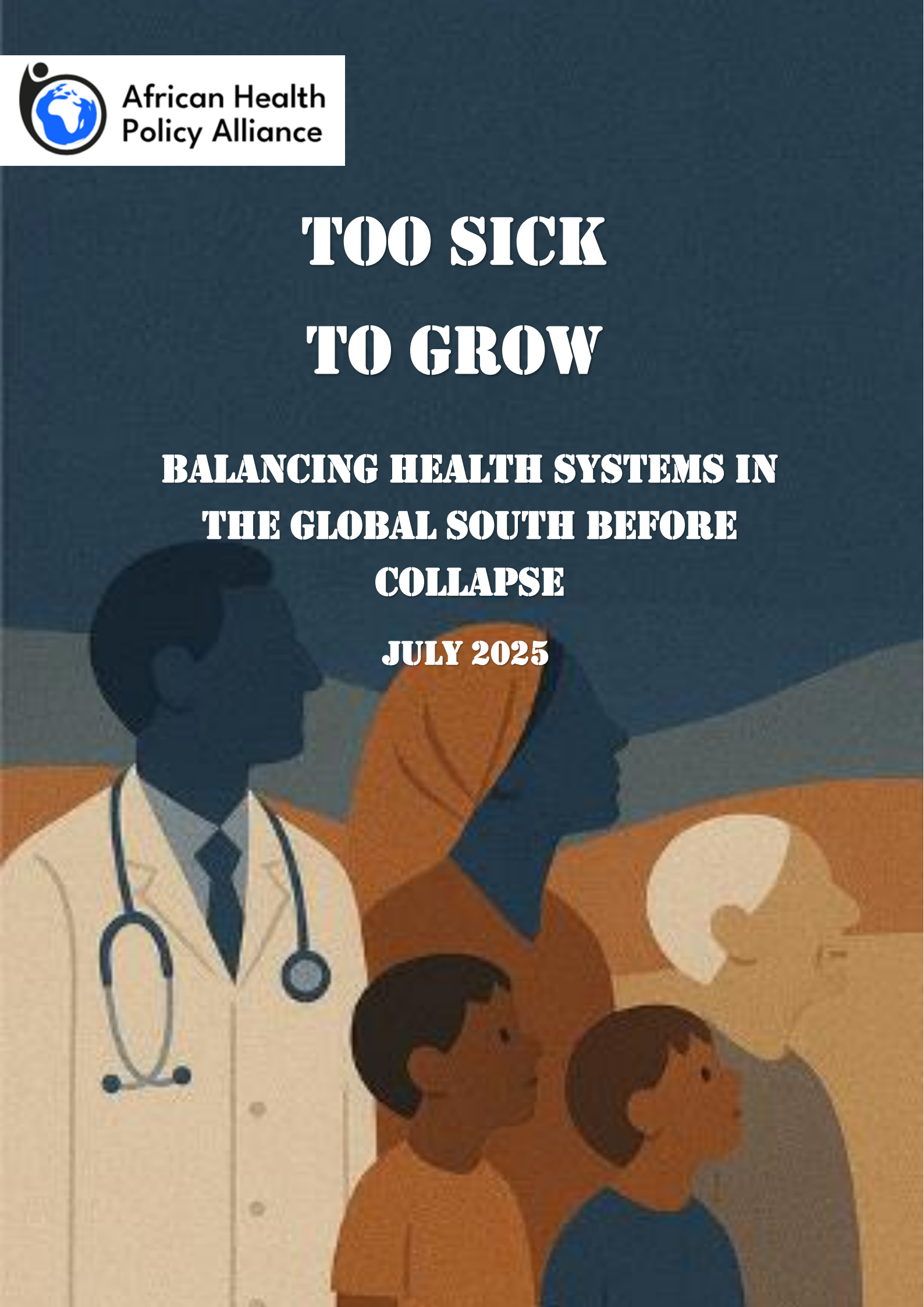
African Health Policy Alliance

TOO SICK TO GROW

BALANCING HEALTH SYSTEMS IN THE GLOBAL SOUTH BEFORE COLLAPSE

JULY 2025



Content

1. Executive Summary

Health systems in the Global South[1] are experiencing increasing strain. This exacerbates inequalities and impedes progress on the Sustainable Development Goals (SDGs). The core issue is the disparity between what people need (demand) and what the health system provides (supply). Therefore, this paper analyzes healthcare demand and supply to identify the root causes on each side and propose practical solutions for both.

SITUATION: Healthcare systems in low- and middle-income countries (LMICs) of the Global South struggle to meet needs due to underfunding, workforce shortages, limited education, poor prevention, inadequate infrastructure, inequitable access to care and untapped digital health. High demand is driven by infectious diseases, chronic diseases, pregnancies (especially teenage pregnancies), malnutrition, violence, climate change.

ESCALATION: The disparity between healthcare supply and demand is increasing. On the supply side - fiscus constraints and diminishing foreign aid, as global priorities become more inward-focused, is putting strain on the already overwhelmed healthcare sector. On the demand side - a growing population and an ageing demographic are escalating the need for healthcare services. This expanding gap threatens to overwhelm already vulnerable healthcare systems, potentially leading to widespread preventable illnesses and premature mortality.

SOLUTION: This paper proposes a framework with five pull forces to boost healthcare supply and five push forces to reduce demand. On the supply side, it suggests improving infrastructure, increasing staffing, and ensuring sustainable financing. On the demand side, it emphasises prevention and promotion of healthier lifestyles.

IMPLEMENTATION: Improving health involves a collaborative effort between the public sector, private sector, and civil society, as all benefit from a healthier population. Implementing the suggested changes requires a comprehensive approach that incorporates efforts from all sectors.

2. Healthcare remains a right out of reach for many in the Global South

Access to healthcare is both a basic human right and a cornerstone of sustainable development. However, in many regions of the Global South, this access is still limited. Although there has been progress over the past decades, health systems in these areas are currently facing significant challenges.

Life expectancy in LMICs is eight years lower than in high-income countries[2], with a 15-year gap in low-income countries.[3] Annually, over 8 million people in LMICs die from treatable diseases (with current medical services).[4] Avoidable deaths and shorter lives are primarily due to a gap between system supply and people's needs (demand).

