The need for Universal Health Coverage: Unpacking the Draft National Health Insurance Bill, 2012

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Abstract

The Draft National Health Insurance Bill 2012 (NHIB) proposes to introduce universal health coverage in Uganda. It is the latest step in a string of mechanisms developed since 1999 to improve the health sector. This is all premised on government's 1995 Constitutional mandate of taking all practical measures to ensure the provision of basic medical services to the population. It is from this overall mandate that the plan to have a national health scheme was hatched. The 1999 National Health Policy enlisted the Government of Uganda (GoU) to explore alternative, equitable and sustainable options for health financing and health service organization targeting the poor and other vulnerable groups. Similarly, in 2006, through Cabinet minute No.63 (CT 2006), the GoU tasked the Ministry of Health (MoH) to design a social health insurance scheme.

It is hoped that the introduction of a national health insurance scheme will lead the GoU to embark on improved health infrastructure, human and financial resources and availability of basic goods and services as a holistic revamping of the provision of health care in Uganda. However, in order for the scheme to have any effective and efficient operation, the Government will be expected to increase resource allocation and financing of the health sector.

This paper briefly discusses some of the contentious issues in the proposed NHIB vis-à-vis the practical realities in the country health sector. The paper also explores different ways of addressing the gaps in the bill, as well as offering some recommendations on how to improve the general health sector. It concludes among others, that the scheme be rolled out in phases first targeting the poorest and other vulnerable groups as they most need the health services, and that deductions from those in formal employment be streamlined within NSSF contributions so as not to increase the already stiff tax burden.

I. Introduction

Uganda's Constitution, which is the supreme law of the land, does not specifically provide for the right to health. However, Objective XIV of the National Objectives and Directive Principles of State Policy provides for general social and economic objectives and enjoins the State, "to endeavor to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that all Ugandans enjoy rights and opportunities [among which are] ...health services." In a 2005 Constitutional Amendment these objectives received more force and full legal effect through the introduction of Article 8A, which is to the effect that, "Uganda shall be governed based on principles of national interest and common good enshrined in the national objectives and directive principles of state policy and that Parliament shall make relevant laws for purposes of giving full effect to this Article.

The right to health was first explicitly proclaimed in July 1946 as one of the founding principles of the World Health Organization (WHO). The organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It further notes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. In a 2010 United Nations Population Fund (UNFPA) report, Paul Hunt and Judith Bueno noted that "...the right to health includes entitlements to goods and services, including sexual and reproductive health care and information.

In Uganda, MoH has over the years initiated a plan to have a national health scheme. The purpose of the scheme was intended to diversify and strengthen health care financing and make a contribution to bridging the financing gap in the sector; to stimulate providers to avail good quality, accessible and affordable healthcare; [and to] increase welfare gain in healthcare through financial risk protection and ensure that everyone has financial access to health care. The National Health Insurance Bill 2012 was prepared and according to Dr. Francis Runumi, "[they] are only waiting for the certificate of financial implications from the Ministry of Finance then [they] will prepare a cabinet paper and have it tabled in Parliament.

II. Government's Political Will towards Improved Health Services

Assessing the Governments political will in regard to addressing issues in the health sector can be well done by taking a look at its resource allocation over the last couple of years. In the financial year (2013/14), the health sector received UGX940 Billion, up from UGX852b in 2012/13, about 7.2% of the national budget of sh13.1 trillion. In 2014/2015 the health budget was 9% of the total national budget. The current budget for the health sector for FY 2015/2016 is 8.2%, a decline from the previous year and not close to the agreed 15% of the national budget, as pledged by State Parties in the Abuja Declaration.

Over the years, Uganda's health sector budget remains one of the lesser funded, showing a consistent regression making the progressive realization of the right to health more on paper than in practice. The GoU cannot be faulted for failure to ratify international instruments or developing policies towards the betterment of the right to health. Nevertheless, policies on service delivery alone cannot address a crippling system and thus, there is a need to provide resources towards implementation of those policies so as to ensure retention of best medical practitioners and improve access to health services especially for the poor and underprivileged.

