

Preliminary look at the motivators and decision-making process of medical tourists from Nigeria to India

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Abstract

Purpose – The past decade has witnessed a tremendous and progressive growth in the number of Nigerians who engage in medical tourism from Nigeria to India. Various commentators have advanced diverse reasons for this trend. However, there is a dearth of research that has sought to provide empirical insights. This paper aims to investigate the decision-making process of Nigerian medical tourists and why they prefer medical tourism to India to medical care locally.

Design/methodology/approach – Eight Nigerian medical tourists are interviewed on a one-on-one basis with open-ended questions using purposive criterion sampling technique from an interpretivist mind-set.

Findings – The paper identifies two major motivators, namely, inadequate medical infrastructure and poor medical, and customer service from health workers in Nigeria, which spurred medical tourism from Nigeria to India. Further, it finds that first timers premise their decisions on advice from reference groups, while previous personal experiences guide decisions on subsequent medical travels. Findings are explained using the template provided by the theory of planned behaviour.

Originality/value – This exploratory nature of this research provides a useful basis to elucidate the course of decision-making of Nigerian patients so that appropriate marketing communication channels can be applied. It improves the process of recruiting and engaging Nigerian patients and nurturing wholesome relationships between Nigerian patients and hospitals.

Keywords India, Nigeria, Consumer behavior, Medical tourism, Health-care marketing

Paper type Research paper

1. Introduction

International trade in medical services has experienced tremendous growth over the last three decades. Every day, people source for quality medical care for their diverse ailments without recourse to where on earth the service is provided. As a result, many countries, especially Low and Middle Income Countries (LMIC) now view this as a huge business opportunity, which can be harnessed for their local health-care industry (Connell, 2013; Heung *et al.*, 2011; Kyritsis Froelich, 2012; Lunt *et al.*, 2013). This international trade is carried out under the concept, “medical tourism”. World Health Organisation (WHO) defines



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medical tourism as “the travel of *patients* across international borders to receive some form of medical treatment” (WHO Patient Safety Programme, 2013). Medical tourism was previously the preserve of the super-rich in developing countries where medical infrastructure and expertise were inadequate (Connell, 2006; Clark *et al.*, 2013). These affluent individuals travelled to nations with top-notch medical services irrespective of the costs because they could afford it. Today, there is a huge paradigm shift, which is demonstrated by the reverse movement of medical tourists (MTs) from developed countries to developing countries (Lee *et al.*, 2012; Lunt *et al.*, 2013).

Nigeria is a major end-user/consumer of the medical tourism service. In 2013, over sixty thousand Nigerians spent nearly US\$1bn in search of medical care abroad (Makinde *et al.*, 2014; Punch Editorial Board, 2014). India is one of the countries that receive the bulk of Nigerian MTs annually. The Indian High Commission in Nigeria reckoned that the number of MTs from Nigeria to India grew from four thousand in 2009 to over eighteen thousand in 2012 with an average expense of 15,000 USD (Simpson, 2015; Abubakar *et al.*, 2018). Medical tourism from Nigeria to India is somewhat contrary to the conventional trend of movement of MTs from developed countries to developing countries because both countries have similar socio-economic profile and development indices (Ezejiakor *et al.*, 2013); they also have similar challenges bedevilling their health-care delivery systems (Wapmuk *et al.*, 2015). Rai *et al.* (2014) pointed out that fellow developing countries provide the highest numbers of MTs to India with Nigeria ranked among the top five for five years. Balogun (2015) identified several commentaries who have discussed the subject of medical tourism from Nigeria to India in times past but a dearth of empirical research subsists.

This research seeks to investigate the decision-making process of MTs from Nigeria who patronise hospitals in India and influencers of the purchase decision of *these Nigerian MTs*. Damasceno *et al.* (2012) had asserted that making a purchase decision on medical care was not a straightforward process. On this premise, this research involves an empirical study to provide useful and relevant insights. The theory of planned behaviour (TPB) propounded by Ajzen (1991) is applied to analyse outbound medical tourism from Nigeria to India. The interplay between the three major constructs in TPB is chosen to provide answers to the following research questions:

- RQ1. Why do Nigerians go to India on medical tourism rather than stay back in Nigeria for their medical needs?
- RQ2. What is the perception of (prospective) Nigerian MTs about the relative safety, quality and costs of medical services locally compared with what obtains in India?
- RQ3. Can effective use of marketing communication tools by health-care facilities in Nigeria stem the tide of medical tourism by Nigerians to India?

2. Literature review

2.1 Medical tourism

Connell (2006, cited in Upadhyay, 2011, p. 27) defined medical tourism as ‘long-distance travel to overseas destinations by people to obtain medical, dental and surgical care while simultaneously being holidaymakers’. Medical tourism offers a patient dual benefits: treatment and leisure. There is a medical condition that needs to be addressed but the patient simultaneously enjoys a period of vacation as well. Kyritsis Froelich’s (2012, p. 1) definition summarises this position succinctly: ‘a vacation that involves travelling across

international borders to obtain a broad range of medical services'. The foregoing, notwithstanding, the primary objective of medical tourism is medical treatment as noted by Cohen (2008, cited in Jung, 2012) who reported that MTs' sole purpose for going to Thailand was for medical treatment only. Monguno and Waziri (2012) also observed that many people living in Nigerian towns bordering Cameroon often crossed the international border to get medical attention, doing so without visiting tourist sites. It is from this perspective that Makinde *et al.* (2014) concluded that medical tourism was just to serve the purpose of treatment in another country; any other thing was, at best, complementary. As WHO succinctly put it, "medical tourism is the travel of patients across international borders to receive some form of medical treatment" (WHO Patient Safety Programme, 2013, p. 3). In practice, however, medical tourism cannot be separated from mainstream tourism because patients and their companions make use of transportation, lodging and catering facilities etc. – all elements of mainstream tourism industry – in their host countries during their stay. Worthy of note is the findings of Hudson and Li (2012) in which domestic medical tourism was established as another growth area of the industry.