2.1 SUPPLY: Public Health Systems Are Under Pressure

Health systems in the Global South face significant strain, with clinics often lacking resources, essential equipment, and the capability to perform basic procedures, emergency surgeries and childbirth care for large segments of the population.[5] Despite accounting for over one-third of the world's population, the poorest third

[1] Throughout this document, the term *Global South* refers broadly to low- and middle-income countries in Africa, Latin America, Asia, and parts of Oceania. While not strictly defined by income level, it reflects a shared history of economic marginalization and development challenges. The term is used here to emphasize both economic disparities and healthcare inequities

[2] World Bank (2025). Life expectancy at birth

[3] World Bank (2025). Life expectancy at birth

[4] Kruk E. M. et al. (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution

[5] Chowdhury J. et al. (2022). Healthcare Accessibility in Developing Countries: A Global Healthcare Challenge

of countries conduct merely 3.5% of global surgeries, while the wealthiest third account for 75%.[6] In LMICs there is a need for an additional 143 million surgical procedures annually to prevent death and disability.[7]

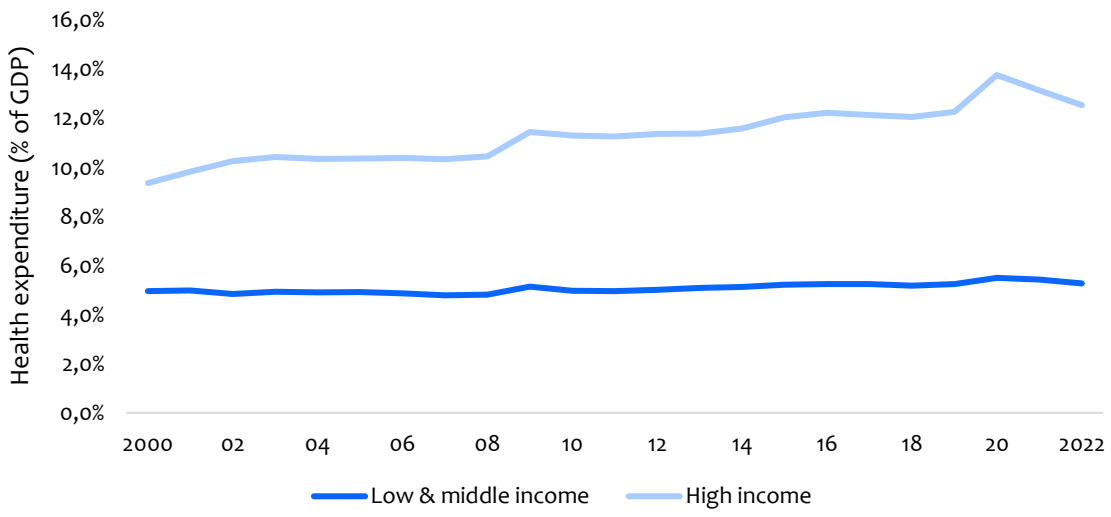
Surgical care in Africa is both scarce and often unsafe, with one in 150 patients dying from anaesthesia complications.[8] This shortage causes preventable deaths. In LMICs, untreated surgical conditions lead to about 4.7 million deaths annually, accounting for 10% of global deaths.[9]
The reasons for fragile healthcare are multiple.

2.1.1 Underfunded System

A major issue with the healthcare system is funding. In LMICs, healthcare spending has barely increased from 5.0% of GDP in 2000 to 5.3% in 2022. Meanwhile, high-income countries have increased their spending, widening the disparity. The gap between the two went from 4.4 percentage points in 2000 to 7.3 percentage points in 2022.

Per capita, the disparity is stark. In 2022, LMICs spent $93 per person yearly on healthcare, over 60 times less than high-income countries at $5,767.[10] This widening gap hampers LMICs' ability to invest in healthcare.

Figure 1. Healthcare expenditure as a share of GDP



Source: World Bank (2025). Current health expenditure (% of GDP)

2.1.2 Workforce Shortage

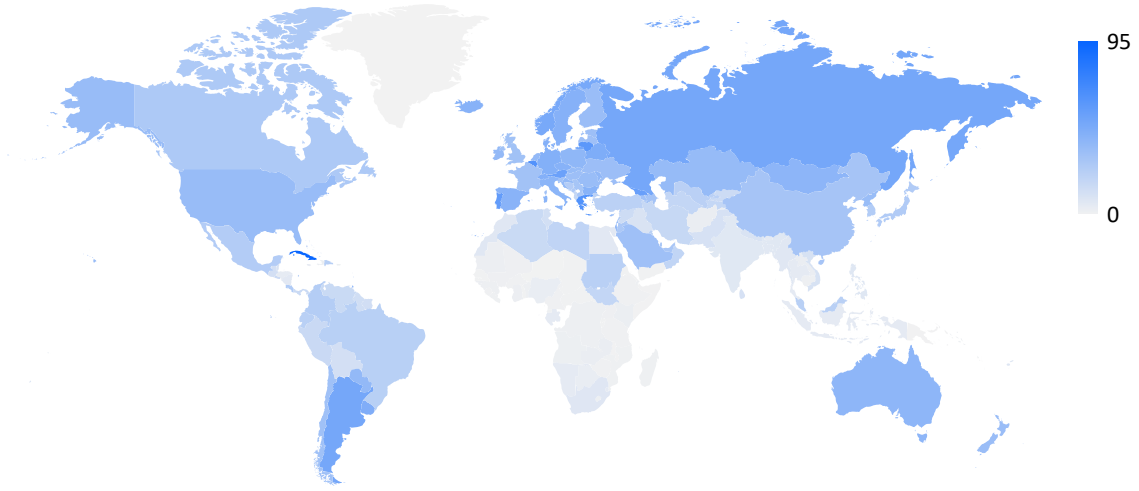
This deficit restricts access to vital services, extends waiting periods, and places significant strain on the healthcare systems.

Many LMICs experience shortages of healthcare workers.[11] For instance, Africa has an average of 2.6 doctors per 10, 000 people (Figure 2). In contrast, Europe averages 37,6 doctors per 10, 000 people which is more than 14 times the average in Africa. Some areas have even lower numbers, such as Niger with 0,38, South Sudan with 0,41, and Malawi with 0,54 doctors per 10,000 people currently South Africa is experiencing immense challenges with unfunded posts for consultants (specialists), registrars, medical officers, community

[6] Phelan H. et al. (2022). Challenges in healthcare delivery in low- and middle-income countries
[7] Meara J. et al. (2015) Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development
[8] Phelan H. et al. (2022). Challenges in healthcare delivery in low- and middle-income countries
[9] Phelan H. et al. (2022). Challenges in healthcare delivery in low- and middle-income countries
[10] World Bank (2025). Current health expenditure per capita (current US$)
[11] Sharpley N. et al. (2024). The Road to Universal Healthcare Coverage in the Face of COVID-19: South Africa's Struggles and Prospects

service doctors and nursing professionals. This has led to many protest actions by young unemployed doctors in the recent past.

Figure 2. Number of doctors per 10,000 people



Source: WHO (2024). Medical doctors (per 10,000 population)

The shortage of healthcare workers is particularly pronounced in rural areas. Even though over 40% of the population resides in these regions, only 23% of health personnel are stationed there.[12] Approximately 56% of rural areas in LMICs lack access to essential healthcare services, underscoring the need for different approaches to healthcare service delivery in these areas, e.g. the potential role of telemedicine in addressing this disparity.[13]

The International Labour Organization (ILO) reports that there is a global need for an additional 10.3 million health workers, with 7 million required in rural LMICs.[14] Without an adequate workforce, even the most fundamental healthcare needs remain unaddressed.

2.1.3 Limited Education and Research

Many LMICs have limited access to quality medical education. Most of the leading public health programmes are implemented in high-income countries, posing challenges for students and researchers from LMICs.[15] High tuition fees and scarce funding opportunities make it difficult to develop local expertise.

