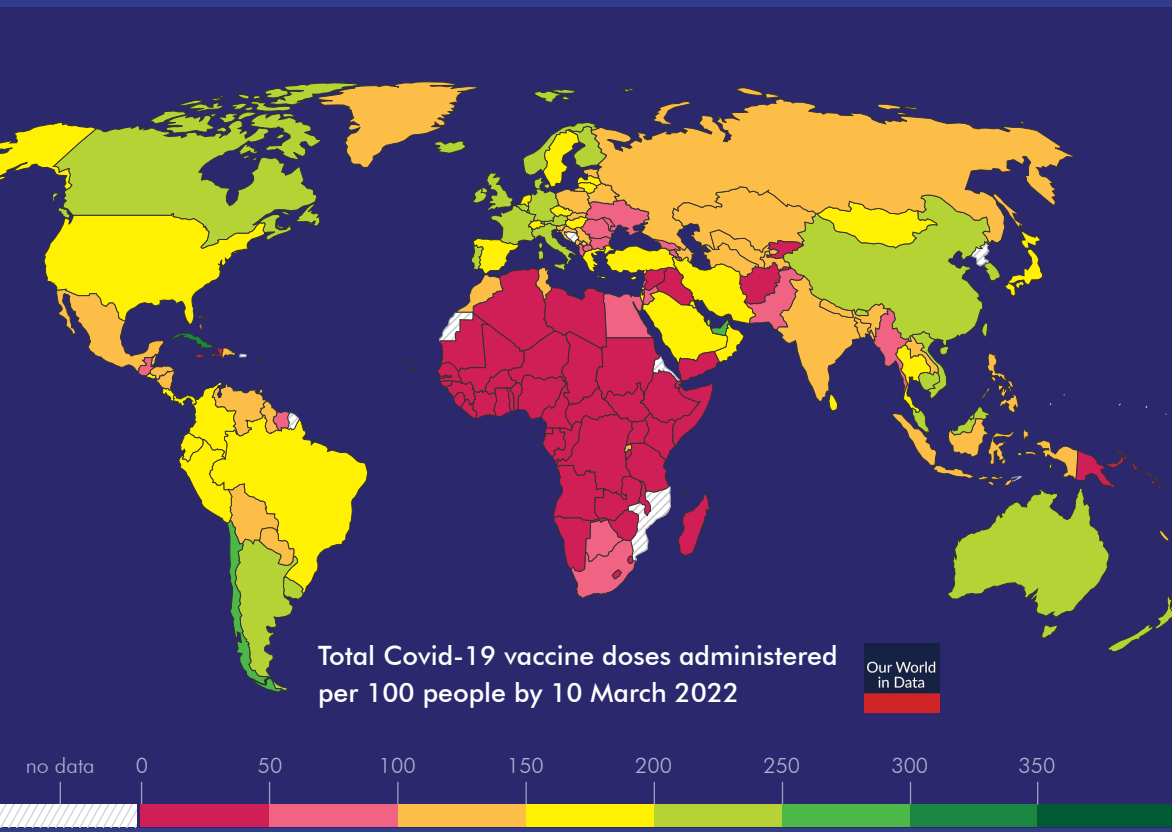
Pandemics and the illumination of "hidden things"

Lessons from South Africa on the global response to Covid-19

L. London

The fight for equity – One Country, One Plan: The role of the state and the private sector in procuring life-saving vaccines in a pandemic – some legal aspects



HEALTH JUSTICE INITIATIVE

Suggested citation: Health Justice Initiative *Pandemics and the illumination of "hidden things" – Lessons from South Africa on the global response to Covid-19*. Edited Volume. June 2023.

Editor: Laura Lopez Gonzalez
Project Lead: Marlise Richter
Proofreader: Sigwabusuku Mafu
Lay-out & Design: Jaywalk Design
Funding: The Health Justice Initiative is grateful to all its organisational and individual donors for funding and supporting its work. We would like to acknowledge the contributions of the Rockefeller Brothers Fund, the Joffe Trust and the Claude Leon Foundation towards funding this Compendium in particular.

