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ANGLO AMERICAN (B)

Just a few short months after Anglo American's groundbreaking new HIV treatment pilot program had been heralded in South African and international media, the program appeared doomed amidst questions about the costliness of the initiative, the difficulty of advancing such an ambitious program without broader industry and government support, and the challenge of resolving thorny issues like how — and whether — to treat dependents. In the face of a 23 percent HIV prevalence rate among Anglo American's workforce, it had been intended that Anglo's Antiretroviral Treatment (ART) initiative would greatly expand the number of employees, particularly miners, who got tested for HIV and provide life-saving drugs to the individuals who needed them most. However, in light of the risks identified above, AngloGold's ethics committee suggested that the pilot study be reconceived as a feasibility study; shortly thereafter, Anglo executives declared that they were suspending the program in order to seek additional partners to share some of the risks.

Reactions in the health and business communities ranged from disappointment to fury, with many viewing the suspension as a “death knoll” for the once-promising program. South African trade and mining unions scathingly held the decision up as proof that the original announcement had been nothing more than a “publicity gimmick,” with “Anglo American's about-face” serving as “a betrayal of the workers who produce the company's profits.”¹ However, according to Brink, Anglo American's senior vice president for medical operations, the “view” from within the company was very different. “It is true that there was a feeling that it was just too complex, too controversial, and too costly for one company to go it alone, against the wishes of the government and with no other company even close to our size offering a similar program. However, rather than viewing it as an end to the program, we viewed it as a pause while we went to seek partners within the mining industry and with government.”²

As a first step, the company opened a dialogue with the Chamber of Mines with the hope of convincing the prominent mining industry organization to undertake a 1,200-person treatment feasibility study. Though initially promising, these negotiations soon stalled as members of the

¹ International Federation of Chemical, Energy, Mine and General Workers' Unions (ICEM) Update, No. 73/2001, 11 October 2001. <http://www.cptech.org/ip/health/sa/icem10112001.html>.

² All quotes from Dr. Brian Brink are taken from phone interviews conducted on May 18, 2003 and August 22, 2003.

This case was written by Kanika Bahl (MBA 2002) and John Newsome (MBA 2001) under the supervision of Professor Joel Podolny at Stanford Graduate School of Business as the basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

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industry group debated the cost of the study and worked to scale it back to a few hundred people. By June 2002, little progress had been made and discussions ground to a halt.

At the same time, however, other changes had begun to transpire — changes external to Anglo American and to the mining industry but relevant to the African firm's ability to implement an ambitious antiretroviral program. Under increasing fire from NGOs (non-governmental organizations) and the international community for their ambitious pricing of life-saving HIV/AIDS drugs, pharmaceutical companies began to offer these drugs at deep price cuts, particularly to developing nations, South Africa among them. Simultaneously, demand in the West for cheaper and more effective HIV treatments was driving pharmaceutical groups to new heights of innovation, increasing the variety and quantity of antiretroviral drugs on the market. By mid-2002, the same course of antiretroviral drugs that, in 2000, would have cost \$12,000 annually was now available for just \$1,200.³ Equally noteworthy, financial analysts were becoming ever more sophisticated about the likely impact of the HIV epidemic on South African and Sub-Saharan companies, demanding information about companies' infection rates and treatment programs, and even prompting changes in financial reporting.

The 14th Annual AIDS Conference in Barcelona in July 2002 was a turning point for Anglo American, highlighting just how much the Group's worlds had changed. On the one hand, the conference provided medical evidence of the efficacy of drug treatment, even in poor country conditions, and demonstrated to Brink and others that administering that treatment was "not that complicated and not that difficult to do." On the other hand, the conference served to underscore the political risks of inaction: Anglo American, a company that had long prided itself for its legacy of social responsibility, was one of only two companies targeted during the conference by activists and protesters, who chanted: "Coke and Anglo, you can't hide. We charge you with genocide."⁴

Just a few weeks later, after months of intense consideration — and despite their failure to garner broader mining industry support and their reservations about "going it alone"— Anglo American executives decided to reinstate the antiretroviral treatment program, and, even more noteworthy, expand it to include all of their workers. "This crisis is not going away," noted Anglo American CEO Tony Trahar regarding the Group's momentous decision, ratified on August 1, 2002. "If there is a lead to be taken, Anglo American will take it. It is a leap of faith."⁵

Decision in hand, Anglo American swiftly began working with Aurum Health Research (AHR), a wholly-owned subsidiary of AngloGold, to finalize plans for the Group's new AIDS treatment program and integrate it into Anglo's pre-existing HIV/AIDS abatement activities. Although the Group had provided many HIV/AIDS related services to its workers and their relations over the years, including education programs, HIV testing, treatments for sexually transmitted infections (which increase susceptibility to HIV infection), individual and group counseling, and drugs to treat tuberculosis and other HIV-related ailments, the provision of antiretrovirals would bolster

³ Fishman, Charles, "One Man's Drive...One Company's Courage," *Fast Company*, June 2003.

