Implications of Outbound Medical Tourism on Public Health Care Development in Nigeria

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Doi: 10.19044/esj.2018.v14n30p353 URL:http://dx.doi.org/10.19044/esj.2018.v14n30p353

Abstract

Medical tourism is the practice of patients travelling out of their country of origin or residence for the purpose of getting access to medical care services abroad. Outbound medical tourism is a phenomenon in Nigeria thereby contributing to the growth of the health care industry in destination countries. The paper examines the implications of outbound medical tourism on public health care development in Nigeria and reinforces the need for the Federal Government of Nigeria to restructure and reposition the health sector in the country towards effective and efficient health service delivery. The study employs secondary source of data. Public administrators and health care practitioners concerned about transforming Nigeria into a centre of medical tourist attraction may find it suitable to start by examining the issues raised in this study to initiate a good policy framework for the health sector. The study concludes that huge investment in the health sector can drastically reduce outbound medical tourism, make health care services affordable to all Nigerians and utilising foreign exchange to develop other relevant sectors of the Nigerian economy.

Keywords: Medical Tourism; Health care; Health financing; Human resources

Introduction

The health sector of a country constitutes the spine for its economic growth and development (Anyika, 2014). Several countries across the world view health care development as having to do with their citizens, institutions and the legal framework created to integrate resources for effective and efficient health management for the prevention and care of diseases, injuries and illnesses. A viable health care system depends on the availability of capable human resources for health, adequate funding, ardent health research,

standard framework and good government that recognizes and addresses the health care needs of the people. Health care services cannot be extricated from the innumerable wants of human beings. Globalization has advanced medical technology, capital funding and consumerism across national borders, giving rise to the production and consumption of health care services over many decades with the rapid growth in the flow of patients and health professionals. The World Trade Organization (WTO) acknowledgement of free movement of goods and services has furthered the liberalization of the business in health care services with the use of bilateral and regional trade agreements amongst nations. Lunt et al (2011) opined that health care services, as a global commodity, is predominantly a service industry that is traded and has brought about rapid changes to health care delivery.

Public health care services in Nigeria are still very poor and flagrantly underfunded and have not been a major recipient of the concrete inclinations across distinct sectors in the country. Okafor (2016) argued that the budgetary allocations to Nigeria's health sector are still far below the recommendation of 11% by the World Health Organization (WHO) of a country's Gross Domestic Product (GDP) and 15% allocation of countries' annual budget by the African Union (AU). Okafor presented statistics from the Central Bank of Nigeria Statistical Bulletin which showed that the percentage of public health expenditure to total government expenditure stood at 7.05%; 4.22%; 6.41%; 4.3% and 4.4% in the mid-1990s, 2000, 2005, 2009 and 2010 respectively and concluded that less than 6% of Nigeria's total budget was allocated to the health sector between the year 2011 and 2015.

The medical tourism industry is a booming industry worldwide. In 2006, McKinsey & Company estimated that the worldwide medical tourism industry generated roughly US$60 billion and projected that it would reach US$100 billion by 2012 (Herrick, 2007). Annually, almost 60,000 people (with an average of 5,000 every month) travel abroad for different forms of treatment which could have been conducted in Nigeria (Abubakar, Basiru, Oluyemi, Abdulateef & Atolagbe, 2018). About US$1 billion is spent annually on medical tourism by Nigerians on an array of health care needs with 60% reported to be across four key specialties: oncology, orthopaedics, nephrology and cardiology due to insufficient investment in the Nigerian health care sector (Okafor, 2017; Phillips Consulting, 2017; PricewaterhouseCoopers [PwC], 2016). The cost of medical tourism is about 20% of the total spend on public health care sector including doctors' salaries, nurses and healthcare workers, cost of predominant care programs like malaria, HIV/AIDS and mother/child care, and operating and capital costs of all the healthcare facilities nationwide. Medical tourism cost is not an insignificant amount of money departing Nigerian healthcare system and is a potential resource to the nation's health sector and overall economy (PwC, 2016).

