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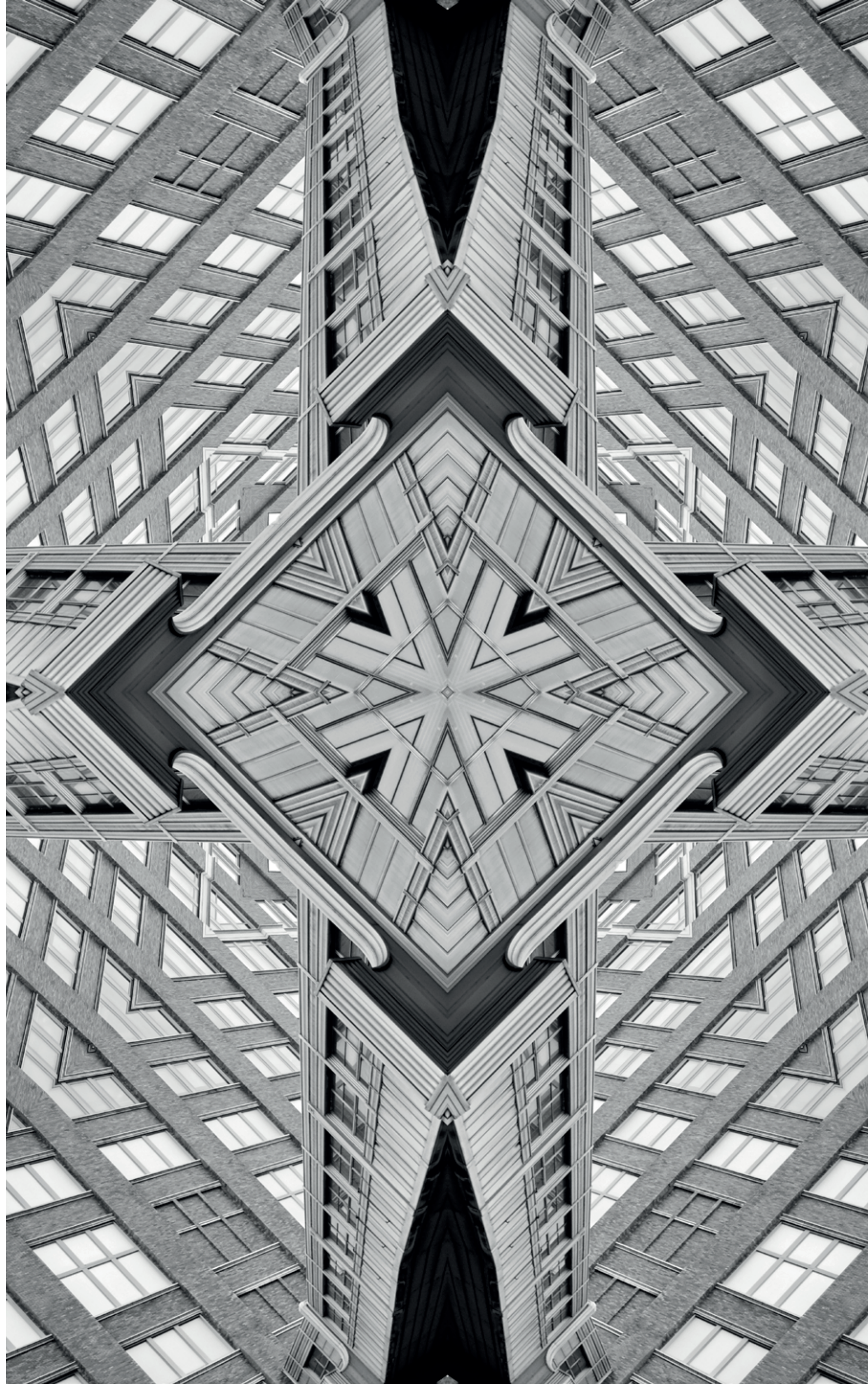

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South Africa's Covid-19 Responses: Unmaking the Political Economy of Health Inequalities

Madalitso Zililo Phiri

Abstract

South Africa's Covid-19 responses are marred by policy paradoxes. How does a country with one of the most sophisticated health systems in Africa account for the highest number of Covid-19 fatalities? This brief argues that contemporary approaches to South Africa's social, domestic, and foreign policy responses should be viewed through the theoretical lenses of *racial capitalism*—a racially hierarchical political economy constituting war, militarism, imperialist accumulation, expropriation by domination, and labour superexploitation. Departing from current paradigms, the brief advocates the unmaking of health inequalities through the abandonment of a racialised neoliberal globalisation by putting decommodification of healthcare at the centrestage of policymaking and recovering the idea of the global commons.

