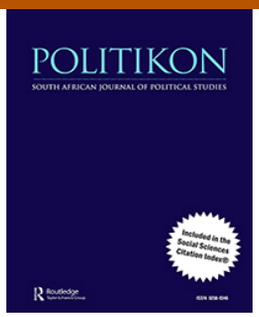

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ARTICLE

Politics of Mental Healthcare in Post-apartheid South Africa

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ABSTRACT

Recent events in post-apartheid South Africa have exposed a decidedly political dimension to mental healthcare. This was exemplified in three important cases: the recent grants crisis of the South African Social Security Agency, a court case between the state and non-governmental organisations, and the Life Esidimeni tragedy. These events demonstrate that despite significant policy shifts toward basic human rights and care of people living with mental illness, these cases demonstrate the contradictory elements of macroeconomic and health policy exposed a neoliberal tendency towards providing public mental healthcare. In examining these case, key features emerged, including: the commodification of people living with mental illness, the pertinence of auditing, accounting practices, and dynamics of globalisation, de- and re-nationalisation. This article speaks to a tangible gap in the discourse on mental healthcare in South Africa, by highlighting the political dimensions that are involved under an era of neoliberalism.

Introduction

In South Africa's post-apartheid period, mental illness and its management has become profoundly political. This is best illustrated in by the Life Esidimeni tragedy, where more than 144 people living with severe mental illness (PLWMI) died of negligence in a botched de-institutionalisation process (Bornman 2017; Moseneke 2018). It exhibited – similar to other tragedies of national significance – a moral miscarriage on the part of the state, where a failure to acknowledge the primacy of communal relationships of identity and solidarity, raised the likelihood of reproducing such tragedy (Metz 2017). Tragedies of this nature occur in an age where 'the principle of cost-benefit' (Dhar, Chakrabarti, and Banerjee 2013, 586) has triumphed over the incommensurable values of human rights-based relationships and processes that underwrite mental healthcare (MHC) (Lukes 2008). In low-to-middle income countries such as South Africa, these considerations have been particularly relevant.

Rapid socio-political shifts place extraordinary demands on the mental health of populations, and low-to-middle income societies in transition have prioritised economic growth by means of integration with global capitalism and public sector reform over mental health service expansion (Burns 2015; Lee et al. 2015; Janse van Rensburg et al. 2018). Despite growing global awareness of the significance of public mental health, increased

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political lobbying for its prioritisation, and substantial research and development, the political dimensions of MHC often remain overlooked (Janse van Rensburg 2018). In South Africa, the nexus between socio-political and socio-economic change on the one hand, and mental health on the other, warrant greater attention (Burns 2015). As we will show, this is particularly salient in the governance of the well-being of people suffering from serious mental and neurological conditions, who are especially vulnerable to neoliberal forces, despite an apparent policy and legislative environment (Makgoba 2017; Janse van Rensburg 2018). Accordingly, in this paper we explore how serious mental and neurological conditions and MHC have been politicised in post-apartheid South Africa by focusing on three key events that exemplify failing MHC under neoliberalism.

On a policy reform level, South Africa has made significant strides towards improving service parity and quality for people suffering from serious mental and neurological conditions during its post-apartheid period (Petersen and Lund 2011; Gillis 2012; Janse van Rensburg 2018; Janse van Rensburg et al. 2018). A particular pressing strategy had been to foster collaboration across the spectrum of different services, including state, non-profit, and private for-profit service providers (Janse van Rensburg and Fourie 2016). This has been in step with global shifts towards more holistic and balanced care (Mari and Thornicroft 2010; Thornicroft and Tansella 2013), a sustained feature of reform documents.

The ANC's National Health Plan for South Africa (African National Congress 1994) called for 'a multisectoral and integrated approach to mental health service', which includes the integration of mental health services into different sectors such as general healthcare, welfare and education systems. It endorsed the development of multi-level inter-sectoral structures from which MHC should be coordinated among different government departments as well as all relevant levels of service provision. Community care and support services for PLWMI was a prominent feature, and the document called for the 'development of non-governmental community-based mental health services and fostering cooperation between the various mental health service providers', including increased cooperation with traditional healers. The tone of the ANC Health Plan continued into the White Paper for the Transformation of the Health System in South Africa (South African National Department of Health 1997), which was meant to be a roadmap for national, provincial and district health system restructuring. It furthered the directive that health services should be provided in an integrated manner across different sectors, calling for collaboration in care between governmental, non-governmental and private services.

