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Tackling Uganda's Medical Expenditures Abroad, a Choice Dilemma of Going Public, Private or Public-Private Partnership

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Abstract

Introduction: This study explored the tackling of Uganda's medical expenditures abroad, a choice dilemma of going public, private or public-private partnership. The study described the commonest conditions and reasons for referrals abroad, estimated Uganda's medical expenditures on referrals abroad from the FY 2017/18 to 2023/24. The paper examines the reasons why Government is the most preferred approach in reducing medical expenditures abroad.

Methods: An exploratory, cross-sectional mixed study design was conducted in Uganda. It was carried out from 1 September 2023 to 29 August 2024. Stratified sampling and snowball sampling techniques were used to select 34 participants. Key informant interview media analysis and desk review of data were done. Quantitative data was analysed using SPSS version 16.0 and thematic analysis for qualitative data. Ethical considerations were done.

Results: The cost estimated for medical referral by government to other countries in the financial years 2021/2022 to 2023/2024 was Ug Shs. 26,596,082,700 (USD. 7.29 million) covering 399 patients. The highest proportion of patients referred were 41.6% in the FY 2022/2023, and the commonest conditions referred were congenital heart abnormalities and other cardiac conditions at 73.1% followed by the kidney transplant at 9%.

Conclusion: High expenditures on medical referrals abroad lead to a significant flight of forex and referrals abroad largely due to lack of adequate health care services. Government led interventions is the most preferred policy option to reduce Uganda's high medical expenditures incurred abroad especially on government officials.

Keywords: Medical Tourism, Medical expenditures abroad, health insurance, private-public partnership, Uganda.

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Introduction

The Global South is no exception to the phenomenon globally referred to as medical tourism (MT)[1,2]. In this paper, MT is defined as the practice of travelling outside one's country of residence on advice of health professionals to access medical treatment is an increasing burden to the health systems and economies of low-income countries[3,4]. Most of the Public health systems in the African countries are in a state of crisis, under-resourced, understaffed, overburdened with inadequate financial protection (universal health coverage)[5]. And those diseases have been estimated to cost Africa $2.4 trillion every year[6]. The problem is exacerbated by the shortage of 3.6 million health workers due to ongoing brain drain of healthcare workers overseas with much worse patient to doctor and nurse ratios than the recommended WHO minimum. Fifty percent (50%) of the African population has no access to modern health services[7,8]. To the contrary, positive effects of medical tourism has contributed to positive economic growth in various countries such as Iran, Malaysia, Pakistan and

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Taiwan[9]. Globally, 408 health facilities from 77 countries showed that 60% of the health facilities experienced growth in international patients.[10] The world's most attractive countries for medical Tourism are Canada, the United Kingdom, Israel, Singapore, and Costa Rica.[11,12] Medical Tourism (MT) has established more healthcare options for individuals. The government officials and elites in Africa, for instance, regularly seek advanced medical care abroad[13].Thus, MT has become a major focus of policy interest in recent years because of its varying positive and negative effects. Globalization and technological advancement including telemedicine, medical procedures as well as integration of artificial intelligence have led to cross country trade in healthcare more convenient to patients who seek medical treatment overseas[14-16] Thus, enhancing the demand of medical tourism.

