Beware the hand that serves what it will not taste: Presidential medical tourism and implications for healthcare development (2015–2025)

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Abstract

Persistent presidential medical tourism in Nigeria between 2015 and 2025 exposes a growing disconnect between elite health-seeking behaviour and the condition of the national health system. This study investigates how successive presidents, despite making ambitious commitments to reform, continued to seek medical treatment abroad, thereby weakening public trust and the credibility of health governance. Guided by the Theory of institutional distrust, the study argues that when leaders avoid the public services they provide, they reinforce citizens' perceptions of institutional failure and diminished accountability. The study employs a qualitative approach based on documentary analysis, policy reviews, media sources, and secondary literature. The results show that, although various reforms, such as increased funding, infrastructural upgrades, and international collaboration, were introduced, health outcomes remained poor. Both presidents made repeated overseas medical visits, indicating a lack of confidence in domestic facilities. Their behaviour contributed to the failure of symbolic leadership, public distrust, economic losses, the departure of medical professionals, and policy inconsistency. The discussion highlights that this contradiction between rhetoric and conduct fuels a cycle of institutional distrust. The conclusion emphasises that genuine health sector reform requires leaders to use and improve local facilities, which is essential for rebuilding trust and achieving sustainable development.

Keywords: Healthcare Provision, Medical Tourism, Nigerian Presidency, Public Trust, Governance, Policy Reform

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INTRODUCTION

Health is wealth. While no country is immune to healthcare challenges, nations with robust healthcare systems enjoy a more substantial, more productive population and waste less on avoidable medical tourism. That is why international, regional, and local actors, both state and non-state, invest heavily in health infrastructure, policies, and human capital. The World Health Organisation (WHO, 2017) and the Sustainable Development Goals (SDGs) rightly underscore this: affordable healthcare is not a luxury but a fundamental right and a development necessity. Nations that ignore this are simply writing off their future. There is a global healthcare burden, with so many deaths. WHO (2023) reported that an estimated 260,000 women died from pregnancy and childbirth-related causes, with about 92% of these deaths occurring in low- and lower-middle-income countries, most of them preventable. Sub-Saharan Africa and Southern Asia were the most affected, accounting for 87% of global maternal deaths, with Sub-Saharan Africa alone responsible for 70% (182,000 deaths) and Southern Asia 17% (43,000 deaths) (WHO, 2025). On April 27, 2001, African Union (AU) governments adopted the Abuja declaration, which set a target of allocating at least 15 per cent of their national budgets to improve health care. However, most of these states have failed to achieve this feat except for two countries, Cabo Verde and South Africa, which met this target in 2021 (Human Rights Watch, 2024). Other states that ratified the laws, including Nigeria, where the convention was held, still grapple to fulfil this promise.

Nigeria, with a population exceeding 200 million, continues to struggle with a poorly funded and overstretched healthcare system as Government spending on health remains low. While healthcare delivery in Nigeria is structured across primary, secondary, and tertiary levels and includes contributions from private actors, religious bodies, and traditional practitioners, access remains limited, particularly among people living in poverty (Thompson, 2021). Government hospitals, though the most affordable, are often under-resourced and overcrowded. The arrival of President Muhammadu Buhari in 2015, as well as that of his successor, Bola Ahmed Tinubu, both promising to end medical tourism by building world-class hospitals and affordable, accessible healthcare for the public, brought great hope to the public. At one point, President Buhari even promised to stop his Ministers from going on medical tourism. However, despite these commitments and claims of developing "world-class" hospitals, both President Buhari and his successor continued to seek medical care abroad. Although prior research (Thompson, Oladele et al., 2024; Thompson & Nwaorgu, 2024) has explored broader healthcare challenges in Nigeria, presidents have paid limited attention to medical tourism.

This study investigates the systemic failures, policy inconsistencies, and socio-economic dynamics that sustain elite medical tourism. It poses key questions: What was the state of healthcare before 2015? How has the presidency utilised medical tourism and what implications does it have for national development? This paper is necessitated by the continued promises of presidents to improve the healthcare sector, with little to show for it over the years. The paper is significant because few papers focus on the presidency, even when it is a symbolic and structural policymaker. The period from 2015 to 2025 is also significant because it saw the greatest pledges in the fourth republic. By focusing on the presidency, this study shifts from individual decisions to state-level political behaviour, offering a much deeper understanding of how elites shape policy through personal choices.

Literature Review

The healthcare system in Nigeria has increasingly drawn scholarly attention, particularly regarding persistent challenges in delivering quality medical services and the rise in medical tourism. The

frequent trips of politicians and elites abroad for medical care highlight critical deficiencies in healthcare infrastructure, governance, and public trust in domestic institutions. This trend raises concerns about political commitment, sectoral investment, and public accountability. Consequently, scholars have examined the politicisation of healthcare, economic losses from outbound medical tourism, and the symbolic impact of elite health-seeking behaviour on public perception and policy.

Tracing the history of medical tourism in Nigeria, Thompson and Nwaorgu (2024) traced it to pre-colonial times when indigenous people moved across their towns and villages seeking powerful traditional doctors who could cure their diseases and ailments. They further argued that, with colonialism, the British encouraged the elites to travel abroad, citing the example of a former Alake who was advised not only to visit the King of England but also to take care of his health.
Medical tourism has become a direct outcome of Nigeria's failing health system. Abubakar et al. (2018) report that about 5,000 Nigerians travel abroad monthly for treatment, costing the country roughly $1.2 billion annually, funds that could improve domestic healthcare. Nigeria's low ranking of 187 out of 191 countries by the World Health Organisation reflects a sector plagued by underfunding, outdated equipment, poor staff remuneration, brain drain, and frequent strikes. They advocate for increased investment, legal sanctions against negligence, and a ban on government-sponsored foreign treatment. Obuh et al. (2020) highlight how medical tourism weakens local healthcare by draining financial resources and reducing trust in domestic services. They argue that reinvesting these funds could revitalise the sector and improve public health outcomes. Folinas et al. (2021) argue that medical tourism thrived in Nigeria due to the domestic system's failure to meet public needs. The sector's weaknesses include limited funding, poor infrastructure, insufficient personnel, and weak surveillance systems, which became evident during the pandemic, resulting in the deaths of some high-profile individuals. The study concludes that reducing medical tourism demands long-term investment and reform. Limited financing or funding has implications for healthcare development. Uzochukwu argues that government spending determines the level of universal healthcare coverage and that Nigeria still lags, thus affecting its overall population. Onwujekwe et al (2019) argue that Nigeria's health financing mechanisms are inefficient, inequitable, and fail to protect households from catastrophic costs. They further argued that weak evidence-based spending, poor regulation, and ineffective insurance, and that achieving universal coverage requires stronger legislation, strategic purchasing, and stricter oversight.

