WILL SMALL AND MEDIUM ENTERPRISES PROVIDE HIV/AIDS SERVICES TO EMPLOYEES? AN ANALYSIS OF MARKET DEMAND

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Abstract

Background: Although many large businesses have begun offering HIV/AIDS prevention and treatment services to employees, the vast majority of small and medium sized enterprises (SMEs) have not. SMEs face constraints reducing their demand for services. This study identifies and evaluates those constraints to determine the extent to which SMEs can be expected to implement HIV/AIDS programmes, and to identify opportunities for strengthening the role of SMEs in South Africa's response to the epidemic.

Methods: Structured interviews were conducted with a random sample of 80 SMEs located in KwaZulu Natal (KZN) and Gauteng provinces.

Results: About one quarter of the companies sampled provided some HIV/AIDS services to employees and fewer than half incurred any direct costs to provide those services. Although 52 per cent of the companies believed they had lost employees to AIDS, few of those employees were regarded as critical to operations. AIDS accounted for 10 per cent of the overall annual employee turnover of 13 per cent. Few companies incur direct costs in recruiting or training, and just 30 per cent of permanent employees have access to employer sponsored healthcare. HIV/AIDS ranked 9th of 10 major business concerns faced by SMEs.

Conclusions: Since managers believe few employees are leaving the workforce due to HIV/AIDS and SMEs appear to incur few costs to replace workers, managers are relatively unconcerned about HIV/AIDS. Serious demand-side barriers exist in the market for HIV/AIDS services for SMEs. For most of the SMEs in our survey, the constraints are too great to expect SMEs to play a major role in the national response to AIDS without assistance.

As the negative consequences of the maturing HIV/AIDS epidemic become evident in South Africa, many larger businesses have begun to implement HIV/AIDS workplace programmes that include prevention and treatment services for employees. The vast majority of small and medium sized enterprises (SMEs), however, have not.[2] A recent survey conducted by the Bureau for Economic Research (BER) found that among companies with fewer than 100 employees, 13 per cent had formulated an HIV/AIDS policy and 29 per cent had offered an HIV/AIDS awareness programme, compared with 92 per cent and 94 per cent, respectively, for companies with more than 500

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[2] 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).

employees (Ellis and Terwin, 2003). Noting the striking difference between large and small companies, the authors commented,

"It is very clear that the smaller companies still lack a strategic response to HIV/AIDS and for the most part have a great deal of work to do in rolling out workplace prevention and awareness programmes" (Ellis and Terwin, 2003).

Surveys like that conducted by the BER can gauge how businesses are responding to the HIV/AIDS epidemic, but they do not reveal what motivates some companies to take action against AIDS while others do not. Given the low level of activity among SMEs, understanding the opportunities and constraints SMEs face in responding to the epidemic is essential to any effort to strengthen the private sector's role in the fight against AIDS.

SMEs face a number of structural constraints to implementing workplace programmes, including a lack of designated human resource personnel and minimal employee benefits. To what extent these constraints have suppressed demand for HIV/AIDS services is not known. SME owners' and managers' knowledge, experience, and attitudes may also affect their willingness to purchase services. Many managers are unconvinced of the effectiveness of HIV/AIDS programmes and question whether an employer should be involved in providing health-related services at all. Without relevant information about the potential costs of HIV/AIDS, smaller businesses lack an imperative to invest scarce resources in mitigating the impact of HIV/AIDS. They are also largely unaware of what services are available and how to access them.

The study reported here aimed to identify and evaluate constraints on SME demand for HIV/AIDS services, to determine the extent to which SMEs can be expected to implement HIV/AIDS programmes, and to identify opportunities for strengthening the role of SMEs in South Africa's fight against AIDS. The paper is organised as follows. The first section provides a brief background on HIV/AIDS and the private sector in South Africa and on the role played by SMEs in the national economy. Section 2 describes the methodology of the study. Results are presented in section 3. In section 4, we discuss our key findings and offer recommendations.