The global medical tourism market is valued at about $439 billion annually, according to international payment systems. The estimated amount for each medical visit is $3,800-$6,000, and globally the total spent every year is estimated at $45-$72 billion. As more people seek affordable quality healthcare abroad, the MT market is poised for tremendous growth in the coming years to increase by 25% per year[17,18]. It is estimated that the number of medical tourists in the world was 14 to 16 million in 2017[19]. Globally, the contest for medical tourism is among 28 nations with only South Africa being the formidable competitor from Africa. The drivers to this rapid growth are globalization, faster access to medical services such as organ transplant that have long waiting periods in many countries and cost savings. Though the presumption of low prices equaling to low quality with lack of medical insurance market is an impediment to the growth of the sector. Other reasons for rapid growth of the industry are high quality healthcare, and supportive government policies that promote medical tourism by streamlining visa processes and accrediting healthcare providers[20,21]. Samoa spent $2.88 million in 2007, Indonesia $1.5 billion in 2008 and Seychelles $1.5 million in 2009 on medical expenses abroad. The Maldivians spent $68.8 million in the year 2013 to get health care abroad constituting $204 per capita and 4.8 percent of the country's GDP annually. The services sought abroad included orthopedic, dental, cardiac, cosmetic surgery and organ transplants. To a smaller extent neoplasm, musculoskeletal system, nervous conditions are sought[10,22,23]. Africa spends $1 to 5 billion per year on medical expenditures abroad, according to the World Bank[24]. However, there is little evidence on how healthcare knowledge from medical tourism, overseas has been replicated in African countries. It's a travesty, that Africa has not fully embraced this new tourism niche market[25-27]. In Nigeria, medical expenditure abroad is 20% of the total expenditure on public healthcare sector. Each year, 60,000 Nigerians travel abroad for treatment spending US 1 billion with 60% spent on orthopaedics, oncology, nephrology and cardiology. Destination countries include India, South Africa, USA, Germany, UK, Saudi Arabia, and Turkey[28,29]. In Burundi, it was estimated that if all patients were to be referred to various destination in Africa, Asia, and Europe, the country would spend more than the $ 11 million required to establish a modern Cancer Care Centre[30].

In most countries, poor economic performance has contributed to crises in the health systems and Uganda is no exception[31,32]. Though a public private partnership has existed way back in the 90's in health care and the first national health policy of 2010, the contribution of the private sector is still below expectation Uganda has increasingly experienced high costs of medical expenditures abroad for treatment of government employees. As such, the medical expenditures abroad continue to be a concern, placing a heavy burden on tax payers, families, communities and the country. While progress has been made in recent years to improve the health care service delivery, there is still much work to be done to address the underlying socioeconomic, leadership and systemic factors contributing to this problem[33-35].

Government spent UgShs270 billion ($73m) on treatment and UgShs418 billion ($113m) on non-medical costs for patients referred abroad in 2024. In the year ending 2016, a total of Ug Shs 10.1 billion ($2,837,909) was spent on 140 senior government officials abroad[36]. The annual cost of referrals abroad as indicated by the Medical Board of MoH was $3.5 million in FY2021/22, $1.9 million in 2022/23 and $0.9 million in 2023/24[37]. This expenditure is significant given that the health sector budget was Ug Shs 2.7 Tn in 2020/21, Ug Shs 3.3 Tn in 2021/22, Ug Shs 4.6 Tn in 2022/23 and Ug Shs 4 Tn 2023/24. This implies significant loss of resources that would support the health sector. The capacity and quality remain a major problem for the East African region and Uganda in particular. India, Kenya, USA, Turkey, UK and South Africa are all major destinations for Ugandans.

The Public Private Partnership (PPPs) have become one of the most promising approaches to addressing the challenge. This provides feasible and alternative high-quality healthcare and medical tourism infrastructure facilities and value for money medical treatment. Thus, is likely to give more patients access to the benefits of scale including expansion of access to healthcare and help improve the quality of services available to people outside their countries. Though Uganda has PPP in the mix of its policy for more than a decade for service delivery the country has not fully engaged PPP

approaches to the maxim in the health sector. By undertaking PPPs, the parties anticipate smooth implementation of the projects. Also, PPPs allow the public sector to undertake projects that would not ordinarily be affordable. This is made possible when the public sector leverages financial resources from the private sector that would not be easily available. Consequently, have high potential for value for money, quality, consumer satisfaction and accountability, risk sharing, saves time and resources[38-40]. Dingel et al. showed that it could be more effective for the government and private health-insurance organizations to pay for patient's medical care abroad than investing in putting more medical infrastructure in remote areas[41]. Similarly, access to private capital (tax free debt) to supplement government funding is made possible through PPPs. More, it spurs innovation and technological transfer which the private sector can provide to the public sector. Thus, PPPs allow government to focus on its strengths such as long-term planning, clearance and setting standards among others. However, the limitation is that countries lose significant revenue and foreign exchange which would be used elsewhere to improve health infrastructure and overall socio-economic development if not well executed [10,27].

