
A RIGHT TO HEALTH ANALYSIS OF UGANDA'S NATIONAL HEALTH INSURANCE SCHEME BILL

RECOMMENDATIONS FOR PARLIAMENT'S CONSIDERATION

Presented By;

THE CENTER FOR HEALTH, HUMAN RIGHTS AND DEVELOPMENT
(CEHURD)



CEHURD

social justice in health

BASED ON A PAPER PREPARED FOR CEHURD BY:

Prof. Lisa Forman and Dr. Diya Uberoi
Dalla Lana School of Public Health,
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Contents

Acknowledgement	3
1. Introduction	4
2. Right to health analysis of the NHIS Bill	5
2.1. Assessing coverage in the NHIS Bill: ‘Contributors’ and ‘Indigents’	5
2.1.1. Who qualifies under ‘contributors’?	5
2.1.2. Who qualifies as ‘indigents’?	7
2.1.3. A stratified scheme between contributors and indigents	8
2.2. Assessing affordability and financing under the NHIS Bill	9
2.2.1. Affordability and out of pocket expenditure on health.....	9
2.2.2. Affordability and financing of the NHIS.....	11
2.2.3. Affordability for self-employed people.....	11
2.2.4. Financing of the NHIS and maximum available resources.....	12
2.3. Assessing NHIS services in terms of human rights principles.....	14
2.3.1. Are the services offered sufficient from a human rights perspective?....	14
2.3.2. Exclusion of pre-existing conditions.....	18
2.4. Accountability under the NHIS Bill.....	18
2.4.1. Representation on the Board of Directors.....	18
2.4.2. Regional Health Insurance Appeals Tribunals.....	20
2.5. Participation under the NHIS Bill.....	21
2.6. The NHIS Bill and COVID-19.....	21
Conclusion.....	23
End Notes.....	24
Annex.....	28

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1. Introduction

In the following brief, we provide a right to health analysis of the Government of Uganda's National Health Insurance Scheme (NHIS) Bill No. 27 of 2019.¹

We analyse the content of this bill according to the binding and authoritative standards of the right to health in international human rights law in order to highlight the extent to which the bill as drafted might assist or fall short in realizing this right.

We also consider where Ugandan constitutional rights and law may support these analyses. In addition, we consider the extent to which this Bill accords with the guiding principles of universal health coverage (UHC) under the Sustainable Development Goals (SDG).

We are also aware that the global COVID-19 pandemic poses tremendous challenges for Ugandan health care settings and for the ability of initiatives like the current NHIS Bill to successfully launch. Accordingly, we consider the implications of a Ugandan COVID-19 epidemic for the NHIS initiative as planned.

2. Right to health analysis of the NHIS Bill

In the following section, we analyse the key provisions of the NHIS Bill and the extent to which they realize or fall short of the key principles of the right to health identified above.

2.1. Assessing coverage in the NHIS Bill: ‘Contributors’ and ‘Indigents

2.1.1 Who qualifies under ‘contributors’?

The NHIS Bill proposes creating a NHI Fund subsidised by “any person who has attained the age of 18 years and who is ordinarily resident in Uganda.”ⁱⁱ In the case of salaried employees, payments to the fund are made by monthly wage deductions and employer contributions,ⁱⁱⁱ while self-employed people pay an annual contribution to the fund.^{iv}

These contributions shall be set a rate indexed to a person’s total income.^v Contributors will receive identification cards which will be necessary to access health care benefits under the scheme.^{vi}

The scope of coverage for contributors is unclear: The Bill states that “[e]very contributor and a spouse and a child of a contributor are entitled to all the health care benefits” specified in the schedule to the Bill.^{vii} These terms raise the potential for considerable disparities and gaps:

- First, how are ‘spouses’ defined? If someone is not formally married, is in a common-law relationship or has several wives under customary law, will they be recognized?
- Second, if all children are recognized, this is not explicit given that the Bill refers to “a child” in the singular. The definition of “child” in the Bill does not clarify the question of how many children are included.
- Third, the scope of who qualifies as a ‘child’ is also muddled since “child of a contributor” is defined in the Scheme to include both those under the age of eighteen years and those over the age of eighteen years who

- i. Has no income of his or her own and is living with the contributor;
- ii. Is a person with a disability who is wholly dependent on and living with the contributor;
- iii. Is undergoing a full-time course of education or other type of qualification in a trade or profession and is not in receipt of any income other than a scholarship, bursary or other similar grant or award.^{viii}
- iv. The inclusion of such groups is commendable from a right to health perspective. However, it is problematic to define such individuals as ‘children’ rather than ‘dependents,’ especially as doing so would classify an already vulnerable group such as people with disabilities in a stigmatizing way. The Constitutional Court of Uganda has recognized that language used to describe people with disabilities should not be needlessly stigmatizing.^{ix}

We note that the bill links the right to health care access to financial contributions. This is problematic as the right to access health care should be linked to need as opposed to the insurance contribution. This means that the national health insurance scheme should provide cover to all residents in Uganda regardless of their ability to pay or their relationships with the contributors and such cover should include persons with existing conditions.