1. BACKGROUND

Over the past four years, a reasonable body of evidence has accumulated about the impact of HIV/AIDS on large companies and the companies' responses to it. The cost of AIDS to six large employers was recently estimated at between 0.4 and 5.9 per cent of the total wage and salary bill, with each infected employee costing the employer an average of 0.5 to 3.6 times his or her annual salary (Rosen *et al.,* 2004). Case studies of large business responses to AIDS have reported on a wide range of prevention, care, and treatment initiatives now underway, although almost entirely without the rigorous monitoring and evaluation that would be required to estimate effectiveness (Global Business Council, 2004). At the same time, many large employers are actively taking steps to shift the economic burden of AIDS onto employees and government, through such practices as outsourcing unskilled jobs and capping benefits premiums (Rosen and Simon, 2003).

In contrast to large businesses, evidence about how the epidemic is affecting small and medium-sized companies in South Africa has been mostly anecdotal. A few surveys have been conducted. One, carried out by Ebony Consulting International in 2002 and focusing on rapidly growing SMEs, concluded,

"HIV/AIDS does appear to be having a negative impact on many SMEs, increasing both direct and indirect costs. Many firms are responding, or trying to respond, but it is difficult for a small business to develop and implement an effective programme" (Fraser *et al.,* 2002).

Another survey in the same year, conducted by Deloitte and Touche, found a similar low level of response by smaller businesses and commented,

"Smaller employers require external support to ensure that effective strategies are put in place in a sustainable manner" (Deloitte, 2002).

More recently, the BER study cited above demonstrated stark differences in HIV/AIDS policies and programmes between large and small businesses.

While these surveys consistently documented a lack of HIV/AIDS-related activity on the part of SMEs, none of them was designed to identify or explain the reasons why SMEs fail to act. Understanding the decisions made by SMEs is important because of the significance of smaller businesses to South Africa's economy. SMEs are estimated to have generated 27 per cent of employment and 30 per cent of GDP in South Africa in 2002 (NTSIKA, 2002). These estimates are likely to be conservative. A report by National Treasury described the contribution of SMEs to GDP and employment to be as high as that of large enterprises and noted that SMEs are particularly important because of the negative growth in job creation by large enterprises and the government sector (Falkena *et al.,* 2001).

2. METHODS

(a) Approach

For purposes of this study, we defined the phrase "HIV/AIDS services" as one or more of the wide range of HIV-related activities and services that an employer can purchase or undertake: impact or cost analysis; seroprevalence survey; workplace policy and programme development; education, information, and awareness; voluntary counseling and testing; sexually transmitted infection diagnosis and treatment; antiretroviral medications for prevention of HIV transmission; prevention and treatment of opportunistic infections; and antiretroviral therapy.

In the market for HIV/AIDS services for SMEs, potential suppliers are service providers, such as private companies, NGOs and government agencies, while potential "demanders" are SMEs. This paper focuses on the demand side of the market and aims to identify factors that constrain or promote SME participation in the market. We hypothesized that an SME's demand for HIV/AIDS services would be influenced by, among other variables:

a) Managers' views about the number of employees who have been or will be lost to AIDS.
b) Managers' understanding of the costs of losing employees to HIV/AIDS.
c) Managers' expectations about the impact of HIV/AIDS on the company.
d) Managers' knowledge of and experience with the services available.
e) Internal (employee) and external (shareholder, union, government or public) pressure to provide services.
f) Relative weight of other problems facing the company.
g) The company's current profitability.
h) Expectations about the company's future growth and profitability.
i) Expectations about the AIDS epidemic in South Africa, including government

policies.

j) The cost of services.

The survey reported here focused on variables *(a)-(f)* in the list above.

(b) Data Collection

Data were collected from a random sample of 80 SMEs located in KwaZulu Natal (KZN) and Gauteng provinces. Small companies were defined as having 20-49 employees and medium sized companies 50-200 employees. KZN and Gauteng were selected because nearly two thirds of South Africa's small (64 per cent) and medium sized (62 per cent) enterprises are located there (NTSIKA, 2002). Together, the two provinces are estimated to account for 52 per cent of employment, 54 per cent of GDP (NTSIKA, 2002), and nearly half of all HIV infections in South Africa (Dorrington *et al.*, 2002). Adult HIV prevalence is believed to be quite high in both Gauteng (23.8 per cent) and KZN (31.4 per cent) (Dorrington *et al.,* 2002).

