

Reclaiming public health services in Uganda

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Introduction

Reclaiming public health services in Uganda

The Covid-19 pandemic has reinforced the importance of strong public health services to deliver equitable healthcare. The countries that most successfully navigated the pandemic tended, overwhelmingly, to have entrenched and resilient public health systems. The clarion call for “health for all” – regardless of ability to pay - is thus unsurprising. The global pandemic has seriously underscored the need for strong public health systems and strong government stewardship of healthcare-related infrastructure, human resources and financing.

Calls to address this need were prevalent at the 73rd World Health Assembly, which was characterized by heated debates on healthcare access and health as a global public good, which were particularly animated during the drafting of a Covid-19 resolution. Discussions centred on a just, post Covid-19 economic recovery also reignited public debate about the chronic underfinancing of public health; with increasing pressure exerted on governments to “build back better,” by, among other things, reclaiming public services to make them not only the first, but more importantly, the most responsive health system, especially for poor and vulnerable persons.

It is against this backdrop that “Reclaiming public health services in Uganda” has been chosen as the theme for this 13th issue of the Economic and Social Rights (ESRA) Brief, which is produced by the Initiative for Social and Economic Rights (ISER). The submissions to this issue provide comprehensive analysis on an expansive range of health-related matters, including the imperative to ensure equitable access to a strong public healthcare system. Global health analyst, Dr. Denis Kibira, sets the pace by motivating for increased government investment in the country’s health sector; while Dr. Ayume Charles, the Chairperson of Parliament’s Health Committee, identifies national health insurance as a potential solution to many of Uganda’s health sector challenges, further motivating for more stringent and effective regulation of the private health sector. Dr. Kizza Besigye, a physician, politician and human rights activist concludes that Uganda’s public health system falls short of the ideal; and Dr. Lulume Bayigga, also a physician and Member of Parliament for Buikwe South Constituency, reinforces the need for adequate investment in public health.

Advocate Eliezer Edwin Ayebare raises concerns about Uganda’s exorbitant healthcare costs – both within the public and private systems – cautioning against the corrosive effects of this on healthcare access. Justice Lydia Mugambe and ISER’s Musa Mugoya spotlight the implications of Uganda’s prohibitive maternal health service costs; while lawyer, Muganga Ambrose, provides analysis on how access to justice can enhance the quality of public health services availed; and legal fellow, Joyce Kirunga, investigates the implications of increased private actor involvement in the provision of healthcare services. Community voices are not omitted, with several representatives recounting their personal experiences of Uganda’s public health system.

We welcome your feedback and any questions, which can be directed to info@iser-uganda.org. Be sure to follow us on Twitter and Facebook at [@ISERUganda](https://twitter.com/ISERUganda) if you would like to be notified of calls for submission to the ESRA Brief and to be exposed to other areas of our work.

Government needs to put more money in health; health insurance is way overdue

Q&A with Dr. Kibira Denis, Global Health Analyst



Question: What is your assessment of the public health system in Uganda?

Dr. Kibira: The public health system is really struggling. It is heavily propped up, largely kept afloat by donors, for example: funders contribute 90% of the budget supporting roll-out of our HIV Antiretroviral (ARV) programmes; 85% respectively to our family planning and anti-malarial programmes. Clearly, we are constantly just waiting for someone to help us. So if you ask me, one of the biggest challenges confronting the country's healthcare is our excessive dependence on external donors.

Question: What are the benefits of a public health system in comparison to a private system?

Dr. Kibira: Health is a fundamental human right, and the state is obligated to fulfil human rights. This duty is enshrined in the Constitution of the country; hence, the purpose of public health facilities should be to facilitate access to healthcare for all persons. The public health sector should, therefore, be the first port of call for Ugandans, with the private sector being merely incidental.

Question: Would you agree with someone who asserts that Uganda's public health system is dead/non-functional? Why?

Dr. Kibira: The public health system is not dead. I just think we have our priorities wrong: we spend so much on public administration of this country – we have so many districts, all of which require budgets to fulfil their functions. However, there are many expenses that I believe could be reduced – consider all the fleets of cars acquired for the different ministries, which must be fuelled, a driver assigned to each...we could easily reduce this expenditure, which in many cases is either not necessary or could be scaled back substantially.

Even the president has, on many occasions, castigated health workers who straddle the public and private sector and who steal from public facilities diverting them for use in their private facilities, and poaching patients from the public sector to benefit from billing them in their private capacities. So while I can concede that private facilities do in many instances provide good care, we must not be naïve – we must look at the ways in which they have profited from leveraging public sector weaknesses. For example, public sector wages are so meagre, that public sector healthcare workers can be easily enticed into supplementing their meagre earnings by moonlighting in the private sector, which then opens the door to pilfering public good to sell in private facilities. We should be sympathetic to healthcare workers who face this predicament - we can't just blame them, government needs to attend to the underlying problems, including ensuring that they are fairly remunerated.

Question: The Ministry of Health and the World Bank calculate that Ugandans spend 38.38% of their income on healthcare, which far exceeds the 10% recommended by the World Health Organisation (WHO). What strategies do you propose to reduce out of pocket expenditure?

Dr. Kibira: The Universal Health Coverage (UHC) agenda, which motivates for leaving no one behind, implies that financial hardships should not be an inherent component of meeting our health care needs. However, public health care facilities frequently experience drug stock outs, many patients complain about healthcare workers being rude and unprofessional and many more challenges, which makes a disproportionate number of Ugandans prefer the private sector, even though it is so much more expensive.

Medical costs pose a serious impediment to healthcare access; most people are not proactive about setting money aside for medical services and medication. In most cases, when people become seriously ill and seek private sector assistance, their medical expenses are so exorbitant that they struggle to pay. This is the reason for the repeated account of people being physically detained by hospitals, sometimes for months, for failure to settle outstanding medical fees. We should thus strive as a country to eliminate, or at the very least to substantially reduce, out of pocket medical expenses, in order to expand healthcare access. Many of the countries that have succeeded in broadening the reach of their healthcare services, have done so by incorporating national health insurance into their healthcare financing. National health insurance is long overdue in this country. However, government also needs to identify other financing mechanisms, so that it can increase investments into healthcare and progressively reduce dependence on foreign donors. I believe the Ministry of Health is stalling on the NHIS, for fear that requiring employers (as opposed to solely individual tax payers) to make contributions for their employees, will discourage foreign investment flows into Uganda.

Question: The global spread of the Coronavirus has led to renewed calls for greater investments in public health systems. What recommendations would you propose to the government to ensure the provision of accessible, affordable and equitable healthcare for all.

Dr. Kibira: There is no doubt that the Covid-19 pandemic has ravaged even those aspects of our healthcare system that we were not seriously concerned about. The pandemic has also highlighted the danger of depending on international actors to fix our health system. The Ugandan government should, therefore, increase its reliance on national resources to expand and improve our health system, and pharmaceutical manufacturing capability.

Question: What role if any do you see national health insurance playing in public health system strengthening?

Dr. Kibira: National health insurance is just one of the many financing mechanisms. It will resource the already struggling public health sector; it will ensure that health workers are better remunerated so that they can work; but also, if people choose to go to the private sector, it also provides leeway that people can choose where they want to go. It empowers the public sector to perform better. Our health system has been structured on mending health; however, when you have a good national health insurance, because it does not want to be overburdened by costs of care, it invests in health promotion so that it prevents diseases at primary health care level. It would, for example, provide nets and wellness programmes that prevent diseases - but right now there is no incentive, if they do not treat they are out of business, whether public or private.

Question: What in your view is the impact of citizen participation in public health service delivery?

Dr. Kibira: It is provided for in the Constitution as a mechanism to transparency and accountability,

and it is one of the tenets of Uganda's Vision 2040 and the National Development Plan (NDP). Citizen participation is acknowledged in our national policy and regulatory framework. Where citizens have been proactive, the proactiveness is not just to hold government accountable but also to assume greater responsibility for your own health care. When you are more responsible and know your entitlements, you elicit responsiveness from the provider, it is synergistic because the provider also benefits. When citizens are empowered and know what their entitlements are; know what their responsibilities are, those are good people, they will bring out responsiveness from someone providing a service and there will be a more cordial relationship between the users and the providers.

Question: Increasingly, there is commercialisation of healthcare in Uganda. What should be done to ensure that healthcare is maintained and provided as a public good for all?

Dr. Kibira: At the moment we live in a free-market economy which dictates that the demand should determine the supply. However, when you look at economics, there are goods that do not have elastic demand, and health is one of those. When you are sick, you are in need, you are at your knees, you are at the mercy of the provider but the provider should not be given the leeway to take advantage of the sick. First of all, why does that happen? Because healthcare in Uganda has been taken as a commercial good, because of a free-market economy, which shouldn't be the case; because when you need health it cannot be determined by the elasticity of demand. We all need to ensure that there is sufficient regulation, ensure that there is standardisation of services and that even costs are well understood. And is well financed because if it is financed as and when the good is needed, then the other party is vulnerable and bound to take advantage. This has a reciprocal effect, people might be sick, but until they are down, they will not utilise the service, then the demand will be on those that are in dire need and you want to prevent that. The incentives should be taken away from the fee for a service (out of pocket), it should be paid for before but even that needs a lot of regulation. We need to keep the standards, do research and monitoring and try to catch the people that commercialise; it is difficult though. You see doctors in the public sector who push you to the private sector by pretending that the commodity is not available in the public sector, or those that tell you this operation you must travel to India for this operation or other medical procedure and it is difficult for the patient to be able to question or make an informed decision on the basis of profit-driven advice. The regulator and the state must take control of this.

“The onus is on me and my committee to ensure that we make the public sector work”

Q&A with Dr. Ayume Charles, Member of Parliament for Koboko Municipality and Chairperson of the Parliamentary Health Committee



Question: What is your assessment of the public health system in Uganda?

Dr. Ayume: It is functional, despite some challenges, such as funding constraints. There are scientific indicators we monitor, like infant mortality rate, under 5 mortality rate, maternal mortality rate, immunization coverage...and these are generally within acceptable standards. As government, we have observed that many of these indicators have improved over the years. Maternal and child health are key priorities for government, which is why we are building new maternity units in health center IIs to transition them to health center IIIs.

An examination of our preventive health strategies shows that we have scored highly over the years. Uganda has a good public health surveillance system, which has enabled the country to successfully contain outbreaks of Ebola, Marburg and Crimean hemorrhagic fever, among others. We have had Ebola outbreaks 3 or 4 times since 2001; however, this has not impacted us to the same devastating extent as in West Africa.

Question: What are the benefits of a public health system in comparison to a private system?

Dr. Ayume: In a country like Uganda, which has many people living below the poverty line, a public health system is essential to ensure that people who cannot afford private healthcare have an alternative recourse. The Ugandan government has, since 1996, taken measures to eliminate public health user fees so that healthcare in Uganda becomes entirely free. Currently, the health policy states that private service is also available within public health facilities, from a general hospital upwards. So, if you have money you can opt for the private wing of a general-, regional referral-, or national - referral hospital; and these are not as exorbitant as mainstream private facilities.

Question: The Ministry of Health and the World Bank calculate that Ugandans spend up to 38.38% of their income on healthcare, which is substantially higher than the 10% the World Health Organisation (WHO) recommends. What strategies do you propose to reduce out of pocket expenditure and its negative impacts?

Dr. Ayume: One good option is the National Health Insurance Scheme (NHIS), which should have been fully implemented a long time ago. It is unfortunate that the process has been held up by a few technicalities here and there. The NHIS offers Ugandans an alternative way to access quality services and incentivises mediocre facilities operating in unethical or questionable ways to clean up shop, because this is a pre-requisite to being eligible for accreditation: the NHIS Inspectorate will visit every prospective facility to ensure that it fully meets a checklist of criteria, such as for example, processes and protocols for hazardous waste disposal, patient, personnel and facility hygiene and sanitation, etc.

Question: The global spread of the Corona virus has led to renewed calls for greater investments in public health systems. What reforms is the Ugandan government considering to optimise the provision of accessible, affordable and equitable healthcare for all?

Dr. Ayume: The Corona pandemic, like all pandemics before it, can be combatted if good public health principles are applied - we don't need to reinvent the wheel. So, considerations such as surveillance, case management, use of Personal Protective Equipment (PPE)s, and appropriate regulations and guidelines to coordinate responses and contain and avert further spread. So I am encouraged by the Ministry of Health's establishment of regional emergency operation centres, whose focus is not solely Covid-19, but any pandemic outbreaks, to which it can respond in real time to identified hotspots. Surveillance is a major component of early detection and intervention. We are also motivating for a Parliamentary dashboard to be put in place, so that emergency operation centres located far from urban centres can still bring their public health concerns to the attention of Parliamentary representatives. This could take the form of a mobile phone app, with updates from areas like Amudat, Nakapiripirit, Kapelebyong, Koboko, Kibale – to enable evidence-based intervention.

Question: In what way, if any, can you foresee national health insurance strengthening Uganda's public health system?

Dr. Ayume: Firstly, the national health insurance system will create an opportunity for many more Ugandans to access quality healthcare services. The national health insurance scheme makes provision for those who are not (or not eligible to be) members of a private medical scheme, which creates an opportunity to tap into and leverage the resources of an overlooked demographic. The national health insurance system is projected to generate substantial resources, because it adopts an economies of scale model. I believe it will augment a significant proportion of the healthcare funding gap currently confronting our public health sector.

Question: What, in your view, is the impact of citizen participation in public health service delivery?

Dr. Ayume: It is important for citizens to participate in health service delivery. As you know, our head of state is a champion of a preventative approach to health; so, one benefit of citizen participation in health service delivery, is the public education component, on the proactive steps citizens can take to enhance positive health outcomes. This is more prudent than focusing solely on curative healthcare.

