



An activist analysis of Coca-Cola Africa Foundation September 29, 2002 announcement

On Thursday September 29 2002, the Coca-Cola Africa Foundation announced an initiative to enroll African bottlers in a cost-sharing program to provide HIV/AIDS care benefits to workers. While Coke announced its intention to expand access to its entire network of 40 bottlers, the Sept 29 announcement only includes 8 of Coke's largest African bottlers-- most of which have existing medicine schemes. Coke offers no timeline for expanding the program for the 32 remaining bottlers.

Coke's initial efforts are deeply flawed but promising if activists keep up the pressure to ensure a timely rollout of affordable and equitable AIDS treatment programs for all workers and their dependents living with HIV/AIDS in developing countries.

Problems with the AIDS treatment program:

- No coverage for dependents and children other than spouses of workers.
- High out of pocket cost to workers will prove to be a barrier to access.
- No promise to procure most affordable AIDS drugs available, such as generics, that can offset burden on workers and bottlers.

Problems with the initiative:

- Coke is setting a poor standard for other corporations by excluding children and high cost to workers.
- No promise to sustain the initiative and to uphold continuity of care.
- Untenable 50/50 cost-sharing scheme for the smaller to medium bottlers that employ the remaining 64% of Coke's workforce.
- No proof of commitment to rapid expansion or rollout of treatment programs.
- No plan to expand the initiative outside of Africa to other impacted areas.

1) COCA-COLA: LOWERING THE BAR ON AIDS TREATMENT PROGRAMS

Coke's actions will influence the actions taken by other corporations. In consulting with other groups at the beginning of this campaign, Coke emerged as a choice target because of its vast workforce, its previous (broken) commitments, and because it could "raise the bar" of what was acceptable for a "private sector response to AIDS." However, now Coke is slipping behind what Anglo has offered (no out of pocket costs for workers) and DaimlerChrysler (4,500 workers and offers coverage to a total dependant population of 23,000).

Many corporations are paying close attention to this campaign--both in terms of the Coke's action and the ensuing public reaction. While we have the media spotlight and the ear of the private sector, it is even more important that activists not accept what is on the whole, a low-ball offer from Coca-Cola.

Because of the prominence of Coke in the business community and its reach in Africa (it is every country in but 2), people with AIDS and their advocates are using Coca-Cola as a platform to stage campaigns against local corporations. Activists in Ghana have been organizing a Coke event and indict a damn building project that

employs a large number of people. In Nigeria, Chevron Texaco could easily be cited as not doing enough for workers, as could the mining companies that still lag behind in South Africa.

2) CO-PAY FOR WORKERS A BARRIER TO ACCESS

10% out of pocket expense is too high a burden for workers. The life-saving treatment must be fully subsidized by Coke and its partners.

Previous estimates from the mining industry in South Africa have predicted annual treatment costs of \$2500 even with price discounted patent medicines. Accordingly, Coke employees, many of whom make well under \$3000 a year, would be required to pay \$250 for themselves and another \$250 for an HIV+ spouse, rendering the 10% co-payment rate cost prohibitive.

It is in Coke's interest to fully subsidize treatment without any cost sharing by workers. As long as cost is a burden on workers, Coke will see less of an uptake on programs and less benefit of HIV/AIDS medical interventions such as have been seen as a result of other programs: reduced absenteeism, lower incidences of hospitalization, reduced morbidity and mortality.

The assumption that workers will adhere to their treatment regimens if they are "invested" in its costs is belied by documented instances of UNAIDS supported ART treatment programs where even cost of treatment resulted in interruptions in treatment and adherence.

Also, Coca-Cola can well afford to subsidize treatment out of its \$261 million fiscal year 2001 African profit margin, based on \$620 million net revenues from Coke sales in Africa. The costs, roughly \$4-5 million in the first year are minuscule. In Africa, Coke enjoys an operating profit margin in twice of than in North America (41% vs. 20%).

Heineken, which has had treatment policies in place since 2001, does not require workers to bear the costs of AIDS care and extends these benefits to workers' dependents. The policy was based in part by a study by the Futures Group of the impact of HIV/AIDS medical interventions justifying the costs in light of overall company benefit.