Most global health research is driven by wealthy countries, with 90% of it benefiting just 10% of the world's population in high-income regions, according to the University of Oxford.[16] Many research institutions lack funding, access to international networks, peer-reviewed publishing, and advanced equipment.[17] Consequently, local health issues are often neglected, and solutions suited to local needs are seldom developed or applied.

[12] Kumar P. et Al. (2018). Rural Health Scenario – Role of family medicine: Academy of Family Physicians of India Position Paper

[13] Lestari H. M. (2024). Barriers to telemedicine adoption among rural communities in developing countries: A systematic review and proposed framework

[14] Chowdhury J. et al. (2022). Healthcare Accessibility in Developing Countries: A Global Healthcare Challenge

[15] Shumba C. et al. (2021) Not enough traction: Barriers that aspiring researchers from low- and middle-income countries face in global health research

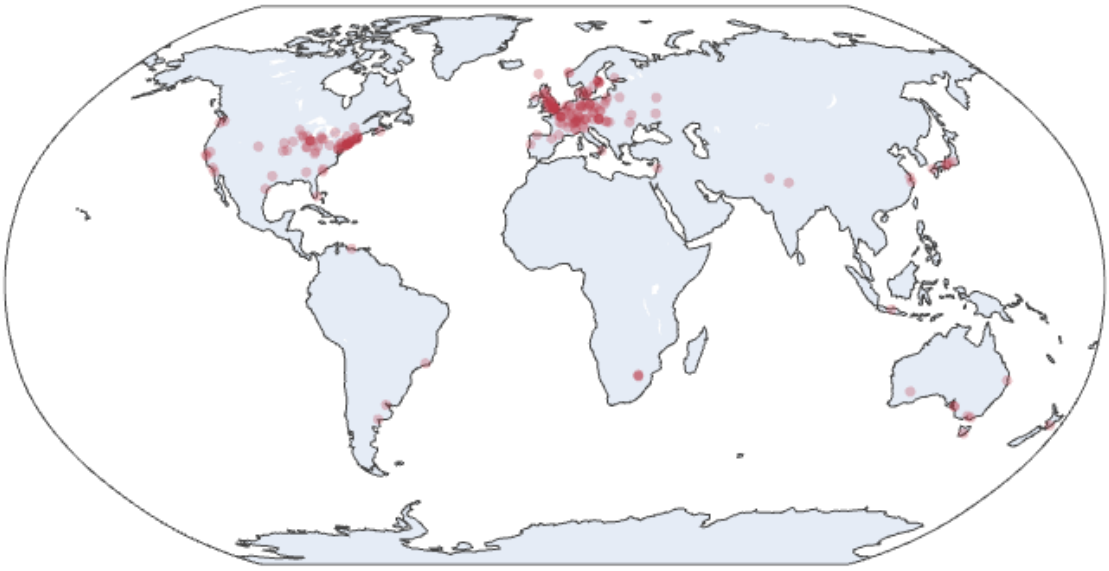
[16] University of Oxford. Towards more equitable health research

[17] Shumba C. et al. (2021) Not enough traction: Barriers that aspiring researchers from low- and middle-income countries face in global health research

The imbalance is evident in global recognition, as nearly all Nobel laureates in medicine originate from high-income countries (see Figure 3). This skew is also present in major global health networks. For instance, the Consortium of universities for Global Health, which was established to support academic institutions worldwide, has only 8.7% of its members from LMICs.[18] Consequently, LMICs have reduced influence over agendas and decisions.

Furthermore, inadequate educational opportunities and insufficient research funding may drive top talent to seek opportunities elsewhere, thereby further diminishing domestic capacity.

Figure 3. Birthplaces of the medicine nobel laureates



Source: Elliot Fosong (2024). Birthplaces of the Nobel Laureates

2.1.4 Overlooked Prevention

Prevention, ranging from promoting healthy behaviours to early illness detection and managing chronic conditions before they worsen, is an effective method for improving health outcomes and reducing costs. The WHO estimates that nearly 7 million deaths could be avoided by 2030 if countries invested an additional dollar per person each year in preventing and treating non-communicable disease (NCDs).[19]

In many LMICs, prevention remains underutilised. For instance, regarding hypertension, only one in three individuals are aware of their condition, and just one in four of those receive treatment.[20] This low level of awareness about common health risks indicates a lack of focus on prevention.

The result of overlooked prevention is delayed diagnosis of untreated conditions that often escalate into the need for hospital-based care.

Furthermore, numerous existing prevention programs often lack efficiency as they replicate models from high-income countries without adapting them to the realities of LMICs.[21]

[18] Sayegh H. et al. (2022). Global health education in high-income countries: confronting coloniality and power asymmetry

[19] WHO (2021). Investing 1 dollar per person per year could save 7 million lives in low- and lower-middle-income countries

[20] Mills K. T. et al. (2016). Global Disparities of Hypertension Prevalence and Control: A Systematic Analysis of Population-Based Studies From 90 Countries

[21] Parra-Cardona R. (2018). Strengthening a Culture of Prevention in Low- and Middle-Income Countries: Balancing Scientific Expectations and Contextual Realities

Hospital care costs more than prevention. Preventing pandemics costs 10 to 11 billion dollars annually, much less than the 30 billion spent on outbreaks.[22]

2.1.5 Untapped Digital Health

Access to digital tools has rapidly increased. By 2024, nearly 70% of the global population used the internet, enabling better care delivery in underserved areas.[23] Digital health tools can improve access, reduce costs and provide personalised care, potentially saving up to 11 billion dollars in Africa by 2030.[24] However, digital health adoption is limited in many LMICs. The State of Digital Health 2024 report shows full integration mainly in developed countries like Portugal, Saudi Arabia, and Austria, while most LMICs are still in early development stages.[25]

Digital health adoption in LMICs faces several obstacles. Firstly, internet access is limited, with only 25% connected in low-income countries in 2024.[26] Secondly, less than one-third of users in these regions are skilled in digital health technologies, and even fewer have sufficient digital health literacy.[27] Lastly, financial constraints hinder development and maintenance of digital health systems, making them inaccessible to those who need them most.

In the Global South, shorter lives and avoidable deaths result from not only poor healthcare supply but also ongoing health risks. Malnutrition, unsafe environments, and harmful habits increase illness rates, raising patient numbers and care costs, straining already stretched systems.