For each province, we identified the four industrial sectors that contributed the largest shares of total formal sector employment. Construction, manufacturing and wholesale/retail were included for both provinces, along with agriculture in KZN and business services in Gauteng. Two databases of SMEs maintained by the Bureau of Market Research and Matrix Marketing were then stratified by company size (small or medium), location (KZN or Gauteng) and industry, and a random sample was drawn from each category.

On-site structured interviews were conducted with owners, managers, or human resource staff of the SMEs in the sample between October 2003 and January 2004. The survey instrument included sections on business characteristics, workforce characteristics and turnover, employee benefits, and HIV/AIDS activities. Survey responses were entered into an Excel database and analyzed using Excel and SAS.[3]

3. RESULTS

In this section, we first briefly describe the companies in the sample. We then use the results of the survey to examine each of our hypothesized "determinants of demand". The sample of SMEs surveyed included five small and five medium sized companies in each industry in each province, as shown in Table 1.

Table 1. Companies included in the survey by size, province, and industrial sector

Sector	**Small**		**Medium**		**Total**
	Gauteng	KZN	Gauteng	KZN	
Agriculture	0	5	0	5	10
Business services	5	0	5	0	10
Construction	5	5	5	5	20
Manufacturing	5	5	5	5	20
Wholesale/retail	5	5	5	5	20
Total	20	20	20	20	80

Of the 80 companies initially selected and approached, 31 declined to participate in the survey, usually citing lack of managers' time available for the interview. Replacements were randomly selected from the same sampling frame, using the same stratifiers to maintain overall sample characteristics.

[3] Only permanent employees are included in much of the data analysis as the numbers of contract and casual workers fluctuate and non-permanent employees usually have no benefits.

The average number of employees in the sampled companies was 60 and the median 48. The composition of the workforces is summarized in Table 2.

Table 2. Composition of workforces in the sampled companies

Job level	Small companies				Medium sized companies				All
	Male	Female	African (black)	WIC*	Male	Female	African (black)	WIC*	
Managers (%)	15.4	3.2	2.6	16.0	9.5	2.6	1.8	10.3	13.8
Skilled employees (%)	32.2	15.7	29.9	18.0	38.7	19.3	31.9	26.2	55.5
Unskilled employees (%)	21.4	12.1	31.0	2.5	22.7	7.1	25.4	4.4	30.7
All	69.0	31.0	63.5	36.5	71.0	29.0	59.1	41.0	100.0

*White, Indian, or Coloured.

(a) Loss of Employees to AIDS

Average employee attrition in the sample companies averaged 13.0 per cent per year over the two years preceding the survey.[4] Average attrition due to natural cause deaths, medical or disability retirements, or other reasons that respondents attributed to AIDS, in contrast, averaged 1.35 per cent over the same period, as shown in Fig. 1. Across the entire sample, therefore, HIV/AIDS accounted for approximately 10 per cent of recent employee turnover.[5]

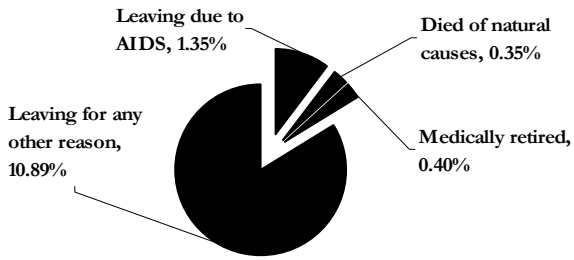

Figure 1. Reasons for employee attrition at companies surveyed

Attrition due to AIDS varied with skill level, with unskilled workers much more likely to leave the workforce due to AIDS than skilled workers or managers. Attrition also differed by industry and location. SMEs involved in agriculture and construction in KZN reported losing 7.6 per cent and 5.0 per cent of employees to AIDS in the last two years, respectively. SMEs providing business services in Gauteng, in contrast, reported having had no vacancies due to AIDS in that period. Companies in industries

[4] All-cause attrition rates varied by skill level and sector. Annual attrition of managers averaged 9.4 per cent, of skilled employees 9 per cent, and of unskilled employees 30 per cent.

[5] 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.

surveyed in both provinces - manufacturing, wholesale/retail, and construction - had two and a half times more AIDS-related attrition in KZN than in Gauteng.[6]

We also investigated how many companies had experienced the loss of an employee due to AIDS and whether the employees lost were critical to the operations of the company. Managers in 52 per cent of the companies believed they had lost at least one employee to AIDS in the last two years. Few of these workers were regarded as "critical" to operations, however. Of the deaths and other terminations attributed by respondents to HIV/AIDS, 69 per cent were among workers whom respondents regarded as "non-critical".

