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SUPPORTING PARTNERSHIPS FOR GREATER ACCESS TO HEALTH CARE COVERAGE IN THE FORMAL PRIVATE SECTOR

SUMMARY OF LEARNING AND NETWORKING WORKSHOPS

Sarova Panafric Hotel
Nairobi, Kenya
May 24, 2012

Southern Sun Ikoyi Hotel
Lagos, Nigeria
May 31, 2012

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This document was prepared by Heather Vincent based on notes from Lucy Mbugua (Kenya) and Akuchi Mbagwu (Nigeria) for the Strengthening Health Outcomes through the Private Sector (SHOPS) project.

SHOPS
Strengthening Health Outcomes *through* the Private Sector

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I. BACKGROUND

The diversity of Africa offers an emerging market for companies of all sizes and country origins to build and develop successful operations. As revealed in a recent Ernst & Young study, these opportunities will continue to grow for years to come: 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).[1]

While growing formal sector presence contributes to economic growth, it also represents an opportunity for corporations to contribute towards their countries' goal to achieve universal health care coverage. Engagement with the private sector in Africa is still under-utilized in the area of health, and is critical as the reality of declining donor funds becomes more apparent. 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 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. 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.

Employers know that healthy employees make for healthy business. Unfortunately, most companies lack the resources to provide on-site health care or reimbursement for the cost of care received elsewhere. In principle, insurance offers the best solution to this issue.[2] Paid either in full or in part by employers, insurance premiums represent a relatively small portion of the actual cost of care due to pooling, and they maximize the impact of companies' investment in their employees' health.

In Africa, insurance companies are already providing health coverage to the upper- and middle-management cadres of companies of various sizes. They have made less progress in developing products for low-income earners, which represent the vast majority of formal sector employees.[3] Insurers have indicated that they are very eager to explore opportunities to expand

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[1] Ernst & Young. 2011. Africa Attractiveness Survey. Johannesburg, South Africa: Ernst & Young.

[2] For the purposes of this document, health insurance is defined as an arrangement under which one party (the insured), upon payment of a specified amount of money (known as premium) to another party (the insurer is provided access to a predetermined set of benefits (health services), rendered by specified health care providers).

[3] For the purposes of this document, low-income earners are characterized by:

- Education: Primary or no education
- Marital status: About half are married with children, and the other half are single parents
    - A significant number of the worker's families live in rural areas while the worker lives and finds work in urban areas
    - Tend to have large families
- Health status: Vulnerable to disease due to low-income/low standard of living

coverage to this group of employees. What they lack is information about successful models to do so, and opportunities to engage with industry leaders to establish the basis of working relationships.

Recognizing the need for stakeholders to better understand the requirements, demand, and opportunities for a low-cost health insurance product, USAID's Strengthening Health Outcomes through the Private Sector (SHOPS) project hosted two events in Kenya and Nigeria to share learning and initiate dialogue among local industrial stakeholders. The countries were selected on the basis of a number of criteria, such as health status, country income group, size of formal sector, health insurance (or other health financing) trends, prominence of private health sector, regional balance, and USAID mission interest. Workshop organizers developed an agenda (see Annex A for the agendas) to provide enough time for presentations to provide context, working groups to brainstorm on challenges and opportunities, and ample time for networking to build business relationships. Overall, the workshops had the following objectives:

1. Support a dialogue among companies and insurers to increase health coverage for low-income employees in the formal private sector;
2. Share experiences and challenges in lowering costs and increasing access of low-income employees to health care through affordable health insurance;
3. Identify key steps for building market linkages and increasing access to insurance coverage in the formal sector.

This report summarizes the contributions from the participants in both events. All presentations from the Kenya and Nigeria workshops can be found in the SHOPS Resource Center at www.shopsproject.org/resource-center.

- Residential status: More likely reside in overcrowded neighborhoods (slums) with poor or no basic amenities such as water, toilet facilities, sanitation etc.
- Labor status: Frequently disempowered, exploited and have high job insecurity.

2. PARTICIPANTS

Both workshops attracted attendance from high-level stakeholders. In total, 107 people attended the events (see Annex B for participant lists). The following charts depict attendance by sector.

FIGURE 1: REPRESENTATION BY SECTOR—KENYA

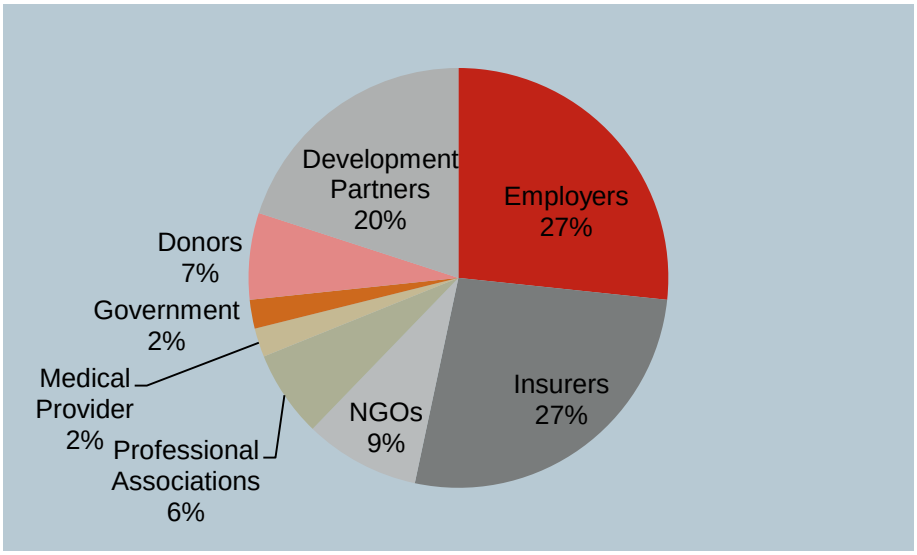
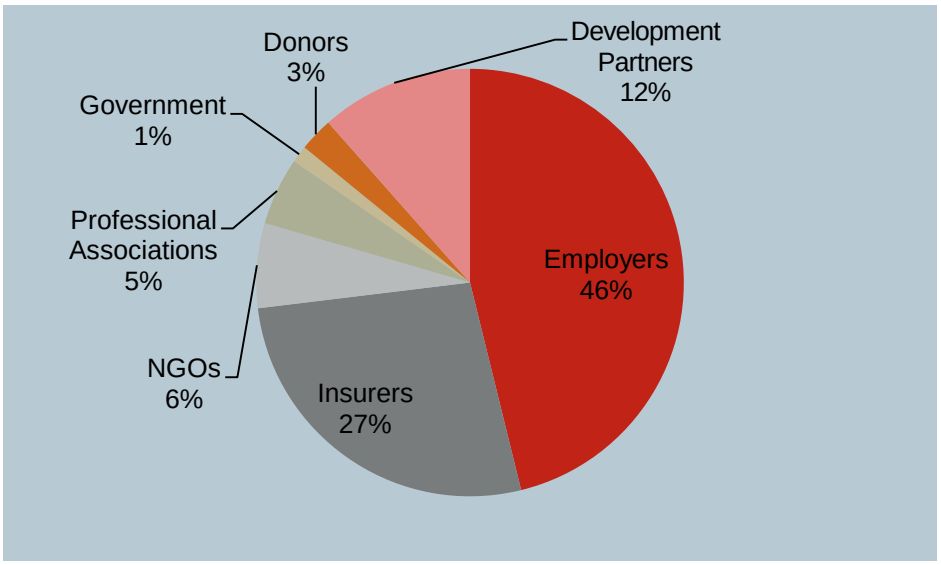


FIGURE 2: REPRESENTATION BY SECTOR—NIGERIA



3. WELCOME AND INTRODUCTION

To set the context and motivate participants for the day, USAID representatives opened each event with insight on the importance of private sector health insurance. Ishrat Husain, senior health advisor with USAID/Africa Bureau, welcomed participants with great optimism: increasing investment in health programs has yielded improved health and economic outcomes. Putting this statement into economic terms, she noted that a one year increase in life expectancy contributes up to a four percent increase in GDP.

