and shared meanings) in nature. Given the diverse meanings amongst the three concepts above, qualitative researchers thus do not always agree with or follow all of them.

The research objectives of this study revolve around identifying the push and pull factors of medical tourism destinations. The participants expressed their opinions in terms of push and pull factors that motivate medical tourists to seek medical treatments in medical tourism destinations. The aim was not to quantify the number of push factors against pull factors and/or the number of responses. The words that were used in describing the participants’ views and observations in terms of the push-pull factors and procedures that medical tourists seek in receiving destinations, were paramount. Thus, this study was qualitative in nature.

4.4 QUALITATIVE RESEARCH

According to Polit and Beck (in Moser & Korstjens, 2017:271), qualitative research is the “investigation of phenomena, typically in an in-depth and holistic fashion, through the collection of rich narrative materials using a flexible research design”. In the opinion of these authors, qualitative research helps researchers to gain in-depth insight and understanding of the real-world problems from the participants’ contexts. The authors further argue that the phenomena may be multidimensional or complex in nature, thus qualitative researchers often prefer analysing and interpreting the multifaceted complexities of the phenomena holistically instead of simplifying them.

Besides being multidimensional, qualitative research is also iterative, i.e. it progresses in cycles, thus the researcher may have to revise his/her research design as the study progresses instead of happening in a linear form as it would in quantitative research (Maylor, Blackmon & Hueman, 2017). The researcher is actively involved throughout the research process, and this enables him/her to collect very rich data (Maylor et al., 2017; Sutton & Austin, 2015). Below are some of the typical characteristics of qualitative research (Creswell & Creswell, 2018; Moser & Korstjens, 2017).
4.4.1 Natural setting or context

The researcher has to be in the same environment with the participants, preferably face to face so as to collect the necessary data as it is experienced by the participants (individuals or groups) in that specific setting. Interviews are conducted telephonically since it would not be possible to have face to face interviews as a result of the Covid-19 pandemic. The participants consented to have the interviews recorded and the purpose for doing this was explained to them.

4.4.2 Researchers collect the research data themselves

Each researcher is the primary instrument. Qualitative researchers use various data collection methods, e.g. intensive examination of documents, observing behaviour, as well as conducting interviews with the participants (Korstjens & Moser, 2017). The above qualitative data collection methods can be used simultaneously, thus data collection (and analysis) is an iterative process. In this study, in-depth interviews with open-ended questions were conducted with medical tourism tour operators.

4.4.3 Collected data may be analysed inductively

The analysis is done by building patterns or categories. The data is organised from simple to more complex abstract units of information, and analysed deductively, i.e. from the various themes to establish the presence of evidence in support of each theme. Just like data collection, data analysis can also be an iterative process. Qualitative content data analysis was used in this study to systematically analyse the collected interview data accordingly, and to comprehend and interpret the participants’ attitudes, perceptions and emotions better.

4.4.4 Focus on participants’ associated meanings, experiences, perceptions, behaviours and processes

This focus is in relation to the phenomenon being studied, not the researcher’s own. In this study, the associated meanings, perceptions, behaviours and processes as per
the medical tourism tour operators’ experiences and interaction with medical tourists were taken into consideration. The researcher’s personal opinions about the phenomenon were not allowed to interfere with the study.

4.4.5 Process is very flexible

The researcher should never be prescriptive as to the sequence of the process, e.g. questions may be changed, the setting may also change or be modified, and as such, most qualitative researchers tend to use emergent designs. In this study, the participants’ commitments, availability and time constraints and/or time zones were taken into consideration when scheduling interview appointments. At the beginning of the data collection processes and after two interviews, the researcher and the supervisor realised that there were issues with the order of certain questions, and that some questions were repetitive. The questionnaire was revised and the problems with regards to the questions were resolved. All participants were asked the same questions in the same sequence, and follow-up questions were asked to probe further or seek clarity where necessary.

4.4.6 Purposes of qualitative research

According to Leedy and Ormrod (2015), qualitative research can serve one or more of the following purposes in research:

- **Exploratory**, i.e. helps researchers gain an understanding of what has previously happened in a specific topic or phenomenon;
- **Multifaceted description**, i.e. can reveal the complex nature of certain situations, processes, relationships, systems or people;
- **Verification**, i.e. allows researchers to test the validity of certain assumptions, claims, theories, or generalisations in the natural setting;
- **Theory development**, i.e. enables researchers to develop new theories about the phenomenon;
- **Problem identification**, i.e. helps researchers uncover key problems or obstacles that exist in a phenomenon;
• Evaluation, i.e. provides researchers with a means to judge the effectiveness of particular policies, practices and innovations.

This study provides a better understanding of what medical tourism tour operators purport to be the medical tourists’ push factors and the medical tourism destinations’ pull factors as learnt from their interactions with medical tourists. Since medical tourism tour operators have rarely been used as sources of data in studies on push and pull factors of medical tourism destinations, their viewpoints could bring new and novel perspectives on the topic, thus the exploratory purpose is relevant to this study. This study also reveals the complex nature of medical tourism destinations and the decisions made by medical tourists in evaluating where to go for treatment, thus providing a multifaceted description. The study is useful in verifying the South African push-and-pull factors, as per the tour operators, in contrast to or in confirmation of what the literature states. The study also evaluates South Africa’s performance as a medical tourism destination.

Another purpose of qualitative research is to obtain in-depth description and understanding of people’s beliefs, actions and events in all their complexities (Brink, van der Walt & van Rensburg, 2018). Using qualitative research methodology helps the researcher to understand the perceptions of medical tourism tour operators with regards to what motivates medical tourists to choose one destination instead of another. Although it was challenging to find many medical tourism tour operators to participate in this study, those who participated were able to provide rich and detailed responses.

4.5 RESEARCH DESIGN

Research designs are found within qualitative, quantitative and mixed methods approaches (Creswell & Creswell, 2018). In qualitative research there are various research designs and methods that are used to study phenomena, and these phenomena often occur in the natural settings or the real world (Brink et al., 2018; Leedy & Ormrod, 2015).
A research design serves as a roadmap for the research in general. It enables researchers to provide accurate, objective and valid answers to the research questions, as economically as possible. A research design is stipulated before data collection, and helps to explain the type of data to be collected, as well as how and where this data will be collected (Easterby-Smith, Thorpe, Jackson & Jaspersen, 2018). According to Emaikwu (2012), a research design also provides clues as to what problems (if any) to anticipate during the data collection process, and helps to delineate the research purpose and boundaries of the study. Emaikwu (2012) further argues that a research design (i) lays out the research methodology to be followed for a given study; (ii) helps to bring empirical evidence in support of the research problem; (iii) enables the researcher to determine the target population and sampling techniques; and (iv) provides the procedural outline for conducting the research. A carefully crafted research design also helps researchers to determine the cost of the study, such as the time, money and material that will be needed for the research to be a success.

Creswell and Creswell (2018) note that the following research designs (among others) are often used in qualitative research: case study, ethnography, phenomenological study, narrative and grounded theory study. The most commonly used designs are ethnography, phenomenology and grounded theory, and as a result are referred to as the “big three” designs (Polit & Beck in Korstjens & Moser, 2017:277). Creswell and Creswell (2018) suggest that narrative and phenomenology designs are usually used when researchers study individuals; case studies and grounded theory are used when they want to explore processes, activities and events, and ethnography when researchers want to learn more about the broad cultural behaviours of individuals or groups. In Creswell and Creswell’s opinion (2018), there is an interconnection between the philosophy/worldview, research design and specific methods for every broad research approach. For this study, a qualitative research approach is used, and interconnections are between the philosophy (interpretivism) and the design (e.g. qualitative design, i.e. phenomenology) and the specific research methods.
As indicated earlier and in Figure 4.1, phenomenology is the design used in this study. In the opinion of Leedy and Ormrod (2015:273), a phenomenological study is “a study that attempts to understand people’s perceptions and perspectives relative to a particular situation”. The phenomenology design requires that conversations take place between the researcher and the participants about a particular phenomenon, from the participants’ perspectives, e.g. in the form of in-depth interviews. In this study, information relating to the lived experiences and perceptions of medical tourism tour operators as intermediaries in the medical tourism industry was sought.
4.6 TARGET POPULATION, SAMPLING, CONTEXT, UNITS OF ANALYSIS AND SOURCES OF DATA

This section discusses and explains the target population, sampling, context, units of analysis and the sources of data. The reasons for the choices made with regards to the above-mentioned aspects are also explained.

4.6.1 Target population

According to Daniel (2015:513), a target population is a “set of elements to which a researcher desires to apply the findings of a study”. For the purpose of this study, the target population was both African (South Africa included) and international tour operators who specialise in medical tourism only, and they were contacted by email to gain permission for them to participate in this study. According to Ferrario (1979:20), the best way to establish the tourists’ market preferences is to ask the tourists themselves. In this study, however, the medical tourists were not approached due to their inaccessibility and their rights to privacy as patients. Instead, the medical tourism tour operators as professionals in the medical tourism industry were used. As intermediaries, their experiences and involvement with the medical tourists and other stakeholders in the industry provided a broader perspective regarding the push and pull factors that motivate medical tourists when seeking medical treatment in receiving destinations.

According to the Collin (2005), tour operators are “travel agencies that organise and sell holiday or tour packages”. According to Tomigova et al. (2016) and Wongkit and McKerchner (2016), tour operators can be used in research as alternative participants because they are a reservoir of crucial information to tourists about the tourism industry in general, and about the tourism destinations. Tour operators are in the business of selling and promoting destination packages, therefore their knowledge regarding destinations has huge potential to influence prospective tourists’ decisions about tourism destinations. The medical tourism tour operators provided a broader perspective with regards to the push-pull factors and the procedures sought by medical tourists in medical tourism destinations. The medical tourism tour operators
also serve as an important link between tourism supply and demand. The following are some of the medical tourism tour operators responsible for promoting South Africa as a medical tourism destination:

Table 4.1: Examples of South African medical tourism tour operators

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afrisurg Medical Tourism</td>
<td>Based in Cape Town and they list the various treatments/procedures they offer on their website.</td>
</tr>
<tr>
<td>Med-Afrique Medical Tours</td>
<td>Prides itself in being a one-stop medical tourism agency with extensive experience of over 35 years in the healthcare/medical industry.</td>
</tr>
<tr>
<td>Medical Tourism South Africa (MTSA)</td>
<td>Based in Cape Town and offers various tailor-made travel holiday package deals for medical tourists depending on the patients’ budget.</td>
</tr>
<tr>
<td>Serokolo Health Tourism</td>
<td>Based in Johannesburg and offers various medical services to medical tourists.</td>
</tr>
<tr>
<td>Surgeon and Safari (Medical Travel Solutions)</td>
<td>Based in Johannesburg and teamed up with medical specialists from private medical facilities, such as Netcare and Medi-Clinic groups and other related ancillary service providers</td>
</tr>
</tbody>
</table>

According to Zikmund, Babin, Carr and Griffin (2013:118), a unit of analysis in a study indicates “what or who should provide the data and at what level of aggregation”. This is where researchers indicate whether the research will collect data about individuals, households, organisations, departments, specific geographic areas or objects. In this study, data was collected from specific medical tourism destinations (geographic areas). Therefore, the unit of analysis in this regard was medical tourism destinations. Data was collected through interviewing medical tourism tour operators, thus the source of data in this regard is the medical tourism tour operators.
4.6.2 Sampling

According to Polit and Beck (in Moser & Korstjens, 2018:10) sampling refers to a “process of searching for situations, context and/or participants who provide rich data of the phenomenon of interest”. Sampling allows researchers to make informed statements about populations without obtaining data from all the people in that population. This means that the sample selected should be knowledgeable about the phenomenon studied for them to be able to provide the researcher with rich data. A sample is therefore a representation or the subset of a population. In this study, to ensure that the sample selected is knowledgeable about medical tourism, tour operators who do not specialise in medical tourism were not approached to participate.

The process of identifying a sample from the target population can be cumbersome, expensive and time-consuming, thus the researcher must strive for representativeness of the population if they are to be successful in choosing a good sample. Emaikwu (2012) argues that a good sample must have the following attributes: a greater scope and accessibility; be representative of the population; reduced costs; greater speed and accuracy. The methods used in sample selection are mainly based on “probability sampling or non-probability sampling principles” (Bryman, 2016:549). Qualitative research mainly uses non-probability or purposive sampling, and this is also known as judgmental, selective or subjective sampling (Sharma, 2017). The following are typical purposive sampling techniques (Bryman, 2016; Sharma, 2017) that can be used: extreme/deviant case sampling; typical case study sampling; critical case study sampling; maximum variation sampling; criterion sampling; convenience sampling; theoretical sampling; snowball sampling; opportunistic sampling; as well as stratified purposive (judgment) sampling.

For the purposes of this study, criterion sampling was the main sampling method. Criterion sampling involves the selection of participants who meet predetermined criteria of importance to the study. The predetermined criteria used for this study was that all the participants had to have similar or shared experiences, e.g. all of them are intermediaries in the medical tourism industry, and have been in practice for at least one year. Participants who did not meet the above requirements were thus excluded.
An online search to identify both African and international medical tourism tour operators was conducted, and 19 South African medical tourism tour operators were sourced. The Medical Tourism Review website, which lists up to 231 medical intermediaries worldwide (including South Africa) was searched. A total of 78 medical tourism tour operators were identified and invited by email to participate in the study. Only one of the medical tourism tour operators did not have an email address and was contacted telephonically. Eleven (3 from South Africa, 4 from the African continent and 4 international) participants accepted the invitation to participate.

The second sampling method used in this study was snowball sampling. According to Suri (2011: 69), snowball sampling involves the "seeking of information from key informants (main participants) about details of other ‘information-rich cases’ (potential participants) in the field". According to Bryman (2016) and Emaikwu (2012), the snowball sampling approach helps researchers to identify and/or access participants which they would not have known about prior to the involvement of the initial identified sample. In this study, two additional international participants (medical tourism tour operators) were successfully invited to participate in the study as a result of the recommendations by the medical tourism tour operators identified through the criterion sampling. The potential disadvantage of snowball sampling is that the recommended participants may be those who are in the inner circles of the initially identified sample, thus researchers need to assess and report on the representativeness of the sample to do away with bias and sampling errors (Emaikwu, 2012). The final sample was comprised of 13 medical tourism tour operators.

### 4.6.3 Data collection

There are four basic data collection procedures associated with qualitative research, i.e. observations, interviews, documents, as well as audio-visual materials. Moser and Korstjens (2018) note that qualitative research data collection is usually flexible and unstructured, hence qualitative researchers can often make data collection decisions whilst already in the research setting.
According to Isaawi (2014), interviews are the most commonly used method for data collection in qualitative research. There are four types of interviews, i.e. structured, unstructured, semi-structured and focus group interviews. Structured interviews relate to the controlled way of obtaining information from the participants, and as a result, predetermined questions are asked, and these are posed such in such a way that all participants will give responses to the exact phrasing of questions (Isaawi, 2014; McGrath, Palmgren & Liljedahl, 2019). Structured interviews therefore reduce the interviewer’s chances of interrupting the interview process (e.g. by asking further questions for clarity), thus they are inflexible. As a result, they do not allow for the collection of rich data.

Unstructured interviews are the direct opposite of the structured interviews. In their responses, participants can elaborate as much as possible, and the interviewer can also interrupt (although to a minimum) and probe to get more information from the participants (Isaawi, 2014). In contrast to the structured interviews, the researcher is also able to collect a lot of data relating to the phenomenon being studied. According to Isaawi (2014), the most common type of interview in qualitative research is the semi-structured interviews. Isaawi (2014) and McGrath et al. (2019) argue that semi-structured interviews are a combination of structured and unstructured interviews, i.e. the questions are pre-determined, but most of the questions asked in the semi-structured interviews are open-ended. According to Easterby-Smith et al. (2018), Payne and Payne (2011), and Sutton and Austin (2015), the use of open-ended questions in semi-structured interviews allows the interviewer to probe further if needs be, thus the participants have an opportunity to elaborate or explain their responses further. This allows for the collection of rich data. Lastly, focus groups interviews relate to the brainstorming with a focus group of about six to twelve participants, and allows for the collection of high quality data as the participants are given an opportunity to interact, challenge, argue and debate with each other about the topic being studied (Isaawi, 2014).

For this study, the qualitative interview procedure, i.e. semi-structured in-depth interviews with medical tourism tour operators, was used. As indicated above, although the questions for the interview schedule used in this study were pre-determined, open-ended questions were asked so that the participants could provide
more information relating to the medical tourism push and pull factors, as well as the procedures. The questionnaire also enabled the researcher to probe further where necessary. The design of the interview schedule was based on the research objectives of the study as indicated in Table 4.2.

According to Payne and Payne (2011), researchers must plan the questions that they want answers to. All the information collected from the participants’ answers was meticulously recorded in audio and notes. Creswell and Creswell (2018) caution that the researcher should avoid asking too many questions, and recommend that there should be at least 5-10 questions and these should be consistently asked of all participants. More than 10 questions were posed in this study, and these helped the researcher to collect rich data from the medical tourism tour operators. All questions asked in the interview schedule were asked of all participants. The interview schedule used in this proposed study is attached as Appendix C. The interview schedule was developed based on the study’s research objectives and the literature consulted (see Table 4.2) (most of which was from international studies) was adapted to also suit the South African situation. Data collection took place from the 25th February 2020 to the 18th May 2020.

Table 4.2: Structure of the semi-structured interview schedule

<table>
<thead>
<tr>
<th>Questions</th>
<th>References from literature</th>
<th>Research Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical travel motivation (Push factors)</strong></td>
<td>Abubakar &amp; Ilkan, 2016; Adams et al., 2015; Ahmadi et al., 2017; Al-Maaitah, 2016; Chikanda &amp; Crush, 2019; Fetscherin &amp; Stephano, 2016; Fisher &amp; Sood, 2014; Hanefeld et al., 2015; Hudson &amp; Li, 2012; John &amp; Larke, 2016; Johnston et al., 2012; Mogavvemi et al., 2017; Abd Mutalib et al., 2017; Österle et al., 2013; Wu et al., 2016;</td>
<td><strong>• To identify the push and pull factors that motivate a tourist to visit a medical tourism destination</strong></td>
</tr>
<tr>
<td>3; 4</td>
<td>Ahwireng-Obeng &amp; van Loggerenberg, 2011; Bacus, 2010; Bass, 2008; Bizcommunity, 2017; Brits, 2017; Caboz, 2017; Chikanda &amp; Crush, 2019; Crush &amp; Chikanda, 2015; de Arellano, 2007; Haarhoff &amp; Mokoena, 2016; Henama, 2014; Meissner-Roloff &amp; Pepper, 2013; Mogaka et al., 2017; Mokoena, 2015; Mudzanani, 2016; Nicolaides, 2011; Nicolaides &amp; Zigiriadis, 2011; Ormond &amp; Sulianti, 2017; Peters, 2016; Pillay, 2017; Schmidt, 2018; Southern &amp; East African Tourism Update, 2018</td>
<td>• To measure South Africa’s performance as a medical tourism destination in terms of its push and pull factors</td>
</tr>
</tbody>
</table>

**SECTION B**

**Medical tourism destination characteristics**  
(Pull factors)

| 1; 2 | Abubakar & Ilkan, 2016; Adams et al. 2015; Al-Maaitah, 2016; Aydin & Karamehmet, 2017; Fetscherin & Stephano, 2016; Hanefeld et al., 2015; John & Larke, 2016; Junio et al., 2017; Khan et al., 2016; Leggat, 2015; Mohimehfar & Nasr-Esfahani, 2011; Mukherjee et al., 2018; Najafi et al., 2017; Shahrokh & Kalamabadi, 2016; Shahrokh et al., 2017; Sultana, Haque, Momen & Yasmin, 2014; Wongkit & McKercher, 2016; Zarei & Maleki, 2019; Zolfagharian et al., 2018 | • To identify the push and pull factors that motivate a tourist to visit a medical tourism destination |

<p>| 3; 4 | Bass, 2008; Brits, 2017; Chikanda &amp; Crush, 2019; Crush &amp; Chikanda, 2015; de Arellano, 2007; Haarhoff &amp; Mokoena, 2016; Henama, 2014; Meissner-Roloff &amp; Pepper, 2013; Mogaka et al., 2017; Mokoena, 2015; Mudzanani, 2016; Nicolaides, 2011; Nicolaides &amp; Zigiriadis, 2011; Peters, 2016; | • To measure South Africa’s performance as a medical tourism destination in terms of its push and pull factors |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Medical treatments or procedures</th>
<th>Example References</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECTION C</td>
<td>Ahmadi et al., 2017; Brits, 2017; Crooks et al., 2010; Fetscherin &amp; Stephano, 2016; Gaines &amp; Lee, 2019; Heung et al., 2010; Lovelock &amp; Lovelock, 2018; Lunt et al., 2016; Nikjoo &amp; Ketabi, 2015; Park et al., 2017; Peters, 2016; Smith &amp; Forgione, 2007; Southern &amp; East African Tourism Update, 2018; UNCTAD, 2017</td>
<td>•To determine if the push and pull factors that motivate a tourist to visit a specific medical tourism destination differ based on the type of procedure undertaken</td>
<td></td>
</tr>
<tr>
<td>SECTION D</td>
<td>Chan &amp; Tay, 2016; Corman &amp; Baloglu, 2011; da Silva et al., 2018; Gan &amp; Frederick, 2011 &amp; 2018; Gill &amp; Singh, 2011; Haarhoff &amp; Mokoena, 2016; Mokoena, 2015; Mwesiumo &amp; Halpern, 2018; Özogul &amp; Baran, 2016; Peters &amp; Sauer, 2011; Picazo &amp; Moreno-Gil, 2018; Runnels &amp; Carrera, 2012; Tomigova et al., 2016; Wongkit &amp; McKercher, 2016</td>
<td>•To provide an overview of the medical tourism industry</td>
<td></td>
</tr>
</tbody>
</table>
In terms of the qualitative interviews, the researcher has various options to use, e.g. telephone interviews, skype or video-calls, or conduct face to face interviews. The main purpose of conducting face to face interviews is to substantially evoke the participants’ experiences, perceptions, thoughts and feelings (Moser & Korstjens, 2018). According to Payne and Payne (2011) and Easterby-Smith et al. (2018), in semi-structured interviews topics or issues related to the topic being investigated must be listed on the interviewer’s interview schedule to enable him/her to also consider the issues. The questions must be organised on the interview schedule in order, usually ranging from the general to the specific. The main aim of the interview should be to understand the meaning of what the participants say. For this study, the researcher used a substantial number of open-ended questions, and these were probed further where clarity was sought.

The recent outbreak of the Coronavirus (also known as COVID-19) pandemic requires that social distancing be observed to prevent or to reduce the spread of the virus. According to the Centers for Disease Control (CDC) and Prevention (2019), social distancing relates to the physical distancing and the concept means “keeping space between yourself and other people outside of your home”. Given that telephones reduce the geographical distance between the interviewers and the participants, it is for this reason that mobile/cell phone and WhatsApp calls or video-calls were used to conduct interviews in this study. The participants were requested to provide their mobile/cell phone number where they could be reached through WhatsApp calls. The scheduling of the interviews was arranged depending on the availability, schedule and the time-zones (where applicable) of the participants. The calls were recorded to enable accurate data analysis, and consent for the recordings was sought from the participants prior to the interviews.

The use of mobile/cell phones for data collection in research has overtaken the use of landline telephones, and this is spurred by the worldwide rise in cell phone ownership/usage (Ghandour et al., 2019; Kennedy, McGeeney & Keeter, 2016). Although cell phone calls yield good quality data (Kennedy et al., 2016), they tend to be expensive compared to landline calls. The use of WhatsApp calls helped the researcher to save costs on calls, as some service providers allow free WhatsApp calls. Besides the cost benefits, WhatsApp calls do not require roaming capabilities as
is the case with mobile/cell phone calls, thus it was also convenient to use with international participants. According to Bryman (2016), when conducting telephonic interviews, the likelihood of experiencing technology glitches, such as poor connectivity during the call, is eminent, and this was also experienced in this study with some calls. It is also impractical to sustain a lengthy conversation with participants using the telephone, and as such, the interviews lasted for 30 minutes at most (unless network challenges were experienced, the calls exceeded 30 minutes).

Collecting data using an interview approach has its limitations, such as being costly (in monetary terms), seem less anonymous, may be inferior to self-written accounts on sensitive issues and are very prone to interviewer bias (Payne & Payne, 2011). Interviews are useful tools particularly when the participants cannot be directly observed, as is the case with this study. To overcome interviewer bias in this study, the researcher ensured that the interview questions were clear and objectively prepared to meet the aims of the study. The questions that were not relevant to the study were not asked, and non-medical tourism tour operators were not asked to participate in this study.

According to Saunders, Sim, Kingstone, Baker, Waterfield, Bartlam, Burroughs and Jinks (2018), data saturation refers to when the researcher repeatedly hears the same information from the participants during data collection. This means that no new information is elicited by the participants. Researchers use their discretion with regards to whether to continue to collect more data to supplement what they are currently hearing or to stop, and such decisions are usually taken before coding and category development, i.e. formal data analysis (Saunders et al., 2018). With thirteen interviews the researcher in this study concluded that data saturation had been reached.

4.6.4 Data analysis

According to Sekaran and Bougie (2016), data analysis in qualitative research is a continuous and repetitive process which involves certain actions taking place simultaneously. For instance, data collection can happen at the same time as data analysis. The focus of the data analysis process in qualitative research is on
establishing meaning, therefore focusing on words instead of numbers. The use of words assists researchers to make sense of the data collected. For instance, this is done through interpreting and summarising the overall findings, comparing the findings with the literature or theories available about the topic being investigated, and through discussing the researcher’s personal views regarding the findings. In addition, identifying and stating the limitations of the study and the potential for future research, indicates that the researcher was able to put the data collected in context and make sense of what the data entailed (or not).

In this study, the researcher used a qualitative content analysis approach. Qualitative content analysis allows categories to emerge out of the data collected and makes it possible to understand the significance and the context in which an item is analysed, thus making it easier for researchers to make valid inferences to the texts. Qualitative content analysis assisted the researcher to interpret the medical tourism tour operators’ perceptions and meanings (which may be subjective).

There are contrasting views as to how qualitative data analysis takes place. For instance, Sekaran and Bougie (2016) maintain that there are three main steps in qualitative data analysis, i.e. (i) data reduction, which relates to the process of selecting, coding and categorising the data; (ii) data display, which refers to the way data is presented, e.g. in a graph, chart illustrating patterns, matrix or quotes; and (iii) data coding, which deals with how data is displayed as well as drawing preliminary conclusions, with the preliminary conclusions influencing how raw data is coded, categorised and displayed. Although Creswell and Creswell (2018) concede that qualitative data analysis involves some of the processes highlighted by Sekaran and Bougie (2016), such as simultaneous procedures (data collection and data analysis taking place at the same time), they (Creswell & Creswell, 2018) however, argue that qualitative data analysis requires that a sequence of steps, as well as multiple levels of analysis, must be followed, from specific to general as indicated below.