2.1.1 Economics of medical tourism. Medical tourism is enjoying tremendous boom today globally. Even though there is non-congruence in figures by researchers, it is reckoned as one of the fastest growing service industries (Lautier, 2008; Yeoh *et al.*, 2013). While Kachipande (2013) put the average annual estimates of MTs at seven million people, Jeffery (2006, as cited in Mugomba and Caballero-Danell, 2006) quoted a figure of 19 million; John and Larke (2016) stated that 2014 saw 11 million people engage in medical tourism and Nachum (2018) put 2015 estimates at 12 million. RNCOS (2008, cited by Woo and Schwartz, 2014) claimed that destination countries earned US\$20bn in 2005 while Yeoh, *et al.* (2013) opined that it was in excess of US\$60bn in 2006. On the other hand, John and Larke (2016) posited that 2014 generated about US\$55bn for destination countries whereas Nachum (2018) gave a range of US\$45bn-US\$70bn for 2015. These diverse data are a result of miscellany of opinions about what constitutes medical tourism in different countries. Balogun (2015, citing Youngman, 2009) stated that 'official valuations of the industry are badly flawed and replete with inconsistencies because many countries lacked independently verified data on medical tourism'. Nevertheless, there are genuine signs indicative of continuous and sustainable industry growth for a long time to come (Woo and Schwartz, 2014).

Governments of many LIMCs, including India have been spending huge resources to support the medical tourism industry and attract MTs (Lunt *et al.*, 2013). India, in particular, has witnessed a tremendous growth of the industry (Connell, 2006; Jung, 2012). In 2002, one hundred and fifty thousand MTs arrived India (Rath *et al.*, 2011), which grew to five hundred thousand in 2005 (Jung, 2012). A policy framework provided by the government of India in 2012 has sustained a 30 per cent growth year-on-year of the industry (Gupta, 2008). Nachum (2018) reported that 600 thousand MTs visited India in 2015 and Debata *et al.* (2013) reckoned that India could reach a million MTs yearly soon, which potentially adds about US \$5bn to its economy and contrasts with the US\$333m returns in 2005 (Jung, 2012).

2.1.2 Nigeria–India medical tourism dynamics. As a major patron of the medical tourism service, Nigeria has made India one of its favourite destination countries. The Indian High Commission in Nigeria noted that the number of MTs who went to India from Nigeria rose from 4,000 in 2009 to over 18,000 in 2012; a 450 per cent growth rate in 4 years (Simpson, 2015). *Reviewing the plethora of challenges bedevilling the health-care delivery system in Nigeria* by Lawal *et al.* (2017), it becomes obvious the reasons why the number of Nigerian MTs rises yearly. Indian hospitals have enjoyed a lot of patronage as a result. With the active backing of their government, they run trade shows and workshops all over the world to

promote medical tourism to India (Crooks *et al.*, 2011). They also make effective use of the internet for advertisement (Sarantopoulos *et al.*, 2014). The foregoing notwithstanding, the most effective advertising and marketing communication tool for Indian hospitals has been word-of-mouth (WOM) and electronic word-of-mouth (eWOM) recommendations (Yeoh *et al.*, 2013; Hanefeld *et al.*, 2015; Lee *et al.*, 2012). *The positive vibes generated therefrom have increasingly attracted Nigerian MTs to India. Using the Trust Transfer Theory as his guide, Abubakar (2016) demonstrated the positive association between eWOM and travel intension.*

*In recent years, India has taken a step further to invest in the Nigerian health-care industry. At present, numerous Indian hospitals have set up fledging practices in Nigeria (Financial Nigeria, 2015; Wapmuk *et al.*, 2015) taking full advantage of the goodwill that medical tourism has generated over the years. Some others have formed partnership with local players to improve personnel capacity. On the other hand, a number of public and private hospitals in Nigeria have taken up the challenge themselves to become better health-care service providers. It is expected that the number of Nigerian MTs to India will dwindle gradually in the long run.*

2.2 Consumer behaviour of medical tourists and health-care marketing

Contemporary marketing literature has made the matter of consumer behaviour a major topic of discourse (Orji, 2013). Consumer behaviour refers to 'all purchase related activities, thoughts, influences that occur before, during and after the purchase itself as performed by buyers and consumers of the products and services and those who influence the purchase' (Williams, 1982, cited in Orji, 2013). In the view of Solomon (2011, cited in Kotler and Keller, 2013, p.173), it is 'the study of how individuals, groups and organisations select, buy, use, and dispose of goods, services, ideas, or experiences to satisfy their needs and wants'. A sound comprehension of consumer behaviour is a *sine qua non* for brands and marketing campaigns to be successful. The concept of health-care marketing and consideration for consumer behaviour took off only a few decades ago. The previous notion had been that marketing principles and models were alien to the health-care industry because health-care services were viewed as essential by service providers without which patrons could do. The question was, 'why market and promote a service that people look for on their own anyway?' (Balogun and Ogunnaiké, 2017). Today, the narrative has changed because health-care (and medical tourism) industry players now incorporate health-care marketing actively in their practice.

