Surgeon and Safari: Producing Valuable Bodies in Johannesburg

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> Clients who really do their homework . . . are looking for value for money, but they . . . are not prepared to compromise in terms of quality. Those are the kind of Americans that we'll get. The Americans that are purely looking for value for money, they won't come here. [They'll] go to India, they'll go to Costa Rica. Not to say that they're . . . getting an inferior-quality product there, but that's what they'll do—they're purely shopping on price.
> —Lorraine Melvill (interview, January 9, 2008, Bryanston, Johannesburg)

Lorraine Melvill, the founder and owner of Surgeon and Safari, a Johannesburg-based cosmetic surgery tourism company, made this statement as we sat in her office, which is attached to the guest cottages on her property where many of Surgeon and Safari's clients stay.[1] Throughout my time observing Surgeon and Safari's practices, Melvill consistently emphasized to me and to clients that "value for money" should not be the sole determining factor in one's choice of destination for surgery.

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[1] This essay is based on fieldwork conducted with Surgeon and Safari during January 2008. All names of clients are pseudonyms. All interviews were conducted by me in English, and transcripts are on file with me. To carry out this work, I inserted myself into the tourism circuit established by Surgeon and Safari, working exclusively with that company, and was treated in ways very similar to a client: tourist trips were arranged for me, and I even had a small (unplanned) surgical procedure performed on me by one of the surgeons affiliated with Surgeon and Safari. By aligning myself so closely with one institution, I employed a method that on the one hand provided a rich experience of tourism and the discourses constructed by Surgeon and Safari but that on the other hand deeply implicated me within this particular tourism circuit, both economically and personally.

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Value for money is a term that links quality and price in a cost-benefit analysis and attempts to negotiate relationships between locales for surgery in these terms. But by understanding her clients as those who are concerned more with quality than with price, attributing to them a degree of discernment and distinction over other consumers, she portrays Surgeon and Safari as offering an experience not only of luxurious surroundings but also of intimate care and attention to clients' bodies. The notion of quality as that which is in excess of price contains within it implicit assumptions about risk to the body. Because cosmetic surgeries, and all surgery, involve an element of risk, basing one's decision about where to have a procedure done solely on the basis of cost represents a risk to the body and even to one's life. Surgeon and Safari offers quality, defined through a complex of factors including surgical skill, surgeon's personality, follow-up care, modern and private medical facilities, and the caring labor of Rebecca, a domestic worker, and Melvill in Melvill's home in Bryanston. Still, services offered by Surgeon and Safari end up being less expensive than the procedures clients would be able to obtain on the medical market in the United States or the United Kingdom, from which most clients hail.[2] Value for money, then, signals the possibility of consuming a certain kind of care (as well as obtaining surgery in the first place) that would not be affordable at home.[3]

On the one hand, Melvill's advice against shopping solely on price is a strategic rhetorical move that figures South Africa, and especially Johannesburg and Surgeon and Safari, as the ideal place to pursue surgery and counters certain fears and stereotypes regarding Johannesburg and

[2] Surgeon and Safari also draws a significant number of clients from the ranks of South Africans living abroad and expatriates, mostly European, living elsewhere in Africa. These subgroups of Melvill's client base raise fascinating questions that are certainly connected with the issues that I explore here, but the specific dynamics of these patient arrangements are outside the scope of this analysis.

[3] It is difficult to generalize about clients' motivations for coming to Surgeon and Safari, specifically. Many clients desired privacy. But relatively few clients, despite the company's name, actually go on a luxury safari in combination with their surgery, usually taking a day trip to a wildlife reserve or a tour of Johannesburg instead. For one client, Jean, the trip fulfilled a lifelong dream of coming to South Africa, and she did go on a luxury safari with her sister and brother-in-law, who were former clients of Surgeon and Safari. For Beth and Charlotte, a well-traveled couple who had undergone surgery together, it represented a chance to add another destination to their cosmopolitan travels. But other clients accorded little importance to the locale. For Martha, the decision to come to Johannesburg was based primarily on her desire to have her surgery performed by a particular doctor whom she had met for a consultation in London during one of his annual trips there. For another client, the desire for privacy was paramount, and location was chosen on the basis of feasibility.

