Review Article

Universal Healthcare Coverage and Medical Tourism: Challenges and Best Practice Options to Access Quality Healthcare and Reduce Outward Medical Tourism in Nigeria

Opubo Benedict da Lilly-Tariah[1], Salami Suberu Sule[2]

[1]Past President, [2]Senate and Governing Board Affairs (SGBA), National Postgraduate Medical College of Nigeria, Lagos, Nigeria

Abstract

Background: Universal healthcare coverage (UHC) leads to access to quality healthcare. Improved quality healthcare can stem outward medical tourism (MT). This review examined challenges and best practice policy options to implement UHC and how it can reduce outward MT in Nigeria. **Methodology:** The designed search terms used were "universal health coverage," "quality healthcare" "medical tourism," "access to healthcare," "primary health care," "healthcare financing," "private health insurance," "social health insurance," and "Nigeria healthcare system." Peer-reviewed research articles and institutional reports published between January 2000 and March 2020 were searched using four databases: PubMed, National Library of Medicine, Web of Science, and Library of Congress. EndNote X9 software and Google search engine were used to access these databases and documents, and 124 publications were retrieved and 106 were reviewed. **Results:** Majority of publications reviewed emphasized building health infrastructure, developing skills and human resources for health, and funding for equipment and drugs. Expanding healthcare coverage through social health insurance, developing a financial system to protect the poor, access to quality healthcare, and reinvigoration of primary healthcare (PHC) were common themes. About 50% of the studies identified unavailability of quality healthcare services, inequalities in the supply side of healthcare services, issue of human resources, and health sector implementation shortfall as challenges to UHC. Another 50% of the studies reviewed identified poverty and poorly funded PHC as a barrier to UHC. Almost all the studies (100%) identified cost-effectiveness, safety, and quality of healthcare services as drivers of MT in all countries. **Conclusion:** Improving the quality of healthcare delivery, increasing accessibility, affordability, and timeliness of access by the population through UHC can stem MT.

Keywords: Financing, medical tourism, Nigeria, quality, SHI, universal healthcare coverage

Introduction

Nigeria accounts for 20% of the population of Sub-Saharan Africa (SSA) and is projected to be the third most populous country in the world, with over 400 million people by 2040.[1] Nigeria citizens face a lot of challenges in accessing quality healthcare. This has led to poor health indices and a driver for seeking healthcare outside Nigeria.[2] Preventable and low-cost treatable communicable diseases still cause significant morbidity and mortality, and this is compounded by the increasing burden of non-communicable diseases.[3]

For most Nigerians, expending money for healthcare during other competing interests and needs can be severely challenging. The consequences of this situation can be catastrophic.[4-6] Healthcare should be a socio-economic investment.[7] Economic productivity is increased with a healthy population as lost hours to ill health is reduced and absence from work is reduced. The role of healthcare in development was stated in the United Nations (UN) Sustainable Development Goals (SDGs) 2030 as "ensure healthy lives and promote well-being for all at all ages," and one of the targets is to "achieve universal healthcare coverage (UHC), including financial risk protection, access to quality essential healthcare

Access this article online

Quick Response Code:

Website: www.njmonline.org

DOI: 10.4103/NJM.NJM_67_20

Address for correspondence: Dr. Salami Suberu Sule, National Postgraduate Medical College of Nigeria, Km 26, Lagos-Badagry Expressway, Ijanikin, Lagos, Nigeria.
E-mail: sssule2002@yahoo.com

How to cite this article: da Lilly-Tariah OB, Sule SS. Universal healthcare coverage and medical tourism: Challenges and best practice options to access quality healthcare and reduce outward medical tourism in Nigeria. Niger J Med 2020;29:351-61.

Submitted: 09-May-2020 **Revised:** 17-May-2020
Accepted: 17-Jun-2020 **Published:** 18-Sep-2020

services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all."[8]

Life expectancy in Nigeria is 54.3 years, and the share of Nigeria's population living in extreme poverty is 42.8% in 2016 and this will rise to 45.0% by 2030, which represents about 120 million people living on < US$1.90 per day.[1,9,10] The UN Human Development Index ranking of Nigeria is 158 out of 189 countries in 2018.[10] The World Bank defined extreme poverty as people living on < US$1.90 per day. People living in extreme poverty are characterized by severe deprivation of basic human needs, such as food, safe drinking water, sanitation facilities, health, shelter, education, and information. Extreme poverty condition does not depend only on income but also on access to services including healthcare services.[11] The Nigerian total expenditure by the federal and state government and private sector on health as a percentage of Gross Domestic Product (GDP) is 3.6% in 2016. Private expenditure on health as a percentage of total expenditure on health is 76.7% (mainly out of pocket [OOP] expenditures) in 2016; the general government expenditure on health as a percentage of GDP is 0.47% and the total government expenditure as a percentage of the national budget is 5.01% in 2016.[12] The Nigerian health indices are poor, for example, the neonatal mortality rate of 23/1000 live births and under-five mortality rate of 76/1000 were reported in 2018, while the maternal mortality ratio of 917/100,000 live births was reported in 2017.[13,14] The physician density per 10,000 was 3 in 2018;[15] births attended by skilled health workers were 43.4% in 2018; the crude birth rate per 1000 was 38 in 2017; and the fertility rate was 5.5 per woman in 2017.[14]

The percentage of Nigerians covered by the National Health Insurance Scheme (NHIS) is about 3%;[16] there are about 74,543 medical doctors, of which 3035 are specialists in the country as of 2018.[15] Nigeria needs to achieve a ratio of one doctor to a thousand patients (the WHO prescribes 1:600), for a projected population of 200 million. This situation is no different for nurses, pharmacists, laboratory scientists, etc., Health workers are vital to SDGs and UHC.[17] Health infrastructure and social support are less than satisfactory.[18] The spate of strikes by doctors and other healthcare professionals is another disturbing phenomenon, often spurred by the perceived neglect of their welfare and inadequate working environment.[19] Paucity of funding of healthcare services by the various tiers of government in Nigeria (Local, State and Federal)[20] leads to increased out of pocket payments (OPPs) and many poor Nigerians cannot pay for these services. This results in them being turned away by healthcare providers if they are unable to pay, forcing them to patronize quacks or resort to self-medication, both of which could worsen their ailments.[21]

Nigeria has been reported to have about 160,000 hospital beds as of 2015, a low ratio of bed per thousand population of 0.9 (<1) in comparison to countries such as South Africa at 2.29 and Japan at 13.32. The number of hospital beds has grown below the population growth rates over the last 5 years, which is coupled with obsolete healthcare infrastructures, equipment, and lack of requisite infrastructure to expand/deepen medical specialization.[18] Budgetary allocations and internally generated funds cannot equip and maintain the hospitals with state-of-the-art equipment. Attempts at public–private partnership (PPP) is still at a low level.[22] This makes a compelling case for Nigeria to adopt a compulsory SHI system to cater for the poor and those who cannot afford medical expenses at the grassroots.[23,24] There is a need to examine the healthcare financial option in Nigeria and the implementation of progressive tax policy that will increase the fund availability for providing healthcare services.[25,26] This will increase the capacity of the healthcare system to be able to deliver quality healthcare services affordable to all.[27] Will implementing UHC through progressive tax system and compulsory SHI be a vehicle to improve funding for health and improve quality of health and affordability to the populace? Will improve quality of health, affordability, and accessibility be a driver to reduce outward medical tourism (MT) in Nigeria? These are the questions that this review is set to answer. Therefore, the aim of this review is to determine issues, challenges, and best practice policy options for implementing UHC and stemming medical tourism (MT) in Nigeria.

