Africa Summary

Private-sector Responsibilities and Opportunities in Combating HIV/AIDS and TB in Africa

Dr Brian Brink
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INTRODUCTION

This document provides a summary of a meeting held at Chatham House on 11 July 2013 with the Chief Medical Officer for Anglo American, Dr Brian Brink.

Despite rising private-sector interest in African countries and the diversification in international engagements of African states, building healthcare capacity and combating disease remain key challenges. Many companies operating in Africa, recognizing the impacts of AIDS and TB on productivity, have taken steps to enhance their role in responding to the epidemic.

Dr Brink discussed the challenges HIV/AIDS and TB pose to business, successes of private-sector strategies in addressing the challenge, and how these can bolster and support policy implementation.

The meeting was held on the record. The following summary is intended to serve as an aide-mémoire for those who took part and to provide a general summary of discussions for those who did not. All graphs used in the summary are taken from the speaker’s presentation slides.
Dr Brian Brink

Dr Brink began by pointing out that this was an excellent time to have this conversation as the attention of the international community turned to the post-2015 development goals, especially in the area of health. He also stated the need to get past Euro-centric thinking about healthcare systems.

He emphasized that the burden of disease in developing countries had an impact on business. If only private companies could see the shared value of lessening the burden of disease, they would invest more in alleviating the burden of disease.

Private businesses can only operate with a ‘licence from the community’ and must therefore prove to be providing a benefit to society. Dr Brink said this issue was about successful business and the bottom line.

He described the effects of past efforts by international organizations such as UNAIDS and the WHO – as well as national governments bolstered by development aid – in dealing with the burden of HIV/AIDS.

Between 2007 and 2011 the amount of state spending by African governments increased from less than $2 billion to almost $4 billion. This and other factors have had an enormous impact on access to antiretroviral treatment (ART), as shown in Figure 1.

Figure 1:

Number of people on HIV treatment is increasing

Antiretroviral therapy, 2005-2012

 Millions

Dr Brink stated that Africa had turned AIDS around. In 2011 there were 33 per cent fewer new HIV infections than in 2001, and 32 per cent fewer AIDS-related deaths than in 2005.

He also outlined recent changes in guidelines that he suggested could go a long way in continuing the positive trends, including the ‘Getting to Zero’ UNAIDS Strategy and the new WHO 2013 treatment guidelines. The new WHO guidelines lowered the clinical threshold for beginning treatment and recommended treatment for a wider variety of patients. Combining new investments strategies with new clinical guidelines should bring the number of new HIV infections to levels similar to those in the US and Western Europe. New technologies could bring these numbers even lower.

Despite these improvements, Dr Brink said policy-makers continued to grapple with how to address this challenge in the context of a burgeoning youth population and a growing, more prosperous middle class. Dr Brink suggested that by targeting the workforce, the age group predominantly affected by HIV/AIDS, the private sector could contribute significantly to addressing the burden of HIV/AIDS and TB.

Dr Brink stated that the decision by Anglo American to make AIDS treatment available to all its employees was not only the firm’s responsibility, but ‘one of the most successful business decisions’. Although 25 per cent of its mining workforce was infected with HIV, an increase in the numbers of employees on the HIV treatment plan had lowered HIV on the risk matrix.

According to Anglo American, employee HIV/AIDS and TB fit firmly within a framework of health that links occupational standards to global health. The Anglo American Employee Health and Wellness scheme focuses on all employees receiving an annual health screening and basic medical examination, which includes voluntary counselling and testing for HIV and TB. Theoretically, this guarantees early diagnosis, ensuring that chronic diseases are properly managed through early access to counselling, care, support and treatment. Furthermore, Anglo American analyses health trends over time to focus management attention on emerging health issues.

To emphasize the point, Dr Brink explained the difference between early HIV treatment and AIDS treatment which occurred later (Figure 2).
Previously, AIDS treatment was not initiated until the patient’s CD4 count had dropped dramatically, as depicted by the blue line in Figure 2. Now the new WHO guidelines emphasize early treatment from the point where the patient’s CD4 count falls below 500, the point marked HIV treatment in Figure 2, which keeps the patient on a stable path, the red line. The early treatment prevents the patient’s condition from worsening, which would increase susceptibility to TB. As such it lowers the level of absenteeism and maintains an effective workforce.

From a business perspective, Dr Brink said proper management of chronic illness would reduce absenteeism and improve productivity. Under standard care, productivity dips when HIV-positive employees develop AIDS and can return to normal after treatment. By treating HIV-positive employees before they develop AIDS, the ‘dip’ of deteriorating health, absenteeism, co-infection with TB, disability and increased risk of death could be avoided. Key HIV/AIDS indicators for employees of Anglo American illustrated the success of the programme. Moreover, a study by the London School of Hygiene & Tropical Medicine further supported the idea that company-level ART provision to employees is cost-saving.

The cost of AIDS in the workforce is due to increased benefit payments, absenteeism, training and recruitment, and medical costs; however, the cost
of ART is only 5 per cent of this total. The savings under ART are mainly due to reductions in benefit payments and absenteeism costs by 14–18 per cent.

