A CRITICAL STUDY ON THE EXISTING LEGAL FRAME WORK ON THE CONSUMER PROTECTION IN MEDICAL

SERVICES IN UGANDA

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DECLARATION

This research dissertation is my original work and has not been presented for a degree or any other academic award in any institution of learning.

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APPROVAL

I confirm that the work reported in this research dissertation was carried out under my supervision.

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DATE.....29/6/2016.....

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DEDICATION

I dedicate this research dissertation to my parents, my Father Mr. Kawesi Kato JOHN and my beloved mum Mrs. Namatovu Mary. MY colleagues and my supervisor who endured daily sacrifices while I was carrying out my work.

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CHAPTER ONE

GENERAL INTRODUCTION

I.0. Introduction

This chapter covers introduction and it covers the background to the research, the statement of the problem, objectives and significance of the study, research questions, scope of the study and the methodology used, Chapterization.

1.1.Back ground of the study.

A priority of health care policymakers in Uganda is to ensure that the vulnerable groups of people (particularly women of child birth, the poor, elderly, and children) have access to high quality health services. Policymakers try to ensure that access in terms of distance (or time taken) to a health facility and cost are affordable to these groups and therefore not a deterrent to health service utilization. Consequently, a sizeable proportion of public resources may go to construction of additional health structures directed at decreasing distance travelled to health facilities and increase the likelihood that these health services will be used. Perhaps what should be noted is that a mere presence of services within a reasonable distance (as a result of standing structures) is not enough to ensure use of those services. Likewise, monetary cost, which is usually mentioned as the major barrier may not always be a deterrent to access and utilization of health services. It is not uncommon therefore to find that many individuals, mainly those using government facilities in developing countries such as Uganda will not use available health services even when they are free or nearly free. One of the explanations for this is the perception that government facilities are of low quality and are of low efficacy.

Public health functions cover assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities; and the formulation of public policies designed to promote health, prevent disease, provide access to

appropriate and cost-effective care, and evaluation of the effectiveness of that care. Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair; to ensure the redistribution of societal resources towards these outcomes and to promote the power and means people have to influence this redistribution as a bid to promote consumer protection.

This thesis presents a review of the different public health laws in Uganda that impact on equity in health to assess the extent to which the current legal framework works bearing in mind protection of the consumers of such health(medical) services and products with the proposed legal amendments and formulation.

Worldwide, public health has become an international topic of concern over the last decade. There are arguments that public health, in many parts of the world, Uganda inclusive has reached crisis levels: over 14 million people are killed by infectious diseases each year (90% of which are in the developing world); over 40 million people globally are infected with HIV/AIDS (90% of which are in the developing world); over 500 million people are infected with malaria each year and the disease kills upwards of two million people annually; over eight million people develop active tuberculosis (TB) each year and the disease kills over two million people annually (95% of those afflicted and 99% of deaths resulting from TB are found in the developing world). Perhaps, even more surprising is the fact that while most illnesses – especially infectious diseases – are preventable or treatable with existing medicines[1]. The paradox in countries like Uganda is the fact that government focuses more on building and expanding health facilities that are largely underutilized by the poor and the non-poor alike. Worse still, services offered are often of low quality that even the poor do not find it worth their time and cost in accessing them.

In Uganda it is the duty of the government to provide and protect the fundamental right to life guaranteed by the Constitution of the republic of Uganda[2]. Therefore, it is

[1]the World Health Organization (WHO) estimates that over 1.7 billion people have inadequate (or no) access to these medicines (WHO, 2004)
[2]Article 22 of the 1995 constitution of Uganda as amended.

the duty of the state to provide to all citizens adequate and proper medical services.The Consumer protections Bill[3]was draftedto provide for better protection of the interests of the consumers'– the consumers of goods and services as defined under the Bill. The Bill, no doubt, has the unique distinction of being the only prospect in the country made exclusively forconsumers to protect their interests against defective goodsand deficient services, even though a plethora of existing legislations do have provisions to deal with consumer rights in different degrees on specified matters. Consumer protection Bill will tryto help consumer to participate actively in the market processes, not only when he goes to buy goods but also when he goes to a medical practitioner for treatment.

It is quite clear that no personintends to go to a doctor or a court unless necessary but no matter how much a person is rich or poor he has togo to the court or to a doctor for the treatment of his ailment.Earlier, the patients aggrieved by medical negligence did not have any effective adjudicative body for getting theirgrievances redressed. There are of course provisions in the Civil and Criminal law offering remedies to aggrieved patients.

This thesis will discuss in detail how the law protects consumers of medical services against negligent medical practitioners and poor medical products.

Consequently therefore, "everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential. Perhaps, this definition does not necessarily mean complete elimination of all health differences so that all people can enjoy the same level and quality of health but defines means which reduce and (or) eliminate inequities that may result from avoidable (or unfair) factors.

3

Motivation for the study.

Having grown up in Uganda's rural setting, a country for which this thesis has been focused, I have developed more interest in affairs that affect poor and vulnerable people who seem to be 'less considered' by the political regime(s) of the day. Major national, regional and international newspapers have published news on the condition of health service providers and the challenges faced in and about Uganda. All these have raised my curiosity to dig into experiences at national and organizational level research using attained documents, laws and policy guidelines.

Background of study.

Uganda faces a multitude of challenges in the health care arena, from ensuring that health care services are delivered in the most equitable manner, to structuring the health care delivery system to be most effective and waging campaigns against masqueraders in the health sector.

Uganda's population currently being about 39 million people (results from the recent population census)[4]and about 41% likely to slip below poverty line. There still exist significant differences and challenges to improve the quality of service delivery and address continuing health status issues such as high infant and maternal mortality[5]. Inequalities exist between rural and urban areas and the different regions of the country[6] while primary health care still remains difficult for some to access in light of inconsistent quality of care. Hospitals and health centers are severely underfunded, understaffed and existent workers unmotivated.

Brief Historical aspects on the Uganda's health sector.

In the early 1960s, Uganda had one of the best health care systems in the region; it had a referral hospital, district hospitals and a network of health units that were well equipped and staffed[7]. The political turmoil and economic decline of the 70s and early

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[4]

[5](MoH, 2015).

[6](UBOS, 2014),

[7](Ssewanyana *et al*, 2004).

80s resulted in a deterioration and virtual collapse of health care system that is still recovering. With this decline in health service provision came increased population now valued at 33milion people(results from the recent census) also came in demand for medicines and health supplies, the increase in local pharmaceutical manufacturers and the rapid increase in the number of pharmacies and chemist shops across the country (UNIDO, 2010). While efforts have since been focused on renovating and rebuilding previously existing services, the extent to which these efforts have been successful is debatable. For instance, since 1972, the number of public, nongovernmental, and private facilities has increased by almost 400 percent and population has more than doubled while the number of trained medical personnel has increased by far less, approximately 14 percent (World Bank, 1999). In fact, the number of doctors has actually declined by 18 percent, leaving the number of people served by one doctor even greater than they were in 1972.Fast-forward to 2016, an estimated 18 mothers die daily in the labour wards. Uganda too has many crooks masquerading as medical practitioners. The ministry of health has tried to make nationwide campaigns against these crooks.

1.2. Statement of the problem

In developing countries like Uganda, several factors impede accessibility (and therefore use) of health services including cost of services, distance to health services, lack of available transportation hence high transport costs, poor health care facilities and lack of independence by women to make choices on matters that directly affect their health, substandard medical services and negligent medical practitioners. Malaria remains the most and leading killer disease in Uganda with 70,000 to 100,000 deaths annually. Uganda is still ranked 15th of the 22 high burden countries. Communicable diseases in Uganda are mainly attributed to poverty and so make it difficult for families and communities to get out of the poverty cycle[8].

[8](UNIDO 2011).

1.3 Objectives.

1.3.1. Main objective.

To analyze the extent to which different legislations in Uganda protect patients (consumers) as regards medical services and the remedies available to such consumers in cases of negligence by the medical workers.

1.3.2. Specific objectives.

(i) To examine the consumer protection laws in Uganda in relation to consumers of medical services and how they respond to consumer protection in the health sector.

(ii) To examine the comparison of the growth and status of consumer protection between the medical and health sector in Uganda and other jurisdictions.

(iii) To demonstrate the available remedies to the medical consumers whose rights have been infringed upon.

(iv) To suggest the legal and policy recommendations and conclusions in a view of protecting consumers in the medical and health sector.

1.3.3. Research questions.

(i) What is the legal framework laws governing medical consumer protection in Uganda?

(ii) What is the status and growth of consumer protection in the medical and health sector in Uganda as compared to other jurisdictions?

(iii) What remedies are available to medical consumers whose rights have been infringed upon?

(iv) What are the legal and policy recommendations and conclusions in a view of protecting consumers in the medical and health sector?

1.4.Scope of study.

1.4.1.Geographical scope.

The scope of the study covered the legal framework on the consumer protection in medical services in Uganda. Health being one of the key priorities of the policy makers in Uganda, consumers of medical services ought to be protected against consumption of defective goods.

1.4.2.Content scope.

Uganda being a developing country is very susceptible to the developments arising as a result of globalization. A remarkable development of this nature is the infringement of medical consumers' rights. With this vice, a variety of legislations and other authorities have been discussed to address this issue that is to say nationally, regionally and internationally.

1.4.3.Time scope.

This dissertation is to be done in a period of four months from March to June and it will cover its references from 1990 to 2016.

1.5 Significance of the study.

Uganda being a developing country, is likely to have many chances where consumers of medical services are taken advantage of, so this research is therefore intended to benefit consumers who go to medical practitioners to know the duty of the practitioners and to know there rights bas medical consumers. Academicians and other policy makers have found a challenge arising out of uncontrollable infringement of medical practitioners' rules and guidelines and the national health guidelines hence infringing on the medical consumers' rights which gap we try to close in this study.

1.6.Limitations of the study.

The researcher faced a number of limitations and challenges. Although every research has its own limitations, it is hard to state the entire list of elements, which have been faced with as limitations of this research.

Material Challenges: although it was essential to get different sources that serve as secondary qualitative or quantitative data, the Faculty Library did not have enough reading materials, and Internet service that are conducive and easily accessible to the researcher. The Law Library did not have reserved place and proper access to websites.
Financial Challenge: Shortage of financial provision to cover the existing cost of inflation was another problem.
Technical Challenge: Access to important primary documents of the Regional economic communities was thus, the major challenge that contributes to the limitations of the study. Though efforts to collect primary documents were made, to some extent, reliance was placed on secondary materials available at the websites of the institutions. There was also difficulty in gaining access to up to date materials and cases since the websites are not updated regularly. Reliance was also placed on scholarly materials written on the Regional economic communities. These and other issues are mentioned as limitations.

1.7. Literature review.

It is important to review the writings on the subject of protection of medical consumers. There is a wide range of literature concerning the protection of consumers of medical services, stretching from the technical issues to the legal and policy issues. However, since this paper discusses legal and policy issues, only the literature touching on these issues will be reviewed.

A priority concern for health care policymakers in developing countries is to ensure that vulnerable groups of the population (that include children, women and the poor) get access to high quality health services. In many studies, terms like inequalities,

disparities and inequities are often used interchangeably in academic and policy literature [9]and even when defined, there seems to be little consensus about their meaning or measurement[10]. In one of his studies[11], states that equity becomes useful since it focuses research, policy and practice on exploring, attending to and monitoring healthcare, deemed to be unfair. However, assessing access to health care requires evaluating the factors that affect use of facilities[12] Culyer *et al* conclude that the concern about access to health care stems from a concern about utilization of health care, which in turn stems from a more fundamental concern about health itself[13]. This means therefore that by understanding theories advanced to explain medical consumer protection, it is possible to establish factors for access of better health care services. In this regard, Andersen[14] developed a health service utilization model which looks at different categories of determinants medical services. Andersen's Phase-2 model of health service utilization[15] combines both supply-side and demand-side factors that affect health care service utilization. For purposes of this study, this conceptual framework serves as a supporting tool in advocating for medical consumer protection laws among vulnerable groups in Uganda.

Equity is defined as the ability to impartially recognize the right of every person, sense of justice and impartiality being its guiding principles. Other terms that have been used instead of equity[16]is fairness or (social) justice. Equity research has been directed towards financing of health care[17], health care delivery[18], access to health care facilities[19] or equitable distribution of health services itself[20]. For equity of access to be

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[9](Pittman, 2006),

[10](Macinko&Starfield, 2002; Braveman, 2006)

[11]Ward (2009)

[12](Hutchinson *et al*, 1999).

[13](Le Grand, 1991).

[14](1968)

[15](Andersen, 1995)

[16] According to Braveman and Gruskin (2003)

[17](Wagstaff*et al*, 1999),

[18](van Doorslaer*et al*, 2000)

[19](Goddard and Smith, 2001)

attainable, it is necessary to take into account some fundamental principles that aim to ensure a health system is appropriate given the social, political, epidemiologic and economic environment. It should also be noted that measurement of equity is dependent on which strand it takes – whether vertical or horizontal. Simply stated, horizontal equity refers to all cases being treated equally (or alike) while vertical equity means giving unequal treatment to unequals[21]. The common acceptable notion of equity is for people to access health care services based on their needs and pay for such care based on their financial abilities. However, what constitutes 'need' in a sufficiently measurable sense by the health system is difficult to determine.