Methodology

Search strategy

The literature review design involved the search for peer-reviewed research articles and institutional reports on UHC and MT that were published between January 2000 and March 2020. Four databases were used: PubMed; National Library of Medicine; Web of Science; and Library of Congress. EndNote X9 software and Google search engine were used to access these databases and documents. The following search terms were used, "universal health coverage," "quality healthcare" "medical tourism," "access to healthcare," "primary healthcare," "healthcare financing," "private health insurance," "social health insurance," and "Nigeria healthcare system." Africa, Sub-Saharan, developing countries, and Nigeria were also used as keywords. The literature search was divided into seven major parts: UHC globally; UHC in developing countries; UHC in Africa: UHC in Nigeria: medical tourism (MT) globally; MT in developing countries; and MT in Nigeria.

Inclusion and exclusion criteria

The inclusion criteria for the studies selected for this review are: empirical studies that were related to at least one of the seven aspects of UHC and MT that provided clear and full information of research design and methods; reports of institutions such as WHO, World Bank, and UNICEF; online Nigeria news reports on UHC and MT in Nigeria; and publications that occurred between January 2000 and March 2020. The exclusion criteria for this review were: studies before 2000 on UHC and MT; and the remaining publications were screened to exclude those that do not meet the inclusion criteria. One hundred and twenty-four publications were retrieved for all the categories and 106 publications were reviewed.

Results

Research question 1

Determination of the issues, best practice options, and challenges of implementing UHC in Nigeria are shown in Table 1. The reports and studies included in this review showed consistent results of strengthening the healthcare system to be efficient and effective, developing financial system to protect the poor and access to quality healthcare by the populace. Majority of review reports and studies emphasize building health infrastructure, developing skills, increasing the number of human resources for health, and the funding of drug and equipment acquisition. Expanding healthcare coverage through SHI and reinvigoration of primary healthcare (PHC) was a common theme and that moving toward UCH is gradual or incremental and should be either medium-term or long-term period for implementation.

Research question 2

Determination of challenges facing implementing UHC in countries is shown in Table 2. Studies reviewed were from SSA and Asian countries. The majority of studies reviewed identified accessibility and availability of barriers to UHC. Political issues and policy implementation toward UHC were also observed. About 50% of the studies reviewed identified availability of quality healthcare, inequalities in the supply side of healthcare services, issue of human resources, and health sector implementation shortfall. Another 50% of the studies reviewed identified poverty and poorly funded PHC as a barrier to UHC.

Research question 3

What are the drivers of MT in various countries to determine how to stem it and use it as an advantage to develop healthcare system, improve the health of the population, and attract foreign exchange earnings? This is shown in Tables 3. Reviewed studies identified the different drivers of MT in both developed and developing countries including SSA countries. Almost all the studies (100%) identified cost-effectiveness, safety, and quality of health services as a driver of MT in all countries. About 50% of the studies identified development of healthcare systems including infrastructure and human resources for health skills as a driver. In Nigeria, improving the quality of healthcare delivery and increasing accessibility, affordability, and timeliness of access to the population were identified as factors that can stem MT. Drivers of circumvention tourism

Table 1: Issues and best practice policy options for Nigeria to achieving universal healthcare coverage

Program recommendation	Institution	Duration	Moving toward goal	Policy objectives	Measurement
2014 Luanda Commitment on UHC[28,29]	WHO: AFRO	Long term	Gradual	Efficient healthcare system Financing system that protects people	Nil
World Bank Report on UHC[30,31]	World Bank	Medium term	Incremental	Basic supply side funding and integrated health system	Nil
The Thirteenth General Program of Work, 2019-2023 WHO[27,32,33]	WHO	Medium term	Incremental	Achieving one billion people benefitting from UHC	The proportion of a population that can access essential quality health services and the proportion of the population that spends a large amount of household income on health
Presidential Summit on UHC[34]	WHO: FRO, Nigeria FGN	Not defined	Not stated	Mandatory health insurance, special funds to cover the poor Package of essential healthcare needs Functional health system Sustainable financing Quality services	Nil
ERGP/2nd National Strategic Health Development Plan 2018-2022[35,36]	Federal Government of Nigeria	Medium Term	Incremental	Quality of health services Expand healthcare coverage through NHIS Sustainable financing Reduce infant and maternal mortality rates. Revitalize 10,000 PHC Partner with the private sector Optimize the health worker-to population ratio	Nil

ERGP: Economic recovery and growth plan, UHC: Universal healthcare coverage, NHIS: National Health Insurance Scheme, PHC: Primary healthcare, AFRO: Africa Regional Office of World Heath Organization (WHO), FGN: Federal Government of Nigeria

Table 2: Challenges of implementing universal healthcare coverage in various countries

Challenges	Country(ies)	Observations	Suggested solution
Missing-middle group; high costs for NCDs[37]	Indonesia	Enrollee of UHC in wealth quintiles Q2-Q3 use services less and low UHC coverage of children from birth to age 4 years	Prevention and promotion of healthy lifestyles Investment in a robust integrated digital health-information system
Sustainable and coherent political efforts; coordinated involvement of all stakeholders[38]	Ghana	Stalled policy change Changes in political landscape and leadership with changed priorities; threaten sustainability	UHC is a political choice Coordinated involvement of all stakeholders
Productivity and efficiency of HCW; common health problem and the environment[39]	Ethiopia	Working and living conditions of HCWs and building capacity for productivity	Development of sustainable and participatory health extension program
How to ensure coverage of the informal sector fiscally sustainably; supply side readiness; quality of services so as to make UHC truly universal[40]	Asian countries	Translating coverage into improvements in health outcomes Large variations and inequities in the supply-side readiness; availability of infrastructure, equipment, essential drugs, and health worker competencies	Using general revenues or employing a combination of tax subsidies, nonfinancial incentives and contributory requirements NCDs and related preventive outpatient care
Rigid public financing structure; disinclination, historical mistrust, and lack of empowerment[41]	Bangladesh	Health sector's implementation shortfalls Issues of human resources, political interference, monitoring, and supervision	Redesigning the public finance structure, improving governance and regulatory mechanism, collaboration with different sectors Improving service quality, strengthening overall health systems, improving monitoring and supervision Patient education and community empowerment
Extreme poverty; inability to pay premiums for SHI; poorly funded PHC system; segmented health insurance fund pool)[42]	Ghana, Kenya, Nigeria, and Tanzania	Large informal sector whose members are mostly uninsured and poor High dropout rate from insurance schemes	Adequate and efficient utilization of finance; improve access and quality of healthcare systems Health coverage for the very poor; reduced proportion of underinsured

HCWs: Healthcare workers, UHC: Universal healthcare coverage, SHI: Social health insurance, NCDs: Noncommunicable diseases, PHC: Primary healthcare

are shown in Table 4. Healthcare opportunities and access to medical services that are legal in the destination country but illegal in the home country are the main drivers globally.