More recently, collaboration between government and non-government role-players was adopted in the Ekurhuleni Declaration on Mental Health, which was included in the National Mental Health Policy Framework and Strategic Plan 2013–2020 (South African National Department of Health 2013). This policy provides a roadmap for future mental health system reform, including a focus on inter-sectoral collaboration. More specifically, it provides for the future expansion of community MHC to formally include NGOs, voluntary groups and consumer organisations. Further, it underlines the responsibility of provincial government to encourage different service collaborations with NGOs. The responsibility for MHC was taken up by the Department of Health (DoH); the absence of voice from other state sectors such as the Department of Social Development (DoSD) and Department of Basic Education (DoBE) cast mental illness in a clear biomedical light. This has been profound, since such discursive power trickles down to service delivery

levels in healthcare workers' approaches to mental illness in biomedical ways (Petersen 2000; Campbell-Hall et al. 2010).

Key legislation was also introduced to nurture collaborative and partnership working in MHC. Financial aspects of state and non-state mental health service collaboration were formalised by the introduction of the Public Finance Management Act No. 1 of 1999 (South African Government 1999). The Mental Health Care Act (17 of 2002) allows for formal agreements between national and provincial government with 'any non-governmental organisation or public or private provider of goods or services' (Section 72) (South African Government 2002). The National Health Act (61 of 2003) obliged the DoH to establish coordinated relationships between public and private service providers, and allowed for formal agreements between government departments and municipalities, and 'any private practitioner, private health establishment or non-governmental organisation' (Section 45) (South African Government 2004).

Key events in the governance of PLWMI

Despite these important reforms in post-apartheid South African policy and legislation, politics have played a central part in structuring the mental health system in ways that have negated care and support for people suffering from serious mental and neurological disorders. Three events have personified the role of politics in MHC: (1) The welfare grant distribution crisis in the South Africa Social Security Agency (SASSA); (2) The court battle between the National Association of Welfare Organisations and Non-Governmental Organisations (NAWONGO) and the Free State provincial government; and (3) The Life Esidimeni tragedy. These cases certainly merit more in-depth discussions, but here we outline salient political features that emerged in order to illustrate how politics have both been part of shaping mental healthcare and adding to negative consequences.

The SASSA grants crisis

The South African government re-prioritised values of equity and social development by introducing SASSA – a welfare grant distribution agency – in 2005 (Ncube, Shimeles, and Verdier-Chouchane 2012). Falling under the governance sphere of the DoSD, it was tasked to distribute a substantial part of the national budget to millions of people who suffered under poverty, illness and disability. On 3 February 2012, SASSA gave a payment system contract to Cash Paymaster Services (CPS), a subsidiary of Net1, an international company trading on NASDAQ and the Johannesburg Stock Exchange, in an attempt to outsource services. In 2013, the Constitutional Court declared this arrangement legally invalid, and ordered SASSA to either re-launch the procurement process, or to find alternative means of welfare distribution. In 2014, SASSA submitted a plan to the Constitutional Court to take over the payment of grants itself when the CPS contract ended on 31 March 2017. However, as the deadline of 31st loomed closer for the transfer, it became apparent that SASSA would be unable to pay the approximately $67 million in welfare grants to 17 million welfare beneficiaries that include PLWMI (altogether one-third of the population). SASSA had acknowledged its failure to meet this deadline (Maregele 2017). Given the possible catastrophic consequences of non-payment, the Court was forced to – under the emergency procurement conditions of the Public Finance Management Act – order

SASSA and CPS to continue the unconstitutional arrangement that was in place before, for another 12 months during which the matter should be resolved. Eventually, a contract was agreed with the South African Post Office (SAPO) as partner, five months from the one year deadline set by the Constitutional Court (Herman 2017). Importantly, the global auditing firm KPMG signed off on reports towards supporting the CPS case during court proceedings, although this was ultimately fruitless (De Wet 2017). KPMG is one of the 'Big Four' global auditors, providing financial auditing, tax and advisory services to the vast majority of public and private companies across multiple countries and multiple stock markets – its global revenues totalled US$25.42 billion for the 2015–2016 financial year (KPMG 2017). Such global firms have a significant footprint in South Africa's MHC and welfare sector, by its involvement in key court cases between state and non-state service providers. At the time of writing, the North Gauteng High Court ruled that SASSA had to cede payments through the Net1 system (in favour of SAPO), triggering a 38.5% drop in Net1's share value on the NASDAQ, while CPS ultimately recorded a 87% decline in value due to losing the SASSA contract (Thamm 2019). This is in sharp contrast to CPS recording R1.1 billion pre-tax profits during 2012–2017 (De Wet 2017).

