

The Private Sector and HIV/AIDS in Africa: Taking Stock of Six Years of Applied Research

The Role of the Private Sector in the HIV/AIDS Response:
Scaling Up on HIV/AIDS: People and Promises

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Presentation Outline

- I. Impacts on large, formal sector, private firms
- II. Impacts on small and medium enterprises
- III. Impacts on labour forces
- IV. Burden shifting and the realities of much of the private sector in the global response
- V. New private sector initiatives
- VI. Conclusions and priority questions

I. Impacts on large, formal sector, private firms:

Summary of Key Findings

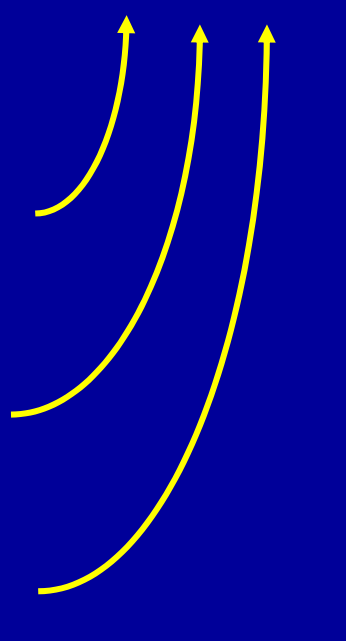
Large Companies (n=14)

Sector	Country	Size	Estimated HIV prevalence	Cost per AIDS death or retirement (multiple of annual compensation)	Aggregate annual costs (% of labor costs)
Retail	South Africa	500	10.5%	0.7	0.5%
Agribusiness	South Africa	7,000	23.7%	1.1	0.7%
	Uganda	500	5.6%	1.9	1.2%
	Kenya	22,000	10.0%	1.1	1.0%
	Zambia	1,200	28.5%	0.9	1.3%
Manufacturing	South Africa	1,300	14.0%	1.2	1.1%
	Uganda	300	14.4%	1.2	1.9%
	Ethiopia	1,500	5.3%	0.9	0.6%
	Ethiopia	1,300	6.2%	0.8	0.6%
Media	South Africa	3,600	10.2%	1.3	1.3%
Utility	South Africa	>25,000	11.7%	4.7	2.2%
Mining	South Africa	600	23.6%	1.4	2.4%
	Botswana	500	29.0%	4.4	8.4%
Tourism	Zambia	350	36.8%	3.6	10.8%

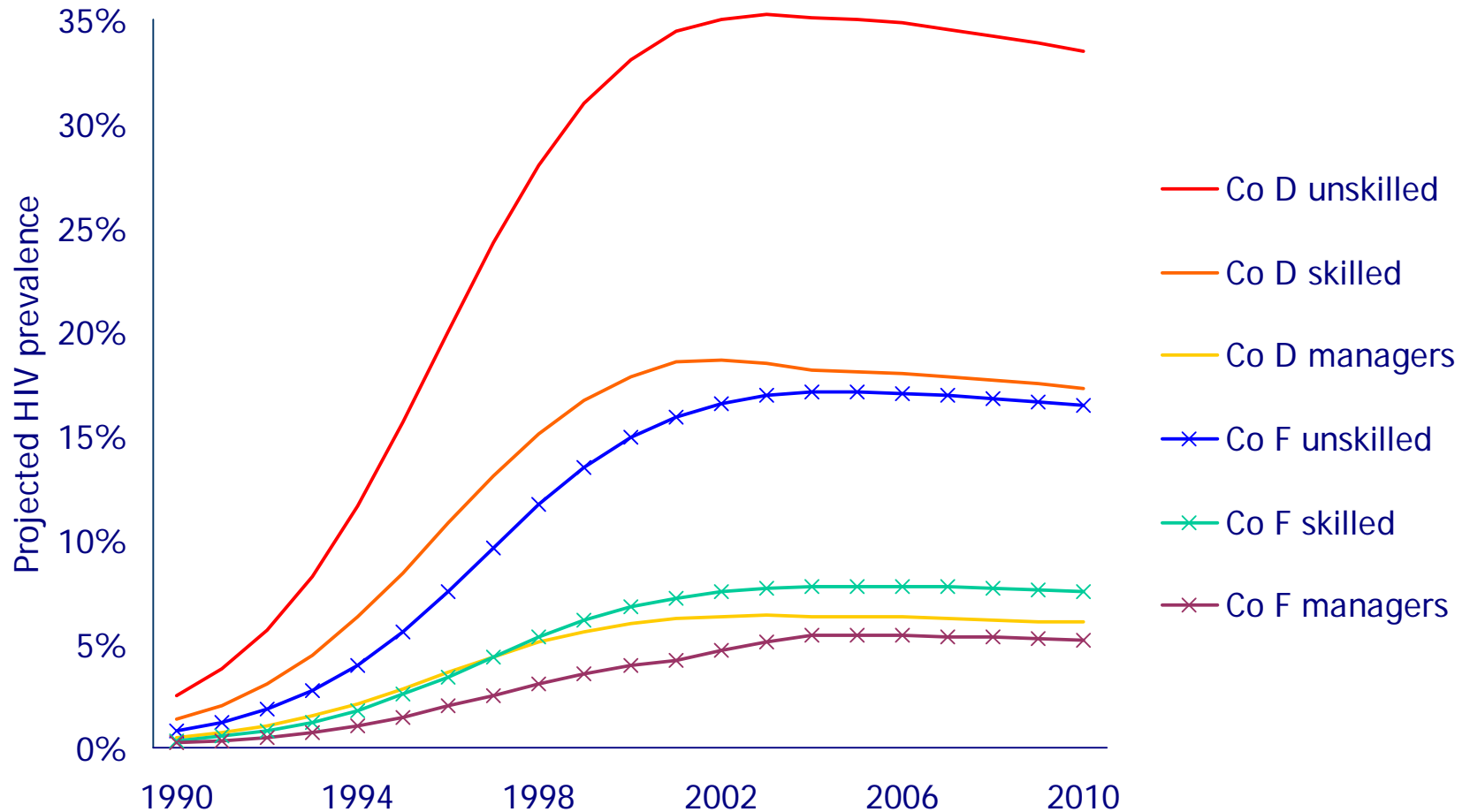
Analytic Framework

	a. Increased expenses	b. Lost productivity
I. From one employee with HIV/AIDS (individual costs)	<ul style="list-style-type: none"> • Benefits payments • Medical care • Recruitment of replacement • Training of replacement 	<ul style="list-style-type: none"> • Increased leave and absenteeism • Reduced on-the-job productivity • Supervisor's time • Vacancy until replacement is hired • Replacement's inexperience
II. From many employees with HIV/AIDS (organisational costs)	<ul style="list-style-type: none"> • Benefits premiums • Accidents due to sick or inexperienced employees • Litigation over benefits, dismissals, etc. • Consultants 	<ul style="list-style-type: none"> • Production disruptions due to missing skills, accidents, vacant positions, etc. • Loss of institutional memory, experience • Breakdown of workforce morale • Diversion of senior managers' time • Deteriorating labour relations
III. From high HIV prevalence in society (market or external costs)	<ul style="list-style-type: none"> • Higher cost of material inputs • More security needed due to breakdown in civil society • Higher wages due to shortage of skilled workers 	<ul style="list-style-type: none"> • Reduced demand for products • Higher risk premium on investment • Higher cost of capital • Higher cost of transactions with government and labour
Total Costs of HIV/AIDS		