Oleribe et al. (2018) identify healthcare worker strikes driven by poor welfare, low salaries, and unfulfilled government agreements as a significant cause of system failure. They recommend honouring agreements, enforcing the National Health Act, and appointing trained professionals to lead the sector. Their 2019 follow-up study, Oleribe et al (2019), found broader issues in African healthcare, including Nigeria, such as poor leadership and insufficient budgets. Public-private partnerships and multinational investments were proposed as partial solutions. Adeoye (2023) identifies infrastructural decay, corruption, underfunding, and a lack of trust in local care, especially for complex treatments, as major drivers of medical tourism. He underscores the need for improved investment and regulation to ensure quality care and legal protections at home and abroad. Makinde (2016) discusses the ethical issues surrounding physicians who serve as Medical Tourism Facilitators (MTFs), often motivated by financial gain. The lack of regulation creates opportunities for patient exploitation. He recommends criminalising unethical referrals and holding foreign hospitals accountable for substandard care. Strengthening local systems and healthcare worker development is also crucial to reducing dependence on foreign hospitals. Omisore and Agbabiaka (2016) found that service quality, cost, and facility standards influence

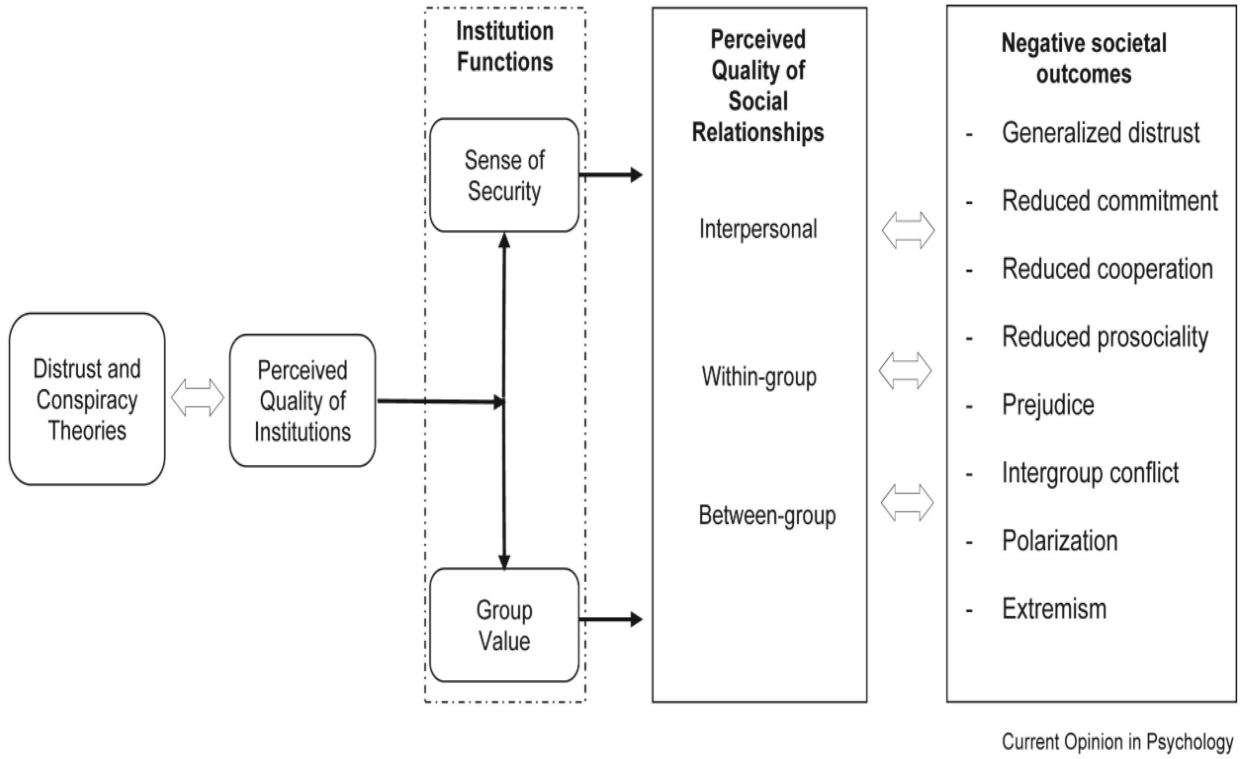
medical tourism in Lagos. Patients were dissatisfied with wait times, inadequate care, and poor equipment. They suggested stricter quality control, improved staffing, and infrastructure upgrades to reduce the appeal of foreign hospitals.

Nwafor (2023) links the poor state of healthcare to political interference, corruption, and ineffective policy implementation. Using a utilitarian perspective, the study emphasises that neglecting collective health needs hinders national development. Nwafor also connects medical tourism to weak local services, which push officials to seek care abroad, deepening inequalities and economic waste. In contrast, Salam, Salaudeen, and Adeniji (2023) investigated whether health insurance reduces medical tourism. Their regression analysis found no significant association between insurance and reduced use of foreign healthcare, suggesting deeper structural problems beyond coverage. Similarly, Orekoya and Oduyoye (2018) emphasise that comprehensive reforms and domestic investment are key to reducing medical tourism and developing Nigeria into a healthcare destination. The COVID-19 pandemic disrupted this trend. Olutuase et al. (2022) examined challenges in the medicines and vaccines supply chain, key to achieving SDG 3. They noted policy gaps, infrastructure deficits, and security threats, and recommended more vigorous enforcement, improved facilities, and increased funding to ensure universal access to essential medicines and vaccines. Idris and Thompson (2024) argue that the government's failure to invest in local cures led to overdependence on foreign intervention through vaccines, which gulped Nigeria's dwindling foreign exchange. Similarly, Agagu and Odiji (2025), whose study, based on the Contingency Theory of Leadership, explores how travel restrictions forced reliance on local services. This led to temporary policy reforms and highlighted the value of decisive leadership in healthcare. However, the authors stress that lasting improvements require sustained investment and commitment.

Despite extensive public debate and media discourse, no systematic academic study has analysed presidential medical tourism as a form of political behaviour that shapes health policy. Moreover, the decade 2015-2025 has not been studied as a coherent period of political and health policy significance. Thus, the extant literature treats medical tourism as an economic or health services issue, not as health governance, a view underscored by elite accountability.

