An excerpt from:
Better Health & Social Care: How are Co-ops & Mutuals Boosting Innovation & Access Worldwide?
An International survey of co-ops and mutuals at work in the health and social care sector (CMHSC14)
Volume 2: National Cases

For the research framework, the analysis of the national cases, and other research components, including a description of the research team members, refer to Volume 1: Report.

For information regarding reproduction and distribution of the contents contact the editor and research leader:
Jean-Pierre Girard
LPS Productions
205 Chemin de la Côte Sainte-Catherine, #902
Montréal, Québec H2V 2A9
Canada
info@productionslps.com
URL http://www.productionslps.com

UGANDA

2014

HEALTH SYSTEM

In Uganda, health services are provided by the public and private sectors. Each covers about 50% of the reported outputs.[1]

In 1999 a new National Health Policy was inaugurated and to implement it, the first phase of a Health Sector Strategic Plan. This plan put in place a Minimum Health Care Package – 12 health programmes to address the most common or debilitating conditions for which relatively cost-effective interventions are available:

1. Control of communicable diseases (malaria, STD/HIV/AIDS, tuberculosis)
2. Integrated management of childhood illness
3. Sexual and reproductive health and rights
4. Immunization
5. Environmental health
6. Health education and promotion
7. School health
8. Epidemic and disaster prevention, preparedness and response
9. Improving nutrition
10. Interventions against diseases targeted for elimination or eradication (includes polio, guinea worm, and neonatal tetanus)
11. Strengthening mental health services
12. Essential clinical care

Implementing the Minimum Health Care Package requires a responsive health system that provides timely, appropriate, and affordable interventions.

Mama Co-op. Photo: HealthPartners.

Population (in thousands): 36,346

Population median age (years): 15.68

Population under 15 (%): 48.54

Population over 60 (%): 3.72

Total expenditure on health as a % of Gross Domestic Product: 8.0

General government expenditure on health as a % of total government expenditure: 10.2

Private expenditure on health as a % of total expenditure: 76.1

HEALTH COOPERATIVES IN UGANDA[2]

The birth of health cooperatives in Uganda is an interesting example of the power of international inter-cooperation. When dairy producers 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 place families in very precarious situations, forcing them to sell off assets in order to pay for the costs of care.

The producers talked it over with **Land O'Lakes**,[3] a USA-based dairy cooperative which has been supporting the development of dairy cooperatives in Uganda since 1994. Land O'Lakes reflected on the issue and approached the giant health cooperative **HealthPartners** of Minnesota about the feasibility of setting up health care cooperatives in Uganda using the foundations of existing dairy co-ops. HealthPartners elected to get involved.

In 1997, HealthPartners[4] and Land O'Lakes helped form the Uganda Health Cooperative (UHC). It originally had worked with dairy cooperatives but then expanded to other groups (e.g., coffee and tea cooperatives, microfinance groups, schools) in order to offer affordable, prepaid health care plans to members. UHC would meet with members of these cooperatives and their families to explain the programme and assess their support and readiness to participate.

Once a group was selected, it became the owner of its health care plan and did not need to register it as a separate legal entity. Some positive outcomes have been lower health care costs for members due to preventive care and earlier treatment of diseases, fewer employee absences, regular incomes, and greater savings for health providers.[5]

CASE STUDY

Affordable access to prenatal care, labour and delivery with a skilled health professional, and support within 72 hours of birth is critical to mitigating maternal and child morbidity and mortality. In 2013 the **Mama Co-op** project[6] was launched to enable pregnant women in Uganda's Buhweju district to recognize, demand, and access quality health care through a member-owned and -operated health cooperative:

> "HealthPartners participated in a competition for the most innovative ideas to Save Lives at Birth .... Out of over 500 applicants, HealthPartners cooperative development strategy was one of 65 finalists and one of 15 winners! As a result, HealthPartners received a one year US$250,000 seed grant to make the Mama Co-op a reality that saves lives for women and children in Uganda. HealthPartners International development projects promote cooperative development for all, but the Mama Co-op focuses on the most vulnerable population at the most vulnerable time, women of reproductive age and newborns. Supporting women is a high-yield investment, resulting in stronger economies, more vibrant civil societies, healthier communities and greater stability."[7]

The Mama Co-op project is based on the model of a HealthPartners Cooperative in another district of southwest Uganda. The project addresses the quality, accountability, and accessibility of health care through the development of a community-owned health co-op that will serve at least 900 pregnant women and newborns (6,000 people in total).