Timing of Cases, Costs, and Liability

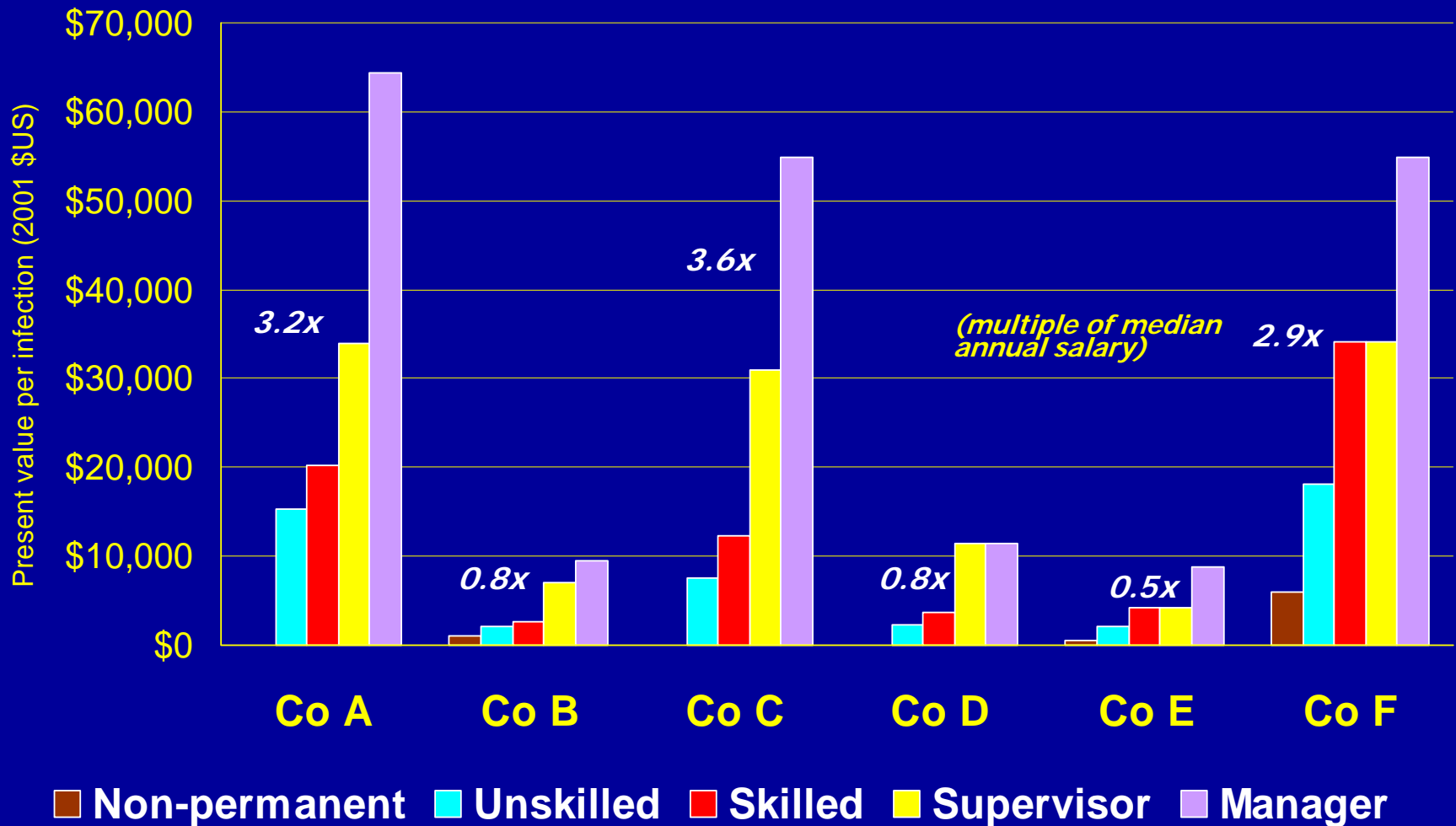
Timeline	Progression of HIV/AIDS in the Workforce	Cost to Company	Liability Acquired by Company
Year 0	Employee becomes infected	No cost to company at this stage	Present value of all costs from years 0-12
Year 0-8	Employee remains asymptomatic and fully productive	No cost to company at this stage	
Year 2-8	Morbidity begins (some early mortality, some long-term non-progressors)	Morbidity-related costs are incurred (absenteeism, productivity, management time, medical care)	
Year 6-12	Employee leaves workforce through death or retirement (some long-term survivors)	Termination-related costs are incurred (death and disability benefits, loss of morale, experience, & cohesion)	
Year 6-12	Company hires replacement employee	Turnover costs are incurred (vacancy, recruiting, training)	

Projected HIV Prevalence By Job Level

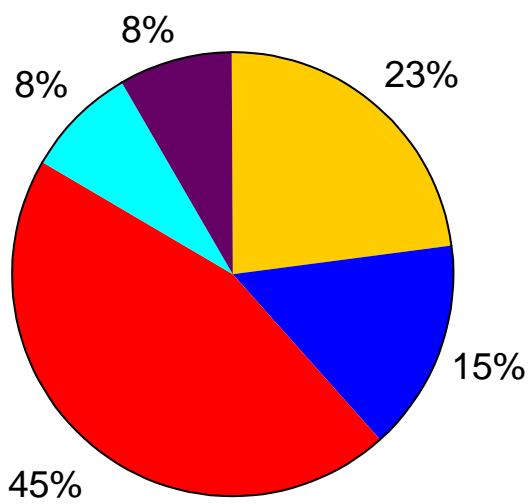


Cost Per Incident HIV Infection

Males, aged 35-49

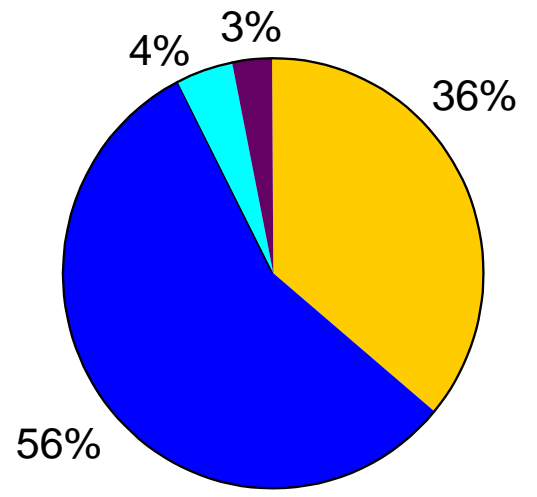


Distribution of the Present Value of an Incident Infection



Company A

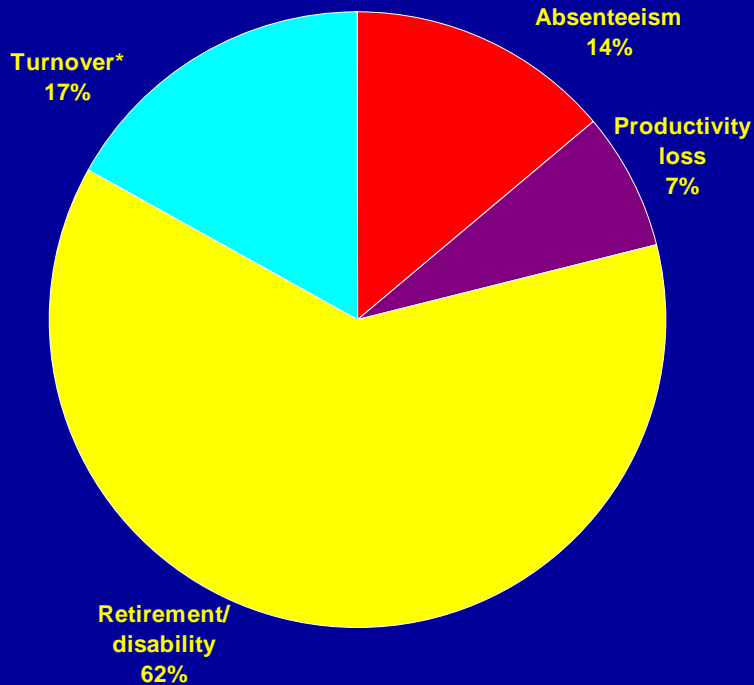
- Leave and absenteeism
- Productivity loss
- Retirement, death, and disability
- Medical care
- Recruitment and training



