HEALTH CARE CO-OPS IN UGANDA
Effectively Launching Micro Health Groups in African Villages

A Ray of Hope for Millions of People
“A fascinating voyage through the health challenges faced by the developing world and a ray of hope for millions of people.”

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Lead Economist; Editor of Health, Nutrition and Population Publications, World Bank

A Model of Self-Help Development
“Sensible, committed, smart and technically well-grounded Minnesotan health care co-op missionaries, who together with the co-op folks of Uganda, have created a model of self-help development that we can all learn from.”

— Harvey Sigelbaum
Former board member and chairman, National Cooperative Business Association; Former board member and chairman, National Cooperative Bank; Former board member, Overseas Private Investment Corporation

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GEORGE C. HALVORSON

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The Permanente Press
Oakland, California • Portland, Oregon
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To the team in Uganda and at HealthPartners who made this entire effort a success.

Thank you all.
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Introduction

When we opened up a new local health care cooperative in rural Uganda, the start of each local plan was usually a joyful celebration involving lots of people.

Community leaders spoke. Dancers danced. Village singers sang songs of welcome and praise. People wore their ceremonial clothes.

The high point of each celebration was always the actual handing out of ID cards. It was a fascinating contrast to what we were used to back home. In America, we simply mail health care ID cards to our members. It’s very much a non-event. In the Uganda health care co-ops, it’s a public ceremony. Each family’s name is announced. The head of the family comes forward and publicly receives a plastic laminated card (with the family member names on the front and the family photo on the back). The head of the family then shakes hands with the leadership of both the co-op and the village, and is applauded. The applause is obviously enthusiastic — heartfelt. Very real. Why is that?

Why do people in Uganda applaud when health plan ID cards are handed out?

The Ugandan applause recognizes that an important event has just occurred. That new ID card allows that family, often for the very first time in their lives, to seek and receive needed health
care without financial hardship. It allows family members to receive sufficient health care without bankrupting the family. Children with malaria, dysentery, and parasitic infections can use that ID card to receive basic, necessary medical care.

Many mothers in urban Uganda who bring deathly ill infants to the hospital register those children under false names. If the child dies, the mother often slips away without paying the bill. Why? Family survival. Hospital bills can easily bankrupt a family, forcing them to sell their only cow, hut, or their small plot of land. The World Bank estimates that more than 30 percent of poor third world families who experience a serious illness are financially destroyed by the cost of care. Their estimate might be light.

So those deliberately misnamed and sadly deceased Ugandan babies are generally buried near the unpaid hospital in unmarked graves — with no one from their families able to be on hand to mourn their passing. It’s unspeakably sad.

That’s why the families celebrate getting that ID card in hand. Talk to the Ugandan parents in those little health care co-ops and it takes only minutes to understand why starting micro health plans is important in Uganda.

Uganda is a poor country full of brave people. Per capita income is a mere $270 per year. AIDS, dysentery, malaria, and parasitic infections are common. The infant mortality rates are among the highest in the world. The health care infrastructure is tiny, fragile, unevenly distributed, and functionally uncoordinated. Almost no one is insured through the private sector, and the government simply can’t afford to provide care to every person who needs it. The tiny health care co-ops we set up in Uganda were really the only available form of health coverage in the communities we served.

So why did HealthPartners, a multi-billion dollar United States health care plan headquartered in Minnesota, decide to help set up tiny health care co-ops in Uganda?
Because HealthPartners is, itself, a health care co-op — the largest health care co-op in the world.

Land O’Lakes, a sister co-op for dairy farms also headquartered in Minnesota, has a long history of going into developing countries to set up local dairy co-ops. Uganda is one of more than a dozen countries that have benefited from the Land O’Lakes outreach initiative over the past two decades.

About eight years ago, members of the Land O’Lakes African dairy co-op staff were meeting with the leaders of a small dairy co-op in Uganda. The dairy co-op was doing well — functioning cooperatively — collecting its milk together, processing it together, protecting the quality together, and selling the milk together at a good price. Farmers working together had better incomes. The local market had better milk. The co-op was also importing carefully selected bull semen from the United States to upgrade the local herds and increase the milk production levels of its cows. Antibiotics were also being made available by the co-op to help ailing members of the tiny cattle herds. The cows in that Ugandan village had never been so healthy or so productive.

One of the farmers at the meeting said to the Land O’Lakes staff, “We now have good veterinary care for our cattle. Is there any way we can also get medical care for our children?”

That question intrigued the Land O’Lakes staff. When they returned to Minnesota, they called HealthPartners and asked that same question. Could it be possible to set up health care co-ops in a third world country, maybe starting with a foundation of small, local dairy co-ops?

HealthPartners decided to explore that possibility. A team from HealthPartners went to Uganda to meet with the co-op leaders. Two doctors and two administrators made that first trip. We met with dozens of rural Ugandan co-op leaders in half a dozen locations, and we concluded that it was worth a try.

This book describes what the staff from HealthPartners has
learned and accomplished since that time. There are now working health care co-ops in Uganda. They are serving thousands of people in a dozen villages and rural communities. People are getting care that they wouldn’t have gotten without the co-ops.

In a country with more than 27,000,000 people, that’s just a tiny beginning. But, it is a start. The government of Uganda is watching closely to see if the approach can be expanded to other sites. The United States Agency for International Development, USAID, program has been incredibly supportive of the entire process. So have the local villages and caregivers. They have created true health care co-ops.

That’s why HealthPartners is involved.

It’s a cooperative thing to do. Co-ops tend to be a bit evangelical in their approach to the world. People who understand the co-op mentality know that the Land O’Lakes efforts to support developing nations’ dairy farmers are very much in keeping with the worldwide tendency of co-ops to help other co-ops get started. HealthPartners is coming from that same perspective. That’s how co-ops think: “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.”

