ABSTRACT

Title of Thesis: Neoliberal Pathologies and African Development: The Case of the Ugandan Healthcare System

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Uganda's healthcare system has undergone significant transformations influenced by neoliberal policies over the past few decades. How has Uganda's historical embrace of neoliberalism influenced the structure of its modern healthcare system, and what are the resultant effects on the quality and accessibility of healthcare services? This paper examines the impact of neoliberalism on Uganda's healthcare system, focusing on disparities in access, high out-of-pocket payments (OOPs), and the role of public-private partnerships (PPPs). Despite policy transitions and objectives, neoliberalism has perpetuated poverty and uneven development, leading to regional and socioeconomic disparities. The implementation of policies such as the Poverty Eradication Action Plan (PEAP) and National Health Policy I (NHP I) failed to address rural/urban healthcare gaps, entrenching neoliberal paradigms further. Subsequent policies under UgandaVision 2040 and NHP II continued to prioritize PPPs but failed to resolve deeper socioeconomic issues. High OOPs remain a barrier to equitable healthcare, despite the abolition of user fees in 2001. The reliance on private healthcare and informal charges exacerbates financial burdens on households, leading to impossible choices compromising living standards. This thesis argues that the neoliberal approach to healthcare in Uganda prioritizes market efficiency over equity, commodifying healthcare and neglecting social welfare. Overall, it highlights the need for a shift away from neoliberal ideologies towards a healthcare system that prioritizes collective well-being and government intervention.

Neoliberal Pathologies and African Development: The Case of the Ugandan Healthcare System

By

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Chapter 1: Introduction

In early 2023, the United Nations released a sobering report evaluating Uganda's progress towards critical developmental goals and sustainable development targets. Ranking 136 out of 163 countries, Uganda's stagnation in vital areas such as poverty reduction, gender equality, and access to clean water and sanitation underscored persistent developmental challenges (United Nations 2023, 17). These results indicated more significant developmental issues in Uganda, such as uneven development and limited social protection for its citizens.

Particularly alarming was the UN's emphasis on the urgent need for high-quality essential social and protection services, highlighting the significant poverty levels and barriers to healthcare access (United Nations 2023, 54). As of 2019/20, 42.2% of Uganda's population lived below the international poverty line, underscoring the depth of the country's challenges (United Nations 2023, 12). Various healthcare reforms have been implemented in Uganda in response to these pressing issues. Despite these efforts, the reforms have struggled to effectively address the persistent problems of inequality and the uneven distribution of benefits within the healthcare system. In light of these challenges and the broader context of Uganda's developmental trajectory, this thesis delves into the impact of neoliberalism on healthcare reforms. Specifically, it explores how neoliberal policies have influenced disparities in access to healthcare services and perpetuated socioeconomic inequality.

Uganda is a compelling case study for examining African development because of its significant history with donor aid and its impacts on the formation of its policies (Lie 2018, 43). Between 1987 and 1999, Uganda underwent a series of economic and political reforms that fundamentally transformed its approach to development (Sejjaaka 2004, 105). These reforms were part of a broader paradigm shift to neoliberalism, defined by its commitment to fiscal

austerity, privatization, and market liberalization. These reforms led to a comprehensive reimaging of Uganda's socioeconomic landscape and focused on neoliberal deregulation and good governance ideas. Until 2005, Uganda was known as the donor darling of Western development for its relatively stable government and overall economic growth because of these monetary policies (Lie 2018, 44). However, in the years after these reforms, structural weaknesses have appeared in Uganda's development and impeded growth and equitable development. The UN's report encapsulates these crucial weaknesses and results in questions emerging about the overall impacts of these reforms on Ugandan citizens today. This thesis focuses on the formation of Uganda's healthcare system after structural adjustment, one of the areas most transformed by neoliberal policies and a significant determinant in quality of life. This thesis explores the concept of neoliberalism and evaluates its legacy through an evaluation of Uganda's contemporary healthcare system. My research seeks to answer the following question: How has Uganda's historical embrace of neoliberalism influenced the structure of its modern healthcare system, and what are the resultant effects on the quality and accessibility of healthcare services? I aim to delve deeper into how neoliberalism has shaped Uganda's approach to social service delivery, particularly in the context of healthcare policy. By examining the impact of these policies on diverse groups of Ugandan citizens, I aim to uncover why such policies persist. Ultimately, my thesis will contribute to discussions surrounding the impacts of Africa's structural adjustment on global south development today.

My thesis argues that this period played a pivotal role in entrenching neoliberal ideas of austerity, deregulation, privatization, and decentralization in Ugandan reforms and formed the basis for its modern healthcare system. These neoliberal reforms and policies have negatively impacted Uganda's efforts to create an equitable and high-quality healthcare system, resulting in

high out-of-pocket expenses and inequality. These represent more significant issues in Uganda's development and have played a prominent role in creating Uganda's current problems with poverty and inequality. Only by resolving these issues can Uganda reach its sustainable development goals and build a more robust healthcare system.

A Brief History of Structural Adjustment in Africa

To understand the impacts of neoliberalism and its role in Uganda's development, it is first necessary to give a brief history of African structural adjustment. During neoliberal reforms in the late 20th century, African economies underwent massive transformations that fundamentally altered the Global South's development landscape. Structural Adjustment Programs (SAPs) were introduced by institutions like the International Monetary Fund (IMF) and World Bank (WB) to help African countries, in theory, optimize their market structures and become more efficient (Stein 2008, 33). African countries would receive loans only if they agreed to introduce strict neoliberal reforms focused on privatization and market liberalization (Sharma 2015, 197).

Structural Adjustment Programs included Sectoral Adjustment Loans (SECALs) and Structural Adjustment Lending (SALs), which both acted as conditional loans in exchange for neoliberal reforms in the trade, finance, healthcare, educational, manufacturing, and agricultural sectors (Stein 2008, 25-26) (Sharma 2015, 197). These conditional loans targeted countries that faced problems with debt and corruption, mainly in the Global South (Sharma 2015, 196). Between 1980 and 1983, the net flow of loans to sub-Saharan African countries totaled $4.4 billion from the IMF and $2.83 billion from the World Bank (Stein 2008, 34). Stein (2008, 35) pointed out that the scale of aid played a significant role in institutionalizing neoliberalism on the

continent. The number of countries receiving SALs and SECALS rose from 6 African countries in 1980-1983 to 27 countries in 1984 and 1989 (Stein 2008, 37). The structural adjustment programs proved to increase inequality and slow African economic development. The policies resulted in overall economic downturns due to the inability of African countries to compete with developed countries on global markets without trade protections like tariffs and subsidies. This damaged an already fragile developing manufacturing industry and led to investors losing confidence due to the lack of economic growth. Investment declined at a rate of 3.9% annually in the 1980s after growth of 4% from 1973-1980, reflecting the impact of the neoliberal reforms(Stein 2008, 39).

These reforms dramatically changed the African public health landscape. In 1987, the World Bank published *Financing Health Services in Developing Countries: An Agenda for Reform,* which outlined four policies that should be included in African healthcare systems (World Bank 1987) (Terris 1999, 153). This included user fees for governmental facilities, insurance, or other risk coverage, using nongovernment resources effectively, and decentralizing government health services (Terris 1999, 153-154). These reforms were included in structural adjustment loans for African countries, including Uganda. Terris (1999, 167) argued that these reforms fed into a neoliberal triad of governmental budget cutting, deregulation, and privatization that deteriorated healthcare services in developing countries. Stein (2008) found that after 1985, the World Bank increasingly committed projects to neoliberal reforms, and more than half were focused on altering the organizational and financial dimensions of the healthcare sector. Sub-Saharan Africa drastically reduced their healthcare budgets under these conditional load programs and privatized a significant portion of their healthcare system. Higher costs for private care were coupled with government funding reductions for public healthcare services,

which damaged public trust in the government (Gatwiri et al. 2019, 90-91). The collapse of these healthcare systems had significant unintended consequences for economic development, causing excess deaths and creating a healthcare system that fostered inequality.

This period was incredibly influential in Africa's development and fundamentally transformed its perspectives on health and social expenditures. Many scholars have thoroughly discussed these events and their implications for development. However, comparatively less literature has focused on the long-term consequences of neoliberal development in the healthcare sector in African countries and the impact on current healthcare systems. Using the healthcare sector in Uganda as a case study, I hope to add to discussions surrounding development and neoliberal legacies in Africa.

Uganda

Geography and Environment

Uganda, located in East Africa, is a landlocked country with rich biodiversity and fertile terrain. The country hosts many rivers and lakes, including the massive Lake Victoria, which supports most of Uganda's agricultural activities. (CIA 2021). The CIA (2021) estimated that 71.2% of Uganda's land is used for agriculture, including crop cultivation and pastureland. Uganda's terrain also contains mineral resources like copper, cobalt, limestone, salt, and gold; however, much of this has been untapped. The country has struggled with droughts, floods, and earthquakes, damaging the agricultural sector and rural populations. The Northern region, in particular, has been increasingly impacted by droughts and natural disasters (CIA 2021). The country is mainly agrarian, and the majority of its citizens are subsistence farmers. Most of the population resides in the central and southern regions, particularly near Lake Victoria and Albert

(CIA 2021). Kampala, the capital city, not only serves as Uganda's political and economic center but also stands as the largest urban center in the country (CIA 2021). Figure 1.1 (below) provides a detailed map highlighting Uganda's geographical features and access to crucial water sources.[1]

Political and Administrative Organization

Figure 1: Map of Uganda[1]

Uganda began as one of the most promising economies in Sub-Saharan Africa at its independence in 1962, with a strong manufacturing sector and solid fiscal and monetary management (Sejjaaka 2004, 100). However, Uganda struggled with stability in leadership and stunted growth in the latter years. This period started with the overthrowing of the first President in Uganda, Sir Frederick Mutesa, by commoner A. Milton Obote in 1966. Soon after Obote

[1] Map of Uganda. Source: The World Factbook

seized power, he pursued a developmental strategy of socialism and nationalization, resulting in a flight of capital and high debt in 1970. The following decade included another coup that resulted in another leader, Idi Amin, whose policies resulted in high inflation, continued social inequality, and social disorder as corruption skyrocketed (Sejjaaka 2004, 101-103). In 1979, Amin was overthrown, and three competing governments arose, including the return of Obote. Between 1979 and 1986, a Civil War took place in Uganda as oppositional groups rebelled against Obote's regime, with over a million lives potentially lost (Sejjaaka 2004, 103-104). This period saw high corruption, an unstable economy that was largely unworkable amidst the violence, and a 20-year insurgency in the north that killed millions (BBC 2023). The current leader, President Yoweri Museveni, seized power in 1986 with the National Resistance Movement party (NRM) (BBC 2023). Museveni has been credited with restoring stability and economic prosperity yet also faced criticism for corruption and political repression (BBC 2023). He was elected to serve for his sixth term in office in January 2021, with the NRM retaining the parliament majority. During his tenure, he removed term limits and consolidated power in an increasingly authoritarian regime (EIU 2024).

Economy

Uganda's economy is primarily agricultural yet has seen growth in other sectors in recent years, such as the service and industry sectors. In 2017, 28.2% of the GDP came from agriculture, industry comprised 21.1%, and services comprised 50.7% (CIA 2021). Uganda has seen GDP growth in recent years, 4.6% between 2021 and 2022, yet the growth has accompanied high poverty and inequality. Additionally, the country faces high debt to donors and multilateral institutions like the World Bank and IMF. The public debt comprised 52% of the GDP in

2021/22, triggering the requirement for Uganda to enact Performance and Policy Actions mandated by the World Bank to identify ways to reduce this debt (United Nations 2023, 16).

People and Society

As of 2021, the population of Uganda is estimated to be 44,712,143 (CIA 2021). Uganda is incredibly diverse, containing ethnic groups like the Bahadna, Banyankole, Basoga, Bakiga, Iteso, Langi, Bagisu, Acholi, and Lugbara (CIA 2021). Uganda is a rapidly growing nation, with a fertility rate of 5.8 children per woman. The high number of births and cultural preferences for large families have contributed to Uganda's incredibly young population. The rapidly growing population has led to concerns about the availability of arable land and natural resources for Ugandan citizens. The Northern region has lagged significantly behind the rest of the country due to the long-term conflict with the Lord's Resistance Army and the Ugandan Bush War 1981-1986. The country has a large rural population, with only 26.8% residing in urban areas (CIA 2021).

Healthcare Sector

Uganda's healthcare sector is comprised of a decentralized public sector, a private sector, and contributions from donors. Uganda's Ministry of Health is decentralized, and both public and private sub-sectors provide healthcare services, each comprising about 50% of reported healthcare services (MoH 2010, 4). The Ugandan National Minimum Health Care Package (UNMHCP) covers all levels of the healthcare system, including district healthcare systems, health clinics, Regional Referral Hospitals (RRH), and National Referral Hospitals (NRH). The private sector includes Private-Not-For-Profit facilities (PNFPs), Private Health Practitioners (PHPs), and Traditional and Complementary Medicine Practitioners (TCMPs). Private healthcare

facilities are permitted to charge user fees, which has led to issues with restrictions in access to care (MoH 2010, 5).

The Ministry of Health operates under a decentralization framework, with district health offices supervising the district health systems and responsible for service provisions (Mukasa 2012, 5). The Ministry of Health primarily focuses on budgeting, regulation, and policy formulation. Donors play a significant role in healthcare policy formation, providing funding and policy support to the Ministry of Health (MoH 2010, 19). Healthcare expenditure is low, comprising only 4% of GDP in 2020 (CIA 2021). The healthcare facility has struggled to accommodate Uganda's rapidly growing population, with only .5 beds/1000 population and .15 physicians/1,000 population (CIA 2021). Additionally, rural areas struggle with low access to primary healthcare, safe water, and sanitation (Mukusa 2012, 9). Uganda has undergone significant reforms over the years, including two different National Health Policies, yet continues to struggle with high rates of infectious diseases and an overall uneven healthcare system.

Methodology

My methodology primarily relies on qualitative data and employs a theoretical approach to analyze Uganda as a case study of African development post-structural adjustment and the influence of neoliberal doctrine within a state. Specifically, this thesis examines Ugandan healthcare policy reforms against neoliberal ideas and constructs to assess their impact on the healthcare system.

The first component of my methodology involved creating a theoretical framework to analyze the concepts of development and neoliberal ideology, accompanied by an exploration of neoliberalism's role in Ugandan structural reforms. This framework draws from the works of

prominent academic voices in developmental theory, such as Amartya Sen, Dudley Seers, Andre Gunder-Frank, and global organizations like the United Nations (UN) and the World Health Organization (WHO). To establish a foundational understanding of neoliberal development, I also examined academic literature surrounding neoliberalism's origins, key concepts, and primary ideals using the works of political economists like Adam Smith, David Harvey, Howard Stein, Sue McGregor, Milton Friedman, and Daniel Jones. This approach aids in creating an analytical framework for analyzing healthcare policies and the presence of neoliberal doctrine.

The second component of my research utilizes the framework established to analyze Uganda's key healthcare reforms post-structural adjustment. This involves an analysis of Uganda's healthcare policy and development plans from 1997, the midst of structural adjustment, and the height of its neoliberal reforms up to 2023. This analysis draws from policy documents and reports from governmental and international sources to examine Uganda's major healthcare reforms, from the Poverty Eradication Action Plan in 1997 to recent developments in healthcare like the Public Private Partnership Act. From 1997 to 2023, Uganda experienced two significant shifts in its healthcare framework, both aimed at addressing the challenges intensified by the structural adjustment policies. By delving into this timeframe, we can analyze how neoliberal ideas perpetuated within Ugandan healthcare policy and its future role in policy formation.

This analysis included a systematic review of policy documents and official reports from the Ministry of Health, National Planning Authority, and external global institutions like the World Bank and IMF. This process involved gathering primary sources of information such as government publications, expert analyses of policy, and statistical data surrounding healthcare elements like funding allocations against GDP growth. The study draws from quantitative data

surrounding economic growth and healthcare expenditures and qualitative data such as Ugandan policy documents. The overarching themes and discontinuities across different policies and reform initiatives within this timeframe were analyzed to identify key policy trends, the presence of neoliberal reforms and justifications, and the intended impacts.

The third component of my research delves into an assessment of the impacts of these healthcare policies on Ugandan citizens. This component specifically focused on equity in healthcare and the overall costs of healthcare across different demographics in Uganda. To assess the equity impact, I conducted a detailed examination of Uganda's regional disparities in poverty concerning the distribution and accessibility of healthcare facilities, both private and public. This regional analysis offers insights into how healthcare policies have influenced regional access and healthcare outcomes. To understand the overall healthcare costs, I also referred to data on out-of-pocket expenditures (OOPs) and compared it with government healthcare spending. This data provided a clear picture of the financial burden on Ugandan citizens and how government spending on healthcare has aligned with the policy goals. In addition to these analyses, qualitative case studies on healthcare in Uganda were employed to offer a more nuanced understanding of the ground realities. The lived experiences of individuals within the healthcare system. These case studies were instrumental in capturing the human aspect of healthcare policy impact, shedding light on individual experiences, challenges, and outcomes within the healthcare system. This section critically assesses several healthcare studies conducted in Uganda, analyzing the impacts of Uganda's healthcare policies against its intended outcomes.

This methodology relies on policy analysis and healthcare assessments to understand how Uganda's healthcare policies transformed in the post-structural adjustment period and the resulting impacts. However, this approach has several limitations, including access to

information and time constraints. The thesis was written over one academic year, limiting the time available for an in-depth examination of development and Uganda's healthcare system. Additionally, my research was primarily a desk review, which is not a participatory process, and introduced certain limitations related to data accessibility. To mitigate potential biases and limitations introduced through a desk review and case study-based methodology, a wide variety of research across institutions with different viewpoints was examined to reduce bias and restrictions in data accessibility. An active effort was made to use a variety of authors who were both critical of and in support of Uganda's healthcare system to create a more holistic assessment. Lastly, this thesis heavily relies on government documents and data from multilateral institutions that have historically advocated neoliberal reforms. This reliance poses potential biases in the objectivity and impartiality of the data presented on the effectiveness of these entities' healthcare reforms. I diversified my data sources to mitigate these biases by incorporating a broader range of studies and measures related to poverty and healthcare access.

The methodology employed in this thesis seeks to broaden our understanding of development in Africa. Utilizing Uganda as a case study, I delve into the existing discussions surrounding healthcare development and prioritize areas of improvement for a robust healthcare system. By highlighting the shortcomings of Uganda's healthcare system, I connect these issues to the broader historical context of neoliberal development. This approach offers a comprehensive understanding of the persistent challenges faced by Uganda in its healthcare system. Ultimately, this research aims to stimulate critical discussions about the global healthcare system and encourage a deeper exploration of the long-term implications of neoliberalism.

Research Overview

This thesis uses Uganda's healthcare policy development as a case study to examine the formative impacts of structural adjustment on African development and healthcare institutions. Overall, my research aims to (1) a framework that can be used to analyze neoliberalism in the years since structural adjustment, (2) assess the role of neoliberal doctrine in the formation of Ugandan healthcare policy post-structural adjustment, and (3) review the impacts of Uganda's healthcare policies on the equity of Uganda's healthcare system, focusing on the costs and access to quality healthcare. By situating Uganda's current healthcare system within the context of its historical neoliberal reforms, we can understand how structural adjustment in the 1990s shaped its effectiveness.

Chapter 2 explores the conceptualization of healthcare as a social good within the neoliberal context and establishes the theoretical foundations of my case study. Drawing upon scholars from various disciplines, I contend that GDP alone is insufficient for gauging a country's developmental strategy. I argue that holistic indicators such as quality of life, inequality, and unemployment are essential to comprehensively understanding a nation's development. Furthermore, I posit that healthcare is a critical indicator of development that can be used to analyze the impacts of economic development on quality of life. This chapter also explores the neoliberal framework that makes up the theoretical foundations of my analysis. I argue that neoliberalism has been a formative philosophy that has significantly influenced countries' perceptions of the roles of the state and the market. The chapter then transitions into a broader discussion of how these economic policies have contributed to uneven development, emphasizing their socio-economic repercussions, particularly in the context of wealth inequality. When Uganda underwent these key transformations, it created a cascading set of effects that

permanently altered its healthcare system and overall development. This analysis contributes to ongoing discussions about the fundamental nature of healthcare in societies influenced by neoliberal ideologies, potentially challenging or enriching existing conceptual frameworks. By examining the historical context, policy trajectories, and reform dynamics within Uganda's healthcare sector, this study provides valuable insights into the factors driving policy change, the outcomes of reform efforts, and the implications for healthcare governance and service delivery.

Chapter 3 evaluates the current state of Ugandan healthcare institutions and scrutinizes the aspects of the Ugandan healthcare system that reflect neoliberal ideology. Utilizing the neoliberal framework introduced in Chapter 2, I assess how current governmental healthcare reforms continue to mirror neoliberal ideology. This chapter juxtaposes Uganda's GDP growth with the transformations in its healthcare sector to ascertain whether current policies have led to positive changes in the healthcare system. By applying neoliberal frameworks to current governmental reforms, I demonstrate how the reforms of the 1990s have had a lasting impact on healthcare policy and governmental perspectives on healthcare access. This examination analyzes Ugandan policy reforms, explicitly focusing on Uganda Vision 2040—a long-term development plan designed to overhaul Uganda's socio-economic landscape. These documents are analyzed by exploring the language surrounding healthcare and how policies aim to enhance Ugandan quality of life through measures such as public-private partnerships and the expansion of the private sector. This focus reveals the enduring influence of neoliberal ideology on perspectives towards healthcare and results in reforms reminiscent of those in the 1990s, which embraced cutbacks and privatization.