Recommendation 1:

- a. *The National Health Insurance Scheme should provide cover for all residents in Uganda as defined under the Uganda Registration of Persons Act of 2015*
- b. *Amend the definition of contributor’s spouse to include common-law and customary marriage;*
- c. *Amend the definition of contributor’s ‘child’ to ‘children,’*
- d. *Amend the definition of ‘children’ over 18 years to a separate category of beneficiaries identified as ‘dependents.’*

2.1.2. Who qualifies as ‘indigents’?

The other primary beneficiaries of this scheme are ‘indigents’ who are defined in the Bill as “poor orphans and other poor vulnerable children, poor older persons, poor persons with disabilities, poor destitutes and poor refugees who are registered as such under section 26.”^x From a right to health perspective, the focus in the definition of indigents on particularly vulnerable populations is commendable.

However, the definition also excludes anyone from this definition who is poor but not an orphan, vulnerable child, older person, person with disability, destitute or refugee. In this regard the principles of non-discrimination, core obligations and priority to vulnerable groups offer important guidance. The principle of non-discrimination requires that the Ugandan Government not exclude anyone from the operation of this scheme on the basis of their “race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social, or other status.”^{xi} Similarly states hold minimum core duties to ensure that the needs of the most vulnerable and marginalized groups in society must be prioritized when implementing and monitoring health care policy and programs.^{xii}

A range of specific populations are not identified in the Scheme’s definition of indigents, including those which the Ugandan Government itself defines as ‘key populations’ including “gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups.”^{xiii}

While these are groups identified as at higher risk for HIV infection, their health vulnerability should make their exclusion from health care coverage particularly concerning, especially given that HIV affects 5.7% of Uganda’s adult population between 15-49.^{xiv} Other vulnerable populations excluded include: the LBGTI population more broadly, undocumented migrants, asylum seekers, internally displaced persons, the rural poor and informal workers.

While progressive realization of the right to health recognizes that states will make trade-offs as they move towards full realization, excluding vulnerable populations from universal health care schemes is an unacceptable trade-off from a human rights and an equity perspective.^{xv}

Recommendation 2:

The definition of indigents should be amended to focus on all poor people and vulnerable and marginalized populations, not simply the identified groups.

2.1.3. A stratified scheme between contributors and indigents

There are also concerns from a human rights perspective about a scheme which differentiates between ‘contributors’ and ‘indigents’ given that in 2018, the poor in Uganda made up anywhere between 21.4% to 41.7% of its total population of 42.72 million.^{xvi} The definition of indigents therefore affects anywhere between approximately 9–18 million people in Uganda, creating multiple problems in implementing the NHI Scheme as proposed.

These problems are compounded by the NHIS Bill’s requirement that in order to access such benefits, the Scheme “shall, as may be prescribed by regulations under this Act, determine and register persons who qualify as indigents ...[and] a person registered as an indigent shall have access to the benefits specified in Schedule 1 of this Act.”^{xvii}

The bureaucratic process of registering between 9-18 million people and administering a system of ‘indigent’ health care will arguably draw significant state and contributor resources which could be better spent on strengthening the health care system itself. There is ample evidence to suggest that health care for the poor often ends up being poor health care, so that the more we “target benefits at the poor only ... the less likely we are to reduce poverty and inequality.”^{xviii}

Indeed, scholarship suggests that societies pursuing universalistic policies have higher levels of equity than those that rely on selectivity.^{xix} As one scholar puts it, universalist policies are “preferable to those targeted at specific groups for several reasons.... targeting implies labelling with all the attendant hazards of stigma ... Targeting only those at highest risk misses much of the problem.”^{xx}

Recommendation 3:

- a. *Rather than offering a stratified scheme for ‘contributors’ and ‘indigents’ the NHIS should aim to assure universal health care for all Ugandans, with a particular focus on ensuring that all (not simply some) vulnerable and marginalized populations can access the scheme.*
- b. *Instead of basing membership to the scheme on qualification as a contributor or indigent, the Scheme should instead offer membership to all Ugandan residents.*

2.2. Assessing affordability and financing under the NHIS Bill

2.2.1. Affordability and out of pocket expenditure on health

A primary objective of the NHIS Bill is to remedy the very high out of pocket expenditure which Ugandans experience, estimated at 41% of total expenditure on health. Out of pocket expenditure on health is defined as “household spending on medicines, health products, out-patient and inpatient care services (such as medical laboratory services) that are not reimbursed by a third party (such as the government, a health insurance fund or a private insurance company). It excludes household spending on health insurance premiums.”^{xxi}

This extent of out of pocket expenditure on health only hints at the scale of human rights and equity problems such spending creates: For example, the WHO estimates that between 3.8% to 15.3% of Uganda’s population experience ‘catastrophic expenditure’ on health care,^{xxii} with catastrophic expenditure defined as out of pocket expenditure on health that exceeds between 10% and 25% of household budget.^{xxiii}

The NHIS Bill proposes regulating the amount of benefits covered under the Scheme in subsequent regulations.^{xxiv} However it does not propose regulating the cost of health care that can be charged by health care providers, indicating that “where the cost of health care offered to a contributor, spouse or child exceeds the amount prescribed, the extra cost shall be the responsibility of the patient to whom health care services are offered.”^{xxv}