2.2 Demand: Healthcare demand is overwhelming

2.2.1 Malnutrition and Food Insecurity

Malnutrition significantly contributes to illness in many LMICs. In 2023, 733 million people globally were undernourished (Figure 4). In Sub-Saharan Africa, nearly one in four individuals did not have sufficient food.[28]

According to the UN nearly 600 million people are projected to experience chronic hunger by 2030, predominantly in LMICs.[29]

[22] World Bank (2022). One Health Approach Can Prevent the Next Pandemic

[23] World Bank (2025). Individuals using the Internet

[24] WHO. (2024) Bulletin of the World Health Organization

[25] Global Digital Health Monitor (2025). State of Digital Health 2024

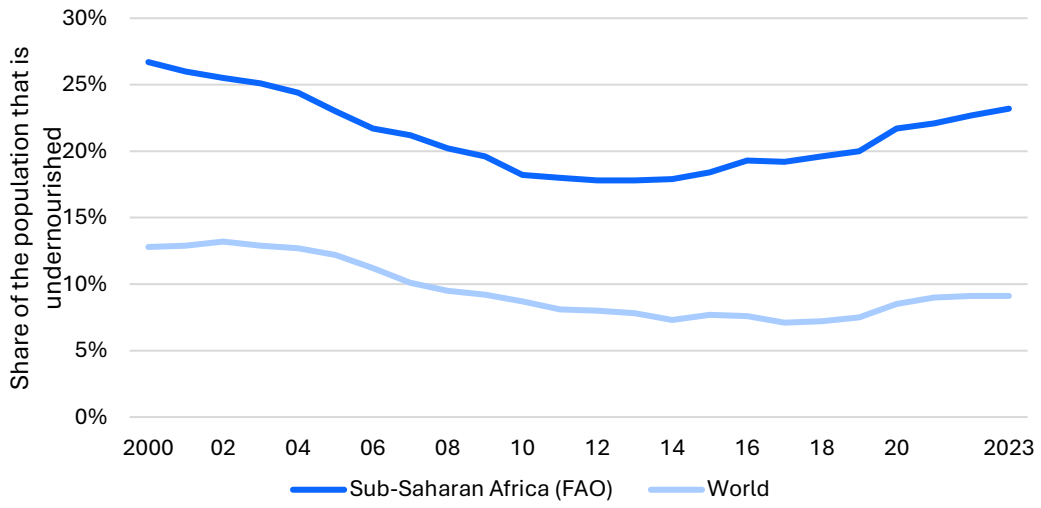
[26] World Bank (2025). Individuals using the Internet

[27] Biga R. et al. (2024). Digitalization of Healthcare in LMICs: Digital Health and the Digital Divide Based on Technological Availability and Development

[28] Food and Agriculture Organization of the United Nations (2025). Share of the population that is undernourished

[29] UN (2023). The State of Food Security and Nutrition in the World 2023

Figure 4. Share of the population that is undernourished (a daily food intake that is insufficient to provide the amount of dietary energy required to maintain a normal, active, and healthy life)



Source: Food and Agriculture Organization of the United Nations (2025). Share of the population that is undernourished

Malnourished individuals are more prone to illness, take longer to recover, and require additional care. A recent study shows that a 1% increase in undernourishment correlates with 0.00348 percentage point drop in life expectancy and a 0.0119 percentage point raise in infant mortality and illness in Sub-Saharan Africa.[30] This health burden raises the demand for healthcare.

2.2.2 Quality of Food

Poor food quality drives healthcare demand. For example, antibiotics in animal feed promote growth but contribute to antimicrobial resistance, which spreads through food and causes 700,000 deaths annually.[31] Microplastics in food, water, and air are a new public health threat, with consumption rising six-fold since 1990, particularly affecting Asia, Africa and Latin America. The consumption of microplastics can cause inflammation, hormonal issues, and weakened immune systems, leading to increased healthcare needs.[32]

2.2.3 Growing Burden of Chronic Diseases

NCDs are now the primary cause of death in LMICs. Over the past 40 years, total deaths from chronic diseases have increased from 31% to 53%. Conditions such as diabetes, high blood pressure, cancer, and heart disease are increasing rapidly (Figure 5). In Sub-Saharan Africa alone, NCDs result in nearly 3 million deaths annually.[33] Health systems in the global South are primarily designed to combat infections. These systems often lack adequately trained personnel, reliable equipment, and mechanisms for long-term care. As the prevalence of NCDs grows, the disparity between patient needs and system capabilities is increasing each year.

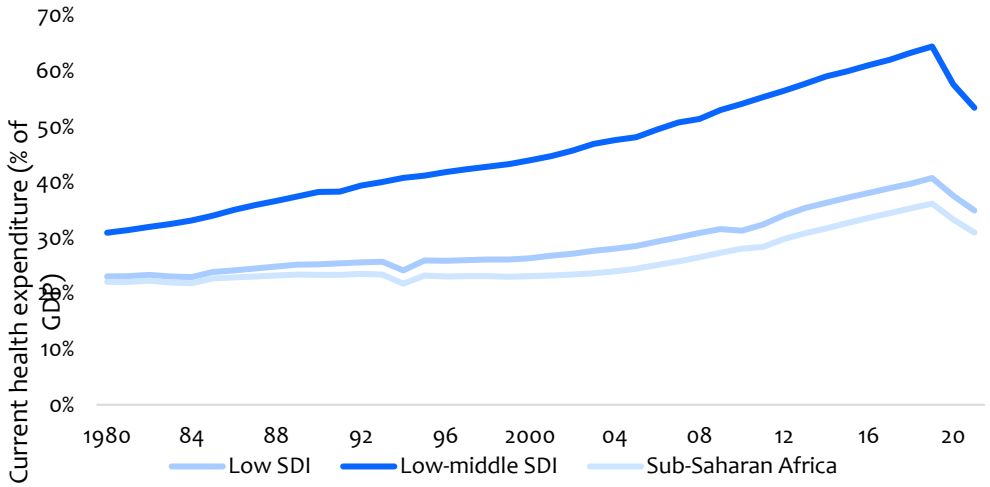
[30] Beyene S. D. (2023). The impact of food insecurity on health outcomes: empirical evidence from sub-Saharan African countries

[31] Pokharel S. et al. (2020). Antimicrobial use in food animals and human health: time to implement 'One Health' approach

[32] Zhao X. et al. (2024). Microplastic Human Dietary Uptake from 1990 to 2018 Grew across109 Major Developing and Industrialized Countries but Can Be Halved by Plastic Debris Removal

[33] Institute for Health Metrics and Evaluation (2024). Global Burden of Disease (GBD) Study

Figure 5. Share of NCDs in total causes of death



Source: Institute for Health Metrics and Evaluation (2024). Global Burden of Disease (GBD) Study

NCDs rise due to economic, environmental, and behavioural factors.

Urbanisation and Air Pollution

Urban populations in the Global South are expected to reach 3.75 billion, or 54,3% of the region's population by 2025.[34] Many cities lack green spaces and walkable streets, reducing physical activity. Urban living also promotes industrialised, poor-quality food, leading to an increase in obesity, diabetes, and heart disease risks. As urbanisation intensifies, air pollution worsens, leading to a rise in NCDs like asthma, chronic lung disease, strokes, and heart disease.[35] Of the 3.7 million premature deaths linked to poor air quality annually, 88% occur in LMICs.