South African medicine, such as fear of crime and HIV-infected blood.[4] But on the other hand, this rhetorical move also serves as part of a larger circulation of the concepts of value and cheapness in connection with the bodies of clients. That is, it affects how clients experience their surgery and travel. The choice of Surgeon and Safari represented, for some clients, a particular valuation of their own bodies. Martha, for instance, resisted her father's advice to go to Thailand for surgery because "I think he was speaking more because it would have been cheaper. . . . And cheaper doesn't necessarily mean better." Similarly, Jean had contemplated having surgery in other locations but decided that South Africa was less risky than other places: "I think it might be a little cheaper, but you don't really want to mess with . . . something as serious as plastic surgery."[5] To shop purely on price would be to treat one's body as cheap. Instead, clients' valuation of their own bodies took place through plotting themselves within an imagined transnational network of care enabled by this form of medical tourism, a network that also reflects political economic relations. The decision to travel to Johannesburg as opposed to other, riskier, locales affirms the worth of their own bodies and constructs a mapping of the world in terms of both the affordability of elective surgical procedures and the level of care that they would receive, a mapping that counters certain stereotypes (e.g., Africa as unmodern) while reinforcing others (e.g., particular locales as risky).

The neoliberalization of health: Macroeconomic policy and the micropolitics of bodies

As the discourse discouraging the use of price as a sole criterion shows, and as I will elaborate further below, an examination of medical tourism allows us to see how macroeconomic policy and the micropolitics of bodies are intimately intertwined. The caution against shopping exclusively on price at once wards off pure market logic, suggesting that bodies are a special kind of investment, while simultaneously acknowledging that the phenomenon is enabled precisely by a market model of health care—a model that allows a cost-benefit analysis to occur in the first place. Medical

[4] At the same time, however, most clients were well aware of South Africa's reputation for quality medicine, physician Christiaan Barnard's heart transplantation being exemplary, and British clients often understood the South African system of training as a mimic of the British system, enhancing their confidence.

[5] For many clients, the fact that South African health care professionals speak English was another risk-mitigating factor.

tourism thus participates in and produces transnational "political econom[ies] of vitality" (Rose 2007, 58). For those working within a neoliberal development framework, including government officials, international agencies, and development theorists, medical tourism represents an opportunity for "less developed countries" to attract foreign capital (Bookman and Bookman 2007, 9), and gendered areas of medicine are playing an important role in this form of the neoliberalization of health care. Fertility treatment, sex reassignment surgery, and cosmetic surgery tourism are all gendered forms of medical consumption that make up significant niches in the broader circuits of medical tourism. Aren Aizura (2009), for instance, explores how in Bangkok, "the 'Mecca' of gender reassignment surgery" (307), "Thai and non-Thai gender variant populations" (303) seeking sex reassignment and cosmetic surgery participate in a racialized economy of beauty production through medical intervention. And while a significant portion of Surgeon and Safari's clients are men, cosmetic surgery remains gendered—many clients claimed, for instance, that women faced a great deal more pressure than men to remain young looking—and assumptions of vanity continue to surround the practice, both in the press and for many clients. Gendered and gendering medicine play a central role in the construction of the transnational racialized economies of medical tourism.

The case of cosmetic surgery tourism to Johannesburg could be read as a clear instance of the neoliberalization of health care: medical services are purchased for a fee within the private health care system by "health consumers" (Irvine 2004) who use the medical system to undertake a form of self-entrepreneurship (Petersen 1997), wherein the self becomes a project enacted through the market. Surgeon and Safari might itself be theorized as an agent of the neoliberalization of medicine, not only in terms of the ethos of consumption that it engenders with respect to medicine but also in terms of its focus on economic development through the infusion of foreign capital into the private sector.[6] But while it is important to keep in view the neoliberal character of the practice, it is also important not to reify the participants in the industry as simply enacting neoliberal values. Rather, in order to understand the subjective effects of cosmetic surgery tourism, I think it is useful to conceive of it as a mode of racialized, classed, and gendered investment in the body.[7] As Ed Cohen (2009) has

[6] See Surgeon and Safari (2010), where Melvill argues that the South African government should promote medical tourism on the basis of the contribution it makes to the economy.

[7] Aizura (2009) develops a similar concept, "somatechnical capital" (309), drawing on the work of Susan Stryker and Pierre Bourdieu.

argued, liberalism and capitalism share a logic wherein the body becomes the originary form of property that forms the ground for the possession of all other forms of property, as well as the ground for the self. In the contemporary era, he argues, "taking care of our bodies has become the cultural equivalent of maintaining our capital. The body is a kind of property that we invest in—psychically and financially—because 'it' gives us back to ourselves. We can exercise 'it,' we can liposuction 'it,' . . . because 'it' is ours to control" (71). Within the neoliberal landscape of health care and especially the form of medical tourism Surgeon and Safari enacts, the proliferation of commodified forms of medicine enables an intensification of these investments—investments that, in the case of Surgeon and Safari, serve to value and affirm the worth of one's "own" (55) body. This form of medical tourism calls on us to theorize the "anatomo-politics" (Foucault 1978, 139) of bodies within a transnational medical market enabling gendered, raced, and classed transformations at the same time that it produces an asymmetry between those who are able to use transnational travel to enhance bodily capacities and respond to ever-expanding redefinitions of health (Puar 2009) and those who are not able to access medical markets in the same way.