The approach HealthPartners is using in Uganda will not solve Uganda’s health care problems. It will make life better for some Ugandans, however. Much better. Women will have prenatal care. Kids will survive dysentery and malaria. Diseases will be prevented for some people, and cured for others. Some people will be healthier. Not everyone — but some.

Is that enough?

One of my favorite stories is of a man walking down a beach early in the morning. As he looked down the shore, he saw another man in the distance walking toward him. The other man was regularly stooping over picking something up, and
throwing it into the ocean.

As the men drew closer, the first man saw that the stranger was picking up shellfish and throwing them out to sea.

“What are you doing?” he asked. “Why are you throwing those shells into the water?”

“Because the tide invariably catches some shellfish and washes them ashore,” the stranger replied. “They die on the shore, so I throw them back into the water.”

The first man looked down the shore in both directions. There were shells far up and down the coast.

“It’s hopeless,” the first man said. “There are huge numbers of them. You’re just one person. You can’t possibly make a difference.”

The second man bent over and picked up another shellfish. He held it for a second and then he threw it far out to sea. He looked at the first man and said softly, “Hey, it made a difference for that one.”

What’s the value of one human life? What’s the value of one surviving child? What’s the value of one mother being healthy enough to care for her family? What HealthPartners is doing in Uganda won’t change the world. But it is making a difference. A real difference in real lives. That’s good enough.

I wrote the first draft of this book just prior to leaving HealthPartners to move to Kaiser Permanente, the nation’s largest non-profit health maintenance organization (HMO). I put the book on a shelf for the past couple of years because I had other priorities. But people kept asking about Uganda and the little health care co-ops there.

I was just in South Africa. A couple of people there who had heard about the Ugandan co-ops asked me, “Is there anything about the co-ops in writing? Do you have anything that describes how that project was done?”

People at the World Bank recently asked the same questions. The story has been the subject of a National Public Radio special
and there were a few articles in various magazines — but each of those reports just told a few things about the project. They didn’t explain it — or help share the learnings that have resulted.

So, I thought I’d bring the book back to life and make it available. HealthPartners is still doing wonderful things in Uganda, and the learnings from that effort deserve to be shared. Those co-ops have taken root. That’s what co-ops aspire to — real rootings.

I actually wrote this book twice, once as an operational “how to” textbook, and once as a narrative story of what we did. This version combines the two approaches. My hope is that this combined approach might, in the long run, be more useful to more people. So, I blended the two books into this single description of the program.

Most of the pure textbook teachings and topics are included in this version, including product design, decisions, actuarial issues, governance structure, negotiations, operational theory, etc. They are just embedded a bit in the story of what we did.

I hope this version works for you, and that the book is useful to anyone thinking about setting up local, consumer- or provider-owned health plans in any setting. In the right place at the right time, health care co-ops can be a very workable way to finance and deliver health care.

George Halvorson
June 2006
Chapter Six
Paying the Providers

Prepaid caregivers increase their emphasis on disease prevention rather than just disease treatment.

The HealthPartners team decided very early in the planning process that the only possible payment approach for care providers that had any chance of success was “prepayment.” As noted in Chapter Five, that was the only approach that gave us a chance of reducing the administrative burden for the Ugandan health co-ops to manageable levels. It also was the best way, we believed, to align the financial incentives of the care providers with the health and care incentives of the co-op members. It was a key discussion, so it might be useful to look, in a little more detail, at why that particular mechanism was selected.

For starters, we knew from our experience in the United States that fully cooperating, carefully selected, participating providers of care were needed to make each local plan a success and we also knew that these providers would need to be paid.

That’s pretty basic thinking. Health Plan 101. The delivery of care requires caregivers. The questions were — How should the caregivers be involved? Who should they be? What role or roles should they play? In order to create care delivery mechanisms for our micro co-ops in Uganda, we needed to figure out how best to
select, recruit, and then appropriately involve local caregivers in the plan operation. We ended up with prepayment as our preferred financial arrangement, but we didn’t just look at prepayments as the only option. We considered other alternatives as well. Deciding on the best approach for Uganda caregiver selection and payment involved looking both at several United States models of caregiver involvement and — of primary importance — at the reality of health care delivery and provider availability in Uganda.

The approach we selected is not the usual approach in the United States. Health insurance in the United States has evolved over the past two decades into several different species of programs, plans, and provider payment mechanisms. Some health insurers in the United States actually own clinics and hire various care providers. That’s a relatively rare model in our country. It’s a very good model — but it’s far from the norm. At the other extreme, some health insurers have absolutely no relationship with caregivers, other than to receive claims forms and pay claims. That complete separation model is also now a relatively uncommon approach. Most plan/provider relationships in the United States fall between those extremes. Most payers in this country now choose to contract in some way with caregivers and most now create some form of caregiver networks for their customers to use. Those contracted networks generally have negotiated price discounts relative to provider fees as their key financial cash flow component. In our own co-op plan in Minnesota, we had a mixed model. We owned clinics and directly employed more than 600 physicians. So we were both a health insurer and a provider of care. We also contracted with nearly 10,000 more local physicians. Most of the contracted physicians in Minnesota were part of “prepaid” contracts rather than pure fee-for-service arrangements. So, we knew from direct experience how both the contracted and direct employment models work. (At
Kaiser Permanente, we have eight regional health plans that contract exclusively with eight very large regional medical groups. The entire Kaiser Permanente entity, in total, owns 32 hospitals and employs more than 140,000 people — including more than 15,000 physicians who own and lead the eight Permanente Medical Groups.) So, in both my old job and my present one, I have worked closely with and believe strongly in the models of care and financing that are much more tightly integrated between the health plan and the caregiver. But, we did not simply assume that was the only model that could work in Uganda.