Question: Increasingly, healthcare in Uganda is becoming commercialised. What steps should be taken to maintain healthcare standards, while ensuring that healthcare remains a public good accessible to all?

Dr. Ayume: As chairperson of the Parliamentary Health Committee, the onus is on me and my committee to ensure that the public health sector conforms to and upholds requisite standards, so that all Ugandans – from the poorest to the most affluent – have full confidence in the system (from the infrastructure, to the personnel, services and medications offered). If we improve and maintain service excellence within the public sector, then we will automatically see an increase in service demand in the public sector which will drive down private sector costs. Improving public health sector quality requires the prioritisation of more than the infrastructure: there needs to be an investment in equipment, medicine stocks, human resources (recruitment, deployment, competitive remuneration, professional development and training, etc.), which will make the public health sector a more appealing career option and increase recruitment and retention rates. However, this investment into the public health sector does not mean that there isn't a need to pay equal attention to the

regulation of the private health sector, especially the pharmaceutical industry. When the Committee convened a meeting with representatives from the private health sector, we learned of exploitation by wholesale pharmacies, for example the scale of demand and relative scarcity – so that an item costing 80,000shs is offered to health facilities at a cost of 200,000shs. And of course, the margin is transferred by the hospital to the patient. We need to ask regulators such as the National Drug Authority to cap pharmaceutical fees, to stop and avert such exploitative practices. This is definitely a priority issue for the Committee.

“There is really no healthcare system here”

Q&A with Dr. Kizza Besigye – Physician, Politician and Human Rights Activist



Question: What is your assessment of Uganda’s public health system?

Dr. Besigye: Basically, we have no public health system to talk off. The public health system is designed to reduce to a minimum morbidities and illnesses so that there are fewer members of society needing medical treatment. The healthcare system should be doing more to prevent people becoming sick, then prioritizing the treatment of patients.

However, to successfully achieve a greater prevention than treatment mandate, one needs an elaborate health system, which first of all has a clear understanding of the demographics and needs of the people it is intended to support. Therefore, every beneficiary of the healthcare system should be known and their health history tracked. This should start from conception, with proper medical care provided to every pregnant woman, and the health of her child

monitored and recorded through foetal-neonatal-infancy stages and beyond. The formal registration of the child should be integrated into the public maternity system, to facilitate the opening of a file under the child’s name, which can then be used to monitor the achievement of developmental milestones and the documentation of medical history, including vaccines obtained, and preventative education provided to parents on how to optimize their child’s growth and health; and, later in the child’s life, advice on available health screenings (for example, cervical and breast cancer), gynecological and reproductive advice, nutritional guidance, and later still, geriatric advice.

Such a healthcare system envisages a holistic, comprehensive and consistent engagement of people, to ensure that they are in a good state of health throughout their lifecycle. In Uganda, we don’t have any such thing: what we call a healthcare system does not know any person in Uganda. If I asked you, where do you have a file in the healthcare system of Uganda, would you be able to show me? If you were to be involved in an accident, and needed urgent medical attention, where could your attending doctors look for reference to, say, your blood group? Ours here, first have to draw and test your blood before they can transfuse, because this information is not readily available. While they are conducting these necessary tests and waiting on the results, you can easily die. That’s why I say there is really no healthcare system here. We may have some healthcare workers and facilities, but we can’t describe this as a healthcare system.

Question: In your view, what benefits does a public health system offer that a private one cannot?

Dr. Besigye: It is essential for a country’s healthcare system to be public if universal health coverage is to be legitimately achieved: it is, in my view, the only way that every person in a country can receive effective healthcare. This cannot be provided by the private sector, which is profit driven and thus will always exclude those who cannot afford its services. So, the private system should always remain a supplementary health system, catering to people who are willing to pay for exclusive facilities,

commensurate with their income or lifestyle. That's what private healthcare should be reserved for. But as for a public health system, it is, and should always be regarded as, a public good, for the benefit of all society, and hence to be provided by public institutions.

Question: The Ministry of Health and the World Bank calculate that Ugandans spend 38.38% of their income on healthcare, which far exceeds the 10% recommended by the World Health Organisation (WHO). What strategies do you propose to reduce out of pocket expenditure?

Dr. Besigye: I think even the 38.38% quoted is a gross understatement! With the shambolic health system I have described above being the only option available to most Ugandans, people even prefer to depend on themselves, which means first of all, never or very rarely getting regular health check-ups, and looking for the cheapest alternative treatment option, in most cases traditional medicine. In my view, the poverty in Uganda and other similar countries, is exacerbated by the absence of a functional and effective public health system. The funds saved by a family with access to such a system, could be put towards education, housing, even saving. Instead, we have a situation where people are constantly having to raise money, sometimes selling even homes to cover healthcare costs. Take for example a woman who experiences complications during childbirth, who is advised to undergo a cesarean section, after which she spends maybe a week or more in hospital, pushing the medical bill to UGX one million¹ if not more. There is no way an ordinary home can pay this at the drop of a hat; and so, they do whatever it takes to avoid their loved one being held against their will, even selling their land. So, healthcare is a large driver not only of poverty, but increasingly landlessness and homelessness. Many Ugandans have to sell their assets to pay for healthcare – even in cases where their loved ones die, and they wish to receive the deceased's bodies from the health facility, in order to perform burial rites.

Changing this status quo is quite straightforward: government must increase the health budget, and put in place efficient management systems within the healthcare sector. It's more than a question of money, good governance is also pivotal. Our current health budget is minuscule and has been so for a long time. Healthcare expenditure has ranged from 3% -7% (the latter a very recent development). Yet, the Abuja Declaration² urges African states to allocate at least 15% of their national budgets to healthcare expenditure. Ugandan has failed to achieve even half of this goal since this call was made in 2001. So, the only way to ease the financial burden imposed on individuals and families, is to: (i) increase the health budget, and (ii) and improve public healthcare-related governance. This will make more funds available to strengthen our public health system, and also ensure that corruption is tackled; because as things stand currently, the porous system is exploited, with everything simply stolen for use within the private sector. You cannot reduce this burden on people as long as these two factors are not addressed.

¹ Approximately 283 USD

² Abuja Declaration on HIV/AIDs, Tuberculosis and other related infectious diseases, 2001

“Government must invest in public health”



Q&A with Dr. Michael Lulume Bayigga, Physician and Member of Parliament for Buikwe South Constituency in Buikwe District

Question: What is your assessment of Uganda’s public health system?

Dr. Lulume: Some health facilities have been renovated; however, we still do not have the requisite human resources. Many of these facilities operate with only about 55% - 65% of the staff actually needed.

Additionally, certain infrastructure – especially for lower health facilities – is lacking. Take for example the district of Buikwe, which has 3 constituencies: not one of these constituencies has a Health Center IV, even though each constituency should have one. The Health Center IIIs in these constituencies do offer a minimum health package by design, but the entire district is serviced by one general hospital, Kawolo Hospital, which is located far from the rest of the territory constituting Buikwe district. The regional referral hospital, Kayunga Hospital, is far away, and while it is a very beautifully renovated structure, it does not have adequate staff to meet the healthcare needs.

Primary healthcare is very difficult to attain when you have the necessary buildings, but lack the health personnel to make those buildings fully functional and capable of delivering quality public health services. A related challenge is the frequent drug stock-outs, attributed to medicinal stocks not being ordered at the appropriate times, being poorly managed or securely stored (and thus susceptible to theft) or failing to reach health facilities. When it comes to medical equipment, there is a similar lack: in Health Center IVs for example, which have dental departments, all too often there are no dental chairs available on site. And we have even heard of theatres that are not operational. This is not how it should be.

Question: Would you agree with someone who asserts that Uganda’s public health system is dead/non-functional? Why?

Dr. Lulume: Uganda’s public health system is partially functional – that’s why I talked about 55%-65%. The functionality of our health facilities is lacking in very many respects, which is what private health facilities take advantage of, offering health facilities which are more appealing to patients than public ones, many of which are dilapidated, lack human resources or essential medicines or medical equipment that is needed to properly deliver services to the public.

Question: What benefits does a public health system offer that a private one cannot?

Dr. Lulume: Public health facilities should provide free healthcare, which would encourage the majority of our people to rely on the public health system, since most don’t have the money to cover private medical treatment. So, a public health system makes healthcare accessible to all Ugandans, which the profit-driven private healthcare cannot.

Question: The Ministry of Health and the World Bank calculate that Ugandans spend 38.38% of their income on healthcare, which far exceeds the 10% recommended by the World Health Organisation (WHO). What strategies do you propose to reduce out of pocket expenditure?

Dr. Lulume: The first thing government should do is make provision for preventive healthcare. An investment should be made to educate and capacitate people to make every effort to, avert both non-communicable (e.g., diabetes, hypertension, cancers) and communicable diseases, (e.g., the cholera, typhoid). Government can prioritise sanitation for all people in Uganda to help prevent waterborne diseases, as well as offer immunization programmes to all Ugandans through its public health system.

Uganda has made some strides with regards to immunization, with coverage around 70%; however, a lot more can be done - the government could, for example, budget resources for immunization research and development, to gradually reduce the country's dependence on external supply, and by ensuring that implementation of immunization activities is facilitated well, so that there is broad reach throughout even the most remote parts of Uganda.

Another key issue is health education: public media platforms can be used to raise citizens' awareness on how to avoid diseases, and where to access medical treatment if this is needed. The public could be educated on how to make positive fitness and nutrition choices to strengthen non-communicable disease prevention. They could also be informed about the benefits of early detection and diagnosis, to encourage what we call health-seeking behavior. An informed, empowered and proactive citizenry will help to promote a consistently healthier Ugandan population.

Question: The global spread of Covid-19 has led to renewed calls for enhanced investment into public health systems. What recommendations would you propose to the government to ensure the provision of accessible, affordable and equitable healthcare for all?

Dr. Lulume: Our healthcare systems were decentralized, which was a positive step with regards to healthcare management. A good referral mechanism also contributes positively to healthcare management. We need to improve our health human resources: we need to assess whether we have sufficient maternal healthcare workers to adequately care for the pregnant mothers at village, parish and sub-county levels. This is important to ensure that all pregnant women are able to be registered for, and receive, good quality antenatal care, to be monitored at community level throughout their pregnancy, and to be referred to a higher healthcare facility in the event complications are detected.

Once health staffing needs are fully identified, resources need to be allocated to ensure that personnel are well trained, provided on-going development, and well-remunerated to encourage their retention within the public sector.

An audit should also be conducted into the infrastructure, pharmaceutical stocks and medical equipment and technology needed within the respective health centres. This will help determine whether the existing number of health facilities, beds, equipment and medication for antenatal checkups, measurement of blood sugar or blood pressure levels, HIV medication, laboratory systems to test for malaria, typhoid, urinary tract infections, etc. suffice and are fit-for-purpose. An investment and prioritization of such an exercise is essential if Uganda is serious about making a good quality, public health system accessible to all our people.

Finally, we need to improve the public's awareness about where to access the appropriate level

of care, as well as the way that different health centres interact with one another in terms of referrals. This will help to avoid bottlenecks and congestion at the specialist level. This will in turn reduce patients' transportation costs, waiting times, and bribes precipitated by long waiting times to incentivize speedier health facility admission.

Question: What role if any do you see national health insurance playing in public health system strengthening?

Dr. Lulume: A National Health Insurance Scheme (NHIS) would help a lot. I believe private healthcare providers would be encouraged to expand into rural areas, if government paid them to deliver services there. As things stand now, who covers the rural poor's private healthcare costs? They do, in their personal capacity. And as has been shown in other contributions to this brief, often they are unable to do so; or they have to sell precious assets, such as land to generate money; and where they are unable to settle their accounts, we hear of private facilities holding them hostage until their family raises the funds to do so.

However, the proposed contribution to the NHIS was about UGX 100,000¹ per person, per year. But not many can afford this when even the graduated tax of UGX 10,000² forced some people into the bushes and swamps in an effort to avoid it. In a pandemic-hit economy it is even more unlikely. So, under these circumstances it becomes very difficult for health insurance to be operationalized effectively so that it works as intended.

One way to get around this problem, would be to focus instead on improving public health facilities, and charging nominal user fees. This would improve the condition of public health facilities, to make them a more appealing healthcare option than they are currently.

I think the environment is not right to introduce a National Health Insurance Scheme law – I believe insurance of this nature is bound to fail at the initial stages, if its adoption is undertaken in the current economic climate. Government was right to abandon it, because they were not yet ready for it – it would've been a still birth.

Question: Uganda's healthcare is increasingly becoming commercialised: what recommendations would you propose to ensure that healthcare is maintained and continues to be provided as a public good for all?

Dr. Lulume: Uganda must deliberately prioritise investments into public healthcare. We cannot depend on foreign donors forever, or health diplomacy to leverage the humanitarian goodwill of developed nations – we can't defer responsibility for our citizens' health to the rest of the world. We must make adequate provision for our country's healthcare budget, and ensure that we have the requisite funds to support healthcare delivery, period. Uganda signed up to the Abuja Declaration, which urges an allocation of 15% of the country's annual budget to health - yet currently we only spend about 6%-7%, while expecting health diplomacy to work so that other international agencies, and well-wishers care for Ugandan citizens... what kind of a country or government do we have? Government must invest in health deliberately, the way they are spending on defense is the way we should defend Ugandans against disease and keep people healthy over the long term.

