Preprints.org

Article

Not peer-reviewed version

Foreign-Owned Tertiary Hospitals, Outbound Medical Tourism, and Health Equity in Lagos State, Nigeria: A Qualitative Case Study

Kingsley C. Iheanacho * and Stephen H. Linder

Posted Date: 16 November 2026

doi: 10.20944/preprints202611.1509.v1

Keywords: foreign-owned tertiary hospitals; outbound medical tourism; health equity; private equity funds; public-owned tertiary hospitals; Nigeria

Preprints.org is a free multidisciplinary platform providing preprint service that is dedicated to making early versions of research outputs permanently available and citable. Preprints posted at Preprints.org appear in Web of Science, Crossref, Google Scholar, Scilit, Europe PMC, OpenAlex.

Copyright: This open access article is published under a Creative Commons CC BY 4.0 license, which permit the free download, distribution, and reuse, provided that the author and preprint are cited in any reuse.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

Disclaimer/Publisher's Note: The statements, opinions, and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions, or products referred to in the content.

Article

Foreign-Owned Tertiary Hospitals, Outbound Medical Tourism, and Health Equity in Lagos State, Nigeria: A Qualitative Case Study

Kingsley C. Iheanacho * and Stephen H. Linder

Department of Management, Policy and Community Health, The University of Texas Health Science Center at Houston School of Public Health, Houston, USA

* Correspondence: kinchima@yahoo.com or kingsley.iheanacho@nimasa.gov.ng

Highlights

Public health relevance—How does this work relate to a public health issue?

- Foreign-owned tertiary hospitals are reshaping healthcare delivery and access to specialized services in Nigeria.
- Their influence on outbound medical tourism and health equity has important implications for health systems in low- and middle-income countries.

Public health significance—Why is this work of significance to public health?

- Foreign healthcare investment may improve specialized care but does not automatically ensure affordability or equitable access.
- Differences between foreign-owned and public hospitals expose persistent challenges in healthcare financing, resource distribution, and regulation.

Public health implications—What are the key implications or messages for practitioners, policy makers and/or researchers in public health?

- Stronger regulations, mandatory corporate social responsibility, and expanded health insurance coverage are needed to promote equitable access.
- Accountable public–private partnerships and sustained investment in public hospitals could strengthen health systems and reduce outbound medical tourism.

Abstract

Healthcare systems in Low and middle-income countries (LMICs) often face inequitable access and inadequate infrastructure, contributing to outbound medical tourism (OMT). In Nigeria, foreign-owned tertiary hospitals (FOTHs) such as Evercare Hospital Lagos (Evercare) provide specialized services for wealthier patients. This research examined how FOTHs influence OMT and health equity and compared them with publicly owned tertiary hospitals (POTHs). It adopted a qualitative case study design, with eight participants purposively selected from the Central Bank of Nigeria (CBN), Nigeria Revenue Service (NRS), Evercare, and Lagos University Teaching Hospital (LUTH) for semi-structured interviews; evidence was analysed using process tracing and ATLAS.ti, with triangulation. Government support differed between FOTHs and POTHs, influencing OMT and health equity. While FOTHs modestly improved OMT by providing premium care domestically, their services remained accessible to affluent patients, leaving the remaining population dependent on overstretched POTHs. FOTHs showed potential to reduce OMT for high-income groups but did not significantly advance health equity in Nigeria. Addressing these issues entails institutional and regulatory reforms that require FOTHs to promote equity. The study was limited to Lagos and a small, targeted stakeholder sample, while OMT estimates relied on bank transactions and excluded parallel-market foreign-exchange transactions.

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

Keywords: foreign-owned tertiary hospitals; outbound medical tourism; health equity; private equity funds; public-owned tertiary hospitals; Nigeria

1. Introduction

Nigeria's healthcare sector faces persistent challenges, including high outbound medical tourism (OMT), poor health outcomes, inadequate infrastructure, and limited public trust [1]. OMT drives capital flight and may undermine health equity by redirecting healthcare expenditure abroad, partly reflecting demand for advanced technologies unavailable domestically [2]. With approximately $1 billion spent annually on medical tourism, Nigeria could potentially forgo 3.7 million treatments annually, assuming a 45% gross margin and $120 average healthcare expenditure per capita [3]. Nigeria also faces substantial infrastructure and financing gaps, requiring an estimated 386,000 additional hospital beds and $82 billion in healthcare real estate investment [4]. Healthcare expenditure is approximately 3.75% of GDP, compared with the WHO-recommended 15% target [5], while population growth could intensify these pressures. COVID-19 further exposed capacity constraints, with only 350 ICU beds and ventilators available for nearly 200 million people. Consequently, foreign investment and ownership of tertiary hospitals have been proposed as mechanisms for strengthening domestic capacity and reducing OMT [4].

Under the NIPC Act 1995, amended in 2004, Foreign-owned Tertiary Hospitals (FOTHs) may repatriate profits abroad subject to a 10% withholding tax [6], raising questions about obligations beyond taxation, particularly where ownership involves foreign private equity (PE). This research therefore examined how FOTHs influence OMT and health equity in Lagos, comparing Evercare Hospital Lagos with LUTH.

Despite improvements in healthcare infrastructure and services by FOTHs in Nigeria, there is limited understanding of their impact on resolving challenges related to OMT and promoting health equity. Most tertiary hospitals in Lagos State have foreign shareholders, except Evercare, which is wholly owned by foreign interests. Additionally, Evercare is the gold standard for FOTHs, not just in Lagos State, but throughout Nigeria [7].

It has also been argued that OMT continues to thrive, indicating ongoing gaps in the local healthcare system and raising questions about the effectiveness of foreign-ownership initiatives in tertiary healthcare [8]. Nigeria's Sovereign Investment Authority estimates that the country's OMT costs over US$1 billion annually, as shown in Figure 1 below [9].

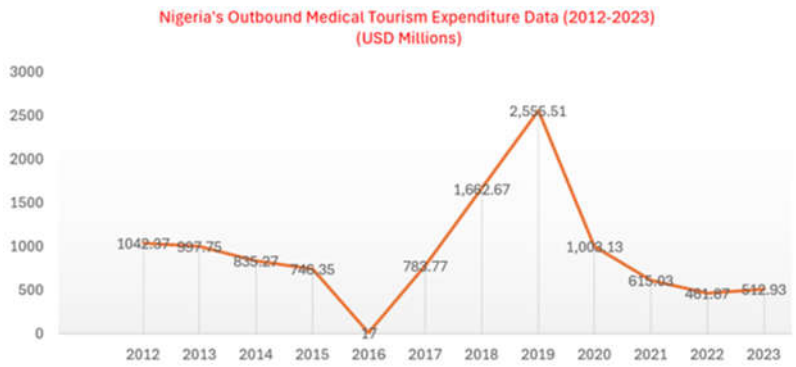


Figure 1. Line graph showing Nigeria's OMT expenditure (2012-2023).

