



## **Opportunities to Expand HIV/AIDS Services to Employees of Small and Medium-Sized Companies in Wynberg, South Africa**

April 7, 2005

Patrick Connelly\* and Sydney Rosen  
Research assistants: Kay Muller and Jeremy Ogusky

Center for International Health and Development  
Boston University School of Public Health  
85 East Concord St., 5th fl  
Boston, MA 02118 USA  
Tel. 1-617-414-1260

Health Economics Research Unit  
Wits Health Consortium  
Themba Lethu Clinic, Helen Joseph Hospital  
Perth Road, Westdene 2032, South Africa  
Tel. 27-11-276-8888

### **Acknowledgements**

The research team that carried out this study also included Mary Bachman and Alizanne Collier at the Center for International Health and Development at Boston University. Support for the study was provided by the South Africa Mission of the U.S. Agency for International Development through Cooperative Agreement No. 674-A-00-02-00018 to Right to Care. We thank the staff of Right to Care and the Rea'Phela Clinic for their assistance in conducting the study.

\*Correspondence to [pcon@bu.edu](mailto:pcon@bu.edu) or [sbrosen@bu.edu](mailto:sbrosen@bu.edu).

## **Contents**

Executive summary  
Acronyms used in the report

### **I. Introduction**

- a. Overview of the study
- b. Rationale for the study
- c. Objectives
- d. Methods

### **II. Results 1: Characteristics of companies and interest in HIV/AIDS services**

- a. Characteristics of the surveyed companies and workforces
- b. Employee benefits
- c. Workforce turnover and replacement costs
- d. HIV/AIDS services
  - i. Current service provision
  - ii. Why don't SMEs provide HIV/AIDS services?
  - iii. What would motivate employers to do more?

### **III. Results 2: Willingness to pay for primary health care and antiretroviral treatment**

- a. Primary health care scenario
  - i. Methods
  - ii. Results
- b. Antiretroviral treatment scenario
  - i. Methods
  - ii. Results

### **IV. Conclusions**

- a. Comparison with earlier findings
- b. Constraints on demand for HIV/AIDS services
- c. Interpreting the willingness to pay results
- d. Recommendations and opportunities
- e. Limitations of the study

## **References**

## **Tables**

1. Companies surveyed by size and sector
2. Bargaining council and business association membership
3. Profile of workforces of surveyed companies
4. Direct costs for recruiting and training new employees
5. HIV/AIDS-related services provided by SMEs
6. Sources of information about HIV/AIDS information
7. Respondents' rankings of major business concerns
8. What would motivate SMEs to provide HIV/AIDS services?
9. Level of interest of SME managers in obtaining specific services
10. Stated WTP for PHC services
11. Primary reason for respondents willingness to pay for primary health care services
12. Primary reason for not being willing to pay for primary health care services
13. Stated WTP for ART
14. Primary reasons for not being willing to pay for ART
15. Summary of responses to WTP scenarios
16. Differences between Wynberg and previous SME survey results

## **Appendices (Available from Authors or Website)**

1. Letter to solicit interviews with prospective companies
2. Questionnaire
3. Informational handout for surveyed companies of HIV/AIDS services offered by NGO and government facilities
4. Informational card used in willingness to pay scenarios

Note: appendices are not attached to this report but can be downloaded from [http://www.bu.edu/dbin/sph/research\\_centers/cih\\_impact\\_hiv.php](http://www.bu.edu/dbin/sph/research_centers/cih_impact_hiv.php).

## **Executive Summary**

### **Introduction**

While a growing number of large companies in South Africa are now providing HIV/AIDS-related services to their employees, very few small or medium-sized enterprises are doing so. Those concerned with broadening civil society's role in combating the HIV/AIDS epidemic have sought ways to motivate and facilitate smaller businesses to take action, but with little success.

SMEs face significant obstacles in providing HIV/AIDS services to employees. In 2003, we conducted a survey of a random sample of SMEs in Gauteng and KwaZulu Natal to begin to identify and understand these obstacles (Connelly and Rosen 2005). That study noted six major barriers to action on the part of SMEs: 1) lack of information about HIV/AIDS services; 2) lack of access to these services; 3) little perception of costs or damages being imposed by AIDS, leading to low willingness-to-pay for services; 4) stigma among employees, who were not requesting HIV-related programmes or benefits; 5) lack of external pressure from labour unions, shareholders, or advocacy groups; and 6) the relative weight of other problems facing the companies, making HIV/AIDS a low business priority (Connelly and Rosen, 2005). We also found that the vast majority of AIDS-related attrition occurs among easily replaceable, non-critical, and/or unskilled employees. Because SMEs offer fewer benefits, have higher employee turnover, and employ fewer skilled workers than do large companies, they are less likely to capture the uncertain benefits of investments in HIV/AIDS programs than are large companies.

One implication of our earlier study was that geographically concentrated groups of SMEs, as are found in planned industrial areas throughout South Africa, might offer an opportunity to expand access to HIV/AIDS services by locating those services within the same geographic area as the SMEs. The study reported here investigated what the demand for services might be if companies were offered accessible and affordable services at a nearby clinic. Data were collected from small and medium-sized companies in Wynberg, an industrial area in Johannesburg, South Africa where a not-for-profit HIV/AIDS treatment clinic has also been established. The study aimed to answer three research questions:

- What is the level of concern about HIV/AIDS among managers of SMEs in an industrial area in Gauteng Province?
- What is the potential demand and willingness of SMEs in an industrial area to pay for obtaining primary health care services and HIV/AIDS treatment services for employees?
- How can a not-for-profit clinic situated in an industrial area effectively market HIV/AIDS services to SMEs?

Interviews were conducted with managers of 34 SMEs from a roster of 100 Wynberg companies with between 20 and 200 employees. Approximately half the 100 companies refused to participate; of these, 16 said they did not have time to be interviewed, and 33 either declined to give a reason or stated that they were not interested. Interviews with 17 companies could not be arranged within the study period, leaving a final sample of 34. Most of the participating companies were in the manufacturing or wholesale/retail sectors. The sample was almost evenly divided between small (20-50 employees) and medium-sized (50-200 employees) companies; the majority of employees at these companies were male (71 percent) and skilled (59 percent).

