

Achieving Equity in Health:

Are Public Private Partnerships the Solution?

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FOREWORD

Public Private Partnerships (PPPs) have been lauded as a way to reach development goals including Sustainable Development Goal 3: *Ensure Healthy Lives and Promote Wellbeing for All* and its attendant target 3.8: *Universal Health Coverage*. Uganda's National Development Plan II (NDP II) envisions strong PPPs for the country's sustainable development over the next ten years, articulating that PPPs will play an important role in the country's development in the form of financing and implementation of the NDP II targets.¹ The National Health Policy II, Health Sector Development Plan 2015/16-19/20 reflect the government's intention to fully utilize PPPs in advancing the right to health.² This includes ensuring the participation of PPPs in policy development, implementation, service delivery and quality assurance.³

If the foundational premise is for every Ugandan to achieve quality healthcare, particularly the most vulnerable and to leave no one behind, then we have to critically assess whether the private sector focused approach and PPPs in healthcare can achieve that for its poorest and most geographically isolated citizens.

This report, as part of a series of reports on universal health coverage and ensuring no one is left behind, provides an overview of the private sector involvement in governance for health, and specifically examines public private partnerships in health. The private sector has played a burgeoning role in the financing and delivery of health services. This report will demonstrate how government financing for public healthcare has reduced over time. In the context of chronic underfunding of the health sector, internal and external pressures led to overlapping and sometimes conflicting strategies and initiatives to finance healthcare in Uganda. These contradictions of strategy, purpose, and identity have resulted in policy incoherence around the subject of private actors in the healthcare space. The most fundamental confusion comes from some stakeholders' failure to distinguish between the different motivations of private for profit and various private not for profit entities, often conceiving of them as a monolithic private sector, and failing to account for their very different natures and structures. Further adding to this confusion is the emerging feasibility of government deploying public funds in partnerships with for profit entities in Uganda's rapidly developing economy.

1 National Development Plan II.

2 Second National Health Policy: Promoting People's Health to Enhance Socio-economic Development (July 2010) at section 6.7

3 Id. at page 26.

PPPs in Health in Uganda have been traditionally Private Not For Profit, often faith based, partnering with the government to deliver health services. Currently, the for profit sector fills in gaps in the public system serving the relative minority of Ugandans who can afford to pay at competitive prices, almost entirely centered around urban Kampala. Private for Profit PPPs are emerging most recently exemplified with Uganda's Parliament approving promissory notes for USD 379.71 million for a hotly contested Public Private Partnership between FINASI/ROKO Construction SPV Ltd. and the government of Uganda to build and manage a specialized healthcare facility in Lubowa. The government also plans to invest in a World Bank/IFC backed Medical Credit Fund to provide loans at competitive rates to the private sector. Institutions such as USAID and the World Bank have been particularly involved in funding voucher schemes, which are a form of PPP, almost as proof of concept research for a future National Health Insurance Scheme that revolves around demand-side, market-based solutions.

Amidst the burgeoning role of the private sector in health, this report examines the numerous national health, finance, and development policies that seek to provide a framework for PPPs, and questions whether these policies provide a suitable structure for the implementation of PPPs that guarantees the human rights of Uganda's most vulnerable populations. As this report reveals, PPPs generally are not designed to function in the healthcare space and Uganda's PPP Act did not envision this. The prototypical PPP is an infrastructure project, where the government provides the concessionaire access to a valuable resource and/or a profitable market in exchange for their ability to provide an essential utility. Hydro-electricity is a typical example. ISER's research finds that even the existing piecemeal regulation is flawed. It is not clear what criteria is used to select PPPs in health. There is no specific methodology that ensures economic analysis, fiscal affordability, risk identification and transfer, value for money, human rights compliance are assessed. PPPs often cost more long term, pass risks to the public sector and transparency, access to information, accountability and public participation in the process of developing and executing a PPP is limited. Access to remedy is often non-existent.

Those who advocate for the possible role of for profit entities in extending quality health-care to poor and rural populations also often fail to consider the financing implications inherent in the profit motive and the structure of capital markets. There is no evidence that strengthening the private sector results in better health outcomes for the poor and rural communities. If anything, evidence has shown that private for profit is unlikely to deliver better health outcomes for the poor people and exacerbates inequalities, resulting in the

rich able to access better healthcare and the poor excluded.

This report cautions against employing PPPs as a vague panacea to Uganda's more intractable health care problems. To achieve universal health coverage, investing in a quality and equitable public health system should be prioritized— both by the government and donors. The public health system is often the first point of the call for the poor and vulnerable.



Salima Namusobya | Executive Director

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LIST OF ACRONYMS

ACHPR	African Charter on Human and People's Rights
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
DHO	District Health Officer
GoU	Government of Uganda
HC	Health Center
HC I	Health Center Level One
HC II	Health Center Level Two
HC III	Health Center Level Three
HC IV	Health Center Level Four
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
HSDP	Health Sector Development Plan
ICESCR	International Covenant on Economic, Social and Cultural Rights

ISER	Initiative for Social and Economic Rights
MOH	Ministry of Health
MOFPED	Ministry of Finance, Planning and Economic Development
OAG	Office of the Auditor General
PPP	Public Private Partnership
PPPH	Public Private Partnerships in Health
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UDHR	Universal Declaration of Human Rights
UDHS	Uganda Demographic and Health Survey
UHC	Universal Health Coverage

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EXECUTIVE SUMMARY

There has been a proliferation of private actors in healthcare. The following report discusses the role and impact of the private sector in healthcare in Uganda. The first part of the report describes the scale and nature of private actors in health, including a brief historical overview of government provided healthcare in Uganda, which will explain how the Ugandan government has historically aspired to provide affordable or even free quality healthcare to its entire population. However, as a poor country with a largely rural population, undeveloped infrastructure, and a low tax and revenue base, quality public healthcare has yet to be achieved. This report found that even as a proportion of GDP and expenditure of public funds, Uganda has not prioritized publicly funded healthcare to meet this goal. It is against this backdrop that the private sector played an increasing role in the health sector. The initial and still dominating role of private actors in Uganda's healthcare sector are not companies that operate for a profit, but rather the various forms of international, religious, and other humanitarian aid funded by donors and donor agencies.

The second part of this report will discuss the concept of Public Private Partnerships (PPPs), which has gained international popularity as a method of aligning the interests of profit driven entities, as well as foreign state actors, with the developmental and humanitarian responsibilities of government. We will discuss the government of Uganda's enthusiasm for PPPs, which it has implemented for several large-scale infrastructure projects. We will also discuss the extension of the PPP framework to Public Private Partnerships in Health (PPPHs), and how the logic and presumed advantages of PPP arrangements potentially break down when applied to the healthcare sector in a poor and largely rural nation like Uganda. This report examines the numerous national health, finance, and development policies that seek to provide a framework for PPPHs, and questions whether these policies provide a suitable structure for the implementation of PPPHs that guarantees the human rights of Uganda's most vulnerable populations.

Summary of Findings

GoU's public healthcare sector is vastly under-financed for meeting its promise of free quality public healthcare.

Government expenditure on health care has hovered between 7-9% of the total budget below the 15% Abuja declaration target African Union countries committed to.⁴

⁴ Ministry of Finance, Approved Budget Estimates from FY 2015/2016 – 2017/18, Report of the Budget Committee on the Annual Estimates for FY 2018/19; Initiative for Social and Economic Rights (2018), Are We Failing To Progressively Realize the Right to Health?

In 2018/19, it was 7.4% of the national budget, 6.4% in 2017/18.⁵ Moreover, out-of-pocket spending has risen to 40% and is far above the recommended maximum of 20% for catastrophic expenditure, meaning that financial risk protection is poor.

There is a growing appetite for various forms of PPPHs

Private actors in the health sector have been increasing. In 2017 there was an increase in private facilities, 48% of facilities (3,084) were Government owned, 15% (947) were PNFP and 37% were PFP.⁶ There has been increasing focus on PPPHs. The PPP model has been articulated in legislation and policies including a specific PPPH policy. The government has emphasized that PPPs have an important role to play in the country's development in the form of financing and implementation of the NDP II targets.⁷ The National Health Policy II reflects the government's intention to fully utilize PPPs in advancing the right to health.⁸ This includes ensuring the participation of PPPs in policy development, implementation, services delivery and quality assurance.⁹ This is echoed in the Health Sector Development Plan 2015-19, which notes the government's intention to promote "a strong and viable public-private partnership for health."¹⁰ The Health Sector Development Plan emphasizes strengthening PPPs in development as a way to improve the health workforce and prioritizes PPPs within health governance and partnerships. Emerging PPPs include those that address infrastructure development and hospital management, management of voucher schemes also partly informed by World Bank's Result Based Financing, insurance under the NHIS.

Growing reliance on public funds to finance private sector involvement in the health sector

GoU has provided public funds in the form of PHC grants to private not for profit PPPHs. In the proposed Medical credit Fund, Government will provide Counterpart Funding in loans to private for profit providers. The proposed International Specialized Hospital in Lubowa is technically a government loan. GoU and World Bank have contributed to voucher schemes implemented by the private sector.

5 USAID (2016). Uganda Private Sector Assessment in Health; at p. 24; See also Health Sector Development Plan at p. 45; <https://www.-globalfinancingfacility.org/uganda-private-sector-assessment-health-exploring-partnership-opportunities-achieve-universal-health/>; last accessed August 17, 2018

6 Ministry of Health, National Health Facility Master List 2017: A complete list of all Health Facilities in Uganda at page v.

7 National Development Plan II.

8 Second National Health Policy: Promoting People's Health to Enhance Socio-economic Development (July 2010) at section 6.7.

9 Id. at page 26.

10 Health Sector Development Plan 2015-2019 (September 2015) at page 44.

GoU has abdicated to PNFPs the responsibility of providing healthcare to poor and geographically remote citizens. Most of these PNFPs charge user fees.

GoU does not fulfill its promise to provide healthcare to the poor and geographically isolated. Instead, it relies on mostly foreign donor and religious PNFPs to provide essential services. Sometimes, the government provides significant funding to PNFPs to service an area in lieu of establishing public facilities. However, PNFPs often charge user fees. In this way, GoU effectively circumvents the prohibition of user fees for public healthcare. PNFPs sometimes resort to coercive measures to extract user fees from indigent patients who struggle to pay. Some of the PNFPs did not provide essential services like sexual reproductive services due to religious beliefs.

Over time, private actors have become so enmeshed in the public system, filling in its gaps, that the line between public and private is not always clear or meaningful.

Almost retroactively, coinciding with an international trend toward major infrastructure contracts between the governments of developing countries and foreign state-owned or for-profit actors, called PPPs, healthcare stakeholders began referring to these enmeshed relationships as PPPHs. The appropriation and extreme broadening of that term muddled the conversation around public/private cooperation. Some public policy makers, lacking a viable solution, offer PPPH as a vague panacea to Uganda's more intractable health care problems. Notably, these solutions involve shifting responsibility from MoH to the private sector and local governments to develop unspecified PPPHs to provide for their districts. Those who are distrustful of geopolitical trends toward privatization of public services view enthusiasm for PPPs as an unwelcome incursion of capitalist ideology into the ideals of socialized health care. Indeed, there is likely some validity behind these concerns, and there are those who see PPPH as a potential vehicle for self-enrichment.

There is a weak regulatory framework for PPPs, which is not enforced.

The existing piecemeal regulatory framework constitutes of among others; the PPP Act, 2015, PPP Policy Framework 2010, National Public Private Partnership in Health Policy 2012 and creates overlapping and contradictory obligations. When formulating PPPs, there is no specific methodology that ensures economic analysis, fiscal affordability, risk identification and transfer, value for money, human rights compliance are assessed. MoH's regulatory environment is particularly problematic. Uganda's health care policy landscape is replete

with underfunded initiatives and understaffed positions. Even the meager legal protections are not enforced. The PPP unit is understaffed, technical working groups rarely meet and more than half of the districts have not constituted PPPH desks as required by the policy. Highly specific and seemingly comprehensive monitoring and evaluation plans are often unenforced.

In this context of an underfinanced, disorganized, under regulated, and inequitable health care system, some private and public stakeholders seek to create more formal relationships and cooperative agreements between private actors and the public system.

Very few of these stakeholders advocate for large scale infrastructure PPPHs. This is fortunate, since large scale infrastructure PPPHs, such as that constructing the USD \$100 million Queen Mamohato Hospital, Lesotho that was financed under the Public Private Partnership (PPP) arrangement supported by the World Bank, have generally been shown to be detrimental to the right to health for vulnerable populations in developing countries. The proposed PPPH to spend USD \$379.79 million to construct an international specialized hospital in Lubowa is unlikely to yield better health outcomes for the underserved and will likely result in increased costs and risks borne by the government and could threaten the realization of the health sector objectives given the costs it will take up. Indeed, even medium-scale PPPHs, such as the development of private/public hospital wing cross-subsidization, as established in Uganda's Mulago hospital, seem not to yield increased equity or access for vulnerable groups.

Rather, international donors, who distrust GoU's ability to effectively manage financial assistance, seek to work with the private sector, in coordination with GoU, to develop demand-side solutions such as vouchers or health insurance capitation schemes. They believe that forcing PFP, PNFP, and public health providers to essentially compete with one another for subsidized reimbursements will help to improve the system. Institutions such as USAID and the World Bank have been particularly involved in funding voucher schemes, almost as proof of concept research for a future NHIS that revolves around demand-side, market-based solutions. In so doing they undermine the government's stewardship role.

There is no clear definition of what constitutes a PPPH. PPPH means many things to many people.

Any definition of PPPH that fully captures its various usages is too broad to have much

utility in policy considerations. For instance, in order to define PPPHs inclusive of its usage in the literature and key stakeholder interviews, this report found it necessary to define PPPHs as any kind of arrangement to provide goods and/or services related to the provision of healthcare, between a state and one or more actors not affiliated with that state. In order to create effective policy around PPPHs, policy makers need to use more specific language that breaks down the various types of PPPHs rather than treating them like a monolithic construct. This is absent in the existing policy and legal framework. Different policies are needed in regulating different types of PPPHs.

Manifestation of PPPs in Uganda lack the element of risk transfer that should underlie PPPs.

On the global level, PPPs have been lauded in part because the main benefit to the government is the shifting of risk and initial cost outlays onto the private entity. This has not happened in Uganda, the government often bears the risk.

PFPs have very little direct role in improving healthcare equity and access for the poor, and even less so for the geographically remote poor.

In Uganda, PFPs fill the gap in a failing public health system by providing quality healthcare to wealthier or insured employed Ugandans who can afford to pay. Providing quality healthcare to the indigent and geographically remote is not a profitable undertaking. Any role PFPs might play in providing healthcare to the poor and geographically remote requires major subsidies, such as voucher schemes. Although the international aid community is currently subsidizing some of these initiatives, they are not a domestically sustainable program given Uganda's financial limitations. Traditional PPP arrangements, such as those seen in the infrastructure sector - where private investors provide capital costs and assume risk in exchange for access to revenues and expected profit - does not apply to the provision of healthcare in poor and geographically isolated communities.

KEY RECOMMENDATIONS

For GoU

- Increase the percentage of the budget devoted to health care, focusing on poor and geographically remote citizens. The current levels are well below international benchmarks for funding universal healthcare. Ensure that public funds go towards strengthening

the public health system that is accessible to all.

- Public Private Partnerships can't compensate for a weak state and require the State to maintain a strong and consistent stewardship role.
- Strengthen PPP Unit in Ministry of Finance and ensure joint planning with PPP Unit in Ministry of Health and PPP TWG.
- Harmonize the regulatory environment.
- Decisions to enter into PPPs especially large infrastructure ones should be backed by evidence and human rights impact assessments to ensure benefit to the poor and marginalized groups.
- Assess RBF in health service delivery before wholeheartedly embracing it and ensure that it does not result in negative impacts for access to healthcare.
- Conduct a macro-prudential review, which reveals the totality of a government's PPP obligations, including contingent liabilities and ripple effects through public lenders. This review should be updated and maintained through out negotiation period.

For MoH

- Address the reality of de facto user fees. The abolition of user fees exists in theory and in legislation, but not in practice. In reality, Ugandans pay for health care through complicated, informal, and often illicit systems of payment that increase inequity and add to the inefficiency of the system.
- Work towards an effective regulatory system. Current oversight instruments, such as monitoring and evaluations plans are uncoordinated and government often lacks the will or ability to enforce them.
- Require transparency. This includes mandating disclosure including contracts, side-agreements and subsequent changes, renegotiations and arbitrations, regular progress monitoring reports.
- Strengthen the PPP Unit and conduct monitoring and evaluation of all PPPs to assess their alignment with the vision to achieve UHC for all. If MoH is serious about PPPs, it would allocate funds to staff the PPP desk positions it created rather than leaving many of them vacant and Government should develop a detailed regulatory framework

around PPPHs. The PPP Act and the NPPPPH are insufficient tools to ensure that PPPHs protect human rights. Even additional policy guidelines like the PHC Guidelines and sub sector implementation guidelines do little to directly address the rights of healthcare consumers; rather their focus is streamlining the operational relationship between the government and the private sector. It therefore follows that there is a need to revise not only the PPP Act, but also the NPPPPH and the myriad of sector policies to deliberately pay regard to the pillars of affordability, availability, quality, and accessibility of health services.

- Adequately fund local governments. Local governments can't regulate PPPHs as envisioned in the policy if they do not have the tools or resources to do so. More than half of Districts lack PPPH desk officers. District Health Officers interviewed indicated they had not heard of PPPs or PPPH desks.
- Put in place a robust, transparent, participatory and accountable framework for determining PPPs.
- Investigate complaints raised about PPPs and offer remedy.
- Routinely collect, analyze and publish comparable data on government hospitals and PPPs to compare outcomes.
- Require PPPs that provide health services to feed their data into government data collection systems.

For Parliament

- Refrain from approving PPP investments unless they follow applicable procedures in law and comply with human rights, particularly principles around non-discrimination, equity and participation.
- Strengthen the regulatory environment for private actors in health by passing new legislation and amending existing legislation.
- Dedicate adequate resources for the government to invest in the Public Health Sector.
- Enforce existing legal protections.
- Pass a National Health Insurance Scheme that enables equitable access to healthcare.

For international donors

- Invest in the public health sector. Find ways of rebuilding trust with GoU, with the goal of gradually returning to the SWAp approach. Incentivize institutional transparency, and reward the government with increasingly greater investment in the public health sector when it succeeds.
- Support for PPPs should be based on evidence.
- Insist on safeguards that strengthen right to health in contracts with public and private sectors.
- Carefully study and assess RBF.

For PFPs

- Be more open to a stricter regulatory environment, even if it means more fees, taxes, or overhead costs. Removing quacks from the marketplace, which benefits the legitimate private sector, is an ongoing battle that requires extensive resources.
- Be transparent about the limitations of applying the profit motive to universal health care schemes, particularly with regard to serving poor and geographically remote Ugandans.

For PNFPs

- Comply with existing regulation.
- Create fora to interface with health consumers to promote accountability.
- Share data with government.

For community and advocacy organizations

- Demand access to information through access to information requests and other strategies.
- Ensure meaningful participation and transparency in Public Private Partnerships (PPPs) by interfacing with Parliament and creating fora for community to provide feedback to PPPHs.
- Be wary of PPPH proposals that shift resources toward Kampala and other urban areas, rather than remote areas where the human rights situations are most dire and conduct research, monitoring and documentation or those that utilize public resources yet

exclude poor and marginalized groups.

- Work with communities to ensure remedies when human rights violations occur including engaging in strategic litigation.
- Closely monitor the government's work toward NHIS. Attempts at NHIS in other countries has sometimes resulted in schemes that were broadly ineffective, or that do not effectively serve the most vulnerable populations.

1 INTRODUCTION

INTRODUCTION

Since the 1990s, partnerships with the private sector in health have emerged gradually, and the private sector is increasingly playing a major role in health. In developing countries, a plethora of private actors work in health, ranging from financing to delivering healthcare. Uganda as a whole is increasingly focused on harnessing the potential of Public Private Partnerships (PPPs). The National Development Plan II (NDP II) envisions strong PPPs for the country's sustainable development over the next ten years. The government has emphasized that PPPs have an important role to play in the country's development in the form of financing and implementation of the NDP II targets.¹¹ The National Health Policy II reflects the government's intention to fully utilize PPPs in advancing the right to health.¹² This includes ensuring the participation of PPPs in policy development, implementation, services delivery and quality assurance.¹³ This is echoed in the Health Sector Development Plan 2015-19, which notes the government's intention to promote "a strong and viable public-private partnership for health."¹⁴ The Health Sector Development Plan emphasizes strengthening PPPs in development as a way to improve the health workforce and prioritizes PPPs within health governance and partnerships.

However, despite the policies in place, which repeatedly allude to the contribution the private sector can make through PPPs, research has not been done mapping out the extent of the private sector's operations in the health sector and their influence in health policy and service outcomes. This research interrogates whether PPPs are being managed in ways that strengthen the health care system and whether they achieve positive public health outcomes for the poor.

¹¹ National Development Plan II.

¹² Second National Health Policy: Promoting People's Health to Enhance Socio-economic Development (July 2010) at section 6 6.7.

¹³ Id. at page 26.

¹⁴ Health Sector Development Plan 2015-2019 (September 2015) at page 44.

2

METHODOLOGY

METHODOLOGY

The researchers deployed numerous methods including key informant interviews, observation and data collection through literature reviews and analyzing the government's data. A review of the literature was conducted to further contextualize observations and provide grounds for analysis of the team's findings. Resources consulted during the review included, among others, the following: legislation, policies; archives of Ministry of Health communications and policy documents accessible to the public; reports and census data from other government ministries; academic literature on healthcare and reports from civil society and donors.

The information collected was analyzed using a human rights impact assessment tool for private actors in health that had been developed in 2018 by the Initiative for Social and Economic Rights, Global Initiative for Economic, Social and Cultural Rights with the support of the University of Essex Human Rights Clinic.¹⁵ The Human Rights Impact Assessment Framework draws from how different international human rights law instruments codify the right to health, including treaties, interpretative texts on treaties, General Comments and concluding observations and case law and identified key prompting questions to assess private actors in health. The Human Rights Impact Assessment Framework is reprinted below.

15 Allana Kembabazi, Ashina Mtsumi (2018), How Can We Assess the Impact of the Private Sector in Healthcare on the Realization of the Right to Health, INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS, GLOBAL INITIATIVE FOR ECONOMIC SOCIAL AND CULTURAL RIGHTS.