Ishrat Husain of USAID/Africa Bureau emphasizes the necessity of health insurance to achieve universal coverage

Trends contributing to increased life expectancy include decreased child mortality and the stabilization of HIV prevalence rates in Africa. While such positive trends greatly assist countries make progress towards achieving Millennium Development Goals (MDGs) and universal coverage, some models to increase access to care are still under-utilized. Referencing the World Health Organization's observations, Husain noted that no country has ever achieved universal coverage without health insurance. Health insurance is particularly important in a time of declining donor funding for the following reasons:

1. Insurance reduces high out-of-pocket (OOP) expenditures for health
2. Insurance creates efficiencies within systems
3. Insurance brings stability and decreases dependency of external financial assistance

The health of Nigerians depends upon the private sector.

In the Nigerian event, Elisa Ayers, head of the Health, Population, and Nutrition office at USAID/Nigeria, welcomed participants by stating that the private sector has a vital role in increasing access to care. The reasoning behind this statement is that private sector organizations of all sizes have developed innovative methods to apply to social issues. Employers also have the responsibility of ensuring stability in their workforce. Private sector stakeholders should therefore be empowered and take ownership of their social responsibility, she stated, because the health of Nigerians depends upon them. While public-private partnerships help breakdown government bureaucracies, other models such as health insurance can provide a sustainable option for Nigerians.

Building off of the encouragement from USAID, the SHOPS organizers walked participants through the agenda for the meetings. Prior to opening the presentations part of the events, they reminded participants of key objectives for the meetings: learning about, creating awareness of, and identifying new opportunities for health insurance in the low-income formal sector.

4. THE NAMIBIA EXPERIENCE

Adapting best practices and successfully proven models is a cost-effective method when implementing new activities. Despite the variety of Africa's geographic, political, and demographic landscape, lessons learned from country programs can be applicable to other countries. With this in mind, an example from a successful program in Namibia opened the presentations in both country events.

Dineo Dawn Pereko of SHOPS Namibia explains the process of developing a low-cost health insurance product

Namibia varies greatly from Kenya and Nigeria in the sense that with a population of 2.3 million people, it is the most sparsely populated country in the continent. However, similar to Kenya, Nigeria, and other countries throughout Africa, Namibia has a large and vibrant private sector that contributes greatly to its economic growth. During a private sector assessment in Namibia, SHOPS discovered that despite the private sector's large presence, it is grossly under-utilized in the health sector (47% of the health workforce belongs in the private sector). Whether the under-utilization is caused by a lack of trust or awareness, or some other factor, is unknown but the preference for public sector services places a certain and unnecessary burden on the government: there are two public sector health workers for every 1,000 Namibians whereas there are eight private sector health workers for every 1,000 Namibians. Additionally, Namibia has a well-established insurance industry with 10 medical funds. Yet, only 17% Namibia's 2.3 million population is insured; 51% of formal sector employees are covered. The reality of these findings called for more research as to why previous efforts at low-cost insurance failed and what can be done to develop a more appropriate product.

In review of previous insurance products, the SHOPS Namibia team looked at three low-cost health insurance projects and schemes:

- **Okambilibili Project:** Focused on the willingness of formally employed and uninsured employees to pay for health insurance; provided basic health insurance services including antiretroviral treatment to 500 home-based care volunteers as an incentive for commitment

- **Diamond Health Services:** Introduced in 2006, it was one of the first medical aid schemes targeting low-income workers and includes primary and HIV/AIDS care; the PharmAccess Foundation subsidized premiums until 2008

- **Vitality:** Introduced in 2006, Vitality exclusively provides HIV coverage at the monthly cost of N$30 (~$4) per employee; the employer is required to cover all uninsured to avoid adverse selection

As new, innovative insurance products entered the market, enrollment appeared encouraging at first. This enthusiasm soon ebbed as the cost was still too high for employees (employers contributed only 50% of costs). Additionally, subsidized premiums and a disease-specific focus decreased the possibility of these products becoming financially sustainable.

In an effort to develop a new, sustainably viable product, the SHOPS Namibia team conducted various analyses and exercises to build a case for their product. These included a cost of illness analysis; a willingness (of employees and employers) to pay analysis; identification of priority illnesses to be covered; identification of the best method for coverage; and actuarial analysis to develop cost points for the product. Overall, they noted the following reasons as to why various stakeholder groups should be interested in low-cost health insurance for low-income earners:

TABLE 1: INTEREST IN LOW-COST HEALTH INSURANCE FOR LOW-INCOME EARNERS

EMPLOYERS	INSURERS	PUBLIC SECTOR
• High cost of sick staff – Sick leave/ absenteeism – Reduced productivity – Early retirement • Help increase access to private health facilities – Better quality – Shorter wait time – Focus on preventative care • 87% of surveyed uninsured employees indicated willingess to pay up to 5% of income for insurance	• Rising health costs create a natural growth opportunity in the market for insurers • Evidence of willingness to pay means that high OOP expenditures can be channeled though insurance • Increase client base • Ability to negotiate favorable rates • Increased risk-sharing opportunities	• Declining donor funding necessitates locating alternative sources for health care financing • Provide coverage for the remaining 49% of uninsured formal sector employees • Reduced the burden on public sector service provision • Savings can be channeled towards unemployed Namibians – 1% increase in enrollment of medical aid funds could result in an annual savings of N$8.5 million (~$1 million)

After building the case for insurance, the SHOPS Namibia team initiated a consultative dialogue process. As with the case building exercise, the team developed and discussed roles with each stakeholder: the **public sector** should support an enabling legislative and regulatory environment for insurance, including promoting public-private partnerships that will allow the private sector to purchase publically procured medicines; **employers** should recognize the social and business concerns of employee health and contribute to insurance plans; **employees** should be informed of the benefits of insurance and be willing to pay; and the **insurance industry** needs to be involved to develop an appropriately priced product, monitor use, and contribute towards primary health care services.

5. EMPLOYER'S PERSPECTIVE

In both countries, employers and federations followed the Namibia presentation by sharing their vision of providing better health coverage to their low-income employees, and the challenges that they face.

Regulations protecting the health of employees vary by country, and minimal standards of care could leave workers vulnerable to diseases such as HIV, TB, or malaria. Insight from employers and professional associations reveals that companies still face significant challenges to providing insurance coverage for low-income earners. Despite these challenges, a sense of morality and responsibility leads employers to think creatively about how to protect their workforce and the bottom line.

5.1 KENYA: EDWARD WANYONYI, OSERIAN DEVELOPMENT COMPANY LTD

Edward Wanyonyi of the Oserian Development Company Ltd (ODCL) noted that while the Employment Act of Kenya mandates employers to provide health care for employers, such provision also makes sense from a business and public relations standpoint. Taking care of employees, Wanyonyi stated, protects productivity through a reduction in sick leave and employees working at a full capacity. Additionally, comprehensive provision of care aids in the recruitment of employees, as it signals to candidates that the employer cares for the safety of staff.

44% of respondents cited monthly premium payments as the primary barrier to purchasing insurance.

In addition to insurance, employers have several options on how to provide care, including reimbursement, in-house self-insured schemes, and on-site clinics. Currently few employers in Kenya can afford comprehensive insurance for low-income employees. The National Hospital Insurance Fund (NHIF) stipulates that all formal sector employees must contribute a portion of their income for inpatient coverage; in this situation the employer acts as a facilitator and does not contribute to any payments. Challenges to providing insurance are rooted mostly in issues related to communication and cost.