## Findings

### *The impact of HIV/AIDS on Wynberg SMEs and their responses to the epidemic*

- The majority (88 percent) of companies surveyed provide retirement benefits (pension or provident fund) for some workers, and 71 percent provide these benefits for all permanent employees. Although 82 percent of the companies subsidize the cost of medical aid scheme membership for some or all of their permanent employees, we estimated that only 30 percent of all employees of the surveyed companies are medical aid beneficiaries. Membership is largely limited to managers and highly skilled workers. Most employees not covered by medical aid utilise government facilities, while only a few use private facilities.
- At this stage of the epidemic, the impact of HIV/AIDS on Wynberg companies is modest.
  - Attrition due to AIDS is low. AIDS accounted for less than 10 percent of employee attrition over the year preceding the survey. Although managers in 53 percent of the companies believed they had lost at least one employee to AIDS in the last two years, a very small proportion of these employees were considered critical to the businesses.
  - Companies incur few direct or indirect costs to replace employees lost to AIDS. About half of the respondents reported that they incur no direct costs to recruit or train new workers of any type, and more than three quarters incur no direct costs to recruit or train new unskilled employees. Indirect costs for replacing employees lost to AIDS were also modest. Positions for new, skilled workers were vacant for a median of 10 days, and new skilled workers were reported to be fully productive within 30 days. Unskilled positions were vacant for just one day, on average, and new workers were considered fully productive in less than two weeks.
  - Employee absenteeism has increased somewhat over the past year. Twelve percent of the surveyed SMEs reported a large increase in sick leave, 24 percent a marginal increase, and the rest no change. Similarly, 9 percent noted a large increase in compassionate leave and 38 percent a marginal increase. How much HIV/AIDS has contributed to this trend is uncertain, however.
- Managers' level of concern about the epidemic is low overall. None of the respondents believe the epidemic is currently having large impact on their business and only a small minority (18 percent) predict a large impact on their company in the future. When compared with other business concerns, managers ranked HIV/AIDS 9th in importance out of 10. The greatest business concern was worker productivity, suggesting that the potential connection between worker productivity and HIV/AIDS is not appreciated. Only about a quarter of respondents said that HIV/AIDS has ever been discussed as a business issue within their management teams.
- Just under half (47 percent) of the companies surveyed provide some HIV/AIDS-related services to employees. Services were usually limited to HIV/AIDS education and awareness sessions, provision of condoms, or adoption of a workplace policy, however. Three quarters of the companies providing services incurred few or no direct costs to implement these services.

- Respondents whose companies do not provide services were asked what factor(s) would motivate the business to provide HIV/AIDS services. Most businesses stated they would only be motivated to take action if the company lost employees to AIDS or was visibly affected by HIV/AIDS. These businesses were most interested in facilitating education and awareness programmes and least interested in paying for treatment of HIV/AIDS. Activities requiring the least administrative effort on the part of the employer were of greatest interest.

#### *Willingness of Wynberg SMEs to pay for primary healthcare services and AIDS treatment*

In a separate component of the survey, we asked respondents about their companies' potential willingness to pay (WTP) for specific packages of healthcare services for employees. Of the 34 companies participating in the broader survey, 27 agreed to consider the two different scenarios described below. Seven did not participate, primarily because the respondent stated that he or she was not a key decision maker and could not accurately present the company's views. Two hypothetical scenarios were presented.

- Under the first scenario, primary health care services would be offered by a non-profit clinic in Wynberg. Services would be available for all workers for a fixed cost per employee per month. Of the companies considering the scenario, 41 percent were willing to pay between R30 and R100 per employee per month to provide primary care to their workforce. Companies that were willing to pay saw the service as a way to reduce indirect costs of illness among employees and to provide additional benefits for workers. Companies that were not willing to pay for primary health care indicated that their workers already had access to employer-sponsored health care (mainly medical aid).
- The second scenario presented respondents with a hypothetical non-profit clinic situated in Wynberg offering antiretroviral therapy (ART) to treat HIV/AIDS. Respondents were asked to give their opinion on their company's willingness to establish a relationship with the clinic and to agree to pay for ART (including all associated services) for permanent employees with AIDS. The financing mechanism for the scenario protected individual employees' confidentiality and charged employers only for employees who actually used the service. Of the companies considering the scenario, 26 percent were willing to pay between R200 and R1000 per employee on treatment per month. All but one respondent cited compassion as the primary reason for willingness to cover this cost. The most common reason mentioned by the companies not willing to pay was that they considered the cost to be too high.

#### **Discussion**

Overall, our results in Wynberg were similar to those of our previous survey of SMEs in Gauteng and KZN (Connelly and Rosen, 2005). Few SMEs in either study provided, or wanted to provide, and HIV/AIDS-related services to employees. We identified several specific constraints to expanding employer-sponsored HIV programs in Wynberg.

1. Even more than cost, the lack of administrative or labour capacity was seen as the greatest constraint by businesses that do not offer HIV/AIDS services. Managers will not or cannot invest time in identifying, selecting, and implementing HIV/AIDS programmes.

2. Information about HIV/AIDS is scarce. Few of the companies not providing HIV/AIDS services know where to go to seek information or contract services. Companies had little understanding of which services are appropriate for them, nor did they appreciate the potential benefits of implementing a workplace programme.
3. AIDS is not regarded as an immediate threat to respondents' businesses, and few think it will become so in the future. It accounts for relatively little employee attrition or absenteeism, and the costs of replacing employees lost to AIDS is modest. It ranks low on the list of business concerns facing SMEs.
4. SMEs do not have a tradition of providing healthcare for employees and have no leverage over benefits premiums. Existing employee benefits are largely mandated by bargaining council agreements.

Companies in the survey expressed some willingness to pay for primary health care for employees, and for the reasons one might expect: reduction in indirect costs of ill health and the opportunity to improve health benefits at low cost. Interest in ART provision was more limited and was due almost entirely to compassion. Cost was viewed as the main objection to expanding ART access, even at the low end of our price range (R200/treated employee/month).

Although there are serious constraints to expanding the demand for HIV/AIDS services among SMEs in Wynberg, we believe there are also opportunities. Despite the current lack of interest, better information about the impact of HIV/AIDS and the options for service delivery may influence some managers. Information like the recent report by Anglo American that workers receiving ART are returning to work and are productive need to be disseminated. The costs and benefits of preventing HIV and of paying for private sector or NGO sector treatment services, rather than leaving HIV-employees to wait in public sector treatment queues, need to be communicated to managers in order for companies to be motivated for reasons of business, rather than simply compassion. A set of specific recommendations for the Rea'phela Clinic in Wynberg can be found in the full report.

### **Acronyms Used in the Report**

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral (Medication)
CIHD	Center for International Health and Development at Boston University
HERU	Health Economics Research Unit at the Wits Health Consortium
HIV	Human Immunodeficiency Virus
GP	General Practitioner
PHC	Primary Health Care
SME	Small and Medium Sized Enterprise
VCT	Voluntary Counseling and Testing
WTP	Willingness to Pay

## **I. Introduction**

### **a. Overview of the Study**

This study describes how small and medium enterprises<sup>1</sup> (SMEs) in Wynberg, an industrial neighbourhood in Johannesburg, South Africa, have been affected by HIV/AIDS and how they have responded to the epidemic. The study also investigates how a non-profit clinic based in this area designed to assist smaller businesses expand their offering of HIV/AIDS services to their employees can most effectively offer HIV/AIDS treatment services to employees at these companies. The Center for International Health and Development at Boston University (CIHD) and the Health Economics Research Unit of the University of the Witwatersrand (HERU) conducted the interviews with SME managers in person between August and December 2004.

Questionnaires were divided into two parts. First, we collected data on employee demographics, existing benefits and experience with HIV/AIDS to serve as a basis for recommendations for some effective ways to promote HIV/AIDS services to SMEs. The second component assessed the potential demand and willingness of SMEs to pay for primary health care services (PHC) and antiretroviral treatment (ART) for employees with AIDS.

The questionnaire responses were intended to provide a gauge of current demand for HIV/AIDS-related services among Wynberg SMEs, identify ways to expand demand, and assist the non-profit clinic to tailor and target its services more effectively. This report presents and analyzes the detailed findings of the survey and offers a set of recommendations for the clinic. We also believe local and national government agencies and international donors will benefit from these findings in order to better target programmes and financial assistance.