4.6.4.1 Step 1: Organising and preparing the data
Organising and preparing the data includes transcribing the interviews, typing notes and sorting and arranging the different types of data according to sources of information. In this study, all the recordings were organised according to the date of
the recording, listened to and transcribed. The necessary notes pertaining to the participants and/or responses were jotted down.

4.6.4.2 Step 2: Reading and looking at all the data collected:
This will give the researcher an opportunity to understand the data better and to reflect on the data’s general meaning if any. The transcribed data was read through per participant, and then further organised per question, so that all the response by all participants for the same question were sorted together. This helped the researcher to contextualise the responses better.

4.6.4.3 Step 3: Start coding the data
This involves the process of organising and categorising the data into texts or symbols or words which represent categories or labels that will be easily understood by the researcher for interpretation. The words or phrases used by the participants in response to the same question were highlighted on the transcripts, and similar concepts were categorised by assigning codes. The researcher encompassed categories for various words/phrases (concepts) which were used by the participants and had the same meaning, e.g. the participants used various words to mean ‘expensive’, such as ‘unaffordable’, ‘cost too high’, and others. All these words were categorised as ‘medical treatments unaffordable’ (see Table 5.2).

4.6.4.4 Step 4: Generating a description and themes
This step is based on the previous step, and involves a detailed description/s about people or events in the setting. The researcher noted the number of times that a category appeared in the data to establish the most important points raised. The researcher studied the responses provided and identified the main themes that developed from the information provided in order to contextualise these correctly.

4.6.4.5 Step 5: Representing the description and themes
The researcher noted the detailed discussions on several themes, a chronology of events, specific illustrations, multiple perspectives from different individuals or groups, and represented these in various formats, e.g. figures, tables, visuals, etc. This step also happens in a sequence similar to how coding takes place, and begins from the preparation of the data up to writing the narrative for each theme that forms part of the
findings or general summary that forms part of the discussion. The participants gave similar responses to certain question and these were calculated per category to establish the most important points raised and their responses put in context in narrative form. The narrative form of the participants’ response is provided in the next chapter with the various categories (in tables) identified as the transcripts were analysed and interpreted.

4.7 ASSESSING QUALITY

Researchers strive to maintain quality in research. To assess quality, they use the concepts validity and reliability.

4.7.1 Validity

In research, validity is based on the views of accuracy from all the stakeholders involved, e.g. the researcher ans participants, as well as those who will be exposed to or read the research findings. According to Leung (2015), validity in qualitative research is influenced by the ability of the researcher to employ appropriate tools, processes and data in their research. This means that researchers throughout the research process are mindful of the importance of making appropriate decisions in terms of the research question/s, research methodology and design, sampling, and data collection and analysis. For example, an inappropriate research question is unlikely to yield the desired research outcomes as the responses by the participants will probably not assist the researcher to achieve the research objective/s.

According to Creswell and Creswell (2018) and Korstjens and Moser (2018), to achieve validity researchers use multiple strategies to check the accuracy of the research findings by applying certain strategies or procedures, e.g. triangulation, member checking, rich descriptions, and clarification of researcher bias. Where applicable, researchers also conduct peer debriefings to review the entire research project and to establish whether or not the research objectives were achieved.
Below are the strategies that the researcher used in this study to achieve internal validity:

- Peer debriefing: the researcher consulted with the supervisor for advice and to ensure that the findings are in line with the objectives of the study.

- Clarification of the researcher bias: the researcher has never participated in medical tourism and does not know anybody who has participated in medical tourism or working in the medical tourism industry. The researcher did not allow herself to be influenced by the information that she has learnt from the literature about medical tourism to influence her interactions with the participants. The researcher treated all participants with the same respect, regardless of where they were from.

- Prolonged engagement: the researcher allowed participants to respond to the questions without interruptions. Where necessary or unclear, follow-up questions were posed for the participants to elaborate on (for clarity) and this helped the researcher to collect rich data.

4.7.1.1 External validity
To ensure external validity, the researcher in this study strove to provide rich, elaborate and accurate detailed descriptions relating to the participants’ responses, which were acquired through in-depth interviews and notes made during the interviews.

4.7.1.2 Construct validity
Dikko (2016) proposes that to ensure construct validity when using interviews as data collection instruments, it is advisable to have a pilot study. The researcher in this study used the first two participants to establish whether the questionnaire was in line with the objectives of the study, to establish the accuracy of questions, this includes duplicates and unclear questions, and the duration of the interview. With the supervisor’s assistance, the questionnaire was amended after some duplicate, ambiguous and unclear questions were identified. The duration of the questionnaire was also reduced from 45 minutes to 25-30 minutes as the unnecessary questions were removed.
4.7.2 Reliability

Leung (2015) argues that reliability in research focuses on the consistency and dependability of the research results. Researchers use two types of reliability, i.e. category and inter-judge reliability. According to Sekaran and Bougie (2016:389), category reliability refers to the “clear use category definitions to classify qualitative data”. If the categorisation of the data is clear enough (not vague, broad or ambiguous), it will lead to better category reliability which will empower the reader/s to make an informed judgment (i.e. interjudge reliability) with regards to the research.

To ensure reliability in this study, the researcher applied the following techniques:

- A detailed account of the objectives of the study was used to guide and inform the data collection process, data analysis and interpretation;
- The researcher’s role as the primary data collector was explained and clarified;
- The participants’ position and the basis for their selection was explained, i.e. only medical tourism tour operators were selected to participate in this study; tour operators not specialising in medical tourism were not approached;
- The context from which data will be gathered was explained, i.e. all data collected was in line with the objectives of the study and related to medical tourism push-pull factors, medical tourism destinations and procedures; participants were also made aware of the objectives of the study and how these informed the interview questions;
- Detailed data collection and analyses strategies that were used to give a clear and accurate representation of the methods used in the study were described;
- The researcher used content analysis to analyse the collected data. The recordings were transcribed, categories were established through separating the questions from the transcripts so that all responses from the participants for the same questions were recorded in the same place (e.g. all question 1 for Section A for all participants were put in one place);
- Participant codes were used to identify the participants;
- The transcripts were also thoroughly checked to check mistakes and where mistakes were found, these were corrected.
The results of the study are presented in a detailed, descriptive and narrative format to give a holistic picture of the study, including the participants’ experiences, perceptions, feelings and meanings as expressed during data collection.

In conclusion, all the interview transcripts from the interview recordings were rechecked and evaluated to establish quality; this is known as validity and reliability. All the steps taken and the criteria used to check the accuracy, validity, and the reliability of the research findings in this study were explained in accordance with establishing quality in research.

4.8 BIAS IN RESEARCH

All research is subjective, regardless of it being qualitative or quantitative, making research prone to bias. According to Tulloch (1993:134), bias can be defined as “a predisposition or prejudice” usually for or against something or someone or a group of people, which is usually considered to be unfair. The existence of bias is prominent across all types of research, research designs, and at any stage of the research process. The subjective nature of qualitative research also makes it prone to bias (Smith & Noble, 2014; Williams & Morrow, 2009).

According to Krishna, Maithreyi, and Surapaneni (2010), Pannucci and Wilkins (2010), Simundic (2013), and Smith and Noble (2014), the following are the common types of bias in research: design bias, selection/participant bias, data collection and measurement bias, analysis bias as well as publication bias.

4.8.1 Design bias

Poor choice of research design and the lack of congruence between the research objectives and methods used in a study are likely to increase bias in research. For this study, the researcher wanted to understand the medical tourism tour operators’ perceptions and perspectives in relation to the push-pull factors of a medical tourism; thus, the research design used is the phenomenological design. To obtain rich data,
sem-structured in-depth interviews with open-ended questions were conducted with the medical tourism tour operators.

4.8.2 Selection/participant bias

To avoid interviewing the wrong people, the researcher in this study extended invitations for participation only to medical tourism tour operators. A tour operator who did not satisfy this criterion was not considered. The selection criterion was applied to both the criterion and the snowball sampling selections.

4.8.3 Data collection bias

In this study, the researcher used open ended questions to elicit rich data and the views and opinions of medical tourism tour operators with regard to medical tourism destinations and medical tourists. Codes were derived from the words, phrases or sentences used by the participants in response to the questions asked, and then organised into categories in accordance with the concepts already identified in the literature, which also relates to the objectives of the study.

4.8.4 Measurement bias

The researcher took the supervisor’s advice in terms of the interview schedule to ensure that the questions asked were consistent with the objectives of the study and that the findings were accurate and reliable.

4.8.5 Analysis bias

The researcher in this study did not allow her personal beliefs to influence the interview data collected. The data collected was analysed meticulously to ensure that it was accurate. Codes or labels were used to identify the frequency of certain words and/or phrases in order to establish their relationship/s and to put these words into contexts and to categorise or group them.
4.8.6 Publication bias

The researcher has highlighted the limitations of this study, e.g. only medical tourism tour operators and no medical tourists will be interviewed. A different outcome is possible should a researcher interview medical tourists directly to get their perceptions and reasons for selecting one medical tourism destination over another, instead of relying on the perceptions of medical tourism tour operators as experts.

4.9 SOURCES OF BIAS IN RESEARCH

Researchers should be able to identify the potential sources of bias when conducting research and try to minimise these as much as possible. Below are the typical examples of the sources of bias in research:

4.9.1 Population and sampling bias

According to Creswell and Creswell (2018), in qualitative research the selection of participants is largely purposeful, and this helps with the reduction of bias in the research process. Criterion sampling is the main sampling method used in this study. The selection of participants in qualitative research is also ongoing, as the original participants, the initially identified medical tourism tour operators, can recommend other participants, i.e. other medical tourism tour operators in their circles (snowball sampling) who would have not been identified by the researcher. To eliminate bias, the researcher invited only tour operators who were working in the medical tourism industry.

4.9.2 Researcher bias

In order to minimise bias in this study, the researcher only selected medical tourism tour operators to participate in this study. None of the tour operators who participated in the study has a relationship with the researcher. The research topic selected by the researcher is not too close to the researcher on a personal level as she has never participated in medical tourism, and does not have relatives who have participated in
medical tourism. The researcher therefore did not anticipate or solicit certain or specific responses from the participants. The researcher also ensured that her own ideas, prejudices and personal philosophies with regards to medical tourism did not influence the study in any way.

4.9.3 Interviewer bias

Hennekens and Buring (in Pannucci & Wilkins, 2011:3) explain that interviewer bias is a “systematic difference between how information is solicited, recorded, or interpreted”. Interviewer bias is very prominent, especially when conducting in-depth interviews, and when the researcher is familiar with the participants in some way. Questions for in-depth interviews should be clear, concise and objectively prepared to meet the objectives of the study.

To reduce interview bias, the researcher avoided contacting the wrong participants, e.g. tour operators who are in no way involved with medical tourism, deviating from the interview schedule by asking irrelevant questions that do not contribute to the achievement of the objectives of the study, mis-recording the participants’ answers, and dishonesty. The researcher also avoided asking biased questions, e.g. leading questions, unclear, vague or ambiguous questions, and unanswerable questions. An effort was made to ensure that the questions were arranged in an order ranging from the more general to the specific.

4.9.4 Participants’ answers bias

Participants can contribute to bias in research by providing biased answers. Bryman (2016) states that biased answers can be untrue or partially true statements in relation to the questions asked (intentionally or unintentionally). In this study, the researcher was always on the lookout for inconsistencies, if any, in the answers given, and the necessary probing and follow-up was done for clarification.
4.9.5 Lack of transparency

Qualitative research has been criticised for lack of transparency. Qualitative researchers must therefore strive for absolute openness in terms of how they are conducting research (Smith & Noble, 2014). In this study, all questions asked during the interview were developed in accordance with the objectives that this study hoped to achieve. To minimise transparency bias, the researcher also validated participants by inviting only medical tourism tour operators to participate in the study. The responses by the participants, as interpreted by the researcher, were re-checked, and constant comparisons across participants’ accounts were made. No effort was made to manipulate the results of this study.

4.9.6 Measurement tool

In this study, the interview schedule used was prepared objectively and accurately to assist the researcher to achieve the objectives of the study. The supervisor was consulted for advice and to ensure that the questions asked were relevant and appropriate for the study. Open-ended questions were asked. Follow-up questions were asked where clarity was sought, or the questions that participants did not understand were explained to them or rephrased to help them understand.

4.10 ETHICAL CONSIDERATIONS OF THE STUDY

Research ethics is an important component of any research especially if human beings and animals are the focus of study. According to Morris (2018), the Economic and Social Research Council (ESRC) recommends that the following ethics principles must be observed when conducting research.

4.10.1 Research should be designed, reviewed and undertaken to ensure integrity, quality and transparency

In order to ensure that researchers’ behaviour is beyond ethical reproach, they must ensure that the research process is conducted with absolute integrity. In this study,
the researcher informed the participants that the in-depth interviews would be recorded, and explained how the recordings were to be used to select the information needed for analysis and reporting.

4.10.2 Research staff and participants must be fully informed

Both the research staff and participants must be fully informed of the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks (if any) are involved. Morris (2018) emphasises that the researcher must ensure that the participants are aware of the nature of the study beforehand and grant written permission to participate in the study. In this study, the researcher provided all the participants with an informed consent form before they participated in the research. The consent form was in English as all the participants understood English. The consent form can be found in Appendix B.

4.10.3 Confidentiality of information supplied by the research participants and their anonymity must be respected

The researcher applied for and was granted ethical clearance before the commencement of data collection (included as Appendix A). To ensure privacy and confidentiality, the participants were allowed to respond anonymously, unless permission to disclose their identity, e.g. the name of the tour operator company was granted. The medical treatments mentioned as part of this study were not linked directly to specific medical tourists.

4.10.4 Research participants must take part voluntarily

According to Leedy and Ormrod (2015), Morris (2018) and Odiya (2009), participation in research must be done voluntarily. In this study, the medical tourism tour operators invited to participate did so voluntarily. None of the medical tourism tour operators who participated in this study were offered any monetary reward for participation; instead, they were offered the findings of the study on its completion.
4.10.5 Harm to research participants and researchers must be avoided

Leedy and Ormrod (2015) and Odiya (2009) emphasise that researchers should treat participants in a courteous, considerate and respectful manner and be careful not to expose them to any form of physical or psychological harm. In this study every effort was made to ensure that no participant was subjected to any situation or required to answer embarrassing or humiliating questions.

4.10.6 Independence of research must be clear and conflicts of interest or partiality must be explicit

Researchers must report their research findings in a complete and honest way without misrepresenting or over-exaggerating what they have done. They should also avoid intentionally misleading others about the nature of their findings (Leedy & Ormrod, 2015; Odiya, 2009). In this study, the findings emanating from the data collected from the participants is represented as it was presented to the researcher in the interviews. All sources consulted are acknowledged in the reference list and within the appropriate literature, and the supervisor provided the necessary guidance and support. No sponsor or funder was sought for this study.

4.11 CONCLUSION

In conclusion, this chapter highlighted the research paradigm, the description of the qualitative research methodology, research design, population, sampling and data collection strategies used in this study. To ensure that the data collected was accurate and reliable, qualitative validity and reliability strategies used in this study were identified and explored. The data analysis steps applicable to the study were highlighted and discussed. The biases that relate to conducting research, e.g. those relating to the researcher, the participants, and the methodology, were identified and strategies to counteract these biases were discussed in-depth. Lastly, the ethical considerations were identified and applied to both the researcher and the medical tourism tour operators. Ethical clearance was obtained from the Economic and
Management Sciences Faculty of the University of Pretoria, and consent to participate in the study and to have the interviews recorded was sought and granted.

The next chapter focuses on the interpretation of the data and the overall findings in relation to the findings.
CHAPTER FIVE
FINDINGS

5.1 INTRODUCTION

The previous chapter described the research methodology and explained the process followed to collect and analyse the data. The data collected is used to meet the objectives of this study, as follows:

- To explain the push-pull theory and its use in tourism literature.
- To provide an overview of the medical tourism industry, globally and in South Africa.
- To identify the push-pull factors of a medical tourism destination.
- To determine if the push-pull factors of a medical tourism destination differ based on the type of procedure offered at the destination.
- To measure South Africa’s performance as a medical tourism destination in terms of its push and pull factors.

In this chapter, the findings emanating from the collected data will be presented and discussed. The questionnaire used to collect the data through in-depth interviews, was divided into four sections, i.e. Section A (Medical travel motivations, i.e. push factors); Section B (Medical tourism destination (i.e. pull factors); Section C (Medical treatments and procedures); and Section D (Tour operator profile) in line with the objectives of the study as indicated above.

5.2 PROFILE OF PARTICIPANTS

Section D explored the profile of participants. Table 5.1 gives a summary of the participants, their locations, gender, how long they have been in operation and their product offerings in the medical tourism industry. The participants are arranged according to the order in which they were interviewed. The participants were allocated identification codes based on their location, and for convenience, the abbreviation 'l' is used for the six international participants. From the African continent, seven
participants took part. The abbreviation ‘SA’ is used for all South African medical tourism tour operators, while ‘A’ is used for the rest. The reason for this distinction is not to disassociate South Africa from the continent, but to enable the researcher to distinguish between the findings and how they relate to the South African push and pull factors and the country’s performance as a medical tourism destination. Six participants were female, i.e. three from South Africa (SA), one from Kenya, one from Zimbabwe (A), and one from Brazil (I). Seven participants were male, i.e. one from Ghana, one from Nigeria (A), one from the UK, one from Hungary, one from Slovakia, one from Portugal and one from Mexico (I). Five participants (i.e. two from South Africa, one from Ghana and one from Kenya and one from Zimbabwe) were offering all the medical procedures that the patients required. Three participants offered specialised services, i.e. one (from Hungary) only offered dentistry, one (from Slovakia) only offered hospital/clinic data data service to patients, and one (from Portugal) offered marketing services to medical tourism destinations. Two participants (from Mexico and the UK) offered cosmetic, dental, IVF and ophthalmology treatments, while one (from South Africa) offered oncology, cardiology, IVF, trauma treatment neurology and medical-checkups. Lastly, one (from Nigeria) offered orthopaedic treatments, oncology, cardiology, cosmetic and overseas-birthgiving services to patients. The need to give for women and midwives to seek better birth services overseas or abroad was investigated in-depth by Parízková and Clausen (2019).

Question 3 in section D related to the other medical tourism destinations offered to medical tourists by the medical tourism tour operators. Six of the participants (SA1, SA2, SA3, I2, I3 and I5) indicated that they focused mainly on their own countries. For example, all the South African-based medical tourism tour operators indicated that they were working only in South Africa. Given an opportunity, participant SA3 said that she would also send patients to countries such as Singapore, Germany, Thailand and America as she had learnt most of her medical tourism lessons from these countries. Participant I2 focused on Hungary, I3 on Mexico, and I5 on Brazil.

Four participants (A1, A2, A4, I1) said that they were sending patients to India for various treatments. I1 sends patients to Hungary, Turkey, Croatia, Czech Republic and Pakistan. Three (A1, A2, A3) participants send patients to Israel for cancer
treatments and heart procedures. Two of these participants (A1, A3) send patients to the UK and US mainly for orthopaedic cases and various procedures respectively. Participant A3 sends patients to Tunisia and Georgia. Participant A4 sends patients to Zambia. Participant I4 focuses on quality treatment data for over 126 countries providing information about clinics, hospitals and destinations so that potential medical tourists can make treatment decisions based on facts. Participant I6 is a strategic consultant in healthcare tourism and conducts research to help countries analyse and assess their current tourism offerings in order to establish what they need to do to be more attractive to tourists.

Question 5 in this section relates to the other services that medical tourism tour operators offer to medical tourists. Ten participants (SA1, SA2, SA3, A1, A2, A3, A4, I2, I3, I5) offered their clients a variety of services, e.g. assisting their clients with visa applications, booking of flights, accommodation and pick-ups at the destination, transportation at the destination, scheduling the patients’ doctors’ appointments, patients’ itineraries, and at times providing companionship. Most of the services that are rendered by these medical tourism tour operators are similar to those also identified by Haarhoff and Mokoena (2016), and according to Chikanda and Crush (2019), these medical tourism tour operating companies serve as an important bridge between medical tourists and healthcare providers.

One participant (I1) mentioned that they do not offer other services to patients as they were not qualified to do so. He mentioned that they can, however, refer the patients to relevant service providers such as travel agencies and others depending on the service that the patient requires. Participant I4 said that he provided treatment quality data to patients from over 125 countries worldwide, so that they can compare hospitals, clinics and countries around the world. This data helps patients to make medical treatment decisions based on facts derived from the data. Participant I6 indicated that his focus was on research for countries, for instance which procedures will be successful in attracting potential tourists to their destination.
### Table 5.1: Profiles of medical tourism tour operators

<table>
<thead>
<tr>
<th>Participant code</th>
<th>Location</th>
<th>Male/Female</th>
<th>Years in operation</th>
<th>Type of product offerings</th>
<th>Medical tourism destinations offered by the medical tourism tour operators</th>
<th>Other services</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA1</td>
<td>South Africa</td>
<td>Female</td>
<td>3yrs</td>
<td>Different treatments (mental care, cardiac/heart, cancer treatments, neurology, gastro and abdominal issues); no cosmetic surgery</td>
<td>South Africa only</td>
<td>Full packages (e.g. visa applications, doctors’ appointments, medical reports, accommodation, flights, itineraries, tourism attractions)</td>
</tr>
<tr>
<td>SA2</td>
<td>South Africa</td>
<td>Female</td>
<td>2yr</td>
<td>No speciality (offer both medical and cosmetic treatments); leaning towards IVF</td>
<td>South Africa only</td>
<td>Full packages (e.g. visa applications, doctors’ appointments, flights, itineraries, accommodation, transportation)</td>
</tr>
<tr>
<td>I1</td>
<td>The United Kingdom</td>
<td>Male</td>
<td>14yrs</td>
<td>Cosmetic surgeries, dental treatments, weight-loss treatments, infertility and ophthalmology (laser treatments)</td>
<td>Hungary, Turkey, Croatia, Czech Republic, Pakistan &amp; India</td>
<td>Treatment only (can make recommendations for patients if they need other services)</td>
</tr>
<tr>
<td>SA3</td>
<td>South Africa</td>
<td>Female</td>
<td>16yrs</td>
<td>Started with everything; now focusing on oncology, cardiac/heart, medical check-up, fertility and trauma treatment</td>
<td>South Africa only (given an opportunity would send to Singapore, Germany, Thailand and USA)</td>
<td>Full packages (e.g. transportation, accommodation, visa applications, itineraries, doctors’ appointments, follow-ups, medical reports,</td>
</tr>
<tr>
<td>#</td>
<td>Country</td>
<td>Gender</td>
<td>Age</td>
<td>Treatments</td>
<td>Destinations</td>
<td>Services Offered</td>
</tr>
<tr>
<td>----</td>
<td>---------</td>
<td>--------</td>
<td>-----</td>
<td>------------</td>
<td>-------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>A1</td>
<td>Kenya</td>
<td>Female</td>
<td>6yrs</td>
<td>Various treatments</td>
<td>Turkey, Israel, USA, UK, &amp; India</td>
<td>Full packages (e.g. visa applications, flights, pick-up transport at destination, itineraries, doctors’ appointments, treatment plans, accommodation, appointment for extra assessments if necessary)</td>
</tr>
<tr>
<td>A2</td>
<td>Nigeria</td>
<td>Male</td>
<td>10yrs</td>
<td>Oncology, orthopaedic (knee replacements and neuro- and spine surgeries), cosmetic surgeries and deliveries/giving birth</td>
<td>India, South Africa, Israel &amp; Egypt</td>
<td>Full packages (e.g. visa applications, doctors’ appointments, flights, accommodation)</td>
</tr>
<tr>
<td>I2</td>
<td>Hungary</td>
<td>Male</td>
<td>25yrs</td>
<td>Dentistry only</td>
<td>Hungary only</td>
<td>Full packages (e.g. airport transfers, car hire, accommodation, treatment arrangements)</td>
</tr>
<tr>
<td>A3</td>
<td>Ghana</td>
<td>Male</td>
<td>2yrs</td>
<td>All treatments that patients request</td>
<td>Georgia, Israel, Tunisia, UK, USA</td>
<td>Full packages (e.g. flights, accommodation, insurance, doctors’ appointments)</td>
</tr>
<tr>
<td></td>
<td>Country</td>
<td>Gender</td>
<td>Age</td>
<td>Services and Treatments</td>
<td>Destination(s)</td>
<td>Packages (Examples)</td>
</tr>
<tr>
<td>---</td>
<td>------------</td>
<td>--------</td>
<td>-----</td>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>I3</td>
<td>Mexico</td>
<td>Male</td>
<td>9yrs</td>
<td>Cosmetic surgeries, dentistry, orthopaedic surgeries, fertility treatments, ophthalmology, bariatric/weight-loss treatments</td>
<td>Mexico only</td>
<td>Full packages (e.g. transportation, accommodation, taking patients for appointments, nurse services, post-operation service and care, companionship)</td>
</tr>
<tr>
<td>I4</td>
<td>Slovakia</td>
<td>Male</td>
<td>13yrs</td>
<td>Provide data to patients (for them to compare hospitals, countries and clinics)</td>
<td>126 countries across the world</td>
<td>Treatment quality data (from hospitals and clinics)</td>
</tr>
<tr>
<td>I5</td>
<td>Brazil</td>
<td>Female</td>
<td>16yrs</td>
<td>Weight-loss &amp; post weight-loss treatments</td>
<td>Brazil only</td>
<td>Full packages (e.g. airport pick-ups, accommodation, doctors’ appointments, medicine collection, blood tests, assist doctor with surgeries, translations services, update families, follow-up care)</td>
</tr>
<tr>
<td>I6</td>
<td>Portugal</td>
<td>Male</td>
<td>30yrs</td>
<td>Strategic consultant to countries and providers</td>
<td>Any country that requires research and marketing services</td>
<td>Conduct research for countries (e.g. which procedures will be successful in attracting potential tourists to their destinations)</td>
</tr>
<tr>
<td>A4</td>
<td>Zimbabwe</td>
<td>Female</td>
<td>5yrs</td>
<td>All procedures (partner hospitals have all specialities)</td>
<td>Zambia &amp; South Africa</td>
<td>Full packages (e.g. visa applications, flights, accommodation, arrange post-care treatments)</td>
</tr>
</tbody>
</table>
5.3 MEDICAL TRAVEL MOTIVATIONS (PUSH FACTORS)

Section A related to objectives three and five of the study. The main aim of the open-ended questions posed in this section was to determine the medical travel motivations or push factors that motivate potential medical tourists to seek medical treatments in destinations other than their own and to rate South Africa’s performance in terms of the push factors identified.

