A Cooperative Approach to Improving Healthcare in Uganda

HEALTHPARTNERS CONNECT GIRLS CENTER FINAL REPORT

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Executive summary

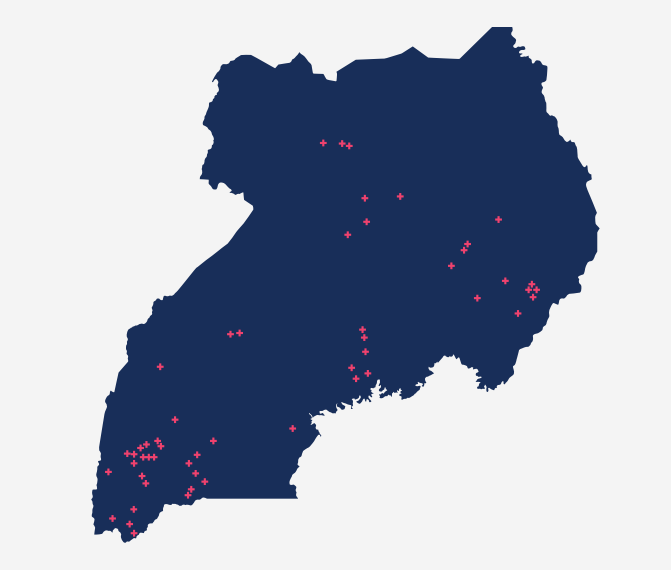
HealthPartners developed an innovative health cooperative model of member-owned, locally led partnerships that sustainably increased access to healthcare, improved health outcomes, and increased health equity, giving members a voice in the quality of care they received, thanks to USAID's Cooperative Development Program.

Worldwide, nations are looking for ways to achieve universal health coverage (UHC). The United Nations and the African Union include UHC in their development strategies. Yet in many cases – particularly in less-developed nations – the informal sector stands as one of the biggest barriers to its achievement. Defined as those working outside legal and regulatory systems, the informal sector has inconsistent and untraceable income and less access to information and technology, making costing and collecting premiums, communicating benefits, and ensuring quality services complex. The challenge is further complicated by the heightened vulnerability of those working outside formal regulation. In Uganda, the informal sector makes up over 80% of the population. The failure to reach them is borne out in the national statistics about poor health outcomes and high catastrophic health costs.

HealthPartners Connect Girls Center (CGC) was a six-year USAID-funded activity, crafted to overcome the challenges of providing health coverage to the informal sector via locally owned and managed health cooperatives. **The objective of CGC was to increase demand for and access to quality health care in a health system responsive to all people's health care needs, including girls and young women aged 10-19.** Progress was measured with three intermediate results, outlined below.

IR1: Improved cooperative business performance

Over the course of the activity, health cooperative members saw a 30-fold increase in the value of their healthcare (2019 ($0.18) and 2023 ($5.84)). At the same time, providers benefited from a 12-fold increase in per member surplus (from $0.09 in 2019 to $1.06 in 2023). What's noteworthy about this data is that you'd assume as treatment value increased for patients, surplus would decrease – but instead, both increased. That is the result of risk pooling and prepayment, which decrease out of pocket costs for members and increase consistent income for providers.



Health cooperative insurance care providers in Uganda, 2024

IR2: Improved cooperative enabling environment

From 2018 to 2024, the number of providers offering affordable cooperative health insurance grew from 27 to 69. Membership grew by 58% and today at least 40,000 Ugandans are covered by health cooperative insurance. Evaluations show that quality of services and patient satisfaction improve with cooperative health insurance. CGC supported the design and inclusion of health cooperatives in the Cooperative Societies Act Amendment (2020), providing the legal foundation for the growth of health cooperatives in the country. CGC also worked with the Ministry of Health (MOH) to integrate health cooperatives in the National Development Plan (IV), National Community Health Strategy, and Community Health Insurance Framework, which together set the stage for the evolution of healthcare in the country. To provide support to nascent cooperatives, former CGC staff – now Uganda's preeminent health cooperative experts – formed a nationally-registered worker cooperative that will continue the work of health cooperative training and expansion.

