

Health Challenges and the Emergence of Medical Tourism in Nigeria: A Historical Analysis

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Abstract

This paper examines health challenges in Nigeria and the emergence of medical tourism. It argues that the challenges confronting the public health sector in Nigeria, despite the wide-ranging efforts by the various governments to provide quality healthcare to all Nigerians precipitated the emergence of medical tourism. The paper discusses some of the problems bedevilling public healthcare and submits that the myriads of problems forced Nigerians to embrace medical tourism as an alternative. The paper further argues that since the popularization of medical tourism in the 1990s, Indian hospitals have proven to be the most favourable destinations to prospective Nigerians seeking health care owing to the higher costs available in Europe and the United States. The paper adopts the multi-disciplinary approach to historical research. This method permits the borrowing of relevant materials from related disciplines thereby giving room for narrative, descriptive and analytical style that yields deeper insights into the history of healthcare system in Nigeria. It concludes that the government should ensure that healthcare is provided for all since it is the right of all citizens of the country, irrespective of status. Finally, it recommends the removal of the bottlenecks in the Nigerian health system and improve the quality of service in the healthcare sector this will reduce medical tourism to its barest minimum.

Keywords: *health-challenges, healthcare, medical tourism, public health, Indian hospitals*

Introduction

Essentially, mental and physical well-being is crucial to good health. Every Nigerian citizen like their counterparts in Europe and other parts of the world desires to live in good health with standard health facilities to sustain it. However, this has not been the case as the public health facilities in the country have witnessed a serious decline over the past two decades. With all its inadequacies, the Nigerian public health delivery arrangements have to be open to the sort of public criticisms that a democratic system permits. Indeed, health outcomes in Nigeria have been in a declining state since the 1990s. This is clearly demonstrated in the life expectancy of Nigerians since the period under consideration.

Similarly, maternal mortality has remained high, particularly in the rural areas across Nigeria. To be sure, the Nigerian healthcare system was seriously undermined by the nearly two decades of military rule. For instance, between 1985 and 1993, per capital investment in health was only \$1.00 per individual whereas the international standard was \$34.00 per individual. (Federal Ministry of Health, 2004: 7) Irrespective of the various reforms to increase the provision of health to the Nigerian people, healthcare delivery has remained low. The inadequacy of the health care system is attributed to the bottlenecks in the health sector. Indeed, Nigeria faces fundamental health care challenges as uncertainty prevails in the health sector of the economy. The Nigerian health care has suffered several infectious disease outbreaks for a long time, particularly in the rural areas. This has necessitated the need for alternative avenues to what the public health is able to provide to the entire citizenry thereby making the middle class elites of the society to desire a better healthcare system outside the country. This phenomenon has been described as medical tourism. It became popularised in Nigeria since the period of the 19990s, and it was during this period that the Indian economy witnessed a robust growth to become the preferred destination for Nigerians.

The State of Public Health in Nigeria

The evidence available suggests that public health facilities and infrastructure in Nigeria since the 1990s are in a spiral downward movement and declining state. Evidently, the government provides

free or subsidized healthcare in competition with private healthcare providers whose services are fee-paying without any subsidy from the government. Factors affecting the Nigerian healthcare system are multifaceted and varied; these include inadequate health facilities/structures, poor management of human resources, poor motivation and remuneration, corruption, illiteracy, high medical bills, absence of integrated system for disease prevention, inadequate access to health care, as well as inadequate drugs and supplies. Indeed, Nigeria lacks integrated healthcare system that is all embracing, where government and private healthcare providers work in partnership as it is practised in many developed and developing countries of the globe. Against this background, over 90% of the common people find it difficult to consult the private healthcare providers since they are quite expensive. This explains why they rely on government owned hospitals to get free or subsidized medical care.

Evidently, more than half of the entire population live below the poverty line of less than \$1.00 a day. This explains why they cannot afford the high cost of health care services that the private healthcare providers offer. Recent research has shown that a poor referral system between the various tiers of the health care system negatively affects the functions of the health care delivery system. (Akanke and Monehin, 2004: 102). Before independence in 1960, a 10-year developmental plan (1946–1956) was introduced to enhance health care delivery. Several health schools and institutions (Ministry of Health, several clinics and health centres) were developed to actualise this plan. By the 1980s, there had been great development in health care—general hospitals and several other health centres had been established.