Figure 1: Human Rights Impact Assessment Framework

3

OVERVIEW OF UGANDA'S HEALTH SYSTEM

OVERVIEW OF UGANDA'S HEALTH SYSTEM

3.1 Structure of service delivery

The Ugandan public health care system has a decentralized and hierarchical structure with various levels of service delivery. At the lowest, community level, there is a Village Health Team, which has no physical structure, but works as a link between the health facilities and the community.¹⁶ There is a Health Center II at the parish level, which serves up to 5000 people and are first point of call between formal medical system and community. Health Center III at the sub-county level which should serve up to 20,000 people and provide basic preventative, promotive, in patient laboratory, and outpatient curative services. Health Center IV at Health Sub-District (HSD) level that should serve up to 100,000 people, provide specialized services including emergency surgery, blood transfusions, laboratory services, and the services provided at lower designation health centers, then district hospitals, regional referral hospitals, and national referral hospitals.¹⁷ Health services are thus delivered through decentralized entities.¹⁸

3.2 Health Financing

Historically, the Government of Uganda (GoU) has aspired to provide basic public health services free of charge to Ugandans, even though it has struggled to make that aspiration a reality. Throughout the 1970's and 1980's public health units charged "informal" fees for services. In the early 1990's, a formal user charge was introduced, but then eliminated in 2001.¹⁹ The 1995 Constitution established a Minimum Health Care Package to which all Ugandans should have access. The package²⁰ was subsequently defined and revised in the in the first and second National Health Policies.²¹ However, the per capita cost of providing

¹⁶ Government of Uganda; Uganda Health Sector Strategic Plan III 2010 - 2014/15; at p. 2; at <http://health.go.ug/publications/strategic-plans>; last accessed August 17, 2018

¹⁷ Government of Uganda; National Policy on Public Private Partnerships in Health (2012); at p. 7; at <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/national-policy-public-private>; last accessed August 17, 2018

¹⁸ World Health Organization Cooperation Strategy, Uganda, 2016-2020; <https://www.afro.who.int/publications/who-uganda-country-cooperation-strategy-2016-2020>; last accessed August 17, 2018

¹⁹ Government of Uganda. National Policy on Public Private Partnerships in Health (2012); at p. 7; at <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/national-policy-public-private>; last accessed August 17, 2018

²⁰ Government of Uganda; Constitution of the Republic of Uganda (1995); at <https://ulii.org/ug/legislation/consolidated-act/0>; last accessed August 17, 2018

²¹ Government of Uganda; Second National Health Policy (2010). At <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/second-national-health-policy>; last accessed August 17, 2018

the Uganda Minimum Health Care Package (UMHCP) was estimated at USD 41.2 in 2008/09. The actual level of public funding (excluding off-budget) was estimated at USD 10.4 per capita in 2008/09, which is far below the estimated requirements. The First National Development Plan (NDPI) acknowledged an “inadequate capacity to deliver the Uganda National Minimum Health Care Package.”²² The Second National Development Plan (NDP II) specified that GoU would achieve universal health care utilizing the primary health care approach, which the Health Sector Development Plan defines as inclusive of promotive, preventative, curative, rehabilitative, and palliative care.²³

GoU and the international community have committed themselves to certain development goals. Some of these goals are complementary and share overlapping strategies toward their achievement. Others seem to be mutually contradictory when applied to the health sector. Uganda’s Vision 2040 proposes a vision of “A Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 Years.” It aims to move the country from a low-income country with per capita income of USD 506 in 2010 to a competitive upper middle-income country with per capita income USD 9,500 by 2040.²⁴ The strategy toward achieving this transformation is laid out in considerable detail in the GoU’s National Development Plan’s second iteration for the five year period 2015 – 2020.²⁵ It is worth noting, however, that if and when Uganda achieves its goal of being reclassified from “low income” to “middle income” it will lose its eligibility for certain health related donor funds.²⁶ Therefore, Vision2040 is not compatible with any long-term health care financing plan that relies too heavily on international aid.

22 First National Development Plan, 2010/11 – 2014/2015; at p. 249; at <http://npa.ug/development-plans/national-development-plan-ndp/>; last accessed August 17, 2018

23 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 23; at <http://www.health.go.ug/content/health-sector-development-plan-201516-201920>; last accessed August 17, 2018

24 Government of Uganda (2010), Uganda Vision 2040; at <http://npa.ug/uganda-vision-2040/>; last accessed August 17, 2018

25 Government of Uganda; Second National Development Plan 2015-2020; <http://npa.ug/wp-content/uploads/NDPII-Final.pdf>; last accessed August 17, 2018

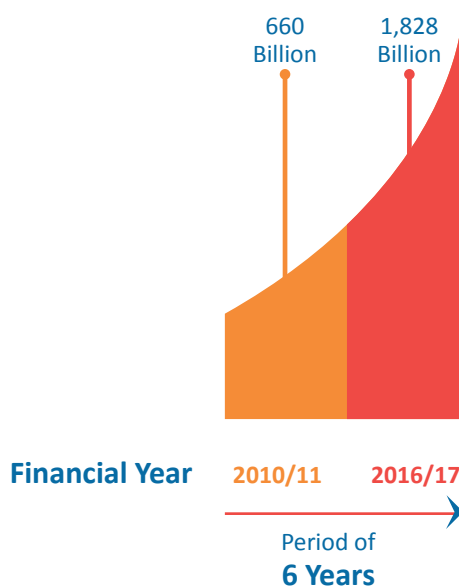
26 Ministry of Health (2016); Health Financing Strategy; at p. 8; at <http://health.go.ug/content/health-financing-strategy>; last accessed August 17, 2018

3.2.1 Limited Government Financing of the Health Sector and Poor Coordination of Aid

At the broadest and most basic level, there is no reconciling current levels of public financing in the health sector with any aspiration for Uganda to achieve a self-sustained health-care system in the near future. Even with its current heavy reliance on donor funds, Government financing falls short of the financing needed to achieve its healthcare goals. There has been a rapid increase in per capita government health expenditure, mainly due to donor funds, from 2010-2016, at USD 53 per capita, but it still falls short of WHO per capita standard of USD 60 to provide essential services in a developing country.²⁷ Moreover, there has been a decline in proportion of government expenditure for health care during that same period, at an average of 8.2% which is below 15% Abuja target for African Union countries, to which the government committed.²⁸ Indeed, with the growth of an overall larger government budget, a lower percentage of public funds have been spent on health-care.

Figure 2: Health Budget Sector Performance

Although Uganda's government budget has been increasing over the years, allocations to the health sector have not matched this increase.²⁹ The health budget increased over 6 years (FY 2010/11-2016/17) from UGX 660 billion (FY 2010/11) to UGX 1,828 billion (2016/17)



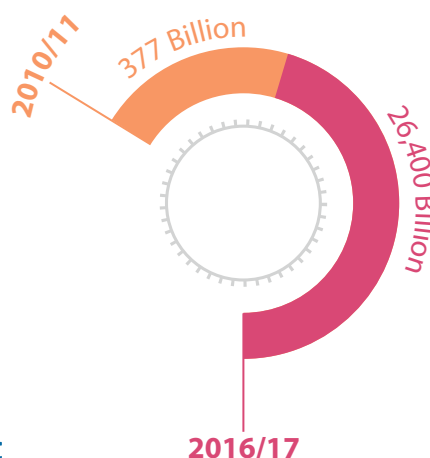
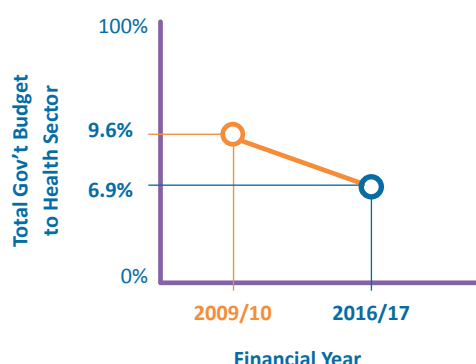
27 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 45; at http://www.health.go.ug/sites/default/files/Health%20Sector%20Development%20Plan%202015-16_2019-20.pdf; last accessed August 17, 2018

28 USAID (2016). Uganda Private Sector Assessment in Health; at p. 24; See also Health Sector Development Plan at p. 45; <https://www-globalfinancingfacility.org/uganda-private-sector-assessment-health-exploring-partnership-opportunities-achieve-universal-health/>; last accessed August 17, 2018

29 Ibid at p. 87

Figure 3: Total Government Budget

while the total government budget increased from UGX 7,377 billion (FY 2010/11) to UGX 26,400 billion in FY 2016/17.³⁰

**Figure 4: Health Sector Development**

The percentage of the total government budget allocated to the health sector reduced from 9.6% in 2009/2010 to 6.9% in 2016/17.³¹

The slight increments in the last few years remain inadequate in light of international targets and benchmarks. The health sector budget as a percentage of the national budget is 8.3% for FY 2017/18, and is projected to rise again in FY 2018/19 to UGX 2,308 billion out of a total budget of UGX 25,093 billion, or 9.2% of the total budget.³² Total Health Expenditure as a percentage of Gross Domestic Product (GDP) has been approximately 1.3%,

30 Ministry of Health (2015). Annual Health Sector Performance Report: FY 2011/2012; at http://health.go.ug/docs/AHSPR_11_12.pdf; last accessed August 17, 2018

31 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 45; at <http://ugandajournalistsresourcecentre.com/uganda-health-sector-development-plan-201516-201920/>; last accessed August 17, 2018; Government of Uganda; Strategy for Improving Health Service Delivery 2016-2021; at p. 2; at <http://health.go.ug/sites/default/files/MoH%20Book-let%20with%20covers-hakuna%20mchezo-2.pdf>; last accessed October 19, 2018

32 Ministry of Finance, Planning and Economic Development; Background to the Budget Fiscal Year 2018/19; at p. 148 and p. 160; at <http://budget.go.ug/budget/sites/default/files/national%20budget%20docs/Background%20To%20The%20Budget%20FY2018.19-compressed.pdf>; last accessed October 19, 2018

against a target of 4%.³³ Contributing to this problem is the fact that on average Uganda collects only about 13.3% of GDP (2014) in taxes.³⁴ The General Government Expenditure on health was USD 9 per capita compared to a GoU target of USD 17 per capita, which itself was well below the WHO Commission of Macro Economics on Health recommendation of USD 34.³⁵ Moreover, inefficiencies have been shown to consume up to 13% of total health expenditure³⁶ As a result, health care in Uganda is either paid for by external donors and the out of pocket expenditures of its citizens – or it is not paid for at all.

3.2.2 Proportion of public versus private financing

Public funds account for a relatively low percentage of total health expenditure in Uganda. From the national health accounts for 2010/11 and 2011/12, public funds accounted for 15.3% of the total health expenditure. Private spending accounted for 38.4%, and international partners, NGOs and donors accounted for 46.3%. In fact, the growth in the health budget has been mainly driven by increased external resources. The share of donor support to the health budget increased from 14% (FY 2010/11) to 42% (FY 2014/15).³⁷ As the World Health Organisation (WHO) points out, this reliance on donor funding “raises concerns about sustainability.”³⁸ Surely, WHO’s concerns are an understated recognition of reality: International aid is not a sustainable long term plan, and may not even be reliable in the short term. Arguably, a national healthcare system can only be considered sustainable if it is internally financed, particularly in Uganda’s case, since it aspires to become a “middle income” country by 2040. When a country becomes “middle income” it also becomes ineligible for certain kinds of aid.

33 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 45; at <http://ugandajournalistsresourcecentre.com/uganda-health-sector-development-plan-201516-201920/>; last accessed August 17, 2018

34 Ministry of Health (2016); Health Financing Strategy; at p. 8; at <http://health.go.ug/content/health-financing-strategy>; last accessed August 17, 2018

35 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 45; at <http://ugandajournalistsresourcecentre.com/uganda-health-sector-development-plan-201516-201920/>; last accessed August 17, 2018

36 Okwero, Peter; Tandon, Ajay; Sparkes, Susan; McLaughlin, Julie; Hoogeveen, Johannes G.. 2010. Fiscal Space for Health in Uganda. World Bank Working Paper; No. 186. Africa Human Development Series. World Bank; at <https://openknowledge.worldbank.org/handle/10986/5949>; last accessed August 17, 2018

37 Ministry of Health (2016); Health Financing Strategy; at p. 7; at <http://health.go.ug/content/health-financing-strategy>; last accessed August 17, 2018

38 WHO Cooperation Strategy, Uganda, 2016-2020 at p. 7; <https://www.afro.who.int/publications/who-uganda-country-cooperation-strategy-2016-2020>; last accessed August 17, 2018

Moreover, out-of-pocket spending has risen to 40% and is far above the recommended maximum of 20% for catastrophic expenditure, meaning that financial risk protection is poor.³⁹ Such high out of pocket expense rates are not consistent with a nationalized universal public healthcare system, and lead to concerns about equity, with poorer Ugandans finding themselves with healthcare expenses well above their means. Such rates guarantee that poor and vulnerable populations within Uganda simply will not have access to healthcare, or at least will be forced to choose between foregoing essential health services or further entrenchment into poverty.

GoU has also committed itself to achieving the UN's sustainable development goals (SDGs) in health. These goals provide target numbers for improvements in health outcomes across the population, focused particularly on child and maternal mortality goals, as well as communicable and non-communicable diseases.⁴⁰ In order to achieve this set of comprehensive humanitarian goals, the international community has encouraged the Sector-Wide Approach (SWAp) to developmental aid projects. Prior to the implementation of the SWAp approach, humanitarian aid was often provided as a scattershot and uncoordinated series of projects. Even when these programs were individually successful, it was recognized that there is inefficiency inherent in having multiple entities provide aid in a manner that is uncoordinated with one another and with larger governmental priorities. Since 2000, Uganda has been applying the SWAp approach to facilitate its health sector coordination and harmonize support for health system strengthening.⁴¹ The SWAp approach is a departure from uncoordinated project-based initiatives in healthcare to strategic development plans by which donor funds and initiatives are centrally coordinated through MoH, in dialogue with various stakeholders.

Although the SWAp approach - which has been endorsed by all the major international donor agencies - directs donors to coordinate aid at the highest levels of national govern-

39 Ministry of Finance, Planning and Economic Development; Background to the Budget Fiscal Year 2018/19; at p. 148 and p. 160; at <http://budget.go.ug/budget/sites/default/files/national%20budget%20docs/Background%20To%20The%20Budget%20FY2018.19-compressed.pdf>; last accessed October 19, 2018; WHO Cooperation Strategy, Uganda 2016-2020 at p.7; <https://www.afro.who.int/publications/who-uganda-country-cooperation-strategy-2016-2020>; last accessed August 17, 2018

40 United Nations Sustainable Development Goals <http://www.undp.org/content/undp/en/home/sustainable-development-goals/goal-3-good-health-and-well-being/targets/> last accessed July 10, 2018

41 WHO Cooperation Strategy, Uganda, 2016-2020; at p. 9; at <https://www.afro.who.int/publications/who-uganda-country-cooperation-strategy-2016-2020>; last accessed August 17, 2018

government, donors have in practice abandoned that strategy in Uganda, where the government is perceived to be fundamentally corrupt. Therefore, donors have turned to private actors and are promoting results-based market solutions such as voucher programs as a means of subsidizing healthcare for Uganda's most vulnerable populations. Similarly, major donors are investigating possible results-based health insurance schemes where the public sector competes with the private sector for subsidized reimbursement of goods and services. Development partner financing is narrow, not well-coordinated and stretching government's capacity.

It is against this backdrop of decreased health financing and the limited coordination of off sector budget support that the increasing proliferation of private actors in health in Uganda must be understood.

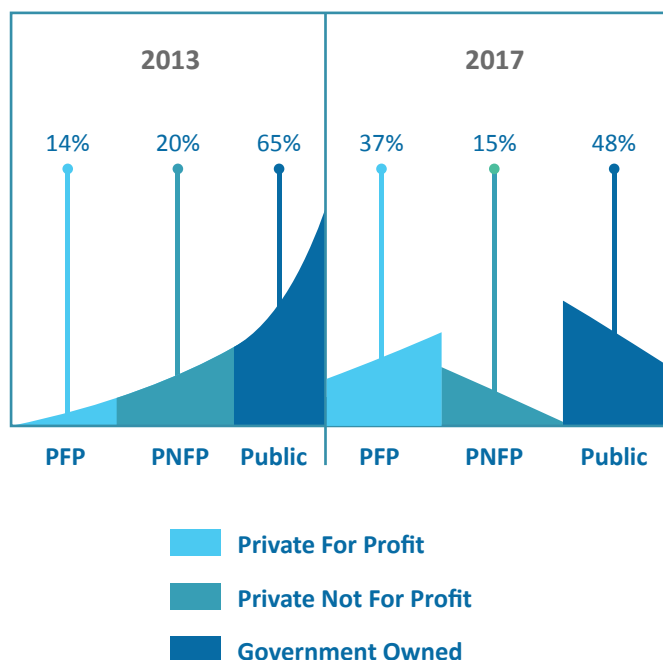
4

**OVERVIEW OF
PRIVATE ACTORS
IN HEALTH IN
UGANDA**

OVERVIEW OF PRIVATE ACTORS IN HEALTH IN UGANDA

4.1 Private Actors in Delivery of Services

Figure 5: Private Actors



The Ugandan health sector is comprised of a mixed private/public service delivery model. In 2013, Uganda had 4,478 health facilities, 65% were public, 20% were PNFP and 14% were Private For Profit (PFP).⁴² In 2017 there was an increase in private facilities, 48% of facilities (3,084) were Government owned, 15% (947) were PNFP and 37% were PFP.⁴³

PFPs are growing in number but nearly all PFP facilities are concentrated in Kampala. PFPs majorly constitute of lower level facilities like clinics or the equivalent of Health Centre IIs.⁴⁴ The PNFP facilities are largely found in the rural areas (86%).⁴⁵ 40% of all hospitals and 20% of all lower-level health centers are PNFPs. The PNFP sub-sector currently employs approximately 34% of the facility-based health workers in the country. The human resource inputs

42 Government of Uganda, 2015; National Medicines Policy; at p. 5; at <http://health.go.ug/download/file/fid/589>; last accessed October 19, 2018; Ministry of Health, Health Facility Inventory, 2013; at <http://library.health.go.ug/publications/health-infrastructure-physical-infrastructure/health-facility-inventory>; last accessed August 17, 2018

43 Ministry of Health, National Health Facility Master List 2017: A complete list of all Health Facilities in Uganda at page v.

44 Ministry of Health, National Health Facility Master List 2017: A complete list of all Health Facilities in Uganda at page v, <http://library.health.go.ug/download/file/fid/467> (last accessed 20 March 2019).

45 National Policy on Public Private Partnerships in Health (2012); at p. 34; Government of Uganda; National Policy on Public Private Partnerships in Health(2012); at p.9; <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/national-policy-public-private>; last accessed August 17, 2018

of the non-facility based PNFP subsector include capacity building, in service training, community empowerment and community-based service delivery. However, to date these inputs have not been well quantified.⁴⁶

Table 1: Summary of Health Facilities by Level of Ownership

Facility Level	Ownership			Grand Total
	Govt	PFP	PNFP	
Blood Collection & Distribution Point	6	-	-	6
Clinic	-	245	15	260
General Hospital	51	36	66	153
Health Centre II	1,834	1,854	520	4,208
Health Centre III	992	219	299	1,510
Health Centre IV	175	19	21	215
National Blood Bank	1	-	-	1
National Referral Hospital	2	-	-	2
Regional Blood Bank	7	-	-	7
Regional Referral Hospital	16	-	-	16
Special Clinic	-	-	26	26
Grand Total	3,084	2,373	947	6,404

Source: Ministry of Health, National Health Facility Master List 2017.

⁴⁶ Health Sector Development Plan, 2015/16 - 2019/20; at p. 35; at <http://ugandajournalistsresourcecentre.com/uganda-health-sector-development-plan-201516-201920/>; last accessed August 17, 2018. Also see Uganda Health Sector Strategic Plan III 2010 - 2014/15; at pp. 5-10 for more detailed statistics.

Table 2: Breakdown of Health Facilities by Level of Ownership

	Govt	PFP	PNFP	GRAND TOTAL
CENTRAL REGION	667	2129	337	3133
Central 1	340	590	163	1093
Central 2	301	168	113	582
Kampala	26	1371	61	1458
EASTERN REGION	838	243	253	1334
East Central	337	91	127	555
Mid Eastern	351	107	77	535
North Eastern	150	45	49	224
NORTHERN REGION	733	176	152	1061
Kampala	120	2	22	144
Mid Northern	366	119	82	567
West Nile	247	55	48	350
WESTERN REGION	896	247	267	1410
Mid Western	347	124	88	559
South Western	549	123	179	851
GRAND TOTAL	3134	2795	1009	6937

Source: Ministry of Health, Ministerial Statement on the State of Health Service Delivery in Uganda, 12th March 2019

Table3: Summary of Health Facilities by Regions. Levels and Ownership

REGION	OWNERSHIP	Blood Collection & Distribution Point	Clinic	General Hospital	Health Centre II	Health Centre III	Health Centre IV	National Blood Bank	National Referral Hospital	Regional Blood Bank	Regional Referral Hospital	Spedal Clinic	GRAND TOTAL
Central Region 2,914	Govt	-	-	14	398	211	40	1	2	1	5	-	672
	PFP	-	58	20	1,663	170	16	-	-	-	-	-	1,927
	PNFP	-	5	22	168	103	8	-	-	-	-	9	315
Eastern Region 1,196	Govt	2	-	14	444	288	45	-	-	1	3	-	797
	PFP	-	82	8	55	18	1	-	-	-	-	-	164
	PNFP	-	5	15	145	60	3	-	-	-	-	7	235
Northern Region 927	Govt	1	-	12	436	234	31	-	-	3	4	-	721
	PFP	-	30	4	32	4	-	-	-	-	-	-	70
	PNFP	-	4	12	61	53	2	-	-	-	-	4	136
Western Region 1,367	Govt	3	-	11	556	259	59	-	-	2	4	-	894
	PFP	-	75	4	104	27	2	-	-	-	-	-	212
	PNFP	-	1	17	146	83	8	-	-	-	-	6	261

Source: Master Facility Inventory List 2017

Despite the high prevalence of PNFPs and to a lesser extent PFPs in Uganda, this was not the direct result of a coordinated developmental strategy. Rather, it is the ad hoc cooperation of private and public actors attempting to fill in service and funding gaps as they present themselves. Public health providers are not entirely funded by public sources and often receive a mix of public and private funding. For instance, public facilities source from private sources for actual medications and equipment.⁴⁷ At the same time private providers, which are funded mainly by private sources, in some cases receive and utilize public funds.⁴⁸ The PNFP entities represent a mixture of religious and secular entities, however, most facility based PNFPs are religious, at approximately 75%.⁴⁹ PNFPs dominate HIV/AIDS related expenditures, with 70% of HIV/AIDS health service coming from PNFPs. Approximately 20% of HIV/AIDS related expenditures are paid out of pocket and approximately >10% are from public expenditures.⁵⁰ The majority of the PNFP hospitals already cater to nearly all components of UNMHCP. The lower level units ensure a significant number of components of the UNMHCP to variable degrees. The non-facility based PNFP programs contribute to virtually all components of the UNMHCP through a variety of initiatives and projects.⁵¹

4.2 Private actors in human resources

The public sector employs 52% of the 81,982 registered health workers. 12% are in the PNFP sector and 36% are in private practice, are unemployed or have emigrated. The proportion of the approved posts filled by health workers in public facilities is 70%.⁵² Both PFP and PNFP medical training schools complement government medical colleges and teaching hospitals to meet training and human resourcing needs.⁵³ PNFP and PFPs increasingly play an important role in training of the health care workforce. Both PNFP and PFPs together own 72% of all 143 health-training institutions (HTIs) in the country, with PFPs

47 Government of Uganda; National Policy on Public Private Partnerships in Health (2012); at p. 9; <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/national-policy-public-private>; last accessed August 17, 2018

48 Government of Uganda; National Policy on Public Private Partnerships in Health (2012); at p. 9; <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/national-policy-public-private>; last accessed August 17, 2018

49 National Policy on Public Private Partnerships in Health (2012); at p. 31; ; <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/national-policy-public-private>; last accessed August 17, 2018

50 USAID (2016). Uganda Private Sector Assessment in Health; at p. 26; <https://www.globalfinancingfacility.org/uganda-private-sector-assessment-health-exploring-partnership-opportunities-achieve-universal-health>; last accessed August 17, 2018

51 National Policy on Public Private Partnerships in Health (2012); at p. 34

52 WHO Cooperation Strategy, Uganda, 2016-2020 at p. 8

53 USAID (2016). Uganda Private Sector Assessment in Health; at p. 21

owning 48% and PNFPs owning 24%.⁵⁴ The public sector owns only 28%. Of the 48 health training schools in the country, 20 are operated by facility-based PNFP organizations.⁵⁵ The numbers of trained medical workers operating in PNFPs is improving but not nearly sufficient. Attrition to private practice and public sector is a concern.⁵⁶ All public Health Training Institutions are licensed and registered but a significant number (52.4%) of PNFPs and PFPs are licensed but not registered. As a result, many of the students who graduate cannot be registered to work in Uganda.⁵⁷

4.3 Private sectors in human resources

There are over one thousand laboratories in Uganda. At the Health Center IV level, MoH owns and operates the majority (68%) of hospital laboratories. PNFPs are the second largest owners of laboratories in hospitals and HC IVs, operating 22% of them.⁵⁸ The PFP sub-sector represents 10% of lab ownership. However, at lower levels, and strictly in urban centers, the PFP sector has a more significant presence. PNFP and PFP laboratory networks fill the need for diagnostic equipment that is lacking in public health facilities.