Credit front-page image:

Adaption of *World in Data*. Image shows Total Covid-19 vaccine doses administered per 100 people, as of 11 March 2022 (two years since the WHO declared Covid-19 a "pandemic").

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The fight for equity – One Country, One Plan: The role of the state and the private sector in procuring life-saving vaccines in a pandemic – some legal aspects

Leslie London

This is an extract of an expert affidavit submitted in the case the *Health Justice Initiative v Solidarity, Afriforum NPC, the Ministers of Health and others* Case Number. 3623/21. The matter concerned a challenge by Solidarity and Afriforum to the strategy and policy adopted by national government for a single procurement and distribution of Covid-19 vaccines for SA.

The HJI intervened in the case as a friend of the court (amicus curiae) in February 2021. It argued that the case sought to entrench a situation constituting vaccine apartheid in SA. All while major industry players and business groups including medical schemes in SA support a national allocation strategy in partnership with government.

The DG of Health (for the first and second respondents) agreed with HJI's expert evidence and relied on it in his replying papers. Afriforum and Solidarity withdrew the case on 2 March 2021.

For the full affidavit and other court documents, see https://healthjusticeinitiative.org.za/2021/05/12/solidarity-and-afriforum-vs-minister-of-health-and-16-others/

Professor Leslie London is Chair of Public Health Medicine in the School of Public Health and Family Medicine at the University of Cape Town. He leads the School's Health and Human Rights Programme and is active in the People's Health Movement South Africa. He serves on the HJI's Reference Advisory Group.

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG PROVINCIAL DIVISION, PRETORIA

Case Number: 3623/21

In the application of:

HEALTH JUSTICE INITIATIVE	Applicant for admission as an *amicus curiae*

In the matter between:

SOLIDARITY	First Applicant
AFRIFORUM NPC	Second Applicant
and	
MINISTER OF HEALTH	First Respondent
PRESIDENT OF THE REPUBLIC OF SOUTH AFRICA	Second Respondent
MINISTER OF CO-OPERATIVE GOVERNANCE AND TRADITIONAL AFFAIRS	Third Respondent
THE CHAIRPERSON OF THE COVID-19 SCIENTIFIC MINISTERIAL ADVISORY COMMITTEE	Fourth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, WESTERN CAPE	Fifth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, GAUTENG	Sixth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, FREE STATE	Seventh Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, EASTERN CAPE	Eighth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTHERN CAPE	Ninth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, LIMPOPO	Tenth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, MPUMALANGA	Eleventh Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, NORTH WEST	Twelfth Respondent
MEMBER OF THE EXECUTIVE COUNCIL FOR HEALTH, KWAZULU-NATAL	Thirteenth Respondent
PHARMACEUTICAL SOCIETY OF SA	Fourteenth Respondent
COUNCIL FOR MEDICAL SCHEMES	Fifteenth Respondent
SOUTH AFRICAN MEDICAL ASSOCIATION	Sixteenth Respondent
PHARMACEUTICAL INDUSTRY ASSOCIATION OF SA	Seventeenth Respondent

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EXPERT AFFIDAVIT: PROFESSOR LESLIE LONDON

I, the undersigned,

PROFESSOR LESLIE LONDON

do hereby make oath and say that –

1 I am a Professor at the School of Public Health and Family Medicine at the University of Cape Town (UCT). I attach a copy of my curriculum vitae marked **"LL1"**.

2 The facts contained in this affidavit fall within my own personal knowledge, except where I indicate otherwise. To the extent that I rely on information supplied by others, I believe that such information is true and correct.

6 I start by summarising Mr. Hermann's contentions as follows. Mr. Hermann contends that:

6.1 The COVID-19 epidemic is a major public health emergency and is an urgent health crisis (referred to as a life-threatening second wave in paragraph 57) that requires urgent measures to address the epidemic.