Firms that reported losing any workers to AIDS were slightly more likely to offer HIV/AIDS services than firms not reporting such losses (RR 1.33, p-value 0.5920), but the results were not significant at the 5 per cent level. This may reflect the fact that most AIDS-related attrition is occurring in the construction and agriculture sectors, which are less able or willing to provide services because their workers are unskilled and their worksites are difficult to reach. Companies losing critical workers were more likely to consider HIV/AIDS among their top five business concerns (RR 2.32, p-value <0.0001), and they were also more likely to provide HIV/AIDS services, though these results were not significant (RR 1.84, p-value 0.17).

Although 52 per cent of companies believed they had lost employees to AIDS in the last two years, only 38 per cent believed that they have HIV-positive employees in their workforce now. This is despite estimated adult male HIV prevalence of 23.8 per cent and 31.4 per cent in Gauteng and KZN, respectively (Dorrington *et al.*, 2002). Nevertheless, companies that believed they have workers living with HIV were much more likely to provide HIV/AIDS services than other companies (RR 4.10, p-value 0.009). Nearly half (48 per cent) of respondents from firms not now providing HIV/AIDS services stated that they would be motivated to offer such services only if they knew that any of their employees had HIV/AIDS or if more of their employees had HIV/AIDS.

(b) Costs of Losing Employees to HIV/AIDS

Previous research in South Africa indicates that HIV/AIDS imposes a wide range of costs on large employers that SMEs might also bear (Rosen *et al.,* 2004). These costs are shown in Table 3.

Table 3. Costs of HIV/AIDS to business

Source of costs	**Increased expenses (Direct costs)**	**Lost productivity (Indirect costs)**
One employee with HIV/AIDS (individual costs)	• Benefits payments • Medical care • Recruitment of a replacement worker • Training of a replacement worker	• Increased leave and absenteeism • Reduced on-the-job productivity • Supervisor's time • Vacancy until replacement is hired • Poorer performance due to replacement's inexperience
Many employees with HIV/AIDS (organisational costs)	• Benefits premiums • Accidents due to sick or inexperienced employees • Litigation over benefits, dismissals, etc.	• Production disruptions or service failures due to missing skills, accidents, vacant positions, etc. • Loss of institutional memory and experience • Breakdown of workforce morale and cohesion • Diversion of senior managers' time • Deteriorating labour relations

[6] This difference may reflect higher AIDS-related mortality in KZN, a greater awareness of HIV/AIDS among KZN managers, or both.

The survey asked respondents about their companies' experience with most of the costs included in the upper half of Table 3. Because reduced performance among sick workers when they do come to work (so-called "impaired presenteeism") is so difficult to estimate, the survey did not address this issue. It should also be kept in mind that most of the costs in Table 3 would be incurred as a result of any employee illness, not solely HIV/AIDS. Since employers often do not know the cause of employee illness, managers' estimates should be taken as "best guesses" only.

(i) Employee benefits. Overall investment in employee benefits by SMEs varied by skill level and industry. Three quarters of companies in the sample provided retirement benefits for some workers, but only 48 per cent provided these benefits for all permanent employees. Of all the employees at surveyed companies, 68 per cent received retirement benefits, typically through a provident fund. Unskilled workers were somewhat less likely to receive retirement benefits than skilled workers. The average contribution by employers was 6 per cent of base salary. Similarly, although 58 per cent of companies offered medical schemes to some workers, participation was largely limited to managers and highly skilled workers. Of all the employees at the surveyed companies, 30 per cent belonged to employer sponsored medical schemes; 84 per cent of these were managers or skilled workers. Eight of the companies surveyed offered on- or off-site health facilities for workers not on medical schemes. For both types of benefits (retirement and medical aid), coverage in the agriculture sector was substantially lower than in any other sector.