The SASSA Crisis was scathingly placed into context by Constitutional Court Judge Johan Froneman in the opening lines of his judgement of a case between the NGO Black Sash and the DoSD, SASSA and others (Mogoeng et al. 2017):

> One of the signature achievements of our constitutional democracy is the establishment of an inclusive and effective programme of social assistance. It has had a material impact in reducing poverty and inequality and in mitigating the consequences of high levels of unemployment. In so doing it has given some content to the core constitutional values of dignity, equality and freedom. This judgment is, however, not an occasion to celebrate this achievement. To the contrary, it is necessitated by the extraordinary conduct of the Minister of Social Development and of the South African Social Security Agency that have placed that achievement in jeopardy. How did this come about?

A particularly important feature of this development was leanings towards building a 'techno-financial system' that track and exploit the poor and socially marginalised (Torkelson 2017). Ways to ensure payment fidelity by means of electronic tracking has been a strong consideration of welfare grant processing, ever since its mention in the White Paper for Social Welfare (South African Government 1997). A principal reason for SASSA's outsourcing of the welfare contract was to consolidate systems and authenticate beneficiaries. AllPay, a major competitor for the contract, claimed that SASSA made last-minute changes to the tender criteria, from requiring mandatory to preferential biometric verification – 'proof of life' was therefore required (Torkelson 2017). Further, Net1 created a range of subsidiaries that targeted beneficiaries to market loans (MoneyLine), mobile phone cards (EasyPay Everywhere), electricity and airtime (Manje Mobile), and insurance (SmartLife).

The NAWONGO court case

The role of NGOs in bringing the SASSA crisis to public consciousness was profound and underlined the importance of their activist role. A section of NGOs have, however, increasingly been subsumed under the state, threatening their accountability to the public as well as their autonomy (Habib and Taylor 1999; Habib 2005). It has also significantly influenced

their operational abilities and survival, as became apparent in a court case where a national coalition of 92 NGOs (the National Association of Welfare Organisations and Welfare Organisations, NAWONGO) sued the DoSD for clarification of service agreements. The Court found that the DoSD has underfunded NGOs for services that the state is constitutionally obliged to provide. It was estimated that the Free State province requires 2000 child and youth care centre beds; 1085 were available, of which only 320 were provided by state facilities. The DoSD spent between US$354 and US$477 per month per child in state-run child and youth care centres, but subsidised non-profit, non-state child and youth care centres US$242 per child per month. NGOs were essentially expected to provide children in their care with three meals for less than one US dollar a day. A similar trend was found regarding the subsidising of people requiring geriatric care (Free State High Court 2010).

In a significant move, the DoSD contracted the services of KPMG to assist in calculating the relative costs of financing NGO services. During the legal process, the DoSD, with the assistance of KPMG, drafted a policy outlining the costing and prioritising of non-profit service remuneration. The report provided the court with a mechanism with which to determine the annual costs of providing a service to a public beneficiary – including those who assist PLWMI. If an NGO provides an essential service, but cannot contribute to its own operational costs in providing this service, the state should supplement the deficit as necessary (Wyngaard 2011). The KMPG report provided a list of options with which the DoSD could address how funds are prioritised, such as by programme only (including adoptions, substance abuse, etc.); by programme and responsibilities (such as nutrition, medical care, or accommodation); and by programme and expense type (such as beneficiary-related costs).

The DoSD employed a strategy that prioritised by programme as well as necessity level (ranked as necessities, partial necessities, and non-necessities). This ranking allowed the priority of a programme to be determined by the DoSD, after which funds from the annual budget were allocated to programme expenses according to necessity level. Two lists were drawn from; (1) a ranked list of 40 priority programmes (consolidated into 34, after combining key programmes in an integrated social work service package) and, (2) a list of expenses ranked according to necessity level. Using this method, the DoSD avoided funding whole programmes. It was concluded that the 'allocation model … remains a deficit-sharing model. Because the department determines the content of each programme, in that determination it can leave out whatever it regards as non-essential' (Free State High Court 2010). This legal process resulted in the adoption of the KPMG model as a central technique in fund distribution to social services in the province, in which mental illness might fall through the cracks of ranked priorities based on economic rationality. It also swayed the power of prioritising towards the state sphere.