However, the treatment of diseases such as malaria, measles, whooping cough, HIV epidemics and tuberculosis have undermined government's efforts and impoverished many Nigerians and continues to do so in the face of major infrastructural and shortage of personnel and poor health management in the country. At the end of the Nigerian National Health Conference in 2009, a Communiqué was released. The Communiqué opined that, the health care system in Nigeria has remained weak as evidenced by lack of coordination,

fragmentation of services, dearth of resources, including drug and supplies, inadequate and decaying infrastructure, inequity in resource distribution, and access to care and very deplorable quality of care. The communiqué further outlined the lack of clarity of roles and responsibilities among the different levels of government to have compounded the situation. (Osain, 2011: 471) Coupled with the problem of declining health infrastructure is the challenge of unending queues in the public health institutions across the country. In fact, patients may queue up in a government hospital from 9.00 am to 4.00 pm before receiving treatment. This is because there are many patients and very few doctors. In some instances, there may be as much as one hundred and twenty patients with only two or three medical doctors available to attend to them.

This has been the situation since the 1990s and successive governments are yet to pay adequate attention to health care sector in Nigeria. In fact, the Nigerian health care system is still at the rudimentary stage one health care system where private practice thrives alongside public healthcare system. However, in many developed and even in some developing countries, medical practice has reached the fourth stage healthcare development being the health care system of the 21st Century. The stage 4 healthcare practice requires that healthcare organizations have the characteristics of high performing organizations and focus exclusively on the six important aims for health improvement, namely: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity. At that stage, patients have as much control over treatment decisions and services are synchronized with substantial use of information systems. A lot more work still needs to be done to move the Nigerian health care system to the advanced stage. Obviously, it requires training and retraining of medical practitioners: doctors, nurses and other health workers. Over the years, policy reversals and other inconsistencies have tended to undermine previous health reforms within the health sector of the economy. (Anyinka, 2014: 114) In this circumstance, the perception of the growing middle class as well as others is that health care infrastructure is so inadequate that going to overseas for proper healthcare is essential and it is itself a symbol of status in the society. (Eiguedo-Okoeguale, 2015: 140)

Structure of the Nigerian Healthcare System

Available evidence demonstrates that the Nigerian health care system is decentralized and organized into a three-tier structure. This derives from the three tiers of government system that Nigeria operates. To this end, the federal, state, and local governments have their responsibilities and functions as far as health issues are concerned in Nigeria. To be sure, all the three tiers are individually and sometimes collectively involved in the management and stewardship of health issues in the local government, state and national levels. For instance, the Federal Ministry of Health (FMOH) is strictly responsible for policy initiative and technical support to the overall health care system as well as the general management of health information, international relations on health issues, and providing healthcare services at the national level through the tertiary and teaching hospitals.

Conversely, the various states are responsible for the provision of secondary hospitals for the regulation and technical support for primary healthcare services. This they do through the states' Ministries of Health.

The third level, which is the local government level is responsible for the primary healthcare by providing health services through the wards. The local governments are divided into different wards numbering from seven to fifteen depending on the terrain.

In 2005, the federal government in a bid to revitalize the worsening state of health care in Nigeria, established the Nigerian Health Insurance Scheme (NHIS) by Decree 35 of 1999, which provided for the establishment of a governing council with the responsibility of managing the scheme. Although, this scheme was first proposed in 1962 in a bill sent to the parliament by the first Minister for Health.

The objectives of the scheme include:

1. Ensure that every Nigerian has access to good health care services
2. Protect Nigerians from the financial burden of medical bills
3. Limit the rise in the cost of health care services
4. Ensure efficiency in health care services

5. Ensure equitable distribution of health care costs among different income groups; equitable patronage of all levels of health care
6. Maintain high standard of health care delivery services within the scheme
7. Improve and harness private sector participation in the provision of health care services
8. Ensure adequate distribution of health facilities within the Federation
9. Ensure the availability of funds to the health sector for improved services.¹

Understandably, the Nigerian national health policy objective was the attainment of a level of health that will enable all Nigerians to attain a social and economic productive lives.² However, since its establishment primary health care has not gained its right place in the scheme of things. Indeed, the aim and objectives of the NHIS have hardly been attained, hence health care delivery in the country continues to be inefficient, and unable to meet the needs of the majority of Nigerians. This is indicative of the high infant mortality rate/poor maternal care, very low life expectancy and regular disease outbreaks. The extra program of the NHIS launched in October 2008 under the Millennium Development Goals Scheme (MDGS) has had little positive impact. For example, the Nigerian National Health Conference 2006 was attended by more than 400 delegates and participants, including high dignitaries ranging from the presidency to local governments and their agencies. It was aimed at ensuring accessible, qualitative, effective and affordable, health care for the entire Nigerian citizenry.