In response to the question relating to what will motivate (push) a patient/medical tourist to seek medical treatments or procedures in another country instead of their own, four themes emanated from the data. The first theme was ‘push factors related to affordability and cost’. The first category was labelled ‘medical treatments unaffordable’, and the majority of the participants (10) identified the high ‘unaffordability of medical treatments’ at home as a push factor that will motivate tourists to seek medical treatment elsewhere. One of the participants highlighted that the price of treatment was also influenced by the patients’ ‘budget’ (I4), while another (I5) emphasised the role that the ‘exchange rate’ at the receiving country plays in making the cost or price affordable to the patients. Patients are therefore said to be likely to travel elsewhere for ‘cost-effective’ treatments (SA 3). The search for cost-effective treatments is also typical for patients from developed countries, such as the UK and the US, as also highlighted in this study. The high cost of medical treatment in one’s home country was also identified as an incentive and one of the major push factors for patients who sought medical treatments in Thailand in a study on medical tourists’ decision-making processes by Veerasoontorn and Beise-Zee (in John & Larke, 2016).

The second theme that emerged from the data was ‘push factors related to procedures and treatments’. The first category in this theme was the ‘lack of expertise and treatments at home’ or in the patients’ home countries, and ten participants identified this as a push factor. Various words were used to refer to the expertise, such as ‘physicians’ (I3), ‘specialists’ (A2), and ‘doctors’ (A1). Some of the participants (e.g. A1) even specified which specialities they were referring to, such as cardiologists, neuro-surgeons and nephrologists. Hence the lack of expertise results in the lack of
treatments (SA1, I1 and I2), as patients will not be able to access these treatments; there will be no expert to perform them. The need for such expertise influences the patient’s decision-making process while at the same time benefitting the healthcare providers at the receiving destination. The role played by the experts is thus two-fold; it serves as a push factor for patients seeking specific treatments that only such experts can render, and also serves as pull factor from the healthcare providers’ perspective as highlighted by John and Larke (2016). One of these participants (I2) indicated that patients would also be pushed by their need for ‘niche treatments'. The need for niche, novel and experimental treatments was also mentioned as a push factor for some patients seeking medical treatment in Thailand in the study by Veerasoontorn and Beise-Zee (in John & Larke, 2016) since such treatments are usually unavailable in the patients’ home countries.

The second category was labelled ‘lack of facilities and services at home’ and seven participants identified this as another push factor. Five of these participants are based locally (SA2, SA3, A1, A3, and A4), and this is similar to the studies with regards to the push factors for patients from developing countries by Chikanda and Crush (2019), Crush and Chikanda (2015), and Lunt et al. (2016). One of the international participants (I3) highlighted the need for the facilities or hospitals in the receiving countries to keep to ‘international standards’. If a facility meets international standards, such as those of the International Organisation for Standards (ISO), then such a facility is perceived as being of good quality, and is likely to have a very good reputation, as indicated by Fetscherin and Stephano (2016). The other participant (I4) distinguished between the availability of medical and non-medical facilities, such as access for the disabled, proximity to the airports, availability of accommodation, and the availability of technology at the receiving destination. The role played by both medical and non-medical facilities, as well as the influence of technology and globalisation in the medical tourism industry as contributors to the outflow of patients from their home countries to medical tourism destinations, was also highlighted by Tiren-Verbeet et al. (2018), Lang (2019) and Xu et al. (2020).

The third category related to the ‘length of waiting time’ and six participants (SA2, SA3, A1, I1, I2, and I3) identified this as a push factor. The emphasis was that in most cases patients would consider their ailment at the time as an emergency, while their home
healthcare could only give them medical attention within ‘four to five weeks’ (I2) and ‘two months’ (A1). The length of waiting time thus restricts the patient’s access to treatment. According to Zolfagharian et al. (2018), many patients have lost their lives due to the lengthy waiting periods to which they were subjected in countries such as the US. As a result, the need to avoid long waiting lists in patients’ own countries, especially in developed countries, was also identified as an important push factor in studies by Zolfagharian et al. (2018) and Gan and Frederick (2018).

Anonymity or privacy when receiving treatment was the fourth category in the second theme and mentioned by only one participant (SA2). This participant also indicated that usually patients did not want people at home to know that they were receiving treatment. The need for privacy and anonymity when receiving treatment was also identified by Zolfagharian et al. (2018), who argued that patients usually make comparisons between their own countries and receiving destinations with regards to the risks of their information being exposed. In their decision-making process, patients are said to be more inclined to choose destinations which are perceived to provide more confidentiality than others (Abd Mutalib et al., 2017; Zolfagharian et al., 2018).

The third theme was labelled ‘travel-related push factors’. The first category in this theme related to the geographical location and accessibility of the receiving country; four participants (I1, I2, I3 and I4) identified this as a push factor. The geographical location of the receiving country relates to how far away the country is located and this has an influence on how easy or difficult it would be to access the country. One of the participants (I1) mentioned that although it was the patient’s choice to travel for medical treatment, usually patients prefer to travel within their own home regions. The participant used the geographical position of South Africa on the continent as an example, and mentioned that African patients could travel for medical treatments to South Africa as it may be geographically closer to most of the countries or because of the similar time zones with other African countries than it would be if they were to travel abroad. The importance of the distance between the patient’s country and the receiving destination as a push factor linking medical tourism demand (by patients) and supply (by the medical tourism destination) was also raised by Alleman et al. (2011). Thus, the proximity of the receiving country plays a critical role in influencing tourists’ decisions on or not whether to travel. According to Zolfagharian et al. (2018),
most patients make medical travel decisions fully cognisant of the complications and risks associated with long haul travel.

The second category in this theme related to the desire to ‘combine health and tourism’, and one participant (SA3) identified this as a push factor. The participant mentioned that patients who did not need major procedures were likely to want to combine the procedure or treatment with a holiday at the receiving destination. The tendency for patients to want to combine health and tourism in medical tourism destinations was investigated by Jónás-Berki et al. (2015) with patients in need of dental treatment in Hungary who are also able to take advantage of the various tourist attractions available in the country.

One participant (I4) indicated that some patients may be influenced by the available data and treatment-results or outcomes, in the form of testimonials from patients who have had treatments in various clinics and hospitals in various destinations. The websites of many medical tourism intermediaries also publish testimonials from patients who have used their services to access medical treatments overseas, and these are open to the public to read. Such testimonials serve as valuable sources of information for patients in need of medical treatments overseas.

The last theme relates to the ‘healthcare needs’ of patients as a push factor. One participant (I6) mentioned that push factors vary by market segments, and indicated that patients may thus be pushed by [their] personal and self-motivation (first category), or the need for relief of pain or survival. The participant explained that patients in need of minimally invasive procedures such as dental procedures, health and wellness treatments would fall in the personal and self-motivation category, and they could be having such procedures to improve their image or have a desire to look and feel better. The need for the medical tourists’ personal and interpersonal interaction and satisfaction (through interactions with friends or family members), which may have been prevented by the patients’ illnesses, was also raised as a motivating factor for patients to achieve personal fulfilment (seeking and escaping) through travel in the study by Adams et al. (2015). In contrast, for patients seeking complex procedures, e.g. lifesaving and non-elective procedures, the motivation could be for the relief of pain or survival. The input by participant I6 is similar to the findings
by Wongkit and McKercher (2016) who found that patients who sought surgical (both invasive and cosmetic) procedures in Thailand, the availability of treatment, the quality of treatment, quality of doctors and facilities at the destination were the most influential in the patients’ decision-making processes.

Table 5.2: Classification of participants’ responses with regards to what will motivate a medical tourist to opt to seek medical treatment in another country

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category (Push factors)</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
</table>
| Push factors related to affordability and cost | Medical treatments unaffordable | 10 (SA1, SA2, SA3), (A1 & A4), (I1, I2, I3, I4 & I5) | “If the cost is too high, they tend to travel elsewhere for cost-effective treatments” (SA3)  
“The price, the most essential reason, for example, in Europe, for dental treatment, the prices are very very different. In dentistry, if a German patient comes to Hungary for prosthesis dental treatment, they will pay 50% of the cost price which is paid in Germany, so, it is the price” (I2) |
| Push factors related to procedures and treatments | Lack of expertise and treatments at home | 10 (SA1), (A1, A2, A3, A4), (I1, I2, I3, I4, I5) | “Some, those who are really sick, but can’t get the right treatment at home, in their home country for various ailments such as cancer and so forth” (SA1)  
“for example, you might be seeking to have surgery with a neurosurgeon, and the neurosurgeon tends to be or is very busy until too late for you, because there are very few neurosurgeons in Kenya, there are few cardiologists, few nephrologists, so, you find the patient saying ‘I can’t wait so long in a queue’, so, they will seek medical attention out of the country” (A1)  
“to get niche treatments, treatments like laser treatments in the dental industry or special kind of bone grafts in dentistry” (I2) |
<p>| Lack of facilities and services at home | 7 (SA2, SA3), (A1, A3, A4), (I3, I4) | “…because they do not have the facilities in their own or home countries, so they look for other places where they can access those services quicker, and that’s usually from sub-Saharan Africa” (SA3) |</p>
<table>
<thead>
<tr>
<th>Factor</th>
<th>Value</th>
<th>Related Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length of waiting time</strong></td>
<td>6</td>
<td>(SA2, SA3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(A1) (I1, I2, I3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“the length of waiting time for elective procedures, to avoid waiting lists, especially in North America and Europe” (SA2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“if the waiting period is too long in their home countries, they tend to want to travel for healthcare, so they look for other places where they can access those services quicker” (SA3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“or the waiting time is too long, for example, the English NHS is very bad, and if you need treatment, for example, for appendicitis surgery, you have to wait 4 to 5 weeks, so, you have to go to other countries for the treatment, for example, the NHSS in Germany might have beds available” (I2)</td>
</tr>
<tr>
<td><strong>Anonymity or privacy when receiving</strong></td>
<td>1</td>
<td>(SA2)</td>
</tr>
<tr>
<td>treatment</td>
<td></td>
<td>“anonymity for conditions that they do not want anybody to know about in their home country” (SA2)</td>
</tr>
<tr>
<td><strong>Available data on results or treatment</strong></td>
<td>1</td>
<td>(I4)</td>
</tr>
<tr>
<td>outcomes</td>
<td></td>
<td>“the patient will always look for reviews, testimonials; maybe some data on the treatment-outcome of the patients who’ve already had treatment there” (I4)</td>
</tr>
<tr>
<td><strong>Travel-related push factor</strong></td>
<td>4</td>
<td>(I1, I2, I3, I4)</td>
</tr>
<tr>
<td>Geographical location and accessibility of country</td>
<td></td>
<td>“I am located in the north west of Hungary, close to the Hungarian, Slovakian and Austrian borders, and the city is close to two airports. And because of this, we have the highest density of dentists in the world, it means, the whole city is built on dentistry - all the hotels, restaurants, is filled with medical tourism” (I2)</td>
</tr>
</tbody>
</table>
"… connectivity and accessibility to the receiving country" (I3)

"proximity, means can I travel that easily. Is it safe? Do they speak my language? How do they treat people from my culture? (I4)

| Combine health and travel | 1 (SA3) | “people who want to combine health and travel, those are the people who are not coming for major procedures, so they will do a minor procedure while they are on holiday” (SA3) |
| Healthcare needs | Personal and self-motivation | 1(I6) | “for minor procedures, such as dental procedures, health and wellness and minimally invasive procedures…personal and self-motivation…could be to improve one’s image or a desire to look and feel better” (I6) |
| Relief of pain or survival | 1(I6) | “for those seeking higher or complex procedures, the motivations are different…could be for relief of pain or survival…different from personal motivations” (I6) |

With regards to the question (question 2) relating to what will motivate (push) a patient/medical tourist to seek medical treatment/procedure in South Africa, the international participants indicated that they were not familiar with the medical tourism industry in South Africa. However, they were willing to give input. In contrast to their international counterparts, the African (South Africa included) participants were familiar with the healthcare system in South Africa. Two themes emanated from the data.

The first category of the theme ‘push factors related to procedures and treatments’, related to the ‘lack of expertise and treatments’. Eight participants (SA1, SA2, SA3, A1, A2, A3, I4 & I5) mentioned that the lack of expertise and treatments in own countries matched by the doctors’ expertise available in South Africa can motivate patients to consider having medical treatment in South Africa. For instance, to demonstrate the lack of expertise and/or brain-drain, participant A1 commented that many specialists, e.g. ‘neurosurgeons have left the country (Kenya) to the UK, Botswana and to other countries’. The availability of doctors’ expertise means that
patients will also receive quality treatment from the country. The patients are thus motivated by the lack or shortage of medical expertise in their own countries. Various expressions were used by the participants to denote the South African doctors’ expertise, such as ‘…doctors really compare with the best in the world’ (SA3), and ‘there is no doubt in terms of the medical personnel’s skills, they have the right skills and expertise and experience’ (SA1). The MTSA (2014) website also emphasises the availability, expertise and professionalism of the South African medical doctors as what potential medical tourists would benefit if they were to visit South Africa for medical treatments.

The second category of the first theme related to a ‘lack of medical facilities at home’. Six participants (i.e. five African, including South African, and one international) indicated that the availability of quality medical facilities in South Africa can also motivate patients to want to receive medical treatment in South Africa. The lack of quality medical facilities in their own countries is thus a motivating factor. One of the participants (SA1) indicated that South Africa has healthcare agreements with various countries in the region, because these countries either have poor healthcare facilities, or have no healthcare systems at all. As a result, citizens from these countries struggle to access healthcare services in their own countries and are forced to visit South Africa for medical treatment. One of the participants (A3) highlighted that South Africa has ‘relatively well-developed facilities’, and that most of these hospitals provide ‘specialised care’ to patients. Patients from all the countries with which South Africa has agreements, are able to access various specialised healthcare (such as oncology treatment) in the South African public and private healthcare facilities. The need for the South African medical facilities is therefore initiated by the absence of such facilities in these countries. The existence and role of healthcare agreements was also highlighted by Chikanda and Crush (2019), and according to Lunt et al. (2016), this is a clear indication of the perceived weaknesses in the domestic health systems of the countries that find themselves sending their citizens to seek medical treatments elsewhere.

To avoid long waiting lists was identified as the third category of the first theme. The potential to receive treatment more quickly in South Africa than in one’s own country was identified by two participants (African and international). Even though one of the
participants (I3) had no knowledge of the South African healthcare system, he thought that the ‘time with which the patient would be received and treated so as to avoid long waiting lists in their own country’ would be a push factor to seek medical treatment in South Africa. Patients from developed and developing countries have different reasons to want to avoid the waiting list. The need to avoid long waiting lists for patients from developed countries, is usually not influenced by the lack of expertise. Most of the patients from developed countries have good quality healthcare systems. The issue for them might be that the healthcare system does not consider the patient’s ailment as urgent at the time that he/she needs the treatment, thus they will be put on a waiting list (Gill & Singh, 2011). With patients from the developing countries, patients will be placed on a waiting list because there are fewer or no specialists available to attend to their ailment at the time, and these specialists (where available) could be fully booked or overbooked at the time, or they would have to get the treatment elsewhere as they cannot get it at home, as also alluded to by participant A1. Three participants (A1, A2 & A3) mentioned that countries such as Kenya, Nigeria and Ghana have lost a lot of specialists who have relocated to other countries in search of better opportunities. This has resulted in internal brain-drain in Nigeria and other countries on the continent, leading to patients being unable to get the necessary life-saving treatments they may need, as also indicated in the study by Anetoh and Onwudinjo (2020). One participant (A2) remarked that sometimes doctors relocate for a lower salary than in their home countries. The tendency for specialists to leave their own countries for better opportunities from developing countries in search of better opportunities (or lost to the private sector), resulting in these countries experiencing internal brain-drain, was also identified as a push factor for patients to seek medical treat elsewhere by Mogaka et al. (2017). The shortage of specialists means that patients will be put on a waiting list before accessing treatments, and as a result, they will opt (or be pushed) to seek medical treatment where they will be able to access it more quickly than at home, as also indicated by Zolfagharian et al. (2018).

The fourth category identified as a push factor to seek medical treatment in South Africa was ‘anonymity and privacy when receiving treatment’ and this was mentioned by one participant (A3). According to participant A3, many high-profile people come to South Africa for treatment as they did not want to be seen by people known to them when receiving treatment.
The last category for this theme was in relation to ‘traditional medicine treatment’ in South Africa, and this was identified by one participant (A3). Participant A3 remarked about South African traditional medicine and the need to make traditional medical treatments acceptable, so that ‘people not only look at the orthodox treatments’. In his opinion, the promotion of traditional medical treatments will enable people to choose traditional medicine. Some governments, such as the Hong Kong government (UNESCAP in Heung et al., 2010) have investigated and invested in traditional medicine so as to establish their treatment capabilities for various ailments. Traditional medicine is part of the alternative treatments or procedures sought by medical tourists in medical destinations, as indicated by Cormany (in Ko, 2011). Traditional medicine also forms part of the cultural factors that some tourists consider when they select a medical tourism destination, as indicated by Shahrokh et al. (2017).

The second theme emanating from the data was labelled ‘push factors related to affordability and cost’ and four participants (SA2, A2, I4 & I5) identified the unaffordability of medical treatments at home as a push factor to South Africa. For example, one of the participants (SA2) highlighted that getting medical treatment in South Africa is ‘cost-effective in comparison to what one would be paying in Europe or America’. The potential for saving on medical costs in South Africa for patients originating from the developed countries, such as Europe and America, was also identified by Chikanda and Crush (2019). According to these authors, even if other costs (e.g. travel and accommodation) were to be included in these patients’ medical costs, it would still be cheaper for them to get medical treatments in South Africa. Medical cost savings as a medical tourism demand or push factor motivating European and American patients and those from other developed countries, was also highlighted by Matiza and Slabbert (2020). However, participant A2 further pointed out that medical treatment in South Africa is not necessarily cheap for the African market, and as such, most African patients choose to go to India, because treatments there are cheaper than in South Africa. The high cost of medical treatment in South Africa was also indicated as one of the reasons why Indian-South Africans (from Johannesburg) opt to go to India for medical treatments (Dangor et al., 2015).
Three international participants (I1, I2, and I6) indicated that they were not familiar with the South African healthcare system or the medical tourism industry in South Africa. However, they made comments which are worth noting. For example, one participant (I1) emphasised that medical tourism is a ‘regional phenomenon’ and not a ‘global phenomenon’. His emphasis was that the African continent should be South Africa’s natural catchment area because of the geographical location of South Africa in the continent. Jónás-Berki et al. (2015) investigated the regional impact of health tourism in Hungary and demonstrated that focusing on the regional demand and supply of health tourism products can contribute positively to the overall health tourism industry as it did in Hungary. Another participant (I2) said that he did not know ‘anybody going to South Africa for treatments’. He also mentioned that they (in Hungary) have had patients from South Africa who had been on holiday in Germany or England, who came for dental treatments in Hungary. The last international participant (I6) mentioned that he would speculate that perhaps it could be someone from

... Botswana or elsewhere who can have access to the sophisticated procedures that are available in Pretoria, Cape Town or Port Elizabeth, then they would leave their location where they don’t have access and be motivated to travel to Pretoria, Cape Town, Port Elizabeth or wherever.

The response by participant I6 above also alluded to the regional tendencies of medical tourism.

Table 5.3: Classification of participants’ responses with regards to what will motivate (push) a patient/medical tourist to seek medical treatment/procedure in South Africa

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Push factors related to procedures</td>
<td>Lack of expertise and treatments</td>
<td>8</td>
<td>“There’s no doubt in terms of the medical personnel skills, that they have the right skills or experience” (SA1)</td>
</tr>
<tr>
<td>and treatments</td>
<td></td>
<td>(SA1, SA2, SA3)</td>
<td>“For example, neurosurgeons have left the country, Kenya, to the UK, Botswana and to other places. They have relocated, so the patient will be motivated to go out of the country to a hospital that has a good name, such as Morningside in South Africa” (A1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(A1, A2, A3) (I4, I5)</td>
<td></td>
</tr>
</tbody>
</table>
"I can say that there are no specialists in Nigeria, or there is a shortage, or most Nigerian specialists don't want to work in Nigeria. They want to work in the UK and other foreign countries. Nigerian doctors can even go for less salaries to foreign countries like Dubai, because, there they know that the healthcare system is secure; African systems are questionable" (A2)

| Lack of medical facilities at home | 6 (SA1, SA2, SA3) (A1, A3) (I4) | "South Africa has healthcare agreements with some governments on the continent, so their patients come to South Africa to get treatments in the public hospitals" (SA1)  
"So, the patients will be motivated to go out of the country to a hospital that has a good name, such as Morningside in South Africa. Morningside is well-known because all the ministers and senior people come to Morningside for treatment" (A1) |
| To avoid long waiting lists | 2 (A1) (I3) | "… so, they will be motivated because they will get quick attention, and treatment will be faster, and they will not be kept in the queue" (A1)  
"I think that the time that they can be received and treated, so to avoid long waiting lists in their own countries" (I3) |
| Anonymity or privacy when receiving treatment | 1 (A3) | "High profile people come to South Africa to hide their identity and to have a low profile, so that they don't get noticed when they get treatment" (A3) |
| Traditional medicine treatments | 1 (A3) | "South Africa also has traditional medicine treatments, let's make it acceptable so that people not only look at the orthodox treatments, so that they can also choose traditional medicine" (A3) |
| Push factors related to affordability and cost | 4 (SA2) (A2) (I4, I5) | "South Africa offers cost-effective treatments in comparison to what one will be paying in Europe and America" (SA2)  
"Most of the patients are looking at their budgets for cost-effective surgeries, so if South Africa offers these, the patients will come, because not all the
patients are affording the big amounts expensive surgeries” (A2)

Question 3 of this section asked participants to rate South Africa's performance on the push factors that they have mentioned. Five international participants (I1, I2, I3, I5 and I6) said they could not rate South Africa's performance as they had already indicated that they were unfamiliar with South Africa’s healthcare system or the medical tourism industry in the country.

The other participants gave various ratings. For instance, five participants (SA2, SA3, A1, A2 and A4) indicated that South Africa was in competition with India for the African market in terms of the costs of medical treatment. These participants emphasised that it is cheaper to get medical treatment in India than in South Africa. The affordability of treatments in India and the fact that African (including South African) patients are seeking medical treatment in India instead of South Africa confirms the findings of Dangor et al. (2015). Three participants (SA3, A1, and A3) also mentioned that in spite of the competition with India, South Africa is doing reasonably well, although it could not be regarded as among the top destinations. For example, one participant (SA3) said that she would 'not rate South Africa on top' like Singapore and the USA. The participant said they would, however, rank South Africa among the 'best'. In spite of the problem identified with regards to the cost of medical treatment in South Africa by the participants in this study and by Dangor et al. (2015), South Africa is ranked as a top 20 medical tourism destination according to the Forbes Africa report (in Matiza & Slabbert, 2020:338). The country also ranks 22nd globally according to the 2020-2021 Medical Tourism Index (MTI) (https://www.medicaltourism.com/destinations/south-africa). This is an improvement from the 2016 global ranking where it ranked 27th out of 41 countries globally. According to Matiza and Slabbert (2020), South Africa attracts patients from Britain, Western Europe and the US. The basis for the Forbes Africa ranking for South Africa is on the potential for the cost savings of “between 25% and 40%” (Matiza & Slabbert, 2020:338) for these patients on certain treatments offered in South Africa. The MTI ranking, on the other hand, can be attributed to South Africa’s quality of facilities and services and the medical tourism industry where it ranked 20th and 28th respectively out of 46 destinations as indicated in Table 3.6.
Two participants (SA1 and I4) emphatically said that South Africa was not doing well in medical tourism. For example, one of these participants (SA1) said that she did ‘not think we are doing well in medical tourism, we have not embraced medical tourism’. On the other hand, participant I4 commented that South Africa ‘ranks very low globally’, and he said that the reason for this could be the perceptions that overseas visitors have about South Africa not being a safe destination and the lack of proof of treatment quality from South Africa.

Table 5.4: Classification of the participants’ responses with regards to how they would rate South Africa’s performance on the push factors

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competing with India</td>
<td>5 (SA2, SA3) (A1, A2, A4)</td>
<td>“our costs can be very high or higher than in places like India” (SA3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“South Africa and India are totally different, South African facilities are a bit [more] expensive than India, so for people travelling out of the country for treatment, they give India the first priority, South Africa is rated second” (A1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“India is actually 30% cheaper [than] the costs that are charged in South Africa, South Africa is not so cheap, it’s expensive” (A4)</td>
</tr>
<tr>
<td>Doing well</td>
<td>3 (SA3) (A1, A3)</td>
<td>“I wouldn’t rate South Africa on top like Singapore and the US; I wouldn’t rate it that high. I would say we rank among the best” (SA3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“South Africa is rated on the higher end, but South Africa and India are totally different, so for people travelling out of the country for treatment, they give India the first priority, South Africa is rated second” (A1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“in terms of the medical facilities per capita, South Africa is very high”</td>
</tr>
<tr>
<td>Not doing well</td>
<td>2 (SA1) (I4)</td>
<td>“South Africa has good facilities and specialists, but I don’t think we are doing well in medical tourism, we have not embraced medical tourism” (SA1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“From a global perspective and from my own perspective, South Africa ranks very low unfortunately. It’s easy to prove proximity, but</td>
</tr>
</tbody>
</table>
there’s a certain fear of the safety in South Africa and the proof of quality” (I4)

| Cannot rate | 5 (I1, I2, I3, I5, I6) | “I cannot rate it. I am not familiar with the medical tourism industry in South Africa” (I1) |
|             |                        | “I really don’t know about South African medical tourism, I have never heard of it. I know about Mexico, India, and others, not about South Africa” (I5) |
|             |                        | “I wouldn’t have a basis for such a rating, I don’t know” (I6) |

Question 2 of section D asked participants **what the profile of medical tourists visiting South Africa is**. It will be discussed here, since it relates to the push factors to South Africa and what will discourage potential medical tourists from choosing South Africa as a medical tourism destination.

The participants (7) indicated that ‘anybody’ can come to South Africa as long as they can afford the costs involved with travelling and getting treatment in South Africa. According to these participants (SA1, SA2, A1, A2, A3, A4, I4), such patients would have to be financially stable. For example, participant SA1 remarked that they are likely to be people who are ‘wealthy or have money, business people or government officials’. The issue about the costs of medical treatments in South Africa being expensive is also raised as something that can discourage people from visiting South Africa for medical treatments as indicated in Table 5.5.