2.2.1 Purchase decision-making process of medical tourists. According to Kotler and Keller (2013, p. 379), services are 'high in experience and credence qualities'. Medical service, more often than not, requires that the potential patron conduct a thorough search and research to guarantee that quality and value would be derived from the service provider. That is why making a purchase decision on medical care is not always a simple process for an average consumer (Damasceno *et al.*, 2012). As is characteristic of service consumers, MTs are expected to consult widely and consider several variables. However, how MTs make destination decisions, choose treatment options and react to medical travel advertisements remain a grey area because of prior limited research (Lunt *et al.*, 2013). Hanefeld *et al.* (2015), Runnels and Carrera (2012) and Woo and Schwartz (2014) acknowledged the complexity of decision-making by prospective MTs because of the myriad of variables which required due consideration. This is what makes predicting the purchase decision of MTs somewhat intricate. For example, Lunt *et al.* (2013) found that migrant ethnic groups in the UK are known to have predisposition towards certain countries for medical tourism based on their cultural heritage while Connell (2013) reported that prospective MTs take decisions based on availability of moral and financial support from

social contacts. Destinations countries are able to improve their competitive appeal and attraction to potential MTs by understanding the interplay of these variables. For instance, [Debata et al. \(2013\)](#) identified eleven medical tourism enablers which India examines and constantly improves on so as to continuously grow its medical tourism industry.

2.3 Theoretical background

Some aspects of medical tourism industry have been subjected to theoretical evaluation and testing in recent times. [Lee and Fernando \(2015\)](#) investigated supply chain in the medical tourism industry and developed a model as a result. [Smith and Forgione \(2007\)](#) designed a two-stage model, which crystalised variables (country-specific and hospital-specific) of medical tourism options into a workable framework to guide industry stakeholders to compete effectively in the marketplace. Similarly, [Heung et al. \(2010\)](#) proposed a conceptual model which balanced on a scale the supply and demand factors of the medical tourism industry. Not much has focussed on behavioural models to decision-making processes of patrons of medical tourism, however ([Na et al., 2016](#)).

The TPB propounded by Ajzen in 1991 has offered universal applicability in predicting human behaviour in various fields ([Balogun, 2015; Na et al., 2016](#)). TPB takes three variables as direct determinants of behavioural intention namely attitude, social norms (SN) and perceived behavioural control (PBC) shown in [Figure 1](#). Attitude is an innate belief; it is ‘a person’s enduring favourable or unfavourable evaluations, emotional feelings, and action tendencies towards some object or idea’ ([Krech et al., 1962](#), cited in [Kotler and Keller, 2013](#), p. 190). SN refers to social influences that come from one’s reference groups. It plays an important role in the service industry because an average consumer rates the opinions of his reference group highly and matches them with his positive beliefs before making purchase. PBC describes ‘a person’s perception of the ease or difficulty of performing the behaviour of interest’ ([Ajzen, 1991](#), p. 183). This perception depends on the availability of two factors: required resources and opportunities. When people believe that they have the resources and opportunities and they expect no difficulties on their way, their perceived control over the performance of an action rises.

Some researchers have applied TPB to investigate consumer behaviour in the US; [Martin et al. \(2011\)](#) developed the MEDTOUR scale from TPB as a new tool for investigating consumer behaviour of MTs while [Ramamonjirivelo et al. \(2015\)](#) further corroborated the validity of the scale in a larger sample size. [Na et al. \(2016\)](#) equally employed the TPB for MTs visiting Malaysia while [Lee et al. \(2012\)](#) did likewise for Japanese MTs to South Korea.

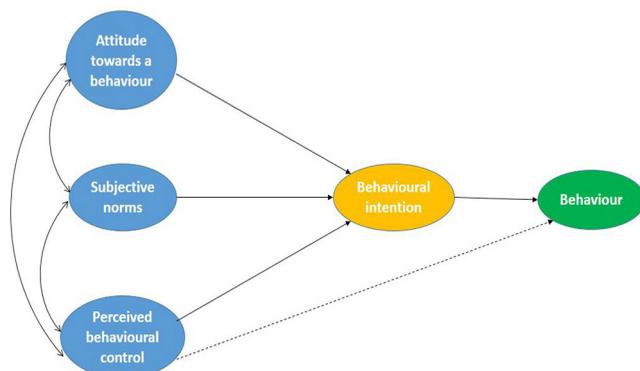


Figure 1.
Theory of planned
behaviour by Ajzen
(1991)

Ferreira (2011) found TPB to be relevant in understanding the intention and behaviour among patients patronising the Portuguese health-care system.

2.4 Contextualisation

According to Ezejioloro *et al.* (2013), the socio-political and economic landscape of India and Nigeria have so much in common, both being former colonies of Great Britain. They also have similar challenges bedevilling their health-care delivery systems (Wapmuk *et al.*, 2015). Given that medical tourism has two cardinal purposes – medical care and vacation – which go hand-in-hand for the average MT, the dynamics must be balanced to induce medical tourism. John and Larke (2016) provided a contextual framework to define motivators for MTs when making a purchase decision concerning medical tourism:

- factors associated with the home country of MTs (referred to as push factors); and
- factors associated with the destination country of MTs (referred to as pull factors)

In summary, the main cited push factors are references given by kith and kin access to certain treatment options and lack of confidence in home-country health-care systems. Commonly cited pull factors include shorter waiting time, quality of service delivery, international accreditation of hospitals, practitioners' expertise and affiliation of MTs to socio-cultural environment of the destination country.

