

Full Length Research Paper

Business management of HIV/AIDS: Case study of a South African contract cleaning company

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Accepted February 2011

The aim of this paper was to outline the costs, options and scope for a company in the South African Contract Cleaning Industry to implement effective HIV/AIDS workplace programmes. Case study methodology is used. A cost model which estimates the costs associated with replacing an AIDS affected employee over time is used. The costs are not significant to the company as they are able to transfer most of the cost of illness onto their employees. There are significant risks for the company however, to the existence and costs associated with insured employee benefits into the future. This company has minimised their risks to the negative impacts of HIV/AIDS by adopting several cost saving strategies. This is however, to the detriment of their employees.

Key words: HIV/AIDS, cost impact, contract cleaning industry, South Africa.

INTRODUCTION

The aim of this paper was to outline the costs, options and scope for a case study company in the South African Contract Cleaning Industry (CCI) to implement effective HIV/AIDS workplace programmes. The results from HIV/AIDS cost impact assessments conducted at the case study company in late 2006 are presented. The options for action by the company are essentially a summary of the key results which describe objectively the situation that the industry confronts. The implications for planning interventions in the company and industry are then discussed.

Background

The industry employs approximately 80,000 people in labour intensive work. The majority of employees are unskilled workers (cleaners) who earn relatively low wages of R1,500 per month and have very limited health and pension benefits. The rate of exchange in late 2006 was US\$1 = 7.5 South African Rands. There are

approximately 340 companies in the industry. The employer organisation, the National Contract Cleaning Association (NCCA), represents over 240 of the companies. In contrast, less than 30% of employees belong to trade unions and several unions operate in this industry. The Bargaining Council for Contract Cleaning Industry (BCCCI) in KwaZulu-Natal was created to maintain fair and equitable industrial relations and conditions of the employment for the Industry. It is made up of an equal number of employer and employee (union) members. The Bargaining Council covers approximately 11,000 employees (15%) in the industry.

The South African Business Coalition on HIV/AIDS (SABCOHA) was formed in 2000 in an effort to encourage the private sector to acknowledge the real threat of the epidemic to businesses and to respond appropriately.

The case study company

A recent sero-prevalence survey of the company was the basis for conducting an HIV/AIDS impact assessment study of the company with the aim of gaining insights into the general threat of the epidemic to the company. The case study company in the sector is a medium-sized one

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with 500 employees.

Company F is located in Durban and has 498 employees. The majority (443) of these employees are carers/cleaners who work mainly in aged care facilities engaged in bathing and cleaning elderly people. Other cleaners work in charitable and corporate organisations. There are also 30 registered nurses employed on a full time basis, as well as 10 supervisors and 15 head office administrative staff.

At the time of the study, there were 419 'black' women employees, 15 'black' men and 9 'coloured' women. 75% of the employees were aged 35 years or older and had been working for the company on a long term basis.

The employee profile is typical of contract cleaning companies: employees are mainly women (the female to male ratio is 80:20); all employees are 'black' in terms of South Africa's current population categorisation model; the majority are middle-aged and have long periods of service for the company.

The average wage for cleaners is R14,000 per employee per annum. Regulated casual wage rates are R9 per hour. Wages are also typical for the industry, but on the low side: R80/day for casual employees and R1,490 per month for full time employees. Other conditions of employment fall within the industry-level agreements. Full time employees are entitled to four weeks paid annual leave in December. They all belong to the BCCCI Provident Fund, administered by Negotiated Benefits Consultants (NBC). Employees contribute 6% of their salary and the company contributes another 6% to the Fund. Benefits in the case of death include one year's salary and R3,000 to assist with funeral costs. There is no medical aid scheme or employer contribution to health insurance and, we believe, no cleaning employee has medical aid cover.

The company does not have a medical aid scheme or employer contribution to health insurance packages for any of its cleaning and carer staff, but the management reported that a few (non cleaning) employees pay for medical aid coverage. Sick leave benefits include two-days salary for temporary absence due to illness as long as the employee has a doctor's certificate. Employees and the company both contribute 1% each of salary to the Unemployment Insurance Fund (UIF). Income insurance is available to employees at a cost of R5 per month.

The HIV sero-prevalence study was conducted by Dr. Mark Colvin from the Centre for AIDS Development, Research and Evaluation (CADRE). This received approval from the University of KwaZulu-Natal Medical Ethics Committee.