The importance of equitable access to health services is recognized world over, both in the fight against social exclusion and poverty. Health is one of the fundamental human rights and national governments have an obligation to provide health to the people and ensure adequate and standard health services. Basic human right principles necessitate that health care is accessible and affordable to all irrespective of their race, gender, religion, region or income. From Andersen's model, health care system includes health policy, resources, and organization as well as their change overtime. Some studies have shown that barriers to access to health care services are influenced to a great extent by national health policy or trends and as such are less amenable to manipulation by actors and events in very localized realms[22]. The Institute for Medicine, Committee for the Study of the Future of Public Health[23] adds that effective health policies and allocation of public health resources can substantially improve public health. Public health interventions occur at multiple levels and involve policy approaches that can affect large populations through regulation, increased access, or economic incentives[24].

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[20](Whitehead, 1991)

[21](Cuyler, 2001)

[22](Fielder, 1981)

[23](1988 in Brownson*et al*, 2010)

[24](Brownson*et al*, 2010)

In low income countries, evidence suggests that the cause of inequalities may be a reflection of the failure of health care services to reach the poor[25].

Some commentators[26] argue that existing inequalities in health are more worrisome than inequalities in other spheres. "Health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value"[27]. This makes health not just the absence of disease but the ability of individuals to realize their potential throughout life. Ultimately, if people can access resources to enable them realize their potential health, the potential to generate well-being and future returns in the economy increases.[28] Consequently any inequities in health can limit opportunities for many people to lead a life they want, since their capacity to actively participate in productive life and get returns from their efforts is restricted. For instance, it is a fact that society especially among the poor is more concerned with poor children likely to die of preventable diseases before their 5th birth day.

In Uganda, the current equity landscape is of great concern. Whereas the Ministry of Health (MoH) admits having significant challenges in matching need for health services with available resources, making equity or fairness is an important issue for advancing national policies for the population as a whole[29]. The Ministry however admits that health inequities exist in Uganda between the rich and poor communities, urban and rural districts, between social groups and across other social differentials. Additionally, economic and geographic barriers still pose a significant barrier to access to health care services. Together with other players, Ministry of Health has increased efforts through policies for equity in health and supports analysis and dialogue to strengthen knowledge and to support policy engagement on the implementation of comprehensive, universal, national health systems, centered on the role of people and of the public sector

[25](van Doorslaer and Wagstaff, 2000)

[26]such as AmartyaSen (2002)

[27]According to AmartyaSen (O'Donnel*et al*, 2007),

[28](Grossman, 1972).

[29](MoH, 2007)

(EQUINET). This equity stand is further supported by the constitutional mandate to the Ministry and the people's rights as stipulated in various charters to which Uganda is a signatory. This chapter delves into existing policies meant to counter inequity (and inequality) in access and use of health services. It starts with the regulatory framework and explores more into various key policies. It further expounds on challenges and shortcomings in specific policy areas.

Uganda has ratified a wide range of international and regional human rights treaties related to the enjoyment of the highest attainable standard of physical and mental health ('right to health'), including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the African Charter on Human and People's Rights (ACHPR)[30]

Internally, there are a number of policy and legal frameworks from which Uganda derives its mandate. Uganda's health policy is guided by the Vision 2040, the 25 year national development plan[31], and the 20-year Poverty Eradication Action Plan[32] the national planning framework[33]. The Uganda Constitution[34] adopted in 1995 obliges government to provide basic health services to its people, and guarantees all people health rights and opportunities in the form of assured access to health services, clean and safe water as well as other social services. This makes right to health a legal instrument - a crucial and constructive tool for the health sector to provide the best care to patients and to hold the government accountable. The constitution further includes provisions against discrimination and others related to specific groups such as the rights of women, children, persons with disabilities and minorities.

[30]Fact sheet on Health and Human Rights in Uganda (WHO). Accessed from http://www.who.int/hhr/news/hhr_factsheet_uganda.pdf

[31]that was launched in 1999

[32](PEAP, 1997-2012),

[33](MoH, 2010)

[34] 1995 constitution for the republic of Uganda as amended.

1.8. Methodology

Research design.

The study in the course of material and information will basically entail qualitative and quantitative research. Basically, use of library information and materials, they will be a useful source of my research. This will review the literature of various authors in the subject of medical consumer protection.

Research tools.

The research tools for this study included, publications from re-known authors of the subject, different legislations and law reports.

Synopsis.

1.9. CHAPTERIZATION.

The thesis was made up of five chapters.

Chapter one looked at introduction, background of the study, objective of the study and Chapterization of the study.

Chapter two looked at legal framework governing medical consumer's services in Uganda.

Chapter three looked at the status and growth of consumer protection in the medical and health sector in Uganda and other jurisdictions

Chapter four looked at remedies are available to medical consumers whose rights have been infringed upon. .

Chapter five is looked at the legal and policy recommendations and conclusions in a view of protecting consumers in the medical and health sector.

CHAPTER T WO.

THE LEGAL FRAMEWORK GOVERNING MEDICAL CONSUMERS' SERVICES IN UGANDA

2.0. Introduction.

This section explores the legal frameworks for equity and public health within major themes. Constitutional provisions for these areas of legal rights are explicitly separated, as they signal a hierarchy of protection of health rights in all areas of economic and social activity. Where public health is given explicit protection in areas of economic and social activity in law this is noted in the analysis.

2.1.Right to life

The right to life is central to humanity[35]. These instruments emphasise that every human being has the inherent right to life which ought to be protected by law and therefore no one shall be arbitrarily deprived of his/her life. Uganda as a country recognises this right in their policies.

In Uganda, the National Health Policy requires government to develop mechanisms to ensure equity in access to basic services to avert pregnancy and birth related deaths and the childhood killer diseases.

The right to life is protected in law in Uganda, particularly in terms of protection of life and the provision of offences that undermine this right. Legal protection of this right is adequate across all the legal frame work of Uganda, but the application of this right is constrained by poverty and poor access to medical services.

The **Constitution** [36]provides that no person should be deprived of life intentionally except under the law in execution of a sentence passed in a fair trial by a court of

[35]It is enshrined in Article 3 of the UN Universal Declaration of Human Rights and in Article 6 of the International Covenant on Civil and Political Rights, making it legally enforceable in every UN member state.

[36](1995)

competent jurisdiction in respect of a criminal offence and the conviction and sentence have been confirmed by the highest appellate court[37]. It also provides that no person has the right to terminate the life of an unborn child except as may be authorised by law[38].

The **Penal Code Act**[39]provides for offences by any person who: by an unlawful act or omission causes the death of another person[40]; with malice aforethought causes the death of another person by an unlawful act or omission commits murder[41]; commits manslaughter when acting in pursuance of a suicide pact between him/her and another he kills the other[42]; kills an unborn child[43]; maliciously administers poison or a noxious thing with intent to harm or endanger the life of any person[44].

2.2. Legal protection of healthy work environments

The **Occupational Safety and Health Act**[45]imposes a duty on an employer to take all measures to protect workers and the general public from the dangerous aspects of the employer's undertaking at his or her own cost[46].

It also requires employers to ensure the working environment is kept free from any hazard to pollution by employing technical measures applied to new plants or processes and employing supplementary organizational measures[47]; and those with at least 20

[37](Article 22(1))of the 1995 constitution of Uganda.

[38](Article 22(2)) of the 1995 constitution of Uganda.

[39] Chapter 120 of the laws of Uganda as amended in 2007.

[40]See (Section 187)

[41] See (Section 188)

[42] See (section 95(1))

[43] See (sections 212 and 213)

[44](section 221).

[45] 2006

[46] See (Section 13) of the Occupational Safety and Health Act 2006).

[47] See (Section 13)

workers at a workplace to prepare and often revise a written statement of policy with respect to the safety and health of the employees while at work[48].

2.3. Legal provisions for cultural practices related to health

The **Constitution** requires development of cultural and customary values consistent with fundamental rights and freedoms, human dignity, democracy and with the Constitution[49]; and the State to promote and preserve cultural values and practices which enhance the dignity and well-being of Ugandans[50] .It invalidates customs inconsistent with any of the provisions of the Constitution[51], as well as cultures, customs or traditions against the dignity, welfare or interest of women or which undermine their status[52].

It confers on every person a right as applicable to belong to, enjoy, practice, profess, maintain and promote any culture, cultural institution, language, tradition, creed or religion in community with others[53]; and preserves the institution of traditional leader or cultural leader in any area in accordance with the culture, customs and traditions or wishes and aspirations of the people to whom it applies[54].

2.4. Legal protections in relation to health services

The **Medical and Dental Practitioners Act**[55]requires those engaged in private practice to have a private practicing licence. Private health units must register [56] and can only operate if attended by medical or dental practitioner[57]; they must be inspected

[48] See (Section 14).

[49] See (Objective XXIV) of the 1995 Constitution

[50] See (Objective XXIV).

[51] See (Article 2).

[52] See (Article 33(6)).

[53] See (Article 37).

[54] See (Article 246(1)

[55] Chapter 272 laws of Uganda.

[56] See (Section 29)

[57] See (Section 31)

by the registrar or authorized medical or dental practitioner[58]. The medical council may inquire into allegations of professional misconduct by a registered practitioner [59].It is an offence to falsely use a name or title implying a qualification to practice medicine, surgery or dentistry[60].

Under the **Nurses and Midwives Act**[61]registered midwives may go into private practice after five years' service in a hospital or health unit[62]; and registered nurses can only apply to engage in private practice after ten years' service in a hospital or health unit[63]. Nurses and midwives need a special licence or permission to stockpile, retail or wholesale drugs[64]. Nurses and midwives may not carry out procedures beyond common conditions and health problems but must refer all cases beyond their ability to a medical practitioner[65]. The Act establishes a disciplinary committee with powers to inquire into the conduct of a registered nurse or midwife [66]and makes it an offence for a person to use any title of a nurse or midwife unless registered under the Act[67].

The **Pharmacy and Drugs Act**[68]requires pharmacists carrying on or employed in a pharmacy business to comply with requests of valid prescriptions[69].

The **National Drug Policy and Authority Act** [70]makes it an offence for anyone to sell any drug, medical appliance or similar article which is not of the nature, substance and quality laid down in the authorised pharmacopoeia[71]. A licence is needed for a

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[58] See (Section 32)

[59] See (Section 33)

[60] See (Section 47)

[61] Chapter 274 laws of Uganda 2000.

[62] See (Section 30(1))

[63] See (Section 30(2))

[64] See (Section 34(1))

[65] See (Section 34(2))

[66] See (Sections 36, 37)

[67] See (Section 53)

[68] Chapter 280 laws of Uganda 2000.

[69]See (Section 28)

[70] Chapter 206 laws of Uganda 200.

[71] See (Section 30)

person to carry out business of a pharmacist or engage in the business of selling drugs[72].

A certificate must be issued to certify the suitability of premises for drug supply[73]. No person or body may import or export any drugs without a licence from the drug authority[74].

The **Public Health Act**[75]empowers the Minister to: inspect, sample and examine vaccines, vaccine lymphs, sera and similar substances imported or manufactured in Uganda and intended for use in preventing or treating human diseases; and prohibit import, manufacture or use of any such substance considered unsafe or liable to be harmful or deleterious[76].

Equitable inputs to health services

Demand for and a challenge to adequacy and equitable distribution of the personnel, drugs and other resources for health services is more fully discussed in other texts[77]. While a range of policy measures are being applied to manage the challenges, limited or no specific legal provisions support these measures. Hence, legal provisions do not support measures to ensure an appropriately sized, structured, skilled, well balanced, distributed, resourced, committed and effectively performing health workforce; to provide retention incentives; or to manage migration. Migration is managed through bilateral agreements and international codes, but no law has been put in place in Uganda to regulate trade in health services, including health workers.

According to the World Health Organization[78], essential drugs are those that satisfy the priority health needs of the population, chosen with regard to disease prevalence, evidence of efficacy and safety, and comparative cost-effectiveness. In the context of

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[72] See (Section 14 and 15)

[73] See (Section 17).

[74] See (Section 44 and 45).

[75] Chapter 281 laws of Uganda 2000.

[76] See (Section 121).

[77](EQUINET SC, 2007)

[78](WHO)

functioning health systems, essential drugs are intended to be available at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and community can afford. Implementation of the concept of essential drugs is intended to be flexible and adaptable to many different situations, with the list of essential drugs a national responsibility. Uganda has adopted this concept. Uganda's National Drug Policy and Authority Act[79], requires that there should be a list of essential drugs, revised from time-to-time[80]. A national formulary should be made of the national list of essential drugs and other drugs as the National Drug Authority (NDA) may approve from time-to-time[81]. It further requires the NDA to receive from the committee on essential drugs proposals of the revised list, made in accordance with available resources and existing diagnostic and therapeutic capacity[82].

International law, particularly the World Trade Organization (WTO) Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) on access to drugs, increasingly affects drug provision. There are concerns about the effects of TRIPS on access to drugs due to increased patent protection and reduced access to generic quality drugs at affordable price.

Recognizing the necessity of generic competition in developing countries to allow access to treatment, in 2001 the Doha Declaration provided that the TRIPS Agreement '*can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, access to medicines for all'* (Article 4)[83].

In particular this gave countries the authority to use TRIPS flexibilities in the interest of public health, including: transition periods for laws to be TRIPS-compliant, *compulsory licensing* or the right to grant a license, without permission from the license holder, on

[79]Cap 206 laws of Uganda 2000.

[80] See (Section 8(1))

[81] See (Section 8(2)).

[82] See (Section 9).

