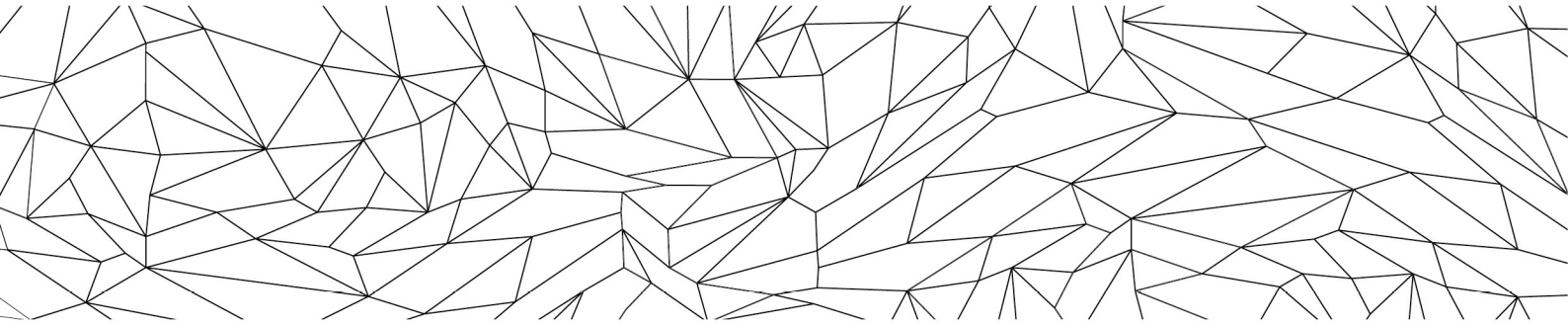
SOAS Department of Economics



Accounting for Some Recent Deaths in South Africa: Zombie Economics Blues

John Sender

Working paper

No. 258

March 2023

SOAS University of London

The SOAS Department of Economics Working Paper Series is published electronically by SOAS University of London.

ISSN 1753 – 5816

Suggested citation
Sender, John (2023), "Accounting for Some Recent Deaths in South Africa: Zombie Economics Blues", SOAS Department of Economics Working Paper No. 258, London: SOAS University of London.

Department of Economics
SOAS University of London
Thornhaugh Street, Russell Square, London WC1H 0XG, UK
Phone: + 44 (0)20 7898 4730
Fax: 020 7898 4759
E-mail: economics@soas.ac.uk
http://www.soas.ac.uk/economics/

Accounting for Some Recent Deaths in South Africa: Zombie Economics Blues

John Sender*

Acknowledgements: A version of this paper will be published by the University of KwaZulu-Natal as a chapter in *A Companion to the Work of Vishnu Padayachee*, edited by Robert Van Niekerk, Rajend Mesthrie and Imraan Valodia. I am grateful to the editors for inviting me to take part in this project. I am also grateful to Chris Cramer, Ben Fine and Hein Marais for extremely useful comments on earlier drafts.

* Department of Economics, SOAS University of London. Russell Square, London WC1H 0XG, UK. T
Email: js@soas.ac.uk

1. Introduction

I've lost a friend
And I'm under pressure
Can't stop singing this song
Cause I'm under pressure

(Mtukudzi 1990)[*]

Too many people are dying in South Africa, especially in rural South Africa. At the same time too many brain-dead economic ideas are roaming the nation; they stalk *lekgotlas* and webinars in South Africa, their hackneyed melodies loudly trumpeting their claims that a 'new improved' snake oil will achieve 'inclusive growth' (and accelerate power generation) while soft pedalling their responsibility for the mediocre performance of private sector investment and for the dismal recent trend in mortality rates. Aiming to silence these raucous claims would be over-ambitious; and it is even unrealistic to hope they might be persuaded to engage in serious debate over conflicting economic and political ideas, let alone contribute to a harmonious resolution of what are the key issues, and how to approach and resolve them.

This chapter has a more modest objective; I hope to pull the plug on some of the the over-amplified renditions of policy refrains that Vishnu helped me criticize all those years ago. Nearly three decades ago we both worked on the Steering Committee of the Macroeconomic Research Group (MERG) and, towards the end of 1993, the Steering Committee asked us to edit and finalise a draft of the MERG Report (Macroeconomic Research Group 1993). It is sad that, after all these years, so many South African policy makers (and economists and policy entrepreneurs) continue to downplay, mispresent or plain ignore key economic arguments published by MERG.

Years of collaborative work have taught me that Vishnu was a remarkably tolerant and affable person. He was loyal to old comrades and was able to relish courteous interchanges with economists who had diverse backgrounds, training and experience. When later we worked together again to put the record straight about the influence of Vella Pillay on economic policy (Padayachee and Sender 2018), Vishnu was especially firm (and fair to a fault); he redacted any attempt to tarnish the halo worn by economists very close to the ANC leadership, although he knew that they had not hesitated to join the board of the largest private healthcare group, to accept the blandishments of Goldman Sachs, JP Morgan, ABSA, AngloGold Ashanti, Old Mutual, Rothschild etc, or to jump at the chance of working for well-funded

[*] Oliver Mtukudzi, 'Under pressure', on the album *Chikonzi* (1990).

institutions that rarely support progressive economists, such as Brookings, the Harvard Kennedy and business schools and World Trade Institute in Switzerland.

I miss Vishnu's calm efforts to reign in my polemical propensities and will commemorate him here by highlighting a few recent policy interventions, rather than attributing South Africa's abysmal performance to the personal defects of individual politicians and intellectuals. It was certainly not Vishnu's style, for example, to dismiss individuals such as Trevor Manuel and Alec Erwin, by calling them 'confirmed neoliberals' (Bond 2021), or to ridicule Alan Hirsch because of his 'weak and one-sided' attempts to legitimise the ANC (Fryer 2006: 605). Vishnu's approach, which I will try to follow in this chapter, was much closer to the nuanced practice of those historians and moral philosophers who, even when writing about the worst fascist horrors of the 1940s, refuse to think in Manichean terms or to adopt the shorthand solution of demonizing easily identified perpetrators (Zbinden and Todorov 2004).