Race, class, and care in the postapartheid city

> We only work in the private health care sector; we don't work in the public health care sector at all. You know, you can hardly expect someone from New York to go to Baragwanath Hospital.
> —Lorraine Melvill

The medical tourism industry's existence in Johannesburg depends entirely on the prior existence of a well-developed private health care infrastructure. The genesis of the contemporary private sector in South Africa is indebted both to its colonial history and to a series of neoliberal moves that began in the 1980s.[8] Thus, the division between public and private

[8] I cannot do justice to the role of medicine in colonial South Africa here, but see Deacon et al. (2004) for a discussion of how the mining industry in Johannesburg and Kimberley was both integral to the establishment of medical specialization and deeply complicit in the establishment of the compound system on the mines. They note that "it was also in Kimberley that another aspect of health care was introduced to South Africa—the hospital as luxury hotel" (235). Public health concerns played an important role in the shaping of South Africa's urban centers. In Cape Town, the Public Health Acts of 1883 and 1897 provided the legal backing for the first forced removal of nonwhites to Locations (see Youde 2005; Fassin

care (in terms of both who can access each sector and the purposes that each has served) is racialized, both historically and in the present.

The more contemporary development of private health care has been driven by the adoption of neoliberal economic policies both before and after the end of apartheid. Despite the fact that the right to health is written into the constitution, the economic means of materially securing that right have proven elusive. The rise of neoliberal economic logic in the 1980s meant that the apartheid government adopted policies influenced by Margaret Thatcher and Ronald Reagan that encouraged privatization of the health system, while medical scheme (insurance) administrators pushed against regulation, using the insurance industry in the United States as their model. "The end result is that the government that came to power in 1994 inherited a substantial and powerful private sector, which was very weakly regulated" (McIntyre, Thomas, and Cleary 2004, 138). During the 1990s, public health expenditure stagnated as a result of the government's efforts to reduce international debt, and real per capita public expenditure fell (McIntyre et al. 2006, 438; see also Bond 2003). According to 2005 figures, "the state spen[t] some R33.2 billion on health care for 38 million people while the private sector spen[t] some R43 billion servicing 7 million people" (Sinclair 2006, 24). Given the still profoundly racialized character of class in South Africa, it is clear that this inequality between public and private health care spending exacerbates not only class inequality but racial inequality as well (McIntyre et al. 2006, 444).

In terms of Surgeon and Safari's everyday practices, a discourse of racialized care and a portrait of the racialized city emerged through both tourist and medical practices, intersecting in interesting ways with the valuation of clients' bodies. Clients and I were told repeatedly by Melvill that our experience was one of "elite" medicine rather than an authentic experience of South African medicine. In the epigraph to this section, Melvill expressed something of the contrast between public and private medicine in South Africa, triangulating it through an imagined New Yorker who would be uncomfortable in the environs of the public Chris Hani Baragwanath Hospital and implying that the conditions of care in

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2007). In Johannesburg, the removal of "Africans" to Klipspruit in 1904, the city's first such removal, was carried out under the banner of public health and "effectively determined the future site for clustering Johannesburg's (African) Locations in what would be collectively known as . . . Soweto" (Beavon 2004, 78). It is against this background that we must understand the dynamics of the racialization of both public and private health in the city.

the hospital serving Soweto would not be suitable for international clients.[9] This emphasis on the elite status of the medical care clients were receiving served to produce value (produce the experience of clients' bodies as cared for) at the same time that it acknowledged racialized inequality in health care and the fact that private care, let alone cosmetic surgery, is available only to a minority. It is through the contrast to spaces of public health, coded as black, that part of the valuation of the clients' bodies emerged. Thus I understand racialization in this context less in terms of the construction of individual racialized bodies through surgery than through the effects of the medical spaces through which clients moved. That is, the (mostly white) clients' lack of experience of the public hospitals associated with South Africa's majority black population itself constitutes an experience that affects how they made sense of their self-transformation through their bodies.