The Life Esidimeni tragedy

In what is now widely known as a significant – largely political – series of events, the Life Esidemeni tragedy was put into motion in the public sphere by the Gauteng provincial member of the executive committee (MEC) for Health, Qedani Mahlangu, during the 2015/2016 budget vote (Mahlangu 2015a). The GDoH claimed that patients suffering from mental illness needed to be deinstitutionalised to community settings, as stipulated in the Mental Health Care Act (17 of 2002) (South African Government 2002).

The well-known complexity and potential pitfalls of deinstitutionalisation in the context of inadequate community support, having been described with exceptional depth and breadth in existing literature as a feature of MHC reform in many countries since the 1960s (Koyanagi 2007; Morrow, Dagg, and Pederson 2008; Sheth 2009; Shen and Snowden 2014; Thornicroft, Deb, and Henderson 2016). The more significant reason for the ending of the contract was a financial one; the annual amount of US$24 million spent on 2378 patients was argued to be excessive, and it was indicated that these funds were to be re-prioritised (Mahlangu 2015b). This assertion was undercut by later assessments that suggested the costs of US$22.50 per patient per day at Life Esidimeni were below market-related healthcare costs; average healthcare costs per patient per day at state-funded Weskoppies, Sterkfontein Cullinan Care and Rehabilitation Centre hospitals were calculated at US$137.82, US$97.45 and US$104.47, respectively (Makgoba 2017). The patients were moved to 27 different NGOs, none of which were regulated by the DoSD. The narrative became one of shifting responsibility for PLWMI from the state to NGOs (Janse van Rensburg et al. 2018).

In February 2017 – following an investigation by the Office of Health Standards Compliance (OHSC) that was initiated by the national minister of health – 94 of the 1371 patients moved to community settings were confirmed to have died due to negligence (Makgoba 2017). MEC Qedani Mahlangu, who initiated the process, resigned (media scrutiny following the report has suggested a death count of more than 100). The unfolding of these events was closely followed in media outlets, countless opinion pieces were produced which universally condemned the events as human rights abuse. The United Nations Human Rights Council noted the following (2016):

> While deinstitutionalisation is the right approach, when implemented without a plan based in human rights that increases community-based services, and provides adequate housing and financial resources, it can have fatal consequences, as this situation illustrates.

While the OHSC report describes the progression of events with a fair amount of detail (Makgoba 2017), for our purposes it will be prudent to revisit the key developments that led to the tragedy. In June 2015, the MEC communicated her department's deinstitutionalisation plans. During the same month, the South African Society of Psychiatrists (SASOP) warned the GDoH of the likely negative consequences that will result from the Life Esidimeni contract termination. Despite repeated concerns raised from interest groups, the GDoH went ahead with the planned deinstitutionalisation, and by June 2016 all state-funded patients were moved out of the Life Esidimeni facilities.

By July 2016 reports surface that patients' families were looking for them, and that many patients were missing after the transfer process. In August 2016, a public letter was addressed to the MEC by Christine Nxumalo, the sister of one of the patients who died by the NGOs negligence. On 13 September 2016, the MEC announced that 36 patients had died since relocation to NGOs, eliciting wide-spread condemnation in the media. Two days later, the national Minister of Health requested an official enquiry from the OHSC into the circumstances of the deaths. Following inputs from the MEC, the final report was released on 1 February 2017; with deaths tolling 94 patients. On the same day MEC Mahlangu resigned.