4.4 Private actors in pharmacy (or EMHS)

Private actors have a large role in pharmaceutical services from supply chain, local production, distribution and retail. The private sector comprises the largest number of manufacturers, importers, and drugstores. There are an approximately equal number of retail pharmacies in the public sector; however, public pharmacies are plagued by frequent stock-outs.⁵⁹ Moreover, public facilities source from private sources for actual medications and equipment. Both PFPs and PNFPs help to alleviate gaps in supply chains that lead to chronic stock-outs of medicines and supplies. More than half of Ugandan's out of pocket health expenses are on drugs, which reflects public facility stock-outs.⁶⁰ In FY 2013/2014, almost half (49.5%) of public health units had monthly stock-outs of indicator medicines,

⁵⁴ USAID (2016). Uganda Private Sector Assessment in Health; at pp. 21-22

⁵⁵ Government of Uganda; National Policy on Public Private Partnerships in Health (2012); at p. 34

⁵⁶ Ibid; at p. 36

⁵⁷ USAID (2016). Uganda Private Sector Assessment in Health; at p. 30

⁵⁸ USAID (2016). Uganda Private Sector Assessment in Health; at p. 26

⁵⁹ Ibid; at p. 28

⁶⁰ USAID (2016). Uganda Private Sector Assessment in Health; at p. 24

meaning patients had to look elsewhere for them.⁶¹ There are undoubtedly inefficiencies in the public EMHS system, but it is also fundamentally underfunded. The per capita government expenditure on EMHS in the FY 2013/14 was about USD 2.4, which is drastically below the estimated requirement in the Health Sector Strategic and Investment Plan goal of USD 12.⁶² Moreover, there is over dependence on donor financing for procurement of EMHS and associated activities, inadequate skilled and professional pharmaceutical human resources in the health sector, mismatch of resource allocation among public health sector facilities and inadequate funding to the National Drug Authority to carry out its regulatory function.⁶³ Private for profit practitioners are also a frequent source for family planning services, presumably because they are frequently not offered by religious based PNFPs. 3/4 private practitioners in Uganda offer family planning services.⁶⁴

4.5 Private actors in human resources

Discussions of private actors in Uganda's health care sector generally differentiate an additional category, referred to as Traditional and Complementary Medicine Practitioners (TCMPs). This group includes private actors unaffiliated with larger networks who use indigenous herbal remedies and practices such as bone setting. TCMP is used by 60% of Ugandans and is the only available option for many.⁶⁵ The estimated ratio of traditional medicine practitioners to population in Uganda is between 1:200 and 1:400 compared with a doctor to population ratio of 1:18,000.⁶⁶ There are many "quacks" that provide low cost care and that also crowd out the market.⁶⁷

In addition to direct healthcare service delivery, there are a variety of private actors present across Uganda's health system. Private philanthropy, NGO networks, health professional associations and umbrella organizations are active stakeholders for policy and planning issues. Academic institutions, Think Tanks and Market Research Organizations contribute to

61 Government of Uganda; National Pharmaceutical Sector Strategic Plan 2015/16-2019/20; at <http://health.go.ug/content/national-pharmaceutical-sector-strategic-plan-iii-2015-%E2%80%93-2020>; last accessed August 17, 2018

62 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 15

63 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 40

64 Government of Uganda; National Policy on Public Private Partnerships in Health (2012); at p. 5

65 Ibid; at p. 53

66 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 35

67 USAID (2016). Uganda Private Sector Assessment in Health; at p. 26

public knowledge in the health arena. Although their role is currently small, private health insurance, community-based financing and microfinance institutions help to finance healthcare.⁶⁸

⁶⁸ USAID (2016). Uganda Private Sector Assessment in Health; at p. 21



5

PUBLIC PRIVATE PARTNERSHIPS (PPPs)

PUBLIC PRIVATE PARTNERSHIP (PPPs)

The World Bank has defined a PPP as “any contractual arrangement between a public entity or authority and a private entity for providing a public asset or service, in which the private party bears significant risk and management responsibility.”⁶⁹ On the global level, PPPs have gained popularity as performance based contracts between governments and private actors. The main benefit to the government is the shifting of risk and initial cost outlays onto the private entity. In developing countries, PPPs are often development related contracts with foreign entities from developed countries that provide the human and technological resources that an undeveloped country might be lacking, to produce a developmental objective, such as improved roads or the harnessing of hydroelectric power. The foreign entities’ interests are often a combination of access to resources, markets, and diplomatic leverage.

PPPs are now used in more than 134 countries. The World Bank has supported countries to create an enabling environment for PPPs.⁷⁰ PPPs generally are not designed to function in the healthcare space. The prototypical PPP is an infrastructure project, where the government provides the concessionaire access to a valuable resource and/or a profitable market in exchange for their ability to provide an essential utility. Hydroelectricity is a typical example. International organizations such as the World Bank, which promote PPPs, tend to have very little information on PPPs in the health sector, and even less information related to PPP’s potential in providing access to health for vulnerable and geographically isolated populations. The World Bank PPP Legal Resource Center website plainly states that its focus has been on PPP in the infrastructure sector.⁷¹ The World Bank PPP Knowledge Lab website’s section on health PPPs only cites research into traditional PPP arrangements in the health care sector, such as the construction of hospitals, for OECD and middle income countries.⁷²

69 International Bank for Reconstruction and Development/The World Bank (2018), *Procuring Infrastructure:Public Private Partnerships Report 2018: Assessing Government’s Capability to Prepare, Procure and Manage PPPs*, https://library.pppknowledge.org/documents/5453?ref_site=kl (last accessed 10 March 2019).

70 Independent Evaluation Group World Bank Group, *World Bank Group To Support Public Private Partnerships: Lessons from Experience in Client Countries, FY 02-1202-12*, https://www.francophonie.org/IMG/pdf/wb_ppp_eval_updated_ieg.pdf (last accessed 10 March 2019) at p.5

71 Worldbank website; <https://ppp.worldbank.org/public-private-partnership/ppp-health> last accessed July 26, 2018

72 Montagu, Dominic & Harding, April. (2012). *A zebra or a painted horse? Are hospital PPPs infrastructure partnerships with stripes or a separate species?*. *World hospitals and health services : the official journal of the International Hospital Federation*. 48. 15-9. http://www.researchgate.net/publication/230721097_A_zebra_or_a_painted_horse_Are_hospital_PPPs_infrastructure_partnerships_with_stripes_or_a_separate_species; last accessed August 15, 2018

⁷³Even the International Finance Corporation of the World Bank Group, which is responsible for one of the few and heavily criticized examples of this type of arrangement in sub-Saharan Africa—in the small country of Lesotho—, does not provide a full-throated endorsement of this type of PPPH arrangement. On its website, it states of PPPHs, “Governments need to carefully weigh their options for meeting these [health care] challenges head on. Well-structured PPPs are one tool available to help deliver new health infrastructure and improve access to higher quality healthcare services.”⁷⁴ Moreover, although this model might arguably be successful in population dense urban environments with a concentration of wealthier citizens, there is no credible rationale for PPPH as a means to provide health-care to poor and geographically isolated populations in a developing country. Still, the World Bank has shown sporadic support for the potential of PPPH in developing nations and in African contexts. For instance, for an African Health Forum in 2013, the World Bank produced a four-page issue brief discussing mostly successful cases of healthcare development projects between governments and private actors. Several of these examples are of smaller-scale projects, but two involve instances of hospital construction arrangements, one of which was with a PFP. The issue brief also discusses the Lesotho project in a positive light, stating that it resulted in a 50% decrease in neonatal mortality.⁷⁵ The World Bank offers one functioning example in a developing country, India, where PPPH is currently being utilized. In this example, health facilities were developed and improved by the private actor, who also contracted to provide services. The World Bank describes the approach as a private hospital built on public land with a requirement to make a certain number of beds/treatments available to publicly funded patients, while the rest of the facilities can be used for private patients. In some cases the private actor paid the government a fee for the right to operate the concession, in others it required a subsidy. Typically the bids are evaluated based on the lowest cost to government.⁷⁶ Again, this example is less applicable to the Ugandan context. It may be a means of providing increased healthcare access to poor communities that live near urban centers like Kampala, where a quality private hospital can be profitable. However, such a model is not applicable to providing healthcare to geographically diverse rural communities.

⁷³ World Bank Group. PPP Knowledge Lab Website. https://pppknowledgelab.org/sectors/health?ref_site=kl; last accessed August 15, 2018

⁷⁴ IFC website: https://www.ifc.org/wps/wcm/connect/Industry_EXT_Content/IFC_External_Corporate_Site/PPP/Priorities/Health/; last accessed November 13, 2018

⁷⁵ World Bank (2013). Africa Health Forum: Finance and Capacity for Results; At <http://siteresources.worldbank.org/INTAFRICA/Resources/AHF-public-private-partnerships-for-health-ppps-are-here-and-growing.pdf>; last accessed August 21, 2018

⁷⁶ World Bank website. See <https://ppp.worldbank.org/public-private-partnership/ppp-health> last accessed July 26, 2018

Other PPPHs such as the Managed Equipment Services project in Kenya has generally been regarded as a successful implementation of PPPH, where a public-private partnership allowed the government to defer the upfront capital cost of radiological services.⁷⁷ However, some have argued that the program did not serve to reduce costs to the government in the long run.⁷⁸ Similarly a PPP between Makueni County, Phillips and Amref Health Africa entitled “Partnership for Primary Care (P4PC) that seeks to improve quality of facilities including improvement of building quality and lay out, laboratory equipment and seeks to increase demand side by training community health unit that encourage people to register for the National Health Insurance Fund is being tested in three facilities in Makueni county, Kenya.⁷⁹ It uses blended funding: grant funding and commercial funding through the Dutch based FMO Entrepreneurial Development Bank. The County government provides human resources, facilities, consumables, a private consortium constituting of Phillips, Amref Health Africa provides medical equipment, solar, human resource training.⁸⁰ It is still a pilot but questions have been raised about whether it substantially improves health outcomes or whether it will serve as a spring board for a company like Phillips to maximize its profit since once it is rolled out nationally, Phillips will be supplying the equipment in all health facilities where it is implemented.⁸¹ Other examples, such as the PPPH negotiated between Netcare and the small country of Lesotho, suggest that PPPH arrangements have a tendency to improve healthcare in urban centers at the expense of public healthcare services in rural areas.⁸² Specifically, Lesotho spent a large proportion of its healthcare funds in the construction and operation of this hospital near its urban center. Unfortunately, the most vulnerable members of the population were not able to access these services, largely due to geographical constraints. Moreover, the funds dedicated to the construction of the hospital left considerably fewer public health resources available for the country’s rural populations. Other examples of PPPH listed on the World Bank Group website include hospitals that were built in major metropolitan areas, as well as PPPH arrangements to

77 World Bank website. See <http://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>; last accessed July 24, 2018

78 See <https://www.nation.co.ke/oped/opinion/Dark-side-of-public-private-partnerships-IN-HEALTHCARE/440808-4491334-6pq9jm/index.html>; last accessed July 24, 2018.

79 Partnership for Primary Care: A Sustainable Model to Revolutionise Primary Care

80 Interview with County Government Official, March 6, 2019.

81 Interview with County Government official, March 6, 2019.

82 See [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)00959-9/fulltext?code=lancet-site](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00959-9/fulltext?code=lancet-site); last accessed July 24, 2018.

supply high tech medical equipment to urban hospitals.⁸³

However, most PPPHs in developing countries generally focus on a looser definition of PPPs, which includes dialogue and cooperative agreements between the public and private sectors, including PNFPs, rather than more ambitious projects aimed at applying the profit motive to the public procurement of healthcare. In fact, the term PPP has been so expansively appropriated in the healthcare space that it is commonly used to refer to initiatives that bear almost no semblance to the PPPs that GoU is pursuing so aggressively in the infrastructure sector. **Therefore, the reader is advised to think of PPPH as a broad and generic term that can refer to a myriad of arrangements, rather than any one particular strategy of achieving healthcare goals.**

5.1 Definition of Public Private Partnerships in Health (PPPHs)

Although there is no single definition in health, public private partnerships in health (PPPH) describe a number of possible relationships between the public and private actors for integrated policy dialogue, planning, provision and monitoring of services widely defined as not only clinical services but also other activities performed in the health sector (e.g. production of human resources in health, supply chain of health goods and medicines). Essential components are some degree of private participation as well as transfer of risk to the private sector in the delivery of traditionally public domain services.⁸⁴ This definition of PPPHs is notably broader than typical definitions of PPPs, which emphasize that PPPs involve an arrangement whereby a private actor assumes control of a government asset in exchange for taking on a significant financial risk, in the hopes of some kind of return on its investment. Therefore, even using USAID's broader definition of PPPHs, the assumption of private sector risk is what differentiates a PPPH as a category separate from public private mix in health care in general. Importantly, by that definition, the typical MOU approach, whereby the government and the PNFP provide a predetermined budgetary input for the PNFP to provide medical services, is not a prototypical PPPH because the PNFP does not take on the same degree of pecuniary risk should they encounter a budgetary shortfall. Therefore, PPPH is a term that can describe a large variety of public/private relationships in health, and it is not useful to evaluate PPPHs as if they represented a single specific

⁸³ World Bank Group website; at <http://www.worldbank.org/en/topic/publicprivatepartnerships/brief/ppp-briefs#health>; last accessed October 29, 2018

⁸⁴ USAID (2016). Uganda Private Sector Assessment in Health; at p. 14

approach toward health policy. For the purposes of this research, we define PPPHs as any kind of arrangement to provide goods and/or services related to the provision of health-care, between a state and one or more actors not affiliated with that state.

5.2 PPPHs in Uganda

5.2.1 Definition of Public Private Partnerships (PPPs)

Uganda's Public Private Partnership Act of 2015 defines a PPP as a commercial transaction between a governmental contracting authority and a private party where the private party acquires the use of property, equipment or other resource of the contracting authority; assumes substantial financial, technical, and operational risks in connection with the performance or function or use of property; or receives a benefit for performing the function through payment by the contracting authority or charges fees collected by the private party from the users of the infrastructure or service, or both.⁸⁵ As this language would suggest, the prototypical PPP arrangement is a large-scale infrastructure investment. The World Bank's PPP Knowledge Lab website for Uganda, for example, lists the ten most recent active PPP projects in Uganda. All ten are in the electricity generation sector.⁸⁶ The website also lists one railway project and one Information and Communications Technology project. There is no mention of PPPs in health.

5.2.2 Rationales for various types of PPPH in Uganda

Under this broadened conceptualization of PPPH, its proponents have offered numerous rationales for its application to the Ugandan context. USAID's Private Sector in Health working group determined that effective mobilization of the private health sector to improve health outcomes and to compliment the MoH's efforts towards Universal Health Care required a policy and operating environment that enabled public-private dialogue, public-private interaction and public-private partnership.⁸⁷ It does not advocate as forcefully for the creation of specific types of PPPHs. Some of the rationale put forward by policy documents and interviewees include:

⁸⁵ Government of Uganda; Public Private Partnership Act (2015) at section 2.1.c; <https://ppp.worldbank.org/public-private-partnership/library/public-private-partnership-act-uganda>; last accessed August 17, 2018

⁸⁶ World Bank; PPP Knowledge Lab website; at <https://pppknowledgelab.org/countries/uganda>; last accessed August 18, 2018

⁸⁷ USAID (2016). Uganda Private Sector Assessment in Health; at p. 22

5.2.3.1 Increase access to healthcare through harnessing private sector efficiency, work ethic

The National Policy on Public Private Partnerships in Health (PPPPH) emphasizes the “capacity building” potential of the private sector, and argues that engaging the private sector would increase access, efficiency, quality, and sustainability. However, it only offers a high level overview of how PPPHs might help to achieve these goals in theory.

The Health Sector Development Plan also states that MoH will increase access to health services “by exploiting private sector geographical reach, efficiency, work ethic, financial mobilization expertise, personnel and physical facilities.”⁸⁸

The Implementation Guidelines of the National PPPH Policy also emphasize that “joint planning and management” between private and public sub-sectors will “increase equitable access to health care by optimizing the use of available resources consistently with the principle of complementarity.”⁸⁹ This joint planning will “promote harmony in programming, implementation, reporting, decisions, procedures, standards and efficiency in the use of available resources.”⁹⁰

5.2.3.2 Private sector will offer more flexible funding and bear the risk

The Health Financing Strategy policy argues that the current input-based Memorandum of Understanding (MOU) system, where funds are provided for particular purposes irrespective of services rendered, is not sufficiently flexible, and therefore might need to be replaced by output-based PPPH arrangements. The Health Financing Strategy explains that in the public sector, purchasing of health services relies mainly on the traditional input-based approach, where the government purchases health services from PNFP health facilities through provision of grants for specified services based on an agreed MOU. This system is problematic because there is need for greater flexibility in the allocation of the funds as needs arise.⁹¹ The input-based approaches used currently have a built-in inflexibility

88 Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20; at p. 44; at <http://www.health.go.ug/content/health-sector-development-plan-201516-201920>; last accessed August 17, 2018

89 Government of Uganda, National Policy on Public Private Partnerships in Health, 2012; Implementation Guidelines; undated; physical copy provided to ISER by Ministry of Health official upon request at p. 7

90 Government of Uganda; National Policy on Public Private Partnerships in Health, Implementation Guidelines; undated; physical copy provided to ISER by Ministry of Health official upon request at p. 7

91 Ministry of Health (2016); Health Financing Strategy; at p. 8; <http://health.go.ug/content/health-financing-strategy>; last accessed August 17, 2018

bility that does not allow funding to be reallocated as needs arise. On the other hand, output-based arrangements focus on reimbursement for services rendered, such as in fee for service, results-based financing, or voucher schemes.

In addition to providing more flexible funding modalities, proponents of PPPHs have argued the private sector bears the risk or at least there is risk sharing with the government.⁹²

5.2.3.3 Better Price and Quality Regulation

Similarly, the Health Financing Strategy suggests that PPPH might allow for better price and quality regulation than an unregulated private sector. In the private sector, payment of services by households is mainly on a fee-for-service basis. A fee-for-service payment mechanism might lead to cost escalation, and increased out of pocket payments, especially considering that PNFPs and PFPs are left to individually determine the service fee rates. Uganda has not developed institutional capacity for purchasing and regulation of pricing of services in the private sector. Relatedly, the quality of health care services purchased from the private sector providers remains unmeasured and not documented.⁹³ Proponents of PPPH believe that a PPPH structure for partnering with the private sector will help to achieve a more functional results-based financing model.

5.2.3.4 PPPHs will result in self-regulation, which will result in Better quality

The Implementation Guidelines for the National Policy on Public Private Partnerships provide the rationale that the “existence of structures of coordination within the PNFP provides a system of accreditation that may enhance the regulatory capacity of Government and promote quality of services in the sub-sector.”⁹⁴ Thus, one of the rationales for PPPHs is that the private sector self-regulatory structures might improve upon the regulatory structures of the public system.

92 Interview with Ministry of Health Official, 1 May 2018.

93 Ministry of Health (2016); Health Financing Strategy; at p. 21; <http://health.go.ug/content/health-financing-strategy>; last accessed August 17, 2018

94 Government of Uganda; National Policy on Public Private Partnerships in Health, Implementation Guidelines; undated; physical copy provided to ISER by Ministry of Health official upon request, at p. 6

5.2.3.5 PPPHs will increase Equity and result into better health outcomes

An important rationale for PPPHs, at least with PNFPs in the form of financial subsidy, is that such arrangements will improve equitable access to healthcare by leading to a reduction or even abolition of user fees for PNFP health facilities. As to the subsidies that GoU provides to the PNFPs, generally in the form of Primary Health Care (PHC) grants, it provides the following rationale:⁹⁵

Government subsidies to the sub sector are meant to minimize economical barriers to users, increasing access to basic services for the poor. They shall be distributed on the basis of agreed outputs, which will be in accordance with the priority of HSSIP. This means that government subsidies will be used to adopt any measure, which can facilitate access to health care. It may result in an increase in number and range of health services provided by PNFP, as well as in the reduction or abolition of user fee for specific priority services.

