

Facing up to Aids

□ Gillian Handley

Aids has the same effect on employee benefits as it has on people. It kills.

SA's HIV crisis has deepened. As Aids begins to affect productivity and increase the real cost of doing business, employers and trade unions must consider the disease's potential impact on benefit structures.

Dr Clive Evian of the Alexander Forbes Aids Consulting Unit says upwards of two million South Africans, 12 to 15% of the sexually active age group, are already infected with the HIV virus. Most are still at work.

Evian says SA has entered the second decade since the first cases of Aids appeared and the disease's latent phase is ending. Studies completed by the unit at companies in different industries and businesses show that the cumulative prevalence in the workforce could reach 10 to 30%, depending on the composition of the workforce.

Aids effects will start getting serious around 2002/3 and become critical thereafter. Evian says "Although corporations, especially those with large numbers of unskilled and semiskilled employees, will be most severely affected, almost all employers will feel the impact."

Peter Doyle, senior general manager of Metropolitan Life's corporate business unit, says the epidemic in SA could be worse than in most countries. This is due to a combination of poor communities living in a country with highly developed urbanisation, labour mobility, civil unrest and an efficient transport infrastructure.

The effects are complex. Janina Slawski, an actuary in the risk management consultancy for Southern Life, says employers will have to face issues such as the legality of pre-employment HIV testing, increases in the time and costs associated with recruitment and training, reductions in productivity, provision of Aids education and counselling for employees, and employee HIV test results private. Evian believes the issue

is urgent. "Aids in the workplace will become a contentious and political issue. It is important to start to address the benefit issues sooner rather than later.

Education of the fund trustees, management and labour about Aids and its potential impact on benefits is critical. It is crucial to assess the future impact of Aids on the employees' benefits to make appropriate adjustments to withstand the future and ongoing ravages of Aids.

Such studies will not only provide the epidemiological and actuarial assessments but will enable the members of the fund, its trustees and managers to understand the implications of Aids and why such adjustments are essential." Evian adds that some of the future impact of Aids on employee benefits may be offset if the infection rate among employees is cut. But the critical time for prevention is now.

Employers are unlikely to maintain current levels of employee benefits in future - that's for sure. Doyle puts the onus on the retirement funding industry to find creative solutions to rocketing employee benefit costs without falling into the mire of unfair discrimination.

"How Aids will impact on any particular employee benefit arrangement will depend on a few important factors, he says. How are the risk benefits structured? Who pays for the risk benefits? Is it the benefit structure or the contribution rate that is fixed?"

Specific actions will obviously depend on the structure of the employee benefit arrangement. Certain principles can be put forward.

- review and agree on the purpose of the employee benefit deal with staff
- cap the risk benefit cost
- cut the basic cover and increase voluntary top-up cover
- protect retirement funding from rising in-service costs
- negotiate changes to benefits
- get professional and objective advice
- implement well-structured health care and educational practices in the workplace.

Defined contribution vs defined benefit

Sanlam's Coetzer believes, with others, that most funds will change from fixed benefit funds. The table shows the cost, as a percentage of wages, of supplying death and disability benefits in a fixed benefit fund to employees in three different HIV scenarios.

Year	1995	2000	2010
Scenario A	4%	4%	4%
Scenario B	4%	5%	7%
Scenario C	5%	7%	13%

Source: Dr P Coetzer, Sanlam Scenario A: No Aids scenario

B: Majority of employees with low Aids risks scenario

C: Workforce consisting of only high risk Aids employees

Fixed contribution cover result in lower pay-outs at retirement. Actuarial calculations show that a person joining such a fund in 1995 with 10% contribution from the employer and 7.5% from the employee will receive a package of R520 000 after 30 years (expressed in 1995 rands with a basic salary of R50 000) in an Aids-free environment (scenario A). In scenario C this will almost halve to R268 000.

Slawski says there could be some savings on normal retirement pensions as fewer people reach pensionable age. But the cost of ill-health retirement pensions will rise as people become sick with Aids. Dependent pensions payable on a member's death will rise because of co-infections.

The swing toward defined contribution schemes, she adds, will not solve the problem for an individual. If they die prematurely, the amount accumulated is unlikely to support their dependents.

If the defined contribution must cover the cost of providing risk benefits before any allocation is made to members' investment accounts, then increases in these costs will erode dramatically the amount put toward retirement benefits.

Group Life and Disability

Evian says "Group life and disability benefits are very vulnerable to the Aids epidemic. Since Aids is determined by

socio-economic factors, the demographic make-up of a company and the socio-economic profile of its members will affect the future risk and vulnerability of a fund. Alexander Forbes predicts that many funds claims rate will double over the next three to five years and accelerate thereafter."