6.2 The discovery of vaccines that are effective against SARS CoV-2 provides the opportunity to address this health crisis and there is, therefore, an urgent need to vaccinate as much of the population as speedily as possible, "in order to achieve herd immunity as soon as possible". (I refer interchangeably to "herd immunity" and "population immunity" as the same concept in my affidavit, being a level of immunity to the virus SARS CoV-2 in the population sufficient to interrupt transmission of COVID-19 at a population level and thereby bring the epidemic under control.)

6.3 There is a restriction on the ability of private health care entities to procure vaccines in some places, Mr. Hermann refers both to a restriction on procurement of vaccines and on the distribution of vaccines being adversely affected.

6.4 This restriction on the ability of private health care entities to procure vaccines will (a) delay or protract the vaccine from reaching those who need it and (b) prevent South Africa from attaining herd immunity in as quick a fashion as possible.

6.5 Allowing the private sector to procure vaccines will enable the vaccine to (a) reach those who need it and (b) allow South Africa to attain herd immunity more rapidly than if the vaccination rollout were based on solely government procurement.

6.6 The restriction on the ability of private sector entities to procure vaccines is an unreasonable limitation on the human rights of the members of Solidarity, on members of various medical schemes, and on practitioners in private practice and provincial health departments.

6.7 I examine each of these arguments in turn below.

COVID-19 AS AN EXTRAORDINARY EMERGENCY

7 First, it is common knowledge that the COVID-19 epidemic is a major public health emergency and requires extraordinary efforts to address it. To the extent that Mr. Hermann recognises the COVID-19 epidemic as requiring urgent responses, I am in agreement. However:

7.1 As an emergency, the crisis cannot be dealt with through measures we would normally expect to be present in the South African health care system. The world has recognised this necessity in the World Health Organisation (WHO) declaring a global Public Health Emergency of International Concern (PHEIC) on 30 January 2020. A copy of the statement by WHO is attached marked **"LL2"**.

7.2 To the extent that existing health systems are stretched and disrupted by the epidemic, the WHO has provided guidance to countries in how best to cope with these extraordinary circumstances. In this regard, the WHO has provided extensive guidance on, amongst other matters related to COVID-19, the prevention and treatment of COVID-19, the protection of health systems, and most recently on how best to roll out vaccines for COVID-19 in the form of the '*WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination*' ('WHO Values Framework') and the 'WHO Roadmap for Prioritizing Uses of COVID-19 Vaccines in the context of limited supply' ('WHO Roadmap') A copy of the WHO Values Framework and the Roadmap are attached and marked **"LL3"and "LL4"** respectively.

7.3 The idea that what pertains under normal circumstances should necessarily pertain under emergency circumstances is therefore not plausible in the present epidemic.

7.4 Extraordinary measures have previously been adopted by nation states in relation to other global health crises such as Ebola, H1N1, and SARS.

7.5 The measures proposed by the South African government with regard to vaccine procurement and allocation are not in my expert view incompatible with the global recognition of the need for extraordinary measures. As I explain below, they are:

7.5.1 rationally based on understanding the need for equity in access to a life-saving health technology for COVID-19;

7.5.2 rationally based on the past experience of uncontrolled private sector procurement of scarce health technologies;

7.5.3 consistent with all the major global vaccine allocation guidance documents rooted in public health and epidemiological considerations that are currently available.

7.6 The measures proposed by Mr. Hermann essentially involve returning the control of the COVID-19 epidemic to the pre-COVID-19 scenario of the private sector paying for those who can afford medical supplies, while the public sector should 'focus on the vaccination of the most vulnerable members of society'. It is therefore a departure from what numerous jurisdictions around the world have recognised – that stewardship of the entire health system is needed to ensure a coordinated response to COVID-19. In this regard, I attach a copy of the '*WHO COVID-19 Strategy Update of 17 April 2020*' **("LL5")**.

7.7 Returning to the pre-COVID-19 scenario would only be justifiable if it could be shown that such an arrangement would expedite the goals of controlling this epidemic and minimise loss of life. As I explain below, there is no evidence that such an approach would benefit COVID-19 public health control measures. On the contrary, there is much evidence that such an approach would harm our capacity to survive the epidemic with the minimum loss of life and would exacerbate inequality in our country.