The PNFP implementation guidelines section states that partnership with PNFPs will improve “equity, access, efficiency, quality and sustainability of health services” in part by allowing them to retain their “administrative autonomy.” The guidelines further state that PPPH can be used to help the public and private sector to “achieve wider coverage of the population, in preference to setting up competing service points.” Thus, the policy appears to imply that physical access to at least one public or private facility is sufficient in guarantying actual access to health. It thus states that under the policy, new construction, reconstruction, and upgrades to existing facilities will be oriented towards increasing coverage in underserved areas.⁹⁶

5.2.3.6 PPPHs will result in increased coordination and harmonization with the private sector

Formally pairing up with the private sector in the form of PPPH has been posited as a way to ensure greater coordination and harmonization, resulting in efficient resource allocation. The PNFP Implementation guidelines apply the same logic of complementarity to financial resource allocation, stating, “To ensure resource allocation with efficiency and equity, sharing of financial information is important.”⁹⁷ They refer to the SWAp budgetary process, stating that the PNFPs will “disclose resources available” and will “develop and agree on an allocation formula between and within the PNFP sub-sector.”

⁹⁵ Ibid at p. 12

⁹⁶ Ibid pp. 28-30

⁹⁷ Ibid at p. 11

The guidelines also propose that PPPHs with PNFPs will aid in the harmonization of staffing norms, salary structures, and terms of employment, so that there is less discrepancy between PNFPs and public facilities. They believe this will lead to improved staffing levels, job securities, and lower employment turnover, which will improve quality of service delivery. Similarly, the policy notes that PNFPs run more than 70% of Uganda's Health Training Institutions. Therefore, it is beneficial and appropriate for the PPPHs to have increased participation in policy fora for training health personnel.⁹⁸

5.2.3.7 Utilizing PPHs will enhance community participation and oversight

The PNFP implementation guidelines assert that PPPHs will lead to community empowerment by developing and strengthening participatory methods and community structures. The document rationalizes that Village Health Teams will work with Health Unit Management Committees (HUMC) as chosen by the District Health Management Team. The committee chair "should be a respected and resident member of the community, and the HUMC should meet at least quarterly. The guidelines state they will utilize participatory methods such as Participatory Rural Appraisal, Focus Group Discussions, and a Community Based Management Information System. The policy also states that non-facility based PNFPs will make excellent partners in mobilizing community participation, and will help to sensitize people in the community on their rights, their roles, and responsibilities.⁹⁹

⁹⁸ Ibid at pp. 17-19

⁹⁹ Ibid pp. 24-26



6

LEGAL AND POLICY FRAMEWORK

LEGAL AND POLICY FRAMEWORK

In the wake of global calls to enhance efforts in the realization of the right to health, partnerships with private actors in the execution of this duty have been gaining ground;¹⁰⁰ not only in as far as financing of the health sector is concerned, but also, and most importantly, in the move to realize the broader object of Universal Health Coverage and the Sustainable Development Goals. It is upon this growing need that Public Private Partnerships in health are gaining more visibility.

This chapter sets out the legal framework governing the right to health and Public Private Partnerships in Health in Uganda. It is against this framework that PPPHs are assessed.

6.1 International Legal Framework: The Right to Health and Private Actors

Traditionally, Governments have been identified as the primary duty bearers of the provision of healthcare in their respective countries. The state duty to regulate private actors, particularly when they provide essential services, is well established in international law.¹⁰¹ The International Covenant on Economic, Social and Cultural Rights (ICESCR), in Article 12 provides for the right to health; recognizing the right of everyone to the enjoyment of the highest attainable standard of physical and mental health¹⁰² and also enjoins States parties to create conditions which would assure to all medical service and medical attention.¹⁰³ To flesh out the obligations that flow from Article 12, the Committee on Economic, Social and Cultural Rights (CESCR), through a series of General Comments, has offered guidance on the extent of these obligations. Under General Comment No. 14,¹⁰⁴ the CESCR lays out three

100 For example, *The Common African Position of the African Union on the post 2015 Development Agenda*, striving for the realisation of universal and equitable access to quality healthcare (para 42), calls for the promotion of public private partnerships in the implementation of such goals (para 77);

101 e.g. CESCR, General Comment 14 (n 26), para 51; CESCR, General Comment 24 (n 44), para 16; CRC, General Comment 15 (n 143), para 80; CEDAW, *da Silva Pimentel (on behalf of da Silva Pimentel Teixeira) v Brazil (Merits)*, Communication No 17/2008, CEDAW/C/49/D/17/2008, 25 July 2011 para 7.5; Inter-American Court of Human Rights, *Case of Ximenes Lopez v Brazil (Merits, Reparations and Costs)*, Series C No 149, 4 July 2006 para 141; European Court of Human Rights, *Mehmet Şentürk and Bekir Şentürk v Turkey*, Application No. 13423/09, 9 April 2013 para 81, Special Rapporteur on the right to health, A/HRC/7/11/Add.4, 29 February 2008, Note on mission to India, para 21

102 Article 12(1)

103 Article 12(2)(d)

104 CESCR, General Comment No. 14, para 33

types of obligations that States Parties have concerning the right to health: the obligations to *respect*, *protect* and *fulfil*. The obligation to protect,¹⁰⁵ which is of most relevance to the foregoing discussion, requires States to take measures that prevent third parties from interfering with Article 12 guarantees. This includes the duty of States to adopt legislation or to take other measures ensuring equal access to healthcare and health related services provided by third parties, ensuring that privatization of the health sector does not constitute a threat to the *availability, accessibility, acceptability* and *quality (AAAQ framework)* of health facilities, goods and services, controlling the marketing of medical equipment and medicines by third parties and to ensuring that medical practitioners meet appropriate standards of education, skill and ethical codes of conduct.

The obligation to protect emphasizes the imperative of government taking measures to regulate private actors¹⁰⁶ in order to observe the AAAQ framework¹⁰⁷; the components of which are as discussed below.

- i) *Availability*: This supposes that health care facilities, goods and services as well as programmes, have to be available in sufficient quantity within the State.
- ii) *Accessibility*: Health facilities, goods and services have to be accessible to everyone without discrimination within the jurisdiction of the State party. Noteworthy is that accessibility has four overlapping dimensions, i.e;
 - *Non discrimination*. Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
 - *Physical accessibility*. Health facilities, goods and services have to be within safe physical reach for all sections of the population especially the vulnerable or marginalised groups. Accessibility further includes adequate access to buildings for persons with disabilities.
 - *Economic accessibility (affordability)*. Health facilities, goods and services

¹⁰⁵ Ibid, Para 35

¹⁰⁶ The state duty to regulate private actors, particularly when they provide essential services, is well established in international law. E.g. CESCR, General Comment 14, para 51; Also, Accountability is a fundamental part of the human rights obligations. Private actor involvement can represent a potential risk if States do not take into consideration their human rights obligations, properly regulate the private actors in the health system, and ensure robust systems of accountability, Audrey Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (Cambridge University Press 2016) 131

¹⁰⁷ CESCR, General Comment No. 14, para 12

related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

- *Information accessibility.* Accessibility includes the right to seek, receive and impart information and ideas concerning health issues.

iii) *Acceptability:* all health facilities, goods and services must be respectful of medical ethics and culturally appropriate. i.e respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

iv) *Quality:* health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

The Committee on Economic, Social and Cultural Rights in General Comment No. 24¹⁰⁸, also further spells out the obligations that are imposed upon States as they engage private actors in the provision of services that have a bearing on social, economic and cultural rights of the people. These obligations include the obligation to *respect*¹⁰⁹, *protect*¹¹⁰ and *fulfil*¹¹¹ as earlier envisaged in General Comment No.14. The Committee underscored that the obligation to *respect* is violated when States Parties prioritize the interests of business entities over Covenant rights without adequate justification, or when they pursue policies that negatively affect such rights.

The obligation to *protect* extensively explores the responsibilities levied against the State to

108 CESCR, General Comment No. 24 on State Obligations under the International Covenant on Economic, Social and Cultural Rights in the context of Business activities. See also, See also UN Committee on the Rights of the Child (CRC), General Comment No. 15(2013) on the right of the child to the enjoyment of the highest attainable standard of health (art 24), para 80 which states that 'All business enterprises have an obligation of due diligence with respect to human rights, which include all rights enshrined under the Convention. States should require businesses to undertake children's rights due diligence. This will ensure that business enterprises identify, prevent and mitigate their negative impact on children's right to health...'

109 CESCR, General Comment No. 24, para 12

110 Ibid, paras 14 – 22

111 Ibid, paras 23 and 24

include establishment of effective remedial mechanisms to victims of corporate abuses, adoption of a legal framework that requires business entities to exercise human rights due diligence in order to identify, prevent and mitigate the risks of violation of Covenant rights and also, direct regulation and intervention.

The Committee notes that when privatization occurs in healthcare, “where the role of the public sector has traditionally been strong,” States should subject Private providers “to strict regulations, imposing on them so called ‘public service obligations.’” States should prohibit private healthcare providers from “denying access to affordable and adequate services, treatments or information.”¹¹² The Committee notes that privatization can result in social economic segregation. Paragraph 22 further adds that;

‘The Committee is particularly concerned that goods and services that are necessary for the enjoyment of basic economic, social and cultural rights may become less affordable as a result of such goods and services being provided by the private sector, or that quality may be sacrificed for the sake of increasing profits. The provision by private actors of goods and services essential for the enjoyment of Covenant rights should not lead the enjoyment of Covenant rights to be made conditional on the ability to pay, thus creating new forms of socio-economic segregation.’¹¹³

The Committee on the Rights of the Child has similarly required states to integrate the principle of the best interest of the child (Art. 3.1 CRC) into legislation and policies shaping business activity,¹¹⁴ and notes that the principle is “directly applicable to business enterprises that function as private or public social welfare bodies by providing any form of direct services for children, including [...], health”.¹¹⁵ It urges States to ensure “large business

¹¹² Paragraph 21 notes that ‘The increased role and impact of private actors in traditionally public sectors such as in the health or education sectors, pose new challenges for States Parties in complying with their obligations under the Covenant. Privatization is not per se prohibited by the Covenant even in areas such as the provision of water or electricity, education or healthcare where the role of the public sector has traditionally been strong. Private providers should however be subject to strict regulations, imposing on them so called “public service obligations.”...Similarly, private healthcare providers should be prohibited from denying access to affordable and adequate services, treatments or information.’

¹¹³ Ibid. at para 22.

¹¹⁴ Ibid, para 15

¹¹⁵ UN Committee on the Rights of the Child (CRC), General comment No. 16 (2013) on State obligations regarding the impact of the business sector on children's rights, 17 April 2013, CRC/C/GC/16

enterprises should be encouraged and, where appropriate, required to make public their efforts to address their impact on children's rights".¹¹⁶ The Committee on the Elimination of Discrimination Against Women (CEDAW) has also clarified that States are obliged to regulate private actors in order to ensure that they do not discriminate against women.¹¹⁷

6.2 National Framework and Private Actors

As early as 1995, GoU has encouraged private sector investment in the health industry, and it has maintained that enthusiastic approach overtime. However, few legal and policy documents address the logistical and regulatory challenges of such reliance on the private sector for health care delivery as will be seen below.

The 1995 Uganda Constitution encourages private sector investment in health.¹¹⁸ Similarly, the National Poverty Eradication Action Plan 1997-2008¹¹⁹ encourages cooperation between public and private sector in health. The first National Development Plan lists several strategies to ensure universal access to a quality Uganda National Minimum Health Care Package (UNMHCP), with emphasis on vulnerable populations. Each of these listed strategies involve close collaboration with, and reliance upon, the private sector.¹²⁰ Vision 2040 calls for a sector wide shift to PPPH arrangements. It states that GoU will collaborate with the private sector to establish insurance and greater capacity for specialized services, including the foundation of international hospitals.¹²¹ The NDP II makes few explicit references to the role of private actors in health care, though it discusses the role of PPPs in developing human resources in the health sector.¹²² The Health Sector Strategic and Investment Plan (HSSIP) 2010/11 – 2014/15 also makes few references to PPPs. It acknowledges that the UNMHCP is underfunded as well as the fact that Uganda relies on foreign aid to

¹¹⁶ CRC, General Comment 15 (n 143), para 80

¹¹⁷ CEDAW, *General recommendation No. 28 on the core obligations of States parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, 16 December 2010, CEDAW/C/GC/28, para 13

¹¹⁸ Government of Uganda; Constitution of the Republic of Uganda (1995); Objective IX of its National Objectives and Directive Principles of State Policy states that 'in order to facilitate rapid and equitable development, the state shall encourage private initiative and self-reliance.'

¹¹⁹ Government of Uganda; National Poverty Eradication Action Plan 1997-2008; http://siteresources.worldbank.org/INTPRS1/Resources/Country-Papers-and-JSAs/Uganda_IPRSP.pdf; accessed August 17, 2018

¹²⁰ Government of Uganda; National Development Plan 2010-2015; <http://npa.ug/wp-content/themes/npatheme/documents/NDP2.pdf>; accessed August 17, 2018

¹²¹ Government of Uganda (2010), Uganda Vision 2040; at p. 91

¹²² Government of Uganda; Second National Development Plan 2015-2020 at pp. 188-194; <http://npa.ug/wp-content/uploads/ND-P-II-Final.pdf>; last accessed August 17, 2018

meet its current healthcare funding needs. It discusses the input-based costing strategy, while acknowledging that it offers an incomplete picture.¹²³ The Health Sector Strategic Plan (III) 2010 – 2014/15 (HSSP III) outlines basic guidance on the formulation of PPPs, emphasizing the role of district and lower levels in procuring the arrangements. The document also specifies one concrete way in which GoU encourages private sector health investment: it does not charge duty on importation of machinery and raw materials for production of pharmaceuticals.¹²⁴ The HSSP III acknowledges that the government's attempts at forming partnerships with the private sector through Health Policy Advisory Committees (HPACs) has not been effective.¹²⁵ The document calls for the establishment of a national policy on PPPH whose content shall be discussed.

6.2.1 Public Private Partnership Framework Policy for Uganda (2010)

This PPP Framework Policy for Uganda was adopted in 2010 to guide PPP projects and would later form the basis of the PPP Act. The objectives were: better utilization and allocation of public funds, efficient delivery of public infrastructure; risk allocation; output orientation; transparency; accountability.

6.2.2 Public Private Partnership Act (2015)

The principle legislation governing Public Private Partnerships¹²⁶ in Uganda is the PPP Act which generally aspires to guide the relationship between government and private actors in the implementation of PPPs.¹²⁷ It establishes structures of procurement, monitoring and

123 Government of Uganda; Health Sector Strategic and Investment Plan (2010); at p. 159; <http://www.health.go.ug/docs/HS-SIP10.pdf>; last accessed August 17, 2018

124 Government of Uganda; Health Sector Strategic Plan III (2010/11 – 2014/15; at p. 26; http://www.health.go.ug/sites/default/files/Health%20Sector%20Development%20Plan%202015-16_2019-20.pdf; last accessed August 17, 2018

125 Health Sector Strategic Plan III (2010/11 – 2014/15; at pp. 25-29

126 Section 4 of the Public Private Partnerships Act defines a Public Private partnership as '...a commercial transaction between a contracting authority and a private party where the private party performs a function of the contracting authority on behalf of the contracting authority...'

127 The long title to the Act states that it's 'An Act to provide for public private partnerships; to establish Public Private Partnership Committee and Public Private Partnership Unit; to establish a Project Development Facilitation Fund; provide for the functions of contracting authorities, accounting officers, project officers, project teams and evaluation committees; to provide for the role of the private party in a public private partnership; to provide for the management of public private partnerships; to provide for project inception and feasibility studies for public private partnerships; to provide for the procurement of public private partnerships; to provide for the disqualification of bidders and the evaluation of public private partnership bids; to provide for public private partnership agreements and the monitoring of projects; to provide for the bidding methods, procurement procedures and types of public private partnership agreements and for related matters.'

regulation of PPPs, as well as laying out the roles and responsibilities of the various players in the implementation of PPPs. It sets out a PPP Unit, PPP Committee and contains information on the procurement rules PPPs must abide by. The PPP Act requires the Auditor General to annually audit every PPP from inception to conclusion and to report to Parliament within nine months from each audit.

Although the Act puts forth a number of commendable provisions, it is insufficient to regulate the nature of PPPs. To begin with, the definition of PPP offered by the document stresses that the private actor acquires use of some national asset, and in exchange assumes “substantial...risks,” and receives a benefit through the government or user fees. This language might be less fitting for donor funded PNFP PPP projects where the private actor does not necessarily acquire a national asset, does not necessarily assume financial risk, and might not receive a benefit through the government. Moreover, the Act, in its application primarily focuses on infrastructure initiatives rather than the implementation of social services and as such doesn’t lend substantial guidance on the implementation of PPPs in health service delivery particularly; a shortcoming that in turn renders the Act’s remedial mechanisms redundant considering that these flow from contractual obligations and yet PPPs in Health are currently predominantly ‘executed’ by way of MOU.

Further still, the Act stipulates that in the implementation of PPPs, ensuring ‘value for money ¹²⁸’ will be a guiding principle; drawing more emphasis on indicators such as ‘cost, quality, quantity and substantial risk transfer.’ It also discusses equity. However, guidance on information that has to be submitted is not provided by the Act. The Act does not recognize the imperative of social impact indicators that are vital in service delivery as vastly considered in the AAAQ framework.

The PPP Act sets out PPP Committee, which reports to the Permanent Secretary of the Ministry of Finance, Planning and Economic Development and Secretary to the Treasury, who is also the head of the committee and this can be a conflict of interest and impair the oversight role of the Permanent Secretary/Secretary to the Treasury.

6.2.3 The National Policy on Public Private Partnerships in Health (2012) (NPPPPH)

The NPPPPH is a more sector specific policy that expounds on the framework governing

¹²⁸ Section 3(a)

PPPs¹²⁹ in health.¹³⁰ The policy acknowledges the crucial role private actors can play in the realisation of the right to health under its rationale and goes further to not only stratify private actors in the health sector¹³¹ into Private Not for Profit health providers (PNFP), Private Health Practitioners (PHP also known as Private for Profit) and Traditional and Complementary Medicine Practitioners (TCMP), but also stipulates the roles of the different stakeholders¹³² i.e government and the private health sector. It could be said that in a developing arena muddled with a lot of uncertainty and limited expertise, the NPPPPH attempts to present a progressive solution. Despite the PPPH Policy's vision of ensuring universal access to affordable healthcare for all the population of Uganda, it predominantly focuses on streamlining the working relationship between partners and government and pays insufficient attention to ensuring the interests of the healthcare consumer are safeguarded in these arrangements. Accordingly, settlement of disputes,¹³³ structures put in place are to handle disputes amongst stakeholders; instances that require remedying of human rights violations of consumers are not represented.

Further still, one of the strategic aims of NPPPPH is for government to encourage PFPs to become more engaged in public health by providing assistance. These forms of assistance are vague and there are no clear financial incentives. For instance, the document pledges that the government will provide "support" to PFPs to serve remote areas, but it does not specify further. The NPPPPH also discusses the role of the PFP sector in helping Uganda achieve its human resource development goals. The policy declares that PFPs should get to have a role in training and accreditation schemes. At the end of the section on PFPs, the policy states the goal of "Enhancing Provision of Quality Services and Regulation and Control of Service Provision," such as through "Annual publishing of licensed health facilities" and "Establishing a database for all registered private providers." These raise some very important regulatory questions, but the policy does not provide much detail in these areas.

129 The Policy defines a PPP as a spectrum of possible relationships between the public and private actors for integrated planning, provision and monitoring of services.

130 However, noteworthy is the fact that the policy is presented as a 'draft policy paper' rather than an official policy document, which raises questions about its statutory weight. See <http://library.health.go.ug/publications/leadership-and-governance-governance/policy-documents/national-policy-public-private>; last accessed July 20, 2018

131 Para 1.2

132 Para 2.4

133 Para 4.4

6.2.3 The Sector Grant and Budget Guidelines FY 2017/18

These guidelines primarily provide guidance for the utilization of the Primary Health Care (PHC) grants and other decentralized health grants and are to be used to prepare and implement annual work plans for both Public and Private-Not-For-Profit (PNFP) facilities as well as Private Health Provider facilities where feasible.¹³⁴ As the document states, ‘the Government of Uganda is cognizant of the limitations faced by both the private health providers and the consumers of health care i.e. populations in areas where public health facilities are lacking and therefore provides financial subsidies to enable them provide affordable health care in those communities in line with the National PPP Act and PPPH policy.’¹³⁵ In addition, the guidelines lay out the criteria and requirements that private actors have to meet in order to access public subsidies.¹³⁶ These largely put the interests of the users of medical services at the forefront; ensuring affordability, quality, accessibility, as well as accountability.

6.2.4 Public-Private Partnership for Health Strategy (2017/18 - 2021/22)

The Ministry of Health has developed a five year Public Private Partnership for Health Strategy.

6.2.5 The Second National Health Policy 2010

The second National Health Policy identifies partnerships as one of its guiding principles. It states that the private sector shall be seen as complementary to the public sector in terms of increasing geographical access to health services and the scope and scale of services provided.¹³⁷ The policy further, in its priority areas notes strengthening health systems in line with decentralization through training, mentoring, technical assistance and financing, as well as establishing a functional integration within the public and between the public and the private sectors in healthcare delivery, training and research. The importance of

¹³⁴ <http://library.health.go.ug/publications/primary-health-care/phc-guidelines-fy-201718-final-edition> at pg 6.

¹³⁵ Ibid at pg 28

¹³⁶ Ibid

¹³⁷ Pg. 13, para 4.5.6

supervision, monitoring and evaluation¹³⁸, enacting legislation and regulatory frameworks, strengthening relevant institutions for enforcement and the establishment of remedial mechanisms for victims of poor service provision¹³⁹ are underlined by the policy as means towards the realization quality healthcare as well as an effective health service delivery system.