As HealthPartners staff looking at African health care, we knew that our Ugandan model wouldn’t initially generate enough cash for the local co-ops to actually build their own clinics, hire their own caregivers, or own their own hospitals. We also knew that we wouldn’t have enough patient volume to create exclusive ‘Kaiser Permanente-like’ relationships with local physicians. We didn’t have enough initial cash flow to actually recruit and hire physicians to take care of the co-op members. We concluded, therefore, that we needed to do deals with local caregivers — deals that encouraged the local caregivers to provide the best care in the most efficient way — with a focus on disease prevention wherever possible. Since directly hiring physicians was not going to be possible, we knew that the only way we would get good deals for our members would be to enter into some kind of positive, mutually beneficial, clearly spelled-out financial relationships and formal contracts with local doctors and hospitals that paid them enough money to create a win/win situation for the co-ops and the providers of care. The question was: what kinds of contracts? And what kind of deal?

Again, we had some United States models to think about. We didn’t want to bring an unworkable fee-based approach to Uganda just because it was popular in the United States. As noted earlier, in most cases in the United States, where provider net-
works exist, the contracted caregivers simply charge discounted fees to the plans they deal with. In that case, the plans are the primary “insurers” and they pay “claims” to the care providers for all care that is delivered. In a number of other American situations where there are contracts between the health plans and the providers of care, the caregivers themselves are “prepaid” or “capitated” — receiving a fixed amount of money each month for every patient that selects them as caregivers. The prepaid providers agree to provide all needed care in exchange for that prepayment, or “capitation.” In that capitated model, the caregivers share in the risk for the cost and efficiency levels of care because the payment mechanism is a fixed, pre-negotiated monthly fee (or capitation) paid per member — rather than a separate fee paid for each individual care encounter by each member.

Those options — and several other blends of those two approaches — needed to be considered as we tried to figure out a model that would work in Kasizi, Bushenga, and greater Kampala.

In putting together our initial plan, we felt four main structural questions had to be resolved. Choices had to be made in several key areas.

“Pre-” or “Post-” Paid Doctors?

The first choice dealt with the issue of “prepayment” versus “post-payment” of providers. As noted earlier, this was a fundamental difference in approach. It has huge ramifications for how any health plan is managed and administered. Both prepaid and post-paid models are used in the United States. In a post-payment approach, providers provide care to a patient and then — after the fact — send a bill to the insurer for each incident of care. The insurer then carefully examines each bill to see if the service is covered by the patient’s insurance benefit package. If it is covered, the insurer writes a check to the caregiver for whatever fee level the provider is entitled to receive. Usually, those fee levels
have been negotiated in advance between the health plan and the caregiver.

That “fee-for-service” model is how most health care is insured in the United States. It has the advantage of paying providers exactly for whatever care is received by each patient.

**Post-Payment**

Post-payment — or fee-for-service medicine — has two major and obvious disadvantages if you want to incent better care or save administrative dollars. Those disadvantages can, in fact, be crippling if you want to reduce administrative costs to a dime a month. A primary disadvantage of that fee-for-service payment model is that it financially incents the caregivers to deliver excess and unnecessary units of care in order to make more money. Multiple American studies have verified beyond any doubt that the problem of inappropriate, sometimes wasteful, fee-incentivized care exists. Fee-for-service providers are not paid for “curing” the patient or for preventing disease or for reducing the complications of a disease. They are simply paid for procedures done for each patient. Outcomes are irrelevant in the payment process. Providers of care in that fee-for-service model make money by doing volumes of procedures — not by improving health. We wanted a model in Uganda that required the providers to deliver all necessary care, but did not create perverse and unaffordable financial incentives to do unnecessary care. We also wanted a model where the provider made money by keeping people healthy, rather than making a profit only when the patients are sick. Those are very different types of incentives.

The second problem — an even bigger one in Uganda when we were trying to design a health plan that could be administered for 10 cents a month — is that post-payment care models with fee-for-service payments always involve a ton of administration. The administration costs are huge. They involve a lot of paper-
work — a huge amount of paperwork. Think again about what I noted in the last chapter about all of the paperwork that needs to be done. In a fee-for-service system, each new incident of care generates a new claim. Each claim generates separate paperwork. Claims have to be mailed from provider to insurer. Each claim has to be examined by someone to see if the benefit is covered. Each approved claim results in a check. Someone has to write all of those checks. They need to be mailed. Each rejected claim results in at least two rejection letters — one to the patient and one to the caregiver. The paperwork and administrative processes inherently involved in post-paid fee-for-service care are staggering — going well beyond anything a dime could handle. That's how most American health care insurance is handled, and that's the primary reason why American health care administrative costs are the highest in the world.

In this country — in prepaid plans like HealthPartners and Kaiser Permanente — a huge portion of that paperwork has been eliminated. HealthPartners now pre-pays for most care and then receives more than 90 percent of all claims electronically. We set up that electronic claims input process so we wouldn't have to handle all of that expensive paper every time care is delivered. That paperless system saves both care providers and the plan a lot of administrative money. At Kaiser Permanente, we have always had a very low cost, paperless system. At this point, we are also installing a computerized automated medical record system that will directly feed the insurance system work flow with no paper and no hands touching the information — again, cutting administrative costs significantly. Those processes are all electronically supported. The electronic infrastructure needed to achieve either of those approaches obviously didn't exist in Uganda in any site we had visited, however. So, we created one based on prepayment.