Discussion

Substantial gaps exist in healthcare systems and access to Millennium Development Goals (MDGs)-related health interventions in Nigeria. There is a need for sound policies and plans with clear direction for strengthening Nigerian health systems and addressing the social determinants of health.[28] Universal Health Coverage (UHC) is guaranteeing that all people use the needed promotive, preventive, curative, rehabilitative, and palliative health services of adequate quality and effective and that their use does not cause financial hardship and impoverishment due to healthcare costs.[29] These should be pursued with SDGs and WHO's General Program of Work 2019–2023[33] in an integrated way is shown in Figure 1.[66] Countries that progress toward UHC will make progress toward the other health-related targets and toward the other goals.[27]

Adequate government investments in healthcare reduce financial impoverishment as a result of catastrophic cost by shifting cost away from OOP expenditures.[67-69] Nigeria should develop an adaptive health system with solid institutional foundations and governance, with an engaged civil society that demands accountability and transparency.[70] All stakeholders should be made to understand that to achieve UHC as shown in Figure 2 is a journey of progressive realization. The emphasis at all times should be that the quality of healthcare services is good enough to improve the health of the people.[71] This also entails building health worker's capacity, good governance, and sound systems of procurement; supply of medicines and health technologies and well-functioning health information systems are other critical elements.[27]

The WHO and World Bank developed a framework to track the progress of UHC and used 16 essential health services in four categories as indicators of the level and equity of coverage in countries.[27] The road map to achieve UHC[72] and what the Nigerian government and all stakeholders can do was clearly articulated at the Presidential Summit on UHC

Table 3: Drivers of Medical Tourism in Various Countries

Medical Tourism	Destination Countries	Drivers	Issues	Patients' country
Medical tourism	Asia-Pacific	Medical expertise, innovative technology, safety Niche services - surgical procedures with Low-risk procedures; high-risk procedures[43] Cost-effectiveness[44]	Equal or greater for medical care; high cost of healthcare; long wait times; affordability of international travel; and improvements in both technology and standards of care[45]	Western developed countries Wealthy patients in developing countries
Medical tourism	United Kingdom[46-48]	Waiting times Quality of health services; regulation and litigation procedures; and continuity of care	Complex patient motivation; availability and distance; economic cost and benefit; growing health systems' inequities	EU, other developed countries; EU; commonwealth countries and other developing countries
Medical tourism	United States[46,49,50]	Provide superior care Niche market of medical/surgical procedures Data about the quality, safety, and risks involved with overseas care and surgery Data regarding clinical outcomes and follow-up	Revenue from patient medical services, accommodations, tourism, and travel Costs of upgrading infrastructure Improved facilities and technology Retention of top health providers. Drawing much needed health providers away from poor and rural hospitals	All countries of the world including Nigeria
Medical tourism	Iran[51]	Healthcare quality; high level of expertise; healthcare costs; and "visa facilities"[52]	High quality of care; cost-effectiveness; tourism facilities Public-private participations; aggressive marketing Improving infrastructures; human resources development	Middle East and Arab countries, developing countries.
Medical tourism	Korea[53,54]	Joint treatment of western and oriental medicine; medical wellness tourism; global healthcare experts; tailored medical services with culture of foreign patients Effect of Hallyu and advanced Korean brand power; tourism activities for companions; support for patients' convenience[55]	Medical tourism marketing for domestic and international medical institutions; counseling Risk management Human resource; future prospect of supply and demand	Countries all over the world including Nigeria
Medical tourism	Central America and the Caribbean[56-58]	Unused capacity in private hospitals International portability of health insurance; hospital accreditation; Internationally trained physicians Promotion of medical tourism by public export development corporations and government	Investment promotion agencies; private health sector economic benefits Health infrastructure health labor force development Environmental health equity: ecosystems threatened by facilities catering to international patients	North, Central, and South America, other developed and developing counties including Nigeria
Medical Tourism	Nigeria[59-62]	Patient seeking better quality healthcare outside Nigeria	Poor infrastructure; paucity of skilled human resources; poor funding, week health system Increasing quality, efficiency, equity, accountability, sustainability, and resilience Financial protections, improve health system stewardship, and access to healthcare	Net outflow of Citizen even to neighboring West-African Countries

EU: European Union

with the theme "UHC… A Vehicle for Sustainable Growth and Development" and documented in 2014.[34] One of the outcomes is to make SHI compulsory for all Nigerians. However, after 6 years, Nigeria is still not implementing compulsory health insurance to drive UHC, due to the lack of political will. To achieve UHC using health financing as the strategy, there is a dire need to review the system of financing healthcare[73] and to adopt primary healthcare as the fulcrum for moving Nigeria ahead toward UHC and the attainment of the health-related sustainable development goals.[74] The NHIS Act was enacted in 1999 with objectives[75] that are in line with the recommendations of the WHO and World Bank on the implementation and achievement of UHC; however, despite these laudable objectives, the implementation in Nigeria is very poor and coverage is very low due to lack of political will.

Table 4: Drivers of circumvention tourism globally

Circumvention Tourism	Destination Countries	Drivers	Issues	Patients' country
Circumvention Tourism[63-65]	Global	Access medical services that are legal in the destination country but illegal in the home country Healthcare opportunities	Traveling outside of the nation state to accommodating cultural or political differences Fertility treatment; abortion, and doctor-assisted suicide; female genital cutting	All countries of the world, including Nigeria

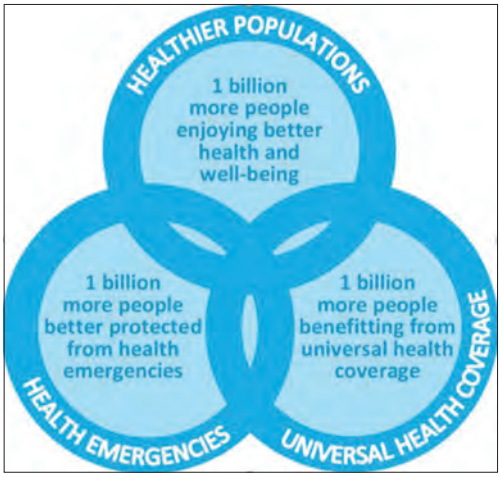

Figure 1: Set of interconnected strategic priorities – WHO's General Program of Work 2019–2023

PHC is an approach to health and well-being centered on the needs and circumstances of individuals, families, and communities that is needed for UHC.[27] It is about providing whole-person care for health needs throughout life in the most efficient and cost-effective way to achieve UHC in Nigeria.[74] A country like Thailand had made a major stride to achieve UHC using PHC as an intervention.[76] It is practically impossible for Nigeria to achieve UHC by 2030 if the PHC system is not improved and if SHI through NHIS and state governments remains voluntary.[77]

