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Protecting the Bottom Line: Five Corporate Models to Lower Costs and Increase Access to Health Care for Formal Sector Workers in Africa

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PRIMER

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SHOPS
Strengthening Health Outcomes *through* the Private Sector

Summary: This primer informs donors and corporations of all sizes and origins about five innovative models used by multinational corporations to lower costs and increase access to health care for formal sector employees. In an age of declining donor funds, private formal sector actors such as corporations are becoming increasingly important health care financiers. By providing employees (especially employees in lower-income brackets) with efficient, affordable health care, corporations can take a proactive stance to protect their financial bottom line by decreasing absenteeism and providing care for employees and their dependents. The five models described here are corporate-owned hospitals; on-site clinics/workplace programs; nongovernmental organization partnerships; reimbursement schemes; and health insurance.

Keywords: health financing, Africa private sector financing, formal sector, health insurance, workplace programs

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Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV/AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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Protecting the Bottom Line: Five Corporate Models to Lower Costs and Increase Access to Health Care for Formal Sector Workers in Africa

BACKGROUND

Africa's diversity offers an emerging market for companies of all sizes and country origins to build successful operations. A recent Ernst & Young study reveals that opportunities will continue to grow for years to come. As of 2011, Africa attracted only 5 percent of global foreign direct investment projects, but momentum is growing. From 2003 to 2010, direct investment grew annually by 13 percent and is forecasted to reach $150 billion in 2015. This phenomenal growth in business has also led to the creation of 1.6 million new jobs across the continent and the emergence of local businesses contracting with multinational corporations (MNC) (Ernst & Young 2011). While the increasing presence of MNCs and the rise in domestic companies will contribute to economic growth, corporations of all sizes and origin also have the opportunity to respond to Africa's struggle with poor or stagnating health indicators and the reality of declining donor funds. Even though foreign development agencies have not set firm timelines for withdrawing funding, the decreasing funding allotments are putting the sustainability of health programs at risk. Increasing pressure to offer sustainable, affordable health care creates an opportunity for corporations to protect their expanding work forces through several outlets. By not offering appropriate levels of health care, companies put production levels at risk by increasing the work force's vulnerability to employee illness, employee deaths, the need to train replacement workers, or absenteeism to care for an ill family member. By providing employees (especially employees in the lower-income brackets) with efficient, affordable methods of health care, corporations can take a proactive stance to protect their financial bottom line by decreasing absenteeism and providing care for employees and their dependents.

HIV/AIDS workplace programs are much more than just a matter of corporate social responsibility.

Corporations of all sizes are at a pivotal moment; they can realize potential gains in terms of productivity, labor stability, and morale resulting from investments in the health of their employees. Moving beyond corporate social responsibility, corporations are now realizing the beneficial financial implications of preserving a healthy work force. For example, an evaluation of SABMiller's HIV/AIDS benefits for employees in South Africa revealed that the company's investment yielded a fourfold return in terms of increased productivity and reduced absenteeism (SABMiller 2011). SABMiller's bottling partner, the Coca-Cola Company in Africa (CCCA), understands that "HIV/AIDS workplace programs are much more than just a matter of corporate social responsibility. Without them, [CCCA's] very existence as a thriving business in Africa would be threatened" (The Coca-Cola Africa Foundation 2006).[1] While these comments pertain to workplace initiatives focused on HIV/AIDS, they nonetheless support the

[1] Coca-Cola estimates an annual loss of $40 to $400 per worker due to HIV/AIDS alone (CCCA 2003a).

view that provision of a safe environment offering prevention, treatment, and care for several health issues can promote a productive business.

This primer profiles MNCs that have developed innovative models to navigate the rocky and often unpredictable African infrastructure in order to increase access to health services—which may include primary care, family planning and reproductive health (FP/RH) services, and HIV/AIDS, tuberculosis (TB), and malaria prevention, treatment, and care—to employees of all skill levels. Through supplementary research and conversations with employers at MNCs, SHOPS has identified five corporate models that have succeeded in various environments and offer potential for scale-up: corporate-owned hospitals; on-site clinics/workplace programs; nongovernmental organization partnerships; reimbursement schemes; and health insurance.

This primer promotes knowledge sharing among several audiences—donors and corporations of different sizes, origin, and continental reach.