The total number of people that participated by providing usable specimens was 147 or 30% of the total workforce. A total of 45 people or 31% of those tested ($45/147 \times 100$) were infected with HIV. Two men out of 12 (16%) and 43 out of 135 (32%) of women were infected.

The data shows that the highest levels of infection are

in the 30 to 40 year age group band, but that infections occur in all ages.

AIDS projection model (APM)

The demographic impact of the HIV/AIDS epidemic on the workforce over the period 2000 - 2015 was computed using the AIDS Projection Model (APM) (Matthews, 2007). The HIV sero-prevalence data is an anonymous list of employees with the following characteristics, categorised as:

- i. Job band - managerial, skilled, labourer
- ii. Race - black, ACW (Asian, Coloured, White)
- iii. Gender – male, female
- iv. Ages 20-34, 35-49, 50-64.

METHODS

The financial cost of HIV/AIDS to companies

Figure 1 illustrates the different types of costs that companies can incur.

The underlying issue here is the way costs of HIV infection are delayed. Notably, for an individual, the virus can incubate for 3 - 5 years before he or she begins to suffer HIV-related illnesses and, if unable to get adequate treatment, suffers increasing bouts of more severe and varied opportunistic illnesses and, ultimately, death 5-10 years after infection.

Likewise, the cost to any organisation arising from an employee becoming infected is delayed. Figure 2 presents a schematic picture of the dynamic.

However, in reality an organisation is incurring costs arising from employees infected several years ago while the costs of new infections arise only in the future (Rosen et al., 2003; 2004; Bureau of Economic Research, 2004 and 2005; SABCOHA, 2004). Furthermore, as the assessment above shows, it must be noted that costs for an organisation do not inevitably increase over time. Any assessment of cost impacts has to take into account both the dynamics of epidemics generally (that is, infection rates eventually taper off) and the development of responses (that is, gradual expansion of prevention and anti-retroviral and other treatment programmes in South Africa over the next few years).

Bowler (2007) reported the results of a descriptive study of HIV/AIDS in manufacturing workplaces in Nelson Mandela metropolis area. The levels of HIV infection, illness and death were established. Although, there had been an impact on costs, these had been contained without a negative impact on profitability. She found that every workplace had engaged in some aspects of HIV/AIDS management and had complied with legal requirements. Further, that the management of every workplace had responded to the specific issue of HIV, although programme usage was limited. It was found that HIV programmes were management driven but there was limited involvement from unions.

RESULTS

Information on the recruitment and employment practices of this company indicated patterns and trends in the way HIV/AIDS is affecting the company. These patterns and

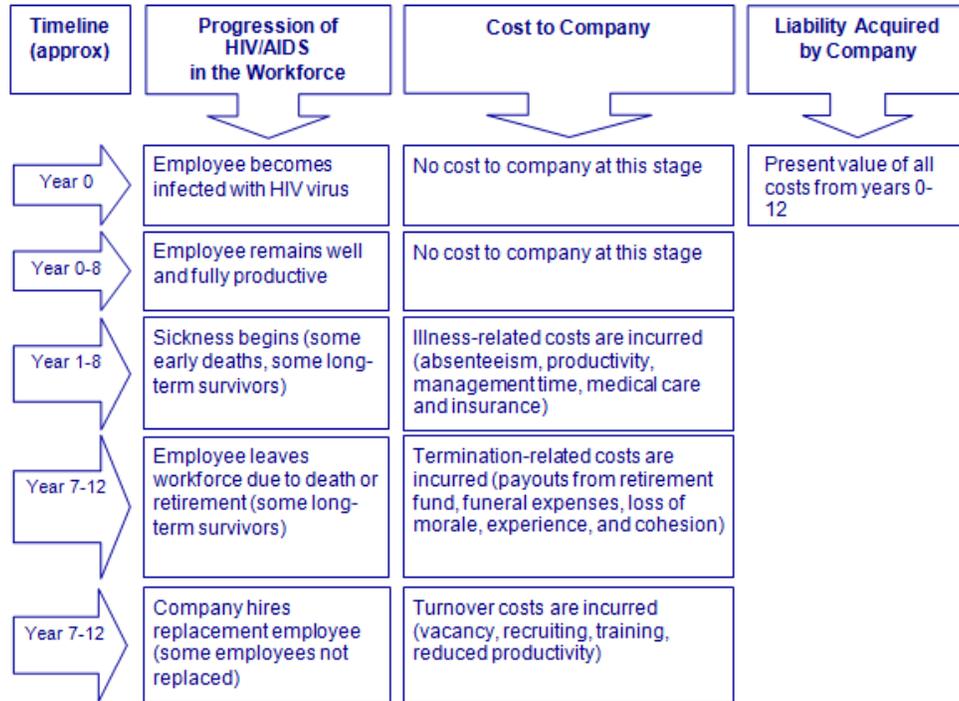


Figure 1. Progression of Cases, Costs, and Liability (Rosen et al., 2000).