Though the government of Uganda budget has not yet supported trade in private sector medical tourism and promoted Uganda to developed countries as a world class-high-tech healing destination for low-cost medical treatment and procedures, several interventions have been fostered through budget allocation, human resource development and staffing of the health sector. Medical referrals abroad have been positioned in the development agenda to enhance government service delivery, thus increasing availability and accessibility to needed specialised services that previously were not available, not accessible and/or are too costly in the home country. Thus, promoting equity by targeting vulnerable populations[42].

This paper presents the commonest conditions and reasons for referrals abroad. Also, it estimates the amount of money the government of Uganda spent on medical referrals to other countries from the FY 2017/18 to 2023/24. Whereas this has been recognized by both politicians and technocrats as an urgent issue to address, there is no consensus on how best to do so. There are no such studies that address the magnitude of medical expenditures abroad and the value of medical tourism for Uganda. The purpose of this study was to establish the most appropriate way of tackling the choice dilemma of Uganda's medical expenditures abroad. Thus, research proposes possible policy options to tackling the problem of Uganda's increasing costs of medical expenditures abroad especially for treatment of high-ranking government officials. This research postulates three existing solutions for addressing the problem. These comprise of the public sector service delivery, Public Private Partnerships (PPPs) and Health Insurance Schemes.

Methods

Process of Getting Authorization to be Treated Abroad

For patients whose doctors recommend seeking healthcare abroad, the doctors write to the Medical Board at the Ministry of Health requesting to assess the need for such a patient to be treated abroad. The Board studies the report and makes a recommendation whether the request is founded or not. The report is forwarded to the Director General MoH who, based on the board's recommendations authorizes or rejects the request for seeking treatment abroad. The accepted referrals are forwarded to Minister of Health for approval and communication to the Rt. Hon. Prime Minister, who Authorizes the use of the Funds by the relevant Ministry or Agency. And for the Members of Parliament, a copy of signed Minute Extract is sent to the Clerk to Parliament in addition to the referral letter and letter from the Minister of Health.

Study Design

An exploratory, cross-sectional mixed study design was conducted involving both qualitative and quantitative data. The study was conducted in Kampala City the capital of Uganda, and Wakiso District. The study population were participants from service delivery, policy makers in public health facilities, legislators and those affected by the policy as well as those that influence policy agenda. The study units were the hospitals, MDAs (Ministries, Departments and Agencies), Development Partners, Private Health Sector, Civil Society and Academia who provided contextual information on the implementation of Uganda's medical expenditures abroad.

Sample Size Determination and Sampling Techniques

Data saturation criterion was used to determine the sample size. Stratified sampling and snowball sampling techniques were used. A two-stage sampling technique was used to select a total of 34 participants in the study areas. In the first stage, the strata created were for public sector and private sector. The stratified random sampling was used to control and organize distribution of sample by sector category into public and private category (sectors). Specifically, institutions from the areas where participants were employed were selected. In the second

stage, snowball sampling was used within each selected sub-sector. The first participants were recruited for the study –those with experience and knowledge concerning medical tourism and medical expenditures abroad. The first participants indicated the next participants who can be included in the study, and these participants indicated the next participants in the study and so on, driving the sampling process. The adaptation of snowball sampling techniques, helped to gain access to participants. All submitted referral reports of FY2017/18 to FY 2023/2024 were assessed. To be included in the study, the report had to mention the reason for referral and diagnosis. For the case of health providers, only those who referred patients abroad were selected. Sampling for this study was based on the following criteria: 1) Participants who those who were working in or supporting the health and medical tourism sectors. They included Service Providers, Policy Makers, Legislators, Clinicians, Hospital Managers drawn from Public, Private sector and Civil Society among others.