Theoretical Framework

The paper adopts the Theory of Institutional Distrust. Mayer et al. (1995) conceptualise trust as vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trust, or irrespective of the ability to monitor or control that other party. Van Prooijen et al. (2022) assert that Suspicion of institutions undermines trust, cooperation, and prosocial behaviour, increasing prejudice, conflict, and extremism, thus weakening societal relationships. He went further to state that when people perceive societal institutions to be of low quality, it also deteriorates the quality of their social relationships. Specifically, well-functioning institutions regulate citizens' social relationships at the interpersonal, within-group, and between-group levels in at least two ways: (1) by providing a sense of security and (2) by providing models for group norms and values. Suspicion of institutions undermines these functions, yielding a range of adverse societal outcomes.



Source: Van Prooijen et al, 2022: 66

Figure 1: How the perceived quality of institutions shapes the perceived quality of social relationships.

The OECD Framework on the Drivers of Trust in Public Institutions provides an overview of these drivers, covering both public governance-related drivers of trust (governments' competencies and values) as well as individuals' socioeconomic factors, political attitudes and behaviour, and the government's capacity to address complex and global challenges (Brezzi et al., 2021). The Theory of Institutional Distrust posits that distrust in institutions (such as government or healthcare systems) arises when there is a perceived gap between the promises or responsibilities of those institutions and their actual performance, transparency, or accountability.

Tiwa (2024), while relating this to citizen-police relations, noted that citizens distrust the Police because of the informal way in which the Police process matters. In other words, he argues that when an institution moves from a formal to an informal way of doing things, the citizenry begins to doubt it. This theory is beneficial for analysing why the Nigerian public, and even the presidency, might distrust domestic healthcare, leading to behaviours such as medical tourism. The theory suggests that rebuilding trust would require transparent policies, consistent investment, and leaders demonstrating confidence in domestic healthcare by using and improving it themselves. This theory is based on the assumption that there is a perceived failure of the healthcare system, elite hypocrisy and double standards, lack of transparency and accountability, historical and cultural context and its impacts on the healthcare system. Leaders distrust local healthcare due to its poor quality, but their actions also signal to the public that the system is not worth improving, creating a vicious cycle.

METHODOLOGY

The paper adopts the qualitative data methodology. It relies on both primary and secondary sources. The primary sources of data collection are the authors' observations and experiences. The authors are versed in health history and health policies. Secondary data sources primarily supported this. Secondary data for this paper were generated through a review of the extant literature. A systematic review of the literature, policy documents and grey articles was conducted. Documents reviewed provided information on health care financing, especially in Nigeria. We searched the internet for articles on healthcare, medical tourism, and healthcare systems using search terms that included, but were not limited to, healthcare financing in Nigeria and public health policies. Further publications were identified in newspapers to sieve speeches by presidents or their representatives, such as Ministers and country directors of global health policies, as well as in books and theses. We reviewed only papers published in English. No date restrictions were placed on searches. The data collected was analysed through content analysis, presented thematically, and then interpreted using a descriptive narrative.

RESULTS

What was the State of Healthcare in Nigeria before 2015?

The foundations of Nigeria's healthcare system were established during the colonial period and solidified in the first decades following independence. In the early 20th century, medical institutions such as the University College Hospital (UCH) in Ibadan emerged as shining examples of medical sophistication. UCH, founded in 1948, became the first teaching hospital in Nigeria and attracted some of the best minds in medicine from within the country and abroad.

Nigeria's healthcare system evolved significantly since independence in 1960, shaped by domestic priorities and international pressures to improve public health outcomes (Alonge, 2020). At independence, it inherited a fragile, hospital-centric structure shaped by colonialism, lacking emphasis on primary and preventive care (Asangansi & Shaguy, 2009). Infrastructure was urban-based, leaving rural populations underserved (Maepa, 2020). Efforts to improve access, such as utilising mission hospitals, such as those of the Church Missionary Society, were inadequate (Nwashindu, Onu & Okonkwo, 2023). The first Development Plan (1962-1968) identified the challenges of healthcare in the country, including a lack of adequate workforce, among others. It focused on curative but was interfered with by the Nigerian civil war, 1967-1970 (Aregbesola, 2021)

The Second Development Plan (1970-1975) did not prioritise preventive healthcare or healthcare generally, but rather social change and post-war reconstruction. Thus, while the 1970s brought expanded hospital construction and state investment, benefits were unevenly distributed (Yemi, 2024). The Third Development Plan (1975-1980) adopted the Basic Health Service Scheme (BHSS. Despite adopting the 1978 Alma-Ata Declaration, which promoted "Health for All," delays in policy implementation stalled progress (Asangansi & Shaguy, 2009; Thompson, 2021). By the mid-1980s, Nigeria restructured its system into primary, secondary, and tertiary tiers via the National Health Policy. However, inadequate funding and poor policy alignment hindered progress (Uneke et al., 2010). This was further exacerbated by declining oil prices, which began in the late 1970s and continued into the 1980s. With the Structural Adjustment Programme (SAP) introduced in 1986, healthcare became deficient and elitist. This continued through the 1990s. In fact, General Ibrahim Babangida travelled abroad for treatment of his leg injury.

In 2001, Nigeria signed the Abuja Declaration, pledging 15% of the national budget to health. However, actual allocations averaged below 6% from 2001 to 2015, constraining access

and quality (Idris & Stephanie, 2024). The National Health Insurance Scheme (NHIS), launched in 2005 to expand coverage, reached only 5% of the population by 2015, mainly among formal sector workers (Olubunmi, 2017).

President Umaru Yar'Adua also frequently visited Saudi Arabia for medical treatment despite promises to end the menace. In November 2009, he travelled to Saudi Arabia for treatment of pericarditis and ended up being away for three months (Agbelogode, 2025). The lack of transparency about his health sparked a constitutional crisis and made Nigerians realise just how much a president's health could affect the nation's stability (The Nation, 2014). He eventually died abroad in 2010 after so many months abroad. His period of illness led to a governance gap and the establishment of a crop of elite known as the cabal.

The inauguration of Goodluck Jonathan was supposed to be a shift from the late president. By the 2010s, infrastructure included 34,675 primary centres, 5,780 secondary centres, and 166 tertiary centres (CCIH, 2017). However, most primary centres lacked drugs, staff, and equipment. Tertiary centres suffered overcrowding, underfunding, and weak outcomes, reflecting systemic inefficiencies. Consequently, medical tourism grew as citizens, including elites, sought quality care abroad. In 2013, President Goodluck Jonathan took ill while on a state visit to the United Kingdom. In March 2014, he condemned the cost of medical tourism. In his statement through his Vice, Architect Namadi Sambo, at a Presidential Summit on Universal Health Coverage (UHC) at the Banquet Hall of the State House, Abuja, he said:

> "We still have a large number of people today, travelling out of the country to seek health care services. The scale of medical tourism is enormous. We are conscious that they can be addressed with appropriate policy review if desirable. The lawmakers and others must come together to make laws that will ensure better health delivery for Nigerians" (The Nation, 2014).