Chapter 4 investigates these reforms' impacts on inequality and healthcare access over the past decade. This chapter critically assesses the contemporary state of Uganda's healthcare

system, emphasizing the effects of public-private partnerships. It examines the extent to which these collaborations influence access to healthcare services and evaluates the quality of care. Public-private partnerships in Uganda have exacerbated healthcare access disparities, particularly between rural and urban populations. Uneven funding allocations that prioritize private healthcare and rising healthcare costs have resulted in deteriorating healthcare outcomes for Uganda's poorer and wealthier populations. An examination of healthcare access across regions and classes reveals that inequality has intensified, leading to a weakened healthcare system that fails to support lower socioeconomic classes.

Moreover, the impact of public-private partnerships has varied, with rising private healthcare costs leading to a decline in overall healthcare quality. Chapter 4 draws on household budget surveys, data from the World Bank and other global institutions, and research case studies to establish the adverse impact on the healthcare system. I explore the link between the adverse outcomes of these policies and the history and neoliberal outlook on healthcare.

Chapter 5 concludes my research and seeks to understand the motivations for continuing these policies. I argue that Uganda’s healthcare system is designed to benefit both the Ugandan elite and donor partners primarily. Neoliberal reforms in the 1990s have entrenched an authoritarian government and incentivized corruption in the healthcare sector, resulting in ineffective policy. This chapter summarizes the existing challenges and deficiencies in the current healthcare system and underscores the need to recognize the neoliberal ideologies that have shaped these perspectives. Uganda’s current healthcare system reveals more profound flaws in its economic development, and the prevailing system may lead to deteriorating living standards and escalating inequality.

Chapter 2: Development, Healthcare, and Neoliberal Reforms

Introduction

This chapter provides the foundations for analysis and a greater understanding of the connections between development, healthcare, and neoliberalism. A country's development is characterized by its progress, and analyzing the healthcare system can offer valuable insights into this development. Through an exploration of the existing literature surrounding development and healthcare, I argue that GDP does not sufficiently measure the development of a country and that indicators like quality of life, inequality, and unemployment are crucial for understanding a country's development. Additionally, I discuss healthcare's pivotal role in development and argue that analyzing the Ugandan healthcare system can provide a holistic understanding of the country's development.

This chapter also explores and critiques the neoliberal framework that makes up the theoretical foundations of my analysis. After outlining the current debates, the chapter transitions into an exploration of the tenets and theoretical foundations of neoliberal theory and extends its definition into the impacts on access to social goods, specifically healthcare. This theoretical framework can then be used to identify the role of these principles in the formation of Ugandan healthcare policy and its direct and indirect implications on healthcare institutions. Lastly, I explore the role of neoliberalism in Uganda's development in the 1990s before transitioning into a more extensive discussion about what gaps exist in the current conversations surrounding neoliberalism and its implications.

Literature Review

Defining and Measuring Development

What does it mean for a country to develop, and how can this development be measured? To discuss Uganda's healthcare system and the impacts of neoliberal theory on development, this thesis will first define development and examine the metrics for measuring development. Development as both a concept and theory has been studied across generations and crosses the fields of political science, philosophy, and economics. For this thesis, development in this context focuses on the economic and social aspects of a society's development (Goldin 2018, 3-4). Amartya Sen's Capability Approach defines development through an evaluative framework for individual welfare and social arrangement. It focuses directly on the quality of life that individuals can achieve under this framework (Dang 2014, 460-462). Under Sen's theories, development is defined as a package of freedoms, including political freedom and transparency, freedom of opportunity, and economic protection from poverty (Sen 1999, 10). An individual's capabilities reflect the levels of functioning that someone can achieve, including being nourished and healthy, not suffering from a lack of respect, and having a broader social life (Dang 2014, 461-462). Sen (1999) argued that development must examine the extent to which one can achieve outcomes they value. This perspective means that empirical measures like income can be insufficient for measuring development from a human-centered perspective. Sen's theories of development expanded the idea of development past macroeconomic indicators into how progress translates into human development. When analyzing African development, this thesis will draw on Sen's concepts of development to justify focusing on the healthcare sector as a metric for development.

Andre Gunder-Frank's Theory of Underdevelopment (1966) complicated the concept of development by including the role of inter-country relationships and colonial histories in forming

current states of development. Gunder Frank (1966) described the concept of core nations, wealthy and powerful nations like Europe and the U.S., and periphery nations, nations with high poverty and low growth and viewed as undeveloped as Zimbabwe and Uganda. Gunder Frank (1966) distinguished between *under*developed and *un*developed, asserting that contemporary underdevelopment reflects the predatory relations between underdeveloped and developed countries. Development in periphery underdeveloped nations will not compare to core nation development because the global capitalist system created the underdevelopment. This global capitalist system is tied into these colonial histories that created an exploitative relationship between core and periphery nations that leads to consistent underdevelopment. Gunder Frank stated that most developmental theories failed to account for the economic and social history that led to current development tracks and instead centered on the experiences of European and other advanced countries (ibid). Even after the end of direct colonialism, these relationships have remained intrinsic in forming both countries' developments. Additionally, Gunder Frank (1966) asserted that these relations were intentionally predatory under a capitalist system and benefitted the developed countries at the expense of the underdeveloped countries. Gunder Frank hypothesized that these core nations continue to limit periphery nation development. Those periphery nations will have the most significant growth when the ties are at their weakest.

Gunder Frank's assertions can be extended into conversations surrounding African development and dependency theory. Dos Santos (1970, 231) defined dependency as 'a situation in which the economy of certain countries is conditioned by the development and expansion of another.' This definition distinguishes between center and periphery nations and situates both within a broader global economy. Both Gunder Frank and Dos Santos use the case of Latin America to explain the concept of dependency theory, arguing that to understand a system of

dependent reproduction and a country's internal development, you must first understand the system of economic relations that are based on control of large-scale capital and control (Dos Santos 1970, 235). This creates a system of dependency reproduction, where development is limited by world relations that lead to the development of specific economic sectors under unequal conditions. Dos Santos (1970) argued that inequality would be greater in more economically and politically dependent countries, meaning that the chances of economic development would decrease as dependency increases.

Taylor (2016) states that Africa's development has only deepened Africa's dependent position in the global economy. Africa's development has been controlled by external forces that have enforced Africa's structural location in the world economy. African economies have been pushed to de-industrialize and remain an economy that is primarily commodity-dependent (Taylor 2016, 12-14). To understand Africa's developmental track, this thesis will seek insight into the formative political and economic systems that led to its current state of development.

Considering these perspectives, the question emerges of how development can be measured on a broader scale. GDP has been one of the primary development measures by many mainstream economists. However, this approach has been criticized for failing to encompass the more complicated aspects of a country's well-being (Sen 1999) (Goldin 2018) (Stein 2020) (Gunder Frank 1966). GDP measures a country's national output and expenditure and is simple to calculate, accessible, quantifiable, and can be compared across borders. In contrast, GDP per capita reflects development accounting for population size (Goldin 2018, 6). Purchasing power parities (PPPs) have also been used to overcome income or expenditure distortion by comparing a country's product to international prices to understand a country's wealth (Goldin 2018, 5-6). The World Bank groups the world's economies by gross national income (GNI) per capita

(Fantom and Serajuddin 2016, 2). Countries are classified as high-income, upper-middle-income, lower-middle-income, or low-income, depending on their GNI per capita.

Fantom and Serajuddin (2016) criticized this classification and pointed out that the indicators may be faulty and fail to capture poverty. They found that more people lived below the World Bank's international extreme poverty line in middle-income countries than in low-income countries, illustrating the issues with the current measures of development (Fantom and Serajuddin 2016, 3). Purely economic approaches can take macro aggregates of economic data surrounding income and development and fail to capture the multidimensional nature of poverty and uneven development within those aggregates. These summary economic measures exclude education, health, and life expectancy (Goldin 2018, 7). Per capita measures can also obscure distributional measures of development and hide inequality. Scholars like Sen (1999), Gunder Frank (1966), and Seers (1969) argued for a more extensive definition of development that extends past simple economic aggregate measures. Goldin (2018, 13) explained that our understanding of development has continued to shift from a narrow focus on economic growth to broader ideas of basic needs and human freedom. This new approach has worked to incorporate poverty and inequality. The UN Committee on Economic, Social, and Cultural Rights (CESCR) described poverty as "a human condition characterized by the sustained or chronic deprivation of the resources, capabilities, choices, security, and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights" (CESCR 2001, 2).

Poverty remains central to development, and measuring and capturing poverty requires a more significant measure than purely economic metrics like GDP. Poverty and development often intersect through uneven development, resulting in inequality. Khrystyna (2013) defines

uneven development as an essential feature of the capitalist economy, reflecting the tendency to focus growth and investment in certain regions. The discussion of inequality and measuring inequality faces similar challenges to measuring poverty. Pure aggregate economic measures like GDP may fail to capture disparities in wealth, gender, or region completely (Goldin 2018, 6-7). Inequality is crucial to measuring development, specifically when examining uneven development. Development without regard to quality of life and equity may result in specific demographics being left behind. Stein (2020) defined inequality as

> "a disease that cripples those who are economically and socially disadvantaged from participating more fully in life processes. It is not a product of individual choices but a result of social dynamics that divide people into gender, race, nationality, religion, and class, which form the core of the divisive separation between those enjoying privilege and those undergoing deprivation" (123).

Stein's definition makes the political element of inequality clear, arguing that inequality is the result of active dynamics that continue toxic cycles of poverty that limit the opportunities of certain people. When analyzing development, the elements of poverty and inequality must be included to understand how development impacts quality of life.

Dudley Seers (1969) argued that poverty, unemployment, and income inequality should fundamentally define development. A country's aggregate GDP may increase due to specific reforms, but if one or more of these problems are simultaneously worsening, can the reforms be defined as 'true' development? Seers argued that countries must center poverty and inequality in developmental strategies and criticized measuring development through aggregated measures that ignore quality of life. Todaro (1977) used these principles to create a more solid definition of development in the context of these concerns. He defined development as a physical reality and a

state of mind that society achieves by achieving three objectives. Economic development is only truly considered development if it (1) expands access to essential social goods like healthcare, shelter, and food; (2) increases general levels of living; and (3) decreases inequality and removes restrictions on human rights. Todoro (1977) contended that economic forces are impossible to extricate from any of these three issues, stating that low levels of living cannot coexist with true development.

The literature surrounding development reveals that relying on purely economic indicators like GDP fails to encompass the complexities of development. To create a holistic understanding of development, conversations must consider aspects of human development to strengthen the understanding of healthcare and its implications. This thesis will adopt Sen's definition of development for this thesis, meaning development is defined as a package of freedoms, including political freedom and transparency, freedom of opportunity, and economic protection from poverty (Sen 1999, 10). This thesis aims to apply these principles to an in-depth case study of the health sector in Uganda and extend this definition by explicitly prioritizing inequality and poverty in development. By focusing on this sector, this thesis can contribute to the literature surrounding sustainable development and the translation of economic growth to human development.

Healthcare as a Development Indicator

Healthcare can act as a development indicator that shows poverty and inequality. Low socioeconomic status is one of the strongest determinants for illness and early death policies and can demonstrate country-wide disparities in healthcare and access. Health was defined in the preamble of the World Health Organization's (WHO) constitution as a state of "complete

physical, mental and social well-being and not merely the absence of disease or infirmity" (Grad 2002, 984). WHO states that governments have a responsibility for the health of their people, something that can only be fulfilled through provisions of adequate health and social measures (Grad 2002, 984). Stringhini et al. (2017) compared socioeconomic status against health risk factors and mortality in high-income WHO countries and found that socioeconomic status was linked to reductions in life expectancy. In both poor and wealthy countries, the poor were disproportionately impacted by health risk factors and had higher mortality (WHO 2002) (Stringhini et al. 2017).

The link between health and development has become more prominent in discussions about sustainable development. The Rio Declaration on Environment and Development, more commonly known as the Rio Declaration, was produced at the UN's Conference on Environment and Development. The Rio Declaration consisted of 27 principles centered on sustainable development (UNCED 1992, 2-3). Sustainable development was defined as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs" (UNCED 1992, 3). The first Principle of the Rio Declaration emphasized the relevance of human health to sustainable development, stating that "Human beings are at the center of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature" (UNCED 1992, 2) These principles make it clear that development must also prioritize the health and well-being of the citizens as well.

Healthcare can, therefore, be understood as an indicator of the development that has occurred and reveals that a country's development has impacted the quality of life. This thesis will attempt to understand some of the social determinants of health in Uganda to get insight into the impacts of its development on quality of life. The Commission on the Social Determinants of

Health published a report that argued that the development of a society can be judged by the quality of its population's health, the distribution across the social spectrum, and then, lastly, the degree of protection provided from disadvantage because of ill-health (WHO 2008, 1-2). Social determinants are defined as the structural determinants and conditions for daily life. These social determinants comprise the distribution of power, income, goods, services, and access to healthcare. The Commission argued that uneven distribution and marked health inequities resulted from toxic combinations of poor social politics, uneven economic policies, and bad politics (WHO 2008).

Healthcare feeds into many other facets of development, such as economic growth. Somé et al. (2019) found that increasing health expenditure had a direct positive impact on growth in Africa. Reducing maternal and infant mortality and investing in healthcare directly impacted strong economic growth. Healthcare expenditure is an essential determinant of health outcomes, with Somé et al. (2019) arguing that African governments should spend more on healthcare and invest further in improving healthcare outcome disparities. Badir (2016) also found that growth in healthcare expenditure had a direct positive influence on GDP, creating a solid case for the consideration of healthcare as an indicator for development. There is a significant linkage between economic growth and population health, as health positively impacts labor productivity, education, savings, and age structure (Bloom and Canning 2009, 53). A healthier population will lose less time from work due to illness and be more productive. Lower mortality and illness also directly impact cognitive development and raise the incentives to invest in education by increasing the average life span. It can also increase the incentives to save for retirement and business investments and create a longer-lived workforce (Bloom and Canning 2009, 53-54).

Health can, therefore, be viewed as an instrument for generating economic growth and improving a nation's development. One of the most critical metrics for measuring a healthcare system's success is focusing on access and equity of healthcare. Universal health coverage (UHC) requires everyone in a country to access the same range of high-quality services, regardless of location, needs, income level, or social status (WHO 2008, 12). Ranabhat et al. (2023) defined UHC as a government system or program that guarantees everyone under that system has access to services, including health promotion, preventive health, medical treatment, and palliative care. Countries must enact policies that alleviate poverty and inequality to obtain Universal Health Coverage. Low-quality and inequitable healthcare systems can feed into cycles of poverty by worsening the health burden and lowering the quality of life. Assessing the impact of policies and programs on health and equity can reveal whether the healthcare system is set up to address these systemic issues.

This thesis will combine health and development concepts to assess Uganda's development. This approach will examine the healthcare system, analyzing Uganda's policies and financing allocations against the outcomes of the policies and reforms on Ugandan citizens to get a larger depiction of their economic system. This holistic analysis will examine and conclude how Ugandan healthcare reforms have impacted access to quality healthcare services and the more significant implications on development.

Neoliberal Approaches and Key Concepts

Defining Neoliberalism

Neoliberalism is a framework that can be used to analyze African development in the late 20th century. However, this leads to questions surrounding how neoliberalism and its core

philosophies can be defined. Stein (2012) argues that neoliberalism can exist simultaneously as an ideology, philosophy, doctrine, assertion, and theory. Jones (2014) defines transatlantic neoliberalism as a free-market ideology based on the principles of individual liberty and limited government, connecting human freedom to the actions of rational actors in a competitive marketplace (ibid, 2). On the other hand, Harvey (2005) views it as a "theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade." Steger and Roy (2012) see neoliberalism as a broad concept existing simultaneously as an ideology, mode of governance, and policy package. These three manifestations lead to neoliberal ideology being backed by powerful groups who believe in the promise of a free-market world that centers production. Neoliberalism can then intercept the policy space and governance and enact changes globally through reforms.

Stein (2012) argues that despite the differences in how neoliberalism is defined, there is a shared recognition of a policy paradigm that assumes growth and development arise from the macro stabilization, privatization, and liberalization of economies. He argues that the neoliberal paradigm exists beyond an ideology and now resonates with the core propositions of economics that dominate the mainstream economics profession (Stein 2012, 2). Neoliberal ideology draws from five primary constructs in neo-classical economics: homo-economicus, methodological individualism, acceptance of equilibrium as a natural state, rational deductively, and axiomatic reasoning.

The theory of *homo-economicus* draws back to Adam Smith's influential novel *The Inquiry into the Nature and Causes of the Wealth of Nations, Volume 1,* more commonly known

as T*he Wealth of Nations* (Smith 1869). Smith theorized that the market was guided by an invisible hand that naturally regulated the economy. Under a free market, individuals act in rational self-interest to buy and sell goods and services. These natural interactions benefit the public by strengthening the economy without government interactions. When the market is free and able to act without the restraints of governmental regulation, the interdependence of individuals allows the market to stabilize and benefit the public naturally (Smith 1869). He used the *homo economicus* theory*,* which viewed individual actions as those made in material self-interest. Under this idea, the economy becomes superior as it acts best with minimal governmental intervention and instead when the economic activities of the citizens are used to create open economic exchange (Steger and Roy 2010, 3). This text is one of the foundational neoliberal texts and became critical in the rise of the neoliberal hegemony in the late 20th century (Stein 2012, 3).

Methodological individualism argues that decision-making starts at the individual level, and the endpoint is the individual (Stein 2012, 3). Under the neoclassical economy, there are two types of participants: consumers and producers (Stein 2012, 3). Both the consumer and producer firms make choices that maximize their own personal utility, and there is the assumption of perfect competition, which allows the market to remain equal. There is also the assumption that no individual has sufficient market power to affect market price. Thirdly, there is the idea of a natural state of equilibrium in the economy. When rational individuals make optimal choices, producers will make naturally efficient choices on what to produce and at what price (Stein 2012, 4). Without government intervention, the economy will remain at a natural equilibrium.

The fourth and fifth components of neo-classical economics rely on rational deduction and axiomatic thinking. Rational deduction assumes that the behavior of individual agents will

follow a set of logical rules and will arise in response to market signals, assuming rational individual thinking. Axiomatically, this assumes that consumers and producers will respond efficiently to market signals and follow rationally. These rational and axiomatic thinking assumptions create a market that exists at a natural equilibrium without external governmental intervention (Stein 2012, 4). These assumptions fed into a shared vision of a freed global economy that existed at a natural equilibrium without public sector intervention. This vision became critical in powering the neoliberal hegemony dominating the globe in the latter half of the 20th century.

The Rise of Neoliberal Ideology

In the latter part of the 20th century, neoliberalism experienced a surge in popularity and transformed into the prevailing ideology for development in both the Western world and Africa. This section aims to explore the evolution of neoliberalism on a global scale and scrutinize the factors that led to its rise as a prominent political and economic doctrine in Africa.

In the early 20th century, Keynesianism had been the global economic guiding ideology for the Western world. Keynesian economics relied on the macroeconomic management of economies, seeking to use government investments to drive the economy. According to Keynes, governments should pump money through deficit spending and tax cuts to boost demand, creating higher employment and economic growth (Keynes 1936) (Jones 2014). Keynesianism believed that the market was inherently unstable and, therefore, required government intervention to keep it in a state of equilibrium (Keynes 1936) (Jones 2014) (Steger & Roy 2012). President Franklin D. Roosevelt adopted this approach during the Great Depression, leading to successful investments like the New Deal and the Public Works Administration

(Jones, 2014) (McGregor, 2001). Keynesian ideas would spread throughout the Western world and become an economic mainstay for post-war development.

Keynes was part of the 1944 Bretton Woods Conference in the United States, which created the International Monetary Fund (IMF) to administer the international monetary system and the International Bank of Reconstruction and Development (now known as the World Bank) to provide loans for Europe's post-war construction (Steger and Roy 2012, 6). Some economists have called the period from 1945 to 1975 the 'golden age of controlled capitalism' for its low inflation, high wages, and rapid economic growth (Steger and Roy 2010, 33). The Keynesian idea of an interventionist state could be considered closer to modern liberalism: a large, active government with progressive taxes and extensive social welfare programs (Steger and Roy 2010, 35).

Neoliberalism's first systematic formulation in the 20th century emerged with the formation of the Mont Pelerin Society in 1947. This society included names such as Milton Friedman, Friedrich Hayek, George Stigler, James Buchanan, and Ludwig von Mises (Jones 2014, 30-32). Steger & Roy (2010) state that the Mont Pelerin Society emerged in reaction to the growing dominance of Keynesianism and its outlook on the economy. The Mont Pelerin Society, led by founder Friedrich August von Hayek, argued that the economic issues lay in the extensive government intervention that hindered growth and restricted natural market interactions (Jones 2014, 31-32). Instead, they advocated for a newer form of liberalism, extending laissez-faire economics to create a new or 'neo' liberal economy free from government intervention (McGregor 2001) (Harvey 2005).