During the days following the release of the report, both the astounding number and causes of deaths following the re-location process was the subject of public discourse. The

full details of the 56-page report cannot be adequately summarised here. Succinctly, clinical and other patient-level records were analysed by an eight-person expert panel; the 26 NGOs involved were investigated by means of on-site visits, inspections and interviews by two OHSC inspectors; the investigation team reviewed popular media coverage, documents, and case presentations with affidavits from civil society group Section 27, and worked with Statistics South Africa to analyse mortality; and the Ombudsman interviewed 73 individuals under oath or affirmation. The findings of the investigation entail widespread condemnation of the Life Esidimeni transfer process, as well as the mental health system as a whole. The rushed manner and consequences of the actual transfer process was described in lurid detail (Makgoba 2017, 2):

> … frail, disabled and incapacitated patients were transported in inappropriate and inhumane modes of transport, some 'without wheel chairs but tied with bed sheets' to support them; some NGOs rocked up at Life Esidimeni in open 'bakkies' [trucks] to fetch MHCUs [mental healthcare users] while others chose MCHUs like an 'auction cattle market' … some MCHUs were shuttled around several NGOs … [T]hese conducts were most negligent and reckless and showed a total lack of respect for human dignity, care and human life.

The deaths of the patients received strong focus – both the manner and number – as did the series of poor decisions and flawed argumentation that led to the deaths, along with the under-capacity of NGOs to have prevented the deaths (Makgoba 2017). At the time of writing, arbitration proceedings were held between 134 patient families and the state, chaired by Retired Deputy Chief Justice Dikgang Moseneke. By following a public arbitration process instead of the courts, litigation was avoided towards promoting healing and redress, much in the same manner as the historic Truth and Reconciliation hearings following the fall of apartheid. During the public arbitration hearings, it was indicated that the death toll rose to 144, although 59 patients were unaccounted for even though NGOs still drew their monthly welfare grants (Bornman 2017). The process had wide participation, with prominent advocacy and professional groups taking part, including the South African Depression and Anxiety Group (SADAG), the South African Federation for Mental Health (SAFMH), the South African Society of Psychiatrists (SASOP), Section 27 and Legal Aid. Following 44 days of testimony and cross-examination, an agreement was reached between the parties that included counselling for the families, a memorial, and financial compensation that totalled R1.2 million for each family – R20,000 for funeral expenses, R180,000 for emotional shock and trauma, and R1 million for constitutional damages (Moseneke 2018). Neither the ombud-report nor the arbitration hearing yielded any tangible orders for system reform, and the plight of PLWMI, both those part of Life Esidimeni and those in other parts of the country – persists.

Neoliberal undertones in governing serious mental and neurological disorders

There are several cross-cutting political dimensions that emerge in the three events described above. However, a prominent feature that has become increasingly telling in the governance of people suffering from serious mental and neurological disorders in post-apartheid South Africa is the consequences of neoliberal restructuring and reframing (Janse van Rensburg 2018). Much has been written about an apparent unbridled global growth of neoliberalism, and how it has influenced MHC in different contexts. In many

countries, neoliberal ideologies aided in the construction of a health policy environment that stresses reduced public responsibility for population health; increased markets and choice; the devolution of national health services to insurance-based systems; privatisation of care; approaching patients as clients and replacing planning with markets; elevating personal responsibility for health improvement; and moving from health promotion to behaviour change (Navarro 2009). Here, we focus on South Africa's contradictory engagement with both neoliberalism and welfare expansion, against the backdrop of increased statism; the commodification of PLWMI; and global influences in local MHC.

Neoliberal contradictions in MHC

The neoliberal project is not path dependent and does not follow the exact same trajectory in South Africa as in other countries and regions, where it has had especially vivid repercussions. In fact, in contradiction to the traditional neoliberal trope of decreased state power and involvement in favour of free market forces (Wacquant 2010), South Africa has – especially during the past decade – seen increased statism in the management of mental illness (Janse van Rensburg et al. 2018).

This statism developed against the background of a particular neoliberal macroeconomic environment, embodied by the introduction of the Growth, Employment and Redistribution (GEAR) plan in 1996. The exclusivity of GEAR put into motion an internecine struggle, when the ANC had to abandon their socialist roots towards creating an environment which inhibits labour (Peet 2002), aligning with domestic and global capital and the black bourgeoisie at the expense of the impoverished majority (Visser 2005). GEAR exposed a nationalist drive, that united well-placed black elites with white capital (Baker 2010), that has continued under the guise of the National Development Plan. Nonetheless, at the same time, welfare spending has increased substantially over the past decade. The number of households receiving social assistance rose from 29.9% in 2003 to 45.5% in 2015, while government social protection spending increased by 39% from approximately US$600 million in 2010/2011, to more than US$850 million in 2014/2015 (Statistics South Africa 2016). While social protection policies often become gauze that hides the widening wealth disparities and social costs of neoliberal strategising (Devereux and Solomon 2011; Harris, Eyles, and Goudge 2016), the contradictions between embracing neoliberal policy while at the same time expanding welfare has had a telling effect on MHC.