Not long after these promises, he also travelled to Germany for healthcare in August 2014, thereby breaking his initial promises (News Express, 2014; Ndili & Olugbile, 2025). It must be noted that Germany was the destination of his wife's medical tourism.

How did Nigeria's Presidents Intervene in Healthcare, 2015-2025?

Before assuming office in 2015, President Muhammadu Buhari campaigned on a platform focused on security, the economy, and anti-corruption. Within the healthcare sector, he made ambitious promises, including increasing the number of physicians from 19 to 50 per 1,000 population, raising health expenditure from below ₦10,000 to ₦50,000 (US$55-US$277), and upgrading all federal hospitals to world-class standards by 2019 (Vanguard, 2015). Other pledges included investing in modern medical technology, providing free antenatal care, free healthcare for children and the elderly, free treatment for infectious diseases like HIV/AIDS and tuberculosis, boosting local pharmaceutical manufacturing, enhancing disease control systems, and banning medical tourism among politicians from May 29, 2015 (Vanguard, 2015). At his inauguration, Buhari reiterated his commitment to improving healthcare for all Nigerians.

In November 2016, he commissioned a 200-bed ultra-modern Central Hospital in Benin City, describing it as a model for future healthcare infrastructure (Vanguard, 2016). In January 2017, Buhari launched an initiative to revitalise 10,000 Primary Healthcare Centres (PHCs) across Nigeria. The goal was to ensure that at least one fully functional PHC was present in each political ward nationwide. The first phase targeted one PHC in each of the 109 senatorial districts. To

support this initiative, the federal government introduced a ₦28 billion Basic Healthcare Provision Fund in December 2017, aimed at strengthening PHC services, with implementation planned for 2018.

In June 2018, Buhari reaffirmed his administration's commitment to healthcare by commissioning the Nigerian Navy Reference Hospital in Calabar, thereby improving the welfare of security personnel (Agency Report, 2018). By December 2018, President Muhammadu Buhari pledged to establish geriatric centres in tertiary health institutions across Nigeria's six geo-political zones to provide free, specialised healthcare for citizens aged 60 and above (Obiejesi, 2018). Ironically, being over 60 himself at the time, one might expect him to benefit from this initiative. In November 2019, Buhari further committed to ensuring that all Nigerians have access to affordable, efficient, and equitable healthcare without facing financial hardship. This pledge was made during the presentation of the report, Funding Universal Healthcare Delivery in Nigeria, by Senior Executive Course 41 of the National Institute for Policy and Strategic Studies (NIPSS). The president directed relevant agencies to study the report and integrate its recommendations into national healthcare policies (Ajimotoka, 2019).

The COVID-19 pandemic further exacerbated these challenges (Idris & Thompson, 2023; Thompson & Nwaorgu, 2024). In 2020, despite the COVID-19 pandemic, President Buhari pledged to improve access to healthcare and education while receiving foreign diplomats (Elusoji, 2020). He promised reforms in governance, security, and productivity. In 2021, Dr Faisal Shuaib emphasised Buhari's commitment to revitalising Nigeria's Primary Health Care (PHC) system, announcing a summit to attract investment for PHC strengthening until 2030 (Salau, 2021). Ironically, politicians still sought treatment abroad. For example, Godswill Akpabio, after commissioning a $95 million hospital as governor, was flown to London for care just months later following a car accident (Oseni, 2015). In 2022, President Buhari inaugurated a world-class Reference Hospital in Okene, Kogi State, built under Governor Yahaya Bello to curb medical tourism and improve healthcare delivery (Daily Trust, 2022). On World Health Day 2023, Health Minister Osagie Ehanire announced that over 4,000 Primary Health Centres (PHCs) had been revitalised, now featuring staff quarters, solar power, and potable water to ensure 24/7 services—enhancing care for childbirth and emergencies.

Source: HealthcareMEA (2023)

Figure 2: Inauguration of the presidential wing of the State House Medical Centre in Abuja, May 2023

In May 2023, near the end of his administration, President Muhammadu Buhari inaugurated the $45 million presidential wing of the State House Medical Centre in Abuja. Positioned within the Presidential Villa, the state-of-the-art facility was part of his legacy projects, intended to reduce VIP medical tourism by offering improved healthcare alongside the existing Asokoro centre.

With renewed hope and a departure from the trend of elite medical tourism, President Bola Ahmed Tinubu signalled a deliberate shift in Nigeria's healthcare trajectory. In August 2024, he launched the Nigeria Sovereign Investment Authority's (NSIA) healthcare expansion programme, which aimed to retrain over 120,000 frontline health workers and strengthen diagnostic and oncology services across the country (Sobowale, 2024). This marked a strategic attempt to rebuild public trust and capacity in domestic healthcare.

In April 2025, Tinubu further demonstrated commitment to healthcare reform by approving the construction of over 8,800 new Primary Healthcare Centres across Nigeria. Additionally, he sanctioned upgrades to tertiary hospitals, with a focus on trauma response, oncology treatment, and infectious disease control (Agbarukwu, 2025). Community-level interventions complemented these efforts. In May 2025, Senator Oluremi Tinubu, the First Lady, commissioned a 100-bed Mother and Child Centre in Ohaji/Egbema, Imo State, a symbolic boost to maternal and child healthcare (Agency Report, 2025). Most significantly, in June 2025, Vice President Kashim Shettima unveiled the $350 million African Medical Centre of Excellence (AMCE) in Abuja. A collaborative project between Afreximbank and King's College Hospital, London, the AMCE is projected to reduce dependence on foreign medical care and offer world-class treatment locally.
These initiatives build upon the Tinubu administration's earlier Nigeria Health Sector Renewal Investment Initiative, valued at $2.2 billion and launched in December 2023. Collectively, they signal a new era in health governance and an institutional commitment to reversing Nigeria's medical brain drain and tourism (Ailemen, 2025).