In the year 2000, the World Health Organization (WHO) ranked Nigeria 187 out of 191 countries in its world health systems ranking (WHO, 2000). It is pathetic to realize that neighbouring countries such as Togo, Ghana, Niger and Mali ranked higher than Nigeria. Although, Nigeria health care sector comprises of the public and private sectors, the recent mass exodus of Nigerians for treatment and health professionals (doctors and nurses) in search of regions that are more favourable is disheartening. Currently, the doctor-to-patient ratio is 1: 2,000 while the nurse-to-patient ratio is 1: 20,000 (Philips Consulting, 2017). The President of the Healthcare Federation of Nigeria, Clare Omatseye, claimed that Nigeria has about 37,000 doctors in diaspora, with about 30,000 doctors in the United States of America, and over 5,000 in the United Kingdom of Great Britain and Northern Ireland (Okafor, 2017).

The key factors affecting the aggregate Nigeria health care system development and responsible for Nigerians to become medical tourists include inadequate health facilities and equipment, poor human resources management, lack of motivation and remuneration, corruption, poor health care financing, decreased expenditure on health by the government, political instability, shortage of essential drugs and supplies, inadequate access to health care, absence of integrated system for disease response, prevention, surveillance and treatment; high user fees and inadequate health care providers, and lack of confidence in the nation's health sector (Obansa & Orimisan, 2013). The crisis has led to the timely response of external agencies, including multilateral and bilateral donors (Onyibocha et al, 2014); however, they have still not translated into improved health status and overall quality of life of the Nigerian masses (Anyika, 2014). Nigeria is faced with the challenge of ineffective and inefficient use of past opportunities to develop a sustainable health care system.

The objective of this study is to explore the implications of medical tourism on public health care development in a developing nation. This paper is divided into five sections. After the introduction, the remaining part of this paper is structured as follows: Section two examines the concept of medical tourism, outbound medical tourism and drivers of medical tourism. Section three focuses on the Nigerian health care system, health care policies, health care financing and human resources for health management. Section five dwells on conclusion and recommendation respectively.

Concept of Medical Tourism

Medical tourism is increasingly becoming a global competitive market (Herrick, 2007). Its growth is associated with globalization, economic development and acceptance of health services (Lunt et al, 2011).

There is no harmonious agreement on the definition of medical tourism. Definition varies substantially as a result of the methods applied by countries (Kelley, 2013). Noree (2015) posits that most definitions of medical tourism concentrate on health services selection ranging from health check-ups, dental care and reproductive interventions and organ transplants, raising concerns about the safety of the patient cum ethical considerations. In some countries, foreign patients are counted as they visit hospitals whilst on the contrary others count individual patients as they make entry into the country. Also, some countries take into cognizance the patients' nationality and not the place of residence (WHO, 2011 as cited in Kelley, 2013). The movement of people to another country in order to receive medical care that is substantively unavailable, inaccessible or unaffordable in their home country has recently gained momentum. Although, the definition of medical tourism seems obscure, various researchers concede that it is a substantial part of health tourism (Al-Lamki, 2011; Lunt et al, 2011).

Medical tourism is a phenomenon in which tourists are attracted to a country by intentionally promoting its health care services and facilities in addition to the regular tourist amenities available in that country (Goodrich & Goodrich, 1987). Medical tourism is described as a planned or organized travel outside one's natural health care setting for the restoration or improvement of an individual's health through medical procedure (Carrera & Bridges, 2006) but with far-reaching health care system and economic implications.

Medical tourism is the habit of patients leaving their home country to other developing or developed countries with the aim of obtaining medical care (Samir and Karim, 2011, Snyder et al, 2011) but does not include patients/individuals who require emergency medical care while on vacation in another country, long-term residents in a foreign country or those who travel as a result of bilateral agreements (Epundu et al, 2017). The Medical Tourism Association viewed medical tourism as a condition in which people residing in one country journey to another country to be given medical care, accepting care equal to or better than that which they would receive in their home country. Medical tourism is when patients elect to travel across international borders for the purpose of receiving medical attention. This medical attention (treatment) may include but not limited to dental care, fertility treatment, cosmetic surgery, and elective surgery (Organisation for Economic Co-operation and Development [OECD], 2010 as cited in Kelley, 2013).

In the proposition of Johnston, Crooks, Snyder & Kingsbury (2010), medical tourism is when patients intentionally leave their home country for the purpose of accessing non-emergency medical services abroad. Medical tourism involves individual leaving their place of residence usually outside of existing cross-border care preparations with the intention of getting medical

care in the form of surgery abroad (Whittaker, 2008). Mogaka, Mashamba-Thompson, Tsoka-Gwegweni & Mupara (2017) noted that medical tourism is the travel of patients in search of health care services that is either, unaffordable, unavailable, or proscribed at their home health care systems due to diverse considerations for kinds of medical procedures and techniques, onerous health care costs, and non-uniformity in accessing quality health care.