The decision was not actually very difficult. A traditional
insurance claims-based, fee-for-service system would obviously have had huge cost disadvantages for Ugandans — particularly if we wanted to administer the plan for a dime a month.

The third problem of fee-for-service-based care compared to a “prepaid” capitated system was, if anything, even more important: incentives to improve health and prevent disease. A prepaid provider has a very direct, clearly understood incentive to improve patient health — to help prevent malaria, avoid dysentery, and avoid parasitic infection. A physician who is prepaid has a financial incentive to help all patients get mosquito nets for people’s beds to help them avoid malaria, for example. A fee-for-service, post-paid physician has no way of being directly or indirectly paid for those kinds of pro-active programs and services and that level of preventive health thinking. We desperately needed that level of pro-active, disease-prevention thinking in Uganda, so a capitated model that created physician incentives for improving population health obviously made the most sense.

Those facts of economic life brought us quickly to “prepayment” as a way of paying the doctors and hospitals.

**Prepayment**

Prepayment, done well, is not a complicated approach. It can be elegantly simple, in fact.

How does it work?

In a prepayment model, the provider is paid a flat sum of money each month in advance for each member of the plan. In exchange for the monthly prepayment amount, the provider in a pure prepayment model simply provides all of the care outlined in the member’s contract. No claims are filed. No paper is generated. Only one check is written — one per month — and that single check covers many people — all co-op members who have enrolled and selected that particular caregiver.

That process eliminates a lot of forms, processes, and huge
volumes of claims checks. It eliminates individual claims as well as the need to do individual claims adjudication. The providers still need to keep a record of all care delivered, but that record can be electronically kept by the provider and simply examined periodically and retrospectively by the plan as a report, rather than processed piece-by-piece as a stack of claims.

If we wanted to keep administrative costs to a dime, prepayment was obviously the only way to go. The challenge, of course, was to persuade Ugandan providers of care who had always been paid on an after-the-fact fee-for-service basis that a lump sum monthly prepayment for each patient was also a very good way to get paid. The challenge was also to help prepaid caregivers increase their emphasis on disease prevention rather than just disease treatment. As you will see, that process was well received by Ugandan physicians.

The good news about working through the negotiated payment levels was that we knew from talking to various rural Ugandan caregivers that 25 to 40 percent of their current patients actually don’t pay their bills at all under the old non-insurance, patient direct pay fee-for-service model. High numbers of patients were non-payers — bad debt in American terms. Many paid only part of the bill. So, our negotiating strategy with physicians and hospitals was to persuade the Ugandan caregivers to accept “prepayment” from the co-ops by telling them, “Getting dependable monthly prepayment from 100 percent of your co-op patients is far better than getting partial and sporadic post-payment from roughly half of the people you already care for.”

As we had hoped, that argument turned out to be very effective with every caregiver with whom we met. That’s not surprising. It was just common sense. These are very smart people. And, very practical people. The rural Ugandan doctors each knew from years of experience how difficult it was to collect money from most of their patients. This new approach eliminated
bad debt for all patients who joined the co-op. It created a dependable monthly cash flow. For the patients, it completely eliminated the whole onerous fee-for-service billing process. It also — as a side benefit — eliminated those awkward and often unpleasant situations where a debtor patient — seeing the doctor come into the village market or local church — felt a need to duck out the back way, to avoid an embarrassing moment. That sort of financially strained doctor/patient relationship doesn’t generally lead to particularly effective follow-up care.

Most usefully, for the caregivers, prepayment gave them a steady, dependable stream of cash. Once they began caring for members of the local co-op health plan, the caregivers knew that they would receive the prepayment amount on a fixed date every month. For many Ugandan health care providers, that capitation was the only regular local source of cash they had ever had.

As we had hoped, that new approach actually did help local providers economically. That new and dependable cash flow let some caregivers expand their facilities and practices — depending on the steady prepayment cash flow from the co-op to service the resulting debt.

So how did the local Ugandan physicians and hospitals respond? They liked the new co-op health plans. They strongly encouraged local people to join the co-op plans once they were set up. Provider support was real and effective. Again, there are interesting and informative parallels in the United States. Strong provider support was actually the main reason that the original Blue Cross and Blue Shield plans were set up in the United States. They were created by doctors and hospitals to create a prepayment revenue source to help those doctors and hospitals stay solvent and avoid patient debt in the Great Depression. The original Blue Plans would never have succeeded without that direct provider support.
“Service Benefits” or “Procedure Fees”?  

The second major financial issue to resolve was whether to assign a fixed fee value to each provider service or to use a “service benefit” approach to figure out what was covered. What does that mean? In a “service benefit” model, the plan and provider agree to cover a defined list of services for a population of patients in exchange for a fixed, pre-negotiated aggregate amount of money rather than assigning a cash value to each service and then charging separately for each service.

In a service benefit model, the agreement is to provide all of the services that a member might need from the pre-negotiated set of defined services. One of the best features of a “service benefit” approach is that the provider doesn’t need to go through the administrative work of assigning a price to each individual procedure or incident of care. It’s a simple model to administer.

So, in Uganda, we decided to just use a pure service benefit approach — stating for example, that “maternity care is a prepaid covered service,” rather than “we will pay or credit 15,000 Ugandan shillings to each provider for each normal delivery.”

Again, the record keeping is much simpler and cleaner without the pre-negotiated fee assignments and without any risk share follow-up. That’s how we started the plan. It’s a smart and good model. Unfortunately, we later found ourselves forced into the fee-based scorecard business to some degree. Malaria epidemics, for example, caused some caregivers to deliver twice as much care in some years as paid for by the “capitation.” As we will discuss later, we ended up with some risk-sharing features that required the providers to do more record keeping. Other parties — foreign governments — who liked the program offered a form of catastrophic cost reinsurance to our plans. More on that topic later. But initially, to keep matters simple, we wanted to use pure service benefits in both our member contracts and provider contracts. Where that can be done, it’s a better, cleaner, easier
approach to administer.