[83](quoted in (Mabika et al, 2007).

various grounds including public health; *parallel importation* or the right to import products patented in one country from another country where the price is less, exceptions from patentability and limits on data protection; and early working, known as the *Bolar Provision,* allowing generic producers to conduct tests and obtain health authority approvals before a patent expires, making cheaper generic drugs available more quickly at that time[84].

The first step is to provide these flexibilities in national laws. Uganda as a country provides for compulsory licensing and parallel importation in their national laws.

2.5. Legal provisions on patenting

The **Patents Act**[85]provides that where the Minister is of the opinion that it is in the vital public interest, and in consultation with the registrar, without the authority of patent owner, s/he may direct that a patented invention be exploited by a government agent or other person[86]. It also makes provisions for compulsory licensing[87].

2.6.Legal provisions on access health information

The **Constitution**[88]confers a right on citizens to access information in possession of the State and its agencies if it does not prejudice the security or sovereignty or interfere with the right to privacy of any other person[89].

It also empowers Parliament to make laws prescribing the classes of information and the procedure for obtaining access to that information[90].

The **Access to Information Act**[91]empowers an information officer to refuse access to health records, if disclosure would constitute an invasion of privacy[92]. An information

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[84](Mabika et al, 2007).

[85] Chapter 216 laws of Uganda 2000.

[86] See (Section 28(1))

[87] See (Section 30).

[88]The 1995 constitution for the republic of Uganda.

[89] See (Article 41(1)).

[90] Also see(Article 41(2)).

officer is obliged to grant a request for access to a record of the public body otherwise prohibited if disclosure of the record would reveal evidence of an imminent or serious public health risk[93].

The **Occupational Safety and Health Act** [94]requires employers to keep and maintain records of medical examination and information for the availability of the employees.

The **Public Health (Notifiable Diseases) Rules**[95], requires: every owner or occupier of land, and every manager of a mine, employer of labour and householder to notify the local authority of any modifiable diseases[96]; and every medical practitioner attending on, or called in to visit, a patient suffering from any modifiable disease to send a certificate indicating the disease, to the nearest medical officer[97].

While access to information is vital to participation in public health and health services, at individual level, protecting patient privacy is an important part of medical conduct. With medical information accessed by individuals not subject to medical ethics codes, such as employers, insurers, program administrators, lawyers and others, the right to privacy is important.

In Uganda the Integrated Code of Conduct and Ethics for Health Workers requires health workers to respect the confidentiality of information relating to a patient and his or her family. The regulatory regime for protecting privacy of health information is complex and fragmented. Some protections apply only to information held by government agencies. Some protections apply to specific groups, such as government employees or school children.

Some protections apply to specific medical conditions or types of information, such as information related to HIV or substance abuse treatment

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[91]Act 6 of 2005

[92]See (Section 21).

[93] See (Section 34).

[94]Occupational Safety and Health Act 2006.

[95]S-I 281—21

[96] Also see (Rule 3)

[97] See (Rule 4).

2.7. Legal protection of the right to privacy

The **Constitution**[98]provides that no one should be subjected to unlawful search[99] or interference with the privacy of their home, correspondence, communication or other property[100].

2.8. Legal provisions for participation and accountability

The **Constitution** provides that government is responsible for developing Health Policy[101] and establishes Health Service Commission[102] to review terms and conditions of service, standing orders, training and qualifications of members of health service and matters connected with their management and welfare; and make recommendations on them to government[103].

It introduces Inspectorate responsible for promoting and fostering strict adherence to rule of law and principles of natural justice in administration, and eliminating and fostering elimination of corruption, abuse of authority and of public office [104]

The **Medical and Dental Practitioners Act[105],** establishes Medical and Dental Practitioners Council[106] to: monitor, supervise and control maintenance of professional medical and dental educational standards, including continuing education[107].

The **Nurses and Midwives Act[108],** establishes the Nurses and Midwives Council[109] to regulate standards of nursing and midwifery, including disciplinary control[110].

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[98]The 1995 constitution for the republic of Uganda.

[99] See (Article 27(1)).

[100] See (Article 27 (2)).

[101] See (Article 189, Schedule 6).

[102] See (Article 169)

[103] See (Article 170(1)c).

[104] See (Article 223 and 225).

[105]Cap 272 laws of Uganda 2000.

[106] See (Section 2).

[107] See(Section 3)

[108]Cap 274 laws of Uganda 2000.

[109] See (Section 2)

The **National Drug Policy and Authority Act**[111]establish the NDA to develop and regulate pharmacies and drugs, approve the national list of essential drugs and supervise the revision of the list[112].

[110] See (Section 3)

[111] Supra 36

[112](Section 3).

CHAPTER THREE

THE COMPARISON OF THE GROWTH AND STATUS OF CONSUMER PROTECTION IN THE MEDICAL AND HEALTH SECTOR BETWEEN UGANDA AND OTHER JURISDICTIONS CASE IN POINT KENYA AND TANZANIA.

3.0 Introduction

The comparison of the growth and status of consumer protection in the medical and health sector between Uganda and other jurisdictions case in point Kenya and Tanzania.

3.1. International and regional instruments include both legally binding and non-legally binding instruments.

International and regional instruments include both legally binding and non-legally binding instruments. This section summarises provisions of principal legally binding international and regional instruments with implications for public health and examines their incorporation into the domestic laws of Kenya, Tanzania as compared to Uganda. There are several regional and international instruments affecting public health. East African countries have ratified most them, but have not fully included their provisions into their national laws.

These regional and international instruments have been applied and interpreted in other parts of Africa. For example in the case of *Media Rights Agenda and Others v Nigeria* [113]a communication submitted by the Constitutional Rights Project stated that on 23 December 1995, Mr NosaIgiebor, the Editor in Chief of *TELL* magazine was arrested and detained. It was alleged that he had been denied access to his family, doctors and lawyers and received no medical help even though his health was deteriorating[114].

[113](2000) AHRLR 200 (ACHPR) 1998,

[114]Referring to Article 16 of the African Charter, the Commission held that there was a violation of Article 6, 7(1), 7(1)(c), 7(2), 9(1), 9(2), 14 and 16 and asked the Nigerian government to take necessary steps to make law and practice conform with the Charter.

In *International Pen and Others (on behalf of Saro-Wiwa) v Nigeria*[115] the Commission held that the protection of the right to life in Article 4 also includes a state duty not to purposefully let a person die while in its custody. In this case, victims' lives were seriously endangered by the denial of medication during detention. The Commission considered that there was violation of Article 4 and Article 16 of ACHPR.
In another case of *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria* [116] the complaint concerned consequences of environmental degradation in Ogoniland (in the Niger Delta) caused by Shell Corporation in collusion with the Nigerian government. In its decision, the Commission referred to state obligations to ensure realisation of rights to a clean and healthy environment and to health.

These cases demonstrate the usefulness of international and regional instruments in the protecting health rights, even outside national legal systems. There is a possible bias against poor people in the benefit from these provisions as they may find it difficult to take cases to regional and international levels.

3.2. LEGAL PROTECTION OF THE RIGHT TO LIFE IN KENYA AND TANZANIA.

Kenya

The **Constitution** provides that no person can be deprived of his/her life intentionally save in execution of the sentence of a court in respect of a criminal offence under the law of Kenya of which he has been convicted [117]

Tanzania
The **Constitution** provides that every person has the right to live and to the protection of his life by the society in accordance with law [118]

[115](2000) AHRLR 212 (ACHPR 1998)
[116](2001) AHRLR 60 (ACHPR 2001)
[117](Article 71(1)).
[118](Article 14).

Kenya

The **Children Act**[119]provides an inherent right to life to a child [120]and puts a responsibility on government and family to ensure child survival and development[121].

Kenya

Penal Code[122]**,** provides for anyone who: unlawfully or negligently does any act which is, and which he knows or can reasonably believe to be, likely to spread the infection of any disease dangerous to life[123]; commits unlawful acts or omits to act and causes the death of another person[124]; of malice aforethought causes death of another person by an unlawful act or omission is guilty of murder[125]; prevent a child from being born alive by any act or omission[126]; and administers poison to another which endangers or causes grievous harm[127].

Tanzania.

The **Penal Code Act** makes is an offence to spread infections or any disease dangerous to life [128]The **Criminal Procedure Act** [129]creates the offence of murder[130].

In Uganda, the National Health Policy [131]requires government to review and update the national food and nutrition policy in collaboration with other sectors, and proposes improving nutrition through programmes that address micronutrient deficiencies, obesity and other nutrition related diseases. The Food and Nutrition Policy [132] promotes household to national level food reserves and use of appropriate technology to enhance

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[119]8 of 2001

[120](Section 4)

[121] Supra 8

[122]Chapter 63

[123](Section 186)

[124](Section 202)

[125](Section 206)

[126](Section 228)

[127](Section 236)

[128](Section 179).

[129]9 of 1985

[130] (Section 196)

[131](1999)

[132]2003

agricultural production and food supply. Government must also provide mechanisms to ensure food is accessible to those who cannot feed themselves. The Plan for Modernization of Agriculture (year?) promotes agricultural production, productivity and farm use storage to reduce post-harvest losses.

In Kenya, the Ministry of Agriculture Strategic Plan 2006-2010 mandates the Ministry of Agriculture as the lead agency to achieve food security. The Strategy aims to create an enabling environment for agricultural development through review of law and policy. The plan calls on government to facilitate increased productivity and agricultural outputs through improved extension, advisory support services, and technology application. These policies are to some extent backed by law, although more so in respect of food safety than food security. In the three East African Countries, only the Ugandan Constitution has explicit provisions for food security, with some legal provisions to support this for children and in employment and prisons settings. In all three countries, the provisions of law are more explicitly geared towards the protection of food safety.

3.3. LEGAL PROTECTION OF THE RIGHT OF ACCESS TO HEALTH SERVICES

Kenya

The **Public Health Act** empowers municipal council to provide temporary supply of medicine and medical assistance for poorer inhabitants of their district, but may at their discretion charge for them (Section 34).

Kenya

The **Children Act 8 of 2001** provides that every child has a right to health and medical care, which is the responsibility of parents and government[133]. It confers a right on disabled children to be treated with dignity and accorded appropriate medical treatment [134]

[133](Section 9)
[134](Section 12).

The **Employment Act,** [135]requires employers to ensure provision of sufficient and proper medicine for employees during illness and if possible, medical attendance during serious illness (Section 34).

The **HIV and AIDS Prevention and Control Act** [136]requires: every health institution, whether public or private and every health management organization or medical insurance provider to facilitate access to healthcare services to persons with HIV[137]; and government to provide essential medicines at affordable prices to persons with HIV or AIDS and those exposed to the risk of HIV infection[138]. It also prohibits denying access to healthcare services in any health institution or charging a higher fee for any such services, based only on person's actual, perceived or suspected HIV status[139].

The **Mental Health Act**[140]makes provisions for law relating to care of persons who are suffering from mental disorder or mental abnormality with mental disorder (Preamble).

TANZANIA.

The **HIV and AIDS (Prevention and Control) Bill**[141]requires government where resources allow to ensure everyone living with HIV and AIDS and orphans are accorded basic health services.

The **Foods, Drugs and Cosmetics Act** permits TFDA to approve registration of a drug, medical device or herbal drug if it considers availability in public interest and is safe, efficacious and of acceptable quality.[142]It also requires labels on containers and directions of drugs to be put in English or Kiswahili or both[143].

The **Prisons Act**[144]requires medical examination for all prisoners[145].

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[135]2007

[136]14 of 2006

[137](Section 19(1))

[138](Section 19(2))

[139](Section 36)

[140]Chapter 248

[141] 2007

[142](Section 51).

[143] (Section 56)

[144]1967

[145](Section 20).

The **Disabled Persons (Care and Maintenance) Act** [146]provides for Care and Maintenance of disabled persons (Preamble) and requires every relative of a disabled person to care and provide for the maintenance of that disabled person[147]: where there are more than one relative, all relatives have obligation to care and provide for maintenance of disabled person[148]. It also imposes an obligation on every local authority either alone or in collaboration to establish, operate, manage and maintain facilities for care of persons who are disabled[149].

3.4. LEGAL PROTECTIONS IN RELATION TO HEALTH SERVICES.

Kenya

The **Medical and Dental Practitioners Act** requires every person eligible to practice as a medical practitioner or dentist to register[150]; infamous or disgraceful conduct in respect of a registered medical practitioner or dentist to be punished[151].

The **Nurses Act, Chapter** [152]requires nurses to acquire a licence to practice[153]; and makes it an offence for a person not licensed or enrolled to act practice as a nurse[154].

The **Nutritionist and Dieticians Act** [155]prohibit anyone from engaging in private practice unless issued with a valid licence to practice[156].

The **Pharmacy and Poisons Act,** [157]requires those engaged in business of pharmacy to be licensed[158].

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[146]1982

[147] (Section 14(1))

[148] (Section 14(2))

[149](Section 16)

[150](Section 6)

[151](Sections 20, 22)

[152]257

[153](Section 17)

[154](Section 20)

[155]18 of 2007

[156](Section 22)

[157]Cap 244

[158](Section 7)

The **Pharmacy Act** [159]requires Pharmacists, Pharmaceutical Technicians and Pharmaceutical Assistants to register and enroll with the Pharmacy Council[160]; and makes it an offence for a registered, enrolled or enlisted person to commit professional misconduct[161].