Data collection

Quantitative including cost data were collected manually from reports. A literature searches for evidence published from FY 2017-2018 to FY 2023-2024 was performed using the search strategy of desk review. The search guide was based on developed Respondent questionnaire and a literature review, Comparison, Outcome (ROCl) questions. We prioritized evidence from Ministry of Health (MoH) Board databases and case referral series were considered where evidence from MoH Board databases was limited or absent. Guidelines from the Ministry of Health and Ministry of Finance Planning and Development were also reviewed. The GRADE system was used to evaluate evidence to formulate and rate the strength of data (i.e. Lack of data for the medical board FY 2017/18-2019/20, initiated obtaining data for the FY 2021-22 to 2023-24 from the medical board at MoH. For the other institutions, years ranging from FYs 2018/19 to 2021/22 were obtained varying from one institution to another). The key informant interviews (KIIs) were done using a semi-structured interview guide. Participant validation to improve the validity of the data was used. Study participants were asked to comment on the accuracy of transcribed data after an interview. Data reliability was also evaluated by three experts experienced in qualitative research by assessing the various aspects of the study. The interviews were face-to-face and duration taken was 45 minutes. All data was collected in English. A pre-test was done at Entebbe Regional Referral and Kiruddu National Referral hospitals for KIIs guide to check for validity and reliability. Both expert and respondent driven pretest was conducted. Results from the pre-test were used to improve the contents and clarity of the questionnaire.

Data Analysis and Management

Data analysis was done for both quantitative and qualitative. Uni-variate analysis was done for both the independent variables (demographic and medical factors) and dependent variables (referral abroad) and their descriptive statistics including frequencies and percentages for categorical variables was done. In this study, medical factors were defined as common conditions referred abroad. The medical referral abroad costs considered refer to FY 2018/19 to 2023/24. Cost analysis was performed using expenditures calculated in the financial years studied. However, expenditures do not provide detailed information about how resources were used at patient-level, for example, staff, drugs, and diagnostic tests. For qualitative analysis the interviews were recorded and transcribed. In this study, the data analysis was conducted using content analysis approach based on the steps proposed by Graneheim and Lundman. The transcript was analyzed thematically, using the constant comparative method. Initial coding was performed and identified by summarizing, interpreting, and analyzing them, and finally, the themes and categories were obtained. Lincoln and Guba criteria were used to survey the strength and transferability of this study[43,44].

Ethical review and approval

The study was approved by the Texila American University. The study received ethical clearance from the Uganda National Council of Science Technology (SFHN-2023-105) and introductory letter from the MoH (N° ADM:100/224/26). The informed consent was sought from respondents and concerned authorities before collecting data. The respondents were informed of their right to withdraw from the interview whenever they so wished. Data has been kept confidentially in a secure place by the corresponding author. Results have been reported anonymously.

Results

A total of 34 respondents participated in the study from both public and private settings as indicated in (Table 1). A total of 7 public institutions were surveyed and 5 private institutions including hospitals and academic institutes. Many of the respondents were males at 85.3% (29). Most of the participants 91.2% (31) had been in service for 5 to 10 years, and the least 8.8% (3). All participants were highly skilled.

Table 1. Characteristics of the participants.

Category of participants (N=34)	Public (N=20)	Private (N=14)
Government policy makers and Technocrats	12 (60%)	n/a
Legislators	2 (10%)	n/a
Civil Society organizations and health Development Partners	n/a	6 (42.8%)
Private health care managers and leaders	n/a	4 (28.6%)
Health professionals/ Practioners & Health Facility Managers	6 (30%)	4 (28.6%)

The average cost of accessing referrals abroad

The estimated amount of money the government of Uganda spent on medical referrals to other countries in the financial years from FY 2021/2022 to 2023/2024 was Ug Shs26,596,082,700 (USD. 7,145,643 at 1 USD = 3,722 BOU exchange rate) covering 399 patients. In the FY 2021/22, the government of Uganda through the Medical Board of the Ministry of Health (MoH) spent on 85 patients Ug Shs12,730,718,200 (USD. 3,420,397). Also, in FY2022/2023 spent on 166 patients Ug Shs 6,777,184,950 (USD. 1,820,845) and in the FY 2023/24 spent on 148 patients Ug Shs7,088,179,550 (USD. 1,904,400) respectively We conservatively assume that the costs of care are uniformly distributed equally among the refereed patients. Based on the assumption that each year 133 (399 patients for 3 years) patients are referred abroad for medical treatment. The reported medical referrals abroad to other countries costs, on average, approximately Ug Shs199,970,546,000 (USD. 54,786) per patient per year.