### **b. Rationale for the Study**

While a growing number of large companies in South Africa are now providing HIV/AIDS-related services to their employees, few small or medium-sized enterprises are doing so.<sup>2</sup> Those concerned with broadening civil society's role in combating the HIV/AIDS epidemic have sought ways to motivate and facilitate smaller businesses to take action, but with little success. SMEs face significant obstacles in providing HIV/AIDS services to employees. In 2003, we conducted a survey of a random sample of SMEs in Gauteng and KwaZulu Natal to begin to identify and understand these obstacles (Connelly and Rosen 2005). That study noted six major barriers to action on the part of SMEs:

- i. Lack of information about HIV/AIDS services
- ii. Lack of access to these services
- iii. Little perception of costs or damages being imposed by AIDS, leading to low willingness-to-pay for services
- iv. Stigma among employees, who were not requesting HIV-related programmes or benefits

---

<sup>1</sup> Throughout this paper, SMEs will be defined according to the National Small Business Act of 1996 definition (micro 0-4, very small 5-19, small 20-49, and medium 50-200)

<sup>2</sup> A recent survey conducted by the Bureau for Economic Research (BER) found that among companies with fewer than 100 employees, 11 per cent offer VCT and 3 per cent offer ART, compared with 61 per cent and 25 per cent, respectively, for companies with more than 500 employees (Ellis and Terwin, 2004).

- v. Lack of external pressure from labour unions, shareholders, or advocacy groups
- vi. Relative weight of other problems facing the companies, making HIV/AIDS a low business priority. (Connelly and Rosen, 2005).

We also found that the vast majority of AIDS-related attrition occurs among easily replaceable, non-critical, and/or unskilled employees. Because SMEs offer fewer benefits, have higher employee turnover, and employ fewer skilled workers than do large companies, they are less likely to capture the uncertain benefits of investments in HIV/AIDS programs than are large companies. As a result, “SME managers thus lack an understanding of both the potential benefits of taking action and the costs of not acting. Taken together, these factors result in an overall willingness-to-pay for HIV/AIDS services among South African SMEs that appears to be far below the price of those services.” (Connelly and Rosen 2005)

One implication of our earlier study was that geographically concentrated groups of SMEs, as are found in planned industrial areas throughout South Africa, might offer the potential to expand access to HIV/AIDS services by locating those services within the same geographic area. An opportunity to explore this hypothesis further arose in 2004 through a partnership between the Center for International Health and Development at Boston University and Right to Care, a South African not-for-profit AIDS treatment provider. In 2003, Right to Care established the Rea’phela Clinic in Wynberg, an industrial area between Johannesburg and Alexandra in Gauteng Province. The clinic, funded by the U.S. Agency for International Development, aims to offer HIV/AIDS treatment to employees of Wynberg area businesses and employees’ families. The survey reported here aimed to help the Rea’phela Clinic understand its potential client base (SMEs in Wynberg) and to deepen our understanding of SME demand for HIV/AIDS services and the potential for expansion of services.

### **c. Objectives**

The objectives of the study were to answer three research questions that arose from the CIHD’s prior research on SMEs:

- What is the level of concern about HIV/AIDS among managers of SMEs in an industrial area in Gauteng Province?
- What is the potential demand and willingness of SMEs in an industrial area to pay for obtaining primary health care services and HIV/AIDS treatment services for employees?
- How can a not-for-profit clinic situated in an industrial area effectively market HIV/AIDS services to SMEs?

### **d. Methods**

#### *Study site and sample selection*

Wynberg is a planned industrial area approximately 15 km north east from the center of Johannesburg. It is adjacent on one side to Sandton, a wealthy business and residential suburb, and on the other side to Alexandra, a former black township. There are no data on HIV prevalence in Wynberg or among the people employed there. The most recent antenatal clinic survey for which results have been released reported that 29.6 percent of antenatal clinic attendees tested positive for HIV in 2003 (Makubalo et al, 2004). The Nelson Mandela HSRC study of HIV/AIDS released in 2002 found 20.3 percent of all adults sampled in Gauteng were HIV positive (Shisana et al, 2002).

An initial roster of SMEs in Wynberg was obtained from Matrix Marketing, a private database consulting company. Criteria for inclusion on the roster were location (Wynberg) and workforce size (20-200 employees). The initial roster contained 131 companies of which 100 companies were located in Wynberg, were still operating, and were of the desired size. To test the completeness of the list provided by Matrix, we conducted a partial street census of a section of Wynberg. From this exercise, we estimated that the list provided by Matrix included roughly 86 percent of companies in the area. We thus estimated that a total of 116 SMEs with 20-200 employees were operating in Wynberg at the time of the study.

Upon contacting the companies, we first inquired which manager would best be able to answer questions about the company's human resources. A letter was then faxed to that individual describing the research and requesting an on-site interview. A follow-up phone call was made to arrange the interview. From the revised roster of 100 companies, interviews were completed with 34 in November and December 2004. Nearly half the companies refused to participate; of these, 16 said they did not have time to be interviewed, and 33 either declined to give a reason or stated that they were not interested. Interviews with 17 companies could not be arranged within the study period.

The survey instrument included sections on business characteristics, workforce characteristics and turnover, employee benefits, and HIV/AIDS issues. Workforce characteristics were included to determine if benefit level and response to HIV/AIDS differs with employee skills and demographics. Questions on benefits were designed to determine current resources invested in employees to see if it is likely employers would add additional benefits. HIV/AIDS related questions were designed to determine company experience, perception, and response to HIV/AIDS epidemic.

A separate set of questions asked managers about their willingness to pay (WTP) for primary health care and for antiretroviral therapy for employees. Prior research by CIHD indicated a strong correlation between companies providing health benefits and those providing HIV/AIDS services. WTP questions were intended to gauge the overall demand for not only PHC but also indicate further interest in HIV/AIDS services.

Roughly 40 percent of interview respondents were directors or owners of the companies and about a third were human resource managers. The remainder were financial directors, managers or administrative personnel.

## **II. Results 1: Characteristics of Companies and Interest in HIV/AIDS Services**

### **a. Characteristics of the Surveyed Companies and Workforces**

Wynberg businesses consist mostly of manufacturing and wholesale/retail companies. We interviewed 19 manufacturing, 13 wholesale/retail, and 2 financial companies.

**Table 1: Companies surveyed by size and sector**

Sector	Small (20-49 employees)			Medium (50-200 employees)		
	# interviewed	% of companies surveyed	% of companies in population	# interviewed	% of companies surveyed	% of companies in population
Construction (0)	0	NA	3%	0	NA	4%
Financial Services (2)	2	6%	2%	0	0%	2%
Manufacturing (19)	6	18%	24%	13	38%	20%
Transportation (0)	0	NA	0%	0	NA	1%
Wholesale/Retail (13)	7	21%	32%	6	18%	12%
Total (34)	15	44%	61%	19	56%	39%

More than half (56 percent) of the companies interviewed belong to business associations, primarily bargaining councils. Businesses operating in certain sectors must belong to the industry bargaining council and adhere to bargaining council agreements. Most of these agreements require companies to subsidise retirement benefits and a few even require health benefits.