The **Traditional and Alternative Medicines** [162]*(this is a bill and not yet in law* requires that for a person to practice as a traditional health practitioner or aide must present identification document and a written statement from local government authority to registrar under the Act[163]. It is an offence to practice as a traditional health practitioner or aide without being registered or[164]. The Act imposes duty on every registered traditional or alternative health practitioner registered to attend and treat their patients with clear knowledge, skills and right attitudes[165]. It empowers the registrar to receive complaints against any traditional or alternative health practitioner or aide and present such complaints to the council[166].

TANZANIA.

The **Nurses and Midwives Registration Act,** [167]requires nurses and midwives to register (Sections 6 and 7).

The **Pharmaceutical and Poisons Act,**[168]protects consumers from purchasing substandard pharmaceutical products; and requires vendors of pharmaceutical equipment to sell only safe, quality products and equipment.

The **Opticians Act,**[169]provides for opticians to register ad bodies corporate carrying on business as opticians to enroll[170].

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[159]2002

[160](Section 13)

[161](Section 34)

[162]Bill, 2003

[163](Section 14)

[164](Section 45)

[165](Section 35)

[166](Section 37)

[167]1997

[168]1978

[169]1966

The **Health Laboratory Technologists Registration Act** [171]provides for health laboratory technologists to register (Preamble), and establishes Health Laboratory Technologists Council, mandated to regulate standards of conduct and activities.

The **Private Hospitals (Regulation) Act,**[172]makes provision to restrict private hospital management to approved organizations, and control fees and other charges payable for medical treatment and other services (Preamble).

Organizations approved to provide medical services must be published yearly in the gazette and national newspapers.

While all three countries regulate health of workers, only Kenya regulates traditional medicine and only Tanzania has a specific law regulating private health providers. The latter is particularly important, as private practice is a potential determinant of inequalities in health, in terms of bias in access and use of resources.

Fair financing of health services

The way a health system is financed is a key determinant of population health and well-being. In the East African countries, the level of health financing is still insufficient to ensure equitable access to basic and essential health services and interventions, making adequacy and equity of resource mobilisation and allocation for health important. Fundamental to equitable health financing is the principle of **financial protection**, that no one in need of health services should be denied access due to inability to pay and that households' livelihoods should not be threatened by the costs of health care.

National policies pay some attention to these issues. In Kenya, under Vision 2030 government pledges to provide resources to those who are excluded from health care by financial reasons.

The National Condom Policy and Strategy [173]aims to ensure that user charges and revolving funds in public service delivery points are established, bearing in mind equity

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[170](Preamble)

[171]11 of (1997)

[172]1977

considerations. It further aims to implement a financing plan that involves the government, donors and other stakeholders.

In Tanzania, the Poverty Reduction Strategy Paper provides for financing of poverty alleviation efforts including primary health care and water while policies for specific areas (AIDS, elderly) include provisions to mobilise resources for services for these vulnerable groups, including protection against inability to pay.

In Uganda, the National Health Policy (NHP) recognises the role of public expenditure in protecting the most vulnerable population. It provides that the government should continue to allocate and spend an increasing proportion of its annual health budget (both domestic and external resources) to provide a minimum health care package in the medium term.

Government spending at central level and on referral and tertiary hospitals should be held constant in real terms and any additional resources for the health sector should be allocated preferentially to financing the Minimum Health Care Package.

The Policy states that efforts to secure supplementary sources of public health sector finance will be intensified, including capturing a greater share of the very significant private expenditure on health. It requires subsidy provision to designated public health and essential clinical services that have visible externalities for the community.

In Kenya, various acts provide for funding of services, for example:

- The **Public Health Act** provides that expenses incurred by the municipal council in maintaining a person in a hospital or in a temporary place for the reception of the sick can be recovered from him/her after discharge from the hospital[174].
- The **Children Act** [175]requires government to use the maximum available resources to achieve progressively full realization of the rights of the child[176].

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[173]2001-2005

[174](Section 33)

[175]8 of 2001

[176](Section 3)

- The **National Hospital Insurance Fund Act** [177]establishes a National Hospital Insurance Fund and makes provision for contributions to and the payment of benefits out of the Fund[178].
- The **Factories Act,**[179]requires the establishment of the Occupational Health and Safety Fund to be administered by the chief inspector[180].
- The **Work Injury Benefits Act,**[181]requires every employer to obtain and maintain an insurance policy, with an insurer approved by the Minister in respect of any liability that the employer may incur to any of his employees[182].

Specific vulnerable groups are provided for in law. For example in Tanzania The Disabled Persons (Care and Maintenance) Act [183] establishes a National Fund for the Disabled Persons whose objectives include: providing assistance to any disabled persons[184], and providing financial assistance to voluntary or charitable organizations engaged in providing for the welfare of disabled persons[185]. Less well provided for are provisions covering tax funding of health services or the allocation of health resources to mobilise resources from the private sector or regulate insurance to ensure equity and cross subsidies in schemes. No comprehensive laws regulate parallel public and private health systems, co-payment for health services or subsidized payment or health insurance.

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[177]9 of 1998

[178](Preamble)

[179]Chapter 514

[180](Section 70A)

[181]2007

[182](Section 7)

[183]1982

[184](Section 19)

[185](Section 19)

3.5. LEGAL PROVISIONS ON PATENTING

KENYA

The **Industrial Property Act** [186]provides: for promoting inventive and innovative activities to facilitate technology acquisition through grant and regulation of patents, utility models,technovations and industrial designs (Preamble); plant varieties in the **Seeds and Plant Varieties Act** but not parts thereof or products of biotechnological processes are not patentable[187]; inventions contrary to public health and safety among others are not patentable[188]; for compulsory licensing[189].

TANZANIA

The **Patent Act,**[190]empowers the minister to declare an order published in a gazette granting a licence for patented inventions of vital importance for defence of, among other things, public health[191].

3.6. LEGAL PROVISIONS ON ACCESS HEALTH INFORMATION

KENYA

Constitution

No provision in constitution.

The **Access to Information Bill 2000** defines access to include the right to examine, look at, peruse, inspect, obtain, copy or procure any record, document or information (Section 2). It confers a right on every Kenyan to access official records held by a public authority (Section 4).

Tanzania.

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[186]3 of 2001

[187](Section 26(a))

[188](Section (b))

[189](Sections 72 and 75)

[190]1987

[191](Section 54).

The **Constitution** confers a right on all to be kept informed of community, national and international developments of concern to the life of people and their work (Article 18).

3.7. LEGAL PROTECTION OF THE RIGHT TO PRIVACY

Kenya

The **Constitution** provides that no person should be subjected to unlawful search[192].

The **Public Health Act** requires inquiries and proceedings concerning venereal diseases to be held in camera[193].

The **Children Act** [194]provides that every child should have right to privacy subject to parental guidance[195].

The **HIV and AIDS Prevention and Control Act** [196]requires the Minister to regulate and prescribe privacy guidelines, including using an identifying code, relating to recording, collecting, storing and security of information, records or forms used in HIV test and related medical assessments[197]. It prohibits anyone disclosing any information concerning results of HIV tests or any related assessments to another[198].

The **Employment Act,**[199]also has provisions on privacy.

The **Public Health Act** establishes a Central Board of Health [200]to advise the Minister on all matters affecting public health[201].

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[192](Article 76(1))

[193](Section 54)

[194]8 of 2001

[195](Section 19)

[196]14 of 2006

[197](Section 20)

[198](Section 22)

[199]2007

[200](Section 3)

[201](Section 8)

The **National Commission of Human Rights Act**[202]establishes National Commission on Human Rights [203]to investigate, on its own initiative or on complaint made by anyone or any group, violation of any human right[204].

The **Medical and Dental Practitioner's Act** establishes the Medical Practitioners and Dentists Board [205]to register and issue private practice licenses for medical practitioners and dentists[206].

The **Nurses Act,**[207]establishes Nursing Council[208] to establish and improve standards of all branches of nursing profession in all aspects and safeguard interests of nurses[209].

The **Clinical Officers (Training, Registration and Licensing) Act,**[210]establishes the Clinical Officers Council to ensure maintenance and improvement of standards of practice by clinical officers and supervise professional conduct and practice of clinical officers[211].

The **Medical Laboratory Technicians and Technologists Act** [212]establishes Kenya Medical Laboratory Technicians and Technologists Board[213] to exercise general supervision and control over training, business practice and employment of laboratory technicians and technologists[214]. It regulates professional conduct of registered laboratory technicians and technologists and takes disciplinary measures to maintain proper professional standards[215].

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[202]9 of 2002

[203](Section 3)

[204](Section 16)

[205](Section 4)

[206](Section 15)

[207]Chapter 257

[208](Section 3)

[209](Section 9)

[210]Chapter 260

[211](Sections 3 and 5)

[212]10 of 1999

[213](Section 3)

[214](Section 4)

[215] Supra 102

The **Nutritionist and Dieticians**[216]establishes Nutritionists and Dieticians Institute to determine and set framework for professional practice of nutritionists and dieticians.

The **HIV and AIDS Prevention and Control Act**[217]establishes HIV and AIDS Tribunal[218].

The **Pharmacy and Poisons Act,**[219]establishes the Pharmacy and Poisons Board[220].

The **Water Act** [221]establishes the Water Resources Management Authority[222] to develop principles, guidelines and procedures to allocate water resources[223].

Tanzania

The **Constitution** gives every person the right to respect, privacy and protection of their person, family and matrimonial life, and respect and protection of their residence and private communications[224].

The **HIV and AIDS (Prevention and Control)**[225]requires all health practitioners, workers, employers, recruitment agencies, insurance companies, data recorders and other custodians of medical records, files, data or test results to observe confidentiality in handling all medical information and documents, especially the identity and status of persons living with HIV and AIDS[226].

The **Tanzania Commission for AIDS Act,**[227]establishes Commission for AIDS to provide AIDS prevention and sensitization.

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[216]18 of 2007

[217]14 of 2006

[218](Section 25)

[219]Cap 244

[220](Section 3)

[221]8 of 2002

[222](Section 7)

[223](Section 8)

[224](Article 16)

[225]Bill, 2007

[226](Section 17)

[227]2001

3.8. LEGAL PROVISIONS FOR PARTICIPATION AND ACCOUNTABILITY.

The **Constitution** provides that no person should be subjected to unlawful search[228].

The **Public Health Act** requires inquiries and proceedings concerning venereal diseases to be held in camera[229].

The **Children Act**[230]provides that every child should have right to privacy subject to parental guidance[231].

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[228](Article 76(1))

[229](Section 54)

[230]8 of 2001

[231](Section 19)

[232]14 of 2006

[233](Section 20)

[234](Section 22)

[235]2007

[236](Article 16)

Policies in all three countries explicitly refer to capacity building in communities for participation in health (e.g. Kenyan Adolescent Reproductive Health and Development Policy; Tanzania National AIDS Policy; Uganda National Health Policy). These policies provide for mechanisms for accountability of services, to co-ordinate stakeholders, monitor performance of services and disseminate information on performance. In Uganda, a Draft National Policy on Public/Private Partnership in Health aims to create an enabling environment to effectively coordinate efforts among all partners in health, to increase effective resource allocation and equitable distribution of resources for health, and provide effective access by all Ugandans to essential health care. It recognizes that private-not-for-profit institutions and non-government organizations (NGOs), have significantly contributed to the health sector, and have a rapidly increasing, proportion of the health workforce.

This policy commitment calls for legal provisions to set out the roles, authorities and mechanisms for such participation and for accountability of health services in relation to these policies. While some laws provide for various boards and professional bodies, few laws provide mechanisms for community participation in health services in the three countries

3.9. LEGAL PROVISIONS FOR PARTICIPATION AND ACCOUNTABILITY

Kenya

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[237](Section 3)

[238](Section 8)

[239]9 of 2002

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[241](Section 16)

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[242](Section 4)

[243](Section 15)

[244]Chapter 257

[245](Section 3)

[246](Section 9)

[247]Chapter 260

[248](Sections 3 and 5)

[249]10 of 1999

[250](Section 3)

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The **Tanzania Commission for AIDS Act,**[261]establishes Commission for AIDS to provide AID Sprevention and control (Preamble); formulate policy to respond to HIV and AIDS, manage consequences; mobilise, disburse and monitor resources; supervise HIV and AIDS prevention and control, especially welfare of orphans and other survivors of people infected and ensure equitable distribution, monitoring and evaluation of ongoing HIV and AIDS activities[262].

The **Nurses and Midwives Registration Act,**[263]establishes Nurses and Midwives Council[264] to Scrutinise, regulate, approve, monitor and evaluate implementation of nurse education curricular and discipline nurses and midwives for professional misconduct[265].

The **Pharmacy Act**[266]establishes Pharmacy Council with right to register, enroll and list Pharmacists, Pharmaceutical Technicians and Pharmaceutical Assistants to regulate standards and practice of the profession[267].

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[254]14 of 2006

[255](Section 25)

[256]Cap 244

[257](Section 3)

[258]8 of 2002

[259](Section 7)

[260](Section 8)

[261]2001

[262](Section 5)

[263]1997

[264](Section 3)

[265](Section 5)

[266]2002

[267](Section 4)

The **Traditional and Alternative Medicines Act,**[268]establishes Traditional and Alternative Health Practice Council[269] to: supervise and control practice of traditional/alternative health practitioners; co-ordinate efforts to develop traditional/alternative health science; promote maintenance and enforcement of traditional/alternative health care; protect society from abuse by traditional/alternative health practitioners and research on human beings[270]; and caution, censure, suspend or remove from roll aides or de-register traditional/alternative health practitioners found guilty of professional misconduct[271].