Average annual and per capita cost

Based on survey findings, we estimated average total annual cost on referrals abroad as indicated by the Medical Board of the Ministry of Health to be Ug Shs23,467,222,800 (USD.6.3 million). In the FY 2021/2022 Ug Shs3,037,346,000 (USD.3.5 million), Ug Shs7,077,416,400 Bn (USD. 1.9 million) in 2022/2023 and Ug Shs3,352,460,400(USD. 0.9 million) in 2023/2024. When non-medical costs are factored in, an average cost per patient was Ug Shs 49,969,826,570 (USD. 13,414,877) in FY 2021/2022; 26,601,385,878 (USD. 7,141,396) FY 2022/2023 and 27,822,083,759 (USD. 7,469,104) for the FY 2023/2024.

The average cost for other institutions that were referring patients abroad

On contrary, taking Uganda Heart Institute as a case study, it costed Ug Shs 366,967,050 million (USD. 98,594) (for 22 patients from FY 2018/2019, FY2020/2021 to FY2021/2022. The total cost on referred patients abroad was Ug Shs127,500,000 (USD. 34,932) in FY2018/2019), Ug Shs111,876,500 (USD. 30,651) in FY2020/2021 and Ug Shs127,590,550 (USD.34956) in FY 2021/2022. On assumption that the costs of care are equally distributed among the patients in the three years, the average cost for referral was Ug Shs 33,360,640 (USD. 9,139) per patient per year and Ug Shs 49,373,747 (USD. 13,527) excluding non- medical costs.

Common Conditions and reasons for referrals abroad

Based on the survey done, the commonest conditions for referrals abroad through the medical board of the Ministry of Health were congenital heart abnormalities and other cardiac conditions at 73.1%, followed by Kidney transplants 9% and other conditions at 4.5%. The least are liver conditions and transplant, and neurosurgical conditions at 1.8% respectively (Table 2).

Table 2. Common Conditions and reasons for referrals abroad.

Conditions referred n (%)	Patients referred FY 2021/22 n (%)	Patients referred FY2022/23 n (%)	Patients referred FY2023/24 n (%)
N=399	85 (21.3)	166 (41.6)	148 (37.1)
Congenital heart abnormalities and other cardiac conditions 292 (73.1)	49 (57.6)	138 (83)	105 (70.9)
Kidney transplant 36 (9)	16 (18.8)	11(7)	09 (6.1)
Others 18(4.5)			18(12.1)
Oncology cases 17(4.3)	8(9.4)	5(3)	4 (2.7)
Orthopeadic cases 14 (3.5)	7(8.2)	4(2)	3(2)
Bone marrow transplant 8 (2)	3(3.5)	2(1.2)	3(2)
Neurosurgical Conditions 7(1.8)	02 (2.5)	03 (2)	02 (1.4)
Liver conditions and transplant 7(1.8)	-	3(1.8)	4(2.7)

The average number of patients referred abroad for treatment are 133 (n=399/3) on assumption that the number of patients referred each year is constant and their population is homogenous (Table2). The highest proportion of patients referred were in FY 2022/2023 (41.6%), then 37.1% in FY 2023/24 and the least at 21.3% in FY 2021/22. The congenital heart abnormalities and other cardiac condition were most referred in the FY2022/23 at 83%, followed by FY FY2023/24 at 70.9% and the least was FY 2021/22 at 57.6%. However, all referred conditions other than the congenital heart abnormalities and other cardiac conditions were referred more in the FY 2021/22 than in any other year. The common reasons for referrals abroad were diverse as well as the conditions for referral. The themes generated from the MoH reports reviewed were lack of specialized care, lack of advanced equipment, medicines, and inadequate trained medical workers.