6.2.6 Health Sector Development Plan (HSDP) 2015-16/2019-20

The HSDP is part of a series of plans aimed at achieving Uganda 2040 of a healthy and productive population that contributes to socio-economic growth and national development.¹⁴⁰ This Plan prioritizes investment in seven health systems areas amongst which is health governance and partnerships which will focus on strengthening the governance and partnership structures; management and stewardship; Public Private Partnerships and coordination; health legislation and regulation, knowledge translation and improving sector competitiveness.¹⁴¹

One of the Health Sector Development Plan's more specific PPPH objectives was to create a Medical Credit Fund. It lists as one of its strategies to achieve financial sustainability as mobilizing private resources from the private sector under the PPPH arrangements, though it does not specify or provide examples.¹⁴² The document establishes the role of umbrella organizations, stating that their role is to represent their members and promote partnership initiatives, to coordinate the different health providers from each sub-sector and promote professional development and ethics, and to provide support services and accredit the member facilities and providers.¹⁴³ The document does not seem to assert PFP's role in providing healthcare to vulnerable, poor, or rural populations. It describes the role of PFP sector in the current Health Sector Development Plan as serving to "provide complementary health services, in areas with populations having higher capacity to pay."¹⁴⁴

138 Para 6.3

139 Para 6.5

140 Pg. XIV, para 1

141 Pg. XVI, para 2

142 Ibid at p. 82

143 Ibid at p. 90

144 Ibid at p. 94

6.2.7 Health Financing Strategy (2016)

The Health Financing Strategy presents a gloomy picture of the public system. It details the ways in which insufficient government spending and tax revenue leave the public system underfunded. It lays out instances of waste and inefficiency due to fraud and incompetence, as well as rising health costs. Oddly, despite reviewing at length the unreliability of future oil revenues, the document ultimately suggests using oil revenues to fund health care. It advocates for Community Based Health Insurance as a shorter-term measure to cover the indigent, while introducing the National Health Insurance Scheme as a long term plan that will eventually be expanded for universal coverage.¹⁴⁵

6.2.8 Local Government Policy documents

The Ministry of Health's *Sector Grant and Budget Guidelines* document lays out the conditions that must be met for local governments to receive funds from the Ministry of Health for healthcare procurement. The guidelines contain a section devoted to grants for PNFPs and PFPs.¹⁴⁶ These guidelines attempt to guarantee that private entities receive government funds only when doing so will improve access to healthcare for vulnerable and geographically isolated populations. However, guidelines in this document pertain more clearly to input-based MOU arrangements, and do not seem tailored for formalized PPPs. The document provides examples of MOUs between PNFPs and GoU, District Local Governments and PNFPs, and GoU and the Joint Medical Stores and EMHS Credit Line for PNFPs. The *Public Private Partnerships for Local Governments* policy on the other hand, specifically addresses PPP type arrangements, but does not offer any guidance specific to PPPs. Moreover, the document is more of an instructional tool kit for local governments discussing the variety of ways to structure PPP arrangements. The document does little to address regulatory concerns.¹⁴⁷

¹⁴⁵ Ministry of Health (2016); Health Financing Strategy; at p. 28

¹⁴⁶ Ministry of Health (FY 2017/2018); Sector Grant and Budget Guidelines; at pp. 30-56; at <http://library.health.go.ug/publications/primary-health-care/phc-guidelines-fy-201718-final-edition>; last accessed August 15, 2018

¹⁴⁷ Ministry of Local Government and United Nations Development Programme (2013); Public Private Partnerships Guidelines for Local Government at <http://www.ug.undp.org/content/dam/uganda/img/Research%20and%20Publications/PPP%20Guidelines%20Final.pdf>; last accessed August 15, 2018.

6.2.9 Other Legislation and policy documents

PPPs should also be construed in light of other legislation, which although not focused on PPPs, guides processes that are relevant to PPPs like procurement. **The National Audit Act, 2008** empowers the Auditor General under section 13 (1)(B) to conduct financial, value for money and other audits” for any project or activity “involving public funds.” Section 18 empowers Auditor General to “inquire into, examine, investigate and report, as he or she considers necessary, on the expenditure of public monies disbursed, advanced or guaranteed to a private organization or body in which Government has no controlling interest.” This includes PPPs. This is also in line with article 163(3), (4) of the Constitution, which requires the Auditor General to conduct financial and value for money audits and annually submit to Parliament a report of the accounts, audited by him. The Public Procurement and Disposal of Public Assets Act 1, of 2003 (as amended) (PPDPA) requires application of basic principles of public procurement and disposal¹⁴⁸ including transparency, accountability and fairness,¹⁴⁹ non discrimination,¹⁵⁰ competition and ensuring value for money¹⁵¹ and emphasizes open competitive bidding¹⁵² and public accessibility.¹⁵³ Section 55 of the Act requires all public procurement to be carried out in accordance with the rules of this Act.

The Service Standards and Service Delivery Standards for the Health Sector, 2016 provides guidelines and regulations that apply equally to public and private institutions, while its companion, the Monitoring and Evaluation Plan for Implementation of the Health Sector Development Plan 2015/16 - 2019/20 provides a comprehensive monitoring and evaluation plan for private and public actors that ensures the delivery of the former.

While there is some regulation, it provides piecemeal protection and does not sufficiently strengthen the regulation function of the State.

¹⁴⁸ Section 43 of the Act

¹⁴⁹ Section 45 of the Act.

¹⁵⁰ Section 44 of the Act.

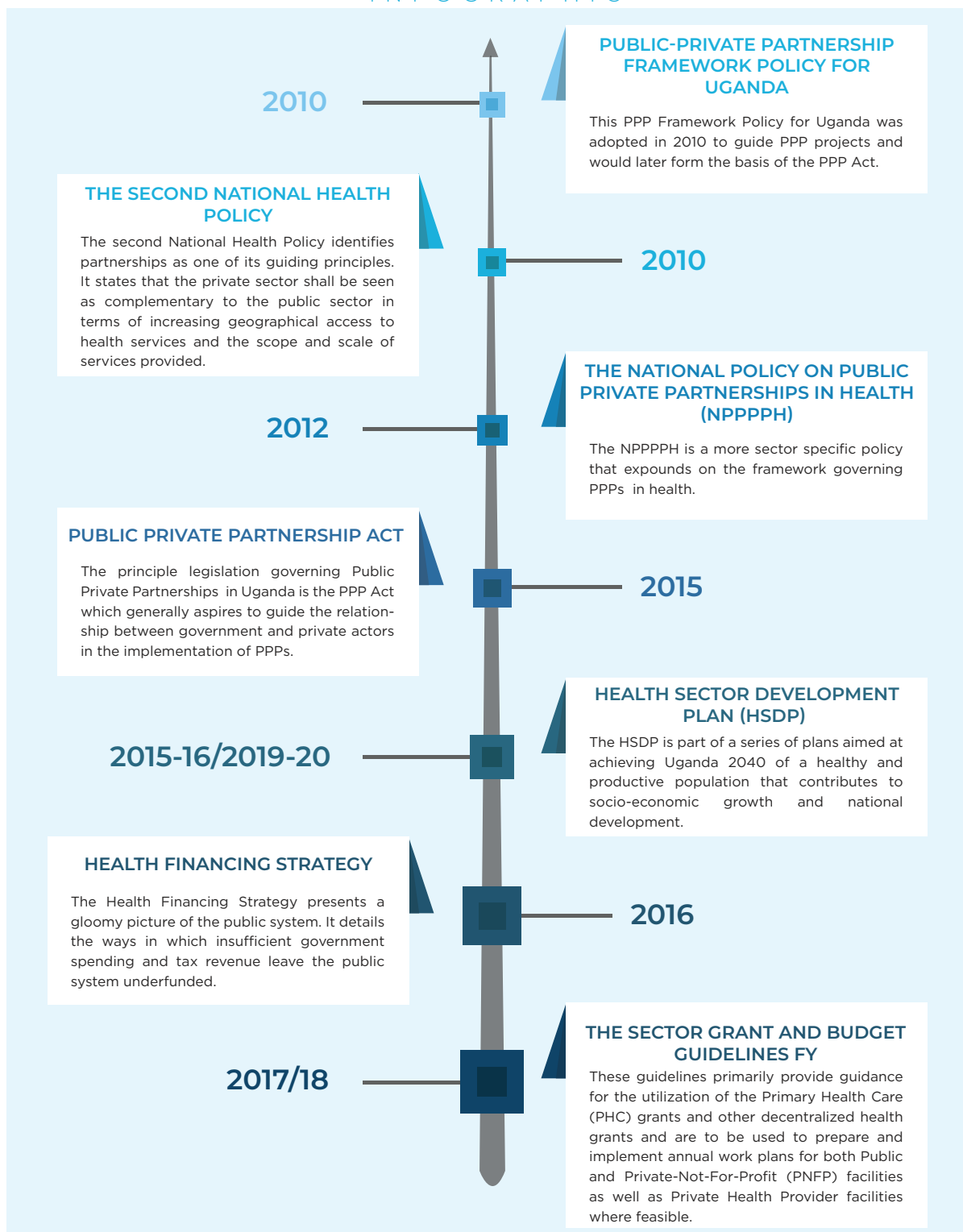
¹⁵¹ Section 46 of the Act.


¹⁵² Section 51 of the Act.

¹⁵³ Section 53 of the Act.

TIMELINE

• INFOGRAPHIC •





7

CASE STUDIES OF PPPs IN UGANDA

CASE STUDIES OF PPPs IN UGANDA

This section provides an overview of salient PPPHs in Uganda.

7.1 Private Not For Profit (PNFP)

Historically, GoU's PPPH efforts have revolved almost entirely around PNFPs, not PFPs, and these arrangements have been MOUs rather than performance-based contracts.

As far back as the early 1960s, GoU implemented a policy that allowed for the provision of financial support to the PNFP sector in health. The GoU established a Non-Governmental Organization (NGO) health sector panel that was tasked with creating mechanisms for cooperation between the government and NGOs for the provision of public health services. The NGO panel's recommendations were formalized in the first National Health Policy (1999) and the Health Sector Strategic Plan 2000/01 to 2004/05 (HSSP I). More recently, the NGO panel's responsibilities were absorbed by the newly created PPPH Working Group, which is tasked with development of policy around all types of PPPs in the health sector, not just NGOs and PNFPs. This more recent development has shaped the current context for PPPH policy in Uganda.

PNFPs in PPPH with the GoU are often faith based. There are currently organized in medical bureaus that negotiate with the government, namely the Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, Orthodox Medical Bureau and Uganda Muslim Medical Bureau. Uganda Protestant Medical Bureau and Uganda Catholic Medical Bureau started the Joint Medical Stores, which is a PPP around the supply of drugs which supplements the National Medical Stores, procuring and supplying drugs to non government facilities paid for by government through quarterly disbursements from the Private Not for Profit Facilities Essential Medicines and health Supplies credit line.¹⁵⁴

Palliative care is also provided through a PPP arrangement between the palliative care providers and the government with the government providing oral liquid morphine, which is then locally reconstituted by palliative care providers and provided through public and private health units.

154 Memorandum of Understanding between Joint Medical Stores.

7.2 Donor Funded Voucher Schemes

Donor agencies often have a complicated relationship with GoU and the SWAp approach. In 2017, USAID spent approximately 90 million USD under its Global Health portfolio in Uganda.¹⁵⁵ USAID focuses its health related expenditures in Uganda under the following categories: HIV/AIDS, malaria prevention, maternal and child health, family planning and reproductive health, and health system strengthening.¹⁵⁶ In accordance with SWAp principles USAID's country development cooperation strategy in Uganda is coordinated with Uganda's National Development Plan. It acknowledges that the decentralized structure of Uganda's government "require[s] a mind-shift to orient interventions toward disparate yet targeted challenges within respective local systems."¹⁵⁷ Moreover, USAID acknowledges that GoU is just as often an obstacle as a partner to its mission in Uganda. It states:¹⁵⁸

Furthermore, Uganda's health system is plagued by inadequate resources, ineffective governance, and corruption. Insufficient GOU health sector financing and weak political resolve remain key constraints to delivering and improving the quality of health services. Uganda recently held elections, and politics will likely continue to affect the ability of the GOU to deliver services and engage in policy dialogue with USAID and other development partners.

Perhaps in part due to a lack of faith in GoU, USAID does not outline a comprehensive strategy coordinating its aid programs with the government. As a result, and despite the objectives of the SWAp approach, much of USAID's intervention in Uganda's health sector remains on the project based level.

As a whole, USAID seems to be undergoing a paradigm shift. Its website notes "We're embracing the notion that the private sector, not donors and government, will be the ultimate drivers and sustainers of development, and we know that we need to re-envision our role accordingly."¹⁵⁹ It will likely continue to intervene through the private sector.

There has been a particularly large amount of recent activity among donor agencies in

¹⁵⁵ US Government; Department of State, Foreign Operations, and Related Programs; Congressional Budget Justification; at p. 135; at https://www.usaid.gov/sites/default/files/documents/1868/FY_2019_CBJ.pdf; last accessed August 17, 2018

¹⁵⁶ US Government; USAID website; at <https://www.usaid.gov/uganda/global-health>; last accessed August 17, 2018

¹⁵⁷ USAID Uganda; Country Development Cooperation Strategy 2016-2021. At p. 1. Accessed at https://www.usaid.gov/sites/default/files/documents/1860/CDCS_FINAL_26092017.tags_.pdf; last accessed August 18, 2018. Also see USAID/Uganda (2015). Ugandan Decentralization Policy and Issues Arising in the Health and Education Sectors: A Political Economy Study, USAID.

¹⁵⁸ USAID Uganda; Country Development Cooperation Strategy 2016-2021. At p. 83. Accessed at https://www.usaid.gov/sites/default/files/documents/1860/CDCS_FINAL_26092017.tags_.pdf; last accessed August 18, 2018.

¹⁵⁹ USAID <https://www.usaid.gov/what-we-do/economic-growth-and-trade/unlocking-private-capital>

piloting and implementing voucher schemes, particularly with regard to maternal health-care and AIDS/HIV prevention. Abt Associates is a research and consulting firm based in the US that often contracts with governments. According to their website, they are leading the USAID Uganda Voucher Plus Activity, which is designed to expand access to quality obstetric, newborn and postpartum family planning (PPFP) services for poor women through the private sector. The Activity provides facility-based deliveries with attendants in 30 districts in the Northern and Eastern regions.¹⁶⁰ The vouchers are subsidized at a rate of 4,000 UGX for services. The website states that the project is coordinated with MoH, but MoH's specific role and degree of collaboration is not specified. In fact, based on key stakeholder interviews, ISER determined that the entirety of the project's funding is donor-based and the Ministry's role would be supervisory. The Voucher Plus website also states that the voucher programs are part of MoH's larger initiative toward output-based financing mechanisms, specifically results-based financing, whereby funding mechanisms are sensitive not just to the supply of health services, but also to their demand.

A similar voucher scheme, called Healthy life and Healthy baby was implemented in Western Uganda from 2008-2012. A four year follow up to the program, called the Uganda Reproductive Health Voucher Project, a US\$ 13.3 million grant project funded predominantly by the World Bank alongside Swedish Development Agency, and the United Nations Population fund, and implemented by Marie Stopes Uganda as the voucher management agent, was initiated in September 2015.¹⁶¹ It is a follow up to the World Bank supported Global Partnership on Output Based Aid, which focuses on Result Based Financing. The program is implemented in 12 districts of South Western and 13 districts of East and Central Uganda. It entitles those who hold the vouchers to a defined package of "safe delivery services from contracted providers," who provide the specified services and submit claims to the voucher management agent for settlement on the basis of prior negotiated fees.¹⁶² The package of services includes: four antenatal visits, safe delivery, one postnatal visit, treatment and management. The project also seeks to "mainstream and scale up" implementation of safe delivery voucher systems in the health sector.¹⁶³ Ministry of Health is

160 Abt Associates Website; <https://www.abtassociates.com/projects/leading-the-uganda-voucher-plus-activity>; last accessed 28 February, 2019

161 Marie Stopes website; <http://mariestopes.or.ug/update-on-the-uganda-reproductive-health-voucher-project-urhvp/>; last accessed 2 March 2019

162 projects.worldbank.org

163 projects.worldbank.org

involved in the coordination of the program, and is supposed to provide strategic guidance and oversight including reviewing and endorsing work plans, and budgets, progress reports, financial statements and overall performance and approval of mechanisms to appoint the voucher management agent.¹⁶⁴ The Ministry of Health under Uganda Health Systems Strengthening Project (UHSSP) provided USD \$3,058,950.¹⁶⁵ BDO, East Africa as an independent verification evaluation agent is supposed to provide external monitoring of the project at 6 month intervals and to report to the Ministry of Health, Development Partners and ICC on project implementation.¹⁶⁶

Between these two programs, it's clear that international donors are interested in health care solutions that involve Uganda's private sector, and that they see vouchers as a promising means of engaging with them. Still, it is unclear how these voucher programs are part of any sustainable development goals considering that the programs function only as long as they are subsidized by these various international donor agencies. Therefore, one is left to question how these programs fit into GoU's overall strategy of promoting private sector investment in achieving public goals, as outlined in legislation such as the PPP Act.

Based on interviews with key stakeholders, the function and purpose of these programs are clearer. The USAID Voucher Plus program and the Uganda Reproductive Health Voucher Project (URHVP) are almost identical save for a few key differences. The Voucher Plus program engages only with private providers, and its funding comes entirely from USAID with no complementary contribution from GoU. In the URHVP program, on the other hand, 3 million dollars are contributed by GoU in order to give GoU a stake in the program. Moreover, unlike the Voucher Plus program, the URHVP works with both private and public facilities although predominantly with private. Of the 241, 92 were public, 40 PNFP and 109 PFP.¹⁶⁷ Thus, the two programs, when compared, can provide answers about the effectiveness of introducing results-based incentives into both the private and public sectors.

164 Marie Stopes website; <http://mariestopes.or.ug/update-on-the-uganda-reproductive-health-voucher-project-urhvp/>; last accessed 28 September, 2018; Interview with Ministry of Health Official, February 26, 2019; Okuny, Michael Eriu, 2019. AG Report on the Fin Statements of URHVP GPOBA TF015995 For the Year Ended June 30,2018, Office of the Auditor General Uganda at p.2, <http://documents.worldbank.org/curated/en/991381552904165091/pdf/AG-Report-on-the-Fin-Statements-of-URHVP-GPOBA-TF015995-for-the-year-ended-June-30-201802072019.pdf>

165 Okuny, Michael Eriu, 2019. AG Report on the Fin Statements of URHVP GPOBA TF015995 For the Year Ended June 30,2018 at p.17

166 Okuny, Michael Eriu, 2019. AG Report on the Fin Statements of URHVP GPOBA TF015995 For the Year

167 Interview with Ministry of Health Official, March 2019.

There are several purposes to the programs. The vouchers are intended to stimulate demand for quality healthcare and to encourage women to seek out reproductive health services at quality facilities. They are also intended to sensitize women to expect to have to pay for healthcare services. Specifically, the vouchers provide coupons for a full suite of reproductive health services, including prenatal, caesarean, normal deliveries, and post-natal care, all at a total cost of 4,000 UGX. A second purpose of the vouchers rests on the supply-side. The URHVP program is intended to create a market atmosphere where all facilities, both public and private, are competing with one another to attract customers with vouchers. The vouchers are redeemable by the facilities (both public and private) for reimbursement by MoH, with Marie Stopes acting as administrative middle man in its capacity as Voucher Management Agency. It is also thought that incentivizing facilities to provide more of these services will improve their capacity to provide these services in greater numbers and at a higher level of quality.

The project does not rely solely on competition and market forces to ensure the quality of services. In order to redeem vouchers, both public and private facilities must provide information attesting to the quality of the services delivered. Marie Stopes provides technical and financial training to the facilities in order to assist with both the clinical and administrative aspects of this objective. Moreover, Marie Stopes works with District Health Teams to provide an additional quality safeguard, and to serve as a conduit to the community. Marie Stopes also contracts with a third-party verifier, the auditing and accounting firm BDO. BDO reviews the voucher transactions before Marie Stopes submits them to MoH for reimbursement. They also assist in the ultimate evaluation of the program.

It is no accident that these voucher programs resemble a typical health insurance scheme, where a user pays a premium and/or a copay for standardized health services, and where facilities submit claims to a centralized insurance agency for reimbursement after delivering said services. According to key stakeholders, these programs are pilots that are meant to function as both tests of and bridges toward NHIS. The bridge involves sensitizing people, including the poor, to pay into the system. It also sensitizes public and private facilities to results-based financing mechanisms, where funding is predicated on service delivery, creating both an incentive to deliver quality services, and a feedback loop between service providers and payers.

According to stakeholder interviews, there are three essential phases to the initiative. The first phase, the donor funded voucher programs, was intended to end in December 2019, at which point the second intermediary phase was intended to start. This second phase, referred to as Results Based Financing (RBF), was intended to continue this results based mode of financing, while relying less on foreign donor funding and management, with MoH taking greater financial and administrative responsibility for the programs. The third and final phase then, would be the introduction of NHIS. The details and the viability of this second intermediary phase are less clear, and its feasibility more suspect. Indeed, according to key stakeholders, MoH's RBF phase has started now but at a "slow pace," and because of this "slow takeoff" the first phase is likely to be extended for another two or three years. In fact, MoH still has not made any explicit financial commitments for the RBF framework. Despite these inauspicious signs, it is hoped that once the RBF phase commences in force, the NHIS phase will commence within five years after that.

Although the voucher program was meant to serve only poor clients, initial results suggest a leakage of approximately 2% to clients who weren't actually poor and who were not in need of heavily subsidized healthcare. Also, a significant number of the programs' beneficiaries are in hard to reach areas, approximately 80% in the Eastern Region, but only 40-50% in the Western region. There are different strategies in serving the peri-urban poor and the hard to reach poor. In the peri-urban areas, the program uses a "poverty-grading" mechanism to determine beneficiaries, while in the hard to reach areas, they use a "geographical targeting" mechanism. In fact, the programs' proof of concept becomes less clear when applied specifically to rural and hard to reach Ugandans, particularly with regard to its reliance on the private sector.

Moreover, the USAID Voucher Plus program, which was intended to contract strictly with private facilities, found that goal impossible in certain hard to reach areas. USAID is actually in discussion with MoH about working with some public facilities in areas where the private sector is just too weak to meet demand.

Although stakeholders involved with these projects insist that the private sector is more efficient, there is acknowledgment that in Uganda's context, that might not be the case from a strictly financial perspective. The voucher programs reimburse private facilities at a 25% higher rate than public facilities because those facilities have greater costs, since their salary and infrastructure needs are not provided through government funds. Therefore, on

that most basic level, a voucher submitted to a public facility is that much more efficient. On the other hand, stakeholders described a number of hurdles in administering the program through public facilities. Thus, they implemented several requirements for how the public facilities could spend the funds. They determined that the public facilities could allocate 30% of the funds to staff motivation – in order to account for the increased work demands on staff spurred by the vouchers. Another 30% was mandated to be allocated to drugs and supplies that stock out at public facilities, and another 20% would go to facility maintenance, as apparently PHC grants were not sufficient for this purpose. At the level of drugs and supplies, the implementers discovered there was need for them to intervene even more directly. Instead of allowing the public facilities to purchase the drugs and supplies themselves, the implementers required that the facilities submitted a request for stocked out materials, and the implementers engaged in centralized purchasing through JMS on their behalf. Every quarter the facilities would provide a list of stock outs and the implementers would make the purchase and ensure delivery to the facilities.