Through the discursive contrasts made between public and private health, the clients were exposed to a medicalized vision of what Achille Mbembe (2004) calls Johannesburg's "aesthetics of superfluity." Mbembe plays on the double significance of "superfluity" to connect it both to "luxury, rarity and vanity" (378), epitomized by the sparkling odes to consumption found throughout the city (e.g., the Melrose Arch), and to the creation of a class of "superfluous men" (379), black miners who were subject to superexploitation and whose labor created the wealth that constructed the city. Clients such as Martha and Jean felt a sense of superfluity emerge through their experience of medicine in Johannesburg's private hospitals and their postsurgery recovery spent in a gated home in an affluent northern suburb.[10] At the same time, however, they were obviously aware of the economic inequality that characterized the city they were in, an awareness amplified by Melvill's emphasis on the eliteness of the medical care they were receiving and on the limited nature of the medical spaces we were moving through. This elite system was seen as removed from the real South Africa, as part of the "first world," in Melvill's words, that exists in pockets of Johannesburg but that is not an authentic experience of the city, just as Melvill's home, whose gate partially eased some clients' fears of crime, was viewed as an elite space not representing the real South Africa. Melvill encouraged her clients to go on a tour of Soweto (an "urban safari," as the trips are billed on South African tourism

[9] At other moments, however, Melvill was more than willing to acknowledge the inequalities within the U.S. health care system and to draw parallels between health care in the United States and South Africa.

[10] On the creation of these suburbs, see Beavon (2000).

Web sites) in order to counter this elite picture.[11] But while framed in terms of countering eliteness, the contrast actually served to enhance the sense of luxury, to valorize the client's own bodies.

The medicalized experience of superfluity in Johannesburg demonstrates the ways in which the macroeconomic forces at work in the production of medical tourism transnationally and within Johannesburg play out in the micropolitics of bodies. Even the practice of cosmetic surgery itself came to seem superfluous to some clients. For instance, the morning before she left for Madikwe on safari, Jean, who had had an eye lift, told me that rather than feeling glad about her surgery, after touring Soweto she felt guilty because the surgery "seems like an indulgence. . . . Especially, you drive around South Africa and [you see] haves and have-not[s]. It's a bit like, just because I have [the means], maybe I shouldn't be using my money to improve myself, but I don't know." The form of self-transformation that she had engaged in through cosmetic surgery had rendered her body valuable in a context where many other bodies were not subject to the same investments, pushing her own investment into the realm of superfluity. That is, the amplification of the divide between the haves and have-nots through touristically exploring nonelite spaces, an important mechanism through which the value and distinction of clients' bodies were emphasized, functions also to make cosmetic surgery become a sign of excessive, superfluous consumption in an unequal landscape.

Thus the experience of superfluity within cosmetic surgery tourism may produce, as it did for Jean, a limited sensing of the neoliberal forces at work in the transformation of the body. This is a process in which racialization takes place not through conformance to a racialized aesthetic but rather though enmeshment in a political economy of vitality. It is not that all patients in private hospitals and all clients of Surgeon and Safari are white, or that all residents of Bryanston are white, or that all patients in public health care are black. Rather, in this economy, spaces of public health, racialized as black, are understood as spaces where the state minimally invests in the bodies of citizens, and these spaces serve as a foil against which the valorization of clients' bodies occurs. Inequities between public and private sectors play out through the micropolitics of the clients' bodies not only through inequality of access but also through the contrast that serves to highlight their enhancement. Inequality itself falls back into the circuit of value production.

[11] Indeed, within an hour of my meeting Melvill for the first time, she was on the phone to a tour guide, arranging a trip to Soweto for me.

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I

Medical Tourism: Reverse Subsidy for the Elite

Amit Sengupta

In India, medical tourism is big business. Industry experts estimate that the medical tourism market was worth more than $310 million in 2005–6 and that it could increase to $2 billion by 2012. These estimates represent a phenomenal jump in the inflow of medical tourists, from a little over 100,000 in 2002 to over 1 million in 2012 (Confederation of Indian Industries and McKinsey and Co. 2002). These figures are significant when contrasted with India's overall health care expenditure—$10 billion in the public sector and $50 billion in the private sector. And government estimates suggest that India's health care industry could expand by 13 percent annually over the next six years, "boosted by medical tourism, which industry watchers say is growing at 30 percent annually" (Swain and Sahu 2008, 478).

Evidence suggests that India is second only to Thailand in the number of medical tourists that it attracts every year (Deloitte Center for Health Solutions 2008). Apart from the perceived exotica of the orient, and the fact that Indian medical professionals are proficient in English and that patients are familiar with Indian doctors who practice in large numbers in many Western nations, the principal attraction of the Indian medical

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