Anyone that has lived in Uganda and tried to access public health care system will appreciate the importance of having a universal health coverage scheme. The health sector is one area in Uganda that needs an emergency overhaul so as to align it with the practical realities of health provisions in growing economies and third world countries. The high levels of mortalities from preventable disease especially among rural setting, coupled with the unethical and disgruntled health practitioners mostly in public health systems, make being sick in Uganda a dire and 'sickening' experience.

Cases of preventable maternal mortality, patients assaulted in hospitals, lack of basic drugs and facilities at local health centers, lack of drugs for common diseases such as malaria, lack of doctors and specialists, and unethical and unprofessional medical practitioners, constantly surface in Ugandan media reports. One area that continues to trigger the loudest outcry from the general populace is that of maternal mortality—an issue that looks to be neglected even from the judiciary that is mandated to enforce fundamental human rights. Whenever pressed to address the dire public health system services, the government always argues that they are working within the available resource—an argument the judiciary has reinforced and complimented with the 'political question doctrine' narrative. However, gauging from the budget allocations to other sectors, this argument is watered down and viewed as merely cosmetic. This can be adjudged on a progressive tier, in juxtaposition with other budget allocation to other sectors such as office of the presidency and defense. The Government needs to look with in its own policy statements and international agreements to realize its minimum core obligation to realizing the right to health and address the continuous regression in budget allocation.

The health sector is such an important area in any country that it cannot be entirely left to politicians to decide what measures to employ in the course to provision of health services to the most at risk populations and the underprivileged. This importance has been well reechoed by Scott and Macklem who noted that,

> Denying an individual or group the ability to make constitutional claims against the State with respect to nutrition, housing, health and education excludes those interests from a process of reasoned interchange and discussion, and forecloses a useful forum for the recognition and redressing of injustices.

It is therefore from this perspective that the realization and enforcement of health rights requires concerted efforts of all sectors including the executive, judiciary, police, health system and Parliament through their legislative powers and oversight roles over budget allocations among others.

It is from these underpinnings that I commend the initiative to enact a law that covers all people more importantly those that cannot afford basic health care or afford access to private health care. This is more important, not only as a human right component, but also as a tool to ensure economic development. The Centre for Health, Human Rights and Development (CEHURD) has noted that the

> Health sector is one of the core yardsticks upon which progress and advancement are realized in a particular country and the state at which a country's health sector is ranked, usually indicates the overall growth and development in the country.

Any third world country that doesn't ensure the physical and mental wellbeing of majority of its citizenry cannot delude itself that it is effectively working towards economic development. Any true lasting form of development is tested through the ability of people to lead a basic modest life where necessaries are available with ease—and this also starts with a health physical and mental state of being.

III. The Practical Challenges

According to 2013 statistics from the Uganda Medical and Dental Practitioners Council, over 2000 doctors, representing nearly 50 per cent of the registered number of medical practitioners have left the country in the past 10 years. In early 2015, the public was further enraged by the Governments decision to export doctors to Trinidad and Tobago.15 A group of activists sought High Court intervention on the matter. While filing the suit, Justinian Muhwezi, the Executive Director, Institute of Public Policy Research Uganda (IPPR-U), noted that they were seeking a judicial review of the decision because they found it irrational that a government that is presiding over a health system that is short of human resources should be at the centre of efforts to export these scarce resources. However, High Court Lady Justice Elizabeth Musoke, invoked the 'political question doctrine' holding that "since the decision to export health professionals to Trinidad and Tobago was a decision of the Executive arm of government, it remains a political decision which would ordinarily have nothing to do with the courts." She further ruled that "the court would normally get concerned if the decision had been implemented by legislation; otherwise the courts may not be able to intervene in how government deploys its resources." After this setback, a petition was sent to parliament in the hope that it passes a resolution against the move. The lead petitioner, Justinian Muhwezi, argued that "the move would irreparably damage the public health sector and lead to loss of thousands of vulnerable patients." While receiving the petition, Speaker of Parliament Rebecca Kadaga wondered how we could help another country when the Health Service Commission is complaining over shortage of midwives. This government move defeats any rational explanation in the face of glaring human resource gaps within the health sector. In the Uganda, it is quite evident that the high levels of brain drain in the medical sector coupled with the lack of doctors in public hospitals has led to further deterioration of access to health care services in an already over stretched health sector.