IR3: Enhanced cooperative development strategies

When HealthPartners started working in Uganda in 1997, health cooperatives didn't exist. By 2018, six health cooperatives had registered with the Ministry of Trade, Industry, and Cooperatives (MoTIC). Today, 30 health cooperatives are registered. The growth over the past six years is a testament to the seeds planted over many years of partnership and training. All 30 registered cooperatives were trained in some way by HealthPartners, and most are now independent. Replication of the model has grown beyond HealthPartners' direction into an autonomous movement.

Achievement of the intermediate results led to demonstrable progress toward CGC's objective. **Demand for care increased**, as measured by both membership growth and increased treatment value per member. **Accessibility improved** in geographic and economic terms. As more providers offered cooperative insurance, more people had access to affordable care. Those who enrolled paid an average of 41% less for care than non-members. **Care was responsive to all people, including girls 10-19**. Prepaid care granted women and girls a voice in healthcare decision-making, since they were not reliant on male partners for funds to go for care. **Increased demand and accessibility led to improved health outcomes for members**. Multiple evaluations have shown that health cooperative members are less likely to have diarrheal disease and malaria and have a 7-fold increase in access to safe antenatal and delivery care. These indicators are significant because malaria, diarrheal disease, and maternal / child welfare are some of the greatest contributors to morbidity and mortality in Uganda, so their reduction has widespread impact.

Cooperative insurance members paid

41% less

for care than non-members

The enabling environment now exists in Uganda to continue to expand health cooperatives without the direct support of HealthPartners. Health cooperatives are being launched autonomously. UHPC provides training to nascent health cooperatives. Regulatory bodies have developed and now enforce supportive health cooperative laws. CGC has effectively passed the torch to local health cooperative experts. Although the CGC activity has ended, its impact will continue to grow through its local partners.

Given the global demand for informal sector solutions, CGC lessons and outcomes should be considered widely by governments and cooperatives interested in expanding health coverage. The result – as evidenced by CGC data – is increased demand for and accessibility of healthcare, improved quality and equity of care, and improved health outcomes.

Lessons learned

Prepayment of premiums is critical to the model

Prepayment incentivizes prompt treatment seeking, improving health outcomes and reducing treatment costs. It ensures providers have the income necessary to provide quality care. It incentivizes providers to educate members about healthy behaviors and ensure quality care because the healthier members remain, the less providers must pay in treatment costs. Importantly, prepayment significantly reduces the costs of health insurance because it bypasses the huge administrative infrastructure required for claims, billing, post-payment, and collections.

Health cooperatives empower women

Because premiums are prepaid, health cooperatives enable women to access care as soon as it is needed instead of relying on a male partner's authorization and distribution of funds. Additionally, a recent study by the International Cooperative Research Group (ICRG) found that female health cooperative members were a) more likely to have higher incomes because of their membership, b) seven times more likely to access safe antenatal and delivery care than non-members, and c) more likely to have access to health education, enabling them to make informed healthcare decisions for themselves and their families.

Health cooperatives are affordable

Because health cooperatives exist to meet the healthcare needs of members, rather than maximize profit, their premiums are set low enough to cover costs through shared risk yet high enough to ensure providers recover treatment costs. This enables members to reduce the financial risk of investing in health insurance while protecting providers from bad debt when patients can't pay their bills.

Health cooperatives are sustainable

Health cooperative funding comes from members and providers. Because it is locally resourced, health cooperatives overcome the common challenge of other health schemes that rely on donor or government funding. A key lesson learned was not to provide premium subsidies. When members prepay for care from day one, they know what it takes to benefit, and nothing changes when donor funding ends.