This provision would permit an unspecified extent of out of pocket expenditure on health for beneficiaries under this act, which could both add to catastrophic expenditures on health for employed ‘contributors’ and entirely block ‘indigents’ from accessing health care at all. The WHO has emphasized that “the challenge for policy is to ensure that any additional resources for health care are channelled through compulsory pooled prepayment mechanisms rather than through out of pocket spending.”^{xxvi}

The WHO Consultative Group on Equity and Universal Health Coverage has confirmed that out of pocket payments could “impede access to needed services,” by delaying utilization or forgoing service at all, and creating significant financial strain that could amplify catastrophic spending or push people into poverty.^{xxvii} Out of pocket payments would particularly create a complete barrier to access for low-income groups.^{xxviii}

Under the right to health principle of affordability, equitable payment for health-care services suggests “either that health services, at least basic health services, will be provided free of cost or that poor and disadvantaged groups will be heavily subsidized.”^{xxix}

Recommendation 4:

The NHIS Bill should reduce out of pocket health care payments in an equitable manner that focuses on removing these wherever possible, with a priority on removing such payments for essential care that falls under core obligations under the right to health and eliminating them completely for low-income and other disadvantaged groups.^{xxx}

2.2.2. Affordability and financing of the NHIS

The NHIS will be financed primarily through contributions made by employees defined as both salaried and self-employed people. The Bill does not specify what this contribution will be, other than to indicate that it “shall be at such rate, depending on the total income of the person liable to make a contribution, as the Board, in consultation with the Minister and the Minister responsible for Finance, may determine.”^{xxxix}

Setting a proportional contribution rate pegged to income is equitable, and averts the potential for regressive financing of the Scheme where a flat contribution rate is applied. However, in the absence of specifying what this rate is, it is impossible to assess its affordability for people liable to make such contributions.

Overall the commitment for Government Sector Funding is missing in the Bill, the government contribution towards the scheme will be key in growing the base of the scheme. The foundation for rolling out a national health insurance scheme should be grounded public funded, responsive quality essential packages of services that are universally accessible to all residents.

Recommendation 5:

- a. *The commitment for Government public sector funding should be made explicit in the bill. The bill should have provisions that describe the expected revenues from government.*
- b. *The rate proposed for contributions should be assessed in terms of its impact on people’s ability to meet other essential needs such as purchasing food, paying rent or mortgages, paying for education etc., as well as on household expenditures.*

2.2.3 Affordability for self-employed people

Another key area that is unclear in the Scheme is who fits into the category of the ‘self-employed.’ There are pressing human rights questions about who will be liable to contribute to the scheme and about the affordability of such premiums

given that 74.8% of Uganda's workforce fits into the category of 'self-employed',^{xxxii} that only 3% of the workforce are classified as 'employers',^{xxxiii} and that 47.3% of the working age population are outside the labour force.^{xxxiv}

When 25% of people who are self-employed face limited financial resources,^{xxxv} the imposition of compulsory premiums is potentially highly inequitable. There are also disparities in the penalties imposed for non-payment, with employers are fined twice missed contributions and the self-employed are fined five times the contribution.^{xxxvi}

Recommendation 6:

- a. *Define who is considered 'self-employed' and exclude workers in the informal sector, people who are under-employed and people who face limited resources from paying high monthly premiums and penalties for non-payment.*
- b. *Standardize penalties for non-payment between employers and the self-employed.*

2.2.4. Financing of the NHIS and maximum available resources

The NHI Scheme will be financed entirely through compulsory pooled pre-paid contributions made by contributors to the scheme. This is in line with WHO recommendations that universal schemes be financed in this way (rather than through out of pocket spending).^{xxxvii}

However WHO has also consistently emphasized that public financing of universal health coverage should not rely on contributor premiums alone, and that states should increase public spending on health from a variety of sources including: increasing the efficiency of revenue collection, reprioritizing government budgets, introducing innovative financing (such as tobacco or alcohol taxes) and securing additional development assistance for health.^{xxxviii}

Similarly, the Political Declaration of the High-Level Meeting on Universal Health Coverage reflects broad consensus that states must increase domestic spending on health and support such spending through “bilateral, regional and multilateral channels, including traditional and innovative financing mechanisms.”^{xxxix}

These responsibilities are in line with state duties under the right to health to “take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of [their] available resources, to achieve progressively the full realization of Covenant rights by all appropriate means, including particularly legislation.”^{xi}

With regard to domestic spending, there is broad international support for minimum national targets of 5% of GDP for public spending on health,^{xii} which should be progressively increased at “an additional 1% to 2% of GDP for expanding access to nationally determined sets of essential health services with a view to achieving such target or higher by 2030.”^{xiii}

This is considerably less than the commitments made by heads of state at the African Union in the 2001 *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, when countries pledged to allocate at least 15% of their annual budget to improve the health sector.^{xiii} It is commendable that Ugandan domestic expenditure on health which was estimated in 2017 at 6.188% of GDP exceeds this minimum.^{xiv} However it is troubling that this figure has also steadily decreased since a 2010 high of 10.51% of GDP.^{xv}

Thus, both accepted wisdom on UHC and the state duty to progressively realize the right to health mandate that health spending should increase over time, and require the state to maximize domestic and international resources. Moreover, the Ugandan government should direct existing international funding or attempt to secure new funding to supplement domestic health spending.