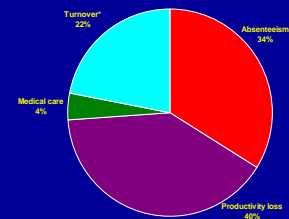
Company B

Magnitude of the Costs of a New Infection

Artisans, Males 35-49



Company A



Actual Size

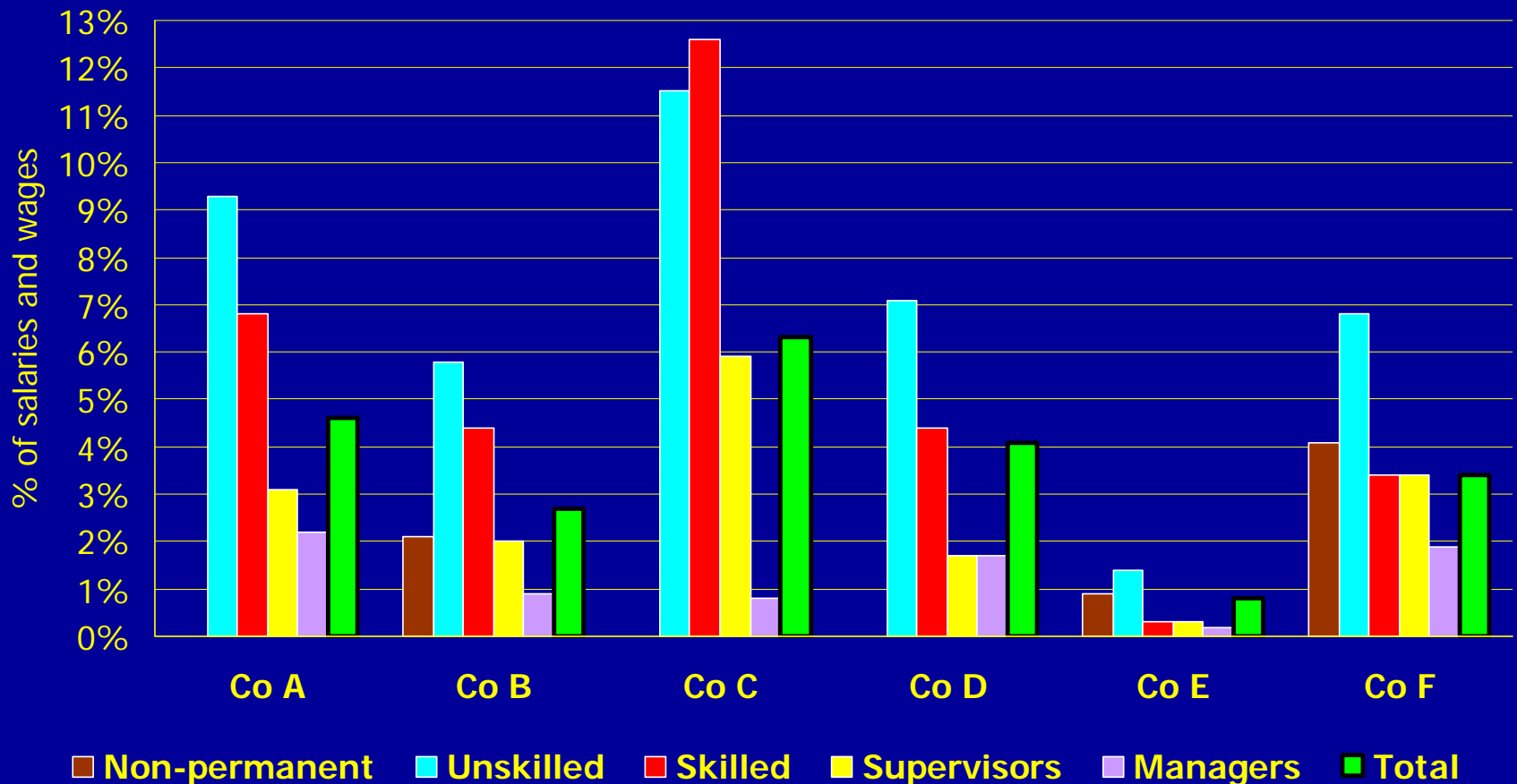
Company B

What Accounts for Differences in the Cost Per Infection?

Variable	High-cost firms	Low-cost firms
<i>Most important:</i>		
Type and level of death and disability benefits	Defined benefit pension; risk benefit levels stable	Premiums capped; risk benefit levels falling
<i>Other differences:</i>		
Medical care	Medical aid coverage for all employees	Most use company clinics and public hospitals
Status of unskilled workers	Permanent employees with full benefits	Many are contractors with few benefits
Salaries (labor productivity)	Higher, so absences and turnover cost more	Lower, so absences and turnover cost less

The "AIDS Tax" on Business: Aggregate Cost of Incident Infections 2001

Shown as a percentage of total annual wages and salaries



Results:

**Returns to Investments from
Prevention and Treatment**

Reducing the AIDS Tax: Profits from Prevention

Example: Company F (2001)

- For an STD management program that:
- Reduces HIV incidence by 50%
 - Costs \$10/employee/year

The profit to the company for providing the program to all permanent employees is:

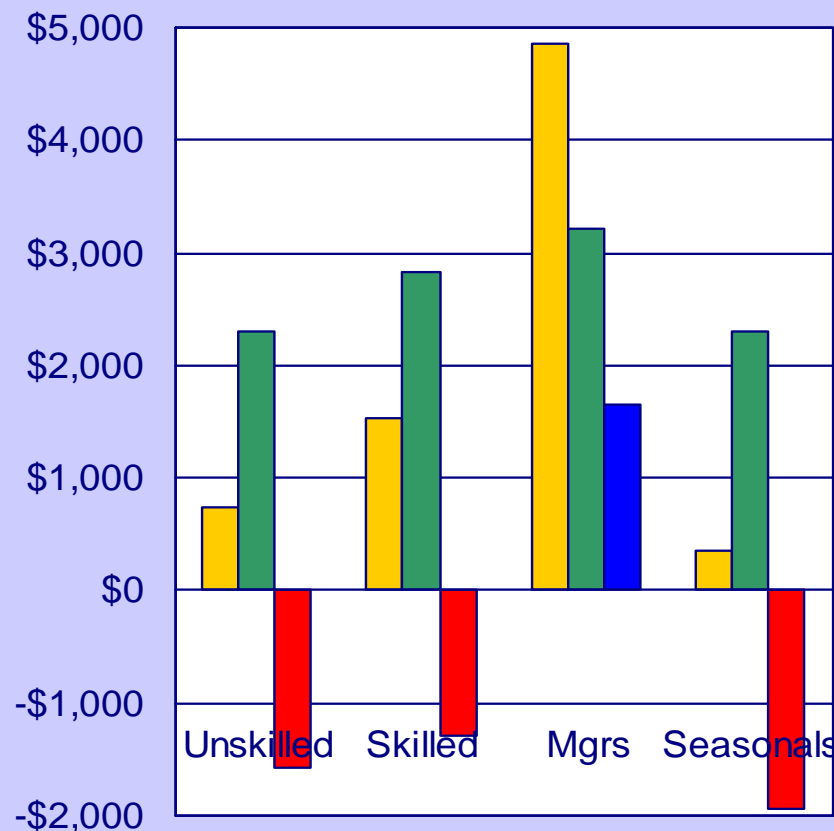
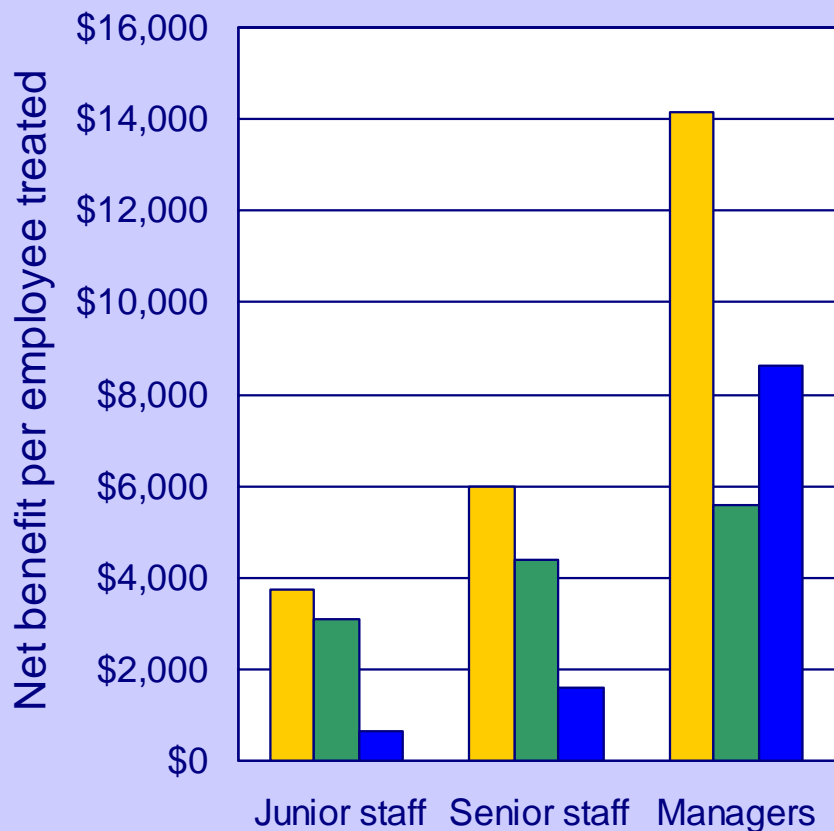


Returns to Investment in Treatment

If treatment costs \$360/patient/year...