The implementers hope that reimbursement requirements can be used to enforce regulations, rather than using punitive mechanisms. This is their approach to ensuring quality of service as well as to incentivizing public and private facilities to submit proper data to the District Health Management Information System (DHMIS) and the broader Health Management Information System (HMIS). The implementers are developing sets of quality indicators that are attached to the reimbursement of submitted vouchers. Moreover, facilities must provide evidence that they fulfilled standardized data reporting requirements before receiving any reimbursements. Implementers also believe they can tap into district level resources to ensure quality of care. The implementers found that there were gaps within the District Health Teams and District Health Organizations in their understanding of quality, so part of the project involved training at this level. They plan for the district to extend this understanding to help support the private players as well.

There is reasonable concern that the introduction of vouchers might degrade the public system. First, the URHVP program is partly funded through GoU, and World Bank funds, which are arguably public funds and part of those funds go to private actors. Therefore, there is a degree - although limited - to which the vouchers divert public funds to private interests. Also, the very existence of the voucher program concedes the breakdown of the public system. Technically, legally, public healthcare is free, even if that is not the case in reality. A voucher for public services essentially acknowledges, and arguably encourages

differential treatment for those who are willing to pay. Marie Stopes has made some effort to counteract this potential effect. Part of their purpose in requiring that 30% of reimbursement funds go to preventing stock outs is so that the public facilities will use those funds to provide free services to women who do not have, or cannot afford, a voucher. In that sense, the patients with vouchers are ideally subsidizing the free care of those without. Of course, an assumption of some degree of differential treatment is built into the voucher program – otherwise the vouchers themselves would have no value. Marie Stopes states that their evaluation, and that of the BDO, are both monitoring for the impact of this adverse effect.

Projects such as the voucher programs, and the World Bank's 140 million-dollar Uganda Reproductive, Maternal and Child Health Services Improvement Project (URMCHSIP) reveal the priorities of the international donor community.¹⁶⁸ Between the voucher programs and the URMCHSIP, it is clear that the international community is currently quite focused on reproductive health. The reason for this focus, partly, is the fulfillment of Sustainable Development Goal (SDG 3), which has a particular focus on maternal and child health. In fact, three of the nine SDG3 targets address maternal mortality, child mortality, and reproductive health.¹⁶⁹

The URMCHSIP, like the voucher projects, is also focused on Results Based Financing, an approach that presumes health sector funds are more effective if provided only after quality services are delivered and verified. This approach is one method used to spur accountability and combat misappropriation of funds, and for that reason it is currently favored by the international donor community. However, it has a detrimental impact on the quality of services offered to vulnerable groups like Persons with Disabilities as health workers rush to make the numbers to get the funds. It also tends to rattle the sensibilities of those who fear the oppressive domination of the “neo-liberal” order, since this approach tends to dovetail with the tenets of free-market capitalism. Some might see the SDGs and other international priorities as a Trojan Horse being employed to spread this ideology. When Results Based Financing is further extended to a certain type of Private Public Partnership in which the government actually concedes state resources to private entities who promise to deliver said results, those with a more socialistic view of ideal governance often become suspicious of the ultimate designs of the capitalist donor countries who support this strategy. It is not unreasonable to be wary of donor countries trying to export their values, and even their

¹⁶⁸ World Bank website; at <http://projects.worldbank.org/P155186/?lang=en&tab=overview> last accessed February 28, 2019

¹⁶⁹ WHO website; at <https://www.who.int/sdg/targets/en/> last accessed March 1, 2019

economic ideologies through their international aid.

Between these programs, it's clear that international donors are interested in health care solutions that involve Uganda's private sector, and that they see vouchers as a promising means of engaging with them. Still, it is unclear how these voucher programs are part of any sustainable development goals considering that the programs function only as long as they are subsidized by these various international donor agencies. Therefore, one is left to question how these programs fit into GoU's overall strategy of promoting private sector investment in achieving public goals, as outlined in legislation such as the PPP Act.

7.3 Private Sector For Profits PPPs.

Uganda has had few PFP PPPs but this is slowly changing. Below are some of the PFPs and those proposed.

7.3.1 Cipla Quality Chemicals Ltd.

Cipla Quality Chemicals Ltd was supported by the government through an initial PPP arrangement to produce ARVs and anti-Malarial Artemisinin Combination Therapies (ACTs). The government invested over sh 6bn over two years. It will also pay 29 billion in tax. On the one hand, the company now produces ARVs. However, questions were raised about the cost effectiveness of this PPP arrangement. The Auditor General's report found prices at which NMS procured ARVs from Cipla were higher than prices for drugs imported under donor supported arrangements, citing five out of eight drugs that were supplied at higher prices than imported ones as a result of the Memorandum of Understanding signed between CIPLA and Ministry of Health.¹⁷⁰ This would likely result in drug shortages since higher prices meant fewer drugs procured and further sustain donor dependency.

At some point, the company proposed to export drugs, a proposal opposed by MPs, who argued that to recoup the government's investment in the company, it should prioritize supplying Uganda's health system.¹⁷¹

¹⁷⁰ Auditor General Blames NMS for Overpricing Cancer, ARV Drugs, DAILY MONITOR, Wednesday April 5, 2017 <https://www.monitor.co.ug/News/National/Auditor-General-blames-NMS-for-overpricing-cancer--ARV-drugs/688334-3877848-rsy81i/index.html>

¹⁷¹ MPs Oppose Export of ARVs, NEW VISION, 10 April 2009, https://www.newvision.co.ug/new_vision/news/1223022/mps-oppose-export-arvs

7.3.2 The Proposed Medical Credit Fund

Part of the purpose of a prototypical PPP is that the private actor agrees to take on the brunt of the financial risk. In the healthcare sector this is a problem for PFPs and PNFPs. PNFPs would need access to credit to finance a PPPH arrangement. However, non-profit organizations are generally restricted from finance through commercial banks. Thus, the essential role of capital in PFP enterprise poses a problem in the health care sector. One proposed solution, as discussed in the Health Sector Development Plan's specific PPPH objectives is to create a special Medical Credit Fund.

Since October 2015, the IFC/World Bank Group through the Health in Africa Initiatives,¹⁷² and in collaboration with Pharm Access Foundation have taken lead working with the Ministry of Health and Ministry of Finance, Planning and Economic Development to establish a Medical Credit Fund for private service providers expected to be rolled out this financial year or the next.¹⁷³ The Ministry of Health top management endorsed the proposal.¹⁷⁴ Uganda's Ministry of Finance, Planning and Economic Development reportedly expressed willingness to support the development of such a fund through government financing and supervision alongside counterpart funding from the IFC and project funded by both public and private funds would be implemented under a PPP arrangement.¹⁷⁵

The concept of a Medical Credit Fund is similar to that of a micro-loan, but for medium-sized businesses in the healthcare sector. Medical Credit Funds generally involve some form of donor agency alleviating the risk to banks to provide loans to Small to Medium Enterprises (SME) in the healthcare sector. The rationale posited is that banks are typically reluctant to provide loans to private health companies, as the health sector is generally

172 The Health in Africa Initiative was launched in 2008 as \$1 billion dollar investment project that aimed to "catalyze sustained improvements in access to quality health-related goods and services in Africa [and] financial protection against the impoverishing effects of illness', with an 'emphasis on the underserved.'" It seeks to achieve this by harnessing the potential of the private sector. The Health in Africa Initiative is backed by other investors like the Bill and Melinda Gates Foundation; DEG, the German development finance institution, the African Development Bank which contribute to a Health in Africa Fund. IFC (2014) 'IFC Backs Africa Healthcare Fund' op. cit., http://www.ifc.org/wps/wcm/connect/news_ext_content/ifc_external_corporate_site/news+and+events/news/health_equity_fund (last accessed 20 March 2019); OXFAM (2014), Investing for the Few: The IFC's Health in Africa Initiative, https://www.oxfam.org/sites/www.oxfam.org/files/file_attachments/bn-investing-for-few-ifc-health-in-africa-100914-en.pdf (last accessed 20 March 2019)

173 Ministry of Health (2018), Mid Term Review Report for the Health Sector Development Plan 2015/16=2019/20 at page 18, available https://health.go.ug/sites/default/files/HSDP%20MTR%20Report-Final_25.10.2018%20final2222.pdf (last accessed 10 March 2019).

174 Ministry of Health (2018), Mid Term Review Report for the Health Sector Development Plan 2015/16=2019/20 at page 18, available https://health.go.ug/sites/default/files/HSDP%20MTR%20Report-Final_25.10.2018%20final2222.pdf (last accessed 10 March 2019).

175 Ministry of Health (2018), Mid Term Review Report for the Health Sector Development Plan 2015/16=2019/20 at page 18; interviews with key stakeholders. The latest information gleaned reveals government would contribute approximately 20% with the rest contributed by the IFC.

perceived to be a risky investment space.¹⁷⁶ Through the cooperation of IFC/World Bank, government of Uganda and the support of private Ugandan banking institutions, the proposed Medical Credit Fund aims to assist private for profit providers to grow their businesses while also reducing the risk they will default on their loans. The IFC and GoU will specify the interest rate, grace period, and repayment plans for the loans, which will be softer terms than typical business loans.¹⁷⁷ The targeted businesses are clinics, pharmacies, and hospitals, for them to invest in areas like construction, expansion, and equipment. Modeled in a similar fashion to the Agricultural Credit Facility set up by the Government of Uganda in partnership with commercial banks, the funds for the Medical Credit Fund will be placed in an escrow account and an advance provided to the financial institutions participating and once the bank approves the health provider for a loan, they can benefit from the fund and get a loan that can be paid back in 3-5 years.¹⁷⁸ At this time it is not clear what will be required of private institutions to secure the loans. The quality and range of services will be factors, as well as pricing. Medical Credit Funds as that run by PharmAccessGroup, generally involve various forms of technical assistance and quality control mechanisms. For instance, PharmAccessGroup utilizes its SafeCare assessment to ensure that the facilities they support maintain certain quality standards.¹⁷⁹ USAID runs a similar version to aid in the development of smaller clinics.

However, in this case the Ministry of Finance, has pledged to fund the project with some of its own money.¹⁸⁰ Thus, if the project rollout occurs, some significant amount of government (i.e. taxpayer) funds will be invested in the private healthcare sector. This stems from a faulty premise: that strengthening the private sector will result in improved health outcomes for the poor. There is legitimate concern that such funds would be better and more appropriately spent to support the public health system. 39 districts have no hospitals at all. These include Alebtong, Amuria, Amuru, Bukedea, Bukomansimbi, Bulambuli, Buvuma, Buyende, Dokolo, Gomba, Isingiro, Kalangala, Kaliro, Kamwenge, Kibuku, Koboko, Kole, Kotido, Kween, Kyankwanzi, Kyegegwa, Luuka, Lamwo, Lwengo, Manafwa, Mitoma, Nakapiripirit, Namutumba, Namayingo, Ntoroko, Otuke, Pader, Rubirizi, Serere, Sironko,

176 USAID (2016). *Uganda Private Sector Assessment in Health*; at p. 26

177 Interview conducted on 19 February 2019.

178 Interview conducted on 19 February 2019.

179 Medical Credit Fund website; at <https://www.medicalcreditfund.org/safecare/>; last accessed February 28, 2019

180 Ministry of Health (2018), *Mid Term Review Report for the Health Sector Development Plan 2015/16=2019/20* at page 18; interviews with key stakeholders. The latest information gleaned reveals government would contribute approximately 20% with the rest contributed by the IFC or at the very list contribute 2 million USD.

Kibale, Kakumiro, Rubanda and Omoro. As a result a number of these districts¹⁸¹ have consistently been the ten worst performing districts in health for the past five years according to the District League Table, the Ministry of Health's annual assessment of district health performance on key health indicators.¹⁸² 29 constituencies that should have Health Centre IVs lack one. 331 sub counties lack health centres IIIs and 132 of those sub counties lack health facilities completely, yet they should have one per the government's policy indicating accessibility of healthcare remains a huge challenge in many parts of the country.¹⁸³ As indicated in the tables in chapter 4, Private providers remain prevalent in predominantly urban areas and are not in the most marginalized areas, which are often rural. Some of the most marginalized areas like the islands do not have private providers. Public providers are often the first point of call for these vulnerable populations.

It is not clear that funds will incentivize private providers to operate in the rural areas where there may not be government facilities. None of the information publically available or from interviewees indicates that where the facility operates and its ability to reach marginalized people will be a determinative factor. Rather the loans are for facilities to use to upgrade. The Medical Credit Fund is likely to attract businessmen seeking to make profit in the health sector hence augmenting the commercialization of health.

The investment of significant systems of money without examining how strengthening the private sector will result in improved outcomes for underserved populations contradicts the World Bank's priority to end extreme poverty and reflects a mismatch between the government's rhetoric and practice. The central premise of universal health coverage is that anyone should be able to access healthcare without falling into poverty. Funds should be used for measures that will make that aspiration a reality. Currently, the proposed Medical Credit Fund seems unlikely to deliver better health outcomes for the poor and vulnerable.

Finally, government investment in the fund is contradictory to the presupposed advantage of PPPs i.e PPP initiatives are designed in part to advance money from the private sector to the public sector. The proposed Medical Credit Fund raises questions about whether it is

181 Amuria, Bukomansimbi, Bulambuli, Buvuma, Kotido, Kween, Luuka, Ntoroko, Sironko.

182 The indicators include fresh still births per 1,000 deliveries; maternal deaths audited; TB treatment success rates; patients diagnosed with malaria that are lab confirmed; approved posts filled with qualified personnel; monthly reports sent on time; Packed Cell Volume(PCV3), the absolute neutrophil count(ANC4)+, Immune thrombocytopenic purpura (IPT2), deliveries; HIV + pregnant woman initiated on ART; latrine coverage; completeness of monthly reports, and timelines of quarterly OBT reporting per percent.

183 Ministry of Health (2019) Ministerial Statement to Parliament on the State of Health Service Delivery in Uganda, 12 March 2019 at p 4.

justified to provide already meager public funds to this investment and the justification for the PPP model.

7.3.3 The International Specialized Hospital of Uganda (ISHU) PPP

In March 2019, Uganda's Parliament approved promissory notes for USD 379.71 million for a hotly contested Public Private Partnership between FINASI/ROKO Construction SPV Ltd. and the government of Uganda to build and manage a specialized healthcare facility. The Minister of Finance, Planning and Economic Development had tabled the proposal before the Committee on National Economy on 12 February 2019.

In 2013, FINASI, a company based in Italy that supposedly provides expertise in International Medical Planning and Facility Development partnered with ROKO construction SPV Ltd. and proposed to the President of Uganda to build and manage specialized healthcare at Entebbe Grade A and Uganda Cancer Institute. The objective would be to reduce morbidity and mortality due to non-communicable diseases.¹⁸⁴ The first phase would be to a construct a 264 bed JCI accredited facility that includes an oncology centre and national ambulance control centre. The second phase is a 500 bed hospital in Medical City.¹⁸⁵ The president directed Ministry of Health and Ministry of Finance Planning and Economic Development to negotiate the project and the contractor financing.

On 28 August 2014, the Ministry of Health Contracts Committee approved the project framework agreement. In October 2014, the government approved the project to construct the international specialized hospital and government and FINASI/ROKO Construction SPV negotiated and signed a number of agreements to have a facility established on 32 hectares at Lubowa, which would be donated by the government.¹⁸⁶ On 17 November 2014, the project framework agreement was signed between the Government of Uganda and FINASI S.R.L, a company incorporated in Italy and this agreement would guide negotiation of final project agreements. In May 2015, the project works agreement was signed for the design, construction and equipping of a 240 bed hospital and staff training that would cost the

¹⁸⁴ Parliament of the Republic of Uganda, Report of the Committee on National Economy on the Proposal to Issue Promissory Notes Not Exceeding US \$379.71 million to FINASI/ROKO Construction SPV Limited For the Financing of the International Specialized Hospital of Uganda at Lubowa, Wakiso.

¹⁸⁵ Ibid.

¹⁸⁶ Report of the Committee on National Economy on the Proposal to Issue Promissory Notes Not Exceeding US \$379.71 million to FINASI/ROKO Construction SPV Limited for the Financing of the International Specialised Hospital of Uganda at Lubowa, Wakiso (March 2019)

government US\$249.9 million and at a financing cost of \$99.5 million. In December 2015, the project services agreement was signed for the operation and maintenance of the hospital for a period of eight years. The agreement stipulated the Ministry of Health shall pay the hospital operations remunerations of US \$5 million per quarter during the first year and US \$6 million in the following years. The Ministry would also pay annual operations services remuneration to be agreed upon by the Ministry of health and the hospital.

On 4 December 2018, the direct agreement was signed with the Government of Uganda and FINASI/ROKO Construction SPV Ltd and African Export Import Bank and Barclays Bank of Uganda Limited. On 4 December 2018, the promissory note purchase agreement was signed between FINASI/ROKO Construction SPV Limited (As Seller); and African Export-Import Bank, ABSA Bank Limited, Barclays Bank of Uganda Limited and Eastern and Southern African Trade and Development Bank (As Arrangers); and African Export-Import Bank (As Note Purchaser, Administrative Agent and Security Agent); and Barclays Bank of Uganda Limited (As Local Administrative Agent); and the Original Note Funders.

On 12 February 2019, the Minister of State for Finance, Planning and Economic Development in charge of planning, Hon. David Bahati, tabled a proposal before Parliament to issue promissory notes, USD, 379.71 million to FINASI/ROKO Construction Special Vehicle Limited to finance the design, construction and equipping of the international specialized hospital at Lubowa, Wakiso district. The proposal was considered by the Parliamentary Committee on National Economy. On 25 February 2019, the President of Uganda wrote to the Speaker of Parliament on his position on the proposed PPP. The committee voted for the promissory note to be issued although a number of members dissented issuing a minority report noting the government had flouted procedure and compliance with enabling laws.

The development of this PPP and the process to approve this promissory note was irregular, revealing the broader lack of accountability, participation, access to information and flouting of the existing regulatory framework. The existing legal and policy framework were deliberately circumvented.

The Public Procurement and Disposal of Public Assets Act 1, of 2003 (as amended) (PPDPA) requires application of basic principles of public procurement and disposal¹⁸⁷ including transparency, accountability and fairness,¹⁸⁸ non-discrimination,¹⁸⁹ competition and

¹⁸⁷ Section 43 of the Act

¹⁸⁸ Section 45 of the Act.

¹⁸⁹ Section 44 of the Act.

ensuring value for money¹⁹⁰ and emphasizes open competitive bidding¹⁹¹ and public accessibility.¹⁹² Section 55 of the Act requires all public procurement to be carried out in accordance with the rules of this Act. The PPDPA prohibits negotiations between a procuring and disposing entity and contractor unless a competitive method was used. In this case, there was no open competitive bidding process and as the minority report of the Parliamentary committee rightly pointed out, it was not clear on what basis FINASI/ROKO SPV LTD emerged the preferred bidder.¹⁹³ This PPP appears to have been engineered on orders from the President. There was no benchmarking of previous work FINASI/ROKO SPV Ltd had constructed elsewhere that would indicate they were the best qualified or that the bid was competitively priced.

Parliament was not consulted at the time the promissory note was signed in contravention of the Constitution and the Public Finance Management Act and PPP Act, 2015. Article 159 (2) of the Constitution permits government to borrow, guarantee or raise a loan on behalf of itself or a public institution only by an Act of Parliament. Article 159(3) prohibits government raising a loan for itself or guaranteeing a loan unless approved by a resolution of Parliament. Section 23 and 39 of the Public Finance Management Act require Parliament approval before loans are taken out.

In this case, the Minister of Finance tabled the proposal before the Committee in Parliament after the agreement had been signed and FINASI/Roko issued notice of default to the government. The Minister tabled the proposal for a promissory note in February 2019, yet the project start date according to the current PIP (project code 1393) was July 2016 and completion date June 2020. The company had even presented the first milestone completion certificate to Parliament duly certified by the Ministry of Health Owner's Engineer on 20 December 2018 totaling to US\$ 86,370,954.13. The agreement signed required Ministry of Finance upon receipt of the certificate to issue a promissory note within two days, and it was accordingly due on 22 December 2018. On 21 December 2018, the Attorney General reversed a prior decision, which had indicated Parliamentary approval was not needed before the signing of promissory notes and noted Parliament approval was required to issue promissory notes. On 30 January 2019, the company issued and delivered a notice of

¹⁹⁰ Section 46 of the Act.

¹⁹¹ Section 51 of the Act.

¹⁹² Section 53 of the Act.

¹⁹³ Report of the Committee on National Economy on the Proposal to Issue Promissory Notes Not Exceeding US \$379.71 million to FINASI/ROKO Construction SPV Limited for the Financing of the International Specialised Hospital of Uganda at Lubowa, Wakiso (March 2019) (Minority report)

had required a remedy to be provided within 45 days from the notice of default, or the company could issue a notice of termination within 30 days.

The Ministry argued that the country would face arbitration and costs and pay more money if a promissory note was not issued. This argument is what swayed the committee, which passed the proposal despite noting that procedure was flouted and what informed the debate the house had that, resulted in the passing of the proposal. However, as the minority report rightly pointed out, a process that started in 2014 could not emerge as an emergency in 2019. Moreover, given that the government did not have the permission to enter into these contractual obligations, it raised questions about whether Parliament was left to condone illegal processes.

Aside from flouting the existing regulatory framework, there is no evidence to show the proposed PPP is cost effective and the best value for money. The government is providing land and USD 379.71 million. In return, it will receive one completed hospital. As noted above, a number of sub counties lack health facilities completely. It is not clear that the proposed hospital would provide additional services that could not be provided by the Uganda Cancer Institute, Uganda Heart Institute if adequately funded and if government invested in other tertiary institutions, particularly regional hospitals to develop their specialized functions. For example, the Uganda Heart Institute is undergoing renovation and expansion at a USD 64.9 million loan,¹⁹⁴ Mbarara regional hospital requires USD 30 million, both are a fraction of the cost it will take to construct the proposed Lubowa hospital. Investing more in regional hospitals like Mbarara, Gulu which serve large catchment populations including underserved populations would be more cost effective. It is worth noting that if no additional funds are earmarked for the Ministry of Health, financing Lubowa facility during the operational period would take up the entire non-wage budget and have negative implications on health service delivery. Providing additional resources would come at the expense of other projects or borrowing to finance the deficit.¹⁹⁵

It would not result in the provision of healthcare to those that need it the most. The direct agreement (clause 15.6) reveals it will not cost more than “average international prices.” The de facto amounts saved would be flight costs and costs of upkeep abroad for those that

¹⁹⁴ Report of the Committee on National Economy on the Proposal to Issue Promissory Notes Not Exceeding US \$379.71 million to FINASI/ROKO Construction SPV Limited for the Financing of the International Specialised Hospital of Uganda at Lubowa, Wakiso (March 2019) (Minority Report at p.7).