The Tanzania Food, Drugs and Cosmetics Act establishes Tanzania Food and Drugs Authority (TFDA) to regulate food and drug[272] matters relating to quality, safety of food, drugs, herbal drugs, medical devices poisons and cosmetics, manufacturing, labeling, marking or identification, storage promotion, sale and distribution of food, herbal drugs and medical devices or any materials or substances used in manufacture of products and ensure clinical trials on drugs, medical devices and herbal drugs are conducted in accordance with prescribed standards[273].

The **Anti-Dumping and Countervailing Measures Act,**[274]establishes Anti-Dumping and Countervailing Measures Advisory Committee[275] to advice on urgent measures necessary to protect domestic industries from dumping or subsidy and investing that could cause or threaten material injury to industry or producer[276].

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[268]2003

[269](Section 4)

[270](Section 6)

[271](Section 7)

[272](Section 4)

[273](Section 5)

[274]2004

[275](Section 4)

[276](Section 6)

The **Tobacco Industry Act,**[277]establishes Tanzania Tobacco Board[278] to: make rules and regulations on tobacco farming, processing, marketing, transport, export and storage; and regulate and enforce tobacco quality standards[279].

The **Protection from Radiation Act,**[280]establishes the National Radiation Commission[281] to: ensure protection of workers, students and the public from harm resulting from ionizing radiation and formulation of Policy regarding safe and peaceful use of atomic energy and other radioactive materials and substances in factories, mines hospitals and military and other establishments or undertakings[282].

In Conclusion laws set generally provide for establishing boards to regulate and monitor the practice of authorities, with some provision for stakeholder involvement. This assists to make public performance more accountable, particularly in relation to the conduct of health workers and performance of statutory bodies. The law appears to provide less well for: direct participation of communities in running of health services, public participation in decision-making, feedback mechanisms for private sector services, inter-sectoral co-operation and co-ordination, monitoring and evaluating services and data, reporting obligations, or accountability of private health services. As all these aspects are relevant to responsiveness of services to poor communities and are generally referred to in policy, this appears to be a gap to address to enhance equity in public and private health services.

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[277]2001

[278](Section 3)

[279](Section 5)

[280]1983

[281](Section 5)

[282](Section 7)

CHAPTER FOUR

THE AVAILABLE REMEDIES TO THE MEDICAL CONSUMERS WHOSE RIGHTS HAVE BEEN INFRINGED UPON. A CASE IN POINT IS MEDICAL NEGLIGENCE, A COMPARISON WITH UNITED KINGDOM, UNITED STATES OF AMERICA, INDIA AND NIGERIA AS THEY ARE AHEAD OF UGANDA IN MEDICAL PRACTICE.

4.0. Introduction

The available remedies to the medical consumers whose rights have been infringed upon. A case in point is medical negligence, a comparison with United Kingdom, United States of America, India and Nigeria as they are ahead of Uganda in Medical Practice.

Patients can bring different types of medical malpractice claims against medical professionals, depending on the degree of negligence involved in treatment of a patient. Below are examples of those types of negligence.

4.1. Negligence

You bring your son to the doctor to perform a routine check-up and to take a look at a substantially deep laceration he just sustained from playing outside with his friends. You sign in at the desk and wait until your son is called.

The doctor, who was in a rush because he was seeing many patients that day, calls your son into an examination room. After performing a routine check-up, the doctor then addresses the laceration on your son's leg, which was no more than half-an-hour old, using tools from the top of the table.

Before leaving the house, you had stopped your son's bleeding and applied an anti-bacterial spray and gauze to protect it. The doctor was not fazed by the deep wound and said it would just take a few stitches to fix. The doctor proceeds to take more tools from the top of a table—which, unbeknownst to him, had just been used to treat a child

who had an infection—and completed the procedure. The doctor office's policy is to only use tools from drawers in the table, because this ensures they were sterilized.

A few days after seeing the doctor, your son begins to suffer pain and discoloration around the cut, and becomes increasingly sick. You bring your son back to the doctor, who denies any responsibility for the infection, which required hospitalization and extensive treatment.

There are four elements to negligence. They include: duty, breach, injury, and damages.

Duty: Once a doctor/patient relationship has been established, the doctor now owes the patient a certain duty of care. This duty is to act as other doctors in a similar position would act, and to follow medical care guidelines accepted in the medical community. In this instance, your son and his doctor established a doctor/relationship patient when you submitted personal information to the office, and an examination was performed. The doctor now had a duty to act as other doctors would under similar conditions and with the procedures and care accepted by the medical community.

Breach: After this duty of care has been established, the doctor is required to exercise reasonable care and treat the patient as would other doctors in his field, following procedures and actions accepted by his peers. Here, this duty was breached when the doctor violated office protocol and used tools from the top of the desk, instead of sanitized ones from a drawer in the table. The use of un-sanitized tools placed your son at a risk of harm.

Injury: An injury must be sustained. Here, your son contracted an infection from the un-sterilized tools the doctor used to treat the wound. To prevail in a negligence suit against the doctor, your attorney must prove that the un-sterilized tools were the direct cause of your son's injury.

Damages: The victim must suffer damages, economic or non-economic, as a result of the injury. Your son's hospitalization and treatment resulted in substantial costs medical bills. You also had to take time off from work to attend to your son and his condition.

Gross Negligence

You suffer severe trauma to your left arm in a car accident, and an ambulance immediately takes you to the hospital.

You are examined by doctors in the emergency room and they determine that you will need immediate surgery to stop the bleeding and prevent further injury. After being escorted to the operating room, your surgeon quickly glances at a chart to see the type of procedure he will be performing. When you wake up, you realize that your right arm is missing. Instead of receiving treatment on your left arm, which was clearly damaged, your right arm, which was in perfectly good condition, has been amputated.

Prior to surgery, the doctor had carelessly checked a chart and believed you were a different patient, who was later scheduled to have his right arm amputated due to infection. As a construction worker, you no longer have the ability to perform the work you once did.

To win a case based on gross negligence, the same four factors needed to prove a negligence claim must be shown: duty, breach, injury, and damage. However, the breach of duty must have been so egregious that it would have been obvious to anyone, even those not in the healthcare community.

Duty: In this instance, a doctor/patient relationship was established when the surgeon accepted the responsibility to perform your procedure. When this relationship was established, the surgeon had a duty to perform his job in a reasonable and careful manner, as any other surgeon would under similar circumstances.

Breach: The surgeon breached this duty when he acted hastily and failed to take certain pre-surgery steps required and accepted by healthcare professionals. By not closely examining the chart to determine the type of procedure he would be performing, the surgeon committed a breach a duty which was so egregious it would be considered gross negligence.

Injury: As a result of this breach, you had a limb amputated. Additionally, the wounds on your left arm went untreated and became infected, resulting in serious tissue damage.

Damages: You must show that you suffered damages that are compensable. In this case, you may be able to recover compensation for pain and suffering, loss of income, loss of potential future income, and mental anguish.

Bad Result

Just because a patient suffers an injury while under the care and attention of a doctor, it does not automatically mean the individual has a medical malpractice suit against the healthcare professional.

For example:

- *Prior to surgery, patients are warned of the risks involved in the procedure. The patient must then understand the risks involved and authorize the surgery, despite its risk factors.*
- *If a patient received follow-up care instructions to the surgery, but fails to closely follow them, and an injury results, they will likely not have a medical malpractice suit.*

The physician's negative act and breach of duty must be the direct cause of the injury for a medical malpractice suit to prevail. Free

In the early nineteenth century it was indeed unusual act for patients to sue their doctors in the court of law. Doctors are considered to be visible gods who can renew the life of persons who languishing from diseases, injuries and defects. They are trustworthy persons. A patient who consults a doctor will presume that he is skillful and competent to heal his disease[283]. Practice of medicine is capable of rendering noble service to humanity provided due care, sincerity, efficiency and professional skill is observed by the doctors. In the area of patient-doctor relationship two important models dominate namely one is based on *Paternalism* and other is founded on the doctrine of *informed consent*[284]. In UK, the paternalistic model of the physician-patient relationship has been a dominant feature[285]in the medical profession since its inception. This has been duly recognized in the English law through the famous **Bolam's** case which states that a doctor is not liable in negligence medical claim when he acted "in accordance with a practice accepted as proper by a responsible body of medical men, skilled in the particular art"[286]. In the United States, the doctor-patient relationship is based on the doctrine of informed consent[287]. A patient must be given all the required information about the nature of treatment, risks involved and the feasible alternative, so as to enable him her to make a rational and intelligent choice whether to proceed with treatment or surgery or not. In informed consent of the patient concerned is not obtained, then, the doctors will be liable. However, today, the patient-doctor relationship has almost diminished its fiduciary character; medical service has become a

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[283]Benjamin MS, and Dr. Raju CB, "Criminal Clinical Negligence: who watches the life saviour- a critical appraisal, Karnataka Law Journal, 2007(1) p.27.

[284] Nayak RK, "Medical Negligence, Patient's Safety and the Law", Regional Health Forum- Vol. 8, No.2 2004, p. 15.

[285]See generally Chapman, "Physicians, Law and Ethics" (1984) pp. 220-223.

[286]Bolam Vs Friern Hospital Management Committee (1957) 2 All ER 118 at 121.

[287]Schloendroff Vs Society of New York Hospital, 211 N.Y 125 N.E. 92 (1914)) as per Justice Cardozo).

purchasable commodity and this business attitude has given an impetus to more and more medical malpractices and instances of clinical negligence.

In this context, the question of patient protection has become highly significant in the medical profession. This chapter deals with various legal provisions in respect of enforcement of liability of health care providers. A victim of medical negligence who intends to sue an erring health care provider has the following options.

a) **Compensatory action**: seeking monetary compensation before the Civil Courts, High Court and any other Forum under the Constitutional Law, Law of Torts/Law of Contract and the Consumer Protection laws available.

b) **Punitive action**: filing a criminal complaint against the doctor under the Ugandan Penal Code.

c) **Disciplinary action**: moving the professional bodies like Uganda Medical Council seeking disciplinary action against the health care provider concerned.

d) **Recommendatory action**: lodging complaint before the Uganda Human Rights Commission seeking compensation.

4.2. LIABILITY OF HEALTH CARE PROVIDER IN THE CONSITUTUIONAL LAW

Strictly speaking, the Constitution of Uganda does not guarantee any special rights to the patient. The patient's rights are basically derivative rights, which emanates from the obligation of the health care provider. The Constitutional Court in various cases has viewed that the right to life as enshrined in Article 22 of the Constitution of Uganda includes the right to health and medical treatment. The right to life would be meaningless unless medical care is assured to a sick person[288]. Article 20 introduces the fundamental freedoms to all its citizens of Uganda.

These fundamental freedoms can be effectively enjoyed only if a person has healthy life to live with dignity and free from any kind of disease or exploitation which further

[288] Sharma MK, "right to Health and Medical Care as a Fundamental Right" AIR 2005, p. 255

ensured by the mandate of Article 22 of the Constitution. When breach of this right occurs, the health care provider will be held liable for negligence.

Objective 22 of the constitution of Uganda guarantees the provision to medical services and it states that "*The State shall take all practical measures to ensure the provision of basicMedical services to the population.*" and stops at that.

4.3. Professional duty to extend helping hand to 'victims of accident in India.'

The Supreme Court of India in its landmark judgment in *Pt. Paramananda Katara Vs. Union of India & others*[289] ruled that every doctor whether at a governmental hospital or otherwise has the obligation to extend his services with due expertise for protecting life. No law or state action can intervene to avoid or delay, the discharge of the paramount obligation cast upon members of the medical profession. Any law of procedure or statute which would interfere with the discharge of this obligation cannot be sustained and must, therefore, give way. The court laid, down the following guidelines for doctors, when an injured person approaches him:

i) Duty of a doctor when an injured person approaches him:

Whenever, a medical man is approached by an injured person, and if he finds that whatever assistance he could give is not really sufficient to save the life of the person, but some better assistance is necessary, it is the duty of the man in the medical profession so approached to render all the help which he could, and also see that the person reaches the proper expert as early as possible.

ii) Legal protection to Medical practitioners:

Where a doctor proceeds with treatment to an injured who appears or is brought before him, does not amount to breach of the law of the land. Zonal regulations and classifications operate as fetters in the discharge of the obligations, even if the victim is elsewhere under the local rules and regardless of involvement of police. The court has attempted to resolve conflict of duties of doctors and police officers pertaining to

[289] AIR 1989 SC 2039.

investigation of the case. Investigation agency cannot supercede the professional obligation of doctors.

iii) No obstacle on medical practitioners from attending injured persons:

There is no legal bar or impediment on the part of medical professional, when he is called upon to attend an injured person needing his medical assistance immediately. The sincere attempt to protect the life of person is the top priority of not only medical professional but also of the police, or any other citizen who happens to be connected with the matter, or who happens to notice such an incident.

iv) Prevent harassment of doctors:

Taking the judicial notice of incidents where the doctors are being harassed by the police in the guise of investigation and unnecessary delay in the medical evidence by way of frequent adjournments or by cross-examination, the court held that unnecessary harassment of the members of the medical professional should be avoided. They should not be called to the police station to unnecessarily interrogation or for the sake of formalities. The trial courts should not summon medical men unless the evidence is necessary, even if he is summoned, attempt should be made to see that the men in this profession are not made to wait and waste time unnecessarily, the law courts have to respect for the men in the medical profession. The Supreme Court attempts to remove apprehension that prevents medical men from discharging their duty to a suffering person. This can prevent defensive treatment which is detrimental to the patients.