Tourism Company in Zambia

Agriculture Company in Zambia



Cost without treatment



Cost with treatment



Net benefit (cost)

Conclusions

- The impact of HIV/AIDS on firms' labor costs has so far been real but moderate: 1-3% for most, more for a few.
- A few variables explain most of the differences in costs among firms: employment conditions (contracts, benefits), HIV prevalence, skill level of workforce.
- Responses to AIDS are also associated with consistent company characteristics (size, ownership, leadership).

Conclusions (Continued)

- Treatment is a good investment for many (though not all) employers.
- Employer provision of treatment can make sense even when public sector treatment is available.
- Businesses have other ways to respond to the cost of HIV/AIDS (“shifting the burden”).

III. Impacts on small and medium enterprises:

Summary of Key Findings

Small and Medium Sized Companies

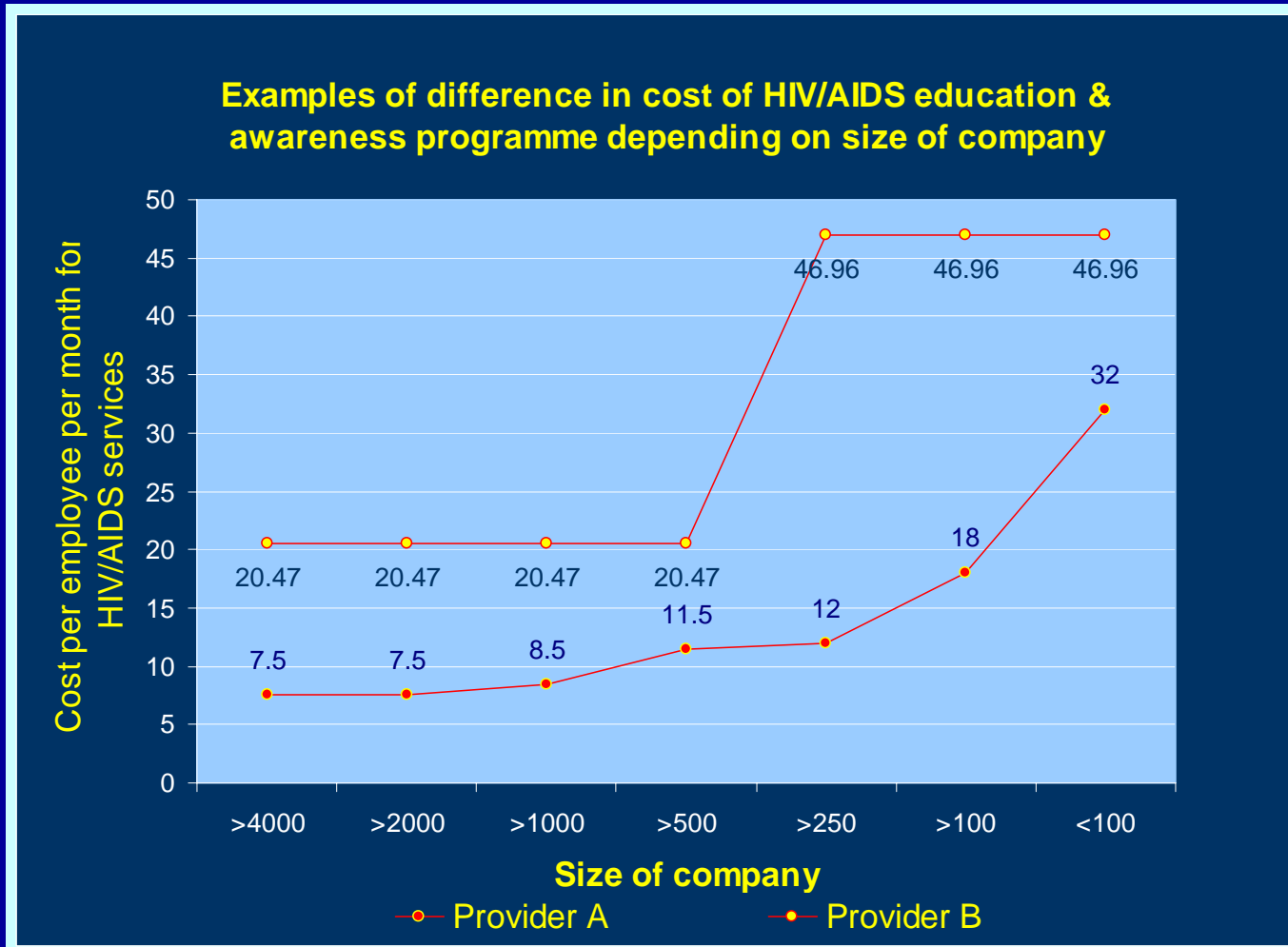
Country and sector	So. Africa, multiple	So. Africa, industrial	Zambia, tourism	Zambia, agriculture	Kenya, agriculture
Description of sample					
Sample size	80	34	30	29	19
Median workforce size	48	53	27	46	17
% unskilled workers	31%	31%	36%	63%	85%
Estimated HIV prevalence	13.7%	9.8%	24.3%	26.4%	10.0%
Attrition (employee turnover)					
Average annual attrition due to ill health or death (any cause)	1.4%	0.9%	1.7%	1.2%	3.7%
Proportion of total attrition attributable to ill health or death	10.4%	10.1%	14.5%	8.2%	45.2%
Managers' views					
% of managers who believe AIDS is having little or no impact on their companies	n.a.	85%	65%	63%	72%
Managers' ranking of AIDS as a business concern	9 th	9 th	5 th	7 th	3 rd
% of companies that had ever discussed AIDS as business issue	38%	26%	47%	41%	37%

SMEs and HIV/AIDS: Status Quo

- 24% of companies provide any services.
- 52% have lost any workers to AIDS, but only 25% lost workers in critical positions.
- 42% believe little or no effect from the epidemic, 25% moderate, and 29% large.
- AIDS accounts for 1.4% attrition of permanent workers per year; overall attrition is 14.5%.
- AIDS is not a business concern for SMEs.

Constraints on Supply (1): Costs

1. Costs: SMEs pay more because of inherent fixed costs and absence of economies of scale.



Constraints on Supply (2): Communication

- Communication
 - Providers' primary contacts are human resources managers at large companies; SMEs lack HR managers.
 - Providers perceive a lack of interest by SMEs; 68% of providers do not market to SMEs.

Constraints on Demand (1): Low Coverage of Medical Aid in SMEs

Sector	Agriculture	Business Services	Construction	Manufacturing	Wholesale/ Retail	Total
% of surveyed companies subsidizing medical aid	30%	50%	55%	75%	60%	54%
% managers on medical aid	100%	80%	87%	85%	82%	87%
% skilled employees on medical aid	23%	87%	36%	24%	59%	46%
% unskilled employees on medical aid	0%	47%	36%	14%	36%	27%
% contract employees on medical aid	0%	7%	0%	0%	0%	1%

Constraints on Demand (2): Cost

- Cost
 - Low willingness to pay for services. Especially for those with no immediate benefit.
 - Currently spend little on employee benefits
 - 74% provide risk and retirement benefits, 48% to all permanent workers
 - Managers believe few critical employees lost to AIDS
 - Very low replacement costs for skilled and unskilled employees.
 - For skilled workers, no direct costs to train in 66% of companies and no costs to recruit in 50%. 85% incur no direct costs recruiting and training unskilled workers.
 - Vacancies for skilled workers are filled in 10 days and workers are 100% productive within 30 days.

