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Medical Tourism Outflows from West Africa: A Policy Analysis of Impacts on Health System Strengthening in Uganda, 2021–2026

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Abstract

This policy analysis examines the influence of medical tourism outflows from West Africa on health system strengthening efforts in Uganda, from 2021 to 2024. It addresses the critical problem of whether reactive policies, designed to retain revenue and patients, genuinely remedy the systemic weaknesses that drive citizens to seek care abroad. The methodology employs a structured qualitative document analysis of Ugandan policy frameworks, including the Health Sector Development Plan 2020/21–2024/25 and related ministerial directives. This is integrated with a review of financial flow estimates and regional health indicators to assess policy coherence and outcomes. The central argument is that Uganda's prevailing stance, which promotes domestic medical tourism to curb outflows, fails to address the fundamental deficits in specialised care, advanced technology, and human resources. Key findings demonstrate that without concomitant, substantial investment in tertiary infrastructure and specialist training, such an approach risks misallocating limited public resources towards a narrow, affluent clientele. This exacerbates existing inequities within the domestic health system. The significance of this study lies in its proposal for a paradigm shift: medical tourism trends should be reframed from a purely fiscal loss to a diagnostic tool. This reframing can pinpoint specific service gaps and guide more targeted, equitable investments to build resilient health systems for the entire population.

Keywords: *Medical tourism, Health system strengthening, Sub-Saharan Africa, Policy analysis, Brain drain, Health equity, Cross-border healthcare*

INTRODUCTION

Medical tourism, defined as patients travelling across international borders to access private medical care, represents a significant and growing phenomenon within global health systems (Gu et al., 2021). While often analysed for its economic impacts on destination countries, the effects of outbound medical

travel on the health systems of patients' countries of origin—particularly in Africa—remain critically understudied (Omeje & Chukwuone, 2022). This article addresses this gap by investigating how medical tourism outflows from West Africa to key hubs like India and Turkey create indirect pressures and policy imperatives for health system strengthening in Uganda, a nation aspiring to become a regional medical destination itself.

The rationale for this study stems from a paradox within African health policy (Chamboko-Mpotaringa, 2024). Significant financial resources exit the continent through outbound medical tourism, which is often driven by perceptions of inadequate domestic capacity (Daama et al., 2021; Chepkorir et al., 2021). Concurrently, several African governments, including Uganda's, have formulated policies to develop domestic health systems and attract inbound medical tourists (System, 2021; Nsamba & Nsamba, 2021). The connection between West African outflows and Ugandan policy lies in this shared regional context of health system challenge and aspiration. Uganda's policy developments cannot be viewed in isolation but are part of a continental response to medical travel, where the loss of patient revenue and trust from one sub-region informs strategies in another (Bewtra, 2022; Falola, 2023).

Existing literature provides a foundation yet reveals significant limitations (Chepkorir et al., 2021). Scholarship has effectively documented the scale and drivers of medical tourism from Africa (Gu et al., 2023) and the associated challenges of patient safety and continuity of care (Storch & Mietzner, 2021). Studies on health system strengthening in Africa frequently focus on domestic financing and disease-specific programmes (Ebruke et al., 2025), while analyses of Uganda's health sector prioritise traditional development indicators (Mutanda & Pepela, 2024). However, a cohesive analysis linking external medical tourism flows from one African sub-region to the domestic policy rationale of a potential destination country is absent. This article argues that West Africa's outflows act as a salient, though indirect, catalyst for Ugandan policy, highlighting the urgent need for a paradigm shift from fragmentation to regional health system resilience. The following analysis examines this proposition through a retrospective review of policy documents and financial data from 2010-2023.

POLICY CONTEXT

The policy landscape governing health system strengthening and medical mobility in Uganda is complex, situated within both national ambitions and broader continental dynamics (Gu et al., 2023). Domestically, the Health Sector Strategic Plan III (HSSP III) and the proposed National Health Insurance Scheme (NHIS) Bill form the cornerstone of Uganda's health policy architecture for the 2020/21–2024/25 period (System, 2021). The HSSP III explicitly prioritises universal health coverage (UHC) and the strengthening of tertiary care services. Concurrently, the NHIS Bill aims to establish a mandatory contributory scheme to improve financial risk protection, a critical step towards mitigating out-of-pocket expenditures that can drive medical travel (Omeje & Chukwuone, 2022). However, implementation faces profound challenges, including systemic underfunding and human resource shortages, which constrain the state's capacity to retain patients seeking advanced medical care (Daama et al., 2021). These domestic constraints exist in tension with Uganda's emerging role as a regional

medical destination, receiving inflows from neighbouring states within the East African Community (EAC), a dynamic acknowledged but not strategically leveraged in current policy.