Recommendation 7:

The Ugandan government should not rely only on individual contributions to fund the NHIS. It should increase domestic health funding through a range of sources, including increasing domestic spending on health by at

least 1-2% of GDP, securing additional international funding for health, increasing the efficiency of revenue collection, reprioritizing government budgets, and introducing innovative financing (such as tobacco or alcohol taxes).

2.3. Assessing NHIS services in terms of human rights principles

2.3.1. Are the services offered sufficient from a human rights perspective?

Under the NHIS Bill, every “contributor and a spouse and child of a contributor are entitled to all the health benefits specified in Schedule 1.^{xlvi} Schedule 1 sets out eleven categories of health care services including:

1. Preventive services;
2. Outpatient services
3. Reproductive maternal, neonatal, child and adolescent health care services;
4. Oral/dental care services;
5. Eye care;
6. Mental health;
7. Radiological investigations;
8. Imaging services;
9. Inpatient services;
10. Surgical services and
11. Mortuary services

The Schedule further specifies which of these services will be available at health centres III, health centres IV, general hospitals and referral hospitals. In the Bill, health care providers include all governments hospitals and health centre, and may include privately owned and non-governmental health facilities,^{xlvii} presumably on the basis of such facilities have been accredited as such.^{xlviii}

Are these services sufficient from a human rights perspective as a package of benefits covered under the NHIS? Important guidance on this front comes from both the right to health and international guidelines on UHC:

- Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) places duties on states to take steps to reduce infant mortality; improve environmental and industrial hygiene; prevent, treat, and control epidemic, endemic, occupational, and other diseases; and create conditions to assure medical services and attention in the event of sickness.
- States also hold minimum core obligations under the right to health to ensure
 1. non-discriminatory access to health facilities, goods, and services;
 2. essential drugs as defined by the WHO;
 3. equitable distribution of all health facilities, goods, and services, and
 4. adopting and implementing a national public health strategy and plan of action addressing the health concerns of the whole population, with particular attention to vulnerable or marginalized groups.^{xlix}
- The NHIS schedule of benefits should therefore at a minimum include services in these key areas, with nationally specific determinations set according to “health concerns of the whole population, with particular attention to vulnerable or marginalized groups.”

Further guidance can be found under SDG guidelines which prescribe coverage of essential health services as a key indicator for realization of UHC.

- Essential health services are “services that all countries, regardless of their demographic, epidemiological or economic profile are expected to provide.”^{li}
- In order to operationalize this target, a UHC Service Coverage Index (SCI) was developed through a broadly consultative process in order to assess “the average coverage of tracer indicators in four essential health services areas: reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access.”^{li}
- These areas are intended to measure services in the primary areas of prevention (comprising health promotion and illness prevention) and treatment (comprising curative services, rehabilitation and palliation).^{lii}

- In 2018, the Inter-Agency Expert Group on Sustainable Development Goals set 14 tracer indicators to be measured across each of the four areas and “then across the four category-specific means to obtain the final summary index.”ⁱⁱⁱ These indicators are “not meant as a complete or exhaustive list of health services ... But they do provide a strong signal on the coverage of health services needed by most populations across sociodemographic settings.”^{iv}

Thus, both core obligations and essential health services under UHC offer a framework for assessing the sufficiency of the NHIS schedule of benefits. As Figure 2 below comparing NHIS benefits and UHC essential health service indicators indicates, in several key respects, the NHIS schedule prescribes services beyond those indicated in the four essential health services areas of reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access.

In other areas, it offers markedly less services than those suggested by UHC essential health service indicators:

- The NHIS benefits for reproductive maternal, neonatal, child and adolescent health care services exceed the UHC indicator, although there is nothing indicated for child immunization.
- A significant shortfall is that instead of providing HIV treatment with ART, the benefits only suggest HIV/AIDS symptomatic treatment for opportunistic infections.
- Access to essential medicines is another area of considerable concern. The NHIS scheme only indicates essential medicines for outpatient services, oral and dental care services, eye care, mental health, in-patient services. Will these extend to all areas of essential medicines in the WHO essential medicines list as required under core obligations under the right to health?
- On infectious disease and non-communicable disease, the NHIS provides no indication of what will be addressed beyond indicating “diagnosis and treatment of common ailments including communicable and non-

communicable disease.” Whether these will include at least cardiovascular disease, diabetes, cancer, tobacco control, tuberculosis treatment, malaria prevention and water and sanitation is unclear.

