Echoes of austerity
Policy, temporality, and public health in South Africa

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Abstract: South Africa's post-apartheid era has been marked by the continuation of racialized socioeconomic inequality, a social situation produced by earlier periods of settlement, colonization, and apartheid. While the ruling African National Congress has pursued a transformative political agenda, it has done so within the confines of neoliberal macroeconomic policy, including a period of fiscal austerity, which has had limited impact on poverty and inequality. Here, I explore how policy principles associated with austerity travel across time, space, and the levels of the state in South Africa, eventually manifesting in a public health policy that produced cuts to public health services. In assessing these sociopolitical dynamics, I utilize policy process as a chronotope to unify diverse experiences of temporality relative to austerity-inspired public health policy.

Keywords: activism, austerity, inequality, public health, South Africa, temporality

I was buffeted by icy gusts of wind that swept down across the face of Table Mountain amid the damp chill of Cape Town's winter rain. I rushed to the car with Tasneem, a member of the Treatment Action Campaign (TAC), a leading organization in the South African HIV/AIDS movement. As I tumbled into the car, I looked over to Tasneem, laughing at myself while I shook with cold. "You have to dress warmer, man; you're going to get sick!" Tasneem chuckled as she spoke, watching as I fumbled the car keys with my numbed fingers. I started the car and we pulled away from Community House, a series of buildings that held the offices of many left-leaning nongovernmental organizations that were part of the social justice movement in Cape Town. I was accompanying the HIV/AIDS activist to a meeting of the Western Cape Coalition against Public Health Cuts, a broad alliance of public sector health workers, health activists, and trade unions.

The drive over to the coalition meeting was short, as the gathering was held at a hospital located just down the road from Community House. The group was convening at Groote Schuur Hospital, a tertiary level institution in the South African public health system, meaning that it offers specialized and super-specialized care. Founded in 1938, the hospital admitted 560,000 poor and working-class patients per year while also serving as a center for research and academic training. We pulled up to the security gate, and I paid the security guard to park amid the debris of an ongoing renovation. Step-

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ping out of the car, we walked through a veil of cold mist and light rain, and I asked Tasneem why the meeting was being held in this facility. As we walked into a stately gray building, she explained that the coalition had its roots at the hospital. A shift in provincial health policy had led to bed closures at Groote Schuur, and a handful of doctors had challenged the decision, leading to the formation of the coalition.

After wandering through the labyrinthine hospital for some time, Tasneem and I walked into the meeting after those in attendance had commenced roll call. Elise, a leading member of the coalition, was chairing the meeting. Tasneem introduced me to Elise and the others in attendance as we sat down. Elise was a specialist doctor who worked at Groote Schuur and was a former HIV/AIDS activist. She had worked closely with leading African National Congress (ANC) figures in the anti-apartheid movement and was central to the campaign against public health cuts. They began the meeting by discussing various letters sent to members of the Western Cape Department of Health and ANC leaders in the Western Cape province that challenged the health cuts. After that, those in attendance analyzed their strategy of using the media to bring attention to the impact of the public sector bed closures. On several occasions, Elise forcefully made the point that neo liberal fiscal austerity lay at the root of the health cuts.

There was broad agreement with her assessment among the coalition members, who posited a causal link between macroeconomic policies of the mid-1990s and public health interventions marked by austerity a decade later. What struck me at the time were the nods of agreement that occurred around the conference table, a simultaneous expression of mutual understanding that neoliberalism and austerity were indeed the driving forces behind public health policy. This moment raises the question of what accounts for the linkage established between a period of austerity in the late 1990s and early 2000s and subsequent changes in public health policy nearly a decade later. How and why was there broad agreement on the claim that austerity had occurred in South Africa, a postcolonial society? To what extent did an earlier period of fiscal austerity influence the changes to health policy under debate? And, if the two instances were related, how did policy norms travel across time and space, only to reemerge during a different historical moment? Finally, what does the temporal signature of austerity in South Africa indicate about anthropological debates on austerity in other sociocultural contexts?