⁴ During this time, The Coca-Cola Company was the target of protests for its labor practices, including "providing treatment access to 1,500 of its 'direct' employees, leaving its 100,000 indirect employees – outsourced canners, bottlers, and distributors – without treatment," according to the Student Global AIDS Campaign.

⁵ Fishman, op.cit.

significantly the Group's prevention and treatment efforts. According to an August 2003 Anglo American report:

Treatment is the single short-term intervention that will make a difference to the way the HIV/AIDS epidemic unfolds, both in the workplace and in the communities within which we operate... We need to find a way to change behavior. This will only be achieved if we bring the reality of HIV/AIDS down to an individual level. The best way to do this is to get everyone sexually active to go for an HIV test. The problem is that a positive HIV test often means stigmatization, discrimination, and death. We need to eliminate denial, stigma and discrimination by improving care for those who are HIV positive. We believe this can be achieved through meaningful wellness programs for HIV-positive individuals, (in particular) providing access to appropriate, affordable and sustainable antiretroviral therapy... Providing treatment is a direct challenge to the ignorance, denial and stigma that have fuelled the AIDS epidemic since inception.⁶

Given the significance of the treatment initiative, Anglo executives worked to facilitate its successful implementation and “ensure a high quality, integrated ART program using a standardized model of delivery; expand access to ART; build local capacity; engage in significant evaluation of feasibility and clinical and economic outcomes; and provide a framework for research.” Key elements of the model would include standardized drug regimens, recording, and follow-up and laboratory monitoring; rigorous pharmaceutical control; and stringent data management.⁷ Two weeks before going onto ART, each patient would receive an eligibility assessment and initial ART counseling, as well as undergo a comprehensive series of tests to ensure drug tolerance. Once an individual began treatment, monthly follow-up tests would be administered to ensure patient safety. Patients would be eligible for two drug regimens: a 1st line regimen consisting of AZT and 3TC [“Combivir”] and Efavirenz [“Sustiva”] and, in the event of drug failure, a 2nd line regimen consisting of three different drugs, including a protease inhibitor. According to Brink, the drugs chosen were “the best on the market,” drugs requiring few doses and with minimal side effects, maximizing both efficacy and ease of administration.⁸

Thanks in large part to pharmaceutical firms' new-found resolve to provide life-saving drugs more cheaply to developing countries via programs like the Accelerating Access Initiative, the antiretroviral drugs would be available to Anglo American at not-for-profit pricing. Each patient's monthly supply of Combivir, for instance, would cost Anglo American just \$27, a significant sum for most South Africans but a fraction of the amount charged to HIV-positive individuals in the United States. The antiretroviral drugs would be carefully controlled — “pharmaceutical firms don't want to see nonprofit drugs intended for people in poor countries

⁶ From an August 21, 2003 presentation entitled “Anglo American: Responding to HIV/AIDS—Antiretroviral Therapy”

⁷ From an August 21, 2003 Aurum Health presentation entitled “A Model for Providing Antiretroviral Treatment in Resource Limited Settings”

⁸ Aurum Health presentation, op.cit. and information submitted by Anglo American to the Global Business Coalition on HIV/AIDS for the Coalition's 2003 Annual Awards for Business

leaking back into richer, Western countries,” noted Brink – and records maintained for adherence monitoring.

During the early phase of the initiative, the program costs (at \$4,000 per patient) proved higher than anticipated due to the intensive training and development required, as well as the relatively few number of patients on treatment. However, Anglo executives expected that, as the program grew to 5,000 patients, the program’s costs would decrease to roughly \$1,400 per patient per year, of which drug costs would account for 46 percent of the program’s costs; management 19 percent; lab costs 14 percent; drug procurement, distribution, and dispensing 11 percent; and professional services 10 percent.⁹

As of August 2003, Anglo American’s ART program was scaling up quickly and showing early signs of success. ART programs had been implemented within eight companies at 52 different sites in seven provinces in South Africa, and 110 nurses, 52 doctors, and 26 counselors had been trained. Enrollment in the ART program had grown from seven patients in November 2002 to 689 patients, and executives anticipated that enrollment would top 1,000 by the end of 2003. More notably, ART participants were responding very favorably to treatment. Of the 689 individuals enrolled in the program, only 67 had stopped treatment, including 21 due to death, 17 due to nonadherence, and only 12 due to adverse effects. 89 percent of the patients showed good viral suppression; 97 percent of the employees on ART were back at work.¹⁰

Taking ART to Scale: New Partnerships

Despite the program’s youth, according to Aurum Health the results already had proved that “ART is feasible in a South African industrial setting” and that “the Aurum model of ART delivery can be done efficiently, achieves high quality results, and allows for rapid scalability of ART delivery.” Aurum also asserted that “the model is transferable to other healthcare settings.” Given the World Health Organization’s target of providing ART to 3 million more people worldwide by 2005, as well as the need for “innovative models of ART delivery in low income settings and places with inadequate public health infrastructure,” Anglo executives hoped that the company’s program would be replicated all over the developing world, serving as a model for other companies as well as for governments – including the South African government.¹¹

In fact, securing the government’s partnership in providing antiretrovirals, particularly for dependents and spouses of employees, and expanding ART access more broadly had long been viewed by Brink and others as critical to Anglo’s efforts to slow HIV infections within mining communities, as well as within the general population. Here, Anglo executives hoped that the South African government might match the company’s efforts and that, together, the two entities might cover entire communities.