4.4. Faith healing is not included in Article 22of the Ugandan Constitution:

Article 29[290], which guarantees right to profess, practice and propagate religion is subject to the provision of the constitution. The point is whether a person can claim right of curing ailments and improve health on the basis of his right to freedom of religion. Every form and method of healing will not be permitted to be practiced in public. A healing practice in order to become a profession, it has to guide the proper procedure which must be proved by known and accepted methods, verified and

[290]The 1995 constitution of the republic of Uganda.

approved by experts in the field of medicines. It is only when a particular form, method, procedure or path is accepted by experts in the medical profession, then such form etc, can be permitted to be practiced in the public interest.

The right to health implicated in Art. 22 does not come in conflict or overlap with the right to propagate and profess religion. These are separate and distinct rights. Where the right to health is regulated by validly enacted legislation, the right to cure the ailment through religious practice like 'faith healing' cannot be claimed as fundamental right.

4.5. SEEKING REMEDY UNDER THE LAW OF TORT:

Common law principles

The history of development of law of tort particularly regarding medical negligence litigation is of recent origin in Uganda. It has its foundation in the English common law of *ubi jus ibi remedium*. Ugandan courts exercise their power to administer law according to 'justice equity and good conscience' that indicate that torts are primarily those wrongs for which either statutory remedies are not available or, if available, are inadequate or inappropriate[291].

In considering actionable negligence, courts are in fact not only identifying the interests which require protection but also the circumstances under which they need to be protected. The interests of aggrieved are preserved and promoted through the grant of a civil right of action for un-liquidated damages.

In a tort of medical negligence, the cause of action is personal one that is against the person who has been negligent in discharging his duties and that cause of action does not survive against his estate or the legal representative[292].

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[291]Legal Framework for Health Care in India, Varma SK (edn), 2002, LexisNexis, Butterworths, p.26

[292] See Balbir Singh Makol vs. Chairman, M/s Sir Gangaram Hospital and others (2001) 1 CPR 49 wherein the rule of action personalis moritur cum persona is recognized

There has been slow growth of tort litigation in India in the area of medical negligence. This is primarily due to lack of awareness about one's own rights, the spirit of tolerance, the expenses involved and the delay in disposal of cases in civil courts owing to overburden of civil dispute litigations.

Test to prove medical negligence

The courts in Uganda follow the test with regard to the negligence of a doctor laid down in **Bolam vs. Friern Hospital Management Committee** in which it was held that a doctor is not guilty of negligence if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

Under the law of torts action for medical malpractice lies in the civil court where the burden of proof is high and adheres to the strict proof of evidence. Mere complying with the requirements like duty of care, breach of duty and damages will not be sufficient to find the defendant doctor being guilty of negligence. The issue of negligence should be proved by the plaintiff with the cogent evidence of medical expert and medical records. The case will fail in the absence of medical witness in support of charge of negligence.

4.6. Procedure and purpose.

The thrust of tortuous liability is to compensate the victim for the injury or loss suffered by him. Since it is in the nature of civil proceeding a civil court has to be approached to seek the remedy. There are two purposes behind the tortuous liability; firstly, it provides compensation in terms of money to those injured as a result of negligence of doctors/hospitals, thereby operates as a source of indemnity. Secondly, by imposing sanctions on guilty professionals, it functions as a deterrent to future negligent behavior.

Issues to consider.

The question of tortious liability of the medical professional poses the following issues

a) What are the principles to be considered in determining tortious liability?

b) What is the extent of liability of the doctor for negligence?

c) Is the State vicariously liable for the wrongs done by its employees employed in the public health care service?

d) What should be the criteria for awarding compensation in case of medical negligence by the health provider?

e) Under what circumstances the principle of the Ipsa loquiter may be invoked by the victim of negligence?

4.7. Substantive principles:

Duty of care:

The starting point for determining tortious liability of the health care provider is the duty of care. A legally recognized obligation of health service provider to the patient is duty to take reasonable care[293]. The duty of care owed by a doctor arises by virtue of the legal concept of "holding out"[294] that if the medical practitioner allows or encourages the patient to believe that he is a doctor, then a duty of care is applied which measures that person by the standard of the reasonable doctor in that situation.

It is a criminal offence for anyone who is unqualified under the law to falsely represent that he is a medical practitioner.

The duty has many different aspects. In practice, it means effectively that the doctor must take reasonable care for the well-being of the patient in all aspects of the medical context in which the doctor is involved[295]. This includes the consultation (or visit) itself[296], giving advice[297]maintaining confidentiality[298], making a diagnosis, referring the

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[293] Andrew Fulton Philip, Medical Negligence Law Seeking a Balance, 1st edition, 1997, Dartmonth Publishing Compnay, Vermount (USA) p. 14.

[294] See Dickson Vs. Hygienic Institute (1990) SC 552; R Vs Bateman (1925) 94 LJKB 791.

[295] Jones MA, Medical Negligence, 2nd edition, Sweet and Maxwell (1996) chs. 2-4.

[296]Morrison and others vs. Forsyth (1995) 6 Med. LR 6.

[297] Professional Conduct and Discipline: fitness to practice, General Medical Council, para 77.

[298] Tucker vs. Tees Health Authority (1995) 6 Med LR 54.

patent to a specialist or other doctor and giving or prescribing any treatment[299]. In addition to the obvious aspects of negligence, such as failure to give an injection properly[300], the duty of care includes other aspects which can be described as non-technical for examples administration of drugs and the duty that includes informing the patient of how the treatment is to be carried out[301] and subsequent adverse effects[302], communicating the relevant and appropriate risk to the patient[303] or what went wrong[304] communicating relevant information to other medical personnel[305] or for junior has hospital doctors to call in more senior colleagues if necessary[306].

4.8. Standard required for duty to take care:

To hold a health professional liable for negligence, what is important standard is the want of competent and ordinary skill and care that has led to the unpleasant result. There is a presumption of competency in favor of the registered medical practitioner. Where the surgeon who is registered as a medical practitioner causes injury to his patient by way of his treatment, the presumption is that he is competent and the treatment correct scientifically and under the medical literature till the contrary is shown.

Din Mohammad J, quoting Bevan on Negligence, observed "a medical man does not undertake that his treatment shall be infallible; and therefore, he is only held to undertake to perform what can be ordinarily done in similar circumstances. If the medical practitioner has the ordinary degree of skill accepted and practiced in his profession, he is entitled to his remuneration although his treatment has failed"[307]. This

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[299]Sidaway vs. Board of Governors of the Bethlem Royal Hospital (1985), All ER 643.

[300]Hunter vs. Hanley (1955) SC 2000.

[301]Clarks vs. Adams, (1950) 94 SJ 599.

[302] Fowlers vs. Greater Glasgrow Health Board (1990) SLT 303.

[303]Moyes vs. Lothian Health Board (1990) SCT 444.

[304] Supra note 20.

[305]Coles vs. Reading and District Hospital Management Committee (1963) 107 SJ 115.

[306]Chapman vs. Rix (1994) 5 Med. LR 239.

[307]V.N. Whitmore Vs RN Rao AIR 1935 Lah 247.

point recognizes that medical treatment is neither exact science, nor favorable outcomes can be anticipated.

The test for medical negligence is essentially objective and does not take formal account of a doctor's experience, level of qualification, the resources available within the doctor's clinic or hospital[308]. The test is also retrospective; deterrence of negligent conduct is one of the aims of tort law. Where negligence is alleged, it is only the incident in question which is examined. It is argued therefore, the present legal approach is too narrow and has failed to take into account of the sophistication and complexity of modern medicine[309]. Nonetheless, the court has taken very lenient approach while deciding or tackling the issue of liability of the health career in view of the risk involved in the surgical/medical treatment. In *Hatcher vs. Black*[310], Lord **Denning** explains law on the subject of negligence against doctors and hospitals in the following woods: "... In the case of accident on the road there ought not to be any accident, if everyone used proper care and the same applies in the factory; but in a hospital when a person who is ill goes in for treatment, there is always some risk, no matter what care is used. Every surgical operation involves risks. It would be wrong and indeed bad law, to say that simply because a misadventure or mishap occurred, the hospital and doctors are thereby liable. It would be disastrous to the community if it were so. It would mean that a doctor examining a patient or a surgeon operating at a table, instead of carrying on his work would be forever looking over his shoulder to see if someone was coming with a dagger; for an action for negligence against a doctor is for him like a dagger. His professional reputation is as dear to him as his body, perhaps more so, and action for negligence can wound his reputation as severely as a dagger can his body. You must therefore, find him negligent simply because something

[308] Jones vs. Manchester Corporation (1952) 2 All Ed 125, where Lord Denning observed: error due to inexperience or lack of supervision is no defence as against the injured person.

[309] Bainbridge, D.I., "computer added diagnoses and negligence," 1991, 32 Med. Sci, Law 127, on the introduction of new technology in relation to liability rules.

[310] 1954 Times 2nd July.

happens to go wrong; ... you should only find him guilty of negligence when *he falls short of the standard of a reasonably skillful medical man."*

Equally pertinent are the observations of Lord Denning in *Roe Vs. The Ministry of Health*[311] to the following effect: "It is so easy to be wise after the event and to condemn as negligence that which was only a misfortune. We ought always to be our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risk. Every advance in technique is also attended by risk. Doctors like rest of us, have to learn by experience and experience often teaches in a hard way. Therefore, we must not look at a 1947accident with 1954 spectacles."

Loss or damage:

Where a claim is brought for tort, damage is a necessary element of the cause of action. Where the plaintiff proves that the doctor was negligent but fails to show any injury or damage caused thereby, he will not be entitled to damages and the claim will be dismissed[312].

4.9. Causation

In the tort of negligence, it is not enough for the plaintiff to prove that he sustained damage. In addition to establishing the existence of damage, the pursuer must prove that the defendant's negligent act or omission was the actual cause of the damage which occurred[313]. If the pursuer cannot establish so, there is no tort and the action fails. In contract a plaintiff who proves that the defendants was in breach of contract is entitled to nominal damages, but again he will not be awarded substantial damages unless he establishes a causal link between the breach and his loss[314].

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[311]1954 2 QB 66.

[312]SidhrajDhadda vs. State of Rajasthan AIR 1994 Raj 68.

[313] McWilliams vs. Sir William Arrol & Co. Ltd (1962) SC (HL) 70

[314]Jones, M.A. Medical Negligence at para 5-10.

Perhaps it is the most problematic stage in a negligence claim under the present law of delict or tort. Once the plaintiff has overcome the difficulties posed by Bolam's case, then, he has to face the hurdle of causation. It is not for the defendant to prove that his negligence did not cause the damage; rather it is for the plaintiff to prove the causal link between the defendant's breach of duty and the damage suffered by him[315]. The requirement to prove causation is very essential and at the sometime a big problem with a medical negligence claim, it involves several factors, for example, the plaintiff may have been suffering from an ongoing disease; however, he must still show that medical negligence caused the damage complained of. In some cases where medical evidence is conflicting or where the adequate medical evidence is not available, the court will find that the plaintiff has failed to prove that the defendant negligence was responsible for the ensuing damage[316].

Requirements to prove causation:

The plaintiff in order to succeed in his action, he must show that:

a) The damage would not have occurred but for the defendant's negligence; or

b) The defendant's negligence materially contributed to or materially increased the risk of injury; or

c) If the claim is for negligent non-disclosure, had he been adequately informed he would not have accepted the treatment.

The 'but for' test:

The plaintiff has to show that the damage or loss which has occurred would not have occurred in any event, if the defendant's conduct is not a cause. However, the defendant's behavior/conduct need not be the sole cause of the damage, there may be other factors which contribute to the damage, it is what is known as 'factual causation'. In *Barnett Vs Kensington and Chelsea Hospital Management Committee*[317] wherein the court held that the defendant was negligent as he did not see and examine the deceased, but he was not liable because the medical evidence indicated that even if the

[315]Ibid.

[316]Loveday vs. Rendon (1990) 1 Med. LR 117.

[317]1969 (QB) 428.

patient had received prompt treatment it would not have been possible to diagnose the condition and administer drug in time to save him. Thus, the negligence did not cause the death.

In **Bolitho's case**[318]a child was ill in hospital; no doctor attended the child in spite of fervent request made by the night sister. It had been agreed that it was negligent, if a doctor had visited and incubated the child, the cardiac arrest and brain damage that he suffered would have been avoided. But the defendants argued successfully that the plaintiff had failed to prove that if a doctor had come, she would have probably incubated. The defendant's expert stated that he would not have incubated, while the plaintiff's expert stated it would have been mandatory to incubate. Facing with the conflict of medical opinion, the court held that the plaintiff had failed to prove that the outcome would have been different if the defendant had responded to the nurse's call[319].

4.10. Material contribution to damage:

The courts appear to be relieving the plaintiff from the rigorous of the "but for" best where the difficulty of establishing causation has been a product of scientific uncertainty. In *Bonnington Castings Limited Vs. Wardlaw*[320], the House of Lords held that the claimant does not have to establish that the defendant's breach of duty was the main cause of the damage unless it maternally contributed to the damage. In this case, employers were sued by an employee who had contracted pneumoconiosis (an industrial disease of the long due to inhalation of dust particles) from inhaling air which contained silica dust at his work place. The main source of the dust was from pneumatic hammers for which the employers were not negligent (the innocent dust).