One major advantage that generally results from combining prepayment with general service agreements is that that approach to prepayment encourages much higher levels of provider flexibility and creativity relative to care. Whenever fee schedules exist in the world, they always tend to make care delivery more rigid. Why? Because care is very much limited to the fee schedule list of acceptable services. Those fee lists also inherently dictate care priorities — sometimes in pervasive ways. Preventive care generally isn’t well rewarded by American fee schedules; so, in our country, extensive and systematic prevention tends not to be done. Innovative approaches to preventive care are less likely to happen.

HealthPartners had benefited greatly by being a prepaid plan in the United States. That payment system allows for a much more flexible, patient-focused use of resources. So, when HealthPartners had a patient with congestive heart failure (CHF) for example, care for that patient wasn’t limited to the strictly defined set of services found on a Medicare fee schedule. Medicare has always used a fairly rigid outline of acceptable medical procedures for its fee-for-service payment program. But, HealthPartners was prepaid by Medicare on a monthly basis for each patient to provide the care that each patient needed. So, HealthPartners used that flexibility and long ago created a whole new approach to team-based care for patients with CHF that involved dedicated nurses, group meetings, telephone consults, and even special electronic scales that we put in the homes of some patients with CHF. The scales actually call HealthPartners to warn the doctors and nurses if the patient has an alarming weight gain that could indicate a CHF crisis might be starting.

As a result of that total program, HealthPartners’ caregiver teams cut those terrifying, painful, life-threatening, and extremely expensive CHF crises by more than 80 percent for our members. That’s an incredible improvement in the quality of life for those
patients. If we had been simply stuck with the list of services authorized by a pure traditional Medicare insurance post-payment fee-for-service model, and if the care had to be delivered only under the more rigid Medicare fee-based procedure list and rules, that wonderful, patient-focused, life-saving program would not exist. It did not exist for Medicare’s non-HMO patients when we invented that approach for CHF care. The Medicare fee list did not pay for group meetings, nurse-level care coordination, phone follow-ups, or electronic, telephone-linked scales. Five times as many patients with CHF in the Minnesota plan would go through the hellish experience of drowning in their own fluids if HealthPartners wasn’t committed to the flexibility given to plan physicians by prepayment and service benefits. Far too many non-HMO Medicare patients, even today in most of the country, are five times more likely to go through that horrible experience. That whole CHF program was widely publicized, and now has many clones in other parts of the country. Medicare now endorses most of the needed services. But, the new treatment approach only evolved because care systems like HealthPartners and Kaiser Permanente were prepaid and therefore able to innovate in care delivery beyond the limitations of a fee list.

So, knowing first hand how that whole prepaid, service benefit process works, we also strongly favored prepayment in Uganda. We didn’t want a rigid fee schedule that limited local provider flexibility. We wanted the Ugandan doctors to have both an incentive to prevent disease, and the ability to be flexible in determining the most efficient ways of delivering care. As you will see, it worked just as we had hoped. Ugandan caregivers became very prevention-focused and creative in their use of resources. (Likewise, at Kaiser Permanente, we may well have won more awards than anyone in America for the effectiveness of our disease management programs and preventive

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care. The flexibility given to the caregiver by the prepayment method is a key to our success.)

Prepayment works.

The model we chose for Uganda was an approach that involved very close partnerships with local caregivers — physicians and hospitals — who were prepaid to avoid the hassle and administrative waste involved in claims processing, and who were incented to provide both best care and preventive care to their patients.

Ugandan caregivers loved that model for reasons discussed in the next chapter.
Chapter Twelve

The Hospital on Bushenyi Hill

An amazing testament to what local people can do given the right opportunities.

On the top of a Buhweju District mountain, 35 kilometers from the nearest electricity, 45 kilometers from what used to be the nearest care, and several thousand feet over the moist and fertile local flat land, members of a two-year-old tea-leaf-based health care cooperative have actually built a tiny hospital and clinic. I visited the site just before I left HealthPartners. The local tea farmers had hand-carried both sand and water up the mountainside to build the hospital. They baked thousands of red bricks and then used those bricks to assemble a five-room building with a tin roof. That building now contains two maternity beds, five acute care beds, a tiny delivery room, one wire bassinet, and a table and chair in an exam room that also serves as a laboratory for doing malaria tests. The new care site has no electricity and no running water. The only lighting comes in through open windows. Flashlights are used after dark. The beds have clean, flat surfaces, but no mattresses or blankets.

But, the site does have a physician and a nurse. And clean water. It takes care of people who really need care. It exists only because of the tea growers’ co-op.
The Bushenyi Medical Center (BMC) — a private hospital and clinic 45 kilometers away — has contracted with the tea co-op to provide a doctor and nurse every day for that clinic. They agreed to provide that care on top of Bushenyi Hill because the co-op members who live on the steep hillsides surrounding the clinic have each agreed to set aside a portion of their tea harvest each month to pre-pay BMC for that care. Care arrived on that remote mountaintop only because the new co-op gave people a way to pay for that care.

A hospital with bare bunks for beds, no electricity, and hand-carried water may not seem like much to Americans. But, before that Bushenyi Hill Clinic existed, every person in the area who needed significant levels of care had to be carried down the mountain on wicker stretchers. As I noted earlier, those stretchers doubled as local hearses — sometimes on the same trip. The road is steep, rock strewn and very slippery in the rain. Uganda has two rainy seasons each year. Carrying a stretcher down that steep mountain on a wet day is not a journey for the faint of heart, or for people who need care quickly.