Gillian Hart (2014) provides a fitting analytical device with which to better understand these apparent contradictory relations. Moving beyond the usual focus on neoliberalism and its internal dynamics, Hart uses the double movement of de- and re-nationalisation to account for the trend of increased statism. De-nationalisation refers to the engagement of South African corporate capital with global capitalist forces following the end of apartheid, with capital flight and wide-spread privatisation and out-sourcing of services. Its dynamics extends to beyond the scope of GEAR, to include forged partnerships between new black elites and white capital and the resulting influence of these partnerships on ANC policy, massive capital flows to the global economy, and denationalisation of conglomerates.

This was apparent both in the supportive policy environment as well as in the outsourcing of services by the South African state in the cases described above: the SASSA crisis involved the contracting of biometric social grant management to a global corporation;

KPMG being heavily involved in the prioritisation processes in the NAWONGO court case; and, in Life Esidimeni tragedy, mental health services were outsourced to a major private hospital group very much connected to global capital. Employing simultaneous economic, political and cultural practices and processes that generate 'surplus populations', de-nationalisation dynamics have deepened abject inequalities and severely negated livelihoods of the bulk of the black South African population. However, as the Life Esidimeni and SASSA cases suggested, the state attempted to reroute capital back into the state sphere. In the SASSA case, this was especially telling in the awarding of the welfare grant payment contract to SAPO (though the example is rather simplistic); the core functions of the contract include managing a corporate control holding account, a special disbursement account, identity card production and distribution, and enlisting of new beneficiaries – all to be done under the shadow of 'cost-effectiveness' (Herman 2017). Further, a backdoor was provided that will allow external companies and banking systems to assist with the delivering of some of these services, thereby facilitating a flow of capital to global networks.

The seemingly contradictory movements between statist and globalist standpoints are crucial elements of ANC hegemony. Attempts to 'take back services' are processes of re-nationalisation, heavily tied to the ANC's post-apartheid project of 'building a new nation', processes that inevitably includes contentions involving race, class, and gender struggles in a post-colonial sense. Re-nationalisation also included the ANC government's immigration policies and practices that fuelled well-documented xenophobic attacks during the past decade, as well as a broader strategy within the ANC that involves the adoption of socialist tendencies after the fall of apartheid. The simultaneous and conflicting processes of de- and re-nationalisation has been a key influence in the ANC's post-apartheid hegemony (Hart 2014).

Commodification of serious mental illness

A key, and often overlooked, feature of MHC that emerge in the cases discussed involve an apparent commodification of PLWMI; the application of cost–benefit, economistic and accounting rationalities in their management; and the reach of multinational bodies with an associated flow of global capital (Miller and Rose 2008). Under the conditions of neoliberalism 'the inability of the human to compete in terms of productivity, efficiency, and corporate values become a signal of the failure of his embedded capital or of his ability to adequately create and cultivate capital' (Dhar, Chakrabarti, and Banerjee 2013, 586). This sentiment is captured in responses to mental illness as featured in significant health policy reforms in post-apartheid South Africa, where any real advances in the fostering of a nurturing environment for mental health was undone by macroeconomic shifts that stimulated the commodification of PLWMI (Janse van Rensburg et al. 2018).

This commodification became apparent in the cases mentioned; PLWMI were left to the devices of the market, where NGOs – the supposed champions of civil society and human rights – are left to compete with each other for the stable capital income generated by caring for this vulnerable population. The monthly SASSA payment system incentivised quantity over quality, and the state and NGOs are embroiled in an enduring and protracted battle for the capital investment associated with the care of people on the peripheries on the social, political, and economic dimensions of the South African landscape. Loic

Wacquant (2009a, 2009b, 2010) and Bernard Harcourt (2011) drew our gaze to the double act of widespread disinvestment in the lives of certain population groups as well as investment in their management, exemplified by the private prison system complex 'managing' (especially) black, lower socio-economic class populations for profit. This entails a flow of capital from tax-payers to private companies, endorsed and supported by the state apparatus who are the legitimate stewards of population health and well-being. At the minimum, PLWMI are denied basic social and healthcare, much like many other people in South Africa. However, it is no longer is a question about quality of care and human rights, but rather of life and death, where 144 people have died as a direct result of an almost extreme expression of biopower, and where 'death and freedom are irrevocably interwoven' (Mbembe 2003, 38).