The consequence of looking for money for the treatment can result in catastrophic expenditure which forms majority of healthcare expenditure in Nigeria,[78] with patients being driven into abject poverty or even death. OOP payment is a direct payment made by individuals to healthcare providers at the time of service use. Statistics have shown that the level of OOP expenditure as a share of total health expenditure in Nigeria is still placed at 72%, the highest on the continent and one of the highest in the world.[79] This problem can be solved by compulsory SHI through NHIS, by pooling funds to take care of treatment by an individual when needed. The NHIS should be improved through policies that include closer integration of the informal and formal sectors under the existing NHIS with improvements in communication and education, higher public and private healthcare funding, and targeted financial assistance.[80]

In Nigeria, private health insurance is still limited in its scope, and even in countries where it has taken root, insurance beneficiaries still have limitation to the utilization of healthcare services and may not ensure financial protection.[81] Funding of healthcare from the general health budget is still poor in Nigeria. The current allocations are in the region of 4% of the budgets,[12] with erratic and none release of the allocated budgets.[73] The law establishing the NHIS did not make contribution by all citizens compulsory, and state governments have exercised their discretion to enroll or not. A few states have joined the scheme. The organized private sector has also not joined. Only federal government employees and their households are covered by NHIS.[82,83] States in Nigeria should setup and manage their own insurance schemes as a unique opportunity for rapidly scaling up SHI for Nigerians. The Nigerian three-tier governance structure should be leveraged to help states establish and manage their own insurance funds while encouraging integration with the NHIS.[20] Nigeria must make health insurance compulsory to achieve UHC.[84]

There should be an effective regulatory regimen to guide behaviors of all institutions and stakeholders involved in SHI toward undesirable business practices.[82,85,86] Which should also include identifying the role of research?[87] The Nigerian government should drive a creative policy to raise the necessary funds to capture all its citizens in the provision of basic healthcare. It must ensure adequate and equitable distribution of good quality healthcare infrastructure and human resources for health so that the insurer will receive equitable and good quality health services.[20,32,73] Nigeria can learn from a country like Thailand which was able to achieve UHC in 2001 started with government employees and dependents and extend mandatory social insurance scheme for formal private employees and later all others citizens under a single fund financed by general tax revenue.[88] Similarly, from an island country of Fiji, which healthcare system has achieved a degree of vertical equity in financing (taxes paid increase with the amount of earned income), therefore, the poor receive a higher share of benefits from government health spending and bear a lower share of the financing burden than wealthier groups.[89]

Taxes that can fund UHC, for example, increasing domestic tax revenues by encouraging progressive tax and discouraging consumption tax, should be integral to achieve UHC, and emphasis should also be on pro-poor taxes on profits and capital gains.[90] International health development agencies can assist Nigeria to make this transition to financing its health systems publicly.[25] Pooled public financing is far greater

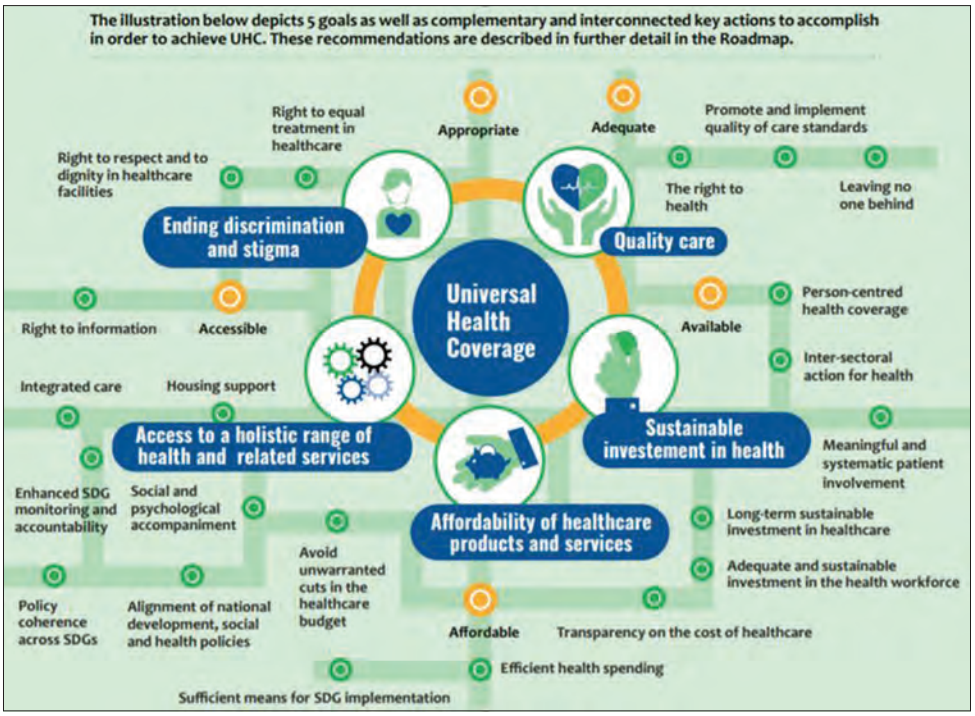

Figure 2: Taking action – A roadmap to achieving universal health coverage for all by 2030

at ensuring better access to healthcare services and health outcomes than out of pockets (OOPs) expenditure or private voluntary insurance which are associated with higher mortality rates.[91] " n financing UHC, collecting taxes, improving tax administration, and expanding the tax base in Nigeria are more achievable.[26]"

There is a need to establish a Commission on UHC in Nigeria with legislative power enacted by the National Assembly and headed by a Public Health Physician as Czar with direct reporting to the President of Nigeria. The Commission should be given extra-ministerial power to cut out bureaucratic bottleneck and have access to national resources such as fund locked up in legislation like the National Health Bill of 2014. The Commission should coordinate with government health insurance scheme and PHC bodies as well. The Commission should have direct supervision of the NHIS, the National Primary Healthcare Development Agency, and the Nigeria PPP Commission.

The derivative from all the potential mechanisms to fund UHC and finance healthcare systems to reach the twin goals of effective quality healthcare services and financial protection for the poor and vulnerable is shown in Figure 3.