**Table 2: Bargaining council and business association membership**

Association	# of surveyed companies belonging
Metal And Engineering Bargaining Council	4
Retail Motor Industry Association	4
Motor Industry Bargaining Council	2
Furniture Manufacturing Industry Bargaining Council	3
Johannesburg Chamber of Commerce And Industry	3
Printing Industry Federation Of SA	1
Contractors Plant Hire Association	1
Entertainment Industry Bargaining Council	1
South African Security Building Association (SASBA)	1
Steel and Engineering Industries Federation of SA (SEIFSA)	1
Total	19

Of the companies surveyed, 21 have union representation and 13 do not. Fifteen have more than 50 percent of employees as members of unions. This represents a high level of union membership which is likely because of the many manufacturing firms and the presence of bargaining councils.

The 34 companies surveyed had a total of 2,697 permanent employees and roughly 250 casual, contract, or part time workers. The composition of the permanent workforces by job level, age, and sex is summarized in Table 3. The average number of permanent employees was 79 and the median 53. Most employees were male (71 percent) and skilled (59 percent). Nearly half (47 percent) of all employees were skilled or unskilled black African males. Most (89 percent) managers were white, Asian, or coloured males.

**Table 3: Profile of workforces of surveyed companies**

Job level	Males			Females			Total
	<35	>35	Total	<35	>35	Total	
Managers	3%	5%	9%	0%	1%	1%	10%
Skilled	17%	21%	38%	9%	13%	22%	59%
Unskilled	13%	11%	24%	3%	4%	7%	31%
Total	33%	38%	71%	12%	17%	29%	100%

Only permanent workers were included in the analysis because the number of contract and casual workers fluctuated greatly and because few non-permanent workers receive any employee benefits. The possibility of these workers obtaining access to specialised HIV/AIDS services from their employer was therefore considered remote. The relatively small number of non-permanent workers, compared to permanent employees, is explained largely by the predominance of manufacturing and wholesale/retail companies in our survey. Companies in both of these sectors are less reliant on casual labour than are companies in construction, agriculture, and some other sectors.

## **b. Employee Benefits**

The vast majority (88 percent) of companies in the sample provided retirement benefits (pension or provident fund) for some workers, and 71 percent provided these benefits for all permanent skilled and unskilled employees. Unskilled workers were as likely to receive retirement benefits as skilled workers. The average overall premium for the retirement funds was 12 percent of base salary, and employers typically contributed 50 percent of the premium.

Part of the reason for the high level of coverage for retirement benefits is bargaining council regulations. Almost a third of the companies in our survey were bound by bargaining councils agreements, which require firms in certain industries to provide specific employee benefits as agreed to by unions and employer representative groups.<sup>3</sup>

For healthcare benefits, 79 percent of companies offered medical aid membership to at least some workers, though for the most part only managers and highly skilled workers chose to join. Sixty-five percent of companies subsidised medical aids for more than 90 percent of their managers, whereas only 32 percent did so for nearly all skilled employees. Only 21 percent of companies subsidised medical aids for nearly all unskilled employees. Of all the employees at surveyed companies, we estimate 30 percent are medical aid beneficiaries.

Two of the companies surveyed offered on- or off-site health facilities for workers not on medical schemes. According to their managers, employees who do not belong to company-sponsored medical aid schemes typically obtain healthcare at public sector facilities, though some also go to private clinics or GPs or traditional healers.

All companies in South Africa are required to offer full time employees 36 days of paid sick leave over 3 three years and 3 days per year of paid compassionate leave. Over the last year, 24 percent of SMEs reported a small increase in sick leave; 12 percent reported a large increase and the rest no increase at all. For compassionate leave, 38 percent noted a small increase and 9 percent noted a large increase. How much HIV/AIDS has contributed to the observed increases is uncertain, however.

---

<sup>3</sup> Bargaining councils, formed by the Labour Relations Act, allow for collective bargaining forums and agreements between employer organisations and trade unions of particular industries and are able to make binding agreements between all members of the councils and others that fall under their jurisdiction.

**c. Workforce Turnover and Replacement Costs**

Average attrition for any reason in the surveyed companies averaged 9.3 percent over the 12 months preceding the survey. Attrition due to natural cause deaths or medical retirement averaged 0.94 percent over the same period. Reported AIDS-related attrition averaged 0.78 percent over the last two years.<sup>4</sup> Across the entire sample, therefore, HIV/AIDS accounted for less than 10 percent of recent employee turnover. HIV/AIDS was the perceived reason for 83 percent of attrition due to medical retirement or death, however.

Managers in 53 percent of the companies believed they had lost at least one employee to AIDS in the last two years. Among all employees of the SMEs surveyed (n=2,697), 40 individuals, or about 1.5 percent, were reported to have died or left the workforce due to AIDS in the last two years.

Previous research on SMEs in South Africa found that attrition due to AIDS differed by skill level, with unskilled workers much more likely to leave the workforce due to AIDS than skilled workers or managers. In this study, managers were first asked to identify critical workers at their companies. Critical workers were defined as workers who are not easily replaced and whose loss would have a significant impact on the business. Most respondents identified managers or managers and specific types of skilled workers as critical. Only two of the 40 workers reportedly lost to AIDS in the past two years were regarded as critical.

Although respondents at more than half of the companies believed they had lost employees to AIDS in the last two years, only 35 percent believed that they currently had any HIV-positive employees in their workforce at the time of the survey. Given the high HIV prevalence in Gauteng’s adult population, from which the surveyed companies draw their employees, this suggests that managers are either confused about the relationship between HIV infection and AIDS sickness or have a fundamental misunderstanding about the extent of the HIV/AIDS epidemic in their area.<sup>5</sup>

The cost to the surveyed SMEs of replacing employees is modest. There is some difference in direct costs a company incurs to replace skilled and unskilled employees, however, as shown in Table 4.

**Table 4: Direct costs for recruiting and training new employees**

Type of cost	Proportions of companies reporting that they incur <i>no costs</i> for	
	Skilled workers	Unskilled workers
Recruiting	44%	88%
Training	62%	79%

Indirect costs of replacing employees were also modest, especially for unskilled workers.<sup>6</sup> Managers spent just under two days to hire a skilled worker, and for unskilled workers, a

<sup>4</sup> This estimate is based on respondents’ reports of cause of death or retirement. Since AIDS is rarely stated as the cause of death on death certificates, we assume that respondents used their own judgment in attributing specific employee deaths to AIDS. Our estimates of AIDS-related attrition should therefore be interpreted with caution. Although these numbers represent perceptions of the loss to AIDS, rather than actual losses, they are useful in understanding managers’ level of concern about HIV/AIDS.

<sup>5</sup> It is also possible that fewer new employees with HIV have been hired in recent years, simply as a result of the requirement that applicants be physically capable of performing the jobs they are seeking.

<sup>6</sup> The following number of days are median figures.

quarter of a day was needed. More than half the managers spent at least a day to train new skilled employees, whereas only 20 percent of managers spent any time training unskilled workers. Positions for new skilled workers were vacant for 10 days, and new skilled workers were reported to be fully productive within 30 days. Unskilled positions were vacant for just one day and new workers were considered fully productive in 7.5 days.