PE-funded FOTHs are a new concept in Nigeria, with firms raising capital, creating value, and selling portfolio companies for investor profits [10]. Some PE-funded FOTHs aim to reduce OMT by providing advanced domestic care. However, concerns persist that PE ownership may compromise patient safety and healthcare quality [10]. Globally, regulatory scrutiny has increased; in the USA, the Department of Justice, the Federal Trade Commission, and Health and Human Services examine PE

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

healthcare investments [11]. In Nigeria, no comparable intervention has been reported, although the FCCPC, established under the Federal Competition and Consumer Protection Act 2018, has health-sector jurisdiction [12]. The research also seeks to determine whether foreign ownership of tertiary hospitals contributes to equitable healthcare access through providing uncompensated care, as outlined in Nigeria's 2019 National Health Promotion Policy. This policy emphasizes equal opportunities and equitable quality healthcare for all, especially underserved and vulnerable populations, regardless of socioeconomic status or other factors [13].

Aims of the Study

1. To understand:
   a. How do FOTHs in Lagos State, Nigeria, impact OMT?
   b. Whether, by influencing OMT, FOTHs provide equitable access to care by offering uncompensated services.
2. To compare FOTHs in Lagos:
   a. With POTHs regarding access to care and the regulatory framework
   b. To compare how foreign investors are treated in the health sector versus other sectors in Lagos.
3. To identify the challenges encountered by FOTHs in Lagos and the implications for healthcare access in Nigeria.

Research Question: How do FOTHs in Lagos, Nigeria, impact OMT, and do they contribute to improving health equity in Lagos, Nigeria?

Conceptual Framework

The Phase 1 framework (Figure 2) proposes that changes in government incentives and regulatory rules governing foreign investment alter the financial incentives of healthcare actors over time, influencing foreign capital flows, OMT, healthcare providers, and ultimately health equity and population health.

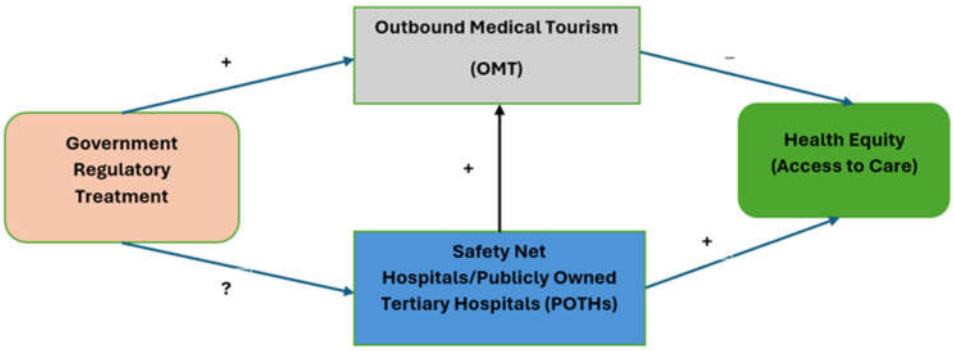


Figure 2. Tertiary care before the advent of FOTHs in Nigeria (Phase 1).

Government regulatory treatment of FOTHs' investment may trigger OMT while adversely affecting POTHs and safety-net providers that may lack the specialized services sought by wealthier patients who usually travel abroad to seek care. This creates a potential cycle in which inadequate domestic specialized care encourages OMT, while regulatory policies may neither discourage OMT nor retain associated healthcare expenditure domestically. The framework further proposed that OMT may affect health equity because expenditures made abroad represent resources unavailable to Nigeria's healthcare system. If such expenditure were retained domestically, increased revenues could potentially strengthen POTHs, reduce uncompensated-care burdens, support safety-net services, improve infrastructure, and expand access to care.

From Phase 2 (Figure 3), the framework incorporated government regulatory treatment that encourages FOTHs investment. Based on the 1985 policy change, favourable regulatory treatment

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

created and sustained the FOTH market. It argued that FOTHs may compete with or complement POTHs and safety-net providers. Hence, increased FOTH services could relieve the burden of POTHs.

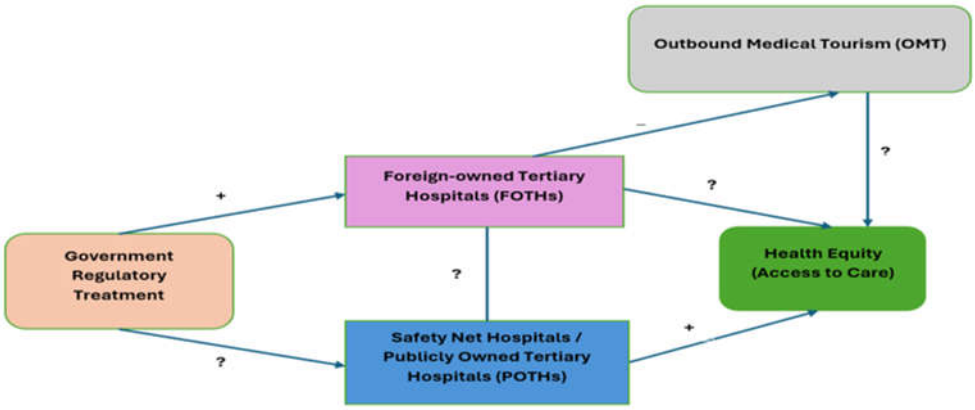


Figure 3. Tertiary care after the advent of FOTHs in Nigeria (Phase 2).

The framework suggested that FOTHs may reduce OMT by providing comparable specialized services domestically. However, although reduced OMT may retain healthcare expenditure in Nigeria, repatriated FOTH profits could limit its potential health-equity benefits. The research examined whether FOTHs contribute more to health equity than they extract, including through support for POTHs and safety-net providers. The research therefore explored interconnected relationships among government regulatory treatment, FOTHs, POTHs, OMT, and health equity. It considered whether favourable regulatory treatment created and sustained the FOTH market; how regulation affects POTHs; whether FOTHs reduce OMT; and whether FOTHs influence health equity directly or indirectly. It also compared FOTHs and POTHs on health equity, the nature of their interactions, and the relationship between OMT and health equity.

2. Materials and Methods

Study Design

The study used a qualitative research design and employed a case study approach. Qualitative methods are appropriate for explaining poorly documented phenomena and examining meanings, perceptions, and experiences through descriptive enquiry [14].

Study Setting

The study was conducted in Lagos, Nigeria.

Case Selection

Researchers selected Lagos State as Nigeria's commercial and financial hub, with diverse tertiary healthcare facilities, including POTHs and FOTHs [15,16]. Researchers chose Evercare Hospital Lagos because it was fully foreign-owned and funded through PE financing from the $1 billion Evercare Health Fund, managed by TPG's Rise Fund [17,18]. At study commencement, it was the only known entirely foreign-owned PE-funded tertiary hospital in Lagos [19]. Its TPG financing supported examination of PE investment, OMT, and health equity [20], while its for-profit model raised concerns regarding affordability, access, and sustainability [21].

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

Participants and Data Sources

The human participants were informants with knowledge of OMT and institutional interactions with FOTHs and POTHs. They provided no private health or patient information. Other evidence came from public documents and reports.

Data Collection

Purposive sampling identified focus institutions, while convenience and snowball sampling facilitated recruitment. Two managerial-level respondents with at least five years' experience were recruited from Evercare, CBN, NRS, and LUTH. We recruited them through LinkedIn [22]. Eight interviews were conducted. Participants were aged 35 to 60; seven were male and one female (Table 1).