Milton Friedman was one of the dominant voices in this Society. He published a paper called "Neo-Liberalism and its Prospects," where he argued that the growing power of the State

had brought on centralized economic control that led to chaos and disorganization by interrupting the market (Friedman 1951, 2). He defined neoliberalism as a doctrine that would severely limit the power of the state to interfere with the activity of individuals while allowing the state to perform essential positive functions. This doctrine would accept the liberal emphasis on the importance of the individual and use competition to create a more vital state. The state would exist to police the system, prevent the creation of monopolies, create a stable monetary framework, and relieve acute misery and distress. The citizens would be protected from the state by a free private market and competition (Friedman 1951, 91). These criticisms would grow in popularity as Keynesianism came under fire in the 1970s. The Mont Pelerin Society and Chicago School of Economics members first began to test their theories in Chile in what would come to be known as the Chile Project (Steger and Roy 2010, 81-83). The Chile Project involved parties like the US State Department, Ford Foundation, and many American corporations and trained hundreds of Chilean economics students in free-market principles in the 1960s, creating an epistemic community of neoliberal economists (Steger and Roy 2010, 81). In 1973, General Pinochet overthrew Chile's then President and started a new regime with a neoliberal blueprint for economic reform, including deregulation and privatization measures to fight inflation. Pinochet's policies were supported by economists like Hayek and Friedman, who argued that Pinochet's policies would result in democracy and freedom despite Pinochet being criticized for political repression and brutality. However, these policies did not lead to the neoliberal nirvana that the Mont Pelerin Society hoped to see. Over the following two decades, Pinochet enacted a violent regime that was marked by torture and systemic human rights violations. His neoliberal policies had resulted in inflation and GDP stabilization, yet economic inequality became

rampant, and social discontent proliferated. The Chile Project was one of the first examples of neoliberal reforms in this period and served as an example of the impacts of neoliberal regimes.

In the 1970s, controversy emerged surrounding the efficacy of Keynesianism amidst rising stagflation and lagging growth (McGregor 2001) (Jones 2014)). Sudden oil shocks in the 1970s coincided with falling corporate profits and rising unemployment, leading to growing dissatisfaction with the current economic state. Jones (2014) argued that Keynesian economics had seemed less and less effective amidst a series of cataclysmic events, including the war of Vietnam and oil shocks, that resulted in stagflation in the U.S. and industrial decline in Britain. The collapse of the Bretton Woods international monetary system only increased the desire to change course, and many politicians in the English-speaking world began to look towards neoliberalism as a response. The election of President Ronald Reagan and Prime Margaret Thatcher in the United States and the United Kingdom, respectively, signaled a transition into a new era where neoliberalism dominated (Jones 2014, 217).

During this period, neoliberalism also took hold in multilateral institutions like the IBRD and IMF in the late 1960s and 1970s. Irving Friedman joined the World Bank in 1964 as an economic advisor to the president and enacted reforms that would later prove instrumental in advancing American interests (Stein 2008, 13). Sharma (2015) described a transformation in these institutions that increasingly stressed eliminating trade barriers and privatizing state-owned enterprises. The impact of neoliberal and neoclassical economics came to the forefront of developmental discussions, with increasing interest in stabilization and economic growth in developing countries like Africa. Stein (2008) argued that interest in Africa was motivated in many ways by the interest in implementing a global neoclassical economy. Elliot Berg wrote a report, Accelerated Development in Sub-Saharan Africa: A Plan For Action (now more

commonly known as the Berg Report), that advocated for a new approach to development in Africa. (Stein 2008, 37-39). Berg's report outlined a liberalization of international trade and development that prioritized macro stabilization and efficiency. Harrison (2010) argued that the Berg Report portrayed a state of African developmental malaise that could only be resolved with domestic policy, institutional reform, and international global economic change. These policy recommendations fed into the creation of the formative structural adjustment packages that would transform the developmental trajectory of Africa (Stein 2008, 39-40).

Liberalization became a vital aspect of the agenda for reforms in Africa. Neoliberals believed the free-functioning market would create optimal use and resource allocation, creating a more robust global economy (McGregor 2001, 83). Liberalization meant that states eliminate tariffs and any trade barriers that would restrict trade, instead opting for a transnational price system for goods and services. Removing price controls would create a free exchange rate and allow interest rates to be determined by the market (Sejjaaka 2004, 105-106). Stiglitz (2003) stated that capital-market liberalization was intended to benefit economic growth by reducing consumption volatility.

However, Stein (2020) argues that this removal of controls on financial and trade flows posed a significant issue for countries with less developed economies. Their goods and services are outcompeted by countries with stronger and cheaper manufacturing industries, creating issues with economic growth. Stiglitz (2003) pushed back against the efficiency of capital-market liberalization, stating that capital-market liberalization contributed to enormous risk in developing countries. Additionally, the areas where the South had a comparative advantage were in textiles and agriculture. The North enacted strong protections and subsidies for their textile and agricultural industries, cutting down the comparative advantage for Global South countries

in those sectors. Removing these trade barriers in the Global South negatively impacted unprotected industries like manufacturing due to the lack of protective trade measures that would allow them to be competitive (Stein 2020, 133-135).

The rise and origins of neoliberal economics explain how neoliberalism became the driving force of development for over thirty years. These paradigm shifts in belief created the formative ideology that would fundamentally alter the trajectory of many Global South countries, such as Uganda.

Neoliberalism and Development in Uganda

Neoliberal reforms in Uganda occurred much later than in many other African countries. The National Resistance Movement (NRM), the ruling party led by current President Yoweri Museveni, took power in 1986; they initially resisted the structural adjustment programs. Instead, they favored the Ugandan shilling and statist economic policies, pointing to the rapid economic deterioration of its neighboring African countries between 1980 and 1986. However, due to high inflation and an almost bankrupt treasury, the NRM eventually accepted economic reform programs from the World Bank and IMF in May 1987 (Sejjaaka 2004, 105). President Museveni's acceptance of these reforms started a critical partnership, where fundamental reforms were traded for foreign aid and political support. Between 1992 and 1996, donor assistance averaged $500 million a year and was over $800 million a year from 1990-2005 (Mwenda and Tangri 2005, 452-453). These reforms focused on liberalizing, decentralization, and stabilizing the economy. Capital liberalization meant the removal of price controls, instituting a free exchange rate mechanism, and allowing the market to determine interest rates. Stabilization involved cutbacks on fiscal and monetary management of public-sector borrowing and reforming

the regulatory framework to control macroeconomic indicators like inflation and incentivize private-sector investment (Sejjaaka 2004, 106). Decentralization involves transferring central state power over social services, such as healthcare, to provincial or regional governments (McGregor 2001, 86-87).

The private sector's role in healthcare also increased through implementing public-private partnerships in healthcare. These partnerships were meant to enhance the private sector's role in the healthcare sector and improve efficiency. Public-private partnerships were also critical points of power accumulation for the NRM and President Museveni, with political leaders using private sector investments to attract political supporters and gain power (Mwenda and Tangri 2005, 455). User fees were also a significant aspect of Uganda's healthcare reforms. Nabyonga Orem and co-authors (2011) analyzed the implementation of user fees in Uganda and its impacts. In the 1990s, when Uganda's healthcare system underwent significant decentralization, many districts faced low-quality service and shortages of supplies. Amidst these reforms, the Ugandan government introduced formal user fees for all public health services in 1993 (Moat and Abelson 2011, 578). Widespread healthcare decentralization reforms resulted in implementing cost-sharing via user fees to generate local revenue for their healthcare services (ibid, ii 42). This was further supported by the passing of the Local Governments Act in 1997, which legally granted locally elected bodies control over many healthcare decisions (Moat and Abelson 2011, 581). Decentralization combined with user fees meant that user fee costs and systems varied significantly between districts. Kivumbi & Kintu (2002) found that some charged only for each service (consultation, laboratory tests, drugs, hospitalization), others opted for annual fees to access any services, and others opted not to have formal fees. These policy prescriptions were

intended to provide Uganda with the tools needed to create a sound economic approach that would work efficiently with a focus on the market.

These reforms have had mixed impacts on Uganda's economy and healthcare system. Sejjaaka (2004) pointed out that since 1987, Uganda has achieved a certain measure of economic stability because of the aid and improved foreign investment. Economic indicators show increased GDP growth at 5.6% from 1986 to 2002 and lower inflation because of the reforms. Additionally, macroeconomic stability was restored, and the Uganda Revenue Authority was established in 1993, giving the Bank of Uganda autonomy in supervising commercial banks and hoping to improve tax revenue collection (Sejjaaka 2004, 105). These indicators point to a positive impact of the neoliberal reforms and portray Uganda as a success story for the World Bank and IMF.

Asiimwe (2018) explored the impact of Uganda's neoliberal reforms on the socioeconomic landscape and found several issues that arose amidst these reforms. While Uganda's economic recovery had been attributed to the reforms at the time, much of the growth had been due to a massive influx of aid. The aid mainly went to budget support and comprised up to 50% of Uganda's budget. The aid influx enabled increased public spending that would generate economic productivity but also fostered elite corruption. Asiimwe (2018) argued that a significant amount of the aid did not 'trickle down' as it was meant to under neoliberal theory and accelerated issues like poverty, unemployment, and poverty. The reforms significantly impacted the NRM's and President Museveni's political domination (Mwenda and Tangri 2005, 452-453). Large amounts of aid enabled the government to invest in law and order and enhance the legitimacy of the Movement regime. The private sector development in the 1990s was criticized for malpractice and corruption, resulting in a top-down privatization process controlled

by incumbent leaders (Mwenda and Tangri 2005, 452-453). The government was given authority over the expansion and operations of private businesses, such as licenses, government contracts, and tariffs, resulting in those in control using their powers to allocate benefits to politically favored groups in the sector.

The liberalized economy meant that Uganda's exports could not easily access international markets, and low export earnings drove the country into debt, making it more reliant on aid. Asiimwe (2018) found that the economic growth was coupled with the deindustrialization of Uganda's manufacturing sector. The deindustrialization of Uganda's manufacturing sector meant that Uganda relied on raw commodities for trade, resulting in unstable growth and development. Sejjaaka (2004) found that 94% of Uganda's exports were primary products with little added value and may have contributed to Uganda's unfavorable trade balance.

The reforms also had a mixed impact on inequality and poverty. Okidi et al. (2005) analyzed the distributional and poverty impacts of Uganda's economic growth between 1992 and 2003. The study found that economic growth induced poverty reduction yet struggled to address inequality. From 1992 to 1997, high growth rates contributed to improvements in poverty and a decline in inequality, especially in urban areas. However, this trend slowed between 1997 and 2003, with growth confined to the wealthiest quintile and increasing poverty in the rural and urban areas. Inequality was especially noticeable between the rural and urban districts, with certain regions benefitting over others. Okidi et al. (2005) attributed the poverty trends to the slowdown of economic growth in the late 1990s. The reforms intended to combat poverty failed to create meaningful long-term changes in poverty distributions. Okidi et al. (2005) concluded

that long-term growth in Uganda would require enhanced efforts to combat poverty and deepening inequality.

There has been significant literature surrounding the impacts of structural adjustment on Uganda, as well as Sub-Saharan Africa as a whole. It has been well established that this period had a strong negative impact on Ugandan poverty and access to care. However, there has been comparatively little research focusing on the impacts of this period on the formation of Uganda's contemporary healthcare system. Additionally, as noted by Brennan and Abimbola (2023), there is a gap in research surrounding the impact of decentralization on health system performance in fragile or conflict-affected countries. This thesis hopes to build on these gaps by qualitatively analyzing Ugandan healthcare policy post-structural adjustment and the presence of neoliberal policies. The healthcare sector can indicate Ugandan human development investment and the impacts of Uganda's growth on overall quality of life and inequality.

Neoliberalism and the Authoritarian State

Authoritarian neoliberalism and power consolidation can often go hand in hand, creating a cycle that manifests in the continual entrenchment of neoliberal policies in authoritarian states. Bruff (2014, 113) defines authoritarian neoliberalism as "the reconfiguring of the state into a less democratic entity through constitutional and legal changes that seek to insulate it from social and political conflict." Altınörs and Akçay (2022) examined the development of authoritarianism in Turkey and argued that the crisis of authoritarian neoliberalism has shaped current authoritarianism dynamics. Neoliberalism requires authoritarian methods like centralizing decision-making, reconfiguring the rule of law, and unifying the ruling party's interests to enact neoliberal reforms. The strategies of this new authoritarian neoliberalism include nationalist or

conservative political forces and development banks to consolidate rule (Altınörs and Akçay 2022, 1034). Power consolidation and neoliberal ideas can go hand in hand, with the erosion of welfare, permanent fiscal austerity, liberalizations, and immigration waves fueling the rise of right-wing authoritarian forces. Conditional IMF programs continue to act in African countries, as seen in inflation-targeting regimes, fiscal austerity, and labor market reforms (Altınörs and Akçay 2022, 1030-1033).

Kashwan et al. (2019) analyzed the dynamics of power and neoliberal policies and argued that neoliberal development persisted because of its ability to serve the constituencies with more power in the status quo. For example, neoliberal discourse frames the state as a 'black hole of inefficiency' while markets are upheld as fountainheads of efficiency, resulting in prioritizing the institutional status quo over more radical reforms that promote inclusive development (ibid, 138). Kashwan et al. (2019) writes:

> "Austerity policies requiring paralyzing cuts in social welfare programs have hollowed out the state's capacity to deliver human development to its citizens (Chang, 2003). These cutbacks disproportionately hurt the poor who rely more exclusively on public services (Blyth, 2013). The resources saved out of retrenched social welfare programs are then sometimes used to subsidize corporations, including corporate bailouts that continue to increase financial volatility or the promotion of multi-national oil corporations that contribute to the exacerbation of climate change. The powerful actors in state and society, who benefit from the status quo, also happen to be the main beneficiaries of neoliberal institutional reforms" (ibid,141)."

These findings illustrate the fundamental driver for neoliberal policies: the disproportionate benefit for the wealthy elite. These led Kashwan et al. (2019) to conclude that the adverse outcomes of neoliberal reforms, including increased inequality and the failure to bring anticipated change, are not because of implementation failure. Instead, it is the essence of neoliberal reforms being attuned to secure the support of the status quo and the elite's beneficiaries (ibid, 141). Harrison (2019) similarly viewed developmental strategies as being

linked to power configurations in Africa, defining authoritarian neoliberalism as a subspecies of authoritarianism disguised by practices and institutions that use bureaucracy and coercion to discipline societies into marketized forms that generate capitalist transformation. He states that Africa continues to show three constitutive features of the neoliberal project: constant crises, authoritarian tendencies, and the expansion of macroeconomic strategy into many other aspects of African societies (Harrison 2019, 280).

Uganda is one of the most recognizable examples of authoritarian neoliberalism. Uganda has been under the control of the National Resistance Movement (NRM) party and President Yoweri Museveni since 1986, meaning they have dictated many neoliberal reforms throughout this period. Tripp (2004) characterized Uganda's tenure under President Museveni as semi-authoritarian, meaning authoritarian, with several democratic caveats, such as the existence of an independent press and autonomous organizations (within limits). During his presidency, Museveni took several steps to centralize power and limit political opposition, such as abolishing the constitutional term limits by bribing parliamentarians and entrenching the NRM's military presence (Anderson and Fisher 2016, 69-71). National and local elections are still held regularly, though the NRM and Museveni have taken several steps to restrict political parties and drawn heavily on state resources to fund campaigns. The return to pluralism in 2005 was included in a set of amendments that centralized executive and presidential power, allowing Museveni to portray the government as democratic while simultaneously entrenching the NRM's domination (Anderson and Fisher 2016, 68-70).

Donor countries have played a significant role in institutionalizing the NRM and Museveni's rule, with funds nearly doubling between 1989 and 1994 from Western countries. The Ugandan government's willingness to adopt structural adjustment policies and strong

macroeconomic growth resulted in Uganda becoming a donor favorite. By investing in Uganda, donors had the potential to create new avenues for accumulation for domestic and international players. The Movement and Museveni received several increases in donor financial support, including a 2000 referendum, interpreted as support of the no-party system and Museveni (Tripp 2000, 19). Anderson and Fisher (2016) point out that the structural adjustment period entrenched the Museveni regime as the World Bank, the US, and the UK gave substantial aid to reconstruct the state and restore economic growth under neoliberal regimes. This created a symbiotic relationship between Museveni and his donors, with neoliberal lobbyists promoting Uganda as a business-friendly and rapidly growing state while supporting the growth of the NRM's regime.

Neoliberal Tenets and Healthcare: A Framework for Analysis

To analyze Uganda's healthcare system from the perspective of its neoliberal history, this thesis will first build a framework to analyze Uganda's current healthcare policies and their impacts. Understanding the complex relationship between healthcare and neoliberal policy requires insight into the core ideas within neoliberal policies surrounding healthcare. This requires understanding these core concepts: deregulation, privatization, austerity, user fees, and decentralization, each playing a distinct role in shaping the healthcare landscape in Africa. This conceptual framework establishes the foundation for the following chapters, where each core concept will be examined in-depth to analyze how it manifests within Uganda's healthcare system. This framework will then analyze the intricate dynamics and transformations that characterize the interplay between neoliberal policies and Uganda's pursuit of an effective and accessible healthcare system.

Decentralization

The World Bank and IMF prioritized systemic objectives of organizational change and financial reform in governmental systems through decentralizing the market (Stein 2008, 102-103). A primary component of the reforms was creating a more efficient system of governance by making bureaucracies more responsive to their clientele. Decentralization was included in roughly 40% of projects from the World Bank, most of them after 1990 (Stein 2008, 102). Decentralization advocated for transferring central state power, responsibilities, and accountability to provincial, individual, or regional governments. This process would enhance accountability, policy innovation, and administrative efficiency (McGregor 2001, 86-87). Decentralizing the healthcare sector allows healthcare to function more like the free market by limiting government overview, bringing consumers closer to the healthcare market, and allowing them to choose.

However, research on decentralization and healthcare systems has shown that decentralization negatively impacts healthcare systems (Sapkota et al. 2023) (McGregor 2001) (Stein 2008) (Gatwiri 2020). Sapkota et al. (2023) found a lack of research on how decentralization's impact on the health system develops over time. However, reported impacts on the health system building blocks are more negative than positive. McGregor (2001) highlighted how decentralization creates smaller, less accountable healthcare centers that cannot support the same healthcare services. Decentralization can result in a lack of oversight that enables corruption and the pursuit of local interests (Stein 2008, 103). This may result in bribes to obtain service, impacting equity. Brennan and Abimbola (2023) examined the impact of decentralization on health systems in fragile and post-conflict countries and found that low capacity and poor planning resulted in decentralization negatively impacting healthcare systems.

Aid-dependent states often fare worse because they lack the capacity and resources to adapt flexibly to issues.

Privatization

Privatization and the role of the market become central in a neoliberal system and can be seen in healthcare system provision and funding allocations. Homedes and Ugalde (2005) argue that the World Bank views the government's function in public health as regulatory, while the private sector provides health and medical care services. Publicly funded social welfare services are considered inefficient and unable to deliver quality healthcare services because of the removal of free market forces like competition. Privatizing the healthcare system accomplishes two goals: increasing consumer spending and eliminating government interference.

By cutting back on healthcare budgets, governments can encourage a shift to private insurance and hospitals while creating new markets for the private sector (Terris 1999, 152-154). The reforms enacted by the World Bank included increasing the proportion of private healthcare facilities in developing countries to improve efficiency, quality, and accessibility. Public Private Partnerships (PPPs) were a large part of this transition and were a significant aspect of the expansion of the private sector. Gerrard (2001), the Head of Public-Private Partnerships at Partnership UK at the time, defined PPPs as businesses with specific public sector obligations set out in constitutional documents and contracts by the public sector. PPPs could result in highly improved value for money regarding private sector risks and improvements in public service investments (Gerrard 2001, 50). PPPs and private sector expansion were a significant aspect of World Bank and IMF reforms in the 1990s, contributing about 29% of total capital spending in sub-Saharan Africa (SSA) (Leigland 2018, 106). The World Bank expected the private sector to

play a significant role in bridging SSA's infrastructural and financing gap, and PPPs became central in this conversation.

However, in the years following the advent of PPPs in healthcare, many have criticized their effectiveness and impacts on equity. Ruckert and Labonté (2014) argued that many partnerships in health are primarily donor-driven and result in various issues, such as inequitable access and fragmented service delivery. The substantial investments into PPPs in SSA can be viewed as a neoliberal donor-driven project that can be criticized for its commodification of public goods. PPPs can be conceived as part of an ongoing neoliberal project that further entrenches private sector interests in the public sphere (Ruckert and Labonté 2014, 1608). Additionally, empirical research has shown that privatization negatively impacts equity and access to care. Homedes and Ugalde (2005) analyzed the impacts in Columbia and found that health reform was accompanied by a significant increase in per capita health expenditure, with benefits mainly accruing to the wealthy. In the. UK, the government intentionally cut back on the National Health Service to decrease the quality and quantity of services and encourage shifts to private insurance and hospitals (Terris 1999, 152-153).