3. Method

A qualitative approach was adopted for this study being a preliminary investigation of the decision-making process of MTs from Nigeria. According to Kazemi (2008, cited in Jung, 2012, p. 17), 'qualitative research is an unstructured, primary exploratory design based on a small sample, and intended to provide insight and understanding'. Qualitative research explores social issues deeper and gives clearer interpretation and understanding to human attitudes and behaviours. The technique is more appropriately fitting for relatively new subject areas where statistical data are still scanty (Heung *et al.*, 2011). This research chose the strategy of extensive interviews of persons who were MTs to India in the last two years and/or companions of a MT to provide detailed account of how their decisions were made. The conversations were on a one-on-one basis with open-ended semi-structured questions meant to generate rich data about how the decisions were made and factors that influenced the decisions in their order of relevance. The approach of Bruwer (2013), which involves in-depth survey, was employed. The exploratory nature of this research required the provision of exhaustive data from a relatively small number of respondents. This approach was chosen because, to the best of my knowledge, the subject matter had not been previously researched in Nigeria.

3.1 Sampling and recruitment

Purposive criterion sampling was used to recruit respondents. According to Palinkas et al. (2015), this sampling technique is a veritable and effective tool for identifying and selecting information-rich cases when resources are limited. The research, being a preliminary study, was designed to limit the sample size from whom rich insights could be derived within four weeks allocated for data collection. The Lagos Office of the Indian High Commission (Embassy) in Nigeria was the rendezvous because it was considered that a high number of potential interviewees who are recent MTs or companions could be found within the short time dedicated to data collection. As many people as possible were contacted randomly to identify those who were at the embassy for medical reasons following which volunteers agreed to be interviewed.

3.2 Data collection and analysis

Each interview was semi-structured, being guided by three open-ended questions (Appendix 1) to which answers were provided by respondents. Following the procedure of Cohen and Crabtree (2006), the questions were prepared and arranged sequentially to elicit the desired insights, *each addressing the corresponding research question in Section 1*). All respondents were asked the same questions for easy comparison of answers. However, being semi-structured interviews, follow-up questions were introduced in between or after the main interview questions depending on the responses from interviewees. All interview sessions were conducted in a face-to-face manner in front of the Lagos Office of the Indian High Commission (Embassy) in Nigeria. Interviews were tape-recorded and transcribed as advocated by Gill *et al.* (2008) and Kyritsis Froelich (2012) followed by *iterative* analyses. Research methods (2019, pp.12-13) outlined how the transcribed data is analysed: 'the researcher learns about the meanings of the data, understands the significance of the data, and then assigns general theoretical significance'. In summary, the sequence of events is as follows:

- identification of potential interviewees;
- selection of participants in the interviews;
- consent obtainment from the participants (see Appendix 2 for a sample);
- conduction of the interviews;
- transcription of the interviews;
- *verification of transcribed materials by the participants*;
- *analysis of the transcribed materials*; and
- *declaration of findings and interpretation*.

The first set of questions sought to find the factors, which made Nigerians pursue medical care in India instead of Nigeria and discuss their relative importance to decision-making. The assumption of Ajzen (1991) that man was rational and, thus, performed behaviours based on logical reasons. The second set of questions focussed on discovering how Nigerian MTs perceived medical services in India before and after medical tourism to India *vis-à-vis* medical services in Nigeria. The questions aimed at identifying possible gaps between expectations and experiences and establishing the order of importance of the elements of TPB (Ajzen, 1991) to Nigerian MTs who patronise India. The third set of questions probed the knowledge depth of Nigerian MTs about available medical services/expertise in Nigeria before their first journey and the significance of the knowledge gap, if any. The claim of Makinde *et al.* (2014) was that there was low public awareness about the significant advancement in Nigeria's health-care delivery system, thus leading to medical tourism.

3.3 Data triangulation

To eliminate the element of researcher bias during data collection and enhance validity of data, I incorporated the concept of triangulation into my chosen research design. Data triangulation was achieved by ensuring that I interviewed volunteers individually and not more than two on a given day each week for four weeks. By so doing, chances that I selected relatives or friends (with similar mind-set) choosing the same day to visit the Consulate volunteering for interview was reduced drastically. Methodological triangulation was achieved through the process of combining formal interviews with informal observations and interactions as well as questionnaire administration.

4. Findings

4.1 Respondents' profile

Eight respondents who have had a history of medical tourism to India within the last two years were recruited for individual one-on-one interviews based on the research design: three males and five females. Five of them had gotten a form of treatment at least once personally while the remaining three had been companions of MTs. *Six persons agreed to being tape-recorded while two preferred filling out a questionnaire instead.* A distinct pseudo name was given to each respondent (Table I).

4.2 Results

4.2.1 Empirical findings from first set of questions. In finding answers to the first research question in Section 1, respondents offered the following reasons and factors why they chose medical tourism to India rather than staying back in Nigeria for their medical needs: long waiting list, inadequate medical equipment (surgical and diagnostic) in hospitals, chaotic laboratory services, inadequately staffed hospitals, comparatively limited degree of expertise among Nigerian medical practitioners, nonchalance and negligence by available medical experts, non-collaboration among medical and allied staff, poor customer service from hospital workers, poor sanitary and environmental conditions, poor response to treatment, concerns about access to quality drugs, lack of trust and confidence in the system, advice from medical consultants, advice from sponsors, and costlier medical services.