Evidence came from public sources, financial reports, corporate and press releases, and interviews. A 10-item open-ended, semi-structured questionnaire was developed for each organization [23], tailored to respondent groups in the interview guide (Appendix B). Key informant interviews were conducted via Microsoft Teams [24] for recording and transcription. Participants were in Nigeria, while the researchers were in Houston, Texas, USA. A five-volunteer pilot assessed procedures, validity, and duration; the interview averaged one hour. Pilot participants requested anonymity and were excluded from reporting.

Table 1. Descriptive Statistics of Key Informants.

Sample size (N)	N= 8
Ethnicity	Nigerian (100%)
Gender	Male (87.5), Female (12.5%)
Geographic Area (Lagos)	Lagos, Nigeria (N=8)
Job Description	Directors (N = 4) Senior Management (N=2) Middle-level management (N= 2)
Organizational Type	Healthcare (N= 4) Bank (N=2) Government Agency (N-2)
Age range	35-65 years old

Data Analysis

Explaining-outcome process-tracing was the analytical approach. This method was used to examine event sequences and causal mechanisms linking factors to outcomes [25,26].

Data triangulation combined interviews with document review. Transcripts were analysed thematically using Braun and Clarke's (2006) six-step approach (Figure 4) and the ATLAS.ti app [27] using inductive semantic-level coding [28].

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

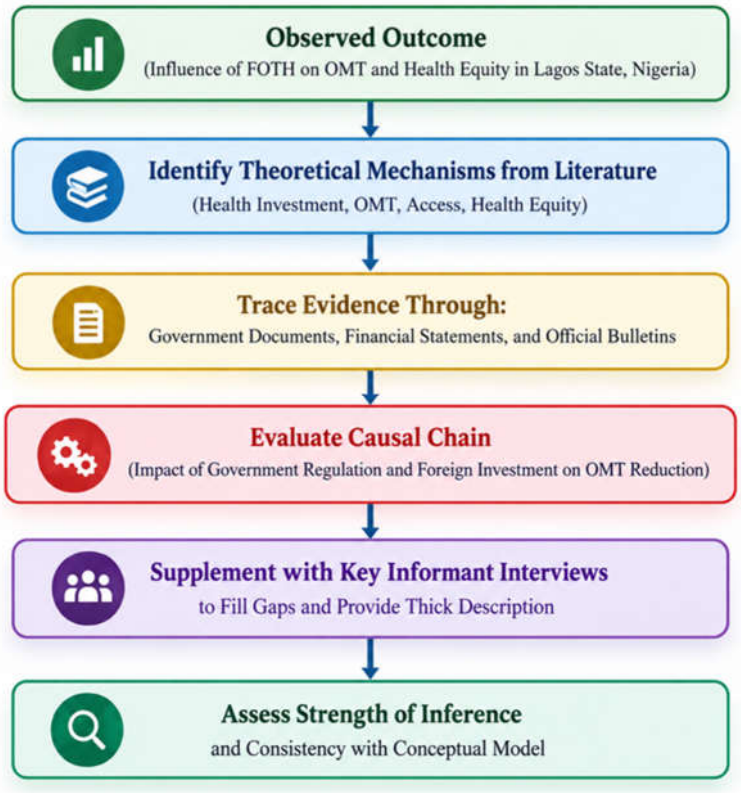


Figure 4. Framework for Explaining Outcome Method of Process Tracing (Levi, 2008; Blatter and Haverland, 2012).

We reviewed transcripts, cleaned and de-identified them, and manually generated and iteratively compared annotated codes with the ATLAS.ti app. The final codebook contained 62 codes. 10 for CBN, 18 for Evercare, 17 for LUTH, and 17 for NRS (Appendix C). ATLAS.ti grouped codes into 32 preliminary themes. After validation, they were reviewed and consolidated into three core themes and 23 sub-themes. The final themes were: (1) Improving local healthcare through FOTHs to reduce OMT and promote Health Equity; (2) Comparing FOTHs and POTHs across sectors in Lagos State, Nigeria; and (3) Challenges facing FOTHs in Lagos State, Nigeria, and their effect on healthcare access. Participant quotations contextualized the findings (Appendix C). ISSM Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist supported transparent reporting [29].

Ethical Considerations

The study was reviewed by the Committee for the Protection of Human Subjects (CPHS) at The University of Texas Health Science Center at Houston and was determined exempt from ongoing Institutional Review Board oversight and full review. The study presented minimal risks, and the evidence obtained was de-identified. The CPHS protocol was HSC-SPH-24-0347 (Appendix E). Evercare Hospital Lagos provided consent for its use as a case study (Appendix D). Evidence was encrypted, de-identified, password-protected, and restricted to authorized users [30]. Files were stored on the University's institutional OneDrive server. All research evidence will be permanently deleted one year after study completion [31].

3. Results

The results were grouped under three themes.

Theme 1: Improving Local Healthcare Through FOTHs: Reducing OMT and Advancing Health Equity in Lagos State, Nigeria

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

Evercare initially emphasized patient-centered care through diagnostics, infrastructure, and international clinical practices: "*Everything centered on patient outcomes, data, and feedback*." This reflected the rationale for FOTHs to reduce OMT [32]. However, respondents reported a mission shift toward financial objectives: "*The focus seemed to shift toward meeting financial targets … more by investor expectations than by its original healthcare mission*," consistent with concerns about PE-driven profitability in healthcare [33]. Revenue bonuses linked to departmental targets were reportedly associated with unnecessary services, while information asymmetry may have encouraged overtreatment [34], potentially undermining trust and clinical integrity where safeguards are weak [35,36]. Respondents described patients receiving timely treatment locally after delays abroad: "*I have treated patients who returned from abroad … stuck on indefinite waiting lists … they feel it was ultimately better here*." Another reported a 34-year-old pregnant woman who died abroad because she "*could not get access to care*." These accounts illustrate OMT's consequences and the potential value of domestic tertiary capacity. Declining OMT was also linked to foreign-exchange liberalization and FOTH investment, consistent with calls to reduce Nigeria's annual capital flight associated with OMT to USD$1–2 billion [37].

LUTH respondents emphasized its safety-net role: "*OMT has not significantly affected the teaching hospital … mostly … lower middle class who typically cannot afford overseas care*." Domestic treatment also provides culturally embedded support: "*Nigeria offers a strong support system … relatives bringing … comfort items … something they cannot find abroad*." However, limited awareness persists: "*Several individuals … were completely unaware of these local options*," consistent with evidence linking misinformation and low trust to OMT [38]. Evercare outreach, including a health talk reaching "*over 500 women*," may improve health literacy. Evercare provides limited equity-oriented assistance, including subsidized cleft surgeries, debt write-offs, and Cochlear implant partnerships: "*We budget to carry out 20 cleft palate correction procedures … write off debt for indigent patients.*" However, no formal charity-care policy, transparent community-benefit framework, or public equity reporting was identified. LUTH, by comparison, works with NGOs to subsidize services such as clubfoot treatment [39]. Thus, FOTHs may reduce OMT through timely, advanced, and culturally responsive care, but their equity effects remain constrained by high costs, insurance dependence, and limited institutionalized subsidies [40].

