



Coca-Cola in Africa: Refusing to Cover AIDS Treatment for HIV+ Workers

Coke is one of the largest foreign private sector employers in Africa, employing 100,000 people directly and indirectly to produce and distribute Coke products to all but two African nations. Although Coke provides full medical coverage, including ARV therapy, for their 1500 "direct" company employees (and family members) who are HIV positive, Coke has thus far refused to provide coverage and treatment for the other 98,500 workers (and 100,000 plus family members) in the African Coca-Cola system.¹ In defense of its policy, Coke argues that it is not the "direct" employer of its African bottlers, canners, and distributors, hiding behind a complex web of subsidiary and affiliate relationships.²

Coke has attempted to position itself as a poster child for UNAIDS, offering logistical support for distribution of AIDS literature, condoms and testing kits in Africa. It has also offered its Madison Ave. marketing resources and 30 bulletin boards for HIV prevention messages. Coke has used those same advertising and media resources to seek and reap favorable publicity for these UNAIDS

¹ I try to refer to these as employees of the Coke "system" mainly consisting of people working for major bottlers, canners, and distributors who have exclusive licensing agreements with Coke and Coke alone according to my information. We are not talking about small distributors who may in fact carry multiple products to final destination small retailers.

² "Our bottling partners, which are independent companies, are at various stages of developing their AIDS strategies. They are responsible for providing healthcare for their employees and some of their healthcare offerings may differ from ours. They, along with many other companies on the continent, are working through the complexities of this horrific endemic disease to help contribute to finding a lasting solution." Form letter to David Bryden from Industry and Consumer Affairs, The Coca-Cola Company, May 1, 2002. Out-sourcing and other ownership strategies have become a key business strategy of multinational corporations seeking to avoid environmental and labor responsibilities and Coke is no exception to this trend. For a detailed analysis of Coke's corporate system in South Africa, see Bureau of Market Research, University of South Africa et al., *Multinational Enterprise, Employment, and Local Entrepreneurial Development: Coca-Cola in South Africa* (Feb. 22, 1999). For additional details on other African bottlers and canners in the Coca-Cola system, visit <http://www2.coca-cola.com/ourcompany/aboutbottling/html> and click on bottler sites.

initiatives³ (despite the fact that it has done little so far to implement its promises made over a year ago).

However, Coke has continued to neglect the health of its African workforce, mostly Black, that suffers infection rates estimated as high as 8.4%-20%.⁴ Despite this prevalence rate, with newly price-discounted HIV/AIDS therapies, Coca-Cola can surely afford to provide treatment out of its \$261 million fiscal year 2001 African profit margin,⁵ based on \$620 million net revenues from Coke sales in Africa. The costs, roughly \$4.5 million in the first year are miniscule.⁶

It is undeniably true that Coke does not currently provide direct employee benefits for its "system," i.e. indirect, workforce. It is also true that its distributors, canners, and bottlers have some degree of operational autonomy, even though Coke has extensive ownership interests in many of its African bottlers and canners.⁷ However, even if Coke cannot provide coverage directly, it can require coverage as part of its exclusive licensing agreements with major suppliers, bottlers, canners, and distributors. It already micromanages some operating procedures (trademark, syrup, carbonated water, inventory, shelf-life, and other standards) through its licensing agreements, so there is no good reason not to do

³ UNAIDS Signs up Coca-Cola in Battle Against Aids, Press Release 20 June 2001, http://www.unaids.org/whatsnew/press/eng/pressarc01/CocaCola_200601.html; Betsy McKay, *Coca-Cola to Tap Its Marketing Muscle to Help Fight AIDS Epidemic in Africa*, Wall Street Journal (June 20, 2001); Donald G. McNeil, Jr., *Coca-Cola Joins AIDS Fight in Africa*, New York Times (June 21, 2001); *Battling the Scourge of AIDS in Africa*, Press Release (Dec. 21, 2001), http://www2.coca-cola.com/ourcompany/wn20011221_aids_in_africa.html.

⁴ It is hard to estimate the rate of HIV infection among the Coke system workforce, and it is certainly higher in Southern African than in Northern Africa. Nonetheless, a reasonable estimate might be 8.4%-20%. Thus, using a midpoint average, about 15,000 system workers might be HIV positive. No one thinks it would be appropriate for all these employees to immediately receive ARV therapy which should ordinarily be initiated only when T-4 cell counts fall below 200 according to the latest protocols. Assuming that fewer than 15% of employees who are HIV positive would be eligible for immediate therapy, the number to be treated would be 2250, admittedly a number that would grow over time.

⁵ Coke's operating profit margin in Africa is twice that in North America (41% vs. 20%). Moreover, Africa is also one of Coke future profit centers as it expects more market expansion there than in its more developed markets. Every day, around 44 million servings of Coca-Cola products are sold across Africa, which equals .75 billion cases a year. Coke's \$261 million profit in Africa is approximately 5% of its staggering global profits of \$5.352 billion on global sales of \$20 billion.