By showcasing a variety of corporate models, this primer promotes knowledge sharing among several audiences—donors and corporations of different sizes, origin, and continental reach—as a first step in discussing and debating lessons learned on how to lower costs and increase access to health care for formal sector employees. While the primer focuses on the successes and challenges of the models, it offers only a sampling of ongoing corporate efforts in Africa. It begins by defining the formal sector in order to inform the audience of the beneficiaries of the corporate models. It then presents the models so that corporations and donors may consider which models might be best applied in a given setting. Next, it describes the models in descending order of management's control over or involvement with the models' financial and delivery aspects. A detailed description of each model then offers insights into its advantages and disadvantages, discusses an example of one or more initiatives under the model, and describes challenges associated with the model's implementation. An appendix provides a snapshot of each corporate model and information sources.

METHODS

The original goal of SHOPS research was to investigate ongoing employee-sponsored health insurance schemes in Africa and to gauge corporate interest in developing benefit plans to cover priority health services in areas such as HIV/AIDS, TB, malaria, and FP. In collaboration with the Corporate Council on Africa, the Global Fund, and UNAIDS, SHOPS identified and reached out to 16 MNCs with an extensive African presence. Of those companies, seven agreed to speak with SHOPS staff about their respective health benefits. The conversations revealed two considerations for SHOPS research: (1) health insurance might not be applicable as a universal response for corporations because various country environments dictate the need to use already defined models; and (2) MNCs with a well-established and expansive presence in Africa already operate functioning models to finance health care for employees and their dependents and therefore might not be as receptive to a health insurance plan as newly created entities.

Accordingly, SHOPS realized that the knowledge gathered from the corporate interviews could be cataloged and used to promote the use of successful corporate models across a wide range of sectors. To complement the insights from the interviews, SHOPS reviewed several sources of information, including peer-reviewed literature, media articles, and corporate policies, reports, and websites (Appendix). SHOPS was careful to include information that directly relates to health benefits for employees and dependents while minimizing the inclusion of corporate social responsibility models. Information on health benefits may contain confidential information and is not widely publicized on corporate websites, in company reports, or in information on health initiatives geared primarily to corporate social responsibility. Further, information on health benefits does not offer substantial information on sustainable models.

What Constitutes the Formal Sector?

The African labor market is split between those employed in the informal sector and those employed in the formal sector. One difficulty in defining and measuring the informal sector is the international community's lack of consensus as to what constitutes the formal sector. For purposes of this primer, the informal sector is made up of people who are self-employed, people who are unpaid workers in a family business, and people who are employed in enterprises that are not officially registered (agricultural businesses, street vendors, and so forth) and who produce goods or services for sale or barter (International Labor Organization, Department of Statistics 2011). In contrast, the formal sector is defined as formally registered entities that vary greatly in size.

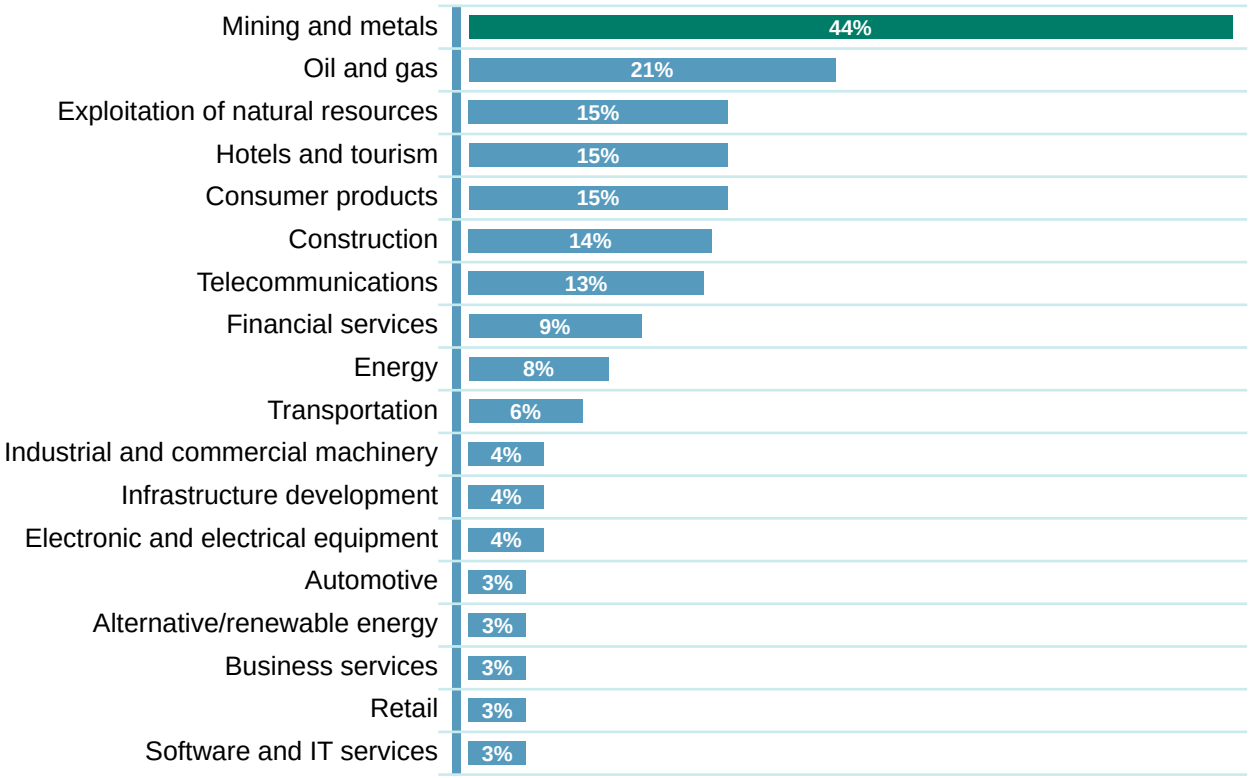
Despite efforts to quantify both the informal and formal sectors, consistent definitions and descriptions are elusive. A recent World Bank publication notes a slight increase in the size of the informal sector ("shadow economies") in select African countries from 1999 to 2006.[2] Using statistical information, Schneider, Buehn, and Montenegro estimated the size of the informal sector in 39 sub-Saharan African countries.In 1999, the countries' informal sector ranged from 22.9 percent (Mauritius) to 59.2 percent (Zimbabwe) of GDP; in 2006, the informal sector ranged from 24 percent (Mauritius) to 62.9 percent (Nigeria) of GDP. Over eight years, the data reveal an average informal sector size of 23.5 percent (Mauritius) to 59.9 percent (Nigeria) of GDP. A further look at the data indicates that the size of the informal sector contracted in eight countries while increasing slightly in the remaining 31 countries (an average annual increase of 0.95 percent for these countries).The formal sector, however, still drives economic growth in the majority of the 39 countries, as only six countries' informal sector accounted for more than half of GDP by 2006 (Benin, Republic of the Congo, Zambia, Zimbabwe, Nigeria, and Tanzania). The formal sector is still essential to the future of Africa's development.

