

*Health co-ops
around the world*

UGANDA



Coordination of the global project

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MAKING A DIFFERENCE IN NOVA SCOTIA COMMUNITIES

The views expressed in this report are not those of IHCO

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Introduction

Health co-ops around the world are a series of publications showing the contribution of health co-ops in the health system from a national perspective. The project has been conducted under a mandate of the International Health Co-operative Organisation (<http://www.ica.coop/ihco/>).

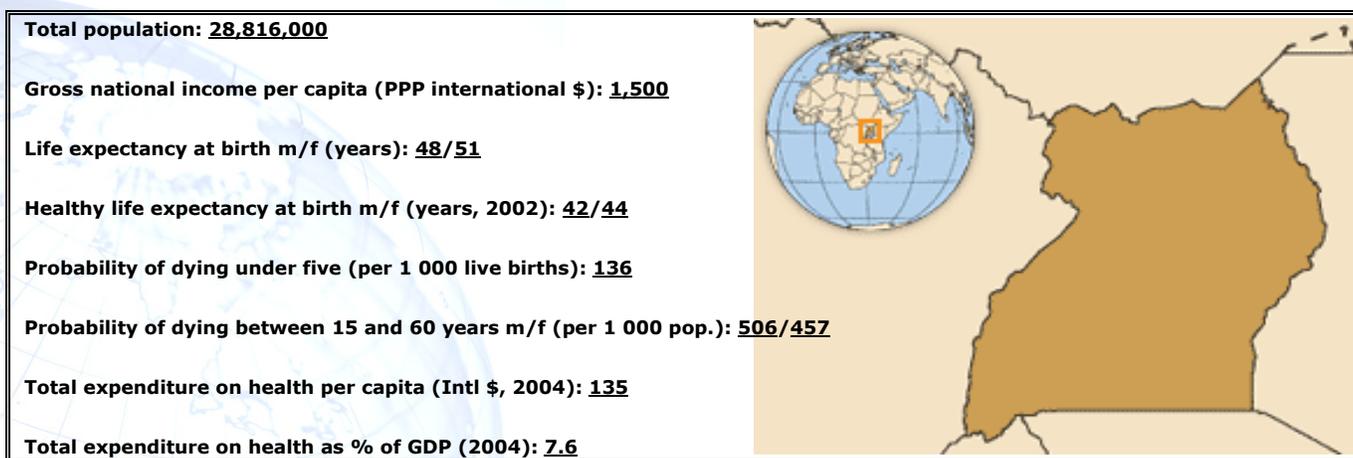
Each case includes a snapshot of the national health system, information on the presence of health co-operatives and practical references. It is based on a survey conducted in 2007 with the kind collaboration of many people involved in health co-ops and other relevant organisations located in targeted countries. The series includes the following national cases:

- ✓ Canada
- ✓ United States of America
- ✓ Benin
- ✓ Uganda
- ✓ Mali

The relation between this research project and the very important study conducted in 1995 and 1996 by the United Nations (published in 1997 under the name *Cooperative Enterprise in the Health and Social Care Sector A Global Survey*), as well as the methodological framework are presented in the document:

- ✓ Global background and trends from a health and social care perspective.

Country Statistics¹



Figures are for 2005 unless indicated. Source: [World Health Statistics 2007](#)

¹ Statistics extracted from: World Health Organization (WHO) – Uganda: <http://www.who.int/countries/uga/en/>, viewed 15/02/2007 and reviewed 12/2007.

Snapshot of Uganda's Health System

Organizational Structure of the Health System²

Health services in Uganda collapsed during the troubles of the 1970s and into the 1980s. In 1993, the Health Policy clearly set out to consolidate and rehabilitate Uganda's health services.

Today, services are provided by a mix of public and private providers with the public sector playing a key role. Through decentralization, the districts have taken on the responsibility for delivering district health services receiving block grants from the Ministry of Health. The role of the Ministry of Health is now focused on providing technical support, supervision and monitoring; setting norms and standards; mobilizing resources and coordinating donors.