#### d. HIV/AIDS Services

##### i) Current service provision

Just under half (47 percent) of the companies surveyed provided some HIV/AIDS services to employees at the time of the survey. These services were usually limited to HIV/AIDS education and awareness (see Table 5). Twelve of the companies had incurred little or no cost to implement services. Only three (20 percent) of the small companies had provided any services and these were limited to HIV/AIDS education and awareness training.

**Table 5: HIV/AIDS-related services provided by SMEs (N=16)\***

Sector	Size	Workplace policy	Prevention education and awareness training	Condom distribution	On site VCT	Any cost incurred?
Financial Services	S		X			No
Manufacturing	S		X			Yes
Manufacturing	S		X			No
Manufacturing	M	X	X			No
Manufacturing	M		X	X	X	No
Manufacturing	M	X	X			No
Manufacturing	M		X	X	X	No
Manufacturing	M		X	X		Don't know
Manufacturing	M	X	X	X	X	No
Manufacturing	M	X	X			Yes
Manufacturing	M		X			Yes
Manufacturing	M		X			Yes
Manufacturing	M		X			No
Wholesale/ Retail	M		X			No
Wholesale/ Retail	M		X			Low
Wholesale/ Retail	M		X	X		Low

\*Does not include benefits that may be provided through medical schemes on an individual basis.

None of the surveyed companies had conducted an impact analysis or a prevalence survey or provided access to a call centre for employee wellness. None were specifically providing treatment for opportunistic infections associated with HIV/AIDS or home-based care, nor were any of the employers paying directly for antiretrovirals for vertical prevention of HIV or treatment of AIDS. However, 28 of 34 companies subsidised the cost of medical aid membership for at least some employees and those employees are eligible for ART through the schemes.<sup>7</sup>

<sup>7</sup> Medical scheme beneficiaries are less likely to be HIV positive. Old Mutual estimates 7.5 percent HIV prevalence among medical scheme beneficiaries in 2001 and the Centre for Actuarial Research estimated 3.5 percent prevalence in 2003. These figures represent 66 percent and 30 percent of the national averages.

ii) *Why don't SMEs provide HIV/AIDS services?*

The survey suggested four main reasons for the low level of HIV/AIDS service provision by the companies.

- *Lack of information.* The survey elicited what knowledge SMEs have of HIV/AIDS information sources and of contracting services. Thirty-five percent of all surveyed companies responded they have sought HIV/AIDS information from a variety of sources, but that there was no obvious source of information for SMEs.

**Table 6: Sources of information about HIV/AIDS information**

Source	# using
SETAs	3
Current suppliers	3
Labour consultant	2
Affiliated companies	2
Seminars	1
Industry association	1
Total number that had sought information	12

Seven of the sixteen companies not offering services stated that they know where to go for HIV/AIDS-related information, while only three said they knew where to go to contract HIV/AIDS services. The National Department of Health's AIDS Helpline, the Internet, and government health care facilities were most often mentioned as sources of information.<sup>8</sup>

One reason many SMEs lack of knowledge of HIV/AIDS information and services is the lack of interest in SMES among HIV/AIDS service suppliers. Solicitation of SMEs by healthcare and HIV/AIDS service providers happens infrequently, if at all. While large companies experience frequent solicitation by providers for general health services and HIV/AIDS services, SMEs in our sample did not. Only 14 of the 34 companies reported receiving solicitations from health care providers, and only 2 companies reported receiving solicitations from HIV/AIDS service providers.

- *Lack of external pressure to provide services.* Many large and multinational companies in South Africa have been motivated to provide HIV/AIDS services and antiretroviral therapy to employees because of external pressures from shareholders, activists, and unions. Of the SMEs surveyed, none of the companies felt pressured to provide HIV/AIDS services.
- *Lack of concern about the impact of HIV/AIDS.* None of the managers interviewed believe that the epidemic is currently having a large impact on their business. Fifteen percent reported a moderate impact and 85 percent reported little or no impact. A small minority, 18 percent, believe that HIV/AIDS will have a large impact on the company in the future. Of the remaining SMEs, 32 percent expect a moderate future impact, and 29

<sup>8</sup>At the end of the survey, we asked SMEs if they were aware of the non-profit Rea'Phela Clinic operated by Right to Care in Wynberg. Only two had knowledge of the clinic, which officially opened in March 2004, seven months prior to the survey.

percent little or no future impact. Respondents at 21 percent of companies could not say. Consistent with this lack of concern, three quarters of respondents reported that HIV/AIDS had never been discussed as a business issue by management.

- *Relative unimportance of HIV/AIDS as a business issue.* To assess the relative importance managers assign to HIV/AIDS, compared to other problems facing their companies, respondents were given 10 cards showing typical business concerns and asked to order them from most serious (1) to least serious (10). Results are shown in Table 7.

**Table 7: Respondents’ rankings of major business concerns**

<b>Business concern</b>	<b>Rank*</b>	<b>Average score (out of 10)</b>
Productivity of workers	1	3.1
Demand for product	2	3.6
Cost of materials	4	3.9
Cost of labour	3	4.8
Regulations	5	5.6
Taxes	7	6.0
Shortage of skilled labour	8	6.0
Crime	6	6.7
<b>HIV/AIDS</b>	<b>9</b>	<b>6.9</b>
Availability of capital or financing	10	7.1

\* Results shown are the average rank of each concern.

HIV/AIDS ranked 9th out of 10. The possible connection between the issue of greatest concern, labour productivity, and HIV/AIDS, was not appreciated.

iii) *What would motivate employers to do more?*

When managers of companies not providing any HIV/AIDS services were asked an open ended question to explain what would motivate their company to provide HIV/AIDS services.<sup>9</sup> As Table 8 indicates, most managers will only be motivated to take action if their company is directly affected by HIV/AIDS.

**Table 8: What would motivate SMEs to provide HIV/AIDS services?**

<b>What would motivate your company to provide HIV/AIDS services to employees?</b>	<b>Number of managers offering response*</b>
If HIV/AIDS affected company	7
If employees had AIDS	2
If company had more capacity to offer services	2
If the benefit of the services was apparent	2
Nothing	2
If HIV/AIDS impacted productivity	1
If employees were interested in HIV/AIDS services	1
Improved social consciousness by company	1

\* n=18. Of 34 firms in sample, 16 were providing some services and were not asked this question.

After HIV/AIDS services were described in detail, interviewees were asked to rate on a scale of 1 to 5 which services they believed were the most needed at their business, realistic to

<sup>9</sup> Responses were subsequently categorised by researchers.

implement, and appropriate to offer given their situation. An education and awareness programme ranked first, followed by distributing condoms. Providing antiretrovirals for treatment of HIV/AIDS ranked last with treatment of opportunistic infections associated with HIV/AIDS. Activities with the least administrative effort and lowest cost ranked the highest.

**Table 9: Level of interest of SME managers in obtaining specific services**

Type of service	Number of 1 “no interest” responses (n=34)	Number of 5 “great interest” responses (n=34)	Average score (1-5) (n=34)
Education/awareness	13	2	2.05
Availability of condoms	13	2	1.81
Workplace policy	15	0	1.74
VCT	15	1	1.71
Impact analysis of HIV/AIDS on company	15	0	1.52
Call centre	15	1	1.43
Treatment of opportunistic infections	14	2	1.26
Antiretroviral therapy for treatment	14	2	1.26

### III. Results 2: Willingness to Pay for Primary Health Care and Antiretroviral Treatment

In addition to the questions about previous experience with HIV/AIDS, current employee benefits, and interest in obtaining HIV/AIDS-related services, we asked respondents about their companies' potential willingness to pay (WTP) for specific packages of healthcare services for employees.<sup>10</sup>

We started the WTP component of the questionnaire by asking the respondent whether he or she had the authority to make key financial decisions for the business. If the response was “no,” we asked if the respondent felt that he or she could comment accurately on behalf of the company with respect to what the company might be willing to pay for additional employee benefits. If this response was also negative, the WTP component of the questionnaire was omitted for that company.