In order for insurance enrollment to increase, both employers and employees must have clear, comprehensive information on available products. To date little information on products exist, and if it does it is written in complex language that might be difficult for employers to explain to employees. Communication and information issues also extend to poor customer service and difficult claim reimbursement processes. Poor communication and procedural infrastructure provide little to no incentive for employers to purchase insurance.

Wanyonyi of ODCL discusses the current challenges and opportunities in purchasing insurance for employers

Costs are an issue for employees, employers, and insurers. As direct beneficiaries, employees claim that premium costs are the largest barrier to purchasing health insurance. Wanyonyi referenced an Association of Kenyan Insurers survey conducted in 2008, in which 44% of respondents cited monthly premium payments as a barrier to insurance. In addition to this low willingness to pay, employers also find current products to be too expensive to cover a large number of low-income employees. From an insurer perspective, claims are also rising faster than premiums, which reduces margins for insurers.

Faced with these challenges, ODCL opted not to purchase insurance for its 5,000 employees (90% of whom are unionized and in the low-income bracket). Under the requirements of international horticultural certification agencies and the labor union's Collective Bargaining Agreement (which is renewed every two years), ODCL provides free medical care to low-income employees and their dependents (a spouse and up to four children). ODCL implements this program via two health centers and a network of preferred private hospitals for referral cases. ODCL has not yet considered providing insurance for two main reasons: 1) the current mechanism suits staff needs and 2) certification regulations and union preference for in-house services hinders development of alternative systems.

ODCL still faces challenges such as increasing costs to cover larger families and services for HIV/AIDS care. Despite the challenges mentioned throughout his presentation, Wanyonyi still sees opportunities, especially for multi-stakeholder partnerships. In working together, more appropriate products targeting low-income families can be developed through innovation, and policymakers could enhance the current NHIF benefit package with the inclusion of both inpatient and outpatient care and a user-friendlier claims process.

5.2 ANNE MWEBI, MONSANTO KENYA AND DR. PETER KUMANYO, AON MINET

Anne Mwebi and Dr. Peter Kumanyo provided a multinational company's insight on providing care for employees. With presence in 10 African countries, Monsanto has a large number of low-income employees for whom to provide care. While Monsanto offers care through several different mechanisms, it offers insurance to employees in Kenya, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe through medical aid schemes and health insurance plans and funds such as AAR Kenya and Momentum Africa.

In Kenya, Monsanto provides care for low-income employees through several outlets. First, Monsanto pays the premiums for an AAR Kenya-managed inpatient scheme with minimal coverage up to KES 1 million (HIV/AIDS services can be covered up to 50% of the coverage). To augment this scheme and reduce visits to outside doctors (absenteeism), the company employs an in-house doctor and nurse to run tests on employees. Outpatient coverage is also provided through an AON Minet-brokered fund and covers services such as optical, dental, and maternity services. Dr. Kumanyo explained AON Minet's process by starting with the fact that it does not have any off-the-shelf products. The company works by first understanding the needs and challenges of an organization and then designing a product to address these specific concerns. Some of the products may revolve around flexible benefits that meet the needs of many people and of varying ages. AON also has a provider network that is supported by rapid payments to ensure that funds are readily available. In addition to these services, AON supports Monsanto through the provision of prevention and wellness programs. The programs consist of regular health talks with employees to promote a healthy and productive workforce.

5.3 NIGERIA: CELINE ONI, NIGERIAN EMPLOYERS' CONSULTATIVE ASSOCIATION

Celine Oni of NECA advocates for the sustainable and affordable provision of care through health insurance

Since its founding in 1957, the Nigerian Employers' Consultative Association (NECA) has been facilitating relationships among the Nigerian federal government and the private sector, especially in regard to socio-economic and labor policy issues. In this capacity, NECA works to achieve its mission to influence policies and practices that will create a favorable environment for business in Nigeria. Providing health coverage, Celine Oni noted, corresponds directly with NECA's goal to promote and manage human capital in the industrial sector. To meet this objective, NECA reaches out through its partnerships and programs, including addressing health care coverage on behalf of the Organized Private Sector (a consortium of five Nigerian business membership organizations). NECA has also partnered with the Nigerian Social Insurance Trust Fund to run the Safe Workplace Intervention Project, and ensure the smooth implementation and compliance of the 2010 Employee Compensation Act. Additionally, over the last six years NECA has cultivated a relationship with USAID on workplace policies, including HIV/AIDS care and workplace programs. By working with multiple stakeholders – donors, government agencies, and private businesses – NECA advocates for promoting healthy and safe workplace policies.

Health insurance is the way to move forward in providing sustainable, affordable care in Nigeria.

As many employers have already realized, health is vital to productivity. Employers recognize the need to offer safe workplace conditions and appropriate care so as to maintain and increase staff morale as well as corporate growth and expansion. Many NECA members have catered to the health needs of staff through various programs aimed at employees at all levels. Adding onto the list of methods that her Kenyan colleagues mentioned, Oni mentioned mechanisms to provide care for employees: cash provision (reimbursement), medical retainership agreements between corporations and private hospitals, medical packages for care abroad, and health insurance. Out of all of these methods, health insurance is the most promising mechanism to provide sustainable and affordable health care in Nigeria.

Many members of NECA have embraced use of health care coverage plans through health maintenance organizations (HMOs). Challenges still affect enrollment rates and implementation, especially in terms of poor capitation, lack of funding, and quality of care. Although there are three separate issues, they are all connected. Within the Nigerian system, the lack of funding greatly limits the ability of the National Health Insurance Scheme (NHIS) to pay sufficient monthly capitation for providers. This funding issue in turn could greatly compromise the quality of care that is available to insured employees, especially those in the lower income brackets. To address and mitigate these issues, NECA is involved in two insurance collaborations. First, NECA is working with HMOs and NHIS on the design, development, and implementation of a National Health Insurance Agency. Second, NECA continues to work with NHIS to reform and increase enrollment of the private sector insurance scheme. This scheme, Oni said, is expected to be voluntary and includes a minimum health care package that HMOs must provide.
In conclusion, Oni commended the convening of the workshop for its motivational objectives, and noted that the proper implementation of today's ideas will be beneficial to all stakeholders.

As a means to encourage active discussion and problem solving, she ended, “More ideas and relationships and will give room for knowledge and experience sharing.”

6. INSURER’S PERSPECTIVE

Risk and profit do not generally go hand-in-hand, but insurers are showing interest in working with corporations to develop appropriate products for low-income workers. Difficulty, however, lies within the small risk pools and staggering levels of fraud that are large liabilities for insurance companies. Despite these challenges, successful low-cost products have been initiated, yielding lessons that insurers present at the events discussed next.

6.1 KENYA: DR. EDWARD RUKWARO, AAR KENYA

Dr. Rukwaro began his presentation by stating the industrial paradox of insurers: insurers deal with and manage risk on a daily basis, yet they are risk adverse by nature. The desire to avoid or minimize risk unfortunately marginalizes a majority of Kenya’s 9 million formal and informal sector workers (the remaining 12 million of the adult population is unemployed); Kenya’s 14 medical insurance providers prefer to target the more predictable middle- and upper-management cadres of workers. This preference does not mean that the lower-income category is or should be completely excluded from coverage; instead it calls for more innovative and non-traditional methods of providing coverage.

Two possible mechanisms to provide health insurance coverage to low-income workers include micro-health insurance (profit-based) and community-based insurance (nonprofit-based). With low-income earners comprising almost 25% of Kenya’s population, this is a large opportunity for the private insurance sector. Based on a successful pilot of a low-cost health insurance product in Eldoret, Dr. Rukwaro recommends the following steps:

- Ensure willingness to pay prior to launching
- Target as homogenous a population as possible
- Develop an appropriate price point for products with needed services
- Think creatively about packages and channels for delivery
- Create partnerships with low-cost hospitals
- Invest in marketing to increase awareness on the benefits of risk pooling and insurance
- Make premium collection easier (i.e., electronic/mobile payments)

Over the past six years, the Kenyan insurance market has grown significantly, with premium volumes increasing by almost 150% (KES 3.5 billion in 2006 to KES 8.7 billion in 2011).