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[318]Bolitho vs. City and Hackney Health Authority (1993) 4 Med. LR 381; CA; affd (1997) 4 All ER

[319]65 See Joyce vs. Merton, Sutton and Wandsworth Health Authority (1996) 7 Med CR, where it was held that the claimant could not such that the surgeon would have operated within the crucial 48 hour period, if the surgeon had been called to the ward to review the patient following the initial operation done on the patient.

[320]1956 AC 613.

The crucial issue in the case was some of the dust ("guilty dust") came from swing grinders for which they failed to maintain dust extraction equipment. There was no evidence as to the proportion of innocent dust and guilty dust inhaled by the claimant.

Nonetheless, the House of Lords drawing an inference of fact that the guilty dust was contributory cause held that the employers were liable for the full extent of the loss.
This case is significant in easing the claimant's burden of proof for the reason that it was a departure from "but for" causation. The claimant need not to prove that the guilty dust was the sole or even the most substantial cause, it was sufficient to prove 'material contribution' to the injury or illness.

Material contribution to the risk:

Following the House of Lords decision in *Bonnington Castings* case, the House of Lords in *McGhee Vs. National Coal Board*[321] emphasized the list of material contribution to the risk. In this case, the claimant who was working at the defendant's brick factory contracted dermatitis as a result of exposure to brick dust. The employers were not at fault for the exposure during working hours, but they were in breach of duty by failing to provide adequate washing facilities. It was agreed that brick dust had caused the dermatitis.

Therefore, it was held that the failure to provide washing facilities materially increased the risk of the claimant contracting dermatitis. The implication of **McGhee** case is clear or apparent in *Clark Vs. McLennan*[322] a medical negligence case where the court held that whenever there is a general practice to take a particular precaution against a specific, known risk but the defendant fails to take that precaution, and the very damage against which it is designed to be a protection occurs, then the burden lies on the defendant to show that he was not in breach of duty and the breach did not cause the damage. But this approach has been criticized as opposed to causation[323].

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[321] 1956 AC 613.

[322] 1983 All ER 41 (per se Pain J.

[323] Per se Lord Mustill J in Wilsher vs. Essex Area Health Authority (1987) QB.730 at 752.

Causation and non-disclosure

Where the action is brought for negligence, the claimant must prove that if he had been warned about the inherent risk in the procedure he would not have accepted the treatment. The court applies a 'subjective test' to decide the issue whether the plaintiff would not have accepted the treatment in question. At first glance, this test would show unduly favorable to the plaintiff; the case law demonstrates that the courts apply the test stringently[324]. However, there are some cases where this test has been successfully applied and awarded compensation to the claimant. In *ThakeVsMaurice*[325] the court held the defendant liable to pay compensation to the plaintiff who contended that if the plaintiff's wife had been informed that she might be conceived despite of her husband undergoing vasectomy, she would have taken the measure to prevent pregnancy.

Remoteness and foreseeability

This issue has been considered by the court in medical negligence litigation or in an action for tortious liability of the health professional. It is not sufficient to establish a duty of care, a breach of that duty and loss of a type recognized by law and caused by the breach, in addition to these what is equally important to hold the defendant liable for the loss or damage is that the loss was *reasonably foreseeable* at the time of breach that it could arise[326]. In other words if the loss caused is too remote and as a reasonable man cannot foresee as likely to occur, the tortfeasor is not liable to compensate the loss or injury.

A recent medical case provides good example of the operation of the principles of remotes and foreseeability. In *R Vs Croydon Health Authority*[327], the claimant, a trained nurse, married and of child-bearing age, underwent a medical checkup with a view to taking employment with the defendants. The radiologist who interpreted her X rays did not refer her for specialist opinion but simply opined she would not conceive and take

[324]See Chatterson vs. Gerson (1981) QB 432; Mills vs. Potter (1984) 1 WLR 641 and Smith vs. Barking, Havering and Brentwood Health Authority (1994) 5 Med LR 285, where the court remained unconvinced that the plaintiff would not have proceeded with the procedure had she received more information about it.

[325]1986 QB 644.

[326]Charles J. Lewis; Clinical Negligence – A Practical Guide p. 212.

[327]1978 Lloyd's Rep Med. 44 CA.

up the employment. However, contrary to this, the claimant became pregnant who contended that she was entitled to damages she suffered trauma of pregnancy and had to bear the cost of upkeep of her daughter. The court said that the claimant's domestic life does not fall within the scope of the radiologist's duty.

4.9. The "egg shell skull" rule

This rule is recognized as one of the exceptions to the rule of foreseeability. It signifies that where the claimant suffers from a latent injury or illness which has been caused by the damage inflicted by the defendant, then the defendant is responsible for the additional, unforeseeable damage that his negligence has produced. The complainant/claimant is entitled to damages to the full extent of his injury. This is usually referred to as the "thin /skull" or "the egg shell skull" rule. If the claimant has thin skull, the defendant doctor cannot complain that the harm or injury was not foreseeable or beyond the expectation of a normal person. The defendant is considered to be in breach of duty and responsible for the loss[328]. This principle will be applied where the claimant has an unusually weak heart[329]or a weak back[330]. On the other hand, the egg shell skull rule overlaps with the general principle that the extent of the damage need not be foreseeable[331] and it is not clear, how does the rule apply where the damage is psychiatric in nature.

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[328]Bournhill vs. Young (1948) AC 92, 119, per Lord Wright.

[329] Love vs. Port of London (1959) 2 Lloyd's Rep. 541

[330]Athey vs. Leonati, (1997)1 WWR 97, 110 (S.C.C.) where he is hemophilic (a person attacked by a disease transmitted by females only to their male offspring).

[331]Smith vs. Leech Brain and Co Ltd (1962) 2 G.B. 405 wherein the court held that the defendant could have foreseen that a burn would cause cancer and the victim would die.the amounts of damages which the patient suffers as a result of that burn, depends upon the characteristics and constitution of the victim.

4.10. Liability of health professionals:

Structure of Liability:

The legal principles which we have considered including the duty, standard of care and causation, in general apply to all health professionals irrespective of whether they work in private hospital or government run hospital or practice privately and independently. The general practitioners, who are not employed by the state, are independent contractors. They render or provide primary health care for consideration or free of charge in case of charitable hospital. Yet, the general principles of law governing the tortious liability apply to the entire health career. In other words, the Bolam test applies to health career.

The following tortuous liabilities can be classified into two categories, namely

(a) Individual liability and

(b) Institutional or hospital liability. Individual liability of the medical practitioner arises where the injury or damage is caused by the negligent conduct. The medical man is bound to compensate the victim or the family of the victim or the patient whose death is caused by his wrongful, neglect or default[332]. Even the executors, administrators, heirs or representatives of any diseased medical practitioners are liable to pay compensation for any wrong committed by the deceased in his life time and for which he would have been subjected to an action. The Maxim *actio personalis moritur cum persona* is modified in Uganda by section 180 of the Ugandan Succession Act Cap 162, which lays down that all rights to prosecute or defend any action for or against a person at the time of his death, survive to or against his administrator or executor, except causes of action for defamation or assault and other personal injuries not causing death[333].

For the negligent acts like a medical professional, a hospital/health care centre or nursing home can also be made liable. It is called health 'corporate liability' or

[332]Section 14 of the Fatal Accidents Act 1855.

[333]Maharani Dey vs. Debabrata Bardhan (1984) ACT 95; AIR 1983, Gau 84.

'institutional' liability. This kind of liability is of two folds namely, i) primary/direct liability and ii) vicarious liability. Where the negligence claim is targeted at the organization or administration of the hospital, such claims are canvassed as direct liability claims against the hospitals. Vicarious liability is an exception to normal legal principles under which individuals are usually liable only for their own actions and not for those of others. Where a health career is held liable for the acts of another because of some relationship like employer and employee is called 'vicarious liability.

4.11. Personal liability of doctors

Liability of doctor for negligence in failing to exercise proper care and diagnosis:

In *Wood Vs. Thurston*[334] a drunken man was brought to the casualty ward of a hospital with a history of having been run over by a motor lorry. The surgeon did not examine him as closely as the case required and even failed to use his stethoscope which could have enabled him to discover the patient's true condition. In addition to this, he permitted the patient to return home who after a few hours died. The surgeon was held guilty of negligence in failing to make a proper diagnosis[335].

Liability of doctor for error of judgments:

The courts have adopted on approach of extreme caution in determining liability of a doctor for medical malfeasance. Mere ever of judgment does not necessarily impose civil liability on the practitioner unless it is shown that he has fallen short of reasonable medical care[336]. It is argued that it will be doing disservice to the community at large if the court were to impose liability on doctors and hospitals for everything that happens to go wrong[337]. The Supreme Court in *LaxmanBalakrishna Joshi Vs. Trimbak*

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[334]1953 C.L.C. 6871.

[335]Edler vs. Greenwich vs. Deptford Hospital (1951) The Times March 7, the court observed that the doctor was liable for failure to diagnose appendicitis.

[336]Gopinath vs. Eskaycee Medical Foundation and Another OP. 199/91 dated 10.4.1992 and Hatcher vs. Block (1954) Times 2 July.

[337]Lord Denning, in Roe vs. Ministry of Health 1954 All ER·131.

BapuGodbole[338] ruled that the doctor has discretion in choosing treatment, which he proposes to give to the patient and such discretion is relatively greater in cases of emergency[339]. In *Dale Vs. Munthali*[340] the doctor diagnosed the patient as suffering from influenza, when in fact he had meningitis. Yet it was concluded that there was no negligence in failing to diagnose meningitis.

Liability of a doctor for not advising the patient to approach a better equipped hospital:

In *Ram Biharilal vs. Shrivastava*[341] the operation theatre was under repair.

There were no facilities for oxygen and blood transfusions, there was no anaesthetist and some life -saving drugs was not available. Pipettes (tubes) for testing blood were broken, the saline apparatus was not in order and there were only two staff nurses for a 28 bed hospital. In these circumstances, the court observed that the doctor should not have undertaken such a major operation in a hospital, which was lacking basic facilities. He should have advised the petitioner to approach another hospital which had all the facilities including specialists. The doctor, therefore, failed in his duty of care in undertaking the operation without taking necessary precautions.

4.12. Institutional liability:

Primary Liability: In *Hillyer Vs. Governors of St. Bartholomew's Hospital*[342] the question arose for the consideration of the court was whether thehospital was liable primarily for the injury caused to the patient by the surgeons and anesthetist during the course of operation. It was held that the surgeons and anesthetists were not servants as they are professionals and not bound by the directions as to the manner of

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[338]AIR 1969 SC 128.

[339] In Dr. Ravindra Gupta and others vs. Ganga Devi and others (1993) 3 CPR 255 it was observed that a mistaken diagnosis is not necessarily a negligent diagnosis.

[340]1976 78 D.L.R. (3d) 588.

[341]AIR 1985 MP 150.

[342] (1909) 2 KB 820, cited in Bournhill, Mobilia and Clifford E. Elias, "The Law of Medical Liability", the West Publishing Company, Minn, 1995, p. 192.

performance of their work, therefore, as regards these professionals, hospital does not undertake to treat the patients through the agency of the surgeon or anesthetist, but to procure the services of the surgeon and the anesthetist. Only the duty undertaken by the hospital is to exercise due care and skill in selecting them and not to ensure that they would not be negligent in treatment. This case makes it clear that the hospital owes a duty to exercise due care in the selection and appointment of its staff including the consulting doctors/surgeons. However, itmust be noted that this case was decided during the period where the "control" test for master servant relationship was so applied as to exclude persons who could not direct and supervise the manner of work performed by the doctor. It shows the primary liability of the hospital cannot be linked with the persons exercising professional skill and care, rather primary liability is limited to secure the services of the health professionals, and provide provisions of proper facilities and appliances.

Vicarious liability

The **Hillyer's** case, the court refused to impose liability on the hospital for neglect act committed by the staff in the course of their employment. The hospitals were able to convince the court that they were not directly dealing with the patients and their role was to entrust the patients under the care of skilled medical practitioner. It was in 1940 onwards when the court started accepting/ recognizing the vicarious liability in the area of medical care. The doctrine of vicarious liability extends the primary liability of the hospital for the wrongs or neglect acts of its servants, irrespective of whether their employment is permanent or temporary or casual paid or honorary, whole time or part time as in the case of visiting physicians or surgeons[343].

In *Gold Vs Essex County Council*[344]the court held that the hospital liable for the negligent acts of its radiograph and nurses. This judgment removes the distinction created in the Meyer's case and extends the primary liability of hospitals. In *CassidyVs.*

[343]RamaswamyIyer's Law of Torts 8th edition P. 521

[344](1942) 2 KD 293; (1942) 2 All ER 237.

Ministry of Health[345] the court found that a hospital employing two doctors on the contract of service vicariously liable for their negligent acts. In the case of patient himself chooses the doctor and goes to him, the employer-hospital were not be responsible for the acts of the doctor. Because under such a situation, the hospital acts as a facilitator of providing medical care, where the patient approaches the hospital for treatment and by virtue of this consult, obtains the service of the doctor employed there, the hospital is liable for the negligent acts of the doctor employed by it.

In *Cassidy's case*, the court missed an opportunity to discuss the extension of primary liability, rather what the court taken the notice was evaluating law pertaining to master-servant relationship. The majority held that the nurses and doctors who happened to be permanent staff were servants of the hospital and therefore, the hospital would be vicariously liable for the negligence of such nurses and doctors[346].