1 Approximately 29 USD

2 Approximately 3 USD

The financial implication of healthcare access in Uganda

By Eliezer Edwin Ayebare, Advocate of the High Court of Uganda

“Out-of-pocket expenditure... [exceeding] 10% of the total household income is considered catastrophic... to both the rich and the poor”¹

Introduction

In January of 2021, a 79-year-old man was rushed to the Intensive Care Unit (ICU) of Mulago Hospital on the brink of death on account of gastrointestinal bleeding caused by diverticulosis.² This condition necessitated a week's stay in the ICU, which wracked up a bill amounting to millions of Ugandan Shillings, separate from the monies required for other medical expenses such as pharmaceutical drugs, laboratory tests, and the patient's general welfare and recovery. With no insurance, this patient's medical expenses were necessarily out-of-pocket, which in the light of his advanced age and financial status no doubt placed him under considerable financial pressure and emotional distress.

The situation above is not, however, restricted to this unfortunate patient: a stay at any of Uganda's hospitals, whether public or private, reveals a great deal about the underwhelming quality of Uganda's available healthcare, and the prohibitive costs associated with accessing it. Very few common persons are immune from this - even middle-income earners are frequently left on the precipice of bankruptcy when faced with an out-of-pocket medical bill. The paucity of financial safety nets within the country's healthcare system is a serious cause for concern.

The Covid-19 pandemic has severely exacerbated the pressures confronting an already struggling public healthcare system, which at the height of transmissions appeared to virtually buckle from the onerous demands made of it, compelling many Ugandans to seek recourse in private hospitals, characterized as “aggressively” billing for Covid-19 ICU services³

The right to health in Uganda

The 1995 Constitution of the Republic of Uganda (as amended) contains a number of key provisions to ensure the realization and fulfillment of the right to health. The fulfillment of this right requires the provision of equal and timely access to basic preventive, curative and rehabilitative health services, preferably at community level.⁴ Objectives XIV (b) and XX of the National Objectives and Directive Principles of State Policy place an obligation on the government to ensure that the citizenry access medical and health services. Article 8A further stipulates that the people of Uganda must be governed according to these principles. It therefore follows, that this provision imposes an obligation on the state to ensure that all Ugandans have access to health goods and services.

Under International law,⁵ the government has a duty to ensure that health- -facilities, -goods and -services, whether privately or publicly owned, are affordable for all, including socially disadvantaged groups.⁶ This principle of equity demands that poorer households should not, relative to richer

1 Press release, from the office of the Minister- Public Relations Unit, Ministry of Health (2019). Available at <https://www.health.go.ug/document/proposed-national-health-insurance-scheme-bill-2019/> See also, Anderson GA, Ilcisin L, Kayima P, Abesiga L, Portal Benitez N, Ngongzi J, et al. (2017) Out-of-pocket payment for surgery in Uganda: The rate of impoverishing and catastrophic expenditure at a government hospital. PLoS ONE 12(10): e0187293. <https://doi.org/10.1371/journal.pone.0187293>

2 A condition in which, small bulging pouches develop in the lining of your digestive system. It is prevalent in people over the age of 40. Diverticulitis occurs when diverticula tear, resulting in inflammation, and in some cases, infection which can result in fever and abdominal pain. Accessed at <https://www.mayoclinic.org/diseases-conditions/diverticulitis/symptoms-causes/syc-20371758> on 3/23/2021

3 Tonny Abet & Elizabeth Kamurungi (2020) 'What is the cost of treating Covid-19 daily' Wednesday December 23 2020, Daily Monitor. Accessed at <https://www.monitor.co.ug/uganda/news/national/what-is-the-cost-of-treating-covid-19-daily--3237640> on 3/2/2021

4 See General Comment 14 of the ICESCR.

5 Ibid.

6 Ibid.

households, be subject to an unreasonably disproportionate health expense burden.⁷ This equity principle obtains even (or perhaps more especially) in times of severe economic constraint, such as the current pandemic, when vulnerable groups are in greater need of access to low cost services and goods.⁸ This is why the government has a special obligation to provide those without sufficient means with the necessary public health care facilities or insurance to offset private healthcare costs.

Gaps and challenges

Notwithstanding Uganda's international obligations,⁹ the country continues to lag behind many peers with respect to availing public health services to the populace.

While the Ugandan government bears the primary obligation to provide healthcare services, the country's public health facilities remain substantially underfunded, understaffed, understocked, and health professionals poorly remunerated.¹⁰ This undermines both healthcare access and quality within public hospitals, incentivizing Ugandans who have the means, to pay to access the higher quality healthcare offered by private hospitals.¹¹ Government's lackluster delivery of health services has given private actors a significant competitive advantage.¹² However, this comes at a considerable cost, since private health facilities are profit-oriented, which at times can result in profits being prioritized over patients and the quality of the healthcare services they procure. The paucity of private healthcare regulations allows private health stakeholders excessive leeway which is susceptible to exploitation; and a common complaint is that government intervention is typically dependent on public outcry.

Uganda's international human rights obligations require government to enact laws requiring private health actors to ensure that their services are accessible, of good quality and relatively inexpensive.¹³

Possible recommendations

- Government needs to appropriately budget for national healthcare expenditure. In the FY 2020/21, the health sector accounted for a paltry 5.1% of Uganda's national budget, a notable decline from the 7.9% allocated in FY 2019/2020.¹⁴ This trend is worrying, particularly in the light of the sustained pressures the Covid-19 pandemic has imposed on healthcare systems all across the world, including Uganda's. Unless Uganda's government is more intentional about budgetary allocations and keeping a tight rein on its internal expenditure, the country will have a harrowing and protracted journey to the realisation of universal health coverage.
- The National Health Insurance Scheme (NHIS) has been touted, rightly so, as a possible solution to high-out-of-pocket healthcare costs. Under this scheme, resources will be pooled from members' contributions; claimants will be issued with an identification card, with which

7 Ibid.

8 See General Comment 3 of the ICESCR.

9 Uganda has ratified a number of international instruments that spell out the right to health. These include the: International Covenant on Economic, Social and Cultural Rights (ICESCR); Convention on the Elimination of All forms of Discrimination against Women (CEDAW); Convention on the Rights of the Child (CRC); African Charter on Human and Peoples' Rights (ACHPR). Initiative for Social and Economic Rights (ISER), 'Introduction to the Right to Health in Uganda. A Handbook for Community Health Advocates'. Available at https://www.iser-uganda.org/images/downloads/A16_10_04_ISER_Booklet_design_layout.pdf

10 James Zeere (2017) 'Who Is Regulating Private Health Care Providers' Centre for Policy Analysis (CEPA). Available at <https://cepa.or.ug/analysis/who-is-regulating-private-health-care-providers/>. Accessed on 06/06/2021.

11 Ibid.

12 Ibid.

13 Ibañez, X.A., Dekanosidze, T. The State's obligation to regulate and monitor private health care facilities: the Alyne da Silva Pimentel and the Dzebniauri cases. Public Health Rev 38, 17 (2017). Available at <https://doi.org/10.1186/s40985-017-0063-6>. Last accessed on 06/06/2021.

14 UNICEF (2020), 'The National Budget Framework FY 2020/21, Budget Brief No. 2020/3' (Source: National BFP FY 2020/21 - 2024/25). Available at <https://www.unicef.org/esa/media/5961/file/UNICEF-Uganda-2020-2021-Health-Budget-Brief.pdf>

to access medical care from both private and public providers.¹⁵ Under the scheme, members will have access to a wide range of medical benefits, as highlighted in the first schedule to the NHIS Bill, which, since it was passed by parliament, now awaits the President's assent to enter into force. This process should be prioritized as a matter of urgency.

- Government must intensify its regulation of the private healthcare sector, so as to ensure that: services are up to par; patients' rights are respected; and patient billing is reasonable and fair.

Conclusion

Access to healthcare in Uganda remains an expensive privilege, which most people ordinary Ugandans simply cannot afford. The government needs to step up its efforts relating to the provision of public healthcare, and more effectively regulate private actors who are egregiously exploiting the many gaps within existing legal frameworks, many going to such lengths as to detain patients against their will until their medical bills are settled.¹⁶ Uganda must prioritise universal health insurance if it is serious about realizing universal health coverage; and government's budgetary allocations for healthcare should be seriously reviewed and increased to ensure the provision of medical care to all Ugandans, not only during this critical pandemic period, but perpetually.

15 Part V of the National Health Insurance Scheme Bill, 2019.

16 Accessed at <https://www.monitor.co.ug/uganda/magazines/healthy-living/it-is-illegal-for-hospitals-to-detain-patients-over-bills-1676672> on 4/21/2021

High maternal healthcare costs undermine Uganda's efforts to combat maternal mortality

By Justice Lydia Mugambe¹ and Mugoya Musa²



The Mulago Specialised Women and Neonatal Hospital

Uganda's prevalence of maternal mortality, that is, deaths occurring during pregnancy, childbirth, or within 42 days of childbirth or termination of a pregnancy,³ remains alarmingly high, despite concerted efforts by the government. Currently, there are approximately 336 deaths registered for every 100,000 live births,⁴ which translates to 16 women dying each day from pregnancy and childbirth-related causes.

The persistence of neonatal and maternal deaths is attributable largely to the high cost associated with accessing maternal health services; which in turn, is due to

entrenched structural deficiencies in Uganda's health service delivery. These include, but are not restricted to, a range of factors affecting antenatal and postnatal patients, including inadequate transportation (compounding inaccessibility), poor referral services, sub-optimal care, an imbalance in the distribution of facilities, (disproportionately disadvantaging rural communities), and an inadequacy of essential medical equipment.⁵ Financial pressures further compound these factors, impeding almost 45% of women aged 15-49 years from being able to access maternal healthcare services.⁶

At the interpersonal level, maternal deaths are associated with three main drivers: intractable poverty and financial constraints more generally, both of which are particularly aggravated for rural women, pregnant women delaying to seek maternal healthcare.⁷ This is affirmed by Uganda's Demographic Health Survey of 2016, which found that only 29% of women undergo their first antenatal care (ANC) visit during the first trimester; the statistics are more alarming for rural women of whom only 8% consult a doctor at some point during their pregnancy. According to the Health Survey, most women start attending ANC around the halfway mark of their gestational period, which eliminates the opportunity to diagnose and address any pregnancy-related complications early on, to increase the prospects of positive health outcomes for mother and child.

Additionally, financial constraints often make it difficult for expectant women who encounter complications during the labour process to access health facilities and receive the appropriate medical attention. The inability to pay for maternal health services is not the only disincentive – the many accounts of patients being forcefully detained, for failure to settle outstanding medical bills is, surely, another reason many pregnant women forego seeking healthcare. Consequently, many die during childbirth - in Uganda, over 67% of maternal deaths are due to haemorrhage, sepsis,

1 DPhil in Law Researcher at Oxford University, England.

2 Program Officer at the Initiative for Social and Economic Rights

3 Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF at <https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf>, accessed on June 19, 2021

4 Ibid.

5 Government of Uganda. Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda, Supra, P.2

6 UBOS and ICF, supra page 161.

7 Ibid

obstructed labour, pre-eclampsia and eclampsia.⁸

Ugandan jurisprudence confronts these shortcomings of maternal health in the country. In *Centre for Health Human Rights and Development & 2 Others v Attorney General & Executive Director of Mulago Hospital*,⁹ the main plaintiff attended Mulago National Referral Hospital in the final stages of her pregnancy. She had undertaken only a single antenatal consultation prior to this, during the early stage of her pregnancy; relying on local herbs thereafter. When she subsequently attended Mulago Hospital, she was not aware that she was expecting twins. On referral for emergency delivery, one of the twins was stillborn, and had macerated skin. The plaintiff in this case acknowledged that she could not afford the prohibitive transport and other associated costs involved in seeking healthcare access. This is consistent with the findings of a 2018 study undertaken by the Initiative for Social and Economic Rights (ISER), which highlighted the challenges expectant mothers experience with respect to accessing emergency health care. This was particularly aggravated for pregnant women living in hard-to-reach island and remote rural areas, where families incur heavy costs hiring and fueling boats and other transportation to be able to access emergency maternal healthcare facilities.¹⁰

In *Joyce Nakachwa v Attorney General and Others*,¹¹ the petitioner was poor, and could not afford to pay maternal hospital fees. She thus delivered her baby on a public roadside, seeking urgent medical assistance at the public health facility, Kampala Capital City Maternity home/clinic with the baby's umbilical cord still attached to her. The hospital did not provide her with medical assistance, opting instead refer her to Mulago hospital – even though the petitioner was unable to walk and was still physically attached to her newborn. A compassionate passer-by accompanied the petitioner to a private clinic, where she received needed assistance. The highly risky circumstances of her delivery were a direct result of her financial constraints.

In 2012, when Mulago hospital's maternal load was considerably high, and a disproportionate number of deliveries was conducted by Caesarean section, Parliament approved a government loan request to facilitate the construction of the Mulago Specialized Maternal and Neonatal Hospital. The dedicated maternal hospital was intended to improve the country's maternal health service delivery, optimizing its efficiency and effectiveness.¹² Upon completion, however, the facility adopted a pay policy, effectively turning what was supposed to be a public health facility into a private one, rendering it unaffordable to the majority of Ugandans. For example, the facility's antenatal package is priced at Ug shs: 890,000 (approximately 251 USD).¹³ For the 68.9% of the country's households still surviving through subsistence economic activity, such costs are quite simply out of their reach.¹⁴ The user fee structure adopted within the public facility is the subject of litigation currently before the High Court.¹⁵ While we await the judgement in this matter, taxpayer revenue is nevertheless servicing the loan procured for the construction of this ostensibly public hospital, even as those who can't afford the user fees are effectively barred access to the facility.