[2] The original study captured data from 1999 to 2007. Data for 2007 were not available for all sub-Saharan African countries; therefore, the primer discusses the data available from 1999 to 2006.

Foreign direct investment in Africa is forecasted to reach $150b by 2015, creating 350,000 jobs alone in 2015.

The report *It's Time for Africa: Ernst & Young's 2011 Africa Attractiveness Survey* reveals that the formal sector has not yet reached its full potential. Using data from a perception-based Africa attractiveness survey of 562 business leaders in 38 countries, the report presents two findings with encouraging signs of growth in the formal sector: (1) projected foreign direct investment in Africa will be valued at $150 billion by 2015; and (2) the growth rate of Africans investing in other African nations reached 21 percent from 2003 to 2010. Based on analysis from Oxford Economics, the projected growth will be responsible for the creation of 350,000 jobs in 2015 alone. The graph below depicts the sectors projected to be most attractive to potential investors from 2011 through 2013. The projection of an expanded formal sector means that more employers will be responsible for maintaining a healthy work force at all income levels.

Most Attractive Sectors for Investment in Africa 2011–2013



Source: *Ernst & Young's 2011 Africa Attractiveness Survey*.
Respondents selected several answers. Total respondents: 562.

The following corporate models show how companies of all sizes can learn from MNCs and protect their bottom line by reducing costs and increasing access to health care for a growing segment of Africa's population.

Model 1: Corporate-owned Hospitals

Definition: *An institution in which specialists offer inpatient and outpatient health services.*
Advantages: *Provides services in rural or hard-to-reach areas and benefits the larger community.*
Disadvantages: *Significant start-up costs with a long recovery process and recurring maintenance costs (i.e., maintaining a safe physical structure for patients).*

Hospitals offer a one-stop shop for patients needing one or several services per visit. Depending on the competition, hospitals can cater to a specific geographic market. While hospitals are in short supply, especially in areas with poor health indicators, the initial barriers to entry for corporate-owned hospitals can be extraordinarily high. First, the construction and sophisticated equipment needs of a hospital represent a significant, upfront financial investment that is a sunk cost. Second, hospitals with a low client volume put both their cost recovery rate and productivity at risk. With a low or stagnant rate of client growth, hospitals are unable to spread the cost of care over a large patient pool, making it difficult to recover construction costs. Lower volume also prevents hospitals from employing specialists who "learn by doing," which refers to the experience gained by health care professionals from continually performing tasks. On the other hand, a hospital with a high patient volume benefits from the reduced costs associated with increased productivity (Santerre and Neun 2010). To succeed, hospitals require a strong funding source, quality assurance, and high-quality equipment and staff.