Insurance is available through 14 medical insurance providers as well as the NHIF. Current estimates state that about 2% of Kenya's population of 40 million can afford private health insurance. As the public health insurance alternative, the NHIF covers 2.3 million principal members and 6.6 million dependents in both the formal and informal sectors. Deductions are collected through a network of over 44,000 employers using modern technologies such as electronic fund transfer and mHealth solutions. The subsidization for informal sector members relies heavily on contributions from high-earning Kenyans and the package covers access to government and low-cost hospitals across the country.

Despite the rapid growth in premiums and the introduction of a government fund, the industry faces severe cost issues. While Wanyonyi mentioned costs for employers and employees, Dr. Rukwaro noted that the exceptional growth of claims poses a credible threat to the sustainability of insurance operations. Claims are growing at a much faster rate than premiums, which in 2011 alone resulted in a staggering loss of over half a billion Kenyan shillings. Continual losses greatly hinder insurers' ability to administer products. The rationale cannot be contributed to an increase in beneficiaries as enrollment in schemes has not increased significantly, nor can it be contributed to medical inflation, which with the exception of 2008 has been below 10% over the past five years.

Fraud is the leading cause in the staggering increase of insurance claims over the past five years in Kenya.

The discovery that the cost of claims exceeded the rise in health care costs point to fraud as the culprit of driving up costs for insurers. Fraud exists in many forms, from physicians providing unnecessary treatment to users colluding with pharmacists to cover perfume instead of prescribed medication. Without appropriate reporting mechanisms, insurers have no means of learning about fraudulent claims and have difficulty finding a way to mitigate the impact of such unpredictable behavior by themselves; increasing premium levels is not a viable solution.

A strong, collaborative consumer chain has the potential to contain costs and prevent fraud. Of the various actors – consumers, health care providers, insurance companies, networks, and government – Dr. Rukwaro believes that health care providers have the most capacity to bring medical costs to a reasonable level. Various methods health care providers can lower costs include:

- Avoid repeat hospitalization through proper diagnosis
- Do not conduct unnecessary tests
- Be honest about the cost of treatment and do not offer clients fake receipts
- Charge the same for insured and uninsured patients
- Do not admit the patient unless required and discharge the patient in a timely manner
- Report fraud through professional associations

Overall, addressing the needs of low-income earners while battling increasing costs is a difficult equation for industry stakeholders to solve. Increasing premiums will bring little benefit, while innovation and partnerships can yield positive results. In terms of a way forward, Dr. Rukwaro sees potential in medical providers taking a lead at bringing claims costs back to a reasonable

level. Insurance coverage to the low-income earners cannot be extended without partnership of the entire consumer chain, from the macro- (government) to the micro-level (user).

6.2 NIGERIA: DR. TOSIN AWOSIKA, HEALTHCARE INTERNATIONAL LIMITED

Well-known and respected within the Nigerian insurance community, Dr. Awosika gave an impassionate presentation about the fundamental right to health care, regardless of socio-economic status. Health insurance, he noted, facilitates this right to care by decreasing OOP payments for services, thereby protecting beneficiaries from the consequences of catastrophic illness. It allows for twenty-four hours access to preventive, curative and rehabilitative services, and includes proper management of chronic ailments and conditions, and wellness and preventive care. With the proper infrastructure, insurance even has the potential to offer emergency care nationwide.

As in Kenya, only a small percentage of the Nigerian population (4%, which translates into about five million people) is covered under health insurance. Of this small number, about 80% are federal government employees covered under the Nigerian Health Insurance Scheme (NHIS), and the remaining 20% are covered under private health insurance. An increasing number of informal workers are paying for health insurance through community-based health insurance schemes.

Dr. Awosika stated that in order to design an insurance product for low-income earners, the target group must first be defined. Constituting a large portion of the workforce, low-income earners provide low- or unskilled labor and tend to work on a part-time, contractual, or temporary basis. Due to low standards of living (poor accommodation and lack of access to sanitary and hygienic facilities) and exposure to unhealthy lifestyles (smoking and excessive drinking), this demographic bears most of Nigeria's devastating disease burden (e.g., malaria, typhoid fever). Additionally, lack of access to finance and modern health care results in patronage of traditional or alternative health care, which may not be of the same quality of care that insurance can provide.

Given the above characteristics, Dr. Awosika argued that coverage for low-income workers is a definite priority in terms of health and economic development. As this population comprises the majority of the Nigerian population, its poor health profile negatively impacts the nation's health indices and progress towards achieving MDGs. Offering access to care at an affordable price under health insurance will increase the available funding pool to provide quality health services throughout the country. Overall, the health and economic benefits of insurance begin with the individual (healthier lifestyles and reduced sick leave), spread to the community and workplace (improved health of families and increased productivity and profits for companies), and ultimately benefits the nation as a whole (improved funding and efficiency of systems).

> Health insurance is the way to move forward in providing sustainable, affordable care in Nigeria.

Preference for previous financing mechanisms, such as retainership, presents a challenge for increasing enrollment in insurance schemes.

As was mentioned throughout the workshops in Kenya and Nigeria, several challenges affect the successful implementation of insurance schemes (in both the formal and informal sectors). As observed in Kenya, a general lack of information and poor understanding of health insurance (from both the employer and employee perspective) greatly deter interest and enrollment in insurance in Nigeria; this lack of awareness or interest could be due to a number of reasons, including educational, religious, or cultural factors. Insurers also have difficulties designing products that adequately cover this target group, especially without high levels of willingness or ability to pay. Recent challenges that arise from the Nigerian context include high staff turnover rates and preference for a financing model known as retainership.

Similar to his colleague in Kenya, Dr. Awosika shared lessons from his direct experience on how to design and sell low-cost health insurance:

- Increase awareness on the benefits of health insurance;
- Conduct health education seminars to improve hygiene, reduce risks, and amend lifestyles;
- Design robust health plans at affordable premiums to meet the needs of the groups;
- Partner with suitable health facilities to provide quality medical services;
- Ensure effective monitoring of services rendered by providers;
- Create a functional grievances claims and resolution system;
- Conduct impact assessments to ensure effectiveness and sustainability of the scheme;
- Collate data/returns from providers for actuarial studies.

While cost is an important factor to consider, Dr. Awosika made the case that it should not be an ultimate deterrent and should be weighed against a number of factors when developing health insurance. Ultimately, the success of a health insurance lies in achieving set objectives:

Everyone has the inalienable right to health care.

- Total commitment to the cause (cost vs. profit)
- Reaching the people (cost vs. beliefs)
- Designing the right Plans (cost vs. willingness)
- Building the required capacity (cost vs. talent)
- Building the required network (cost vs. cost)

Closing his presentation, Dr. Awosika emphasized that stakeholders in the health and development sector have the responsibility to make sure that everyone can embrace his/her

inalienable right to health. Accordingly, no one should be denied access to health care due to his or her socio-economic status.

7. GOVERNMENT'S PERSPECTIVE

While the workshops focused on facilitating discussions and relationships between corporations and health insurers, organizers and participants recognized that the success of increasing health insurance coverage depends upon engagement of all actors, in particular the government. In terms of contributions, the government could work with the private sector to regulate and monitor insurance schemes, while it in turn could greatly benefit financially and programmatically through partnerships with the private sector to decrease the burden on the public sector. A member of the Kenyan Ministry of Medical Services actively participated in the morning events in Nairobi and provided insightful comments; participants in the Nigeria workshop heard the following from a NHIS representative.