Four participants (SA1, SA2, SA3, I3) mentioned that such patients are also likely to be from the African continent due to the geographical location of South Africa on the continent (I3). According to this participant, this would be someone who prefers to be closer to home and thus South Africa will be more suitable for them. Most patients coming to South Africa for treatments are likely to be from the African continent as South Africa has health bilateral agreements with 18 countries on the continent, as indicated by Crush & Chikanda (2015) and Lunt et al. (2016).

Three participants (SA2, I1, A1) indicated that the patients were likely to be English-speaking or familiar with the languages spoken in South Africa. English is one of the
main languages of communication in South Africa, and is also used by most medical professionals. The use of English is also mentioned as an important factor that is likely to encourage potential patients to choose to South Africa for treatment (Mudzanani, 2016). Two participants (SA1, A3) mentioned that it was possible that the patient might have been sponsored by family members or friends if they could not afford the costs themselves. One participant (A4) also added that such patients may also have relatives in South Africa who are likely to recommend treatments or service providers or sponsor the patient to get treatment in South Africa.

Table 5.5: Profile of medical tourists visiting South Africa for treatment

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The wealthy or financially stable</td>
<td>7 (SA1, SA2) (A1, A2, A3, A4) (I4)</td>
<td>“someone with money, such as members of parliament and business people” (A1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“could be anyone who is very sick and need good facilities, and can afford to pay for treatment abroad” (A2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“could be someone who doesn’t trust that locally they will get the treatment they are looking for, and the price or cost thereof, where they will get the best value for money” (I4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“could be someone who is financially stable because South Africa is not cheap” (A4)</td>
</tr>
<tr>
<td>Someone from Africa</td>
<td>4 (SA1, SA2, SA3) (I3)</td>
<td>“mostly from the African continent” (SA1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“will be from the sub-Saharan Africa, will be from the neighbouring countries, because of the ease of travel, Visa issues and the distance itself” (SA3)</td>
</tr>
<tr>
<td>English-speaking</td>
<td>3 (SA2) (A1) (I1)</td>
<td>“would be English speaking” (SA2, A1, I1)</td>
</tr>
<tr>
<td>Sponsored</td>
<td>2 (SA1) (A3)</td>
<td>“could be somebody who has a sponsor for their treatment, usually sponsored by a family member” (SA1)</td>
</tr>
<tr>
<td>Someone with relatives in South Africa</td>
<td>1 (A4)</td>
<td>“could be someone who has relatives in South Africa” (A4)</td>
</tr>
</tbody>
</table>
Question 4 in section A required the participants to give input on **what will discourage prospective medical tourists from choosing South Africa**. Various reasons were given. The most popular reason from nine participants (SA1, SA2, SA3, A1, A2, A3, A4, I4, and I6) was in relation to costs, i.e. medical and travel costs to South Africa. Six of these participants (SA1, SA3, A1, A4, I4 and I6) indicated that the cost of medical treatment could be the repelling factor for patients. For example, participant SA3 mentioned that patients were complaining about the medical treatment ‘pricing model’ used in South Africa. According to this participant, the South African pricing model is completely different from other medical tourism destinations, such as India, where patients pay a single fee and they are treated by various specialists. In South Africa, patients get multiple invoices from various specialists, even if all of these specialists were from the same hospital. The multiple invoices and the uncertainty of how much the patients will eventually pay for medical treatment, was thus identified as a possible deterrent by the participant. The participants’ reasoning with regards to the expensive cost of medical treatment in South Africa is also similar to the observations made in the study by Dangor et al. (2015), i.e. that the cost of medical treatment in South Africa was one of the reasons Indian-South Africans (from Johannesburg) seek medical treatment in India. In his study on the challenges faced by Nigerian tourists in South Africa, Ezeuduji (2013) identifies medical care as one of the purposes for which Nigerians visit South Africa. Among the challenges faced by Nigerians visiting South Africa is the cost of medical treatment. Five participants (SA2, A2, A3, I4 and I6) mentioned that travel costs to South Africa were expensive. For example, participant A3 mentioned that ‘air transport and evacuation costs’ to South Africa are expensive, and at times, it is even ‘cheaper to travel to the UK than to South Africa from West Africa’.

Seven participants (SA2, A2, I2, I3, I4, I5 and I6) identified South Africa’s geographical location as a possible reason that may discourage potential medical tourists from choosing South Africa as a medical tourism destination. For example, participant SA2 indicated that it is ‘too far to travel to South Africa, South Africa is long-haul’. The distance also means that travellers will thus have to pay more to get to South Africa. In addition to the cost of travelling to long distance destinations, another participant (I5) highlighted the risk of patients developing ‘blood clots’ after surgery if they were to take a long flight back home (due to the long distance). The risks associated with
long-haul travel are very serious and can also lead to death, and as such, Gaines and Lee (2019) are of the view that medical tourists should seek advice on the risks associated with surgery and travel, so that they are able to make informed decisions before travelling or when they are recovering from surgery.

The issue of safety and security, including xenophobic attacks on foreign nationals in South Africa, was raised as a concern for potential tourists by five participants (SA2, SA3, A3, I4, and I6). For example, one participant commented on the role played by both local and international media in the provision of information about the rate of ‘crime and xenophobia in South Africa’. The frequent broadcast of information about crime in South Africa thus increases the perception that South Africa is not a safe destination, and if potential tourists have this perception about South Africa, they may not want to visit the country, as indicated by participant I4. In Ezeuduji’s (2013) investigation of the challenges faced by Nigerian tourists to South Africa, he identifies safety and security as another challenge, although he does not specifically say that visitors face this challenge when trying to access medical care.

Two participants (SA3, and A3) raised the problems experienced by potential tourists when making visa applications to visit South Africa. One of the participants (A3) indicated that the application process is cumbersome and the multiple trips that one has to make to the embassy before approval are demotivating. The other participant (SA3) commented that the struggle the applicants go through before they can get a visa, could make the applicants ask themselves whether the whole exercise is worthwhile. The patient may also not necessarily have the time to wait or to go through the processes, and therefore they are very likely to go to another destination where the processes are quicker. Drinkert and Singh (2017) identified the visa application process as playing a significant role in the medical tourist’s decision-making process with regards to the medical tourism destination. The lengthy visa application process has been identified as another challenge for Nigerians travelling to South Africa by Ezeuduji (2013), although this was not specifically identified as being applicable to those seeking medical care in South Africa. In their study, Soltani, et al. (2020), argue that the existing visa restrictions for countries outside the Middle East had a negative impact on the growth of medical tourism in Iran. Destinations perceived to have quicker
application processes or minimal restrictions are therefore likely to be more attractive to potential medical tourists.

One participant (I1) indicated that he was not familiar with the South African healthcare system and how it works, and thus he would not know what could discourage a potential medical tourist from visiting South Africa for medical treatment.

Table 5.6: Classification of participants’ responses with regards to what will discourage prospective medical tourists from choosing South Africa

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs (medical and travel)</td>
<td>9 (SA1, SA2, SA3)</td>
<td>“In my experience, the cost of medical treatment is very expensive in South Africa” (SA1)</td>
</tr>
<tr>
<td></td>
<td>(A1, A2, A3, A4)</td>
<td>“Patients sometimes complain about costs. Our pricing model is very different from other countries who do medical tourism. For example, if they go to a centre, they pay one fee and they’ll be treated by different people, whereas in South Africa, because we have independent practitioners housed under one hospital, you tend to get multiple invoices from multiple service providers. People don’t understand why you have to pay the hospital, the doctors, the laboratories, and so on. Multiple fees, and this tends to be the demotivating factor” (SA3)</td>
</tr>
<tr>
<td></td>
<td>(I4, I6)</td>
<td></td>
</tr>
<tr>
<td>Geographical location</td>
<td>7 (SA2), (A2)</td>
<td>“The distance to travel to South Africa. South Africa is far, long-haul to travel to South Africa” (SA2)</td>
</tr>
<tr>
<td></td>
<td>(I2, I3, I4, I5, I6)</td>
<td>“Depending where the patients are coming from, maybe the distance, the hours of flight, that’s something that influences a lot, especially after surgery, because of the risk of blood clots and stuff. So maybe how long the trip is, may be a factor that influence or discourage” (I5)</td>
</tr>
<tr>
<td>Safety and security</td>
<td>5 (SA2, SA3) (A3)</td>
<td>“Isolated cases of theft and violence we hear about. Security plays a vital role for the development of medical tourism. For example, armed robberies and crime on medical tourists. Even though people may not have the experience, they might rely on another person who’s had the experience. We need to work on the safety and security” (A3)</td>
</tr>
<tr>
<td></td>
<td>(I4, I6)</td>
<td>“There was the time when there was xenophobia - they wouldn’t want to be there, no!” (A4)</td>
</tr>
<tr>
<td>Visa issues</td>
<td>2 (SA3)</td>
<td>“You know, if people have to struggle to access South Africa, it makes the people wonder, what’s the point?” (SA3)</td>
</tr>
<tr>
<td>-------------</td>
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<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>2 (A3)</td>
<td>“Visa application processes. These are sometime cumbersome and may take a longer time to get a medical patient transferred to South Africa. You have to book an appointment with the embassy, then take your documents more than once to see if the documents will be accepted. Patients who are doing their own coordination might find this very hard to do” (A3)</td>
</tr>
</tbody>
</table>

Question 5 and 6 in this section related to what or who are the medical tourists’ (or potential medical tourists’) source/s of information regarding getting medical treatment in another country instead of their own, and what are the medical tourists’ (or potential medical tourists’) source/s of information regarding getting medical treatment in South Africa respectively. Both questions will be dealt with in this section as the participants indicated that the sources of information are applicable to all medical tourism destinations, including South Africa.

The majority of the participants (11) identified the internet as the main source of information for potential medical tourists. The internet enables potential medical tourists to conduct searches on various treatments that they may be interested in having, locating service providers globally, reading the reviews and testimonials from patients who may have had similar treatments. For instance, one participant (SA1) mentioned that patients conducted research on the ‘internet or website’ to get information they needed. Another participant (I2) indicated that the internet was the main source of information as there are many websites on the internet that specialise in information on various treatments and healthcare providers abroad, and patients can find information they need from these platforms. Veerasoontorn and Beise-Zee (2010) found that before patients participate in medical tourism, they tend to use the internet to obtain information about the doctors’ credentials and expertise, hospital accreditation and reputation and also to check other patents’ testimonials. In their study on the role of information sources and image on the intention to visit a medical tourism destination, de la Hoz-Correa and Muñoz-Leiva (2019) found that medical
tourists are more likely to use online sources such as social networks, web pages, forums, and blogs to help them with the decision whether to travel for medical treatment or not. Six participants (SA3, A2, A4, I3, I4 and I5) mentioned that potential medical tourists could also get information by contacting healthcare providers in the potential medical tourism destinations directly. Many healthcare providers include their contact details as well as information with regards to their treatment offerings on their websites. Access to the internet is crucial as it enables patients to conduct searches about the various healthcare providers, regardless of where they are located, as also identified in the study by Abd Mutalib et al, (2017) and Drinkert and Singh (2017).

Word of mouth was identified by eight participants (SA1, SA2, SA3, A2, A3, I4, I5 and I6) as the other source of information. Word of mouth relates to information sharing between family members, friends, doctors and other people who may be in possession of the information required at the time. For example, participant SA3 mentioned that patients who have had certain treatments would usually share their experiences with others, and this helps with spreading information. In their study, de la Hoz-Correa and Muñoz-Leiva (2019) found that word of mouth was the most important and trusted source of information (above the internet) for medical tourists, and that they would usually consult with their relatives, friends and doctors. In contrast, Drinkert and Singh (2017) found that word of mouth was the second (just after consulting the doctors) most important source of information for potential medical tourists’ destination choice.

Five participants (SA1, SA2, A3, A4 and I4) identified medical tourism intermediaries or companies as another source of information for potential medical tourists. Medical tourism intermediaries include medical travel/tourism agencies, facilitators, brokers and operators. For instance, participant A4 mentioned that potential medical tourists are likely to contact medical tourism tour operators for information about hospitals and treatments in various medical tourism destinations. Given the knowledge about destinations possessed by intermediaries, it is no surprise that all types of tourists, including medical tourists, will consider intermediaries as sources of information. Not only do they serve as sources of information, but they are also responsible for the formation of a positive destination image for destinations, including medical tourism destinations, as indicated by de la Hoz-Correa and Muñoz-Leiva (2019) in their study.
on the role of information sources and image on the medical tourists’ intention to visit a medical tourism destination.

Five participants (A1, A2, A3, A4, and I2) indicated that in some countries, e.g. Kenya, patients who need specialised treatments would sometimes have to be referred to medical facilities and doctors in medical tourism destinations by doctors from the home destination. Two scenarios were given by the participants. For instance, with regards to scenario one, participant A2 mentioned that sometimes patients would be referred by specialists from the home country because of the limitations of the specialist, e.g. lack of facilities, machinery or technology, to provide the treatment efficiently, or lack of experience in dealing with such a procedure at the local hospital. In terms of scenario two, the doctors in the home country will usually refer a patient to a medical tourism destination if the treatment or procedure required is unavailable in the home country. In such instance, the patient is then referred to a destination where such a procedure can be accessed, as indicated by participant A3. Although getting formal referral from the local doctors or hospital seem to be a preferred practice in the above-mentioned examples, this is however not a common practice for most patients or most destinations, as indicated by Johnston et al. (2012).

Table 5.7: Classification of participants’ responses with regards to what or who are the medical tourists’ (or potential medical tourists’) source/s of information regarding medical treatment in another country instead of their own

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim response</th>
</tr>
</thead>
</table>
| The internet    | 11 (SA1, SA2, SA3, A2, A4) (I1, I2, I3, I4, I5, I6) | “definitely the patient will go on Google, there are so many hospitals that are there” (A4)  
“patients would also conduct their own research in terms of the internet or websites” (SA1)  
“they get information from the internet and Facebook groups. You know, here in Brazil, you are not allowed to share the ‘before and after’ pictures, the Board does not allow that, so we have closed groups on Facebook, so people get to know about the treatment here” (I5) |

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<table>
<thead>
<tr>
<th>Method</th>
<th>Source(s)</th>
<th>Reference(s)</th>
<th>Additional Notes</th>
</tr>
</thead>
</table>
| Word of mouth                                       | 8 (SA1, SA2, SA3) (A2, A3, A4) (I5, I6) | “For example, to India, if I am a patient and I go to India for treatment and my treatment was good, I will recommend to other people to go to that hospital, this is patient reference” (A2)  
“also, word of mouth, where patients who would have been there tell others that they’ve been to South Africa for this and that treatment” (SA3) |
| Direct contact with healthcare providers in the receiving country | 6 (SA3) (A2, A4) (I3, I4, I5) | “so maybe people might have heard of a specific hospital or specific group of hospitals where some people might have been treated before, and they will call that place and ask and find out” (SA3)  
“on the internet they will find and communicate with the hospitals directly, and they will get the invitation letter” (A2)  
“the bigger hospitals must have the right promotion strategy and have digital presence to promote their services online” (I3) |
| Medical tourism intermediaries                      | 5 (SA1, SA2) (A3, A4) (I2) | “Patients get information through medical tourism associations, like the MTA, global agencies for medical tourism and other agencies” (SA2)  
“They will also seek for medical tourism [tour operators] to ask where they can go. When you go to Google, you will see a hospital, but is it good enough? Who has been there? How have they been treated? So, that’s why they turn to us [tour operators] because we have information of patients who have been there” (A4) |
| Doctors’ and hospitals’ referrals                   | 5 (A1, A2, A3, A4) (I2) | “Practising doctors, all referrals are given by the treating doctor in Kenya. You cannot just go for medical treatment out of the country without the doctor recommending it. Because we have a body called the Medical Board, they inspect your documents and check whether the doctor is listed under the medical board. It is not every doctor who refers, no GP can recommend that you go out of the country. Specialists recommend because sometimes the treatment is bigger than or beyond his abilities and capabilities” (A1)  
“also, there are referral hospitals, for example, the national, federal and district hospitals will always
In summary, the medical tourism push factors identified by participants confirmed those in the literature, and no new factors were discovered. It was interesting though to find that there may be patients who would need traditional medical treatments in South Africa as indicated by one of the participants.

5.4 MEDICAL TOURISM PULL FACTORS

Section B related to objectives three and five of the study. The main aim of questions posed in this section was to determine the medical travel destination characteristics or pull factors that motivate potential medical tourists to choose one destination over others when seeking medical treatment in destinations other than their own. In turn, South Africa’s performance was rated in terms of the pull factors identified.

In the first question in this section, participants were asked to provide the physical attributes or characteristics in a medical tourism destination that will influence or pull potential medical tourists towards the specific destination. Two themes emerged from the data, i.e. destination-specific pull factors and healthcare provider pull factors.

The first category in the theme ‘destination-specific pull factors’ related to the geographic location of the destination and was identified by nine participants (SA3, A1, A3, A4, I1, I2, I3, I5 and I6). The main aspect with regards to the destination was the geographical location of the destination. For example, participant I1 emphasised that medical tourism was a ‘regional phenomenon’, and for it to be successful, the potential medical tourism destination had to be within the patients’ ‘comfort zone’, or in a destination which was not far from home. The regional aspects of medical tourism are also indicative of the existence of bilateral agreements between neighbouring countries to facilitate access to healthcare for people from these countries, as indicated by de la Hoz-Correa and Muñoz-Leiva (2019). The geographical location of the medical tourism destination was identified as an important pull factor for American patients mostly going to Mexico for various medical treatments due to its proximity to
the US in the studies by Drinkert and Singh (2017) and Miller, Smith, Woods and Warholak (2020). Most patients do take into consideration the possibility of complications after surgery, and the fact that their mobility might be limited after such surgery. In the event of the patient needing evacuation from the medical tourism destination, and the destination being distant, the flight back home might take longer, and therefore put the patient at risk during evacuation. If they are at a closer destination, this process can be done more quickly, and the health risks may be reduced. The various health complications associated with long-haul destinations were also identified by Gaines and Lee (2019), and their take was that patients must seek advice relating to travel after surgeries from their healthcare providers.

The second category in the first theme was labelled ‘tourism facilities’. According to participant I6, patients seeking minor procedures may consider the destination tourism characteristics in the same way as any regular traveller. For such patients, the destination characteristics may be important. The emphasis with regards to how the complexity of the procedure sought by the patient informs and influences their decision on the medical tourism destination was also highlighted in by Wongkit and McKercher (2013). According to these authors, tourism activities at the destination are the last things in the mind of a dedicated medical tourist because such tourists travel to medical tourism destinations solely to receive medical treatments.

Related to the geographical location of the destination, is the destination’s ‘accessibility’. Six participants (SA2, A1, I1, I3, I4, and I6) highlighted that medical tourism destinations that are easy to travel to or to ‘access’, tend to be more attractive to potential medical tourists. For example, participant SA2 explained that patients usually take into consideration how easy or difficult it is to get to the medical tourism destination, and usually if access is difficult (e.g. no frequent flights or visa application problems), the patients will not prioritise such a destination. In their investigation of medical tourists’ posttravel experiences, Drinkert and Singh (2017) identified the travel logistics, which included the affordability of travel costs to the destination, visa application process and the overall travel experience to the medical tourism destination. The issuing of visas to medical tourists is most critical to the smooth transit of medical tourists to medical tourism destinations, as also highlighted by Matiza and Slabbert (2020) and Soltani et al. (2020). Medical tourism destinations perceived to
have complex processes are unlikely to be chosen for medical treatments especially if the patients do not have the time to go through the processes due to the magnitude of their ailment.

The fourth category related to the safety and security of the destination. Four participants (SA2, A3, I4 and I5) mentioned the value of safety and security at the destination as a pull factor. For instance, participant A3 emphasised that the medical tourism destination must be ‘devoid of crime and illegal activities’ for it to attract potential medical tourists. In the study by Gan and Frederick (2018) medical tourists as consumers of tourism are also said to have concerns about the safety and security of travelling to medical tourism destinations, and the decision to eventually travel is determined by their willingness to endure the hassle and hardship of travel, which could be as a result the treatment or the trip itself. Medical tourists are likely to be vulnerable having had a procedure in an unfamiliar environment; hence it is important for receiving destinations to ensure that all tourists are safe.

Six participants (SA2, A2, A4, I1, I2, and I6) identified the ‘quality of medical facilities’ (first category of the second theme) at the medical tourism destination as a pulling factor. For instance, participant SA2 mentioned the value associated with the ‘global recognition of the healthcare industry’ at the destination as a pull factor. Participants A2 and A4 emphasised that patients wanted good quality hospitals and nice bigger hospitals, respectively. Participant I6 emphasised that patients in need of complex and life-saving procedures are interested in the reputation of the healthcare provider, not the destination. The quality of medical facilities in the medical tourism destination also includes aspects such as the accreditation of the facilities. Accredited medical facilities are associated with the potential to provide quality medical treatments and they were also identified as an important pull factor for medical tourism destinations by John and Larke (2016).

The second category of the theme ‘healthcare provider pull factors’ related to the affordability of costs at the destination. Five participants (SA1, SA2, A1, A2 and I2) identified the affordability of healthcare costs at the receiving destination as a pull factor. For example, participant SA1 emphasised the patients’ ‘personal income and budget, while participant A2 emphasised how the patient’s personal budget influences
the ‘affordability’ of the treatment at the destination. The availability of affordable or lower medical costs while receiving quality treatments in quality medical facilities at the medical tourism destination has also been identified as an important pull factor by John and Larke (2016), especially for patients from the developed countries as they have the luxury of choice compared to patients from most developing countries.

The last category in the second theme related to ‘the doctors’ expertise and quality of treatment’. Four participants (SA3, A1, I1 and I6) indicated that the expertise of the doctors and quality of treatments at the medical tourism destination have a pulling effect on potential medical tourists. For instance, participant A1 said that for patients to be attracted to medical tourism destinations, they expect doctors to give perfect treatment. Even if patients need minor procedures, they will have peace of mind if they know that they will receive quality treatment. Only doctors with expertise can give perfect treatments or the expected quality treatments. Participant I6 pointed out that for patients in need of life-saving treatment, the tourism aspects of the destination are insignificant. For such patients, the expertise of the doctors who will be performing the surgeries is the most important pulling effect. In contrast, patients seeking minor procedures may consider the destination tourism characteristics in the same way as any regular traveller, but these will only be enjoyed after the surgery, thus they are considered to be the main pulling factor. For these patients, the destination characteristics may be important, but not as important as the expertise of the doctors. The emphasis with regards to how the complexity of the procedure sought by the patient informs and influences their decision with regards to the medical tourism destination was also highlighted in by Wongkit and McKercher (2013). The value and the doctors’ expertise in medical tourism destinations as a pull factor were also identified by Collins et al. (2019).
Table 5.8: Classification of participants’ responses with regards to which physical attributes or characteristics in a medical tourism destination will influence or pull potential medical tourists towards the specific destination

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Destination specific pull factors</td>
<td>Geographic location</td>
<td>9 (SA3) (A1, A3, A4) (I1, I2, I3, I5, I6)</td>
<td>“It has to be within the comfort zone, how far is it? It has to be regional, medical tourism is a regional phenomenon, because the mobility of the patient is limited to within their comfort zone after surgery” (I1)</td>
</tr>
<tr>
<td></td>
<td>Tourism facilities</td>
<td>2 (A4) (I6)</td>
<td>“Maybe those coming from Europe to African countries, maybe they want the experience, like wildlife and safari” (A4) “Patients in need of minor surgeries may consider the attributes of the destination, but this is also not a priority. Patients are concerned about the expertise of the surgeons who will be performing surgery on them” (I6)</td>
</tr>
<tr>
<td></td>
<td>Easy access to destination</td>
<td>6 (SA2) (A1) (I1, I3, I4, I6)</td>
<td>“Accessibility to the country; how easy or difficult is it to get to the country?” (SA2) “Easy access to the destination, well connected airport. A more open community that is welcoming to international tourists, so that patients and their companions can be comfortable. It is easier for them” (I3)</td>
</tr>
<tr>
<td></td>
<td>Safety and security</td>
<td>4 (SA2) (A3) (I4, I5)</td>
<td>“safety and security, the destination must be devoid of crime and illegal activities, I mean crime-free or drug-free” (A3) “safety and security, the destination is not very dangerous” (I4)</td>
</tr>
</tbody>
</table>
| Healthcare provider specific pull factors  | Quality of medical facilities | 6 (SA2) (A2, A4) (I1, I2, I6) | “good quality hospitals, for example, in South Africa, there may be some hospitals that can do quality surgeries” (A2) “Normally patients want to go to nice hospitals, the bigger the better. Look at India, what’s there
In terms of question 2 in this section, participants were asked to provide the physical attributes or characteristics which will influence or pull potential medical tourists towards South Africa as a medical tourism destination. The data is grouped into two themes, i.e. healthcare provider-related pull factors and destination-specific pull factors.

The first category of the theme ‘healthcare provider related pull factors’ related to ‘quality of facilities and services’. Seven (SA2, SA3, A1, A2, I3, I4 and I6) indicated that the physical attribute that is most likely to pull potential medical tourists to South Africa is the quality of medical facilities. For instance, both participant SA2 and SA3 mentioned that South Africa has a very well-developed private healthcare industry, and participant SA2 elaborated further and indicated that the healthcare system is also
regulated to ensure the professionalism of the medical personnel. Henama (2014) and Mudzanani (2016) also identified the availability of good quality medical facilities as a pull factor for medical tourists to visit South Africa for medical treatments. Participant SA3 also remarked about the advances in medical technologies and innovation available in the private healthcare sector. In her opinion, the medical technologies available in various private hospitals are what make South African hospitals state-of-the-art and this puts hospitals to be on an equal footing with the best in the world; this is definitely a pull factor to South Africa. Participant SA2 mentioned that another pull factor to South Africa could be the fact that English is widely spoken. Given that medical treatments are perceived to be affordable to patients from Europe and America, the fact that English is widely spoken should be an advantage for coming to the country as communication will be far easier between patient and service provider. The importance of communication and use of English in medical tourism destinations, especially those attracting the European and American markets such as South Africa, was also highlighted by Bacus (2010). However, some medical tourism destinations may also have translators to assist medical tourists in need of such services, as was also indicated by participant I5 for English-speaking patients seeking medical treatment in Brazil.