In July 2025, Prof. Muhammad Ali Pate announced that cancer centres in Katsina, Nsukka, and Benin are ready, with others in Zaria, Jos, and Lagos coming soon (Anofi, 2025). In September 2025, the Presidency directed federal ministries, departments, and agencies to enrol their employees and to link procurement, licensing, and regulatory approvals to proof of coverage, with real-time digital checks. Hence, compliance is not on paper but in practice. Moghalu (2025) asserts that between late 2023 and mid-2025, more than 3.2 million Nigerians were newly enrolled in health insurance, bringing total coverage to about twenty million people, most of them through social schemes. This led the President to say that his administration has reduced medical tourism by 52 per cent (Adejoro, 2025a). However, have the presidency and their relatives used these same facilities or have they stopped them from patronising foreign healthcare centres?

Medical Tourism by Nigerian Presidents, 2015-2025

Despite interventions by both presidents between 2015 and 2025 and assurances of world-class standards, they consistently avoided using the healthcare services they provided or promised to citizens. This raises a critical question: are these services not good enough for them? Buhari's medical tourism officially began on February 5, 2016, with a six-day medical trip to London, though earlier visits may have been disguised as investment missions.

Figure 3: Selected Medical tourism of President Buhari, 2015 to 2022

The diagram in Figure 1 may not accurately reflect the number of times the president travelled for medical reasons. By May 2018, it was reported that he had spent about 171 days on medical tourism since his 2015 inauguration, which amounted to approximately 15 per cent of his time in office (Campbell, 2018). On 26th July 2021, President Buhari departed for the United Kingdom for a previously scheduled medical check-up. This marked the 13th time he had travelled to the UK for healthcare since assuming office in 2015. Notably, some of these visits were officially described as opportunities for rest or as investment meetings, reflecting the troubling audacity with which the presidency continues to seek foreign medical care while providing substandard

healthcare to the Nigerian populace. For instance, in one official statement released by the presidency, it was noted that President Buhari would participate in the Global Education Summit on Financing the Global Partnership for Education (GPE) 2021–2025, held in London, and also hold a bilateral meeting with Prime Minister Boris Johnson. After the summit, the statement added, the President would spend a few days for an earlier scheduled medical check-up and was expected back by the second week of August 2021 (Ilo, 2021).

Even just days before the end of his tenure in May 2023, President Buhari revisited a clinic in London, this time for a dental issue. Reports indicated that he extended his stay in the UK after attending the coronation of King Charles and Queen Camilla to consult a dentist. This persistent indulgence in foreign medical care, even for minor health concerns such as ear or dental issues, reveals a stark contradiction. Buhari had previously campaigned on a promise to prohibit medical tourism for public officials. Ironically, his successor, who made no such pledge, followed the same path shortly after taking office.

Igbinadolor (2023) characterised Buhari's eight-year administration as exploitative and ineffectual, marked by unfulfilled promises, disconnection from national realities, and extravagant overseas medical trips, while Nigeria's public health system deteriorated, leaving the population exposed to easily preventable ailments like typhoid and malaria. Campbell (2018) similarly observed that in Africa, leaders' health is often portrayed as sound until they die abroad. Fittingly, Buhari passed away in a London hospital in July 2025, only a few years after leaving office.

Bola Ahmed Tinubu Presidency and Medical Tourism, (2023-2025)

Bola Ahmed Tinubu's presidency mirrors his predecessors in terms of medical tourism. Despite claims of attending private meetings or investment summits abroad, some of his health-related travels are embedded in these visits. Notably, just before his May 2023 inauguration, Tinubu spent nearly a month abroad, citing rest. Since assuming office, he has travelled internationally over 20 times, with France and Britain his longstanding medical destinations. Several factors fuel this trend among Nigerian elites: distrust in the local healthcare system, preference for foreign services, perceived superior quality abroad, desire for second opinions, and access to public funds. These travels also reflect deeper psychological and systemic issues, including elite hypocrisy, failure to invest in local institutions, and disconnection from citizens' realities. The implications are profound, reinforcing healthcare inequality and undermining national development.

Implications of Presidential Medical Tourism on National Development

i. Symbolic Failure of Leadership

The ongoing trend of medical tourism by Nigeria's presidency from 2015 to date has significant consequences for governance, public trust, and the country's global reputation. Fundamentally, it highlights a deep failure in leadership. When the nation's top officials repeatedly seek healthcare abroad, it signals to both Nigerians and the international community that the leadership itself lacks confidence in the local health system. This undermines national development efforts and weakens the institutions the government is meant to support.

Table 1: court Outcomes of select Alleged Corrupt Elites Seeking Medical Leave during Trial, 2016-2025

Politician	Charges	Year	Medical Trip Request	Outcome
Yahaya Adoza Bello	₦80.2 b money laundering	2025	UK hypertension care	Denied
Darius Ishaku	₦27 b money laundering, breach of trust	2025	UAE check-up	Granted
Godwin Emefiele	Fraud / illegal banknote issuance	2024	UK medical treatment	Denied
Hadi Sirika:	₦8 billion contract fraud	2024	Medical leave abroad alongside his sick mother	Granted (after a lengthy period)
Taiwo Oluomo	₦2.4 b Assembly fund fraud	2023	Medical leave abroad	Granted (unopposed)
Rochas Okorocha	₦2.9 billion fraud charges	2022	Medical leave abroad	Granted (after a lengthy period)
Abba Kyari	Drug Trafficking	2022	Medical treatment from prison custody	Granted to see medical personnel of his choice
Abdulrasheed Maina	Pension fraud	2020	Medical leave abroad and failed to return	Granted (after a lengthy period)
Ayodele Fayose	N6.9 billion fraud and money laundering	2019	Medical leave	Granted and recently acquitted
Sambo Dasuki	siphoning of arms procurement funds	2016	Medical leave abroad	Denied
Diezani Alison-Madueke	corruption and financial misconduct	2016	Medical leave abroad	Granted (after a lengthy period)
Patrick Akpobokemi	fraud, conspiracy, and stealing	2016	Medical leave abroad	Granted (after a lengthy period) and discharged
Olisah Metuh	Money Laundering	2016	Medical leave abroad	Granted (after a lengthy period)

Source: Anyaogu (2016); Otera (2025), and other sources compiled by the authors

More than just a symbolic gesture, this behaviour sets a harmful example of elite withdrawal from public services. It normalises the idea that local healthcare is unsuitable for the political class, encouraging a mindset of abandonment and detachment. What may have started as rare trips for serious health concerns has now become regular travel for relatively minor issues. This pattern is no longer limited to the president and his family; many high-ranking officials now use public resources or privileges to access foreign healthcare.