7.I NIGERIA: A.T. B. OJUOLAPE, NATIONAL HEALTH INSURANCE SCHEME

Describing the NHIS as a blessing, A.T.B. Ojuolape emphasized that early and frequent engagement with the private sector builds the foundation for a strong health insurance system. Partnership is especially critical for the most populated country on the continent.

Ojuolape from NHIS looks forward to exploring partnership opportunities with the private sector

In collaboration with 63 licensed HMOs, the NHIS flagship Formal Sector Health Program offers care for public and private sector employees, members of the army, police, and allied services, students from tertiary institutions, and voluntary beneficiaries. Under this plan, subscribers contribute 5% of wages to the plan, while employers provide a contribution of 10-100% and can pay extra contributions for benefits outside of the traditional package. The plan will cover the employee, a spouse, and up to four dependents. Enrollment of this very comprehensive package (primary, in- and outpatient, preventive, maternal, dental, and surgical care) has experienced tremendous growth in both the formal sector and armed forces. To-date, at least six states have adopted this program, which has further allowed the government to focus on and make further progress towards achieving MDGs. However, with over 8,000 participating health care providers for the approximate 5 million beneficiaries, less than 5% of the Nigerian population is covered under NHIS.

Along with the low coverage percentage, other barriers need to be addressed, such as bartering for payments and insufficient and credible data. These challenges have not deterred the NHIS program, and other health insurance programs are being explored for the benefit of informal sector workers, children under five, and retirees. In closing, Ojuolape stated that the NHIS looks forward to pooling efforts with the private sector to improve health insurance for all Nigerians.

8. WORKING GROUPS

After a morning of presentations, participants were divided into working groups to address questions regarding low-cost health insurance for the low-income earner. To ensure lively, constructive discussion, workshop organizers divided participants by sector (insurer, employer, NGO, donor) as evenly as possible. The following sections describe the questions that participants were asked to answer, and the insights that the groups provided.

8.I WHAT ARE THE UNIQUE CHALLENGES OF PROVIDING HEALTH INSURANCE COVERAGE TO FORMAL SECTOR LOW-INCOME EMPLOYEES AND THEIR FAMILIES?

Participants in both countries discussed the challenges from the perspective of multiple actors, including the employee, employer, provider, and insurer. As expected, this list of challenges was the most extensive and articulated response out of the four questions. Overall, low acceptability tends to be one of the greatest challenges, as it stems from several root problems: costs, poor communication, and lack of coverage.

8.I.I KENYA

Communication issues (poor information flows from both insurers and employers) creates a general lack of awareness, and sometimes mistrust, of the insurance industry within the lower cadre of employees. Even if information is available on products, the complexity of the language is challenging for illiterate workers (for example, the majority of ODCL's low-income workers are illiterate) or those with only a primary diploma. Language is not the only communication barrier. Employees are likely to be hesitant to contribute from their small wages to something that they might not deem necessary; they might feel that they are at low risk of illness and therefore do not see the need in taking funds from the small amount of disposable income. Without proper information on the benefits of insurance as well as adopting a healthy lifestyle, employees are in danger of not taking preventative action for their care, and curative care can be much more expensive than preventative.

Participants in Kenya walk through the challenges of low-cost insurance

In addition to communication issues, low-income employees in the rural areas face access and quality issues. Due to the limited costs of insurance products for this target group, the extent of the available network might be limited and employees in certain rural areas might not have close access to approved facilities;

the opportunity cost of travelling to an approved provider or facility would be more expensive than for other provision alternatives.

With the rising costs of health insurance in the Kenyan market, employers feel that they would be doing a disservice to their low-income employees by purchasing the most affordable product available for that income bracket. The reasoning behind this decision is that the cover would be more restrictive than providing coverage under other alternatives, such as on-site health clinics. In general employers feel that the products lack flexibility in packaging low-cost products, and are they weary of a potential misuse of the schemes that could result in higher premiums. A general complaint from employers is that administrative processes (such as claims reimbursement) make health insurance a complicated, cumbersome, and unattractive option.

As validated by Dr. Rukwaro's presentation, fraud makes insurers most hesitant to venture into low-cost health insurance. Additionally, insurance is a for-profit business, and to date insurers are not aware of a large enough potential low-income client base in order to make the low-cost product viable in business terms. Insurers also want to make sure that they can offer a reputable product, and as seen with the NHIF, gaps between the costs and quality of low-cost products are a concern for them. Without an extensive network of providers willing to be included in the low-cost scheme, insurers are unlikely to have a desirable product to market.

8.1.2 NIGERIA

Low-income employees face discrimination at multiple levels, and health care is no exception. Bearing the majority of the disease burden for the country, this cadre of worker has difficulty contributing wages to a plan that will provide enough coverage (in terms of quality, location of provider, and type of care provided) for the entire family. With limited disposable income, workers could easily misconstrue the contributions as an unwanted, additional taxation rather than a health benefit. This misunderstanding could stem from a lack of communication/ marketing of the benefits of health insurance, as well as a sense by employees that they are immune to disease and would therefore be paying an additional tax on much needed wages. This in turn greatly affects, and limits, the acceptability of insurance, especially when employees feel that they are better off under other schemes (i.e., reimbursement).

Nigerian participants debate the challenges of current health insurance products

Costs can also be prohibitive for employers, especially small business owners. As with employees, the complex language of health plans, mistrust, and lack of communication between insurers and employers makes employers hesitant to provide health insurance to their respective workforces. Additionally, as alluded to during Wanyonyi's presentation in Kenya, workers unions can be "vociferous advocates" and prevent the adoption of health insurance into corporate policy.

While inconsistent quality of care across providers is a concern in Nigeria, a greater concern is the various levels of discrimination of patients with various levels of health insurance coverage. This inequality is difficult to monitor and regulate in a country as large as Nigeria. Another concern, although not as pervasive as in Kenya, is the issue of fraud and collusion among providers that results in overutilization and therefore rising costs for employers and insurers.

Insurers face a difficult balance in developing an adequate, affordable product for a target population that is considered risky in terms of disease incidence and ability to pay. These products tend to deter insurers and providers, as they yield small profits for high risks. Not only is the target group a risk, but the history of delayed payments from employers makes the low-income group even less attractive for insurers from a business sense.

The federal government has made tremendous progress in terms of developing comprehensive packages, but has not been as successful in providing guidance for, and supervision of stakeholders. Without the necessary political will and organization, the system will not have an appropriate framework for proper regulation, legislation, or enforcement of insurance. This can lead to undesirable results for all stakeholders, especially the vulnerable, low-income population.

8.2 TO WHAT EXTENT DO CURRENT HEALTH INSURANCE PRODUCTS AND SERVICES MEET THE NEEDS OF FORMAL SECTOR LOW-INCOME EMPLOYEES AND THEIR FAMILIES?

Nigerian participants were more positive than their Kenyan counterparts about how the needs of low-income workers and their families are being met. Nigeria certainly has obstacles to overcome, but the optimism seems warranted, given the strong HMO presence and integration with the NHIS. As Kenyan participants relayed, the will exists in the country, but coordination and cost issues must be better controlled.

8.2.1 KENYA

As mentioned during the morning presentations, most insurance products currently on the market do not meet many of needs of low-income employees and dependents. From a user perspective, most products are overly complex in design, demand high premiums, and feature various limitations. The choice of provider is rather restrictive, especially in terms of quality physicians. Additionally, existing products lack wellness and prevention programs, and place restrictions of eligible family members. From an insurer perspective, products for low-income earners have limited operational scope because of a popular culture that regards health care as cheap, if not free. Insurers also face a territorial issue, as uncertainty about the scope of NHIF packages (in terms of public vs. private sector coverage) leaves the private insurers unsure of how their scope will be affected.

A few small schemes have recently been developed to address the specific needs of low income earners; e.g. NHIF, Tanykina Community Healthcare Plan (TCHP), CIC, Faulu, Kenya Women Finance Trust (KWFT), Afya Milele, Britak's 'kinga ya mkulima', AAR Afya Maisha, and Changamka Medisave. More evaluations, however, need to be conducted to see if these products are effective and meeting the target audience.