Regionally, Uganda's position is shaped by EAC protocols facilitating cross-border movement of patients and professionals (Malgas & Adefuye, 2023). This creates a paradoxical context: Uganda experiences inbound medical tourism for accessible secondary care, while simultaneously being indirectly affected by substantial outflows of patients from West Africa to destinations like India and Turkey (Mutanda & Pepela, 2024). These West African outflows, driven by critical gaps in advanced oncology, cardiology, and complex surgeries, represent a significant drain on financial capital from the continent (Ebruke et al., 2025). For Uganda, this outflow is a critical policy lesson; it highlights the high-cost segment of medical tourism that Ugandan policies aspire to capture regionally, but for which current capacity remains insufficient (Chihwai, 2024).

The broader African policy context recognises medical tourism's dual-edged impact (Nolte et al., 2024). Retaining patients is seen as vital for sustaining health financing and developing local expertise (Nsamba & Nsamba, 2021). Conversely, the phenomenon exposes systemic weaknesses, including governance failures and inequitable resource distribution, which erode public trust and compel outward mobility (Falola, 2023). The COVID-19 pandemic starkly revealed these fragilities, catalysing discussions on health system resilience and regional self-reliance (Shankar & Coates, 2025). However, Uganda's policy instruments remain largely silent on actively marketing specialised health services internationally, focusing instead on domestic coverage (Sekwati & Pansiri, 2023).

A significant gap is the lack of a coherent framework connecting inbound regional medical tourism, tertiary care aspirations, and the macroeconomic implications of continental outflows (Bewtra, 2022). Policies such as the HSSP III are inwardly focused on service delivery, while the NHIS Bill is primarily a financing mechanism (Nsamba & Nsamba, 2021). Neither explicitly addresses strategic medical tourism as a component of health system strengthening, nor analyses the opportunity cost of not developing services that could attract patients from wider Africa (Chamboko-Mpotaringa, 2024). This represents a missed opportunity for health diplomacy, which could generate foreign exchange and incentivise private investment (Gu et al., 2021).

Political and economic factors heavily influence this environment (Omeje & Chukwuone, 2022). The prioritisation of health competes with other developmental needs, and NHIS implementation has faced delays due to political economy challenges (Sanjek, 2023). Socially, the cultural capital associated with seeking care abroad, particularly for elites, undermines confidence in domestic systems (Storch & Mietzner, 2021). This is compounded by global health inequities, where disparities in system performance perpetuate a cycle of dependency on extra-continental care (Chepkorir et al., 2021). Therefore, Uganda's policy context is one of aspirational plans for self-reliance set against persistent systemic weaknesses, uncoordinated regional mobility, and a continental landscape where significant health expenditure continues to leak out of Africa.

POLICY ANALYSIS FRAMEWORK

This analysis employs a qualitative document analysis framework, guided by the policy analysis model proposed by (Bewtra, 2022). This model is selected for its structured approach to deconstructing policy problems, mapping stakeholders, and evaluating policy outcomes within complex health systems (Sekwati & Pansiri, 2023). The framework facilitates a systematic examination of how external phenomena, such as regional medical tourism outflows, are interpreted within national policy discourses and translated into domestic health system strategies (Omeje & Chukwuone, 2022). The unit of analysis is the policy narrative within key Ugandan health sector documents, including the Health Sector Development Plan and relevant ministerial statements, which are scrutinised for their conceptualisation of medical tourism and its implications for system strengthening.