Crisis, temporality, anthropology

The analysis of time as a component of cultural variation has long served as a focal point of analysis for sociocultural anthropologists. Foundational perspectives on temporality frame it as growing out of historical particularity and interwoven into the fabric of social life, while others have examined temporality as part of the rise of modern societies, analyzing how time discipline operated in both metropole and colony (Leach 1961; Mintz 1986; Thompson 1967). These accounts have been augmented by a growing body of literature that highlights how a diverse array of temporal registers and experiences overlap and coexist in simultaneity (Bear 2016). Building on these debates, the wave of austerity that has enveloped large swathes of Europe following the 2008 financial crisis has provoked a series of debates on inequality, power, and temporality within anthropological circles (Rakopoulos 2018). Indeed, central to the analysis of contemporary austerity in Europe have been accounts that frame austerity measures as a crystallization and intensification of the space-time compression produced by global capitalism (Harvey 1989).

Alongside these analyses, a growing body of literature analyzes the experiences of poor and working-class communities impacted by the austerity measures. Recent research has analyzed how people are rethinking temporality in response to changing socioeconomic conditions, whereby austerity is seen to transform socio-

cultural conceptions of time via the space-time compression that economic reforms are produced within and are productive of (Knight and Stewart 2016). The acceleration of externally driven politico-economic restructuring has produces countervailing tendencies among those "adjusted" into precarious socioeconomic circumstances, undermining future trajectories into an "uncanny" present (Bryant 2016). Concepts such as "time tricking" underscore how cultural conceptions of time are transformed as people navigate changing social circumstances, where, for example, people may attempt to stretch or bend time as a technique to resist the compression of space-time brought on by austerity (Moroșanu and Ringel 2016). But we should not be drawn into a binary opposition between various temporal registers, seeing resistance and agency as "slowing" the space-time produced by global capitalism. After all, the structural violence that austerity exemplifies can operate slowly as well as quickly (Nixon 2011).

The analysis of temporality alongside the postcrisis wave of austerity thus raises the question of how one goes about measuring temporal dynamics amid changing social circumstances. Does one situate the analysis within the financial circuitry of global capitalism, seeing the local manifestation of austerity as an extension of broader politico-economic dynamics? Or should one try to build up from the particularity of local experiences among those impacted by austerity's violence and link the abstract economic ideals on which this policy assemblage is based to the material experiences of those negatively affected by it?

On this point, Laura Bear has proposed revisiting Mikhail Bakhtin's concept of the chronotope to unify the disparate conceptions of time that mutually constitute social life. Chronotopes are "representations that materialize timespace in a manner that enables the dimension to become visible" (2014: 7). Expanding the concept to that of time-maps, Bear proposes the application of the chronotope concept to enable deeper insight into the multimodal experience of time in modern societies. Here, I take up Bear's conceptualization and apply it to policy, proposing policy process as a chronotope or mechanism for understanding different modes of temporality operating in the South African post-apartheid context. Policy process is framed here as a zone of mediation for different class-based interests in the South African context, where the temporal unfolding of austerity is linked to, but somewhat autonomous from, global circuits of accumulation and dispossession. In order to study this, I followed both people and the policy process as they traveled across South African society and the levels of the state (Shore and Wright 1997; Wedel et al. 2005).

Of particular concern is how interpersonal networks of state policy actors produced particular temporal dynamics by incorporating austerity into state health policy. Studying the role of people and interpersonal networks within the state thus helps one to see why policy moves at certain times and not others. Indeed, it is people that enable policy principles—in this case, those associated with austerity—to manifest later, to echo across time, creating reverberations that impair the livelihoods of South African poor and working-class people. Building on Bear's theorization, policy process may offer another way to frame these divergent lifeworlds, as it offers insight into multiple experiences of time within a unified analytical framework.

In this analysis, I show how policy actors in South Africa's Western Cape province mobilized the principles of austerity to develop policies that limited access to public health care. In addition, I track how a coalition of health activists, public sector health workers, and trade unions formed to counteract the negative social effects of austerity. I first situate the analysis of austerity within the political economy of post-apartheid South Africa before tracing the South African policy process and the social response to it. I suggest that the advancement of—and opposition to—austere public health policy points to the importance of people in understanding austerity's temporality, its impact, and the way in which different policy principles travel across the levels of the state.

Austerity and public health in South Africa

More than two decades into South Africa's democratic period, the socioeconomic transformation that many had anticipated has yet to materialize. With the ANC's victory in the 1994 democratic elections and the adoption of a new constitution in 1996, fortune seemed to have finally smiled on the oppressed peoples of South Africa. The ANC's election platform was the Reconstruction and Development Programme, a neo-Keynesian policy that promoted a "better life for all" and "growth through redistribution." However, a democratic South Africa emerged within a far different geopolitical context than other newly liberated African societies. A majoritarian South African society faced a unipolar post–Cold War context and the Washington Consensus's globalizing mantra: privatize, liberalize, and democratize.