There have been strong objections to the use of the term "medical tourism" as it is believed that it is a misnomer, insinuates leisure travel and frivolity and does not take into consideration the importance of patients' mobility and jettisons the suffering that patients' encounter (Glinos, Baeten, Helbe & Maarse, 2010; Kangas, 2010; Whittaker, 2008). Some writers however have suggested various nomenclatures deemed as the most suitable term to depict the movement of persons overseas for medical care. These nomenclatures are "biotech pilgrims", "medical refugees", "medical outsourcing", "international medical travel" (Cormany and Baloglu, 2010; Crozier and Baylis, 2010; Fedorov, 2009; Huat 2006; Jones & Keith, 2006; Milstein & Smith, 2006; Song, 2010). Lunt et al (2011) argued that medical tourism possess analytical value, that is, as a concept, it depicts willingness to travel and willingness to treat which form the significant features within the pristine global market of health travel. The health sector constitutes the wider economic influence of medical travel and implies the commercialisation and commoditization of such travel. Medical tourism showcases the role of the industry, issues of advertising, supplier-induced demand and extends beyond the notion of "willingness to travel".

Outbound Medical Tourism

Nigeria is well known not as a tourist destination for public health care but serves as a vital source country to destination countries such as India, Turkey, South Africa, Saudi Arabia, United States of America, United Kingdom, and Germany among others for procedures such as cardiology, oncology, orthopedic surgery and nephrology (Nigerian Health Sector Market Study Report, 2015).

The Elitist View about Health care: It has been discovered that Nigerians have an insatiable appetite for anything foreign (Bruce, 2016). Many well-to-do Nigerians hold this view due to the fact that they prefer to travel abroad in order to seek medical care (Connell, 2006). The wealthy prefer to travel to the United States or Europe for treatment while the Nigerian masses prefer to go to South Africa or even India for treatment due to reasons best known to them. This perception is increased by the fact that government officials and politicians are sponsored abroad for medical treatment on the nation's expense (BBC, 2016; Buhari, 2009). This holds through for other

politicians and government officials who travel abroad for the treatment of minor ailments which could have been treated in Nigeria.

Figure 1 describes the loss of US$1bn to health care needs abroad leading to the unavailability of US$1bn to other sectors of the Nigerian economy. The indispensable impact of the US$1bn spent on outbound medical tourism is a huge loss to the local health care system. The patients who travel abroad to access medical facilities for their wellbeing can afford the healthcare services of Nigerian health care providers. Without the loss of US$1bn, there is the possibility of cross-subsidizing health care needs for patients who cannot afford to pay for their costs of treatment. PwC (2016) argued that the assumption of a gross margin of 45% and an average health care pay per capita of $120 per patient for the entire Nigerian population means that the US$1bn expenditure on outbound medical tourism translates into a huge loss of potential 3.7 million treatments of patient per year in Nigeria.

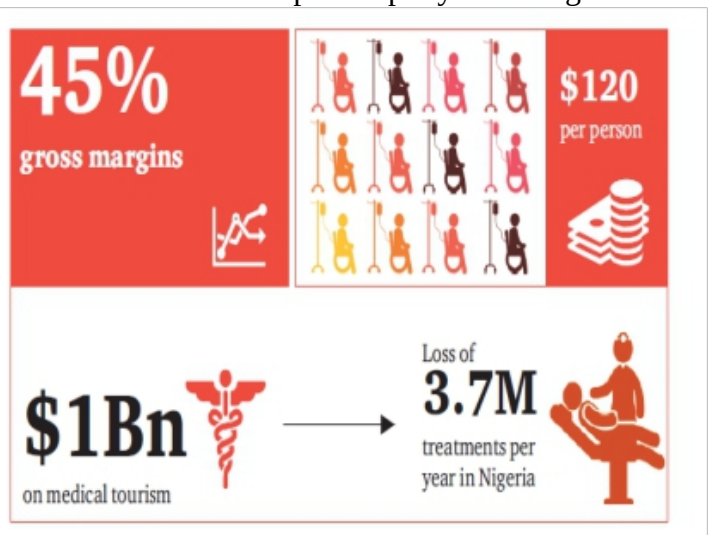

Figure 1: Loss of foreign exchange to outbound medical tourism
Source: PwC (2016)

Drivers of Medical Tourism

Truly, medical tourism is a global phenomenon with the patients equally divided between people in high and low GDP countries. These patients come from Africa, Europe, North America, the Middle East and Asia to receive treatment abroad in at least three continents (Ehrbeck, Guevara & Mango, 2008). Countries across the world are turning into medical tourism destinations with some countries such as Germany and Thailand, securing the market through a reputation of high quality gesture and by offering medical care and epicurean lodgings for reduced prices.