Changing the question somewhat, participants discussed how current health insurance products could *better* meet the needs of formal sector low-income employees and their families. The following is a list of some main points they made:

- Review, and potentially redefine, the attributes of the term "poor" and "low-income";

- Conduct a willingness to pay study to validate or disprove the historical ideology that people do not want to pay for health care;
- Decrease distribution issues through ICT solutions;
- Allow for an initial subsidy to help start the scheme;
- Increase investment in peri-urban areas;
- Invest in awareness and training at a national level;
- Embrace PPPs, e.g. NHIF and TCHP.

8.2.2 NIGERIA

As in other countries, insurance plans in Nigeria are separated into different coverage and limits categories such as “gold,” “silver,” and “bronze’” with low-income earners covered under the bronze plan. Under this type of plan, approximately 60% of the needs of this target population are met. Beneficiaries are covered for registration, consultation, prescriptions, preventive care, (limited) inpatient care, and laboratory tests. Some employers restrict the coverage to solely the employee and not the entire family, and various health centers do not provide an equal level of quality across the board.

Nigerian participants contemplate the degree of coverage under current low-cost health insurance products

8.3 HOW CAN WE IMPROVE MARKET LINKAGES AND PARTNERSHIPS BETWEEN HEALTH INSURANCE PROVIDERS, EMPLOYERS, GOVERNMENT, AND DEVELOPMENT PARTNERS REGARDING INSURANCE COVERAGE OF LOW-INCOME EMPLOYEES AND THEIR FAMILIES?

Absorbing one of the key messages from the SHOPS Namibia presentations, participants in both countries all came to the consensus that open, honest dialogue among partners builds a strong foundation for successful market linkages.

8.3.1 KENYA

As evident in the presentations and discussions throughout the day, this event jump started critical thinking about how to understand and jointly address the challenges and opportunities to provide low-cost health insurance. To continue the momentum initiated at the events, consultations should develop into partnerships in different areas to support health insurance as a sustainable, viable health financing mechanism. Insurers can work with human resources mangers to develop and widely disseminate clear, simple messages to different audiences (employers, employees, government, unions) about the benefits of health insurance. Addressing

frequent employers' complaints, insurers could work with information communication and technology service providers (such as Smart Applications) to improve administrative processes. In addition to its legislative and regulatory mandate, the public sector has great potential within the realm of forging public-private partnerships.

In order for these partnerships to succeed, open channels of communication must remain open among all stakeholders. One of the first for a of exchange should involve insurers, employers, and representative bodies of low-income workers (i.e., unions) in order to debate appropriate areas and delivery channels for this target group. On a more macro-level, there should be a forum for information sharing among all sectors in order to share information and create industrial standards and performance benchmarks.

8.3.2 NIGERIA

As the direct beneficiaries of health insurance, employees need to undergo a culture and behavior change that involves processing new, complex language and adopting healthier lifestyles. Focusing on enhancing the knowledge and increase acceptability is key, and a useful starting point for improving market linkages.

A participant in Nigeria explains the connections between all stakeholders

Employers should be viewed as key mediators between employees and the HMOs. In this capacity, employers can begin by actively engaging in conversations with HMOs, assist in the design and marketing of insurance product, and coordinate education talks with employees to help promote a health and wellness campaign in addition to offering health insurance. Ensuring a reliable, willing market for HMOs will greatly assist in developing strong, profitable relationships in the insurance landscape.

Insurers' best long-term interest is to operate in good faith and complement comprehensive products with complimentary wellness talks for employees. Promoting healthy lifestyles has the potential to result in lower and more responsible utilization of insurance products. Another way to engage employers and employees is to also improve customer service mechanisms, such as a 24 hour call center, to increase the level of information and trust from stakeholders.

Governments have the power, but not necessarily the capacity, to provide the political and regulatory framework needed to support and promote health insurance. In order to improve market linkages, policy makers and private sector liaisons within the government should engage in open dialogue with and seek guidance from insurers, employers, representatives of employees, and development partners. Setting the right diplomatic tone and policies for insurance has great potential to stimulate the market.

Completing the circle of stakeholders, development partners can become involved in different capacities, from advising on best practices to data analysis or assistance in the development of a low-cost health insurance product.

Overall, in order to improve market linkages, there must be simultaneous levels of trust, consistent communication, and interest to ensure that implementation of insurance goes as

smoothly as possible. In order to supporting this approach, strong data collection and sharing systems need to be developed and used consistently. Data is critical for market linkages in order to appropriately price, distribute, and regulate low-cost insurance products. Valuable data points include actuarial data to guide costing decisions and tracking of where clients seek care to develop as extensive a network as possible.

8.4 WHAT WOULD BE AN IDEAL HEALTH INSURANCE PRODUCT FOR FORMAL SECTOR LOW-INCOME EMPLOYEES?

Participants in both countries called for a product that is accessible, affordable, inclusive, and understandable. Clearly this is a difficult equation to balance, but as seen so far in Namibia, it can be accomplished.

8.4.1 KENYA

Although a challenging concept, the ideal product for low-income workers and dependents would be affordable, comprehensive, family-inclusive, and simple in formulation and implementation. Ideal components of this package would include family planning, health education and promotion, access to reliable health care providers, and incentives for healthy behavior. Such products should be developed in collaboration with multiple stakeholders and defined in the context of a minimum health package. Methods to attract more policymakers (thereby increasing risk pooling opportunities) can include flexible payment terms with easy collections systems (e.g., electronic/mobile payments and provider payment mechanisms) or in-house schemes with strong referral systems. Implementing such systems present great potential to also encourage scheme utilization and cost containment, thereby making insurance a viable, trustworthy health financing model.

8.4.2 NIGERIA

Similarly, Nigerian participants centered discussions of the ideal product on affordability, accessibility, inclusivity, and quality. In comparison to other wealth quintiles, low-income earners are disproportionately more prone to instances of child and maternal mortality, diseases, and infections. Through an ideal insurance product, low-income earners should be offered a benefits package covering: general consultations, treatment of common ailments, maternal and child health, auxiliary services, prescriptions, dental care, minor surgeries, and health awareness programs.

9. LESSONS LEARNED AND OPPORTUNITIES

To conclude the workshops' activities in their respective countries, Dr. Gitonga and Bassey synthesized the information shared throughout the day. They re-emphasized the importance of health insurance in a broad sense. In an era of global budget cuts, pressure to become cost-effective and make progress towards sustainability is increasing. This reality then trickles down to the country-, state-, and individual level, where scarce funding streams greatly affect health programs. As Husain mentioned during her opening remarks in Kenya, insurance is an essential element of efforts to achieve universal coverage. Although not a panacea, insurance has the proven capacity to lower OOPs for beneficiaries and the ability to make health systems and delivery channels more effective. This health care financing mechanism deserves more attention and piloting in key target groups, such as low-income earners in the formal sector. Although reliable data on insurance coverage remains scarce, countries have experimented with health insurance and are exploring concepts such as community-based health insurance, national health insurance schemes, or social health insurance products. Relatively little focus has been placed, however, on insuring the low-income employment bracket. The will exists, and stakeholders are piloting some programs, but certain challenges are deterring progress. As showed in the table below, issues such as cost and communication could likely be universal issues, but other, more culturally-sensitive challenges relating to trust and religious biases might need to be addressed on a more individual country case.