Constraints on Demand (3): Information and Stigma

- Information
 - 82% of companies do not have a designated HIV/AIDS coordinator.
 - 33% said they know where to go to contract services; of those, 66% would go to government facility.
 - When managers were asked what would motivate them to provide HIV/AIDS services, 41% responded only if more employees had AIDS.
- Stigma
 - Of 15 companies that had considered implementing services but did not, 7 cited refusal or lack of interest of workers.
 - Of companies with services in place, the greatest difficulty in implementing or expanding services has been stigma, not cost.

Conclusions

- SME demand for HIV/AIDS services is low, and existing constraints are severe.
- Providers have not (yet) developed models that are appropriate for SMEs.
- Though there are opportunities for expanding services to many SMEs, it may be overly optimistic to assume service expansion will occur

III. Impacts on labour forces:

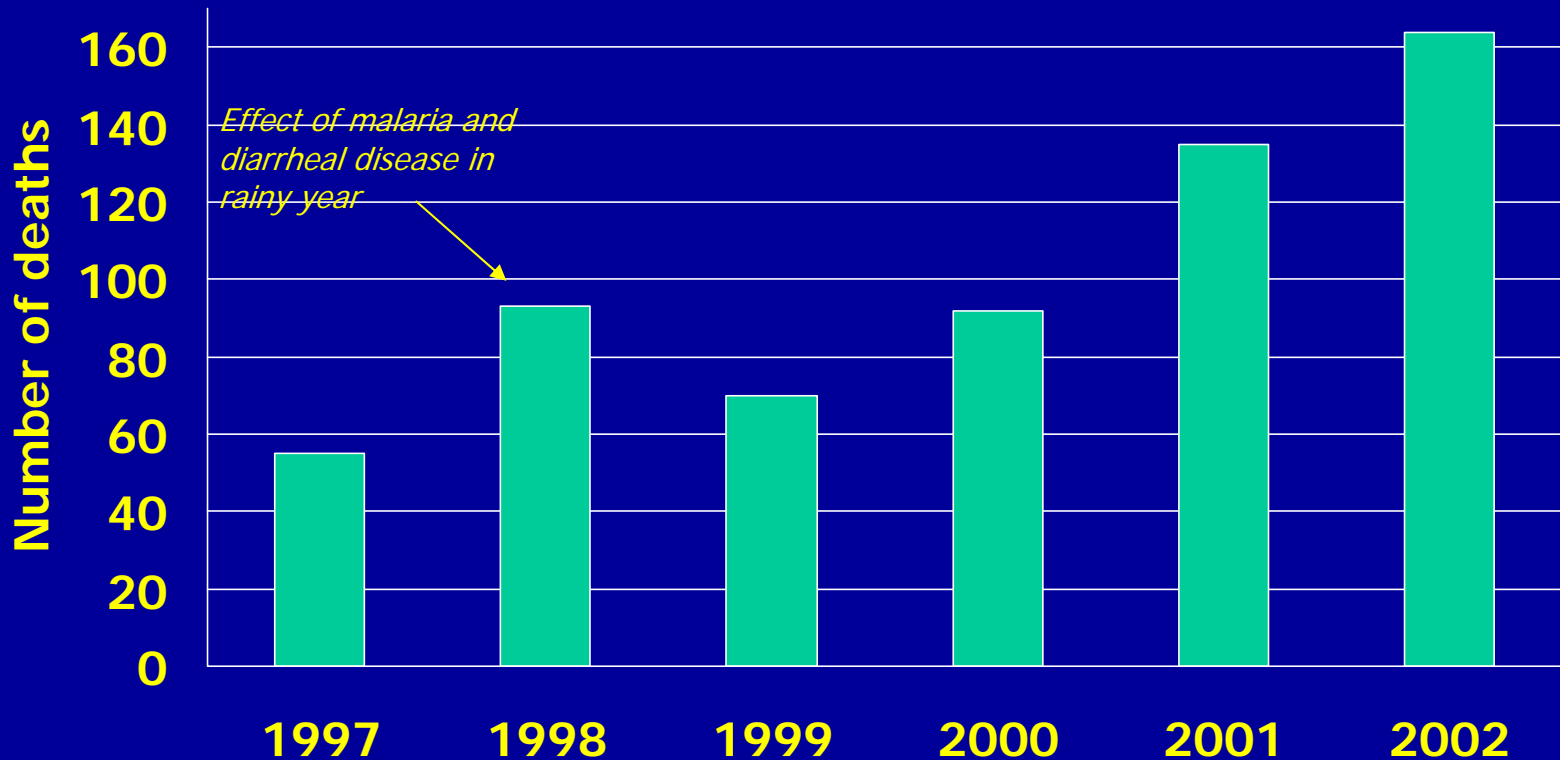
Summary of Key Findings



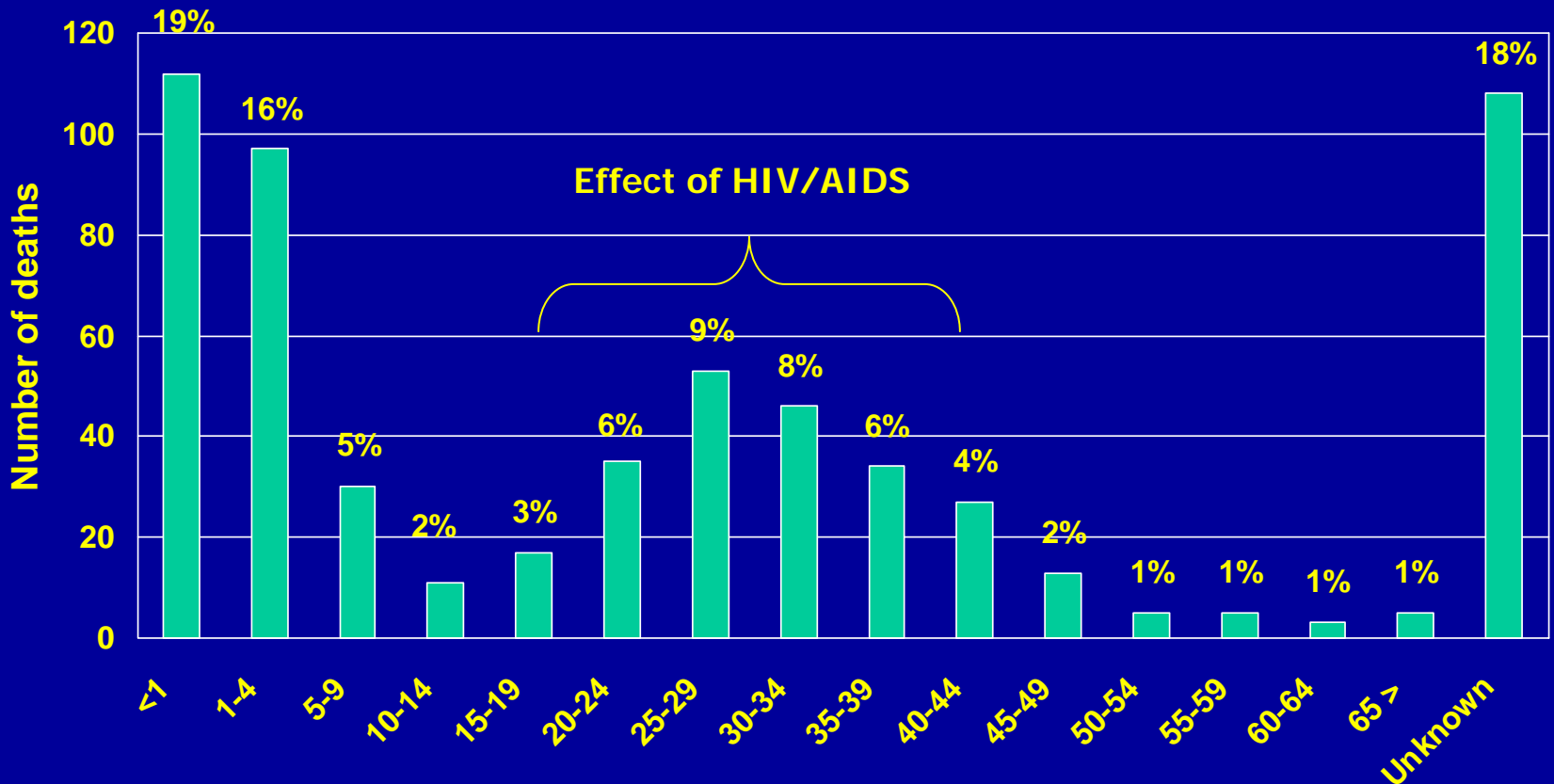
**The Impact of HIV/AIDS on
Labor Productivity in
Rift Valley Province, Kenya
ISHED I**