VACCINES CAN HELP US REACH POPULATION (HERD) IMMUNITY FASTER

8 We face a global crisis that requires scientific consensus and cooperation, using the best evidence and data available, given that severe acute respiratory syndrome coronavirus 2 ('SARS-CoV-2') presents many complex and scientific uncertainties, while we deal with imperfect scientific knowledge. This is why the integrity of any vaccine programme is critical to ensuring, over time, widespread access to vaccines that are safe and effective, and convincingly so for the public.

9 It is correct that several new vaccines for COVID-19 have been reported to be effective to varying degrees in providing protection against COVID-19 infection, severe disease, and death associated with COVID-19. However, there are a number of scientific uncertainties regarding the vaccines:

9.1 None of the vaccines available globally have been formally registered as yet in South Africa other than through a Section 21 authorisation by the regulatory body in South Africa, SAPHA, for Covishield and the authorisaton for the Johnson and Johnson vaccine to be 'rolled out' to health care workers through a research study (the Sisonke study).

9.2 Although much is said about many vaccines in the public domain and used in other countries, the producers of some of these vaccines have generally not approached the SAPHRA with their information dossiers, which slows down the registration process and which complicates assessments of efficacy, risk, and guidance for use. I attach a copy of the SAPHRA authorisation for Covishield, as well as a copy of a news article related to the rollout of the Johnson & Johnson (the Jansenn) vaccine (annexures **"LL6"** and **"LL7"** respectively).

9.3 In several cases, global vaccine manufacturers have pre-committed hundreds of millions of doses for certain governments first (including but not limited to the US, countries in the EU, UK, Canada, Israel, Australia, China, Russia, UAE), with limited immediate supplies for the COVAX facility and other regional blocs such as the African Union (AU). A recent academic article in the Lancet, published on 12 February 2021, illustrates the current status globally of inter alia vaccine approvals, COVAX participation, and forecasted supplies. A copy of the article, entitled '*Challenges in ensuring global access to COVID-19 vaccines: production, affordability, allocation, and deployment*', is attached marked **'LL8'**.

9.4 As yet, there is no consensus on how long immunity is conferred through vaccination;

9.5 The effectiveness of these vaccines varies, and it is unclear if effectiveness for the strain most prevalent in South Africa will turn out to be the same as that found to date in vaccine trials elsewhere in the world;

9.6 There is no current certainty regarding the effects of receiving multiple different vaccines;

9.7 Delivering a vaccine requires adherence to vaccination schedules, maintaining a cold chain, and ensuring quality control in the stocks and the administration of the vaccine.

9.8 Thus, while promoting the uptake of vaccines will, in general, be a positive development towards population levels of immunity that will interrupt transmission (also known as 'herd' immunity), an uncoordinated and poorly applied vaccination programme may hinder our country from attaining population or herd immunity. For example, if vaccinees do not receive a second dose of a two dose regimen, or receive it late, or receive a different vaccine the second time, or receive a vaccine that has expired or been damaged by the failure of the cold chain, then they will have been vaccinated, but ineffectively.

10 Furthermore, it is incorrect to assume that population or herd immunity can be achieved simply by vaccinating the highest number of people as quickly as possible.

10.1 It is an incontrovertible reality that there is an absolute shortage of vaccine supplies globally, at least at this early stage of the epidemic.

10.2 For this reason, it is widely recognised that rationing based on public health evidence, data and need, and the input of public health and scientific experts, will be necessary, at least at the early stages of the epidemic.

10.3 The 'WHO Roadmap for Prioritizing Uses of COVID-19 Vaccines in the context of limited supply' notes that "*sufficient vaccine supply will not be immediately available to immunise all who could benefit from vaccination.*" The guidance goes on to model three scenarios of constrained vaccine supply (different levels of availability). In all three models, it proposes strategies for vaccination of priority groups. In this regard, I refer to **"LL4"**.

10.4 Mr. Hermann's proposal that anyone who wants vaccination should be able to access vaccination is unscientific and contrary to global public health guidelines which also emphasise equity in access alongside an effective rollout.