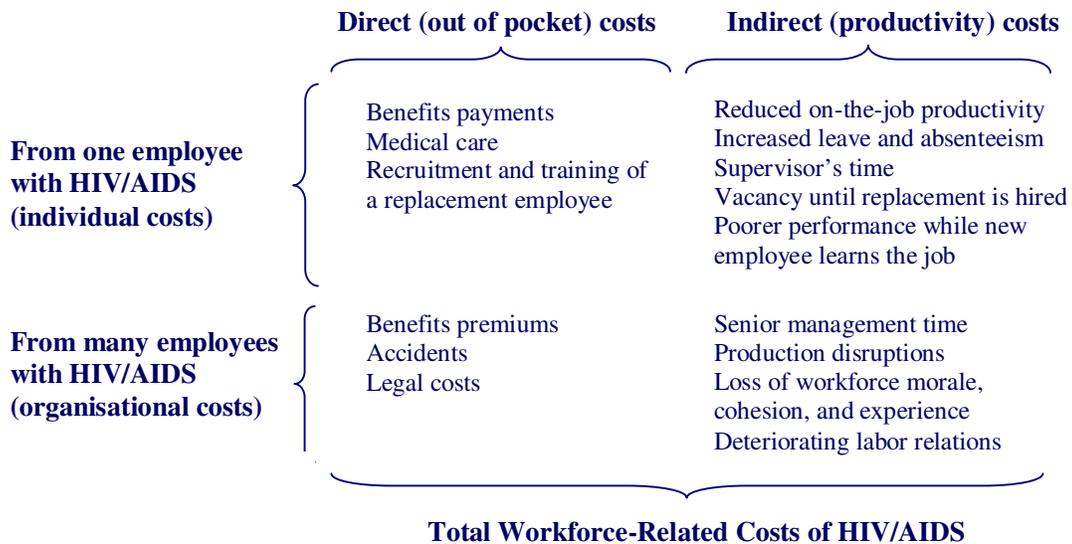


Figure 2. Costs of HIV/AIDS to Companies (Rosen et al., 2000).

trends, though suggestive rather than definitive, provide important factors that need to be considered in the planning of any industry or company-level interventions.

The findings for the case study company were:

1. The company will entail an average cost of R9,007 for each individual employee who becomes infected with HIV.

2. That cost is 63.2% of average annual salary of an individual.

3. The bulk of the cost is incurred in the provident fund payment (R8,515)

4. The incidence of new HIV infection will decrease (projections up to 2015).

5. The number of employees dying or retiring due to disability to work will increase threefold (from approx 7 to

Table 1. Direct and indirect costs of a new HIV infection (Case Study Company) (R).

Type of costs	Amount (R)
Direct	
Provident Fund	8515
Medical Care	0
Recruitment	59
Training	148
Indirect	
<i>Sick Leave</i>	285
Total	9007

Table 2. Total cost of HIV/AIDS in the year incurred, 1999-2015 (Case Study Company) (R).

Year	Total in year incurred	Present value
2000	20,172	177,814
2001	33,624	166,193
2002	53,088	142,602
2003	79,495	119,023
2004	113,103	100,965
2005	153,481	87,969
2006	199,519	77,898
2007	249,133	69,247
2008	299,815	61,338
2009	348,072	54,099
2010	390,977	47,566
2011	425,810	41,867
2012	450,959	36,927
2013	465,782	32,812
2014	470,788	28,998
2015	467,543	26,134

22 individuals per year).

6. The overall financial cost of HIV/AIDS to the company decreases over the next ten years.

Table 1 summarises the direct and indirect costs to the company for each employee who becomes infected.

The overall cost of HIV/AIDS actually decreases over time. Although, the cost increases from R11,439 in 1999 to R467,543 in 2005, the value or worth of those sums in relation to the current value shows that:

- 1) The cost to the company was R167,558 in 1999; in 2006, it was R77,898; and in 2015, it will be R26,134.
- 2) The current cost R61,338 amounts to approximately 1.0% of the annual salary bill of R6.28 million, but that proportion decreases to approximately 0.7% of the salary bill in 2010 and thereafter (up to 2015) it remains relatively flat at 0.4% of the salary bill.