The NGO sector also plays an important role. Traditionally, there has been great antagonism between the Government and the NGO sector but this is disappearing and the Government is now providing direct support to the NGO sector. However, the NGO sector remains primarily self-financed. Also there has been an explosion of the role played by the private sector especially in urban areas.

Health Care Financing and Expenditure³

In Uganda, the total health care expenditure represented approximately 7.6% of the GDP in 2004. Government expenditure represented 32.7% and private expenditure 67.3% of the total expenditure on health. Of the total private expenditure, 51.30% came from out-of-pocket payments.

Health Care Provision⁴

Only 49% of households in Uganda have access to health care facilities in Uganda. Access has been limited by poor infrastructure, especially in the rural areas where the majority of the population lives.

In order to address these issues, the Government of Uganda has developed a Health Sector Strategic Plan (HSSP) which looks at issue of access by using the existing political structure of the country. This is a five level political structure with the district at the apex. At the parish level, it is expected that there will be minimal facilities to be able to directly address the immediate health needs of the village dwellers.

² Extracted from : DFID (2000), Uganda Country Health Briefing Paper:

http://www.dfidhealthrc.org/publications/Country_health/Uganda.PDF, pages 1-2, viewed 03/2007.

³ WHO statistics – Core health indicators (2007), http://www.who.int/whosis/database/core/core_select.cfm, viewed 11/2007.

⁴ Extracted from: WHO/AFRO (2001), Uganda – Health Systems, <http://www.afro.who.int/uganda/healthsystems.html>, viewed 03/2007.
The statistics in the box are from WHO - core health indicators.

It should however, be noted that the human resource base for the health sector is grossly inadequate. Therefore in the first few years of HSSP implementation, the capacity building of human resources is one important aspect that the Government is focusing on.

In 2004, the physician density per 1000 population in Uganda was of 0.08 and the nurse density, 0.55. Hospital beds per 10 000 population totaled 7.0.

Developments and Issues⁵

Decentralization in Uganda is part of the 1995 National Constitution. While the Ministries are responsible for policy, standards, guidelines and monitoring of activities, the direct implementation of the various programs has been placed in the hands of district officials. Decentralization is still in its early days in Uganda. Therefore, there are issues like ownership of the programs, planning cycles and accountability which still need to be improved upon.

Health Cooperatives in Uganda

The birth of Health cooperatives in Uganda is an interesting example of the power of international intercooperation⁶. When producers of dairy cooperatives in Uganda saw the benefits of cooperating to secure veterinary care for their cattle, they began to wonder if the same approach could be used to secure health care for their children. Health care emergencies often placed families in very precarious situations forcing them to sell off assets in order to pay for the costs of care. They talked about it to Land O' Lakes, a USA-based dairy cooperative who had been supporting the development of dairy cooperatives in Uganda since 1994.⁷ Land O' Lakes reflected on the issue and approached the giant health cooperative, Health Partners of Minnesota, about the feasibility of setting up health care cooperatives using the co-operative foundations of existing dairy co-ops in Uganda.

Health Partners decided to get involved because, as George C. Halvorson, then CEO of Health Partners said, "It's a cooperative thing to do! [...] If we can use some of the tools we've developed to help others go down a similar path, then, we co-ops believe that's a reasonable thing for us to do. It fits our value system, and our cooperative commitment to helping others."⁸

In 1997, Health Partners and Land O' Lakes helped form the Uganda Health Cooperative (UHC). It originally began working with dairy cooperatives but eventually, it expanded to other existing groups such as coffee and tea cooperatives, micro-finance groups, schools, etc, to offer affordable prepaid

⁵ Extracted from: WHO/AFRO (2001), Uganda – Health Systems, <http://www.afro.who.int/uganda/healthsystems.html>, viewed 03/2007.

⁶ Intercooperation: refers to cooperation between cooperatives.

⁷ Halverson, George C. (2007), Health Care Co-ops in Uganda: effectively launching micro-health groups in African villages, The Permanente Press, Oakland, California, page 3.