The Ugandan government holds a core obligation to develop a national public health strategy and plan of action addressing the health concerns of the whole population, with particular attention to vulnerable or marginalized groups. This strategy should be developed in a participatory manner with significant consultation. The Ugandan government’s duty to expand access to health care services is all the greater since currently Uganda’s coverage under indicator 3.8.1 is estimated at 45.4%.^{iv}

Another approach to assessing fair progressive realization of UHC comes from the WHO Consultative Group on Equity and Universal Health Coverage which suggests that countries should categorize services into priority classes according to relevant criteria including cost-effectiveness, priority to the worse off and financial risk protection. States should then first expand coverage for high-priority services to everyone, and ensure that disadvantaged groups are not left behind.^{vi}

Recommendation 8:

1. *Finalize the schedule of benefits based on a participatory consultation that takes into account the health concerns of the whole population, with particular attention to the health needs of vulnerable or marginalized groups.*
2. *Gaps in essential areas should be remedied including child immunization, ART treatment for HIV, and access to essential medicines, commodities and supplies including mama kits and new born resuscitation devices.*
3. *Greater specificity is required with regard to essential medicines to be provided outside the specified areas, and with regard to what communicable and non-communicable diseases will be addressed.*
4. *Medicines and Services for neglected tropical diseases including Bilhazia, Sleeping sickness, elephantiasis, trachoma, liprosy, liver blindness and snake bites anti vernoms should be included.*

2.3.2. Exclusion of pre-existing conditions

The NHIS Bill has a range of exclusions which raise human rights , including that benefits under the scheme “do not include treatment or the supply of medicines where the health care provider did not diagnose the illness or injury or prescribe the medicine.”^{lvii} This provision threatens to effectively exclude all pre-existing illnesses, injuries or prescriptions diagnosed before the initiation of the Scheme or by non-accredited or new health care providers.

Doing so would be entirely at odds with the equity ambition of the NHIS Bill and with the right to health. This requirement could also create an extraordinary financial and logistical burden on both patients and health care workers to re-diagnose pre-existing conditions.

Recommendation 9:

Remove the exclusion of pre-existing illnesses, injuries or treatments in article 26.2.a from the Scheme. Alternatively, allow such diagnoses to roll over into the operation of the NHIS.

2.4. Accountability under the NHIS Bill

2.4.1. Representation on the Board of Directors

The NHIS Bill indicates that a Board of Directors will be the governing body of the scheme, and responsible for the general direction and supervision of the Scheme.^{lviii} The Bill indicates that the Board will have 11 members with relevant qualifications in relation to health, business or finance.

Yet the majority of these positions (7 of 11) focus on financial considerations rather than on health (these include a chairperson with qualifications relevant to health insurance or business entrepreneurship; the permanent secretary of Ministry responsible for finance; a successful entrepreneur; a person with experience managing insurance companies; a pension fund management or investment expert; an accountant or economist; and an advocate in business or corporate law).^{lix} In contrast, only 3 positions focus on health including the permanent

secretary of Ministry responsible for health; a medical professional, and a social worker or social scientist working in community mobilization.

In principle we think that the large board as currently proposed under the bill will affect the success of the proposed scheme. Such a large board comes with challenges of conflicts of interest and accountability to the population is always a challenge. It is important that the proposed board focuses on a set of skills and the separations of powers principle if its to be effecient. The board should also have a separate reporting channel from the accountability channel.

There is no indication of the kind of expertise the Chief Executive Officer should hold, however even if their experience was medical or health oriented, it would not shift the overall focus of the Board on non-health related issues. This unequal representation threatens to skew the priorities of the Scheme overall away from health towards financial considerations. Moreover, there is no-one to advise on the human rights implications of the Scheme and this should be remedied. It is noted that the Board has the authority to appoint committees to advise it, and it could appoint a human rights committee made of domestic legal experts to do so ^{ix}

Recommendation 10:

- a. We propose that the board should comprise of five skilled and eminate resident persons with a CEO of the fund as the Ex-officio.*
- b. The nominating authority should take into consideration the qualifications of the proposed members, there proffesional rank and competence. The nominating authority should be separate from the appointing authority.*
- c. Ensure a balanced representation on the Board of Directors of health and community interests.*
- d. Add representation of a human rights advocate/legal to ensure that legal and human rights considerations are taken account of, alternatively create a human rights committee to advise the board.*

2.4.2. Regional Health Insurance Appeals Tribunals

The scheme indicates that regional health insurance appeals tribunals will be established to hear complaints from “both contributors and health service providers.”^{lxi} Contributors may lodge complaints regarding violations of their rights, “wilful neglect of duties by an officer of the Scheme which results in loss to the contributor, or any other reason that tends to undermine, delay or defeat the objectives [or] functions of the Scheme.”^{lxii}

Health care providers may lodge complaints regarding unreasonable delays in processing and payment of claims and “any other reason that tends to undermine, delay or defeat the objectives [or] functions of the Scheme.”^{lxiii}

The Scheme further indicates the actions which tribunals can take, which include suspending actions by health care provider pending tribunal decisions, directing health care providers on anything to be done or redone, suspending or restoring health care provider accreditation or the right to benefits of a contributor, and requiring payment of compensation for any costs due to unlawful acts by health care providers.^{lxiv} Parties to such decisions can appeal decisions to the High Court.^{lxv}

These mechanisms are commendable in light of the principle of accountability which requires that people negatively affected by health care decisions should have access to effective judicial or other appropriate measures. However, they also have a range of gaps and areas requiring clarity: (a) Why are indigents who are primary beneficiaries under the scheme excluded from these claims? It would be inequitable to limit remedies under the scheme to a significant proportion of beneficiaries.