User Fees

User fees were implemented as part of the structural adjustment packages and envisioned to be an essential source of revenue generation that would reduce the financial strain on the government (Olasehinde, Osakede, and Adedeji 2023, 180). Additionally, user fees could improve access by providing revenue that could be reinvested into the healthcare system and used to curb demand and increase healthcare delivery efficiency. These principles operate under the neoliberal ideology where individuals become consumers of healthcare products, and the healthcare financing system becomes a process of revenue production. Healthcare financing can

occur through out-of-pocket payments (OOPs), donor funding, co-payment, mandatory prepayments, indirect and direct taxes, and voluntary prepayments (Uzochukwu et al. 2015, 437). Theoretically, it would allow consumers to make their own decisions in choosing which care to seek and at what price. Consumer choice indirectly betters the system by forcing private healthcare providers to compete to attract consumers. By privatizing healthcare systems, consumers stimulate the economy by directly spending discretionary money on healthcare instead of paying taxes that fund inefficient governmental systems.

However, user fees were found to generate minimal revenue and negatively impact healthcare access (Stein 2008) (Gilson 1997). Gilson (1997) analyzed the implementation of user fees in Africa and found that they were unlikely to achieve equity, efficiency, or sustainability objectives independently. User fees tended to have more significant impacts on the poor than the wealthy and were shown to be associated with delays in care access and informal sources of care (Gilson 1997, 283). Stein (2008) found that user fees consistently caused a dramatic decline in attendance at health facilities and had a more severe impact on people experiencing poverty. These user fees and rises in prices for public goods can place more significant burdens on lower socioeconomic classes. In this way, the function and quality of healthcare services in this sector can show the levels of inequality due to these healthcare costs. The greater power placed in the private sector can also negatively impact workers, as lay-offs or downsizing are perceived as necessary social costs to allow for higher profits and competitive advantage (McGregor 2001, 85-86). User fees were abolished in Uganda in 2001, resulting in a rise in use among the lowest-income groups and reducing the financial burden of care (Yates 2009, 2079). However, when user fees have been removed, they may be replaced with alternate charges that continue through OOPs and indirect payments like taxes or insurance (Uzochukwu et al. 2015, 440-443).

Deregulation

Deregulation of the healthcare system can also be seen as a fundamental aspect of neoliberal healthcare policy (McGregor 2001) (Stein 2008). Deregulation is intended to boost efficiency, with neoliberal economists arguing that government intervention was inefficient and reduced the capacity of the healthcare system to adapt to rising challenges (McGregor 2001, 85-86). Economic deregulation limits state interference in the workings of the free market, intending to create a broader space for healthcare (Kentikelenis 2017, 2-3). The public sector must be reduced as much as possible with the potential of creating a free market (McGregor 2001, 85). In this free market, decisions about what to produce are made by businesses over the government. McGregor (2001) states that deregulation involves reworking laws to give more power to the private sector, removing pieces of law that enabled the government to deliver public services, and reworking laws to give more power to the private sector. This simultaneously stymies governmental growth while growing market power, allowing for 'superior allocation of resources' (McGregor ibid). Deregulation also involves budget cuts for social service programs meant to address poverty, such as nutrition programs (Terris 1999, 151). Kentikelenis (2017) points out that this method enhances the private sector's role in healthcare. Opening this market can allow those able to afford private healthcare access to more services, yet it is coupled with rolling back public service provisions for people experiencing poverty.

McGregor (2001) points out that deregulating the healthcare system may negatively impact healthcare service access and reduce accountability in the healthcare system. This perspective can lead to overlooking or justifying high social and environmental costs for private healthcare. Freeing the market and deregulating state-owned and public enterprises, such as healthcare, schools, universities, and public infrastructure like trains and roads, can be

complicated by poverty and inequality. McGregor (2001) states that neoliberalism makes significant assumptions that view citizens as consumers who have the individual choice to choose the best source of healthcare rather than limited by economic means or regional access. For countries that already face issues like inequality, deregulation can result in lower-income groups being marginalized and viewed as burdens on the perfect market.

Austerity

Austerity measures were used in structural adjustment packages to promote economic recovery. Austerity was defined by Blyth (2013) as a form of voluntary deflation in which the economy adjusts by reducing wages, prices, and public spending to restore competitiveness. Advocates argued that excessive government debt undermined business spending and crowded out the private sector (Sibeko 2019, 8). Austerity measures are meant to stabilize the government and reduce debt, resulting in growth as the private sector regains confidence. Austerity measures implemented in Sub-Saharan Africa included spending cuts, regressive tax increases, reassignment of funds away from public sector investments, privatizing public sector companies and services, eliminating subsidies, and controlling budget deficits (Sibeko 2019, 6-8).

Blyth (2013) viewed austerity as an extension of the neoliberal doctrine and the aims of shrinking the welfare state, deregulating labor, and boosting the private sector. Farnsworth and Irving (2018) argued that neoliberal austerity manifested in inequality and economic downturns. Stuckler et al. (2017) analyzed the impact of austerity measures on health and found an overall detrimental impact both directly and indirectly on healthcare access and quality. Indirectly, there is a ‘social risk effect’ where austerity measures increase unemployment, poverty, and homelessness, exacerbating health risks (ibid). The second mechanism is through a ‘healthcare

effect' where cuts to healthcare services and equity measures result in increasing socio-economic gaps in access to services and reductions in health coverage.

These facets provide valuable insight into how exactly to identify a neoliberal policy and the potential negative implications to a healthcare system. When examining Uganda's healthcare system in the era after its neoliberal reforms, this framework will be used to examine whether current policies continue to reflect neoliberal philosophies.

Conclusions

Stein (2012) argued that neoliberalism achieved a meta-development status on the continent over a three-decade-long neoliberal experiment and became embedded in the conducts, habits, and repertoire surrounding development policy practice. This thesis tests this assertion by analyzing Ugandan development post-structural adjustment through neoliberal principles. Evaluating the current literature surrounding development reveals that the healthcare sector represents more significant aspects of development by focusing on how economic growth translates into positive human investment.

The impacts of Uganda's structural adjustment and aid programs have also been extensive and well-covered. However, as Kentikelenis (2017) mentions, structural adjustment programs' medium and long-term effects often receive little attention in the literature. Additionally, there is comparatively little research that focuses on the long-term impacts on the healthcare sector within Uganda because of structural reforms. An in-depth analysis of Uganda's healthcare policies can connect the ongoing work surrounding healthcare and structural adjustment to fill this gap. Additionally, this work can expand on current discussions surrounding equity in healthcare and how to evaluate healthcare reforms in Global South countries.

An in-depth analysis of the impacts on Uganda's healthcare sector and inequality provides further insight into the complexities of healthcare reforms and equity. By analyzing the trajectory of Ugandan healthcare development in the 1990s with their contemporary healthcare sector, it is possible to see where neoliberal legacies of privatization and cutbacks have altered Uganda's healthcare system. The framework laid out in this chapter serves as a conceptual foundation for analyzing the formation and success of Uganda's current healthcare system.

Chapter 3: The Evolution of Neoliberal Principles in Ugandan Healthcare

Introduction

Between 1987 and 1999, Uganda underwent significant neoliberal reforms and transformed its economic and governance system. These alterations resulted in economic growth, yet the development was uneven and resulted in degradations to social services like healthcare, negatively impacting Ugandan quality of life (Ssonko 2008, 132-147). Under structural adjustment, uneven development had occurred in aspects like childhood malnutrition, education levels, maternal mortality, and AIDS (UBOS 1996). A 1995 Demographic Health Survey found many areas in dire need of improvement. One area that particularly suffered was childhood mortality, which had an under-five mortality rate of 147 per 1000 and a maternal mortality ratio of 506 per 1000 (UBOS 1996). The mortality rate was significantly impacted by region and background. One in ten children in the Northern region died before their fifth birthday. The ratio in the eastern region was one in twelve, fourteen in the central region, and seventeen in the western region. These adverse outcomes continued, and in 1997, the life expectancy in Uganda was estimated to be 42 years, and 44% of the population was estimated to consume less than what was needed for the basic needs of life (MoH 1999). The SAPs were criticized for exacerbating poverty and widening the disparities between classes. The healthcare system, in particular, was viewed as inaccessible and ineffective due to the poor infrastructure and lack of quality public services (Ssonko 2008, 141-143). The following healthcare reforms attempted to address these issues and create a more equitable system.

This chapter will examine Uganda's major healthcare reforms from 1997 to 2023 through the neoliberal framework introduced in Chapter 2. During this period, Uganda underwent two

significant healthcare framework changes intended to remedy the issues that structural adjustment policies exacerbated due to policies prioritizing macroeconomic efficiency over social services. The first period lasted from 1997 to 2008, under the Poverty Eradication Action Plan and National Health Policy I. These guiding policies were formed amidst the height of neoliberal reforms and can be used as a baseline to analyze how Ugandan healthcare reflected neoliberal donor reforms. The second period started in 2008 and includes larger policy frameworks like UgandaVision2040 and National Health Policy II under the new National Development Plan (NDP). These two periods within this timeframe can be compared through an analysis of the policies, intended reforms, areas of priority, and overall guiding doctrines for the reforms. Therefore, current governmental healthcare reforms can be understood using the historical context of neoliberal development and structural adjustment. This chapter explains the linkages between neoliberalism and authoritarianism, arguing that the healthcare reforms introduced are oriented towards benefitting the Ugandan elite and donor partners. I argue that Uganda's reforms entrenched a profoundly authoritarian government incentivized to follow its donors' interests, many of which do not prioritize equity.

Neoliberal doctrine continues to manifest in language surrounding the justification for cutbacks in the healthcare system and the lack of reform to alleviate inequality. Focusing on these aspects reveals how neoliberal ideology remains intrinsic in perspectives towards healthcare and results in reforms similar to those in the 1990s, where cutbacks and privatization were embraced. Despite stated changes in developmental strategy and numerous reforms to create a more effective system, the underlying principles have remained the same and fed into Uganda's healthcare system.

The Poverty Eradication Action Plan and Institutionalizing Structural Adjustment

Political discontent emerged among rural Ugandans during the 1996 presidential election, and they pushed for policies that resulted in tangible improvements in their livelihoods (Isooba and Ssewakiryanga 2005, 39). President Yoweri Museveni, re-elected for the third time, worked with donors and policymakers to determine how to resolve this issue, specifically focusing on rural poverty. These negotiations resulted in the Poverty Eradication Action Plan (PEAP), which aimed to reduce absolute poverty to less than 10% by 2016 (Isooba and Ssewakiryanga 2005, 39). PEAP was intended to provide a policy framework that could address and guide poverty for the next 20 years, creating a space for both lower and higher classes to benefit from market opportunities and improve the quality of social services (MoFPED 2000). An essential factor in PEAP's creation was the heavy influence of donor funding and Uganda's development partners (i.e., financial institutions).

Cammack (2007) outlined the World Bank's shift in interest towards poverty reduction and the motivations behind the stated switch in narratives. The IMF and World Bank introduced the Heavily Indebted Poor Countries (HIPC) Debt Initiative in 1996 as part of a more significant stated shift toward poverty reduction and 'country ownership.' Countries seeking debt relief, such as Uganda, would produce full Poverty Reduction Strategy Papers (PSRPs) and work with the Bank to approve them. These PSRPs intended to create a more assertive and country-driven approach to poverty that would promote opportunity, facilitate empowerment, and enhance security. Critics of the World Bank's new focus on poverty reduction argued that the World Bank's aid strategy remained geared to market incentives and used the same neoclassical strategies to enact change (Cammack 2007, 2-4). Uganda was the first beneficiary of this fund,

and the role of multilateral institutions in the following policy reforms was clear (Isooba and Ssewakiryanga 2005, 39).

The first PEAP in 1997 was established on four central pillars:

- Creating a framework for economic growth and transformation
- Ensuring good governance and security
- Directly increasing the ability of people experiencing poverty to raise their income.
- Directly increasing the quality of life of people experience. (Republic of Uganda 2000)

PEAP argued that health outcomes depend on at least six factors: income, education, information, health services, water supply, and sanitation (Republic of Uganda 2000, 10). Future development plans focused on finding effective ways to alter these factors while maintaining the fiscal austerity demanded by neoliberal reforms. Reforms had to be thoroughly vetted to avoid waste, as the public sector's role was to intervene in only areas where the market functioned poorly or produced inequitable outcomes (Republic of Uganda 2000). PEAP was set to be revised every two years to ensure it remained relevant amidst Uganda's development. The revised PSRP, approved by the World Bank as part of the HIPC loan, outlined the framework for economic growth under which the private sector can expand: macroeconomic stability, macroeconomic incentives, equitable and efficient public resource use, and removing constraints on private sector competitiveness (Republic of Uganda 2000). Through the HIPC Program, the Government of Uganda would receive roughly 2 billion dollars for poverty mechanisms and economic reforms, which continued to follow the neoliberal formula (Kjær and Ulriksen 2014, 11).

Pursuing macroeconomic stability meant that the Ugandan Government committed to fiscal discipline that would make economic growth sustainable. This included the removal of tariffs to

encourage open competition and liberalize the market for market stabilization of prices. The Ugandan Government also prioritized the equitable, efficient collection and use of public resources to directly reduce poverty through budgetary reforms and stringent regulation on government spending. Lastly, removing private sector competitiveness constraints was essential through infrastructure development, deregulation of the market, and the growth of private sector investments in public projects (Republic of Uganda 2000). The deregulation and liberalization of the market to prioritize private growth is a crucial facet of neoliberal theory, as outlined in Chapter 2. These policies hoped to stabilize the economy by cutting back on Uganda's public spending and reducing inflation through tight monetary control.

Tumukwasibwe (2010) argued that Uganda's PEAP program was simply a continuation of the World Bank and IMF's structural adjustment program. PEAP prioritized providing a conducive environment for the private sector and facilitating private sector growth over developing policies that would redistribute wealth (Tumukwasibwe 2010, 59-61). He argued that PEAP was created not out of genuine interest in inequality and poverty reduction but as a "palliative treatment through so-called 'social protection' in the unbridled promotion of the free market economy" (Tumukwasibwe 2010, 58). Tumukwasibwe touches on a crucial element of PEAP, the continuation of neoliberal theory under the guise of poverty reduction. PEAP claimed to prioritize poverty reduction and focus on creating equitable development, yet PEAP's recommendations prioritized freeing the market and hoping that economic growth would result in poverty reduction. Tumukwasibwe cites a statement by President Museveni on the reduction of poverty in rural regions:

> "Rural poverty persists because of the conceptual confusion as to who should play what role in the economy: If somebody does not have enough money to meet his needs, he blames the government: I am poor, and it is the government's fault. People must do their part… According to my demarcation of roles, the government has taken on an extra role, not

> normally its work, which is to prop up the financially weak, through a revolving loan fund of 'seed money,' known as Entandikwa."
> - President Yoweri Museveni (Tumukwasibwe 2010, 60)

This statement places the responsibility for poverty alleviation on the individual over the system, reflecting neoliberal ideas of individualism. Welfare policies were perceived as the cause of a lack of individual responsibility, where the safety net deters individuals from working to improve their living conditions (Pendenza and Lamattina 2019, 101). McGregor (2001, 84) applied the concept of neoliberal individualism to the formation of state healthcare policy and stated that advocates of neoliberalism believe in pressuring the poorest people in society to find their own solutions to their lack of healthcare. The emphasis is placed on individual success and self-interest over the state's responsibility.

PEAP and the revised PRSP continued to reflect development partners and donor interests. Donors and NGOs were involved in developing sector plans and budgets and ensuring that budgetary decisions aligned with HIPC guidelines (Craig and Porter 2003, 63-66). Cammack (2004) argued that the HIPC framework shaped social and structural policies in recipient countries to reinforce neoliberal ideas and lock them into a partnership. I would argue that Uganda's PEAP and PSRP followed a similar track. While the new healthcare framework claimed to have a new focus on poverty eradication, it simply entrenched the World Bank and donor partners as guiding policymakers. A 2001 World Bank Publication designated Uganda and Ghana as the only successful case studies from the reform program in Africa (Devarajan, Dollar, and Holmgren 2001, 116-120). Pointing to the increased private sector investments and decreased inflation, they argued that the structural adjustment reforms had created macroeconomic stability and long-term growth. The Ugandan Government was critical in enacting these reforms, and groups like the Ugandan Parliament were highlighted as acting 'as a

useful instrument and watchdog' (Devarajan, Dollar, and Holmgren 2001, 129). PEAP served as a plan for national development with strategies in place for donor support and input as well as Sector-wide Approaches designed to align sectoral priorities with donor interests (Lee 2022, 71-72). The NRM and President Museveni's strong relationship with donors had served to enact the World Bank's widespread policy reforms that continued through PEAP while entrenching the NRM as the ruling government party. Throughout this period, donor funding for general budget support increased three-fold from 1998 to 2003/04 to over 451 million USD (Kjær and Ulriksen 2014, 11).

By embracing individualism and privatization, PEAP/PRSP created a foundation for future healthcare policies prioritizing personal responsibility for health outcomes. Individual responsibility for healthcare manifested in decreased responsibility in the public sector for managing healthcare outcomes and increased funding for the private sector. PEAP prioritized deregulating the private sector, decentralizing the healthcare sector, and placing the responsibility of obtaining healthcare on the individual over creating an equitable system. Macroeconomic stability and cutbacks continued under this framework despite healthcare being a central aspect of poverty reduction (Republic of Uganda 2000). PEAP created the groundwork for Uganda's first National Health Policy and the Uganda National Minimum Healthcare Package and set several clear neoliberal precedents that continued into future healthcare reforms, focusing on individualism, decentralization, fiscal discipline, and privatization.

NDP and Uganda Vision 2040: A Neoliberal Blueprint?

In the early 2000s, there was a revival of support for a more interventionist government role to accelerate national development, supported by the formation of the National Planning

Authority (NPA). Uganda hoped to update the NRM's mixed economy approach and create rapid economic growth through long-term solid central planning (Byamugisha and Bashasha 2015, 177-179). In July 2007, the Ministry of Finance, Planning, and Economic Development (MoFPED) created a PEAP revision task force that evaluated PEAP's impacts and effectiveness from 1997-2007. The evaluation found that while poverty had reduced substantially, the reduction was uneven and tended to benefit the wealthy (Byamugisha and Bashasha 2015, 180). Additionally, investment productivity had not improved due to the lack of attention paid to infrastructure and rural economic drivers like agriculture.

The Ugandan Government used this analysis to push for creating another new policy mix that would aim to reduce poverty and improve Uganda as a whole, focusing on competitiveness and raising foreign investment (NPA 2009, 9-11). This policy mix would aim to harmonize the country's long and medium-term development planning (ibid). In 2009, Uganda's National Planning Authority (NPA) introduced the Comprehensive National Planning Development Framework (CNDPF), which outlined how Uganda intended to operationalize its national vision through the NDP framework (NPA 2009, 10-12). Between 2010 and 2040, the National Planning Authority aims to strengthen central planning and accountability by releasing development plans, reports, and a national vision. This includes a 30-year shared national vision, UgandaVision2040, three ten-year development plans, six five-year development plans, and national development reports annually (NPA 2009, 11-12). This shared national vision would guide the country's development agenda by articulating long-term aspirations and projections for the desired future. These include four major stages that attempt to answer the following strategic questions:

I. *Stage 1:* Where are we as a country? This involves an assessment of the state of development of Uganda and the underlying factors.

II. *Stage 2*: Where do we want to be? Aspirations for the desired future.

III. *Stage 3*: How do we get there? This is an assessment of the conditions that must prevail if we are to achieve the desired future (challenges, prerequisites, and strategies).

IV. *Stage 4*: How will we know that we are there? That is measuring progress using predetermined indicators and targets (NPA 2009, 12).

UgandaVision 2040, the official national vision, was launched in 2013 and outlines Uganda's long-term development plan and provides insight into the future of Ugandan healthcare. It was intended to operationalize President Museveni and the Government of Uganda's vision of "a Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 years" (NPA 2013, III). Uganda hoped to transform into a competitive upper-middle-income country through a centralized long-term planning framework that could guide policy decisions for the next 30 years.

Uganda also launched National Development Reports (NDRs) that would be produced to inform the government and other stakeholders on economic performance and the standing of development initiatives during the reviewed period. NDRs, produced annually, provided insight into Uganda's strategies for improving its healthcare system. The first NDR was produced in 2010 and outlined some of the issues the government aimed to fix in Uganda's healthcare system and overall quality of life (NPA 2011, 22-30). Some of these struggles included an increasing Gini Coefficient (which demonstrated an overall increase in inequality), an inadequate capacity to deliver Uganda's National Minimum Healthcare Package, and shortages in healthcare equipment and workers (NPA 2011, 125-128).

During this period, the relationship between President Museveni and donors became strained due to a series of political controversies. In 2006, President Museveni altered the

Ugandan Constitution and abolished the presidential term limit, extending his tenure indefinitely (Habraken, Schulpen, and Hoebink 2017, 780). This alteration in the political space in Uganda and the entrenchment of an increasingly authoritarian regime resulted in questions of human rights issues and corruption. The lifting of the term limit had emboldened the ruling elite and meant that spending priorities started to focus on gaining political support by buying loyalty or policies that would benefit important factions (Kjær and Ulriksen 2014, 14). During this period, there was increased expenditure for the state house and presidential office, more patronage positions in new districts, and increased presidential advisors. These activities increased tensions with the donor community, with Western donors like Ireland and Norway reducing their donor budget by 25% (Lee 2022, 72). However, most budgetary donors did not drastically cut aid and instead opted to redirect it to humanitarian issues and sectoral projects deemed less controversial (Lee 2022, 72). Uganda's continued willingness to accept conditional reforms, strategic importance in trade, and role in the African Union Peacekeeping Force in Somalia resulted in donors taking limited action against the NRM's growth in power (Habraken, Schulpen, and Hoebink 2017, 789). The formation of NDP and Vision 2040 remained connected to donor funds, with donor support continuing to comprise a significant portion of Uganda's budget (Kasirye and Lakal 2019, 28).