In 2008, the Nigerian senate in a bid to advance the health care system in the country launched a bill for an act to provide a framework for the development, management and regulation of a national health system and set standards for rendering health services within the country and other matters associated with it. Regardless of the inadequacies and shortcomings of the Nigerian health care system, the National Health Insurance Scheme (NHIS) if well managed could be a veritable ground for qualitative, effective and standard health care delivery in the nation. It is a truism that at its

present state the scheme does not sufficiently cater for the health needs of the people as expected. Indeed, indicators of the health care delivery in Nigeria suggests that in spite of the huge development efforts in the health care system in the last two decades, much is still needed to be done to make the health care system effective, efficient and reliable. This is evident in the various health indicators and mortality rates from several disease outbreaks, control and management in the country.

The evidence available suggests that, health institutions rendering health care in Nigeria are 33, 303 General Hospitals, 20, 278 Primary Health Centres and Health Posts, and 59 Teaching Hospitals and Federal Medical Centres.³ These figures represent a huge improvement in the availability of health institutions compared to previous decades. Nonetheless, health care institution continues to suffer shortage. The backward and forward reference searches on second phase keywords search revealed increasing role of health information, communication as integral to leadership, as well as increasing role of medical intelligence/surveillance in the health care system obtainable in other parts of the world.

Despite, this seemingly beautiful arrangement however, the Nigeria health care system has not yielded the expected dividends to the Nigerian peoples by providing services that are inadequate to the people's demand owing to the problems listed earlier in this chapter. In the face of this growing inefficiency and inadequacies, the middle class and the elites in the country thought that standard medical services could be obtained outside the country through the instrument of medical tourism. The concept of medical tourism became popularised in the country since the period of the 1990s, and it was during this period that the Indian economy witnessed a robust growth that turned her into health-hub thereby becoming the preferred destination for Nigerians who desired medical tourism.

The emergence of Medical -Tourism

Over the years, the growth in the flow of patients across national borders has given rise to new patterns of consumption and production of healthcare services and delivery in Nigeria. Indeed, a new element of growing trade in healthcare that involves the movement of patients

across borders in the search of state-of the-art medical services and healthcare has emerged and has continued to dominate the health sector of the Nigerian economy.

Evidently, the sale of high-tech medical care to foreigners is currently a reality in numerous developing countries including Nigeria. It has captured the worldwide attention of governments, policy-makers, academics, and the press in both destination and sending countries. It is a growing trend, despite possible risks of life-threatening complications that could occur far away from home. Some scholars and authors refer to this act of travelling across international boundaries for health-related issues as medical tourism. (Connell, 2008: 106) It is defined as travel with the aim of improving one's health. Medical tourism is an economic activity that entails trade in services and represents the linking of at least two sectors: medicine and tourism. It has emerged owing to greater willingness of Nigerians to accept alternative practices and procedures, as well as experience different cultures and places outside the country.

Medical tourism occurs when patients choose to travel across international borders with the intention of receiving some form of medical treatments. These treatments may span the full range of medical services, but principally includes dental care, cosmetic surgery, elective surgery, and fertility treatment. (Milica and Karla Bookman, 2007:1) Technological change has been crucial to the rise of medical tourism. Since the 1990s, economic growth has enabled expenditure on rapidly improving health systems in some developing countries, principally in Asia, where new technologies have been developed, experimented and adopted.

India: the main destination for Nigerians in Medical Tourism

Today, the best hospitals in some Asian countries such as India, Malaysia, and even Singapore have access to technology that is comparable to that of any hospital in developed countries, and superior to what is obtainable in many regional and provincial hospitals in developing countries. Thus, the advancement in technology was responsible for the national development of superior and world-class hospitals that now play a key role in medical tourism.(Connell, 2011:53) Some of the big hospitals that attract the

attention of Nigerians in India include Indraprastha Apollo Hospital, Fortis Healthcare, Artemis Health Sciences, Kerela Institute of Medical Sciences, Mendanta Group, Primus Super Speciality and Max Healthcare.

Medical tourism was almost unheard of at the end of the 20th Century; in fact, the media ignored it. However, the number of news items in the global media rose dramatically at the dawn of the new millennium. Remarkably, the growth in global media coverage was coordinated by the emergence of new destinations, expansion in established destinations, the emergence of medical travel companies, and the arrival of guidebooks, and belated academic interest. Indeed, the rise of medical tourism was a response to a combination of factors, which include the Asian financial crisis of the late 1990s, the wider globalization of health services and the poor healthcare system in most developing countries including Nigeria. Thereafter, Asian countries sought alternative sources of economic growth, this coincided with the growth of medical tourism and the nature of its privatization, and the business orientation of what has become a medical industry. (Connell, 2011: 62) However, State involvement in the medical tourism industry is not confined to Asia. As with Asian countries, State involvement varies from country to country with a mixture of private and public facilities catering for medical tourism. In India, the authorities encourage medical tourism by helping train over 20,000 new doctors per year. (Milica and Karla Bookman, 2007)

