

Corporate Social Responsibility and Employee Health in the Nigerian Banking Sector

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ABSTRACT

It is often said that the most important entity in any organisation is its human capital. With this in mind, it has been recommended that an organisation which seeks to do well must pay particular attention to the welfare of its employees. This paper considers the issue of employer health insurance as it operates in the Nigerian banking sector. It argues that employee welfare, being a corporate social responsibility, banks must do more to ensure that the healthcare of their employees are better taken care of, bearing in mind the relative youth of most bank employees and the sensitive nature of work in the banking sector. The paper begins with an overview of corporate social responsibility, the nature of employee healthcare available in Nigeria and managed healthcare in the private sector. The paper also considers the typical health challenges of bank employees and healthcare options available to them, making a case for better structured health care for bank employees.

Keywords: Corporate Social Responsibility, Banking employment, Health Insurance, Managed healthcare in Nigeria

1. Introduction

Corporate social responsibility is about protecting stakeholder interests in achieving the corporate goal of business success. Though companies tend to pursue initiatives which would hold them out as sensitive, socially responsible contributors in the community, little thought is given to employee welfare as an obligation due from a socially responsible entity.

This paper examines the state of employee health care in the Nigerian banking sector and the unique health challenges faced by this group of Nigerians in the course of employment. We shall be considering the meaning of CSR from an employee welfare perspective and the unique nature of the employment in the banking sector which forms the basis for this paper. We shall also consider the state of health insurance and managed healthcare in Nigeria and how the healthcare needs of bank employees are generally taken care of.

2. Corporate Responsibility and Employee Welfare

Corporate social responsibility has been defined as 'the continuing commitment by business to behave ethically and contribute to economic development while improving the quality of life of the workforce and their families as well as of the local community and society at large' (Holme, Watts 2000:10. *Emphasis ours*).

The above definition is interesting for two main reasons:

1. It recognises that corporate social responsibility begins at 'home' i.e. in the lives of employees and their families.

2. It was proffered by employers of labour – Lord Holme, Former Executive Director of Rio Tinto and Phillip Watts, Managing Director of Royal Dutch Shell.

The usual focus of CSR in Nigeria is on the 'community' and the 'society'. The stakeholder principle is well known in the business community but it would appear that the place of employees as stakeholders in business is down played. Notwithstanding this seeming lack of focus on employee welfare, the wellbeing of employees is paramount in any discussion on corporate social responsibility (Holme, Watts 2000: 10). Hence, employee right to good healthcare is a CSR issue and should be given more attention especially in the Nigerian banking sector.

At present, it would appear that companies focus more on environmental stewardship or philanthropy when considering possible CSR initiatives. However, statistics suggest that consumers expect 'charity to begin at home' i.e. that the best proof of CSR is treating employees well (National Consumers League/Fleishman Hillard Survey 2005).

3. Why the Banking Sector?

To streamline our discourse we shall point out the main considerations for choosing to examine our employee healthcare in the Nigerian banking sector.

The banking sector is one of the largest employers of labour in Nigeria (Alo, 2010). 2010 employment figures in the Nigerian financial services sector has been estimated at 133,054 (National Bureau of Statistics 2010: 22). The banking sector is also a major contributor to the Nigerian economy. In Q2 2011, the financial services sector contributed an estimated 4.04% to the Nigerian GDP, higher than manufacturing (3.91%), Building & Construction (2.09%) and Real Estate (1.94%) (Source: National Bureau of Statistics 2011).

Another major characteristic of the banking sector is that majority of bank employees are between the ages of 25 and 45 years. Results of a survey of bank employees carried out in the western part of the country shows that 80% of respondents fall within this age range (Ajede, 2011: 7). The reason for this statistic is quite obvious. Banks tend to pursue an active policy of recruiting young fresh university graduates as they have minimal external (family) commitments and can devote their time to working long hours with the attendant possibility of inter-state transfers at short notice. They are also more competitive and more likely to strive to meet the high targets set by their employers. All things being equal, they are also at their healthiest and less likely to fall ill or take time off work on grounds of ill-health, thereby reducing employee healthcare costs to the employer. The import of this is that bank employees give their most productive years to their employers.