The principal motive that patients travel to access medical care over the last two decades include: technology, trade liberalisation, food and

religion, geographical proximity, cultural affinity in terms of language, desire to remain anonymous and preserve privacy abroad, bioethical legislation (fertility treatment, abortion and euthanasia services), advanced quality and accessibility of health care, unavailability of services, drugs and surgery methods in the country of origin (Glinos et al, 2006; Helbe, 2011). Generally, travel patterns are influenced by a complicated and mutual set of variables and to extricate these drivers, especially on a market-by-market basis, can be difficult. Discontent with their own home health system, low quality or unavailability of suitable treatment and affordability of medical care in the home market are some of the largest drivers of people travelling to access medical care (Helbe, 2011). Lunt et al (2011) supposed that the drivers of medical tourism include globalisation – technological, economic, social and cultural. Several domestic health systems are experiencing significant difficulties and strain-tightened eligibility criteria, waiting lists, and changing priorities for health care may all have significant effect on the decision making of consumers. There is also the sudden appearance of forms of consumerism and patient's choice among countries that traditionally possess public-funded services. Transparency of information and growth of distinct providers competing on excellence and cost now provide for all needs. Noree (2015) categorized set of drivers of medical tourism into push and pull factors. The push factors consists of established medical routine in home country, absence of insurance, high cost of out of pocket expenses, and lengthy waiting times for medical attention. The push factors are peculiar to patients from developed countries and comprised of high quality of medical service facilities, vacation elements, mutual language, religious and political climate (Ruka, 2015).

Ehrbeck et al (2008) identified five major drivers of medical tourism termed as *five discrete segments* that influences the decision of patient's on destination. They are classified in order of importance as: most advance technology, better-quality care for medically necessary procedures, quicker access for medically necessary procedures, lower-cost for medically necessary procedures, and lower-cost care for discretionary procedures (p. 4).

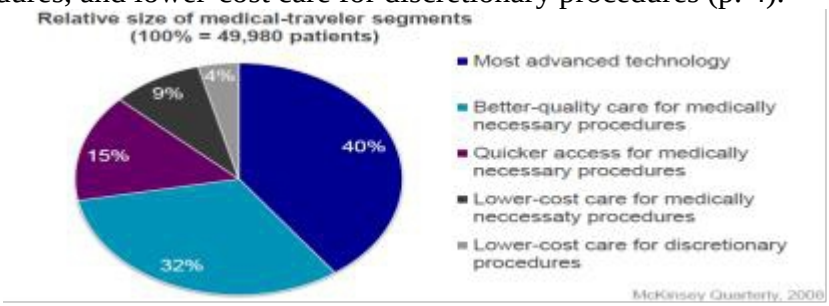

Figure 2: Drivers of Medical Tourism
Source: Ehrbeck et al (2008) and reproduced in Kelley (2013)

Figure 2 showcases the relative size of medical-traveller segments. 40% of all medical tourists which depicts the largest segment strive after the world's state of the art technologies. These medical tourists seek for a global sophisticated medical care, with little alertness to the closeness of currently unrealized destinations or the amount of money required for health care. 32% of entire medical tourists which made up the second largest segment seek improved health care that they could find in their own countries, which are usually in the developing world. The medical tourists in this segment select a destination by comprising the perceived quality in exchange for responsibility such as distance, costs and unfamiliar cultures. Some of these patients jettison costs to a certain degree while other patients concentrate on higher quality of health care at the best obtainable price. The third largest segment consists of people who want faster access to medical care due to long waiting time at home country. The number of medical tourists in this segment is contingent on the capacity in their home countries and medical investments in these countries can bring down the need to seek health care overseas. 9% of medical tourists comprise the fourth segment with the largest potential for expansion. These tourists seek reduced costs of medical care. The cost of medical treatment varies significantly across the world putting patients in the vantage position to save significant amounts of money for any medical procedure. The fifth segment (4%) represents patients that seek reduced cost for discretionary medical procedures such as rhinoplasty, liposuction/abdominoplasty, or breast augmentation and reduction. These patients come mainly from developed countries such as the United States. Patients in this segment prefer to travel to several specialized health care providers rather than bigger hospitals with diverse specialties.