TABLE 2: COUNTRY-SPECIFIC CHALLENGES

KENYA	NIGERIA
• Cost containment • Fraud • Lack of knowledge or information sharing on available, affordable products • Little emphasis on prevention • Identifying/creating an appropriate insurance product for low-income earners	• Cost containment • Lack of trust between stakeholders • Lack of communication, knowledge or information sharing on the benefits of health insurance (marketing) • Biases among stakeholders • Identifying/creating an appropriate insurance product for low-income earners

Lastly, to maintain the positive momentum generated by the workshops, the organizers walked participants through the opportunities awaiting stakeholders in terms of developing health insurance products for low-income workers. One important item to note is that despite the varying (and overlapping) challenges that Kenya, Nigeria, and other countries face, communication is key to capitalize on opportunities. The following figure lays out the various roles stakeholders can start playing right away.

TABLE 3: STAKEHOLDER ROLES

STAKEHOLDER	ROLE
Employees	• Actively participate in the design of a product • Adopt healthy lifestyles and utilize insurance benefits appropriately • Provide constructive feedback to managers and providers
Employers	• Evaluate the appropriate method of health care financing • Promote health education and awareness among staff • Conduct economic evaluation/willingness to pay studies
Insurers	• Communicate with employers and employees to better understand the latter's unique needs • Use solid actuarial data to develop products • Respond to needs with innovation and flexibility • Invest in education and target studies • Monitor use and distribution of services
Health care providers	• Develop standardized and quality health care services • Accept more sustainable payment modalities: fixed reimbursement, DRG, capitation • Use comprehensive costing data to price services • Partner with employers and insurers to develop sustainable health plans • Play their part in combatting fraud
Government	• Define regulatory structure for health insurance • Promote public-private partnerships in health financing and education • Make health plans mandatory and work out how each socioeconomic group will be covered • Hold all parties (insurers, employers, and providers) accountable for results • Collect and collate industry innovation and share data/benchmarking
Donors and development partners	• Provide knowledge from global best practices • Provide technical assistance for willingness to pay and actuarial studies • Promote product development in different markets

Once this dialogue process is functional, collaboration will yield opportunities such as information sharing, leveraged partnerships to build extensive provider networks, and products that accurately address the needs of low-income earners and their families.

10. NETWORKING RECEPTION AND MARKETPLACE

As the workshops' agenda was arranged to provide ample time for networking and exchange between participants, activities ended in the mid-afternoon and led into a networking reception and marketplace. With ample food and beverages, the reception aimed to set a relaxed environment for participants to discuss potential business partnerships and learn about each other's current initiatives in a marketplace setting. Numerous business contacts were made between participants, who mentioned repeatedly that they had long been looking for such an opportunity for exchange and networking.

11. PARTICIPANT FEEDBACK

The workshops in Kenya and Nigeria provided a rare opportunity for knowledge sharing and networking among key stakeholders in the insurance industry. Attendees listened to various perspectives, debated important topics about the various obstacles and opportunities, and made new connections that will hopefully prove fruitful. Insightful comments highlighted the days' agenda, and continued even in the workshop feedback forms. Comments from participants provided a variety of thoughts, from compliments to helpful feedback to consider for further action. The following are excerpts from the feedback forms.

11.1 GENERAL COMMENTS

"I treasure the opportunity to have participated in a group session as well as the experience gained from contributors. I am thinking differently now about our employees' wellbeing." (Nigerian participant)

"My company is already managing our employees' health under HMOs. The seminar of today will help in improve our relationship." (Nigerian participant)

"Keep the interactive nature of the conference. Change it from a one-day event to two-day event so as to accommodate more sessions and in-depth discussions." (Nigerian participant)

“There should be more of these workshops and symposiums to shed more light on what is happening in the industry.” (Kenyan participant)

“Can we engage with the informal sector? Excellent workshop with lots of new insights and great networking opportunities. Future engagement of health care providers and target group.” (Kenyan participant)

11.2 RECOMMENDATIONS FOR NEXT STEPS

“Engage the government to come up with a multi-sectoral approach to deal with the issues identified.” (Kenyan participant)

“Look into ways of venturing into the rural set-up, instead of just concentrating in urban areas.” (Kenyan participant)

“Actuarial analysis should be done to come up with appropriate costing, and a fraud survey should be carried out to establish the level of fraud in the medical field.” (Kenyan participant)

“This kind of engagement among stakeholders should be a continuous process until there is a meaningful progress.” (Nigerian participant)

11.3 CONSIDERATIONS FOR FUTURE EVENTS

“Provide more case studies on how other countries are providing insurance coverage/health coverage to low-income earners, and how ICT systems can improve efficiencies and reduce administrative costs.” (Kenyan participant)

“Expand more on the wellness program as an advantage to employers.” (Kenyan participant)

“Include sessions to expand on the roles played by the government, insurance, and trade unions in other countries where the program is a success.” (Kenyan participant)

“The low-income earners should be well-represented when discussing issues that deal directly with them. The government should be well-represented, cutting across all aspects of relevant government health organizations.” (Nigerian participant)

ANNEX A: WORKSHOP AGENDAS

I.I SUPPORTING PARTNERSHIPS FOR GREATER ACCESS TO HEALTH CARE COVERAGE IN THE FORMAL SECTOR (KENYA)

Thursday, May 24, 2012 | Sarova Panafric Hotel | Nairobi, Kenya

MEETING OBJECTIVES

1. Support dialogue among medium- and large-size companies and insurers in Kenya to increase health coverage for low income employees in the formal private sector
2. Share experiences on lowering costs and increasing access of employees to health care through various models, with a focus on health insurance
3. Identify key steps for building market linkages and increasing access to insurance coverage in the formal sector

AGENDA

Session I – Welcome and Setting the Context		
8:30-9:15	Morning refreshments – Registration	
9:15-9:20	Welcome	Ishrat Husain, Senior Health Advisor, USAID
9:20-9:30	Introduction and workshop overview	Dr. Nelson Gitonga and Dr. Thierry van Bastelaer, SHOPS
9:30-9:45	Low-Cost Health Insurance? Why and How – *The Namibia Experience*	Dineo Dawn Pereko, SHOPS
9:45-10:00	The employer perspective – *Oserian Development Company*	Edward Wanyonyi, Health Center In-Charge, Oserian Dev Company

10:00-10:15	The insurer perspective – *AAR Kenya*	Dr. Edward Rukwaro, General Manager – AAR Healthcare
10:15-10:25	Question and answer session	Dr. Nelson Gitonga, SHOPS
10:25-10:45	Morning break	
Session II – Working Groups		
10:45-11:00	Review of goals for group work	Dr. Nelson Gitonga, SHOPS
11:00-13:00	Working group sessions	
13:00-14:30	Lunch	
Session III – Report Out and Discussion		
14:30-14:40	The multinational perspective - *Monsanto*	Anne Mwebi, Director of Health Resources, Monsanto Kenya
14:40-15:55	Reporting out by working groups	Veronica Musembi, SHOPS
15:55-16:40	Discussion of lessons learned and opportunities	Dr. Nelson Gitonga, SHOPS
16:40-16:45	Closing remarks and thanks	USAID/Kenya
16:45-18:00	Marketplace and reception	

I.2 SUPPORTING PARTNERSHIPS FOR GREATER ACCESS TO HEALTH CARE COVERAGE IN THE FORMAL SECTOR (NIGERIA)

Thursday, May 31, 2012 | Southern Sun Hotel | Ikoyi, Lagos, Nigeria

MEETING OBJECTIVES

1. Support a dialogue among companies and insurers to increase health coverage for low-income employees in the formal private sector

2. Share experiences and challenges in lowering costs and increasing access of low-income employees to health care through affordable health insurance