Hospitals offer a one-stop shop for patients needing one or several services per visit.

Recognizing the importance of a healthy work force and community, the **Shell Petroleum Development Company of Nigeria Ltd. (SPDC)** has developed several models of care delivery in the Rivers and Delta states of Nigeria, including corporate-owned hospitals. From 1998 to 1999, SPDC invested $25 million to reconstruct the hospital in Port Harcourt for its 4,500 workers. While SHOPS could not locate updated information on the hospital, the project learned that, in 1999, the hospital had an annual drug budget of $500,000 and employed 75 staff, including seven doctors, anesthetists, pharmacists, and surgeons. The hospital offers primary and secondary care and provides resuscitation and incubation units and air-conditioned maternity, casualty, emergency, and isolation wards. In addition to its 40-bed capacity, the hospital operates four ambulances and provides access to other hospitals for medical evacuations (Vidal, 1999).[3] In a poor health environment with little access to high-quality health care, SPDC has created a self-sufficient health care system to serve its employees and their dependents.

[3] The author is uncertain of the hospital's capacity to treat HIV/AIDS, TB, or malaria, as the available literature made no mention of such services. SPDC offers access to these services through several corporate social responsibility outlets, such as community-based health insurance, the distribution of bed nets, and immunizations.

In August 2010, the Council for Hospital Services Accreditation of Southern Africa accredited two SPDC-owned and -operated hospitals in Port Harcourt and Warri, Nigeria. The first two hospitals in West Africa to be internationally accredited, Port Harcourt and Warri are certified followers of international best practice standards and will be eligible for accreditation renewal every two years (SPDC 2010).

While the presence of a hospital in a hard-to-reach area (such as the Niger Delta in the case of SPDC) could greatly benefit the work force and the larger community, the corporate-owned hospital model might encounter challenges in urban environments with an already established competitive market for hospitals or in environments that lack a cadre of qualified health care professionals to staff corporate facilities. This corporate model is perhaps best suited to large corporations in remote or hard to reach areas. The development of a hospital may represent an investment beyond the means of small and medium-sized enterprises, although such entities could look into sharing the costs of a corporate-owned hospital.

Operating on a smaller scale than hospitals, clinics can potentially offer employees an all-encompassing health care center

Model 2: On-site Clinics/Workplace Programs

Definition: *A health center located on company grounds that delivers health services to employees.*
Advantages: *Reduces absenteeism and minimizes labor loss by offering a convenient location for employees; provides a large potential market for specialized services such as HIV/AIDS care.*
Disadvantages: *Age restrictions on entrance into corporate premises (e.g., breweries) may limit access to services; stigma and operational issues may result in low uptake of services.*

On-site clinics appear to be a popular option for corporations. Operating on a smaller scale than hospitals, clinics can potentially offer employees an all-encompassing health care center (some corporations operate clinics only for HIV/AIDS or various primary health care conditions). In-house facilities help prevent employee absenteeism and resolve issues such as access to high-quality providers. Dr. Stefaan Van der Borght, director of health affairs at Heineken International, sees tremendous benefit in working with in-house clinicians to maintain quality of care and minimize external pressures. Close relations between the employers and the providers also help ensure that health care professionals are aware of employees' health needs, permitting clinic staff to determine how best to care for employees. For example, Heineken International's management has noted an increase in the number of employees in Africa reporting issues with hypertension. While the company will continue with its highly regarded clinics and HIV/AIDS programs, it will develop interventions to address non-communicable diseases as well.

Operating in 19 countries, **Heineken International** provides access to health care services to approximately 30,000 employees and dependents in 26 clinics. In 2009, the company employed 13 doctors, 12 laboratory technicians, and about 80 nurses in 18 of its clinics (de Man 2009).[4] The

[4] In the absence of further information, the author assumes that staff employed at the other corporate clinics are contract staff.

clinics offer comprehensive care, including primary care and HIV/AIDS, TB, and malaria services.

Similarly, **SABMiller** provides on-site comprehensive care for almost 13,500 employees (and an unspecified number of dependents) at nearly every one of its 53 plants across 16 countries (SABMiller 2012).[5] The capacity of the clinics varies, but, at a minimum, employees and dependents receive primary care services; HIV/AIDS, TB, and malaria services; and care for work-related injuries. Some clinics are equipped with operating theaters, able to perform minor surgical operations, and one clinic offers male circumcision.