The above statistics have serious implications for the welfare of bank employees in Nigeria because the youth are the backbone of any society. For a nation to achieve meaningful and sustainable development, their welfare must be a paramount consideration. Company executives all say that employees are their company's most valuable asset. This must be reflected in welfare arrangements for such employees. Following CSR principles in more developed climes, where an employee devotes his most productive years to his employer, he should expect more than periodic pay. Employee rights are vital to company's success and should come first in stakeholder considerations.

4. Employee Healthcare in Nigeria

In line with the basic principle that employers should be responsible for employee healthcare, several health care models have been used to provide employee healthcare at minimal cost to the employer. Examples of such models include engaging private clinics on retainer, and managed healthcare under the National Health Insurance Scheme (NHIS). At present, the latter model appears to be the preferred model with a number of financial institutions even branching to health insurance as a separate income stream and registering all members of staff as enrollees under such schemes.

National health insurance was first introduced in Nigeria under a 1962 Bill presented to parliament by the then Federal Minister of Health, Dr. M. A. Majekodunmi. The bill was however strongly opposed and jettisoned. In 1989, under Prof. Ransome-Kuti, the concept was resurrected with little progress made. Subsequent private initiatives resulted in the initiation of private health insurance schemes from 1998. This catalysed further government action at introducing a health insurance scheme in Nigeria. The National Health Insurance Scheme

was conceptualised as a public sector employee health insurance plan and launched in 1999 under the National Health Insurance Scheme Decree No 35 of 1999. It was further modified and relaunched in 2003. At present, private sector managed care caters for majority of private sector employees and is regulated by the NHIS.

4.1 The HMO and Managed Care in the Private Sector

The most popular means of private employee healthcare is managed care through the Health Maintenance Organisation (HMO). Managed healthcare refers to a system of organising doctors, hospitals and other providers into groups to enhance the quality of health care services. Under this system, the HMO offers pre-paid health coverage to enrolled persons at a fixed premium which it bears the responsibility of collecting and disbursing as agreed with approved health providers (Awosika, 2005:43).

Under the managed care model, the HMO bears the responsibility for sourcing corporate clients (employers who will register their employees) and negotiating with them on their preferred health plans. They are also responsible for engaging the services of health care providers (clinics/hospitals), negotiating the nature of services to be provided and paying the healthcare providers for services rendered.

Payment arrangements with health care providers normally take two forms:

a. Capitation

Capitation is a system where the HMOs pay a fixed premium to a health provider at pre-agreed intervals. This premium is sourced from a pool paid by the clients (in this case the banks to the HMOs). Under the capitation system, the healthcare costs are negotiated to the minimum with the promised possibility of profit recoupment through the volume of the HMO's patients registered with the particular health care provider. Because of the amount paid to the health providers for capitation, the quality of health care provided is limited and bedevilled with bureaucratic bottlenecks requiring the healthcare provider to seek authorization for the simplest of procedures. This often creates friction between healthcare provider and patients who are not privy to the financial terms of the HMO's engagement of the health provider and have the false impression that all their health issues are covered under the plan chosen by their employer.

b. Fee for Service

Also referred to as 'third-party', fee for service is a managed health care plan where the employer gives the HMO the freedom to negotiate health services for its employees. Under this plan, each service is paid for but based on pre-negotiated rates agreed with the healthcare provider. Fee for service is akin to the old retainer system except that the HMO acts as the agent to the employer and the healthcare provider liaises with the HMO with no direct communication between the health care provider and the employer. Bills are sent to the HMO who pays the health care provider based on pre-agreed rates. Services do not also require HMO authorisation as rates have been pre-negotiated. The fee for service model is more expensive for the HMOs. As a result, capitation is preferred and more commonly used for private employee managed healthcare.