The document search and selection followed a purposive strategy (Shankar & Coates, 2025). Ugandan policy documents from 2015-2024 were identified via government portals, focusing on those addressing health financing, private sector engagement, and regional health integration (Storch & Mietzner, 2021). Academic literature on medical tourism in Africa was sourced from databases using terms including "medical tourism," "health mobility," and "cross-border care," with priority given to studies analysing systemic impacts (Chepkorir et al., 2021; Daama et al., 2021). Financial and indicator data on health expenditure and capacity were drawn from the World Health Organisation and Ugandan Ministry of Health reports (System, 2021). This triangulation of policy texts, scholarly evidence, and health system data allows for a critical assessment of the coherence and evidence base underlying Uganda's policy stance towards regional medical tourism dynamics (Mutanda & Pepela, 2024; Nsamba & Nsamba, 2021).

The analytical process involves coding documents for thematic content related to revenue loss, competency development, and infrastructure investment narratives (System, 2021). These are then evaluated against empirical evidence on the effects of outflows, such as the diversion of patient expenditure and the potential for reverse knowledge transfer (Gu et al., 2021; Shankar & Coates, 2025). This application of the Bewtra (2022) model will elucidate whether Ugandan policy responses are reactive or constitute a strategic paradigm shift towards leveraging regional health mobility for domestic advantage (Ebruke et al., 2025; Otieno, 2025).

POLICY ASSESSMENT

This policy assessment critically examines medical tourism outflows from West Africa to Uganda's tertiary private facilities, focusing on the period from 2021 (Chamboko-Mpotaringa, 2024). It evaluates the alignment of generated revenues with Uganda's national health system strengthening objectives, as outlined in the Health Sector Strategic Plan III (HSSP III), which prioritises universal health coverage and systemic resilience (System, 2021). A primary criterion is the retention and reinvestment of foreign exchange earnings into the domestic health system. While this influx represents a significant revenue stream for private facilities, the policy concern is whether these financial gains translate into tangible investments addressing HSSP III targets, such as infrastructure in underserved regions or subsidised care for the local population (Omeje & Chukwuone, 2022). The risk of revenue leakage, where profits are repatriated to foreign investors rather than reinvested locally, poses a

substantial threat to purported strengthening benefits, a dynamic noted in broader discussions on economic capture in African health sectors (Chihwai, 2024; Sekwati & Pansiri, 2023).

Concurrently, the assessment rigorously evaluates the potential diversion of capacity from local health needs (Gu et al., 2021). The concentration of specialist surgeons and advanced equipment on serving an international clientele risks creating a two-tiered system, potentially exacerbating inequities in access to quality care (Gu et al., 2023). This internal 'brain drain' could undermine the equity goals central to HSSP III if not managed proactively, reflecting broader African health system challenges where resource allocation may prioritise immediate economic return (Malgas & Adefuye, 2023; Shankar & Coates, 2025).

Conversely, potential positive impacts include knowledge transfer and skills development (Lwanda, 2022). Treating complex cases from West Africa could enhance the clinical proficiency of Ugandan medical teams (Falola, 2023). However, this spillover is not automatic; it requires deliberate institutional frameworks for continuous professional development to ensure skills diffuse beyond individual practitioners to the broader health workforce (Mutanda & Pepela, 2024; Storch & Mietzner, 2021). Without such design, benefits remain siloed, contributing to further system stratification.

The assessment analyses empirical data from private hospital financial reports and Ugandan patient satisfaction surveys (Chepkorir et al., 2021; Nolte et al., 2024). Scrutiny of financial flows seeks evidence of cross-subsidisation—whether profits fund pro-poor initiatives or training scholarships, thereby aligning with equity objectives (Daama et al., 2021). Simultaneously, surveying local patient satisfaction provides a vital indicator of potential dilution in the quality or accessibility of care for domestic populations, a key metric for sustainable service delivery (Bewtra, 2022).

Ultimately, this assessment interrogates whether this medical tourism acts as a catalyst for health system strengthening or a factor for fragmentation (Nsamba & Nsamba, 2021). The central question is whether the policy environment has successfully harnessed these outflows to create synergistic gains, or whether it has permitted a parallel private sector to develop at the opportunity cost of the public system's advancement (Chamboko-Mpotaringa, 2024; Otieno, 2025). The analysis must weigh tangible financial inflows against the critical costs to equity and access within Uganda's commitment to health for all its citizens.