3. Identify key steps for building market linkages and increasing access to insurance coverage in the formal sector

AGENDA

Session I – Welcome and Setting the Context		
8:30-9:10	Morning refreshments and registration	
9:10-9:15	Opening prayer	
9:15-9:20	Welcome	Ayo Iroko, Chief of Party, SPS FP/RH Nigeria
9:20-9:25	Opening remarks	Elise Ayers, HPN Team Leader, USAID/Nigeria
9:25-9:30	Introduction and workshop overview	Dr. Thierry van Bastelaer, Health Finance Advisor, SHOPS
9:30-9:45	Low-cost health insurance? Why and how – *The Namibia experience*	Ilana Ron Levey, Senior Country Manager, SHOPS
9:45-10:00	The employer perspective – *Nigerian Employers' Consultative Association (NECA)*	A. O. Oshinowo, Director-General, NECA
10:00-10:15	The insurer perspective – *Healthcare International*	Tosin Awosika, MD/CEO, Healthcare International
10:15-10:30	The national health insurance perspective – *National Health Insurance Scheme (NHIS)*	Alhaji A. T. B. Ojuolape, NHIS
10:30-10:50	Question and answer session	Bassey Daniel, Business and Financial Advisor, SHOPS
10:50-11:20	Morning break	

Session II – Working Groups		
11:20-11:30	Review of goals for group work	Dr. Thierry van Bastelaer
11:30-13:15	Working group sessions	
13:15-14:30	Lunch	
Session III – Report Out and Discussion		
14:30-15:55	Reporting out by working groups	Bisi Bright, 1st Vice Chairman/CEO, LiveWell Initiative
15:55-16:20	Discussion of lessons learned and opportunities	Bassey Daniel
16:20-16:25	Closing remarks and vote of thanks	Ayodele Iroko
16:25-16:30	Closing prayer	
16:30-18:00	Marketplace and reception	

ANNEX B: PARTICIPANT LISTS

I.I KENYA

#	Organization	Names
Employers		
1.	Bawan Limited	Betty-Ann Mboche
2.	Bins Nairobi Services Ltd	Serah Mudeshi
3.	Intercontinental Hotels	Caroline Karanja
4.	Kenya Bus Services	Joseph Wangalwa
5.	Kikuyu Highland Tea	Hanniel Mwaura
6.		Lydia Wanjui
7.	Monsanto Kenya	Anne Mwebi
8.	Oserian Development Company	Tom Gandani

#	Organization	Names
9.		Samson Lukoba
10.		Edward Wanyoyi
11.	Perapet Cleaning Services	Mildred Anyango
12.		Winnie Mugi
Insurers		
1.	AAR Kenya	Charles Kariuki
2.		Dennis Munene
3.		Edward Rukwaro
4.	AON Minet	Irene Chesire
5.		Peter Kamunyo
6.	APA Insurance	Fridah Mburu
7.	Mercantile Insurance	Jane Wanjau
8.		Shem Nyamai
9.	Pacis Insurance	Peter Makhanu
10.		Catherine Waiyaki
11.	Pioneer Assurance	Njeri Kinyanjui
12.	UAP	Isaac Nzyoka
NGOs		
1.	GBCHealth – Kenya	Julie Cege
2.	Smart Applications	John Brown
3.		Isaiah Mosiori
4.		Serah Waithera
Professional Associations		
1.	Association of Kenya Insurers	William Kiama
2.		Ben Waweru
3.	Federation of Kenya Employers	Gentrix Juma
Medical Provider		
1.	Avenue Healthcare	Amit Thakkar
Government		
1.	Ministry of Medical Services	Geoffrey Kimani
Donors		
1.	USAID/Africa Bureau	Ishrat Husain

#	Organization	Names
2.	USAID/Kenya	Maria Francisco
3.		Bedan Gichanga
Development Partners		
1.	Population Services International	Anthony Okoth
2.	SHOPS	Nelson Gitonga
3.		Lucy Mbugua
4.		Roselyne Mburu
5.		Veronica Musembi
6.		Pamela Mutua
7.		Dineo Dawn Pereko
8.		Heather Vincent
9.		Thierry van Bastelaer

I.2 NIGERIA

#	Organization	Name
Employers		
1.	Cameron	Lauara Okereke
2.	CAP Plc	Imaobong Aliyu
3.	Consolidated Breweries	John Aigbonohan
4.	Edge Nominees	Obioma M. Ajaonu
5.	Eternit Ltd	Solomon Ugbenu
6.	Felix Okaka Nigeria Limited	Felix Itoadan
7.		Osas Itoadan
8.	Halogen Security	Fadekemi Adenyi-Adele
9.		Adeyemi Ajala
10.	Hartford Nigeria Limited	Banjo Adebola

#	Organization	Name
11.	Jetwaypro Imaging Services	Ademola Jet
12.	Mantrac Nigeria Limited	Jumoke Adepoju
13.		Victor Esenowo
14.	Mc-DEK Nigeria Limited	Vincent Omoamilor
15.		Yomi Oluwafemi
16.	Megavons West Africa Ltd	Susan Jaiwo Akindele
17.		Femi Olaitan
18.	Multi-Trex Foods Plc	Olasunkade Azeez
19.	Nigeria Cleaning Service	Micheal Iroghama
20.	Nigerian Foundries Ltd	Tolulope Onyeri
21.		Babagana Mustapha
22.	Nzealbertech Nig. Ltd	David Olorunlogbon
23.		Chino Oleka
24.	Odu'a Investment	Fetuga Adewumi
25.	Olam Nigeria Ltd.	Chinyere Nwachukun
26.	Pera-Beam Ltd	Ibe Chris
27.	Phillips Consulting	Adetokunbo Agbede
28.		Eyinmisan Okitikpi
29.	Sadwanis Nigeria Ltd	Chris Uzoalu
30.	Safe Edge Consulting Ltd	Sola
31.	ShopRite	Adeola Kagho
32.	Sol Nigeria Ltd	Adeola Ojo
33.		Godwin Uhumagbo
34.	Total Nigeria Plc	Emobong Udoh
35.	UPS	Seyi Fasanya
36.		Jumoke Oyebanji
Insurers		
1.	Accion Microfinance Bank	Emmanuel Michael
2.	ExpatCare HMO	Mambidzeni Madzivire
3.		Adesola Ayandigi
4.		Tosin Olaniran

#	Organization	Name
5.	Health Partners Ltd	Idongesit Okon
6.		Chibuzor Iweajuna
7.	Healthcare Nig.	Ayobami Ogungbemi
8.	Healthcare International	Tosin Awosika
9.	Integrated Healthcare Limited	Charles Omwenyeke
10.		Chris Emmanuel Nwachukwu
11.	Managed Healthcare Services Ltd	Faith Nwachi
12.	Multishield Limited	Kemi Oluwabamise
13.		Oladiran Okunlola
14.		'Leke Oshunniyi
15.	RedCare HMO	Cecilia Nebo
16.		Davis Iyoha
17.		Bunmi Gbologe
18.	Total Health Trust	Adeola Majiyagbe
19.		David Adeo
20.		Aniberra Chinedu
21.		Femi Adegbami
NGOs		
1.	Blood Pressure Control Foundation	Jacob Nwachukwu
2.	Health Initiatives for Safety and Stability in Africa	Augustina Akugbe
3.	LiveWell Initiatives	Bisi Bright
4.		Adebola Aderonke
5.		Omolana Jokodola
Professional Associations		
1.	Association of General Private Nursing Practitioners (AGPNP)	Olusola Oyebode
2.	Nigerican Employers' Consultative Association (NECA)	Celine Oni
3.	Nigerian Business Coalition Against AIDS (NIBUCAA)	Olusina Olulana
4.		Oluremi Ojo
Government		
1.	National Health Insurance Scheme (NHIS)	Alhaji A. T. B. Ojuolape
Donors		
1.	USAID/Nigeria	Elise Ayers

#	Organization	Name
2.		Tara O'Day
Development Partners		
1.	PATHS2	Ayodeji Ajiboye
2.	SHOPS	Ilana Ron
3.		Robin Keeley
4.		Heather Vincent
5.		Thierry van Bastelaer
6.		Akuchi Mbagwu
7.	SPS FP/RH Nigeria	Ayodele Iroko
8.		Deji Adeyi
9.		Bassey Daniel