10.5 As stated by the UN Committee on Economic, Social and Cultural Rights (UNCESR) in its Statement on Vaccines for COVID-19: '*It is impossible to guarantee that everyone will have immediate access to a vaccine for COVID-19, even if several vaccines are approved soon. The mass production and distribution of vaccines implies not only enormous financial costs but also complex administrative and health procedures. The prioritisation of access to vaccines by specific groups is unavoidable, at least in the initial stages, not only nationally but also at the international level. In accordance with the general prohibition of discrimination, such prioritization must be based on medical needs and public health grounds.* A copy of the statement by the UNCESR is attached to the affidavit by Dr. Tlaleng Mofokeng.

It is generally accepted public health practice to focus on those at high risk who can benefit maximally from vaccination. This meets both utility and justice principles. If one vaccinates *ab initio* fit and healthy adults or young people, who are low risk, even if one does reach high numbers, then one is doing so at the expense of individuals who have immediate health risk-based needs and who should be vaccinated first, on public health grounds. Thus, if a vaccination programme rolls out as proposed by the applicants there will be many persons at high risk who will be exposed to infection before they are vaccinated. This will result in preventable and unnecessary illness and death in the country because of failure to follow a common national strategy.

The pathway to population or herd immunity cannot be reached by disregarding the priority needs of those most at risk. This principle is enunciated in several international guidance documents on vaccine access. For that reason, vaccination of fit and healthy young adults is generally left for the last phase of vaccine rollout plans, as is reflected in the South African government's national plans. I attach a full copy of the *'WHO SAGE Roadmap for Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply'* ("LL4" above)

Mr Hermann's affidavit appears to pay no attention to the fact that attaining population or herd immunity as rapidly as possible cannot be achieved at the expense of the health and survival of persons at risk of severe COVID-19 disease.

The 'rapid and effective' distribution of vaccines (as articulated in paragraphs 28, 36, and 59 of Mr Hermann's affidavit) will only contribute to the effective management of the COVID-19 epidemic if done in line with scientific principles. There is no evidence in his argument that he has taken account of any scientific principles, the most widely accepted of which is the *WHO SAGE Roadmap for Prioritizing Uses of COVID-19 Vaccines in the Context of Limited Supply*, attached above as **"LL4"**.

I also draw attention to the *WHO Values Framework* for guiding the allocation and prioritisation of COVID-19 vaccination attached above as "LL3". The framework articulates the aim of any vaccination programme as recognising that "COVID-19 vaccines must be a global public good. The overarching goal is for COVID-19 vaccines to contribute significantly to the equitable protection and promotion of human well-being among all people of the world". The document goes on to elaborate on six principles that should guide vaccine allocation, these being Human Well-Being, Equal Respect, Global Equity, National Equity, Reciprocity, and Legitimacy.

10.10.1 By promoting a vaccine programme that vaccinates on the basis of first-come, first-served, the applicants' proposed programme will fail to "protect and promote human well-being including health, social and economic security, human rights..."

10.10.2 If healthy adults secure vaccination earlier because they able to pay, then the applicants' proposed programme will fail the principle of recognising and treating "...all human beings as having equal moral status..."

10.10.3 The requirement to ensure "equity in vaccine access and benefit within countries for groups experiencing greater burdens from the COVID-19 pandemic" will be undermined by diverting vaccines to those who have lesser or no burden which will be a consequence of the applicants' proposed programme.

10.10.4 There is no recognition of reciprocity in the applicants proposals for private sector procurement.

10.11 Professor Keymanthri Moodley, head of Bioethics at the University o Stellenbosch, has noted that, with regard to COVID-19 vaccines "Rationing processes should be fair and based on transparent consistent criteria that can be subjected to objective scrutiny with the goal of ensuring accountability, equity, and fairness". A copy o Professor Moodley's article is attached marked **"LL9"**. The relie sought by the applicants will create inconsistency in who will receive the vaccine, inequity in distribution and unfairness in a situation o already extreme pre-existing inequalities.