8 Supra Note 6. Also see. Ministry of Health, Annual Health Sector Performance Report, 2019/20, P. 36.

9 HCCS No.212 of 2013

10 Initiative for Social and Economic Rights (ISER), 2018 "Here When you are poor, You die!" Healthcare on Sigulu Islands, Kampala Uganda at <https://www.iser-uganda.org/images/downloads/Sigulu.pdf> accessed on May 6, 2021

11 Constitutional Petition No.2 of 2001.

12 The approved loan request amounted to \$30.28M from multiple funders to finance the construction and equipping of a 450 bed capacity women's hospital in Mulago National Referral Hospital to provide specialized maternal and neonatal healthcare

13 The Statement to Parliament on Operationalization of Mulago Specialized Women and Neonatal <http://parliamentwatch.ug/wp-content/uploads/2018/09/Operationalization-of-the-specialized-women-and-Neonatal-Hospital.pdf> (accessed August 5, 2021).

14 See the Minister of Finance, Planning and Economic Development's Budget Speech for FY2018/19 https://www.finance.go.ug/sites/default/files/Publications/Government%20of%20Uganda%20Budget%20Speech%20for%20Fiscal%20Year%202018-2019_1.pdf (accessed August 5, 2021)

15 Daily Monitor "Govt sued over Mulago's specialised women wing" Monday August 12 2019 at <https://www.monitor.co.ug/uganda/news/national/govt-sued-over-mulago-s-specialised-women-wing-1842528> accessed on May 4, 2021.

Meanwhile, the private sector, in addition to their exorbitant charges,¹⁶ have adopted even more unlawful, cruel and humiliating methods of recovering their medical bills. Reports abound in different media spaces of illegal detention of patients, including mothers, for failure to pay medical bills. These dehumanizing actions of the private actors are also being challenged in court.¹⁷

As noted above, maternal healthcare in Uganda includes substantial provision of emergency services. The most pressing concern for an expectant mother nearing childbirth, who suffers a miscarriage or experiences other pregnancy-related complications, should be the preservation of life – hers and the infants – and not whether or not she can afford the medical bill! If maternal healthcare costs remain prohibitively high, women will continue to seek assistance from traditional birth attendants and other risky and life-threatening practices not based on sound medical and scientific intervention. This threatens to seriously erode trust in the country's health sector and to reverse the public health gains made through concerted efforts to reduce maternal mortality.

In Article 33 and Objective XV of the National Objective and Directive Principles of State Policy of the Constitution, Uganda recognized the significant role of women in society and committed to provide facilities to enhance this role and protect women and their rights, taking into account their unique status and natural maternal functions in society. Under Objective I, this must guide all organs in policy decisions. Similarly, Uganda committed itself to the sustainable development agenda that aims to reduce maternal mortality to less than 70 deaths per 100,000 live births by 2030.¹⁸ However, the current maternal mortality ratio of 336 deaths per 100,000 live births, cannot achieve these commitments. It requires a reduction rate of 30 deaths annually for Uganda to meet the 2030 target.

A commitment, on the part of the state, is required to reclaim public health services, especially maternal healthcare, which is an urgently needed public good. The recent adoption of the National Health Insurance Scheme Bill by Parliament is a tremendous and encouraging step in the right direction.¹⁹ Health insurance not only cushions poor people against the shock of having to divert household income towards paying the catastrophically high out-of-pocket healthcare bills; it also increases resource mobilisation for the health sector, securing and expanding legitimate access to quality health care.

However, the benefits of health insurance are redundant in the absence of Government commitment and proactive steps to avail the requisite resources to strengthen delivery of maternal health services within public facilities, since these are the first port of call for the vast majority of Ugandans, in particular, poor, vulnerable and marginalised persons.²⁰

16 The cost of normal delivery in facilities in Kampala; Kampala hospital – UGX 820,000; Nakasero hospital – UGX 1,550,000; International Hospital Kampala – UGX 1,200,000; Kibuli Hospital – UGX 700,000; Nsambya Hospital – UGX 1,200,000. See Initiative for Social and Economic Rights (ISER), 2018 Why Mulago Women's Hospital will do very little to address Maternal and Child mortality in Uganda, Kampala Uganda at https://www.iser-uganda.org/images/downloads/ISER_Fact_Sheet_Mulago_Fees.pdf accessed on May 6, 2021.

17 In May 2021, ISER together with community members filed a case in the High Court, Mukono District, challenging detention of mothers in private health facilities who fail to clear hospital bills at https://www.iser-uganda.org/images/downloads/Stop_hospital_detention_of_women_seeking_maternal_health_services.pdf accessed on June 19, 2021

19 Parliament passes the Bill and it is currently awaiting assent by the President

20 In its recent decision in the case of *CEHURD & Ors v Attorney General* (Constitutional Petition No.16 of 2011), the Constitutional court observed and directed that Government has a responsibility to mobilize resources including application of equitable taxation and appropriately allocate the funds to fulfill constitutional demands such as provision of health care services.

Access to justice as a means of ensuring quality public health services

By Muganga Ambrose Ibabaza, Lawyer and Activist

Access to justice – What does it mean?

Bedner and Vel¹ suggest a broad definition of ‘access to justice,’ which centres the perspective of the justice seeker, and looks at the process a justice seeker must pursue to achieve appropriate redress. The various elements of Bedner and Vel’s definition leave room to understand ‘access to justice’ as a process and not merely a situation or goal. This approach is crucial, because it upholds a rights-based approach to access to justice programming. Within this conceptualization, access to justice implies the following:

- ☐ People, notably the poor and vulnerable;
- ☐ Who suffer from injustices;
- ☐ Have the capability;
- ☐ To air their grievances;
- ☐ And obtain proper treatment of said grievances;
- ☐ By state and/or non-state institutions;
- ☐ Leading to the redress of prevailing injustices;
- ☐ On the basis of rules or principles of state-, religious-or customary- law.

Public health, in contrast, can be understood as ‘the science and art of preventing disease, prolonging life and promoting physical health and efficiency through organized community efforts for the sanitation of the environments, the control of community infections, the education of individuals on the principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of society machinery, which will ensure to every individual in the community a standard of living adequate for the maintenance of health.’²

Human rights underpin both access to justice and public health. In order to provide quality public health services, it is necessary to realise the right to health. Hence there is increasing recognition that the fields of public health and human rights are complementary, and pursuant of the same goal, namely the advancement of human well-being.

In Uganda, public interest cases aimed at advancing the realization of quality health services have been instituted against the government; and those which have succeeded, have positively impacted public health services in the country. Courts and other quasi-judicial bodies have been instrumental in ensuring quality public health services in Uganda. Examples of the abovementioned public interest litigation include Constitution Petition No. 16 of 2011,³ which was filed by the Center for Health Human Rights & Development & others against the Attorney General, which challenged the unavailability of basic maternal commodities, the unethical conduct of health workers in public health

1 Bedner, A. & Vel, J. A. C., (2010), An Analytical Framework for Empirical Research on Access to Justice, 2010(1) Law, Social Justice & Global Development Journal (LGD). https://www.go.warwick.ac.uk/elj/lgd/20010_1/dedner_vel (Accessed on 16th April 2021)

2 Fundamentals of Health Law in Uganda: Prof. Ben Kiromba Twinomugisha [publisher?]; 2015 at p 90.

3 Center for Health, Human Rights and Development (CEHURD) & 3 Ors v Attorney General (Constitutional Petition-2011/16) [2020] UGCC 12 (19 August 2020).

facilities and the government's failure to provide emergency obstetric care services, amongst other considerations. The judgement, delivered on 30th September 2019, recognized that the Ugandan government is obligated to provide adequate equipment and supplies for preventive, diagnostic, and curative services, including training of medical staff and development of treatment guidelines and protocols for the management of maternal complications, in line with Uganda's minimum core obligations to regional and international human rights instruments such as the African Charter on Human and People's Rights and the International Covenant on Economic, Social and Cultural Rights.

In the same judgement, the court emphasized that the mere existence of health-related policies does not suffice as grounds for government to claim it is giving expression to the right to health; neither are impediments to the operationalization of said policies sufficient justification for government's failure to realise the right in question. The court asserted that the Ugandan government is expected to demonstrate the practical measures or steps it is taking to make provision for maternal healthcare services. An order was handed down for government to prioritise and increase its budgetary allocations for maternal health and compile full audit reports on the status of maternal health in Uganda for submission to parliament in the financial years 2020/2021 and 2021/2022. Notwithstanding this court ruling, the Ministry of Health is yet to submit to parliament an audit report on the status of maternal health in Uganda; of equal concern, are the continued cuts to the Ministry of Health Budget. In the financial year 2020/2021, only 5.1% of the national budget was allocated to the health sector, a substantial decrease from the 7.9% allocated in FY 2019/2020.⁴

One encouraging healthcare development in Uganda while the abovementioned case was underway, was the official commissioning of the Mulago Specialized Women's and Neonatal Hospital (intended to offer specialized healthcare services to women and children)—, by the President of the Republic of Uganda, His Excellency Yoweri Kaguta Museveni, on the 2nd of October 2018. Shortly preceding this commission, on the 18th of September 2018, Uganda's Health Minister, Dr. Ruth Acheng, issued a ministerial statement on the operationalization of Mulago Specialized Women's and Neonatal Hospital, wherein she stated that the hospital will charge user fees for its services, with the pay policy distinguishing between Standard, VIP and VVIP services.⁵ Research⁶ conducted by the Initiative for Social and Economic Rights (ISER) reveals that despite this hospital's construction being facilitated by public funds, its prohibitive fees will likely make it inaccessible to the majority of Ugandans..

It is important to remember that the obligation to provide healthcare extends beyond the provision and administration of treatment, also encompassing a responsibility to provide patients with adequate and accurate information about their healthcare intervention. In *CEHURD & 2 Others v Attorney General and Executive Director of Mulago Hospital (HCCS No.212 of 2013)*, a mother who delivered twins in Mulago Hospital, received possession of only one baby after delivery, with the second child alleged to have died (Uganda High Court, 2013b). On challenging this allegation, the hospital gave the mother an infant corpse it claimed was that of her deceased twin; however, DNA testing ruled out biological compatibility, proving that the corpse in the mother's possession was not her baby. The High Court determined that a hospital's failure to inform a mother of the whereabouts of their new-born baby, constitutes cruel, degrading and inhuman conduct and a clear violation of a mother's right to access information pertaining to her child. In addition to instituting remedies for the affected parents, the court directed Mulago Hospital to strengthen protection measures for new-born babies, and to account for the whereabouts of the missing second twin. The Hospital was also ordered

4 <https://www.unicef.org/esa/media/5961/file/UNICEF-Uganda-2020-2021-Health-Budget-Brief.pdf> (accessed July 12 2021)

5 Unresolved Maternal Deaths, By Namaganda **Jane Kibira and Ajalo Ruth**; Center for Health Human Rights and Development. (CEHURD). <https://www.cehurd.org/unresolved-maternal-deaths/> (Accessed on 20th April 20, 2021)

6 <https://www.iser-uganda.org/news-events/news/391-why-mulago-women-s-hospital-will-do-very-little-to-address-maternal-and-child-mortality-in-uganda> (accessed July 12 2021)

to implement or enhance procedures for the movement and safety of babies, a measure aimed at addressing the deficits highlighted by the case, to prevent violations of this nature from occurring at the hospital in future.

It is unclear from the judgment what Mulago Hospital's current procedures are for handling newborn babies (those born alive and those who die). What is clear, however, is the extent to which existing procedures are either ineffectual or inadequately adhered to, exacerbated by the absence or deficiency of oversight and accountability mechanisms.

Structural interdicts were granted against the hospital by Lady Justice Mugambe, which, inter alia, required Mulago to report to the plaintiff the steps taken to reduce baby theft at the hospital. This is only the second time Ugandan jurisprudence features the granting of structural interdicts, and the first in respect of the right to health⁷. A Press Release of 22nd March 2021 from the Centre for Human Rights and Development (CEHURD) on Mulago National Referral Hospital's progress report to the High Court [Civil Division] documents the steps Mulago hospital has taken to improve safety in the handling of babies delivered at the facility; which include:

- Installing security cameras in maternity wards to monitor the movement of babies;
- Placing security guards at the entrance of the Hospital to register people entering and exiting the hospital;
- Tagging newborn babies and their mothers for ease of identification;
- Establishing a compassion ward where counseling services are provided to mothers who have lost their babies.

In conclusion, public interest litigation is one mechanism which can simultaneously facilitate access to justice and the realization of quality public healthcare services. Various public interest representatives and organizations have advocated for improvements to public health and enhanced fulfilment of the right to health, which in turn has positively impacted the quality of public health services offered in Uganda. From the case law discussed above, it is evident that access to justice through Uganda's Court system and other quasi-judicial bodies, together with cooperation from Government Ministries, Departments and Agencies on the implementation of court judgements, presents substantial potential to improve the accessibility and quality of the country's public healthcare services.

⁷ Review of Constitutional Provisions on the Right to Health in Uganda: A case study report. Centre for Human Rights and Development (CEHURD) (September 2018) at p 27 [please insert

The human rights impact of increased private actor involvement in the provision of healthcare services in Uganda

By Kirunga Joyce, Legal Fellow – Centre for Public Interest Litigation

The right to human health is intrinsic to the enjoyment of other fundamental rights and freedoms. For example, to participate in civic life and fully exercise the rights associated with this – voting, being consulted by government on matters of national importance, enjoying freedom of movement and expression...presupposes that a person is in sufficiently good health to practically do these things.¹

While the right to health is not expressly provided for in the 1995 Ugandan Constitution, it can be inferred from the National Objectives and Directives of State Policy,² other constitutional provisions³ and on account of the principle of the interdependence and indivisibility of human rights. Additionally, Uganda is a signatory to various international conventions and treaties that do expressly provide for the right to health,⁴ including the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12(1) of which *...recogniz[es] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, also enjoining State parties to create conditions which assure medical services to all persons.⁵ State Parties to the ICESCR are thus recognized to have a duty to protect, promote, respect, and fulfil the right to health.⁶

However, Uganda's government has been criticised for undermining its role as primary provider of healthcare, placing greater emphasis on Private Public Partnerships (PPPs) as the vehicle for the provision of healthcare services and by implication the advancement of the right to health, as can be discerned in the National Development Plan III,⁷ the National Health Policy II,⁸ and Vision 2040.⁹ An illustrative case of government prioritising PPP, is the ROKO/FINASI Construction Special Purpose vehicle for the financing of the Lubowa International Specialised Hospital, which parliament sought to approve with minimal public consultations and flouting procurement procedures, when the value of the promissory notes was approximately \$379.71 million (UGX 1,347,567,627,690).¹⁰

The private health actors discussed in this article include Private Not for Profit Health Practitioners (PNFP), Private for Profit (PFP) and Traditional and Complimentary Medicine Practitioners (TCMP).