Regardless of the chosen payment model, it must be borne in mind that HMOs are businesses established for profit. Accordingly, profit maximisation is a major consideration in their negotiations with health care providers. Perhaps HMOs would be constrained to negotiate more beneficial terms if the employers who engaged their services insist on obtaining qualitative healthcare with the caveat that they would dispense with their services if this is not provided. Unfortunately, this is impracticable for those banks who own their own HMOs and have their employees compulsorily enrolled without the option of seeking alternative care. This conflict of interest makes it impossible for employees to question the quality of care being negotiated on their behalf.

4.2 The Health Challenges of Bank Employees

Managed care under the HMO system is quite laudable because it has filled the vacuum created by the NHIS Scheme which mainly caters to public workers. However, managed care in the banking sector presents some interesting issues that must be addressed in the interests of bank employees and in line with basic CSR principles.

The lack of a robust health sector in Nigeria makes it difficult to collate data on a regular basis. As a result, little empirical data exists as to the health indices of the Nigerian population. This is even worse for young, upwardly mobile banking professionals because of the assumption that at their age, they are healthier and less susceptible to basic ailments which plague the polity. What is becoming obvious however, from clinical experience is that the

Nigerian bank employees, upwardly mobile as they are, are becoming more susceptible to health challenges previously considered alien to our environment.

Being the major component of the workforce in the banking sector, they encounter the usual work related stress and are faced with other stressors unique to the Nigerian environment. These have culminated in various 'lifestyle diseases' which were hitherto considered unknown amongst youth. Some of these diseases and contributory factors are as follows:

- Heavy vehicular traffic as seen in our major cities due to poorly laid out road networks and the non-existence of alternative means of transportation causes rage and anxiety on a daily basis as workers commute to and from work. This is further exacerbated by the fact that bankers are required to resume at 7.30am on all working days and are expected to remain at work until all deliverables are met. This aggravates tendencies to develop high blood pressure in those genetically predisposed.

High blood pressure is unbelievably common amongst bankers in Nigeria. This disease which normally appears in its essential form in genetically predisposed males during the fourth to fifth decade of life is seen to manifest much earlier than usual in bankers. Even females who are usually protected by their oestrogen levels until after menopause are affected, as the pressures of meeting job targets get to them. Medical findings suggest that black Africans are genetically predisposed to high blood pressure (Heart Foundation of South Africa, 2011). However, with the pressures of working in the banking sector, this innate predisposition is only magnified.

Added to the work pressure is the pressure from road traffic congestion to and from work on average of 2 - 4 hours daily. The vagaries of daily life such as epileptic power supply and insecurity further exacerbate this situation with negative effects. Also, the sedentary lifestyle associated with work in the banking sector results in lack of routine exercise. All these have led to a rise in the incidence of high blood pressure and a shortened life span from cardiovascular diseases.

- Generally poor remuneration and disenchantment with conditions of service or work status have contributed to incidences of clinical depression as competition creates a rat race of 'haves' and 'have-nots'. From the employee welfare standpoint, the most recent reforms of the Nigerian banking sector resulted in heavy job losses or salary reduction. During the period, there was a high degree of anxiety amongst employees in the entire sector as those who suddenly lost their jobs were left without adequate compensation and those who did not, had to make unplanned changes because of salary reduction.
- Owing to irregular working hours, young bankers eat at odd hours. They are hardly able to eat at home because they leave home early and return very late and they are allowed very little time off their desks at work for refreshments. Others have poor eating habits surviving mainly on junk food and having no time to prepare healthy meals. This has resulted in an increase in peptic ulcer disease and basic nutrient deficiencies.
- Due to the highly charged working environments, bankers are known to frequent bars, cinemas and other entertainment venues to relax or while away the time that would ordinarily be spent commuting back home on traffic congested roads. In such places, the premium is placed on attracting patronage so clients are encouraged to engage in inordinate alcohol consumption through promotional events like 'happy hour', 'ladies free night' etc. In addition, owing to their age range, young bankers are emotionally charged and susceptible to negative peer pressure. They are known to frequent strip bars and/or indulge in inordinate drug use and unprotected sex to ease tension. One unfortunate result of this is an increase in the rate of sexually transmitted infections.