¹⁹⁵ Report of the Committee on National Economy on the Proposal to Issue Promissory Notes Not Exceeding US \$379.71 million to FINASI/ROKO Construction SPV Limited for the Financing of the International Specialised Hospital of Uganda at Lubowa, Wakiso (March 2019) at p.24.

could afford to go or take their relatives abroad for treatment.

This situation is compounded by the government's insistence that it is a public private partnership. Traditionally with PPPs, part of their appeal lies in the fact that the risk is borne by the private entity. Uganda's PPP Act defines a PPP where the private party assumes "substantial financial, technical and operational risks." In this case, the government seems to bear all the risk. The promissory note modality ensures the investor will receive 100% of the funding and will be shielded regardless of whether or not losses are made during the eight year period it will take to construct and start operating the facility. Civil society has sued the government.

8 FINDINGS

FINDINGS

Few advocates of PPPH have directly or explicitly posed their rationales from a human rights- based perspective, or with a specific focus on how PPPHs will impact the state of health care for Uganda's most vulnerable populations. However, supporters of PPPH often make indirect or implicit arguments that reflect on the main themes (Acceptability, Availability, Quality, and Acceptability), or other concerns guided by the human rights approach (e.g. Participation, Regulation, Monitoring, Review, Access to Remedies, Transparency). Here, we analyze the facts gathered from the literature and key stakeholder interviews to assess the role of private actors in health from a human rights based perspective.

8.1 Availability

Following the legacy of missionary medical clinics, PNFP facilities operated by the religious medical bureaus comprise a crucial portion of health services and infrastructure in hard to reach areas. Moreover, much of the funding for health services, particularly related to communicable diseases such as HIV/AIDS, comes from international donor agencies. With regard to EMHS, stock-outs in the public system are common. Lab services, equipment, and training institutions for medical personnel all revolve around the private sector. Therefore, the existence of, and some degree of cooperation with, private actors, specifically the religious medical bureaus and foreign donor agencies, is crucial to promote the availability of health care for vulnerable populations, particularly when GoU lacks the financing or the will, or both, to serve these communities.

Proponents of PPPHs believe that augmenting and further formalizing the relationship between these private actors will increase the availability of health services in remote and underserved areas. Given the ubiquity of stock-outs in the public system and private actors' role in the manufacturing and distribution EMHS, there is a natural argument to be made that coordination of the public and private sector through PPPH might increase the availability of EMHS. A similar argument could be made for lab services, equipment, and human services training, given that these necessities are ultimately resourced from the private sector. Surely, if the public and private systems mutually share information concerning the needs of these populations, there is potential for benefit. With respect to EMHS, according to stakeholder interviews, PPPH can increase availability. MoH's PPP Unit's initiative to provide purchase guarantees to the pharmaceutical industry reportedly built capacity to develop EMHS. On the other hand, this arrangement also resulted in the commercial export

of pharmaceuticals to other African countries, which does not apparently increase, and might actually decrease, the availability of those medicines for domestic populations in need. The PPP Unit's support for JMS arguably improved the availability of EMHS, although an audit of the Office of the Auditor General found that the prices at which the medicines were procured through Joint Medical Stores were more expensive than those through the National Medical Stores—92% of the drugs issued by NMS to health facilities were cheaper than those issued by JMS.¹⁹⁶ The provision of palliative care in Uganda is through a public private partnership between Ministry of Health and civil society that has resulted in the increased availability of morphine as a form of palliative care, although questions have been raised about its sustainability as the government continues to fall short of budgeting for palliative care. Coordination with international donors, such as USAID, who during interviews discussed the promotion of pooled procurement of EMHS to lower costs, might also improve availability.

There are no PPP guidelines to ensure equitable distribution of facilities. It would seem that allowing an array of private actors, most typically, the traditional PPPH, in this case the faith-based medical bureaus, to develop facilities in whatever locations they see fit might not be an optimal plan for ensuring maximum geographical coverage to the population. Private providers tend to choose areas that are accessible. An analysis of the distribution of Private Health Facilities found most of them to be in urban areas. Compare the 1,432 private facilities in Kampala to the 24 in Karamoja.¹⁹⁷ Logically, it stands that local governments are in a better position to distribute resources according to population needs with fewer gaps or duplications. Based on interviews with faith-based bureau officials, these are valid concerns. Interviewees acknowledged that coordination within and between the faith-based medical bureaus, and between the bureaus and the government was highly imperfect. One official stated that despite the existence of an inter-bureau coalition, there is likely insufficient communication over the strategic locations of facilities and resources. Coordination with district level PPPH Units would conceivably improve this aspect of availability, but these units are largely unstaffed.

Diverting public resources to PNFPs has been justified on the basis that it would supposedly increase availability. Government funding to these PNFPs in the form of Primary Health

¹⁹⁶ Office of the Auditor General (2016), *Management of Procurement and Distribution of Essential Medicines and Health Supplies by National Medical Stores: A Report by the Auditor General* at p.vii, 21, available at <http://www.oag.go.ug/wp-content/uploads/2017/04/Procurement-Distribution-of-Essential-Medicines-Health-Supplies-by-NMS.pdf> (last accessed March 20, 2019).

¹⁹⁷ Ministry of Health, *Ministerial Statement on the State of Health Service Delivery in Uganda*, 12 March 2019 (on file).

Care grants (which meet our criteria for PPPH), provide a portion of the funds necessary to maintain these operations, which are all the more crucial in areas where there is no viable public option. In most cases, PNFP budgets are comprised less than 20% from public funds. However, there are districts such as Amudat, where the MoH supplies 80% of the budget for the only HC III level facility in the district. The Church of Uganda, which operates that facility, supplies only 20% of the budget. In situations such as this, the argument that the PPPH arrangement increases availability is more suspect. It begs a question: If MoH did not rely on a PNFP to operate this facility, but instead applied those public facilities, would that increase the availability of services in this region?

8.2 Accessibility

In starkly theoretical terms, private actors, when they exist in lieu of public options, are detrimental to the accessibility of health care for vulnerable populations because by law public health care is free, whereas private actors can and do charge user fees. Even PNFPs charge user fees that are prohibitively high to a significant portion of indigent Ugandans. In practical terms, however, public health is often inaccessible to hard to reach Ugandans, and service, if available, might require illicit payments that are also prohibitive to the poor. Therefore, the impact of private actors on access to health care must be weighed not against the promise of free public health care, but against the reality of a public system that largely fails to provide access to health for poor and geographically remote Ugandans.

According to the NPPPPH Implementation Guidelines for PNFPs, MoH's rationale for PHC grants, is that the funding will reduce or eliminate the need for user fees. However, officials for the faith-based bureaus acknowledged that the PHC grants have not sufficiently led to that result. One official was quite candid in acknowledging that most PNFP facilities are not in a position to serve the indigent. The official stated, "If I was [working] in a [PNFP] hospital and I could tell that [a patient] was unable to pay, I would tell them to go to a government hospital." On the other hand, it should be noted that the government often provides increased financial support for PNFPs in impoverished and post-conflict areas such as in the Karamoja region. According to faith-based bureau officials, these facilities provide care at significantly reduced user fee rates. Still, in most cases it appears that these PHC grants do not specify the required reduction in fees, and there is no regulated mechanism to determine the appropriate user fees in an equitable manner. Moreover, as long as the user fees are not brought down to zero, truly indigent individuals in these regions will not have access to health care. In Amudat and Buikwe districts, PNFPs that serve as the equivalent

of a health centre IV and are the only higher level facility available in the area, communities pointed out that these PNFP facilities charged fees considered exorbitant by the population and detained those that were taken there in an emergency and were later on unable to pay. It is apparent then that PHC grants for PNFPs, as they exist today, are not effective vehicles for increasing access to health care for the most vulnerable populations, and are therefore an insufficient solution from a human rights perspective.

For international donors, PNFPs are the custodian of choice for PEPFAR and other funds that stipulate medications be provided to patients free of charge. These international donors are reluctant to allow these funds to travel through GoU budgeting mechanisms, due to perceived corruption in the Ugandan government. However, faith-based bureau officials acknowledged that their facilities typically do not provide those medications truly free. They explained that there are costs associated with the provision of those medications that funds like PEPFAR do not account for. They must charge service fees in order to avoid providing those medications at an unsustainable loss. Therefore, just as with GoU subsidization, PNFPs appear to be imperfect vehicles for increasing access to health through international aid.

Another significant factor impacting the accessibility of services are transportation costs. Health services are inaccessible for hard to reach and poor Ugandans who cannot afford to pay for transportation to health facilities. The public system does not seem to provide a remedy to this problem. Supporters of demand-side PPPH solutions such as voucher programs, such as USAID, government officials, and other private stakeholders interviewed, argue that these approaches will increase accessibility. Their argument is that under such a system, it will be in the financial interest of providers to provide services to poor and hard to reach Ugandans in order to redeem more vouchers and meet their operating costs. However, the system works with already existing health facilities that are accredited to join. Those areas that lack these facilities remain uncovered by these voucher schemes. Charging 4,000 UGX for a voucher seems like a nominal fee, but given the large number of teenage pregnancies, single mothers from extremely poor backgrounds this may not also be affordable. Incidents were reported of people that could not afford to pay the 4,000 UGX. In the current input-based public system, or input-based MOUs with PNFPs, providers are not financially incentivized to overcome these obstacles toward delivery of care. In fact, they are disincentivized to help impoverished Ugandans find ways to access their services. Thus, in theory, demand-side schemes will improve accessibility. Surely, it depends on the financing of such schemes, and the cost of a voucher to the patient. If the vouchers are

prohibitively expensive, or their redemption value too low, they will not help to increase accessibility.

PPPHs with PNFP and for profit entities, in which private hospital wings subsidize public facilities, might be a tool to subsidize healthcare to the poor in mixed class urban areas, namely Kampala. However, such arrangements are risky: If planned and managed incompetently, or without a primary concern for human rights, they serve to decrease healthcare equity and access for the urban poor, as well as geographically remote populations. Key stakeholders described problems in the implementation of private wing subsidization programs in Uganda. They spoke of facilities where treatment in the public wings still required formal, informal, and sometimes illicit payment. Moreover, they discussed instances where this arrangement led to public resources subsidizing the healthcare of wealthier private patients, exactly opposite to the intended effect. Even when such arrangements are successful, they have no application in poor and geographically isolated areas, where there is an insufficient base of wealthier individuals to subsidize the public system. At its worst, as seen in Lesotho, this type of PPPH diverts public funds needed to reach geographically remote citizens. Similarly the proposed PFP PPP international specialized hospital in Lubowa will not be affordable for the majority of Ugandans and likely divert funds that could be used to actually increase accessibility of services.

8.3 Quality

Data on health care quality in Uganda is limited with respect to both public and private providers. Although comprehensive monitoring and evaluation tools exist, they appear to be underutilized. According to some private stakeholders interviewed, they are overly burdensome instruments that are not pragmatic indicators of health care quality. There are reasons to be concerned about the impact that PPPHs might have on private actors' quality of care. In theory, PPPHs such as Primary Health Care grants, especially if they were made to be more contractual and less MOU-based in nature, provide the government with leverage over PNFP providers, giving them the ability to enforce quality standards. In practice, that does not seem to be the case. Since the PNFPs are essentially fulfilling the government's health care obligations where the MoH does not have the will and/or the financing to do so, MoH seems to have limited leverage over the PNFPs. As one faith-based bureau official stated during an interview, "The faith PNFPs have covered a certain gap that tends to shield the nakedness of government."

There is also a concern that introducing market or profit incentives to the health care system, or fee for service financing, might incentivize providers to provide higher volumes of lower quality care, since reimbursement is ultimately tied to quantity, not quality. Demand-side payment mechanisms, on the other hand, theoretically force providers to compete with one another. Those who offer higher quality services will attract more customers and redeem more vouchers. However, this assumes that the forces of competition will be great enough that the market will produce for poor and hard to reach Ugandans actual choices, which seems unlikely. Moreover, low-information consumers might not have enough medical literacy to make educated judgments about which providers offer higher quality care.

A rationale often posited that the private sector provides better quality of care and its efficiency can be leveraged during PPPs to enhance overall quality. On the one hand, the private sector under the umbrella of the Uganda Healthcare Federation has launched a Self Regulatory Quality Improvement System to allow private providers to assess the quality of their facilities and the services offered. It seeks to mention ten dimensions of quality including client centred care, access, continuity, safety, competence, effectiveness, efficiency, equity, interpersonal relationship and choice.¹⁹⁸ Through the Voucher Management Agencies like Marie Stopes, it is assessing quality.¹⁹⁹ However, this tool is voluntary. There is no repercussion when quality is not adhered to. As described on the website, rather than serve as a tool for “fault finding” the tool is supposed to serve as “a mirror that will help identify gaps in service provision.”²⁰⁰ The PPPH policy states that for PFPs, it will enhance provision of quality services through “annual publishing of licensed health facilities” and “establishing a database for all registered private providers.” This has not improved quality. It seems a facility getting licensed depends on the ability to pay. Once you pay you are licensed by the Medical and Dental Practitioners Council, and discussions of quality are divorced from the licensing process.²⁰¹

For PNFP PPPs, quality would be supposedly improved through the medical bureaus, which accredit facilities to ensure they meet standards. However, interviews revealed not all

198 Uganda Healthcare Federation, Self-regulatory Quality Improvement System, <https://uhfug.com/resources/sqis/> (last accessed 20 March 2019).

199 <https://uhfug.com/1753-2/>; <http://sqis.med.ug/>

200 Uganda Healthcare Federation, Self-regulatory Quality Improvement System, <https://uhfug.com/resources/sqis/> (last accessed 20 March 2019).

201 Interview with official from faith based bureau, November 30, 2018.

facilities operated by the faith based bureaus are accredited. Even when accredited, accreditation requires a facility to score above 75%. Those that perform below get conditional accreditation where the faith based bureau works with them to improve. However, the effectiveness of this is undermined by the fact that all facilities, whether or not they meet the accreditation score are included in the MOUs with the MOH. In other words, the facilities' ability to receive PHC grants is not contingent on it being accredited and meeting certain quality standards.²⁰² Regardless of whether the facility received the passing accreditation score, facilities will still receive PHC grants, undermining the accreditation process as a way to improve quality.

The failure to regulate quality negatively impacts health consumers. In one PPP facility, the community complained of the facility lacking functional equipment. For instance a woman underwent a scan at the hospital and was told she had a tumor and had to be operated on immediately. When she sought a second opinion from a different facility, she was told the supposed tumor was a pregnancy and her baby growing.²⁰³ In a bid to implement cost cutting measures, some private providers and PPPs have offered low quality services, for example hiring staff that are not necessarily qualified.²⁰⁴

8.4 Acceptability

A major factor in acceptability of care involves how patients are treated on a human level. PNFPs' treatment of indigent Ugandans, including those who receive PHC grants, is highly problematic. One faith-based bureau official stated that users were not charged until after receiving services, and that PNFP facilities did not hold patients who failed to pay against their will. However, this official stated that "escapees" were a major problem for PNFP facilities. For example a patient, after receiving health services, might say they were going out to get a soda, but then not return to pay their bill. Whether it is in their policy or not, facilities are incentivized to engage in some form of loss prevention. Indeed, one DHO who was interviewed acknowledged that patients who failed to pay were sometimes prevented from leaving health facilities until the facility could determine that they were telling the truth about their inability to pay. The DHO stated that after being held against their will, patients would ultimately acknowledge that they could pay the fees, and they would produce their

²⁰² Interview with official from a faith based medical bureau, November 30, 2018.

²⁰³ Interview with community members, Buikwe, February 2018.

²⁰⁴ Interview with health worker, PPP facility, December 201

balance. Certainly, there are issues in the acceptability of a health care system where an indigent person is forced to choose between foregoing their right to health or committing theft of services. The possibility of being held at a hospital against one's will is also not an acceptable circumstance. When the line between hospital and debtor's prison begins to blur, surely the system is outside the range acceptability.

Acceptability also becomes a major issue for a health care system that relies so heavily on PNFs funded by foreign interests. Naturally, foreign entities are less attuned to Ugandan cultural considerations. Similar concerns exist with respect to PNFs funded through religious ministries. When serving religiously diverse populations, religious ministries might have interests that do not reflect those of the individuals they serve, who might ascribe to different religious traditions. Provision of sexual reproductive information and contraceptives are one such example. Family planning services were often not offered by religious based PNFs. This is gradually changing.

8.5 Regulation

According to the USAID Private Sector Assessment, governance structures to foster public-private dialogue are currently weak. Assuring the quality of services within the private sector is a big challenge because it is still fragmented and the tools for government to monitor and supervise it are lacking. There are multiple agencies involved in regulating private sector quality with similar functions that overlap and poor coordination among them creating cumbersome and often duplicated procedures. The legal and policy framework chapter sets out legislation and policies that create entities with similar functions with no overarching coordinating framework. Section 11(5) of the PPP Act requires the Permanent Secretary of the Ministry of Finance, Planning and Economic Development to develop a framework that harmonizes relationship between PPP Unit and departments within Ministry of Finance but a 2017 Audit found this has yet to be done. For example the Project Analysis and Public Infrastructure Department (PAPI) and the PPP Unit have contradictory reporting structures and it is not clear whether to report to the Permanent Secretary of Director Budget. Additionally, quality enforcement is weak due to limited resources (for staff and facilitation).²⁰⁵ The Office of the Auditor General found that the upfront detailed PPP feasibility study and analysis required to design a robust structure to meet government objectives do not take place since the Project Development Facilitation Fund, which should

²⁰⁵ USAID (2016). *Uganda Private Sector Assessment in Health*; at p. 23

support the PPP Unit and contracting authorities when preparing PPPs and provide funds to meet contingent liabilities had not been set up.²⁰⁶ The Audit also found PPP Unit had not established comprehensive monitoring and evaluation framework, without which authorities cannot assess achievement of the PPP objectives.²⁰⁷ A 2017 Audit found the position of Director of the PPP Unit had not been filled and someone had been acting in this position since 2015. Other key positions including legal expert, project finance expert, technical expert, technical specialist had not been filled.²⁰⁸ Within Ministry of Health, the PPP Unit is understaffed, it had two dedicated staff, one of whom has left and staff do not work on only PPPs but also work on other issues within the planning department. This not only affects regulation but also raises questions about the country's preparedness for PPPs. To negotiate complex contracts, specific knowledge is necessary, particularly for more complex PPPs like those involving clinical services. The availability of stable knowledgeable teams including how frequently staff rotate affects the government's ability to effectively negotiate in these contracts.

Other flaws in regulation are exemplified by the failure to clarify fees for essential medicines supplied through private facilities in a PPPH arrangement. The USAID Private Sector Assessment found there was a general lack of clarity with regard to fees charged for HIV/AIDS and Anti-Retroviral Therapy services by both PNFPs and PFPs accredited to access free supplies. While recent case studies stated that the MoH required facilities to dispense the drugs free of charge, both facilities and MoH/GoU staff interviewed had a wide range of interpretations of what that meant in practice.²⁰⁹ According to the Private Sector Assessment's research, some facilities did not charge patients, while others charged for all or some services, including drugs, though sometimes at a lower rate. One PNFP facility provided standard HIV/AIDS services for free or a nominal fee (UGX 2,000) but charged extra fees for ancillary services. According to some respondents, there was no strict guidance on how private sector facilities should or should not collect fees under the program.²¹⁰ One of the ways the MoH and private sector representatives seek to resolve these issues is through the PPPH Working Group.

206 Office of the Auditor General, Extracts of Findings of the Auditor General's Annual Report to Parliament, 2017 at p.45., available at http://www.oag.go.ug/wp-content/uploads/2018/01/Extracts-of-Key-Findings-of-the-Auditor-Generals-Report_2017.pdf (last accessed March 28, 2019)

207 Office of the Auditor General, Extracts of Findings of the Auditor General's Annual Report to Parliament, 2017 at p.45.

208 Office of the Auditor General, Extracts of Findings of the Auditor General's Annual Report to Parliament, 2017 at p.45

209 Ibid at p. 27

210 Ibid at p. 140

8.5.1 Structure of PPPH Working Group

The PPPH Working Group is one of the Technical Working Groups that operate under the Health Policy Advisory Committee (HPAC) for the implementation and monitoring of the national strategic plans. The MoH, with assistance from the Italian Cooperation, established a PPPH Desk to coordinate PPPH activities in 2000. The areas for partnership were identified as: policy development, coordination and planning; resources management including financial resources mobilization and allocation, and human resources for health development and management; service delivery including management and provision of health services and community empowerment and involvement.²¹¹ The NPPPPH further delineates a hierarchical system of levels. At the central level: there is the Joint Review Mission, the Health Policy Advisory Committee (HPAC) Working Group on PPPH, and sub-working groups for PNFP, PFP, and TCMP; and the MOH/PPPH Desk. At the local government level, there is the District Health Management Team, the District PPPH Desk Officer, Co-ordination Committees (and other 'key structures'). The descriptions of these various roles are generally vague and lacking in executive mechanisms. For instance, the description of the role of the District PPPH Desk Officer is to “facilitate information flow between district authorities and private sector representatives” and to “facilitate understanding and harmonization of implementation arrangements.” Dispute mediation is folded into that hierarchical structure, with any dispute being handled at the appropriate level.²¹² However, policy documents do not provide further detail about how disputes are mediated at any given level. According to the USAID Private Sector Assessment, within the PPPH Node at the MoH, there is need to source for more resources to enable the unit to function more effectively, particularly for recruiting additional staff and/or training in PPP skills (e.g. financing, contract law, dialogue, contract management and conflict resolution).²¹³

8.5.2 Professional Councils

The Uganda Medical and Dental Practitioners Council, alongside Uganda Nurses and Midwives Council, Allied Health Professionals Council and Pharmacy Council are responsible for enforcing standards and educational requirements and sanctioning health providers that do not comply, including the private sector. There have been efforts to strengthen their

²¹¹ USAID (2016). *Uganda Private Sector Assessment in Health*; at p. 23

²¹² Government of Uganda; *National Policy on Public Private Partnerships in Health* (2012); at p. 20

²¹³ USAID (2016). *Uganda Private Sector Assessment in Health*; at p. 23

regulatory role like reviewing and harmonizing their laws and reviewing standards for facilities.²¹⁴ However, they face challenges that affect their effectiveness. The latest Auditor General Report found the Medical and Dental Practitioners Council understaffed with 27 % of the positions not filled due to inadequate funds.²¹⁵

8.5.3 Contractual approach as a form of regulation

The PPPH guidelines provide a rationale for the development of a “contractual approach” to PPPHs. They state that “[c]ontractual approaches are meant to improve efficiency of resource allocation to more public purpose needs of the society.” They also state, “The contractual approach should lessen the need for detailed attention to managerial processes of the partners and increase reliability and dependability of either partner.” The policy also states that the contractual approach will improve “transparent accountability in service delivery and financial management.” However, most of the existing PPPHs use MOUs rather than contracts.

