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Impact of HIV/Aids on the Labour Force: Exploring Vulnerabilities

Abstract

This paper explores the impact of HIV/Aids on vulnerability in the labour market, and in the labour force specifically. Research to date has concentrated on the social-behavioural and macro-economic impact of HIV/Aids on the development agenda of the hardest-hit countries, especially in sub-Saharan Africa. Understandably, most of the analysis is geared at establishing the scale and nature of the pandemic, as well as emphasising the human tragedy that is unfolding. Most labour market analysis derives from macro-economic simulation studies as well as the few firm and sector level studies in the public domain. The focus is largely on risk assessment in relation to mortality and morbidity costs faced by governments, businesses and households. However, what is often neglected is the risk faced by the labour force in terms of increased vulnerability, the extent to which it will have to carry the Aids burden, and how the balance of power between business and labour may be shifted in terms of collective bargaining. In this paper, I argue that there is an interdependent relationship between HIV/Aids and social and labour market inequalities. HIV/Aids disproportionately affects the most vulnerable and marginalised in society and in the labour force. It therefore deepens unequal relations of power, both in the structure and organisation of production and in the labour market as a whole. This paper takes South Africa as a case study and examines the challenges it faces in redressing inherited social and economic inequalities in the context of the HIV/Aids epidemic..

Jocelyn R. Vass
Senior Researcher
Employment & Economic Policy Research, HSRC
Pretoria, South Africa

Current Vulnerability in the Labour Market

The South African labour market, even in the post-apartheid period, is highly differentiated by historical cleavages of race, gender, education, skills and income. Factors internal and external to the local economy contribute towards this trend. The South African economy, like most exposed to globalisation, has shifted towards services and knowledge intensive sectors, including finance, business services and information technology. This shift has been accompanied by fundamental changes in the size and nature of labour demand. Household surveys report high levels of unemployment, between 25 and 35 percent using a narrow definition of unemployment, and between 35 and 42 percent using a broader definition (Statistics South Africa 2001).The September 2001 Labour Force Survey records an annual loss of one million jobs between February 2001 and September 2001, presumably in the informal sector and subsistence agriculture (Statistics South Africa 2001). A similar number has been lost in the non-agricultural formal sector since 1989 through restructuring in the private and public sectors (Reserve Bank 2000). There has also been a structural shift in the skills composition of the labour market. Thus the demand for highly skilled and skilled labour has increased at a higher rate than that for unskilled or semi-skilled labour (Bhorat 2000). However the education and training system is not producing enough skilled and highly skilled personnel to meet this demand.

This human capital deficiency is characterised by the highly differentiated nature of the labour market. Thus, large pockets of vulnerable groups, unskilled, poorly educated, poorly paid, mostly Black men and women, co-exist with smaller concentrations of well-paid, well-educated and highly skilled, mostly White man and women. Affirmative action, both in the private and public sector, has not substantively changed this profile. There have been some advances in restructuring and transforming the education and training systems in order to fast-track more equitable human resources development and supply to the labour market. However, progress and implementation have been slow, despite fundamental policy shifts.

The Main Drivers of HIV/Aids Impacts

The main projection models in South Africa, those of Abt/Metropolitan and the Actuarial Society of South Africa (ASSA), estimate current infection levels at between four and six million (Bureau for Economic Research 2001). Prevalence for the total population in 2001 is estimated at 13 percent and is expected to peak at over 16 percent by 2006 (ASSA 2000). For the labour market the crisis of HIV/Aids locates itself in age, sex and race distribution as shown in the prevalence and mortality patterns. Thus HIV/Aids affects the economically active population disproportionately, with an adult (20-65 years) prevalence rate of 22.3 percent, peaking at 27 percent. There is a particular concentration amongst those aged 15-49 years (ASSA 2000). HIV/Aids also has a differential impact on racial groups. The highest peak prevalence is for Africans (19.5 percent), compared to 3.24 percent for Whites, 4.8 percent for Asians and 6 percent for Coloureds (Bureau for Economic Research 2001:7). Women are

more vulnerable than men; more are infected and at a younger age. The most recent antenatal clinic survey shows that women aged 15-49 years constitute 56 percent of the 4.74 million people currently infected (Department of Health 2001). Women also tend to be infected earlier (15-35 years) than men (20-45 years) (Bureau for Economic Research 2001). Given the median survival time of 8-10 years, in the absence of treatment women will die sooner than men.

Aids is now regarded as the single biggest cause of death within the entire population. Mortality data trends for 1985-1999 show that more adults are dying and at younger ages as well, doubling in the 30-35 year range (Dorrington *et al*. 2001: 5-6). In 2000, 40 percent of adult deaths in the age range 15-49 are attributed to HIV/Aids, as are 20 percent of all adult deaths. Mortality patterns are gendered, as young women (25-29) were dying 3.5 times faster in 1999-2000 than in 1985 (Dorrington *et al* 2001:6). UNAIDS (2002) projects that mortality amongst youth (15-34 years) will be seventeen times higher by 2010-2015 as a result of HIV/Aids. A decline in average life expectancy from fifty-six years in 2000 to forty-one years in 2015 is also projected (ASSA 2000). Even more pessimistic is the Abt/Metropolitan model, which predicts a life expectancy of thirty-eight for men and thirty-seven for women by 2015 (Bureau for Economic Research 2001).