Nigeria should adopt the hybrid healthcare financing system option. It should incorporate progressive tax revenues from profits, capital gain, and income, as well as some indirect taxes (for example, on luxury goods) and other indirect taxes that might help improve health outcomes (for example, taxes on tobacco and alcohol).[90]

MT has been described as "travel across international borders with the intention of receiving some form of medical treatment. This treatment may span the full range of medical services but most commonly includes dental care, cosmetic surgery, elective surgery, and fertility treatment."[92] MT has also been described as combination of "the two of the fastest growing industries in the world; healthcare and tourism." There is a paradigm shift in MT from wealthy patients from developing countries traveling to developed countries to seek healthcare services to take advantage of their technologically most advanced medical facilities. The current prevailing pattern is that less wealthy patients from developed countries seeking expert healthcare services at most affordable rates and quick response in the developing countries[93] and mostly in the Asia-Pacific region of the world.[94]

The failure of Nigeria's health system is responsible for the thriving foreign MT as a result of poor quality and service delivery, poor funding, inadequate human resource for health capacity, poor infrastructure, and inadequate specialist services, among other flaws [Figure 4]. MT in Nigeria is largely net outflow of patients seeking better quality healthcare outside Nigeria which has led to a net outflow of scarce foreign currency. A significant number of Nigerians travel abroad every year for MT, and estimates showed that Nigeria may be losing about $1.3 billion yearly as a result which places a burden on the Nigerian economy.[95] This is often facilitated by MT facilitators that market healthcare services over the internet and social media.[59] There is a need to regulate MT agencies and physicians and to invest more resources into Nigeria's healthcare.[60]

The MT sector has a lot of potentials to grow but is also confronted with many challenges that need to be tackled.[96,97]

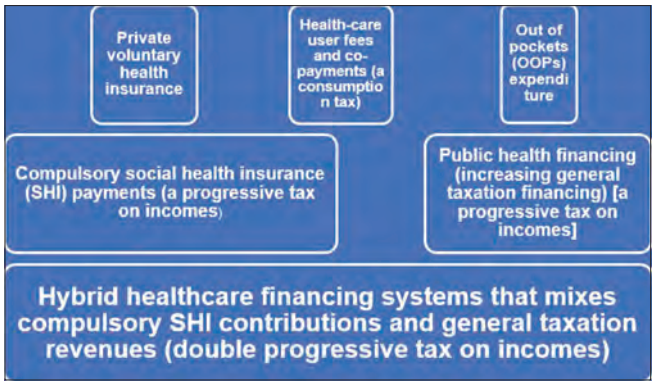

Figure 3: Healthcare financing system hierarchy for universal healthcare coverage

Figure 4: Factors responsible for increase outflow for medical tourism in Nigeria

Figure 5: Challenges with medical tourism

MT presents a new and challenging health ethics frontier, being largely unregulated as shown in Figure 5.[98] Patient autonomy and informed consent, obtaining honest information, quality of care in destination facilities, limited health literacy, and risks of seeking healthcare in another country are some of these ethical issues.[99]

Improving the quality of healthcare delivery in Nigeria can solve the problems facing healthcare systems.[61] Nigeria can learn from many countries that are destinations for MT in the Asia-Pacific region.[62] There is need for massive investment in the healthcare industry in Nigeria both by the government and by the private investors either by Nigerians or foreigners[9] by investing in infrastructures, human resources for health, technology, hospital/medical supplies, and drugs for higher coverage as well as improving public health services.[100] Encouraging medical doctors in the diaspora to provide rare disease treatment and advanced medical services in Nigeria, enhancement of private hospitals with excellent services to provide more services,[48] etc., can also help. However, the drawback will be cost and access issues because of the high prevalence of poverty in Nigeria. This can be addressed by compulsory social health insurance (SHI) programme and progressive tax on income.

PPPs are on-going long-term agreements and collaboration between government and private sector organizations. Each participate in the decision-making, sharing of risks, responsibilities, rewards, and production of a public good or service that has traditionally been provided by the public sector.[101] Evidence supports PPPs as a strategy for improving healthcare infrastructure and operations.[22,102] This is a win–win situation for both the public and private sector players in healthcare as well as the general population,[18,103] by developing human resources for health capacity and improving quality of healthcare services.[104] There is quicker market entry and guaranteed revenue streams as well as an increased ability to attract more patients with higher purchase power.[105]

With UHC, access to healthcare is easier and diseases are treated well before they are advanced.[27] The medical infrastructure will be better developed due to increased funding from the public budget, compulsory health insurance, and the private sector. More human resources for health capacity will be available. This will lead to the development of confidence of Nigerians in the quality and variety of healthcare services available at an affordable cost to them. The attainment of such a level of development in the Nigerian healthcare system will stem an outward flow of Nigerians for medical treatment abroad and foreigners will flock to Nigeria for MT. Nigeria will be saving and earning foreign currency through inward flow MT just like as it is in Thailand.[106]

Recommendations

Political will at the federal and state government levels of Nigeria to implement UHC through the hybrid health financing systems that mix compulsory SHI contributions and general taxation revenues (double progressive tax on incomes) and encourage private investments in healthcare. Nigeria needs to commit massive resources to the health sector. Health system operators should focus more on improving the quality of services to improve public confidence.