Table 2 presents a summary of the calculations.

Adequate human resource information to undertake the detailed analysis was available from the case study company.

It will not be possible to do the same for many other companies in the industry because many do not have adequate data on employees in their human resource records.

The findings from this company may or may not be indicative of a pattern in other companies in the industry. It is a slim base from which to assess the broader implications. Accordingly, the following assessment needs to keep that caveat in mind.

DISCUSSION

The key conclusion of the cost impact assessment is that

the company has not and will not likely incur a large financial burden as a result of HIV infections amongst its workforce. The cost of R9,007 per individual, it must be remembered, is actually spread out over time. The total costs of all infections actually decrease in real terms. This conclusion supports the anecdotal reports from managers and supervisors at other companies that they had not perceived any significant financial effects of HIV/AIDS (Fraser et al., 2002; Chao et al., 2007; Rosen et al., 2007).

However, it must be noted that the conclusion ignores hidden costs that the study could not determine; for instance, lower productivity of workers if sick yet present at work (presenteeism). It is these costs that are possibly significant. There is the possibility that there will be more instances of workers taking time off to obtain treatment at public health facilities which could reduce work productivity generally (for example, in time spent by supervisors to re-arrange teams and greater workloads on staff present) in addition to potential increases in direct costs such as sick leave payments.

However, even if that scenario is likely, for many companies one must also acknowledge the evidence from the company that their labour practices minimise the threat of HIV/AIDS raising their indirect costs. On the one hand, general practice in the industry seems to be for companies to each have a pool of casual workers to draw upon; thereby enabling them to offset occasional absences of full time staff. On the other hand, the demographic characteristics of the workforce in the case study company, if common throughout the industry, is a *de facto* means to reduce the financial costs of HIV/AIDS. The workforce in the company is primarily women over the age of 35. This means, from a statistical perspective, that a large proportion (if not majority in most companies in the industry) fall within a category of the population that is less at risk of infection than others (for example, 15 - 20 year-old youth; 20 - 40 year-old men and women).

Implications

The data presented do not indicate that a significant financial threat to the company exists from the observed level of HIV/AIDS in their workforce. This situation may or may not be applicable across the industry. However, it does indicate that there is a possible significant threat to the BCCCI provident fund. The bulk of the costs that arise from HIV infection of an individual worker occur in the provident fund contributions to support death and disability retirement benefit payment to an employee's estate. This cost is insignificant, however, compared to the actual costs borne by the fund itself. Simply put, the threat is that there will be increasing rate and number of payments from the fund. An additional threat is that the fund might not be able to absorb this increase in expenditure if there is a marked increase in the number

of members who have been employed for relatively short periods of time by companies. In other words, the general sustainability of the fund depends on long term contributions to the fund on the part of members.

The limited evidence from the study suggests, however, that there is as yet no discernable threat to the fund. On the one hand, evidence of labour turnover at the company indicates that HIV/AIDS is not a principal cause for attrition. In the case study company, the average annual turnover of staff is 20% but only 6% were attributed to illness and/or death due to HIV/AIDS. That proportion will increase but as the projections also indicate, the rate will level off. A survey of 80 small and medium sized businesses in Gauteng and KwaZulu-Natal indicated an average of 13% staff attrition annually but HIV/AIDS-related attrition accounted for 1.4% only of that attrition (Connelly and Rosen, 2004). Accordingly, the question is whether the levelled percentage imposes more than simply a small yet notable burden on the fund, but also reduces the funds overall financial footing. This seems unlikely given the established practice in the South African insurance industry to raise marginally contribution levels to cover that burden (and also to reduce benefits). Furthermore, the employment practices of companies indirectly mitigate the threat. If it is, or becomes, common practice for companies to employ middle-aged and older women primarily, then the threat of HIV/AIDS to the fund would not increase. Benefit payments for other causes of death could, of course, increase.

Managing the risk to insured benefits

Many companies purchase death, disability, and medical benefits from outside insurance providers. The employer and the employee share the cost of the premiums for these benefits, and the insurance provider assumes the risk that the employee will make a claim for payment.