Six participants (SA1, SA2, SA3, I3, I4 and I6) mentioned that the other pull factor for South Africa is the doctors’ expertise and the quality treatment (second category) that is offered in the healthcare system. For example, participant SA2 highlighted that South African medical doctors and other medical professionals are very well trained, and need to be registered and maintain registration with the HPCSA. The HPCSA is a “statutory body established to provide for control over the education, training and registration for practicing of health professions registered under the Health Professions Act” (https://www.hpcsa.co.za/?contentId=463&actionName=About%20Us). According to participant SA2, to guarantee and ensure professionalism, doctors are also required to keep their professional skills up-to-date by participating in continuous professional development (CPD) courses. Heung et al. (2010) identified the availability of quality medical treatments and the expertise of medical professionals as a pull factor. South Africa has good quality medical professionals, and is thus in a good position to render
good quality medical care. As a result, patients who visit South Africa are able to get various treatments in both public and private hospitals (Chikanda & Crush, 2019).

The third category related to the ‘cost of treatment’. Three participants (SA1, A1 and A4) indicated that the cost of medical treatment could be another pull factor to South Africa, but this is only applicable for European and American patients as most African patients feel that medical costs are not cheap in South Africa. When asked to profile a potential medical tourist who would choose South Africa as a medical tourism destination (in section D, question 2), four of the participants said that the potential medical tourist is likely to be African (SA1, SA, SA3 and I3). For the same question, the majority (7) of the participants (SA1, SA2, A1, A2, A3, A4 and I4) indicated that such a potential medical tourist would be financially stable or wealthy, because the cost of medical treatment in South Africa is perceived as being expensive. In the current question, participant A1 emphatically expressed the view that ... cost is not a pull factor, South African medical treatment is expensive, unless you are from Europe.

The study by Ormond and Sulianti (2017) also emphasises that medical treatment in South Africa is perceived as affordable by European and American patients. Ormond and Sulianti (2017) further mention that for middle-class African patients who come to South Africa for medically necessary treatments, which in most cases are unavailable in their countries, the cost of treatment is usually not a problem. Besides them being wealthy, they normally pay 25% of the medical treatment cost in cash because their private healthcare insurance is likely to pay up to “70% and the remaining 5% is paid by their employer or the government” (Ormond & Suliant, 2017:6).

One of the participants (SA3) also indicated that the South African healthcare system is innovative and uses advanced medical technologies (fourth category) in various private hospitals. The availability of state-of-the art medical technologies in the healthcare system can ensure that South Africa is able to attract potential medical tourists, especially from developed countries where such technologies are a norm. The availability of advances in medical technologies in the private sector as well as the state-of-art private hospitals is a pull factor to South Africa as a medical tourism destination was also identified by Matiza and Slabbert (2020).
The second theme, destination-specific pull factors, was made up of two categories. The first category related to the weather as identified by four participants (SA2, A3, A4, and I4). According to participants SA2 and I4, South Africa is a beautiful destination with glorious weather throughout the year, which can encourage an array of tourism activities. However, participant I4 also pointed out that medical tourists do not prioritise the destination per se; they tend to be more interested in medical facilities and services, the results of treatment, and then the proximity of the destination. On the other hand, participant I6 highlighted the importance of tourism facilities (second category) by saying:

For a person seeking a non-surgical cosmetic surgery, for example cool-sculpting, leisure and recreation would be more important than a person seeking a heart surgery.

The importance that potential medical tourists place on the quality of medical facilities and services over the tourism attributes in medical tourism destinations was also highlighted by Zarei and Maleki (2019). Thus, if patients were to visit tourism attractions in medical tourism destinations, this would usually be after surgery.

Three participants (I1, I2 and I5) said that they were not familiar with what medical tourism industry in South Africa had to offer. For example, participant I1 commented on the first heart transplant operation by Dr Christiaan Barnard in 1967, and said that the world still remembers Dr Barnard as a South African medical icon. He further mentioned that what South Africa does in healthcare currently, is a ‘closely guarded secret’. He remarked that the world is waiting to hear that there is quality in South Africa; the story needed to be told.

Table 5.9: Classification of participants’ responses with regards to which physical attributes will pull potential medical tourists towards South Africa as a medical tourism destination

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare provider pull factors</td>
<td>Quality of facilities and services</td>
<td>7 (SA2, SA3) (A1, A2) (I3, I4, I6)</td>
<td>“South Africa has a regulated healthcare industry” (SA2)</td>
</tr>
</tbody>
</table>
| Table of Destination-specific pull factors |  | “There are good hospitals in South Africa; I have referred a few patients, but the problem with the hospitals is communication. If you want to send a patient, they are eager, they want the patient’s information from you, I’m not giving the patients details directly” (A2)

“if South Africa has good hospitals and other medical and non-medical facilities” (I3) |
| --- | --- | --- |
|  | Doctors expertise and quality of medical treatment | 6 (SA1, SA2, SA3) (I3, I4, I6) | “the doctors’ expertise, there is no doubt about the personnel’s skills in South Africa” (SA1)  
“good medical outcomes” (SA3)  
“physicians or specialists who offer excellent medical care” (I3) |
|  | Cost of treatment | 3 (SA1) (A1) (A4) | “The cost is not a pull factor. South African medical treatment is expensive, unless you come from Europe” (A1)  
“… but also, it’s cheaper to be treated in South Africa when you’re coming from Europe” (A4) |
|  | Advances in medical technology | 1 (SA3) | “the innovative way in which we provide health. We are a leader, we are the first ones to come with the heart transplant. We have invented various machines. The fact that we have invented things like the CAT-scan, we have created some X-ray machine where you can look at the whole body. So, there are things that we can show as South Africa that we are a leader in medicine and therefore we can be trusted. We have shown the continent and the world that we are in a position to provide good services to our neighbours and our visitors” (SA3) |
|  | Destination specific pull factors | Weather | 4 (SA2, A3) (A4) (I4) | “for American and European clientele, the beautiful weather throughout the year, the sunshine, can encourage an array or variety of tourism activities to various types of tourists, regardless of where they originate from” (SA2) |
“the pull factors will vary depending on the nature of the services sought, for a person seeking a non-surgical cosmetic surgery, for example cool-sculpting, leisure and recreation would be more important than a person seeking a heart surgery” (I6)

<table>
<thead>
<tr>
<th>Tourism facilities</th>
<th>1 (I6)</th>
</tr>
</thead>
</table>

Question 3 of this section required the participants to rate South Africa’s performance on the pull factors they have mentioned above. Three participants said that South Africa was doing well. Of these three, one (SA3) said that SA was doing very well in the private sector. The main problem the participant mentioned was that South Africa was not promoted as a medical tourism destination; as a result, ‘people do not know’ about South Africa’s potential in medical tourism. The participant rated South Africa quite high and even allocated a general score of ‘7 or 7.5’. Another participant (A1) said that South Africa was on the ‘higher end’, while another (A3) indicated that South Africa was ‘topmost in the African continent’. The high rating for South Africa as a top medical tourism destination is similar to the rating observed by Mazzaschi (in Ormond & Sulianti, 2017:96) who argued that South Africa was “touted as one of the world’s top medical tourism destinations”. The rating is also similar to the ranking by the Forbes Africa report (Matiza & Slabbert, 2020:338) which ranked South Africa as a top 20 medical tourism destination. The latest global MTI rankings also ranked South Africa 22nd out of 46 countries. This is a good ranking and an improvement from the previous ranking in 2016 where the country ranked 27th out of 41 countries.

Two participants (SA1, A1) remarked that for patients in Africa, South Africa was in competition with India. For example, participant A1 said that if they could get good rates for medical treatment from South Africa, patients would go to South Africa instead of India. She explained that although people do not really like going to India,
they prefer it because it is cheaper than South Africa. According to participant A1, African patients give India first priority, then South Africa, and this was mainly due to the cost of medical treatment. The medical cost difference between South Africa and India is similar to the observation by Dangor et al. (2015). Another two participants (SA2 and I4) indicated that South Africa was not doing well as a medical tourism destination and thus they rated it ‘very low or poorly’. It was interesting to note that participant SA2’s reason for rating South Africa’s medical tourism performance at this level (very low or poorly) was similar to SA3 above (i.e. lack of the promotion of medical tourism in South Africa), but SA3 rated South Africa’s performance higher. The reason for participant I4 to give the low rating was that South Africa was perceived as an ‘unsafe place’ by overseas visitors. The issue of safety and security was also raised in the previous section as a reason that could discourage people from choosing or visiting South Africa as a medical tourism destination.

Seven participants (A2, A4, I1, I3, I5 and I6) indicated that they could not rate South Africa in terms of its pull factors. For example, participant I1 remarked that he would not know how to rate South Africa as it (South Africa) is a ‘very closely guarded secret’. Participant I3 indicated that she did not know much about the South African medical field, and as a result it was difficult for her to rate South Africa.

Table 5.10: Classification of participants’ responses with regards to how they would rate South Africa’s performance on the pull factors mentioned above

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing well</td>
<td>3 (SA3) (A1, A3)</td>
<td>“We are doing well in the private sector, except that people don’t know. I think we have not really done much to prioritise medical tourism. So, I would say the experiences of those that get treated in the private sector is that people are happy. I would put it quite high, 7 or 7.5 in general” (SA3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“South Africa is ranked as topmost in the African continent; it is a bit ahead of Tunisia in terms of tourism policies, tourism development, and political stability” (A3)</td>
</tr>
<tr>
<td>In competition with India</td>
<td>2 (SA1) (A1)</td>
<td>“South Africa is in competition with India for the African market in terms of medical treatment costs” (SA1)</td>
</tr>
</tbody>
</table>
"I would say number 1- because in India, the population is too high. People who go to India, they really do not like it. It is because they say it is cheaper. In the real sense, if we can get very good rates from South Africa people would [rather] choose South Africa than going to India. I would like South Africa to be number 1 because we don’t have another country in Africa that we send cases to" (A1)

Not doing well 2 (SA2) (I4)

"I would rate South Africa very low, poorly, because medical tourism is not something that is actively promoted. It is very difficult to attest how we fare in an environment where medical tourism is not regarded as a type of niche of tourism" (SA2)

Can’t rate 7 (A2, A4) (I1, I2, I3, I5, I6)

"I wouldn’t know how to rate South Africa, it is a very closely guarded secret. South Africa’s story needs to be told" (I1)

"There a few good hospitals that I know of in South Africa. The problem is that there is no popularity for medical tourism. I do not know how South Africa is doing, so I do not know how to rate it" (A2)

The responses for question 4 in this section are merged with the responses for question 6 in section D. Question 4 related to what South Africa can do to be more attractive to prospective medical tourists, while section D, question 6 related to any other comments about medical tourism in South Africa that the participants could think of.

Ten participants (SA1, SA2, SA3, A1, A3, A4, I1, I2, I3 and I6) remarked that South Africa needs to promote and market itself as a medical tourism destination for it to be more attractive to prospective medical tourists. Participants SA1, SA2 and SA3 unanimously mentioned the need for the government to be involved in the promotion of South Africa as a medical tourism destination. For example, participant SA2 remarked that in her own research in 2015, she found that over 500 000 people were entering South Africa to access healthcare. In her opinion, these numbers were an indication that people were choosing South Africa as a medical destination, and thus she felt that the South African government’s concerns regarding the bad impact that medical tourism may have on the healthcare system were not justified. In her opinion, the National Departments of Health and Tourism needed to actively promote South
Africa as a medical tourism destination for South Africa to see a significant increase in medical tourists’ arrivals in South Africa. There was a time when the South African government was contemplating medical tourism, until the Netcare group was involved in the transplant scandal in 2010 (Chikanda & Crush, 2019). According to Chikanda and Crush (2019), it was after this scandal that South Africa backtracked from promoting medical tourism in this country. Currently, the promotion of medical tourism in South Africa is done mainly through word of mouth, probably by patients who received medical treatment in South Africa, the private sector and medical tourism companies such as the medical tourism tour operators (Chikanda & Crush, 2019).

The cost of medical treatment in South Africa was another area of concern to which eight participants (SA1, SA2, SA3, A1, A2, A4, I4 and I5) alluded. Although South Africa is said to be offering affordable quality medical treatments, the participants (e.g. participants SA2 and A4) remarked that the cost of medical treatment in South Africa was affordable for European and American patients, or financially stable middle-class Africans (e.g., participants SA2 and A1) because they are able to afford to pay. The cost of medical treatment in South Africa is largely responsible for most of the African clients choosing India over South Africa, as indicated by participant A1. Even though there is acknowledgement of the South African doctors’ expertise and quality of medical treatment from the African market, the barrier remains the medical cost, hence participant A1 remarked that ‘cost is not a pull factor’ for South Africa in question 2 above (see also Table 5.6). The high cost of medical treatment in South Africa was also identified as the reason for Indian-South African patients going to India for treatments by Dangor et al. (2015). The other problem that was identified with regards to the cost of medical treatment in South Africa was that patients were usually frustrated by the multiple invoices that they get if they receive medical treatment in the country, as indicated by participants SA3 and A2. The participants suggested that it would be best if there was a way to streamline the cost (SA3) so that when patients decide to get treatment in South Africa, they have an idea as to how much they were likely to pay (A2), even if this was an estimate.

Five participants (SA3, A2, A3, I1 and I6) highlighted the role that South Africa can play as a medical tourism destination on the continent, given that medical tourism is a regional phenomenon, as argued by participant I1. Participant I1’s argument was that
South Africa has the opportunity and the resources to leave its healthcare footprint throughout the African continent. One way of doing this, according to participant I1, was to take the South African healthcare services (in the form of flagship hospitals) to the region to demonstrate its healthcare centres of excellence on the continent. In his opinion, such hospitals could be backed-up with treatment offers in South African hospitals. Another role that could be played by such hospitals, according to participant I1, was that they could also serve as referral and diagnostic centres practising telemedicine to deliver diagnostics, rehabilitation and pre-rehabilitation centres. Another participant who was also of the view that South Africa should take its medical services to the region in the form of establishing mission hospitals which would handle certain treatments, and then refer complex treatments to South African hospitals, is participant A1.

In contrast to participant I1 and A1, participant SA3 was of the view that centres of excellence need to be established on the continent. The basis of her argument was that the continent does have pockets of medical excellence, and it would benefit the region immensely if such excellence was identified and centres of excellence were established throughout the continent. In her opinion, South Africa is very strong in cardiothoracic operations, and as such, all the cardiology related treatment needs on the continent can be treated in South Africa, while other treatments could be done elsewhere on the continent. If the recommendations by participants I1 and A1 are to be considered, the financial implications and burden that South Africa is likely to carry, will be vast and may also not benefit South Africa. According to participant A1 and A2, some countries on the continent are spending a lot of money (in the range of 2-3 billion USD) sending patients annually to India for treatment, and their wish was for such money to remain in Africa. Perhaps the question should be what is preventing African countries from using the money to strengthen or build their healthcare systems. The benefits associated with the regional features of medical tourism with regards to struggling neighbouring countries having access to healthcare from other medical destinations were also highlighted in the studies by Lunt et al. (2016) and Chikanda and Crush (2019).

Four participants (SA1, A3, A4 and I1) remarked that South Africa needed to reach out and form partnerships and strong relationships between all stakeholders in the
medical tourism industry and on the continent. For example, participant SA1 mentioned that some form of cooperation was needed amongst all medical tourism stakeholders to make medical tourism a reality, especially between medical professionals and medical tourism companies. This sentiment was also echoed by participant A4, and in her opinion hospitals and other related healthcare were very reluctant to cooperate with medical tourism companies. The role played by medical all stakeholders and tourism companies as links between medical tourists and healthcare providers (and destinations) for the success of medical tourism was also highlighted by Kamassi et al. (2020), Lu and Wu (2018), and Yusof and Rosnan (2020). Not only do they link medical tourists and healthcare providers, but they are also at the forefront of promoting the medical tourism industry in general (Chikanda & Crush, 2019).

Four participants (SA1, SA2, I3 and I6) remarked that more education and transparency is needed around medical tourism, especially with regards to the quality of treatments in South Africa. For instance, participant SA2 indicated that there was a lot of ‘scepticism’ and ‘naivety’ regarding medical tourism. In her opinion, medical tourism should be spoken about at length by people from all walks of life (including the various tourism backgrounds) in South Africa to alleviate the fears (real and imagined) that they may have about medical tourism. According to participant I4, the country also needs to consider investing in systems that will help make the country transparent with treatment data from both public and private healthcare systems in South Africa. He further remarked that this can be done without compromising patients’ information. In this participant’s opinion, the availability of such data would be valuable for potential patients (both local and international) in their comparison between hospitals, clinics and destinations globally against South Africa based on factual and credible data. At the moment potential patients rely on the anecdotes and testimonials from patients who have received treatment through the various medical tourism companies. Testimonials as sources of information for potential medical tourists, as well as the role played by medical tourism companies in this regard, were also mentioned in question 5 and 6 of section A of the interview schedule.

Three participants (SA3, A2 and A3) indicated that South Africa needs to improve its accessibility as a destination. Accessibility refers to the ease with which tourists would be able to travel to the country, and the main emphasis from the participants was the
frequency of flights from certain countries on the continent and the visa application processes. According to participant A2, flights to South Africa from most of the countries on the continent are not frequent. In his opinion there are more flights to India in most African countries than there are to South Africa. Sharing the same sentiment, participant A3 remarked that not only are the flights to South Africa infrequent, sometimes the flights (to South Africa) are more expensive than it would be to travel to the UK. According to John and Larke (2016), the ease of access to the destination, the affordability of international travel, and the increased frequency of flights to the medical tourism destinations were also identified as important factors considered by medical tourists when they decide to participate in medical tourism.

Another issue that relates to ease of access is the visa application process. According to participant A2, the visa application process is very lengthy and cumbersome, and most patients would not be able to tolerate the back and forth process to the embassy. The visa problem was also raised by participant A3, who remarked that even if patients were making their own arrangements to travel for treatment to South Africa, they are usually demotivated by the visa application process. Participant A3 indicated that usually the patients would also look at other destinations, and if the process is faster and less frustrating, the patients would rather go elsewhere than to South Africa. Participant SA3 added that patients often wonder why they should bother with such lengthy application processes, and end up deciding on other medical tourism destinations with less-stressful systems. Another suggestion made by participant SA3 was that perhaps South Africa should introduce a medical visa. The South African Department of Home Affairs website (http://www.dha.gov.za/index.php/immigration-services/types-of-visas) indicates that a medical visa is one of the visas they offer, and such visas are issued for a maximum period of six months at a time. As indicated in chapter 3, many patients from the African continent, do not necessarily require a special permit to visit South Africa. As a result, these patients simply use their valid passports and cite ‘holiday’ instead of ‘medical purposes’ as a reason for their visit; this makes them indistinguishable from ordinary holidaymakers (Chikanda & Crush, 2019:329).

One participant (SA1) emphasised the need to also pay attention to domestic medical tourism in South Africa. In her opinion, there are numerous patients who were
travelling within the country from one location to the next, it could be interprovincial or from one city to the other, in search of medical treatment. In her opinion, there are few or no specialists in most poor provinces, e.g. Limpopo province, and this leads to people travelling to other provinces in search of specialised and life-saving treatments which could be either inaccessible or unavailable where they reside. If there are few specialists, this may mean that the patients will be subjected to waiting lists which might delay the patients’ access to treatment, and may also put the life of patients at risk. The participant mentioned that in some instances patients would have received treatment, but the treatment would not have been successful or the patient would not be feeling better. As a result, they would then need to travel for a second opinion and/or treatment from other physicians elsewhere in the country. In their study Haarhoff and Mokoena (2016) found that many people in South Africa travelled within the country for cosmetic surgeries, thus confirming the existence of domestic medical tourism in South Africa.

Participant A3 also mentioned the need to promote and make South African traditional medicine treatments acceptable, so that medical tourists could also choose these treatments and not only look for orthodox treatments. According to Cormany (in Ko, 2011), traditional medicine treatments are some of the alternative treatments sought by medical tourists in medical destinations such as China and India. Traditional medicine is also part of the cultural factors that some tourists look for in medical tourism destinations as indicated by Shahrokh et al. (2017).

In addition to the above, participant A3 indicated that South Africa needs to tackle and deal with crime and violence. This issue was also raised in response to the question dealing with what would discourage potential medical tourists from visiting South Africa for treatments, as indicated in Table 5.6 in this chapter.
Table 5.11: Classification of participants’ responses with regards to what South Africa can do to be more attractive to prospective medical tourists (and related comments)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
</table>
| Promotion and marketing         | 10 (SA1, SA2, SA3) (A1, A3, A4) (I1, I2, I3, I6) | “therefore, if the National Department of Health as the custodian of health in South Africa and that of Tourism, were to actively start promoting South Africa as a medical tourism destination, we would see a massive uptake in the numbers of travelling to South Africa, internally and globally” (SA2)
“Every country has its specialities, for example, South Africa can expose and promote its specialities, to make sure it is well-known, and the best plan to do this is online. People need to know that they have access to more options of what South Africa has to offer, in that regard, whether there’s some specialities or facilities, equipment, technology and other things” (I3)
“The health tourism markets in the world are highly regionalised and highly fragmented. So, unless you segment your market that way, unless you segment the parts and prospective consumers based on the intention and need, it’s not possible to understand what actually occurred in the market. And it’s not possible to attract prospective consumers because you will be sending messages to attract the wrong people with the wrong messages. It’s about matching the services to the prospective consumers with the proper messaging” (I6) |
| Cost of medical treatment       | 8 (SA1, SA2, SA3) (A1, A2, A4) (I4, I5) | “Provide an estimation of the treatment cost to patients so that they don’t feel cheated” (A1)
“Lower the prices. If medical tourists could get lower prices for good treatment, then you become the country they know they can get to for everything, but you pay less” (I5)
“also, streamline the costs, so that when somebody comes for treatment, they know for sure what they will be paying for, and standardise the costs” (SA3) |
<table>
<thead>
<tr>
<th>Topic</th>
<th>Scores</th>
<th>References</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Become the medical tourism hub in the region</td>
<td>5</td>
<td>(A2, A3) (I1, I6)</td>
<td>“If South Africa has excellence in healthcare that it can offer to its neighbours, then it should think of opening flagship hospitals of South African excellence, showcasing that and delivering healthcare services to those countries, and in the very least, also back it up with offering treatments in South Africa. It can be centres of excellence, can be referral and diagnostic centres, can be centres for practising telemedicine to deliver diagnostics, rehabilitation and pre-rehabilitation referrals” (I1) “There are some countries where medical systems are stronger, like in South Africa, we are very strong in cardiothoracic operations. We could then have regional centres of excellence where people could come to South Africa to South Africa for certain things, and go elsewhere for certain things” (SA3)</td>
</tr>
<tr>
<td>Form partnerships</td>
<td>4</td>
<td>(A1, A3, A4) (I1)</td>
<td>“Reach out outside South Africa, on the continent to develop the customer base there. There’s no reason why South Africa should not be the capital of healthcare in the whole of Africa. Reach out, and be available and accessible to patients, and establish South Africa as a destination of choice for all Africans” (I1) “South Africa must build broader partnerships with medical tourism agencies throughout Africa” (A3)</td>
</tr>
</tbody>
</table>
| Education and transparency                | 4      | (SA1, SA2, I3 and I6) | “Medical tourism tour operators need to have relationships with doctors. Many doctors, especially our black doctors, are not informed with regards to medical tourism. These doctors have the necessary skills and experience needed by patients. Because most of them are found in the public sector and working under very difficult circumstances and they see the worst cases. By the time they get to the private sector or practice, they have so much exposure and experience, that is why I needed them on board” (SA1) “The number one thing for all industries in South Africa, including medical tourism, your country needs transparency. Transparency of data and quality available so that patients and anybody can look at this hospital across the board and say this hospital has this type of score, so it is safe for me to go. I can go to this hospital and not that hospital in another
| Improve accessibility | 3 (SA3, A2 and A3) | “Improve the frequency of flights because this is a problem. There are fewer flights in a week from Nigeria to South Africa” (A2)
“South Africa must also develop or improve road transport facilities to connect with its neighbouring countries to make South Africa more accessible, this will make South Africa as a destination more ideal for people to easily connect to South Africa” (A3) |
| Domestic medical tourism | 1 (SA1) | “I also worked on domestic medical tourism, with sick people moving from one doctor to another and still can’t get the help they need. I would help such patients by referring them and help them the same way I would the international patients” (SA1) |

The last question (question 6) in this section related to the top medical tourism destinations based on the opinions of the participants. The question is dealt with in conjunction with question 1 of section C that relates to the procedures which most well-known destinations are popular for, and what contributes to the popularity. The reason for combining the two questions is that destinations are known for certain treatments and when potential medical tourists compare destinations, they usually compare destinations that offer similar treatments (based on treatment quality data if available), as indicated by participant I4 in the previous question above. Potential patients may also find information through an internet search about treatments and service providers, and they might even go through the testimonials and reviews of other patients who have had the treatments that they may be looking for. According to participant I4, top medical tourism destinations depend not only on treatments that patients are looking for, but they are also influenced by the target group for which the treatments are meant. Thus, destinations must identify who their target market is, and phrase their promotional messages in such a way that they are able to attract the right market. This is similar to what participant I6 highlighted in Table 5.11 about matching the services to the prospective consumers with the proper messaging.
In conclusion, the participants identified various pull factors which were organised into two main themes, i.e. the healthcare provider-related pull factors and the destination-specific pull factors. The themes were also represented for South Africa, although this was on a smaller scale as compared to the pull factors for medical tourism destinations in general. This was not surprising as most of the participants had mentioned that they were not aware of the existence of medical tourism in South Africa.

5.5 MEDICAL TREATMENT OR PROCEDURES

This section relates to objective four of the study. The aim of the questions in this section was to establish if the push-pull factors of a medical tourism destination differ based on the type of procedures offered in the destination.