Once we ascertained that the respondent was a key decision maker or could represent that person, we explained that the objective of this component of the study was to explore the notion that private sector employers should provide greater healthcare benefits to their employees and determine what businesses think about the matter. In order to avoid response bias, the interviewer explained he or she held no strong views on the subject and was merely investigating this proposition. We then presented two hypothetical scenarios: 1) primary health care services; and 2) antiretroviral treatment.

<sup>10</sup> There is a vast literature on contingent valuation and willingness to pay (WTP) for a wide range of environmental goods and an increasing body of literature about WTP for healthcare. Almost all of these studies, however, estimate WTP from the perspective of the individual. Asking small business owners about their potential WTP for hypothetical services, such as ART for employees, appears to be unusual, and little has been written about it. We are aware of only one other study that asked small business owners in Africa their willingness to pay for services not yet available, in that case for improved water connections in Uganda (Davis 2001). We therefore cannot compare our results to those of similar studies or speculate on the extent to which stated WTP will match real future behaviour.

## **a. Primary Health Care Scenario**

### *i. Methods*

In the first scenario, primary health care services, would be offered by a non-profit neighborhood clinic. Services would be available for all workers for a fixed cost per employee per month. In order to provide the respondent with relevant background information, we also reviewed common ways in which employees' health care services costs are currently financed. These include:

- Employees directly pay for private care from a local GP or private sector clinic (no employer contribution).
- Employees use the public health system, for which little or no payment is required (no employer contribution).
- Employer subsidises the employees' medical aid premium (50 percent is the standard employer contribution).
- Employer pays a set fee to a private sector clinic each month for each employee eligible for services.
- Employer reimburses a local GP or private sector clinic for actual costs whenever an employee receives services.

The hypothetical scenario was then presented of a nearby nonprofit clinic offering to supply the company's workers with primary health care services. The clinic would be located within the same industrial area as the respondent's company. The services included were described and further explanation of any of the items were offered.

- Access to basic medical treatment and medications.
- Treatment for sexually transmitted diseases.
- Access to HIV/AIDS information, education, and training.
- Voluntary HIV testing and counseling.

Interviewers provided an information sheet explaining potential benefits to an employer of paying for healthcare for employees. While this could have influenced their answers somewhat, it is common to provide interviewees in a WTP study with a substantial amount of background information. The potential benefits to the company for providing the services were presented as follows:

- Better health care for the employee.
- Reduced costs of absenteeism, overtime, and sick leave.
- Improved productivity and performance due to a reduction in illness.
- Reduction in the time required for employees to access care, which is time away from work.

To provide a frame of reference for respondents, we limited the prices the clinic could hypothetically charge the company to a range of between R20 and R120 per employee per month for PHC services (see Annex 3). The respondent was first asked whether the company would pay the starting point price of R70. The starting point price was then either increased or decreased iteratively to the bounds of the range, until the maximum the respondent believed the company would be willing to spend was found.

*ii. Results*

Of the 34 companies participating in the broader survey, 27 agreed to consider the “primary care” scenario. Seven declined to participate in the exercise for various reasons, primarily that the respondent could not comment accurately for the company.

Of the 27 companies that participated, 16 were not willing to pay any amount to provide primary health care to employees under the scenario presented. The other 11 were willing to pay between R30 and R100 per employee per month, as shown in Table 10.

**Table 10: Stated WTP for PHC services**

<b>Fee per employee per month</b>	<b>Number of responses</b>
R100	1
R90	0
R80	1
R70	0
R60	1
R50	4
R40	3
R30	1
<b>Total</b>	<b>11</b>

Respondents’ stated reasons for being willing to pay at least R30/employee/month for primary health care are shown in Table 11.

**Table 11: Primary reason for respondents’ willingness to pay for primary health care services**

<b>Reason</b>	<b># of responses</b>
PHC services can reduce indirect costs of employee ill health	4
Scenario presented is a way to offer a health care services to employees	4
Scenario presented is an affordable way to offer health care services	2
Could not say	1

Of the 16 companies not willing to pay any amount for PHC, 10 had no interest in services because the managers stated that all of their workers were beneficiaries of medical aids or the workers already had access to other employer-sponsored provided health care. The remaining 6 companies flatly rejected the scenario presented for a variety of reasons. Of those, two companies cited no interest in paying for health care without a co-payment by employees and two companies reported that their employees had no interest in health care services. The two other reasons mentioned by managers was that they see no need for health care benefits and they see no benefit to the company for adding primary health care services.

**Table 12: Primary reason for not being willing to pay for primary health care services**

<b>Reason</b>	<b>Number of responses</b>
Bargaining council or union medical scheme in place	3
All employees covered by medical aid	3
Company sponsored clinic services available	2
Employees will not want services	2
Company would provide only if employees contributed	2
Prefer to pay for HC services out-of-pocket	1
Manager does not see health care as a need for employees	1
Company's co-funding of medical aid is sufficient benefit	1
Manager does not see PHC as a benefit for company	1

## **b. Antiretroviral Treatment Scenario**

### *i. Methods*

After the questions regarding PHC services, we asked the interviewees to consider a second completely different and independent scenario concerning employer sponsored antiretroviral therapy (ART) for employees needing treatment for AIDS. Interviewees were presented with a hypothetical scenario of a nearby not-for-profit clinic offering ART and asked to give their opinion of the company's willingness to pay to obtain ART at the clinic for permanent employees with AIDS.

To provide relevant background information in order for respondents to make an informed assessment, we read the following statement about the status of the public sector's provision of antiretrovirals:

“You are probably aware of the fact that ART is being provided by the public health sector. Currently, the South African government facilities are treating about 8,000 patients out of approximately 400-500,000 HIV positive people who need treatment. Thus, people seeking treatment for AIDS face limited access and long waiting periods and multiple visits to facilities in order to enroll in the treatment programme. The government's current goal is to treat 53,000 people by March 2005.”

ART and its associated services and the potential benefits for the employer were then explained. ART included all associated services (GP visits, counselling, and lab costs). The potential benefits of ART to the company were presented to the interviewee on a card:

- A reduction of absenteeism and lost productivity
- Reduce labour turnover (retain your workers longer)
- Replacement costs avoided
- Improved labour relations and morale.

In addition, interviewers read:

“According to recent data, around 85 percent of workers with AIDS return to work productively after commencing ART (according to AngloGold, 85 percent of workers with AIDS return to work productively). They are likely to have around 5 more years of

productive working life, and possibly much more. The benefit for your business would be that the employee would likely return to work and be productive and the business would not have to incur the direct and indirect cost of replacing that worker in terms of lost productivity, training and recruiting.”