I begin the chapter with a mournful overture to set the scene. Readers are reminded about the appalling scale of death from HIV/AIDS. I also insist that in the period since 1990, discussed under the heading 'Pandemic I', the number of *preventable* deaths in South Africa has been horrifically high, in both absolute and relative terms. More recently, as discussed under the heading 'Pandemic II', South Africans, especially those living in poorer rural communities, have suffered from relatively high COVID 19 mortality rates and there has been an accelerating failure, especially in some of the poorer Provinces, to reduce mortality thanks to the failure to vaccinate the poorest rural children against the common diseases continuing to kill them.

The monopolization of the supply of COVID-19 vaccines by rich countries is said, especially in nationalistic speeches delivered to other African leaders, to have made a major contribution to this suffering and to the inadequate rate of vaccination in South Africa. This claim will briefly be discussed (and compared to earlier conspiratorial claims about the evil intentions of foreign pharmaceutical corporations exporting harmful antiretroviral potions). More generally, I argue that the inadequate policy responses to Pandemic I and to Pandemic II appear to have some similarities. I argue that, during both Pandemics, mainstream economists had a malign influence on policy making, on South African thinking about state intervention in the health (and other) sectors. The enduring influence of their economic dogmas helps to explain some of the similarities between Pandemics I and II.

I end the chapter – with what has now become the refrain of an old classic tune – by emphasising differences between the MERG Report's approach to policy issues and the arguments that many economists currently make when discussing public

expenditure on health (and other forms of state intervention). The final words are a strained search for a more upbeat tune, for reasons to be less pessimistic about possibilities for positive economic outcomes.

How the Living Die: Pandemic I

The number of deaths from HIV/AIDS in South Africa peaked in 2006 at 663 per 100,000 people, falling to 251 in 2019. In other African countries, the average mortality rate from HIV/AIDS has been very much lower – about one third of the mortality rate from HIV/AIDS in South Africa; and the comparable rate for all upper-middle-income countries is lower still – below 9 per 100,000 in 2019.

It can readily be seen that SA Government policy has had a direct and dramatic effect on these trends in AIDS-related deaths. While deaths from HIV/AIDS increased at a terrifying speed between 1997 and 2006, after 2006 there was a remarkable decline in HIV/AIDS and tuberculosis mortality. This decline can be directly attributed to the implementation of new policies adopted by the South African authorities (as well as to the support of some international donors). The government reluctantly agreed – after five years of bullying, prevarication, and litigation – to begin to distribute antiretrovirals (ARTs) to people living with HIV (Johnson 2022). As late as 2004, fewer than 50,000 South Africans were receiving ARTs and, although 4.6 million people did manage to gain access to ARTs by 2018 (equivalent to about 60 percent of the population living with HIV), the inordinate delay in improving free access to ARTs caused the death of many hundreds of thousands of Black African Adults (and thousands of children), especially those living in the rural areas of the poorer provinces (Burger, Burger and van Doorslaer 2022; Achoki et al. 2022; Kabudula et al. 2021).

These dismal facts are well-known, as are the names of the prominent national and provincial ANC leaders who, by stubbornly denying the efficacy of ARTs while slandering activist critics of denialism, may be considered responsible for so many deaths. But what was the broader ideological context encouraging widespread fear of ARTs and welcoming the advice of economists claiming that pharmaceutical treatment was unaffordable? Hein Marais provides an answer to some of the contextual questions; he notes that denialist claims were not only warmly applauded by almost all ANC parliamentarians, but ‘scarcely any ANC figure of note publicly broke ranks, including stalwarts revered for their independence of thought and the courage of their convictions’ (Marais 2012). When the ANC’s National Executive Committee (NEC) met in March 2002 to discuss AIDS policy, there was a general rush to rebuke and rebuff Mandela because he had made statements critical of

Mbeki's (and Mokaba's) position on ARTs. At the end of the meeting the NEC issued a statement asserting that these drugs 'could not be provided in the public health system because of prohibitive costs' (Heywood 2005: 15-6; Jobson 2013).

Trade Union leaders such as Cyril Ramaphosa, as well as key employers including the Chamber of Mines, sympathized with Mbeki's rejection of the results of rigorous academic medical research – on the spurious grounds that such research fueled racist sexual stereotypes and the stigmatization of miners (Webster 2022: 51). Many of Mbeki's feelings and prejudices were even more widely shared; in 2006 (according to reliable Afrobarometer results), about two-thirds of South Africans who were ANC supporters approved of the government's handling of the AIDS crisis – Mbeki's national job approval rating was even higher, at 77 percent (Lodge 2015: 1583). Probably a large majority of young people had become convinced that the internationally accepted scientific research on HIV/AIDs 'reflected deeply entrenched white racist beliefs and concepts about Africans and black people' (Lawson 2008: 263).

Popular support for lethal policies intensified when intellectuals (as well opportunist political leaders at national and provincial levels) began to fan the embers of nationalist sentiment; the malevolent foreign forces many intellectuals identified as threatening the nation were not just the usual suspects (the CIA and the pharmaceutical MNCs), but also the United Nations WHO – accused of 'pushing' ARVs in South Africa – for ignoring their dangerous side effects.

It is not difficult to point to other epidemics in Africa (such as Ebola in Liberia) where much of the population, traumatized by a long history of violence, displacement and corruption, could be persuaded (by radio reports, for example) that corrupt domestic and foreign elites – supported by UN agencies and the CIA – were recruiting nurses to inject poisons (Epstein 2014). In rural South Africa, historians and anthropologists regard the range and complexity of popular beliefs and prejudices about AIDS as bewildering, with too little understood about the origins and impact of these beliefs (Delius and Glaser 2005).