Health cooperatives protect the informal sector where social and private schemes cannot

Because health cooperatives are locally managed, resourced, and owned, they overcome the challenges that often plague larger schemes – costing and collecting premiums, communicating benefits, retaining members, and ensuring quality services. Health cooperative members come from the same community and rely on existing groups for membership, which allows them to collect premiums at convenient locations and community members hold each other accountable to pay. Members are empowered to negotiate their premiums – and since health cooperatives exist to meet needs rather than make profit – costing is simple, affordable, and benefits can be adjusted based on needs and ability to pay. Cooperative meetings and provider bulletin boards are used to share benefits information and success stories, building ownership and promoting retention without adding marketing costs. Quality services are driven by increased provider cost recovery as well as cooperative negotiation power.

Future challenges and opportunities

Challenges

New health cooperatives need initial training and managerial support

Launching a health cooperative and maintaining a surplus is complicated at first. Nascent cooperatives not only need training for all stakeholder groups, but they often need managerial and data analysis support when they run into challenges like deficits. The answer is not to provide subsidies when cooperatives have deficits, but to train cooperatives to understand and address the root causes of their deficits so they can overcome them independently. To address this future challenge, CGC developed a series of support supervision guides and trained local partners as trainers. The guides include 6-point capacity building measurement tools for both providers and health cooperative boards, along with corresponding trainings.

MoTIC and MOH need to enforce cooperative regulations and quality control measures

MoTIC plays a significant role in ensuring boards are held accountable to their members. MoTIC staff's understanding of how a health cooperative works and how to audit a health cooperative, and their willingness to enforce cooperative regulations, builds trust in the model. MOH is responsible for ensuring service providers are held to the highest quality standards. CGC has spent six years training MoTIC and MOH to understand and appreciate the model and has called on their authority over the years to mediate conflict and address quality concerns. To ensure continued support, CGC has also networked cooperative leaders with ministry officials, so they have the connections to call on the ministries as needed.

High provider staff turnover

Management and data entry for the health cooperative is carried out largely by provider staff. Ensuring they are highly trained is critical to the success of the cooperative. Each time provider staff leave, the provider or its partners must train new staff to implement the model. To reduce the reliance on CGC for retraining, CGC used a training of trainers model, so once cooperative stakeholders are trained, they have the tools and knowledge to train new staff. Additionally, UHPC can provide training for new staff.

Opportunities

The government of Uganda (GOU) now has the regulations, tools, and local expertise to incorporate health cooperatives in their national health insurance scheme (NHIS)

Through consolidated risk pooling, cross-subsidization, regulation, and quality control measures, NHIS can build on the existing health cooperative infrastructure to reach the informal sector with relatively little direct investment. GOU has spent over 20 years trying to formulate a realistic plan to cover its population and countries around the world face the same challenge. Evidence now shows, health cooperatives are a cost-effective solution. Hurdles of marketing, enrollment, premium collection, renewal, and claims and billing can all be overcome if the government builds on existing cooperatives to expand coverage affordably and sustainably.

MOH can leverage the health cooperative model to reach its health outcome goals

One of the unique benefits of the health cooperative is its intrinsic incentive to maintain the good health of members, because healthier members mean lower treatment costs. Recognizing this opportunity, care providers invest in health education. Evidence shows that, as a result, health cooperative members have better health outcomes – they are less likely to have diarrheal disease and malaria, more likely to deliver with a skilled professional, and more likely to access antenatal care. MOH could take advantage of the incentive structure to roll out health education campaigns through cooperatives to boost health outcomes.