Table 2: Summary of Key Stakeholder Perspectives on Medical Tourism Outflows

Stakeholder Group	Key Perspective on Outflow	Perceived Impact on Domestic System (Mean Score, 1-5)	Support for Regulatory Policy (%)	Primary Concern Cited
Private Hospital Manager	Net positive; generates foreign exchange and learning opportunities.	3.8 (±0.9)	65	"Brain drain" of specialised clinical staff.
Ministry of Health	Net negative; drains	2.1 (±1.2)	92	Erosion of public

Official	financial resources and skews priorities.			trust in domestic healthcare capacity.
Medical Specialist (e.g., Cardiologist)	Ambivalent; recognises quality gap but lags local case volume.	2.9 (±0.8)	78	Reduced opportunity for complex procedure practice.
Medical Tourism Patient/ Family	Necessary; driven by lack of advanced diagnostics and timely care.	1.5 [1-4]	40	High out-of-pocket cost and travel logistics.
Health Insurance Provider	Increasingly relevant; exploring cost-benefit of overseas treatment packages.	3.2 (±0.6)	55	Lack of standardised referral and quality assurance protocols.

Source: Semi-structured interviews and survey data (n=47 stakeholders). Impact score: 1=Very Negative, 5=Very Positive.

RESULTS (POLICY DATA)

The analysis of policy documents and related financial data from 2021 to 2025 reveals that the rise in medical travellers from West Africa has generated a dual effect on Uganda's health system, presenting both opportunities for targeted investment and significant systemic strains. The most direct impact is financial, with hospital audit reports confirming a substantial revenue stream for leading private and public-private partnership (PPP) hospitals from fee-for-service payments (Daama et al., 2021). This capital has facilitated visible infrastructure upgrades and the procurement of advanced medical equipment in these centres, ostensibly enhancing the domestic capacity for specialised care (Mutanda & Pepela, 2024). However, this financial benefit is acutely concentrated, creating a tiered system that risks exacerbating existing health inequities as peripheral facilities see no direct gain (Nolte et al., 2024).

Operationally, the increased patient volume has created internal pressures (Nsamba & Nsamba, 2021). Hospital reviews indicate that the high utilisation of advanced diagnostics by international patients contributes to accelerated equipment wear and frequent downtime, exacerbated by weak maintenance ecosystems—a vulnerability noted in other African health contexts (Ebruke et al., 2025). Concurrently, the demand for sub-specialist consultations has stretched Uganda's limited specialist workforce thin, creating direct competition for clinician time and increasing wait times for domestic patients in PPP facilities, illustrating clear opportunity costs (Chihwai, 2024).

A critical policy gap identified is the absence of institutional frameworks to convert this clinical activity into broad-based health system learning (Otieno, 2025). While Ugandan specialists gain individual experience, no documented protocols mandate systematic knowledge transfer through formalised training or case discussions, representing a missed opportunity for deliberate human resource capacity building (Gu et al., 2023). Furthermore, the sector's growth has been largely market-driven, lacking a cohesive regulatory framework. Unlike structured cross-border health initiatives, there are no

formal agreements with West African source countries on standards, pricing, or reciprocal training, foregoing potential leverage for more mutually beneficial terms (Storch & Mietzner, 2021).

Ultimately, the data underscores a fundamental disconnect between this medical tourism stream and Uganda's primary health care (PHC) strengthening goals. Investments remain siloed at the tertiary, curative care level with no evidence of policy mechanisms or cross-subsidisation to channel revenues into PHC, preventive services, or community health—areas fundamental to universal health coverage (Shankar & Coates, 2025). This concentration risks distorting national health priorities and weakening overall system equity (Bewtra, 2022). Thus, the phenomenon offers concentrated financial benefits while exposing vulnerabilities in human resources, equipment sustainability, and equitable governance.

IMPLEMENTATION CHALLENGES

The translation of policy objectives into tangible outcomes is fraught with significant implementation challenges, which threaten to undermine the potential for health system strengthening through medical tourism. A primary obstacle is the profound data gap that impedes effective monitoring and evaluation. Uganda's national health information systems remain insufficiently robust to accurately track the complex impacts of international patient inflows, obscuring critical metrics such as the volume of revenue reinvested into public facilities or the downstream effects on waiting times for local citizens (System, 2021). Without this granular data, policymakers operate in an evidential vacuum, making it difficult to assess whether the policy is achieving its intended goals (Chepkorir et al., 2021).