Number of Deaths by Year, 1997-2002

All natural cause deaths at company facilities



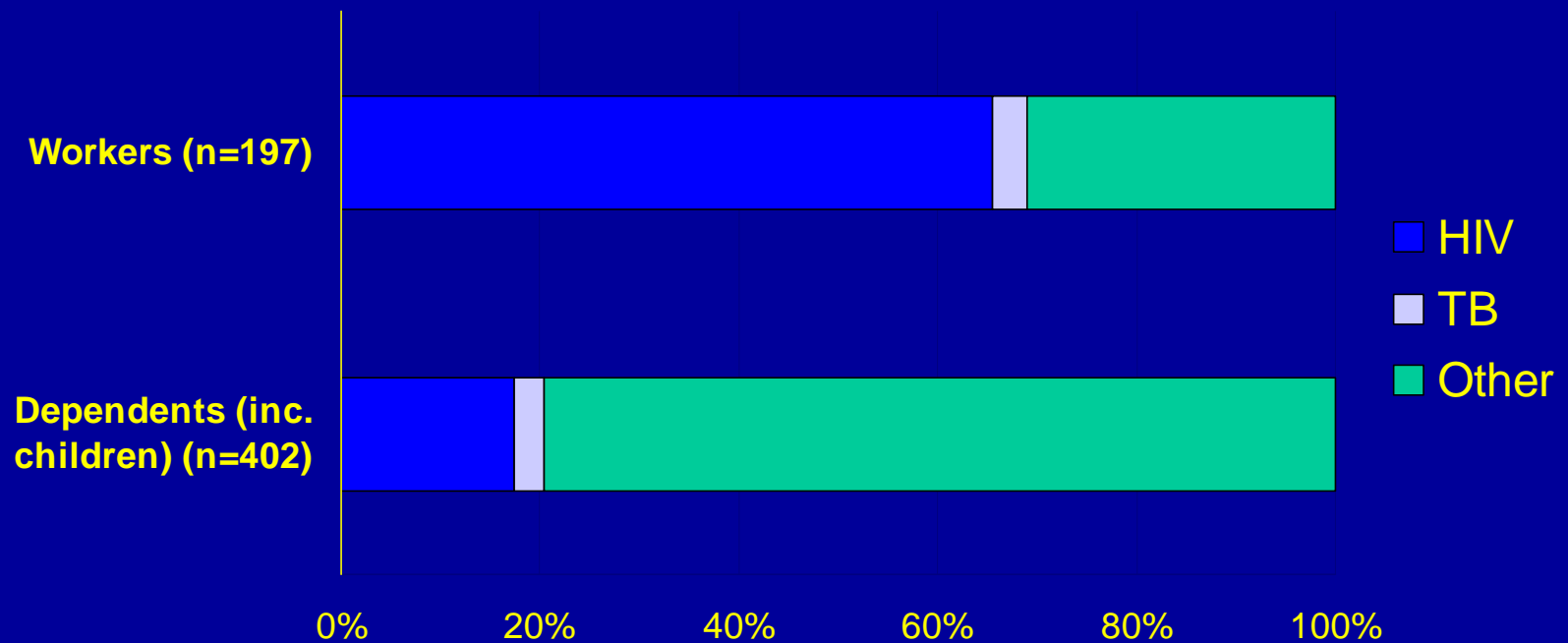
Distribution of Deaths by Age



HIV/AIDS accounted for 2/3 of tea plucker deaths in this period.

Distribution of Deaths by Cause

All natural cause deaths, 1997-2002

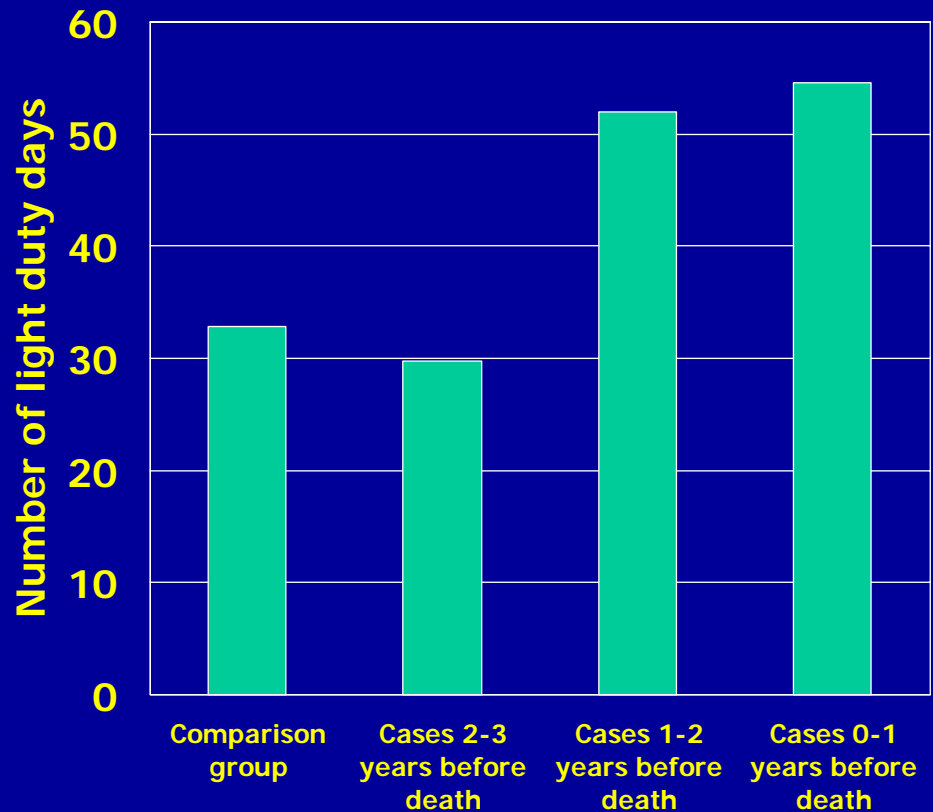


Effect of HIV/AIDS on Kgs of Tea Plucked Per Day

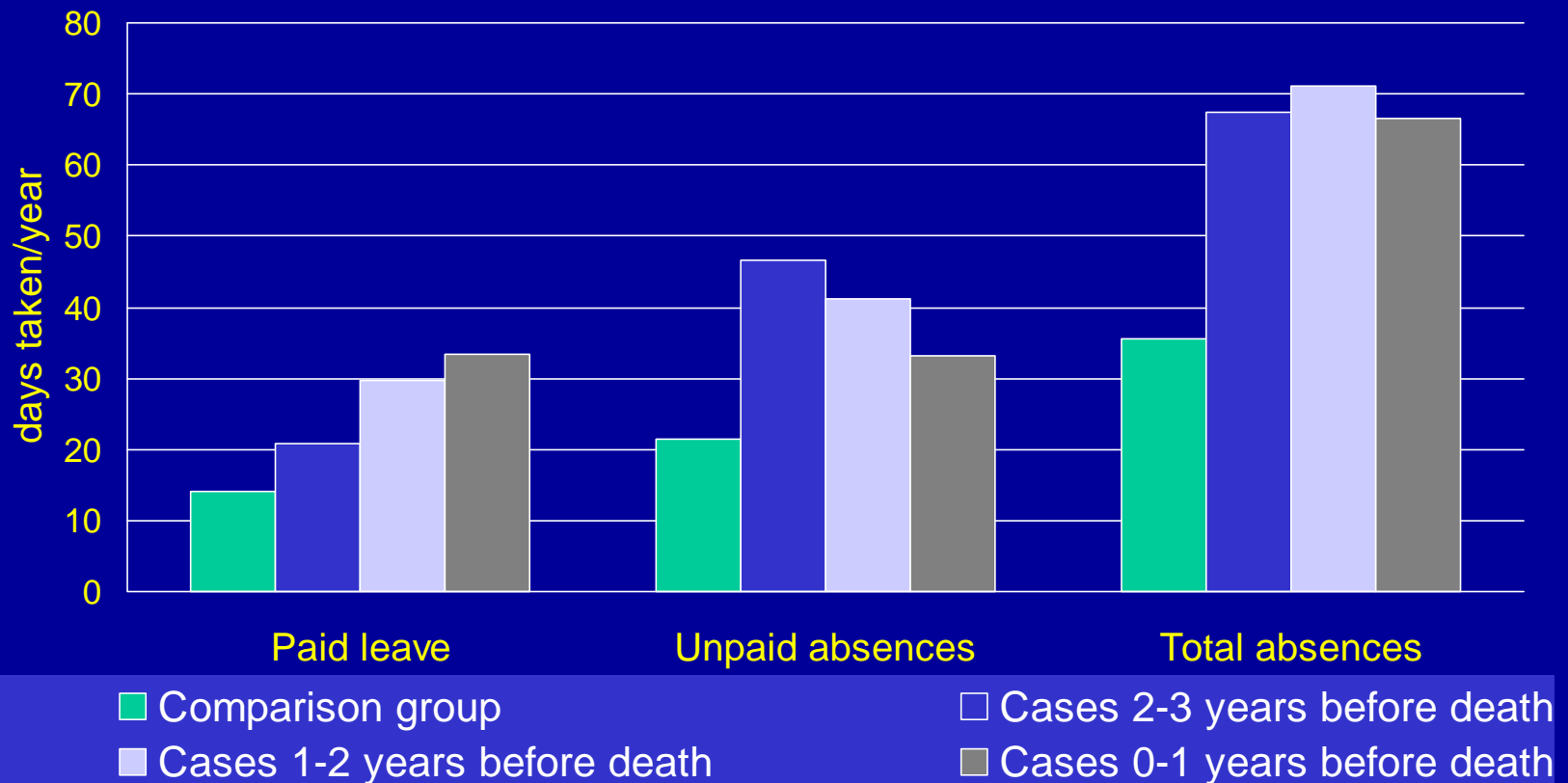
- Comparison group averaged 40-42 kgs of tea/day.
- On days in the fields, pluckers who died of AIDS (cases) plucked:
 - 8% less in the 3rd year before death
 - 9% less in the 2nd year before death
 - 18% less in the last year before death.