Now babies are delivered, minor surgery is performed, malaria is treated, and broken limbs are repaired on the mountaintop.

Also, now that the Bushenyi Hill Co-Op Hospital and Clinic is in place, the people who are in the most dire straits have a new and more convenient access to the Bushenyi Hospital 45 kilometers away. The co-op has also created the area’s first real “ambulance” service. Taxicabs do the work. The health plan members who built the clinic building have collectively pooled part of the money they earn from selling their tea leaves to purchase a small solar-powered two-way radio. That radio lets the doctor on the hill call down to the main clinic to have a local taxicab come up the narrow, deeply rutted and sharply winding road to pick up the most severely ill patients. The co-op now pays for that otherwise totally unaffordable taxi ride for seriously ill co-op members. It’s part of the co-op benefit package.
Women having difficult labor were the first patients to use that service. The local taxis are small, dirty and definitely not new, but they are a massive improvement over an open wicker stretcher and a 12-hour carry. Particularly, as I noted, in the rainy season.

**“Rain Harvest” Water Tank**

That particular tea-funded health care co-op has also installed a “rain harvest” water tank and gutter system to take advantage of the rainy seasons and collect clean water off the tin roof of the clinic. Until that tank was built, any water brought to the clinic — or to the tea growers’ small homes on the mountainside — had to be hand-carried, usually in bright yellow 20 gallon plastic jugs. The new, co-op-funded “rain harvest” process saves a lot of carrying. Fresh water is also an obvious asset for patient care. Uganda is blessed with ample rain. The new rainwater-harvesting system uses metal gutters placed at the edge of the all metal clinic roof to divert rain water into a large storage tank. That relatively clean source of water helps treat patients in the clinic.

Similar rain harvest tanks will soon be built in several local co-op members’ homes, with the goal of reducing the parasite infections and dysentery that come all too often from the nearby highly polluted small river that is otherwise the primary source of water for the tea growers and their families.

The co-op is encouraging the development of those water harvest tanks as part of the disease prevention agenda for the health plan and is helping to fund the construction.

Before the tea co-op existed, there was absolutely no disease prevention agenda on Bushenyi Hill. Now there is a carefully thought-out plan that is already making real improvements in local health.

**Preventing Disease Is a Top Priority**

The number one health care problem in Uganda is malaria. It kills far more Ugandans than HIV/AIDS. Over 90 percent of
Ugandans have had malaria at least once.

Malaria in Uganda is spread almost exclusively by a night-flying mosquito. These mosquitoes are particularly plentiful in the rainy season. In the two rainy seasons each year, mosquitoes thrive in the puddles that form. Malaria epidemics often follow. The disease weakens most Ugandans and kills many thousands — with children most vulnerable to dying. Children who are already anemic from other common, local parasites are at the very highest risk.

Now, because the health care co-op is in place, if you look into the houses of many co-op members on top of that mountain, you will also see large, rectangular fine-meshed mosquito nets suspended over many of the beds. The nets are permanently impregnated with a chemical that kills mosquitoes. (The chemical used on the nets is a natural extract from the chrysanthemum flower.) Because homes in rural Uganda have no screens or glass in the windows, these nets create the only place that the community members can go to avoid the mosquitoes.

Initial data indicates that the new nets have cut the incidence of malaria in that co-op by more than half.

So, at the top of the Bushenyi Mountain, because a small health care co-op was formed, there is now a tiny hospital, a miniscule clinic, a medical transportation service, a malaria prevention program, and better access to safe water. It’s totally self-governed and totally self-financed. There is no charity care on the top of that hill.

The local tea farmers own the care site as a co-op. Those same farmers “own” and lead the local mini health plan. Those farmers, as a group, make the key decisions about their benefits, their care sites, their premium levels, and their care.

Life is better for entire families because the co-op exists on the top of that hill.

No portion of that care system — except for the warmth, caring, and personal skills of the wonderful medical and nursing staff — is provided by outside philanthropy.
staff — would meet minimum standards of care anywhere in the United States. But those standards are not relevant on the top of that mountain. The whole effort has to be seen in the perspective of local reality. In Bushenyi, that care site is a blessing and a miracle. More than 100 people walked up to 15 kilometers one way — mostly uphill — for the grand opening. Singers, dancers, drummers, and local politicians made the opening day a memorable and festive occasion.

A key part of the celebration was the sense by the community that they were helping themselves because the co-op that was the foundation for the new and improved care was not a charity, but a local organization that the co-op members governed and owned.

A Guide Book, Not a Rule Book

This book was written to help people think about setting up similar cooperatives and micro health plans in places other than Uganda. It was intended to be both a story about an idea and a guidebook — a partial implementation manual of sorts. My goal was to describe some of the underlying principals used to run the plans, along with some of the specific tools needed to get similar health plans started.
Starting a co-op health plan — or micro health “scheme” as our Ugandan friends sometimes term it — offers some obvious immediate challenges. Issues need to be addressed and resolved. There are actuarial issues, administrative issues, training and marketing issues, cash flow challenges, care delivery challenges, and major communications and continuity problems. Current funding for health care in the areas served by the co-ops is almost always overwhelmingly inadequate. The local care system is slender, fragile, heroic, and overworked.

Total health care spending in Uganda averages about $12 per person per year. There is one doctor for every 18,450 patients. There is no government health plan — although the government does try very hard to set up its own hospitals and medical groups in various areas of the country. Technically, the government is responsible for everyone’s health care. Budget constraints make that obligation pretty much impossible to achieve.