Table 4. Employee benefits at surveyed companies

Benefit	Sector	% of companies offering benefit	% of all employees enrolled	% of managers enrolled	% of skilled workers enrolled	% of unskilled workers enrolled
Retirement	Agriculture	60%	35%	33%	38%	33%
	Business services	70%	77%	80%	78%	50%
	Construction	70%	80%	60%	82%	84%
	Manufacturing	85%	73%	79%	76%	65%
	Wholesale/retail	75%	71%	75%	74%	64%
	All	74%	70%	73%	73%	63%
Medical aid	Agriculture	30%	6%	28%	8%	0%
	Business services	50%	60%	54%	26%	23%
	Construction	55%	36%	53%	33%	35%
	Manufacturing	75%	24%	62%	21%	16%
	Wholesale/retail	60%	31%	70%	39%	2%
	All	58%	30%	58%	33%	13%

We asked managers how much their company invested in employee benefits in order to determine if there was a relationship between the level of employee benefits and the HIV/AIDS services provided. Companies that invested more in employee benefits, especially for healthcare, were more likely to have HIV/AIDS services already in place. We calculated a fringe benefit rate to measure the amount employees are compensated beyond base salary, and thus indicate the effective level of employee benefits. Companies with a fringe benefit rate above the median of 12 per cent of base salary were more than two and a half times more likely to provide HIV/AIDS services (RR 2.62, $p = 0.07$) than companies that provide less benefits, though the finding was not significant. The 22 companies that provided health services to more than 80 per cent of skilled workers were also much more likely to provide HIV/AIDS services to all workers (RR 3.32, $p = 0.0273$). Firms with no history of providing employee benefits, in contrast, did not make an exception for HIV/AIDS.

The survey also asked if benefits premiums had increased over the last two years. Managers reported increases in risk benefits premiums in 42 per cent of SMEs; 28 per cent of those that had experienced such increases believed that HIV/AIDS was responsible. All companies that offered medical schemes noted increases in premiums, and 41 per cent blamed HIV/AIDS for the increases. None of the SMEs surveyed self-financed their retirement, risk, or medical benefits, as some large companies do, and therefore could not manage premiums except by reducing benefits. The financial incentives offered to large companies by the life assurance industry for providing comprehensive workplace HIV/AIDS programmes, including antiretroviral therapy, are generally not available to SMEs.

(ii) Absenteeism. Although 26 per cent of SMEs reported an increase in sick leave and 24 per cent an increase in compassionate leave, just how much HIV/AIDS has contributed to this trend is uncertain. Most managers experiencing increased levels of absenteeism believed workers and their relatives with AIDS may be a factor, but many commented that workers are becoming more knowledgeable of the Basic Conditions of Employment Act and were taking advantage of time permitted for absenteeism (30 days over three years) and compassionate leave (3 days per year) allowed for in the Act.

(iii) Replacement costs. Companies incurred few direct costs for recruiting or training new employees. To replace skilled workers, half the SMEs sampled incurred no direct costs to recruit and 66 per cent of companies incurred no costs to train new workers. For unskilled workers, 85 per cent of companies incurred no direct costs to recruit or train new employees. Indirect costs were also modest, as shown in Fig. 2. For skilled workers, managers spent a half a day to recruit and three and a half days to train new employees. Positions were vacant for an average of 10 days, and replacement workers were reported to be fully productive in 20 days. To hire a replacement unskilled worker, a manager spent an average of about an hour to hire and half a day to train new employees. Positions were vacant for just one day and replacement workers were considered fully productive in five days.