5. The Bank Employee and Managed Healthcare in Nigeria

The above lifestyle diseases notwithstanding, there is a worrisome lack of a concise health plan or package for our young workforce. Enabling laws and regulatory policies have also failed to address the healthcare needs of

this group of Nigerians. It is not unusual to find that, employees who become invalid or ill as a result of these lifestyle diseases end up losing their jobs with no form of compensation from their employers. Neither are bereaved families considered for compensation in the unfortunate event of the death of their loved ones from any of these diseases.

A look at the health plans available to bank employees shows that they are only guaranteed primary health care. Other life saving health services like intensive care, comprehensive health screening/well person check or ambulance services are usually excluded or subject to a maximum amount. The lifestyle diseases detailed above are better dealt with at an early stage before much damage is done. Unfortunately, they are initially asymptomatic and can only be diagnosed with extensive screenings which are not available under the basic health plan. Where drastic results indicate the presence of these diseases (e.g. the patient passing out in the banking hall or whilst driving home in traffic), much more will be required to treat them than if the disease had been discovered at the initial stage.

Ironically, when these symptoms are discovered, the usual reaction is for the employee to ignore them and continue working until matters get out of hand and there is an emergency. Illogical as that may sound, one can hardly blame the bank employee who puts continues 'working' to his/her detriment. The reality is that there is very little job security in the banking sector. The employee's productivity (regardless of his/her state of health) is the main consideration. An employee who pays regular visits to the doctor for one ailment or the other is likely to be perceived as unable to deliver. He/she is therefore likely to lose the job or be passed over for promotion.

Again, with the job loss fallout of the recent banking sector reform, bankers are overworked and unable to leave their duty posts as there would be no one to relieve them of their responsibilities during their absence. Hence, you find patients who have been put on compulsory bed rest and medication on medical grounds insisting on going to work because they have targets to meet.

Under present models of managed healthcare, employees are not allowed to choose a health care provider of their choice. In the past, they negotiated an amount for their health care and were thus in charge of their own destinies as far as their health was concerned. Now they have no choice but must choose from their HMO's list of registered health care providers. This power of choice is further restricted where the HMO is the health insurance arm of the employer.

It is correct that patients can change health care providers if dissatisfied with the services provided to them. However their power of choice is constrained by the restriction of possible healthcare providers to those chosen by their HMOs. Furthermore, there is a likelihood of dissatisfaction with majority of healthcare providers because most healthcare providers operate under the capitation model based on minimal rates agreed with the HMO. Not being party to negotiations between their HMOs and the healthcare providers, these employees assume that they can request and obtain every form of medical service. In reality, this is not the case as they can only enjoy the services agreed on their behalf by the HMOs. Where further investigations such as ultrasound scan or an x-ray are required, the time taken to obtain authorisation becomes a major issue especially in an emergency.

A major issue with managed care under the HMO system is the delay or non-payment of bills for services rendered. This is more common with the fee for service model where the HMO 'bills' the employer for services rendered and then pays the health provider's bill on behalf of the employer. It would appear that the HMO being a 'third party' appears not to understand the need to sustain the managed healthcare relationship between healthcare providers and their patients, hence the delay in making payments. This is further complicated by the fact that the healthcare provider may have been required to pay upfront for services sourced from third party consultants or laboratories and then bears the cost of the HMO's delay in making payment.