Worse still is the use of medical tourism as a legal loophole to avoid accountability. Several individuals facing corruption charges have increasingly claimed health-related reasons to seek treatment abroad, effectively delaying or obstructing legal proceedings. A notable case is that of Yahaya Bello, former Kogi State governor, who asked the court for permission to travel abroad to treat high blood pressure, a condition that could be managed locally. Ironically, during his tenure, he had commissioned new health facilities, including hospitals, but chose not to use them. Similarly, in 2016, Dame Patience Jonathan, wife of former President Goodluck Jonathan, claimed that the $15 million frozen in four company accounts was meant for her medical expenses overseas, appealing to the EFCC and Skye Bank to release the funds (Akinkuotu, Nwogu, and Oladimeji, 2016).

Debo Adeniran, president of the Coalition Against Corrupt Leaders (CACOL), acknowledged that illness is a human reality but insisted that it should not be used as a shield against justice. He emphasised that sympathy for health conditions should not interfere with due legal process, particularly since many of the same officials had funded prison medical services while in office and should not fear using them now. He continued that:

The situation that the corrupt elements have put the country into is such that the victims of their corrupt acts are sicker than they claim to be. People with low incomes, the ordinary people, are the real victims of the corrupt practices perpetrated by these 'I am sick' elements. Let justice take its full course! Name, Nail, Shame and Shun Corrupt Leaders, anywhere, everywhere (Anyaogu, 2016). Such hypocrisy reflects a governance crisis and a lack of accountability. If leaders shun the hospitals they built, why should citizens trust them? Presidential medical tourism erodes public trust, weakens institutional legitimacy, and reinforces a system where elite privilege and impunity prevail over patriotism, equity, and responsible leadership.

ii. Public Trust Deficit

Citizens are increasingly reluctant to trust or invest in Nigeria's public healthcare system. According to the Nigerian Sovereign Investment Authority (NSIA), 60% of healthcare expenditure abroad is reportedly attributed to four key specialities: oncology, orthopaedics, nephrology, and cardiology. Many healthcare professionals feel undervalued and migrate to countries with better pay and facilities. This brain drain is worsened by the widespread belief that Nigerian hospitals lack modern equipment, qualified personnel, and essential drugs. Nwanze (2025) observes that medical tourism often results in African leaders dying abroad, reflecting a profound betrayal of public trust and misplaced priorities. Supporting this view, Dr Benjamin Olowojebutu, the first vice president of the Nigerian Medical Association (NMA), described the trend as a glaring indication of the elite's lack of confidence in local healthcare. He stated

Right now, we have about $7 billion leaving the country on medical tourism every year because we do not trust our system. The government has failed Nigeria's health sector. We now have one doctor for about 10,000 patients. I think it is important we know that you cannot say Nigerians should be patriotic, and that you, as a leader, cannot do the same. There have been a lot of problems over and over again: leaders leave the country in jeopardy, leave it in this bad state, and use taxpayers' money to go abroad to get themselves sorted. I think it is not very good (Ihejerika, 2025). Corroborating this, a former president of the Pharmaceutical Society of Nigeria (PSN), Mazi Sam Ohuabunwa, described the practice as deceitful and a clear indication of failed leadership. In his words:

> If you have confidence in what is set up, you use it. However, they do not. Since the late President Umaru Yar'Adua, after the embarrassment that followed his medical saga, Buhari came, and we thought he would make a change, having gone

through the same experience. Now Tinubu is often in France. It is a pattern, a failure to build or trust our own system (Leadership, 2025).

iii. Economic and Brain Drain

Millions of dollars are lost annually to foreign hospitals, particularly in the UK, India, Germany, and the UAE. According to the Central Bank of Nigeria's balance of payment data, Nigerians spent US$11.01 billion on healthcare abroad between 2011 and Q1 of 2021. The peak was in 2019 with US$2.56 billion spent, while the lowest was US$17 million in 2016. Former President Muhammadu Buhari reportedly spent £3,500 daily at the London Clinic, where he eventually died, including covering hotel bills for family and well-wishers. His nephew, Mamman Daura, confirmed that arrangements had been made to offset these costs before Buhari's formal discharge (Okocha & Addeh, 2025). This gives insight into his long-standing reliance on foreign healthcare during his presidency, often accompanied by the presidential jet, whose costs (including hangar fees) added to national expenses. The current president, Bola Ahmed Tinubu, has also come under scrutiny. Although official records of his medical travels remain undisclosed, reports show he has visited over 37 countries within two years, with frequent stops in France and the UK—both known medical destinations. According to Ambassador Sola Enikanolaye, Tinubu's trips spanned Africa, Europe, Asia, and the Americas, including visits to Benin, Ghana, France, the UK, Germany, the US, and more (Elumoye, 2025). However, the lack of transparency around his travels makes it challenging to distinguish between official duties and personal medical tourism, continuing the trend of elite escape from Nigeria's healthcare system. At the same time, millions of citizens suffer from its inadequacies.