All in all, the NHIS is a plan long overdue, notwithstanding the Government policy of providing free health services at government facilities, which has for the greater part been left only on paper, as in practice, the so-called free services are inadequate or largely unavailable. According to Dr. Francis Runumi, most people have been forced to sell their property or to acquire loans from loan sharks to address their health needs. This reinforces the importance of 'putting your money where your mouth is,' and in this regard, any policy developments and legal mechanisms put in place cannot bring any significant changes in the sick health sector if they are not beefed up with financial resources to aid in implementation.

IV. The Proposed National Health Insurance Scheme

The main objective of the draft National Health Insurance Bill 2012 is to establish the National Health Insurance Scheme (NHIS) and its functions; accordingly, it enables among other things the establishment of the Scheme's Board, outlining its composition, functions and powers; provide for staffing and funding; registration of contributors and their beneficiaries; the articulation of benefits available under the scheme; the creation of an accreditation committee to review prospective health care contractors and their service and payment agreements; regional health insurance offices; and an Appeals tribunal to hear disputes arising from the implementation of the Bill. With this plan in the offing, Uganda becomes the last country within the East African region to introduce a national health insurance scheme.

The object of the scheme is among others to facilitate the provision of accessibility, affordable, acceptable and quality healthcare services to the public servants and the members of the National Social Security Fund; to develop health insurance as a complementary mechanism of health care financing in Uganda; to ensure that every resident has access to good health care services; to ensure efficiency in the health care services; to limit the cost of health care services for the residents, and to provide finance to subsidise the cost of provision of health care services to the indigent. Under the scheme, contributors can access health services either under the National Health Insurance Scheme (NHIS), which covers every public servant or member of NSSF and their beneficiaries or the Community Health Insurance Schemes (CHIS) which are set up to cover those persons that do not qualify as members of the NHIS. Section 11 (2) lays out the benefits package for the members under the scheme, which can be found in Schedule I of this Act.

The proposed scheme is to be implemented in phases—first targeting those employed, including all government employees. Moulded around the operation of the NSSF scheme, it is envisaged that employees will contribute about 4% of their gross salary to the health scheme, which their employers would match. However, this initiative still faces stiff resistance from a broad range of sectors among which are employers, trade unions and workers representatives in parliament. Generally, employers who are already legally mandated to contribute 10% of employees' gross income to NSSF, "questioned how the 4% was determined and wondered whether the government could guarantee efficient service delivery, considering the poor state of public health facilities."

Nevertheless, this positive initiative to have a universal health coverage scheme is commendable and if streamlined to the current needs in the sector, will go far in improving health services. However, there are some propositions that need to be revisited if the bill is going to address the practical realities of our traditional family set up and the underlying health problems.

a. Who is a child?

In most countries all over the globe, including Uganda, the working legal definition of a child is anyone below the age of 18. The bill broadens this definition in respect of children to be covered. It extends the definition of a child to involve only below 18 biological or lawfully adopted children of a contributor or any person who is above 18 years and is wholly dependent on the contributor. However commendable this broad definition is, it is not practical in a Ugandan context where children in a household are not always biological or lawfully adopted. The people that stand to benefit largely from the health scheme are mainly rural based, poor and unemployed who normally live extended family setups with many children and young adults from dead relatives or others unable to take care of their own. This is a reality in Uganda and families don't normally go through the intricate legal process of adoption. Therefore, this clause as is proposed automatically excludes many children who are under mere guardianship or foster care placement. There is need to harmonize this clause with the extended family set up of Uganda without necessarily opening up more case load for the judiciary in adoption applications which are in themselves not practical under temporal foster care and guardianship, which is a norm in traditional society Uganda

b. Number of Dependants

On this matter, it appears the GoU learnt nothing from the experiences of Universal Primary Education (UPE). At the initial stages of UPE, there was provision that up to only 4 dependants were to benefit under UPE for each household.