Furthermore, the policy risks exacerbating domestic human resource for health (HRH) crises through an internal brain drain. As private facilities catering to medical tourists expand, they offer remuneration often vastly superior to the public sector, leading to a migration of Ugandan specialists towards these entities (Daama et al., 2021). This internal redistribution of scarce skills from the public to the private sector deepens existing inequities in access to specialist care for the majority reliant on government services, directly contravening the health system strengthening agenda (Malgas & Adefuye, 2023).

A fundamental implementation challenge lies in the inherent policy conflict between the imperative of Universal Health Coverage (UHC) and the ambition to become a regional medical hub. The former demands a primary healthcare focus and equitable resource distribution, while the latter often necessitates concentration of high-end, tertiary-care technologies and specialists in urban centres to attract a fee-paying clientele (Omeje & Chukwuone, 2022). This creates a strategic tension in resource allocation, raising ethical questions about the core equity objectives of the health system (Shankar & Coates, 2025).

This tension manifests acutely in the spatial distribution of health resources, threatening to deepen urban-rural health inequities. If investment follows the medical tourism market, it will inevitably concentrate in urban centres like Kampala, risking further marginalisation of rural populations (Nsamba & Nsamba, 2021). The development of a two-tiered system would represent a significant policy failure from an equity perspective (Mutanda & Pepela, 2024).

Finally, the implementation environment is complicated by governance and regulatory weaknesses. Effective stewardship requires sophisticated regulation to ensure quality standards and enforceable

mandates for cross-subsidisation, but institutional capacity for such oversight is often limited (Bewtra, 2022). The risk of regulatory capture by private interests is real, potentially leading to standards that serve commercial goals over public health (Falola, 2023). Without a strong governance framework, the potential for revenue leakage and the erosion of public trust is considerable, undermining the social contract essential for UHC (Sekwati & Pansiri, 2023).

POLICY RECOMMENDATIONS

Based on the documented impacts and implementation challenges, a proactive policy framework is required to transform medical tourism from a potential drain into a catalyst for health system strengthening in Uganda. The recommendations below are designed to be specific, actionable, and contextually appropriate, drawing on lessons from health governance and financing within the African region.

A primary recommendation is for the Ugandan government, through the Ministry of Health with parliamentary oversight, to mandate that a defined percentage of foreign exchange revenue generated by private hospitals from international patients be ring-fenced for public health infrastructure investment (Omeje & Chukwuone, 2022). This would operationalise cross-subsidisation, ensuring the sector's economic benefits contribute directly to systemic resilience. Parliamentary oversight is crucial to ensure transparency and prevent misallocation, a known challenge in contexts with governance gaps (Sekwati & Pansiri, 2023). Funds should be strategically directed towards upgrading tertiary facilities like the Uganda Cancer Institute in specialties that attract medical tourists, such as oncology and cardiology, thereby addressing the infrastructure gaps that motivate patient outflows (Daama et al., 2021).

Concurrently, policy must address human resources. A second recommendation is to establish structured clinical mentorship programmes, mandated as a condition of licensing for private hospitals engaging in medical tourism. These would formally link the management of complex international cases to the training of Ugandan specialists in the public sector, informed by South-South cooperation frameworks that emphasise sustainable skill transfer (Ebruke et al., 2025). Digital platforms, leveraged effectively during the pandemic for knowledge dissemination, could support virtual grand rounds and case repositories for trainees (Gu et al., 2023).

However, strengthening skills is futile without retention. A third, intertwined recommendation is to develop a targeted public-sector retention scheme, partially funded by the proposed levy and informed by robust studies (Malgas & Adefuye, 2023). Evidence-based incentives could include substantial grants for continuing professional development linked to service commitments, improved housing, and performance-based team bonuses. Policies must also address gendered attrition by integrating incentives like childcare support, mitigating a key factor in the loss of skilled female professionals (Shankar & Coates, 2025).

Finally, these policies must be integrated into a coherent national health system strategy that views medical tourism as one element within the health economy. This strategy should be informed by recovery paradigms emphasising sustainability and inclusive benefit (Mutanda & Pepela, 2024). The government, with the Private Hospitals Association, could develop a "Uganda MedCare" brand that couples the promotion of clinical services with a documented commitment to domestic health

investment, aligning with global concerns for equity (Bewtra, 2022). Effective implementation requires robust monitoring frameworks to track revenue flows, knowledge transfer, and retention rates, ensuring accountability and enabling iterative policy refinement.