There is, however, clear evidence that a high proportion of those currently living with HIV/AIDS have continued to make use of traditional healers, even when they are receiving ARTs; moreover, because they relied on treatment from traditional health practitioners seeking help from conventional medical practitioners, a very large number of South Africans prolong the period when they risk infecting others (Mothibe and Sibanda 2019: 7). Official policies and institutions are funding and encouraging 'Traditional Healers' while promoting 'African Spirituality', thereby increasing the morbidity and mortality risks associated with delayed treatment; the South African

Government's stated objective in 2022 was to remove South Africans' historical bias – their long-standing preference for high-cost Western healthcare over older (and cheaper) care traditions.

Apart from the directorate of Traditional Medicine established within the National Department of Health, generously funded South African think-tanks serve as platforms for prominent intellectuals to lament all forms of 'imposed alien modernity' and to promote an African Renaissance (Netshitenzhe 2015). Wishful thinking about solidarity with other African countries and assertions about the benefits of south-south and especially regional co-operation are highlighted in these think-tank discussions about reducing the costs of epidemics, for example in the policy conclusions published by the Mapungubwe Institute (Mazibuko 2019). The Human Sciences Research Council supports the work of researchers on the COVID-19 epidemic who advocate a switch to 'people's science', while criticising the role of 'western' theories and 'western medical experts' (Bank and Sharpley 2020: 7 and 19). Steven Friedman is one of South Africa's most respected public intellectuals. During the COVID-19 epidemic, he also found fault with 'curative medicine valued by the west' and now advocates an alternative approach based on learning from African countries, contextually appropriate forms of 'peoples science', communal ties and traditional African healers (2021: 114-7).

It should come as no surprise that both the MERG Report (which included the proposal for a National Health Service focusing on primary and preventative provision) and NGO proposals made in the late 1990s for the immediate distribution of ARTs, were denounced for being 'Western'. For example, Stellenbosch economists who remained well-connected to key state institutions responsible for economic policy in the 1990s (as well as earlier and later) criticized MERG proposals on the grounds that they were mainly produced by foreigners (Kentridge 1993). Similarly xenophobic criticisms of MERG policies - because they had been proposed by 'a network operating out of London' - were later repeated by the ANC's Department of Economic Planning (Du Toit 2022: 161).

Proposals for new forms of state intervention that would require increased public expenditure were also rejected on other grounds, especially by deploying reactionary rhetoric (Sender 1994). Economists insisting on reducing public expenditure and committed to fiscal conservatism latched onto the assumption that the cost per life-year gained if ARTs were to be distributed to adults would always remain too high (much higher than the costs per life-year gained by promoting abstinence, for example). Yet, they failed to take account of the massive reductions in the fiscal burden of HIV treatment that would follow from a scale up in the distribution of low-cost ARTs (Forsythe et al 2019). Their argument was that treating adults with ARTs was not cost-effective; in the financially constrained South African public health

system this high-cost policy should be rejected as too risky, as unaffordable and impossible (Creese et al 2002; Marseille, Hofmann and Kahn 2002; Regondi and Whiteside 2012).

Many well-known economists subscribed to these impossibility theses, probably because they were unable to imagine that standard ARV treatment costs could fall from about R3420 per month in 1998 to less than R120 per month in 2009; this imaginative failure was consistent with many other pessimistic (and self-fulfilling) prophecies made by influential advisors to the ANC. These advisors firmly believed that, for the foreseeable future, the South African state would lack the capacity and experience to intervene to promote a domestic supply of low-cost generics, far less to protect and support a nationalized national champion to produce generics – such as the Brazilian national pharmaceutical manufacturer, FarManguinhos that partnered so successfully with the public procurement agency CEME (Urias 2019).

Other advisors preferred playing the third-worldist victim card, refusing opportunities to take advantage of readily available supplies from multinational corporations – even when these were offered at lower costs than imported generics (Geffen and Cameron 2009; Lawson 2008: 241). Nationalistic opposition to multinationals involved posturing and little else. It was not complemented by any practical initiatives to secure South Africa's access to low-cost essential medicines; the policy agenda excluded imposing tariffs, using compulsory licenses (as in Brazil and Thailand) or providing support to the exercise of TRIPS transition periods (Wilson 2019). Instead, the Pharmaceutical Manufacturers Association in South Africa, the US government, and lobbyists for multinational pharmaceutical corporations were at the same time both demonized and appeased; policy makers clung to the belief that their overriding priority should be to avoid any restrictions on corporations or commitments to public expenditure that might undermine 'private sector confidence' – a shadowy phenomenon that would continue to loom over economic policy debates in South Africa (Krugman 2012).

The development of successful import-substituting industries, whether they were to manufacture pharmaceuticals or any other technologically complex goods, would have required massive public investment in tertiary education and in R&D, as attempted in both India and Brazil. Investment on the required scale has never been seriously considered or attempted in South Africa; and, indicatively, the relatively tiny number of doctoral researchers and Ph.D. graduates produced in the country is one clear measure of inadequate state intervention in research capacity building. In 2017 South Africa only produced about 1,300 Doctoral Graduates in Science and Engineering (compared to about 10,500 in Brazil and 24,500 in India); the number of full-time researchers per million people in South Africa is currently half that in Brazil and only one fifth the number in Malaysia, while South Africa is ranked 64th in the

world in terms of the number of doctorates produced per million people (Government of India 2020; Wolhuter et al 2020).

There are other indicators of inadequate investment in R&D and in the specific technologies that could improve prospects for the poorest people in South Africa. Most of the rural poor depend, directly or indirectly, on the rate of growth of agricultural output and employment, but the research base to maintain or increase such employment has been severely eroded. Massive reductions in state support – for example to the Agricultural Research Council – have diminished excellent prospects for a less narrowly conceived and more viable industrialization strategy (Sender 2016; Cramer, Di John and Sender 2022).