As Africa's largest employer, the **Coca-Cola Company in Africa (CCCA)** supports about 65,000 employees in 160 plants across the continent. The CCCA model is somewhat of a hybrid, incorporating partnerships with insurers and public or private health providers. Nonetheless, it focuses primarily on providing services in the workplace. In 2002, the Coca-Cola Africa Foundation (TCCAF), CCCA's corporate social responsibility arm, initiated a workplace-based treatment, care, and support program for employees and their families. Under a comprehensive approach, the program relies on several forms of intervention to prevent the spread of HIV/AIDS. Each plant is equipped to offer employees and their dependents voluntary counseling and testing, 24-hour psychological and informational assistance, and treatment for all sexually transmitted diseases. When needed, the company provides antiretroviral treatment through a company medical plan that involves a network of insurers and preferred providers. To inform program managers about the quality and quantity of care needed and provided, TCCAF collects and evaluates data on a quarterly basis; indicators include: health care costs, treatment uptake, employee participation rates, and absenteeism. After five years of successfully managing the workplace program, TCCAF transferred governance responsibilities to the human resources departments of CCCA and its bottling partners, signifying full corporate participation in the provision of benefits as well as corporate recognition that the delivery of health care is critical to business operations (TCCAF 2006). TCCAF has designed a paradigm workplace model for HIV/AIDS and has incorporated years of experience into five comprehensive manuals to help other companies implement successful workplace programs (CCCA 2003a–e).

The availability of on-site health care can offer the advantage of increased access to care and reduced absenteeism, but increased access relies on voluntary buy-in from employees, especially with respect to HIV/AIDS prevention and voluntary counseling and testing. In an open environment such as the workplace, stigma and concerns about confidentiality may be deterrents to the uptake of HIV/AIDS services. Fear of status disclosure and/or the inference of one's status may prompt employees to seek services at locations other than the workplace. Stakeholders (union representatives and management) have touted peer education as a method to minimize stigma, but the variable quality of peer educator training greatly limits

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Expanding the Workplace Program

Recognizing the success and extensive reach of the workplace program, TCCAF worked with the company's Africa-based bottling partners in 2003 to extend the program to an additional 60,000 employees and their dependents. To attract further buy-in for the program, TCCAF offered to reimburse partners up to 50 percent of implementation costs from 2003 to 2006; 26 partners accepted the offer, and 15 partners were able to cover the costs of the workplace program (TCCAF 2006).

[5] As of October 2011, the breweries in Nigeria and Kenya had been recently acquired, and health systems were not yet in place, though they will be.

its effectiveness (Mahajan et al. 2009). In terms of HIV/AIDS treatment programs, workplace programs are more successful when management plays a supportive role and shares communication of potential benefits (Feeley et al. 2009). Regardless of a program's focus, corporations are advised to conduct a willingness-to-participate study to gauge interest in employee participation before fully implementing an on-site program.[6]

Model 3: Nongovernmental Organization (NGO) Partnerships

Definition: *A relationship between an NGO and a company that leverages an NGO's expertise to deliver health services to employees.*
Advantages: *Corporations can use their supply chain and distribution systems to deliver care and replicate successful models.*
Disadvantages: *Ensuring sustainability can be an issue if the partner NGO faces decreased funding.*

NGO partnerships can take root in a variety of environments, but they tend to focus on the workplace or are synchronized with company supply chains.

If corporations do not have the expertise or connections required to implement a health care initiative, management may look to outsource health care services or engage in a partnership to deliver such services. An NGO partnership permits a corporation to preserve a healthy work force by leveraging the expertise of specialized firms or NGOs. The model may be more appropriate for small and medium-sized companies that do not command the financial or technical resources needed to establish and operate a health care program. NGO partnerships can take root in a variety of environments, but they tend to focus on the workplace or are synchronized with company supply chains.

In 2000, five international institutions — the United Nations Population Fund, the United Nations Children's Fund, the World Health Organization, the World Bank, and the Joint United Nations Program on HIV/AIDS —aligned to create a partnership known as the Accelerating Access Initiative (AAI). Through the partnership, public and private entities may purchase antiretroviral drugs (ARVs) at 10 percent of the commercial price. Taking advantage of the reduced price for brand-name drugs, **Heineken International** extended its health benefits plan to include highly active antiretroviral treatment (HAART) in six African countries with Heineken operations, targeting approximately 30,000 employees and their dependents (Van der Borght et al. 2009). To deal with issues such as quality control, monitoring and evaluation, and program design, Heineken International entered into a partnership with PharmAccess, an NGO known for private sector solutions to HIV/AIDS in Africa. Through the AAI, PharmAccess arranged for the purchase and shipment of ARVs through contracts with six pharmaceutical companies. In 2005, Heineken International conducted an evaluation of HAART at three breweries in Burundi, the Democratic Republic of the Congo, and Rwanda. The evaluation showed that not only did the average annual number of days of medical leave decrease from 1.06 to 0.91 but that the number of hospitalizations declined from 49 to 32 per 100 beneficiaries as well. Such a decrease in hospitalization most likely allowed the cost per beneficiary to decrease from €45.80 to €42.70. By entering into the partnership with

[6] The literature reveals other challenges that companies may face when implementing on-site clinics or workplace programs, such as compliance with national laws; monitoring and evaluation; language barriers between/among physicians, counselors, and employees; and the transition of treatment for employees who leave the company (Mahajan et al. 2009; George and Quinlan 2008).