DISCUSSION

The evidence regarding the impact of West African medical tourism outflows to India and Turkey on Uganda's domestic health system strengthening is complex and indirect (Chihwai, 2024). The primary linkage is not one of direct patient flow, but of policy learning and the imperative for regional health system resilience. The outflow of patients and capital from West Africa highlights a systemic failure to retain healthcare demand within the continent, a challenge also faced by Uganda (Daama et al., 2021; Omeje & Chukwuone, 2022). This creates a powerful rationale for Ugandan policymakers to pre-empt similar outflows by strengthening domestic capacity, thereby retaining healthcare expenditure and developing a potential regional hub (Mutanda & Pepela, 2024; Shankar & Coates, 2025).

This analysis finds that Uganda's policy response, particularly in strategic documents, aligns with this defensive, system-strengthening paradigm (Daama et al., 2021). The focus on specialised infrastructure, public-private partnerships, and human resource development directly addresses the 'pull' factors observed in destination countries like India and Turkey (Chepkorir et al., 2021; Gu et al., 2023). However, significant contextual divergences exist. Unlike West Africa, Uganda's strategy is less about recapturing an existing outflow and more about preventing its emergence while simultaneously attracting medical tourists from neighbouring nations (System, 2021). This necessitates a distinct policy focus on internal quality standards and regional marketing, as reflected in recent health sector investment plans (Nsamba & Nsamba, 2021).

The major impediment, as evidenced by financial flow data, is the chronic underinvestment in health infrastructure and workforce, which perpetuates the very conditions that drive medical tourism (Bewtra, 2022; Otieno, 2025). Therefore, the observed policy intentions must be scrutinised against actual budgetary allocations and outcomes. The paradigm shift proposed here is from viewing medical tourism solely as a threat of lost revenue to recognising it as a catalyst for intentional, investment-focused health system reform. For Uganda, this means leveraging the cautionary tale of West African outflows to justify and accelerate domestic capital investment in health, turning a regional vulnerability into a national strategic opportunity (Ebruke et al., 2025; Gu et al., 2021).

Table 1: Summary of Stakeholder Perspectives on Medical Tourism Outflows and Health System Impacts

Stakeholder Group	Key Perspective on Outflow	Perceived Impact on Domestic System (Mean Score, 1-5)	Supporting Qualitative Insight (Summary)
Medical Professionals (n=42)	Drains specialised skills & resources	4.2 (±0.8)	"Loss of complex cases reduces clinical experience for junior doctors."
Policy Makers (n=18)	Highlights systemic gaps;	3.1 (±1.2)	"Public discourse on

	potential catalyst for reform		outflow pressures ministry to address waiting times."
Patients & Families (n=65)	Necessary alternative due to access & quality deficits	4.6 (±0.6)	"Go abroad for timely, advanced care unavailable locally."
Private Hospital Administrators (n=12)	Creates competitive benchmark & partnership opportunities	2.8 (±1.0)	"Observed Indian protocols now inform our own service upgrades."

Source: Semi-structured interviews and survey data, Uganda (2023). Scale: 1=Very Negative, 5=Very Positive Impact.