Theme 2: Comparison of FOTHs and POTHs in Lagos State, and Between the Health and Transport Sectors

Evercare aims "*to transform healthcare delivery in Nigeria by providing world-class, accessible, and sustainable medical care that meets international standards*," with investment in modern facilities and specialist care to reduce OMT [17]. LUTH seeks to reduce morbidity and mortality and improve life expectancy and quality of life through patient care, workforce development, and research [41], but faces underfunding, infrastructure shortages, personnel constraints, delays, and limited specialized services [42].

Evercare's streamlined governance and PE financing facilitated rapid infrastructure and technology investment [43], whereas LUTH depends on government allocations and internally generated revenue within federal bureaucratic structures [44]. This creates socioeconomic segmentation: Evercare primarily serves insured and wealthier patients, while LUTH functions as a safety net. Some physicians practice in both facilities, indicating overlapping clinical ecosystems.

Respondents identified Evercare's privacy, environment, personalized service, and specialist access as strengths: "*Evercare now allows patients to have their caregiver, such as a house-help, stay with them in a private admission room… beautifully decorated single rooms that create a 'wow' impression*." Its consultant-led multispecialty model attracts patients seeking prompt, high-quality care [45]. Another respondent stated, "*The hospital's mission focuses on providing high-quality, affordable care… most specialties are covered by in-house consultants*." Distrust also influences healthcare choices, although respondents noted improvement: "*Over the past decade, Nigeria's healthcare system has significantly improved… treatments that once required travel abroad are now available locally*" [46].

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

Some respondents perceived a quality gap: "*LUTH isn't in the same league… the standards are significantly lower*," and "*Doctors from LUTH… lack poise and professionalism… their bedside manner tends to be poor*." FOTHs generally follow international standards, whereas POTHs face infrastructure and supply constraints [47]. Nevertheless, LUTH officials viewed FOTHs as complementary: "*FOTHs are seen as welcome partners… Many patients return to LUTH when costs at FOTHs become unaffordable*," and their presence was described as "*a positive contribution to strengthening Lagos State's overall healthcare system*" [48].

Government facilitates PE-funded FOTHs through certificates of capital importation: "*CBN issues a certificate of capital importation… ensuring the investor can later repatriate profits*." However, respondents questioned preferential treatment: "*I am not aware of preferential treatment… why should we prioritize PE-funded FOTHs?*" Both sectors face regulatory inconsistencies and bureaucratic inefficiencies [49].

Evercare reportedly achieved break-even in less than three years from inception: "*Our strategic plan was to break even within five years… we achieved that milestone in less than three*." It was reportedly the group's top revenue-generating African facility, with funds retained or reinvested: "*The funds have not yet been transferred to TPG… If not immediately needed, we can keep it stored or invest it*." POTHs such as LUTH remain dependent on unstable government funding [42].

Regarding Health Equity initiatives, Evercare reported NGO partnerships, approximately N100 million annually, USD 255,000 in bad-debt write-offs, and USD 98,000 in discounts between 2021 and 2024. Yet "*Evercare's services are essentially meant for individuals who have health insurance or can pay out of pocket… when someone does not have insurance and cannot pay, they are denied care*." This may exclude vulnerable Nigerians from receiving care [50], while offshore parent structures raise transparency concerns [51]. With limited comprehensive insurance coverage [1], FOTH benefits accrue disproportionately to wealthier groups, while poorer populations remain dependent on overstretched POTHs. Thus, FOTHs may reduce OMT while reproducing inequitable access, limiting their broader contribution to population health and health equity.

Compared with healthcare, maritime transport has stronger regulatory mechanisms. The Cabotage Act 2003 protects Nigerian-owned and crewed vessels and regulates foreign participation [52]. The Nigerian Maritime Administration and Safety Agency (NIMASA) conducts flag- and port-state inspections and can detain non-compliant vessels. The Lagos Health Facility Monitoring and Accreditation Agency (HEFAMAA), Nigeria Medical Association (NMA), and Medical and Dental Council of Nigeria (MDCN) have comparatively limited inspection and enforcement capacity. Participants therefore identified maritime governance as a potential model for healthcare regulation, transparency, local-content requirements, and alignment of investment with public-health priorities.

Theme 3: Challenges Facing FOTHs in Lagos State, Nigeria

FOTHs face economic, regulatory, operational, and socio-political constraints. Although tariff reductions and pioneer-status incentives exist, FOTHs otherwise operate profit-seeking businesses [53]. High interest rates, bureaucracy, unreliable electricity, and imported equipment increase costs: "*Medical and transport equipment may receive reduced customs tariffs... However, in terms of interest rates and general business operations, they are treated like any other profit-driven entity*". These costs constrain affordability and expansion [54]. Foreign-exchange constraints affect imported equipment and consumables, while limited awareness persists: "*Several individuals have mentioned that they were completely unaware of these local options*" [55].

PE ownership also creates uncertainty because TPG's buy-and-build strategy anticipates an exit after approximately 5–8 years [56]: "*TPG does not intend to operate Evercare indefinitely... they will likely aim to exit by 2027*." Ownership changes may affect staffing, costs, quality, and public-health alignment, particularly under weak regulation [57].

Weak governance and ethical oversight were also identified: "*There are currently no specific government regulations or policies that Evercare's management is particularly concerned about...*". Public officials seeking treatment abroad may further undermine confidence in domestic healthcare [58]. Human-resource constraints include physician migration: "*We have brain drain; you know, qualified*

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

medical doctors going out of the country to seek greener pastures." Dual practice and moonlighting enabled some POTH physicians to work in FOTHs despite restrictions during official hours, potentially weakening POTH capacity [59].

4. Discussion

Across the three themes, it was evident that specialized care provided by FOTHs could curb OMT, but their equity-enhancing potential is limited by structural, regulatory, economic, and ideological barriers.

Compared with POTHs, FOTHs show stronger performance-driven leadership, accountability, efficiency, and quality orientation, whereas POTHs face underfunding, weak incentives, inconsistent leadership, and bureaucratic inefficiencies. Some of the issues that resonated with the research findings include regulatory disparity, private equity build-and-exit strategy, brain drain, and physician dual practice and moonlighting. Limited public trust in local care was also found to reinforce OMT. FOTHs' fee-for-service and insurance-dependent model may reduce OMT among middle- and upper-income groups while widening equity gaps unless integrated into affordability and universal coverage reforms.