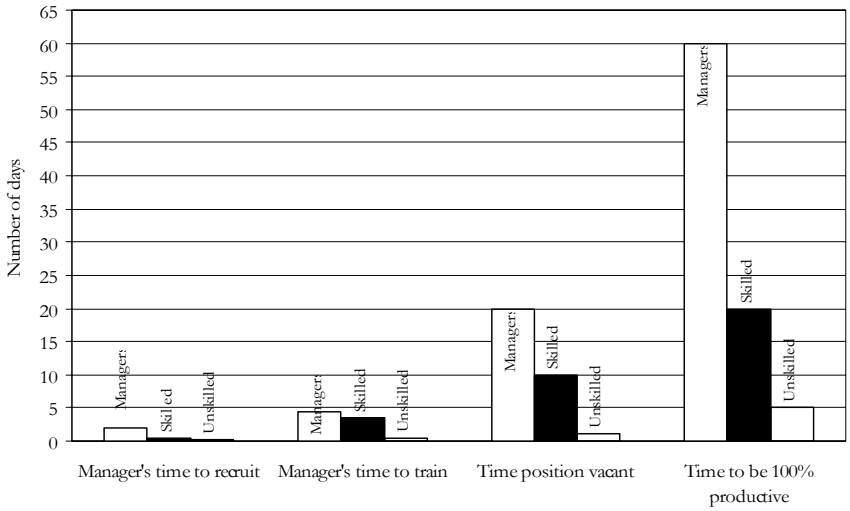

Figure 2. Time required to replace an employee lost to AIDS

(c) Expectations of Impact

Only a minority of SME managers responding to the survey anticipated that HIV/AIDS would have a major impact on the company in the future. Among the SMEs surveyed, 29 per cent expected the epidemic to have a large impact, 25 per cent a moderate impact, and 43 per cent little or no impact (4 per cent did not respond). Firms expecting a large impact on their business from the HIV/AIDS epidemic were significantly more likely to be located in KZN (RR 2.82, p-value 0.001). The industrial sector was also a more significant predictor of a large impact of HIV/AIDS based on the managers' expectations. Four out of the five agricultural firms surveyed expect the epidemic to have a large impact on their business, while only one of the five business services firms had this expectation.

(d) Knowledge of and Experience with HIV/AIDS Services

The survey elicited information about both the existing provision of HIV/AIDS and knowledge of service availability.

(i) Existing services. About one quarter of the companies sampled (24 per cent) provided some HIV/AIDS services at the time of the survey. These services were usually limited to condom distribution, education and awareness of HIV/AIDS and the development of a workplace policy on HIV/AIDS. Companies in KZN were more than three times more likely (RR 3.38, p-value 0.019) than companies in Gauteng to provide HIV/AIDS services to employees. Fewer than half (48 per cent) of those that provided services incurred any direct costs for them. For the rest, services and materials were provided by the local or provincial Department of Health or were incorporated into existing programmes at no extra cost. Some employees were covered for HIV/AIDS treatment on an individual basis by company-subsidised medical aid schemes. Understanding of these benefits was poor, and of the 46 companies that subsidised medical aid coverage for some workers, respondents in only 11 knew if antiretroviral treatment was an included benefit.[7]

(ii) Availability of information. Sampled companies had little information about HIV/AIDS services and the potential benefits of implementing a workplace programme. Thirty-four per cent of managers responded they were not aware of any HIV/AIDS services. There appeared to be two main reasons for this lack of information. First, because few SMEs are large enough to maintain dedicated human resource staff, personnel-related decisions were usually made by business owners or operations managers who did not have the time or the inclination to become knowledgeable of HIV/AIDS issues. Only 14 of the 80 sampled companies had someone specifically designated to handle HIV/AIDS issues. Second, solicitation of SMEs by HIV/AIDS service providers is infrequent. While large companies face frequent solicitation by providers for general health services and HIV/AIDS services, SMEs in our sample did not. More than three quarters (78 per cent) reported never or rarely receiving solicitations regarding general health services. An even larger proportion, 88 per cent, had seldom or never been solicited by HIV/AIDS service providers.

Most managers indicated they would turn to government sources if information or

[7] At the time of the survey, the vast majority of medical schemes offered antiretroviral therapy as part of their benefit package. As of January 1, 2005, ARVs were included in the prescribed minimum benefits that medical schemes must provide beneficiaries.

services were needed. When asked "do you know where to go for HIV/AIDS information?" 73 per cent of managers responded affirmatively; with most (60 per cent) of these saying they would contact government facilities or the National Department of Health AIDS Help Line. Only 37 per cent answered affirmatively when asked "do you know where to go to contract HIV/AIDS services?"; again, most (59 per cent) reported they would contact a government facility.

(e) Pressure to Provide Services

Pressure on SMEs to provide HIV/AIDS services could come from employees (internal) or from shareholders, government, communities, or the public at large (external).