The scenario presented a financing method whereby patient confidentiality was maintained. Employers would provide ID numbers to the clinic for all eligible employees. The company would be billed at the end of the month only for employees on treatment. There would be no costs incurred for the benefit being available but not utilized. The following was read to the employee.

“Under this scenario, you would issue the clinic with a list of all your employees and their ID numbers. The clinic would provide treatment to any listed employee that sought treatment. You would be billed for each employee receiving treatment on a monthly basis. To retain confidentiality, you, the employer, would not know which employee was receiving treatment. Finally, you will not pay unless services are delivered.”

Respondents were asked to consider what the maximum average cost per month per employee on ART their company would be prepared to pay. In order to provide a frame of reference for respondents, a price range for each employee on treatment per month of R200-R1200 was presented on a card (see Annex 3). As in the PHC scenario, the respondent was asked whether the company would pay a particular amount determined by the study team to be the starting point, in this case R700. If the starting point bid was accepted, the interviewer then proposed the upper bound price of R1200; if not, the lower bound price of R200 was proposed. Depending on the response, the proposed price was then either increased or decreased iteratively until we reached the maximum the respondent believed the company would be willing to spend.

*ii. Results*

Of the 34 companies participating in the broader survey, 27 agreed to consider the ART scenario. Among those that did, 20 (74 percent) were not willing to pay any amount to provide ART to employees, while 7 (26 percent) were willing to pay between R200 and R1000 per employee on ART per month, as shown in Table 13.

**Table 13: Stated WTP for ART**

<b>Average fee per employee on ART per month</b>	<b>Number of responses</b>
R1000	1
R800	1
R700	0
R600	0
R500	1
R400	0
R300	2
R200	2
<b>Total</b>	<b>7</b>

All but one company cited compassion as its primary reason for being willing to cover this cost. Among the companies not willing to pay (WTP=0), about a third (35 percent)

considered even the lowest proposed cost as too high. The next most commonly cited reasons were that the manager did not consider HIV/AIDS as a problem for the business (18 percent) and that the manager wanted to decide on a case-by-case basis which employees should receive the benefit (18 percent). Companies that currently provided other HIV/AIDS services or that had lost workers to HIV/AIDS were more likely to indicate a willingness to pay for ART, but this was not a significant finding.

**Table 14: Primary reasons for not being willing to pay for ART**

Reason	Number of responses
Too expensive (minimum price R200)	6
No problem with HIV/AIDS at business	3
Want to decide on a case by case basis	3
Already provided by medical aid	1
Would provide through company clinic	1
Employee's problem	1
Not interested	1
Easy to replace employees	1
High turnover of employees	1
Depends on how many employees needed services	1
No reason given	1

Table 15 summarizes the responses to both WTP scenarios.

**Table 15: Summary of responses to WTP scenarios**

Scenario	Number not willing to consider the scenario	Number not willing to pay any amount for the service (WTP=0)	Number willing to pay some amount for the service (WTP>0)
Primary health care	7	16	11
Antiretroviral treatment	7	20	7

#### IV. Conclusions

##### a. Comparison with Earlier Findings

Overall, our results in Wynberg were similar to those of our previous survey of SMEs in Gauteng and KZN (Connelly and Rosen, 2005).<sup>11</sup> Few SMEs in either study provided, or wanted to provide, and HIV/AIDS-related services to employees. In both cases, the main reasons appeared to be the same.

- AIDS is not a major reason for employee attrition. Of the workers suspected of leaving the workforce due to AIDS, moreover, most have been unskilled and not considered critical to operations.
- The direct and indirect costs of losing and replacing employees are modest for most SMEs, especially for unskilled workers.

<sup>11</sup> A report on the earlier survey can be downloaded from [http://www.bu.edu/dbin/sph/research\\_centers/cih\\_impact\\_hiv.php](http://www.bu.edu/dbin/sph/research_centers/cih_impact_hiv.php).

- Managers do not perceive HIV/AIDS as a serious risk to their businesses. From a list of 10 potential business concerns presented to managers, AIDS ranked 9<sup>th</sup> in importance out of 10 possible concerns in both surveys.
- SMEs do not face external pressure from unions, shareholders, or others to offer HIV/AIDS services.
- SMEs are less able to make informed decisions because few are aware of what services are offered and the potential benefits of these services.
- SMEs are rarely solicited by health care or HIV/AIDS service providers.
- Most managers would be motivated to provide HIV/AIDS services only if they saw a negative impact on the business from AIDS or became aware of employees who were sick.

There were two important differences between the surveys, however, with regard to employee benefits and HIV/AIDS services provided, as described in Table 16.

**Table 16: Differences between Wynberg and previous SME survey results**

Difference	Previous survey	Wynberg survey	Comments
Proportion of companies providing retirement benefits (pension or provident fund)...			This difference can be attributed mainly to the high proportion of manufacturing companies in the Wynberg survey. These companies are more likely to be unionized and fall under an industry-based regulatory body, like a bargaining council, than are companies in other sectors.
...to at least some employees	70%	88%	
...to all employees	48%	75%	
Proportion of companies providing some HIV/AIDS-related services	24%	47%	For most firms in both surveys, “services” consisted only of HIV/AIDS education and awareness training, provision of condoms, and/or adoption of an HIV/AIDS workplace policy, and just a few incurred any cost, even for these relatively low-effort activities.

**b. Constraints on Demand for HIV/AIDS Services**

We identified a number of constraints that have and will inhibit small and medium-sized companies in Wynberg from offering HIV/AIDS services.

1. Even more than cost, the lack of administrative or labour capacity was seen as the greatest constraint by businesses that do not offer HIV/AIDS services. Managers will not or cannot invest time in identifying, selecting, and implementing HIV/AIDS programmes.
2. Information about HIV/AIDS is scarce. Few of the companies not providing HIV/AIDS services know where to go to seek information or contract services. Those that do state they would contact government facilities. The Gauteng DOH currently provides very little assistance aimed at businesses. Surveyed companies had little information about services that are appropriate for them to implement and also lack information to appreciate the potential benefits of implementing a workplace programme. Companies do not recognize the benefit of providing ART for their workers and see this additional employee benefit as too expensive.
3. AIDS is not regarded as an immediate threat. Without information and with few evident costs associated with AIDS, managers do not recognize AIDS as a threat to their businesses, and few think it will become so in the future. Although over half of the

companies surveyed reported losing workers to AIDS, it accounted for only a small share of overall attrition and almost no losses of critical workers.

4. SMEs do not have a tradition of providing healthcare for employees and have no leverage over benefits premiums. Only about a third of employees at surveyed companies had access to medical aid coverage. Most employees relied on government facilities for healthcare. Not surprisingly, none of the companies surveyed self-financed their retirement or risk benefits or maintained a closed medical aid scheme, as some large companies do. Their only strategy for controlling benefits premiums is therefore to reduce the level of benefits provided. Since SMEs are not individually risk rated, moreover, the financial incentives offered to large companies by the life assurance industry for providing comprehensive workplace HIV/AIDS programmes, including antiretroviral therapy, are not available to them.
5. Existing employee benefits are largely mandated by bargaining council agreements. This may reduce interest by companies in paying for additional employee benefits, especially health benefits. Survey respondents expressed displeasure with bargaining council and union-based medical schemes because they consider them inadequate, but individually, the companies have no power to change them.