This court's interpretation impliedly appears to suggest that doctor not serving as permanent staff would not be servants, thus the hospital could not be liable for their negligence vicariously. In the subsequent case of *Roe vs. Ministry of Health*[347] that the hospital is liable for its entire staff, irrespective of whether they are permanent or temporary or visiting, even if they are not servants, they are agents of the hospital. The only exception would be in the case of consultant selected and employed by the patient himself.

Liability of the Government Hospitals/Doctors

In *State of* ***Rajasthan Vs. Vidyavati***[348], the Supreme Court of India observed that the State is vicariously liable for the tortious acts of its servants or agents which are not committed in the exercise of its sovereign functions. The issue is, whether providing or undertaking medical care through the primary health centre constitutes sovereign function of the state. The Supreme Court of Indai in *AchutraoHaribhauKhodwaVs. State*

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[345]1951 All ER 574.

[346](Trehan S.P. and DebashishSankhari, Medical Professional Patient and the Law, TILEM, NLSIU (2nd edition, 2002) p. 45).

[347](1954) 2 QB 66.

[348]AIR 1962 SC 933.

ofMaharashtra[349]While overruling the judgment of the High Court makes it clear that the high court has erred in arriving at conclusion that maintaining and running a hospital was an exercise of the state's sovereign function. Disapproving this line of thought, the Supreme Court pointed out that running a hospital is a welfare activity undertaken by the government, but is not exclusive function or activity of the government so as to be classified as one which could be regarded as being sovereign power of the state[350]. The state would be vicariously liable for the damages payable on accounts of negligence of its doctors and other employees. Applying this principle, the Supreme Court held the state of Haryana liable for negligence of the doctor in a Government Hospital in performance of sterilization operation resulting in birth of an unwanted child[351].

This was the same position held in Uganda in the case of Sarah Watsemwa Goseltine Baby David Goseltine (through Sarah Watsemwa Goseltine mother and next friend) vs Attorney General of Uganda by Hon. Lady Justice Elizabeth Musoke[352]

The principle of law which emerges is that of vicarious liability and States are liable for damages occasioned by the negligence of employees serving / employed in the services of the Government Hospital as if law would render an ordinary employer liable. The government is required to be impleaded as a party to the suit instituted against a Medical Officer of Government Hospital for damages in respect of neglect act alleged to have been done by him in his official capacity104. Like a private employer, the state is liable to pay compensation for negligence of its medical practitioners who have committed the wrong in the course of their employment as a public servant. However, the state is not vicariously liable for negligence committed by Medical Practitioners of

[349](1996) 2 SCC 634; (1996) 4 CTJ 950 (SC)

[350]the court referred its earlier decision in Kasturilal's case (AIR 1965 SC 1039) wherein it was noticed that in pursuit of the welfare ideal, the government may enter into many commercial and other activities which have no relation to the traditional concept of government activity in exercise of its sovereign function, similarly, running of a hospital, where the members of the general public can come for treatment, cannot be regarded as being an activity having a sovereign character).

[351]103 State of Haryana vs. Santra 2000 CTJ 481 (SC); 1 (2000) CPJ 53 (SC).

[352]Civil Suit No. 675 OF 2006

Government hospitals in course of their private practice or beyond the course of their employment as public officers.

4.13. LIABILITY OF DOCTORS / HOSPITALS IN LAW OF CONTRACT:

Actions of medical malpractice are primarily actions based on the tort of negligence. This is because for majority patients there is weak factual basis in contract[353].Most patients receive treatment in the state run hospitals and as such there is no direct contract between the government hospital patient and his treating doctor. Whereas, when a patient approaches a private health professional for medical care, the relationship between the hospital and the patient is one of contractual in nature. The private patient is entitled to sue his medical practitioner concurrently in tort and contract, although has not entered into a strictly defined contract with expressly written terms governing the agreement for medical case.

It has been suggested that there is a contract between a patient and his practitioner even when the medical care is availed of the state run hospital. An agreement of this nature was canvassed in the Canadian case of *Pittman Estate Vs Bain*[354] in which a hospital claimed that there was no contractual relationship with a patient because there was no consideration, the payment to the medical care is not paid by the patient. It was held that patients provide *indirect consideration* for their hospital care. They contributed indirectly through taxes and they also conferred a benefit on a hospital by providing the hospital with patients without which the hospital would not operate. A hospital benefited in terms of government financial assistance and enhancement of its reputation when patients choose it for their care. This aspect was sufficient consideration to support a contract between the hospital and the patient[355]. In theory,

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[353]Rodney Nelson-Jones and Frank Burton, Medical Negligence, Case Law, (2nd Edition 1995) Butterworths, p. 26).

[354](1994) 112 D.C.R. (4th) 257 (Out. Ct., Gen. Div.)

[355]Ibid.

this rationale should apply to patients receiving treatment in the state hospitals, but was rejected in U.K and India.

CHAPTER FIVE

CONCLUSION. RECOMMENDATION

5.0. Introduction.

This chapter discussed the conclusion and conclusion of the study.

5.1. Conclusion.

A paper of medical mal practice /negligence in Uganda. Current trends and solutions by Justice Godfrey Kiryabwire.

Legal compensation for loss, injury or damage comes in the form of "Monetary damages" no (not suspension or deregistration of the medical worker.)

Trends in Uganda

- Conversation as to informed consent.
- Application of the principle of Res ipsa loquitor - a question of level of complication of procedure.
- Cases against nurses.
- Bulk of medical malpractice cover directed against government not the medical workers.

Changing trends in Uganda on medical negligence.

- Growing awareness of patient right consider the patient character
- Unqualified medical personals
- Growing number of private clinics and health centers (look at private liability vicarious liability).
- Consider the right to health / life as an emerging issue (human right).
- Look at public interest litigation in medicine article 80 of the constitution

Solution /way forward

The use of professional indemnity insurance and the establishment of medical defense union as it is in the UK and USA.
Good Samaritan legislation for medical emergencies – consumer protection bill of 2004.

As the constitution provides the right to life and an increased number of NGO'S on patients right e.g. PCAU (Palliative care Association of Uganda). And UGANET (Law Ethics and HIV AIDS. There is need to enforce medical standard as means of avoiding an escalation of these case.
Time has also come to protect medical some form of indemnity insurance (by government for public doctors and private doctors to take out insurance policies.

5.2. Recommendations.

The legal and policy recommendations and conclusions in a view of protecting consumers in the medical and health sector.

The review presents a range regional and international instruments that provide basic public health obligations that have been useful at regional level for securing rights for particular vulnerable groups. East African countries have ratified most of them, signaling policy commitment to these instruments, but have not yet fully included their provisions in their national laws.
In this respect, particular attention could be given to ensuring national laws cover the relevant provisions in Article 12 of the International Covenant on Economic, Social and Cultural Rights[1], the African Banjul Charter on Human and Peoples' Rights, and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[1]. Various areas of law are provided for in all countries, and it is more in their application that there may be deficits.

In some instances, laws are not implemented because specific regulations to enforce provisions of the parent Acts are not made, especially where new laws are made which

save the regulations made under the old Act. For example, most regulations required to be made under the Uganda Public Health Act have not been made. This greatly affects the operation of the Act.

These include:

- the right to life, with poverty, access to medical services leading to differentials in the exercise of this right;
- overcoming barriers to application of laws on sexual and reproductive health rights in vulnerable groups such as women and children relating knowledge, taboos and norms about sexuality and reproduction, provision of victim-friendly mechanisms for reporting, investigating and prosecution of abuses, and services for rehabilitation of offenders;
- constitutional provisions for non-discrimination on grounds of gender, ensuring gender equity is adequately protected in all laws, and overcoming gender inequalities in decision making for and access to services;
- applying provisions for compulsory licensing and parallel importation of essential drugs, to ensure adequacy and affordability; and
- supporting disadvantaged communities to exercise rights to information and participation in health, including in relation to ethical practice of health workers.

In terms of implementing the law, there are opportunities for improved interaction across institutions, such as:

- strengthening interaction between health and education services and stimulating shared mandates, such as in promotion of Primary Health Care;
- strengthening coordination between central and local government and other institutions, including private sector and non-governmental entities working in health;
- strengthening the capacity of regulatory agencies and professional regulatory bodies established under the law in terms of their operations, technical knowledge and expertise, reporting and accountability, infrastructure and equipment, financial resources, number and skills of staff;

- providing public information on existing policies and laws;
- strengthening access to courts by vulnerable groups by creating more awareness of the existence of the rights and the available avenues for redress in case of breach; and
- legal training in public health to increase competencies in the courts to manage public health cases.

Improved practice could also be stimulated by ensuring wider public debate and input to laws when they are under development, adequate operational guidelines for laws and regulations after they are enacted and improved health literacy on legal provisions for the public through mass media and civil society.

Some areas of law are provided for in some laws but not all relevant laws, or not in all countries. This signals policy commitment to these areas, and calls for measures to harmonise legal frameworks within countries to ensure consistency, and across the three countries at East African level, make reference to examples from existing law. Such harmonization not only facilitates consistency in and cross border management of health issues, but also ensures health is protected across sectors, across the region as a whole, and in wider international and global engagement in an increasingly liberalized environment.

This would include:

- Harmonise health provisions in constitutions to set a fundamental platform of rights, obligations and responsibilities for health and access to health care that guide specific national policies and laws. Each country has important specific provisions that would usefully contribute to such a harmonized set of provisions, particularly given the degree of social, cultural and legal interaction between the three countries.
- Ensure explicit legal provision of the *precautionary principle*, 'requiring that where there is risk of serious, irreversible advance effects to health occurring the lack of scientific certainty should not prevent or impair the taking of precautionary measures to protect public health'.

- Harmonise and update public health law to add to existing provisions dealing with specific forms of health related nuisance in the environment, to more comprehensively provide for environmental health (water, sanitation, pollution etc) rights, standards, authorities and obligations, including of private providers and developers, given the growth of informal settlements and privatisation of supplies.

This includes consumer rights and supplier obligations to basic levels of provisioning for protection of public health, to health impact assessment prior to introduction of new technologies or processes with potential environmental impacts, to provision of public information and reporting, and elaboration of roles, powers and responsibilities in environmental health from national to local level.

- Harmonise provisions dealing with hazardous food, drugs and substances, and developing laws to cover obligations arising in trade in services affecting public health, (e.g. financial services, advertising) to comply with public health standards, minimize health risks and provide for health impact assessments and public information where impacts are not clear.
- Widen the current focus in public health laws on primary *medical* care and infectious disease control to cover primary health care and its elements.
- Strengthen laws governing private health providers in terms of their co-ordination, requirements for service provisioning, principles covering practice, reporting obligations and the government authorities and public rights to information, consultation and participation in relation to these services. This includes traditional health practice.
- Updating public health law to include provisions for public information, awareness and participation such as those in more recent laws such as those around HIV and AIDS.

- Setting out roles, authorities and mechanisms for public participation in health services and for public accountability of health services. This includes providing mechanisms for direct community participation in running health services and for inter-sectorial co-operation and co-ordination, and data and reporting obligations of public and private health services.

In some cases, policy commitments exist but omissions or gaps in law do not reflect these policy commitments and ensure they are applied at national level across all sectors. Many public health laws were made decades ago, some during the colonial periods, and have not since then been comprehensively reviewed. Changing socio-economic conditions call for laws to be updated, and often strengthened. In these cases, it would be important to open dialogue on legal review under the relevant enabling acts to address gaps between policy and law. This includes:

- legal provisions to provide for food security, including food vulnerable groups, with current laws more focused on food safety;
- legal provisions to set out public health requirements in trade related aspects of food security, together with consumer rights or supplier obligations to provide information on prohibitions and standards applying to their products in source countries; and
- laws specifically providing for rights to shelter beyond provisions specifically for employees and disabled persons, with scope for strengthening national law to: set and monitor housing standards; prohibit the construction of substandard shelter and provide the obligations to remedy or upgrade this; inspect and provide public information on areas of substandard housing and plans to address these; provide for requirements and obligations for shelter and housing security for specific vulnerable groups, including lodgers, children, disabled people, and people with terminal illness;
    - provisions regulating the financing of health services to ensure equity, adequate financial protection, inclusiveness and cross subsidies in public and private health financing arrangements and their reporting on these matters;

    laws governing trade in health and health related services, to ensure adequate protection of public health principles, equity and access within these areas of market activity in the health sector. In this respect such provisions would need to give widest policy latitude for government authorities to protect public health, and avoid irreversible commitments and other policy concerns arising in relation to the WTO General Agreement on Trade in Services (GATS); and rights and obligations in

relation to health worker migration, including of authorities and agencies financing, managing and negotiating such issues.

The author shave suggested that these areas be reviewed by health authorities, parliamentary committees, health professional associations and health civil society to identify an agenda to widen public awareness on existing laws, unambiguously secure public health rights, obligations and roles in all areas of economic and social activity, and address deficits where they exist, particularly in gaps between policy and law.

Finally, we identified knowledge gaps. These exist, for example, in relation to legal provisions that reflect social norms in new areas of public health, such as in relation to organ transplants, DNA tests, cloning, euthanasia, human trafficking, and emerging international epidemics such as bird flu virus and Ebola.

Research is also needed in how to more effectively and equitably provide for law and its implementation in areas such as health financing, decentralization of health systems, trade in health services, health worker migration, forensics, and governance of health systems at local, national and international level.

This calls for further research in these areas, guided by policy and a research agenda on emerging public health law issues. Public health law has perhaps not had adequate profile in academic and professional practice, but is a critical area of work if countries in east and southern Africa are to protect public health and health equity in an environment increasingly influenced by global challenges and policies.

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