Inadequate medical facilities and equipment in Nigerian hospitals was the most important reason. Dorcas said, *I was on admission for about seven months. One surgeon somehow told me that the hospital lacked certain equipment [. . .],* while Bisi retorted, *my rate of improvement was slow [. . .][. . .] the facilities do not support speedy recovery.* For Clinton, his conclusion was spontaneous: *I just could not have any trust/confidence in the infrastructure [. . .][. . .] the public hospital did not look like a professional outfit [. . .][. . .] right from the gate, I was left wondering if I would like to be treated in such premises with look old and dilapidated facilities.*

Issues around the medical team ranked as the next important reason. Ngo remarked that *doctors are not empathetic enough[. . .]I understand that they could be overwhelmed with many patients but, at least, give proper and adequate attention to the ones you can* while Dan pointed that *the level of expertise among Nigerian medical practitioners was not high enough in my opinion.* From Pat's experience, *the government hospitals have experts but it is the junior doctors that handle most of the cases. The consultants usually come[. . .][. . .]when it may be too late [. . .]* Clinton lamented the air of secrecy around the medical consultants: *the hospital cannot tell you about the success stories and details of the specialists they have[. . .]*

S/No.	Pseudo name	Gender	Profile	Status	Mode of interview
1	Dan	Male	Tourist	Veteran	Audio-taped
2	Dorcas	Female	Tourist	Veteran	Audio-taped
3	Ngo	Female	Companion	Veteran	Audio-taped
4	Bisi	Female	Tourist	Veteran	Audio-taped
5	Clinton	Male	Tourist	Veteran	Audio-taped
6	Pat	Female	Companion	Veteran	Notes-taking
7	Stan	Male	Tourist	Veteran	Notes-taking
8	Maria	Female	Companion	Veteran	Audio-taped

Table I.

Sample population

Note: Veteran is the respondent with history of journey to India within the last two years

How can I entrust my life to such a medical practitioner whose antecedence I am unaware of? Maria stated that, the hospital was not adequately staffed and[. . .]could not provide adequate medical attention. Opportunity for vacation or leisure was found not to be a major factor for Nigerian MTs to India. Clinton's statement sums up the position of other respondents: I am sick and need treatment not tourism. When I am well, I can go anywhere I like for tourism.

4.2.2 Empirical findings from second set of questions. The second research question in Section 1 meant to uncover the perception of (prospective) Nigerian MTs about the relative safety, quality and costs of medical services locally compared with what was obtainable in India. Only three respondents reported a splendid experience that absolutely matched their perception. One hundred percent, exclaimed Ngo. The other five narrated one incident or another that left them with reservation. Most of the complaints had nothing to do with the medical services sought, however. Stan and Maria premised their misgivings on cultural differences. I just could not tolerate their food, lamented Stan; communication with some of the care givers was not always smooth because[. . .]they either don't speak English or speak it with distorted accent. Maria cried, we relied on interpreters interact with some nurses. Pat's challenge was with Immigrations: I had some issues at the embassy in India which caused unnecessary further delay for our return journey.

When asked about how they formed their perception about medical services in India, they all spoke of the impact of testimonies that known former MTs and online remarks gave. Dorcas' comments was a good summary for every respondent: *I heard from previous MTs that India had hospitals of international standard with modern equipment and not so expensive.* Two respondents relied chiefly on doctors' references. All respondents categorically rated medical services in India more highly than in Nigeria and would advise anyone who needed their guidance accordingly. *I won't lie to you, I have recommended to a number of people,* Bisi assured while Pat noted, *seriously, if you can afford it, you should not even consider Nigeria. Some Nigerian hospitals claim they have success stories but I don't believe them.* However, Dorcas gave a note of caution: *I would not recommend in a hurry. For instance, I feel they play to the gallery at times and make you think you are in a really precarious situation that requires urgency even though I don't always see it that way.* Clinton corroborated: *you have to be careful so that you don't fall into the hands of a cheat.*

4.2.3 Empirical findings from third set of questions. The third research question in Section 1 intended to find if effective use of marketing communication tools by health-care facilities in Nigeria could stem the tide of medical tourism by Nigerians to India. When asked whether they personally conducted a thorough search for options locally before considering India, only two respondents answered in the affirmative. The remaining six just did not bother. They premised their decision on the unsatisfactory service they got hitherto. Pat posited: *the Teaching Hospital [. . .] made four attempts at correcting the health challenge but without much success [. . .].* Bisi similarly said, *because I had stayed too long at the hospital with very little to show [. . .]* When these six were enlightened about possible local options, two remained sceptical while the others emphasised that it wasn't their responsibility to 'search'. Pat pointed: *If a Teaching Hospital cannot address your[. . .]need, where else do you want to turn?* Conversely, Clinton argued, *Indian hospitals are always in your faces with information about their services unlike Nigerian ones[. . .]everywhere including internet. It is apparent that hospitals in India are able to communicate more effectively with the target market than hospitals in Nigeria.*

All respondents expressed their desire to seek medical services locally if the factors mentioned in Section 4.2.1 were addressed/removed *and improvement in service delivery is well communicated. I prefer to stay back,* pointed Maria. *One hundred percent,* argued

Clinton. Pat and Dan were more cautious. *Yes, if I can find verifiable evidence [...]*, responded Pat. *It's 50:50. I still have concern about ancillary infrastructure [...] such as power. A surgical operation which could last nine hours may be jeopardised [...]*, replied Dan. Bisi, however, insisted she would have none of it: *while on admission, I was being seen by up to six senior doctors [...] I believe they gave it their best but it wasn't good enough. So, why should I risk seeing another Nigerian doctor in another Nigerian hospital? After my first journey, I developed some complications [...] went to see another doctor in another hospital [...] but could help me [...] I had to go back to India!*

5. Discussion

This study used TPB to explore the views of Nigerian MTs to India to empirically uncover their motivating factors and decision-making processes and answer the research questions in Section 1. Application of the theoretical framework to the key findings above has led this study to propose 2 models for decision-making by Nigerian MTs to India.