However, to the dismay of Brink and others, the South African government initially proved uncooperative, if not hostile, to Anglo’s efforts. In fact, a *Fast Company* article noted:

⁹ Anglo American presentation, op.cit.

¹⁰ Anglo American presentation, op.cit.

¹¹ Aurum Health presentation, op.cit.

[The Minister of Health] denounced Anglo American for providing the drugs, failing to consult her in advance, and putting the government in the awkward position of refusing to provide medicine that a mining company would be giving away. In a meeting with Brink, she was scorching. “Oh, she was very angry. She said, ‘You’re squeezing me.’ For that,” says Brink, a twinkle in his eyes, “I don’t apologize.”¹²

Week after week, pressure on the South African government to provide antiretroviral treatment mounted. Highly influential people — including former President Nelson Mandela — began speaking out against the government’s HIV/AIDS policy, while a 2002 survey showed that 95 percent of South Africans thought the government should be providing antiretroviral treatment.¹³ Likewise, a highly publicized civil disobedience campaign by the South African activist group Treatment Action Campaign ensured that the issue remained in the public’s eye.

The final push for a governmental treatment program may have come from a much-awaited report released in 2003. The report, a joint effort by South Africa’s health and finance ministries, showed that a treatment program was not only affordable, but also could save 1.7 million lives by 2010.¹⁴ Faced with growing public pressure and strong evidence of the benefits of a treatment program, the South African Cabinet issued a groundbreaking statement on August 8, 2003 instructing that the Department of Health’s next implementation plan, due in September 2003, include provisions for antiretroviral therapy.

While many in the international community remained skeptical about the government’s commitment to HIV abatement, Brink remained optimistic. “It’s like the apartheid system breaking down, where the tide started and it couldn’t be halted. We’ve seen a number of employers beginning to offer this, beginning to consider it as something they must do. Finally the South African government is beginning to consider this. Anglo American is very big, and I think its actions have had impact.”

Beyond ART

According to Anglo American: “The development of an effective vaccine offers the best, if not only, prospect for ultimate control of the HIV/AIDS epidemic in Southern Africa. Mining companies together with employee organizations are uniquely positioned to carry out Phase II and Phase III clinical vaccine trials, in association with country specific AIDS vaccine initiatives. Anglo American is working with the South African AIDS Vaccine Initiative to develop pilot clinical trial sites.”¹⁵ Likewise, in the aftermath of the ART’s successful launch, Brink and others turned their focus to “extending workplace programs into surrounding communities in partnership with government, unions, NGOs, and international donor agencies” via Anglo’s social investments as well as “new ways of working.” In 2002, the Fund devoted R4.3 million to HIV/AIDS programs, 7 percent of the fund’s total, the bulk (55 percent) of which

¹² Fishman, op.cit.

¹³ Schoofs, Mark, “South Africa May Finally Bend To Antiretroviral Medicines,” *Wall Street Journal*, May 13, 2003.

¹⁴ UN Integrated Regional Information Networks, August 5, 2003
<http://www.egis.com/news/irin/2003/IR030804.htm>.

¹⁵ From an August 2003 presentation by the Anglo American Fund’s Tshikululu Social Investments entitled, “Anglo American Group Company HIV/AIDS initiatives”

was devoted to education. As of August 2003, Anglo American and AngloGold had identified four focus areas for Anglo American Fund HIV/AIDS social investments:

- Youth: Behavior and attitudinal change
- Hospices: Care for those already infected, terminally ill, relief for families, basic medication, dying with dignity, and assistance to children
- Home-based care: Community outreach workers and palliative care
- Infected and affected AIDS orphans: Community mobilization for greater support structures and responses versus orphan institutionalization

Anglo American also was working to implement “platforms of excellence,” a newly funded program to build partnerships in five selected geographies located within Anglo operational areas and create a platform for a range of HIV/AIDS interventions, “extending and broadening access within host communities to services previously only available to company employees.” Among the services provided by the platforms of excellence: “Youth appropriate education and awareness programs; specific capacity building intervention programs within state clinics with a view to improving service delivery on all levels in preparation for full-scale ART roll-out; and focused interventions on the need for community clinics to become non-judgemental... accessible to youth, and enabling of treatment for STIs.” According to Anglo: “We believe that the intervention has the potential to become a national model of public/private partnership.”¹⁶

Reflecting on Anglo American’s journey from ART planning to implementation and beyond, Brink noted: “Every little thing we do now, we’ll be judged for later, 15 years from today. The problem with HIV is that it’s so insidious, and the impact is felt over a long time. You know the power of compound interest? That’s the power of this disease. It’s a little bit at a time, but over a long, long time. And that impact over the long term is massive. That’s why waging war is what we really need to do. The need to act now is urgent.”

¹⁶ Anglo American Fund presentation op.cit.