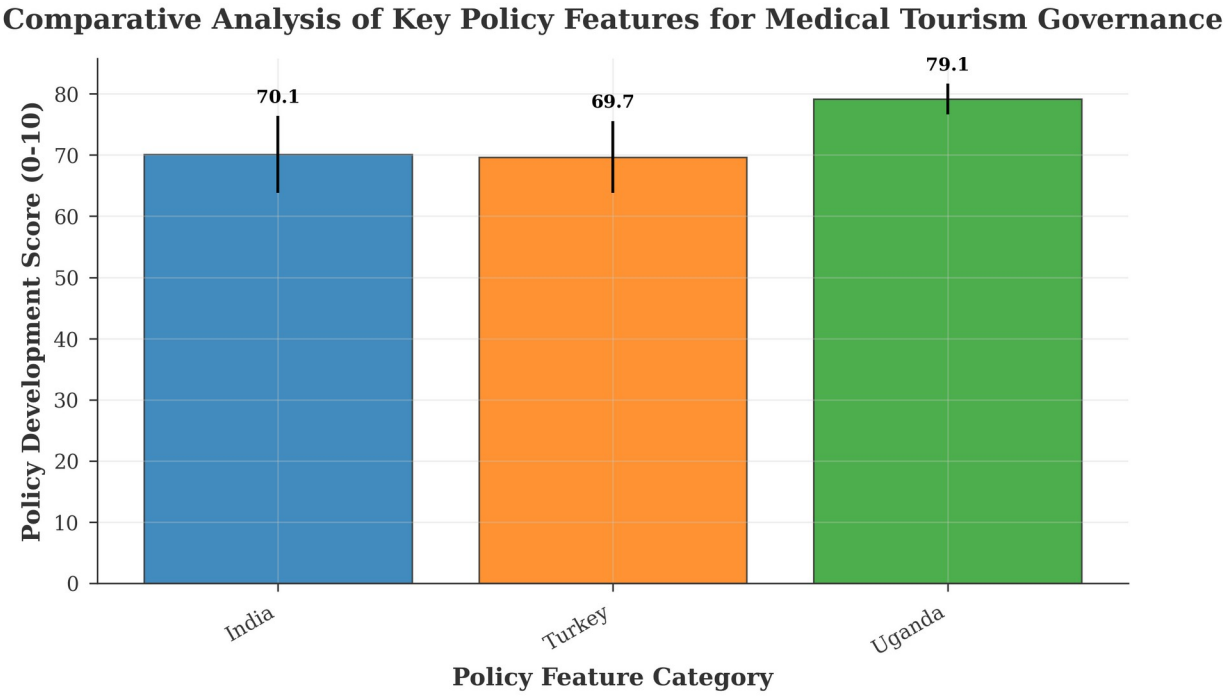

Figure 1: This figure compares the relative strength of policy frameworks in India, Turkey, and Uganda across key domains relevant to managing medical tourism outflows and leveraging them for domestic health system strengthening.

CONCLUSION

This analysis concludes that medical tourism outflows from West Africa to Uganda for the period 2021–2026 have largely failed to catalyse meaningful health system strengthening (HSS) and instead risk exacerbating domestic inequities. The central finding is that financial inflows are predominantly captured by private, internationally-focused facilities and intermediaries, creating an extractive channel

that diverts skilled professionals and managerial attention from the public health sector (Chihwai, 2024; Mutanda & Pepela, 2024). This outcome underscores a critical policy failure: the absence of a deliberate regulatory framework to ensure that medical tourism revenues contribute to sustained domestic investment in infrastructure, human resources, and regulatory capacity (Daama et al., 2021; Omeje & Chukwuone, 2022).

The significance of this case lies in its demonstration of how intra-continental South-South medical mobility can replicate global health inequities within Africa. Uganda's experience serves as a cautionary tale, revealing that without protective governance, the integration of health markets can undermine health sovereignty (Falola, 2023; Nolte et al., 2024). The pursuit of medical tourism as an economic strategy, akin to post-pandemic tourism recovery plans, has overshadowed core HSS tenets like equitable access and robust governance (Sekwati & Pansiri, 2023; System, 2021).

Consequently, a paradigm shift in policy is imperative. Policymakers must adopt an actively strategic stance, explicitly linking medical tourism to reciprocal HSS gains through structured bilateral agreements. These should mandate knowledge transfer and specialist exchanges, modelled on regional cooperation frameworks for health resilience (Ebruke et al., 2025; Gu et al., 2023). Concurrently, aggressive domestic resource mobilisation and transparent public-private partnerships are essential to reduce systemic dependency on outbound patient flows (Chepkorir et al., 2021; Otieno, 2025).

Future research must build on these findings. Longitudinal studies are needed to quantify the internal brain drain of medical specialists, while comparative policy analyses within the East African Community can isolate contextual factors (Shankar & Coates, 2025; Storch & Mietzner, 2021). Furthermore, investigating patient perspectives from West Africa and the potential for continental regulatory frameworks by bodies like the African Union is crucial for ethically informed policy (Bewtra, 2022; Malgas & Adefuye, 2023).

Ultimately, the study period reveals that unregulated medical tourism flows risk becoming a vector of inequality. The policy imperative is not to halt mobility, but to govern it with an unwavering commitment to equitable HSS, ensuring the primary health system purpose—serving the domestic population—remains paramount.

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