5.1 Unmet needs serve as trigger

Interviewees revealed a long list of factors that they considered (Section 4.2.1) before a decision to embark on medical tourism to India was taken. The factors listed are consistent with the works of [Anyika \(2014\)](#) and [Ezejiolor, et al. \(2013\)](#) who reported similar myriads of problems bedevilling the health-care system in Nigeria. Consequently, Nigerians have had their confidence in the system eroded and now resort to medical tourism to India for specialist treatment and surgery ([Eme et al., 2014](#); [Uchendu, 2013](#); [Ezejiolor et al., 2013](#)). All the factors listed by respondents can be categorised into four groups: inadequacies of the health-care infrastructure and equipment; health workers and their attitude to work; medical costs; and tourism ([Table II](#)). According to this research, inadequate medical facilities and (surgical and diagnostic) equipment in hospitals ranks as the number one reason why Nigerians go to India for medical care according to the respondents. [Gyoh \(2014\)](#) also alluded to this finding. As a result, medical practitioners in Nigeria tend to advise their patients to seek medical care for certain conditions abroad. The second ranked factor centres on the health workers themselves. Patients relate directly with health workers and trust them to offer empathy, prompt attention and treatment, and good customer service. However, respondents complained of mistreatment. They observed inadequate staff strength in many hospitals, a position [Ogungbo \(2013\)](#) and [Okunoye \(2013\)](#) agreed to. Both internal ([Eme et al., 2014](#)) and external ([Asaju, Arome and Anyio, 2014](#); [Clemens and Petterson, 2007](#), cited in [Mba and Ekeopara, 2012](#); [Abubakar et al., 2018](#)) brain drain have deprived the health sector of sufficient skilled personnel. Complaints also result from numerous routine strike actions ([Anyika, 2014](#); [Oyewunmi and Oyewunmi, 2014](#)), the delivery of pharmaceutical services in public hospitals ([Oparah and Kikanme, 2006](#)) and dysfunctional working relationships among the various groups of health workers ([Ogunbodede, 2013](#)).

Table II.
Factors that Nigerian
MTs to India
consider in
descending order of
influence

S/No.	List of major factors
1	Medical facilities and equipment
2	Health-care personnel
3	Medical and ancillary costs
4	Tourism

Lunt *et al.* (2013), Rath *et al.* (2011) and Jung (2012) pointedly highlighted the proactive efforts of the government of India and the huge resources being committed to promote the country-attractiveness status of India of both medical and ancillary services. These constitute potent pull factors for MTs from Nigeria. On the contrary, (Lunt *et al.*, 2013). India, in particular, has witnessed a tremendous growth of the industry (Connell, 2006; Jung, 2012). In 2002, one hundred and fifty thousand MTs arrived India (Rath *et al.*, 2011), which grew to five hundred thousand in 2005 (Jung, 2012). A policy framework provided by the government of India in 2012 has sustained a 30 per cent growth year-on-year of the industry (Gupta, 2008). Nachum (2018) reported that six hundred thousand MTs visited India in 2015 and Debata *et al.* (2013) reckoned that India could reach a million MTs yearly soon, which potentially adds about US\$5bn to its economy and contrasts with the US\$333m returns in 2005 (Jung, 2012).

Medical costs came a distant third as a factor for consideration. Even though medical expense is generally less in India than in Nigeria for most conditions (Connell, 2006; Anand, 2009; Govindarajan and Ramamurti, 2013; Falase *et al.*, 2013), the aggregate of feedbacks from respondents strongly suggests that Nigerians travel to India not because of less cost but for access to better quality of medical service. As Han and Hyun (2015) also discovered, Japanese MTs similarly emphasised perceived price reasonableness rather than actual cost before making their choice. On the contrary, 'value for money' was the topmost among five reasons why Indonesian MTs visited Malaysia (Musa *et al.*, 2012). Similarly, John and Larke (2016) found that comparatively lower treatment cost was the primary pull motivator for MTs in their meta-analysis study. Opportunity for vacation or leisure was found not to be a major factor for Nigerian MTs to India. Clinton summarised: *I am sick and need treatment not tourism. When I am well, I can go anywhere I like for tourism.* Thus, Nigerian MTs focus solely on treatment in contrast with MTs from the developed world who spend some time on leisure in destination countries (Jung, 2012). *Embarking on medical tourism with the opportunity to enjoy vacation has no relevance to the average Nigerian MT to India. This position may, however, turn out differently if the destination country is somewhere else.*

From the foregoing, it is apparent that Nigerian MTs to India would have preferred to seek medical care locally if the opportunity was available. This finding contrasts with the postulation of Runnels and Carrera (2012) whose model indicated that an average MT was open to all options, both local and foreign, right from the beginning of its search. This study demonstrated clearly the Nigerian MTs choose Nigerian hospitals first and then go for Indian hospitals only after Nigerian hospitals have disappointed them.