Nigerian healthcare system

The Nigerian health sector maintains a multi-dimensional health care delivery system including private health care, public health care, non-governmental and faith-based organizations and traditional health care. The onus of the provision of health care in the country lies majorly in the hands of the three-tiers of government: the federal, state and local government. The primary health care system is operated by the 774 local government areas as well as private medical professionals while the secondary health care system is managed by state ministries of health. The tertiary health care system is provided by teaching hospitals, specialist hospitals and federal medical centres. The secondary and tertiary levels also collaborate with voluntary, non-governmental organizations, faith-based organizations as well as private professionals in order to deliver medical care (Adeyemo, 2005).

In 2005, an estimated total of 23,640 health facilities was given by the Federal Ministry of Health. 85.8% are primary health care facilities, 14%

secondary and 0.2% tertiary. It was also estimated that 38% of these facilities are owned by the private health sector. Despite these figures, the Nigerian health system is still lacking in the area of health facilities and equipment, human resources, medicines and advanced technologies and sufficient funding (Obansa and Orimisan, 2013).

Outbound Medical tourism is increasingly becoming a tradition in Nigeria as a result of the moribund state of her health care system birthed by several factors such as poor infrastructural facilities, obsolete medical equipment and technology, health worker migration and lack of knowledge of existing specialist hospitals and health centers. These factors are further highlighted in details:

Poor health infrastructural facilities: The prevalence of communicable and non-communicable diseases in Nigeria has continued to increase due to the moribund state of existing infrastructural facilities and obsolete equipment and technology (Abubakar et al, 2018). Despite the surplus of available medical institutions in Nigeria, infrastructure and equipment are grossly inadequate and insufficient, especially the government owned hospitals (Akinsete, 2016). This is supported by Mekwunye (2016) who opined that government owned hospitals do referrals to private owned hospitals and laboratories for laboratory tests and procedures.

Inadequate and Insufficient funding: Another major factor causing medical tourism in Nigeria is the issue of underfunding of the health sector. A decisive factor in attaining universal health for all is the way and manner in which the health sector of a particular country is funded. This is because it determines the affordability of the available health services by the masses. In spite of the giant strides and popularity of Nigeria among other African nations globally, Nigeria's health care sector is still grossly underfunded (Asangansi & Shaguy, 2011). Suffice it to say that only 4.3% of the total 2016 budget was allocated to health as against the recommended 26% allocation by the United Nations (Azi, 2011; Ibekwe, 2016).

Shortage of health care workers: In addition to the challenges mentioned above is the issue of inadequate and insufficient health care workers. Medical tourism has enormous economic and health implications in both destination and home countries. A decrease in a country's revenue for strengthening its local health system occurs when high-income patients leave such country (Johnston et. al, 2010). This further reduces the government's support for investing in the health system and providing advanced technologies and medicines for the health improvement of the masses (Lunt et al, 2011). When this occurs, health workers begin to migrate to countries with sophisticated health technologies that are favourable to their profession (Mills et al, 2011). Nigeria is one of the major health workforce emigrants' countries in the world. Many doctors and nurses travel abroad after their studies in

various medical schools across Nigeria for better job opportunities and field experiences. It has been discovered that some of the best doctors across the world with outstanding contributions in the medical field are Nigerians (Akande, 2015).

Incessant strikes: The government at different levels including the health sector go on strikes and stop work activities due to various demands, intermedical conflict including doctors, nurses and allied health professionals of different cadres. This has led to innumerable disabilities, complications and deaths of patients left unattended to because of lack of health professionals on ground who would have managed such cases (Ogbebo, 2015).

In 2016, PwC Nigeria published a report entitled "*Restoring Trust to Nigeria's Healthcare System*". A survey was conducted on the perception of healthcare in Nigeria and found out that over 90% of Nigerians believed that advanced healthcare delivered in Nigeria is synonymous with low quality. This perception has been established over the years. The local doctor is contacted whenever primary care needs or routine medical attention is needed, but if advanced medical care is necessary, the patient(s) travel out of the country. Some factors responsible for motivating patients to seek medical care abroad were discovered via the survey. These factors include:

Lack of trust in the local healthcare and patient protection system: Evidence have shown that generally, Nigerians are less litigious than other nationals' due to low confidence that when things go wrong, there is protection from the authorities by taking legal action thereby explaining the relatively low number of legal actions brought against medical malpractices. The standard of regulation of clinical practice in Nigeria is at the minimum creating an environment for a poor clinical practice leading Nigerian patients to harbour serious concerns on the quality of health.