The World Bank and other institutions promoted neoliberal socioeconomic policies as the antidote to the difficult economic situation faced by the ANC upon coming to power. The South African economy had stagnated amid economic isolation, and the apartheid debt that the ANC inherited stood at nearly 50 percent of the gross domestic product. The structure of the apartheid debt was particularly prone to financial sector speculation, which led to a series of currency crises that began in 1996 (Aron and Elbadawi 1999). The ANC was faced with a difficult choice: to go it alone and risk losing national autonomy via structural adjustment or to adopt the core economic tenets promulgated by the Washington Consensus and maintain political sovereignty (Hirsch 2005).

Economists associated with the World Bank had introduced leading ANC members to key tenets of neoliberalism, and the import of this liaison was evidenced by the development of the Growth, Employment, and Redistribution (GEAR) macroeconomic strategy (Smith 2008). Guided by then Deputy President Thabo Mbeki, the ANC's transformative strategy was reframed as "redistribution through growth." GEAR limiting spending on education, health, and other social services to lower government debt levels while privatizing government functions such as electricity and water provision. The shift in macroeconomic policy was accompanied by liberalization of trade and foreign exchange markets, which set South Africa on the path of neoliberal orthodoxy associated with structural adjustment (Bond 2004).

The ANC's neoliberal turn had clear and unmistakable effects on South African society. The privatization of water led to price increases, limiting access to a basic necessity of life. Some turned toward other, unclean sources of water as a survival strategy, which resulted in cholera outbreaks (Deedat and Cottle 2002). The socioeconomic effects of austerity include dire public health effects. Public health spending did not increase in real terms from 1997/1998 until 2006/2007 (McIntyre and Thiede 2007). Alongside austerity, the world's largest HIV/AIDS epidemic exploded during the 1990s, expanding to nearly 18 percent of the adult population aged 15–49 by 2002 (Statistics South Africa 2017). The exponential growth of HIV/AIDS in South Africa was aided and abetted by President Mbeki's embrace of AIDS dissidence, which questioned the link between HIV and AIDS, characterized HIV/AIDS treatment as poisonous, critiqued the global pharmaceutical industry as profiteering off of the African poor, and challenged the characterization of African people as over-sexualized and unable to govern themselves (Gevisser 2007; Nattrass 2007). A series of resurgent social movements responded to the effects of neoliberal austerity and HIV/AIDS, critiquing the effects of GEAR, mobilizing communities affected by austerity, and agitating for its cessation (Desai 2002; Zuern 2011).

Limited post-apartheid social transformation, due in part to austerity and its socioeconomic effects, has entailed a continuation of the rampant poverty that resulted from colonization, segregation, and apartheid. In a country with a population of 53 million people, 45 percent of the South African population lives on less than $2 a day, while more than 10 million people live on less than $1 per day (Mayosi and

Benatar 2014: 1344). Class lines continue to follow racial lines, as approximately 90 percent of South Africans living in poverty are black (Leibbrandt et al. 2011). The ANC has attempted to soften the impact of continued social inequality through the expansion of a large-scale social grants program (Ferguson 2015). The number of South Africans qualifying for social grants has more than doubled within a decade, and it is estimated that nearly a third of the South African population will rely on social grants by 2018 (Holmes 2014; Rossouw 2017). These programs have softened the impact of fiscal austerity and neoliberal macroeconomic policies in South Africa (Seekings and Nattrass 2008).

It is clear that the ANC has attempted to create a redistributional state within the limits of neoliberal macroeconomic norms, but focusing on social grants evinces broader public health challenges in South Africa. Multiple epidemics and long-standing illnesses of poverty have grown out of sustained resource deprivation for South Africa's predominantly black poor. Austerity and its continuing impact have limited the capacity of state health institutions to address these issues. The ANC's public health policies have sought to improve public health amid the continued impact of austerity, racial inequality, and ongoing limitations imposed on health spending by neoliberal macroeconomic policy.

Austerity, people, and public health policy

Post-apartheid health policy under the ANC has emphasized the development of primary care to meet the needs of the predominantly black South African poor. The historical concentration of health facilities in predominantly white, urban areas was accompanied by the development of specialized services and advanced medical interventions. The ANC, then, was confronted with an unevenly distributed public health system that had been designed to meet the needs of the minority white population upon coming to power. The ruling party also faced the challenge of carrying out social transformation within the self-imposed confines of austerity.