Effect of HIV/AIDS on Job Assignments

- Comparison group were assigned 33 days of “light duty” per year.
- No difference between cases and comparison group in third year before death.
- Cases were assigned 19 more days of light duty in the second year before death (increase of 58%).
- Cases were assigned 22 more days of light duty in the last year before death (increase of 67%).



Effect of HIV/AIDS on Attendance at Work (Absenteeism)



Loss of Productivity Due to HIV/AIDS

- In each of the last year before death, a plucker with HIV/AIDS:
 - Is absent from work 32 days more often (an increase of 87 percent)
 - Spends 22 more days on light duty (an increase of 66 percent)
 - Produces an average of 7.6 kg less tea leaf per day (a decrease of 18 percent)
 - Has reduced earnings of 18%.

Conclusions

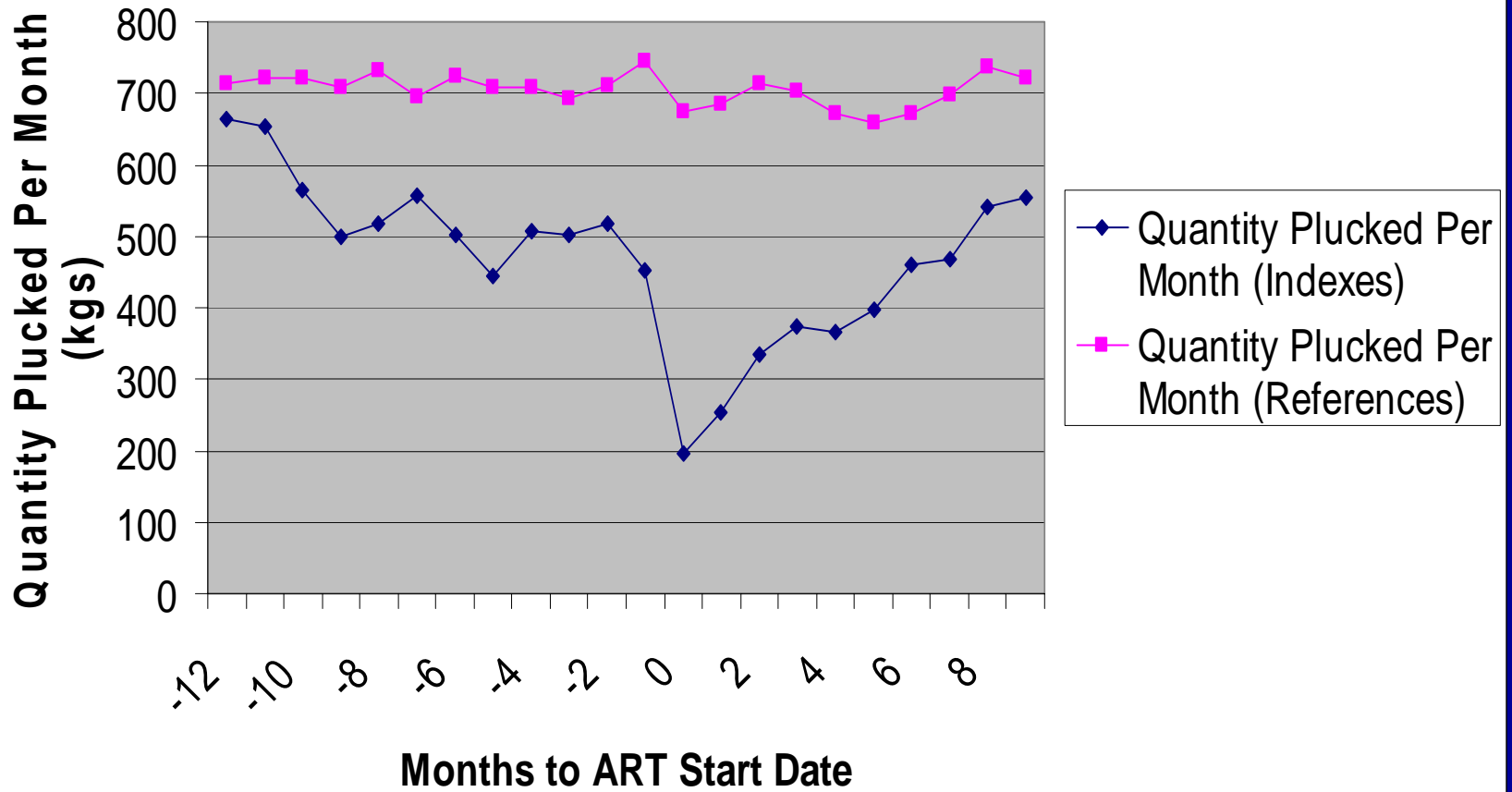
- HIV/AIDS is substantially reducing the productivity and earnings of individual workers.
- Effect on overall productivity of agricultural labor force is muted by introduction of family labor and availability of casual workers.
- Tea estate data provide first empirical findings on relationship between HIV/AIDS and labor productivity.
- Now need to determine if better care and treatment can offset the effects of illness.