Evidently, medical tourism is primarily a 21st Century phenomenon. It is perceived as the movement of patients from relatively poor developing countries such as Nigeria and other Third World countries to developed countries such as Europe and America for standard medical treatments. However, India has recently emerged as a Medical tourism hub within the last decade. Over the years, medical tourism in its various manifestations and occurrence has boomed and becomes highly complex in terms of new destinations and sources and the quantity of patients that are involved. Many countries are now involved as sources of tourists, as privatization of medical care continues. Similarly, there is widespread discontent with public healthcare in Nigeria thereby giving room for medical

tourism. In this connection, destination countries seek foreign exchange and new means of economic growth. (Connell, 2011:59)

Throughout the period covered in this study, the number of Nigerians from the middle class as well as the affluent class who travel across international borders to receive medical treatments has increased tremendously. These Nigerians want first world treatment at third world prices. Indeed, “First World treatment for Third World prices” has become the slogan of medical tourism. For example, if a liver transplant costs about Rs 60-70 lakh in Europe and double that in the US, a few Indian hospitals would do it within the range of Rs 15- 20 lakh. In like manner, if a heart surgery in the US costs about Rs 20 lakh, Indraprastha Apollo Hospital group would do it for about Rs 2 lakh. (Somasekhar, 2004:17) Similarly, cosmetic, dental, and eye surgeries in Europe and America cost three to four times as much as they cost in India. While medical tourism is presently small in comparison to the overall service trade or the consumption of medical services worldwide or even the trade in tourism services, it cannot be dismissed as either temporary or irrelevant.

Since India’s emergence as a global health hub in the 1990s, India has become the first point of attraction for most Nigerians owing to the cheap medical facilities that are available in India compared to the United States or Europe.⁴ India has large private hospitals that have grown to attract patients globally. These world-class hospitals operate different billing systems for Indians and foreign nationals. Among the large private health centres that qualify for Multinational Corporations, Indraprastha Apollo International Hospital was the first to get into the stock market in India.⁵Over the past three decades, Apollo Hospitals’ transformative journey has formed a legacy of excellence in Indian healthcare sector. The group has continuously set the agenda and led by example in the blossoming private healthcare space. In fact, one of Apollo’s important contributions has been the adoption of clinical excellence as an industry standard.

Available evidence demonstrates that India’s health care system is very effective. Indeed, there is a strong synergy between the government of India and the private multinational hospitals that offer medical tourism. These multinational hospitals offer a vast array of treatments to patients. For instance, the variety of treatments

available in two of the large international hospitals visited to collect data for this study (Primus Super Speciality Hospital and Indraprastha Apollo International Hospital) includes:

- ❖ eye surgery
- ❖ fertility/reproductive system (IVF, gender reassignment)
- ❖ cardiology/cardiac surgery
- ❖ orthopaedic surgery (hip replacement, knee replacement, joint surgery)
- ❖ cosmetic surgery (breast, face, liposuction)
- ❖ dentistry (cosmetic and reconstruction)
- ❖ bariatric surgery (gastric by-pass, gastric banding)
- ❖ organ, cell and tissue transplantation. (Eiguedo-Okoe-guale, 2015:158)

Undoubtedly, a critical look at the services available shows that it is not all of these treatments that could be categorized as acute and life threatening as some are clearly within the purview of mainstream health care. The poor medical facility in Nigeria's health sector is one of the main factors that contribute to the ever-expanding number of Nigerian seeking medical assistance from India. However, some Nigerian patients go for medical treatments in India based on referral from their medical doctors in Nigeria.⁶ Apart from the issue of referral based on lack of standard facilities, there is also the emergence of patient choice to travel across international borders simply because they can afford to do so. In fact, some affluent patients explore the option of getting treatment abroad due to dissatisfaction with the domestic health care system in Nigeria. Unlike other forms of patient mobility where an expert makes decisions on behalf of the patient, medical tourism involves individuals taking their own decisions regarding their health needs and the most appropriate hospital to consult. Since health care is principally a service industry, it has made health services a globally tradable commodity.