Table 5.12: Classification of participants’ responses with regards to the top medical tourism destinations, the procedures they are known for, and what contributes to the popularity of these destinations

<table>
<thead>
<tr>
<th>Top destinations</th>
<th>Procedures they are known for</th>
<th>What makes them popular</th>
</tr>
</thead>
<tbody>
<tr>
<td>India 11 (SA1, SA2, SA3) (A1, A2, A3, A4) (I1, I2, I3, I5)</td>
<td>All procedures (example: orthopaedics, ophthalmology, organ transplants, etc)</td>
<td>“they offer affordable treatments” (A1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“it’s easier and cheaper to get organ donors and organ transplants” (A3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“they have specialists for various procedures” (A1)</td>
</tr>
<tr>
<td>Thailand 5 (SA3, A3, A4, I3, I6)</td>
<td>Cosmetic surgeries and therapies Heart procedures Transgender procedures specialists</td>
<td>“they offer affordable treatments” (I3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“well-known for heart procedures” (I6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“they are known for successful transgender operations” (I3)</td>
</tr>
<tr>
<td>Turkey 4 (SA3) (A1) (I1, I2)</td>
<td>Cosmetic surgery; organ transplants and making inroads</td>
<td>“A lot was spent to develop their healthcare system, and they managed to pull people from various destinations, for example North Africa, and East and west Europe” (I1)</td>
</tr>
<tr>
<td>Country</td>
<td>Procedures in other procedures as well</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| South Africa            | Cosmetic surgeries; cardiology, IVF and other treatments | “Cape Town is well-known for plastic surgeries, although most of the plastic surgeons are in Johannesburg, nobody knows much about this. Cosmetic surgery is very affordable in South Africa for patients from Europe and the US” (SA3)  
“South Africa is well-known in Southern Africa, it is better, so people would want to come to South Africa, but it is not cheap” (A4) |
| Mexico                  | Cosmetic surgeries                      | “affordable treatments and its proximity to the USA” (I5)                    |
|                         | Dentistry                               | “offers treatment plans to patients” (SA2)                                 |
| Hungary                 | Dentistry                               | “highly affordable dental treatments for consumers all over the world” (I6) |
|                         |                                        | “it’s the dental capital of the world, and this is because of the number of patients that are growing from within Europe” (I1) |
| Costa Rica              | Various procedures                      | “They have inexpensive cosmetic surgeries and also offer a payment plan to travel. This makes it possible for all potential medical tourists, not only the elite” (SA2) |
| United States of America| Various procedures                      | “They do a lot of procedures there, and they also have credit facilities for patients to pay for treatments or procedures on a payment plan” (SA1)  
“The US has a well-developed healthcare system, it receives and sends out the most patients” (I3) |
| Brazil                  | Bariatric (weight-loss) treatments; Cosmetic surgeries | “It has board certified cosmetic surgeons, it is the capital of cosmetic surgeries, also famous for the Brazilian Butt Lift, the BBL, which is achieved through liposuction” (I5) |
| United Kingdom          | Neuro and spine surgeries               | “They have the best surgeons” (A2)                                        |
| South Korea             | Cosmetic surgery                        | “They spent a lot of money to develop their infrastructure, they put out a word about Korean excellence in healthcare, |
they improved accessibility to Korea and now they are making medical tourism into an industry” (I1)

**Poland**
- **Cosmetic surgeries**
  - “Its proximity for European clientele” (I2)

**Germany**
- **Dentistry**
  - “geographically location to Arabs” (I4)

**Israel**
- **Oncology procedures; heart procedures**
  - “has invested in oncology research” (A3)

**Italy**
- **Heart procedures**
  - “Here in Zimbabwe, Italy is well-known, especially by kids, they also offer free heart procedures for heart patients” (A4)

**China**
- **Holistic treatments**
  - “holistic medicinal treatments and Chinese traditional medicine” (A4)

**Dominican Republic**
- **Bariatric (weight-loss) procedures**
  - “they are well-known for the best hour-glass look in the world” (I5)

**Switzerland, Germany & Austria**
- **Bariatric treatments (weight-loss) and elderly care**
  - “proximity for different cultures, for Arabs, they will always go to these three countries because of the proximity” (I4)

**Question 1** of section C begins with establishing **which specific procedures specific destinations** are known for, and what contributes to their popularity. Participants’ responses are documented in Table 5.12 above as most participants mentioned the same destinations that they had mentioned as top destinations for the last question of the previous section. Eleven participants (SA1, SA2, SA3, A1, A2, A3, A4, I1, I2, I3, and I5) identified India as the top destination. India is well-known for various procedures (A1), and medical treatments in India are said to be affordable and easily accessible (A1, A3 and A4). The affordability and accessibility of a multitude of medical treatments in India was also identified by Dangor et al. (2015). Other countries
identified (by participants SA2, SA3 and I2) for doing various procedures are Costa Rica, Indonesia and Malaysia, and according to participant SA2, the reason for the destinations’ popularity was that the three destinations offered affordable medical treatments. Three participants (SA2, SA3 and I3) identified the US as a leading medical tourism country also offering various treatments, and the destination’s popularity was attributed to the availability of credit facilities for medical treatments in the US, according to participant SA1.

A lot of destinations offer cosmetic surgeries, but Thailand was identified as a leading destination by five (SA3, A3, A4, I3, and I6) participants in this study. One of the reasons for its popularity was that it was well-known for affordable cosmetic surgeries (SA3, A3, A4, and I3), transgender procedures (I3), and cardiology (I6). Thailand was also identified as one of the top and most successful medical tourism destinations in the world (even though most of the medical travel is South-South and intra-regional) by Ormond and Sulianti (2017). Although Thailand has medical tourists coming from all over the world, it receives most medical tourists from its neighbouring states (due to the healthcare agreements it has with its neighbours) and because of the perceived affordability of medical treatments at the destination (Chia & Liao, 2020). Most of these medical tourists go to Thailand because the treatments they need may be unavailable in their own countries or because of the lack of, or insufficient, expertise at home. Accordingly, affordability of medical procedures in Thailand is commonly associated with patients from the Global North (Ormond & Sulianti, 2017), and the financially stable patients from the neighbouring states, who can access the Thai private healthcare system (which may also not be affordable to most underprivileged Thai locals). In this regard, the Thai affordability situation is similar to the affordability of medical treatments in South Africa, as indicated by the participants in this study. Other destinations that were identified by four participants (SA3, A1, I1 and I2) as also offering cosmetic surgeries are Turkey, South Africa (SA3, A1, A2 and A4), Mexico (SA2, I2, I3 and I5) and Brazil (SA3 and I5). According to participant I1, the reason for Turkey’s popularity is that the country has invested in the development of its healthcare system. In their study, Sag and Zengul (2018) also found that there was growing demand by patients to visit Turkey for medical treatment and this was attributed to the availability of highly trained doctors and well-equipped hospitals in Turkey. South Africa’s popularity, according to participant SA3, was that South Africa
was offering affordable cosmetic surgeries for patients from Europe and the US. The popularity for Mexico was attributed to its close proximity to the US, which is the biggest market for cosmetic surgeries and dentistry according to participant I3, as also highlighted by Miller et al. (2020). According to participant I5, Brazil is popular because of its huge number of Board certified or accredited cosmetic surgeons.

Hungary was identified as the dentistry capital of the world by three participants (I1, I2 and I6), and it is the main medical treatment offered in Hungary. Although Hungary can get patients from anywhere in the world, their source market is Europe (I1). Their number of patients is growing from Europe because Hungary is perceived as offering affordable and quality dental treatments. According to participant I2, there is a huge difference between dental treatment prices in Europe. To demonstrate the difference and affordability of dental treatments in Hungary, participant I2 remarked that German patients could pay up to 50% less for a prosthesis (dental) treatment in Hungary than they would have paid in Germany. Hungary was also identified amongst other countries which were only focusing on their main treatment-speciality, i.e. dentistry, by Nicolaides and Zigiriadis (2011). Other destinations that offer dentistry are Germany (I2 and I4), and Mexico (SA2), but Hungary is well-known as a leading dentistry destination.

Other destinations offer weight-loss treatments, such as Brazil (I5), Dominican Republic (I5), Switzerland, Germany and Austria (I4). According to participant I5, Brazil specialises in liposuction and they are famous for the Brazilian Butt Look (BBL), and their treatments are affordable. According to participant I1, weight-loss is one of the main reasons for medical travel, and this is influenced by the fact that this treatment may not be covered by the local healthcare system or the patients’ private medical insurance. Thus, when patients travel for weight-loss treatments, they pay from their own pockets. Hudson and Li (2012) also identified weight-loss treatment as one of the services that patients seek when they engage in medical tourism, as this is not covered by healthcare insurance.

Question 2 in this section relates to the **procedures that South Africa is known for**, and question 4 required the participants to identify which **procedures** needed **to be introduced**. Both questions will be dealt with simultaneously as they are related and
the responses to the one could be used to inform the other. Ten participants (I1, I2, I3, I4, I5, I6, A1, A2, A3 and A4) remarked that they did not know or they were not sure what procedures South Africa was known for. This was understandable as most of them had already indicated that they were not familiar with the healthcare system, or were not aware of the existence of the medical tourism industry in South Africa. For example, participant I1 remarked that he ‘would like to know, I don’t deal with South Africa’, and participant A3 mentioned that he did not ‘have much knowledge about South Africa’s procedures’. Participant I6 remarked that he did not know, and further remarked that he could not give an answer to the question because when he thinks of South Africa, he only thinks of ‘apartheid, nothing else’. However, some of the participants who did not know much about the procedures that South Africa was known for in question 2 were eager to recommend or suggest procedures which they thought should be introduced in South Africa.

With regards to the responses for question 2, three participants (SA1, SA2 and SA3) mentioned that South Africa was well-known for affordable cosmetic surgeries. Participant SA1 indicated that she had never worked with a patient requiring cosmetic surgery in South Africa before, but she was aware that South Africa was doing well in cosmetic surgeries, albeit for the European and American patients only. Participant SA1 further remarked that South Africa offers diverse procedures and this is because it has a multitude of specialists who can treat various ailments. Participants SA2 and SA3 highlighted that South Africa was well-known for fertility treatments. For example, participant SA2 remarked that South Africa was gaining reputation ‘as an IVF country’ on the continent. Participant SA3 further indicated that in her research, she has identified infertility treatment as one of South Africa’s strengths. In her opinion, if centres of excellence were to be identified or established in South Africa, she would have ‘Infertility treatment centre’ as one of such centres. The availability of affordable fertility treatments in South Africa (especially for the Global North patients) was also identified in the study by Chikanda and Crush (2019). Other procedures that were identified by participant SA3 were neurology and trauma treatments. As a result, she had identified three centres of excellence, i.e. the Headache Clinic (for neurological treatments), the Trauma Unit (for all emergency treatments) and the Infertility treatment centre (mentioned above); all of these centres are based at Milpark Clinic in Johannesburg.
With regards to question 4, the participants made many suggestions for treatments, e.g. cosmetic surgeries, fertility treatments, dentistry, cardiology, oncology, orthopaedic surgeries, and these are already available in South Africa (Nicolaides & Zigiriadis, 2011). For example, five participants (SA3, A3, I3, I4, I5) indicated that South Africa needed to introduce cosmetic surgeries. Participant SA3 commented that although South Africa is well-known for cosmetic surgeries, it is possible that there could be some cosmetic procedures (she said she could not think of anything at the top of her head) that are done elsewhere ‘that we do not have in South Africa. Participant I5 indicated that South Africa could think of a complete ‘mom-makeover treatment’ which could include liposuction, tummy tuck, muscle repairs and breast implants. South Africa already offers different types of cosmetic surgeries, such as breast augmentations, facelifts and others, as indicated by Haarhoff and Mokoena (2016).

Three participants (SA, I3, and I4) identified dentistry as another procedure that could be introduced in South Africa. In some countries, dental treatment may not be covered by the healthcare systems (such as the NHS in the UK as indicated by participant I1). Therefore, patients have to pay from their own resources for dental treatments. The need for dental treatments by medical tourists in general has also been identified by Hudson and Li (2012), and also as one of the popular medical tourists’ requests in South Africa by Nicolaides and Zigiriadis (2011).

Table 5.13: Classification of responses with regards to procedures that South Africa is known for and which procedures needed to be introduced

<table>
<thead>
<tr>
<th>Category (known procedures)</th>
<th>Examples of verbatim responses</th>
<th>Category (procedures to be introduced)</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t know or not sure</td>
<td>“I don’t know because South Africa is an enclosed country, and nobody comes to give information” (A1)</td>
<td>Don’t know 4 (A2, I1, I2, I3, I4, I5, I6)</td>
<td>“I don’t know, hospitals in South Africa are good but have no publicity (A2) “Not a clue. I have no data. What you need to do introduce is</td>
</tr>
<tr>
<td>Procedure</td>
<td>Quote</td>
<td>Source</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgeries</td>
<td>“South Africa is popular for cosmetic surgeries, mostly for the wealthy European and Americans” (SA2)</td>
<td>Cosmetics</td>
<td></td>
</tr>
<tr>
<td>IVF</td>
<td>“South Africa is gaining reputation as an IVF country across the African continent” (SA2)</td>
<td>IVF</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td>“for example, the Headache clinic in Milpark is one of the centres of excellence” (SA3)</td>
<td>Neurology</td>
<td></td>
</tr>
<tr>
<td>Trauma treatments</td>
<td>“the Trauma unit at Milpark is one of the centres of excellence” (SA3)</td>
<td>Trauma</td>
<td></td>
</tr>
<tr>
<td>Various procedures (SA1)</td>
<td>“South African doctors have a lot of expertise on various procedures and basic healthcare” (SA1)</td>
<td>Various</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic treatments</td>
<td>“the biggest demand for procedures such as orthopaedic surgeries” (I3)</td>
<td>Orthopaedic</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>“South Africa must do most of the heart procedures, like the mitral-valve replacements” (A4)</td>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td>“medical tourists travel for various treatments like for dialysis” (I4)</td>
<td>Nephrology</td>
<td></td>
</tr>
</tbody>
</table>
Question 3 in this section is dealt with last and related to the various push-pull factors (travel motivations and physical attributes or characteristics) that influence medical tourists to select a medical tourism destination, and whether the push-pull factors differ based on the procedure that a tourist wants to undertake. This question is directly linked to research objective four of this study. The question was said to be very complex by the participants, and the complexity thereof is evident in the responses that were given. A further clarification was also given for the question (i.e., in other words, do some of these factors become more or less important based on the procedure OR are all factors equally important regardless of procedure?). The aim of this question was to establish if the push or the pull factors differ (or not) based on the procedure that a tourist wants to undertake at the time.

Eight participants (SA1, SA3, A3, I1, I2, I3, I4 and I6) indicated that the push factors play the important role, and in their explanations, they highlighted the various push factors mentioned in the first section of the interview. Some of the push factors that were identified (as indicated in Table 5.2) by the participants in this study are: the cost of medical treatment at home; the lack of expertise and treatments at home; the lack of facilities and services at home; the length of waiting time; the geographical location and accessibility of the receiving country. For example, participant I6 highlighted the importance of the markets for health tourism as a starting point. It is very important to understand medical tourists from the perspective of them being part of this market. In his opinion (I6), the health tourism markets are not homogenous, i.e., it is not only one market or one group of people with similar attributes. Given their heterogeneous natures, medical tourists must therefore be segmented in accordance with their respective medical tourism demand (push) and supply (pull factors). Thus, the demand (i.e. the push factors) is dependent on the services sought, in this regard, the procedures sought at the time. Participant SA3 explained that if the patient was looking for a medically necessary treatment, such as cancer treatment, which was ‘unavailable in his/her country’ and/or they did not have ‘a cancer treatment centre’ (facilities) in the
home country, then they are very likely to go to a country where they will be able to access the treatment and the facilities. In her opinion, in response to this question, the procedures or the services sought at the destination are the most important. Participant SA1 responded by indicating that the ‘availability of the treatments and procedures’ that a patient wants at the destination is more important. The remarks given by the participants in response to this question are similar to what Runnels and Carrera (2012) identified as the pattern followed by patients when they decide to embark on medical tourism. According to Runnels and Carrera (2012), the patients establish what their core health needs are (i.e. medically necessary treatment [SA3]) at the time. They then think about and weigh the available treatment options at home and/or abroad (if the treatment is unavailable in the home country they will go to a country where they will be able to get the treatment [SA3]). They will then have to take into consideration the cost of treatment at home and abroad (although this may not matter if the patient feels that the condition for which they need treatment is life-threatening [A3]); and whether they have the time (or can they make time) to travel for the treatment.

Four participants (SA2, A2, A4, and I5) indicated that the push and pull factors are equally important or identical. According to the participants, the following are some of the important pull factors (as indicated in Table 5.8):

- the destination,
- quality of medical facilities;
- ease of access to the destination;
- cost of medical treatment at the destination;
- doctors’ expertise, and
- the quality of the treatment at the destination.

For example, participant (A4) remarked that whatever decision the patient takes is likely to be dependent on (pushed by) ‘the procedure’ that they want at the time. Participant A4 also emphasised that the patients are likely to be pulled by ‘the hospital itself’ and the ‘expertise of the doctor who is going to do the procedure’ at the receiving destination. The participant further clarified that patients are not concerned about other tourism features of the destination, e.g., the attractions that they will visit once they
are at the destination. In conclusion, the participant indicated that both factors are equally important. Looking at the push and pull factors from the perspective that they are equally important reminds us of the interrelationship between these factors as identified by Al-Maaitah (2016). For example, Al-Maaitah (2016) demonstrates the interrelationship between cost as both a push and a pull factor, by indicating that patients are likely to compare the high cost of medical services at home against the perceived low or affordable prices of medical services at the medical tourism destination.

One participant (A1) indicated that the value of the push-pull factors differs from person to person. The participant emphasised that patients tended to prefer certain destinations over others for various reasons, such as how easy it would be for them to access the destination (pull factor). For example, the participant remarked about the people’s preference of Mumbai instead of New Delhi and why more patients preferred Mumbai. In his opinion, a lot of patients do not like connecting many times before getting to their destination. The participant indicated that the availability of a number of direct flights to Mumbai, unlike to New Delhi, is the main reason why many patients preferred Mumbai.

Table 5.14: Classification of responses with regards to various push-pull factors that influence medical tourists to select a medical tourism destination, and whether the push-pull factors differ based on the procedure required

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of responses</th>
<th>Examples of verbatim responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Push factors more important</td>
<td>8 (SA1, SA3)</td>
<td>“If you are looking for a medically necessary treatment, like cancer treatment, and in your country, they don’t have a cancer treatment centre, you’d want to come to South Africa because you don’t have a cancer centre in your country. So, it differs based on the service you are coming here for. It depends on the procedure” (SA3)</td>
</tr>
<tr>
<td></td>
<td>(A3) (I1, I2, I3, I4, I6)</td>
<td>“Exceptions come from the budget. If the patient has a high budget, no matter the treatment cost, they will want to go. If the ailment is life-threatening, they might want to go get the treatment” (A3)</td>
</tr>
</tbody>
</table>
“They will be driven by the treatment. Treatment will always come before destination” (I4)

“Depending on the procedure. People are normally worried about the hospital itself and the expertise of the doctor who is going to do the procedure. They are not worried about other things like where they will go to visit. They are more worried about the quality of the hospital. That’s what they want. So, they are equally important” (A4)

“I think they are the same, does not depend on the procedure. They are the same regardless of the procedure the patient is going through” (I5)

“IT differs from person to person. For example, people tend to choose Mumbai instead of New Delhi. For Mumbai, there are a lot of direct flights unlike New Delhi. Patients do not like connecting many times before getting to their destinations. So, Mumbai has more patients” (A1)

In conclusion, the participants’ suggestions with regards to the procedures that need to be introduced in South Africa is a clear indication that South Africa should promote its medical excellence to the world so that the world can know what the country has to offer. It is also interesting to note that most participants considered that push factors play a prominent role and are based on procedures in comparison with the pull factors.

5.6 CONCLUSION

This chapter discussed the findings from the interviews conducted in the empirical phase. The findings of this study revealed the following as the most frequently mentioned push factors for motivating potential medical tourists to seek medical treatment in countries other their own: the cost/price of medical treatment at home is high; lack of expertise and treatment at home; lack of facilities and services; and the length of waiting time at home. The most prominent pull factors identified by the participants were: the destination; the quality of facilities at the destination; the ease of access to the destination; the cost of medical treatment at the destination, the doctors’ expertise and quality of treatment at the destination and safety and security.
at the destination. This study also revealed that South Africa is not performing sufficiently well in terms of the push factors motivating potential tourists to visit the country for medical treatment. South Africa is, however, doing better in terms of the pull factors to the destination as a medical tourism destination.

The findings also revealed that patients are most likely to be motivated (pushed) by the nature, seriousness and urgency of the treatment they needed at the time. This motivation is heightened if the treatment that is needed is unavailable in their country or is available, but not readily, and the patients are aware that they can get the treatment elsewhere without difficulty, regardless of the cost of treatment or the tourism attributes of the destination.

The following chapter draws conclusions and makes recommendations based on the findings as indicated in this chapter.
CHAPTER SIX
DISCUSSION, RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

The aim of this research was to identify the push and pull factors of a medical tourism destination and based on these, to measure South Africa’s performance as a medical tourism destination.

The objectives of this study were the following:
- To explain the push-pull theory and its use in tourism literature
- To provide an overview of the medical tourism industry, globally and in South Africa
- To identify the push-pull factors of a medical tourism destination
- To determine if the push-pull factors of a medical tourism destination differ based on the type of procedure offered at the destination
- To measure South Africa’s performance as a medical tourism destination in terms of its push-pull factors.

The following sections provide a discussion of each of these research objectives, also link findings to existing academic literature as reviewed in Chapters 2 and 3. The managerial implications are discussed, limitations identified and recommendations made for future research studies.

6.2 DISCUSSION AND INTERPRETATION OF RESULTS

As indicated in chapter 1, the aim of this study is two-fold: firstly, to identify the and pull factors of a medical tourism destination, and secondly, based on these factors, to measure South Africa’s performance as a medical tourism destination.
6.2.1 Explanation of the push-pull theory and its use in tourism literature

Although there is no general agreement as to what motivates people to travel, a number of scholars, e.g. Crompton, Dann, Iso-Ahola, Pearce (in Morrison, 2019) have tried to explain what makes people decide to travel (e.g. for pleasure or any other reason). Dann (1977) used the push-pull theory to explain tourists’ motivation to travel based on two concepts, i.e. anomie and ego-enhancement. The anomie and ego-enhancement relate to travellers’ motivations or internal needs and desires to travel. In Dann’s (1977) opinion, the anomie and the ego-enhancement are responsible for inducing the internal desire to travel (in order to satisfy the travel, need at the time) in tourists, and therefore they can be regarded as the push factors. According to Uysal et al. (2008), push factors and the tourists’ needs and wants explain what motivates (why) tourists to travel from their regular destinations to other destinations, and this could be the need for escape, rest and relaxation, self-esteem, prestige or health and fitness.

Travellers are drawn or pulled to specific destinations by the destinations’ attributes that have the potential to satisfy their internal needs and desires to travel (Whyte, 2017). The attributes at the destinations are also known as pull factors, and their role is to attract inbound-tourists to the destination. Pull factors explain where people travel, i.e. the destination choice. The pulling effect is therefore in response to the anomie and ego-enhancement effects. After Dann (1977) various other authors such as Cha, et al., (1995), Klenosky (2002), Kim, Lee, and Klenosky (2003), and Morrison (2019) have used the push-pull theory in different travel contexts, such as to specific tourism destinations or to consume certain tourism products, and to illustrate the relationship between push and pull factors.

The push and pull theory has also been used in medical tourism studies. Medical tourism push factors are mainly related to the medical tourists’ individual characteristics and healthcare needs. According to Khan et al. (2016) and Runnels and Carrera (2012), medical tourists are mainly pushed by the need for medical or healthcare which most of the time cannot be fulfilled in their home countries, which then leads to the demand for medical tourism. According to Heung et al. (2010), the
demand for medical tourism illustrates the medical needs that motivate potential medical tourists to seek medical treatment and what influences their selection of the doctor, hospital and the destination. The demand for medical tourism is therefore generated by medical tourists themselves (Allen in Ile & Tigu, 2017). The demand aspects of medical tourism can also be referred to as the push factors.

The physical attributes at medical tourism destinations are referred to as pull factors. According to Heung et al. (2010) and Matiza and Slabbert (2020), pull factors are closely related to the supply-side of the medical tourism destination and they also relate to the infrastructure, promotion, quality and communication at the destination. Adwan (2020), Fetscheri and Stephano (2016) and Zarei and Maleki (2019), further argue that medical tourism pull factors relate to factors of the healthcare or medical services providers and the physical (tourism) external attributes as well as the general local environment in medical tourism destinations.

6.2.2 Overview of the medical tourism industry, globally and in South Africa

Participants indicated India, Thailand, Turkey, South Africa and Mexico as top medical tourism destinations. Among the reasons for India’s popularity as a medical destination is that Indian hospitals perform various procedures and treatments, all at affordable prices. The availability of diverse affordable treatments in India is similar to the findings by Dangor et al. (2015), in which India-South Africans who sought treatment in India were able to do so more cheaply than in South Africa. According to Dangor et al. (2015), some of the South African patients who sought medical treatments in India had been unsuccessfully treated in South Africa and for this reason decided to go to India for additional treatment (for the same ailment). One of the participants in this study also indicated that when patients go to India for treatment, they usually have an estimate of how much they will be paying in contrast to when patients come to South Africa for treatments. India was also found to be the most transparent in terms of the pricing of medical treatments in the study by Mogavvemi et al. (2017), which compared medical tourists’ admissions and services between India, Malaysia and Thailand. The participants mentioned that India has medical experts for various treatments and also has good quality hospitals. India is ranked among the top 10 medical tourism
destinations in the latest MTI (2020-2021) global rankings. In the same ranking, Thailand is ranked 17th, South Africa 22nd, Turkey 30th, and Mexico 42nd. It is not surprising to see South Africa identified as one of the top destinations by the participants. The country is also described as a top medical destination in studies by Chikanda and Crush (2019) and Matiza and Slabbert (2020) as indicated in Table 3.5.

Medical tourism tour operators tend to focus their services on the destination where they are located. For example, participants from South Africa were only offering destinations in South Africa to medical tourists. The same applied to the participants from Hungary, Brazil and Mexico. Other participants were offering other destinations in addition to those where they were located. Additional destinations identified are India, Israel, Hungary, the USA, UK, Tunisia, Turkey, Croatia, Georgia, Czech Republic and Zambia. In terms of the procedures in which participants specialised, most of them indicated that they were offering any procedure required by their customers. The provision of all treatments was made possible by the fact that they had partnered with healthcare providers in various countries who were providing a variety of treatments. Some participants were offering only specialised procedures, e.g. dentistry and bariatric treatments. The tendency for some countries to focus on specific procedures only was also highlighted by Nicolaides and Zigiriadis (2011).

In terms of the profile of patients who are likely to seek treatment in South Africa, the participants indicated that it could be anybody, regardless of their gender or sexual orientation who was familiar and comfortable with what South Africa was offering in terms of healthcare services, and also able to travel to South Africa for the treatments. Given the geographical location of South Africa, the participants also indicated that patients were likely to be from the African continent, specifically from sub-Saharan Africa as South Africa has bilateral agreements with some of these countries. This is similar to studies by Chikanda and Crush (2019), Matiza and Slabbert (2020), and Ormond and Sulianti (2017) who also found that the majority of medical tourists that visit South Africa are from the African continent, with the majority of these patients coming from sub-Saharan Africa. The findings of these studies are confirmed in reports by Statistics SA (2018 & 2019).
In addition, the participants mentioned that the potential patients would have relatives living in South Africa. It is possible that the relatives of these patients’ relatives would have informed them of the availability or quality of healthcare in South Africa, or they (the relatives) would have sponsored the patient if the patient needed treatment but did not have enough funds or was unable to find an alternative sponsor for treatment. Furthermore, the participants indicated that such patients would be financially stable as South African medical services are not necessarily cheap. In their studies, Chikanda and Crush (2019) and Ormond and Sulianti (2017), also found that wealthy or middle-class Africans were travelling to South Africa for medical treatments, and because they could afford to do so they also sought specialised treatments such as chemotherapy. According to these authors, besides the fact that such patients were financially stable, most of them had healthcare insurance which they are able to use in South African hospitals, and they were also subsidised by their governments. Lastly, the participants indicated that patients who were likely to want medical treatment in South Africa were likely to be English-speaking, and in need of a general medical check-up.