Global influences on local MHC

The involvement of key global actors – notably Net1 and KPMG – in key events that shape South Africa's MHC for people suffering from serious mental and neurological conditions have been telling in the cases described. This is a key feature of neoliberal governing, namely increasingly blurred lines between the global and the local (Wacquant 2010). The power of accounting practices, in part at least, by governance structures that adhere to practices that are 'often demanded by outside agencies, and which makes various kinds of internal and external intervention possible' (Power 2000, 114). The reliance on the discipline of auditing to inform priority setting in the NAWONGO case, as well as to support the case for Net1 to continue facilitating welfare payments, are central dimensions of neoliberal strategising. It speaks to a shift from the power of the medical professions such as psychiatry in public MHC, towards embracing decentralised control driven by auditing-driven governance practices (Rose 1996).

The effects of global forces on local MHC are further facilitated by increased global financial integration. There has been a general overall trend towards international financial integration, with global capital flows steadily increasing from less than 7% of the global GDP in 1998, to more than 20% in 2007 – this was led by an expansion of flows from and to more advanced economies (Milesi-Ferretti and Tille 2011). As the SASSA crisis demonstrated, social protection of PLWMI is very much linked to global capital flows, not only in terms of cash, but also in terms of technocratic governing and control of specific populations by means of technologies of surveillance and auditing (Miller and Rose 2008). This also made local mental health policy and legal processes more accessible for global corporations, who have benefited from trade liberalisation and reduced state intervention (De Vogli 2011; Moore et al. 2011). There is a correlation between increased healthcare commercialisation and foreign investment (Smith 2004), and South Africa's strong private health sector provided opportunity for the involvement of multinationals. The result of these neoliberal influences has been – in concert with ANC politics – detrimental for the vulnerable, with significant and growing disparities in the care for PLWMI.

Conclusion

In this paper, we explored the ways in which MHC has been politicised in South Africa's post-apartheid period. Despite the country's measurable strides towards policy and

legislation skewed on equity and social justice, significant macroeconomic shifts have rendered PLWMI a distinct subject of politics. Three key events exemplify this: the SASSA grants crisis, the NAWONGO court case, and – perhaps most strikingly – the Life Esidimeni tragedy. The three events contained core elements of the governance and management of vulnerable populations under neoliberalism: rational conduct and reasoning, the centrality of auditing and accounting practices, and the setting of specific standards for human capital (Miller 2001; Dhar, Chakrabarti, and Banerjee 2013). Specifically, the events suggested that the structural conditions of post-apartheid South Africa underwrote the commodification of PLWMI, the auditing and accounting involved in governing MHC, all within reach of global capital. The enduring relations between the global neoliberal project and national responses to mental illness are both real and important (Carney 2008; Teghtsoonian 2009).

Nonetheless, this does not mean that South Africa turned into a 'hollow state', where state power is completely dispersed throughout a third party network (Millward and Provan 2000). Instead, ANC politics have resulted in processes of de- and re-nationalisation, where contradicting movements have taken place between strategies of statism and globalisation – this was evident both in ANC policy, as well as in the attempts by the state to consolidate its power in health and welfare sectors.

Finally, this paper moved away from analyses of failures in governing MHC that focus on individual culpability and negligence, towards interrogating the relational and structural conditions that make tragedies like Life Esidimeni possible. This certainly does not absolve individual wrong-doing, nor do we argue that agency is irrelevant. Rather, we argue for more nuanced analyses of the governance of MHC, and more compelling insights that engage with the deeper mechanisms of causality. Events such as the SASSA crisis, the NAWONGO court case, and the Life Esidimeni tragedy indicate a deeper malaise, made possible in South Africa's post-apartheid landscape despite robust policy and legislation. Such events are both discursive and illuminating, drawing a gaze to the subtler forms of power – 'a small burning candle may be the most visible object in a closed room, until sunlight pours into the windows' (McCubbin 1998, 97). Ultimately, while these events shed light on the plight of PLWMI, the conditions that make their suffering possible remain, calling for radical intervention.

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