In an increasingly globalizing world, the internet aids prospective patients to access health care information from any part of the globe. The health care system in Nigeria is facing significant challenges such as endless waiting lists, and shifting priorities for health care,

lack of standard facilities and other factors, which generally affect the patients' decision-making. Obviously, the colonial links between India and Nigeria makes medical travels between the two countries flourishing. This is true because the lingua franca of both countries is the English Language. This helps to remove communication gaps between Nigerian patients and their Indian medical experts. Evidently, India sees considerable economic development potential in medical tourism. This explains why it seeks to promote its comparative advantage, as a global medical hub.⁷ Indeed, there is evidence to suggest that India's private healthcare industry has quietly facilitated a revolution that enabled it to emerge as a leading health destination; a destination for advanced patient care. To facilitate this, India introduced a special visa category, an M-visa. This M-visa caters for the demand of the growing number of Nigerians seeking medical assistance from India.

Economically, the medical travels greatly affect the Indian economy on a positive note. For example, in year 2012, it was estimated that India's medical market worth US\$2 billion. Having learnt from Cuba's experience, India strives to reinvest income from foreign patients into the national system. Analysis of history demonstrates that India seeks foreign patients in order to develop facilities to serve local patients better. For instance, in 2002 the government of India declared in its National Health Policy, that medical tourism is an export product and awarded its providers some fiscal incentives, such as lower import duties, prime land at subsidized rates and tax concessions. (Chinai and Goswami, 2005:17) Conversely, Nigerians spend heavily to obtain these medical services. Indeed, the evidence available establishes that, no fewer than five thousand Nigerians travel to India annually for medical treatments. In this regard, Nigeria loses some US\$800 million (about N125 billion) annually to medical tourism. (Nigerian Medical Association, 2013:38)

Conclusion

From the foregoing analysis, it becomes clear that the Nigerian health care system since the 1990s has been ill-equipped, and it has suffered several setbacks especially at the Local Government levels. The myriads of problems that bedevilled the Nigerian healthcare system such as inadequate health facilities/infrastructure, poor management

of human resources, poor motivation and remuneration, corruption, illiteracy, higher medical bills, etc., precipitated the emergence of medical tourism. In fact, the era of the 1990s witnessed the popularization of medical tourism following the spiral downwards movement and decline of the health sector in Nigeria.

Today, quite a large number of Nigerians visit India to seek medical attention. This development affects the economies and health sectors of both countries as Nigerians spend their hard-earned money for Indian expertise and bio-medicals. This allows for mutual benefits of both Nigeria and India in line with the non-zero sum game of international relations. Therefore, to achieve success in Nigerian health care in this modern era, a system well-grounded in routine surveillance and medical intelligence is necessary. Similarly, proper and effective management couple with strong leadership qualities are inevitable. Therefore, the recommendations given in this chapter if carefully implemented will help to improve the standards of health care delivery in Nigeria and reduce the occurrence of medical tourism.

Recommendations

- The Nigerian government should see the need to train and re-train all health practitioners, medical doctors, nurses and other health workers in the public healthcare system.
- Nigeria and India should collaborate in joint bio-medical researches that will be of benefits to both countries.
- The bureaucratic bottlenecks that push Nigerians to embark on medical tourism should be addressed without further delays
- Nigeria should see the need of hiring India expatriates to assist in training and retraining Nigerians in the areas that attract Nigerians to embark on medical tourism.
- The Nigerian government should adopt the 4th stage of health care system that is obtainable in the advanced democracies since healthcare is vital to economic development.
- The Nigerian government should embark on mass renovation and refurbishment of all health infrastructures across the country, particularly those in the rural areas.

Notes

- ¹ National Health insurance scheme Decree No 35 of 1999. Laws of the Federation of Nigeria. See, [www.nigeria-law.org/National Health Insurance Scheme](http://www.nigeria-law.org/National_Health_Insurance_Scheme). (Accessed 24th May 2018).
- ² See, <https://www.researchgate.net/publication> The Nigerian health care system Need for integrating adequate medical intelligence and surveillance systems. (Accessed 24th Oct 2018)
- ³ Ibid.
- ⁴ Oral interview with Alhaji Abdul Razaq, from Kano Nigeria (New Delhi: Indraprastha Apollo Hospital, 15 May 2013, Time: 1:00-1:30pm).
- ⁵ Oral interview with Dr. Jamah Moosa (New Delhi: Jamia Millia Islamia University, 15 May 2013, Time: 11:00am- 12:20pm).
- ⁶ Oral interview with Mr Muhammed Lawan Ishaq (New Delhi: Indraprastha Apollo Hospital, 15 May 2013, Time: 1:40- 2:50pm). A case referred from Jos University Teaching Hospital in Nigeria to Indraprastha Apollo international Hospital in New Delhi.
- ⁷ Oral interview with Inrayani Mulay (New Delhi: Confederation of Indian Industry, May 22, 2013, Time: 11:00 -12:20 noon).

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