Smoking, Alcohol Use, and Diet

Unhealthy habits are contributing to the increasing prevalence of NCDs in LMICs. We are seeing high levels of alcohol consumption, smoking, and excessive intake of sugar, salt, and fats. For instance, in South Africa, sugar consumption is up to 24 teaspoons per day, which is twice the WHO recommended limit.[36] Between 2000 and 2022, adult obesity increased from 21% to 30%, while childhood obesity nearly tripled.[37] The number of smokers is also rising. In Africa, the number pf smokers grew from 52 million in 2000 to 66 million in 2015 and is expected to reach 84 million by 2025.[38]

Alcohol consumption impacts health systems, in South Africa, alcohol consumption is 45% higher than the global average. According to the WHO, alcohol accounts for over 10% of the global NCDs burden.[39] In Africa, it is linked to approximately 6.4% of all deaths.[40] These factors contribute significantly to increasing healthcare costs. New behavioural risks are also being observed. In Africa, an estimated 340 million people participated in gambling last year, with nearly 80 million at risk of problem gambling.[41] These behaviours are associated

[34] Warren S. (2021). Urbanization in the Global South

[35] Wang M. et al. (2025). Particulate matter air pollution as a cause of lung cancer: epidemiological and experimental evidence

[36] University of the Witwatersrand (2016). Facts about sugar-sweetened beverages (SSBs) and obesity in South Africa

[37] WHO (2025). Prevalence of obesity among adults, adolescents and children.

[38] Egbe C. et al. (2022). Landscape of tobacco control in sub-Saharan Africa

[39] WHO. Noncommunicable diseases

[40] Ferreira-Borges C. et al. (2015). The impact of alcohol consumption on African people in 2012: an analysis of burden of disease

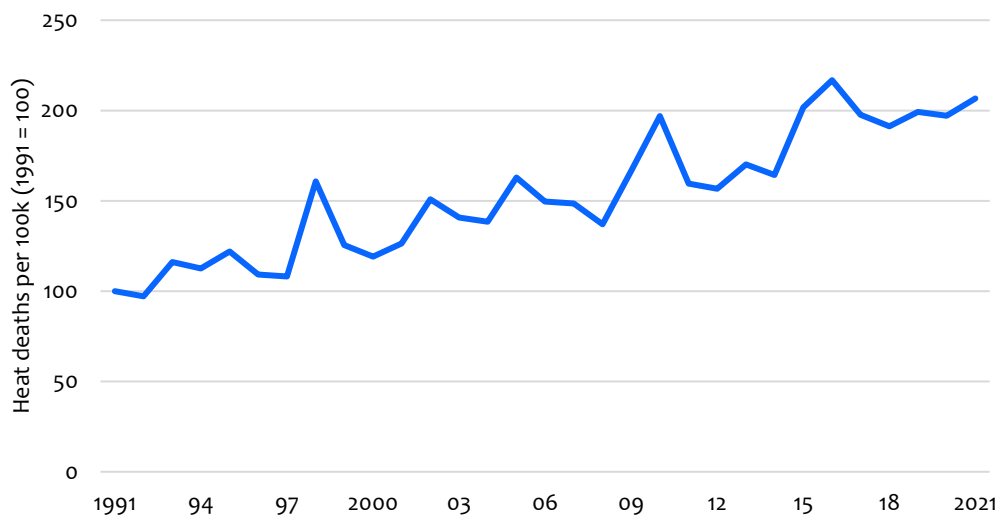
[41] Wardle H. et al. (2024). The Lancet Public Health Commission on gambling

with depression, anxiety, substance abuse, and family stress – all of which increase the demand for mental health services and add pressure on already stretched systems.[42]

2.2.4 Climate Change

Climate change is impacting health. Higher temperatures elevate the risk of heat-related illnesses and decrease worker safety. In 2021, Africa experienced over 78,000 deaths linked to extreme heat- double the number in 1991 (Figure 6). Vulnerable groups, such as the elderly and individuals with chronic conditions, face higher risks, including mental health illnesses. Additionally, increased temperatures lead to droughts, reducing crop yields and limiting access to nutritious food, which can result in more cases of malnutrition.

Figure 6: Number of heat-related deaths per 100,000 people in Africa (indexed to 1991 = 100)



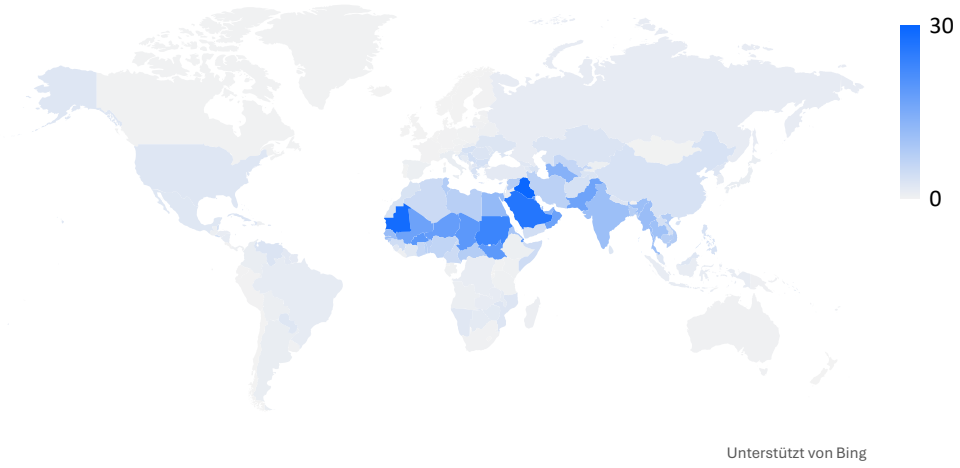
Source: Institute for Health Metrics and Evaluation (2024). Global Burden of Disease (GBD) Study

Rising temperatures lead to increase in diseases like malaria, increasing risks and straining health systems. Changes in rainfall and heatwaves worsen floods and fires, disrupting care and displacing families. In 2022, weather-related disasters caused 98% of the 32 million internal displacements globally.[43] Health services must adapt by providing new clinics, mobile units, and emergency care to service these and other locations.

[42] Wardle H. et al. (2024). The Lancet Public Health Commission on gambling

[43] Internal Displacement Monitoring Centre (2023). 2023 Global Report on Internal Displacement

Figure 7: Number of death cases due to high temperatures per 100,000 inhabitants in 2021



Source: Institute for Health Metrics and Evaluation (2024). Global Burden of Disease (GBD) Study

In summary, healthcare systems in the Global South face challenges as demand surpasses supply. Contributing factors include underfunded systems, workforce shortages, limited education and research, insufficient prevention efforts, inadequate infrastructure, inequitable access to care and unutilised digital health solutions. Concurrently there is an increase in demand for healthcare services by an increase of infectious diseases, chronic diseases, pregnancies (especially teenage pregnancies), malnutrition, violence, climate change.

3. Declining Aid and Demographic Pressures Widen the Health Gap

The gap between healthcare supply and demand is widening, driven by a growing demand for service and a weakening of supply capacity.