⁸ Ibid, page 4.

health care plans to members⁹. UHC would meet with members of the cooperatives and their families to explain how the program functions and survey the degree of support and participation of the group. Once the group was selected, it became the owner of its health care plan and did not need to register it as a separate legal entity.¹⁰

At their peak, health care plans topped at 53 and covered about 5,600 members. In 2004 however, funding cuts caused UHC to reduce its staff and the plans went down to 17 (mostly older, larger plans), covering approximately 3000 members. The program has become largely self-sufficient.¹¹

Some positive outcomes have been lower health care costs for members due to preventive care and earlier treatment of diseases, fewer absences from employees, regular incomes and increased savings for health providers.¹²

The Uganda Health Cooperative¹³

The Uganda Health Cooperative (UHC) was founded in 1997. It groups together several cooperative health care plans mainly in the Bushenyi District of Uganda, all of which are user-owned. It has four employees and generates annual revenue of \$1917. Approximately 4300 people per year benefit from health services through UHC.

The creation of the UHC originated with dairy farmers supported by USAID Cooperative Development grants. Funding was given to HealthPartners in order to help farmers build a health cooperative. The cooperative expanded in 2000 to include other employment groups.

Its development was marked by the first subgrant received in 1997 by HealthPartners in order to help develop a health cooperative in Uganda. Funding was renewed in 2002 and 2004. In 2006, a Board of Directors was elected and the first annual general meeting was held. In 2007 intensive capacity building for providers and the board of directors began.

The UHC's main purpose is to provide health care coverage for members when they need it. It is involved in health promotion activities, funded by United States Agency for International Development (USAID) Child Survival. Preventive services are also funded through USAID Child Survival and target members such as pregnant women and children under five. Curative health care services offered to members are funded by premiums paid to the cooperative health plan. Cooperative health services are provided in clinics or community health centers as well as hospitals¹⁴. The cooperative also provides health promotion and prevention activities. The medical professionals currently working with UHC include 15 doctors (general practitioners), 30 nurses and 5 midwives.

⁹ Weihe, Ted (2004), Case Study: The Ugandan Health Cooperative, Land O' Lakes, Inc, St-Paul Minnesota , page 1.

¹⁰ Ibid, page 5.

¹¹ Ibid, page 2.

¹² Ibid, page 1.

¹³ Information collected from the survey completed by Health Partners' Uganda Program Manager in July 2007.

¹⁴ "UHC works with local authorities and providers. Though in some cases, the health co-op has built its own clinic in most cases, the co-ops simply serve as purchasing groups and buy coverage from local contracted caregivers." Weihe, Ted (2004), Case Study: The Ugandan Health Cooperative, Land O' Lakes, Inc, St-Paul Minnesota , page 5.

USAID has supported the Uganda Health Cooperative through cooperative development subgrants and Child Survival funding is enhancing the preventive initiatives available to this community. Premiums paid by members cover the cost of treatment and are being transitioned to also create a reserve start-up fund and to cover administration of the health plans.

Members chose to join the health cooperative because they know they will not have to sell their only financial assets to pay for health care. The advantages are that members can receive care when they need it. They can plan ahead to pay premiums so the health plan saves them from life threatening illnesses. Also, providers can pay staff and plan ahead to order stock supplies. Providers receive increased payment since the chances of poor credit rating and debt is reduced.

The UHC identifies its main strengths as being premiums which cover treatment costs so providers do not lose money as well as the very committed Board of Directors. As for its challenges, the UHC states that membership growth has been slow and has not increased sustainably between July 2006 and June 2007. There has been a history in this area of groups starting programs and disappearing with the financial contributions from the community therefore, non-members are afraid the health plan will not be there when they need it. Bushenyi, being a poor district with a history of altruistic benefactors, is used to free services, which makes financial contribution and community participation challenging.

The Uganda Ministry of Health requested feedback from the Uganda Health Cooperative as they were developing the National Health Insurance Bill, 2007. While government policy is to provide universal health care coverage, due to lack of government funding the reality is that community based financing is the only way to ensure drugs, staff and quality cares are available in some rural districts.

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