3) CHILDREN LEFT BEHIND

Coke refuses to cover children and dependents of workers other than spouses. This is an entirely unacceptable rollback of standards created by companies such as DaimlerChrysler and Heineken, not to mention morally egregious. This policy is not in line with the claim from Alexander B. Cummings, President of Coca-Cola Africa Group: "Coca-Cola is completely committed to the future of the African continent, its economy, people, communities and health. We will do all that we can to enable Africans to reach their full potential."

4) AFFORDABLE TREATMENT & USE OF GENERICS

Coke must ensure the most affordable drugs are procured. With the heavy cost burden for bottlers and workers to shoulder (50% in some cases), Coke must not simply use the proprietary drugs such as those sold by its "partner" in the initiative, GlaxoSmithKline while ignoring the potential cost savings of procuring generics. As it is, the treatment costs are unnecessarily high because of Coke's decision to partner with GlaxoSmithKline, a major producer of AIDS medicines, but one that is able to charge monopoly prices given its patent rights in many African countries. Activists have urged Coke and other multinationals to source cheaper medicines from generic producers, especially in countries where the brand names are not patented. Since high quality generics are being sold at a fraction of the brand name price, treatment activists have insisted that affordability for workers and bottlers will be enhanced.

5) TIMELINE: REMAINING BOTTLERS

For the first phase of the initiative, Coke has enrolled the largest bottlers, including 3 multinational corporations and anchor bottlers in low-prevalence areas in Egypt and Morocco, with existing medicine schemes that now will be expanded to include antiretrovirals. Depending on the cost burden to workers, the availability of treatment programs--once in place--will have significant meaning for workers and spouses (other dependents are not covered) living with HIV/AIDS.

However, up until recently, Coke has moved at a glacial pace. This has only changed because of activist pressure. It has been 15 months since Coke first announced it would negotiate with bottlers to implement treatment policies and since May of this year that they were handed various models of cost-sharing schemes by third party experts.

The number of bottlers so far enrolled in the initiative total only 35% of Coke's total workforce. Given Coke's record to date, activists questions Coke's commitment to enroll the remaining 32 bottlers in a fair and equitable initiative and to rollout programs in a timely manner matching the urgency of the crisis if the pressure from activists is removed.

Note: it is disingenuous for Coke to list Heinekin as one of the 8 considering Heinekin already had ARV treatment policies in place.

6) SUSTAINABILITY AND CONTINUITY OF CARE

Coke is requiring a 50% cost-saving provision with many of its bottling affiliates. Perhaps some of the bigger bottlers, like some in the initial 8, can afford this cost-sharing as they themselves are substantial multinational corporations. However, for the remainder of the 32 bottlers, many of whom are smaller enterprises, the 50% share could be problematic, especially given Coke's drive to increase its profits by squeezing the profit margins of its bottlers (Coke rate of return 17% vs. bottler 6%). This concern is even more serious given Coke's stated intention to phase out its support over time--based on a naive assumption that the costs of treatment will reduce to the point where bottlers would not require subsidizing. Any sensible bottler would worry about sustainability of the program given Coke's profit squeezing, Coke's stated intention to withdraw, and the rising costs of treating more and more workers and dependents each year as percentage utilization increases and as more and more HIV positive workers reach the treatment threshold.

People with AIDS and their advocates have been fighting for access to AIDS treatment as a human right. By extension, corporations must uphold workers right to access to affordable healthcare. We are concerned about Coke's commitment to sustaining a program that is announced more as charity under the aegis of Coke's "Africa Foundation," a non-profit outfit Coke set up to oversee its benevolence programs, than as corporate operational investment in its human resources.

7) REGIONAL LIMITS

The initiative is limited to Coca-Cola Africa operations, neglecting workers in heavily impacted areas in Southeast Asia such as India and Thailand. Coke's immediate inclusion of these elements in its Africa treatment program would satisfy the demands of activists. However, it is important to emphasize the desperate need for treatment programs in other regions heavily impacted by AIDS, where Coke operates. Coke must expand a version of its initiative, improved according to activist demands to other developing countries.

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