Activities and attainment of results

Goal: Improve cooperative business performance and strengthen the enabling environment under local leadership in order to increase health care access and quality for improved health outcomes and community resilience

OUTCOMES	INTERMEDIATE RESULT	ACTUAL RESULTS
R1 Improved cooperative business performance	**1.1** Improved governance and management	By 2023: • 100% of cooperatives reported improved governance • 531 provider staff trained in climate-smart practices • 45% of BOD members were female (Life of Activity (LOA) Average)
	1.2 Improved cooperative market performance	• Members received $606,345 USD-worth of healthcare (LOA) • Treatment value per patient increased 30-fold (LOA) – $0.18 (2019) to $5.48 (2023) • Surplus per member increased by 1,078% over LOA ($0.09 (2019) to $1.06 (2023)) • LOA cumulative provider surplus: $98,097 • Average annual provider surplus increased 600% from $81 to $570 USD (LOA)
	1.3 Improved cooperative financial health	• Members invested $37,723 in share capital to improve healthcare services • 100% of cooperative had income that exceeded their expenses • Cooperatives held AGMs, audits, quarterly meetings without donor funding
R2 Improved cooperative enabling environment	**2.1** Improved access to services and resources	• Membership increased an average of 20% per year (save 2020, when COVID reduced membership) • 57% of cooperative members were female, critical because females make most healthcare decisions for families • Providers offering services increased from 27 in 2019 to 69 in 2024 • Members and providers agree that services improve with cooperative affiliation
	2.2 Improved legal and regulatory framework	• Health cooperatives included in revised Cooperative Societies Act (2020) • Health cooperatives included in National Development Plan IV and Community Health Strategy (2024) • MoTIC and MOH trained in health cooperative management • MoTIC and MOH have tools and expertise available to support growth of health cooperatives
R3 Development community's support to cooperatives enhanced	**3.1** Increased learning and replication of the cooperative model	• 30 health cooperatives have registered, most working independently • Locally-registered worker cooperative – Uganda HealthPartners Cooperative – has taken over the work of expanding and supporting health cooperatives in Uganda
	3.2 Improved collaboration among cooperatives	• HealthPartners worked with the Kenyan Ministry of Health, Ministry of Cooperatives, and Council of Governors to bring cooperative solutions for health to the Kenyan government • HealthPartners convened a working group of cooperative development organizations in Kenya to reach mutual cooperative objectives and is using those objectives to drive strategy • HealthPartners presented and shared papers at five international conferences to popularize cooperative health solutions, advancing UHC and leveraging partnerships

Impact and results

Cooperative performance improved for both members and providers, the legal and regulatory environment now fosters health cooperative growth and regulation, and the wider community is replicating the model independent of HealthPartners. CGCs hypothesis was that progress in each IR would lead to advancement toward the larger goal: **"Increased demand and access to care with improved health outcomes within a health system that is responsive to all people including girl's age 10-19".** Below, the goal is broken down by component and evidence shows significant progress was indeed made in each.

Demand for care increased over the life of the activity

At the beginning of the activity, membership was 25,254. By 2024, membership had grown by 58% to 39,783. Each year, the value of treatment per member increased, except in 2021 when treatment value was much higher than expected due to pandemic response costs (table below). According to the ICRG, women cooperative members in Uganda were 7-8 times more likely to access safe antenatal and delivery care. Importantly, demand for care increased at the early stage of illness, when members are less ill and less expensive to treat. The final CGC evaluation, carried out by Just Results, Inc., showed 86% of health workers surveyed reported there was an increase in the number of members seeking care at an early stage of illness and they reported the main driver of the increased demand was community-driven dissemination about and enrollment of members into the cooperative model.