This became very problematic due to the average number of children among the rural families and the poor. It is estimated that on average, Ugandan families have 6-7 children. This meant the parents had to choose which children to benefit at the expense of others. Clause 5(2) of the NHIB borrows the same provision, in that a member can register up to a maximum of 4 dependents as beneficiaries under the scheme. In effect, this will trigger parents choosing which children to benefit and whom to leave out, in the end creating or reigniting more traditional intersections around sex and gender preferences with their underlying societal discriminatory practices where the boys and able bodied children enjoy more privileges than girls and the physically handicapped. Therefore this clause needs to be reconciled with the practical Ugandan rural family and the poor, who will be the main beneficiaries under the scheme—so as to realize its main objective.

c. Contributions

The Ugandan tax payer is already feeling the pinch of ever increasing taxes and thus the health scheme as is proposed introduces new taxes. Clause 11 (1a & b) proposes an additional 4% deduction from employees salaries, which would be matched by another 4% from their employers. This, in addition to the NSSF contributions are bound to strain both employees and employers, further stifling their income. In agreement, Dr. Ian Clarke, the chief executive officer of International Hospital Kampala, argues that “the plan will increase an already stifling tax burden on the public without addressing the underlying problems, especially inefficiency in the current system and slow economic growth.”27 A more practical means of deductions would be to impose it on the NSSF contributions. Those already making contributions under NSSF may utilize a smaller percentage off their savings as a contribution to the health scheme, rather than more deduction on their meager salaries. Then government would use the funds budgeted for free medical access in public hospitals, to make contributions for the indigent persons that do not qualify for either the NHIS or the CHIS—especially those not in employment, the elderly and other underprivileged persons.

d. Criteria for Accreditation

Part VIII of the Bill makes provision for Health Care Providers and Clause 39 provides for the minimum requirements for accreditation of health care providers. Among these minimum requirements is that the provider must ensure that the human resource, equipment and infrastructure conform to the standards determined by the Ministry responsible for health; the health care provider adopted referrals protocol and health resource sharing arrangements; the health care provider meets the information management system requirements and can regularly transfer information; and the health care provider has a professional indemnity policy, among others.

Whereas all these are intended to streamline the health sector and ensure total safety of the patients and easy access to health services, these requirements may not easily be met by many rural health facilities. This may leave the arena to be dominated by private players who are mostly driven by profit accumulation. It is therefore important that government takes a thorough revamping of these public health units to bring them in conformity with the standards set out by the board. This will in the end help in ensuring that intended objectives of the scheme are realised.

e. Defining Indigents

As noted above clause 9 makes provision for indigents. However, it doesn't clearly define who qualifies as an indigent. It is broad and would lead to practical problems in determining which people should be catered for by government under this category. The drafters need to revisit this provision, clearly create criteria for determining who is an indigent, so as to ensure that wealthy persons that do not fall under the NHIS or the CHIS, do not take advantage of this provision to benefit from government subsidization.

f. Accessibility

The bill in its current state has been attacked by health insurance players as locking out the majority of Ugandans. Clause 4 of the bill provides for membership to the scheme and is to the effect that membership to the scheme is for all public servants and all employees who are employed in Uganda and are residents in the country. However, this provision is problematic as it leaves out those that most rely on public health care system. The reality of it is that majority of employees in the formal sector and public service, who represent less than 20 per cent of the total population, are already benefiting from private health schemes—mostly organized under their employee contracts. The Uganda Community Based Health Financing Association, has noted that "the scheme is only targeting about [20] per cent of the population in the formal sector, locking out over 80 per cent of the population in the informal sector." Mr Fredrick Makaire, the executive director, Save for Health Uganda, also noted that "government should setup a health insurance scheme which is compulsory for all Ugandans, not voluntary." He adds that "the NHIS should begin with Community Health Insurance which targets the vulnerable and the adults who are not the formally employed as opposed to the few employed by the formal sector."30 This issue is very pertinent and one that requires further interrogation in order to reconcile the overall objective of the national health insurance scheme with the health realities in the country.