As more employees succumb to AIDS, claims for medical care and death and disability benefits will increase, and the cost of purchasing these benefits will inevitably also rise. To avoid losing money, the providers must charge enough in premiums to cover their claims, administrative costs, and profits. If a particular employer's claims are increasing, it is very likely that the premiums charged by the insurer will increase as well.

There are various strategies that have been implemented by employers to manage the impact of rising benefit costs as a result of HIV/AIDS in provident and pension funds (Stevens et al., 2005; Rosen et al., 2007; Dickinson et al., 2005). The appropriate strategy must be in line with the objectives of the fund for benefit provision. The following are possible strategies that could be put in place:

1. Capping the contribution rate to risk benefits for all

categories of members. This change would cause a reduction in benefits over time should the contribution level remain the same.

2. Increase employer contributions to maintain current benefit levels. This is only a short-term solution and may well not be affordable in the longer term.

3. Set up a Risk Reserve to mitigate future cost increases and volatility. This will tie up some of the company's capital and has equity implications, since one generation will be subsidising another.

4. Restrict access to benefits. Strategies designed to limit or exclude access to benefits of people who are HIV positive include pre-benefit testing, exclusions and waiting periods. Before any strategy in this category is to be implemented consideration needs to be given to various legal and moral issues.

5. Implementation of an HIV/AIDS management program. All the options above manage the symptoms and effects of the epidemic and not the epidemic itself. This can be done by implementing a holistic HIV/AIDS management program, including full treatment and medication. In the long run this could lead to not only savings on the cost of risk benefits, but also other direct and indirect employment-related costs.

The potential for industry interventions

The case study company has minimized the threat of HIV/AIDS to their operations. On the other hand, their workforces are very vulnerable in that the costs of the epidemic have been defrayed onto a population that has very limited financial and social security. This is the situation broadly applicable in the industry and is the starting point for any consideration of where and how it might intervene constructively (SABCOHA, 2002).

The findings do not provide substantive reasons for companies themselves to support development of HIV/AIDS workplace programmes. Reports of managers during the study affirm the general view that most companies are motivated to provide HIV/AIDS services only when they see a negative financial effect on the business from AIDS or became aware of employees who were sick. A survey by Connelly and Rosen (2004) as well as those of SABCOHA (2002), Global Business Coalition on HIV/AIDS (2006) and George (2003) reveal little appreciation in the private sector of the benefits of pro-active prevention, treatment, care and support interventions. The projected financial costs of future HIV infections in the workforce of the case study company provide the sums which, hypothetically, the company should invest annually in a reserve fund to cover the future costs to the company. Equally, these are sums that the company could invest in HIV prevention activities to reduce future costs but there is no means to predict the effectiveness of such an investment.

Irrespective of whether the assessment of the case study company is representative of the industry, there is

certainly no incentive for companies to support promotion of workplace ART programmes or even worker membership of medical aid schemes. The 2008 annual cost of a currently standard treatment regime for an AIDS patient, on the protocol recommended by the World Health Organisation, is R3,200 (1st line treatment) and R6,400 (2nd line treatment) (National Department of Health, 2008). These sums amount to 20-40% of the average cleaner's annual wages. To demand support from companies to cover these costs is unrealistic. Direct support would inevitably pose questions about why HIV/AIDS specifically and not other life-threatening and/or terminal diseases deserves investment. The cost of providing health insurance would be prohibitive for workers and increase substantively the overall labour costs for a company working in a context that is highly competitive and geared to reducing those costs. Contract cleaning companies exist because of efforts by their clients to reduce not only wages but the benefit costs of labour.

Nonetheless, the findings show that there is a need for intervention as the workforce is particularly vulnerable. HIV/AIDS is having an impact on the industry but the costs are largely hidden and they are mainly borne by the workers who are poorly paid and have minimal welfare assistance and health insurance.

The results and analysis presented here do not present a strong business case for firms to undertake amelioration activities around HIV/AIDS. However, there is a strong case for industry level initiatives especially with regards to managing HIV/AIDS in the workforces of small and medium sized businesses. To enable this, BCCCI, SABCOHA and the Services SETA should facilitate an industry wide plan to assist companies. This would involve at a minimum the development of policies and the design of programs on prevention (condom distribution, peer education) and linking with the government's national anti-retroviral treatment program to enable their AIDS ill workers to access treatment.

ACKNOWLEDGEMENTS

The authors would like to thank the owners, managers and workers at Company F without whom this study would not have been possible. The funding for this study was provided by The Global Fund for HIV/AIDS, TB and Malaria.

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