How the Living Die: Pandemic II

The AIDs pandemic prefigured the distribution of mortality and morbidity recorded during the next (COVID-19) pandemic, as well as some of the dubious policy responses, nationalistic posturing, and the xenophobic outbursts that appeared in 2020. The well-known problem of finding reliable estimates of the resulting number of deaths has not been solved. The Medical Research Council and University of Cape Town professionals conclude that ‘there is an urgent need to re-engineer the civil registration and vital statistics system … [because] there is considerable uncertainty around what proportion of the excess deaths was due to COVID-19 (directly or indirectly)’ (Bradshaw et al 2022: 1-6). This urgent need has still not been addressed (Maqungo et al 2022).

Stats SA, like the official statistical agencies in other African countries, has only been able to publish data on deaths of those that are more than three years old – their most recent publication on cause-of-death was in 2018. One explanation for the delay may be that Stats SA lacks the resources to recruit enough staff to process the forms (Dorrington et al 2021: 1). Not only has there been an inordinate delay in the publication of cause-of-death statistics, but their usefulness to policymakers has also been reduced because the gap between the reports of officially tabulated COVID-19 deaths and the true number of these deaths appears to be widening over time, with especially severe underestimates in poor Provinces such as Limpopo and Mpumalanga (Bradshaw et al 2022: 5). Underinvestment in the vital registration system means that the total number of deaths recorded on the National Population Register (NPR) is also unreliable; it is widely acknowledged that not all deaths are registered on the NPR, especially in rural areas and especially if deaths take place outside hospitals, if the deceased is under the age of five or lacks a South African birth certificate or identity document (Whittaker et al 2021; Price et al 2019).

What evidence there is does suggest that South Africa, despite implementing a severe lockdown on its relatively young population, has had higher excess death rates per 100,000 than most other countries in the world, including a comparable Upper Middle-Income country such as Brazil. The excess death rate per 100,000 population has tracked the death rate from COVID-19 closely and has, unsurprisingly, been very much lower in South Africa's richer Provinces (such as the Western Cape) than in poorer Provinces (such as the Eastern Cape) (Bradshaw 2022). Even within the Western Cape, the risk of dying from COVID-19 has been much higher in the poorest districts (Hussey et al 2021). People living in the lowest-income rural households appear to be much more vulnerable to COVID-19 than other South Africans (Yu 2023: 100).

In 2021, COVID-19 probably overtook HIV as the leading cause of death in South Africa and, by May 2022, it is likely that COVID-19 had caused the death of about 260,000 people (Geffen and Low 2022). But the full impact of the pandemic on excess mortality, particularly for the poorest South Africans in the poorest areas, will only become evident in the future; 'collateral deaths (in terms of missed diagnoses or treatment, for example) arising from lockdowns and the overburdening of the health system during the various waves remain unknown' (Bradshaw et al 2022: 5). But there is already evidence that between 2019 and 2020 the state was unable to protect access to primary-level care, including immunization, contraception and testing for TB and HIV. These reductions in access to key services will inevitably result in increasing morbidity and mortality for the poor. Problems were certainly more severe in the poorer Provinces. Mpumalanga and the Eastern Cape, for instance, experienced especially large falls in contraception prescriptions and in the percentage of children fully immunised at one year of age (ibid; Pillay et al 2021; Barron et al 2022). This reduced access to care will have a cumulative and long-term negative impact on health that will 'dwarf the damage done by COVID-19' (Burger and Ngwenya 2021: 862).

The mechanisms propelling unvaccinated children towards both a short-run deterioration in cognitive development and towards lower standards of living in the medium term have been well documented in India (Summan, Nandi and Bloom 2022). In South Africa, lockdowns exacerbated a longstanding problem; immunization coverage had been stagnant since 2014 (with more than 40 percent of South African children incompletely vaccinated in 2016). Reasons for the new, COVID-related decline in the immunization rate – a fall of as much as 50 percent in some rural areas – include not only the poverty of some children's households, but also vaccine stock-outs (Ndwandwe et al 2021; Iwu-Jaja 2022). Poor people may be unwilling to bear the expense of travelling to attend clinics where they do not receive treatment because there is 'poor stock management' and it is not surprising that

poorer people are much less likely to immunize their children than richer households. The Financial Times reported at the end of May 2022: ‘Vaccination sites remain poorly advertised, are hard to get to, and close too early for workers and those in poor areas to reach them’ (Cotterill, Barnes and Burns-Murdoch 2022). Immigrants not only suffer from inconvenient access and stock-outs but also from ‘denial of treatment, and in some instances name-calling and outright discrimination by frontline health workers’ (White and Rispel 2021: 1293). As already noted, the intelligentsia have not always resisted the temptation to respond to popular fear by deploying nationalist, xenophobic, and anti-immigrant arguments in response to pandemics; these responses, in South Africa and elsewhere, appear to have grown as COVID-19 spread (Steenberg et al 2023). Some of the rural intelligentsia, who continue to affirm that traditional healers, or eucalyptus-infused steam, can provide an adequate response to COVID-19, may also have provoked vaccine hesitancy among the poor (Mphekgwana, Makgahlela & Mothiba 2021).