(i) Internal pressure. Stigma associated with HIV/AIDS reduces the demand for services by employers and may reduce the utilisation of services that already exist. Respondents cited stigma as a constraint in introducing programmes because of the apparent lack of interest among employees or even employees' refusal to participate in programmes. Of the 15 companies that had considered implementing services, but had not done so, seven cited employees' fear of stigma as the reason. Among the companies that were offering services, the main limitation in implementation reported by managers was not cost but the stigma associated with HIV/AIDS among workers. Stigma may also be dampening demand for claims for benefits already offered to employees. Managers reported that many employees leave the workplace without claiming benefits. In the surveyed companies, very few employees had claimed disability benefits in the previous two years.

(ii) External pressure. 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 regulatory bodies, shareholders, activists, and unions. This is not the case for SMEs. Of the SMEs surveyed, only four companies felt pressured to offer services. Two companies had workplace policies in place because they believed policies were required by regulation, and two companies offered education and awareness because it was included in mandated industry programmes.

(f) Relative Weight of Other Problems Facing the Company

SMEs presumably have less capacity to address multiple problems at once than do large businesses. To assess the relative importance managers assign to HIV/AIDS, respondents were given 10 cards showing potential business concerns and asked to order them from most serious (1) to least serious (10). Results are shown in Table 5.

Table 5. Respondents' rankings of major business concerns

Business concern	**Rank***	**Average ranking**
Productivity of workers	1	3.66
Demand for product	2	3.98
Cost of labour	3	4.19
Cost of materials	4	4.59
Regulations	5	5.53
Crime	6	6.00
Taxes	7	6.14
Shortage of skilled labour	8	6.24
HIV/AIDS	9	6.99
Availability of capital or financing	10	7.53

**Results shown are the average rankings for each concern.*

HIV/AIDS ranked 9 out of 10 among respondents' concerns about their businesses. It had never even been discussed as a business issue by 62 per cent of companies surveyed.

4. DISCUSSION AND RECOMMENDATIONS

The results reported in this paper indicate that current demand for HIV/AIDS services among small and medium sized businesses in South Africa is minimal. There are clear and consistent reasons for the lack of action on the part of SMEs, and these constraints limit the extent to which SMEs can be expected to implement HIV/AIDS programmes. In this section, we summarize and assess these constraints. We conclude with a discussion of the limitations of the study and recommendations for strengthening the SME response to AIDS.

(a) What Are the Constraints Facing SMEs?

(i) Lack of information and access to services. SME managers face serious information deficits on HIV/AIDS issues. Few SMEs are large enough to develop and implement programmes in-house; services must typically be purchased from outside providers. Most survey respondents had little knowledge of the available services, the benefits and costs of providing them, and where they could be obtained. Without such information, managers cannot make informed decisions. SMEs lack human resources expertise and rarely receive unsolicited information from healthcare or HIV/AIDS service providers. Even managers who are interested in taking action reported that they lack the time to find, consider, negotiate, and implement programmes.

(ii) Low willingness-to-pay. For the majority of SMEs surveyed, HIV/AIDS accounts for only a tiny fraction of overall employee attrition and contributes even less to turnover among skilled or critical employees. Ironically, industries in which attrition due to AIDS has been somewhat higher - construction and agriculture - were the least likely to provide services. This may reflect the fact that most losses to AIDS have been among unskilled workers, who are least likely to be eligible for health and risk benefits. While absenteeism seems to be rising, SME managers are not convinced that HIV/AIDS is the reason. Even when SMEs do lose employees to AIDS, the cost of replacing unskilled workers, who make up the vast majority of AIDS-related terminations, is negligible.

The dearth of readily available and relevant information about AIDS, combined with largely unskilled workforces and the ease of finding replacement workers, also makes SME managers loathe to invest in HIV/AIDS interventions that may require many years to show a positive return. SMEs are even less likely than large companies to be able to capture the uncertain benefits of HIV prevention programmes. Treatment of sick workers offers immediate benefits in terms of reduced HIV/AIDS-related morbidity and mortality, and the associated productivity losses, but few SME managers understand those benefits or realize that access to high quality primary care and treatment of opportunistic infections, even without antiretroviral therapy, can reduce or postpone the costs of illness.

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.

(iii) Stigma. Also dampening employers' demand for HIV/AIDS services, and inhibiting utilisation of existing benefits, is the stigma attached to HIV/AIDS by employees. Some surveyed companies reported that they had considered implementing services but did not because of stigma among employees. Managers also believed that many employees with AIDS had left the workforce without claiming benefits to avoid risking exposure of their HIV status.