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Introduction: South Africa's COVID-19 Responses

As of February 2021, official statistics show that South Africa has recorded over 47,000 COVID-19-related fatalities.[1] Seen against the global Western epicentres of the pandemic such as the United States (US), the United Kingdom (UK), and Italy—which South Africa mythologically compares to—the number for the African country is relatively minuscule.[a] It was, for example, common at the start of the pandemic for health advisers and politicians to warn that South Africa should avoid ending up like Italy or Britain.[2] Indeed, compared to other countries in the African continent, South Africa has the highest number of COVID-19-related fatalities.

The arrival of the first doses of vaccines manufactured by the Serum Institute of India through a sublicensing agreement only served to deepen conspiracy theories that alienate the people from government's efforts to tackle the pandemic. The issue that emerged is market segmentation: as Fatima Hassan, a South African health activist has suggested, AstraZeneca through Oxford University has segmented the global market. "They were supposed to supply Europe and the United States of America – and other rich nations – and have Serum [Institute of India] … supply the Global South. [When] a government or those responsible for researching, acquiring, or distributing vaccines are [not] transparent [in] sharing information, that is when it is fertile ground for disinformation and conspiracy theories."[3] This is in the context of the increasing ubiquity of "vaccine nationalism" that is shaping the trajectory of global responses. How does a country that boasts one of the most sophisticated health systems on the African continent account for the highest number of COVID-19 deaths?

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a The idea of modern South Africa is a product of British colonial and imperial cartography, leading to fragmented identities and arbitrary boundaries that divorced South Africa from continental geographical location. The year 1910 saw the formation of the Union of South Africa, whose sole aim was to unite antagonistic British and Dutch (Boer) territories to exclude Black Africans from participating in this newly formed state under the guise of the *mission civilisatrice*. 1912 however, saw the birth of the African National Congress (ANC) whose sole aim was to resist the exclusivist colonial idea that South Africa will be governed under the hegemonic ideas of empire that privileged White citizens. 1913 further consolidated ideas of difference and White economic privilege by the promulgation of two legislations: the Land Act and the Immigration Act. On May 8, 1913 the colonial parliament promulgated a legislation that banned the recruitment of migrant workers from areas north of latitude 22 degrees which included British governed territories like Southern Rhodesia (Zimbabwe), Nyasaland (Malawi) and the Portuguese colony of Mozambique. The ban of the tropical native served to cement the ideas of puritanical citizenship that has shaped South Africa's post-apartheid migration policies and engagement with the rest of the African continent.

Introduction: South Africa's COVID-19 Responses

This brief argues that modern South Africa's health policy choices should be viewed through the theoretical lenses of *racial capitalism* which—borrowing from the African American political theorist, Burden-Stelly—is a racially hierarchical political economy constituting war, militarism, imperialist accumulation, expropriation by domination, and labour superexploitation.[4] The policy decision to borrow from international lending institutions such as the International Monetary Fund (IMF) to mitigate the effects of Covid-19 ignores the political economy of empire and global power asymmetries. South Africa's Covid-19 responses are enveloped in a global capitalist financial architecture that is unequal, undemocratic, and unstable; further, it champions narrowed public provisioning from the state opting for the primacy of markets to provide public goods, especially healthcare.

Between March 2020 and January 2021, several national lockdowns were imposed in South Africa to contain the spread of the pandemic. These restrictions on movement reified the manifold oppressions and crises that already existed in South Africa's social fabric, around unemployment, health, food, education, economy, and political morality. Structural inequalities in South Africa, however, have always been predicated on pernicious histories of anti-Black racism, racial capitalism, White supremacy, and Black genocide, which are experienced across race, class, gender, and geography.[5] Job and income losses were heavily concentrated among those who were already disadvantaged in the labour market: the Black Africans, low wage earners, manual labourers, and women experienced the greatest losses.[6] The government responded by extending social assistance programmes—called the Special COVID-19 Social Relief of Distress Grant—to relieve poor households of the deleterious effects of the pandemic. An economic stimulus package of ZAR 500 billion (US$35 billion) was also announced.

"South Africa's pandemic responses are enveloped in a global financial architecture that champions the markets."