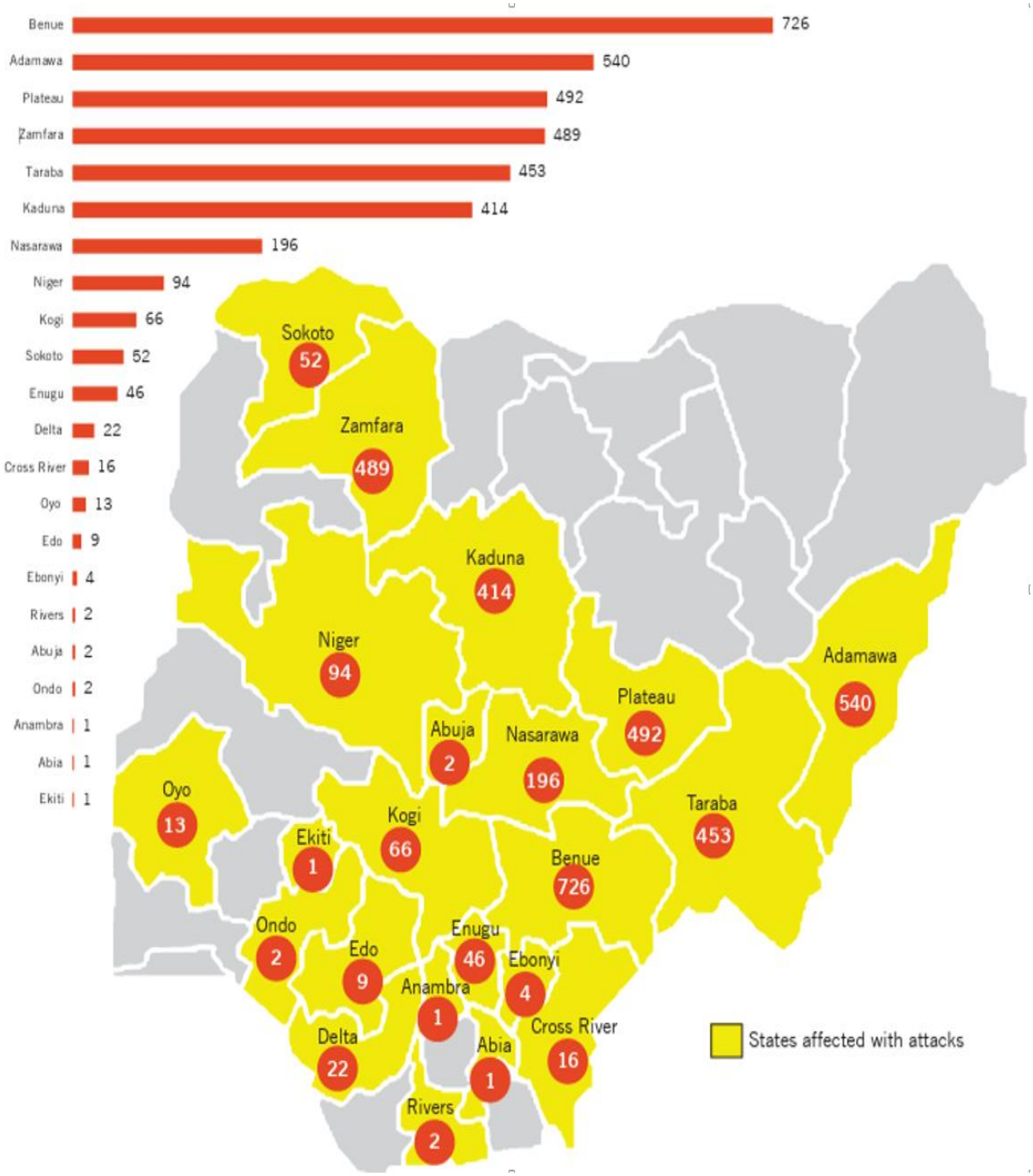
Nigeria's health sector continues to grapple with the problem of brain drain. According to Prof. Olawale Tomori, a leading virologist, the country's health system could have thrived with well-trained professionals, reliable infrastructure, functional equipment, and steady power supply. He observed that while Nigeria possesses talented personnel, the absence of a conducive environment hinders their optimal performance (Chima et al., 2021). As a result, many young Nigerian doctors are migrating in large numbers to the UK, USA, and Canada in pursuit of better opportunities. Back home, doctors and health workers frequently embark on strike due to poor working conditions and inadequate pay. Primary healthcare centres (PHCs) across the country remain understaffed and poorly equipped despite the Ministry of Health's pledge to revitalise 10,000 PHCs (Obiejesi, 2018).

One would assume that if Nigerian hospitals are inadequate for the public, then the well-funded State House Clinic in Aso Rock should sufficiently serve the presidency. However, this has not been the case under the last two administrations. The UK General Medical Council reported that 11,055 Nigerian-trained doctors were practising in the UK as of 2023, ranking Nigeria third, after India and Pakistan, as the highest contributor of foreign doctors (African News, 2023). Additionally, between 2017 and 2023, approximately 75,000 Nigerian nurses migrated to countries such as the UK, the USA, Canada, Saudi Arabia, and Australia. In just one year, 18,224 Nigerian health workers received UK visas, a staggering figure that signals a deepening crisis. This data was confirmed by the Medical and Health Workers Union of Nigeria (MHWUN) and the National Association of Nigerian Nurses and Midwives (NANNM) (Ezigbo, 2024). The direct implication is a growing shortage of healthcare professionals in Nigeria, with the few remaining overburdened, leading to diminished healthcare delivery nationwide.

iv. Policy Inconsistency and Dilemma

Another pressing concern is the inconsistency in the implementation of health policies. Prior to assuming office, President Buhari pledged to end medical tourism. However, his own recourse to overseas medical treatment following a health crisis contradicted this commitment. This reversal not only reflects a policy inconsistency but also reveals a troubling level of hypocrisy. Consequently, presidential assurances of revitalising Nigeria's health sector are undermined by personal choices. Furthermore, a policy dilemma emerged during his 2017 medical trip to the United Kingdom, when his spokesperson's justification further highlighted the disconnect between official rhetoric and actual governance behaviour. His spokesperson, Femi Adesina, wrote, "President Buhari wishes to reassure Nigerians that there is no cause for worry. During his normal annual checkups, tests showed he needed a longer period of rest, necessitating the President staying longer than originally planned" (Wakili, Mudashir, Idris, & Krishi, 2017). The president's absence from the country to seek care abroad often leads to delays in policy implementation and decision-making. Though the constitution is clear on the separation of powers and delegation of authority, this is hardly adhered to during such tourism. A good example was during the Buhari era, when, instead of allowing Vice President Yemi Osinbajo to act, he would prefer to rule from wherever he was.

Even during one of his visits abroad, especially following the 2016 Nembe massacre, the Enugu State governor alleged that the Presidency's inaction was due to the president being out of the country (Vanguard, 2016; Amnesty International, 2018). That attack resulted in numerous deaths and widespread displacement in Enugu State. This incident highlights how presidential medical tourism can delay crucial decisions, potentially resulting in avoidable tragedies. The table below illustrates the nationwide spread of insecurity and corresponding casualties. Had the president been present, some of these deaths might have been prevented.



Source: Amnesty International (2018:6)
.Figure 4: Nationwide spread of insecurity and corresponding casualties

The absence could also cause a policy U-turn if the persons acting took a decision not in the best interests of the ailing president. A notable example occurred in August 2018 when Vice President Yemi Osinbajo, acting as President, dismissed the Director of the State Security Services, Lawal Daura, following an unauthorised raid on the National Assembly. Although constitutionally sound, the decision strained executive dynamics, and since then, Osinbajo has been appointed Acting

President. While there are designated officials to take over in his absence, some decisions require the president's personal approval. Dilemmas can also arise from religious or cultural rites. For instance, when Buhari died in the UK on July 13, 2025, Islamic tradition required his burial on the same day or before sunset the following day, July 14. However, due to diplomatic protocols, his body had to be cleared by the British government, delaying the burial until July 15. While Islam does not prohibit such a delay, some extremists might perceive it as a violation and use it as grounds to protest, especially from someone seen as a devout Muslim. Thompson and Nwaorgu (2024) similarly warned that health or political issues could challenge the cultural expectations of traditional rulers in Yorubaland, particularly when they frequently travel abroad for medical care.