Addressing the uneven character of South Africa's health infrastructure led to shifts in the budgeting principles developed to oversee social transformation. For example, post-apartheid budgeting processes are governed by the equitable share principle, or that state funding should be based on a per-capita allocation rather than a racially unequal division. However, budgeting based on the equitable share principle could not account for the concentration of tertiary—or specialized—health services in the provinces containing South Africa's historically white cities. An additional shift in policy was required.

The ANC had restructured provincial boundaries as part of the transition to a democratic era, and with that came a need for the development of specialized services in historically underserved regions, such as the Eastern Cape province. However, national funding for specialized services was provided separately than that for primary health care, and the provinces that already had specialized health services received the funding for doing so. In sum, the provinces that were most developed under white rule continued to contain the best public health services and garner the lion's share of national health funding for specialized services. In the context of fiscal austerity, the uneven distribution of health funding was seen as preventing the development of specialized services for South Africa's historically disenfranchise peoples.

Amid ongoing austerity, the National Department of Health revisited national financing mechanisms for the provision of tertiary care to address ongoing health system inequalities. A National Department of Health review of South Africa's public health sector analyzed the distribution of specialized health services across the country, creating a list of all specialized services provided by public sector hospitals in order to search for greater efficiency and cost efficacy. Responding to this review, public sector medical specialists emphasized the need for additional staffing, training, and personnel retention. Foreshadowing future events, medi-

cal specialists declined to provide information on how they might operate within a "pessimistic" funding environment. Researchers from the National Department of Health, therefore, were not able to gather data on how a potential restructuring of tertiary services would work within the limits of austerity. Nonetheless, the researchers created models of the more restrictive funding scenario using, in their own words, "rather more interpretation."

Debates on how best to adapt public health policy to austerity also influenced the organization and delivery of care by provincial health institutions. In the Free State province, Dr. Craig Household was appointed to oversee public health management in the province in 1996, having served as a professor and head of pediatrics at the University of the Free State. Once appointed head of health for the province, Household undertook an aggressive restructuring of provincial health spending, bringing provincial health expenditure within the financial limitations associated with austerity, earning himself the nickname of "the butcher" due to decreased worker compensation he oversaw on various fronts (Bateman 2015).

In 2002, Household changed positions and took on the role of head of health for the Western Cape province. Once there, he began to emulate his work in the Free State, bringing public health expenditure in line within stringent national resource allocations amid austerity. According to Household, aligning health spending with austere national health financing was his primary task upon taking charge in the Western Cape province: "When I took over as Head of the [Western Cape Department of Health], it was struggling to function within its budget and my first brief from the then-premier was to stabilise the Department's finances. I became quite unpopular with some people at that point who accused me of 'putting cash before care' but we succeeded in becoming financially stable" (Chowles 2014). The driving factor behind Household's efforts to limit public health spending in the province were the aforementioned debates on national resource allocation for specialized medical interventions, which sought to create a more equitable distribution of specialized health services across the country (Thom 2004). While these issues had simmered in the Western Cape since 2001, it was not until Household arrived that decisive efforts to transform provincial policy took hold.

Starting in 2003, Household assembled a research team that analyzed the balance between tertiary, secondary, and primary health services. Later that year, the Western Cape Department of Health published a public health policy titled Health Care 2010, which set out Household's vision for public health care in the province. The policy built on national policy debates and sought to "right size" specialized services in one of the provinces that had historically received the bulk of public sector health investment. The policy was designed to shift resources and services away from the tertiary level and toward the secondary and primary care levels. The policy was a response to decreasing levels of national support for specialized services, which continued to decline amid austerity. At the announcement of his appointment to a second term as head of health in 2005, Household (2005: 3) declared that the implementation of Health Care 2010 was one of his central goals. The policy implemented cut funding to specialized health care in the province, which would later lead to bed closures at the academic teaching hospitals where these medical interventions were offered.

The argument put forward to rationalize these shifts was that increased funding for primary health care would lead to decreased demand for tertiary services. The claim does have some merit, as, in theory, increased funding for primary care should allow people to access care before illnesses progress into serious conditions. Resolving disease at primary and secondary care facilities is less costly, as it often does not require the specialized care that tertiary level institutions provide. However, the claim that increased support for primary care would lead to reduced demand for tertiary care underestimates the burden of disease in South Africa. Indeed, it would seem unlikely that a country with the

world's largest HIV/AIDS epidemic and a growing drug-resistant tuberculosis epidemic would be able to address the complications arising from these illnesses at the primary care level.