South Africa's Covid-19 responses cannot be abstracted from a racialised, neoliberal globalisation process which has resulted in the further segmentation of social provisioning. In 2016 the IMF not only identified neoliberalism as a coherent doctrine but asked if the policy package of privatisation, deregulation, and liberalisation had been "oversold".[7] Patrick Bond, a Northern Irish-born South African political economist has argued that in the field of healthcare, the Bretton Woods Institutions (BWI) promoted—through policy and International Finance Corporation investments—"managed healthcare". It is a "super-commodification" process that sets insurance companies atop a vertically integrated system whose main purpose is to cut costs by closing health facilities and limiting patient access and equality.[8]

Indeed, South Africa faces a violent, racialised, neoliberal globalisation on two fronts: a fragmented social contract that emanates from colonial apartheid segregated public provisioning; and a hostile international hierarchical capitalist global governance architecture that is highly racialised. Thiven Reddy, a South African political scientist, has opined that the South African story provides a unique lens to observe the global narrative of modernity and its ills.[9]

Multilateral institutions such as the IMF and World Bank heightened their response and commitment to assist many countries on all official bilateral creditors to suspend debt payments from the International Development Association countries requesting forbearance.[10] South Africa was among those countries that benefited from this arrangement, culminating in the decision to borrow from the IMF's Rapid Financing Instrument. Yet, some policy researchers noted the perceived 'benefits' of borrowing from the IMF, citing what they said were two benefits for South Africa: that it is getting $4.2 billion at about 1.1 percent interest rate, and that the IMF loan will catalyse other funds for the country. Investors in South Africa and abroad will interpret the IMF's action as an expression of support for South Africa and this will give them the confidence to invest in South African debt.[11]

> "The South African story presents a unique lens to observe the narrative of modernity and its ills."

The financing of public goods through public debt pays lip service to the divorce of the economy from social goals. The Indian historian and scholar activist Vijay Prashad suggests that "the external debt of developing countries is higher than $11 trillion, with projections that debt servicing payments will amount to nearly $4 trillion by the end of this calendar year. Last year, sixty-four countries spent more on debt servicing than on health care."[12] South Africa's policymaking prowess is compromised through political elite bargaining that fail to challenge the pernicious effects of commodified public policy since the demise of colonial apartheid in 1994 and, more specifically, amidst the pandemic. Further to this, Prashad suggests, "the various programmes to suspend debt servicing payments – such as the G20 Debt Service Suspension Initiative – and the various programmes of aid – such as through the IMF's COVID-19 Financial Assistance and Debt Relief initiative – are certain to fall short. The G20 package has only covered 1.66% of debt payments since it has failed to corral many private and multilateral lenders into its agreements."[13] Borrowing from multilateral lenders will ultimately perpetuate a policy environment that champions underinvestment of public goods like healthcare which will in the long run debilitate efforts to curb the pandemic. As Prashad rhetorically argues, "the IMF urges countries to borrow since interest rates are generally low. But this provokes another important question: what should governments do with the money that they would borrow? What the differential impact of the pandemic has shown us is that countries with a robust public health system – including significant numbers of well-equipped public health workers – have been able to better break the chain of the infection than countries that have cannibalised their public health systems."[14]

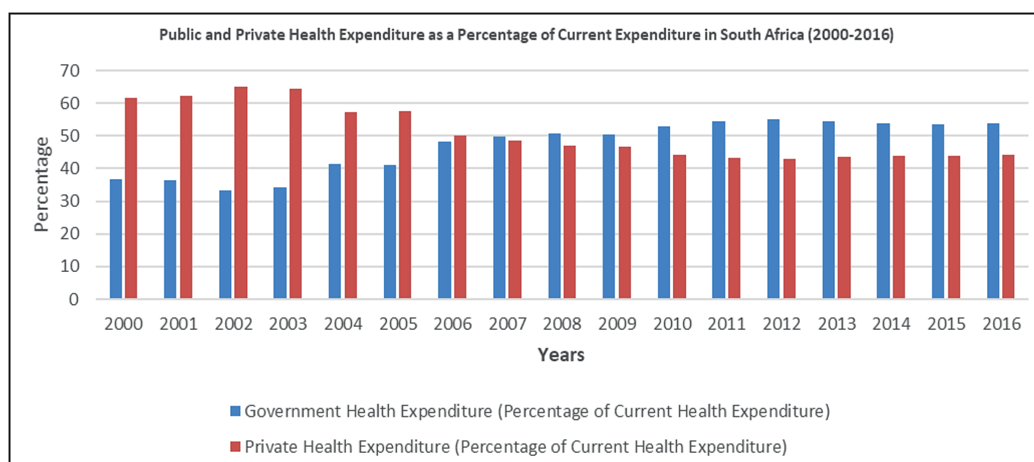
South Africa has committed to the alleviation of health inequalities through the universal coverage of the National Health Insurance (NHI) which envisions decommodified services to its citizens by 2025. The Department of Health suggests that health services covered by NHI will be provided free at the point of care.[15] The realisation of the NHI is being promulgated in the context of a recycling of anachronistic ideas and a deepened hijacking of state machinery by private interests to deliver on public goods. The gulf between public and private social provisioning in South Africa has never been so wide. The country's Department of Health reported that almost 50 percent of Total Health Expenditure (THE) is spent on 16 percent of the population covered by medical schemes, whilst the other 50 percent is spent on 84 percent of the population in the public sector.[16] South Africa rather presents a health policy enigma when both perspectives of both the public and private realms are examined.