A study¹¹ by the Initiative for Social and Economic Rights (ISER), found that Uganda's public health budget has steadily declined, opening up the market to private actors, some of whom are unscrupulous, operating in a manner exploitative of the poor and vulnerable.¹² Although health sector budgetary allocations indicate a nominal increase, in real terms – once population growth and inflation rates

1 CESCR General Comment NO 14 'The right to the highest attainable standard of health (Article 12 of the International Covenant on economic Social Cultural Rights) E/C. R 2000/4(2000) para1

2 Objective XIV of the 1995 Constitution.

3 Article 39, Ibid

4 For example, International Covenant on Economic, social and Cultural Rights (ICESCR), The Convention on the Elimination on all Forms of Discrimination, African Charter on Human and Peoples Rights.

5 Article 12(2)(d) ICESCR

6 General comment 14, Ibid

7 Government of Uganda: Third National Development Plan 2020/21-2024/25 <<https://www.health.go.ug/cause/third-national-development-plan-ndpii-2020-21-2024-25/>> Accessed on 23rd/04/2021.

8 Second National Health Policy < <http://library.health.go.ug/publications/policy-documents/second-national-health-policy-2010> > Accessed on 23rd /04/2021.

9 Uganda's Vision 2040< <http://www.npa.go.ug/uganda-vision-2040/> > Accessed on 23rd/04/2021

10 Lubowa Hospital :Uganda should Learn from the Lesotho Experience < <https://www.iser-uganda.org/news-events/news/396-lubowa-hospital-uganda-should-learn-from-the-lesotho-experience> > Accessed on 23rd/04/2021 <https://webcache.googleusercontent.com/search?q=cache:Jz6QoK9RG4kJ:https://www.iser-uganda.org/news-events/news/396-lubowa-hospital-uganda-should-learn-from-the-lesotho-experience+&cd=21&hl=en&ct=clnk&gl=ug> > Accessed on 23rd/04/2021

11 Achieving Equity in Health: Are Public Private Partnerships the Solution 2019 < <https://www.iser-uganda.org/> > Accessed on the 26/04/2021

12 Ibid

are taken into account – they have, in fact, decreased. The health sector budget has decreased from 8.9% of the national budget in FY2016/17 to a projected 6.2% in FY 2021/22,¹³ far below the 15% aspiration member states committed to in the Abuja declaration.¹⁴

Private for Profit and Not For Profit facilities have capitalised on the increasing demand for healthcare as the state budget supporting the public health sector has stagnated and regressed. This as the number of private actors providing healthcare services in Uganda continues to proliferate each year. Ministry of Health statistics attest to the existence of approximately 2976 PFP (40.31%) and approximately 1008 PNFP (14.53%) healthcare facilities; whereas public healthcare facilities constitute about 31339 (45.16%)¹⁵

This is problematic, because poverty, socio-economic - exclusion, - marginalisation and - inequality, and the resultant poor human development are challenges that continue to plague Uganda. In the United Nations Development Programme's (UNDP) Annual Human Development Index 2020,¹⁶ Uganda was ranked 159th, placing it in the category of a low human development countries, – a full 158 positions lower than the country with the highest human development ranking in the world.

The steady increase of private health actors in Uganda, coupled with consistent under-financing of the public health sector, has negatively impacted enjoyment of the right to health, particularly for impoverished and vulnerable persons. To fully appreciate the extent to which the right to health has been undermined in Uganda requires an understanding of what this right entails: General comment 12 elaborates the essential elements which must obtain for the right to health to be fully realized:

- (i) Availability implies an adequate number of healthcare facilities, to reasonably meet national health needs. In Uganda, PFPs are disproportionately concentrated in urban areas, skewing the distribution of facilities positively for urban dwellers, but disadvantaging those living in rural – often hard to reach – places, for whom the availability of healthcare facilities cannot be said to be sufficient. This is especially problematic in the case of PNFPs, which receive government grants to deliver primary healthcare.
- (ii) Accessibility implies public health services that can readily be procured by all persons, without undue discrimination on the basis of factors including physical residence, economic status and so forth. Accessibility is not restricted to the provision of health services, but additionally entails ensuring that people can acquire pertinent, health-related information. This is not currently the situation in Uganda: many private actors require people to pay a user fee to obtain medical information essential for making informed decisions, which makes it especially hard for poor and other vulnerable groups to know important considerations such as, for example, what medical options exist, their cost implications, the comprehensive range of interventions available, etc.
- (iii) Acceptability implies that all health- -facilities, -goods and -services conform to prescribed standards, uphold medical ethics, are culturally appropriate, and patient-centric to ensure all persons are treated with dignity. Far from adhering to these values, private actors are renowned for detaining patients who are unable to settle their accounts, depriving them

13 National Budget Framework Paper FY 2021/22 < <https://budget.go.ug/sites/default/files/National%20Budget%20docs/National%20Budget%20Framework%20Paper%20FY%202021-22.pdf> > Accessed on 3rd /03/2020

14 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Infectious and Related Diseases (2001) (2001) < <https://africanarguments.org/2020/04/19-years-africa-15-health-abuja-declaration/> > Accessed on 3rd/06/2021

15 Ministry of Health National health facility Master List 2018: A complete list of all health care Facilities in Uganda Page 8 < <http://library.health.go.ug/publications/health-facility-inventory/national-health-facility-master-facility-list-2018> > Accessed on 21st/04/2021

16 United Nations Development Program, Human Development Report 2020 “The Next frontier Human Development and the Anthropocene” < <http://hdr.undp.org/en/content/latest-human-development-index-ranking> > Accessed on 26th/04/2021

of their dignity and personal liberty. Many private health providers also do not attempt to tailor their offerings to the local context, one such example is faith-based PNFs, which withhold family planning services from unmarried women.

- (iv) Quality refers to the scientific and medical standard that public health- -facilities, -goods and - services -personnel, - medications and - equipment is expected to meet. In a bid to cut costs, private health facilitators have been known to hire unqualified staff, which jeopardizes patients' safety, and impedes their ability to access healthcare.

In conclusion, the Ugandan government's underfinancing of its public health sector, and increased involvement of private healthcare actors is driving healthcare inequality, with the right to health of poor and vulnerable members of society being the worst affected, threatening to derail the country's Universal Health Coverage efforts.

COMMUNITY PERSPECTIVES

“Accessing healthcare is costly”

Interview with Harriet Rwabugashya, Community Advocate from Nkokonjeru Town Council in Buikwe District



1. When was the last time you needed to seek healthcare? Where did you go? Why?

Ms. Harriet Rwabugashya: July 2021. I had symptoms of Covid-19, but I stayed home even though I was in pain, because of the presidential pronouncements restricting movements and travel in an effort to control the spread of Covid-19. I used a lot of airtime to interact with my doctor, and also had to cover the cost of having my medicine delivered to my home. If I had resorted to physically accessing the mission hospital in my area, St. Francis Hospital Nkokonjeru, I might have been detained because the fees are high and I am currently not working, so do not have the money to pay for treatment.

2. Do you have experience of accessing a private health facility? If yes, how does it compare to your experience in a public health facility?

Ms. Harriet Rwabugashya: I have used a private facility in Mukono district and often the service is good but the charges are high. Public healthcare has always been a pain, all through. From the lack of on-duty staff, to receiving rude and unprofessional service, to no drugs in the facility.

3. Is there a public health facility in your area of residence? If there is, what do you feel is the benefit of having a public health facility close by?

Ms. Harriet Rwabugashya: Yes, there is, Nkokonjeru Health Centre II but it is only for preventive care. It is the only government facility in our area. The alternative is the mission hospital, which offers curative care, but the charges have always been high and they have a tendency of detaining customers for failure to pay the medical bill. They detain you until your relatives and community members fundraise to come to your rescue. I have seen people, especially mothers who are detained after giving birth by c

cesarean section, being detained for as long as six months until their relatives sell property to rescue them. This mission hospital is the only health facility in the whole of Nkokonjeru that can handle delivery by C-section. The public facility is in Kawolo Lugazi municipality, and one needs a minimum of 30,000 shs for the public transport fees. If we had a public health facility on the level of the mission hospital, it would save us time, and we wouldn't worry about medical bills and seeking specialist care which is currently out of reach for most of us here.

4. What, in your view, is the impact of citizen participation in public health service delivery?

Ms. Harriet Rwabugashya: Having citizens participate in public health service delivery helps planning authorities to know and understand residents better, for example, what are our needs, how

to meet them. It creates a good basis for health planning, budgeting and implementation.

5. What challenges do your experience in accessing health care?

Ms. Harriet Rwabugashya: Because of the long distance, I incur high transport costs. Treatment costs are also high.

6. How can government strengthen the public health system?

Ms. Harriet Rwabugashya: Government can strengthen the public health system by increasing the budget for health, ensuring the availability and maintenance of healthcare facilities and equipment, making sure drugs are available, and that there is good and professional staff. Government must bring health services closer to communities. They should also collect information on patients – who are they, what treatments do they receive, what are their health outcomes, etc. – because if you can't measure things, then you can't manage them well.

“I gave up on Government hospitals, I use local herbs”

Interview with Ntumwa Matia from Namugongo Division Kira Municipality in Wakiso District



1. When is the last time you needed to access healthcare? Where did you go? Why?

Mr. Ntumwa Matia: It was in June 2021. I went to a drug shop in our trading centre to buy paracetamol to relieve my pain and then I went to the bush to get some herbs we use to treat Malaria. I felt like I had Malaria symptoms. But I didn't go to the clinic because I don't have money, and the last time I went to the government health facility in Kira [at the municipality headquarters] I failed to even get paracetamol, so I haven't gone back since then.

2. Have you accessed a private health facility? If yes, how does it compare to your experience in a public health facility?

Mr. Ntumwa Matia: At the government facility, sometimes you will be lucky and find a doctor, but then you will not get drugs. Me, I gave up – I now treat myself, with local herbs and Paracetamol.

3. Is there a public health facility in your area of residence? If there is, what do you feel is the benefit of having a public health facility close by?

Mr. Ntumwa Matia: Yes, there is, a Health Centre at Kira, at the municipality offices. I have not seen any benefits, because there are no drugs – what you need you won't find there.

4. What, in your view, is the impact of citizen participation in public health service delivery?

Mr. Ntumwa Matia: Leaders just do what they want, no one listens to us. They only think we are important during election time, when they come asking for our votes.

5. What challenges do your experience in terms of accessing health care?

Mr. Ntumwa Matia: Money. The cost of treatment is very high. This is why I buy Paracetamol for pain relief and use herbals from the bush. The hospitals do not have drugs so I no longer go there; what is the point?

6. How can government strengthen the public health system?

Mr. Ntumwa Matia: Let them put drugs in government health facilities, and monitor and prevent health workers from removing those drugs to sell to private facilities.

“Improve supervision at Government health facilities”

Interview with Ssentongo Ananias from Busimbi Sub County in Mityana District



1. When is the last time you needed to access healthcare? Where did you go? Why?

Mr. Ssentongo Ananias: In April 2, 2021: I went to Mityana General Hospital, the hospital in my area. I went to receive the Covid 19 vaccination.

2. Have you accessed a private health facility? If yes, how does it compare to a public health facility?

Mr. Ssentongo Ananias: I don't have experience of a private health facility. Accessing the public one is always difficult – it is like lining up for money or food, with everyone looking at you as if they didn't know what has brought you. OMG!

3. Is there a public health facility in your area of residence? If there is, what is the benefit of having a public health facility close by?

Mr. Ssentongo Ananias: Yes, there is, a Health Centre II called Kigenge and Mityana General Hospital. One of the benefits is immunisation and vaccines (especially for children) which are always there.

4. What, in your view, is the impact of citizen participation in public health service delivery?

Mr. Ssentongo Ananias: This is a tricky one, many people fear health workers, fearing that if you say anything negative, they will revenge the next time you go to the hospital. Here everyone knows everyone: sometimes that is a good thing, but at other times, it is a challenge.

5. What challenges do your experience in accessing health care?

Mr. Ssentongo Ananias: The long waiting period to receive health care: you can spend 3-5 hours without being attended to. The lack of drugs in government hospitals is another problem, because going to pharmacy is very expensive.

6. How can government strengthen the public health system?

Mr. Ssentongo Ananias: Government can strengthen the public health system by implementing supervision of the facilities and staff. But the challenge with improving supervision is that public healthcare staff don't seem to care. Supervision is very poor.

The national health insurance scheme bill 2019 - An opportunity for universal health coverage in Uganda

By Joseph Byomuhangyi, Advocate & Project Coordinator, Uganda Consortium on Corporate Accountability (UCCA)

The right to health enjoys equal standing with, and is indivisible from, all other fundamental human rights; however, it is unique in that good health is generally a prerequisite for the full enjoyment of other rights. The right to health is expansively construed, extending to a person's physical, mental and social well-being; hence healthcare systems need to provide services and treatments that speak to these three spheres. And health insurance is one mechanism with the capability to resource many of the health components – facilities, services, treatment/medical interventions integral to the fulfilment of the right to health.