Uganda is not a place where either standard European health financing models or typical American health financing approaches have much chance of success at this point in Ugandan history. The co-op approach is designed to fit into that harsh, but clear, economic reality — to create what leverage can be built around local people who want better health care. Local heroes have made local co-ops possible.

Offsetting the immense problems involved in setting up these little health care co-ops is an immense, compelling, and totally understandable desire by many Ugandans to provide affordable health care to their children, families, and community.

Also offsetting these problems is an obvious desire by the heroic and overworked Ugandan caregivers — hospitals and physicians — to make care accessible and affordable for their patients.

Into that setting, the HealthPartners staff brought many decades of experience with just about every variation of American insurance and prepaid systems. That experience was coupled with
a strong commitment to the concept and practice of cooperative health care organizations, buying groups, and risk-sharing plans. Some parts of these several decades of United States-based comparative health experience have, we believe, proved to be both relevant and useful to local communities in Uganda.

**Premium For Pennies**

If you measure by American dollars, the insurance coverage that has been created in Uganda by the new health care cooperatives is a miraculous value. Premiums run 12,000-20,000 shillings for a family of four for three months. Each additional family member usually costs about 2,500 shillings. The exchange rate, at the time we started the plan, was roughly 1,700 shillings for one United States dollar. So our initial health care coverage cost less than 50 cents a month for each person. By contrast, coverage in the United States often now runs more than $200 a month per person.

That's an amazing cost difference. It's interesting to break it down into comparable terms. American health plan premiums are now roughly 27 cents per person per hour. Uganda health plan premiums, when I last personally worked with the plans, were only 49 cents per person per month. The contrasts are stunning. And, a bit humbling.

In the United States, of course, health plans have to buy care at American prices. A routine day in a United States hospital can easily cost $4,000. Many United States hospitals now charge $5,000 to $10,000 for a day of care. A few charge $20,000 a day — and more. By comparison, a private room at Ishaka Hospital in southern Uganda costs 5,000 shillings a day, or about $3. The care delivered in the United States for $4,000 a day is, of course, very different from the hospital care in Uganda that costs $3 a day. But the $3 a day hospital care has saved a lot of lives. It's a pretty good deal when the alternative is a dirty mat on the muddy ground and no caregivers in sight.
Medical care cost differences are almost equally extreme, and also amazing. A Ugandan doctor working in a government hospital will be paid roughly $500 a month. A United States doctor — right out of medical school and residency program — will be paid $120,000–$360,000 per year, depending on specialty. So, it’s possible to buy medical care in Uganda for a lot less money. Premium — in both the United States and Uganda — is simply based on the cost of care. In the United States or Uganda, plans compute premium by adding up the costs of care and dividing by the total number of members. In Uganda, the care costs a lot less. So, a health plan in Uganda can charge a lot less for coverage.

What HealthPartners has done in a few rural areas of one African country may or may not have wider application in some other part of the world. Each local setting has its own unique characteristics that may or may not lend itself to approaches similar to the ones described in this book. This book does not offer this model of co-op-based micro health units as a cookie cutter for international care. I only offer the story as an example of what seems to work in this particular place at this point in time.

It is my hope, however, that some of what we’ve learned in Uganda might prove to be useful to you as a reader in some other comparable setting.

What Have We Learned?

So what have we learned in setting up tiny health care co-ops in the heart of equatorial Africa?

We learned that people everywhere want health care for their kids and are willing to work both hard and cooperatively to make that happen.

We learned that caregivers in those kinds of impoverished areas can be really good partners in creating community-based health care programs.

We learned that prevention really does work, and that caregivers
who are prepaid can do very creative, patient-focused things to help patients avoid malaria, avoid dysentery, and avoid the complications of problem pregnancies.

We learned that local people, given the right tools, can set up self-perpetuating prepayment programs with local providers of care in ways that work for both the provider and the patient.

We learned that care providers everywhere share an inconsistency of practice patterns that aren’t always optimal for patient care. (See *Epidemic of Care* and *Strong Medicine* for a United States perspective on that issue.)

We learned that many parts of the American insurance underwriting and benefit design tools and concepts can be transformed in useful ways for decision making by small health care co-ops whose leaders are sometimes illiterate and whose members are almost all breathtakingly poor.

What are we still debating about this approach?

We’re not entirely sure about the “no charity” rule. It’s hard to hold ourselves to that standard. We very much wanted the local health plans to be self-sustaining — not subsidized in any way by charity money. It seems to work. But, it’s a very painful rule to maintain. It probably does have a real impact on how well providers deal with prepayment — but it’s a really hard rule to follow, when we have resources and those resources are so badly needed in Uganda.

We’re also not sure about the role of reinsurance to help with the occasional epidemic, and its cost impact on prepaid caregivers. Some form of reinsurance probably makes sense — but having the reinsurance kick-in at 120 percent of total cost obviously creates a major physician incentive to spend more than 20 percent beyond capitation — adding costs as quickly as possible to get to the richer pot of money. A disease-specific reinsurance approach probably makes the most sense — with malaria as the key disease to be reinsured.
We’re not sure about the best way to continuously support the continuing formation of the micro health co-ops. They can be self-sustaining, once started, but they do take expertise and skill to be initially organized and set up properly. They don’t just happen.

**Brazil and Chile**

I spent some time in both Brazil and Chile looking at the variations of local health plans in those countries. Both were fascinating. The Chilean model didn’t seem as directly applicable, but some portions of the Brazilian model looked a lot like the provider-instigated and owned health plans we helped start in Uganda. More than 1,000 small, prepaid health plans have sprung up in various Brazilian towns, villages, and communities — all built by local care providers on the basis of locally available care. As near as I could tell from talking to local caregivers and government officials, none of the Brazilian mini-plans had a consumer co-op base. The government of Brazil was wrestling with the issue of how to regulate those plans. It seemed to me that excessive regulation by the Brazilian government could potentially drive more than a few of those small but thriving local plans into extinction.