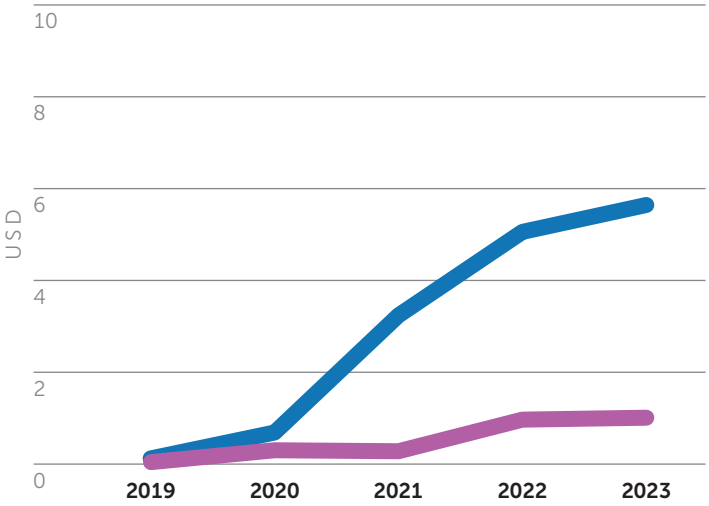
Value of care received

YEAR	CUMULATIVE VALUE OF TREATMENT (USD)	TREATMENT VALUE PER MEMBER (USD)
2019	67,206	0.19
2020	59,534	2.92
2021	83,028	7.55
2022	165,782	5.10
2023	198,867	5.48

While demand for care grew, so did accessibility

The number of health cooperative providers rose over the life of the activity from 27 facilities in 2019 to 69 in 2024, easing access to affordable care. Both the midterm and Just Results final evaluation results showed that accessibility to care was easier when participants were members of a health cooperative. The midterm evaluation results showed 94% of members thought that it was much easier to access healthcare with cooperative membership. Just Results found trends in healthcare service utilization by members that suggested a positive influence of cooperative health insurance coverage in improving access to essential healthcare services.

Per member treatment costs and provider surplus



Notably, while the demand and cost of treatment increased per member, providers were still able to grow their surpluses

This is due to risk pooling and prepayment, which spreads the cost of treatment over many people, reducing out of pocket costs for families and increasing revenue for providers. When everyone pays a small amount, it covers the treatment costs of the few who fall ill. This is a particularly important finding, because it clearly shows that the cooperative relationship between members and providers is beneficial for both parties.

Another critical component of accessibility is affordability. Results from the midterm and Just Results evaluations showed a decrease in healthcare expenditures of about 41% for health cooperative members compared to non-members. According to the midterm evaluation, average annual expenditure per health cooperative member for healthcare-related costs was about $32 USD compared to $55 USD for non-members. Respondents reported reduced financial strains and reduced debt.

Care is responsive to all people including girls 10-19

Prepayment is a game changer in health care for women and girls. Women must often request funds from their partners or male relatives for care – leaving the decision-making power about care-seeking to men. In contrast, prepaid health cooperative insurance empowers women to access care without delay. The impact was found in both the midterm and Just Results evaluations, where women shared that the prepaid structure granted them ownership and a voice in healthcare decision-making. In some cases, members even attributed the model to reductions in gender-based violence in their homes. For women of reproductive age, having a voice in healthcare decision-making, access to care, and health education is critical to their autonomy and their ability to build the lives they want and deserve.

Health Equity

- Health cooperatives give women a voice in healthcare decision-making due to prepayment.
- Women health cooperative members report improved decision-making power in their homes and attribute it to membership.
- Women have improved access to safe antenatal and delivery care by a factor of 7-8.

Increased demand and improved accessibility led to improved health outcomes for members

The full impact of health cooperative membership on health outcomes is a long-term measurement but there are clear indicators that member health outcomes are better than those of non-members. An impact assessment of health cooperative members in Uganda showed that members were less likely to have diarrheal disease and malaria. The Just Results evaluation reviewed facility records and found the prevalence of malaria significantly decreased with health cooperative membership. One facility showed malaria prevalence of 1 in 3 patients prior to cooperative health insurance, dropping to 1 in 100 after offering insurance. The evaluators attributed the reduction to access to affordable care and health education by facilities. Health cooperative members were also more likely to have access to safe antenatal and delivery care by a factor of 7-8, according to ICRG findings. These indicators – prevalence and treatment of malaria, diarrhea, and maternal health indices – are critical, because they are some of the greatest contributors to morbidity and mortality in Uganda, so their prompt treatment makes a widespread and valuable difference.