Moreover, the legal framework of international and domestic ascribes rights relevant to health to all Ugandans, not just ‘contributors.’ (b) Similarly, what are the “rights of contributors” that would be applicable in these tribunals? These rights clearly cannot be limited to rights accruing under this Scheme, and would include rights under domestic and international human rights law as indicated in this brief.

Recommendation 11:

- a. *Enable all beneficiaries of the scheme, including ‘indigents’, dependents and children to lodge complaints under the Scheme;*
- b. *Clarify that the rights which all people benefitting the scheme can claim include domestic and international human rights to health.*
- c. *Domestically incorporate Uganda’s ratified international human rights treaties to ensure that they are domestically enforceable.*

2.5. Participation under the NHIS Bill

The principle of participatory decision-making requires that health policy, plans and programs must be created in a “participatory and transparent process,”^{lxvi} This also requires that health policies should not just assess population health concerns from epidemiological data but should also seek and include “people’s expressed priorities.”^{lxvii} As a primary health care initiative that will have significant implications for all Ugandans, the NHIS Bill in particular requires a high degree of consultation and participation.

Recommendation 12:

The Ugandan government should engage in a broad process of consultation to ensure that the NHIS Bill reflects the Ugandan people’s expressed priorities regarding their health. This process of consultation should include all key stakeholders, with a particular focus on vulnerable and marginalized groups.

2.6. The NHIS Bill and COVID-19

The Ugandan government’s duties under the right to health are not lifted during the breakout of epidemics and pandemics like COVID-19. Instead the principles of core obligations and shared responsibility require the state to prioritize people’s ability to access essential health care services during a pandemic, including

through accessing international funding to support same.^{lxviii} The UN Committee on Economic, Social and Cultural Rights confirms that in the context of COVID-19, states must “make all efforts to mobilize the necessary resources to combat COVID-19 in the most equitable manner, in order to avoid imposing a further economic burden on these marginalized groups. Allocation of resources should prioritize the special needs of these groups.”^{lxix}

Human Rights principles have particular relevance for considering the NHIS Bill in the context of the COVID-19 pandemic. In April 2020, the UNCESCR issued a statement on COVID-19 and economic, social and cultural rights which emphasizes that in “responding to the pandemic, the inherent dignity of all people must be respected and protected, and minimum core obligations imposed by the Covenant should be prioritized.”^{lxx} In other words, efforts to realize universal and affordable access to health care like the NHIS Bill should be prioritized in government responses.

This interpretation is reinforced in the statement which emphasizes that States must “adopt appropriate regulatory measures to ensure that health-care resources in both the public and the private sectors are mobilized and shared among the whole population to ensure a comprehensive, coordinated health-care response to the crisis.”^{lxxi}

Moreover that states must: devote their maximum available resources for the full realization of all economic, social and cultural rights, including the right to health. As this pandemic and the measures taken to combat it have had a disproportionate negative impact on the most marginalized groups, States must make all efforts to mobilize the necessary resources to combat COVID-19 in the most equitable manner, in order to avoid imposing a further economic burden on these marginalized groups. Allocation of resources should prioritize the special needs of these groups.^{lxxii}

Recommendation 13:

The NHIS Bill should be prioritized for adoption during COVID-19, with access to essential health care for all Ugandans given high political and economic priority.

Conclusion

The NHIS Bill is a welcome initiative to realize the right to health of all Ugandans. We hope that the recommendations in this brief are considered in order to make the Scheme a more equitable and human rights compliant initiative capable of assisting the Ugandan government to realize its duties under the right to health.

End Notes

- i. Government of Uganda, National Health Insurance Scheme (NHIS) Bill No. 27 of 2019, 9 August 2019, Bills Supplement No. 10, Bills Supplement to the Uganda Gazette No. 38, Volume CXII (NHIS Bill).
- ii. NHIS Bill, article 21.1.
- iii. NHIS Bill, article 21.2.a and 22.1.
- iv. NHIS Bill, article 21.2.b.
- v. NHIS Bill, article 21.3.
- vi. NHIS Bill, article 25.1-3.
- vii. NHIS Bill, article 26.1.
- viii. NHIS Bill, article 2 on interpretation, p6.
- ix. Uganda Constitutional Court. (2011) Petition No. 64, Centre for Health Human Rights & Development v. Attorney General, Kampala.
- x. NHIS Bill, article 2 on interpretation, p7.
- xi. General Comment No. 14, paras, 12 and 18.
- xii. General Comment No. 14, para. 43.f; Ooms et al, 2014, p3; Sridhar et al, 2015, p.495.
- xiii. The Republic of Uganda, “Synthesis, Consolidation and Building Consensus on Key and Priority Population Size Estimation Numbers in Uganda: Final Report October 2019,” Online at <http://library.health.go.ug/download/file/fid/2560>. See also Doshi RH, Apodaca K, Ogwal M, et al. “Estimating the Size of Key Populations in Kampala, Uganda: 3-Source Capture-Recapture Study.” (2019) 5:3 JMIR Public Health Surveillance e12118.
- xiv. World Bank Data on Uganda, accessed online: https://databank.worldbank.org/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=UGA
- xv. This point is made explicitly in Ole Frithjof Norheim, “Ethical Perspective: Five Unacceptable Trade-offs on the Path to Universal Health Coverage,” (2015) 4:11 International Journal of Health Policy Management 711-714, at p713: It is an unacceptable trade-off to “first include in the universal coverage scheme only those with the ability to pay and not include informal workers and the poor, even if such an approach would be easier.”
- xvi. World Bank Data on Uganda, accessed online: https://databank.worldbank.org/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=UGA
- xvii. NHIS Bill, article 26.5.
- xviii. Korpi, W. and J. Palme. 1998. “The paradox of redistribution and strategies of equality: Welfare state institutions, inequality, and poverty in the Western countries.” American Sociological Review, Vol. 63, No. 5, pp. 661–687, at p 81; see also Amartya Sen.1995. “The political economy of targeting.” in van de Walle, D. and K. Nead, eds. 1995. Public Spending and the Poor: Theory and Evidence. Johns