Conclusion

Improving the quality of healthcare delivery and increasing

accessibility, affordability, and timeliness of access to the population through UHC can stem MT. Exploring funding options that ensure access to healthcare for all and revitalization of PHC in Nigeria are necessary to achieve UHC.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. The World Bank Group. Nigeria on the Move: A Journey to Inclusive Growth – Moving Toward a Middle-Class Society. Report No.: 145345. The World Bank; 2020. p. 1. Available from: http://documents.worldbank.org/curated/en/891271581349536392/Nigeria-on-the-Move-A-Journey-to-Inclusive-Growth-Moving-Toward-a-Middle-Class-Society. [Last accessed on 2020 May 09].
2. Maheshwari S, Animasahun BA, Njokanma OF. International patients with congenital heart disease: What brings them to India? Indian Heart J 2012;64:50-3.
3. Oni T, Unwin N. Why the communicable/non-communicable disease dichotomy is problematic for public health control strategies: Implications of multimorbidity for health systems in an era of health transition. Int Health 2015;7:390-9.
4. Aregbeshola BS, Khan SM. Determinants of catastrophic health expenditure in Nigeria. Eur J Health Econ 2018;19:521-32.
5. Okedo-Alex IN, Akamike IC, Ezeanosike OB, Uneke CJ. A review of the incidence and determinants of catastrophic health expenditure in Nigeria: Implications for universal health coverage. Int J Health Plann Manage 2019;34:e1387-404.
6. Ukwaja KN, Alobu I, Abimbola S, Hopewell PC. Household catastrophic payments for tuberculosis care in Nigeria: Incidence, determinants, and policy implications for universal health coverage. Infect Dis Poverty 2013;2:21.
7. Boyce T, Brown C. Economic and Social Impacts and Benefits of Health Systems. World Health Organization Regional Office for Europe; 2009. Available from: http://www.euro.who.int/__data/assets/pdf_file/0006/395718/Economic-Social-Impact-Health-FINAL.pdf?ua=1. [Last accessed on 2020 May 19].
8. United Nations. Transforming our World: The 2030 Agenda for Sustainable Development: Sustainable Development Knowledge Platform; 2015. Available from: https://sustainabledevelopment.un.org/post2015/transformingourworld. [Last accessed on 2020 May 19].
9. Stenberg K, Axelson H, Sheehan P, Anderson I, Gülmezoglu AM, Temmerman M, *et al*. Advancing social and economic development by investing in women's and children's health: A new Global Investment Framework. Lancet Lond Engl 2014;383:1333-54.
10. United Nations Development Programme. Human Development Report 2019: Beyond Income, Beyond Averages, Beyond Today: Inequalities in Human Development in the 21st Century; 2019. Available from: http://hdr.undp.org/sites/default/files/hdr2019.pdf. [Last accessed on 2020 May 19].
11. United Nations. World Summit for Social Development. DISD; 1995. Available from: https://www.un.org/development/desa/dspd/world-summit-for-social-development-1995.html. [Last accessed on 2020 May 19].
12. The World Bank Group. Domestic General Government Health Expenditure (% of General Government Expenditure) – South Africa, Nigeria, Uganda, United States, Zimbabwe, Tanzania, Kenya, Zambia. Available from: https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=ZA-NG-UG-US-ZW-TZ-KE-ZM&name_desc=false. [Last accessed on 2020 May 19].
13. United Nations Children's Fund (UNICEF. Nigeria (NGA) – Demographics, Health & Infant Mortality. UNICEF DATA. Available from: https://data.unicef.org/country/nga/. [Last accessed on 2020 May 19].
14. World Health Organization. General Health Observatory (GHO), By Country, Nigeria – Statistics Summary (2002-Present). World Health Organization. Available from: https://apps.who.int/gho/data/node.country.country-NGA?lang=en. [Last accessed on 2020 May 19].
15. World Health Organization. Global Health Observatory data Repository (GHO), By Category, Medical Doctors. Available from: https://apps.who.int/gho/data/node.main.HWFGRP_0020?lang=en. [Last accessed on 2020 May 09].
16. Aregbeshola BS, Khan SM. Predictors of enrolment in the national health insurance scheme among women of reproductive age in Nigeria. Int J Health Policy Manage 2018;7:1015-23.
17. Fairall L, Bateman E. Health workers are vital to sustainable development goals and universal health coverage. BMJ 2017;356:j1357.
18. Akinsete PN-E. PPPs: The Antidote to Nigeria's Healthcare Infrastructure Deficit, Lexology. Available from: https://www.lexology.com/library/detail.aspx?g=9d3ea77f-78ce-48d0-ad70-f9d6e999779a. [Last accessed on 2020 May 09].
19. Oleribe OO, Udofia D, Oladipo O, Ishola TA, Taylor-Robinson SD. Healthcare workers' industrial action in Nigeria: A cross-sectional survey of Nigerian physicians. Hum Resour Health 2018;16:54.
20. Okpani AI, Abimbola S. Operationalizing universal health coverage in Nigeria through social health insurance. Niger Med J 2015;56:305-10.
21. Onwujekwe O, Hanson K, Uzochukwu B. Do poor people use poor quality providers? Evidence from the treatment of presumptive malaria in Nigeria. Trop Med Int Health 2011;16:1087-98.
22. Osibogun A. PPP as tool for Improving Health Infrastructure. The Guardian Nigeria News-Nigeria and World News; 2016. Available from: https://guardian.ng/features/ppp-as-tool-for-improving-health-infrastructure/. [Last accessed on 2020 May 19].
23. Ogundeji YK, Ohiri K, Agidani A. A checklist for designing health insurance programmes – A proposed guidelines for Nigerian states. Health Res Policy Syst 2019;17:81.
24. Osamuyimen A, Ranthamane R, Qifei W. Analysis of Nigeria health insurance scheme: Lessons from China, Germany and United Kingdom. IOSR J Humanit Soc Sci 2017;22:33-9.
25. Yates R. Universal health coverage: Progressive taxes are key. Lancet 2015;386:227-9.
26. Aregbeshola BS. A tax-based, noncontributory, health-financing system can accelerate progress toward universal health coverage in Nigeria. Med Rev 2018;20:40-5.
27. World Health Organization. Universal Health Coverage (UHC): Fact Sheet. World Health Organization. Available from: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc). [Last accessed on 2020 May 09].
28. Sambo LG, Kirigia JM. Investing in health systems for universal health coverage in Africa. BMC Int Health Hum Rights 2014;14:28.
29. World Health Organization, African Union. Universal Health Coverage in Africa: From Concept to Action: 1st African Ministers of Health meeting jointly convened by the AUC and WHO, Luanda, Angola. Luanda: World Health Organization Regional Office for Africa and the African Union; 2014. Available from: https://www.who.int/health_financing/policy-framework/auc-who-2014-doc1-en.pdf?ua=1. [Last accessed on 2020 Feb 04].
30. The World Bank Group, World Health Organization, JICA, The Global Fund to Fight AIDS, Tuberculosis and Malaria, the African Development Bank. UHC in Africa: A Framework for Action. Washington, D. C.: The World Bank Group; 2016. Available from: http://documents.worldbank.org/curated/en/735071472096342073/pdf/108008-v1-REVISED-PUBLIC-Main-report-TICAD-UHC-Framework-FINAL.pdf. [Last accessed on 2020 Apr 04].
31. Workie NW, Shroff E, S Yazbeck A, Nguyen SN, Karamagi H. Who needs big health sector reforms anyway? Seychelles' road to UHC provides lessons for sub-Saharan Africa and Island Nations. Health Syst Reform 2018;4:362-71.
32. World Health Organization. Arguing for Universal Health Coverage. Report No.: 978 92 4 150634 2. Geneva: World Health Organization; Available from: https://www.who.int/health_financing/UHC_ENvs_BD.PDF?ua=1. [Last accessed on 2020 Apr 15].
33. World Health Organization. Draft Thirteenth General Programme of