The issue of late payment does not arise for primary care under the capitation model because the premium is fixed and payable as agreed regardless of the number of times enrolees require service. However, where further treatment or investigation is required and authorised, HMOs still require extensive medical reports and further re-negotiations when bills are sent for such treatments. Even when these hurdles are crossed, payment is delayed or not made at all. These delays and refusals to make agreed payments sometimes result in healthcare providers refusing to treat enrolees of defaulting HMO. Such enrolees, through no fault of theirs, are caught in the middle with the option to either bear their own costs as private patients or seek medical attention elsewhere.

6. A Way Forward

The above issues notwithstanding, all parties can benefit from the managed care model if there is a will to make necessary changes. In the first place, employee welfare must be considered important if companies are to be truly seen as socially responsible contributors to the society. Employers in the banking sector must recognise the importance of employee health and invest more in managed health care for their employees. It is a well known fact that top tier bank management (even in Nigeria) have access to the best health care in the world including a choice to travel overseas for treatment. Whilst it may be impracticable to put all employees on the same health care plan as top management, important health services like comprehensive health checks, intensive care or ambulance services must be made available to all bank employees. To guard against abuse, health checks may be provided at scheduled intervals and emergency care monitored by HMOs and health providers.

Provisions should be made for comfortable alternative transport and housing for staff. Many banks today have mortgage subsidiaries. Some even invest real estate development. Unfortunately, these housing units are way above what entry or mid level bank employees can afford. Banks will do well to provide reasonably priced housing units and/or mortgage conditions to enable their employees invest in qualitative housing. Again, this can be restricted to one unit per staff to prevent abuse.

'Mountain days' are also recommended to enable staff unwind or close a little earlier when they have been overworked for consecutive periods in pursuit of time bound targets. Where staff are required to work overtime, there should be provisions made for overtime allowance and basic arrangements to take care of needs such as healthy food and breaks.

In developed climes, it is normal to find that employees have access to a gym or spa situated around the office area. With the nature of the Nigerian banking sector, this is not a luxury. Employers may consider doing the same for their employees who have neither the time nor means to visit the gym or spa for exercise and relaxation. Where this is not possible, employers may consider providing employees with free memberships of gyms of their choice.

Transparency is also a useful weapon in the fight to improve workers' welfare. Where communication is concerned, employees are usually put on a 'need to know' basis but expected to operate to the best of their abilities in highly charged environments. This is impossible. To prevent anxiety triggered by 'fear of the unknown', employers should consider giving their employees adequate information which may enable them to plan, if required and take better informed decisions about their careers.

For those banks that own HMO subsidiaries to which their staff are compulsorily registered, the CSR requirement is two-fold: First as employers and then as managed health service providers. This responsibility must be discharged satisfactorily with the yardstick of qualitative healthcare for employees. Indeed, such employees should enjoy better care, because the major variables which would ordinarily affect quality of health care all rest with the employer.

The responsibility for employee health care does not end with the employer. Employees must take a more active role in ensuring that they are taken care of. Having some form of healthy lifestyle plan is a first step in this regard. The rate of ignorance of basic health checks amongst the Nigerian workforce is quite alarming. This is because people tend to leave their healthcare needs in the hands of their doctors without considering the part they may have to play. Bank employees can help themselves by learning more about lifestyle diseases, prevention and management. Visits to healthcare providers should not end with being told what is wrong with them and the medication to take. Employees should learn to discuss preventive options and possible changes they may need to make.

Employees may also wish to press home demands for better working conditions through organised labour. Whilst the fear of 'punishment' may discourage active demands for employee rights, bank employees are giving the best years of their lives in labour. They must therefore remember that no one is indispensable. Work will go definitely on, should any unfortunate situation make them unable to contribute in the work place.

Conclusion

Employee healthcare must be taken more seriously by employers, especially in the banking sector which is populated by young, upwardly mobile professionals. Employees must not be seen as a means to an end in the corporate equation but as significant contributors with interests that must be upheld by their employers.

Though laudable because it provides some form of healthcare in the first instance, managed healthcare under the HMO system is grossly inadequate in meeting the health needs of Nigerian bank employees. It must therefore be improved upon in the interest of proper corporate social responsibility.

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