Creative adjustments will need to be made to the benefit structure in order to provide reasonable benefits without impossible contributions. These could include a basic core benefit with flexible options, some of which will require a clean bill of health, not only HIV-negative.

Evian again: "Significant erosion of the retirement benefit (especially in a defined contribution scheme) could result from unlimited and mismanaged contribution to death and disability benefits. Capping death benefits with or without a differential benefit for deaths related to illness and death with regard to accidents is an optional approach."

Health care

Most medical aid schemes have excluded HIV-related diseases. Evian says this is unfairly discriminatory. He adds there is no rational argument to exclude HIV other than a fear of being swamped with claims. On the other hand, most HIV conditions can usually be disguised as other diseases and claimed.

What to do about Aids?

Dr Pieter Coetzer of Sanlam says a well-structured programme aimed at every staff member should inform employees about the disease, its statistics, methods of spreading, ways to avoid contracting Aids, explain why working with a Aids patient poses no threat to co-workers, explain why HIV screening is necessary and the confidential handling or test results, brief employees on the company's Aids policy.

Dr Simmy Waner of the Medical Research Institute recommends businesses make condoms available and have a good attitude to HIV. Otherwise it will be driven underground. People should be aggressively educated against sexually transmitted diseases as Waner says they are an important predisposing factor to HIV.

The schemes have little knowledge of such claims. This has hampered actuarial assessments and made future planning difficult. He sees managed care as a solution. "For the care of HIV to be affordable in the face of the predicted epidemic, patients have to be managed in a cost-sensitive and cost-effective manner".

Says Coetzer, "Even without Aids, the rising cost of medical care is already crippling most medical aids. They will have to limit the amount they pay annually for Aids-related diseases. This will have to be managed according to the disease's prevalence."

Slawski agrees, "With appropriate medical care, an HIV-infected individual can have many fruitful years. They will have more time to build up funds to support dependents. However, care will be expensive because of the many opportunistic infections an individual will suffer. Putting the patient on a total health programme which include factors such as diet, exercise, treatment regimes etc will improve longevity." She agrees that as costs rise, benefits will be cut. Where to allocate scarce resources needs a holistic and creative approach. Coetzer believes underwriting applicants to these funds should include HIV screening.

A positive HIV candidate should not be denied work, but membership to these funds should be refused, as is the case with any other life-threatening disease. The HIV screening procedure should be structured to ensure proper confidentiality and quality control of test results.

Doyle says Aids and the new LRA will come face to face over the issue of employee benefits. Many employers actions, pre-employment testing being one, have been challenged as unfair discrimination. There are two points of view. Many of the actions which ensure the financial soundness of retirement funding can be construed as unfair discrimination. But at the same time, if some action is not taken, all employees will face significant loss of their benefits and possibly also the profitability of their employers.

"It's time to face up to Aids. The disease is going to change the employee benefit status quo for ever. And it's going to stretch society's resources to the limit. Nedlac has yet to debate Aids. Why not now? It is time to get the support structures in place - it's going to get rough out there." PMR

PMR's abstracts of AIDS/HIV articles in UK/USA Medical Journals Apr-Jul 1996

□ **Drug on trial may control HIV infection:** World AIDS conference in Vancouver told that new drugs "protease inhibitors" have ability to block virus replication.

□ **Genetics HIV/AIDS:** Experimental gene therapy in three HIV positive patients suggests that gene manipulation can protect the immune system from the onset of AIDS.

□ **US mandatory tests for babies:** New legislation approved by Congress. The American Medical Association calls for testing on pregnant women to prevent transmission in utero.

□ **"Fusin" protein discovered:** A newly-discovered protein molecule dubbed "Fusin" may explain, in part, how the AIDS virus can enter the immune system cells.

□ **HIV plasma viral load predicts how quickly infection will progress:** The concentration of the AIDS virus in the blood is more accurate in predicting disease prognosis than counting the number of white cells.

□ **PHLS comment on HIV tests approved by FDA:** Two diagnostic tests for HIV and AIDS development, now approved for use in the USA, the Orasure Western blot test and Hoffman-La Roche's, Amplicor.

□ **AIDS: HIV survival related to age of patient:** The older people become infected with HIV the sooner they are likely to die of it. Medical records of 1216 men with haemophilia infected with HIV from blood transfusions were studied at Oxford University.

□ **HIV: Transmission to babies-risks and strategies:** 90% of all children with AIDS and all HIV acquisitions in children are now thought to have been acquired through mother-to-infant transmission.

□ **HIV/AIDS: Spread of TB is "most worrying" side-effect:** In sub-Saharan Africa a third of AIDS patients die of TB and a third of TB patients are infected with HIV.

□ **Genetics:** People who are apparently resistant to HIV infection, despite repeated exposure, may be genetically resistant to infection. CD4-cells from 25 apparently resistant people were cultured and HIV infection attempted under laboratory conditions.

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