The tax contributions of corporate entities in the South African healthcare sector have a direct bearing on the lives of the poor. Figure 1 illustrates that public expenditure as a percentage of current health expenditure began increasing in 2008. It increased from 36.8 percent in 2000 to 53.7 percent in 2016. However, as Ataguba and McIntyre, health economists in South Africa have argued, government expenditure on health as a share of general government expenditure has remained relatively constant and consistently lower than the 15 percent Abuja target over the past two decades. Private healthcare companies are the most profitable, dominated by three oligopolies: Medi Clinic, Life, and Netcare. Private expenditure on healthcare between 2000 and 2006 eclipsed public expenditure by almost 30 percent. Further, private healthcare expenditure as a percentage of current expenditure decreased from 61.7 percent in 2000 to 44.3 percent in 2016. The decline coincided with an increase in public spending on healthcare, which soared from 48.3 percent in 2006 to 53.8 percent in 2016.

South Africa is a health policy oddity: the richest 20 percent of the population spend more on health financing as a proportion of their income than the poorest 20 percent. The bottom 20 percent of the population spends a relatively small share of their income on health services via direct taxes and medical scheme contributions compared to the other groups. The result for private health insurance is not surprising as the poorest 20 percent of the population, statistically speaking, has few insured people, if at all. Direct taxes, as proxied by Personal Income Tax, are by design progressive based on the progressive tax rates.[17] The bottom income quintiles with access to private medical schemes are forced to resort to Out-of-Pocket (OOP) arrangements. OOPs are regressive because the poorest 20 percent of the population pay more as a proportion of their income than the richest 20 percent. Also, the poorest 60 percent of the population pay more as a proportion of their income OOP for health services than the average of all the quintiles.[18]

> “The gulf between public and private social provisioning in South Africa has never been so huge.”

Figure 1: Public and Private Health Expenditure as a Percentage of Current Expenditure in South Africa (2000-2016)



Source: World Bank. World Development Indicators. (2019).

The worst affected areas of the pandemic have characteristically followed the patterns of geographical anti-black racism that is ubiquitous in South Africa's racialised urban and rural planning. A British Broadcasting Corporation (BBC) investigation during the first wave of the pandemic highlighted the plight of frontline workers, underinvestment in public facilities, graft, and understaffed hospitals. One doctor expressed skepticism at a public-private partnership (PPP) between the provincial government in Port Elizabeth and the German car manufacturer Volkswagen: "They have got 1,200 beds, but only 200 are oxygenated, and there are currently only enough staff for 30 beds."[19] Fatalities have been reported in mostly poor and overcrowded communities whose residents painstakingly access understaffed public healthcare services in provinces where the pandemic is the epicentre—for instance Gauteng, and both the Eastern and Western Cape. Meanwhile, relatively wealthier communities are buffeted from the virus, having access to less crowded dwellings and private healthcare facilities that are provided through private insurance. Some of the services that can be purchased are comparable to conditions that are more common in developed countries. These inequalities are a function of the design of South Africa's social policy architecture and the ideas championed by the

neo-liberal policy prescriptions from BWIs through initiatives like PPPs that have divorced the "social" from the "economy" through financialisation and commodification of public provisioning.