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- Hopkins University Press, Baltimore, MD, 14; Titmuss R. *Essays on the Welfare State*. London: Unwin Hyman, 1958.
- xix. Thandika Mkandawire, “Targeting and universalism in poverty reduction,” United Nations Research Institute for Social Development, Social Policy and Development Programme Paper Number 23, December 2005.
- xx. Marmot, M. 2014. Commentary: “Mental health and public health.” *International Journal of Epidemiology*, Vol. 43, p295; see also Carey, G., Crammond, B., & De Leeuw, E. 2015. “Towards health equity: a framework for the application of proportionate universalism.” *International journal for equity in health*, 14, 81. <https://doi.org/10.1186/s12939-015-0207-6>
- xxi. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p27.
- xxii. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p137. The range is between 25% of household total consumption or income and 10% of household total consumption or income.
- xxiii. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p27.
- xxiv. NHIS Bill, article 26.2.d. “the benefits granted under this Act—shall not exceed the amount prescribed by regulations made under this Act.”
- xxv. NHIS Bill, article 26.4.
- xxvi. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p25.
- xxvii. World Health Organization, “Making fair choices on the path to universal health coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage,” 2014, p32.
- xxviii. World Health Organization, “Making fair choices on the path to universal health coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage,” 2014, p32.
- xxix. Chapman, 2016, p3.
- xxx. This recommendation is adapted from that made in World Health Organization, “Making fair choices on the path to universal health coverage: Final report of the WHO Consultative Group on Equity and Universal Health Coverage,” 2014, p36.
- xxxi. NHIS Bill, article 21.3.
- xxxii. Uganda Bureau of Statistics 2018, *The National Labour Force Survey 2016/17 – Main Report*, Kampala, Uganda, p.iv.
- xxxiii. Uganda Bureau of Statistics 2018, *The National Labour Force Survey 2016/17 – Main Report*, Kampala, Uganda, p.ii.
- xxxiv. Uganda Bureau of Statistics 2018, *The National Labour Force Survey 2016/17 – Main Report*, Kampala, Uganda, p.iii.
- xxxv. Uganda Bureau of Statistics 2018, *The National Labour Force Survey 2016/17*

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- Main Report, Kampala, Uganda, p.xii.
- xxxvi. NHIS Bill, article 23.1 and 24.2.
- xxxvii. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p25.
- xxxviii. See WHO, Health systems financing: The path to Universal Health Coverage, 2010, pxii-xiii, and World Health Organization et al, “Universal Health Coverage: Lessons to guide country actions on health financing.”
- xxxix. Political Declaration of the High-Level Meeting on Universal Health Coverage “Universal Health Coverage: Moving together to build a healthier world,” paras. 32-36.
- xl. ICESCR, article 2.
- xli. See for example, the Political Declaration of the High-Level Meeting on Universal Health Coverage “Universal Health Coverage: Moving together to build a healthier world,” para. 34, and Sustainable Development Solutions Network, “Health in the framework of sustainable development: Report from the thematic group on health for all.” 2014.
- xl.ii. Political Declaration of the High-Level Meeting on Universal Health Coverage “Universal Health Coverage: Moving together to build a healthier world,” para. 34.
- xl.iii. African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, “Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases” Abuja, Nigeria, 24-27 April 2001 OAU/SPS/ABUJA/3, at paras. 30 and 31. [African Summit, Abuja Declaration].
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- xl. v. World Bank Data on Uganda, accessed online: <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=UG>
- xlvi. NHIS Bill, article 26.1.
- xlvii. NHIS Bill, article 37.1. and 37.2.
- xlviii. NHIS Bill, article 38.
- xl. ix. General Comment No 14, para. 43.
- l. World Health Organization, Tracking Universal Health Coverage: 2017 Global Monitoring Report, p3.
- li. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p.12. online at: https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1
- lii. WHO, Tracking Universal Health Coverage: 2017 Global Monitoring Report, p4.
- lii. iii. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p.12. online at: https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1
- li. v. World Health Organization, 2019 Monitoring Report: Primary Health Care on the Road to Universal Health Coverage, 2019 Geneva, p.12. online at: https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1
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Road to Universal Health Coverage, 2019 Geneva, p137.