10.12 The claim that South Africa is 'lagging' behind other countries in acquiring vaccines shows a lack of understanding of the problems facing countries classified as middle income – which are increasingly shouldered out of the market by richer and more powerful countries. Paragraphs 71 to 76 of Mr. Hermann's affidavit appear to attribute the entire responsibility to the South African government when many observers and commentators, including the Director-General of the WHO and the UN Secretary-General, have lamented the behaviour of richer nations and vaccine manufacturers in creating the conditions where less developed countries are disadvantaged in the global marketplace. A copy of an article highlighting the UN Secretary General's warning is attached marked **"LL10"**.

10.13 For example, in Paragraph 78, the applicant appears to think South Africa's inability to secure speedy supplies of safe and effective vaccines in a pandemic lies in the fact that it 'did not commit sufficien funds into COVAX'. However, it would seem that the applicants do not appreciate that given the design of COVAX, South Africa would not necessarily obtain any preferential supplies or better price by purchasing through COVAX and may even be substantially disadvantaged to do so. This is a serious design fault of the COVAX mechanism, amongst a number, which the applicants do not seem to appreciate.

10.14 COVAX depends on funding from donors and high-income countries but is still hugely underfunded. It also depends on voluntary participation by manufacturers and imposes tiered cost-recovery with Upper Middle-Income countries having to self-finance and pay higher prices. Only Low-Income countries will be supplied at a subsidised cost, and only some vaccine producers have put their products into COVAX. As a result, COVAX does not provide supplies of all efficacious vaccine candidates, is not yet transparent in the pricing of its vaccines, and procurement through COVAX involves forfeiture fees and penalties associated with transacting in a commercial arrangement. Further, COVAX is not accountable to any domestic institution in South Africa, including Parliament, as a result of which millions of Rands of public funds have to be spent with little or no oversight and accountability in the event that prices are excessive or supplies do not arrive on time, or at all.

10.15 In any event, South Africa has now seemingly secured supplies from other mechanisms, including bi-lateral negotiations for large quantities and through the African Union (AU) Vaccine Access Task Team.

10.16 Given the above scenario, the claim that South Africa's late payment was somehow responsible for delays in procurement appears to be irrelevant.

10.17 What is clear is that the procurement landscape is extremely complex. It is simplistic to contend that a free market would enable efficient private sector procurement and rational allocation of vaccines.

10.18 Moreover, it is now evident that some vaccine manufacturers are requiring governments to purchase vaccines on the basis that those governments indemnify the manufacturers against claims should vaccinees develop adverse reactions. Mr. Hermann gives no indication that private sector actors in South Africa would be willing to accept such liability. It is extremely unlikely that a private entity would do so.

10.19 It is therefore implausible that, in the current situation, a vaccine manufacturer will directly sell its vaccines to a South African trade union, a health insurance entity, a local pharmacy chain, or even a provincial government. I have not seen any evidence that a vaccine producer will do so.

RESTRICTING THE PRIVATE SECTOR FROM DIRECTLY PROCURING VACCINES IN A PANDEMIC

11 It is correct that the South African policy on vaccines is that the State shall be the sole procurer of vaccines with a negotiating team that includes representatives from business associations, the largest medical scheme in the country (Discovery Medical Scheme) and the National Treasury. I do not comment on the legal question of whether the policy imposes or proposes a legal prohibition on procurement by other entities. The policy is however in accordance with international practice. The affidavit deposed to by Ms Hassan of the Health Justice Initiative deals with the approach of foreign jurisdictions including India, the United States and the European Union. For the sake of brevity, I will not repeat those examples in this affidavit.

12 There are important reasons why this is the case.

12.1 This is a pandemic with global impact and consequences.

12.2 Vaccines for COVID-19 are not just any ordinary commodity that can be purchased by someone with the resources to do so. They are, as UN Secretary-General António Guterres articulated, "a global public good, affordable and available to all."

12.3 A global public good that should be affordable and available to all cannot be distributed through a private market or just by some provinces or nations. Mr. Hermann has said 'that a state monopoly should not exist' for the procurement of COVID-19 vaccines (paragraph 56). As a public health expert, I do not understand what this means as it is the obligation of the state to negotiate, select and procure vaccines for everyone in our country to meet the requirements of our Constitution. The private market in South Africa, which serves less than 20% of our people, cannot distribute a public good for reasons outlined below, nor should just one or two provinces.