Anglo American thermal coal mines have been saving 9 per cent on the annual cost of HIV/AIDS (from $31.2 million to $27.6 million) by making ART available to their workforce since 2003. Not only did the numbers illustrate the value of investment in treatment, but Dr Brink argued that the benefits extended beyond the workplace. The families and communities in direct contact with the employees benefited as well. He even suggested that if this strategy worked well in a business setting, it could work just as well in an entire country.

Dr Brink went on to address the challenge of TB, which is much more difficult to diagnose. It is also estimated that 80 percent of the population of South Africa has had TB, suggesting there is a large reservoir of latent TB. It is especially dangerous due to its nature of becoming resistant to drugs if left undiagnosed, misdiagnosed, untreated or mistreated.

Globally, the burden of TB is enormous and under a ‘business as usual’ model it will take 200 years for the global TB mortality rate to equal that of Belgium now. Out of an estimated 9,000,000 cases, only 6,000,000 are diagnosed and treated. The burden of TB falls largely on Africa and Southeast Asia (Figure 3).

Figure 3:
The Global Fund has had a great impact on the provision of TB treatment, the detection of TB cases, and treatment success – and global trends in TB mortality, prevalence and incidence continue to decline – but further effort is needed. For its part, Dr Brink said Anglo American had contributed to an increase in the detection of TB and decrease in deaths attributed to the disease among its employees. Anglo American extends its health mandate to contractors, requiring them to participate in and comply with Anglo American occupational health standards. The basic package of care will include a comprehensive response to HIV and TB including treatment.

Dr Brink said that Anglo American promotes better community health by facilitating tangible health improvements in local communities and being a positive influence on health in developing countries. The pillars of health system strengthening were: improving facilities and equipment; human resources for health; procurement and supply chain management; financial management and funding (health insurance); health information systems; governance and accountability; monitoring and evaluation. Dr Brink stressed that there were many opportunities for companies to get involved by sharing core competencies.
SUMMARY OF Q&A

Question:
What role do other stakeholders such as the unions have in tackling HIV/AIDS, TB and occupational health issues such as silicosis?

Answer:
It was explained that this question was particularly relevant as at the time there was a legal case against Anglo American from workers seeking compensation for silicosis.

Anglo American has formed a tripartite partnership with the unions and the government. This was originally primarily concerned with safety issues, but is increasingly focused on health.

The effects of silicosis are prevalent across the mining industry but gold mining is particularly problematic as the nature of the rock increases the risk. Although Anglo American no longer operates in the gold industry, Dr Brink argued that the compensation system for silicosis had to be fixed, especially as it increases the risk of TB.

Although the compensation system for legacy problems is broken, Anglo American acknowledges that these illnesses are progressive and care must go beyond retirement. Weak health systems compound the problem and the company addresses it by going directly to the people and by removing risk from the environment, by addressing health and safety.

Question:
What are the ethical issues within these partnerships, and are there issues with members’ principles? How does the business case translate to the family and community levels? And what are the political constraints on such partnerships?

Answer:
When the health programme started, it did not have a foundation in human rights; it was difficult to work with NGOs at first too, but Dr Brink said that had now changed: they are seen as partners now, including faith-based organizations, and it is a two-way street.
Dr Brink argued that businesses understand that new markets are in emerging economies, and they must understand that is where the largest burden of disease often lies. Unfortunately, many businesses will not believe this until they suffer a disaster. Firms require a ‘licence to operate’ from the community; although the community’s satisfaction is essential, it is difficult to get community-level numbers to satisfy the donors.

There was agreement that the private sector must realize that it is beneficial for it to take action. The private sector must be seen as an investor, not a donor, and this requires better communication among all parties.

Diseases anywhere should be fought. Human rights should be the foundation for any successful programme and health care should not discriminate. There ought not to be any political constraints in this type of work.

**Question:**

What effect has this programme had on public health policy? How can public suspicions over these partnerships be mitigated?

**Answer:**

The programme started at a time when the government was in denial about HIV/AIDS. Since then, many organizations have formed advocacy coalitions and pushed the government to act. This cannot be attributed solely to the private sector, but clearly businesses can have an impact on public policy. Public policy in South Africa today is at the front edge of tackling HIV.

It was recognized that public suspicion has been an issue, particularly with regard to pharmaceutical companies, which are often excluded as partners even when they genuinely want to help. Dr Brink said that generic pharmaceutical companies, for example, shared human rights ideals with other advocates; more often now, they were welcome partners. Civil society had pushed hard for this change. Getting this right was essential for businesses, as was repairing past damage.

Dr Brink said that one case where progress has been made was Ethiopia. While it was in an entirely different situation from South Africa, the government had dealt with the burden of disease very well, which would in turn help the economy. Another example of the synergistic relationship
between investment in health and a strong economy was Rwanda, where reducing the burden of disease had been crucial to economic growth.