Work 2019–2023. Geneva, Switzerland: World Health Organization; 2018. p. 46. Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf. [Last accessed on 2020 Apr 14].
34. World Health Organization (Regional Office for Africa AFRO). Presidential Summit on Universal Health Coverage in Nigeria. WHO | Regional Office for Africa; 2014. Available from: https://www.afro.who.int/news/presidential-summit-universal-health-coverage-ends-nigeria. [Last accessed on 2020 May 09].
35. National Institute for Policy and Strategic Studies. President Buhari Inaugurates NIPSS Senior Executive Course 41. National Institute for Policy and Strategic Studies – Kuru, Nigeria. Available from: https://www.nipsskuru.gov.ng/index.php/79-research/133-president-buhari-inaugurates-nipss-senior-executive-course-41.html. [Last accessed on 2020 May 09].
36. Budget Office of the Federation (Federal Government of Nigeria). Economic Recovery & Growth Plan 2017-2020 – Budget Office of the Federation – Federal Republic of Nigeria; 2017. Available from: https://budgetoffice.gov.ng/index.php/economic-recovery-growth-plan-2017-2020. [Last accessed on 2020 May 09].
37. Agustina R, Dartanto T, Sitompul R, Susiloretni KA, Suparmi S, Achadi EL, *et al*. Universal health coverage in Indonesia: Concept, progress, and challenges. Lancet 2019;393:75-102.
38. Assan A, Takian A, Aikins M, Akbarisari A. Challenges to achieving universal health coverage through community-based health planning and services delivery approach: A qualitative study in Ghana. BMJ Open 2019;9:e024845.
39. Assefa Y, Gelaw YA, Hill PS, Taye BW, Van Damme W. Community health extension program of Ethiopia, 2003-2018: Successes and challenges toward universal coverage for primary healthcare services. Global Health 2019;15:24.
40. Bredenkamp C, Evans T, Lagrada L, Langenbrunner J, Nachuk S, Palu T. Emerging challenges in implementing universal health coverage in Asia. Soc Sci Med 2015;145:243-8.
41. Joarder T, Chaudhury TZ, Mannan I. Universal Health Coverage in Bangladesh: Activities, Challenges, and Suggestions. Vol. 2019. Advances in Public Health. Hindawi; 2019. p. e4954095. Available from: https://www.hindawi.com/journals/aph/2019/4954095/. [Last accessed on 2020 May 25].
42. Umeh CA. Challenges toward achieving universal health coverage in Ghana, Kenya, Nigeria, and Tanzania. Int J Health Plann Manage 2018;33:794-805.
43. Chen HC, Kuo HC, Chung KP, Chang S, Su S, Yang MC. Classification and comparison of niche services for developing strategy of medical tourism in Asian countries. Int Surg 2010;95:108-16.
44. Park J, Ahn J, Yoo WS. The Effects of price and health consciousness and satisfaction on the medical tourism experience. J Healthc Manag 2017;62:405-17.
45. Tompkins OS. Medical tourism. AAOHN J Am Assoc Occup Health Nurses 2010;58:40.
46. Medical Tourism; 2020. Available from: https://en.wikipedia.org/w/index.php?title=Medical_tourism&oldid=953999910. [Last accessed on 2020 May 09].
47. Martínez Álvarez M, Chanda R, Smith RD. The potential for bi-lateral agreements in medical tourism: A qualitative study of stakeholder perspectives from the UK and India. Global Health 2011;7:11.
48. Hanefeld J, Smith R, Horsfall D, Lunt N. What do we know about medical tourism? A review of the literature with discussion of its implications for the UK National Health Service as an example of a public health care system. J Travel Med 2014;21:410-7.
49. Franzblau LE, Chung KC. Impact of medical tourism on cosmetic surgery in the United States. Plast Reconstr Surg Glob Open 2013;1:e63.
50. Lunt N, Horsfall D, Hanefeld J. Medical tourism: A snapshot of evidence on treatment abroad. Maturitas 2016;88:37-44.
51. Jabbari A, Delgoshaei B, Mardani R, Tabibi SJ. Medical tourism in Iran: Issues and challenges. J Educ Health Promot 2012;1:39.
52. Rezaee R, Mohammadzadeh M. Effective factors in expansion of medical tourism in Iran. Med J Islam Repub Iran 2016;30:409.
53. Kim KL, Seo BR. Developmental Strategies of the Promotion Policies in Medical Tourism Industry in South Korea: A 10-Year Study (2009-2018). Iran J Public Health 2019;48:1607-16.
54. Seo BR, Park SH. Policies to promote medical tourism in Korea: A narrative review. Iran J Public Health 2018;47:1077-83.
55. Kim S, Arcodia C, Kim I. Critical success factors of medical tourism: The case of South Korea. Int J Environ Res Public Health 2019;16:4964.
56. Johnston R, Crooks VA, Cerón A, Labonté R, Snyder J, Núñez EO, *et al*. Providers' perspectives on inbound medical tourism in Central America and the Caribbean: Factors driving and inhibiting sector development and their health equity implications. Glob Health Action 2016;9:32760. doi: 10.3402/gha.v9.32760. eCollection 2016. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5120386/. [Last accessed on 2020 May 09].
57. Johnston R, Crooks VA. Medical tourism in the Caribbean region: A call to consider environmental health equity. West Indian Med J 2013;62:250-3.
58. Ramírez de Arellano AB. Medical tourism in the Caribbean. Signs (Chic) 2011;36:289-96.
59. Makinde OA, Brown B, Olaleye O. The impact of medical tourism and the code of medical ethics on advertisement in Nigeria. Pan Afr Med J 2014;19:103.
60. Makinde OA. Physicians as medical tourism facilitators in Nigeria: Ethical issues of the practice. Croat Med J 2016;57:601-4.
61. Johnston R, Crooks VA, Snyder J, Kingsbury P. What is known about the effects of medical tourism in destination and departure countries? A scoping review. Int J Equity Health 2010;9:24.
62. Yeoh EK, Johnston C, Chau PYK, Kiang N, Tin P, Tang J. Governance functions to accelerate progress toward universal health coverage (UHC) in the Asia-Pacific Region. Health Syst Reform 2019;5:48-58.
63. Cohen IG. How to regulate medical tourism (and why it matters for bioethics). Dev World Bioeth 2012;12:9-20.
64. Cohen IG. Circumvention tourism. Cornell Law Rev 2012;97:1309-98.
65. Jackson C, Snyder J, Crooks VA, Lavergne MR. "I didn't have to prove to anybody that I was a good candidate": A case study framing international bariatric tourism by Canadians as circumvention tourism. BMC Health Serv Res 2018;18:573.
66. Ooms G, Ottersen T, Jahn A, Agyepong IA. Addressing the fragmentation of global health: The Lancet Commission on synergies between universal health coverage, health security, and health promotion. Lancet 2018;392:1098-9.
67. Awosusi A, Folaranmi T, Yates R. Nigeria's new government and public financing for universal health coverage. Lancet Glob Health 2015;3:e514-5.
68. World Health Organization. Commission on Macroeconomics and Health. Macroeconomics and Health: Investing in Health for Economic Development. World Health Organization; 2001. Available from: https://apps.who.int/iris/handle/10665/42435. [Last accessed on 2020 May 09].
69. Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A, *et al*. Global health 2035: A world converging within a generation. Lancet 2013;382:1898-955.
70. Maeda A, Cashin C, Harris J, Ikegami N, Reich MR. Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies. Report No.: 88862. The World Bank; 2014. p. 1-75. Available from: http://documents.worldbank.org/curated/en/575211468278746561/Universal-health-coverage-for-inclusive-and-sustainable-development-a-synthesis-of-11-country-case-studies. [Last accessed on 2020 May 09].
71. Nabarro D. Why Universal Health Coverage and Functioning Health Systems are so Important, Reflections David Nabarro – A Global Health Leader who Puts People First. Available from: https://archive.davidnabarro.info/whodg/en/reflections/universal-health-coverage/. [Last accessed on 2020 May 10].
72. European Patients' Forum, Universal Health Coverage for All 2030. Taking Action – A Roadmap to Achieving Universal Health Coverage for All by 2030. Brussels, Belgium: European Patient Forum and Universal Health Coverage for All 2030; 2017. p. 24. Available from: https://www.eu-patient.eu/globalassets/campaign-on-access/taking-action---a-roadmap-to-achieving-universal-health-coverage-for-all-by-2030.pdf. [Last accessed on 2020 Feb 04].
73. Uzochukwu BS, Ughasoro MD, Etiaba E, Okwuosa C, Envuladu E,