5.2 Decision-making process of Nigerian medical tourists to India

All respondents claimed they would have preferred to seek medical care locally if the unmet needs enumerated above were absent. This shows a positive disposition of Nigerians to visit Nigerian hospitals. However, personal experiences of disappointments with one hospital eroded the initial positive attitude of Nigerian patients about local medical services, which subsequently dissuaded them from looking for local alternatives. Thus, medical care abroad became an option. They also stated that previous MTs shaped their positive perception about medical services in India before their first journey, which spurred their decision-making. Other reference groups included personal physicians, family members and the internet. The positive reviews they got assured them that their expectations would be met. Hence, WOM recommendation appears to have a strong influence on first-timer Nigerian MTs. Lee *et al.* (2012) similarly found that reference groups had strong influence on the decision-making process of Japanese MTs just as Musa *et al.* (2012) found that over 60 per cent of Indonesian MTs relied mainly on reference groups. Yeoh *et al.* (2013) equally

reported this scenario among Indonesian and Singaporean MTs. Reference groups, as identified by [John and Larke \(2016\)](#), constitute the most important *push* motivators for MTs. This is more so in collectivist cultures such as Nigeria. It is seen that Indian hospitals reach out to the Nigerian market directly and indirectly through reference groups. They also upload testimonials of MTs online, thereby making use of WOM recommendation as the most effective marketing communication tool for promoting their services to potential first-timers ([Sarantopoulos et al., 2014](#); [Yeoh et al., 2013](#); [Hanefeld et al., 2015](#); [Lee et al., 2012](#)).

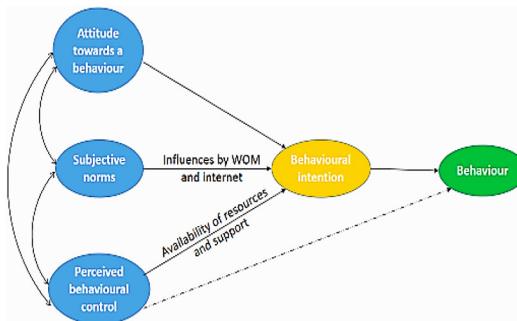
For veteran Nigerian MTs, the main decision influencer for repeat visit was their previous personal experiences. Therefore, they do not necessarily seek a second opinion from reference groups as they did the first time. [Hassan et al. \(2018\)](#) affirmed that patients become loyal to their medical service providers when the quality of service received matches their desires. The satisfactory services obtained by Nigerian MTs during their first visits tend to strengthen their belief that subsequent visits would also be satisfactory. It was also found that they became advocates for medical tourism to India as a result. Thus, medical service providers have to ensure they satisfy the patients always.

From the foregoing, it is evident that marketing strategies have become useful for hospitals to attract and retain their clientele. [Balogun and Ogunnaike \(2017\)](#) reported that management of health-care organisations did not place much value on marketing strategies in monitoring or shaping consumer behaviour until recently. However, today, health-care marketing has become an important tool for winning customers by hospitals ([Gbadeyan, 2010](#)) and has further stimulated the growth of the medical tourism industry. Technology is also being adapted to market medical tourism as the Taiwanese government has done with the Taiwan Medical Travel App ([Chang, Chou, Yeh and Tseng, 2016](#)).

5.3 Decision-making model of Nigerian medical tourists to India

Based on the findings from this research, two models of the decision-making process of Nigerian MTs are proposed using the TPB as a template. For first-timers, both SN and PBC are the variables with weight while attitude have much less influence on decision-making. In choosing medical tourism to India, these MTs relied heavily on WOM recommendations of previous MTs and endorsements from their reference groups; this is the SN component. In addition, the influence of PBC was evident in helping the MTs to make decision in favour of medical tourism to India ([Figure 2](#)). For old-timers, attitude and PBC were the dominant factors while SN played a minor role. A personal experience of an event, object or a place deepens one's conviction about the thing in question. Because the medical services obtained in India generally left a positive impression on the respondents, attitude towards a repeat journey becomes more favourable. Thus, Nigerian MTs to India depend on their personal

Figure 2.
SN and PBC have superior effects on decision-making process of first-timer Nigerian MTs to India



previous experiences principally and very little on comments of reference groups. In addition, the influence of PBC further supports SN so that the MTs can make decision in favour of medical tourism to India (Figure 3).

PBC is the element that explains how a person views his ability to implement an action (Gao, 2009). This ability was chiefly defined by the availability of funds and time. The respondents did not see the cost of medical tourism as a hindrance. Also, sourcing for a companion among their social network (family and friends) for the journey was not difficult. Other opportunities, such as official leave from work, were not lacking. Thus, the influence of PBC for both first-timers and old-timers was strong. In contrast, Na *et al.* (2016) recounted that PBC was a weak predictor of purchase behaviour among MTs to Malaysia. Also, when Martin *et al.* (2011) applied their MEDTOUR scale on undergraduates in an American university, PBC score was the least among TPB variables. In both instances, there is a weak perception of having the time, funds and support for medical tourism. However, for Nigerian MTs to India, it is apparent that they benefit from the collectivist nature of the society (Anandarajan *et al.*, 2000), which makes PBC impact high on decision-making.