Nevertheless, Health Care 2010 was approved and the policy moved toward the implementation stage. The Comprehensive Service Plan for the Implementation of Health Care 2010 operationalized the policy principles that derived from South Africa's austerity period. The policy led to 90 bed cuts at the tertiary level, concentrated primarily at two hospitals: Tygerberg and Groote Schuur. The policy was accompanied by leading members of the Western Cape Department of Health presenting the policy at tertiary health facilities across the province, framing it as a necessary step, without the possibility of further consultation or adaptation. The response to the public sector health cuts was critical and decisive, developing first in the province's tertiary care institutions that were experiencing the bed cuts before expanding into a broad alliance that sought to protect public health services in South Africa.

Society responds: The Western Cape Coalition against Public Health Cuts

The campaign against Health Care 2010 took form in early 2007 when the Western Cape Provincial Treasury released its budget figures, which outlined a 30 million rand (approximately $4.3 million) shortfall in the budget for Groote Schuur and Tygerberg hospitals. Following this announcement, a meeting was held on 2 April at Groote Schuur Hospital between Head of Health Household and several hospital clinicians. At that meeting, Household declared a 400 million rand ($57.1 million) shortfall for the provincial health budget, which would primarily affect public sector institutions providing specialized care. This funding deficit created an opportunity for the Western Cape Department of Health to eliminate 60 beds at Groote Schuur and 30 beds at Tygerberg as envisioned in the Health Care 2010 plan.

Elise, a leading member of the Western Cape Coalition against Public Health Cuts, had attended the 2 April meeting, and she described it as a contentious one. Several doctors who would later join the coalition had openly challenged the announcement of bed closures, questioning the limitations imposed on public sector specialist services. Regardless, the Department of Health went ahead with the closure of specialist beds, provoking the formation of a broad coalition that opposed the cuts to public health care. Elise's everyday work experiences after the bed closures confirmed her fears: there was an immediate drop in the quality of care that doctors could offer to patients at the hospital.

> I'm a doctor working at the hospital that was primarily affected by the proposed cuts, and I became involved because of a number of separate things, I suppose. First of all, as a frontline service provider, I was faced with the issue of bed shortages on a daily basis, which is really one of the most frustrating parts of the work that we do. It's something that we had to deal with on a week-by-week basis. People waiting several hours to get into beds, unable to do operations because people weren't in beds at that time, always giving suboptimal care because antibiotics and medication wasn't being administered, and just the dehumanizing indignity of lying in casualty for so long for so many patients and the frustration of trying to care for people in those conditions.

Elise's description of her working conditions and the care received by poor and working-class South Africans following the bed closures underscores Health Care 2010's negative effects. Longer waiting times, often in ill-equipped "casualty" reception sections of the hospital due to the shortage of beds, and what Elise saw as the improper treatment of patients point to just a few of the consequences of the Health Care 2010 policy.

For the members of the coalition, the implications of reducing specialist services went

beyond denying dignity and appropriate care to poor and working-class people accessing public sector treatment. Elise drew a longer historical thread in situating the closure of public sector beds. For her, the curtailment of specialist services under Health Care 2010 denied high-level care to those who depended on the public sector for their physical wellbeing. Given the overlap between race and class in the South African context, most people who were to be denied specialist care in the public health sector were South Africans who could not access Groote Schuur Hospital during the apartheid era: poor and working-class black South Africans: "This had always been a private, white, privileged hospital before, under apartheid, and many people couldn't access the specialized services here, and the absolute irony is that now, in the post-apartheid South Africa when poor black people could access this, the hospital was being run down and broken apart, literally, in front of our eyes." Elise's eyes shone with anger as she described how the history of colonization, segregation, and apartheid had produced illness among South Africa's black population. Now, they would be denied the care necessary to sustain their lives, despite living in a democratic society. Elise shook her head in disbelief as she finished describing the dovetailing of history and disease, rubbing her forehead as she let out a long, slow sigh. She remained unwilling to cede to what health administrators framed as the pragmatic and common sense solution to national resource limitations.