Onwujekwe OE. Health care financing in Nigeria: Implications for achieving universal health coverage. Niger J Clin Pract 2015;18:437-44.
74. Tilley-Gyado R, Filani O, Morhason-Bello I, Adewole IF. Strengthening the primary care delivery system: A catalytic investment toward achieving universal health coverage in Nigeria. Health Syst Reform 2016;2:277-84.
75. National Health Insurance Scheme. National Health Insurance Scheme, Nigeria Vision, Mission and Objectives. Available from: https://www.nhis.gov.ng/company-alternative/. [Last accessed on 2020 May 10].
76. Sumriddetchkajorn K, Shimazaki K, Ono T, Kusaba T, Sato K, Kobayashi N. Universal health coverage and primary care, Thailand. Bull World Health Organ 2019;97:415-22.
77. Onyeji E. What Nigeria must do to achieve universal health coverage – Experts – Premium Times Nigeria; 2019. Available from: https://www.premiumtimesng.com/health/health-news/324745-what-nigeria-must-do-to-achieve-universal-health-coverage-experts.html. [Last accessed on 2020 May 10].
78. Aregbeshola BS, Khan SM. Out-of-pocket payments, catastrophic health expenditure and poverty among households in Nigeria 2010. Int J Health Policy Manag 2018;7:798-806.
79. Ifijeh M, Thisday Newspaper. Nigeria's Grossly Inadequate 2017 Health Budget. THISDAYLIVE; 2017. Available from: https://www.thisdaylive.com/index.php/2017/02/09/nigerias-grossly-inadequate-2017-health-budget/. [Last accessed on 2020 May 10].
80. Odeyemi IA. Community-based health insurance programmes and the National Health Insurance Scheme of Nigeria: Challenges to uptake and integration. Int J Equity Health 2014;13:20.
81. Wu R, Li N, Ercia A. The Effects of private health insurance on universal health coverage objectives in China: A systematic literature review. Int J Environ Res Public Health 2020;17:2049.
82. Onoka CA, Hanson K, Hanefeld J. Towards universal coverage: A policy analysis of the development of the National Health Insurance Scheme in Nigeria. Health Policy Plan 2015;30:1105-17.
83. World Bank Open Data. Available from: https://data.worldbank.org/. [Last accessed on 2020 May 25].
84. Onyeji E. Premium Time Online News. Analysis: Why Buhari should Sign Bill Seeking Mandatory Health Insurance for Nigerians; 2019. Available from: https://www.premiumtimesng.com/news/headlines/350995-analysis-why-buhari-should-sign-bill-seeking-mandatory-health-insurance-for-nigerians.html. [Last accessed on 2020 May 10].
85. Onoka CA, Hanson K, Mills A. Growth of health maintenance organisations in Nigeria and the potential for a role in promoting universal coverage efforts. Soc Sci Med 2016;162:11-20.
86. Okoronkwo IL, Onwujekwe OE, Ani FO. The long walk to universal health coverage: Patterns of inequities in the use of primary healthcare services in Enugu, Southeast Nigeria. BMC Health Serv Res 2014;14:132.
87. Seyi-Olajide JO, Ameh EA. Investing in pediatric surgical research to advance universal health coverage for children in Nigeria. Niger J Surg 2020;26:1-8.
88. Limwattananon S, Tangcharoensathien V, Tisayaticom K, Boonyapaisarncharoen T, Prakongsai P. Why has the universal coverage scheme in Thailand achieved a pro-poor public subsidy for health care? BMC Public Health 2012;12 Suppl 1:S6.
89. Asante AD, Irava W, Limwattananon S, Hayen A, Martins J, Guinness L, *et al*. Financing for universal health coverage in small island states: Evidence from the Fiji Islands. BMJ Glob Health 2017;2:e000200.
90. Reeves A, Gourtsoyannis Y, Basu S, McCoy D, McKee M, Stuckler D. Financing universal health coverage–effects of alternative tax structures on public health systems: Cross-national modelling in 89 low-income and middle-income countries. Lancet 2015;386:274-80.
91. Moreno-Serra R, Smith PC. Does progress towards universal health coverage improve population health? Lancet 2012;380:917-23.
92. Lunt N, Smith RD, Mannion R, Green ST, Exworthy M, Hanefeld J, *et al*. Implications for the NHS of inward and outward medical tourism: A policy and economic analysis using literature review and mixed-methods approaches. (Health Services and Delivery Research). Southampton (UK): NIHR Journals Library; 2014. Available from: http://www.ncbi.nlm.nih.gov/books/NBK263160/. [Last accessed on 2020 May 10].
93. Badulescu D, Badulescu A. Medical tourism: Between entrepreneurship opportunities and bioethics boundaries: Narrative review article. Iran J Public Health 2014;43:406-15.
94. Dang HS, Nguyen TM, Wang CN, Day JD, Dang TM. Grey system theory in the study of medical tourism industry and its economic impact. Int J Environ Res Public Health 2020;17:961. doi: 10.3390/ijerph17030961.
95. Shoroye A; The Guardian Newspaper. Reversing Medical Tourism in Nigeria. The Guardian Nigeria News – Nigeria and World News; 2018. Available from: https://guardian.ng/features/reversing-medical-tourism-in-nigeria/. [Last accessed on 2020 May 10].
96. Agarwal A, Chetty P. Challenges in medical tourism. Project Guru; 2012. Available from: https://www.projectguru.in/challenges-in-medical-tourism/. [Last accessed on 2020 May 10].
97. Mestrovic T. Medical Tourism Risks; 2010. Available from: https://www.news-medical.net/health/Medical-Tourism-Risks.aspx. [Last accessed on 2020 May 10].
98. Mogaka JJO, Mupara L, Tsoka-Gwegweni JM. Ethical issues associated with medical tourism in Africa. J Mark Access Health Policy 2017;5:1309770.
99. Gobalakrishnan C. Sociology of Medical Tourism. Chennai, India: MJP Publishers; 2019. p. 274.
100. Hsieh VC, Wu JC, Wu TN, Chiang TL. Universal coverage for primary health care is a wise investment: Evidence from 102 low- and middle-income countries. Asia Pac J Public Health 2015;27:NP877-86.
101. Roehrich JK, Lewis MA, George G. Are public-private partnerships a healthy option? A systematic literature review. Soc Sci Med 2014;113:110-9.
102. Wadge H, Roy R, Sripathy A, Fontana G, Marti J, Darzi A. How to harness the private sector for universal health coverage. Lancet 2017;390:e19-20.
103. Clarke D, Doerr S, Hunter M, Schmets G, Soucat A, Paviza A. The private sector and universal health coverage. Bull World Health Organ 2019;97:434-5.
104. McPake B, Hanson K. Managing the public-private mix to achieve universal health coverage. Lancet 2016;388:622-30.
105. Nabyonga-Orem J, Nabukalu JB, Okuonzi SA. Partnership with private for-profit sector for universal health coverage in sub-Saharan Africa: Opportunities and caveats. BMJ Glob Health 2019;4:e001193.
106. Noree T, Hanefeld J, Smith R. Medical tourism in Thailand: A cross-sectional study. Bull World Health Organ 2016;94:30-6.