PharmAccess, Heineken International successfully controlled costs and helped increase the productivity and health of its employees (Van der Borght et al. 2006).

Clearly, the workplace often represents a large catchment area, but other settings might require a different approach. Operating in an isolated, rural area of Uganda, **Nile Breweries Limited**, a SABMiller subsidiary, employs 400 on-site permanent workers and 9,240 indirect workers (small farmers, truck drivers, and hospitality workers in bars) in eastern Uganda. In 2005, Nile Breweries developed a workplace HIV/AIDS program. In 2007, the company partnered with the USAID-funded project Health Initiatives for the Private Sector (HIPS) to adapt the program to include TB, malaria, and FP/RH services and to leverage the company's supply chain, thereby increasing access to care and reducing costs. In 2010, Nile Breweries started training community advisors to introduce care along the supply chain. Armed with cell phones and traveling by bicycle, peer educators travel door-to-door to provide information on the company's comprehensive care package (HIV/AIDS, TB, malaria, and FP/RH services) and to register those willing to participate in the program. Once registered, participants receive a visit by a medical team of four people to conduct voluntary counseling and testing and address other priority health conditions and record relevant data. Since the launch of community outreach along the supply chain, 4,500 individuals have registered to participate in the program; 4,300 people have been counseled and tested for HIV; and 2,000 people have received information on HIV/AIDS, TB, malaria, and FP/RH (Nile Breweries Limited 2010).[7]

Utilizing the corporate supply chain, NGO partnerships can help scale up and extend workplace programs to the broader community.

Both the Heineken International and Nile Breweries experiences highlight models with the potential to reduce costs and reach a large number of people, but the question of sustainability lingers as programs expand and donor funding decreases. Donor-sponsored NGOs often lack the financial independence of their corporate partners, potentially posing operational challenges related to limited human resources, equipment, and training programs for corporate partners (Kigarra 2009). The sustainability of the Heineken International example differs somewhat as the corporate partner absorbed most of the financial burden through the purchase of pharmaceuticals. While representatives of Heineken International and PharmAccess note that large corporations such as Heineken International have the financial capacity to support health benefits programs, they acknowledge that the procurement of pharmaceuticals can be complex and pose a challenge to the continued availability of needed drugs (Van der Borght et al. 2009). Even though NGO partnerships increase access to programs, companies are advised to outline each partner's explicit roles and responsibilities and develop graduation plans to ensure a smooth transition in the event that a partner's funding is withdrawn or significantly reduced.

[7] More information on the overall partnership between Nile Breweries Limited and HIPS can be found in Kiragga 2009.

Model 4: Reimbursement Schemes

Definition: *An employee pays for medical expenses out-of-pocket and submits a claim to the employer for full or partial repayment.*
Advantages: *By setting limits, corporations can control and minimize health care costs.*
Disadvantages: *Potentially large upfront, out-of-pocket expense for employees without immediate reimbursement; without proper regulatory mechanisms in place, the employer could be susceptible to fraudulent claims.*

A consumer-driven model of health care, reimbursement places the onus on the employee to choose needed services. Such a model empowers the employee by allowing him or her to purchase services that might not be covered under traditional medical schemes. Despite anecdotal evidence of employers compensating employees, written documentation is difficult to find. As revealed during interviews, both Monsanto and SABMiller offer employees reimbursement up to a predetermined ceiling in some countries.

A reimbursement scheme empowers the employee and allows him or her to purchase services that might not be covered under traditional medical schemes.

The paucity of documentation on reimbursement limits the author's ability to outline explicit challenges to a reimbursement program. For the arrangement to succeed on a hypothetical basis, employees need adequate information on the availability, price, and quality of the desired health care goods and services (Santerre and Neun 2010). With such preconditions, however, implementation of a reimbursement model on a large scale may be difficult. In an environment with a low understanding of public and private services, employees could be at risk of high out-of-pocket payments, especially if employers set low rates for compensation or do not reimburse in a timely manner. Such a policy may cause consumers to base service decisions on price rather than on the quality or appropriateness of services. At the same time, employers could put themselves at risk without proper policies or regulations. The absence of a well-designed and properly implemented verification system could leave employers vulnerable to fraudulent health care claims.