Universal Health Coverage and the right to health

Universal Health Coverage (UHC) is defined as 'all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them.'¹ The priority health services referred to in this definition include: preventive, curative, rehabilitative and palliative health services. The objectives of UHC are; equitable access to priority health services (health for all); quality and effectiveness of health services; and financial protection.²

National Health Insurance Schemes have been hailed as a key tool in the move towards achieving UHC.³

The right to health imposes three distinct obligations on State parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR), namely: to respect, protect, and fulfil the right to health.⁴ The obligation to fulfil the right to health requires States to undertake actions that create, maintain and restore the health of their populations.⁵ This involves governments making health services available to people in a timely, affordable, efficient and accessible manner.⁶

In addition ICESCR state parties to making provision for the general health of their populations, are additionally 'obliged to fulfil a specific right...when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal.'⁷ It is against this backdrop that this paper will examine how and to what extent a Ugandan National Health Insurance Scheme can assist and facilitate the government's ability to fulfil its obligations with respect to the right to health: both in terms of the mandate to provide a general public health system, and the duty to provide more targeted health interventions for those whose financial constraints make it impossible to procure healthcare under their own auspices.

1 'What is universal health coverage? In: Health financing for universal coverage' Geneva: World Health Organization; 2016 <http://www.who.int/health_financing/universal_coverage_definition/en/> Accessed March 17, 2021.

2 Making fair choices on the path to universal health coverage: final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: World Health Organization; 2014:3.

3 Joseph Kutzin, 'Anything goes on the path to Universal Health Coverage?' No. Available at <<https://www.who.int/bulletin/volumes/90/11/12-113654/en/>> Accessed March 17, 2021

4 United Nations Economic and Social Council, General Comment No 14: The right to the highest attainable standard of health. United Nations document E/C.12/2000/4 (11 August 2000): para 33.

5 Para 37 of General Comment 14 of the Committee on Economic Social and Cultural Rights at its Twenty-second session Geneva, 25 April-12 May 2000. Retrievable at <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en> Accessed March 17, 2021.

6 Para 12 of General Comment 14 of the Committee on Economic Social and Cultural Rights at its Twenty-second session Geneva, 25 April-12 May 2000. Retrievable at <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2f2000%2f4&Lang=en> Accessed March 17, 2021.

7 Ibid.

National Health Insurance Schemes

A National Health Insurance Scheme (NHIS) is a system of insurance, which is intended to insulate a nation's population and healthcare system from excessive financial and inflationary pressures, to the detriment of healthcare access and provision.⁸ In Africa, countries like Ghana⁹ have implemented fully functional NHIS, which have positively impacted the country's healthcare service delivery.

In Uganda, the NHIS Bill 2019 is one mechanism by which Uganda aims to fulfil its obligation to provide citizens with quality, accessible, affordable, appropriate healthcare, irrespective of a patient's age, economic-, health-, or social -status.¹⁰ This NHIS Bill intends to reduce Uganda's out-of-pocket expenditure on healthcare and associated services; which is imperative, since the current rate of medical out-of-pocket spend in the country is 41% - far higher than the 15% recommended by the WHO.¹¹

The Bill envisions concerted effort between public and private healthcare facilities.¹² As a quality control measure, the role players envisaged by the Bill to benefit from NHIS support, include among others privately owned healthcare facilities, non-governmental facilities which must be formally accredited and licensed,¹³ incurring sanctions and penalties where they fail to do so.¹⁴

The NHIS also has the potential to make out-of-pocket health service expenditure¹⁵ a thing of the past in Uganda, through the benefits of aggregative and compound saving, which drastically undercuts the financial risk inherent in payments imposed on individuals. The Bill thus represents a positive first step towards ensuring the availability of essential health services and goods, in the right quantities, quality and prices, factors which are essential in order to entrench an efficient and effective public health system.¹⁶ In Ghana, the introduction of the NHIS fast-tracked the expansion and improvement of existing health infrastructure, facilitating enhanced access to quality medication and skilled personnel.¹⁷ The passing of the bill in Uganda could help revitalise the state of Health care in the country.

Furthermore, the NHIS bill provides an avenue for accountability through setting out the parties, procedures, requirements as well as penalties in cases of a breach, which in essence streamlines health service delivery in Uganda.

The Ugandan Parliament passed the National Health Insurance Bill, raising citizen's hopes that they will finally obtain a vastly improved public health system. Unfortunately, a substantial proportion of the Ugandan population is not well-versed on the role envisaged for them by the bill. Therefore, it is critical, and incumbent upon the ministry of health and other key stakeholders, that public education and sensitization is broadly undertaken, to capacitate the public to play an active role in supporting implementation of the NHIS. This will ensure that sound governance standards are upheld and there is transparency and scrutiny of budgets, that public officials are held accountable for expenditure, and

8 Gobah, F. K. and Liang Zhang. 'The National Health Insurance Scheme in Ghana: Prospects and Challenges: a cross-sectional evidence' in *Global Journal of Health Science* 3 (2011): 90.

9 Aryeetey, G.C., Westeneng, J., Spaan, E. *et al.* Can health insurance protect against out-of-pocket and catastrophic expenditures and also support poverty reduction? Evidence from Ghana's National Health Insurance Scheme. *Int J Equity Health* 15, 116 (2016)

10 Clause 4 of the Bill. Also see Commissioner for Planning Sarah Byakika addressing the media about National Insurance Bill Approved by Cabinet; available at <<https://www.independent.co.ug/national-health-insurance-scheme-bill-approved-by-cabinet>> Accessed March 17, 2021.

11 The National Health Insurance Bill, 2019 Submission to the Health Committee of Parliament 20 NOVEMBER 2019, ISER Policy Brief No.9.

12 Clause 37 NHIS Bill 2019.

13 Clause 38 NHIS Bill 2019.

14 Clause 43 NHIS Bill 2019.

15 Aryeetey *et al.* The Effect of the National Health Insurance Scheme (NHIS) on Health Service Delivery in Mission Facilities in Ghana: a Retrospective Study, *Globalization and Health* (2016) 12:32.

16 (n 8) *supra*

17 (n 7) *supra*.

ultimately, that implementation benefits society broadly.

The Ministry of Health should also assume a leading role in lobbying for swift Presidential assent, particularly whilst the urgency of public health services is immediate and pressing in the light of the global pandemic.

NHIS is a necessary and positive step towards the realization of the right to the highest attainable standard of physical and mental health; moreover, given the health system challenges highlighted by the Covid-19 pandemic, it is a timely step, particularly as Uganda aspires to achieve UHC. Therefore, the government should not superficially give expression to the right to health, but it should take concrete steps to fully achieve this right – which measures should certainly include prioritising the NHIS.

Uganda's public health system is on its knees gasping: something must be done!

By Labila S. Musoke, Human Rights Lawyer and Activist



ISER lawyers with women from Buikwe and Kumi districts after filing a case of patients detention in hospitals for failure to pay medical bills; case was filed at Mukono High Court on May 7, 2021

It is a common scenario in Uganda to have politicians, including Ministers of Health and other wealthy individuals, leave our ailing health system to fly abroad to seek first rate medical care – paid for using public tax funds – while constituents are left to bear the brunt of a collapsing public health system. This is shameful.

Time and again, patients are told: “sorry, we have no beds in the Intensive Care Unit (ICU).”¹ Or “we are out of stock: you will have to buy these medications from a private drug store.” And again: “all the beds in the maternity ward are occupied, so you will have to deliver your new born on a chair.”² These incidents demonstrate that Uganda’s public health system as it is currently, is unable to meet the nation’s health needs. This crisis does not concern and affect patients only; it also has a negative impact on health workers. Our health system is suffocating: if something is not urgently done, it may well die.

Over the past decades, Uganda’s health sector has received inadequate funding, leading to a progressive decline in health services and degradation of health infrastructure; notwithstanding the fact that public health facilities are the first port of call for the majority of the population. For the past years, the health sector budgetary allocations have hovered at between 7-9 %³ of the national budget. Health will be assigned Uganda shillings 2,523,2 billion,⁴ which is lower than the previous financial year’s allocation (FY 2020/2021) of Uganda shillings 2,781,84⁵ billion – both of which are still far below the 15% target encapsulated in the Abuja commitment.⁶

Government capital contribution towards the health budget is about US\$ 15.5, far below the

1 See Atukunda, N. 31 December 2020. Senior doctor dies after failing to get ICU bed. Daily Monitor., available at: <https://www.monitor.co.ug/uganda/news/national/senior-doctor-dies-of-covid-after-failing-to-get-icu-bed-3244326>, last accessed 6 April 2021.

2 See URN. August 16, 2019. Babies transferred from Kawempe Hospital after social media leaks. The Observer, available at: <https://observer.ug/news/headlines/61672-premature-babies-transferred-to-mulago-from-kawempe-after-social-media-leaks>, last accedd 6 April 2021

3 Ministry of Finance, Planning and Development: National Budget Framework Paper, FY 2019/2020- FY2023/2024, December 2018, available at: <https://finance.go.ug/sites/default/files/National%20Budget%20Framework%20Paper%20FY%202019-20.pdf>, last accessed 6 April 2021.

4 70, 9679784,30 USD

5 782251082,10 USD

6 Abuja Declaration on HIV/AIDS, Tuberculosis and other related and Infectious Diseases African Union, OAU/SPS/ABUJA/3, available at: <https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf>, last accessed 4 April 2021. At Par. 26, Heads of state, pledged to allocate 15% of the national budget to improvement of the health sector.

World Health Organisation's (WHO) recommendation of US\$ 34⁷. Consequently, the health sector is consistently dependent on funding support from external actors to meet its obligation. This dependence syndrome is unsustainable, and arguably a large contributor to the decline in the quality of the health sector.

Public healthcare in Uganda also relies heavily on out-of-pocket expenditure by patients. According to World Bank estimates, the average Ugandan spends approximately 38.38% of their income on healthcare.⁸ This is entirely unreasonable, considering that the average household in Uganda is supported through the subsistence economy, largely living hand-to-mouth: being required to spend over a third of their income on healthcare, threatens to immediately drag them below the poverty line, or incentivize recourse to loans to finance accrued medical bills.⁹

Nevertheless, despite out-of-pocket contributions, the public health system continues to be characterised by, among other things, inadequate drug supplies, long waiting queues for life-saving healthcare, and an ineffectual referral system. The lack of public sector alternatives, particularly in rural and hard-to-reach areas, makes people increasingly reliant on private health providers, who are largely unregulated, and in many instances exploit this lax regulatory environment, adopting unscrupulous practices that negatively affect their patients. Private healthcare users are thus subject to exorbitant service costs; and those who fail to settle their medical accounts in full, are subjected to unlawful practices, the most extreme being forcibly detained within health facilities until they or their families have paid outstanding monies in full.¹⁰

How did we get to where we are today? A growing private healthcare agenda

Uganda's health system, like that of many countries in Sub-Saharan Africa, owes its existence and current configuration to structural adjustment programs¹¹ and neo-liberal reforms, which undermined the state's role in the provision of public services, including healthcare, by severely constraining budgets on the one hand, necessitating the introduction of user-fees, which had the effect of essentially privatizing some state functions, including healthcare provision. This 'new normal' was motivated for on the grounds that public sector delivery is inadequate, and comparatively inefficient, allowing private actors to be perceived as better positioned and optimally structured to assume the lead role in healthcare provision. This in turn progressively disincentivized the state from aggressively taking charge of primary health care delivery, causing the public health system to incrementally corrode over time. Uganda is yet to recover from this.

When international actors, including the likes of the World Bank, were granted the discretion to redefine Uganda's health system in a manner that was to their benefit, introducing austerity measures that necessitated patients pay user fees to access healthcare services (by implication, undermining

7 Ministry of Health . Health Sector Development Plan, 2015-16- 2019-20, available at https://health.go.ug/sites/default/files/Health%20Sector%20Development%20Plan%202015-16_2019-20.pdf, last accessed 6 April 2021. Also see: ISER. Are We Failing to Progressively Realize the Right to Health in Uganda? An Analysis of the Health Sector Budget Trends, November 2018, available at: https://iser-uganda.org/images/downloads/health_budget.pdf, last accessed 6 April 2021.

8 World Bank. According to the World Bank report, a single Ugandan spends approximately 38.38% of their income on healthcare.2018. Out-of-pocket expenditure may include user-fees, over the counter, and prescription drugs, and related hospital fees. available at: <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=uganda-UG> , last accessed 7 April 2021.

9 Abet, T. 16 June, 2021. Hospitals Charge Shs. 5million per day to treat COVID-19. The Monitor. See: <https://www.monitor.co.ug/uganda/news/national/hospitals-charge-shs5m-per-day-to-treat-covid-19-3439408>, last accessed 21 June 2021.

10 Initiative for Social and Economic Rights (ISER). 7 May 2021. Stop hospital detention of women seeking maternal health services, Civil Society Petitions Court. (Press Release) . Available at: <https://www.iser-uganda.org/news-events/notable-developments/484-stop-hospital-detention-of-women-seeking-maternal-health-services>, last accessed 15 June 2021.

11 Structural adjustment refers to policy reforms mandated by the International financial institutions like the International Monetary Fund and the World Bank and regional development banks at country level- in exchange for financial resources. These reforms usually concentrate on four prescriptions; stabilization, liberalisation, deregulation, and privatization.

equitable access), healthcare was effectively transformed from being a human right, to becoming a commodity. Such profit-driven motives were later documented in a 2008 World Bank report,¹² which highlighted the critical role of the private sector in providing high-quality healthcare.