Principal Findings

The research identified overtreatment incentives by FOTHs, dual practice, affordability barriers, organizational culture, POTH resource constraints, foreign investor taxation, PE Ownership, and revenue maximization as interconnected issues linking OMT, FOTHs, POTHS, health equity, and governance in LMICs (Figure 5). FOTHs contributed to reducing OMT through faster access, modern infrastructure, and specialty services [60]. However, OMT trends from 2012 to 2023 were also shaped by foreign exchange fluctuations, travel disruptions, COVID-19, and improved local services. As one respondent noted, "*I believe the rate of OMT has declined, partly because of FOTHs but largely due to the COVID-19 pandemic…*"

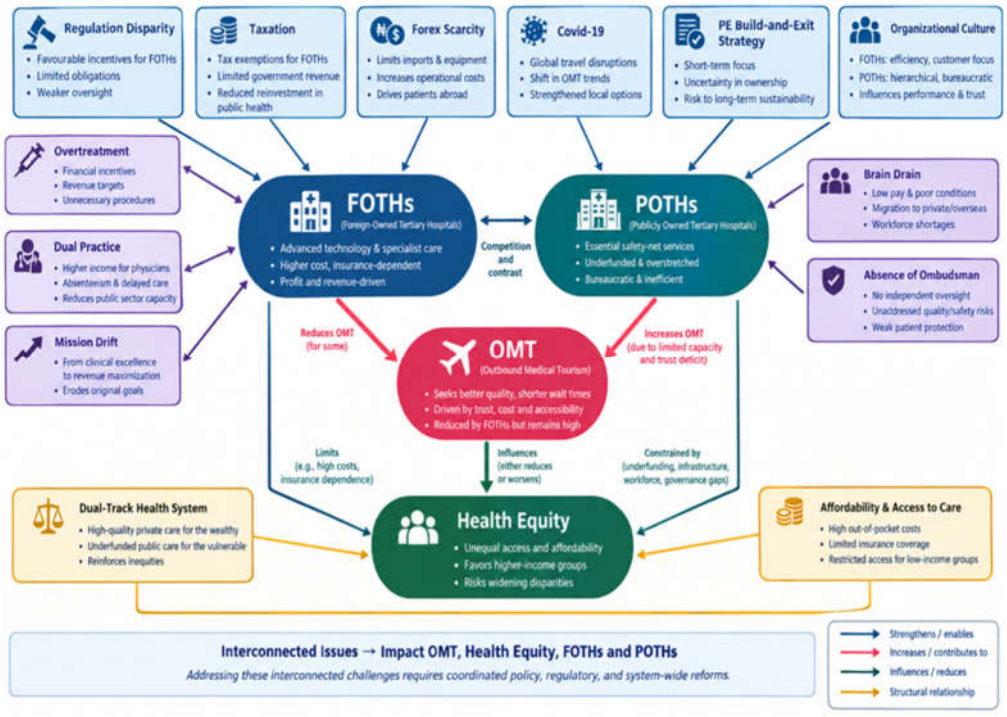


Figure 5. Nigeria's Tertiary Healthcare System Intersections (Source: Kingsley C. Iheanacho 2026).

Government regulation favored FOTHs through foreign exchange waivers and earnings repatriation, tax exemptions, and investment incentives, while POTHs faced bureaucratic funding

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

and procurement constraints. Cross-sector comparison indicated more structured oversight and standardized incentives for foreign investors in the transport sector than in healthcare services. FOTH's revenue-based bonuses reportedly encouraged overtreatment. A clinician stated, "*However, the focus now leans more towards meeting financial targets and not on patient-centeredness and health equity. This motivation drove staff to be more revenue-generation-minded*". This aligns with evidence linking financial incentives to overtreatment [61]. In Kenya, TPG-linked hospitals were associated with pressure for unnecessary tests, admissions, and bloodwork to increase revenue [62], raising concerns about profit and patient welfare [63]. TPG-linked hospitals in Pakistan also faced scrutiny over financial and operational practices [64]. These cases underscore the need for regulation protecting quality and equitable access [64]. Dual practices among POTH physicians, including employment at FOTHs, increased affected physicians' income but contributed to absenteeism, delayed procedures, and waiting times, consistent with LMIC evidence [61].

Organizational cultures differed. FOTHs emphasized efficiency and customer experience, while POTHs reflected hierarchical public sector norms. Evercare reported tax losses from inception in 2019 to 2024, and with 25% of share capital originating from offshore, it remained exempt from minimum tax remittance to the government for up to five years from inception under the Companies Income Tax Act and the Finance Act [65]. Although legally compliant, these practices raise ethical questions following the reported break-even of the hospital in early 2025 and the potential exit from Nigeria.

POTHs face financial constraints that limit their operations, infrastructure, research, and workforce retention. These constraints contribute to health-worker migration [45]. Evercare's build-and-exit model raises sustainability concerns consistent with evidence of cost-cutting and mission drift under PE funding [66]. This reflects mission drift toward financially driven goals [67].

FOTHs and OMT

Respondents reported patients choosing FOTHs over travelling overseas because of comparable quality of care, lower costs, and convenience; some diaspora Nigerians reportedly returned for treatment. One respondent stated, "*Timely service is crucial. You can walk in here and receive quality care without delay, unlike overseas where patients often would have to schedule appointments weeks or even months in advance*."

Health Equity, Health System Policy and Governance Implications

Affordability also differentiated the hospitals. FOTHs primarily served affluent and privately insured patients. FOTHs' health equity contributions included NGO partnerships, free cleft-palate surgeries, and limited bad-debt write-offs, while low-income and vulnerable populations' access to care remained restricted without sponsorship. From 2021 to 2024, Evercare recorded $255,000.00 in bad debts and $98,000.00 in discounts, but these were not part of an institutionalized uncompensated care policy. POTHs functioned as a safety net for vulnerable populations despite chronic shortages. FOTHs worsen disparities when financial barriers are high [68].

Thus, FOTHs have limited system-wide equity effects. FOTHs may retain patients and professionals, but the long-term effects of PE ownership require policy attention. As Nigeria attracts PE funds in healthcare, policymakers must balance investment benefits with equity and social responsibility. TPG's anticipated exit from Nigeria creates uncertainty regarding Evercare's future. Respondents described improved standards and trust initially, but shared concerns about revenue-driven practices and post-exit governance challenges.

Policy and Management Implications

Equitable regulation of FOTHs and POTHs should mandate affordable-care quotas, community-health obligations, transparent reporting, and independent clinical and billing audits [69]. Public–private partnerships should strengthen knowledge transfer, training, referrals, and shared services [70], while expanding National Health Insurance Authority (NHIA) coverage to tertiary care,

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

conditional on FOTH equity performance [71]. POTHs require sustained investment in infrastructure, equipment, workforce, and systems [40]. Mandatory, auditable FOTH corporate social responsibility, responsible-investment incentives, and dual-practice reforms should protect vulnerable populations and address internal brain drain [72].

Patient education and ethical incentives should curb overtreatment. Enacting the proposed National Health Facility Regulation Agency (NHFRA) legislation would strengthen national quality, affordability, access, and safety standards [73]. PE-funded hospitals should adopt governance bonds covering sliding-scale fees, charity care, conditional incentives, and monitoring of ownership exit [74]. Transparent profit taxation, reinvestment in public healthcare, and continuous monitoring of affordability, quality, utilization, and patient satisfaction are essential to accountability, equity, health-system strengthening, and reducing OMT.

Limitations

The research focus on two tertiary hospitals in Lagos State might limit generalization to other parts of Nigeria. The small, purposively selected sample and dependence on self-reported interviews and internal documents may introduce selection, recall, and social desirability biases. Restricted access to proprietary financial and operational data limited financial analysis. CBN OMT data may also underreport expenditures because informal foreign exchange transactions were not included. Findings on governance, investment, and pricing may change following TPG Capital's anticipated exit. The cross-sectional comparison with Transportation was also limited by the absence of regulatory and investor interviews. Nevertheless, triangulation strengthened the research insight into FOTHs, OMT, and health equity in Nigeria.