Stuck in the Orthodox Groove Playing Old Policy Refrains

By the end of January 2023, only about one third of South Africa’s population was fully vaccinated against SARS-Cov-2. The number of administered COVID-19 vaccine doses per 100 people was very low relative to many other African countries – including Rwanda, Morocco, Cape Verde, Botswana, Tunisia, Egypt, Mozambique, Mauritania, Cote D’Ivoire, Liberia, Zimbabwe, Sierra Leone, and Angola. Recent failures to vaccinate vulnerable people and children against COVID-19 have triggered old, familiar, and unconvincing policy proposals. It is not clear, for example, that the nationalistic proposals to increase South Africa’s capacity to produce vaccines domestically rather than continue to rely on imports, or that posturing demands to reduce the rents secured by intellectual property rights, will solve the failure to vaccinate many poor rural people. Even after COVID-19 vaccine supplies and domestic vaccine production had been ramped up, these supplies certainly did not reach all of the unvaccinated – and over-supply soon became a problem. By the end of 2021 the Government was compelled to request Johnson & Johnson and Pfizer to delay delivery of Covid-19 vaccines, because it had too much stock (Khan 2023). By mid-2022, the Gqeberha plant established to produce Aspenovax in the Eastern Cape was forced to consider closure, because it had no orders from South Africa’s Department of Health (nor anyone else). At the end of 2022, the installed Aspenovax production lines were still idle and the company had received no orders for its own brand COVID-19 vaccinations.

If we are not convinced that getting rid of the malign influence of foreign patent owners will improve COVID-19 vaccination rates in South Africa, another school of policy advisors is at hand to offer us an (old) solution that remains surprisingly popular in debates about public health (and electricity) provision. For example, the usual suspects in Washington (the International Finance Corporation) and a large JSE-listed logistics corporation (Imperial) have offered a time-honoured solution to the COVD-19 pandemic. Their remedy involves bypassing the 3500 state-funded and 'financially unsustainable' Primary Health Care Clinics and substituting a new private sector health provider. The International Finance Corporation will give a sweetener to Imperial to encourage new markets for the private sector – to provide more efficient testing, vaccination, and 'quality' treatment of COVID-19 in specially manufactured primary healthcare units/modules. The aim is to install these modules in densely populated urban areas – not, of course, in those rural areas less attractive to private investors where access to services is far more limited. 'Nurse entrepreneurs' are subsidised to run these urban showcases for philanthrocapitalism, but uptake has been slow; only about 100 clinics had been established by mid-2022. The national outcomes and the cost-effectiveness of these new units has not been established, but the Lancet Global Health Commission's exhaustive review of the evidence reached the conclusion that the interventions usually delivered by state-funded Primary Health Clinics are cost-effective (Hanson et al 2022: e717).

Readily available evidence of the high costs and inefficiencies of the most important private sector health providers in South Africa is often brushed under the carpet. The South African state continues to subsidise the non-competitive corporations dominating the health sector. Nowhere else in the world is such a high percentage of total current expenditure on health accounted for by private insurance; but less than 17 percent of the population benefit from the burgeoning facilities and resources that now absorb about half of health expenditure and 70 percent of all health workers (Barber et al 2018; Pauw 2021). The MERG Report highlighted subsidies received by the private sector and predicted that private provision would, in a context of extreme income inequality, inevitably tend to the over-treatment of the wealthy and, by the criteria of social efficiency and equity, the inefficient crowding-out of the treatment of the impoverished. Our argument was that:

'The private sector is never self-sufficient, but often benefits from direct subsidies, and is totally dependent upon medical personnel whose training has been publicly funded. Nor does the dependence upon private practice necessarily release funds for the use of the public sector; apart from the economic and political pressures that the private sector will place upon the public sector, it itself suffers from the diseases of modern commercial medicine – over-treatment, over-charging and over-administration, not to mention … over-litigation' (1993: 106).

Some rather similar conclusions about over-treatment were reached (decades later after an absurdly lengthy and high-cost investigation) by the Competition Commission's Health Market Inquiry, published in 2019:

'the combination of healthcare practitioners acting as agents for ill-informed individuals requiring healthcare and the perverse incentives associated with the largely fee-for-service remuneration environment facilitated supplier-induced demand; this was the key driver for increases in healthcare utilisation and costs' (Solanki et al 2020a: 89).

The social costs of private provision and over-treatment are particularly evident in the South African data on maternity services. In the private sector the caesarean section (CS) rate is one of the highest in the world at 73 percent – the public sector CS rate (24.7 percent) is closer to the global norm. There are no obstetric indications for the extremely high CS rate in the private sector, suggesting that sections are often performed to suit the convenience or pockets of providers Solanki et al 2020b). About 60 percent of all pregnant women relying on the public sector must give birth in Community Health Centres or District Hospitals, but many of these institutions (especially in remote rural areas) are unable to respond to a life-threatening need for a CS because the required theatre facilities and staff are not available (Pattinson et al 2015). The solution proposed is that the private sector should be offered contracts to provide CS services under the new National Health Insurance scheme, but it is not at all clear how such proposals will overcome perverse incentives to over-treat or solve the current inability of an under-staffed and under-resourced public sector to monitor contracts with private providers.

The most widely discussed, piloted and accepted policy proposals to achieve Universal Health Care involve contracting private sector providers to 'strengthen' Primary Health Care facilities (Pauw 2021). Senior Policy analysts at one of South Africa's most influential think tanks continue fiercely to defend the relative 'excellence' of private healthcare on the familiar grounds that it is impossible for the state to manage anything, especially health services. But they do (inconsistently) suggest an important new role for the state; low-cost medical schemes and insurance policies should be introduced and should receive additional subsidies so that the poor can become members too – using their share of 'tax-funded health vouchers' (Roodt and Fleming 2018: 1; Settas 2020). These recommendations to 'include' the poor, alongside the fashionable promotion of new mobile and telemedicine technologies, have effectively increased ideological pressure for patients 'to take greater responsibility for their own health' and, especially, to cover

the costs of health provision by paying their health insurance premiums digitally. The MERG Report anticipated some these pressures and reactions:

‘Privatisation … creates or reinforces those interest groups (whether in the service of, or served by the system), who also have the economic and political power and voice to undermine and shift government intent. The medical profession has proved itself to be powerful, as have the insurance companies that organise the finance for private schemes. In addition, there will always be economic and political pressures from those who receive or benefit from private medicine to be the beneficiaries of direct or indirect subsidies equivalent, or even preferential to, those allocated to the public sector, and for the latter to be a target for reduced expenditure and further privatisation’ (1993: 109).