A global policy oddity is that countries that have registered the highest number of fatalities also suffer from grandiose ideas about the exceptionalities of nationhood and a faulty thesis on construction of a new 'civilisation': the United States, Brazil and the United Kingdom. The myth of South Africa's nationhood exceptionalism on the African continent, cemented through a polarising colonial lexicon of 'South Africa' and 'those in Africa', explains South Africa's policy idiosyncrasies. South Africa's Covid-19 response is a social policy paradox, with increased public healthcare expenditures that are offset by mediocre achievements in accessing healthcare. Political scientist, Friedman asserts that part of the reason why countries in the Global North have fared worse in the effort to contain the pandemic is their focus on curative medicine, which treats people who are already ill.[20]

Curative medicine is not a huge help if there is no cure and so fighting Covid-19 was easier for countries that have used public health measures to prevent the spread of viruses. Unfortunately, current policy positions have perpetuated a dystopian view of social and health policy, abstracting it from the broader continental aspirations predicated on solidarity. Although South Africa has for decades been the epicentre of pandemics like Tuberculosis and HIV/AIDS, some African countries have been burdened with disease with minimal or no infrastructure to protect citizens from health challenges. As, again, Friedman observes, these countries have so far been better able to cope than countries with state-of-the-art curative health systems. In contrast, South Africa emphasised getting people into hospital because that is what was done in the countries which its politicians and scientists take seriously—a measure that favours curative medicine.[21]

"Countries that have registered the highest numbers of Covid-19 deaths also suffer from grandiose ideas about the exceptionalities of nationhood."

Conclusion

South Africa's decision to borrow from international multilateral institutions to finance public goods is plagued by an ideas-deficit and the influences of a racialised neo-liberalism. Such public policy choices need to be located as an interlocutor within a hierarchical, racialised financial architecture that privileges Western nations thereby maintaining their genetic survival and dominance—this calls for an ideational and practical abandonment of this pattern of racialised globalisation.

Covid-19 reified the financial bankruptcy of the current phase of capitalist development which is built and sustained by debt. The Hebrew Scriptures prophetically warn that "the wealthy rule over the poor, a borrower is a slave to a lender."[22] The slave/master relationship constitute the very foundations of colonial modernity and South African public policy formulation. It can be unmade through ideational militancy and a democratic sharing of power and resources, to offset a racialised capitalist system that is unstable, undemocratic and unequal. South Africa should rather broaden medical solidarity and rejection of the IMF and creditor-driven limit placed on government sector salaries; because of these limits, former colonised countries have been losing medical personnel to the North Atlantic states.

> "Democratic sharing of power and resources will unmake the slave/ master relationship that is the pillar of South Africa's public policymaking."

The first measure to unmake South Africa's health inequalities is the abandonment of a racialised neoliberal globalisation that informs South Africa's contemporary health policy choices. The entire private health sector must be nationalised, and smaller medical centres need to be created so that people can easily access public health facilities. Government must withdraw from public insurance for private healthcare. Public health systems must be strengthened, including the production of medical equipment and medicines and the distribution of essential medicines (whose prices must be controlled by regulations).[23] The idea that the global health architecture is organised around commodification of public goods could never be more apparent. States in the Global North have dismissed the call from South Africa and India to suspend intellectual property rules regarding the vaccine. These Northern states have underfunded the COVAX project which, as a result, is at a high risk of failure, with growing expectations that many people in developing countries will not see a vaccine before 2024. These countries

have hoarded vaccines, drawing these vaccines from the COVAX, with Canada for instance building up reserves of five vaccines per Canadian. Countries in the Global South, meanwhile, such as South Africa, must use precious scarce resources to enhance public medical education and train medical workers within communities to provide public health services.[24]

Second, a recovery of the idea of the global commons will go a long way to offset commodification of health policy. The distinction between commodification and decommodification of public goods has become more evident in the rollout of the vaccine. Aragon Eloff, a South African thought leader, suggests that as with the historical commons – the land and resources humans held and worked collectively before they were enclosed through the violent imposition of private property – so too is the patenting of urgent medical intervention by Big Pharma a new form of enclosure of our collective wealth.[25] In the value chain that has worked on the production of vaccines, the big pharmaceutical companies that have relied on publicly financed research and development stand to benefit immensely. In opposition to a dystopian capitalistic approach of global public initiatives, Eloff highlights the other side of the coin: "from public-access medical data sets to the open-source software used to visualise and model virological data to the digital communications infrastructure that has allowed scientists to collaborate freely across the globe, there is a great common of knowledge, mutual aid and solidarity that underpins and nurtures the foremost scientific endeavours of our time."[26]

> "A recovery of the idea of the global commons will go a long way to offset commodification of health policy."

Conclusion

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