Reasons for Government's choice in reducing medical expenditures abroad

Data analysis revealed the reasons why Government was the most preferred approach in reducing medical expenditures abroad. Four main themes with 8 related sub-themes and 16 codes emerged from analysis of the interviews. The main themes were: (i) mandate of government (ii) sustainability of financing health investments (iii) already existing health infrastructure and (iv) Saving foreign exchange for national development. The themes and related sub-themes are summarized in (Table 3).

Table 3. Theme, Subtheme and Categories for reasons the Government is the most preferred approach.

Theme 1	**Mandate of government**			
Subthemes	Laws and policies		Responsibility of government	
Categories	Develop laws and policies	Amend existing laws and policies	Provide care to all citizens	Regulate health care system
Theme 2	**Sustainability of financing investments in healthcare**			
Subthemes	Provide innovative financial mechanisms		Resource utilization and allocation	
Categories	Formalize risk pooling and management through health insurance	Increase public private partnerships	Ensure cost effectiveness and efficiency	Strengthen system through monitoring and evaluation of financial investments
Theme 3	**Health Infrastructure**			
Sub themes	Investment in healthcare		Investment in human resource for health	
Categories	Develop and rehabilitate facilities	Invest in modern equipment and advanced diagnostics	Train specialist health professionals	Deploy adequate health staff for timely care
Theme 4	**Saving on Foreign Exchange**			
Sub themes	Government expenditure on treatment abroad		Develop medical tourism sector	
Categories	Establish world-class healthcare capacity locally	Improve equity and management of resources	Increase foreign exchange inflows	Promote technology use in health sector

Mandate of government

In this study, mandate of government was expressed by participants as the main theme of why government is the most preferred approach in reducing medical expenditures abroad (Table 3). The mandate of the government through the MoH is to ensure that the population is healthy 45. Thus, the healthcare services provision is a primary responsibility of government to its population. To this, one respondent when asked the reasons why government was a preferred option to reducing medical expenditures abroad observed:

"It is government's responsibility to do so. The cost is too high and not sustainable without government support".

"Uganda's healthcare system is plagued by inequality. It's perplexing that while the average citizen struggles to access basic medical care, the affluent can effortlessly seek treatment overseas. The right to health fundamentally applies to all and not exclusively for the elite."

"The precarious state of our healthcare system casts a shadow over the future, leaving many Ugandans helpless….the government must fast track universal healthcare for all.''

Sustainability of financing investments in healthcare

The capacity for the government to sustain the investments given the high capital requirements, especially in specialized healthcare services was found wanting as opposed to private sector was observed. However, fear is that while many Ugandans who require specialized medical attention, they suffer due to inadequate modern facilities and expertise to perform sophisticated medical procedures. This was expressed by a respondent in affirmative:

"The government must explore choices for fostering a sustainable approach to ensure that all citizens can access quality medical care without financial hardship and the need to seek treatment abroad. A national health insurance scheme could be a viable solution."

"Ugandans are growing increasingly desperate as soaring medical care costs render life-saving treatment unaffordable. The increasing community based fundraising initiatives for ordinary citizens afflicted with life-threatening illnesses have become a stark reality. Yet, this option is inherently unsustainable."

Health Infrastructure

Most respondents indicated that there is already existing infrastructure that the government can build on to reduce medical expenditures abroad. This can as well as benefit the government in building a strong national health system for all. Regarding this a respondent emphasized that:

"Strengthening a national health system is cost-effective and using local resources and experts allows to train human resources and no visa, hotel costs and saves forex.''

"The health sector is witnessing profound momentum in infrastructural growth, implementing optimism for improved medical care in the future.''

Saving on Foreign Exchange

Many of the respondents observed the potential savings from medical expenditures abroad on health and foreign exchange that can be realized by the government especially the foreign exchange. This narrative raising discussions about equity and efficiency in healthcare service delivery was expressed by a respondent:

"Money spent for treating government officials abroad annually can be used to build 10 hospitals accredited at the international standards. As such, that saving would benefit many than a few."