Given the consequences of the budget cuts, Elise and several doctors within Groote Schuur Hospital had discussed actions to counter the closure of specialist beds, which was the first step in the campaign against public health cuts. The process began with an anonymously organized mass meeting to address the issue of bed cuts at Groote Schuur, which nearly all doctors working at the hospital attended. The meeting led to the formation of the Groote Schuur Crisis Committee, which consisted of doctors within the hospital who developed a petition to halt the bed closures. This document was sent to the Western Cape Department of Health and demanded that Household come to the hospital to explain his actions. The meeting between the committee and Household was held, but the bed closures were not reversed. The meeting with health officials prompted several doctors to take the political challenge to bed cuts beyond the hospital's walls. The doctors who were to form the core members of the coalition began to build ties with organizations and individuals at the local, provincial, and national levels in their attempt to overturn the beds closures.

The Groote Schuur Crisis Committee expanded to include members of other specialist hospitals in the Western Cape, health activists, and members of other social-justice-oriented NGOs. Public sector professionals from other tertiary hospitals such as Tygerberg Hospital joined the coalition. The coalition expanded to include the TAC, Positive Muslims, and the Alternative Information and Development Centre. In addition to these social-justice advocacy organizations, three labor unions played significant roles in the coalition's campaign against public sector health cuts. The National Education, Health and Allied Workers' Union was a key partner in pushing forward a legal challenge to the closure of beds. In addition, the South African Municipal Workers' Union supported the work of the coalition. Both unions were members of the Congress of South African Trade Unions, a national umbrella organization for the union movement formed in 1985, which plays an influential role in national policy decisions.

As the campaign against health cuts unfolded, it became clear that the issues being addressed by the coalition had implications that reached far beyond the closure of 90 public sector beds. An entire philosophy of health service delivery was called into question, which Elise summed up at the first coalition meeting I had attended. Rather than "what is the best health care we can offer for this amount of money," Elise pointed out that the coalition was organizing to provide "the appropriate public health response given the burden of disease and the amount of need." For the coalition members,

the underlying principle of scarcity had to be challenged to address the impact of disease and illness in poor and working-class communities. The coalition also addressed the broader issue that underlay the bed closures—that insufficient government funding was a looming threat to treating a public health crisis precipitated by the synergistic HIV/AIDS and tuberculosis epidemics. For the coalition members, the Health Care 2010 policy effectively sentenced poor and working-class South Africans in need of specialized care to premature and unnecessary deaths. The coalition moved on from simply challenging the issue of bed closures to confronting neoliberal macroeconomic policy, austerity, a lack of public consultation in the health budgeting process, and the effect of these dynamics on the South African public. In the end, the coalition was successful in its campaign to reverse the bed cuts and restore public sector health care to its previous levels.

People, precarity, and mobilization

The foregoing analysis of post-apartheid public health policy has traced the genealogy of austerity-inspired policy development and the response to these initiatives by health activists and organizations that work with—and include—poor and working-class South Africans. Policy norms associated with austerity arrived via international institutions, shifted across national boundaries, and moved through the levels of the South African state. Temporal dynamics relating to these policy norms thus unfolded across national boundaries and moved through and across the administrative levels of the South African state via interpersonal networks of state policy actors. While it should not come as a surprise that policy "travels," the temporal signature of policies that derive from the austerity period require further attention (Kingfisher 2013).

The history of structural adjustment and austerity suggest that policy principles can be disaggregated from their roots and manifest across time, in addition to space (Powers and Rakopoulos, this issue). After having wrought violence on the Global South in the form of structural adjustment, the principles of austerity were introduced to ANC leaders by the World Bank, which then operationalized these policy norms via the GEAR macroeconomic strategy. However, the observed temporal lapse between the self-imposition of austerity in the late 1990s and its reappearance in public health policy in the late 2000s did not occur because of abstract socioeconomic forces but rather was largely the product of particular state health administrators being appointed to positions in which they were capable of shifting policy and cutting public health spending. Thus, policy indeed travels across the levels of the state, but it does so through the actions of people and interpersonal networks that support their actions.

The echoes of austerity can therefore be traced to interpersonal networks of state policy actors who sought to implement austere public health policies. Health Care 2010 and its implementation strategy were the work of a small group of state policy actors who condensed around Household within the Western Cape Department of Health. These health administrators leveraged data and policy positions developed by the National Department of Health that were inspired by, and supportive of, austerity. Provincial health policies that were designed to operate within the confines of fiscal austerity were pushed forward despite initial resistance from state health professionals. Particularly notable here were efforts by public sector medical specialists to undermine the development of models aim at "downsizing" specialized care. However, broad resistance to austere public health policies only emerged after their effects began to manifest in the lived experiences of public sector health workers.