5. Conclusions

FOTHs can reduce OMT by providing timely, advanced care that sustains healthcare spending locally, but their gains remain concentrated among the wealthy [75,76]. Episodic corporate social responsibility (CSR) initiatives by FOTHs have not addressed structural inequities, while POTHs remain underfunded and overstretched [77]. Flexible healthcare regulation, compared with stricter local content requirements in other sectors, may limit socially responsible investment. Evercare's mission drift from patient-centered care to a revenue-generation-focused model further constrained affordability and access. Chronic underfunding of POTHs, workforce disparities, regulatory gaps, and market-driven pricing reinforce a dual-track system of healthcare for the rich versus the vulnerable, which may perpetuate OMT and health inequities in Lagos, Nigeria.

Author Contributions: The following were the authors' contributions to the work: Conceptualization, KCI and SHL; methodology, KCI and SHL; software, KCI; validation, KCI.; formal analysis, KCI.; investigation, KCI; resources, KCI; data curation, KCI.; writing—original draft preparation, KCI.; writing—KCI and editing, KCI and SHL; visualization, KCI and SHI; supervision, SHL; project administration, KCI; funding acquisition, KCI. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding. The research was solely funded by Kingsley C. Iheanacho.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board (or Ethics Committee) of The University of Texas Health Science Center at Houston, Texas, USA (protocol code HSC-SPH-24-0347 and April 14, 2024). Ethical review and approval were waived for this study because it does not meet the regulatory requirements for human subjects' research.

Data Availability Statement: Nigeria's outbound medical tourism data were extracted from the central bank website: Statistical Bulletin: Balance of Payments Statistics. CBN. https://www.cbn.gov.ng .

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

Acknowledgments: The authors gratefully acknowledge the support, encouragement, and understanding of their respective families throughout this research. The lead author wishes to express his deepest gratitude to his wife, Dr. Ogechukwu (Oge) Iheanacho, for her unwavering support, patience, encouragement, and sacrifices throughout his doctoral studies and the completion of this research. The lead author also extends sincere appreciation to the members of his dissertation committee and faculty of the UTHealth Houston School of Public Health for their academic guidance, mentorship, and constructive contributions. Special recognition goes to Dr. Stephen H. Linder (committee chair and co-author) and Aanand D. Naik, M.D., Professor of Public Health and Chair of the Department of Management, Policy and Community Health (MPACH), for their invaluable academic guidance and support. The lead author is profoundly grateful to the sponsors of his doctoral scholarship and fellowship, particularly the late Dr. Ann Carol Galeener and her late husband, John W. Galeener Jr., whose generosity made one of his doctoral fellowships possible. Their philanthropic commitment to education and investment in the development of future scholars remains deeply appreciated. The lead author dedicates this special expression of gratitude to their memory. Finally, the authors sincerely thank the case study organization, Evercare Hospital, and all key informants and pilot study participants for their time, cooperation, and invaluable contributions to this research.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

OMT	Outbound Medical Tourism
LUTH	Lagos University Teaching Hospital
FOTH	Foreign-owned Tertiary Hospitals
POTH	Publicly owned Tertiary Hospitals
PE	Private Equity
HEFAMAA	Lagos State Health Facilities Monitoring and Accreditation Agency
NIPC	Nigerian Investment Promotion Commission
NEFRA	National Health Facilities Regulatory Agency (proposed)
NMA	Nigeria Medical Association
NIMASA	Nigeria Maritime Administration and Safety Agency
NHIA	National Health Insurance Authority
NRS	Nigeria Revenue Service

References

1. Olasehinde N. Healthcare Seeking Behavior in Nigeria. *JPSS*. 2018;26:207–18. doi:10.25133/JPSSv26n3.015
2. U.N.C.T.A.D. International Trade in Health Services: Difficulties and Opportunities for Developing Countries. In: Trade and Development Board Commission on Trade in Goods and Services, and Commodities Meeting of Experts on Strengthening the Capacity and Expanding Exports of Developing Countries in the Services Sector: Health Services Geneva [Internet]. 1997. Available from: https://unctad.org/
3. Iwelumo M. Restoring Trust to Nigeria's Healthcare System [Internet]. 2016. Available from: www.pwc.com/ng
4. Coker T. Bridging the Funding Gap in Healthcare Infrastructure. TC Health Nigeria [Internet]. 2024. Available from: https://www.tchealthng.com/thought-pieces/bridging-the-funding-gap-in-healthcare-infrastructure
5. Ayetoto-Oladeinde T. Private Funds in Fresh Bid to Reverse Nigeria's $1.5bn Medical Tourism. The BusinessDay Nigeria Newspapers [Internet]. 2021. Available from: https://businessday.ng/news/article/private-funds-in-fresh-bid-to-reverse-nigerias-1-5bn-medical-tourism/
6. US Department of State. Investment Climate Statements: Nigeria [Internet]. US Department of State; 2021. Available from: https://www.state.gov/reports/2021-investment-climate-statements/nigeria/