The racial and gendered pattern of prevalence and morbidity has its roots in the structural susceptibility of the historically disadvantaged groups: Africans and women. Thus, increased high-risk sexual behaviour and increased exposure may be ascribed to a continued lack of economic power, less access to education and information, a lack of social cohesion in families (as a result of the migrant system) and the relatively low social status of women compared to men. There is thus a complex combination of social and economic circumstances impacting on risk-aversive behaviour and exposure to risk.

Impact on the Size and Structure of the Labour Force

All predictions indicate a slowdown in population growth, as opposed to an absolute reduction. Given mortality rates and the age distribution of the epidemic, projections are that by 2015 the total labour force will be at least 21 percent smaller as a result of HIV/Aids (Bureau for Economic Research 2001). The age and gender distribution of HIV/Aids may also contribute to deficiencies in the quantity and quality of the labour force. Thus, the morbidity and mortality effects on those aged 15-49 years, and a concentration among older people up to 65 years, may lead to the so-called funnel or chimney effect (Lisk 2002: 4). In addition, an increase in the numbers of Aids orphans and school dropouts may contribute to increased use of child labour, as children enter the workforce at even younger ages in search of financial support. ASSA (2000) predicts the number of maternal Aids orphans will increase from 190,000 in 2001 to over 1.8 million by 2015.

The dependency ratio will also increase, as fewer working-age people will take responsibility for increasing numbers of economically inactive dependents. Similarly the doubling of mortality amongst those aged 30-35 years will result in a decline in the labour participation rate of those in their peak economically active years (Dorrington 2001). The participation rate of both men and women peaks in their mid-thirties (Statistics South Africa 2001), but the effect on women may be particularly negative, as they are more likely to take responsibility for the care of sick or dying relatives or to suffer more sickness or deaths themselves. This gender disparity may translate into a gender imbalance in favour of men in the labour force.

Given the relatively high rates of unemployment amongst Africans, they have lower participation rates than all other groups, especially Whites (FAFO 2002). Thus, while increased mortality amongst Africans may not result in an absolute reduction relative to other smaller groups, it may further reduce labour force participation rates and access to productive work. However, it is the gender and skills composition of the HIV/Aids impact that will most affect the relative status of Africans in the labour force. With a prematurely younger and older labour force and uneven levels of skills and experience, will it result in a "race to the bottom" and further "crowding in" of the historically disadvantaged at the bottom of the skills ladder?

Skills and Occupational Segmentation

The interplay of race, gender, education and skills contributes to occupational segmentation. Research in South Africa on the skills and occupational distribution of HIV/Aids incidence, prevalence and mortality is very uneven and tentative. Extrapolation from the demographic models (based on antenatal clinic survey data) is contentious. There are inherent elements of bias in the antenatal clinic data, while complementary data such as the 1996 Census and the October Household Survey (OHS) are weak. Furthermore projections tend to assume that risk behaviours will remain uniform within skills categories and broad economic sectors. The risk distribution at skill levels and occupational groupings is a function of various demographic and socio-economic factors coming into play. In the absence of establishment, sector-based or even household sero-prevalence data, these projections remain very tentative and should be regarded with caution. More in-depth research is required.

Nevertheless existing data does indicate an inverse relationship between skill levels and HIV/Aids prevalence levels. Thus lower-skilled and more poorly paid workers have higher prevalence levels than higher-skilled and better-paid workers, see study conducted by (Abt Associates 2000, 2001). The dominance of Africans, a high-risk group, may explain high prevalence levels in the semi-skilled and unskilled occupations. At the other end of the scale, Whites have lower prevalence levels and are mostly in higher-skilled occupations.

Although the data reveals unacceptably high infection levels and Aids prevalence rates at all levels (Abt Associates 2000; Quattek 2000), the prevalence rates among skilled workers are nearly as high as among semi-skilled and unskilled workers. However, the skilled level also includes large numbers of White workers, who are supposed to have lower prevalence rates. Another anomaly is that the prevalence rate among highly skilled workers is considerably lower than at other levels, yet the skilled category includes teachers and nurses, who are predominantly Black (Bureau for Economic Research 2001). The fact that the expected effect does not occur in either of these examples indicates that there must be something else at play. A more in-depth investigation of the interplay between socio-economic characteristics, including income, education and skill level, and demographic factors in risk group formation and vulnerability is clearly necessary. Nevertheless the current prevalence trends have very

negative implications for the skills shortage in the labour market. Already the decline in the economically most active sector of the population (15-49), along with increased child labour, may lower the general level of skills and experience in the workforce, even if those closer to retirement age remain in the workforce (ILO 2000). One can expect a worsening of the shortage of skilled and highly skilled employees, as the pool of eligible workers shrinks even further.