Success stories

Ms. Atwine Deo

Ms. Atwine Deo lives in western Uganda. Like many of her neighbors, she struggles to pay her medical bills. One day, she fell ill and sought care, but afterward she found she could not pay her bill. Atwine had to sell her goat to a neighbor to pay for her care. The neighbor told her about the health cooperative model and urged her to join. The next quarter, Atwine joined a health cooperative with her family. She shared that enrollment has meant not only reduced costs, but reduced illness since she and her family receive health education from their local provider. Membership has even reduced domestic violence in her family and given Atwine a more active role in shaping her life: "Since I joined a health cooperative, my family income has improved which has reduced the domestic violence in my family. I am healthier and more productive which has helped me to achieve both personal and community developmental goals."

Ms. Catherine Nabukisa

Ms. Catherine Nabukisa lives in southwestern Uganda. She is part of a savings group, and they found that most of their savings were used for paying off treatment costs when a member fell ill. Recognizing the challenge, the group enrolled in a health cooperative and, according to Catherine, it was life changing: "Health cooperative insurance has changed my life in a positive way because I used to spend so much money on treatment costs, but since I joined, my costs have reduced." Since enrolling, the savings group has avoided paying for treatment costs out of savings and instead is using them to purchase assets that help them improve their lives like land, animals, motorcycles, and other business development needs. Catherine shares that savings from each member increased up to 20-fold and attributes their ability to save not only to insurance but the health education they receive from their provider that helps them avoid illness.

Global significance

Worldwide, nations are striving to achieve UHC. Both the United Nations and the African Union have included it in their development strategies. Despite the global commitment to expansion of health coverage, UHC's attainment remains out of reach for a variety of reasons – one of which is the challenge of covering the informal sector. In Africa, where 83 percent of employment is informal, the challenge is of particular significance. The results of lack of coverage are poor health outcomes and financial instability for families, as seen in the high levels of mortality, disability, and catastrophic health care costs in many African nations.

Health cooperatives insure the informal sector through shared risk by mobilizing local resources to improve health outcomes, protect households financially, and strengthen the existing healthcare infrastructure.

Owing to its hyper-local and member-owned nature, the health cooperative model overcomes the challenges that centrally administered national insurance schemes face like costing and collecting premiums, valuing and paying claims, communicating benefits, and retaining members. Instead, members rely on existing community structures and social capital. Health cooperatives are particularly suitable for nations without significant government investment in health, since costs and benefits are negotiated directly between members and providers, so the scheme meets member care and affordability needs while also empowering providers to cover their own costs at little to no cost to the government. Where the political will exists to build a national scheme, but funding is insufficient, health cooperatives can form a foundation and the government can build in cross-subsidies, consolidated risk pools, and quality control mechanisms with significantly less investment than nationally administered contributory schemes.

HealthPartners work in Kenya as part of CGC made this broader global opportunity clear. The Kenyan government is committed to expanding health insurance to its population, but like many nations, it struggles to reach the informal sector. HealthPartners is using the lessons learned in CGC to support the government to reach the informal sector by leveraging cooperative infrastructure and building a network of local stakeholders to champion the initiative. Similar opportunities exist across many nations in Africa where, according to the International Labor Organization, an estimated 40 percent of all households belong to a cooperative society.

Improved health and household financial stability have broader impacts for families, communities, and nations. Research indicates that improved health contributed to up to a third of the overall GDP-per-capita growth in the past century. Better health reduces premature deaths, expands the working population, decreases early retirement, and mitigates productivity losses associated with illness. Literature suggests that the effect is particularly pronounced in less developed nations where improved health spurs a cycle of development that reaches far beyond improved health outcomes.

Important research findings

Quality of care

In addition to the evaluation findings noted above regarding demand, accessibility, affordability, and health outcomes, evidence showed that quality of care improves with health cooperative membership and affiliation. Just Results found that, "Cooperative health insurance contributed to the improvement of healthcare infrastructure by providing the necessary financial resources for facility upgrades, equipment procurement, and on-time salary payment. The investment in infrastructure helped to enhance healthcare accessibility and quality, benefiting the members and the broader community." It also found that health facilities invested in essential medical equipment, medications, and other supplies, so they were better equipped to meet the healthcare needs of their patients. Notably, facilities shared that the financial incentive for keeping members healthy helped them prioritize preventive care and ensure quality care upon treatment so patients would not need as much follow up.