Competence of healthcare professionals (HCP): The competence of HCP is a pertinent area of health care system that needs solid attention as confidence in HCP core competencies form the bedrock of trust in the medical care system. PwC (2016) queried how effective the training system is in preparing HCPs on the use of brand new technology, trends on disease and treatment, and developing sound judgement. The absence of technical expertise or competence of HCPs is enough to convince a patient that his or her needs will be fully met abroad.

Health care policies

In order for a country to grow and develop, there is need for good governance with formidable plan of actions including well defined vision, mission, goals and objectives and strategies to achieve such goals within a specified period of time. Without such plans, a country might not scale through the ground level (Oyibocha et al, 2014). Nigeria has development plans, goals

and strategies like other countries which is as far back as her independence day on October 1, 1960. However, with these documented plans, Nigeria still lacks in the provision of basic healthcare services to the masses.

The first comprehensive National Health policy was promulgated in 1988 and a review was later done in 2004. The objective of the National Health policy was to bring to fruition an all-encompassing health care system focused on primary health care with readily available resources to protect, restore and rehabilitate all Nigerian citizens, as well as to assure individuals and communities of productive social well-being and good quality of life to achieve health promotion. The overall policy objective is to strengthen the national health system such that it will be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health-related Millennium Development Goals (MDGs). Most of Nigeria's disease burden is due to preventable diseases while poverty remains a major cause of these fundamental problems. The maternal mortality rate (about one mother's death in one hundred deliveries) is one of the highest in the world. Some other health status indicators like the under-5 mortality rate and adult mortality rate are higher than the average for Sub-Saharan Africa.

There is a limited capacity for policy/plan/programme formulation, implementation, monitoring and evaluation at all levels. There is no health act describing the national health system and defining the health functions of each of the three tiers of government. Some of the health care policies available in Nigeria include: National Health Policy, National Health Financing Policy, National Health Bill, National Strategic Health Development Plan (2010 – 2015), National Policy on Integrated Disease Surveillance and Response (IDSR), mental health policies and reproductive health policies.

Health care Financing

WHO (2000) defined health financing as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively." Health care financing is described as the channel of funds from patients to health care providers in exchange of services. These funds can be generated from primary and secondary sources such as direct and indirect taxes, out-of-pocket payments (OOPs), donations, health insurances, subsidies, deferrals, etc. A good health care financing scheme should be able to provide sufficient financial protection so that no household suffers because of the need to utilize health services. This can be achieved through the introduction of risk-sharing method such that the risk of being caught up in unexpected health expenditure does not rest solely on one individual or household as the case may be (McIntyre, 2007).

In the opinion of Adebola (2016), "a current major worrisome issue in health care financing in Nigeria is the heavily disproportionate skew of sources of funds for the sector" (p. 4). The way a country finances its health care system is a major factor for attaining universal health coverage. This is because it determines the existence, availability, accessibility and affordability of health services. Nigeria runs a pool and un-pool form of generating revenue for financing the health sector (Uzochukwu et al, 2015). The pooled sources are collected from budgetary allocation, direct and indirect taxation, and donor funding. In contrast, the un-pooled sources are generated from out-of-pocket payments which contribute over 70% of total health expenditure. In spite of these health financing options, the finances are still inequitably distributed across the health system. In the study of Adebola (2016), a clear distinction was made between financial and economic concepts of cost in the context of health financing. Financial costs focuses on monetary payments that are directly associated with the purchase of goods or services while economic costs relate to time, skills, energy, infrastructure and equipment that are employed in the course of the health care delivery transactions.

Human Resources for Health Management

A vibrant workforce is indispensable for a successful health intervention. Human resources for health serve as the cornerstone of the health system of every nation. The National Strategic Health Development Plan (NSHDP, 2010-2015) identified the main categories of human resource in the Nigerian healthcare system. The categories include doctors, nurses, midwives, laboratory staff, public health nurses, public health nutritionists and the community health and nutrition officers. According to NSHDP (2010), there are about 39,210 doctors, 124,629 nurses and 88,796 midwives registered in Nigeria. The aggregate of these numbers does not exhibit a large variation between states or geo-political zones.