At the same time, enterprises may not wish to invest in training. The return on human capital investment is reduced or lost altogether when the life expectancy of employees is reduced. Investment in training to replace or retrain lost labour may become too costly as enterprises face declining productivity and profit levels. Thus, for skilled and highly skilled workers, companies may prefer to offload the costs of recruitment, training and replacement by reverting to poaching or even importing skills from abroad. In addition the achievement of equity in fast-tracking the flow of more Blacks and women into skilled and highly skilled occupations may be at risk. Mobility out of semi-skilled and unskilled occupations may become even more difficult for Blacks and women, further entrenching overall occupational segmentation and inequity. Anecdotal evidence suggests that despite advances under the National Skills Development Strategy (NSDS), a legislative framework geared at upgrading skills and lifelong learning through partnerships between government, business and labour, most employees receiving enterprise training at highly skilled and skilled levels are White males, whereas most employees receiving training at semi-skilled and unskilled levels are African males. The implication is that if current training continues to relegate the historically disadvantaged to low-skilled, low-paid occupations, HIV/Aids-induced constraints on training may entrench this trend further. It will also become even more difficult for women to accumulate the skills and experience needed to break through the "glass ceiling" at the skilled and highly skilled levels of traditionally male-dominated occupations. Even now very few companies have effective managed care programmes that include succession planning in order to provide sufficiently trained people to replace those lost due to Aids-related illnesses.

Labour Force Substitution

Macro-economic simulation studies point to a decline in productivity levels as a result of the projected labour force decline (Bureau for Economic Research 2001). The overall decline in skills and experience will lead to lower productivity, thus increasing the possibility of capital substitution. For skill-intensive sectors capital and skilled labour are complementary inputs. Thus technological substitution may be hampered by an inability to fast-track high skills acquisition in the system, given the costliness of replacements and retraining. As noted before, a reversal to poaching and importation of skills is likely. Less skilled and labour-intensive industries are already experiencing increased capital intensity, which may be exacerbated by the cost impact of HIV/Aids.

Many companies regard the large pool of unemployed and unskilled Black workers as an effective option to fill the gaps left by ill or dying unskilled and semi-skilled workers. However, this may not be a sustainable option. The unemployed, Black, young and female sectors have a highly susceptible demographic profile and projected HIV prevalence rates of above 30 percent (Bureau for Economic Research 2001). In the absence of training, and with reduced replacement possibilities, capital substitution becomes even more entrenched. As a result reduced labour demand impacts negatively on both the currently employed and the unemployed.

Impact on Atypical Forms of Employment

Another replacement option is to intensify the current shift towards atypical forms of employment such as casualisation and outsourcing. These reduce labour costs, as non-permanent (temporary or contract) workers have more flexible conditions of employment and fewer benefits. Current projections assume that enterprises will shift some of the HIV/Aids burden onto their employees through casualisation and outsourcing. Other studies confirm the trend towards "burden shifting," especially with regard to medical and retirement benefits (BER 2000; Whiteside 2002). Thus the increased replacement of ill or dying permanent employees with temporary or contract workers with little or no benefits may become a viable option, increasing especially at lower-skilled levels. Finally atypical forms of employment are part of the general reorganisation of the production process. The labour force may be faced with increased demands for more flexibility and multi-tasking or multi-skilling in order to maintain productivity and efficiency. The overall effect will be to shift the burden to the most vulnerable and marginalised in the labour force.

Impact on Wage Distribution

Currently there is no comprehensive analysis available on the impact of HIV/Aids on wage distribution. In the aggregate it is expected that wages will rise with the decline in labour supply (Bureau for Economic Research 2001). However, given the direct and indirect costs of HIV/Aids, labour demand may fall, which will have a dampening effect on wages, especially at low and unskilled levels. Macro-economic studies indicate that household savings capacity is eroded as more household income is shifted towards medical, care and funeral costs (Bureau for Economic Research 2001). Given the increased dependency ratio, the labour force faces increasing income vulnerability. Very poor households rely heavily on remittances from working members, which they are now likely to lose completely or partly. This will contribute to further destitution in very poor households.

Medical and care costs related to HIV/Aids will increase expenditure for infected individuals and their families. Medical benefits are very expensive and mostly concentrated amongst so-called white-collar workers in skilled and highly skilled occupations. Thus skilled and highly skilled workers will have relatively enhanced access to medical treatment and care in order to prolong their productive lives. However, with medical benefits either absent or unaffordable, those in lower-skilled positions are more likely more to carry the cost from their own savings, or else use the overburdened public health system. The estimated cost of treatment per person per year ranges from R13,000 to R25,000, which is completely out of reach of most of the labour force (*Business Day* 12 September 2002). The overall impact may increase levels of debt and deepen poverty within the labour force. South Africa already has among the highest levels of income inequality. The differentiated burden on wages may worsen this trend. Collective