What the authors of the MERG Report obviously failed to anticipate was the feebleness of ‘government intent’, the ANC’s unwillingness to discipline, or even negotiate firmly with the handful of large corporations dominating health expenditure and the market for new forms of debt/insurance. Some MERG economists also over-estimated the ANC’s capacity to commission and make effective policy use of alternatives to mainstream economic arguments. In the early 1990s it was hard to imagine how very rapidly all alternative negotiating positions and policies would be ditched, or that the old orthodox arguments would so rarely be questioned in Cabinet and NEC discussions.

If this chapter has had any success in isolating and exposing the crackle produced by worn-out economic ideas, then it may be possible to hear a far more hopeful tune, there all along but buried under the clashing cymbals of post-apartheid policy advice. More hopeful and upbeat tunes are being sung in South Africa – by the chorus of voices that together represent the rise and the impact of such critical and independent organisations as the National Minimum Wage Research Initiative, TRAC, Section 27, Collective Voices against Health Xenophobia, and publications such as Groundup Opinion Pieces and Spotlight. The contributions of this chorus were also not anticipated or given sufficient emphasis by the MERG report. South African civil society still continues to produce activist authors and progressive academics who, like Vishnu, are capable of arguing very effectively against economic illiteracy and/or orthodoxy.

References

Achoki, T, Sartorius, B, Watkins, D, Glenn, SD, Kengne, AP, Oni, T, Wiysonge, CS, Walker, A, et al. 2022. Health trends, inequalities and opportunities in South Africa's provinces, 1990–2019: findings from the Global Burden of Disease 2019 Study. Journal of Epidemiology and Community Health. 76(5):471–481.

Baker, L. 2023. New frontiers of electricity capital: energy access in sub-Saharan Africa. New Political Economy. 28(2):206–222.

Bank, L & Sharpley, NV. 2020. The State and the People in Rural South Africa in the Time of COVID. Africa Insight. 50(2):4–22.

Barber, SL, Kumar, A, Roubal, T, Colombo, F & Lorenzoni, L. 2018. Harnessing the private health sector by using prices as a policy instrument: Lessons learned from South Africa. Health Policy. 122(5):558–564.

Barron, P, Subedar, H, Letsoko, M, Makua, M & Pillay, Y. 2022. Teenage births and pregnancies in South Africa, 2017-2021–a reflection of a troubled country: Analysis of public sector data. South African Medical Journal. 112(4):252–258.

Bradshaw, D, Groenewald, P, Laubscher, R, Nannan, N, Nojilana, B, Norman, R, Pieterse, D, Schneider, M, et al. 2003. Initial burden of disease estimates for South Africa, 2000. South African Medical Journal. 93(9):682–688.

Bradshaw, D, Dorrington, R, Laubscher, R, Groenewald, P & Moultrie, T. 2022. COVID-19 and all-cause mortality in South Africa – the hidden deaths in the first four waves. South African Journal of Science. 118(5/6).

Bruce Baigrie. 2022. Eskom, Unbundling, and Decarbonization Bruce Baigrie. Available from: https://www.phenomenalworld.org/analysis/eskom-unbundling-and-decarbonization/ [Accessed 27 February 2023].

Burger, R & Ngwenya, M. 2021. The economics of health in South Africa. In: The Oxford Handbook of the South African Economy. (Chapter 39). Oxford: Oxford University Press.

Burger, C, Burger, R & van Doorslaer, E. 2022. The health impact of free access to antiretroviral therapy in South Africa. Social Science & Medicine. 299:114832.

Cramer, C & Sender, J. 2015. Agro-processing, wage employment and export revenue: Opportunities for strategic intervention. TIPS Working paper for the Department of Trade and Industry.

Cramer, C, Di John, J & Sender, J. (in press). Classification and Roundabout Production in High-value Agriculture: A Fresh Approach to Industrialization. Development and Change. (March, 22):dech.12708.

Creese, A, Floyd, K, Alban, A & Guinness, L. 2002. Cost-effectiveness of HIV/AIDS interventions in Africa: a systematic review of the evidence. Lancet. 359(9318):1635–1643.

Crompton, R & Matsika, R. 2021. Energy in South Africa. In: The Oxford Handbook of the South African Economy. (Chapter 14). OUP. 283–304.

David Fryer. 2006. Review of : Season of Hope: economic reform under Mandela and Mbeki. By Alan Hirsch. International Affairs. 82(3):604–5.

Delius, P & Glaser, C. 2005. Sex, disease and stigma in South Africa: historical perspectives. African Journal of AIDS Research. 4(1):29–36.

Dorrington, RE, Bradshaw, D, Laubscher, R & Nannan, N. 2021. Rapid Mortality Surveillance Report 2019 & 2020. South African Medical Research Council Cape Town.

Du Toit, P. 2022. The ANC billionaires: big capital's gambit and the rise of the few. Jeppestown: Jonathan Ball Publishers.

Forsythe, SS, McGreevey, W, Whiteside, A, Shah, M, Cohen, J, Hecht, R, Bollinger, LA & Kinghorn, A. 2019. Twenty years of antiretroviral therapy for people living with HIV: global costs, health achievements, economic benefits. Health affairs. 38(7):1163–1172.

Friedman, S. 2021. One Virus, Two Countries: What COVID-19 Tells Us About South Africa. Wits University Press.

Geffen, N & Cameron, E. 2009. The deadly hand of denial: Governance and politically-instigated AIDS denialism in South Africa. University of Cape Town.