Mothers in rural areas face two challenges: 1) lack of access to accurate information on healthy preventive and treatment-seeking behaviours; and 2) lack of access to quality health services. The absence of demand for health services is due to a lack of financial resources, cultural beliefs, and practices that discourage seeking care. The care which is available is often poor in quality. HealthPartners supports the efforts of local stakeholders to overcome these challenges sustainably, by building their capacity to start and manage their own health cooperative.

HealthPartners' scalable co-op model is designed for resource-poor settings with roles and responsibilities filled by local stakeholders, especially pregnant women, women of reproductive age, and the poor. A member-elected board of directors approves benefit packages selected by groups. Factors ranging from low administrative costs to inclusion of large family sizes are key to health insurance plans driven by local stakeholders. Members pay inexpensive quarterly premiums and co-payments at the time of health care service. The board also supports negotiations with providers for annual Memorandums of Understanding (MOU). Premiums and membership lists are turned over to group leaders who deliver them directly to the provider. Volunteer Village Health Teams, trained by the Ministry of Health, sensitize the community (employers, other co-ops, women's groups, burial societies, etc.) to encourage preventive and treatment-seeking behaviours and to recommend health co-op membership. In exchange the volunteers receive discounted co-op membership rates.

Health care providers participate in the co-op model, too. Member premiums secure providers a consistent, reliable source of revenue, enabling them in turn to recruit and retain quality staff and keep a stock of supplies and drugs. The health co-op increases members' ability to seek treatment early. This reduces treatment costs for providers and improves health outcomes. If the provider does not administer services at the level of quality specified in the MOU, members are free to select a different provider. This motivates providers to give the best care possible. They employ data entrants to check member identification cards and current member lists before delivering services and to track premiums and treatment costs.

Health insurance schemes already exist in Uganda. The problem with most donor-funded health insurance models is their lack of sustainability. Implementers use donor dollars to reinsure providers, subsidize premiums, or introduce technology. Beneficiaries eagerly embrace these options and donors are pleased with the results. But when these projects conclude, beneficiaries cannot afford to pay premiums and have not developed the skills to maintain or update the technology.

Unsustainable projects such as these can create dependency that is a disservice to beneficiaries and donors. The sustainability of the HealthPartners model is its most critical innovation. Through a member-owned and -operated health co-op, members continue to receive quality health care and providers continue to profit even after the project has ended.

The Mama Co-op project is very new. As yet there is insufficient data on which to base a discussion of its progress, activities, etc.

SOURCES

[1] Much of the information for this case originates in the following study: Republic of Uganda, Ministry of Health. 2010. "The Second National Health Policy: Promoting People's Health to Enhance Socio-Economic Development." Kampala. (http://www.usaid.gov/sites/default/files/documents/1860/National_Health_Policy_July_2010.pdf).

[2] See the book which has been released on this project: Halvorson, George C. 2007. *Health Care Co-Ops in Uganda: Effectively Launching Micro Health Groups in African Villages*. Oakland, CA: Permanente Press.

[3] "Since 1981, Land O'Lakes International Development has applied an integrated approach to international economic development that capitalizes on our company's 90 years as a leading farm-to-market agribusiness. We use our practical experience and in-depth knowledge to facilitate *market-driven business solutions* that generate economic growth, improve health and nutrition, and alleviate poverty." Quoted from: Land O'Lakes Inc. 2014. "Innovative Solutions for Global Prosperity." Webpage. (http://www.idd.landolakes.com/).

[4] HealthPartners is an independent, private, member-owned and democratically-governed business, created with member equity. It has been active in Uganda since 1997 as part of the company's commitment to global social responsibility. (For more information on the HealthPartners family of health care companies, see the United States national case, p. 172.) HealthPartners. 2014. Website. (https://www.healthpartners.com/public/).

[5] For more details, see: Girard, Jean-Pierre, and Geneviève Bussière. 2007. "Health co-ops around the world: Uganda." International Health Co-operative Organisation (IHCO). (http://www.usherbrooke.ca/irecus/fileadmin/sites/irecus/documents/ihco_jeanpierre_girard/coops_world_anglais/uganda_anglais.pdf).

[6] For more information see: Walters, Paul, and Christine Makole. 2013. "HealthPartners Mama Co-op." Midterm Report AID-OAA-F-13-00025. HealthPartners. (https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_041663.pdf).

[7] Saving Lives at Birth was a project sponsored by the Bill and Melinda Gates Foundation, the Government of Norway, the United Kingdom Agency for International Development, the United States Agency for International Development, and Grand Challenges Canada. Quoted from: HealthPartners. 2014. "Partnerships: Mama Co-op." Webpage. (https://www.healthpartners.com/public/about/uganda/partnerships/).