In order to ensure a smooth operation of the scheme—covering the over 70 per cent of Ugandans that do not fall within the formal sector should be paramount. Clause 6 (k) that provides for Community Health Insurance Schemes should be streamlined with clear modalities on how these schemes will be setup, operated, regulated and how they fit into the overall NHIB management. All in all, to have a scheme that will stand the taste of time and benefit those that need it most, Uganda needs to take extreme care not to rush the universal health coverage scheme. It should be implemented in phases—first to benefit those that need it most, that is the poor and underprivileged that represent majority of people in the informal sector. Majority of people in the formal sector and public employment already have private health insurance schemes and hence should not be a priority in the start up phase. In agreement, Dr. Richard Alia, a health specialist and World Bank consultant, has noted that

> While health insurance is the best way to meet rising health costs, it will take decades for African countries to overcome the challenges. Developed regions like the United Kingdom and Japan took over 3 decades to perfect their systems, and if Africa realizes this in 30 years, that would be a miracle.

Alia adds that

> Africa's rapid population growth, combined with inadequate economic planning, poses a difficulty to health care delivery and affordability. Most Africans are too poor to afford premiums and there's too much dependence on aid. If African governments can introduce these schemes with low premiums, this dependency may be broken eventually.

It is thus important to borrow a leaf from other African countries that are in the process of introducing national health schemes as a mechanism of confronting the difficulties in health financing. This is in relation to the pledge African countries made at the African Union health ministers meeting in 2005 in Gaborone, Botswana, to realize universal health care by 2015. Therefore the GoU, though way behind on this pledge, should employ a gradual plan rather than rolling the scheme out in its entirety. The plan cannot be rushed in a sprint manner—it should be approached in a marathon style where if you take off with sprinting speed you may not be able to reach the finish line. In this regard Some African countries have made progress, including Tanzania (5% coverage, Ghana (20%) and Senegal (5%–10%). Nigeria started an insurance program in 2005 and now covers about 3 million people. And Rwanda, where the social scheme is co-managed by facilities–community partnerships with promotion from local governments, covers more than 70% of its population. These countries initial coverage was directed towards the poor and those that could not afford basic medical care. Uganda should also address the health sector challenges by first directing health insurance to the poor as they are category that need it most.

According to Dr. Kenneth Omona, Chairperson of the Committee on Health in Parliament, "the formally employed represent roughly 25% of the workforce in Uganda, [and] the revenues raised from their contributions is insufficient to sustain the scheme to a profitable level." It is therefore more realistic for the government to borrow best practices from countries that have overtime developed a practical scheme that reaches those most at risk populations and the poor and are working towards comprehensive insurance schemes for all. The goal should be to target those that need it most.

Lessons from Ghana, Thailand and Rwanda

a. Ghana

The Ghana National Health Insurance Scheme (GNHIS) was launched in 2004 with the overall "objective to secure the implementation of the national health insurance policy that ensures access to basic healthcare services to all residents of Ghana." The program components of the Ghana NHIS revolve around a major hub of the system, which is the National Health Insurance Fund (NHIF), administered by the National Health Insurance Authority (NHIA). To reach the grassroots, the system also runs further satellite networks. As reported,

> The satellites are a country wide network of CBHI schemes known as District Wide Mutual Health Insurance (DWMHI) schemes which are monitored, subsidized and re-insured by the hub. The NHIS is interesting in that it has adapted the Social Health Insurance (SHI) model so that informal workers can be included into the scheme. By combining a network of CBHI schemes with a centralized authority and source of funds (the SHI component) to ensure nationwide coverage and to guarantee the financial sustainability of the schemes, the NHIS has attempted to adapt the best aspects of these two very different health financing models to fit the particular socio-economic landscape of Ghana.