DISCUSSION OF RESULTS/FINDINGS

Observations found that healthcare before 2015 had not improved across all standards, as funding remained inadequate, facilities remained indigent, and access to healthcare remained poor. This is further compounded by the fact that the presidents who promised to stop medical tourism by investing in health and leading by example, by patronising Nigeria's hospitals, fell short of these promises. Since the 1980s, the presidents have been travelling abroad, openly or secretly, in the name of private visits. This explains the secrecy in governance and even in their dealings with the citizenry, with whom they had entered into a social contract by engaging them at all times. It also shows the lack of inclusivity in carrying the people along in government day-to-day dealings.

Observations from the paper also show that the presidents from 2015 up to date have made several efforts to improve the country's healthcare services and facilities—these they have done in several ways. First, there was an increase in health care financing or budget. Despite this, it still falls short of the stipulated Abuja declaration. Also, the government has made interventions through laws, programmes, and policies. This includes. Third, there have been partnerships with private individuals and with international organisations and governmental bodies such as the World Health Organisation, United Nations Children's Fund (UNICEF), and USAID, among others, to improve the country's healthcare situation. Be that as it may, the presidents have refused to take what it provides to the people. Aside from their family members, others have also followed in the same line, showing that the government itself does not trust what it provides to the citizenry. Aside from the presidents, ministers, and some average Nigerians, others also follow suit by seeking healthcare abroad, ranging from serious health concerns to plastic surgery (Thompson et al., 2024). It appears as if, apart from healthcare, Nigerians do not trust most of their institutions or government agencies.

Finally, the medical tourism by Nigerian presidents has implications for Nigeria's healthcare system. First, it is a symbolic failure of leadership. Over the years, the absence of Nigeria's presidents due to ill health has led to governance gaps, thereby creating tension in the polity. This guise has also helped some corrupt politicians hide under it to escape justice, especially while being tried for corruption and other criminal offences. Second, it leads to a public trust deficit. Africa Polling Institute (API) 's 2025 study reveals that trust and confidence in public institutions are at their lowest levels since similar surveys were conducted in 2019, 2021, and 2022 (Africa Polling Institute, 2025). Recently, a United States Congressman, Riley Moore, has said that the Nigerian people do not trust their government. He continued:

> The Nigerian people do not trust their government. 'How can you trust a government that does not show up when you ask them to? A case that just happened recently in Plateau state. We had a pastor there who warned the Nigerian government that they were under attack. There is an imminent attack force here in

> the next 24 hours. Please come and help us. The Nigerian government not only ignored it but also issued a press release stating that it is fake news (Atungwu, 2025).

Nigerians also have trust issues with other government agencies. These institutions range from enforcement to the presidency. As Tiwa (2024) asserts, it is one reason why the police are mistrusted. Third, there is economic and brain drain. When the citizen expects the government to lead by example and it flips its decisions or policies, it creates room for citizens to follow suit by disobeying the laws. In the economic sense, money has gone down the drain in medical tourism. The issue of medical tourism is also a way by which the government lost touch with its citizens. While billions of dollars have been lost annually by the state to medical tourism, what the President has spent from 2015 remains secret. However, the recent encounter of late President Buhari could give a glimpse of what is usually spent by presidents, as they travel with aides, relatives, and officials, among others, all of which are paid for with taxes collected from the people. Also, there is the brain drain. The drain in health and medical worker is a challenge to a state which is still grappling to fulfil its WHO ratio of doctor: patient of at least 1:600. The Nigerian Association of Resident Doctors in October 2025 in a letter signed by NARD President, Dr. Mohammad Suleiman; Secretary-General, Dr. Shuaibu Ibrahim; and Publicity and Social Secretary, Dr. Abdulmajid Ibrahim decried the country's poor doctor-to-patient ratio of 1:9,083, describing it as far from global best practice (Adejoro, 2025b). According to the Coordinating Minister of Health and Social Welfare, Prof Muhammad Pate, over 16,000 Nigerian doctors have left the country in the last five to seven years to seek greener pastures abroad (Adejoro, 2025b). This has no doubt led to the opprobrious rate of mortality among infants, maternal patients, and others. However, aside from patients, doctors are also dying as a result of overwork (Aderinto et al, 2024)—finally, policy inconsistency and dilemma. When the president says something and does something, it is a red flag for policy analysts. Scholars have discussed the challenges of public policy in Nigeria and its implications for national development.

Both presidents who have ruled Nigeria in recent years have pledged to improve the health sector and have made visible investments in healthcare infrastructure. However, neither has consistently utilised these domestic facilities, despite claiming they meet international standards. This disconnect reveals a contradiction between presidential rhetoric and personal conduct, weakening public confidence in such promises. The recurring preference of Nigerian political elites for foreign medical treatment highlights a deep mistrust of local healthcare systems. More importantly, the revival of quality healthcare delivery in Nigeria could not only restore citizens' faith in local institutions but also attract highly skilled diaspora professionals back home. However, as things stand, many healthcare initiatives appear merely cosmetic and poorly implemented. It is no surprise then that Dixon (2017), writing during Buhari's prolonged absence in 2017, remarked that "his month-long trip continues a controversial tradition in Nigeria and elsewhere on the continent: presidents disdaining their own health services in favour of overseas medical trips often shrouded in secrecy." Hänninen et al. (2019) were right when they argued that whoever sows distrust reaps distrust – while the same seems to be true for trust as well. Thus, the presidency must at least begin to taste the goods it serves the people in order to gain their trust.

CONCLUSION

The practice of presidential medical tourism in Nigeria between 2015 and 2025 reveals a profound disconnect between leadership rhetoric and lived reality. Despite numerous promises, policy

initiatives, and infrastructural investments aimed at revitalising the healthcare sector, successive presidents have consistently opted for treatment abroad, thereby undermining confidence in the very systems they claim to reform. This paradox, in which leaders "serve" healthcare solutions to citizens but "refuse to taste" them themselves, exemplifies elite hypocrisy, weak institutional commitment, and a failure of political accountability. Such actions have far-reaching implications: they erode public trust, legitimise the abandonment of local health systems, worsen brain drain among medical professionals, and siphon off national resources to foreign economies. Most troubling, they send a dangerous message that Nigerian public institutions, including hospitals, are good enough for the people but not for their leaders. This double standard not only deepens inequality but also renders health policy reform cosmetic and unsustainable. To reverse this trend, Nigeria's leadership must go beyond symbolic gestures. They must actively use, trust, and improve domestic health facilities as a matter of duty and example. Only then can meaningful healthcare reform take root, restore public confidence, and lay the foundation for a truly equitable and self-reliant healthcare system.

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