**The Impact of HAART on
Labor Productivity in
Rift Valley Province, Kenya
ISHED II**

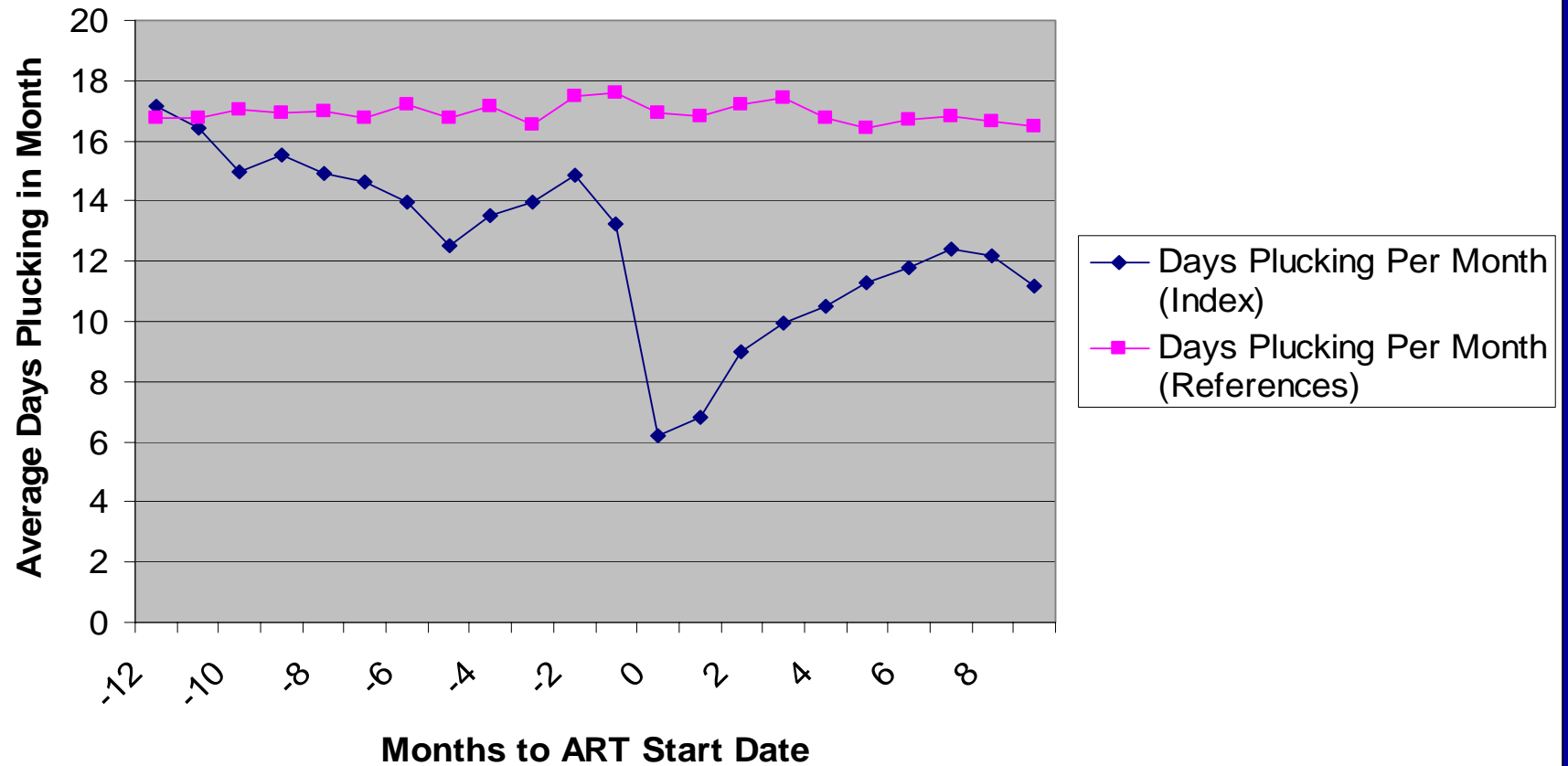
Objectives of the Study

1. Estimate the recovery in individual labor productivity associated with ART for HIV/AIDS.
2. Estimate the reduction in additional paid and unpaid leave taken by workers with HIV/AIDS as a result of being on treatment.

Total Quantity Plucked Per Month



Number of Days Plucking Per Month



IV. Burden shifting and the place of the private sector in the global response

“We’re not concerned about the cost of AIDS. We’ve gotten around the problem by contracting out.”

Owner of a South African business with 20 permanent employees and 1600 contractors, July 2, 2002

Strategies for Reducing the Burden on Employers

- Diminish the size of the burden.
 - Invest in HIV prevention interventions.
 - Invest in HIV/AIDS care and treatment interventions.
 - Invest in replenishment of human capital (training).
- Shift the burden onto others.

Shifting the Burden

- Shift the burden onto others
 - Private sector to public sector
 - Public sector to NGO/CBO sector
 - NGOs/CBOs to households
 - Households to elderly women and girls
 - Women to ???

Business Response: Fight or Flight?

Which firms will fight?

- Enlightened corporate leadership
 - Political, moral, historical/geographic
- Global brand to protect
- Fixed assets (primary products - agricultural or mineral or oil)
- Forced by local or global activism

How firms will flee:

**Cost avoidance and
cost reduction**

Cost Avoidance

- Move to an area of low prevalence
- Screen employees (legally or illegally)
- Replace labour with capital (reduce size of workforce)
- Out-source non-core functions to minimize exposure
- Institute effective prevention programs

Cost Reduction

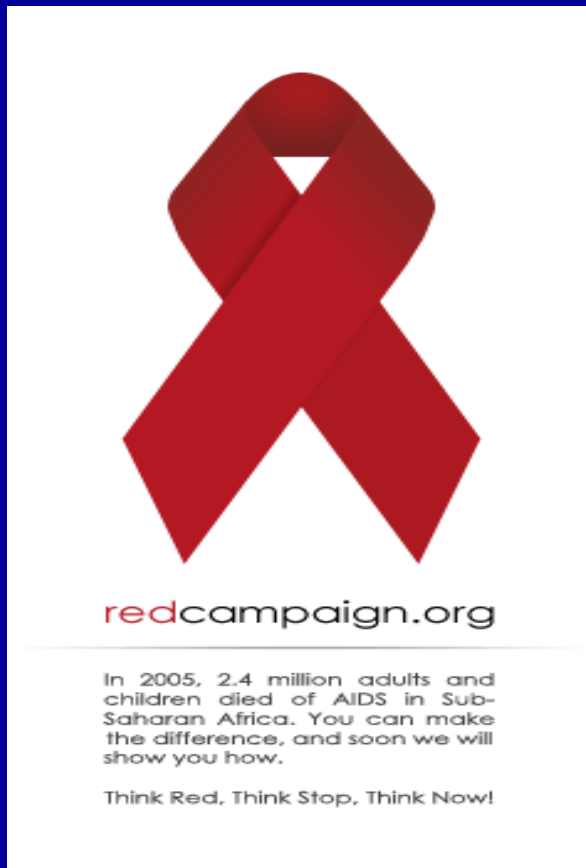
- Change structure of benefits
- Medically retire ill employees
- Change governmental policies and regulations to reduce burden on firms

How Important Is It?

- Examples of burden-shifting practices abound and surveys suggest they are widespread.
- The shift reinforces the impoverishing effects of AIDS on households and communities.
- The expectation of a major private sector role in mitigating the impacts of the epidemic (or even “caring for its own”) may be unrealistic.

V. New Private Sector Initiatives

(RED) Campaign



- Gap
- Motorola
- Converse
- Armani
- American Express



Airline Tax and Unitaid Campaign

- Brazil
- Chile
- France
- Norway
- United Kingdom
- Others to follow
 - (but not the U.S.A
....yet)
- 1st line pediatric drugs
 - 100,000 children
- 2nd line adults
 - 100,000 children
- TB drugs for children
 - 150,000 children
- Malaria drugs
 - 28 million children

IFC and Gates Foundation

- Finance research on commercially-based approach to private health care
- \$2.6 million initial support to determine which business models provide best services at differing income levels
- Guide future IFC investments

Overall Conclusions and Priority Questions

Conclusions

- The impact of HIV/AIDS on private sector firms' labor costs has so far been real but moderate.
- A few variables explain most of the differences in costs among firms.
- Responses to AIDS are highly varied depending on industry, size, location, and leadership
- Provision of treatment services is a good investment for many (but not all) employers.

Priority Questions

- How effective is care and treatment (ART) in restoring labor productivity and reducing labor costs in the short and long terms?
- Should workers start therapy earlier?
- What are the benefits and costs of workplace HIV/AIDS interventions other than treatment?
- Are workplace-based interventions efficient, compared to community-based interventions?
- Should skilled workers and trainees be prioritized for interventions? How (whether) to ration?
- What are the benefits and costs to employers of maintaining a healthy workforce, including but not limited to treatment of AIDS?

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- Co-authors and contributors: Mary Bachman DeSilva, Margaret Bii, Yosef Burka, Paul Bukuluki, Alizanne Collier, Mark Colvin, Patrick Connelly, Jill Costello, Rich Feeley, Matthew Fox, Eleanor Gouws, Petan Hamazakaza, Bruce Larson, Lawrence Long, William MacLeod, Kelly McCoy, Sarah Richards, Sydney Rosen, Tobias Rinke de Wit, Ian Sanne, Donald Thea, Jeffrey R. Vincent, Alan Whiteside, and Brian Williams.

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