### **c. Interpreting the Willingness to Pay Results**

The WTP component of the research was exploratory and intended only to provide some indication of the price SMEs in Wynberg would be willing to pay for primary health care and antiretroviral therapy for employees. An employer's WTP for the health of his or her employees should reflect the value he or she places on maintaining a healthy and productive workforce. This would be a function, in turn, of the perceived impact of ill health and HIV/AIDS on workforce or firm productivity, now and in the future. Some other factors that may influence willingness to pay are profitability of the firm (reflecting the ability to pay) and the manager's or owner's personal opinion about how much responsibility an employer has for employee welfare. WTP may also incorporate a broader sense of the value of an individual worker's life or the "social conscience" of the employer.

Of 27 companies that considered the primary health care scenario, 11 (40 percent) were willing to pay at least R20/employee/month for this service, and some would pay considerably more. There is some encouraging news to be found in the relatively favourable response to the primary health care scenario for two reasons. First, most of the companies not willing to pay for primary health care stated health care benefits were already in place. Second, companies were interested in PHC for the strategic business reasons: reduction in the indirect costs of ill health and a good way to expand employee benefits.

It is harder to find encouragement in the ART scenario. Even presented with an accessible and affordable HIV/AIDS treatment package, three quarters of SMEs were not willing to pay any amount for ART for their employees. Even at the lower bound of our price range—R200/treated employee/month—cost was the primary obstacle. Others did not regard HIV/AIDS as a problem for their business. A few companies were willing to provide ART to employees only on a cases by case basis, thus rejecting the individual worker's right to confidentiality. Among those who stated a positive willingness to pay for ART, all but one cited compassion as the motivating reason to offer the additional benefit. The respondents thus seemed to regard HIV/AIDS as a social issue, not a business issue.

#### **d. Recommendations and Opportunities**

Although there are serious constraints to expanding the demand for HIV/AIDS services among SMEs in Wynberg, we believe there are also opportunities. Despite the current lack of interest, better information about the impact of HIV/AIDS and the options for service delivery may influence some managers. Information like the recent report by Anglo American that workers receiving ART are returning to work and are productive need to be disseminated. The costs and benefits of preventing HIV and of paying for private sector or NGO sector treatment services, rather than leaving HIV-employees to wait in public sector treatment queues, need to be communicated to managers in order for companies to be motivated for reasons of business, rather than simply compassion.

It is also apparent that HIV/AIDS-related morbidity and mortality, and the resulting costs, absenteeism, and attrition among employees, have not yet hit Wynberg SMEs. Both the Wynberg survey and our earlier study of SMEs in South Africa confirm that few SMEs will take action on HIV/AIDS before they have tangible evidence of its impact. The inevitable increase in morbidity and mortality might also increase managers' willingness to pay for treatment.

Although the Rea'Phela Clinic may be somewhat ahead of its time, there are steps that could be taken that would likely lead to more demand for the clinic's services. For example:

- The Rea'Phela Clinic could offer additional services to Wynberg businesses including a rapid risk assessment of the impact of HIV/AIDS on individual companies and education and awareness training for employees. These services may serve as an entry point to more comprehensive services, such as VCT and ART.
- The Alexandra clinic was mentioned often by companies as a source of HIV/AIDS services and health care services. The Alex clinic could refer businesses to the Rea'Phela Clinic as an alternative to the public sector.
- Since companies have a greater interest in primary health care for employees, PHC could be regarded as an opportunity to build relationships with managers. In our earlier survey, SMEs that offered more generous employee benefits, particularly health benefits, were more likely to provide HIV/AIDS-related services as well. Increasing the coverage of primary health care services may lead to further interest by SMEs in HIV/AIDS services. The Rea'Phela Clinic could offer various packages of primary health care services for individuals, small companies, and larger companies. In our prior research, we found that clinics charge companies between R30 and R80 per employee per month for primary health care services. VCT, HIV/AIDS disease management, and ART could be added on a reimbursement basis.
- Since many companies use SETAs to train employees, the Rea'Phela Clinic could SETA certified HIV/AIDS training as an entry point into the local companies.
- VCT and HIV/AIDS care and treatment services at Rea'Phela should be promoted directly to employees and their families as an alternative to public health care services. An alternative fee structure when charging for treatment services to individuals would have to accompany this change. The current fee of R50 is low and attractive compared

with private sector clinics (e.g. Prime Cure) and with public sector facilities, which charge R30. Almost three quarters of the employees of the surveyed SMEs in Wynberg are skilled and likely could afford the modest fees charged by Rea'Phela. A subscription plan could thus be offered directly to individuals or to companies.

- Popular media outlets such as radio, billboards at transportation areas in Sandton and Wynberg and taxis should be considered to promote clinic services.
- The Rea'Phela Clinic could host workshops for businesses in Wynberg. To guarantee good participation, however, some sort of incentive will have to be offered. The Wynberg Action Group and Alexander Chamber of Commerce could be contacted as a means to communicate with individual businesses.
- Finally, marketing messages about Rea'Phela should reflect our understanding that SME managers' decisions about ART reflect non-financial considerations—compassion for employees—as well as the financial benefits and costs to the companies.

#### **e. Limitations of the Study**

The study presented here had several limitations that should be noted. First, we were only able to interview 34 companies, out of a target population of approximately 100. The refusal rate was quite high (49 percent). Companies that declined to participate may have been less concerned about HIV/AIDS than those that accepted, biasing our results. The reason most often given for refusal was lack of time for an interview; this might have reflected lack of interest in the issue of HIV/AIDS or simply lack of enthusiasm for or trust of research. Second, many questions in the survey relied on recall and on managers' subjective perceptions, rather than company records (which generally did not exist). Since it is these same perceptions that will influence managers' decisions about HIV/AIDS issues, however, the subjectivity of responses does not negate the value of the findings. Finally, the results of the willingness to pay component of the study should be interpreted with caution. The number of responses was small, and in most WTP surveys, there is a tendency for respondents to overstate their true willingness to pay when presented with a hypothetical scenario. As noted earlier, moreover, we are also unsure of the validity of the WTP approach when the respondent is representing a company, rather than simply himself or herself.

## References

Connelly P & Rosen S. Will Small And Medium Enterprises Provide HIV/AIDS Services To Employees? An Analysis of Market Demand. *South African Journal of Economics* Forthcoming February 2005.

Davis J, Kang A, Vincent J & Whittington D. How Important is Improved Water Infrastructure to Microenterprises? Evidence from Uganda. *World Development* 2001 29 10 1753-1767.

Ellis L. & Terwin J. *The Impact of HIV/AIDS on Selected Business Sectors in South Africa 2004*. Stellenbosch: Bureau for Economic Research, University of Stellenbosch,; 2004.

Rosen S, Simon J, Vincent JR, MacLeod W, Fox M, & Thea DM. AIDS is Your Business. Harvard Business Review. *Harvard Business Review* 2003 81 2 80-87.

Makubalo L, Netshidzivhani P, Mahlasela L & du Plessis R. *National HIV and Syphilis Antenatal Sero-prevalence Survey 2003*. Pretoria: Department of Health Republic of South Africa; 2004

Shisana O, Sibayi L. The Nelson Mandela/HSRC study of HIV/AIDS Human Sciences Research Council. Cape Town; 2002