Nigeria's human resources for health management faces several major challenges to the development of the health sector in the country. The reasons for these challenges include limited production capacity, negative attitude to work, poor supervision and motivation, migration within and outside the country, work environment and remuneration. The regulation of the health profession in Nigeria is presently in the charge of 14 professional regulatory bodies with the responsibility of maintaining and regulating training and practice standards for various health professionals. These 14 regulatory agencies lack strong structures and possess weak capacities to execute statutory functions for the effective monitoring and accreditation of health training institution programmes. In 2013, the Medical and Dental Council of Nigeria declared that Nigeria has 30,323 medical doctors in satisfactory standing in its books out of over 85,000 registered doctors constituting a

physician density of 0.17 doctors to 1000 population, which is among the lowest in the continent.

Figure 3 shows that availability of health professionals varies from geo-political zone to the other. Equitable distribution of health workforce amongst the zones must be done based on the needs of the affected zones.

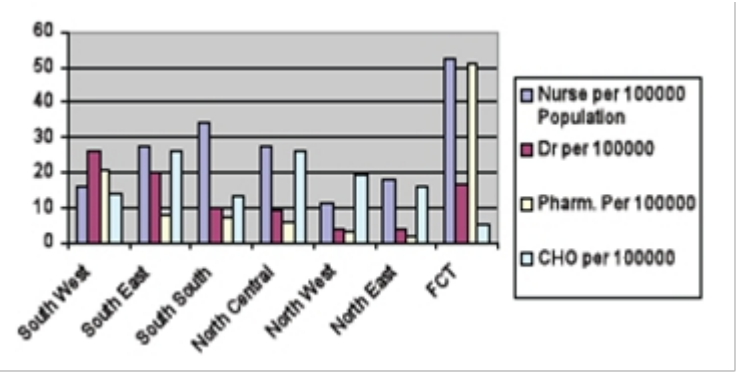

Figure 3: Health workforce/100,000 Population by Geo-Political Zone
Source: NSHDP (2010 – 2015)

NSHDP (2010) estimated that about an average of 2,500 doctors, 5,500 nurses and 800 pharmacists graduate from health training institutions and enter the health sector every year. Also some cadres of staff are mass-produced leading to unemployment in some states and at the same time, there is minimal production of some cadres of staff that is critically needed in some states. The effective and efficient performance of health professionals is hinged upon better working conditions and regular remuneration to lower attrition rates. However, the supply of practicing doctors is about 35% of the officially stated numbers due to no upgrade of the data used since 1963.

Omoluabi (2014) compared Nigeria to South Africa taking into consideration the number of people who seek the health resources. Nigeria has a population over three times that of South Africa which indicates that her human resources for health management should be over three times that of South Africa to have a significant comparison of both countries. In a further critical assessment of the published figures of the human resources for health, Omoluabi affirmed that these published figures contained inaccuracies as no census have ever been conducted to determine the accurate population of the practicing health workforce. Also, no serious action has been taken to enforce the regular payment of licensing fees by practitioners.

Conclusion and Recommendations

Globalization has brought a lot of changes to several countries of the world. The free movement of people seeking health care has resulted in the sporadic rise in the medical tourism industry of some countries with profitable

revenues to show for it. There is a need to shift from outbound medical tourism to transform Nigeria's health care system in order to attract medical tourists for revenue generation and good public image of the country.

The importance of stemming the tide of outbound medical tourism is to ensure the development of home health facilities to cater for the needs of citizens. The unimpressive state of the health care system has led to inequities in the Nigerian society with the affluent possessing the means to seek for treatment overseas while the low income citizens stay put with the health system that needs a total overhaul. Reversing outbound medical tourism entails investing heavily in the health sector and ensuring it is affordable to all Nigerians.

The authors' pertinent recommendations to reverse outbound medical tourism. First, there is the need for adequate remuneration and good working conditions. Second, the National Health Insurance Scheme should be expanded to accommodate all Nigerians. Third, the Federal and State governments should employ every graduate from health institutions to avoid them been forced out of the system. Fourth, the Nigerian government should identify and collaborate with capable Nigerian medical personnel in the diaspora who are willing to significantly contribute their core competencies for the betterment of the nation's health sector. Fifth, discouraging greener pastures amongst health workers require the provision of enticing incentives to attract them to work in rural areas. Sixth, the provision of regular electricity is indispensable to a viable health sector.

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