(iv) Lack of pressure to act. Many of the conditions that motivate large businesses to provide HIV/AIDS services - the need to adhere to international standards; pressure from organised labour, activists, and shareholders; a tradition of "corporate responsibility" programmes; and a long enough time horizon to capture the benefits of investing in employee welfare - do not apply to most SMEs. For SMEs, there are few ethical expectations; little internal or external pressure from labour, activists, or shareholders; little tradition of investing in either human capital or the community, and no pressing financial incentive to offer an HIV/AIDS workplace programme. The provision of antiretroviral treatment at public sector health care centres will likely further reduce the likelihood of SMEs directly paying for treatment services. The ranking of HIV/AIDS as ninth out of ten possible business concerns clearly demonstrates that managers are not persuaded that AIDS is a serious business issue, at least in comparison to other more obvious and urgent problems.

(b) Limitations of the Study

The study reported here had several limitations. First, our sample size was small, and the number of companies in some sectors was not sufficient to establish statistically significant differences for some outcomes. Second, the initial refusal rate was relatively high (39 per cent). Companies that declined to participate may have been less concerned about HIV/AIDS than those that accepted, creating a selection bias in our sample. The reason most often given for refusal, however, was lack of time for an interview. Third, 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. Further, there was great variability in the knowledge managers had of HIV/AIDS interventions and the impact of the epidemic on their company. Finally, the survey covered only two provinces and six industrial sectors. It may thus not be fully generalizable to SMEs in South Africa as a whole. We speculate that SMEs face even greater barriers to action in poorer provinces where the business climate is less favourable and markets for HIV/AIDS service provision are less developed than in Gauteng and KZN.

(c) What Can Be Done?

Serious demand-side barriers exist in the market for HIV/AIDS services for SMEs. For most of the SMEs in our survey, the constraints discussed above are too great to expect SMEs to play a major role in the national response to AIDS without assistance. The survey did, however, identify a number of opportunities for governments and donor agencies to help at least some SMEs overcome these constraints.

Because the dearth of information about HIV/AIDS is so severe, an information campaign directed at SME managers would likely increase demand for the lower-cost services offered by private and not-for-profit providers. Both the information itself and

the avenues for disseminating it, however, must be tailored carefully to the SME market. Unlike large companies, SMEs have little time or money to invest in "shopping" for services or in "do it yourself" approaches. Clear and concise information about locally available services that can be purchased or obtained "off the shelf" is thus essential.

Many of the barriers to SME provision of HIV/AIDS services can be overcome by business and employee associations. Associations, such as chambers of commerce, trade groupings, and labour unions, offer a promising vehicle for reaching SME employees because of their existing networks, effective communication channels, experience in organizing services, trust from employers or workers, and, most important, mass purchasing power. Projects that build capacity within associations and help them overcome existing financial, managerial, and technical limitations, have the potential to expand SME demand for services while simultaneously creating models of service delivery that are appropriate for the SME market.

As with large companies, medium-sized companies and, to a lesser extent, small companies do offer one valuable asset for service delivery: a centrally located and well-monitored population. To take advantage of this circumstance, it may make sense to subsidize the cost of services, in return for access to the SME population and infrastructure. At SMEs where employees are mostly unskilled or casual, employers may offer an effective means to inform HIV-positive employees of treatment options available in the public sector. This may be particularly appropriate for the agriculture and construction sectors, where employees tend to be at higher risk of HIV infection and have low incomes and few existing benefits.

The results of the survey presented here make it difficult to avoid the conclusion that many small and medium-sized companies - particularly those in the agriculture sector and those that rely most heavily on unskilled labour - do not represent a feasible or cost-effective way to expand access to HIV/AIDS services. The best strategy for these companies may be to encourage them to keep employees in permanent jobs, rather than contract or casual positions, to ensure that HIV-positive workers have stable incomes and access to at least some health and risk benefits.

Finally, interventions to help SME employees and their families should recognize that SMEs are not homogeneous but in fact differ widely in terms of HIV risk, cost exposure, capacity, or future expectations. Some SMEs will respond positively to low-cost interventions and incentives, while others will not. Employees of those in the latter category will continue to rely on the public sector for healthcare and social support. Understanding the differences among SMEs will help governments and donors target HIV/AIDS funding and programmes more effectively.

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