Jessica Scranton

Out-of pocket medical expenses such as those for prescription drugs could be reimbursed by the employer.

Model 5: Health Insurance

Definition: *A health care plan involving three parties: an insurance company, employers, and employees. The insurance company develops a financing structure based on actuarial analysis of health expenses for a target group. Employers and employees then finance the plan through corporate contributions and wages.*
Advantages: *Pools medical risk and health care costs across several actors.*
Disadvantages: *Requires several actors (competent health care providers, insurance companies, employers, and employees) to cooperate and participate.*

The market for health insurance varies across the broad landscape of Africa. Some countries such as Nigeria mandate formal sector employees to participate in the national health insurance scheme.[8] Under such an arrangement, the employer selects one of 62 accredited health maintenance organizations (HMO) that provide employees and their dependents with services for primary health care and FP; some providers even cover malaria services.[9] Other countries such as South Africa take the mandate one step further and provide employers with a tax deduction for contributions to plans for formal sector employees (Department of Health, Republic of South Africa 2011). Meanwhile, other countries struggle to generate sufficient competition in the formal sector to create a market for insurance or to help the insurance market thrive.

Expanding health insurance packages beyond primary health coverage to include services for HIV/AIDS, TB, malaria, and FP/RH requires additional negotiations and costing exercises. Corporations that already offer basic health insurance to employees will be more able to facilitate the provision of supplemental benefits, but companies without a health insurance structure will face a competitive disadvantage. Evidence suggests that insurance companies extending coverage to HIV/AIDS services and disease management programs specializing in HIV/AIDS are now emerging (such as Lifeworks and AllLife in South Africa).

Although operating on a smaller scale than other companies profiled in this primer, **Monsanto** employs about 50 staff in Kenya. In a competitive insurance market, Monsanto contracted with Aon Minet Insurance Brokers Limited and AAR Insurance to develop two insurance products for employees in different income brackets. Under the lower-income plan, employees receive coverage for up to KES 1,000,000 per family (approximately $12,250) for inpatient care and KES 150,000 per family (approximately $1,840) for outpatient care. Extremely comprehensive, the package insures employees for several services, including maternity care, pre-existing and chronic conditions (including HIV/AIDS), dental care, and prescription drugs (Mwebi 2011).

SPDC has realized a way to work with the national health insurance scheme (NHIS) in Nigeria, NHIS-approved HMOs, and clinics to

Health Insurance Funds

This section describes the specific insurance plan an employee may subscribe to as part of his or her total labor compensation package. Not included are health insurance funds, which involve a donor subsidy. While such funds greatly increase access to care, they are not a sustainable model.

[8] Nigerian companies with more than 10 employees are mandated to contribute 10 percent of an employee's salary to an employee health insurance plan (National Health Insurance Scheme 2012); employees contribute 5 percent.
[9] In Nigeria, all HIV/AIDS care and treatment services are referred to the public sector.

Health insurance offers an efficient platform to provide health care to employees by spreading costs and medical risks across employees, employers, and insurers.

promote an uptake in malaria diagnosis and treatment services. Under a performance-based contracting mechanism, contracted clinics (selected in a competitive bidding process) received a slightly higher rate if they met general standards of care and equipment. The clinics then received a 1 percent bonus if more than 90 percent of patients treated for malaria had a positive diagnosis and received the artemisin-based combination therapy. This financial incentive not only promoted greater standards of care but, after three years (2007–2010), led to 90 percent of patients subscribing to the therapy after receiving a positive diagnosis.[10]

When available, health insurance offers an efficient platform to provide health care to employees by spreading costs and medical risks across employees, employers, and insurers. For insurance schemes to be efficient and affordable in a corporate setting, certain conditions must be satisfied: employees and employers must be willing to contribute a portion of the employee's salary to the scheme; the company must have a sufficiently large pool of candidates in order to share risk and minimize high health costs; premiums should be low; and employers should continually receive actuarial data on health spending, utilization, and risk patterns in order to maintain sustainable premium levels (Kutzin 2005). In this regard, health insurance may present a challenge for small companies; they employ too few employees to create an optimal risk pool.

[10] This profile of SPDC is just one of many companies profiled in the Roll Back Malaria Progress and Series report *Business Investing in Malaria Control: Economic Returns and a Healthy Workforce for Africa*. Other companies profiled are: Azalaï Hotels Group, Clarke, ExxonMobil, First Quantum Minerals, Heineken, Konkola Copper Mines, MADAM:, MTN Group, Nando, Novartis Malaria Initiative, Sanofi-aventis, Said Salim Bakhresa, Standard Bank, Sumitomo Chemical Company, and Vestergaard Frandsen.