3.1 Supply: Declining aid will further undermine health supply

3.1.1 Shrinking Foreign Aid

The United States has been a significant donor supporting these initiatives. In 2022, the US contributed $7.22 billion to Sub-Saharan Africa, accounting for nearly 47% of the regions total $15.4 billion in Development Assistance for Health (DAH) (Figure 8). This funding enabled governments to implement treatment programmes, train healthcare workers, and finance the procurement of essential medicines and equipment. For instance, in South Africa, the US funded 17% of the national HIV/AIDS response.[44]

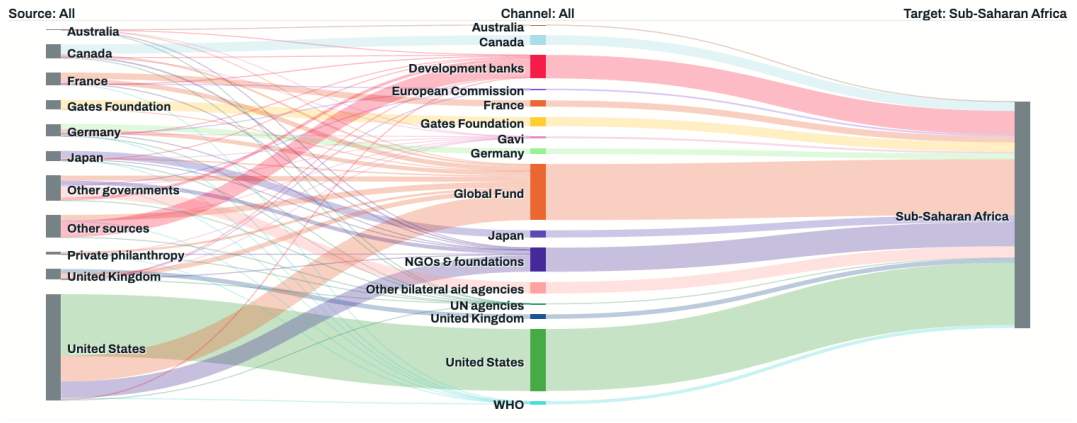
In January 2025, the US suspended foreign aid as part of a broader shift toward protectionism.[45] Past reductions, such as the 2017 Global Gag Rule, resulted in clinic closures, decreased access to contraception, and impacts on HIV programmes across Africa.[46] The 2025 cuts have the potential to disrupt many essential services and affect already delicate healthcare systems.

[44] Reuters (2025). Trump attack on South Africa exposes divisions over race and land

[45] The Washington Post (2025). Trump USAID foreign funding cuts rubi

[46] Maistrellis E. et al. (2022). Beyond abortion: impacts of the expanded global gag rule in Kenya, Madagascar and Nepal

Figure 8. Development assistance for health (DAH) flows to Sub-Saharan Africa, 2022



Source: Institute for Health Metrics and Evaluation (2024). DAH flows

The withdrawal of foreign aid may affect key system functions, such as workforce training, supply chain management systems making LMICs more vulnerable and less prepared to meet healthcare needs.

3.1.2 Risk of shifting supply chains

High-income countries are shifting production domestically to secure supply chains post the COVID-19 pandemic and geopolitical tensions.[47] This trend may exclude LMICs from foreign investments and global procurement, weakening their economic outlook and straining health systems even further. Consequently, protectionism could adversely impact healthcare supply in LMICs.

3.2 Demand: Population growth and ageing will intensify pressure on weak healthcare systems

3.2.1 Growing Population

Populations in many LMICs are rapidly increasing. Sub-Saharan Africa's population is expected to reach 2.5 billion by 2065 due to high fertility rates.[48] The region's average fertility rate is 4.3 children per woman, nearly double the global average and almost three times higher than Europe's.

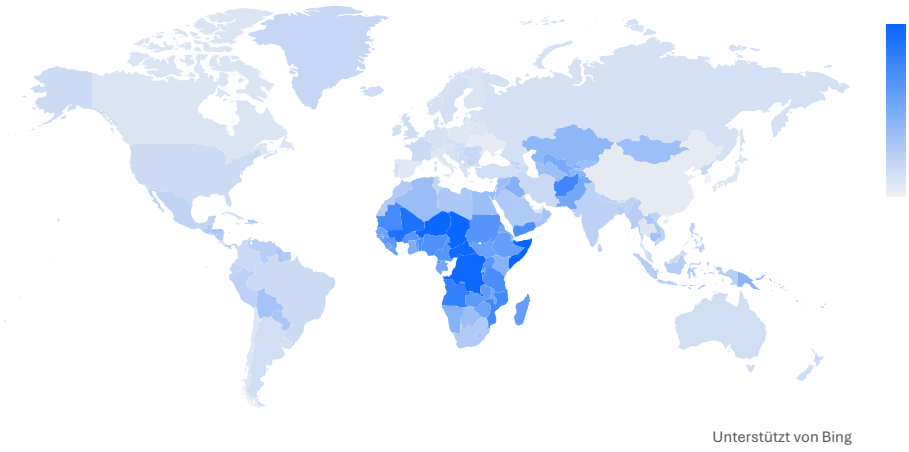
Rapid population growth will boost the number of people and demand for healthcare, worsening existing health gaps.

As populations grow, providing affordable, nutritious food will become more challenging. This could lead to an increase in diet-related diseases

[47] European Parliament (2021). Post Covid-19 value chains: options for reshoring production back to Europe in a globalised economy

[48] UN (2025). Data Portal

Figure 9. Fertility rate (births per woman)



Source: World Bank (2025). Fertility rate

3.2.2 Ageing Population

Populations in LMICs are ageing, with life expectancy in Sub-Saharan Africa increasing from 51 years in 2000 to 62 in 2024 and projected to reach 69 by 2065.[49] As a result, the number of older people will rise globally. By 2050, nearly 200 million people aged 65 and over will reside in Sub-Saharan Africa, Northern Africa, and Western Asia.[50]

As life expectancy increases, the prevalence of long-term illnesses such as diabetes, cardiovascular disease, asthma, and dementia also rises.[51] These chronic conditions necessitate prolonged care, including routine medical examinations, consistent medication management, and ongoing support. Consequently, there is an increasing demand for healthcare services.

Longer lifespans increase the demand for assistance with daily activities, with many requiring residential care or home support. This demand strains existing social care systems.

In summary, the gap between healthcare supply and demand is widening. Foreign aid is declining as global priorities shift, while an increasing and ageing population escalates demand. This imbalance threatens fragile health systems, endangering millions with preventable illnesses and premature death.

4. Poor Health in the Global South slows progress to SDGS

The growing gap between healthcare supply and demand in the Global South hampers public health and human progress. The imbalance between healthcare supply and demand in the Global South represents both a significant public health concern and a barrier to human development. Health-related issues lead to higher absenteeism from work and school, thereby affecting productivity, education, and long-term development prospects.