6.2.3 Identification of the push factors of a medical tourism destination

The participants identified four themes related to medical tourism push factors: the healthcare needs of tourists; affordability and cost-related push factors; procedure-related push factors; and travel-related push factors.

6.2.3.1 Push factors related to affordability and cost

The majority of the participants in this study indicated that if patients perceived the cost of medical treatment at home to be expensive, they were likely to consider going elsewhere where they would be able to have treatment at an affordable rate. The need to save on medical costs as the main push factor for most patients participating in medical tourism was also highlighted by Abubakar and Ilkan (2016) and Gaines and Lee (2019), given that most of these patients pay cash for treatments sought at the receiving destinations. The cost of medical treatments is usually very high in developed countries, and in most cases patients from these countries travel to developing countries being lured by the prospect of affordable treatments (Horowitz &
Rosensweig, 2007). For example, patients from developed countries such as the UK, Western Europe and the US can save between 25% and 40% on medical costs in developing countries such as South Africa (Matiza & Slabbert, 2020; Nicolaides & Zigiriadis, 2011).

The cost factor was also associated with the availability of expertise or specialists at the receiving destination. If the patients felt that they would get good quality treatment at an affordable price at the destination, they were very likely to travel for medical treatment. Some of the local (3 African and 1 South African) participants highlighted the lack of specialists and hospitals in some African countries as a push factor for patients to want to travel elsewhere for medical treatment. However, the participants pointed out that most patients from the African continent considered the cost of getting medical treatment in South Africa as expensive, and as such, some African patients were choosing to go to other destinations, such as India, instead of South Africa. The high cost of medical treatment for African patients in South Africa was also identified as contributing to medical travel from Africa to India by Dangor et al. (2015).

6.2.3.2 Push factors related to procedures and treatments

(i) Lack of expertise and treatments at home

The majority of participants also identified the lack of expertise and treatment at home as another push factor. Sometimes patients may need life-saving major procedures, such as heart surgeries, and they may not be able to access these if there is a shortage of or no surgeons in their countries to expedite the surgeries. Sometimes the shortage of expertise is due to the internal brain-drain (Mogaka et al., 2017) as some specialists relocate to other countries in search of better opportunities or are lost to the private sector within the same country. Patients in need of such surgeries will be motivated to seek treatment elsewhere, where expertise is available, as highlighted by Ko (2011). The shortage or lack of expertise, especially in developing countries, was also identified as an important push factor for patients by Chikanda and Crush (2019) and Matiza and Slabbert (2020). The lack of expertise has a direct impact on the availability of medical treatments as indicated above.

Treatments may be unavailable in the patient’s country because they are deemed illegal or banned. Typical treatments include fertility and reproductive treatments, sex
changes, and euthanasia (Cormany in Ko, 2011). Patients in need of such treatments will be motivated to go to destinations where they will not be prosecuted for having such procedures. According to Gaines and Lee (2019), patients may also be in need of novel or experimental treatments that are unavailable or not authorised at home, such as experimental cancer treatments.

(ii) Lack of facilities at home
Some participants identified the lack of facilities at home as another important push factor. This is common for patients from developing countries as most of these have poor or no healthcare systems, as also indicated by Khan et al. (2017) and Abd Mutalib et al. (2017). The healthcare needs of most people from these countries usually range from the need for basic healthcare, such as immunisation, to general healthcare services, which are usually provided in countries with good healthcare systems through their national healthcare systems.

It is usually for this reason that most developing countries have bilateral agreements (as indicated by one of the participants) with other countries. Sometimes these agreements are made with other developing countries which have better healthcare systems than them, such as the bilateral agreements between South Africa and many countries in sub-Saharan Africa (Chikanda & Crush, 2019). The healthcare agreements help patients from these countries to access both public and private facilities, and this also gives them access to life-saving major surgeries if needed, as indicated by another participant in this study. The lack of facilities in developing countries was also identified as a push factor for medical tourists by Chikanda and Crush (2019) and Ormond and Sulianti (2017).

(iii) Long waiting lists at home
Participants identified the length of the waiting time before accessing treatment at home as another push factor that would motivate patients to seek medical treatment at another destination. This is common with patients from developed countries, but may also be experienced in developing countries. The need to avoid long waiting lists for patients from developed countries is usually not influenced by the lack of expertise. Most patients from developed countries have good quality healthcare systems. The
issue for them might be that the healthcare system does not consider the patient’s ailment as urgent at the time that he/she needs the treatment, thus they will be put on a waiting list (Gill & Singh, 2011).

Patients from developing countries may be placed on a waiting list because there are too few specialists available to attend to their ailment at the time, and these specialists could be fully booked or overbooked at the time when the patient needs an appointment. Thus, for these patients, the waiting list is influenced by the lack of expertise. Not only will being on a waiting list delay the patient’s access to treatment, it may also put their lives at risk; as a result, patients may decide to seek medical treatment elsewhere where they will be able to access treatment more quickly. The patients’ need to avoid long waiting lists in their home country was also identified as an important push factor by Zarei and Maleki (2019).

6.2.3.3 Travel-related push factors
Travel-related push factors have to do with tourism factors at the destination and describe how easy or difficult it is to access the medical tourism destination. The participants mentioned that easy access to the medical tourism destination is influenced by the proximity and/or geographical location of the medical tourism destination and the convenience and ease of getting to this destination. One of the participants highlighted how the location of the airport in Hungary facilitates travel to Hungary and to access other facilities like hotels and restaurants that medical tourists may want to use at the destination. Another participant emphasised that connectivity to the receiving destination is very important as it facilitates getting to the destination with ease. Among other factors, connectivity refers to the availability and frequency of flights to the medical tourism destination. One of the participants also indicated that medical tourists tend to consider how they will be welcomed at the medical tourism destinations, thus they tend to choose destinations which they feel to be culturally similar and these are usually closer to the medical tourists’ home locations. The role played by travel-related push factors in terms of the tourists’ decision-making process was also identified by Collins et al. (2019) and Miller et al. (2020) with regards to why some American patients choose to go to Mexico for treatments, i.e. the proximity of the destinations.
6.2.3.4 Healthcare needs push factors

Patients participate in medical tourism because of the healthcare need that they feel cannot be satisfied at home. Healthcare needs thus determine the medical tourist’s travel decisions, and therefore lead to the demand for medical tourism. Healthcare needs range from basic to optimum needs. The participants indicated that patients may be motivated by personal or life-saving reasons to want to get treatments from their home countries, and if they cannot access these for whatever reason, they will consider other destinations where they will be able to access the treatment without difficulty. The role played by healthcare needs as a determinant for participation in medical tourism was also mentioned by Heung et al. (2010). In the opinion of these authors, the medical needs that the patients have at the time lead to their search and selection of doctors, hospitals and destinations, as also indicated by the participants.

6.2.4 Identification of the pull factors of a medical tourism destination

Participants identified two themes related to pull factors: (i) healthcare provider-related, i.e. quality of medical facilities, affordability of healthcare costs at the destination, doctors’ expertise and quality of treatment; and (ii) destination related, i.e. geographic location, easy access to destination, and safety and security.

6.2.4.1 Healthcare provider pull factors

Healthcare provider pull factors are related to the healthcare service providers at the receiving destination, and these draw potential medical tourists to such destinations. According to Zarei and Maleki (2019), potential medical tourists are drawn towards healthcare providers in the receiving destination if these providers are perceived to offer affordable and personalised quality medical treatment or services. In this study, the participants frequently mentioned the following healthcare-provider pull factors in medical destinations: the quality of medical facilities at the destination, the perceived affordability of costs, and the expertise of the doctors at the destination. The quality of medical facilities relates to the facilities being accredited, having quality surgeons who can perform various procedures with expertise, and at a price perceived as affordable and better than where the medical tourists originate. Medical tourists not only take into
consideration the cost of medical treatment, they also consider the travel costs and other related expenses at the destination.

6.2.4.2 Destination-specific pull factors

Medical tourists take into consideration various external attributes at the medical tourism destination when embarking on such a journey. Destinations that are perceived to be safe, offering good quality healthcare, and welcoming to tourists, are likely to be given preference, as indicated by John and Larke (2016). In this study, the following destination-specific pull factors were identified: the geographic location, tourism facilities, accessibility to the destination, and safety and security at the destination. The participants pointed out that medical tourists usually consider the location of the destination and, where possible, would want to travel to a destination that is within their comfort zone, i.e. where they can travel to and from without incurring health-risks, especially after procedures. For example, the participants pointed out that for patients with life-threatening ailments or in need of complex procedures, the proximity of the destination and its facilities is very important as this will help reduce complications, e.g. blood clots as a result of lengthy air travel. The risks associated with receiving procedures in long-haul locations was also identified by Gan and Frederick (2018) and Gaines and Lee (2019). Although medical tourists usually travel to locations that are geographically closer to where they originate, nothing stops them from going to destinations which are further afield if they can obtain good quality treatments there, and they are comfortable to travel that far (Gaines & Lee, 2019). According to the participants, medical tourists also consider how they will access the medical destination, e.g. the availability, affordability and frequency of flights to the destination and whether the destination is politically and economically stable.

Medical tourists may also want to take advantage of the beauty of the destination by visiting attractions available there. Hence some patients combine their treatments with vacations, as also indicated in the study by Zolfagharian et al. (2018). In this regard, the participants emphasised that the tourism attributes at the destination are not necessarily important for patients who need complex lifesaving procedures and/or treatments. For such patients, the most important facility they need is a hospital with competent personnel who can give them the treatment that they need at the time. Accordingly, patients in need of minor cosmetic surgeries and dentistry treatments
may be interested in sightseeing and other tourism features in the destination. The significance of medical procedures taking precedence over tourism features was also highlighted by Ko (2011).

In conclusion, the role and value of healthcare provider and destination-specific attributes as important pull factors luring potential medical tourists to medical tourism destinations were also found in studies, e.g. by Collins et al. (2019) and Zolfagharian et al. (2018).

6.2.4.3 Sources of information for medical tourists
The most frequently mentioned sources of information as indicated in Table 5.7 were the internet, word of mouth, medical tourism tour operators and doctors’ referrals. The role played by the internet as a vital source of information for medical tourists has been raised by various authors, such as de la Hoz-Correa and Muñoz-Leiva (2019), Mogavvemi et al. (2017), and Rahman (2019). Prospective medical tourists are said to use the internet to search for a variety of information with regards to medical tourism destinations, i.e. the healthcare providers (including the staff and accreditation status) at the destinations, cost comparisons between countries for specific treatments, checking other patients’ testimonials, and the travel and accommodation options available in the destinations. In addition, the internet gives information seekers an opportunity to access a number of social media platforms such as Facebook and Instagram, where they will also be able to source further information on various topics, or follow certain healthcare providers to find the information they may need, as also highlighted in the study by Alghizzawi, Habes and Salloum (2020) in the marketing of Jordan as a medical tourism destination. The role of the internet as a source of information was likewise highlighted as applicable to potential medical tourists seeking treatment in South Africa.

It was not surprising to see medical tourism tour operators mentioned by some of the participants as sources of information. In many countries such as South Africa, the promotion and marketing of the destination as a medical tourism destination is the responsibility of the medical tourism tour operators. Medical tourism intermediaries (medical tourism tour operators), as indicated in the studies by da Silva et al. (2018) and Picazo and Moreno-Gil (2018), serve as a link between demand (push factors)
and supply (pull factors) for both local and international travellers. According to the participants, they provide various services, e.g. arranging medical treatment for patients, identifying suitable hospitals and doctors, arranging accommodation, and some even helping patients with their travel arrangements.

The participants indicated that patients would in addition to the above-mentioned sources of information, find information through word of mouth from various sources such as their relatives, friends and doctors. Word of mouth as a source of information for patients was also identified by Chan and Tay (2016), Crooks et al. (2010) and Johnston et al. (2012). Although the patient does not normally require a formal referral from their doctor or healthcare system, some participants in this study indicated that a formal referral was required in other destinations, such as in Kenya, before the patient can embark on medical travel. For such cases, proof is required that the treatment required is not available in the home country.

6.2.5 To determine if push-pull factors of a medical tourism destination differ based on the type of procedure offered at the destination

Before participants could answer whether the push-pull factors of a medical tourism destination differ based on the type of procedure offered at the destination, they first had to identify the procedures for which patients travel in order to receive at medical tourism destinations, and then identify which countries were well known for which procedures. The participants mentioned various procedures that are performed at medical tourism destinations, e.g. dentistry, cosmetic surgery, cardiac surgeries, in-vitro fertility and fertility treatments, weight-loss, dermatology, liver and kidney transplants and spine surgeries. The participants mentioned that most patients would have any of the above procedures for a variety of reasons. These include the lack of expertise at home for the procedures and/or to avoid the waiting lists, i.e. for major procedures such as cardiac surgeries.

Another reason provided for the popularity of the procedures was the affordability of the procedure at receiving destinations and that the procedures (e.g. cosmetic surgeries) may not be covered by healthcare insurance. All the procedures identified
by the participants in this study were also identified as the most frequently treated conditions by Dalen (2019). In addition to the treatments above, some of the participants also mentioned rehabilitation, wellness, traditional medicine and holistic treatments, as some of the treatments required by patients in medical destinations. The need for alternative treatments in medical destinations was also raised by Dangor et al. (2015) as being some of the treatments sought by Indian-South African patients in India.

For cosmetic surgeries the participants identified Poland, Thailand, Costa Rica, Brazil, the UK, South Korea, South Africa and Mexico. The reasons provided why these destinations were known for cosmetic surgeries ranged from the surgeries being affordable, to some destinations offering treatment plans. For example, South Korea was said to have invested a lot of money in developing its medical infrastructure and promoted Korean excellence through marketing the destination as a medical tourism destination of choice, as also highlighted by Junio et al. (2017). Hungary was identified as the dentistry capital of the world, while Brazil was identified for weight loss, liposuction and the Brazilian Butt Lift, also known as the BBL. Thailand, Poland and South Korea were also identified as leading cosmetic destinations by Griffiths and Mullock (2018) and Holliday, Bell, Jones, Hardy, Hunter, Probyn and Hunter (2015).

Some countries were said to be well known for various transplants, including heart surgeries, e.g. Israel, Thailand and Turkey. For example, Turkey is said to have invested a lot of money in developing its medical tourism industry and is also venturing into offering other treatments. For affordable dentistry and general dental treatments, Hungary, Germany, Costa Rica and Cuba were identified. Some countries were said to be specialists in all treatments, e.g. India, Malaysia and Indonesia. Israel was identified as a specialist in oncology and this was because they have invested in oncology research. Some of the top destinations identified by the participants are in top 30 medical destinations, according to the MTI (2020-2021) and Patients Beyond Borders (2019), with the exception of Mexico (rated 42nd) which is not in the top 30 destinations, and Malaysia, Indonesia and Cuba which are not rated in the MTI. The top destinations identified by the participants are also similar to the top 10 destinations identified in the commentary by Dalen (2019).
In terms of the procedures for which South Africa is known, it was encouraging to note that the participants who were familiar with the South African healthcare system indicated that this country was gaining a reputation as an IVF country, especially on the African continent. Another participant emphasised the need for the establishment of centres of excellence in South Africa, and she identified three centres of excellence in South Africa as The Headache Clinic, The Trauma Unit, and The Infertility Centre, all located at the Milpark Hospital. Milpark Hospital is one of the first private facilities in South Africa, and forms part of the Netcare group of hospitals. This hospital is currently one of only two private hospitals in South Africa to receive accreditation by the Trauma Society of South Africa (https://www.netcarehospitals.co.za/Hospital/Netcare-Milpark-Hospital).

Objective 4 of the study wanted to determine if the push and pull factors of a medical tourism destination differ based on the type of procedure offered at the destination. Some of the participants remarked that this was a complex question. After rephrasing the question, some participants mentioned that both factors were equally important, but more emphasis was on the procedures or treatments needed at the time than on the destination attributes at the destination or pull factors.

More participants agreed that push factors are more important than pull factors, but some participants disagreed and said that pull factors were more important. The participants who mentioned that push factors were more important than pull factors explained their argument from the perspective of the medical tourist being motivated by their need for medical treatment. Some of them reiterated the push factors that they had mentioned earlier and explained why it was important for a patient who needed medical treatment to be more concerned about getting treatment from surgeons who are experts in their field and in good quality medical facilities. Some participants indicated that without the medical need at the time, the patient would not be participating in medical tourism. Hence even if the patient would eventually want to explore what the medical tourism destination had to offer in terms of tourism activities, this would be done after the patient had had the procedure for which they had travelled to the destination. One of the participants further explained that it would be a mistake to think of medical tourists as being comprised of similar people with the same needs. His explanation was that if medical tourists are distinguished as such, it would
be far easier to understand how they are likely to select and consume medical tourism services. Thus, according to this participant and others in this category, patients who need less invasive procedures such as dental treatments, are likely to want to participate in tourism activities than those patients who need major surgeries, such as heart bypass or cancer treatments.

Some participants felt that both push and pull factors were equally important. The participants mentioned the role played by the medical need in their selection of a medical tourism destination. One participant remarked that the patient’s decision when selecting a medical tourism destination is determined by the medical need that is pushing them out of their home country or immediate location, while at the same time being pulled by the attribute at the destination that is likely to satisfy the medical need. For example, if the patient is pushed by the unaffordability of medical costs for a specific procedure at home, they are likely to be attracted by the prospects of affordable medical costs at the receiving destination.

One participant commented that the importance (or not) of the push and pull factors differs from person to person, and this may be dependent on the patients’ preferences. In his opinion, some patients may prefer certain destinations over others for diverse reasons. Thus, for some people both factors may be equally important. For others, push factors may be more important than pull factors, while for some, the pull factors may be more important than push factors.

In conclusion, based on what the majority of participants said in terms of which was important between the push and pull factors, it can therefore be concluded that the push factors are more important than the pull factors. Given that the patients will be pushed by the need for medical treatment (procedure) that they are unable to access at home) and simultaneously be pulled by the potential to access the procedure at the medical tourism destination, the push and pull factors in relation to procedure therefore have equal value. If the patient was able to access the treatment at home, the medical tourism destination would not be in the picture. In their decision-making, the patient evaluates various medical tourism destinations and selects the destination that is most likely to satisfy his/her medical need/s.
6.2.6 South Africa’s performance measured as a medical tourism destination in terms of its push-pull factors

The second part of this study aimed to measure South Africa’s performance as a medical tourism destination based on the push and pull factors identified above. With regards to this objective, the following will be discussed: the push and pull factors relating to South Africa as a medical tourism destination and South Africa’s performance in terms of these factors; the procedures that need to be introduced; as well as what South Africa can do to become a better medical tourism destination.

6.2.7 Push factors and South Africa’s performance

The international participants indicated that they were not familiar with the medical tourism industry in South Africa, but still made their input. All the African (South Africans included) participants were familiar with both the South African healthcare system and the medical tourism industry. The participants’ responses were grouped into two themes, i.e. cost/affordability and procedure-related push factors.

6.2.7.1 Push factors related to procedures and treatments

Most participants identified the lack of expertise and treatments at home as a push factor for patients to come to South Africa for treatment; lack of expertise leads to the lack of treatments. According to the African participants (including South African), most of the patients from the African continent would visit South Africa because of the lack or shortage of specialists, e.g. neurosurgeons, in their own countries. The participants indicated that most specialists have left countries such as Kenya, Nigeria and Ghana, in search for better opportunities in countries such as Botswana, the UK and the US. According to the participants, patients from developed countries can come to South Africa to access treatments which they are unable to access at home for various reasons, e.g. because of the waiting list before accessing the treatment, which at times can be up to two months. Waiting lists restrict patients’ access to medical treatments and at times can lead to patients losing their lives due to not receiving life-saving treatments, such as cancer treatment (as indicated by one of the participants) timeously. According to Zolfagharian et al. (2018), faced with such restrictions,
patients will opt (be pushed) to seek medical treatment where they will be able to access it faster than at home, such as in South Africa where patients are not likely to be put on a waiting list.

Some participants mentioned the lack of medical facilities in the patients' countries as the push factor to seek medical treatment in South Africa. Lack of medical facilities is typical of developing countries as most countries on the African continent are in his situation. These countries usually make healthcare agreements with other developing countries with better healthcare systems so that patients from poorer countries can have access to healthcare. One of the participants mentioned the existence of healthcare agreements between South Africa and many countries on the continent. Patients from countries that have healthcare agreements with South Africa are thus pushed to seek medical treatments by such agreements, and these also enable them to access medical care from both public and the private hospitals. The existence of healthcare agreements between South Africa and its neighbouring countries and the role that these agreements have in ensuring access to healthcare by patients from these countries was also highlighted by Chikanda and Crush (2019).

The need for privacy was also raised as another push factor to South Africa. According to Zolfagharian et al. (2018), getting medical treatment at home is usually accompanied by a great deal of information sharing. As a result, patients concerned about the privacy of their treatment opt to have the treatment at a location where they are not known. According to Horowitz and Rosensweig (2007) and Ko (2011), patients usually prioritise privacy for procedures such as cosmetic surgeries, gender reassignment and drug addiction therapy. The participant in this study indicated that high profile patients, such as members of parliament, would opt to go to South Africa for privacy when having any treatment, because if they were to have the treatment locally, many people would know about it. The need for privacy when receiving treatment at medical tourism destinations was also indicated by Chia and Liao (2020), Haarhof and Mokoena (2016), and Abd Mutalib et al. (2017).

6.2.7.2 Push factors related to affordability and cost
The participants identified unaffordable medical costs in the patients’ home countries as a push factor for patients to seek medical treatment in South Africa. This is typical
of patients from developed countries such as the UK and the US. Although these countries have good quality healthcare systems, and many people from such countries may have healthcare insurance, most procedures sought by patients in medical tourism destinations are not covered by insurance, e.g. dental treatments and IVF. Faced with a need for medical treatment which is not covered by healthcare insurance, they have to decide whether to pay huge amounts for treatment at home or seek an alternative destination where they will be able to receive the treatment at an affordable price without compromising the treatment quality. Thus, according to the participants, patients from Europe and America can have various procedures, such as cosmetic surgeries, in South Africa at an affordable price. Affordable medical costs in South Africa is therefore a push factor for patients faced with expensive medical costs in their home countries. The affordability of medical costs for patients from the developed countries was also raised by Matiza & Slabbert (2020) who indicated that the ranking of South Africa as a top 20 medical tourism destination by the Forbes Africa report was attributed to the potential for these patients to save between 25% and 40% on medical treatment.

6.2.8 South Africa’s performance

When asked to rate the performance of South Africa in terms of the push factors they mentioned, some participants indicated that they were not aware of and/or did not know much about the existence of medical tourism in South Africa. As a result, it was not possible for these participants to rate South Africa as they felt that they had no basis to give a rating.

Those participants who were knowledgeable about South Africa’s healthcare system and the medical tourism industry gave diverse ratings. It was interesting to note that even if South Africa was rated as performing at the higher end or very high, the rating was given in comparison to India in terms of the cost of medical treatment. The emphasis was that given a choice between South Africa and India, patients were very likely to choose, i.e. prefer to go to, India. Even when the participants mentioned the high quality of facilities available in South Africa, the major issue highlighted was the high cost of medical treatment in this country. The availability of quality medical
treatments with highly skilled medical professionals at an affordable price in India were also raised in the study by Jain and Ajmera (2018) The high cost in South Africa in comparison with India and the likelihood for African patients to go to India for treatments as a result, was also highlighted by Dangor et al. (2015). The participants also indicated that South Africa was doing well, in spite of the cost competition with India, but it was not performing higher than destinations such as Singapore and the USA. Based on the quality of medical facilities and services, the participants thus ranked South Africa high. Recent medical tourism rankings rated South Africa very well, e.g. in terms of cost-saving potential, South Africa was ranked among the top 20 destinations (Forbes Africa report in Matiza & Slabbert, 2020:338). South Africa also ranked very well on the MTI 2020-2021 global ranking, which ranked the country 22nd out of 46 destinations.

Some participants said that South Africa rated very low globally and this was attributed to how South Africa is perceived overseas, for instance, that South Africa is perceived as an unsafe destination. Safety and security issues in medical tourism destinations is not unique to South Africa; medical tourists remain vulnerable to crime in medical destinations is also indicated in studies by Gan and Frederick (2018) and Khan et al. (2017). South Africa’s relationship with its neighbouring countries and the issues of xenophobia were raised by the participants as deterrents for visiting this country. The perception held by international travellers with regard to safety and security in South Africa has also been raised as a challenge and deterrent for the growth of the tourism industry in South Africa in a survey of 18 countries conducted by South African Tourism (SAT) (Smith in Fin24, 24 November 2019).

The other reason for the low rating was the lack of transparency in terms of the tracking of the treatment quality. For these participants, not only does the absence of the proof of treatment quality in South Africa make it difficult to compare it with other medical destinations, it also makes it impossible to do so. The South African Lancet National Commission report (2019) recommended the need for the development of a healthcare information system in South Africa to ensure that reliable health information (quality treatment data) was collected in a timely and harmonised manner, i.e. without compromising the patients’ confidentiality.
6.2.9 Pull factors and South Africa’s performance

Medical tourists are attracted to medical destinations that have quality medical resources and facilities, and also have medical professionals who will be able to provide quality medical treatments. The participants identified the following two themes of pull factors to South Africa: destination-related pull factors and healthcare-provider pull factors.

6.2.9.1 Healthcare-provider pull factors
The majority of participants indicated that South Africa has quality medical facilities that meet international standards, both in the public and private sectors. The participants also pointed out that South African medical facilities have skilled surgeons able to offer a variety of procedures for their patients. Although medical tourism in South Africa mainly takes place in private sector facilities, medical tourists are also able to access medical treatment from public sector facilities (Chikanda & Crush, 2019; Ormond & Sulianti, 2017). One of the participants also indicated that the South African healthcare system is innovative and uses advanced medical technologies in various private hospitals. The availability of state-of-the-art medical technologies in the healthcare system can ensure that South Africa is able to attract potential medical tourists, especially from the developed countries where such technologies are a norm. According to Iajevardi (in Matiza & Slabbert, 2020) and Ormond and Kaspar (2018), the availability of advanced medical technologies in the healthcare system will also ensure that South Africa is able to compete, and even collaborate, on an equal footing with the best facilities in the world.