The transformation of Uganda's economy and long-term development focuses on a national vision for growth and economic transformation. It also reveals a continuation of healthcare policy that privatizes, liberalizes, and deregulates the healthcare sector while imposing austerity measures. Vision2040 outlined required policy reforms in the healthcare sector. It focused on a quasi-market approach (NPA 2013, 16), changes in government service delivery (ibid, 16), and creating a prudent and efficient public finance sector (ibid, 36).

UgandaVision 204 also promised a "policy shift in health delivery system from mainly public centered to public-private partnership arrangement" (ibid, 90-91). Privatization remained central throughout discussions of healthcare and other services, with the NPA describing the private sector as the engine for growth and development. Discussions surrounding government spending were vague, with efforts to 'eliminate wasteful spending' and 'increase efficiency' in resource use (ibid, 11). UgandaVision 2040 also stated that there will be "a paradigm shift from facility-based to a household-based health delivery system. The main thrust of this paradigm was empowering households and communities to take greater control of their health by promoting healthy practices and lifestyles" (ibid, 89).

This language echoes the sentiments expressed in the earlier 2000s and in PEAP, where the responsibility to obtain healthcare is placed on the individual over the system. The healthcare reforms outlined in this section continue to center on user fees, deregulation, privatization, decentralization, and austerity, with minimal change in the healthcare priorities from PEAP. Uganda's healthcare policies post-PEAP include the Second National Health Policy (NHP II) and the Public-Private Partnership Framework Policy and Act. These policies encompassed transitions in funding allocations for healthcare, infrastructure reforms, and attempts to alleviate uneven healthcare access in health.

Funding Allocations in the Healthcare Sector

Neoliberal austerity prioritizes creating fiscal discipline and efficient public healthcare systems in budgetary allocations and public spending. Under neoliberal structural reforms, austerity measures became central in Uganda's healthcare policy. Examining healthcare budgetary allocations in Uganda over time against its economic growth can demonstrate

Uganda's economic development post-structural adjustment and how it translates to human development. Figure 2.1 (below) shows Uganda's rapid GDP growth between 1960 and 2020, with a notable uptick between 1999 and 2008. In 2022, Uganda's GDP was 45.57 billion (current US$), and its GDP per capita was 964.4 US$ (World Bank 2024). Between 2010 and 2020, total exports of goods and services grew from USD 3.83 billion in FY 2010/11 to USD 5.3 billion in FY 2017/18, nominal terms (NPA 2020, xvi). The size of the economy also doubled from UGX (the Ugandan shilling) 64 trillion in FY 2010/11 to UGX 128 trillion in FY 2018/19 in nominal terms (NPA 2020, xvi).[2]

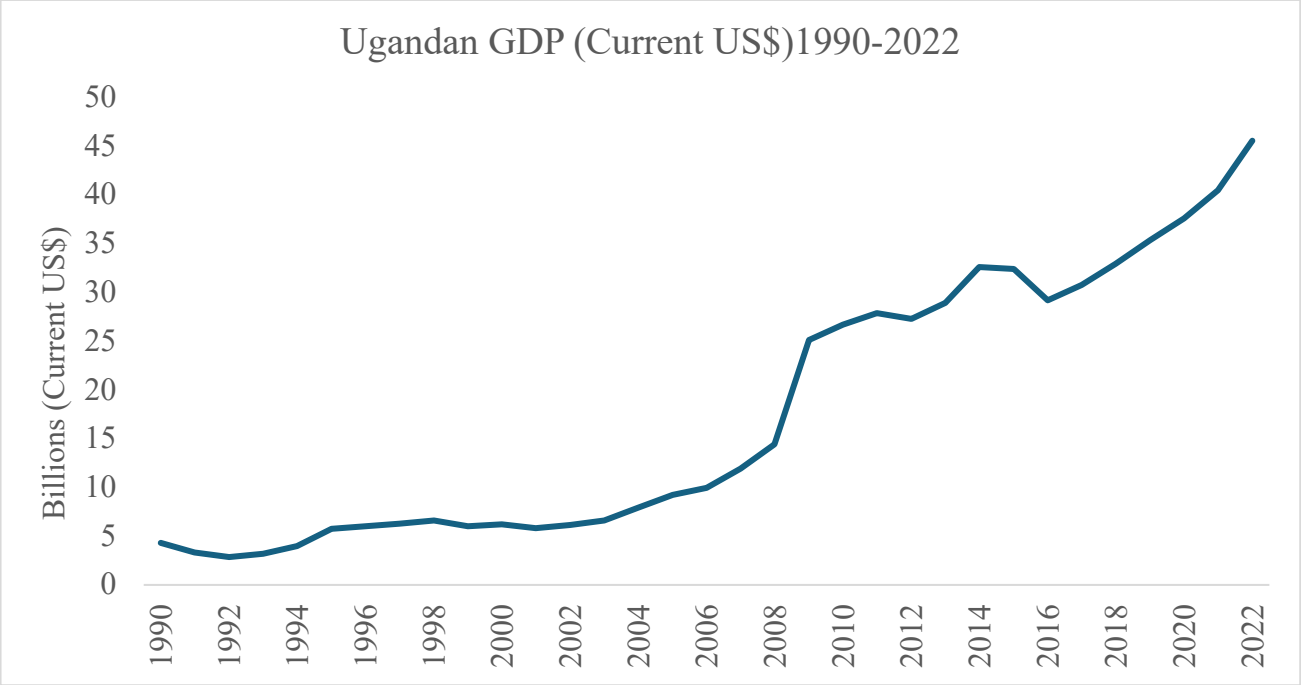

Figure 2: Ugandan GDP (Current USD) 1990-2022[2]

This economic growth can directly contrast with how financial priorities have changed under decentralization in Uganda. In 2020, Uganda spent 3.96% of its GDP on health expenditures (World Health Organization). This number does not include capital health expenditures like buildings, machinery, IT, and vaccine stocks for emergencies or outbreaks.

[2] Shows the growth of Ugandan GDP (in current USD) from 1990 to 2022. Source: World Development Indicators

Healthcare spending remains exceptionally low, oscillating between 3% and 7% since 2000, hitting a high in 2010 at 6.8% of GDP (WHO 2024). Despite Uganda's stated interest in reforming the healthcare system, funding allocations depict a low governmental interest in permanent changes. Since 1990, Uganda has consistently spent less than international targets like the Abuja Target, which sets a target of 15% spending on health, something that Uganda has continually been unable to or unwilling to reach (UNICEF 2023, 11). In Figure 2.2 (below), we can track the domestic governmental health expenditure as a share of total governmental spending in different World Bank income classifications against Uganda. Uganda has the lowest spending among any of these groups, below the average African health expenditure levels and low-income group levels. Uganda's health expenditure as a share of total government expenditure decreases between 2000 and 2019, pointing to the shifting priorities of the Ugandan Government over the years.[3]

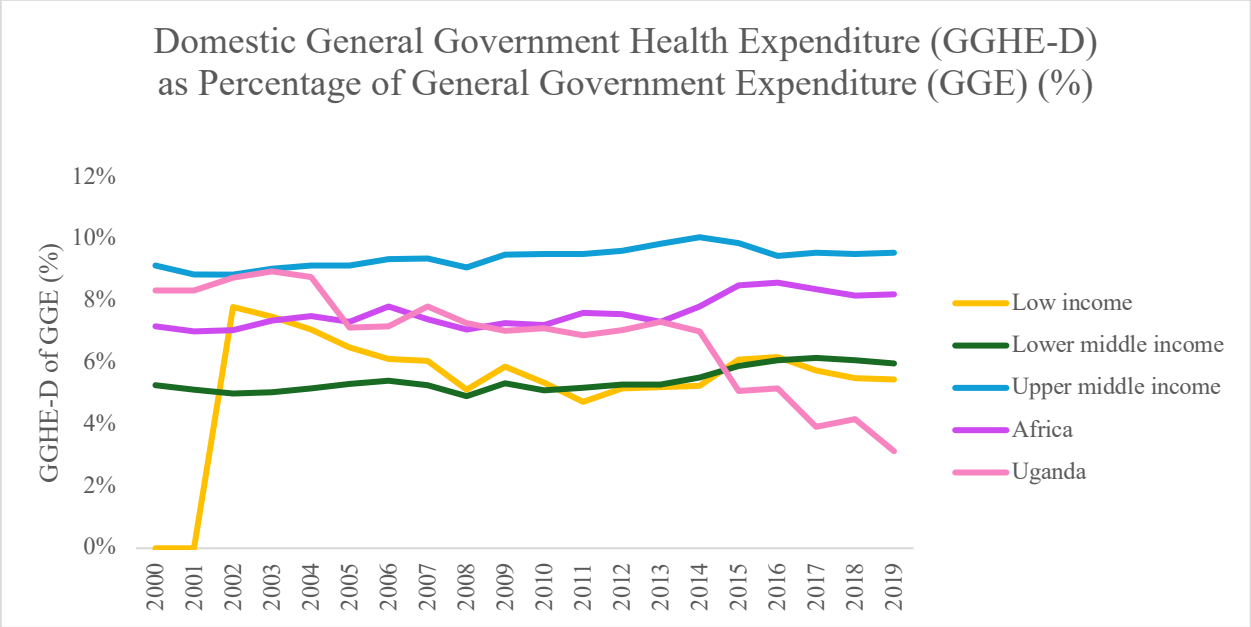

Figure 3: Governmental Health Expenditure[3]

[3] Depicts the Domestic General Government Health Expenditure (GGHE-D) as a percentage of general government expenditure from 2000-2019 across different World Bank income classification groups and Uganda. Source: Global Health Expenditure Database

The allocation of funds feeds back to neoliberal ideologies of fiscal austerity and cutbacks in social services. Austerity measures in Uganda date back to the structural adjustment period and demonstrate that neoliberal ideas of austerity and cutbacks remain present in Uganda's healthcare budget. These findings demonstrate that the low healthcare expenditure is part of a larger pattern dating back to structural adjustment policy. Donor interests were a primary driver for healthcare investments in the 1990s, yet healthcare was never given high priority. Torrente and Mwesigye (1999) wrote that the early economic reforms were disjointed, fragmented, and ineffective. In the latter half of the 1990s, amidst the formation of PEAP, social services came back into the picture, and healthcare aid became central. In 1993//94, healthcare made up 8.3% of disbursed funds. In 1996/97, health comprised 14.1% of disbursed donor funds (Torrente and Mwesigye 1999). However, despite the increase in donor interest and general government expenditure, Ugandan healthcare expenditure remained low amidst structural reforms. These can be tied to the development strategy reforms imposed by the World Bank, which was tied back to fiscal austerity norms and liberalization devaluing social services (Torrente and Mwesigye 1999).

Fiscal austerity measures can be tied back to Uganda's public debt and interest in debt reduction. Uganda's debt stock has been steadily rising from UGX 15.8 trillion (USD 6.1 billion) in 2013 to UGX 78.7 trillion (USD 21 billion) in July 2022 (Nuwaha 2022, 1-2). More than half of the current outstanding debt (61%) was borrowed from outside the boundaries of Uganda, including money owed to private commercial banks, other governments, and international financial institutions (ibid, 2). As of February 2024, this debt crisis has continued to be ongoing and put pressure on reducing Uganda's expenditures in aspects like health. At the end of the last fiscal year, Uganda's public debt stock hit 49.2% of GDP due to increasing government spending

on public infrastructure (Biryabarema 2024). This reflects the prioritization set by UgandaVision 2040, which demoted healthcare as a priority in favor of PPPs and increased public spending on infrastructure.

This debt has meant that Uganda's fiscal policy must pursue fiscal policy that reduces debt reliance and creates a stable economy. This policy approach ties back to neoliberal austerity measures, which focus on reducing public expenditures to decrease debt. Cutting expenses or increasing taxes can depress tax revenue and spending in the private and public sectors, negatively impacting the growth and size of GDP. Debt levels are measured as debt to GDP ratios, so measures to decrease debt by austerity measures may lead to poor economic growth and multiply the effect of shrinking private sector expenditure (Sibeko 2019, 10).

An analysis of 2019 Current Health Expenditures (CHE) found that government healthcare funding comprised 17% of CHE, private sector spending/ Out-of-Pocket (OOP) expenses made up 41.4% (95% of which were OOPs incurred by Ugandans), and donor support made up 41.4.%. (Think Well 2021, 1-3). The underfunding of the public sector due to this low government funding has resulted in heightened costs for healthcare and concerns about a lack of access to quality care.

Public-Private Partnerships (PPPs) in Ugandan Healthcare

PPPs first became a part of Uganda's healthcare system in the mid-1990s, during the peak of neoliberal reform. Since then, it has become a primary feature of the healthcare system and includes private-not-for-profit (PNFP) providers, for-profit private health practitioners (PHP), and traditional and complementary medicine practitioners (TCMP) (Lochoro et al. 2006, 84). Currently, Uganda has 6,937 health facilities (including public, PFP, and PNFP). Of those

facilities, 45.16% (3,133) are government-owned (Public), 14.44% (1,008) are PNFP (Private Not For Profit), and 40.29% (2,976) are Private For Profit (PFP), and .10% (7) are community-owned facilities (Think Well 2021). This means that private facilities make up more than half of all health facilities in Uganda.

The earliest recognized form of Public-Private Partnership for Health in Uganda dates to the early 1960s when the government supported the Private-Not-For Profit Sector (Tashobya et al. 2007, 49). However, support dwindled amidst the economic crises of the 60s, and it was not until 1987 that private sector integration was introduced. However, the private sector and public-private partnerships (PPPs) were prioritized in structural adjustment policies and NHP I. These partnerships were intended to act as institutional arrangements to 'support the growth and vigor of the private market' while fulfilling a public sector need (Mitchell-Weaver and Manning 1991, 54). Early PPP programs were intended to 'fill the gap' left by the withdrawal of the state and were funded explicitly by donors and multilateral institutions like the World Bank (Torrente and Mwesigye 1999). These organizations were believed to be more competent and efficient than the state, and funding was granted for operational/recurrent costs to assist with their early integration. This type of investment is done through project aid, which is done directly from donors to recipients and grants the donor more autonomy over the program requirements and activities. Direct project-based support to facilities has continued to be a significant center of donor funding for both PNFPs and PFPs (Think Well 2021). Mitchell-Weaver and Manning (1991) argued that the adoption of public-private partnerships in developing countries in the Global South was primarily due to pressure from the World Bank, International Monetary Fund, and donor agencies.

Miraftab (2004) argued that public-private partnerships could act as a 'trojan horse' of neoliberal development. PPPs were fostered in the 1980s and 90s during an era of deep neoliberal reform, and many global south countries, including Uganda, enacted PPPs during the 1990s from conditional aid. PPPs often accompany deregulation to free the market and expand the private sector's role, resulting in inadequate capacity to monitor and control private partners. The decentralization of the healthcare sector to create a competitive advantage for private firms may result in the commodification of public goods such as healthcare and an unregulated market. This causes private-sector healthcare to have higher prices, creating disparities in access that favor the upper class. As seen in Chapter 2, privatization is a crucial aspect of neoliberal healthcare policy and can be intertwined with concepts of deregulation and decentralization under public-private partnerships. Public-private partnerships are an extension of neoliberal ideas surrounding the government's role in the public sector, relying on market forces to fill gaps created by low public healthcare funding.

Guided by the recommendations made in NHP I, the collaboration was laid out in the Health Sector Strategic Plan in 2000/2001, and an active effort was made to create a more robust framework for implementation (Tashobya et al. 2007, 49). The PPP policy outlined in NHP I aligned with Uganda's PEAP framework and focused on expanding infrastructure and creating a space for the private sector in healthcare (MoH 2000). Uganda's financial resources began to reflect this prioritization, and in 1997/98, the government resumed provisions of subsidies to facility-based PNFPs in addition to money invested in infrastructure (Tashobya et al. 2007) (MoH 2000). Between 1997/98 and 2005/06, funding grew from 1 billion UGX to just under 21 billion UGX (Tashobya et al. 2007, 50). This reflected the desire to expand the private sector and make it one of the critical components of Uganda's evolving healthcare system.

In NHP II, PPPs became central to Uganda's current healthcare system. The Public-Private Partnership (PPP) Framework policy introduced the framework for implementing PPPs in healthcare in 2010. PPPs were defined as "a medium to long-term contractual arrangement between public and private sector to finance, construct/renovate, manage or maintain a public infrastructure, or the provision of a public service; involves the sharing of risks and rewards; delivers desired policy outcomes that are in the public interest" (MoFPED 2010, 638). This framework policy aimed to create a more efficient, robust, and competitive system of allocating and using public funds in the healthcare system. By applying PPPs to provisions of public services and infrastructure, the Ugandan Government hoped to:

- Enable better utilization of public funds.
- Bring about more efficient development and delivery of public infrastructure.
- Ensure good quality public services.
- Boost economic growth and FDI (MoFPED 2010, 636)

The PPP Framework Policy laid the groundwork for the more extensive Public-Private Partnerships Act implemented in 2015. The Public-Private Partnerships Act applies to all PPPs and social infrastructure, such as healthcare facilities (MoFPED 2015, 2). This act also established a Public-Private Partnerships Committee that included both members of the Ugandan government and representatives of the Private Sector Foundation. This committee ensures that project agreements remain consistent with provisions of the Act and national priorities. However, critics have argued that this committee comprises Ugandan officials who have ignored serious red flags and failed to prioritize equitable access to healthcare (Tumukwasibwe 2010, 59-60). Bagenda & Ndevu (2024, 186) stated that Uganda's adoption of PPPs lies in the need to fast-track construction of infrastructure projects, budgetary constraints, inefficiencies with traditional

public procurement, and the massive demand for infrastructure investment. PPPs can result in better investment decisions, higher quality healthcare, and higher efficiency that appeals to donors. Privatization has been shown to remain a critical element within Uganda's healthcare policies through the development of public-private healthcare systems. These partnerships are expected to grow and become a significant part of this system. The push to liberalize the economy has provided more space for private investment in the public sector, reflecting the neoliberal prioritization of market liberalization over social service provisions.

Donor investment has been crucial in the push for public-private partnerships in Uganda, especially in the last decade, with the passing of the Public-Private Partnership Act and Policies in 2010 and 2015, respectively. The World Bank published a report in 2016 titled "Public-Private Partnerships in Health" that explained its current outlook on PPPs in healthcare development. The World Bank believed that PPPs could revolutionize healthcare by securing high-quality health services and leveraging capital and managerial capacity from the know-how of the private sector (World Bank 2016, vi). This was followed up in 2017 with a diagnostic report analyzing whether PPPs can 'fill the gap' for Ugandan infrastructure (World Bank 2017, 1). In this 2017 report, the World Bank highlights the need for creating a Project Development Facilitation Fund (PDFF) to mobilize budgetary and non-budgetary resources from bilateral and multilateral donors. Donor financing is a crucial aspect of developing PPPs in Uganda, especially considering the lack of available funds in Uganda's budget. The growth of PPPs as a source of healthcare in Uganda reflects the continued influence of the World Bank and donor interests in healthcare policy formation, even in light of President Museveni's controversies with power consolidation. Through direct project aid, multilateral institutions continue to create and implement reforms that reflect neoliberal ideas.

Comparison of National Health Policy I and II

Uganda published National Health Policies (NHP) in 1999 and 2010 that outlined how the state intended to approach healthcare reforms and improve the healthcare system. A comparison of these policies reveals that neoliberal ideology remains central to both policies, reflecting Uganda's overall approach to healthcare development and prioritization.

NHP I was formed under the influence of PEAP and reflected PEAP's prioritization of overall improvements in healthcare status and quality of life. At the time of the report, approximately 46% of the population lived in absolute poverty, and 75% of lives lost due to premature death were due to ten preventable diseases (MoH 1999, 1-2). Geographic access was limited to about 49% of the population living within five kilometers of health service units (MoH 1999, 3). NHP I also identified a lack of funding to the healthcare sector, maldistribution of human resources, low healthcare staff morale, weak management system, and insufficient collaboration between the public and private sectors as critical concerns. NHP I intended to address these critical issues using the Primary Health Approach (PHC) as the guiding philosophy and strategy for national development. PHC is based on the premise that all people have the right to achieve the highest attainable level of health. WHO and UNICEF defined it in a 2018 report:

> "PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment" (WHO and UNICEF 2018, 2).