Geffen, N. and Marcus Low. 2022. Two years into the Covid disaster, where do we stand? Groundup. 12 May. Available from: https://www.groundup.org.za/article/two-years-into-covid-disaster-where-do-we-stand/.

Gruchy, T de & Vearey, J. 2020. "Left behind": why implementing migration-aware responses to HIV for migrant farm workers is a priority for South Africa. African Journal of AIDS Research. 19(1):57–68.

Hanson, K, Brikci, N, Erlangga, D, Alebachew, A, De Allegri, M, Balabanova, D, Blecher, M, Cashin, C, et al. 2022. The Lancet Global Health Commission on financing primary health care: putting people at the centre. The Lancet Global Health. 10(5):e715–e772.

Hein Marais. 2012. Making sense of the indefensible. Mail & Guardian.

Helen Epstein. 2014. Ebola in Liberia: an epidemic of rumors. New York Review of Books. 61(20).

Heywood, M. 2005. The price of denial. SA National NGO Coalition and Interfund.

Hussey, H, Zinyakatira, N, Morden, E, Ismail, M, Paleker, M, Bam, J-L, London, L, Boulle, A, et al. 2021. Higher COVID-19 mortality in low-income communities in the

City of Cape Town – a descriptive ecological study. Gates Open Research. 5:90. doi.org/10.12688/gatesopenres.13288.1.

Iwu-Jaja, CJ, Jordan, P, Ngcobo, N, Jaca, A, Iwu, CD, Mulenga, M & Wiysonge, C. 2022. Improving the availability of vaccines in primary healthcare facilities in South Africa: is the time right for a system redesign process? Human Vaccines & Immunotherapeutics. 18(1):1926184.

Jobson, R. 2013. When the ANC Jeered Mandela. Groundup.

https://www.groundup.org.za/article/when-anc-jeered-madiba/

Joel Netshitenzhe. 2015. Theorising the South African Renaissance Ideal'. In: Rountable on the Role of Intellectuals in the State-Society Nexus. Johannesburg: Mapungubwe Institute for Strategic Reflection. Available from: https://mistra.org.za/mistra-media/rountable-on-the-role-of-intellectuals-in-the-state-society-nexus/.

Johnson, LF, Meyer-Rath, G, Dorrington, RE, Puren, A, Seathlodi, T, Zuma, K & Feizzadeh, A. 2022. The effect of HIV programmes in South Africa on national HIV incidence trends, 2000-2019. JAIDS Journal of Acquired Immune Deficiency Syndromes. Publish Ahead of Print. doi.org/10.1097/QAI.0000000000002927.

Joseph Cotterill, Oliver Barnes, & John Burn-Murdoch. 2022. Why Africa's first Covid vaccine factory struggles to find customers. Financial Times (London). 30 May.

Kabudula, CW, Houle, B, Ohene-Kwofie, D, Mahlangu, D, Ng, N, Van Minh, H, Gómez-Olivé, FX, Tollman, S, et al. 2021. Mortality transition over a quarter century in rural South Africa: findings from population surveillance in Agincourt 1993-2018. Global Health Action. 14(sup1):1990507. doi.org/10.1080/16549716.2021.1990507.

Kentridge, M. 1993. Turning the tanker: the economic debate in South Africa. (CPS social contract series). Johannesburg, South Africa: Centre for Policy Studies.

Krugman, P. 2012. Death of a fairy tale. New York Times. 26.

Lawson, L. 2008. Side effects: The story of AIDS in South Africa. Cape Town: Double Storey Books.

Lodge, T. 2015. The politics of HIV/AIDS in South Africa: government action and public response. Third World Quarterly. 36(8):1570–1591.

Macroeconomic Research Group (MERG). 1993. Making Democracy Work: A Framework for Macroeconomic Policy in South Africa. Cape Town: Centre for Development Studies.

Maqungo, M, Nannan, N, Nojilana, B, Nichols, E, Morof, D, Cheyip, M, Rao, C, Lombard, C, et al. 2022. Can verbal autopsies be used on a national scale? Key findings and lessons from the South Africa National Cause-of-Death Validation Study. (Preprint). In Review. doi.org/10.21203/rs.3.rs-2349584/v1.

Marseille, E, Hofmann, PB & Kahn, JG. 2002. HIV prevention before HAART in sub-Saharan Africa. The Lancet. 359(9320):1851–1856.

Mazibuko, Z Ed. 2019. Epidemics and the health of African nations. Johannesburg: Mapungubwe Institute for Strategic Reflection (MISTRA).Available from: https://www.google.com/search?q=Mazibuko+epidemics&oq=Mazibuko+epidemics&aqs=chrome..69i57.20181j0j4&sourceid=chrome&ie=UTF-8 [Accessed 14 February 2023 a].

Michael Settas. 2020. Covid-19 and the case against a state-run National Health Insurance. Daily Maverick. 13 September. Available from: https://www.dailymaverick.co.za/opinionista/2020-09-13-covid-19-and-the-case-against-a-state-run-national-health-insurance/.

Mothibe, ME & Sibanda, M. 2019a. African traditional medicine: South African perspective. In: Traditional and Complementary Medicine. IntechOpen: IntechOpen London, UK. 1–27.

Mphekgwana, PM, Makgahlela, M & Mothiba, TM. 2021b. Use of Traditional Medicines to Fight COVID-19 during the South African Nationwide Lockdown: A Prevalence Study among University Students and Academic Staff. The Open Public Health Journal. 14(1):441–445. doi.org/10.2174/1874944502114010441.

Ndwandwe, D, Nnaji, CA, Mashunye, T, Uthman, OA & Wiysonge, CS. 2021. Incomplete vaccination and associated factors among children aged 12–23 months in South Africa: an analysis of the South African demographic and health survey 2016. Human Vaccines & Immunotherapeutics. 17(1):247–254.