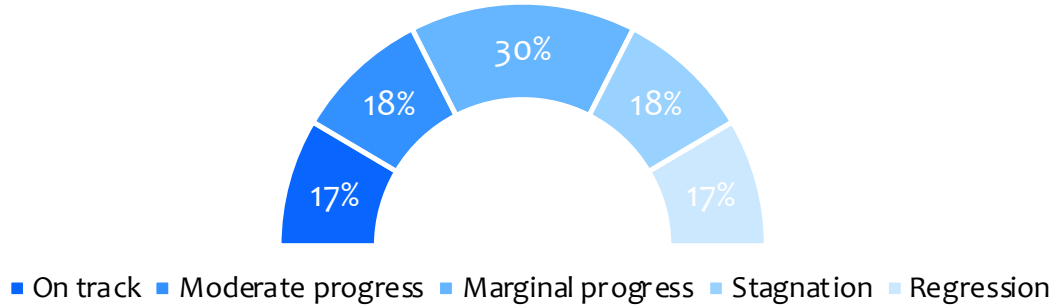
UN data indicate that global progress is off track. The SDGs reveal that the world is falling behind. Only 35% of targets are on track, while another 35% have fallen below 2015 baseline levels. The remaining 30% show little or no progress (Figure 10).

[49] UN (2025). Data Portal

[50] Padeiro M. et al. (2023). Global aging and health determinants in a changing world

[51] World Bank Blogs (2023). Health systems must address the unique needs of aging populations

Figure 10. Progress assessment for SDG goals



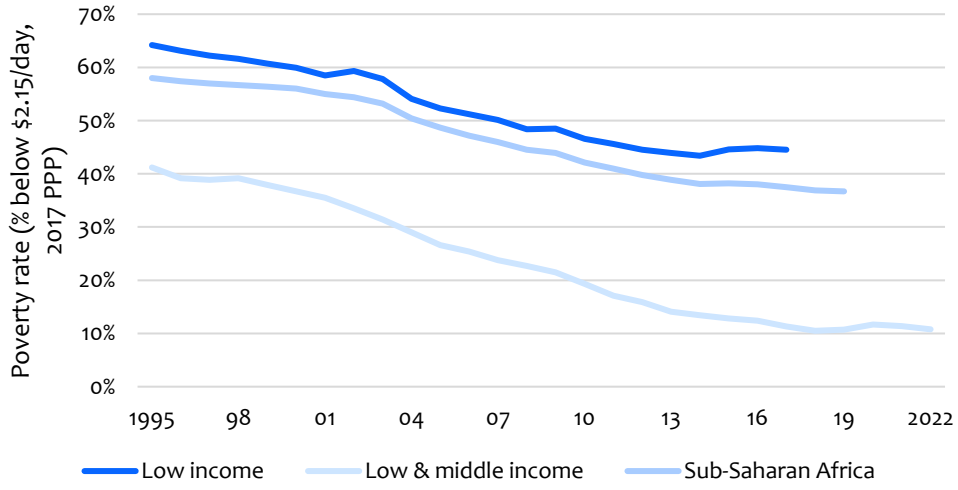
Source: UN (2025). The Sustainable Development Goals Report 2024

While all SDGs are interconnected, some are affected more than others when health systems fail. More directly impacted SDGs include SDG 1 (No Poverty), SDG 8 (Decent Work and Economic Growth), and SDG 10 (Reduced Inequalities).

4.1.1 SDG 1. Poverty

Global progress in reducing extreme poverty has decelerated, particularly In Sub-Saharan Africa. Between 2014 and 2019, the region's poverty rate declined by merely 1,4 percentage points, which is significantly less than the nearly six-point reduction observed between 2009 and 2014. In some low-income countries, poverty levels are now increasing again (Figure 11). More than 1 billion individuals remain at risk of falling into poverty.[52] Limited access to quality healthcare directly contributes to this issue, as poor health results in higher out-of-pocket expenses, loss of income, and diminished economic activity.

Figure 11. Poverty rate in LMICs



Source: World Bank (2025). Poverty headcount ratio at $2.15 a day (2017 PPP)

4.1.2 SDG 8. Weak Economic Growth

Sustained economic growth in LMICs depends on a productive workforce. Poor health reduces labour participation, increases absenteeism, and lowers productivity. Each year, $1.6 trillion in productivity is lost due to poor healthcare, with LMICs suffering the most, leading to slowed economic growth.[53]

[52] WHO (2025). Primary health care

[53] The National Academies of Sciences, Engineering, Medicine (2018). Crossing the global quality chasm: improving health care worldwide

4.1.3 SDG 10. Inequality

Inequality is high in LMICs in the Global South. In Africa, over half of the countries have severe income gaps (Gini index above 40). South Africa has the highest inequality globally (Gini coefficient at 63).[54]

Access to healthcare serves both as a reflection of- and a contributor to socioeconomic disparities. Individuals from lower-income households experience higher exposure to illness and have limited access to diagnostic and treatment options. Consequently, lost wages, missed educational opportunities, and untreated medical conditions perpetuate cycles of disadvantages among impoverished families. Conversely, individuals with greater financial resources can utilise private healthcare services to maintain their health and economic productivity. Over time, these dynamics hinder social mobility and complicate efforts to achieve inclusive growth.

In summary, inadequate health systems in LMICs throughout the Global South are impeding progress towards the SDGs. The inability to meet these targets compromises the vision of a fairer, safer, and more stable world. Consequently, global progress is contingent upon enhanced healthcare provision in the Global South.

5. Solution: Five Push Forces reducing demand and Five Pull Forces strengthening supply can help close the Healthcare Gap

Bridging the healthcare disparity in the Global South necessitates addressing the fundamental causes on both the supply and demand fronts. On the supply side, this entails reinforcing health systems by enhancing infrastructure, augmenting workforce capacity, and ensuring sustainable financing. On the demand side, it requires mitigating illness through preventive measures and promoting healthier lifestyles.

We propose ten forces: five push forces aimed at addressing demand and five pull forces designed to strengthen supply.

5.1 SUPPLY: Pull Forces

The following pull forces focus on expanding and strengthening healthcare systems by increasing capacity, improving efficiency, and attracting resources.

5.1.1 Pull Force 1. *Train Health Workers*

Training, retaining and empowering healthcare workers can improve service quality.

Implementation: Develop retention packages that include housing, flexible contracts, and performance-based incentives. Enhance health workforce training by establishing new medical and technical schools in underserved areas.

Outcome: Expanded service coverage and improved quality of care. Enhanced morale, retention, and productivity.

5.1.2 Pull Force 2. Leverage Public-Private Partnerships (PPPs)

Public-private partnerships enable health systems to improve accessibility, modernise quickly, and operate efficiently.

Implementation: Develop service models that integrate private delivery with public care. Establish infrastructure such as cloud diagnostics connected to provincial and national systems. Consider blended financing for the strategic use of development finance and philanthropic funds to mobilize private capital flows for improved health outcomes.

[54] World Bank (2024). Leveling The Playing Field

Outcome: Enhanced service accessibility, improved system planning, and accelerated innovation scale-up. Achieving public objectives with private sector efficiency while maintaining equity.

5.1.3 Pull Force 3. Digitise Health Systems

Digital health systems, including Internet of Medical Things (IoMT) devices, eHealth, mHealth, and AI-powered tools, play a growing role in modern healthcare. These systems facilitate the collection, storage, and interpretation of health data, thereby enhancing the identification of needs, outcome monitoring, and strategic planning. When effectively designed, they significantly improve communication between patients, healthcare providers, and decision-makers.