CONCLUSION

Through five corporate models, MNCs have redefined the notion of corporate social responsibility and have identified an excellent entry point to reduce the costs of health care benefits for a growing segment of the African population. By starting with the workforce, employers not only enhance productivity and revenues, but they also promote healthy living, which undoubtedly has a ripple effect throughout communities. To foster replication and extension of successful models, companies could conduct evaluations to generate quantifiable data for demonstrating program benefits. The five corporate models also provide a potential entry point for donors or corporate managers interested in designing and implementing cross-country and cross-sector studies in order to collect and analyze data on the models' cost-effectiveness or efficiency. Corporations should also be amenable to sharing information and showing how a healthy work force promotes productivity.

With the several models, corporations can adapt to the unique infrastructure and environment of a given country and develop appropriate methods to reduce costs and increase access to care. As the varying landscape requires different responses, corporations may choose more than one model per country or even create hybrid models. For example, SABMiller provides services in on-site facilities but complements the services with initiatives such as health insurance or NGO partnerships. In Nigeria, SPDC uses a mixed-method approach to address primary and priority needs for employees and dependents.

One common aim of several of the approaches is mitigation of the effects of HIV/AIDS on productivity. Indeed, Africa is at the epicenter of the global AIDS epidemic, and some of the models are intended to reverse the impact of HIV/AIDS. Yet, the target of each model may be recast to address several health challenges: TB, malaria, and unmet need for FP/RH services. In terms of next steps, the corporate models represent an excellent opportunity for MNCs, local enterprises, and the donor community to collaborate in developing sustainable models to increase access to health care and reduce health care costs while enhancing productivity.

Heineken

A doctor at the Heineken on-site clinic and a sampling of the many employees and dependents covered.

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Appendix: Examples and Information Sources for Corporate Models

Model	Example	Information Source

Corporate-owned hospitals	• Shell Petroleum Development Company (SPDC) in Nigeria owns the first two internationally certified hospitals in West Africa	• Interview with Mr. Femi Oduneye, regional health manager, Shell/Sub-Saharan Africa
		• SPDC corporate website
		  • Annual reports
		  • Press releases
		• Media articles (*The Guardian*)

On-site clinics/workplace programs	• Heineken International provides free comprehensive care on site
	• The Coca-Cola Company in Africa (TCCCA) has implemented the most extensive workplace program in Africa
	• SABMiller has on-site clinics in every brewery, offering primary health services and voluntary counseling and testing; one clinic provides male circumcision
		• Interview with Dr. Stefaan Van der Borght, director of health affairs, Heineken International
		• Interview with Mr. Kelly Brooks, group director, stakeholder relations, Coca-Cola
		• Heineken International and TCCA corporate websites
		  • Annual reports
		  • Press releases
		  • Reports from respective corporate social responsibility branches
		  • Corporate presentations
		• Peer-reviewed literature
		  • *AIDS*
		  • *The Lancet*
		  • *Sustainable Development*

NGO partnerships	• Nile Breweries Limited partners with the USAID-funded project Health Initiatives in the Private Sector (HIPS) in Uganda
	• Heineken International partners with PharmAccess to purchase ARVs for employees
	• CCCA extends its workplace program to bottling partners
		• Interview with Dr. Stefaan Van der Borght, director of health affairs, Heineken International
		• Interview with Ms. Jenni Gillies, group HIV/AIDS consultant, SABMiller
		• Heineken International, SAB Miller, and Nile Breweries Limited corporate websites
		  • Annual reports
		  • Press releases
		  • Reports from respective corporate social responsibility branches
		• Website for the HIPS project
		• Peer-reviewed literature
		  • *WHO Bulletin*

Reimbursement	• SABMiller and Monsanto offer reimbursement to employees who pay out-of-pocket for services	• Interview with Ms. Anne Mwebi, human resources and administration, Monsanto/Kenya • Interview with Ms. Jenni Gillies, group HIV/AIDS consultant, SABMiller • Heineken International

Insurance	• Monsanto/Kenya pays a premium for employee insurance, including ART coverage (up to a limit)
	• SPDC in Nigeria partners with HMOs to increase uptake of malaria diagnosis and treatment
		• Interview with Ms. Anne Mwebi, human resources and administration, Monsanto/Kenya
		• Donor websites
		  • World Bank
		  • World Health Organization

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For more information about the SHOPS project, visit: www.shopsproject.org

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