In practice, PHC focuses on creating integrated health services across the healthcare sectors, multi-sectoral policies to address wider healthcare determinants, and empowering families and communities for increased participation in the healthcare system and self-care

(WHO and UNICEF 2018, 1-3). Uganda aimed to fulfill PHC's vision through the Uganda National Minimum Healthcare Package (UNMHCP). UNMHCP comprised interventions that reference significant causes of the burden of disease and determined the allocation of public funds/other inputs by creating a prioritization system. These components are summarized below:

1. Control of Communicable Disease
    a. Malaria, STI/HIV/AIDS, Tuberculosis
2. Integrated Management of Childhood Illness
3. Sexual and Reproductive Health and Rights
    a. Essential Ante-natal and Obstetric Care, Family Planning, Adolescent Reproductive Health, Violence against Women
4. Other Public Health Interventions
    a. Immunization, Environmental Health, Health Education and Promotion, School health, Epidemics and Disease Prevention, Preparedness and Support, Improving Nutrition, Interventions against diseases targeted for eradication, Mental Health Services (MoH 1999, 9-13)

This package would be financed through central government spending, and any additional resources for the referral/tertiary sector would be allocated preferentially to funding this plan. The Ugandan government also intended to progressively increase government financing for the health sector, specifically for delivering the UNMHCP. These interventions would focus on cost-effective health services with the most significant impact. The government also would finance the healthcare sector by developing and supporting alternative financing schemes such as user fees, health, insurance, and other community resource mobilization efforts (MoH 1999, 16). User fees and cost-sharing were *ad hoc,* meaning the charges were primarily

determined by service delivery levels. These user fees would provide revenue that could incentivize health workers to purchase medications and ensure the cleanliness of the health facility (Nabyonga-Orem et al. 2011, ii43). As outlined in Chapter 2, user fees are neoliberal policies introduced to promote efficiency in their allocation while raising government revenues (Stein 2012, 422-423).

NHP I outlined the intention to expand national health infrastructure through a medium-term health facility development plan implemented by the Government, District Administrations, and private health sector, expanding the private sector's role in healthcare (MoH 1999, 13). This includes incentives to attract private health services to all parts of the country and help private providers expand. The private sector was a crucial component in enacting the UNMHCP by providing more comprehensive coverage of healthcare services and potential revenue for the government. It also extends neoliberal ideas of privatization by commodifying a public good.

Decentralization was a central component in NHP I and divided the roles of the Ministry of Health and the District Health System. This decentralization involved strengthening district health services management and decentralizing operational responsibility for integrated health promotion, disease, and rehabilitative services below the district level. The Ministry of Health was responsible for policy formulation, monitoring overall performance, resource mobilization, health research, capacity development, and providing nationally coordinated services. The District Health System oversaw planning and managing district health services, provisions of UMNHCP, vector control, health education, and implementing NHP I (MoH 1999, 12-13). The justification for this decentralization was to create a network that is closer to the people while improving efficiency. Decentralization ties back to neoliberal ideas of reducing government interference in healthcare services. Hypothetically, decentralizing the system and removing

government bureaucratic inefficiencies would increase innovation and efficiency on a district level (McGregor 2001, 25). NHP I was developed at the height of Uganda's neoliberal reforms and acted as a baseline for comparisons to analyze whether there has been a significant change in ideology and reforms.

Nabyonga Orem and co-authors (2011) discuss one type of OOPS eliminated in 2001 in Uganda: user fees. In the 1990s, when Uganda's healthcare system underwent significant decentralization, many districts faced poor quality of service and shortages of supplies. Amidst these reforms and issues, the Ugandan government introduced formal user fees for all public health services in 1993 (Moat and Abelson 2011, 578). Widespread healthcare decentralization reforms resulted in the implementation of cost-sharing via user fees as a mechanism to generate local revenue for their healthcare services (ibid, ii 42). The Local Governments Act was passed in 1997, and locally elected bodies were legally granted control over healthcare aspects like user fees (Moab and Abelson 2011, 579). Under these decentralization policies, people were meant to be brought closer to the decentralized local units while revenue was generated locally to support their activities (ii42). Decentralization and user fees meant user fee systems varied significantly between districts. Kivumbi and Kintu (2002) explain that some charged only for each service (consultation, laboratory tests, drugs, hospitalization), others opted for annual fees to access any services, and others opted for no formal fees.

During his 2001 re-election campaign, President Yoweri Museveni abolished user fees (Moat and Abelson 2011, 578). The reasons behind Museveni's decision were highly debated, with Moat & Abelson (2011, 579) arguing that it may have been a campaign strategy that could secure voter support. Others, such as Nabyonga et al. (2011), posited that President Museveni's decision may have been influenced by the rising public concerns surrounding the impact of user

fees on health outcomes. Stein (2008) argued that President Museveni had been influenced by the changing priorities of the U.S. Government and the World Bank, who had become more concerned about the impact of user fees. By eradicating user fees, these policies could improve access to health services for low-income households. The government implemented a dual system involving private and public sectors to replace user fees. Within this new healthcare system, private services would be available for a cost while public services would be available for those without the capacity to pay (Nabyonga et al., 2011, ii43). Eliminating user fees appeared to signal a move away from neoliberal privatization policies and could potentially increase healthcare equity.

In 2008, Uganda abandoned PEAP and embraced the NPA's new centralized vision of transforming Uganda under the Comprehensive National Planning Development Framework (CNDPF). This marked the second era in Ugandan healthcare reform, from 2008 to the present. The second National Health Policy (NHP II) was created in 2010 to reflect these new priorities. NHP II stated that NHP I, which guided the health sector between 1999 and 2009, had to be updated to incorporate emerging issues and identify new strategies for action focusing on the Millennium Development Goals (MDGs) (MoH 2010a, 1-2). The Ministry of Health admitted that while health indicators have generally improved over the last ten years, there were still significant disparities in access and low overall satisfaction in the healthcare system (MoH 2010a, 1). NHP II focuses on healthcare promotion, disease prevention, early diagnosis, and disease treatment (MoH 2010a, iv). The NHP also prioritized efficiency, strengthening the private sector, and universal access to the UNMHCP.

NHP II outlined how Uganda intended to achieve its commitment to "a healthy and productive population that contributes to socio-economic growth and national development" (MoH 2010a, 11) by strengthening its healthcare system. The priority areas of NHP II included:

1. Strengthening health systems in line with decentralization through training, mentoring, technical assistance, and financial support.
2. Re-conceptualizing and organizing supervision and monitoring of health systems at all levels in both public and private health sectors and improving the collection and utilization of data for evidence-based decision-making at all levels.
3. Establishing a functional integration within the public and between the public and private sectors in healthcare delivery, training, and research.
4. Addressing the human resource crisis and redefining the institutional framework for training health workers, including the mandate of all actors. Leadership and coordination mechanisms to improve the quantity and quality of health workers' production shall also be a priority. (MoH 2010a, 14).

NHP II continued NHP I's commitment to decentralizing the healthcare system and argued that the district health system must be strengthened so public and private partners could carry out their responsibilities (ibid, 15). Additionally, the Government strengthened the national referral system for primary, secondary, and tertiary care so lower-level facilities could function. The NHP II aimed to strengthen UNMHCP with an emphasis on vulnerable populations. Notably, one of the policy strategies for enhancing UNMHCP involved gradually strengthening responsible self-care, especially at the primary care level (ibid, 17). This aspect can be linked to the neoliberal concepts of individualism, where individuals are empowered to care for their health over the governmental system (McGregor 2001, 83-85). The Ministry of Health also

focused on the shortage of medicines and health supplies and attributes these issues to poor quantification, inadequate financing, and a lack of trained pharmacists/dispensers (MoH 2010a, 23). To improve this aspect, the Government planned to encourage the integration of private sector activities into the Ministry of Health's pharmacy policy framework, especially with training institutions. Development partners, including large private donors and multilateral institutions, continued to play a crucial part in Uganda's healthcare framework in NHP II (MoH 2010a, 25-27).

NHP II's priorities were expanded in the HSSP III 2010/11-2014/15. HSSP III aimed to strengthen the capacity of hospitals to provide specialized care by investing in recruitment and specialized care and enhancing the referral system (MoH 2010b, 131-133). Uganda also hoped to increase the quality of care at all health system levels, including the private sector. This meant developing and disseminating higher standards and providing in-service training. The private sector would also be integrated into financing for medicines and health supplies in the national budget to strengthen the delivery and storage of goods in private and public facilities (MoH 2010b, 107-109). Healthcare access remained a priority, with the intention to increase the proportion of Ugandan citizens living within 5 km of a health facility from 72% to 90% and increase the number of health facilities by 2015 (MoH 2010b, 107). Decentralization remained a critical part of NHP II, prescribing that delivery of health services shall continue under local governments. At the same time, MoH and central-level departments focus on the development of policies and guidelines.

A comparison of the two National Health Policies reveals several similarities in concerns and proposed strategies. Both plans confront a healthcare system rife with inequalities and struggles to create infrastructure and quality healthcare services. NHP I and II both continue to

encourage decentralizing the healthcare system and working to increase capacity at the local level, a profoundly neoliberal philosophy. Lastly, both systems intended to expand public-private partnerships to address rising demands and create a more robust healthcare system.

Conclusions

In conclusion, exploring neoliberal ideologies in the context of Uganda's healthcare system has revealed vital inputs into the evolution of policies, budgetary allocations, and overarching developmental frameworks. This chapter began by examining the historical roots of neoliberalism in Uganda, particularly within the Poverty Eradication Action Plan (PEAP). With its distinct emphasis on individualism in healthcare, PEAP emerged as a guiding force that shaped subsequent policy decisions. This ideological underpinning, deeply rooted in the neoliberal paradigm, echoed in the rhetoric surrounding healthcare and the allocation of financial resources.

Moving beyond the PEAP, the analysis then delved into the practical manifestations of neoliberal ideologies in the form of budgetary allocations. Analyzing funding decisions within Uganda's healthcare sector uncovered a complex interplay between economic priorities and healthcare policies. Comparative analyses of GDP growth alongside healthcare transformations provided a nuanced perspective, illustrating how economic development aligns with healthcare trajectories. The examination of public-private partnerships, National Development Plans (NDPs), and the organizational structure of the healthcare system further contributed to an understanding of how neoliberal principles explain various aspects of Uganda's healthcare landscape.

The alignment of fiscal decisions with neoliberal rhetoric presents a challenge where the ideals of individualism and privatization intersect with the realities of public health provision. The implications of these neoliberal influences extend far beyond mere economic indicators, shaping the fabric of healthcare accessibility, quality, and equity in Uganda. The groundwork in this chapter serves as a foundation for the subsequent exploration of the tangible impacts of these neoliberal policies on healthcare outcomes. Chapter 4 will delve into the consequences, challenges, and disparities that occurred because of these policy decisions. By dissecting the intricacies of healthcare delivery and health outcomes, this thesis can be used to understand how neoliberalism left its mark on Uganda's healthcare system.

Chapter 4: Navigating Healthcare Realities in Uganda

Introduction

A review of Ugandan healthcare policy from 1997 to date reveals the continuation of neoliberal approaches under an increasingly authoritarian government and permissive donors. The healthcare policies and alterations in this period claimed to have addressed critical issues like regional inequality, high healthcare costs, and low-quality care overall. However, as the assessment in this chapter reveals, the policies have prioritized market efficiency and liberalization of the market over an equitable healthcare system, creating an uneven and ineffective healthcare sector. Regardless of policy transitions and objectives, neoliberalism has continued to result in poverty and uneven development. Regional and socioeconomic disparities and high healthcare costs have resulted from Uganda's reliance on private healthcare and a lack of public sector funding for healthcare. An examination of poverty distributions and the burden of healthcare costs reveals that the current healthcare system operates regressively and disproportionately impacts rural and low-income groups.

Ugandan healthcare disparities also exist between private and public hospitals, resulting in lower quality care and restricted access to those who cannot afford the cost of private healthcare. Chapter 4 draws from household budget surveys, data from the World Bank and other global institutions, and qualitative and quantitative data to create a more extensive holistic understanding of the impacts of Uganda's healthcare reforms on access and quality of care. The reforms that have taken place since structural adjustment have failed to address the significant issues created by neoliberal reforms by failing to alter the approach to healthcare and development.

Poverty Distributions and Regional Access

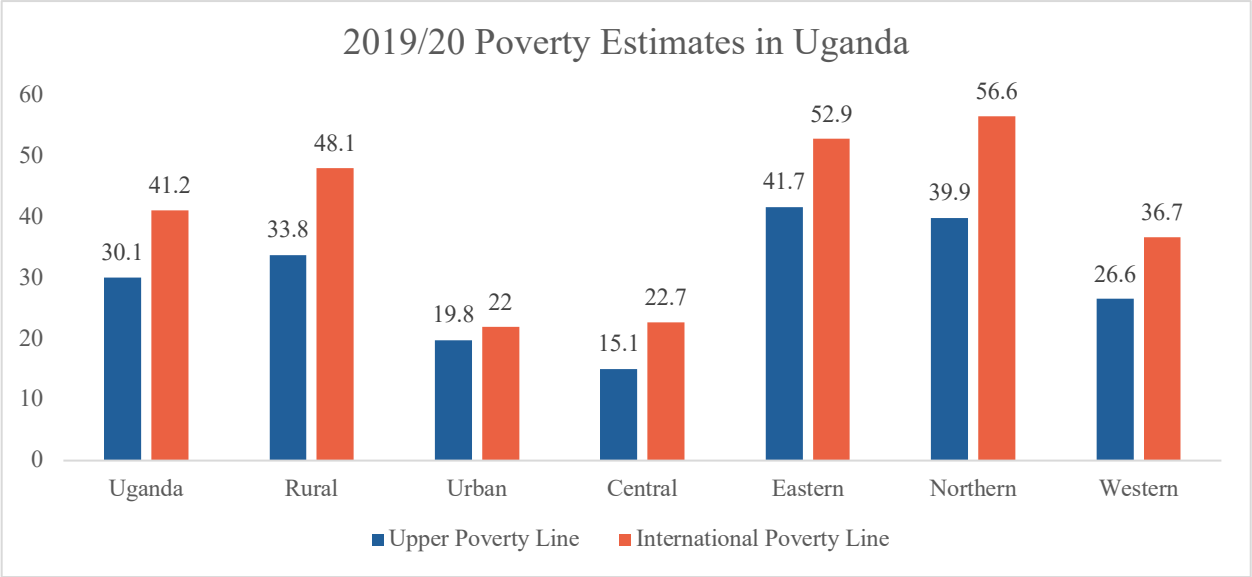

Figure 4: 2019/20 Poverty Estimates in Uganda [4]

Uganda has made considerable progress in reducing poverty since 1993, with poverty rates decreasing from over 57.7% in 1993 to 41.2%, based on the International Poverty Line of US $1.90 per day (2011 PPP) (Owari 2020, 2). The Ugandan 2021 Poverty Status Report tracked poverty trends between 2012/13 and 2019/20 between the poor, insecure non-poor, and middle class and found that poverty distributions remained relatively the same despite the growth in population and economic reforms to alleviate poverty (MoFPED 2023, xi). Table 4.1 (above) shows the 2019/2020 poverty estimates using both Uganda's national poverty line of US $1.77 per person per month and the international poverty line of US $1.90 per person per day (2011 PPP) (Owari 2020, 2). This figure shows evident disparities in poverty concentrations across regions and within rural and urban communities

In 2022, the international poverty line was updated from US $1.90 to US $2.15 to reflect the change from international dollars given in 2011 prices to international dollars given in 2017

[4] Shows 2019/20 poverty estimates based on the upper poverty line (USD 1.77 per month) and the international poverty line (USD $1.90 per person per day*). Source*: UBOS 2021.

prices, the equivalent of 2838.8 Uganda Shillings (UGX) (2019 PPP) (World Bank 2023) (Hasell 2022). Based on this international poverty line, 18.1 million people were designated poor in 2019, representing 42.2% of the Ugandan population (World Bank 2023). The Gini Coefficient also remained high in this period, measuring 42.7, representing a continued trend of high inequality in Uganda. The Gini Coefficient measures income or wealth inequality, where 100% represents maximal inequality. Uganda's Gini Index has oscillated between 40 and 50 since 2002 without significant improvements (World Bank 2023).

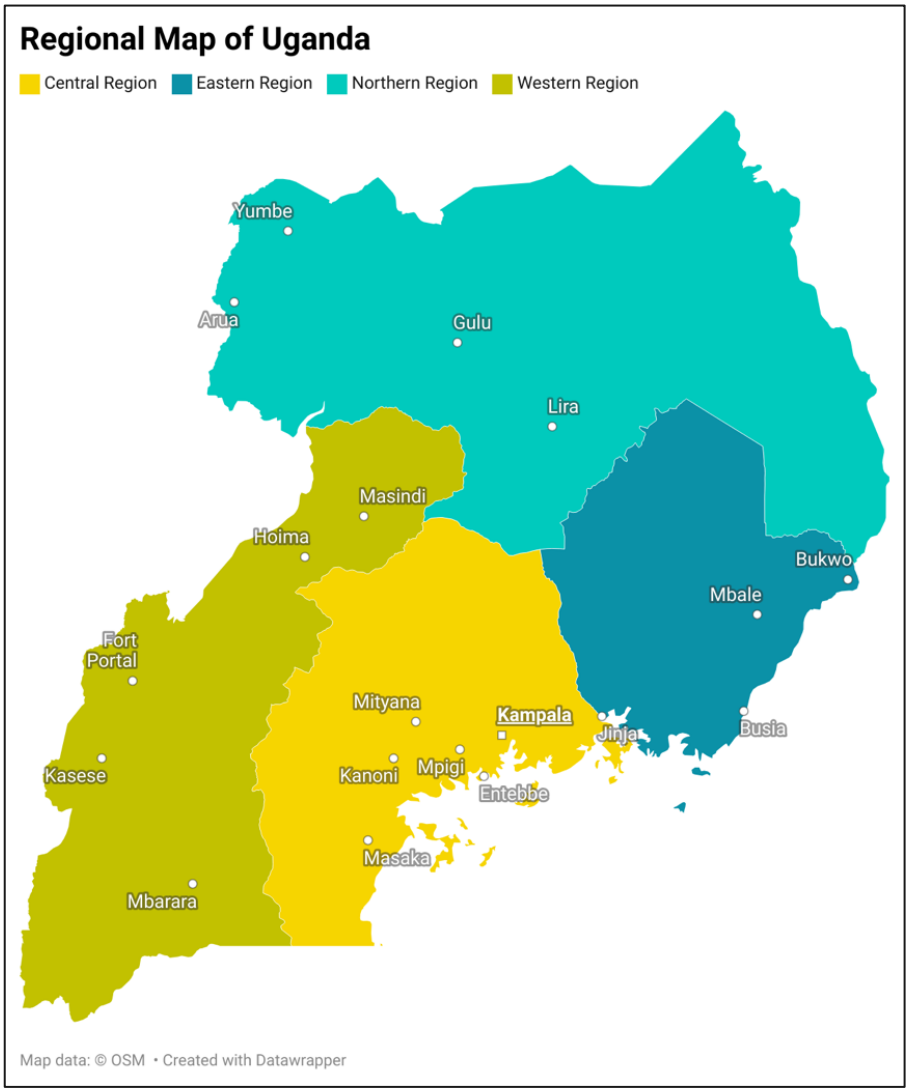

Figure 5:Regional Map of Uganda[5]

[5] Regional Map of Uganda. *Source:* OpenStreetMap Foundation, Datawrapper GmbH (2024).

The impacts of reforms on poverty can be further understood through a regional examination. Uganda can be divided into four regions: Central, Western, Eastern, and Northern (see Figure 4.2). Within these regions, 111 districts vary in poverty levels and access to healthcare. A 2020 Statistical Brief revealed that the most chronically poor were in the Northern region (21.6%), then the Eastern Region (10.7%), the Western Region (4.9%), and the least chronically poor in the Central Region (.5%) (UBOS 2021, 43). These regions have struggled to alleviate poverty, with poverty increasing in the Northern region from 2016/17 (32.6%) to 2019/20 (35.92%) (MoFPED 2023, xiii). A 2022 evaluation by the World Bank stated that location played a crucial role in poverty status in Uganda, with significantly higher poverty rates in rural areas and the Northern and Eastern Regions (World Bank 2023, 5-6).

As established in Chapter 2, a holistic understanding of poverty requires insight into the healthcare sector. A thriving healthcare sector can serve as a tool to alleviate poverty, while an ineffective and costly healthcare system can feed into the cycles of poverty and inequality. This section examines how neoliberal healthcare policies can intersect with Ugandan poverty distributions and the impact on regional access to healthcare. Due to the significant poverty issues of poverty, this thesis will examine the impacts on healthcare access and quality across districts and socioeconomic classes to measure the success of Ugandan healthcare reforms,

In 2002, at the height of NHP I and PEAP reforms, Okurut, Odwee, and Adebua (2002) released a study detailing the determinants of regional poverty in Uganda. Northern and Eastern Uganda have historically faced the highest levels of poverty. Northern Uganda was characterized by the poor having the lowest mean household income, the lowest education levels, the lowest health expenditures, large mean household sizes, and high rural concentrations. The cost-sharing schemes implemented under PEAP intended to increase the availability of drugs and higher-

quality equipment had increased costs through user fees. Low-income households that could not afford these user fees opted for self-treatment or traditional healers, creating long-term implications for the labor force's health and household income (Okurut, Odwee, and Adebua 2002, 19-20). The study argued that a healthy household is needed to engage in more productive and higher-income activities, enabling households to escape poverty. Okurut, Odwee, and Adebua (2002) argued that the inequities present in the Ugandan healthcare system had implications for poverty distributions and could feed into a toxic cycle of poverty. These findings illustrated the need to increase the provision of healthcare services and create a more feasible system of health insurance provision to address disparities in access. A re-evaluation of poverty distributions and healthcare access reveals the continuation of the same issues outlined in 2002. Owari (2020) found that Northern Uganda scored the lowest among the four regions in health indicators performance, household sanitation coverage, and overall life expectancy (Owari 2020, 12-15).