Padayachee, V & Sender, J. 2018. Vella Pillay: Revolutionary Activism and Economic Policy Analysis. Journal of Southern African Studies. 44(1):149–165.

Patrick Bond. 2021. Can South Africa urgently evolve, from victim-globalisation to passive-deglobalisation to active-localisation? Available from: https://www.cadtm.org/Can-South-Africa-urgently-evolve-from-victim-globalisation-to-passive.

Pattinson, RC, Makin, JD, Pillay, Y, van den Broek, N & Moodley, J. 2015. Basic and comprehensive emergency obstetric and neonatal care in 12 South African health districts. South African Medical Journal. 105(4):256–260.

Pauw, TL. 2021. Catching up with the constitution: An analysis of National Health Insurance in South Africa post-apartheid. Development Southern Africa. (July, 1):1–14.

Pillay, Y, Pienaar, S, Barron, P & Zondi, T. 2021. Impact of COVID-19 on routine primary healthcare services in South Africa. South African Medical Journal. 111(8):714–719.

Pillay-van Wyk, V, Msemburi, W, Laubscher, R, Dorrington, RE, Groenewald, P, Glass, T, Nojilana, B, Joubert, JD, et al. 2016. Mortality trends and differentials in

South Africa from 1997 to 2012: second National Burden of Disease Study. The Lancet Global Health. 4(9):e642–e653.

Price, J, Willcox, M, Kabudula, CW, Herbst, K, Kahn, K & Harnden, A. (in press). Home deaths of children under 5 years in rural South Africa: a population-based longitudinal study. Tropical Medicine & International Health. (May, 14):tmi.13239. doi.org/10.1111/tmi.13239.

Regondi, I & Whiteside, A. 2012. Fiscal Space for Health: Assessing Policy Options in South Africa. Journal of Contemporary Management. 1(1):14–26.

Roodt, M & Fleming, M. 2018. South Africa's National Health Insurance Scheme. South African Institute of Race Relations, Johannesburg.

Sender, J. 1994. Economic restructuring in South Africa: reactionary rhetoric prevails. Journal of Southern African Studies. 20(4):539–543.

Sender, J. 2015. Backward capitalism in rural South Africa: prospects for accelerating accumulation in the Eastern Cape. Journal of Agrarian Change. Available from: http://onlinelibrary.wiley.com/doi/10.1111/joac.12105/full [Accessed 8 October 2015].

Solanki, GC, Cornell, JE, Daviaud, E & Fawcus, S. 2020. Caesarean section rates in South Africa: A case study of the health systems challenges for the proposed National Health Insurance. South African Medical Journal. 110(8):747.

Solanki, GC, Cornell, JE, Besada, D, Morar, RL & Wilkinson, T. 2020. The Competition Commission Health Market Inquiry Report: An overview and key imperatives. South African Medical Journal. 110(2):88.

Statistics South Africa. 2021. Alternative Sources of Demographic Data. (03-00-17 73). Pretoria: Statistics South Africa. Available from: http://www.statssa.gov.za/publications/03-00-17/03-00-172021.pdf.

Steenberg, B, Sokani, A, Myburgh, N, Mutevedzi, P & Madhi, SA. 2023. COVID-19 Vaccination Rollout: Aspects of Hesitancy in South Africa. Vaccines. 11(2):407.

Summan, A, Nandi, A & Bloom, D. 2022. A shot at economic prosperity: Long-term effects of India's childhood immunization program on earnings and consumption expenditure. (Discussion Paper DP17386). London: Centre for Economic Policy Research.

Tamar Khan. 2023. Government has a massive surplus of vaccine doses Round of Covid-19 booster shots available as demand dwindles. Sowetan. 16 January. Available from: https://www.sowetanlive.co.za/news/south-africa/2023-01-26-round-of-covid-19-booster-shots-available-as-demand-dwindles/.

Urias, E. 2019. The potential synergies between industrial and health policies for access to medicines: insights from the Brazilian policy of universal access to HIV/AIDS treatment. Innovation and Development. 9(2):245–260.

Webster, E. 2022. Choosing sides: The promise and pitfalls of a critically engaged sociology in Apartheid South Africa. In: Critical Engagement with Public Sociology. Bristol University Press. 44–60.

White, JA & Rispel, LC. 2021. Policy exclusion or confusion? Perspectives on universal health coverage for migrants and refugees in South Africa. Health Policy and Planning. 36(8):1292–1306.

Whittaker, C, Walker, PGT, Alhaffar, M, Hamlet, A, Djaafara, BA, Ghani, A, Ferguson, N, Dahab, M, et al. 2021. Under-reporting of deaths limits our understanding of true burden of covid-19. BMJ. (October, 12):n2239.

Wilson, KR. 2009. A manufactured solution? The transfer of technology to developing countries for the local production of affordable antiretrovirals: Case Studies from Tanzania and South Africa. Doctoral Thesis submitted to Graduate Department of Pharmaceutical Sciences in the Leslie Dan Faculty of Pharmacy. University of Toronto.

Wolhuter, C, de Beer, Zacharias Louw, Niemczyk, Ewelina, Botha, Johan, Gore, Oliver, Marimo, Artwell, Neethling, Marinda, Santhakumar, V, Seleti, J, Steyn, Hennie J & Taylor, B, Vos, Deon, Wolhuter, Charl, de Beer, Zacharias Louw, Niemczyk, Ewelina. 2020. Critical Issues in South African Education Illumination from international comparative perspectives from the BRICS countries. Available from: https://directory.doabooks.org/handle/20.500.12854/70683 [Accessed 17 June 2022].

Yu, D. 2023. Revisiting the COVID-19 vulnerability index in South Africa. Development Southern Africa. 40(1):91–108.

Zbinden, K & Todorov, T. 2004. In Praise of Nuance: An Interview with Tzvetan Todorov. Salmagundi. (141/142):3–26.