Discussion

Medical tourism is growing rapidly in Uganda, similar to other developing countries. However, it has not been well documented or scientifically researched. This study aimed to establish the most appropriate way of tackling the choice dilemma of Uganda's Medical Expenditures Abroad. The paper argues that reducing approvals for government officials to be treated abroad would significantly improve the country's health system and influences better health outcomes. It is anticipated that while findings from this study will lead to clearer understanding of expenditure on medical tourism in Uganda, the study will also contribute to the discussion on resolving of complexities of healthcare issues in the country. The cost incurred by the government of Uganda for government officials on medical care abroad may give an indication of the level of efficiency, effectiveness and equity in the health sector in Uganda. Although there is no complete picture on the magnitude of the medical tourism (MT) sector in Uganda, drawing from these findings, the medical referrals abroad (outbound MT) to other countries is estimated to cost on average, approximately Ug Shs199,970,546 million ($53,439) for each patient per year. Given the size of this market and the complications that may be experienced by returning medical travelers, it appears opportune to address this gap in strategy and regulation.

The annual cost of referrals abroad as indicated by the

Medical Board was USD. 3.5million in FY 2021/22, USD.1.9million in 2022/23 and USD 0.9 million in 2023/24. These expenditures are comparable to the Samoans who spent USD.4.9 million, Mongolia USD. 2.88 million and Seychelles USD. 1.5million and Nigerians spends USD.1billion a year on MT.[29] The Maldives Island spent up to USD 68.9 million but the subsidy by government was estimated at USD.5.5 million annually[10]. The findings though do not reflect the popular belief and press reports that huge amounts of funding are spent on medical referrals abroad especially on the government officials. This could be explained by the fact that the media can obtain data from various sources including the beneficiaries including anonymous sources. Secondly many costs reported were largely medical costs excluding living and travel costs; thirdly, not all referring centres for patients abroad provide information through the medical board and with some expenditures that are considered 'sensitive' not being shared. Thirdly, in case high-ranking government officials are visited by other officials while they are on treatment abroad, the costs may not be captured by the medical board as such. Lastly, in the event of death, huge amounts of money are spent on transporting the body back and are rarely captured by the medical board or referring institutions.

Of all the average 133 patients referred abroad for medical treatment every year, a few of them can afford the costs involved to access healthcare abroad. The participants in this study reported a similar narrative of the too high a cost not sustainable without government support. Yet the inadequately equipped health facilities in Uganda could not manage the conditions of the people that sought for care abroad. The proportions of patients referred abroad for treatment could be higher given the high out-of-pocket expenditures as high as at 41%, catastrophic house expenditures at 14%, high poverty rates at 30%, limited allocation to health at less than 2% of the GDP below the recommended 5% and lack of a National Health Insurance Scheme for universal health coverage. Subsequently, leading to weak health system and lack of equitable access to healthcare. Cognizant of that, most of the patients in the country delay to know or will never know what they suffer from due to lack of access to diagnostic services and least ever be treated for the diseases and conditions they experience as individuals.

The findings of this study suggest that the commonest medical conditions and cases for which people were referred abroad the most prevalent was congenital heart abnormalities plus other cardiac conditions. This was followed by kidney transplant, and other conditions. The least were Liver conditions and transplant, and neurosurgical conditions. This trend is different from what is reported in other studies. In the Maldives, diseases of circulatory system topped the list followed by musculoskeletal, genito-urinary and the least endocrine diseases.[10] In Japan and China plastic surgery was most prominent reason for referrals to South Korea.[48] This could be due lack of developed infrastructure for management of heart conditions contrary to Japan and China who have it. On the other hand, the Asian perceptions of beauty and the broader context of Korean popular culture may encourage Korea to become a destination for the Asian countries.