The Ghana NHIF has also benefited from a wide range of funding sources, which include "a 2.5% health insurance levy added to VAT, formal sector contributions, Member premiums of between 7.20 to 48.00 Ghana cedis annually (USD 5.00 - USD 34.00), Investments made by the NHIC, Funds allocated to the scheme by the Government of Ghana, central exemptions fund, formerly used to provide exemptions from user fees for those classed as indigent and Donor funds." In the Ghana scheme, "the basic benefits package is fairly extensive and purports to cover 95% of all health problems reported in Ghanaian health care facilities, though there is a noticeable emphasis on female reproductive health."

In order to provide the basic package of services, the NHIS covers both public and private health care providers at all levels of the health system, subject to their accreditation by the NHIA. This program has covered 12 million people.

b. Thailand

The Universal Coverage Scheme (UCS) Thailand was launched in 2001, and “has since become one of the most important social tools for health systems reform in Thailand.” The scheme aims to provide “universal access to essential health care and reducing catastrophic illnesses from out- of pocket payments by establishing a tax-based financing system and paying providers on a capitation basis." The UHC revolves around the National Health Security Act which was enacted in 2002, with very strong support and influence from civil society.43 The Universal Health Care (UHC) scheme in Thailand is structured in a way that

> Private health insurance organizations play no role in this reform, and remain only as a supplemental option for high income groups. Since October 2001, the Universal Coverage Scheme has combined the previous Medical Welfare Scheme and the Voluntary Health Card Scheme to further expand coverage to an additional 18 million people. This UHC scheme covers 74.6 percent of the population as of 2007 estimates. The benefits package is a comprehensive package of care, including both curative and preventive care. The scheme is financed solely from general tax revenue. Public hospitals are the main providers, covering more than 95 percent of the insured. About 60 private hospitals joined the system and register around 4 percent of the beneficiaries.

More still, since October 2003, the government of Thailand embarked on universal access to antiretroviral drugs (ARVs) and in November 2006, the new Government further abolished the Baht 30 co-payment, and the system is now totally free of charge.45 The report further notes that different methods of financing are applied for the various public health insurance schemes in Thailand. The Compulsory Social Security Scheme (CSSS) is financed by contribution from employees, employers, and central government contributions. However, the Civil Servant Medical Benefit Scheme (CSMBS) and the Universal Coverage Scheme (UCS) are financed from general tax revenues. The UCS is financed through general tax revenues paid to local contracting units on the basis of population size. The target population for the scheme is largely in the informal, agricultural sector and does do not have access to consistent cash income for any kind of regular premium payment, therefore making premium collection difficult. 50 million people are covered under Thailand's Universal Healthcare Program.

c. Rwanda

Another exceptional turn around in the health sector has been witnessed in Rwanda. This has been majorly successful due to the governments focus on improving access to health services for the poorest and most vulnerable people. According to Rwanda's Minister of Health Dr. Agnes Binagwaho, in the country's Vision 2020 plan, the government of Rwanda initiated a strategy "to develop economically into a middle-income country over the next two decades," and health was a key pillar to that development.46 The government identified that without improving health, they would never alleviate the country's poverty. The Rwandan government was committed to equitable health services and whatever they did, focused on ensuring that the poorest and most vulnerable had benefits too. Dr Agnes notes that they 'just don't provide health services for people who can access healthcare normally.' All this was triggered by the government's realization that the country's utilization of health care lagged in the poorest fifth of the population. They thus started to subsidize premiums and co-payments for those living in extreme poverty through the support of The Global Fund to Fight AIDS, Tuberculosis, and Malaria. It was highlighted that 'for Rwanda, health equity is both a matter of ethics and epidemiology:' The government made sure that access to health care for all citizens is a prerequisite for controlling diseases such as HIV—and for continued economic growth to lift more Rwandans out of poverty.