Equally, the decentralization of the health system further problematized the situation, by transferring the primary responsibility for healthcare delivery from the state to lower government structures lacking the financial and technical resources to guarantee quality and broad and equitable access to health services, ultimately leading to the less-than-exemplary public health system we have today.

Saving public health facilities. Lessons from Covid -19

The year 2020 will be remembered primarily for the onset of the Covid -19 pandemic, which exposed pre-existing health deficiencies, including the dire inadequacy of health infrastructure and medical supplies, most notably oxygen, ICU beds, blood, vaccine stocks, etc.

Additionally, the Covid -19 pandemic has spotlighted the importance of bringing essential public health services closer to communities, particularly in the light of the population being overwhelmingly under- or un-insured, and therefore largely unable to meet out-of-pocket expenses to access health services. Likewise, the adoption of a bottom-up approach, focusing on meaningful community engagement and people's lived experiences, has the potential to transform the health system into a more sustainable and equitable one.

Establishing the next steps to save Uganda's ailing public health sector provides a key opportunity, both for the present and future generations. Health must be mainstreamed into all relevant development policies and national laws, to provide renewed financing and progressive tax revenue streams to improve and expand Uganda's public health system.

The Ministry of Health must exercise its oversight role and more effectively regulate private health providers, since the building blocks of a strong public health system cannot be predicated on the private sector. Health is a human right, not a commodity. Every role player in the health space must be fully cognisant this.

Furthermore, the government must, in order to achieve equitable access to healthcare, prioritise the National Health Insurance. The National Health Insurance Bill makes provision for the accreditation of a greater number of health facilities, to ensure quality service delivery; and to this end, funds will be directed to the health sector to broaden access and ensure greater coverage, more especially for the poor and other vulnerable and marginalised segments of society, who have typically fallen through the cracks. The above notwithstanding, it is crucial to establish enforcement mechanisms to ensure that health is prioritized as a substantive human right.

Conclusion

Uganda's public health system has been underfunded for decades, creating space that has been leveraged by private health providers. The problem with increased private healthcare provision, is that the primary motive of these role players is profitability, as attested by the unscrupulous conduct witnessed in relation to the Covid -19 response, which saw hoarding by private actors of vaccines and other limited but essential medical supplies such as oxygen. Until the government enforces stricter regulation of private health providers, neoliberalism and corporate capture will prevail. Civil society also needs to play a role, by building a bold public movement to win community support and apply pressure on political representatives to change policy, the dominant narrative, and most importantly the scope and standard of our public health system so that it legitimately provides quality healthcare for all.

12 World Bank Group. The Business of Health in Africa: Partnering with the Private Sector to Improve Healthcare. International Finance Corporation, Washington, 2008. Available at: <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/878891468002994639/the-business-of-health-in-africa-partnering-with-the-private-sector-to-improve-peoples-lives>, last accessed 4 April 2021.

The political economy of a pandemic: Covid -19 and public health in Uganda

By Lawrence Jjumba, Advocate of the High Court of Uganda

“Health epidemics represent a unique test of governmental accountability. Compared to other disasters, the way the government responds is crucial to stop the contagion and limit the ultimate costs to citizens. However, political motives may distort the allocation of governmental resources.” Elisa M Maffioli¹

Introduction

Since Covid -19 was declared a pandemic by the World Health Organization (WHO) in March 2020,² African countries – most of them developing or middle-income – have reported fewer mortalities³ than developed nations, despite the outsize difference in the public health systems of developed nations, relative to developing/middle-income nations. This has prompted a polarizing debate as to whether the stringent Covid - 19 containment policies, implemented by most countries in the world, were motivated by political rather than public health considerations. In the case of Uganda, an impending public health crisis is anticipated, which the government will inevitably have to address, attributable to primary healthcare shortcomings that have been exploited by private health actors, to the detriment of ordinary Ugandans. This paper argues that a Market approach has been proven to be an inefficient public health response to a pandemic.⁴

The right to health

The right to health is enshrined in several international human rights instruments to which Uganda is a signatory. For example, Article 12 of the International Covenant on Economic, Social and Cultural Rights mandates state parties to recognize the right of every person to enjoy the highest standard of physical and mental health possible, considering the resources available to a state, in view of the principle of progressive realization. In **Center for Health, Human Rights and Development (CEHURD) V Attorney General**⁵, the Constitutional Court cautioned that progressive realization should not be advanced by a state as a blanket justification for its failure to provide basic services; neither should it be deemed a shield against executive scrutiny. Notwithstanding this ground-breaking judgment, the Ugandan government has not prioritized adequate budgets for the health sector generally, and maternal health more specifically; this is attested by a consistently declining health budget over the past few years, with this most current financial year witnessing a drastic cut, despite the raging pandemic. For example, the health sector budget has decreased from 8.9% of the national budget in FY2016/17 to a projected 6.2% in FY 2021/22.⁶

Additionally, in terms of Objective XX of the National Objectives and Directive Principles of State Policy found in the 1995 Constitution of the Republic of Uganda (as amended), the state is mandated to take all practical measures to ensure the provision of basic medical services to the population. It was noted, in **CEHURD V AG (supra)**, that provisions of international Conventions, read together with the National Objectives and Directive Principles suffice to impose on the state a duty to

1 Elisa M. Maffioli; The Political Economy of Health Epidemics: Evidence From the Ebola Outbreak, S-51208-LIB-1 accessed at <http://www.theigc.org> on 20 April 2021

2 See WHO Director-General's Opening remarks at the Media Briefing on Covid-19 <https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020> (accessed 1 August 2021)

3 However, there has been critique of African state's testing statistics and their disaggregation and reporting of cases of mortality during the pandemic.

4 Horne, CL. 'Public Health, Public Goods and Market Failure' in Public Health Ethics, Vol 12, Issue 3, November 2019, Pages 287–292 at <https://doi.org/10.1093/phe/phz004> (accessed on 04 June 2021)

5 Constitutional Petition No. 16 of 2011 (Unreported)

6 National Budget Framework Paper FY 2021/22 < <https://budget.go.ug/sites/default/files/National%20Budget%20docs/National%20Budget%20Framework%20Paper%20FY%202021-22.pdf> > Accessed on 3rd /03/2020

provide basic healthcare facilities in Uganda.

The state and health epidemics

As Covid - 19 ravaged populations, many governments – including Uganda’s – implemented strict public health measures, which included among other things, the imposition of curfews and lockdowns, which curtailed free public movement. This approach was adopted to mitigate the consequences of the pandemic, both on the population and to avert straining the health system. While the government’s actions have been commended, they were in large part reflexive, motivated by the pragmatic recognition that Uganda’s public health system is weak and deficient at the best of times, let alone when managing a global pandemic outbreak. In March of 2020, at the onset of the pandemic, the country indicated it had 8,231 hospital beds, 55 functional intensive care units (ICUs), and 411 functional ambulances for the entire population;⁷ with thirty-nine districts not having a hospital at all.⁸ The state affirmed its intention to prioritize and strengthen public health facilities, as a strategy to effectively deal with the pandemic.

However, fourteen months into the pandemic, many of the state’s commitments are yet to be translated into action; and the situation remains dire. The continued cyclical upsurge in infection rates, has brutally exposed government’s failure to adequately budget to increase the number of public health facilities, an omission that has led to an increase in morbidities and avoidable deaths. COVID-19 continues to expose the state’s failure to properly fulfil its mandate as a primary healthcare provider; it’s poor record in health governance, and pandemic -preparedness and -response disproportionately affecting poor and marginalized persons, who have to contend with a scarcity of vaccines, medical oxygen, hospital beds, even as the private health sector charges premium prices, profiting from their misfortune. These factors have rendered access to quality healthcare a privilege available to the highest bidder, as opposed to a fundamental human right accessible to all persons.⁹

The Covid -19 pandemic should, therefore, serve as a jarring wake-up call to the Ugandan government to strength the country’s public health system before it is too late.

Is Uganda ready for the next pandemic?

The Covid -19 pandemic is an unprecedented public health emergency.¹⁰ However, the Ugandan government has amassed experience managing other public health crises – most recently the Ebola and Cholera outbreaks – which it should leverage for its pandemic response.

Uganda should also maximize the opportunities presented by the Covid -19 relief funds from national and international sources, which could potentially be used to more robustly plug existing healthcare gaps and build a resilient and responsive public health system that endures beyond the pandemic.¹¹ Anything short of this will mean that Covid -19 represents yet another missed opportunity for public healthcare reforms in Uganda.

Reinforcement of public health infrastructure

Government plays a crucial role in responding to health emergencies, which it should not abdicate to private actors. During the early days of the pandemic, patients were managed at government-

7 Calculated in 2019 to comprise more than 44 million people – see further, Proscovia Nambatya, “Uganda’s Covid 19 Supplementary Budget: Pandemic Response or Cash Bonanza?” <https://www.cmi.no/publications/7279-ugandas-covid-19-supplementary-budget-pandemic-response-or-cash-bonanza> on 04 June 2021.

8 Ibid

9 See further ‘*Enough is Enough*,’ a poem by Kiira Brian Alex recited at a memorial convened by the Institute for Social and Economic Rights (ISER), to commemorate those who perished from Covid-19 in Uganda poem. , <https://www.youtube.com/watch?v=x9f89sHOWT0>, accessed, 13 July 2021.

10 (n 3) supra

11 Bill Gates, The next outbreak? We’re not ready? Accessed at https://www.youtube.com/watch?v=6Af6b_wyiwl on 26 April 2021

owned facilities, including Mulago National Referral Hospital and Entebbe Grade B Hospital; however, rising positive cases threatened to overwhelm already strained public healthcare facilities, compelling the state to seek recourse from the private health sector (contracted to provide testing, treatment and vaccination). The private sector has, consequently, profited enormously from the pandemic, charging obscene fees – for example, charging a daily rate of 3.5-5 million UGX¹² for an ICU bed¹³ and resorting in some instances to unlawful practices such as hoarding essential medical supplies like oxygen, holding patients physically hostage and refusing to release corpses to families for non-payment of medical bills, etc. The government thus needs to substantially increase its investment in public health infrastructure and human resources to attract those Ugandans who place themselves at the mercy of the private health sector through sheer desperation and frustration with the public sector.

It would also be prudent for government to invest in the following: health planning; partnership development, as well as meaningful community engagement and participation; policy- -development, -analysis and -decision-making support; communication; public health research, evaluation and quality assurance; and the construction of well-equipped and accessible public health facilities.¹⁴

Developing a comprehensive, participatory and rights-based approach to public health¹⁵

In *Reclaiming Comprehensive Public Health*,¹⁶ concern is raised about the increasingly authoritarian and militarized public health response adopted by many governments following the onset of the Covid -19 pandemic - a similar response was observed in 2014, when an Ebola epidemic broke out in West Africa. A military response is problematic, both because it is a temporal public health solution, and because it generally costs more than a long-term investment into establishing and maintaining efficient public health infrastructure.¹⁷

In Uganda, following the imposition of a partial national lockdown, the Local Defense Unit of the Military, a paramilitary outfit, was deployed to enforce Presidential Directives. This top-down, de facto state of emergency not only accentuated conditions conducive to the commission of human rights abuses, but it also greatly undermined the agency of local communities to develop localized pandemic solutions. A preferable approach would have been to make provision for citizen input and involvement, for example, through the mobilization of grassroot structures such as Village Health Teams and Local Councils; to earmark the budget that was ultimately assigned to the military, towards improving Uganda's ailing public health infrastructure.¹⁸

Conclusion

In Uganda, public health facilities are the first port of call accessed by the majority of citizens with health concerns. The social contract that exists between the Ugandan government and its people, positions basic, quality and free – or at the very least affordable – healthcare provision, as one of the public goods citizens expect their government to facilitate. To deliver such a public healthcare system, Government must prioritise several things, including the progressive allocation of health sector resources, revisit its public-private partnership models to one that centers the health needs of the

12 1,048 USD

13 <https://www.aa.com.tr/en/latest-on-coronavirus-outbreak/ugandan-health-facilities-charging-covid-19-patients-a-fortune/2290793>

14 Minnesota Department of Health (2014). 'Government's Responsibility for Public Health,' in *The Community Health Services (CHS) Administration Handbook* at <http://www.health.state.mn.us> (accessed on 26 April 2021)

15 Loewenson R, Accoe K, Bajpai N, *et al* *Reclaiming Comprehensive Public Health* *BMJ Global Health* 2020 at <http://dx.doi.org/10.1136/bmjgh-2020-003886> (accessed on 26 April 2021)

16 Ibid.

17 Snowden FM. *Epidemics and society: from the black to the present*. 1 edn. London: Yale University Press, 2019 accessed at <https://news.yale.edu/2019/10/24/epidemics-and-society-black-death-present>

18 Nambatya, Supra n.4.

poor, marginalized, stigmatized and the elderly.¹⁹ In addition, the government has an important role to play in enhancing public health through increased investment and enlisting grass root involvement in generating solutions to public health problems. Government must be alive to the fact that a relatively low Covid-19 death rate was achieved in spite of the dire state of the health sector and complacency should be avoided.

19 Mafioli, *ibid*

Reclaiming public health services in Uganda

By Nampwera Chrispus, Public Interest Lawyer

Public health has been defined as ‘the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society.’¹ This “scientific art” is implemented ‘through the participation, organized efforts and informed choices of society, state and non-state organizations...to act on the social determinants of health and health equity, in order to ensure and improve the conditions and capacities for health and well-being for all.’

Prevention strategies are a fundamental component of public health promotions efforts, since these are far more effective and cost-effective than curative measures. Preventing the onset of health issues also aids people to more generally prolong and improve the quality of their lives. Public health systems are intended to detect symptoms as early as possible and to respond appropriately to avoid progression to disease. Public health systems are concerned with the aggregate health of the entire population; hence educational programmes and advocacy campaigns are central to ensuring individuals are made aware of health hazards, preventative measures, and empowered to take proactive steps to enhance their health outcomes and to influence government policy.