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

7. Smith R, Martínez Álvarez M, Chanda R. Medical tourism: A review of the literature and analysis of a role for bi-lateral trade. *Health Policy*. 2011; 103:276–82. doi:10.1016/j.healthpol.2011.06.009
8. Dupasquier C, Osakwe PN. Foreign direct investment in Africa: Performance, challenges, and responsibilities. *Journal of Asian Economics*. 2006;17:241–60. doi:10.1016/j.asieco.2005.07.002
9. Thisday Newspapers. Evercare: Making Nigeria a Destination for Inbound Medical Tourism. Thisday Nigeria Newspaper [Internet]. 2024. Available from: https://www.thisdaylive.com/index.php/2021/07/22/evercare-making-nigeria-a-destination-for-inbound-medical-tourism
10. Todd S. Private Equity in Healthcare. Medical Economics [Internet]. 2019. Available from: https://www.medicaleconomics.com/view/private-equity-healthcare
11. Todd S. Growing without private equity. Medical Economics [Internet]. 2019. Available from: https://www.medicaleconomics.com/view/growing-without-private-equity
12. Federal Government of Nigeria. Federal Competition and Consumer Protection Act. Laws of the Federation of Nigeria (LFN) [Internet]. 2018. Available from: https://fccpc.gov.ng/resources-library/fccpa/
13. Federal Ministry of Health. National Health Promotion Policy, revised 2019. In: Nigeria Investment Promotion Commission [Internet]. 2019. Available from: https://scorecard.prb.org/app/uploads/2022/03/National-Health-Promotion-Policy-Revised-in-2019.pdf
14. Pyo J, Lee W, Choi EY, Jang SG, Ock M. Qualitative Research in Healthcare: Necessity and Characteristics. *Journal of Preventive Medicine and Public Health* Yebang Uihakhoe Chi. 2023; 56:12–20. doi:10.3961/jpmph.22.451
15. World Bank. Nigeria economic update: Resilience through reforms [Internet]. The World Bank Group; 2021. Available from: https://www.worldbank.org/en/country/nigeria/publication/nigeria-economic-update-resilience-through-reforms
16. National Daily N. 24 commercial banks in Nigeria with headquarters in Lagos. National Daily Newspaper [Internet]. 2020. Available from: https://nationaldailyng.com/24-commercial-banks-in-nigeria-with-headquarters-in-lagos/
17. TPG Group. TPG Group [Internet]. 2021. Evercare Group set to deliver accessible, quality healthcare in Nigeria through new world-class multispecialty hospital. The Rise Fund. Available from: https://www.tpg.com/news-and-insights/evercare-group-set-deliver-accessible-quality-healthcare-nigeria
18. I.F.C. IFC supports Evercare Group to improve access to healthcare in Africa and South Asia [Internet]. 2022. Available from: https://www.ifc.org
19. Laide I. See the owners of the largest private hospitals in Nigeria. Crest Africa [Internet]. 2026. Available from: https://crestafrica.com/see-the-owners-of-the-largest-private-hospitals-in-nigeria/
20. TPG Capital. About us [Internet]. 2023. Available from: https://www.tpg.com
21. Adewole DA, Adebayo AM, Udeh EI, Shaahu VN, Dairo MD. Payment for Health Care and Perception of the National Health Insurance Scheme in a Rural Area in Southwest Nigeria. *The American Society of Tropical Medicine and Hygiene*. 2015;93:648–54. doi:10.4269/ajtmh.14-0245. PubMed PMID: 26195464; PubMed Central PMCID: PMC4559712.
22. LinkedIn Corporation. LinkedIn Social networking service [Internet]. 2025. Available from: https://www.linkedin.com
23. Neergaard MA, Olesen F, Andersen RS, Søndergaard J. Qualitative description- The poor cousin of health research? *BMC Medical Research Methodology*. 2009; 9:52. doi:10.1186/1471-2288-9-52
24. Microsoft Corporation. Microsoft Teams [Computer software [Internet]. 2025. Available from: https://www.microsoft.com/en-us/microsoft-teams/download-app
25. Levy JS. Case Studies: Types, Designs, and Logics of Inference. Conflict Management and Peace Science. 2008; 25:1–18.
26. Blatter J, Haverland M. Designing Case Studies: Explanatory Approaches in Small-N Research. Palgrave Macmillan; 2012.
27. ATLAS.ti GmbH SSD. ATLAS.ti Scientific Software [Internet]. 2024. Available from: https://atlasti.com
28. Tracy SJ. Qualitative research methods: Collecting evidence, crafting analysis, communicating impact. 2nd ed. Wiley-Blackwell; 2020.

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

29. Damanik LE. ISSM COREQ checklist [Dataset]. Figshare [Internet]. 2021. Available from: https://doi.org/10.6084/m9.figshare.14236271.v1 doi: 10.6084/m9.figshare. 14236271.v1
30. US Department of Health and Human Services. Health information privacy [Internet]. 2020. Available from: https://www.hhs.gov/hipaa
31. American Psychological Association. Publication manual of the American Psychological Association. 7th ed. American Psychological Association; 2020.
32. Ojo, M. Private teaching hospitals will reverse medical tourism. Punch Newspapers [Internet]. 2016. Available from: https://punchng.com/private-teaching-hospitals-ll-reverse-medical-tourism/.
33. Gondi S, Song Z. Potential Implications of Private Equity Investments in Health Care Delivery. *JAMA*. 2019; 321:1047. doi:10.1001/jama.2019.1077
34. Chee TT, Ryan AM, Wasfy JH, Borden WB. Current state of value-based purchasing programs. *Circulation*. 2016; 133:593–7. doi: https://doi.org/10.1161/CIRCULATIONAHA.115.010268
35. Hurst SA, Perrier A, Pegoraro R, Reiter-Theil S, Forde R, Slowther AM, et al. Ethical difficulties in clinical practice: Experiences of European doctors. *Journal of Medical Ethics*. 2020; 33:39–47. doi: https://doi.org/10.1136/jme.2005.014266
36. Li J, Hurley J, DeCicca P, Buckley G. Physician response to pay-for-performance: Evidence from a natural experiment. *Health Economics*. 2020; 29:1449–64. doi:10.1002/hec.2971
37. Orekoya IO, Oduyoye OO. Implications of Outbound Medical Tourism on Public Health Care Development in Nigeria. *ESJ*. 2018;14:353. doi:10.19044/esj. 2018.v14n30p353
38. Palmer A, Gorman S. Misinformation, trust, and health: The case for information environment as a major independent social determinant of health. *Social Science & Medicine*. 2025; 381:118272. doi: https://doi.org/10.1016/j.socscimed.2025.118272
39. Adelakun, E. O. (2021). The implications of health financing for health access and equity in Nigeria. *Healthcare Access*. (pp. 1-20). doi: https://doi.org/10.5772/intechopen.98565
40. World Health Organization. Health Financing Country Profile: Nigeria [Internet]. 2022. Available from: https://www.who.int/data
41. L.U.T.H. About us [Internet]. LUTH; 2025. Available from: https://luth.gov.ng/node/186
42. Uzochukwu BSC, Ughasoro MD, Etiaba E, Okwuosa C, Envuladu E, Onwujekwe OE. Healthcare financing in Nigeria: Implications for achieving universal health coverage. *Nigerian Journal of Clinical Practice*. 2018; 21:1395–401. doi: https://doi.org/10.4103/1119-3077.154196
43. Umeha C. Evercare Commences Operations Of Its Ultramodern Hospital in Lagos. Independent Newspaper [Internet]. 2021. Available from: https://independent.ng/evercare-commences-operations-of-its-ultramodern-hospital-in-lagos/
44. Uroko C. Evercare Hospital reduces energy use 39% as building gets EDGE certification. BusinessDay [Internet]. 2022. Available from: https://businessday.ng/real-estate/article/evercare-hospital-reduces-energy-use-39-as-building-gets-edge-certification/
45. Adeyemi KS, Olugbenga Olatunji E. Challenges and Prospects of Tertiary Healthcare Delivery in Nigeria: A Case Study of the University College Hospital (U.C.H.), Ibadan. *African Journal for the Psychological Studies of Social Issues* [Internet]. 2026;29. Available from: https://ajpssi.org/index.php/ajpssi/article/view/866
46. Onwujekwe O, Hanson K, Ichoku H, Uzochukwu B. Financing incidence analysis of household out-of-pocket spending for healthcare: getting more health for money in Nigeria? *Health Planning & Management*. 2014;29. doi:10.1002/hpm.2166
47. Onwujekwe O, Mbachu C, Ezenwaka U, Arize I, Ezumah N. Characteristics and Effects of Multiple and Mixed Funding Flows to Public Healthcare Facilities on Financing Outcomes: A Case Study from Nigeria. *Front Public Health*. 2019; 7:403. doi:10.3389/fpubh.2019.00403 PubMed PMID: 32010658; PubMed Central PMCID: PMC6974794.
48. Obembe TA, Olumide AE, Osungbade KO. Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities. *Journal of Public Health and Epidemiology*. 2017; 9:88–94.
49. Alubo S. The political economy of doctors' strikes in Nigeria: A Marxist interpretation. *Social Science & Medicine*. 1986; 22:467–77. doi:10.1016/0277-9536(86)90051-1