NHP I Reforms such as the Ministry of Health restructuring, UNMHCP introduction, and private sector integration were intended to improve access and progress towards PHC goals of equitable healthcare. Pariyo et al. (2009) evaluated the impacts of PEAP and NHP I health reforms on changes in health services utilization among rural and poor residents in Uganda. They found that the odds of not seeking care were 1.79 times higher in 2005/06 than in 2002/03. One of the most common reasons given was the high cost of seeking care and the continued poor geographical access to health facilities. Physical access, measured as the population living within 5 km of a health facility, increased from 49% in 1999 to 72% in 2004 (Pariyo 2009, 7). However, poorer households lacked transportation to reach healthcare facilities in their region, and many perceived the closest facilities as inaccessible. Cost remained an issue even after user fees were

eliminated in 2001, and Pariyo (2009) attributed this barrier to the gaps in service between public and private facilities. Most respondents who had fallen sick in the 30 days preceding the survey had opted to use private clinics over public. Concerns over the quality of public facilities, such as a lack of training and medical supplies, had resulted in the preference for private facilities if they could pay.

Overall, the reforms under NHP I and PEAP proved ineffective at addressing the rural/urban gap in healthcare access and resulted in Ugandan healthcare reforms feeding into regional poverty distributions. Low government prioritization in healthcare funding and decentralization resulted in unequal healthcare access and an ineffective healthcare system. Despite the overall utilization of public and PNFP facilities increasing for rural and poor populations, PFP facilities remain the primary care providers over free government services (Pariyo 2009, 9). My findings indicate that the PEAP and NHP I era failed to accomplish the state's goals of alleviating poverty regionally and had instead entrenched neoliberal paradigms into Ugandan healthcare.

In 2009, the Ugandan Government introduced the National Development Plan, including UgandaVision 2040 and NHP II. Unlike PEAP, which had prioritized poverty eradication and there were more donor-led efforts for social services, NDP had an enhanced focus on socioeconomic transformation through infrastructural development and wealth creation over social expenditures (Owari 2020, 4). This period, which continues to date, has focused on the increased role of the private sector, reflecting changing donor priorities and overall economic growth. The recent reforms have had a mixed review on poverty, with poverty levels increasing from 35.9% in 2012 to 41.7% in 2016 based on the International Poverty Line (Owari 2020, 7).

The Uganda 2022 Multidimensional Poverty Report focused on expanding the empirical work on poverty beyond one-dimensional measures like income or household expenditure (UBOS 2022). The Multidimensional Poverty Index (MPI) focuses on developing a comprehensive poverty measure by examining four dimensions: education, health, living standards, employment, and financial inclusion. The four dimensions were measured through quantitative indicators like years of schooling or access to healthcare services and then weighed to create a multidimensional poverty index (UBOS 2022, 1-5). At a regional level, it was found that multidimensional poverty estimates replicated the monetary poverty patterns in Uganda. There were significant disparities between rural and urban areas in healthcare indicators like improved water, electricity, housing materials, and access to healthcare services. These indicators' deprivation was almost double in rural areas than in urban areas in 2016/17 and 2019/20. The study found that mainly those in rural areas and the Northern, Western, and Eastern regions faced high deprivation.

Under NHP II and NDP, the Ugandan Government and Ministry of Health prioritized expanding the number of healthcare facilities across Uganda to increase access for rural and lower-income demographics. Distance, especially in rural areas, has been a significant boundary for those in rural and low-income regions. Konde-Lule et al. (2010) examined private and public healthcare in rural areas and found that a lack of access had decreased healthcare facility utilization. In the rural communities surveyed, of the 42% who reported experiencing illness once or more in the previous 30 days, only 54.1% sought care from a healthcare facility. Those who sought self-treatment or took no action would cite reasons such as a lack of transportation, money, or facility nearby. Among those who self-treat and were ten years or older at the time of the survey, 59.7% reported missing work due to the illness (ibid). Restricting healthcare access

has impacted the workforce and productivity, reflecting healthcare's linkage with development. By expanding infrastructure, the Ugandan Government hoped to simultaneously address inequities in access to care and build long-lasting infrastructure for healthcare service delivery.

The NDP reforms from 2009 to date have focused on expanding access to care by expanding healthcare facility coverage across Uganda. During this period, there was a significant increase in the hospital infrastructure, such as an 8.3% increase in facilities in 2017/18 from 2016/17, constituting 533 additional health facilities (UBOS 2021). Table 2 (below) summarizes the number of health facilities in different regions. Uganda's health facilities are classified into seven levels based on their services. Special clinics are health facilities with specialized services, such as only HIV-related services, and are not included as one of the official levels. Expanding hospital infrastructure and investing in different levels of healthcare was intended to strengthen Uganda's referral system while building on its specialized healthcare sector. Facilities at the lower levels are intended to provide less intensive and specialized services. Clinics primarily provide community-based and promotive health services, while HC II, HC III, and HC IV facilities focus on preventive services, promotive services, outpatient curative health services, and basic laboratory services. 74% of clinics are in central Uganda, demonstrating a bias in health facility location.

Similar trends can be seen in HC II facilities and HC III facilities. Overall, the poorest and most rural regions had the fewest health facilities and, as a result, continued to have the lowest access to care. The more specialized services provided at higher-level facilities, such as General Hospitals and Referral Hospitals, include expansions on service training and specialized training services. RRH and NRH facilities are highly specialized, offering services in fields like psychiatry, dentistry, intensive care, and pathology. Additionally, the NRH is the center for

teaching and research. These facilities are primarily concentrated in the Central region and continue to reflect an urban and regional bias. By developing the primary centers for training and research in urban areas and the Central and Western regions, healthcare access and development remain concentrated in these areas.

#	**Level of Health Facility**	**Number of Facilities**	**Region**			
			Central	Eastern	Northern	Western
1	Clinic	1572	1,166	161	118	133
2	Health Centre II (HC II)	3,365	1,323	694	554	793
3	Health Centre III (HC III)	1,574	498	380	320	372
4	Health Centre IV (HC IV)	222	68	52	33	69
5	General Hospital	163	62	37	29	35
6	Referral Hospital (RH)	3	2	0	0	0
7	Regional Referral Hospital (RRH)	13	3	3	4	4
8	National Referral Hospital (NRH)	2	2	0	0	0
-	Special Clinics	23	9	7	3	4
	Total Facilities:	6, 937	3,133	1,334	1,061	1,410

Table 1: Ugandan Healthcare Facility Regional Distributions [6]

A review of health sector performance found that health service provision in Uganda improved because of these investments, with most facilities proving capable of providing

[6] Ugandan Healthcare Facility Regional Distribution Source: Ministry of Health. National Health Facility Master List 2018

essential health services, such as immunizations and family planning (Fullman et al. 2014, 8-9). Additionally, a higher proportion of facilities across levels of care had functional electricity and piped water because of the ongoing investments in bridging physical infrastructure deficiencies at health facilities (Fullman 2019. 8-9).

However, the reforms did not alleviate the deficiencies in access to healthcare that had remained a problematic aspect of the healthcare system. Dowhaniuk (2021) assessed country-wide equitable healthcare access in Uganda and found that strong disparities exist between urban and rural populations, with poor rural residents facing disproportionately long travel times to health centers compared to wealthier urban residents. The proportion of Ugandans within a 1-hour walk from the nearest government health clinic (HC) was 71.3%, yet the proportion drastically decreased as the levels increased from HC II to NRHs (Dowhaniuk 2021, 11). The most limited access was in the northern and eastern portions of the country. Access to HCs was significant in urban centers, whereas poor rural areas had slow access to HCs, demonstrating that Ugandans unable to afford transportation could not access health facilities. Low healthcare access clusters continued to mainly occur in Northern and Eastern Uganda, demonstrating the urban bias in healthcare development.

This uneven development impacted the availability of HIV services in rural Uganda as well (Akullian et al. 2016, 4-8). People living with HIV (PLHIV) traveled an additional 1.9 km to access healthcare than those not living with HIV and were 56% less likely to access healthcare at the nearest facility to their residence. PLHIV required specialized HIV services like ART and frequently had to travel farther and pay more to access healthcare than those who were HIV-negative in the same communities. This distance could negatively impact HIV in Uganda, as Akullian et al. (2016) found that PLHIV were less likely to seek healthcare at facilities with ART

services the farther they lived from those services. This reluctance to seek care has been exacerbated by the passing of anti-homosexuality laws in Uganda, which have further increased the stigma around HIV.

These case studies and analyses of health sector investments reveal more profound flaws in Uganda's healthcare development approach under NDP. Despite the investments to improve healthcare infrastructure, the NHP II reforms have failed to address the disparities in healthcare access. Their failure to do so can be rooted in Uganda's refusal to invest in healthcare access and equity. NDP's investments focus on socioeconomic transformation over poverty reduction, prioritizing macroeconomic growth over inequality and even development. These policies have created a healthcare system that feeds into the cycle of poverty in Uganda, leaving those in rural areas and low-income regions behind in the pursuit of an efficient healthcare system.

Private vs. Public Hospital Care

Public-private partnerships have become a central component of Uganda's healthcare system and have significantly impacted access to and quality of healthcare. Under NDP reforms, they act as the engine for growth and development in this sector and have been critical players in expanding Uganda's healthcare coverage. This section analyzes how these public and private facilities function in Uganda's healthcare system, focusing on accessibility, quality of care, and affordability in both sectors. A comparison of public and private facilities reveals that healthcare disparities continue under these partnerships. Public-private partnerships work to fill the gap created by low-quality public healthcare, yet they serve as a faulty alternative that creates barriers to access for poor and rural Ugandan populations. NHP I and NHP II have both prioritized the development of these partnerships and argued that they would result in a more

efficient and capable health sector. However, the growth of public-private partnerships may have proven to be counterintuitive to the ideas of poverty reduction.

Reforms under PEAP and NHP I reflected donor interests and a private-sector-led push for PPPs. Under NHP I, subsidies for PNFP facilities were implemented to reduce healthcare fees. However, the reduction of fees was found to be uneven and was attributed to rising operational costs. The higher private healthcare costs disproportionately impact lower-income groups, yet low-quality public care has forced citizens to pay for private care. Pariyo et al. (2009) found that public-private partnerships had a significant role in creating disparities in healthcare access. Pariyo (2009) noted that investments in public services remained low under PEAP/NHP I reforms, resulting in gaps in service quality, a lack of medicine and supplies, untrained and under-supervised workers, and dysfunctional facilities. Due to these issues, wealthier people were less likely to use government clinics over private clinics, so those who could pay for better quality services sought out the private sector.

Due to policies encouraging the private sector's growth to fill the low-functioning public health sector gap, private sector healthcare has become much more common. Konde-Lule et al. (2010) analyzed the type and numbers of different healthcare providers and the quality, cost, and utilization of care delivered by these providers in rural Uganda directly after the end of PEAP and NHP I reforms. This study found that private providers not only outnumbered public providers but also were preferred by most of the participants interviewed in the survey. Private for-profit providers comprised 75% of available formal healthcare facilities in the districts studied, and private providers' use was considerably higher than public services. Though public healthcare was officially free, many healthcare workers often levied informal fees, which could be combined with the documented low quality of public services.

The Ugandan National Household Survey in 2009/10, at the end of PEAP and NHP I reforms, demonstrated the impacts of PPP growth on healthcare access and equity. Under NHP I, the Government of Uganda made active efforts to upgrade health infrastructure, abolish user fees in public facilities, upgrade health training, enhance drug availability, and provide PNFP subsidies (UBOS 2010, 52). The survey found that the expansion of private facilities had resulted in more individuals seeking private care than in 2005/06. However, this increase in usage can be associated with healthcare expenditures remaining high despite eliminating user fees. The share of health in total health expenditure had remained the same in Kampala and the Northern region, declined in the rural areas of the Central and Eastern regions and the Western Region, and increased for urban areas in the Central and Eastern regions (UBOS 2010, 71). Overall, in the 2005/06 to 2009/10 period, there was no significant reduction in the number of citizens classified as poor, and income inequality worsened (UBOS 2010, 92). Additionally, communities ranked access to healthcare as the top problem affecting communities, with the Northern and Western Regions indicating the highest levels of concern (UBOS 2010, 160). One of the critical issues outlined was the cost of medicine, with 38.2% purchasing medicine from a government or private facility over other sources. This had become a more significant issue in the Central and Western Regions due to a lack of supply from other sources (UBOS 2010, 158-159).

The private healthcare system offered advantages like greater trust when seeking care for stigmatized diseases like HIV/AIDS, longer opening hours, larger healthcare supplies, and shorter waiting lines, something that the public healthcare system could not match (Konde-Lule et al. 2010, 6). Kiwanuka et al. (2008) examined access and utilization of health services for the poor in Uganda and found that the poor and vulnerable continue to experience a more significant disease burden. Some of the barriers to access included distance to service points, issues with

perceived quality of care, the availability of drugs, lack of skilled staff in public facilities, cost of care, lack of knowledge, late referrals, and health worker attitudes (Kiwanuka et al. 2008, 1067). Private facilities can assist with drug availability, staff capability, and perceived quality of care. However, their expansion under PEAP and NHP I had failed to address the cost of care and equity.

However, the overall benefit to the Ugandan Government and private sector resulted in the continuation and expansion of PPPs in the second set of reforms in NDP. The role of public-private partnerships was cemented through the Public-Private Partnership Act in 2015, UgandaVision 2040, and NHP II. The Public-Private Partnership Act of 2015 is the legal foundation for all PPP projects under NDP. PPPs now comprise a significant percentage of hospital infrastructure and healthcare expenditures. In 2018, only 45.16% of the 6,937 health facilities in Uganda were government-owned (MoH 2018, 8). A study looked at the Ruharo Mission Hospital in Uganda and found that PPPs could create significant positive benefits for hospitals but required more government assistance and subsidies due to the higher costs of certain services (Asasira and Ahimbisibwe 2018, 8-9). Most importantly, PPPs could increase geographical access to healthcare in rural regions. These drivers have resulted in Uganda's continued investment in PPPs. Investments in healthcare infrastructure have resulted in 100% of the population living within 5 km of a health facility (public or private) (NPA 2018, 93).

One of the most criticized PPPs in Uganda was the Lubowa International Specialized Public Private Partnership Hospital. The Lubowa Project was intended to be a private sector-led initiative with public sector funding yet delays and slow movement have dragged the project out for over five years. The Lubowa hospital had initially cost US$379.91 million and required US$69.7 million annually to pay off the investors (Enriquez 2023, 161). Without proper

regulation and monitoring, PPPs may result in a worsening debt crisis. A report published by ISER (2023) criticized the legal, financial, and social repercussions of the high investment into PPPs in this health project. Though the project was due to be completed in June of 2021, the Lubowa Project is now set to be completed in December 2024 (Otto 2021). Developers have cited heavy rains, the pandemic, cash flow, and plan alterations as the reason for the delay (Otto 2021). So far, over 406 billion shillings in promissory notes have been issued, yet construction has continued to be delayed. As of February 2024, there have been no updates, and some have become concerned that it was a conduit for public fund theft (Monitor 2024).

The Initiative for Social and Economic Rights (ISER), a Ugandan non-profit focused on social and economic rights, published a report that contended that even if the Lubowa PPP succeeded, it would create unaffordable specialized care for most Ugandans (ISER 2023). ISER (2023) cites the case of another Ugandan hospital PPP, the Mulago Women Specialized Hospital, which was paid for by Ugandan taxpayer funds yet charged high costs for care that many cannot afford. ISER (2023, 6) points out that the money allocated to the Finansi-Roko joint venture could have been used to support national and regional referral hospitals three times over. The funding for the project has relied on government budgets and end-users, resulting in deductions from the health ministry's budgets to finance the project. The Lubowa PPP illustrates a critical flaw in the neoliberal understanding of healthcare: the assumption that the government is inherently ineffective and must be reduced to create optimal functioning. This understanding results in undervaluing social welfare and the lack of prioritization in healthcare policy and budgetary allocations. Instead, the market is considered the optimal method of improving health service delivery by leaving the sector up to the forces of the free market. This understanding results in the commodification of healthcare, where the government is relieved from its

responsibility to provide needed social goods to citizens. Neoliberal ideology also assumes that the market will be more rational than the public sector, though it can be seen from the Lubowa PPP that this may not always be the case. This project has been insufficiently monitored and has manifested in significant expenditure with minimal results.

Buregyeya et al. (2017) compared the capacity of public and private health facilities to manage under-five children with febrile illnesses in Uganda. They found that private hospitals were more equipped to provide competent care. The private sector outperformed the public sector in stock of medical supplies, with just over half of public facilities reporting quinine stock, an anti-malarial drug, compared to 85% of private facilities. Public facilities had sub-optimal capacities compared to the private sector in treating severe malaria. The availability of medical supplies has played a significant role in whether individuals seek public or private care, with many public healthcare facilities facing frequent issues with a lack of supplies. In 2017, Ugandan doctors staged a strike against the frequent drug shortages and low wages (Kim et al. 2022, 2). Armstrong-Hough et al. (2018) found that PFPs had a 98% higher availability of essential medications for treating non-communicable diseases than public facilities. Public facilities are subsidized and can dispense medication free of charge, whereas PFP medications are only available at cost. If public sector facilities face drug shortages, Ugandan citizens are forced to turn to the high costs set by PFPs. A controller medicine for asthma, like a beclomethasone inhaler, costs about seven US dollars, equivalent to three days' wages (Armstrong-Hough et al. 2018, 8). The introduction of the private sector into healthcare has manifested in a free market system for healthcare, where those who can afford healthcare can obtain it. Those who cannot afford private healthcare prices are forced to seek alternative options or take out loans (Nabyonga et al. 2011, ii49).

Examining public-private partnerships in Uganda through a neoliberal framework shows that the nature of healthcare has been cyclical. It is built into a neoliberal system in which access to healthcare relies on the individual over the collective, and government action is not endorsed. Private partnerships in healthcare offer revenue and create more market opportunities, centering economic growth, yet come at the cost of privatizing the healthcare system to the detriment of the citizens.

Power, Corruption, and Healthcare Policy

In 2023, Transparency International assessed 180 countries for perceived levels of public sector corruption. The Corruptions Perceptions Index (CPI) assesses aspects of corruption like bribery, diversion of public funds, the ability of the government to contain corruption, nepotism, laws that ensure public disclosure of finances/conflicts of interest, government officials using their offices for private gain, and legal protection for people reporting cases of bribery and corruption (Transparency International 2024). Uganda was found to have high corruption, scoring 26/100 for perceived public sector corruption (100 is very clean, and 0 is highly corrupt). This ranking was equal to that of Guinea and Russia and under the average corruption perceptions index (CPI) for Sub-Saharan Africa of 33/100 ((Transparency International 2024, 3). Uganda was ranked 141 out of the 180 countries surveyed, demonstrating the significance of corruption and the size of the problem.

Fazekas and Nikulina (2021) investigated the cost and extent of corruption in the healthcare sector of Uganda and found that corruption hindered access to vital services, worsening poverty and increasing inequality. The total cost of bribery in the healthcare sector in Uganda amounted to nearly UGX 670 billion, meaning that eradicating corruption in Ugandan

healthcare could result in annual savings equivalent to 25% of government spending on health (ibid, 10). The main factors/drivers for the weak control included the weak capacity and resources of auditors/inspectors/regulators, conflicts of interest that compromise the ability of officials to exercise their oversight function, outright bribery that incentivizes officials to overlook or cover up issues, and the politicization of structures for monitoring and rule enforcement. An interviewed Ministry of Health official stated that supervisory mechanisms that could oversee and engage with health workers were dysfunctional because of inadequate funds and oversight capacity (ibid, 34). These findings can be tied back to policies of decentralization that weaken central oversight systems and enable corruption.

On a larger scale, corruption can also occur in the public-private partnership sector of healthcare. Fazekas and Nikulina (2021) state that contractors for healthcare infrastructures are selected based on bribes/political collections. Corruption in healthcare procurement in Uganda amounted to UGX 3.5 billion or EUR 811,000 in 2019 (ibid, 40). The Corruption Risk Indicator noted many red flags in contract selection, such as only a single bidder for a contract, manipulating the bid period, and using non-competitive procedure types to inhibit competition (ibid 40). This favoritism results in losses to state budgets as the allocation of contracts means poor value for money for the state due to inflation in prices and poor-quality goods being delivered (ibid 43). These findings demonstrate how neoliberal policies of decentralization and privatization can result in further corruption. Decentralization simultaneously weakens the healthcare system yet benefits those in power by enabling corruption and reducing oversight. Simultaneously, the growth in public-private partnerships allows the government to use contracts as favors for their benefit.

The decentralization of the overall healthcare sector is accompanied by the policy process's centralization with the elites' exclusive participation. Mukuru et al. (2020) analyzed the primary actors shaping maternal health policies in Uganda. They found that the policies were mainly driven by a small elite group, including senior Ministry of Health (MoH) officials, some members of the cabinet, and health development partners (HDPs). These guidelines officially excluded the citizens from direct involvement in policy-making, resulting in policies often skewed to the elites' personal and political interests over maternal mortality reduction (Mukuru et al. 2020, 388). For example, political elites often prefer to win votes through healthcare investments like infrastructure that could be showcased amidst campaigns over interventions not so readily on display. Donor interests remained a significant factor in policy determination, with HDPs often having an international development agenda and employing local staff to implement that agenda. HDPs controlled the policy process through participation, technical, and financial support, with members of the MoH reportedly engaging in donor-driven policy reforms for personal economic gain (ibid, 398). Mukuru et al. (2020, 399) argued that these processes and elite influences resulted in public policies that did not wholly address public health problems. A lack of oversight and incentives for donor-driven policy reforms means that elites were mostly adjusting to fit with donor funding streams.