As the Covid -19 pandemic continues to burden Uganda, government-imposed measures such as lockdown and mobility restrictions; which were intended to curb the spread of the pandemic, had the unintended consequence of negatively impeding timely access to healthcare. The negative effects of these measures have been disproportionately felt by the elderly, poor, disabled under-insured, and HIV/AIDS-infected persons, among others. This highlights a need to galvanise renewed focus on improving and strengthening Uganda’s public health system, to make it more fit-for-purpose and responsive to the country’s needs.

Global public health responses to mitigate the impact of the pandemic have underscored a long acknowledged, but under-prioritized, need for an effective public health system. Cooperation between international and national stakeholders, solidarity, accountability and meaningful citizen participation in decision-making, evaluation and implementation processes, is essential to accomplish this effective public health system.

The prevalence of poorly regulated private health actors further compounds the challenges besetting Uganda’s public health sector, which include inequitable healthcare access, since in many instances private healthcare providers are the only or most proximate health service available to the public, leaving excessive scope for private facilities to impose exorbitant user fees. Owing to an inability to pay their medical bills, patients are increasingly reporting private actors who resort to unlawful measures, such as detaining patients as a strategy to recover outstanding monies. Decades of government failure to adequately regulate these providers has created space for private health actors to proliferate, exploiting the public with steeply priced service offerings, and evading accountability where the quality and cost of the healthcare availed falls short of government standards.²

Therefore, there is compelling motivation to reform to Uganda’s national public health infrastructure and services, as part of the country’s Covid -19 recovery efforts, to make the public health system more accessible and attuned to the needs of the public. The continued toll of the Covid-19 pandemic spotlights the shortcomings of private actor involvement in healthcare. Moreover, the pandemic has exposed pre-existing health inequities, which if not holistically addressed, will merely become exacerbated and intractable. Countries like South Korea were able to more rapidly respond and bring

1 Committee of Inquiry into the Future Development of the Public Health Function. (1988). Public health in England: Report of the Committee of Inquiry into the Future Development of the Public Health Function (Cm. 289). London: The Stationery Office.

2 Applying an intersectional lens on the social contract during the pandemic response to protect sexual and reproductive rights and health (Published 31st July 2020 and accessed 15th April, 2021)

the pandemic under control, because they already had entrenched, capable, responsive, efficient and effective public healthcare systems and protocols, compared to many other – both developed and developing – countries across the globe. Korea's health system enabled the country to implement pandemic management tactics, such as early testing, contact tracing, social distancing and isolation, enabling the country to more effectively contain pandemic spread.

In addition to the abovementioned, targeted financing is also essential to facilitate the improvement of Uganda's public health system. This is especially critical, if the country is serious about being prepared and appropriately capacitated to confront the on-going and any future pandemics. Such financing would make it possible to decently remunerate all levels of health workers, sustain nationwide vaccination drives, upgrade medical testing systems to enable swifter detection, management and treatment.

Additionally, key government ministries, departments and agencies must prioritise an upward trend in the recruitment, training and retention of healthcare workers at all levels, to reduce the current patient to healthcare worker ratio, thereby boosting the quality of health service delivery, and by implication positively impacting overall health outcomes.

To progressively reclaim public health, it is necessary to address existing market failures, which are in large part attributable to the over-commercialization of healthcare for many years, and government failure to effectively regulate and hold accountable private healthcare actors. The role of the international community should also be acknowledged, as it has frequently championed and funded private healthcare projects, many of which displayed a blatant disregard for Uganda's sovereignty and national health priorities, importantly ensuring healthcare is accessible to the poorest, most marginalized and vulnerable members of society

In closing, if there is anything the Covid-19 pandemic has taught us, it is that Uganda's health system is crumbling, ill-equipped to handle even basic healthcare provision, let alone a pandemic outbreak. It is, therefore, self-evident that it well past time to reclaim our public health system for the sake of the greater public good.

Resilient public health systems: A critical necessity for Uganda's older persons

By Herbert Walusimbi, Senior Legal Officer – Law Development Centre

The onset of the Covid -19 pandemic, and resultant health system burden, served as a rude awakening to the health systems of most countries across the globe. Many health systems proved incapable of managing the substantial pandemic caseloads urgently requiring specialist medical attention. The deficiencies of many health systems were revealed, with inadequate infrastructure, outdated medical equipment and technology, a paucity of medical treatments options and drug stocks, being among the more commonly observed constraints.

This unprecedented health crisis has once again brought to the fore, the country's health systems deficiencies, which acutely affect older members of society. The National Council for Older Persons Act 2013 defines 'older persons' as person aged 60 years and above.¹

Article 32 of Uganda's 1995 Constitution, as amended, mandates the Government to adopt affirmative action measures in respect of older persons, for the purpose of addressing any legal impediments that unfairly disadvantage them, on the basis of their age. Objective VII of the National Objectives and Directive Principles of State Policy also enjoins the Government to make reasonable provision for the welfare and maintenance of aged persons. This includes taking steps to ensure that all persons of advanced age in Uganda have access to proper public services, including medical care. This is to ensure that aged persons who can no longer fend for themselves on account of health constraints associated with their age, have access to appropriate state support.

To this end, Uganda's government passed the National Policy for Older Persons in 2009, after which it enacted the National Council for Older Persons Act in 2013. This Council is enjoined to lobby and monitor the implementation of older person-focused legal and policy frameworks. In 2011, the government rolled out a pilot programme in 14 districts, for the Social Assistance Grants for Empowerment (SAGE), awarding a measly Shs. 25,000 per month – through bi-monthly electronic transfers – to each qualifying older person. These meagre grants enabled recipients to either access food, in some cases to contribute to the support of child dependents (known in Buganda as *Bazukulu*) quality medical care – in other words, recipients could meet one or two of their monthly expenses, but could not comfortably cover all of their monthly expenses. Research on SAGE found that older persons overwhelmingly used their grants to cover healthcare and education-related (typically of dependents) expenses.²

Uganda is a country with a high incidence of non-communicable diseases, which include among others, diabetes, high blood pressure, cancer and the like, which are particularly common among the elderly population. According to some estimates there are currently approximately 1.6 million or 5% of the population directly affected by non-communicable diseases, a rate projected to increase to 5.5 million by 2050.³ For a segment, of society those predominantly resident in rural and under-served areas, it becomes progressively less possible to engage in income generating activities, placing them in a general state of economic precarity or chronic poverty; a population beset by health challenges, and; which at times receives little or no material assistance from family members... it is inconceivable that Uganda, which has obligations under the International Covenant on Economic,

1 National Council of Older Persons Act 2013. Page 4 (accessed August 5, 2021)

2 See Nekesa Winny Akullo (2017) Social Assistance Grants for Empowerment (SAGE) Programme in Uganda, available at <https://socialprotection.org/discover/blog/social-assistance-grants-empowerment-sage-programme-uganda>, available at <https://socialprotection.org/discover/blog/social-assistance-grants-empowerment-sage-programme-uganda>, accessed on June 2, 2021.

3 See Wandera, S.O., Ddumba, I., Akinyemi, J.O. *et al.* Living Alone among Older Persons in Uganda: Prevalence and Associated Factors. *Ageing Int* 42, 429–446 (2017). <https://doi.org/10.1007/s12126-017-9305-7> (accessed 1 August, 2021) accessed on March 28,

Social and Cultural Rights (ICESCR), would not have in place a public health intervention tailored to respond to older persons' unique health needs.⁴

Article 12 of the ICESCR, recognizes health to be a fundamental human right that is indispensable for the enjoyment of other human rights. Every human being is acknowledged as being entitled to the enjoyment of the highest attainable standard of health conducive to living a life of dignity. As a state party to the ICESCR, Uganda is enjoined to take steps to ensure that its vulnerable, elderly population has access to proper healthcare. However, for the time being at least, this obligation remains an aspiration, whose achievement is far from being attained.

The Government of Uganda should draw on global best practice to ensure that the health challenges its older population experiences, are efficiently and effectively addressed. HelpAge International, an organization that helps older people claim their rights ...provides some guidance in a publication on health interventions for older persons in emergency;⁵ including assessing the health needs of older people, strengthening the health system so that it can cope with older people's health needs through the provision of mobile clinics and age friendly services, and ensure that older people (as well as the general population) have access to free primary health care services.

In conclusion, the right to health can be progressively realized, with regions possessing the largest populations of elderly persons given greater priority. Covid-19 has highlighted both the critical need for quality healthcare, and the overwhelming structural deficiencies of existing systems, undermining fulfilment of a fundamental human right that is necessary for the enjoyment of most others. Therefore, it is paramount that governments, including Uganda's, should earmark resources to facilitate the improvements needed to bring health systems to a standard that is more responsive to the health challenges globally.

4 85% older persons in rural areas live chronic poverty. Many of them are burdened with providing for dependents from their dead children as well as those that are left by those living in townships. See Investing in Social Protection in Uganda: The case for the expansion of senior Citizens' Grant, available at <https://socialprotection.org/discover/blog/social-assistance-grants-empowerment-sage-programme-uganda>, accessed on June 2, 2021.

5 <https://www.helpage.org/resources/publications/?ssearch=health+interventions+for+older+people&adv=0&topic=0®ion=0&language=0&type=0> (accessed August 5, 2021)

A rights based response to a social need - Health as a public good

By Ruth Kitamirike, Student, School of Law, Makerere University

‘Health for all,’ a key goal of the 1978 Alma-Ata Declaration,¹ requires an even distribution of health resources, to ensure essential healthcare is accessible to every person. The aspiration of health for all, seeks to bring healthcare within the reach of everyone in a given country, facilitated by government’s budgetary prioritization to make this a practical reality.

However, an examination of Uganda’s public health sector today falls far short of the abovementioned aspiration: health service provision is characterized by inadequate and poorly maintained infrastructure, recurrent drug stock-outs, poor patient care/customer service, the over-commercialization of what should rightly be a public health sector, excessive price inflations, and the human rights violation of patients, most notably their forced – often protracted – detention within health facilities, for failure to settle outstanding medical bills.

Due to the sustained and chronic underfinancing of Uganda’s health system, public health facilities are consistently failing to meet the health interests and needs of society. Consequently, the state has resorted to opening up the health sector to private actors, who in many cases are contracted to fulfil the state’s duty to provide citizens with essential health services. However, over reliance on these largely un- or under-regulated private health providers, negatively affects the poor and vulnerable, who have to bear the brunt of these costly services, in the absence of comparable public health services. The WHO has severally highlighted that such detentions are unlawful;² however, this has not discouraged the practice, which private health providers continue to exploit, virtually with impunity.

Sadly, the all too common practice of private healthcare providers unlawfully detaining patients who are unable to settle their medical bills in full, disproportionately affects impoverished persons. This practice would undoubtedly occur less frequently, if government’s budgetary allocations to the public health sector were adequate to, among other things: increase the footprint of available public health facilities; upgrade existing infrastructure, medical equipment and technology; train, appropriately remunerate and thus retain greater numbers of healthcare professionals...thereby expanding the scope of and quality public healthcare services.

Apart from attracting WHO censure, forced hospital detentions constitute a contravention of international human rights laws, including Articles 9 and 11 of the International Convention on Civil and Political Rights (ICCPR), which enshrine the rights to liberty and freedom from detention,

Health as a public good

De Negri Filho³ posits that conceiving of health as a public good with individual and collective dimensions, significantly alters the nature of health policies prioritized by a state, further promoting appreciation of health and its outcomes as key drivers of social and economic change and development. Therefore, there is merit to viewing a rights-based approach as central to the attainment of health as a public good. This is because such a model emphasizes equality, meaningful public participation and the need to hold accountable the state, as the duty bearer mandated to fulfil the right to health for all.

1 Available at, https://www.who.int/publications/almaata_declarations_en.pdf

2 WHO: Ending hospital detentions for non-payment of bills. Available at: <https://www.who.int/publications/i/item/ending-hospital-detention-for-non-payment-of-bills-legal-and-health-financing-policy-options>

3 De Negri Filho, A. (2008) ‘A Human Rights Approach to Quality of Life and Health: Applications to Public Health Programming’ in Health & Human Rights Journal. Vol 10(1) pp93-101

In the context of reclaiming health as a public good, a rights-based approach requires meaningful engagement with a wide-range of civil society actors, including, but not restricted to, communities (their leaders, members, relevant structures, etc.), especially in the design, monitoring and implementation of health policies and programs. Through their participation in public consultation and monitoring processes, communities are able to articulate their needs, identify gaps in service delivery and ensure that public officials are held accountable for health-related expenditure and -service delivery.

To this end, advocacy efforts by both private and public actors, as well as practices towards the improvement of health infrastructure and services, can greatly curtail and discourage hospital detentions. Moreover, facilitating the participation of citizens and communities in public consultations, where they are able to contribute to the identification, design, oversight of implementation and accountability for healthcare delivery, substantially strengthens the general realization of the right to health.

Therefore, there is merit in Civil Society Organisations collaborating with government to facilitate the abovementioned, health-related public consultations. Such action should be preceded by increased engagement and sensitization of communities on this interrelation between needs and rights. Such an intervention will empower citizens and communities to know what their right to health consists of and practically entails, which will empower them not only to assert and claim this right, but also to hold public officials accountable where they fail to appropriately fulfil their duty to give expression to this right. It is only through such action that the right to health for all will be achieved in Uganda.



ISER

Facilitating Social Justice

About the Initiative for Social and Economic Rights - Uganda

ISER is a registered national Non - Governmental Organisation (NGO) in Uganda founded in February 2012 to ensure full recognition , accountability and realization of social and economic rights primarily in Uganda but also within the East African region.

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