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

50. Oxfam. Vulnerable people being bypassed or bankrupted as rich countries pour development billions into Africa's private healthcare [Internet]. 2025. Available from: https://nigeria.oxfam.org/latest/press-release/vulnerable-people-being-bypassed-or-bankrupted-rich-countries-pour-development
51. Baker D, Jayadev A, Stiglitz JE. Innovation, intellectual property, and development: A better set of approaches for the 21st century. AccessIBSA Project [Internet]. 2020. Available from: https://accessibsa.org
52. Federal Ministry of Transport. Guidelines on the implementation of the Coastal and Inland Shipping (Cabotage) Act, 2003. In: Nigerian Maritime Administration and Safety Agency (NIMASA [Internet]. 2007. Available from: https://nimasa.gov.ng/
53. N.I.P.C. Pioneer Status Incentive Guidelines [Internet]. 2023. Available from: https://nipc.gov.ng
54. World Bank. Nigeria Economic Update: Navigating Uncertainty [Internet]. 2023. Available from: https://www.worldbank.org/en/country/nigeria/publication
55. Epundu U, Adinma E, Ogbonna B, Epundu O. Medical Tourism, Public Health and Economic Development in Nigeria: Issues and Prospects. *AJMAH*. 2017;7:1–10. doi:10.9734/AJMAH/2017/36658
56. Hall MA, Fuse EC. Private Equity and the Corporatization of Health Care. Harvard Law School Forum on Corporate Governance [Internet]. 2023. Available from: https://corpgov.law.harvard.edu/2023/04/19/private-equity-and-the-corporatization-of-health-care/
57. Adeoye AO. Assessing the associated medical, legal, and social issues in medical tourism and its implications for Nigeria. *PAMJ*. 2023. doi:10.11604/pamj.2023.45.145.41104 PubMed PMID: 37808433; PubMed Central PMCID: PMC10559151.
58. Oleribe O et al. Sustainable Health Development Goals (SHDG): breaking down the walls. *The Pan African Medical Journal*. 2015;329–31. doi:10.11604/pamj.2015.22.306.6468
59. Anyangwe SCE, Mtonga C. Inequities in the global health workforce: The greatest impediment to health equity in Sub-Saharan Africa. *International Journal of Environmental Research and Public Health*. 2007;4:93–100. doi:10.3390/ijerph2007040002
60. Olaniyi PO, Oluwatobi FT, Olaniyan ME, Olajide OA, Sunday BA, Aborode AT, et al. Healthcare systems strengthening in Africa: The call for action to achieve SDG 3. *Health Planning & Management*. 2022; 37:14–20. doi:10.1002/hpm.3338
61. Zhang Q, Zhang H, Xu H. Health tourism destinations as therapeutic landscapes: Understanding the health perceptions of senior seasonal migrants. *Social Science & Medicine*. 2021;279:113951. doi:10.1016/j.socscimed.2021.113951
62. Bloomberg. Takeaways from Bloomberg investigation of hospitals owned by TPG [Internet]. Bloomberg; 2025. Available from: https://www.bloomberg.com/news/articles/2025-08-25/takeaways-from-bloomberg-investigation-of-hospitals-owned-by-tpg
63. Bloomberg. A private equity giant took over African hospitals. Then the complaints rolled in [Internet]. Bloomberg; 2025. Available from: https://www.bloomberg.com/news/features/2025-08-25/private-equity-giant-tpg-s-african-hospital-push-sparks-safety-complaints
64. Dooley B, Reddy M. The World Bank set out to transform health care for the poor in Africa. It drove patients deeper into poverty [Internet]. ICIJ; 2025. Available from: https://www.icij.org/investigations/2025/07/the-world-bank
65. NRS. CAP C21 LFN 2004 [Internet]. 2023. Companies Income Tax Act (CITA). Available from: https://www.nrs.gov.ng/page/corporate-income-tax
66. Offodile Ii AC, Cerullo M, Bindal M, Rauh-Hain JA, Ho V. Private Equity Investments In Health Care: An Overview Of Hospital And Health System Leveraged Buyouts, 2003–17. *Health Affairs*. 2021;40:719–26. doi:10.1377/hlthaff.2020.01535
67. Ebrahim A, Battilana J, Mair J. The governance of social enterprises: Mission drift and accountability challenges in hybrid organizations. *Research in Organizational Behavior*. 2014;34:81–100. doi:10.1016/j.riob.2014.09.001
68. McPake B, Hanson K. Managing the public–private mix to achieve universal health coverage. *The Lancet*. 2016;388:622–30. doi:10.1016/S0140-6736(16)00344-5

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.

Preprints.org | NOT PEER-REVIEWED | Posted: 16 November 2026 https://doi.org/10.20944/preprints202611.1509.v1

69. Uzochukwu B, Ughasoro M, Etiaba E, Okwuosa C, Envuladu E, Onwujekwe O. Health care financing in Nigeria: Implications for achieving universal health coverage. *Niger J Clin Pract*. 2015; 18:437. doi:10.4103/1119-3077.154196
70. World Bank. Private health sector assessment in Nigeria [Internet]. The World Bank Group; 2020. Available from: https://openknowledge.worldbank.org/handle/10986/33486
71. Onwujekwe O, Hanson K, Uzochukwu B. Examining inequities in incidence of catastrophic health expenditures on different healthcare services and health facilities in Nigeria. *PLoS ONE*. 2019; 14:0222658. doi: 10.1371/journal.pone.0222658
72. Dovlo D. Wastage in the health workforce: Some perspectives from African countries. *Human Resources for Health*. 2005;3. doi:10.1186/1478-4491-3-6
73. Salako IA. Press release: FG assures activation of reports of committee on establishment of National Healthcare Facility Regulatory Agency (NHFRA. Federal Ministry of Health & Social Welfare [Internet]. 2025. Available from: https://health.gov.ng/fg-assures-activation-of-reports-of-committee-on-establishment-of-national-health-facility-regulatory-agency-nhfra/
74. Offodile Ii AC, Cerullo M, Bindal M, Rauh-Hain JA, Ho V. Private Equity Investments In Health Care: An Overview Of Hospital and Health System Leveraged Buyouts, 2003–17. *Health Affairs. 2021*; 40:719–26. doi:10.1377/hlthaff.2020.01535
75. World Bank. Nigeria Economic Update: Addressing inequality in healthcare access [Internet]. 2023. Available from: https://www.worldbank.org/en/country/nigeria/publication/nigeria-economic-update-2023
76. Sidhu AS, Vuckovic NS, Gupta S, Garcia CM, Patel MB, Ueno CM. The impact of private equity acquisition of US hospitals on patient outcomes: A systematic review. *Journal of Hospital Medicine*. 2026; jhm.70369. doi:10.1002/jhm.70369
77. Isaac N. National Healthcare Facility Regulation Agency will Transform Health in Nigeria. Science Nigeria [Internet]. 2025. Available from: https://sciencenigeria.com/national-healthcare-facility-regulation-agencyll-transform-health-in-nigeria/

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.

© 2026 by the author(s). Distributed under a Creative Commons CC BY license.