6. Concluding remarks

Nigerian MTs to India consider medical tourism as an enforced necessity rather than a desired first choice. They usually consult domestic hospitals for their medical conditions because of their belief system that their needs would be met locally. Unmet needs resulting from service failure lead them to medical tourism. *Having noted that the contextual meaning of medical tourism was foreign medical treatment and vacation, for Nigerian MTs to India, medical tourism equates foreign medical treatment only unlike nationals of Western countries of whom Jung (2012) posited value vacation as much as the medical treatment component of medical tourism. The implication is that more practical research could be conducted to fathom the disposition of Nigerians towards vacation during medical tourism.*

*This research also shows that would prefer local medical care if all conditions are right. Hitherto, wholesale accounts figured that Nigerians always preferred foreign goods and services to local ones (Abubakar *et al.*, 2018). As discovered by Madichie (2011) and buttressed by this study, this is not so. The implication is that if Nigerian health-care providers could raise the standard of their practice, the current trend of medical tourism could reverse as a consequence. Besides winning over potential Nigerian MTs to India to seek medical care locally, the Nigerian health-care providers could potentially attract foreign*

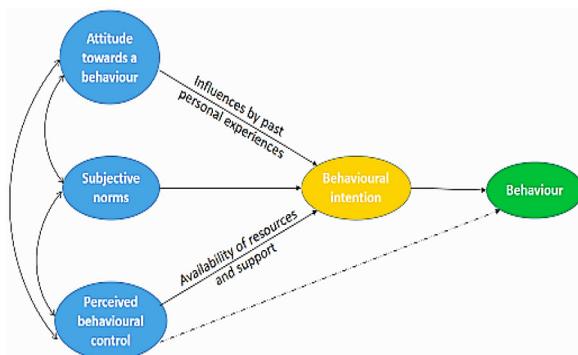


Figure 3.
Attitude and PBC
have superior effects
on decision-making
process of old-timer
Nigerian MTs to
India

nationals too. Current geopolitical drivers of future tourist flows favour Nigeria (Webster and Ivanov, 2015). An area for practical research is how Nigeria's health-care system could benefit from the global geopolitical drivers and draw an influx of foreign nationals who want the whole package of medical care and vacation when they embark on medical tourism.

This research also distinguished between medical tourism first-timers and old-timers in their decision-making process. SN had a stronger influence than attitude for the former while the reverse was the case for the latter. This information is vital for hospitals who are looking to recruit new patients; they have to delight their old patients with excellent customer service, which in turn, makes them loyal raving fans and indirect advocates. It is a loyal customer that keeps returning and in the process, comes along with another.

Finally, the limitations of this study must be acknowledged. First, the sample size was relatively small and the data collection approach produced diverse response. Adoption of open-ended questions as the research methodology may not have produced definite answers to specific research questions. Thus, the result of this study may not apply to another set of Nigerian MTs and caution must be taken not to generalise. Second, data collected did not include the specific nature of medical conditions that took the respondents to India. Even though the crux of the study was investigating consumer behaviour, knowing the actual medical/surgical care sought in India could have helped in understanding and interpreting their responses better. For instance, the actual medical conditions affects comparative cost of medical treatment and of course, consumer behaviour (Hanefeld *et al.*, 2015). In addition, demographic and psychographic variables were disregarded even though Kotler and Keller (2013, p. 175) and Kotler and Armstrong (2010, pp.170-172) stated that both variables have strong influence on consumer behaviour and dispositions. Guy *et al.* (2015) reported that demographic characteristics could be used to predict the likelihood of Americans embarking on medical tourism. Lunt *et al.* (2013) found that cultural affiliations was a major influence on medical tourism decisions among ethnic migrants residing in UK. *Third, the research was based on primary data analysis of the researcher. Goodwin and O'Connor (2006) opined that this method is often easily influenced by the preconceptions of the researcher to arrive at certain 'predetermined' destination. I relied on the triangulation process to ensure that researcher bias did not affect the process of data collection and analysis.* Fourth, secondary data on the subject matter was not readily available as only few local studies have been conducted on medical tourism previously. Researchers can learn from all these shortcomings in designing relevant further studies.

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Preliminary
look at the
motivators

Appendix 1

Question 1

Q1. What factors, in your own opinion, made you to pursue medical care in India rather than your home country, Nigeria? Can you put them in order based on the relative degree of influence they had on your decision process?

Question 2

Q2. Based on information available to you before your journey, how did medical service in India compare with what you know of Nigeria's health-care system? Having returned from India, do you think your expectations matched experience? Will you want to recommend their services to anyone who asks for your opinion?

Question 3

Q3. Can you confidently say you are fully aware of availability of options in Nigeria before you journey? If in reality, there was equivalent service delivery in Nigeria, would you still have embarked on your journey?

CONSENT FORM FOR INTERVIEWS

I hereby certify that the aims and objectives of this interview was discussed with me before commencement. I acknowledge that I was told that the central theme of the conversation is to understand the *Consumer Behaviour of Nigerian Medical Tourists to India*. The purpose is for me to answer questions about all the factors that I considered which made me to seek medical care in India rather than staying back in Nigeria, and put those factors in descending order of influence during my decision making process.

I have expressly agreed to participate fully in this one-on-one interview with the researcher, Balogun Babatunde. I am aware that my information is needed solely for the purpose of his research about medical tourism, which can bring about positive social changes.

I have been told that the interview shall not last more than forty minutes but I am free to expand on the topic, if you want. I am also aware that I could decide to discontinue with the interview at any time, however, without giving any explanation. My participation is voluntary.

I have been informed that the interview shall be audiotaped (but with an option of a questionnaire) and that all information shall be kept confidential. The researcher has reviewed the social benefits and risks of this project with me. I am entitled to see the transcribed data for review and/or withdraw information prior to analysis for the dissertation. I have been told that the data I provide shall be treated as anonymous with respect to my personal identity. A pseudo name is permitted to be used.

Participant's consent

I have read the above form, and, with the understanding that I can withdraw at any time, and for whatever reason, I consent to participate in today's interview.

Participant's signature

Date

Interviewer's signature

Corresponding author

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