Quality of care is a key factor attracting patients to seek treatment abroad. In this study poor quality of healthcare was the main reason cited for medical referrals abroad. In this regard, poor quality of care implied lack of specialized care, lack of advanced medicines, medical tourism, and inadequate trained medical workers. The finding is similar to other studies that have indicated reasons such as lack of available health services locally in addition to cost and legal issues in their home country[47,48]. However, Uganda like many developing countries such as Nigeria is characterized by inadequate or poor-quality healthcare services.[28,29] This is attributed to limited availability of highly specialized human resource and diagnostic equipment. In Yemen, a patient observed that Yemen's health care services were not anywhere comparable with those of India. This was summed up in a statement that an operating room in Yemen looked like a bicycle repair shop or carpenter's workshop[49]. To make matters worse, several government employees seek healthcare abroad even when such services can be found in the country. In Nigeria, it was reported that some politicians and government officials sought healthcare for minor ailments that could be treatable locally[28]. A study done in China indicated for countries with limited medical resources, services inform of VIP medical care will harm healthcare industry, and proposed necessity of policy restrictions on VIP medical care abroad[48].

Nonetheless, medical referrals abroad are not entirely a bad idea since it provides relief to the local health system and has a positive effect on host economies output growth[50].This is true for low-income countries such as Yemen and Uganda where the infrastructure and human resources needs cannot be met in the short term yet those that need service must be attended too. Thus, re-examining the process of approval for treatment abroad as at the same time re-creating confidence in the local health system were seen as key undertakings to ensure an efficient medical referral system. While the private sector

has always been a fundamental source of medical care the establishment of government polices supporting the private sector could spur rapid growth and give impetus to inbound medical tourism. This could be enhanced through increased health financing and increasing accountability in the execution of PPPs.

Our study had strengths and limitations. The strength of this study is that it benefited from a diversity of the key respondents from healthcare providers, legislators, and administrators from both private and public sectors thereby enriching enough information to inform policy. The centrality and analytic utility of the findings, offered the opportunity to review medical referral abroad data and highlighted ongoing debates over processes of medical referrals abroad. A limitation of our study is that the former patients referred abroad for medical care were not covered as well as costs of referrals abroad that do not go through specialised hospitals and medical board under MoH. However, this limitation was overcome by collecting data on the causes of referrals and expenditure trends were adequately captured through the Medical Board and referring hospitals and institutions. Even where "official" data existed some gaps were encountered. To this triangulation was done with medial analysis data, participation in meetings at MoH where health issues including medical tourism was discussed. This helped in testing of empirical questions that are central to this field and identifying the possible remedies. The findings could help policymakers to develop a policy framework that increases financing investments in health and a basis for calling for more research in regulation and guidelines. Despite the challenges of MT, the current level of expenditure from inbound medical tourists highlights the potential of this market, for specialist hospitals that have a particular brand to market. Comprehensive (Unified data collection) to form a data base for both hospitals and other institutions regarding costs on patients both public and private, including whether these are government officials, is needed. This will enable the government nationally and individual institutions to address outbound MT and plan for potential market for the inbound MT. Thus, government as a preferred option can reduce outbound MT through strengthened health system which can result in increased inbound TM.

Conclusion

Findings indicate that high expenditures on medical referrals abroad lead to a significant flight of forex. Further findings suggest that referrals abroad are largely due to lack of adequate health care services locally to handle the most common conditions that people look for abroad especially congenital heart abnormalities and other cardiac conditions. Government led interventions is the most preferred policy option to reduce Uganda's high medical expenditures incurred abroad especially on government employees which has potential negative effects on the health system and the economy. Thus, Uganda's strategy must aim at solving the iron triangle equation of every healthcare system: cost, access, and quality.

Highlights

What Is Already Known?

Uganda is a net exporter of medical tourism. However, little is known about the scale of medical tourism and the potential effects, including costs and foreign exchange.

The country has no clear policy to regulate the medical tourism industry, which is concerning. Such policy is needed to guarantee adequate health system responses in place, and prioritize patients' health and safety.

What Does This Study Add?

First Ugandan national level study of medical tourism for government officials.

This study estimates the volume and direction of flows of outbound Ugandan medical tourists.

The findings estimate the possible costs and potential savings for Uganda resulting from medical tourism.

Majority of the medical tourists were found to be suffering from congenital heart abnormalities plus other cardiac conditions, as recorded in the financial years of referrals.

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Conflicts of Interest Disclosures

We declare that there is no conflict of interest.

Consent For Publication

We consent to the publication of this paper.

Ethics approval

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