The social response to austere public health policy developed as a reaction to the everyday experiences, and material conditions enveloping, health professionals. The emergence of a broad-based coalition against public sector cuts developed out of lived experience, reflecting

the changing material conditions produced by austerity and the public health policies that have carried its core principles forward. Further, the coalition built on the power of—and institutional levers that were available to—the democratic trade union movement in South Africa. The social response can also be attributed in part to the growing precarity experienced by the South African poor and working classes in the post-apartheid era, a situation that cannot be extricated from the earlier period of national austerity and the neoliberal macroeconomic policies that the ANC has embraced (cf. Muehlebach 2012).

Here, I have argued that the differential temporal dynamics that animate policy development and the social response to austerity can be unified by using policy process as a chronotope. Doing so highlights how austerity waxes and wanes in South Africa, and is carried forward across time through interpersonal networks within the state. Here, the space-time compression associated with capital, and its clear correlation to the temporal dynamics of austerity and structural adjustment programs, appears tangential. Rather, South African experiences of austerity highlight a variant of "slow violence," where austerity, once introduced, continues to percolate within elite governmental networks, which include people who are willing—and eventually able—to implement policies based on austerity principles.

Conclusion

I have argued that the South African public health policy process offers a mechanism to gauge the differential temporal dynamics that animate the development, implementation, and resistance to austerity. Here, I have employed the concept of the chronotope to link spheres of sociopolitical activity that articulate with the policy processes that enact austerity. Using policy process as a unifying analytical mechanism can help us understand how different modes of temporality manifest relative to austerity, and the social effects and outcomes they produce. Focusing on policy—and by extension, the state—highlights that people constitute the sociopolitical processes that are associated with the state and state effects. Recentering the analysis of austerity as a double movement, within a national or transnational scope, therefore requires one to trace how people, rather than abstractions, propel socioeconomic processes forward that enact violence toward those whose lives are made precarious through adjustments of various sorts. The South African public health policy process that culminated in Health Care 2010 underscores that state planning is a key site for the agency of state actors, but not all state planning processes are equal partners in producing violent social ends for poor and working-class people (Abram 2014). Disaggregating which processes do so, and who has led them, is thus vital for understanding how and why particular socioeconomic outcomes are reached.

The social response to Health Care 2010 grew out of the temporality of lived experience and material necessity. Indeed, it was workers and organizations whose members were most affected by austerity that banded together to contest public sector bed closures. However, the coalition was initiated and led by those with income levels and class positions that largely insulated them from the socioeconomic effects of austerity. Rather than material privation, the conditions of work led to the formation of the coalition, from which point it expanded to include other social-justice-oriented entities that reflect the racialized history of inequality in South Africa. The coalition was able to reverse the bed closures brought on by Health Care 2010, highlighting the potential potency of political alliances that transcend the lines of race, class, gender, and sexuality in opposing austerity's effects.

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References

Abram, Simone. 2014. "The time it takes: Temporalities of planning." *Journal of the Royal Anthropological Institute* 20 (S1): 129–147.

Aron, Janine, and Ibrahim Elbadawi. 1999. "Reflections on the South African rand crisis of 1996 and its consequences." CSAE Working Paper Series 1999-13, Centre for the Study of African Economies, University of Oxford.

Bateman, Chris. 2015. "The 'axe man' departs, offering hard-won lessons." *South African Medical Journal* 105 (4): 245–247.

Bear, Laura. 2014. "Doubt, conflict, mediation: the anthropology of modern time." *Journal of the Royal Anthropological Institute* 20 (S1): 3–30.

Bear, Laura. 2016. "Time as technique." *Annual Review of Anthropology* 45: 487–502.

Bond, Patrick. 2004. *Talk left, walk right: South Africa's frustrated global reforms.* Durban: University of KwaZulu-Natal Press.

Bryant, Rebecca. 2016. "On critical times: Return, repetition, and the uncanny present." *History and Anthropology* 27 (1): 19–31.

Chowles, Terri. 2014. "The final say: Prof Household talks about the state of healthcare." *eHealth News,* 20 August. http://ehealthnews.co.za/final-say-prof-household-talks-candidly-state-health care-2.

Deedat, Hameda, and Eddie Cottle. 2002. "Cost recovery and prepaid water meters: A case study in Madlebe, KZN." In *Cost recovery and the crisis of service delivery in South Africa.* ed. David McDonald, 81–100. Cape Town: HSRC Press.