12.4 Global experience, including our own experience in South Africa, has shown that private acquisition and allocation cannot be relied on to achieve equitable availability of health resources.

12.4.1 The huge divide between public and private health care sectors, which characterises South Africa's current divided health system, results in significant resources being inefficiently sequestered in the private sector.

12.4.2 Inequity arises because the private sector will service those who pay, be they members of a medical scheme or wealthier individuals but will not reach people in need who cannot afford private health care – the majority of people living in South Africa. Lack of access to private medical aid schemes is discussed in Dr. Mofokeng's affidavit.

12.4.3 As a result, South Africa has severe inequalities in health status by race, rurality, class, and gender. This inequality is associated with poor health outcomes for the amount of money we spend on health. It reflects inequalities in the distribution of both the determinants of health and in access to health care.

12.4.4 It is within this context that the COVID-19 epidemic hit South Africa in 2020. The epidemic has exacerbated inequalities, both in social conditions and livelihoods and in health outcomes.

12.4.5 An analysis of data from the National Income Dynamics Study (NIDS) in 2017 and the first wave of the NIDS-Coronavirus Rapid Mobile Survey (NIDS-CRAM) suggested that income-related health inequality in the COVID-19 era increased six-fold compared with what was obtained in 2017. For example, cumulative mortality due to COVID-19 was noted in January 2021 as approximately twice as high in poorer township areas of Cape Town compared with the rest of the city. This is partly explained by differences in access to care between the public and private sectors. A copy of the relevant portions of the data by the NIDS and article of the cumulative mortality in poorer areas are attached marked "**LL11**" and "**LL12**" respectively.

We also saw the impact of public-private inequality first-hand in South Africa in the last year. During the COVID-19 epidemic, disparate or unequal access to testing technologies (test kits) for diagnosis of COVID-19 was well documented. A copy of an article describing this is attached marked "**LL13**". As a result, many public sector patients could not be tested, or their tests were wasted as a result of long delays. The consequence in terms of missed infections, failure to prevent transmission, and any associated deaths have not been quantified. However, it was clear that the private sector laboratories did not always share scarce resources to ensure that there was equitable testing capacity across the health system, but deployed testing for those who were paying customers. Those who could not afford private care and who could, therefore, not access testing, were likely to have worse outcomes.

Even with the best of intentions, charities and major pharmacy chains that stepped in could only provide limited tests and, in some cases, carried out limited stop-start programmes with limited reach and an urban bias. These voluntary efforts are not sustainable unless coordinated through a national programme that prioritises equity in access.

12.7 Centralised procurement of a scarce resource thus ensures that there is the possibility of ensuring equity in its distribution. It does not guarantee equitable distribution, but it does make equitable distribution possible if it is an explicit policy objective of a vaccine programme, which is the case in South Africa and in almost all major democracies right now.

12.8 The converse of centralised procurement, in the form of uncoordinated and 'independent' procurement, makes equity in allocation impossible to achieve, as confirmed in a US National Academics of Science guideline referred to in the affidavit of Ms. Hassan from the Health Justice Initiative.. I note that this does not preclude all stakeholders, including those in the private, business or NGO sectors, assisting with the administration of a vaccination programme. The scale of the epidemic surely requires everyone's cooperation.

12.9 However, as Mr. Hermann implies in paragraph 84, it is unclear if all private sector providers will be able to administer vaccines or will want to administer vaccines to the maximum degree possible if vaccination is to be offered through private purchase or through a medical scheme. There is a very real possibility that stock purchased in the private sector could remain unused, sequestered within private contractual arrangements and unavailable to those who need it most.

12.10 Where there are multiple entities independently procuring a scarce resource, it is inevitable that there will be difficulties in ensuring adequacy of supplies and equity in distribution. This has been demonstrated at an international level in the uneven access to vaccines between countries, where according to the WHO, those with more economic and political power have purchased more vaccines than their population needs, at the expense of poorer countries.