On a statutory level, there is an imperfect, albeit functioning regulatory system that serves the country. In reality, according to interviews with private stakeholders, that system is both overly burdensome and unenforced, and in many cases regulatory obstacles are more likely to be met with bribes than quality improvement.

Based on interviews, GoU essentially leaves PNFPs to regulate themselves. According to these officials, their respective bureaus have a rigorous, self-enforced monitoring and evaluation system that meets and often exceeds those stipulated by MoH with respect to quality of care. However, the Ministry deliberately refrains from regulating the fee structures of their facilities. Thus, on an oversight level, there is no assurance that PPP facilities will establish or maintain equitable fee structures.

8.5.4 Private Sector Self Regulation

During interviews, other private stakeholders advocated for self-regulation through positive financial incentives as opposed to punitive governmental regulations. More specifically,

²¹⁴ Ministry of Health (2018), Annual Health Sector Performance Report at p.92.

²¹⁵ Office of the Auditor General (2018), Report of the Auditor General to Parliament for Financial Year Ending 30 June 2018 at p.79, available at

<http://www.oag.go.ug/wp-content/uploads/2019/01/Report-of-the-Auditor-General-to-Parliament-for-the-FY-ended-30-June-2018.pdf> (last accessed March 20,2019).

some private stakeholders advocate a system of quality service requirements in order to gain access to subsidies and reimbursements, which would fit into an overall results-based scheme. They believe that punitive government regulation is less effective, and often overly burdensome. As discussed during our interviews, the private sector has advocated for self-regulation through tools such as SafeCare²¹⁶ and the Self-Regulatory Quality Improvement System (SQIS)²¹⁷. The government has increasingly bought into self regulation. The Uganda Medical and Dental Practitioners Council, one of the regulatory bodies, supports self regulation.²¹⁸ This raises concerns about the government potentially ceding regulatory control to the Private sector's self-regulation yet as articulated in the legal section, the government has an obligation to regulate the private sector. Moreover, the enforcement mechanisms for these schemes in Uganda's context are not fully fleshed out. Moreover, private stakeholders' self-regulatory schemes do not necessarily include adequate protections for Uganda's most vulnerable citizens. When asked about regulation, several of the private sector stakeholders expressed concerns that focused on their self-interest, noting overly burdensome regulations. For instance, when asked about regulatory challenges in the industry, several interviewees primarily cited excessive taxation to the private sector. Therefore, it seems dubious that ceding more influence to private sector stakeholders will lead to a regulatory environment that provides greater protection to vulnerable groups.

8.6 Accountability of private actors

Despite the increasing proliferation of PPP arrangements in health, very little has been done to ensure accountability. Proponents of PPPs could argue that accountability is strengthened since consumers can directly interact with the service providers, enabling them to correct wrongdoing quicker, rather than waiting for government intervention, which may take a longer time and be less effective. A bureau official noted PNFPs have Health Unit Management Committees comprised of community members that can seek

216 According to its website: "The SafeCare Foundation is designed for health care providers in resource-poor settings to assist them in step-wise quality improvement and the delivery of safer care to their patients." See <https://healthmarketinnovations.org/program/safe-care-foundation>; last accessed November 13, 2018.

217 According to its website; "The SQIS allows private providers to easily assess quality of their facility and services offered and to develop action plans to address the gaps identified. The SQIS standards are not meant as a tool for fault finding but as a mirror that will help identify gaps in service provision. One assumes that improved quality, on the supply side, will increase efficiency and effectiveness of care. On the demand side, quality services lead to greater client satisfaction, increased use of services, and better adherence to recommended treatment." At <http://sqis.med.ug/introduction/>; Last accessed November 13, 2018.

218 Interview with official from Uganda Medical and Dental Practitioners Council, 10 September 2018.

accountability from the facilities. They noted community dialogues held like health assemblies. However, the efficacy of these measures is undermined by the limited access to information the health consumers have and whether or not they have access to markets of providers and possibility of changing providers. In one dialogue the research team held, the community wanted to know whether they have the right to information, “Are we allowed to question the health personnel or raise issues we find wrong?” In communities where the PPP is the sole provider of a service, for example in a district where a PPP hospital that is the only equivalent of health centre IV, the lack of the possibility of changing providers meant the community could not hold the PPP accountable.²¹⁹ The community feared retaliation if they spoke out at dialogues.²²⁰

The criterion to assess and select a PPP is not clear. There is no specific methodology to assess risk identification, value for money, fiscal affordability, and social impact assessments.²²¹ Private actors have little accountability in Uganda’s health sector. Although MoH has developed detailed health care monitoring and evaluation plans, and although, on a statutory level, those instruments apply equally to public and private facilities, in reality there is little evidence that these instruments are utilized, particularly with respect to the private sector. To the extent that private actors act independently from GoU, and finance and operate project-based assistance, it is difficult to imagine GoU holding them accountable since GoU has no leverage to do so. Moreover, private actors do not always spend the resources required to share data with MoH.

Current PPPH arrangements do not provide much more accountability. The PHC grants are typically in the form of MOUs, which are more of a gentleman’s agreement than a contract for services. There is a current trend for these MOUs to include increasingly contractual language. For instance, some MOUs are specifying maximum fees facilities may charge for various services, and they are including results-based mechanisms, in which funds are partially dependent on performance. NHIS, if it utilizes voucher or capitation models, might provide an additional form of leverage for accountability. Specifically, MoH can require private insurance companies and/or private facilities to share some minimum of information if they are to be eligible for voucher redemption or provider status under a capitation model. Therefore, in theory PPPH can increase accountability. However, it also seems naïve

219 Interviews with community members, Buikwe, February 2018; Nordtveit, B. H. (2005). *The Role of Civil Society Organizations in Developing Countries: A Case Study of Public-Private Partnerships in Senegal*. Dissertation, University of Maryland. Available at: <http://hdl.handle.net/1903/2193>

220 Interviews with community members, Nkokonjeru Buikwe, 22 February 2018.

221 Interviews with government officials; World Bank, Summary of Benchmarking of PPP Procurement 2018 in Uganda.

to assume that a move toward private partnership, and away from direct public provision of services, is likely to lead to greater accountability.

Accountability is further hampered by the government's weak stewardship role. The Health Sector Development Plan notes that the mechanism for coordinating partnerships is not functioning, stating:²²²

With regard to sector partnerships, most of the existing structures for partnership engagement are largely moribund, and not providing the needed forums for sector engagement. Some partners are therefore sidestepping these structures, and providing support that is not coordinated and harmonized. The SWAp process and the Health Policy Advisory Committee (HPAC) functionality are therefore compromised, with current focus primarily on statutory actions (e.g. endorsing proposals) as opposed to being forum for dialogue. The Technical Working Groups (TWGs) and Intersectoral coordination functionality are sub optimal, and there is limited real engagement of some stakeholder groups.

Even though health service delivery is supposed to be financed by the government, private sources and development assistance continue to play a major role in financing health services. Since this financing is off-budget, the government is frustrated in its ability to act as a steward of the system. There still exist many donor 'projects' – bilateral, multilateral and global initiatives – which, according to the Health Sector Development Plan - need to be integrated fully into strategic and operational planning and budgeting, even if the finances do not flow through the Ministry of Finance.²²³

8.7 Participation

From a human rights perspective, participation by vulnerable groups is threatened by private actors. In theory, at least, elected officials, who are responsive to the will of the people, manage a public health care system. In reality, in Uganda's context, vulnerable groups' ability to participate even in a fully public system is questionable. Nevertheless, for the government to cede control of the system to unelected private actors can only act as an additional barrier between vulnerable groups and the health system designed to serve them, even when those private groups have positive intentions. If PPPHs can actually be responsive to the demands of local governments, and if local governments can in turn be responsive to the needs of their communities, then there is the possibility that PPPHs can incrementally improve vulnerable groups' participation in health care systems, since private actors already dominate those systems. During interviews, bureau officials

²²² Ministry of Health, Health Sector Development Plan, 2015/16 - 2019/20; at p. 44; at <http://www.health.go.ug/content/health-sector-development-plan-201516-201920>; last accessed August 17, 2018 at p. 42

²²³ Government of Uganda; Health Sector Development Plan, 2015/16 - 2019/20 at p. 45

discussed various ways that they facilitated community participation. Still, under system dominated by private actors and PPPs, that public participation is more likely to be treated as a privilege than a right.

8.8 Access to Information and transparency

Participation is further limited by the lack of access to information and limited transparency. The public is often not able to access information regarding PPPs. The contracts are often difficult to obtain with parties hiding behind confidentiality clauses. Not all the contracts regarding the proposed international specialized hospital were made available to Parliament. Members of the public have not been able to easily access them.

Patients lack access to information regarding their medical records. Communities reported lacking information on whether facilities are PPPs and what that entails, whether or not the facilities receive monetary support from the government. The lack of transparency around this information facilitates corruption on both ends. Although Uganda has an Access to Information Act, 2011, it focuses on information within the purview of the State. Civil society has started to initiate access to information cases regarding public private partnerships, arguing they serve public functions and as such, the Access to Information Act applies to them. The Initiative for Social and Economic Rights (ISER) has initiated legal action against a PPP facility that denied access to information and ignored access to information requests. ISER has also intervened in a number of incidents where patients are seeking their medical information from private actors and which have been denied.

A connected drawback is that private actors often have asymmetrical information where they have more information than the partner government institutions. Private actors can take advantage of this to safeguard their own interests at the detriment of community interests. This is salient when negotiating contracts. For example the contracts to build and operate the international specialized hospital have a number of clauses that raise questions about the information government had at the time of signing. This is particularly concerning given that the government cannot exert much control in private sector operations, unlike public and there has been evidence of abuse and an overt focus on profit maximization above else.²²⁴

²²⁴ This was evidenced in the Phoenix Logistics Project and Apporel Tri-Stor (ATS) Uganda Ltd, which although not a PPP, reflects the danger of private sector focusing on profit maximization above all else and raising questions about whether government was taking on a similar risk with regard to private sector obligations in PPPs.

Finally, transparency suffers in a complicated system where the lines between public and private actors are blurred. For instance, there is no transparent justification for why PNFPs who receive public funds are exempt from the prohibition against user fees. One interviewee explained that the prohibition of user fees was a “presidential declaration, but not a policy.” Another explained that the prohibition was a legitimate policy, but that it only applied to public facilities. The current ad hoc combination of public/private service delivery is murky, and translucent at best. As a resident of the Amudat district in Karamoja stated during interview, she would prefer that the health facilities in her area were either entirely public or private. She expressed frustration and confusion regarding the obligations of the local Health Center Level III facility that was operated by the Church of Uganda using largely public funds, as well as the ways in which it coordinated its operation with her local public level II facility.

8.9 Access to Remedy

As can be expected, the relegation of health care provision to private actors is not conducive to access to remedy for vulnerable populations. PNFPs do have their own structures to deal with complaints, however, there is little to no state support to pursue complaints outside of the system established by the private actors themselves. It seems inevitable that without external, or state sponsored structures, these processes will favor the private actors who themselves are allowed to set the rules of the process. The PPP policy states the contractual approach will aid in the “development of mediation and arbitration mechanisms [and] legislation and enforceable sanctions.”²²⁵ However, MOUs have been predominantly used except for the design and build PPPs, eroding the articulation of clear mediation and arbitration mechanisms.

For PPPs like the proposed International Specialized Hospital, the contract insists on arbitration being carried out in London and specifies English law applies, making it expensive for the government or any one else seeking access to remedy.²²⁶

²²⁵ Ibid at pp. 14-15

²²⁶ Direct Agreement 2018

8.10 Efficiency, Cost Effectiveness and Transfer of Risk

Cost effectiveness is often fronted as a benefit of PPPs. Cost effectiveness inherently considers the transfer of risk. Part of the purpose of a prototypical PPP is that the private actor agrees to take on the brunt of the financial risk. The PPP Act, 2015 requires the private party to assume “substantial financial, technical and operational risks” and in return receives a benefit either through payment by contracting authorities or charges or fees collected by the party from the users of the infrastructure or service or both. Government’s are not best placed to take up the risks of large infrastructural projects.

In the healthcare sector this is a problem for PFPs and PNFPs. Existing PPPHs do not transfer the risk from the government to the private factor. Traditional health service delivery PPPHs like PNFPs do not transfer the risk to the private sector since the government subsidises them through PHC grants. The private sector would need access to credit to finance a PPPH arrangement. However, non-profit organizations are generally restricted from finance through commercial banks. Moreover, banks are typically reluctant to provide loans to private health companies, as the health sector is generally perceived to be a risky investment space.²²⁷ Therefore, PPPHs will generally rely on international donor funds. Donors tend to prioritize communicable diseases such as HIV, TB and malaria despite an increasing need for treatment for non-communicable diseases like diabetes.²²⁸ Even when a private party could raise the funds, there has not been transfer of risk. The contract to build and operate the proposed international specialized hospital is an example where the converse is true; the government solely bears the risk, rather than the company Finasi/Roko Construction, SPV.²²⁹

Moreover while transaction costs can be fixed, for example traditional PPPHs where the existing infrastructure is owned by churches or faith based bureaus, in other instances variable transaction costs can quickly add up, making the PPP more expensive than if the government directly provided the service. Variable transaction costs could include monitoring and inspection, running costs of the contract managing entity. For example for the proposed international specialized hospital in Uganda, the direct agreement notes the government will pay the company “Management Service Remuneration” to cover the

227 USAID (2016). Uganda Private Sector Assessment in Health; at p. 26

228 Government of Uganda; National Medicines Policy (2015); <http://health.go.ug/content/national-medicines-policy-2015>; last accessed August 17, 2018

229 Direct Agreement, 2018.

general overall management of the project, which shall be paid quarterly at a rate of US \$5,152,000 (exclusive of tax) for the first year of operation and thereafter US\$6,086,000 (exclusive of tax) per quarter for the rest of the service period. The Government is responsible for all taxes directly related to the scope of the project.²³⁰ In the Direct Agreement, 2018, the construction works cost compensation that was in the 2015 agreement specified at US\$95,300,000 was increased to US\$116,985,881.91, which in turn increased the Works Remuneration Agreement to US\$366,885,881.91 all before construction has commenced.²³¹ The Direct Agreement noted the total cost of the project was supposed to be at a fixed contract price of US\$249.9 million at a financing cost of US\$116 million, which would amount to US\$365.9 million but in a February 2019 appearance before Parliament, the Ministry of Finance sought approval for promissory notes worth US\$379.71 million, noting costs had gone up.²³²

Cost effectiveness as a benefit of PPPs has been increasingly debunked. The European Union Expert Panel on Effective Ways of Investing in Health in its Health and Economic Analysis for the Evaluation of the Public Private Partnerships in Europe found no evidence that a PPP model is more efficient than a public provider, finding PPPs have been more expensive in the long run.²³³ When assessing cost effectiveness, the following were evaluated: whether the cost of borrowing will be lower; whether the total cost of construction and/or management of the facility will be lower, compared to traditional public procurement, assuming the same function; whether function will improve at the same or lower costs, compared to traditional public procurement; whether health service productivity will be higher, for example measured as cost per hospital episode or physician visit; whether cost-effectiveness in terms of cost in relation to health outcome will be improved. In Spain, where at least 44 PPP initiatives have been developed in the health sector, the Regional Court of Auditors of Valencia Region in its 2013 report, “MRI a chance to save” found

230 Section 9.3 of the Project Service Agreement for the Management, Operation and Maintenance of the International Specialized Hospital of Uganda Between Government of the Republic of Uganda Represented by the Ministry of Health and the Ministry of Finance, Planning and Economic Development and the International Specialized Hospital of Uganda Limited (December 2015).

231 Clause 5.3 of Government of the Republic of Uganda Represented by Ministry of Health and the Ministry of Finance and Planning Development and Finasi/Roko Construction SPV Limited and African Export Import Bank Acting as Note Purchaser, Administrative Agent and Security Agent and Barcaus Bank Uganda Limited acting as Local Administrative Agent, Direct Agreement relating to the International Specialised Hospital of Uganda (the “Hospital”) (hereinafter referred to as Direct Agreement, 2015)

232 Direct Agreement, 2018; Parliament of the Republic of Uganda, Report of the Committee on National Economy on the Proposal to Issue Promissory Notes Not Exceeding US \$379.71 million to FINASI/ROKO Construction SPV Limited For the Financing of the International Specialized Hospital of Uganda at Lubowa, Wakiso, March 2019.

233 Expert Panel on Effective Ways of Investing in Health, Health and Economic Analysis for an Evaluation of the PublicPrivate Partnerships in Health Care Delivery across Europe at p.38, adopted 27 February 2014, https://ec.europa.eu/health/expert_panel/sites/expert-panel/files/003_assessmentstudyppp_en.pdf (last accessed March 28, 2019).

that using traditional public provision would have resulted in a 40% saving compared to using concessions through a ten year PPP contract.²³⁴

To ascertain efficiency, annual audits are necessary. As mentioned in the section on the legal framework, the PPP Act requires annual audits. However, this is often not done. The audits we came across are on the CIPLA/Quality Chemicals Ltd. Moreover, the audits do not focus on the contracts phase.

²³⁴ Ibid.

9

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS AND RECOMMENDATIONS

The private sector and PPPs are often promoted as a quick way to respond to the increasing national and international pressure to realize development objectives such as the Sustainable Development Goals including Goal 3.8 Universal Health Coverage. As the country considers national health insurance, private actors in health will play a more pronounced role, particularly given the requirement to receive accreditation before being added to the scheme. This report raises questions about whether investing in arguably risky private sector initiatives is a better approach than investing in public health care, which is often the first point of call for the most marginalized. This research has revealed the use of PPPs can result in a growing discriminatory gap between the have and have-nots and debunked unsubstantiated assumptions that the private sector is more efficient, cost effective and its involvement will have a positive correlative effect on health outcomes. Efforts to promote accountability are undermined by limited access to information, limited transparency, limited citizen participation and the weak remedial mechanisms. The report concludes with recommendations on how to address this.

9.1 Recommendations

For GoU

- Increase the percentage of the budget devoted to health care, focusing on poor and geographically remote citizens. The current levels are well below international benchmarks for funding universal healthcare. Ensure that public funds go towards strengthening the Public health system that is accessible to all.
- Public Private Partnerships can't compensate for a weak state and require the State to maintain a strong and consistent stewardship role.
- Strengthen PPP Unit in Ministry of Finance and ensure joint planning with PPP Unit in Ministry of Health and PPP TWG.
- Harmonize the regulatory environment.
- Decisions to enter into PPPs especially large infrastructure ones should be backed by evidence and human rights impact assessments to ensure benefit to the poor and marginalized groups.

- Assess RBF in health service delivery before wholeheartedly embracing it and ensure that it does not result in negative impacts for access to healthcare.
- Conduct a macro-prudential review, which reveals the totality of a government's PPP obligations, including contingent liabilities and ripple effects through public lenders. This review should be updated and maintained throughout negotiation period.

For MoH

- Address the reality of de facto user fees. The abolition of user fees exists in theory and in legislation, but not in practice. In reality, Ugandans pay for health care through complicated, informal, and often illicit systems of payment that increase inequity and add to the inefficiency of the system.
- Work towards an effective regulatory system. Current oversight instruments, such as monitoring and evaluations plans are uncoordinated and government often lacks the will or ability to enforce them.
- Require transparency. This includes mandating disclosure including contracts, side-agreements and subsequent changes, renegotiations and arbitrations, regular progress monitoring reports.
- Strengthen the PPP Unit and conduct monitoring and evaluation of all PPPHs to assess their alignment with the vision to achieve UHC for all. If MoH is serious about PPPHs, it would allocate funds to staff the PPP desk positions it created rather than leaving many of them vacant and Government should develop a detailed regulatory framework around PPPHs. The PPP Act and the NPPPPH are insufficient tools to ensure that PPPHs protect human rights. Even additional policy guidelines like the PHC Guidelines and sub sector implementation guidelines do little to directly address the rights of healthcare consumers; rather their focus is streamlining the operational relationship between the government and the private sector. It therefore follows that there is a need to revise not only the PPP Act, but also the NPPPPH and the myriad of sector policies to deliberately pay regard to the pillars of affordability, availability, quality, and accessibility of health services.
- Adequately fund local governments. Local governments can't regulate PPPHs as envisioned in the policy if they do not have the tools or resources to do so. More than half of Districts lack PPPH desk officers. District Health Officers interviewed indicated they had not heard of PPPs or PPPH desks.

- Put in place a robust, transparent, participatory and accountable framework for determining PPPs.
- Investigate complaints raised about PPPs and offer remedy.
- Routinely collect, analyse and publish comparable data on government hospitals and PPPs to compare outcomes.
- Require PPPs that provide health services to feed their data into government data collection systems.

For Parliament

- Refrain from approving PPP investments unless they follow applicable procedures in law and comply with human rights, particularly principles around non-discrimination, equity and participation.
- Strengthen the regulatory environment for private actors in health by passing new legislation and amending existing legislation.
- Dedicate adequate resources for the government to invest in the Public Health sector.
- Enforce existing legal protections.
- Pass a National Health Insurance Scheme that enables equitable access to healthcare.

For international donors

- Invest in the public health sector. Find ways of rebuilding trust with GoU, with the goal of gradually returning to the SWAp approach. Incentivize institutional transparency, and reward the government with increasingly greater investment in the public health sector when it succeeds.
- Support for PPPs should be based on evidence.
- Insist on safeguards that strengthen right to health in contracts with public and private sectors.
- Carefully study and assess RBF.

For PFPs

- Be more open to a stricter regulatory environment, even if it means more fees, taxes, or overhead costs. Removing quacks from the marketplace, which benefits the legitimate private sector, is an ongoing battle that requires extensive resources.
- Be transparent about the limitations of applying the profit motive to universal health care schemes, particularly with regard to serving poor and geographically remote populations.

For PNFPs

- Comply with existing regulation.
- Create fora to interface with health consumers to promote accountability.
- Share data with government.

For community and advocacy organizations

- Demand access to information through access to information requests and other strategies.
- Ensure meaningful participation and transparency in Public Private Partnerships (PPPs) by interfacing with Parliament and creating fora for community to provide feedback to PPPs.
- Be wary of PPP proposals that shift resources toward Kampala and other urban areas, rather than remote areas where the human rights situations are most dire and conduct research, monitoring and documentation or those that utilize public resources yet exclude poor and marginalized groups.
- Work with communities to ensure remedies when human rights violations occur including engaging in strategic litigation.
- Closely monitor the government's work toward NHIS. Attempts at NHIS in other countries have sometimes resulted in schemes that were broadly ineffective, or that do not effectively serve the most vulnerable populations.



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