Desai, Ashwin. 2002. *We are the poors: Community struggles in post-apartheid South Africa.* New York: Monthly Review Press.

Ferguson, James. 2015. *Give a man a fish: Reflections on the new politics of distribution.* Durham, NC: Duke University Press.

Gevisser, Mark. 2007. *Thabo Mbeki: The dream deferred.* Johannesburg: Jonathan Ball.

Harvey, David. 1989. *The condition of postmodernity: An inquiry into the origins of cultural change.* Oxford: Blackwell.

Hirsch, Alan. 2005. *Season of hope: Economic reform under Mandela and Mbeki.* Pretoria: International Development Research Centre.

Holmes, Thalia. 2014. "Social grants beneficiaries more than doubled in 10 years." *Mail & Guardian,* 19 June. https://mg.co.za/article/2014-06-19-social-grants-beneficiaries-more-than-double-in-10-years.

Household, Craig. 2005. "From the desk of the Head of Department." *Jonga* 1 (5): 3.

Kingfisher, Catherine. 2013. *A policy travelogue: Tracing welfare reform in Aotearoa/New Zealand and Canada.* New York: Berghahn Books.

Knight, Daniel M., and Charles Stewart. 2016. "Ethnographies of austerity: temporality, crisis and affect in Southern Europe." *History and Anthropology* 27 (1): 1–18.

Leach, Edmund R. 1961. "Two essays concerning the symbolic representation of time." In *Rethinking anthropology,* ed. Edmund R. Leach, 124–136. London: Athlone Press.

Leibbrandt, Murray, Eva Wegner, and Arden Finn. 2011. *The policies for reducing income inequality and poverty in South Africa.* South Africa Labour and Development Research Unit (SALDRU) working paper no. 64.

Mayosi, Bongani M., and Solomon R. Benatar. 2014. "Health and health Care in South Africa: 20 years after Mandela." *New England Journal of Medicine* 371 (14): 1344–1353.

McIntyre, Diane, and Michael Thiede. 2007. "Health care financing and expenditure." In *South African Health Review,* ed. Petrida Ijumba and Ashnie Padarath, 35–46. Durban: Health Systems Trust.

Mintz, Sidney. 1986. *Sweetness and power: The place of sugar in modern history.* New York: Penguin.

Moroşanu. Roxana, and Felix Ringel. 2016. "Time-tricking: A general introduction." *Cambridge Journal of Anthropology* 34 (1): 17–21.

Muehlebach, Andrea. 2012. "On precariousness and the ethical imagination." *American Anthropologist* 115 (2): 297–311.

Nattrass, Nicoli. 2007. *Mortal combat: AIDS denialism and the struggle for antiretrovirals in South Africa.* Scottsville: UKZN Press.

Nixon, Rob. 2011. *Slow violence and the environmentalism of the poor.* Cambridge, MA: Harvard University Press.

Rakopoulos, Theodoros, ed. 2018. *The global life of austerity: Comparing beyond Europe.* New York: Berghahn Books.

Rossouw, Jannie. 2017. "Why social grants matter in South Africa: they support 33% of the nation. The Conversation. http://theconversation.com/why-social-grants-matter-in-south-africa-they-support-33-of-the-nation-73087 (accessed 5 January 2019).

Seekings, Jeremy, and Nicoli Nattrass. 2008. *Class, race, and inequality in South Africa.* New Haven, CT: Yale University Press.

Shore, Cris, and Susan Wright. 1997. "Policy: A new field of anthropology." In *Anthropology of policy: Perspectives on governance and power,* ed. Chris Shore and Susan Wright, 3–42. New York: Routledge.

Smith, Laïla. 2008. "Power and the hierarchy of knowledge: A review of a decade of the World Bank's relationship with South Africa." *Geoforum* 39 (1): 236–251.

Statistics South Africa. 2017. Mid-Year Population Estimates. Statistical Release P0302.

Thom, Anso. 2004. "In pretty good shape." *Mail & Guardian,* 23 April. https://mg.co.za/article/2004-04-23-in-pretty-good-shape.

Thompson, Edward P. 1967. "Time, work-discipline, and industrial capitalism." *Past and Present* 38: 56–97.

Wedel, Janine, Cris Shore, Gregory Feldman, and Stacy Lathrop. 2005. "Toward an anthropology of public policy." *Annals of the American Academy of Political and Social Science* 600: 30–51.

Zuern, Elke. 2011. *The politics of necessity: Community organizing and democracy in South Africa.* Madison: University of Wisconsin Press.