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- lvii. NHIS Bill, article 26.2.a.
- lviii. NHIS Bill, article 8.1.
- lix. NHIS Bill, article 8.2.
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- lxi. NHIS Bill, article 45.1
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- lxiii. NHIS Bill, article 45.3.
- lxiv. NHIS Bill, article 50.2.
- lxv. NHIS Bill, article 52.
- lxvi. General Comment No. 14, para. 43.f.
- lxvii. Sridhar et al, 2015, p3.
- lxviii. See for example, United Nations Committee on Economic, Social and Cultural Rights, “Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights,” 6 April 2020, UN. Doc. E/C.12/2020/1, para. 12.
- lxix. United Nations Committee on Economic, Social and Cultural Rights, “Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights,” 6 April 2020, UN. Doc. E/C.12/2020/1, para.14.
- lxx. United Nations Committee on Economic, Social and Cultural Rights, “Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights,” 6 April 2020, UN. Doc. E/C.12/2020/1, para. 12.
- lxxi. United Nations Committee on Economic, Social and Cultural Rights, “Statement on the coronavirus disease (COVID-19) pandemic and economic, social and cultural rights,” 6 April 2020, UN. Doc. E/C.12/2020/1, para. 13.
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Annex:

Recommendations on the Right to Health Analysis of Uganda's National Health Insurance Scheme Bill	
Recommendation 1:	(a) The National Health Insurance Scheme should provide cover for all residents in Uganda as defined under the Uganda Registration of Persons Act of 2015; (b) Amend the definition of contributor's spouse to include common-law and customary marriage; (c) Amend the definition of contributor's 'child' to 'children,' (d) Amend the definition of 'children' over 18 years to a separate category of beneficiaries identified as 'dependents.'
Recommendation 2:	The definition of indigents should be amended to focus on all poor people and vulnerable and marginalized populations, not simply the identified groups.
Recommendation 3:	(a) Rather than offering a stratified scheme for 'contributors' and 'indigents' the NHIS should aim to assure universal health care for all Ugandans, with a particular focus on ensuring that all (not simply some) vulnerable and marginalized populations can access the scheme. (b) Instead of basing membership to the scheme on qualification as a contributor or indigent, the Scheme should instead offer membership to all Ugandan residents.
Recommendation 4:	The NHIS Bill should reduce out of pocket health care payments in an equitable manner that focuses on removing these wherever possible, with a priority on removing such payments for essential care that falls under core obligations under the right to health and eliminating them completely for low-income and other disadvantaged groups.

Recommendation 5:	The rate proposed for contributions should be assessed in terms of its impact on people's ability to meet other essential needs such as purchasing food, paying rent or mortgages, paying for education etc., as well as on household expenditures.
Recommendation 6:	(a) Define who is considered 'self-employed' and exclude workers in the informal sector, people who are under-employed and people who face limited resources from paying high monthly premiums and penalties for non-payment. (b) Standardize penalties for non-payment between employers and the self-employed.
Recommendation 7:	The Ugandan government should not rely only on individual contributions to fund the NHIS. It should increase domestic health funding through a range of sources, including increasing domestic spending on health by at least 1-2% of GDP, securing additional international funding for health, increasing the efficiency of revenue collection, reprioritizing government budgets, and introducing innovative financing (such as tobacco or alcohol taxes).
Recommendation 8:	(1) Finalize the schedule of benefits based on a participatory consultation that takes into account the health concerns of the whole population, with particular attention to the health needs of vulnerable or marginalized groups. (2) Gaps in essential areas should be remedied including child immunization, ART treatment for HIV, and access to essential medicines. (3) Greater specificity is required with regard to essential medicines to be provided outside the specified areas, and with regard to what communicable and non-communicable diseases will be addressed.
Recommendation 9:	Remove the exclusion of pre-existing illnesses, injuries or treatments in article 26.2.a from the Scheme. Alternatively, allow such diagnoses to roll over into the operation of the NHIS.

<p>Recommendation 10:</p>	<p>(a) We propose that the board should comprise of five skilled and eminent resident persons with a CEO of the fund as the Ex-officio. (b)The nominating authority should take into consideration the qualifications of the proposed members, their professional rank and competence. The nominating authority should be separate from the appointing authority. (c) Ensure a balanced representation on the Board of Directors of health and community interests. (d) Add representation of a human rights advocate/legal to ensure that legal and human rights considerations are taken account of, alternatively create a human rights committee to advise the board;</p>
<p>Recommendation 11:</p>	<p>(a) Enable all beneficiaries of the scheme, including 'indigents', dependents and children to lodge complaints under the Scheme; (b) Clarify that the rights which all people benefitting the scheme can claim include domestic and international human rights to health. (c) Domestically incorporate Uganda's ratified international human rights treaties to ensure that they are domestically enforceable.</p>
<p>Recommendation 12:</p>	<p>The Ugandan government should engage in a broad process of consultation to ensure that the NHIS Bill reflects the Ugandan peoples' expressed priorities regarding their health. This process of consultation should include all key stakeholders, with a particular focus on vulnerable and marginalized groups.</p>
<p>Recommendation 13:</p>	<p>The NHIS Bill should be prioritized for action during COVID-19, with access to essential health care for all Ugandans given high political and economic priority.</p>

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