Women's health agency

ICRG evaluated the impact of health cooperatives on women's health agency. Findings showed that women who are health cooperative members are more likely to have higher incomes than non-health cooperative members. Researchers were able to attribute the effect to membership and rule out the probability that higher-income women simply were more likely to enroll. Compared to non-members, women health cooperative members had greater access to health education and safe antenatal and delivery care. In their study, women were more likely to perceive that they have control over their healthcare decisions, empowering them to access the care they and their families need. The ICRG findings were reinforced by Just Results, which found that women had more decision-making power in their households because of health cooperative membership. These findings clearly indicate that health cooperatives drive women's equity and empowerment.

Sustainability

Just Results reported that the model has a "high degree of sustainability" due to three factors. The first is the economic benefits to members and providers. Since both parties benefit financially from the model (not to mention the health benefits to members), they are likely to continue to participate in the scheme. The second factor is the level of government buy-in. Because health cooperatives have been written into law and regulation, and both MOH and MoTIC see the model as a feasible component of their larger strategies, they are likely to continue to support its growth. And the last factor is its flexibility and community-based approach, which meets the needs of the informal sector. Because each cooperative is free to negotiate for its own needs, it can adapt as the needs of its members change.

Comments and recommendations

In 1997, when HealthPartners began working in Uganda, health cooperatives did not exist. Today there are 30 registered health cooperatives working independently, protecting over 40,000 members with improved health who no longer need to worry about health shocks or catastrophic health expenditures. Health cooperative providers made almost $100,000 USD in surplus over the last five years – an impressive feat in an environment where many providers work under persistent debt. Providers reinvested their surpluses in the quality of services, benefitting not only cooperative members but all patients. Female cooperative members have higher incomes than non-members and are empowered to make decisions for themselves because of their membership.

Health cooperatives are being independently launched and managed. UHPC is working with partners to provide training to nascent cooperatives. Regulatory bodies – MOH and MoTIC – have developed and now enforce supportive health cooperative laws. HealthPartners has effectively passed the torch to local leaders who are now health cooperative experts. The end of this activity is the first chapter of a locally led movement. After years of global struggle to reach and effectively insure the informal sector, the health cooperative movement shows what is possible.

Recommendations

- Build on the foundation and momentum of medical bureaus, MoTIC, MOH, and UHPC to integrate health cooperatives into the national health insurance scheme. The motivation exists in Uganda to expand universal health coverage – and now the evidence exists that health cooperatives provide a base for its growth in the informal sector.
- Support the expansion of health cooperatives in other nations as part of the effort to achieve UHC.
- Health financing global development partners are encouraged to use publicly available tools at OCDC.coop.

Health cooperative member seeking care at St. Mary's Emmaus HC II

Success story

In 2020, St. Mary's Emmaus, a primary healthcare facility in Luweero District, Uganda, was grappling with growing bad debt. The clinic would offer care to patients who were unable to pay treatment costs, leaving both the patient and provider in debt. The result was declining quality of services as the facility could not stock medicines or pay workers' salaries.

In early 2021, St. Mary's administration learned about the health cooperative model and CGC staff trained them to manage it. By April of the same year, St Mary's signed an MOU with its first group of 40 members. Over the next year, the cooperative grew to 1,016 members. Together they elected a board to oversee relations between the facility and members such that each party would benefit.

Before the introduction of cooperative health insurance, the health facility had a patient debt of $1,500 USD. Within a year, the facility had climbed almost entirely out of debt and was able to stock medicine and supplies and pay staff regularly for the first time. Facility staff noted that patients came in early to seek treatment without fear that they may not be able to pay since they were on the insurance scheme, reducing treatment costs and improving health outcomes.