It wasn’t at all clear whether various local populations in Brazil would be better off without their small local plan. Some policy leaders argued that the gap that was left would be filled nicely by much larger and better capitalized national and multinational insurers. That may be true. I doubt it, however, because the local mini-plans were set up to be very much local niche products — and the large national plans didn’t seem to have the potential to reach out to each and every niche.

I could be wrong. It was a fascinating learning experience to spend time looking at these plans.

I’ve also talked to people from India about some micro plans that have been forming there. Again, not co-op plans as such. The
micro credit groups of Bangladesh, however, seem to come from that particular market context, and the health plans they are trying to create might be fairly similar to the Ugandan micro credit centralized health plans.

So, I can’t speak with any comfort about the existence of the pure consumer co-op model in any setting other than Uganda. But, there do seem to be some similar local prepaid approaches evolving from various micro credit groups in a number of settings.

If that’s true, that may well be enough to create a workable co-op model that could have some relevance in other developing country settings.

**Urban United States**

Interestingly, it’s not impossible to imagine some relevancy for that cooperation model in some of the inner cities of the United States. Building very local, consumer-run health care co-ops might well turn out to be a viable program for certain United States urban settings. If those very local plans were supported with some workable external infrastructure, they could well serve as a mechanism for very local health care reform. The idea is worth exploring. It would require some very progressive legislation to permit local models to form. It could be very interesting to have some of the same underwriting and coverage discussions in urban America that we had in rural Uganda.

**In The End**

Overall, the Uganda effort has been a success. People are receiving care. The model works.

It’s not entirely clear whether or not that co-op model would work anywhere else — but it’s worth thinking about. The little hospital on the top of the mountain is an amazing testament to what local people can do given the right opportunities.

I hope this book was useful. Be well.
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Community-Based Action at its Best

“The developing world carries 90 percent of the global burden of illness but spends less than 10 percent of total worldwide health resources. Even in poor countries, the major causes of illness are both well known and within their financial reach. Yet lack of public funding and ineffective health services often prevent poor and other vulnerable households from having access to basic care. In this book George Halvorson — the CEO of Kaiser Foundation Health Plans and one of the leading thinkers on managed care — applies his knowledge to the special challenges faced by Uganda, a small country in the center of Africa. The book provides a fascinating chronicle of community-based action at its best — small rural cooperatives that have joined people together at the local level to support each other’s health needs. Mr. Halvorson brings to this debate his outspoken and widely lauded views on affordable and quality health care — services that can be both consumer-oriented and sensitive to cultural needs. The book provides a fascinating voyage through the health challenges faced by the developing world and a ray of hope for millions of people.”

— Alexander S. Preker, Lead Economist; Editor of Health, Nutrition and Population Publications, World Bank

Co-Op Missionaries We Can All Learn From

“Stories like this are stories of how the world grows — better and healthier — how people helping people, people working together, can bring what looks like on its surface that which is impossible, possible and ultimately actual. Three cheers for George Halvorson and his band of sensible, committed, smart and technically well-grounded Minnesotan health care co-op missionaries, who together with the co-op folks of Uganda, have created a model of self-help development that we can all learn from. We’re looking at simplicity at its elegant best, efficiency at its ultimate, how to get the most from the least, in an area of human need — health care — that is fundamental to human development and well-being and yet without that most basic of human potential — cooperation — is not always available. Okay … five cheers!”

— Harvey Sigelbaum, Former board member and chairman, National Cooperative Business Association; Former board member and chairman, National Cooperative Bank; Former board member, Overseas Private Investment Corporation
George C. Halvorson was named chairman and chief executive officer of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals, headquartered in Oakland, California, in March 2002. Kaiser Permanente is the nation’s largest integrated health plan, serving more than 8.4 million members in nine states and the District of Columbia.

Halvorson has more than 30 years of health care management experience. He was formerly president and CEO of HealthPartners, headquartered in Minneapolis. Prior to joining HealthPartners, he held several senior management positions with Blue Cross and Blue Shield of Minnesota. He was also president of Senior Health Plan, as well as president of Health Accord International, an international HMO management company.

Halvorson serves on a number of boards, including those of America’s Health Insurance Plans and the Alliance of Community Health Plans. He is the current president of the board of directors of the International Federation of Health Plans, and a member of the Harvard Kennedy School Healthcare Delivery Policy Program, the Commonwealth Fund Commission on a High Performance Health System, and the new Institute of Medicine Task Force on Evidence-Based Medicine. He also serves on the Executive Council of La Clínica, and on the Ambassadors Council of Freedom From Hunger, an international development organization working in 17 countries. He is a former board member and trustee of the National Cooperative Business Association.

Halvorson is the author of books on health care, including *Epidemic of Care*, published in April 2003, and *Strong Medicine*. He is currently writing two new books, one about racial prejudice around the world, the other about how to systematically reform health care in America. He has written numerous articles on subjects ranging from health information technology to the changing marketplace.

Halvorson has interacted in a number of settings with academics, policy makers, and health industry leaders, including the HR Policy Association, the World Bank, the European Health Care Congress, the National Business Group on Health, the Microsoft Annual Health Plan Executive Forum, the National Governors Association, the World Health Care Congress, and a number of universities and colleges. He has served as an advisor to the governments in Great Britain, Jamaica, Uganda, and Russia on issues of health policy and financing.