⁶ Cost of therapy varies greatly depending on whether pharmaceutical giants get away with charging \$10,000 per patient per year, or whether high quality low cost generics could be used (currently available for approximately \$300/year). Assuming drug and treatment costs of \$1400-\$2000 a year (based on academic and mining industry estimates), the highest total first year cost for Coke would be \$4.5 million, .08% of total operating profits worldwide, 1.7% of operating profits in Africa, 2.4% of annual advertising budget.

⁷ There are 140 bottling and canning plants across Africa and 76 different bottling partnerships. Coca Cola has a 52% stake in Coca Cola Canners, a 51% interest in Amalgamated Beverages in SA, a 100% ownership interest in Coca Cola Nigeria and a 21%-24% stake in SABCO, which is an 'anchor bottler.' In addition, coke has an intimate business affiliation with four other bottlers in Southern Africa. See <http://research.badm.sc.edu.research/studies/SoAfrica/chapt3.pdf>

so with respect to mandatory HIV health care benefits. If and when Coke does mandate these benefits for its system workers, it will necessarily have to permit operating margins for its affiliates that would permit HIV coverage. This might require Coke to sell its syrup on slightly better terms.⁸

Coke might legitimately raise issues about the public health consequences of providing treatment to an impermanent workforce where there is a significant degree of turnover. Although figures for turnover in the Coke system are not readily available, most of the affiliates provide relatively good wages within the African formal economy and thus labor turnover is presumably much less than in the informal sector. Even to the extent labor turnover is a legitimate concern, however, Coke could investigate ways to continue care through extended coverage (medical aid), through cooperative agreements with the public sector (admittedly problematic in most African countries), and/or through funding proposals for continuing care to the Global Fund to Treat AIDS, TB, and Malaria.

Coke might also legitimately raise issues about the practicalities of providing care in more rural contexts where health infrastructure is poor and of extending care to dependents, especially for dependents who live at a distance from HIV treatment centers. Obviously, the actual delivery of care is different than coverage issues. Accordingly, Coca-Cola could provide coverage contingent on the provision of care at qualified treatment centers. To help expand treatment, however, Coke, like Heineken's could help to fund, some treatment centers in non-urban areas, particularly near their smaller and mid-size bottlers and canners. Even where Coke cannot fund a rural treatment infrastructure, treatment capacity will expand in response to employees and dependents being able to access resources to purchase medicines and tests. Thus, once Coca-Cola and its affiliates begin to offer expanded coverage for treatment, it is likely that the capacity for treatment will expand operationally and geographically.

The fundamental question, however, is not about legalistic issues like corporate control, strategic outsourcing, and licensing agreements. The issue is whether the corporate sector has responsibility to respond to an HIV pandemic that it has historically neglected at best and intensified at worst. Coca-Cola proudly reports that its system provides employment not only for its system workforce but for nearly a million Africans in upstream and downstream commerce. It has made huge, even disproportionate profits in Africa. Like many of its corporate counterparts, it may have contributed to single-sex worksite and trucking routes that have directly intensified the pandemic.

⁸ Coke's recent corporate strategy has been one of overcharging bottlers and canners for cola concentrate and strong-arming high-priced acquisitions of weaker bottlers. Thus, non-US canners and bottlers are earning lousy rates of return – on average 5% on invested capital. Patrick Sellers, *Who's in Charge Here? Coke's Sales are weak. Its stock is down. Its execution is lousy. And one more thing ...* Fortune (Dec. 24, 2001).

In the nexus of neglect and complicity by the U.S. government (and its European allies), the pharmaceutical companies, and major multinational corporations, a continent is dying. Coca-Cola has the most famous brand name in the world and has amassed enormous wealth for its managers and shareholders off the labor of its workforce, domestic and foreign. And Coke brags on its web page about the diversity of its workforce and its intent to treat them equally.

The Coca-Cola system is one of the most diverse organizations on earth, with a rich mosaic of talented colleagues who bring a variety of intellectual, professional, ethnic and cultural perspectives to our enterprise. They reflect the nations, cultures and languages of the world. Our policy is to foster an inclusive environment that encourages all employees to develop and perform to their fullest potential.

Our workplace must be a place where everyone's ideas and contributions are valued. Our employees deserve equal treatment under our policies governing compensation, advancement, health, safety and other aspects of workplace life. We understand that fairness in the workplace, coupled with the opportunity to develop individual capabilities, fosters our collective success.

How is it fair, or equal, that Coke provides AIDS coverage to its formal corporate employees but not to brothers and sisters employed in the larger Coke system? Why is it not morally imperative to require Coca-Cola to respond to one of the major human rights dilemmas of our time, a pandemic currently infecting 28.5 million Africans out of a worldwide total of 40 million infected?

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