When these factors are contextualized with Uganda's overall healthcare system and evolution over time, a more extensive understanding of the future of Ugandan healthcare emerges. It becomes increasingly clear that despite the issues that have persisted in the healthcare system, there appears to be no apparent action to change the system that enables this poor behavior. Kagaha and Manderson (2020) analyzed power and abortion care in Uganda and found that priority setting is primarily shaped by donor interests and results-based financing

(RBF). Prioritization is set based on World Bank paradigms focusing on investment returns, cost-effectiveness, and efficiency in maternal healthcare delivery. Epistemic governance continues through neoliberal concepts of RBF and market-based reforms that tilted prioritization towards identifying maternal health conditions and advancing the private sector's role (Kagaha and Manderson 2020, 193). The study concluded that existing abortion care interventions are shaped by existing neoliberal funding regimes, pointing out how Uganda's high donor dependency means it is highly vulnerable to the interests of development partners like the World Bank.

The high levels of corruption and healthcare benefit allocations indicate a continued neoliberal system that has entrenched President Museveni and the Ugandan elite in positions of power in exchange for donor fealty. The influence of these large donors means that Ugandan policy reforms may not be wholly made in the interest of the public good. Instead, these policies create a mutualistic relationship of aid and support that prioritizes market-based reforms and policies that benefit the interests of the elite.

Inequitable Healthcare Burdens: User Fees and Out-of-Pocket Expenses

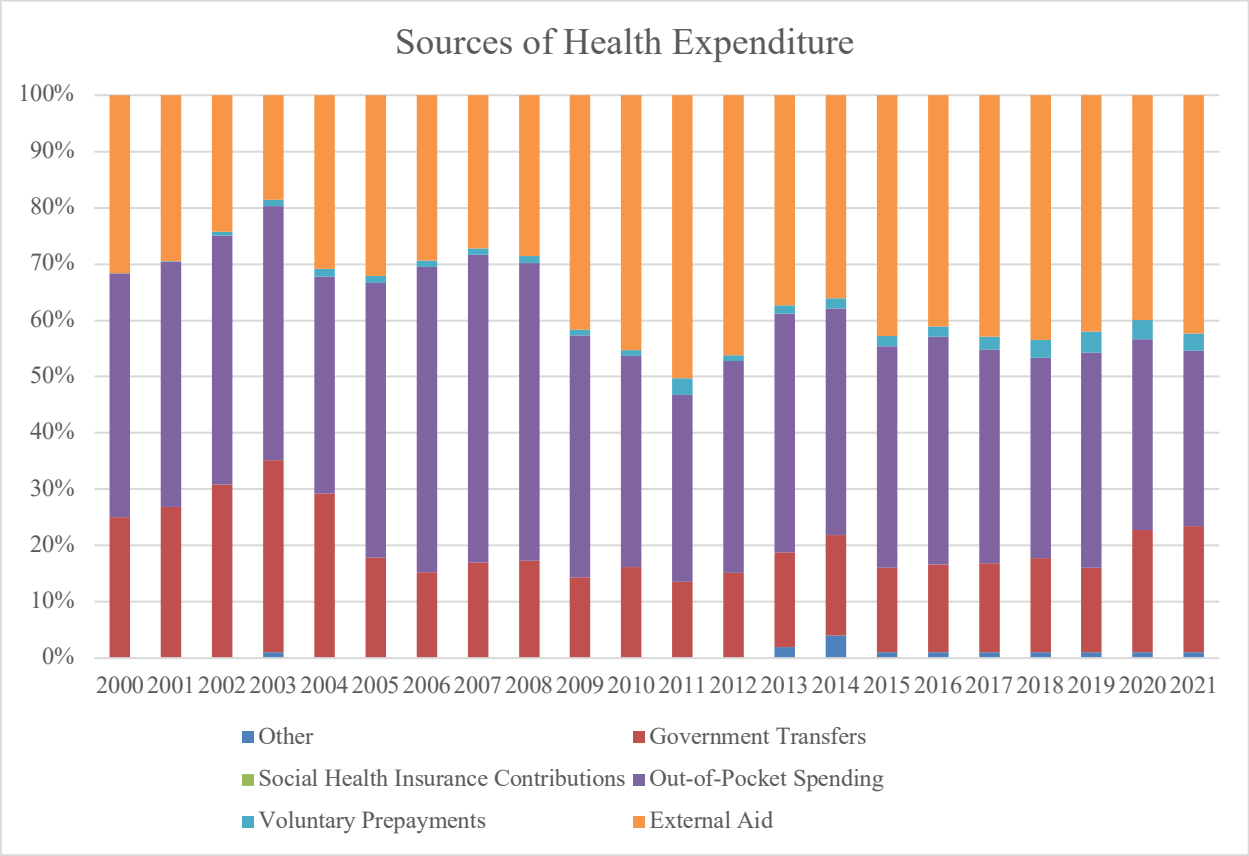

Figure 6: Sources of Ugandan Health Expenditure 2000-2021[7]

Healthcare costs remain a primary barrier to creating an equitable and accessible healthcare system in Uganda. Uganda has struggled with high personal fees for healthcare, specifically with out-of-pocket payments (OOPs). OOPs are payments made by households to receive health services and may include cash or other forms of payments (Xu et al. 2006, 869). Despite Uganda's aims of creating a universal healthcare system, OOPs comprised more than 31% of health expenditures in 2021 (WHO 2024). Figure 4.4 (above) compares Uganda's domestic general government health expenditure as a percentage of current health expenditure against Ugandan OOPs as a percentage of current health expenditure.

[7] Shows the sources of Ugandan health expenditure as percentage of Current Health Expenditure from 2000-2021. Source: Global Health Expenditure Database

The rest of the funding is provided by donor funding. Year after year since 2000, OOPs have outnumbered governmental health expenditure, creating a system that is reliant on Ugandan private citizen spending.

Uganda's OOP expenditure includes indirect fees like transportation costs, illegal informal fees for public services demanded by medical staff, supplementary fees for medicines and supplies from private vendors, and private healthcare costs (Basaza, O'Connell, and Chapčáková 2013, 2). Anderson et al. (2017) identified three categories of healthcare expenditures included in OOPs: direct medical, non-medical, and indirect expenses. Direct medical expenses include the costs of medicine, medical supplies, informal payments, imaging, and bandages, while direct non-medical expenses are costs for transportation to and from the hospital, as well as food at the hospital. Indirect expenses focus on the larger impacts of illness, such as lost wages by the patient and attendants, borrowed funds to pay for procedures, removing a child from school, and job loss. In an underfunded healthcare system, these costs can prove highly detrimental and become an impoverishing expense, which is defined as a fund that pushes a household into poverty (Anderson et al. 2017, 4). Catastrophic health expenditures were defined as events where the household faced financial catastrophe when its total out-of-pocket health payments equaled or exceeded 40% of its non-subsistence expenditure (Xu et al. 2006, 869). These expenditures can feed into the cycle of poverty and represent critical issues of inequality in a healthcare system.

PEAP's healthcare reforms from 1997-2008 attempted to reduce the burden of OOPs but were unsuccessful. Under PEAP, user fees were removed and replaced with a dual-wing system where public healthcare was rendered free while the private wing remained available at a cost. The removal of user fees had several positive and negative impacts on access to and quality of

healthcare. Xu et al. (2006) studied how removing all user fees at first-level governmental health facilities in March of 2001 impacted utilization and health expenditures in Uganda. They found that overall, the abolition of user fees at public facilities had made the services more accessible, and both poor and non-poor households had used public facilities more in 2003 than in 2000 (ibid, 873).

Nabyonga et al. (2011) also examined the impact of abolishing the user fees and noted that an increase in utilization of healthcare services was registered in the period immediately following user fee abolition and had the most substantial impacts in the poorest quintile (ii43). People were more willing to report illness, and "the increase in illness reporting for all quintiles was highest between the 2002/03 and the 2005/06 surveys, but the highest increase in utilization occurred between the 1999/2000 and the 2002/03 surveys, coinciding with the time user fees were abolished" (Nabyonga et al. 2011, ii48).

However, despite the elimination of user fees, some sectors of the healthcare system did not improve. Xu et al. (2006) describe the track of catastrophic health expenditures before and after the abolition of user fees. Catastrophic expenditures for the non-poor declined from 2000 to 2003 but did not decline for people experiencing poverty (ibid, 873). Additionally, the demand for public services did not increase when user fees were abolished. Furthermore, the use of private facilities increased from 1997 to 2003 in both poor and non-poor groups despite removing user funds from public facilities. One of the potential explanations for the continued rise of private facilities may have been the frequent unavailability of drugs in public facilities due to the abolition of user fees, leading to people being forced to seek private care for medication. Xu et al. (2006) also theorized that informal payments in public facilities had returned and increased to compensate providers for lost revenue. Informal economic activities in

public health workers include charges in addition to official charges. These charges sometimes amounted to five to ten times the original charges (McPake 1999, 861).

Decentralized healthcare systems struggled to adequately supervise the district health centers, resulting in corruption, such as continuing informal charges. Under these decentralized, unmonitored systems, abolitions of user fees become less effective in alleviating OOPs for impoverished demographics. These findings demonstrated the complexity of healthcare costs and reduced the unequal impacts. The reduction of expenditure on user fees was then offset by the increase in payments for other services, specifically the private sector. Nabyonga et al. (2011) note that OOP expenditure per household increased by an average of US$21 in 2000 prices between 2002/03 and 2005/06 (OECD 2024).

Uganda's lack of National Health Insurance (NHI) has worsened the inequitable financing burden. Of the five countries in East Africa, Uganda remains the only one without. National Health Insurance (Basaza, O'Connell, and Chapčáková 2013, 2). Over the years, there have been many proposed National Health Insurance Schemes (NHIS), yet progress has been slow, and it has yet to be implemented. NHP I aimed to create universal coverage through a Social Health Insurance (SHI) model (ibid, 4). Consultations with the Ministry of Health, local government associations, European governments, multilateral institutions, the UN, WHO, and others took place between 2001 and 2005, and in 2006, the SHI bill was introduced. The National Task Force (NTF), a multi-sectoral group set up by the MOH to revise the bill, conducted a stakeholder analysis that resulted in significant criticism of the bill.

The SHI framework was criticized for lacking backing from key private sector stakeholders and concerns regarding the Bill's effectiveness and efficiency (ibid, 4-5). In 2011, the prime minister created a cabinet sub-committee that redrafted the SHU principles, renaming

it to NHIS. Renaming the bill from SHI, which implied universal coverage, to NHIS, which signaled the continuation of multiple insurance components to cover various sectors of the population, was strongly endorsed by private insurance providers who wished to preserve the existing market of private sector firms. The revised bill also established a solidarity fund that included tariffs, greater market liberalization for health insurance provision, and a CHI component to target the informal sector (ibid, 5). The proposed NHIS would be financed by a solidarity plan where annual contributions from donors, the formal sector, and the government would cover indigent persons (roughly 25% of the population). At the same time, a Community Health Insurance (CHI) component could reduce competition with the private sector. However, a lack of funding and continued setbacks resulted in the lack of national insurance plan under PEAP and NHP I reforms. The lack of insurance results in high healthcare costs that require citizens to take out loans or compromise on other aspects of daily life to afford care. Uganda's National Household Survey in 2009/10 found that 13.5% of citizens who took out loans did so to pay for health expenses (UBOS 2011, 99).

It becomes clear that PEAP and NHP I's removal of user fees had not resolved the high burden of healthcare costs for Ugandan citizens. OOPs as a percentage of private health expenditure in Uganda increased from 56.7% in 2000 to 64.8% in 2011 (Kwesiga et al. 2015, 2). The neoliberal emphasis on privatization and market-based reforms continued to treat healthcare as a commodity rather than a right. Under these reforms, citizens were treated as consumers of a high-demand good, which private sector facilities could fill at a cost. The public sector remained underfunded and ineffective at meeting citizens' demands; therefore, it could not effectively intervene in the high healthcare burden.

Under the new reforms by NDP and NHP II, healthcare burdens have remained high, rendering healthcare inaccessible to citizens. Kwesiga et al. (2015) assessed the overall effects of healthcare payments in Uganda. They found that Uganda's healthcare system's lack of financial protection critically impacted poverty and quality of life. OOPs impoverished about 4% of Ugandans and represented an over 17% relative rise in poverty in the country (ibid, 4). Higher out-of-pocket payments would result in decreases in other areas of household expenditure, resulting in a decrease in household welfare and a potential increase in poverty among the non-poor. The extent of the impacts of the higher OOPs is challenging to assess as the poor may understate their levels of illness to avoid incurring payments and are more likely to use free accessible public facilities than the rich to avoid OOPs (ibid, 5).

In 2019, after years of deliberations and governmental red tape, the revised National Health Insurance Scheme Bill was introduced and passed in 2021. It is currently awaiting the approval of President Museveni before it becomes passed. If passed, the revised Bill will be crucial for achieving universal health coverage by 2030 and mandating health insurance for the entire population (Otieno and Namyalo 2024, 91). The scheme hopes to enroll roughly 25% of the population in the initial phase. Under this new plan, the government will continue to fund public health interventions in healthcare spending, but the funding will decrease as the scheme expands and contributions increase. There are various continued concerns with this bill, with some scholars pointing out the lack of explicit emphasis placed on improving equity for the vulnerable (Otieno and Namyalo 2024, 92). In Uganda, health insurance remains far below the Vision 2040 target of 70%, estimated at roughly 4% among people aged 15 and above in 2019/20 (UBOS 2021a, 47-48). Political and bureaucratic hurdles, coupled with resistance from vested interests, complicated legislative efforts and impeded progress toward implementing a

comprehensive NHI scheme. Despite periodic discussions, proposals, and attempts to push forward, the establishment of the NHI scheme in Uganda remains elusive, reflecting the complexities and challenges inherent in reforming the healthcare system.

OOPs continue to be the primary cost of healthcare in Uganda. Makika et al. (2022) analyzed the effect of out-of-pocket health expenditure on household welfare using Uganda's National Household Survey 2016-2017. They determined that OOP significantly decreased household food consumption expenditure and asset base. Healthcare costs include direct and indirect expenses, such as OOP expenditures, lost income from an inability to work, and transport costs to seek medical care. Households may be forced to use savings or sell assets to pay if their income is insufficient or borrow from informal or formal institutions (Makika et al. 2022, 18, 29). The public healthcare system has struggled, resulting in private actors filling the gaps at a higher cost. Makika et al. (2022, 21-22) argue that OOPs adversely impact the utilization of healthcare services in Uganda because (1) poor households are forced into deeper poverty due to exorbitant healthcare costs; (2) OOPs force households to cut back expenditures on other basics like clothing, food, and housing; and (3) high expenditures force households to avoid necessary household services due to the impoverishing impact it would have on welfare. The 2016/17 National Development Report found that Uganda's per capita health expenditure averaged US$5611. The share of household income spent on healthcare was 33%, far above the WHO's recommended maximum level of 15% (NPA 2018, 97). The National Development Report in 2015/16 found that between 2011/12 and 2015/16, OOPs as a percentage of private health expenditures increased from 62% to 95% (NPA 2018, 117).

Together, this data illustrates how neoliberal policies of cost-cutting and privatization have resulted in a healthcare system that not only enables poverty but creates it. OOPs, due to

private healthcare and informal charges, create situations where citizens are forced to make impossible decisions that compromise their living standards to obtain necessary healthcare.

Conclusions

The neoliberal reforms in the 1990s and early 2000s shaped how the Ugandan government viewed healthcare and influenced the reforms implemented under this ideology. These policies were detrimental to health in the 1990s, and when examining current healthcare policies and their impacts, we see that this system continues to be ineffective. By focusing on the market and efficiency under donor reforms in the 1990s, the government created an epistemic community where all reforms from that point forward remain rooted in these ideas. These policies have manifested in high OOPs, privatization, and disparities in quality and access to healthcare. By exploring the impacts of modern neoliberal healthcare reforms in Uganda, we see that this approach has harmed those in rural regions and more vulnerable demographics. Establishing how these policies have acted to the detriment of the citizens reveals what must be changed and how to improve the current system.

Chapter 5: Conclusions

Introduction

Chapter 5 concludes my research and condenses my findings into an overall assessment of the Ugandan healthcare system. This chapter summarizes the challenges and shortcomings in the current system and discusses the need to acknowledge the neoliberal ideologies that formed these outlooks. I argue that Uganda's current healthcare system demonstrates more profound flaws in its economic development and the current reforms will lead to worsening living standards and increasing inequality. I also give my recommendations for strengthening the current healthcare system before discussing the contributions and implications of my work.

An Overall Assessment of the Ugandan Healthcare Sector

In writing this thesis, my primary goal was to assess Ugandan healthcare reforms post-structural adjustment and understand whether its current trajectory was (1) accessible, (2) equitable, and (3) effective at addressing healthcare issues. My research revealed that though Uganda has undergone significant changes and grown substantially since independence, its healthcare system reflects problematic neoliberal ideology favoring market efficiency and macroeconomic growth over equity. Structural adjustment and the conditional loans enacted by multilateral institutions and Western countries used countries like Uganda as an experiment to assess the success of neoliberal development. Since then, Uganda has continued to act as a long-running example of neoliberal social engineering, firmly entrenched by its authoritarian government and relentless pursuit of neoliberal efficiency.

Over time, an assessment of Uganda's healthcare reforms reveals that neoliberalism remains the lens through which the Ugandan government views development. My research found that Uganda's healthcare policy reforms continued to value neoliberal goals and focus on austerity, decentralization, deregulation, and privatization to reach those goals. Tracking their major reforms and development frameworks reveals that despite stated efforts to alleviate poverty, most policies fail to make effective changes in equity and access. Through the development of public-private partnerships and policies that prioritize limiting public funding and intervention, the Ugandan government has continued and evolved into a profoundly neoliberal regime that cannot effectively address the healthcare issues created through their reforms.

Uganda's policy reforms are made to reflect the interests of donors and the multilateral institutions that partner with them. An examination of how healthcare access and quality have changed in the last 20 years reveals that despite overall economic growth and progress towards SDG goals, the reforms have failed to acknowledge the consistency of their uneven development and the poor left behind by these reforms. Investments in private sector growth and uneven healthcare facility distribution result in Ugandan citizens being forced to choose between expensive private sector facilities or ineffective and understocked public facilities that may demand bribes in exchange for services. Those in poorer regions or more vulnerable populations face high OOP expenditures for healthcare or choose to go without healthcare.

The entrenchment and growth of neoliberalism in Ugandan healthcare can be tied back to corruption and the interests of the elite and international donor partners. Through a highly centralized committee of policymakers that lacks adequate oversight, healthcare policy is passed based on what may benefit private interests over the public good. An analysis of the 20-year

guiding policy framework UgandaVision2040 points to a continuation of these policies and increasing growth in the private sector that manifests in continued problematic legacies. Though structural adjustment ended, the problematic ideals and neoliberal legacy have continued to be highly influential in policy-making spaces in the Global South. By analyzing the healthcare system in Uganda, we see that these policies have benefitted the elite while disenfranchising the more vulnerable demographics.

This assessment emphasizes the critical need for healthcare reform in Uganda and finds several fundamental issues that must be addressed. Firstly, the neoliberal paradigm that remains intrinsic in Uganda's government must be reassessed and dismantled for future development. Under the current NDP reforms, Uganda stands to continue with a highly market-driven approach to societal transformation. External aid has benefited a corrupt and profoundly authoritarian government that fails to prioritize the needs of the Ugandan citizens over the potential for private. Social services represent a critical aspect of development and must be understood as a fundamental component of Uganda's growth. Reforming the healthcare system must extend beyond increased donor aid and infrastructure expansion, as these serve as a temporary solution to a more extensive problem. To reach Universal Healthcare Coverage, Uganda must introduce reforms that increase government healthcare expenditure and address disparities within the dual-wing healthcare system. The private sector expansion in healthcare should be matched with efforts to increase equity and implement an effective insurance scheme to bridge cost and access gaps. Only by reassessing the flawed neoliberal development approach and implementing reforms focused on equity and access can Uganda create a fair, accessible, and equitable healthcare system.

Final Thoughts

This thesis has challenged the dominant mode of development in Uganda and criticized the continued role of donors by analyzing the transformations of the Ugandan healthcare system after structural adjustment. Much of the literature surrounding neoliberalism has focused on the theory and overall impacts of structural adjustment in Africa. My work has hoped to build onto these discussions by understanding what development looks like and neoliberal legacies in countries most impacted by these reforms. Future research could explore other sectors impacted by neoliberal development, such as education. Research could also be conducted in nations outside of Africa that underwent structural adjustment, such as Latin America, and explore long-term donor dependency and policy reforms.

My findings have demonstrated that neoliberalism exists not as a period of history for reflection, but as a continued engine for structural transformation that forms modern African development. While these changes have brought macroeconomic growth and improvements in social services, they have also brought rampant inequality and a relentless pursuit of market freedom and efficiency that fails to value equity and social services. For Uganda to develop and resolve the deep-seated flaws in its healthcare system, it must address the problematic approaches that created these issues in the first place.

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