12.11 Lastly, while Mr. Hermann asserts that centralised procurement of vaccines and 'stifling of the private sector ... can only result in unwarranted protraction in the distribution and administration of vaccines to the population,' he presents no evidence that this will be the case – only that the private sector has the capacity to deliver vaccination. Since the private sector, medical schemes and businesses will be involved in the distribution and delivery of vaccines and has been included in almost all relevant task teams including on the National Vaccine Acquisition Task Team, it is unclear on what basis Mr. Hermann makes this claim of central procurement delaying administration of vaccines to the whole population.

12.12 If one accepts that there is an absolute shortage of vaccines at this early stage of the epidemic, then it is clear that affording the private sector or some provinces the capacity to also procure vaccines and then decide whom to vaccinate and when to do so (i.e. outside of a national strategy of prioritisation and without central allocation) will mean that persons at low risk, with financial means, will be free to be vaccinated – assuming the regulatory authority, SAHPRA, approves a vaccine for use. At the same time, some of those at risk to severe COVID-19 disease will have to wait longer in other sectors / provinces, therefore risking their health and their survival and the country's ability to achieve population immunity safely.

12.13 The approach that the most rapid path to population immunity is through vaccinating the highest number of people as quickly as possible, irrespective of who is vaccinated, is therefore not justifiable on public health grounds, nor on medical and epidemiological practice and needs.

13 Mr. Hermann appears to conflate selection, regulatory approval, procurement, allocation and distribution when describing what is prevented by national policy, and as to what would be implemented, should the applicants be granted the orders which they seek.

13.1 I point out that there is nothing in the national strategy documents released thus far that precludes private practitioners from *participating* in the vaccine roll-out. To the contrary, Mr. Hermann himself cites evidence of government's commitment to *involve* the private sector in administering and delivering vaccines (paragraphs 43, 47).

13.2 The fact that the mining industry has health services capable of providing health care services to the members of Solidarity (Para 29) is irrelevant to the question of private procurement. On the contrary, it is entirely consistent with the state procuring vaccines and allocating vaccines to the mines to administer to its employees in line with a national policy focusing on priority groups based on risk, age, or co-morbidity status.

13.3 Further, Mr. Hermann provides no evidence that even if the private sector were to procure vaccines, the providers in the private sector would speedily vaccinate as many people as possible. Current evidence shows that private providers' behaviours are largely determined by financial incentives, and that they are unlikely to adopt behaviours that will specifically focus on maximising the numbers of persons vaccinated unless incentivised to do so. I attach, in this respect, the Competition Commission Health Market's Inquiry Report: An overview and key imperatives, marked **"LL14"**.

13.4 Even then, financial incentivisation of private sector providers to achieve population health goals has a weak evidence base internationally and in South Africa. I attach an extract from a discussion paper entitled 'Private sector involvement in funding and providing health services in South Africa: Implications for equity and access to health care' written by Professor Diane McIntrye. Pages 13 to 23 of the paper are attached, marked **"LL15"**.

13.5 It is therefore unclear how Mr. Hermann can deduce that private procurement and allocation will advance national vaccine coverage and support earlier attainment of population or herd immunity.

COULD PRIVATE SECTOR PROCUREMENT BE COMPATIBLE WITH PROMOTING ACCESS AND ACHIEVING POPULATION IMMUNITY?

14 Implicit in Mr. Hermann's argument is that allowing the private sector to procure vaccines will (a) enable vaccines to reach those need it and (b) allow South Africa to attain population or herd immunity more rapidly than if the vaccination rollout were based on solely government acquisition and

CONCLUSION

36. In summary: If provinces and some trade unions and private groups select, procure, and administer vaccines independently and outside of national processes and guidelines, there will be a lack of coordination, poor accountability and an inability to ensure equity in access, which will be at the cost of the health and survival of high-risk and vulnerable groups in our country. Such an approach has no support in any of the large body of technical, scientific, and ethical guidance presently available in the public domain.

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