Overall, Uganda needs to build institutions, address the overreaching corrupt tendencies that have eaten up all sectors and ensure that mechanisms are put in place to drive the sector forward. This cannot only be done on paper and resources—both human and financial must be allocated to the sector to help in implementation of any developed strategies. It is therefore prudent that Uganda borrows best practices from these countries, developing a scheme that targets the informal sector first. It is only through this avenue that the objectives of the scheme will be realized.

Conclusion

According to a Countdown 2015 report, Sub- Saharan Africa and South Asian countries have had the highest concentration of maternal mortality. And over the years, the need to reduce on global maternal mortality, has led to the increased recognition that reducing maternal mortality is not just an issue of development, but also an issue of human rights.52 This was expounded by the 2009 UN Human Rights Council Resolution which recognized that,

> The unacceptably high global rate of preventable maternal mortality and morbidity is a health, development and human rights challenge, and that a human rights analysis… and integration of a human rights perspective in international and national responses to maternal mortality could contribute positively to the common goal of reducing this rate.

Dr. Francis Runumi, argues that "health insurance with a legal mandate towards universal coverage is a possibility here, but Uganda is still caught up in skepticism." Whereas this is true on a large scale, realities of high levels of corruption, abuse of office and massive embezzlement of public funds by those we have entrusted with these institutional offices, inform the skepticism surrounding rolling out a scheme of such a magnitude without addressing all gaps first. Aloysius Ssemanda, former head of the Federation of Uganda Employers, has noted that "employers cite precedents, including the Global Fund and National Social Security Fund, where officials allegedly misused monies, [and thus doubt] whether the government [can] implement such a big program without falling into corruption pitfalls."

Generally, Uganda's crippling public health system coupled with the meager resources channeled into the health sector both for medical practitioners' remunerations and ensuring availability of essential goods and services at the grassroots health units have greatly and continue to hinder any possibilities of addressing the major concern of high mortality rates especially from preventable diseases. This is not helped by the government's reluctance to address issues affecting the health sector.

All in all, Uganda needs to carefully reassess the scheme and make it more practicable if it is to meet the overall objective. Improved service delivery, infrastructure, resources both human and financial should be at the forefront if the scheme is to meet its objectives and goals. Although the public health sector needs to be strengthened and equipped as the major player in the implementation of the scheme, there is need to have a strong collaborative partnership between the private and public sector especially around specialist needs.

Those already remitting NSSF contributions need to have a small deduction from their savings as contribution to the health scheme. Ones retirement savings will not do them any good if there are not alive to enjoy them. This will help address the tax burden issues that will be compounded in more deductions in their meager salaries. Similarly, health insurance is a social security issue, and thus it should not be handled as a voluntary undertaking.

Taxes may be levied on lifestyle goods such as alcohol, cigarettes, wines and spirits and these will be channeled into the scheme to help cover the poor and underprivileged. Overall, as a priority, the scheme should target those not in formal or public sectors and then rolled out to everyone else, once those that need it most have been catered for.

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[Political Question Doctrine is a doctrine which prevents a court of law from determining issues which are essentially political; within the purview of the executive branch of government. This doctrine originated in the 1803 U.S Supreme Court case of Marbury v. Madison where Chief Justice John Marshal noted that "The province of the court is, solely, to decide on the rights of individuals, not to enquire how the executive, or executive officers, perform duties in which they have a discretion. Questions, in their nature political, or which are, by the constitution and laws, submitted to the executive, can never be made in this court."]

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Section 6.

Section 5. [Section 9 creates another category of beneficiaries under the NHIS. It provides that a person who does not qualify for membership of the Scheme under section 5 and who is not, able to join a CHIS under section 8, shall for purposes of this Act, be an indigent person who shall be a beneficiary of the NHIS.]

Section 8. [(1) Every person resident in Uganda who is not a member or a beneficiary ofthe scheme as prescribed under section 5 shall be registered as a member of a community health insurance scheme.]

Rosebell Kagumire, 'Public Health Insurance in Uganda still only a Dream' Supra note 24

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