Participants identified the doctors’ expertise and the quality of treatments as another pull factor. South African medical professionals are well trained, highly reputable and experienced in various specialities, and therefore patients who come for medical procedures in South Africa will be provided with good quality care (Chikanda & Crush, 2019; Mudzanani, 2016). To ensure good quality medical treatment, it is compulsory for South African medical doctors and other medical professionals to be registered and maintain registration with the HPCSA, which regulates the education, training and registration for practising of health professions in the country. Medical professionals
are also required to attend professional development courses to continuously learn and improve their skills. The expertise of medical professionals as a pull factor to South Africa was also identified by Mudzanani (2016) and Haarhoff and Mokoena (2016).

Given that the participants had already mentioned that medical treatment in South Africa is expensive, it was not surprising that cost of treatment was featuring low. The three participants who mentioned cost of treatment were emphatic that medical treatment was not cheap in South Africa, especially for patients originating from the continent. Their emphasis was that medical treatment is only affordable if the patient is from Europe or the USA. The cost of medical treatment as a deterrent to having medical treatment in South Africa was also raised in studies by Dangor et al. (2015) and Ezeuduji (2013: 7).

6.2.9.2 Destination-related pull factors
Participants mentioned that South Africa had beautiful features that had an appealing effect on tourists. South Africa’s beautiful features were also identified by Henama (2014). Despite this factor, some participants pointed out that medical tourists do not necessarily prioritise the destination because they tend to be focused on their treatments and the results thereof, the doctors’ expertise, and the quality of medical facilities. The destination features and their proximity are said to be considered last. Where the participants mentioned the tourism activities available in South Africa, this was qualified with an explanation relating to the patients having had minor cosmetic surgeries. Because the participants had already mentioned that South Africa’s geographical location was unfavourable, it was expected that the country’s proximity would feature very low as a pull factor. The importance that potential medical tourists place on the quality of medical facilities and services over the destination was also highlighted by Zarei and Maleki (2019). Although English is widely spoken in South Africa, as highlighted by Bacus (2010) and MTSA (2014), this did not seem to have a strong pulling effect.

6.2.10 South Africa’s performance

With regards to measuring South Africa’s performance as a medical tourism destination based on the pull factors identified above, most participants were not
familiar with the existence of medical tourism in South Africa. It was therefore impossible for them to give a rating on South Africa's performance in terms of the pull factors above.

Those who were familiar rated South Africa in terms of its medical facilities. The ratings ranged between very low and very high, or at number 1. Those who rated it low indicated that medical tourism was not actively promoted, and thus even if there were good medical facilities, a lot of patients would not be aware of these.

Those who ranked South Africa high, were quick to point out that South Africa ranked high or is top of the continent in terms of its medical facilities, ahead of Tunisia, but patients from the continent preferred India to South Africa.

6.2.11 Procedures that should be introduced in the South African medical tourism industry

With regards to the procedures that needed to be introduced in South Africa, one of the participants indicated that this would be dependent on what South Africa is currently doing well in healthcare. Various suggestions were made such as dentistry, cosmetic surgeries, oncology, cardiology, orthopaedic, fertility treatments, renal dialysis and neurology.

6.2.12 What would discourage potential medical tourists from choosing South Africa as a medical tourism destination?

In terms of what would discourage prospective medical tourists from choosing South Africa as a medical tourism destination, the participants highlighted that South Africa was expensive, both medical treatments and travelling to South Africa, as indicated in Table 5.6. The participants indicated that the geographical location of South Africa, in terms of its distance from many destinations globally, worked against the country. The argument was that it could be because of the distance of the country that many people do not really know that they can travel to it for medical tourism, or that if patients knew about South Africa as a medical tourism destination, they were not willing to travel so
far for treatment. Not only does a destination’s geographical location have cost implications, as this means that travellers will have to spend more to access the destination because of the distance, but long-haul destinations also have healthcare implications for patients who had procedures. The distance issue for travelling to South Africa, as with many other long-haul destinations, was highlighted as having the potential to put patients at the risk of developing blood clots after surgery. This is one of the risk factors identified in studies by various authors such as Gaines and Lee (2019), Kumar and Hussain (2016) and Leggat (2015).

In addition to the country considered being distant, the participants also indicated that there was a lack of frequent flights to South Africa, and this in turn had an impact on the patients’ capability to access the destination. India’s popularity in terms of the availability and frequency of flights was also highlighted in this regard. A comprehensive list of direct flights from various destinations is provided on the Health-tourism.com website (https://www.health-tourism.com/medical-tourism-south-africa/). Some medical tourism tour operators in South Africa, such as MTSA, also list destinations where patients can get direct flights to South Africa. This indicates the role of medical tourism tour operators as important information sources as some of them are able to make flight bookings for potential medical tourists on request.

The participants raised the lengthy visa application process as another deterrent to visit South Africa for treatment. The participants highlighted that patients may not necessarily have the time to wait or to go through the processes, and therefore they are very likely to consider another destination where the processes are quicker or less cumbersome. Although it is a requirement for visitors to have a valid passport to visit South Africa, the country has visa-free agreements with many countries, especially if the visitors are visiting for less than 90 days. The names of visa-exempted countries are available on the Department of Home Affairs website: http://www.dha.gov.za/index.php/immigration-services/types-of-visas. For example, many countries from the African continent are on the visa-free list, thus most medical tourists from the region only use their passports to visit South Africa and access medical treatments, especially basic healthcare treatment as South Africa has healthcare agreements with some countries from the continent (Chikanda & Crush, 2019). It may be a requirement for patients who visit South Africa to have a medical
visa as indicated on the Department of Home Affairs website, but most patients, especially those from the continent, do not indicate medical treatment as the reason for their visit to South Africa, even if they do access treatment (Chikanda & Crush, 2019). Perhaps the inconsistencies relating to the use of medical visas in South Africa to access medical treatments may be contributing to the inaccuracies in terms of the medical tourists’ data collection in South Africa. Nevertheless, the frustration expressed by the participants in relation to the application process makes it understandable why patients, especially those from visa-exempted countries, simply use their passports to visit and get treatment in South Africa.

6.2.13 What South Africa can do to be more attractive to prospective medical tourists

The lack of knowledge about South Africa as a medical tourism destination became very clear when the participants were asked what South Africa could do to be a more attractive medical tourism destination. The participants, including those who were aware of the South African healthcare system and medical tourism, were unanimous in expressing the need for the country to actively promote and market itself and its medical services as a brand on as many platforms as possible. The participants also mentioned that the government needed to be more involved in the promotion of South Africa as a medical tourism destination. Chikanda and Crush (2019) also identified the need to promote South Africa as a medical tourism destination for the South African medical tourism industry to grow.

The major problem highlighted was the cost of medical treatment and costs of travelling to South Africa. The participants indicated that when patients came to South Africa for treatment, they were frustrated with the pricing model here. Patients would usually have to deal with various invoices from different service providers. The patients preferred India because when they go to India, they know beforehand how much they will be paying because in India healthcare providers are able to provide potential patients with estimations for their treatments. The medical cost issue in South Africa and the patients’ likelihood of choosing India instead of South Africa was also identified as a problem by Dangor et al. (2015) and Jain and Ajmera (2018). To resolve this, the
participants indicated that South Africa should consider reducing its medical costs and/or streamline them. The cost issue also related to travelling to South Africa, which was also said to be costly at times. The lack of regular or frequent flights from other destinations was also seen as a hindrance for potential tourists who may want to come to South Africa. The participants also mentioned the need for the introduction of a medical visa in South Africa. The medical visa would also help to coordinate data and accurate recording of the actual number of medical tourists who visited South Africa at a certain time.

Given that health tourism markets are regional and segmented in nature, the participants highlighted the need for South Africa to match its healthcare services to prospective consumers. This would be possible if proper education and research was done around medical tourism. The participants also indicated that South Africa needed to prioritise medical tourism, including domestic medical tourism as there was a market for both. The need for education around medical tourism was also indicated as something that should happen between doctors and medical tourism tour operators, so that both could better serve the medical tourists.

The other comment, closely related to the above, was that South Africa needed to establish regional centres of excellence in healthcare, or consider opening flagship hospitals, or mission hospitals, in the region or in neighbouring countries. Such hospitals, according to the participants, could serve as catalysts for accessing and providing treatment in South Africa. The participants also indicated that the country should build or mend its relationship with neighbouring countries on the continent so that it could become a destination of choice in the region for all Africans. The media reports on violence and xenophobic attacks on fellow Africa nationals were damaging the country’s image both on the continent and globally.

The participants mentioned the need for South Africa to be transparent with the data on the quality of treatments offered, so that potential patients could use these to make informed decisions about treatments based on facts. The participants emphasised the importance of customer experiences and a need to establish and maintain a balance between hospitals and hospitality service providers in South Africa. The participants
emphasised that South African service providers needed to be available and accessible to patients.

6.3 PUSH-PULL FRAMEWORK FOR MEDICAL TOURISM DESTINATIONS INCLUDING ROLE OF PROCEDURES IN DETERMINING THE FACTORS

In chapter 3 a conceptual framework was developed based on the literature (Figure 3.3) portraying the push-pull factors and procedures for any medical tourism destination. The conceptual framework depicts the relationships that exist between these factors that attract a tourist to a medical tourism destination. This framework was tested in the empirical phase, and based on the findings the tested framework is presented in Figure 6.1. The double-ends for the arrows used in Figure 6.1 illustrate the interrelationships between the push and the pull factors, and how the procedures that potential medical tourists may need at the time influence the relationship between these factors. The participants also indicated that medical tourism push factors were more important than the pull factors. The procedures shown in Figure 6.1 were identified by the participants as typical procedures sought by medical tourists in medical tourism destinations across the globe.
Figure 6.1: Push-pull framework for any medical tourism destination including the role of procedures in determining the factors

Based on the findings, a framework was also developed for South Africa. Even though participants were not asked whether the push and pull factors of South Africa differ based on the type of procedure offered in South Africa, they did identify the procedures that South Africa is well known for, and these are depicted in figure 6.2 below. The
use of double-ended arrows indicates the interrelationship between the push and pull factors; the procedures (sought) and the push factors; as well as the procedures (to be accessed) and the pull factors. Patients will be pushed by the demand (for treatments/procedures from their own countries), and they will be pulled by the availability of these treatments in South Africa.
6.4 MANAGERIAL IMPLICATIONS OF THE STUDY

This study highlights the need for medical tourism stakeholders in South Africa to market its healthcare excellence to the world. Currently, there exists a perceived lack of involvement and interest from government in promoting South Africa as a medical tourism destination.
tourism destination (Chikanda & Crush, 2019), and the efforts of medical tourism tour operators seem to be in vain. The governments of successful medical tourism destinations, e.g. India, Malaysia and Thailand as indicated in the study by Mogavvemi et al. (2017:155-156), have invested in and are supportive of promoting their destinations as medical tourism destinations. Not only are these governments actively involved in the promotion of their countries as medical tourism destinations, they are also giving incentives to hospitals and intermediaries to actively promote themselves and their customer service standards, to develop or improve their facilities, and to acquire international accreditation, while at the same time promoting the countries as medical tourism destinations (Moghavvemi et al., 2017).

In addition to African patients, South Africa also attracts patients from Europe and the US, and these patients are known to have access to good quality healthcare systems in their countries. According to Abd Mutalib et al. (2017), medical tourists associate internationally accredited hospitals with good quality treatments, and patients are likely to check whether the hospital that they are considering for medical treatment is internationally accredited with accreditation bodies such as the JCI. It is likely that hospitals that are internationally accredited would be preferred above those that are not. Currently, no hospital in South Africa is on the JCI list. The South African government could consider assisting some medical facilities, such as academic hospitals to qualify for international accreditation with bodies such as the JCI. Not only would international accreditation boost medical tourism, it will also create awareness of South Africa’s medical excellence.

South Africa’s geographic location is unfavourable for patients beyond the continent, especially if they are seeking major procedures as the long distance is likely to expose these patients to health risks. The distance to South Africa for most African patients is very convenient, regardless of the procedure they might want. Currently, the destination of choice for African patients seems to be India. Although South Africa is a leading medical destination on the continent, this study has highlighted that given a choice, African patients will choose India over South Africa. The participants pointed out that besides the fact that medical costs are affordable in India, Indian doctors have actively promoted Indian medical excellence in various African countries, such as Nigeria, Kenya, and Uganda, and this is paying off, and as such India is one of the top
destinations (Patients Beyond Borders, 2019). Indian hospitals are said to have international patients’ desks strategically placed in various national or federal hospitals in countries such as Kenya or Nigeria, and the purpose of these desks is to link patients to Indian hospitals. As a result, South Africa should also find innovative ways to promote itself as a medical tourism destination to the continent so that it can become the medical tourism destination of choice for patients from the continent.

It has already been mentioned that there is little or no awareness with regards to South Africa as a medical tourism destination. One way of overcoming this ignorance could be through attending or presenting at medical tourism conferences. Such conferences help create awareness and perhaps hospital groups could use them to raise awareness of their facilities, expertise, procedures offered, pricing models, and at the same time promote South Africa as a medical tourism destination. Hospital groups could also send delegates, or sponsor medical tourism tour operators, to medical tourism conferences to present papers, hold exhibitions demonstrating their excellence, or simply to listen and learn from other delegates. The participants also indicated that there is a need for an improved working relationship between medical tourism operators and healthcare providers in the country. Given the role played by medical tourism intermediaries as a connection between medical tourists and healthcare providers, a stronger working relationship would ensure that tour operators actively promote the expertise and procedures offered by the healthcare providers and this would in turn promote South Africa. Medical tourism tour operators can also help promote medical tourism by attending, presenting or holding exhibitions at international medical tourism conferences.

The findings also show a need for the South African government to provide a healthcare information system where they are transparent regarding the quality of treatment data; without compromising patients’ confidentiality. According to the South African Lancet National Commission (2019), the existence of a healthcare information system would ensure the collection of credible healthcare information relating to the quality of the healthcare provided in South Africa. Discretion should be used to determine which information becomes publicly available so that it is accessible online to potential patients, both locally and globally. Both local and international patients need credible data with regards to the quality of treatments offered in both public and
private healthcare sectors in South Africa, so that they can make informed healthcare-related decisions.

The findings of this study, especially as indicated in Table 5.6 regarding what would discourage potential medical tourists from choosing South Africa as a medical tourism destination, should be seriously considered. South Africa needs to address the various issues raised, such as being transparent with regard to our medical costs. If costs can be streamlined, maybe the perception that medical treatment is expensive in South Africa can be addressed. Given that medical tourists will have to travel to South Africa for treatment, they are likely to want to know beforehand how much they will need for the treatment, and other related costs, so that they can budget properly. Perhaps South African hospitals and the physicians offering treatments to medical tourists should consider providing these patients with quotations indicating the potential estimated cost of treatment for the specific procedures that the patient may be considering to have at the facilities. On receipt of the quotation, the patients could also request additional estimates of extra costs which may arise due to complications during surgery or additional tests that may be required.

The other issue raised was the lengthy visa application process. According to the Department of Home Affairs, Immigration services (Department of Home Affairs, 2020), South Africa does have a medical visa and perhaps the processing of the medical visa could be prioritised, especially if the patients have provided all the necessary documents required. The issuing of medical visas to medical tourists will also benefit the data collection agencies such as Statistics SA (as they will have accurate data relating to the tourist’s purpose of visit), and the Department of Health as the custodian of healthcare in South Africa.

South Africa also needs to mend its relationships on the continent. The South African government needs to deal decisively with the perceived xenophobia expressed towards foreigners, and the general perception that South Africa is unsafe for tourists. Safety and security was raised as a challenge and deterrent for the growth of the tourism industry in South Africa in a survey of 18 countries conducted by the South African Tourism (SAT) as indicated by Smith (in Fin24, 24 November 2019). Patients are very apprehensive about visiting destinations perceived as unsafe; hence the
South African Police Services and the Department of Tourism must make every effort to ensure the safety of all tourists who visit South Africa.

6.5 LIMITATIONS OF THE STUDY

The following limitations apply to this study.

6.5.1 Reluctance to participate

Although 78 invitations were sent to potential medical tourism tour operators, only 13 agreed to participate. Follow-ups were made by email and SMS in an effort to persuade medical tourism tour operators to participate, but this was unsuccessful.

6.5.2 Target population

Medical tourism tour operators were used as the target population in this study because of their direct involvement between the medical tourists and healthcare providers in medical tourism destinations. According to Ferrario (1979), the best way to establish the tourists’ market preferences is to ask them. Unfortunately, this was not possible due to the researcher’s need to observe the patients’ privacy protocols necessary when conducting research with patients, given that most medical tourists participate in medical tourism for privacy and confidentiality. Furthermore, the advent of the Covid-19 pandemic would have made it difficult to access patients as the country and the world was on lockdown when the researcher began with data collection.

6.5.3 Qualitative research design and criterion sampling method

The qualitative research design and criterion sampling method used in this research meant that the findings could not be generalised to reflect the entire target population. Although the sample size and sampling method is appropriate and sufficient for qualitative research, with data saturation being reached for the sample selected, a generalisation reflecting the entire target population is not possible.
6.5.4 Covid-19 pandemic

The outbreak of the Coronavirus, also known as Covid-19 led to many countries globally implementing strict lockdown restrictions that led to many institutions and organizations closing, some even closing abruptly. It is likely that the poor response rate for the potential participants who were contacted to participate in this study could be attributed to the lockdown restrictions, as many people were inaccessible during lockdown. Due to the restrictions, it was also impossible to have face to face interaction with the participants.

6.6. ACADEMIC AND INDUSTRY CONTRIBUTIONS TO THE STUDY

This study contributed to the body of knowledge available on the push and pull factors of medical tourism destinations from the medical tourism tour operators’ perspectives, and measured South Africa as a medical tourism destination against these factors. This study has demonstrated that medical tour operators are knowledgeable about destinations and service providers, and serve as a link between patients and healthcare providers and/or destinations. The study contributes to the available literature by determining that the push and pull factors differ based on the procedures or treatments that are sought by medical tourists in medical tourism destinations. The identification of the push and pull factors that draw medical tourists to South Africa should assist medical tourism tour operators to develop packages that will be more attractive to prospective medical tourists. Having knowledge on the push and pull factors will also help to market and promote South Africa as a medical tourism destination in order to attract more medical tourists to South Africa.

6.7 RECOMMENDATIONS FOR FUTURE RESEARCH

Given that this study was qualitative, quantitative research from the perspectives of medical tourists as consumers of medical tourism, is necessary to determine whether medical tourism push and pull factors differ based on the procedures offered in medical tourism destinations.
Numerous developing countries benefit from medical tourism because many patients from developed countries are weary of the high medical costs in their own countries. Although South Africa is regarded as a top medical tourism destination, this study has highlighted that many patients from the continent prefer travelling to India for medical treatments. South Africa needs to increase its footprint in Africa so that it can become a medical tourism destination of choice for African patients. More effort is required to promote South African medical excellence on the continent, and this cannot be the work of medical tourism tour operators alone. Research is needed to establish whether the reluctance of the South African government to support medical tourism is justified or reasonable, and perhaps from this study a way forward can be found to resolve the impasse. Lastly, it is recommended that further research with a larger sample than in the current study, with face to face interaction with the participants be conducted.

6.8 CONCLUSION

Chapter 6 concludes this study, which was undertaken to identify the push and pull factors of a medical tourism destination, and based on these, to measure South Africa’s performance as a medical tourism destination. The findings should be evaluated, taking into consideration the limitations and scope of the study. All the objectives of the study were successfully achieved and the research problem addressed. First, the study identified various push factors of a medical tourism destination, and these were categorised as: healthcare needs of tourists; procedure-related push factors; travel-related push factors; and cost/affordability.

Second, the findings revealed two major categories of pull factors for a medical tourism destination, i.e. destination-specific pull factors, and healthcare-related pull factors.

Third, the findings confirmed that the push and pull factors of a destination differ, based on the type of procedure offered at the destination, and when deciding on a destination, tourists find the push factors to be more important than the pull factors.

Fourth, the study measured South Africa’s performance as a medical tourism destination, and found mixed views. While some reports show South Africa to be a top
medical tourism destination, not all participants agreed, and highlighted a lack of awareness on medical tourism in South Africa as contributing to their views.

Finally, this study contributes to the literature available on the push and pull factors of medical tourism destinations, how these factors differ based on the procedures sought at these destinations, and also measures South Africa as a medical tourism destination against these factors.
7. LIST OF REFERENCES


Adwan, A.Al. 2020. The impact of motivation factors and intention to adopt Jordan as a destination for medical tourism in the Middle East. *Innovative Marketing*, 16(2):146-158.


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APPENDIX A
Ethical Clearance
RESEARCH ETHICS COMMITTEE

Faculty of Economic and Management Sciences

Approval Certificate

14 February 2020

Miss CCL Ngobeni
Department: Marketing Management

Dear Miss CCL Ngobeni

The application for ethical clearance for the research project described below served before this committee on:

<table>
<thead>
<tr>
<th>Protocol No.</th>
<th>EMS197/19</th>
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<tr>
<td>Principal researcher</td>
<td>Miss CCL Ngobeni</td>
</tr>
<tr>
<td>Research title</td>
<td>Identifying the factors that determine a medical tourism destination’s attractiveness</td>
</tr>
<tr>
<td>Student/Staff No.</td>
<td>87251688</td>
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<tr>
<td>Degree</td>
<td>Masters</td>
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<tr>
<td>Supervisor/Promoter</td>
<td>Prof A Douglas</td>
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<td>Department</td>
<td>Marketing Management</td>
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The decision by the committee is reflected below:

<table>
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<th>Decision:</th>
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<td>Period of approval</td>
<td>2020-02-28 - 2020-08-31</td>
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The approval is subject to the researcher abiding by the principles and parameters set out in the application and research proposal in the actual execution of the research. The approval does not imply that the researcher is relieved of any accountability in terms of the Codes of Research Ethics of the University of Pretoria if action is taken beyond the approved proposal. If during the course of the research it becomes apparent that the nature and/or extent of the research deviates significantly from the original proposal, a new application for ethics clearance must be submitted for review.

We wish you success with the project.

Sincerely,

[Signature]

pp PROF JA NEL
CHAIR: COMMITTEE FOR RESEARCH ETHICS
APPENDIX B

Consent Form
Dear Participant

You are invited to participate in an academic research study conducted by the University of Pretoria. The purpose of this study is to identify the push and pull factors that motivate a tourist to visit a medical tourism destination, and based on these factors, to measure South Africa's performance as a medical tourism destination.

Please note the following:
- This is an anonymous interview as your name will not appear on the interview. The answers you give will be treated as strictly confidential as you cannot be identified in person based on the answers you give.
- Your participation in this study is very important to us. You may, however, choose not to participate and you may also stop participating at any time without any negative consequences.
- Please answer the questions posed during the interview as completely and honestly as possible. This should not take more than 30 minutes of your time.
- The results of the study will be used for academic purposes only and may be published in an academic journal. We will provide you with a summary of our findings on request.
- Please contact the researcher above if you have any questions or comments regarding the study.

Please sign the form to indicate that:
- You have read and understand the information provided above.
- You give your consent to participate in the study on a voluntary basis.
- You have been given an opportunity to ask questions.

Participant's signature

Date
APPENDIX C
- Semi-structured Interview Schedule
IDENTIFYING THE PUSH AND PULL FACTORS OF A MEDICAL TOURISM DESTINATION

IN-DEPTH INTERVIEW SCHEDULE

Thank you for agreeing to participate in this interview.

SECTION A: MEDICAL TRAVEL MOTIVATIONS (PUSH FACTORS)

1. In your opinion, what will motivate a patient/medical tourist to opt to seek medical treatment or procedure in another country instead of their own?

2. In your opinion, what will motivate (push) a patient/medical tourist to seek medical treatment/procedure in South Africa?

3. Rate South Africa’s performance on the push factors you've mentioned above

4. What will discourage (not motivate) a prospective medical tourist from choosing South Africa as a potential medical tourism destination?

5. What or who are the medical tourists’ (or potential medical tourists’) source/s of information regarding getting medical treatment in another country instead of their own

6. What are the medical tourists’ (or potential medical tourists’) source of information regarding getting medical treatment in South Africa?

SECTION B: MEDICAL TOURISM DESTINATIONS CHARACTERISTICS (PULL FACTORS)

1. Which physical attributes or characteristics in a medical tourism destination will influence or pull potential medical tourists towards the specific destination?
2. Which physical attributes or characteristics will influence or pull potential medical tourists towards South Africa as a medical tourism destination?

3. Rate South Africa’s performance on the pull factors you’ve mentioned above.

4. What can South Africa do to be more attractive to prospective medical tourists?

5. In your opinion, which countries or destinations are the top or most popular medical tourism destinations?

SECTION C: MEDICAL TREATMENTS AND PROCEDURES

1. Are there specific destinations that are well-known for specific procedures? What contributes to this popularity?

2. Is South Africa known for specific treatments? Are there any reasons why we are known for these treatments?

3. In the previous sections, you have mentioned various push and pull factors (travel motivations and physical attributes or characteristics) that influence medical tourists to select a medical tourism destination. In your opinion, do these push and pull factors differ based on the procedure that a tourist wants to undertake? In other words, do some of these factors become more or less important based on the procedure OR are all factors equally important regardless of procedure?

4. In your opinion, which other treatments/procedures should be introduced in the South African medical tourism industry to make the industry more attractive to prospective medical tourists?
SECTION D: TOUR OPERATOR PROFILE

1. How long have you been operating as a medical tour operator/company?

2. In your opinion, how would you profile or what is the profile of the medical tourists’ visiting South Africa?

3. What other medical tourism destinations do you offer to medical tourists?

4. Which procedures/treatments do you specialize in?

5. Which other services do you offer to medical tourists?

6. Any other comments about medical tourism in South Africa?

7. Lastly, do you have any other medical tourism companies/tour operators that you can recommend to participate in this study?

Thank you very much for agreeing to participate in this important study.
APPENDIX D
Editor’s Certificate
This Certificate serves to confirm that

Dr E. M. Murray, DLitt et Phil (English) University of Johannesburg
MA English Unisa (cum laude)
Editing Principles and Practices, University of Pretoria (cum laude)
Freelance editor
jane@jvmtb.co.za

Judiciously edited a master’s dissertation titled:
Identifying the Push and Pull Factors of a Medical Tourism Destination

Issued without prejudice to

CLARA CLAIRE LOBISA NGOBENI

On this day
30 September 2020