Implementation: Mobilise and encourage private investment in IoMT, eHealth, mHealth, and AI-tools for continuous monitoring, remote diagnostics, and early intervention through financial incentives (e.g., tax credits, guaranteed procurement contracts). Use AI to improve diagnostics and care coordination. Expand digital-first initiatives where suitable. Protect digital investments by allocating savings from administrative reforms. Ensure interoperability of health technologies and present data in a meaningful way for clinicians and patients.

Outcome: Lower administrative burden and decreased in-person delays. Enhanced quality of care, particularly in rural and remote regions.

5.1.4 Pull Force 4. Build Local Research and Innovation

A robust domestic research ecosystem can facilitate the design, testing, and implementation of solutions that address local challenges without significant dependence on external knowledge.

Implementation: Provide funding to national health research centres with the objective of translating scientific findings into policy and care delivery. Facilitate joint PhD and faculty exchange programmes between universities in LMICs and centres of excellence. Establish regional research challenge funds focused on local NCDs priorities, managed by institutions led by LMICs.

Outcome: Retains highly skilled professionals while fostering a self-sustaining workforce. Promotes home-grown innovation in prevention, diagnostics, and care models that enhance population health and system resilience. Enables institutions in LMICs to produce locally pertinent evidence, thereby reducing reliance on research from high-income nations.

5.1.5 Pull Force 5. Mobilise Health Financing

Effective and stable healthcare in LMICs requires financing systems that prioritise primary health care, reduce reliance on fragmented donor aid, and enable predictable resource flows.

Implementation: Harmonise health financing by consolidating benefit packages, provider payments, and performance tracking. Pool donor and domestic funds within unified national systems to avoid duplication. Expand capitation or performance-based funding directly to providers. Utilise PPPs and integrate public and private funds to attract investors for long-term health goals.

Outcome: Improved financial coordination, reduced duplication, enhanced trust in public health systems, and flexible funding empowering local providers.

5.2 Demand: Push Forces

The following push forces aim to reduce healthcare burdens by preventing illness, delivering care in communities, promoting healthier behaviours, and involving private entities in preventative health efforts.

5.2.1 Push Force 1. Reduce Environmental Risks

Lowering environmental risks can prevent health issues from air pollution and climate change.

Implementation: Enhance air quality regulations and encourage the adoption of clean energy. Integrate green spaces and sustainable urban planning. Establish community-based early-warning systems for climate-related health issues.

Outcome: Improved air quality and environmental conditions. Enhanced community readiness for climate-related events. Elevated public awareness of environmental health risks.

5.2.2 Push Force 2. Expand Health Education

Improved health literacy may help communities manage their health more effectively, potentially resulting in early prevention, reduced disease incidence, and decreased healthcare demand.

Implementation: Integrate health education into school curricula and adult education programmes, focusing on preventive care and chronic disease management. Train community health workers to provide door-to-door education and early intervention, particularly in areas with low school enrolment rates. Create Community Health Clubs, led by trained local facilitators or health workers, that convene regularly to discuss hygiene, disease prevention, nutrition, and healthy living. Utilise group dialogue and practical activities to encourage sustained behaviour change.

Outcome: Enhanced awareness of health-related behaviours and informed decision-making. Increased participation in preventative healthcare practices.

5.2.3 Push Force 3. Incentivise Less Harmful Habits

Behavioural economics can effectively promote healthier behaviours on a large scale, thereby reducing the prevalence of chronic diseases and the demand for healthcare services. It might be in the interest of public health that we look at the risk attributed to harmful products and whether harm reduction strategies might contribute to better health outcomes over the short to medium term.

Risky behaviours like drinking, smoking, eating unhealthy foods, and gambling are inherent to human nature. Despite policymakers' efforts, these habits persist. Harm reduction strategies encourage shifts to less harmful alternatives.

We can address the challenges imposed by alcohol consumption by adopting a more equitable framework that reflects the relative harm of different alcoholic beverages and supports public health objectives by encouraging the consumption of lower-alcohol alternatives. Implementing a more consistent and risk-and harm-based taxation strategy, calculated on the basis of litres of pure alcohol, could substantially enhance public health outcomes in South Africa by incentivising healthier drinking behaviours and mitigating the burden of alcohol-related costs.

Promotion of smoking cessation programmes or offering less harmful nicotine products to protect those unwilling or unable to quit smoking can lower smoking-related harm.

Implementation: Employ nudges (e.g., opt-out organ donations), visual portion guides, smoking cessation programmes, safer smoking alternatives, and mobile prevention care clinics. Introduce targeted taxes on products such as cigarettes, alcohol, sugar, fat, and salt. Conduct sustained social campaigns to promote healthy behaviours.

Outcome: Increase in the adoption of healthier lifestyle choices. Enhanced effectiveness of preventative measures. Improved adherence to health-promoting behaviours.

5.2.4 Push Force 4. Strengthen Food Security

Enhancing food security can mitigate malnutrition-related health problems, subsequently decreasing the demand for healthcare services.

Implementation: Create community nutrition programmes that connect agriculture with health education, such as home gardening and nutritional counselling. Increase school feeding programmes using local, nutritious foods. Enhance food safety regulations and improve cold-chain logistics.

Outcome: Greater access to nutritious foods, increased community nutrition awareness, improved nutritional status among vulnerable groups, and lower malnutrition-related disease rates.

5.2.6 Push Force 5. Enable At-Home Care

Empowering people, particularly the elderly, to manage minor conditions independently reduces strain on health systems and aids chronic disease control.

Implementation: Provide training to community members on fundamental care practices and self-monitoring techniques. Ensure that digital health tools are accessible, inclusive, and reliable.

Outcome: Reduced frequency of unnecessary clinic visits, increased patient autonomy, and enhanced early detection and management of common medical conditions.

6. Implementation: Improving Health outcomes requires coordinated action across the Public Sector, Private Sector, and Civil Society through a Whole-of-Society approach focused on Primary Healthcare

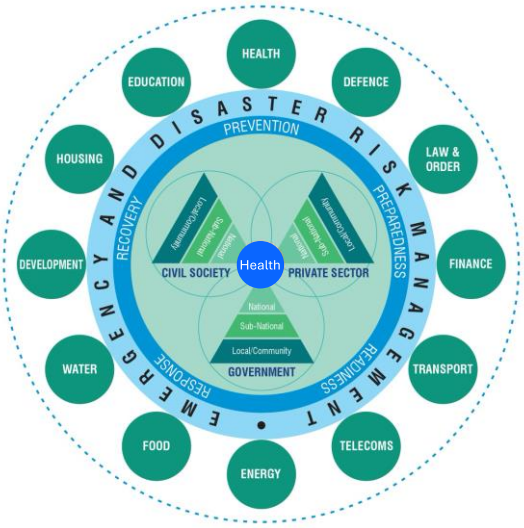
6.1 Whole-of-Society Approach

A healthy population yields universal benefits. A healthier populace results in a more robust workforce, increased productivity, and a larger customer base for the private sector, with reduced service needs and social costs for the public sector; and a civil society that enjoys improved community well-being. Therefore, it is essential that all sectors contribute to fostering better health.

Additionally, numerous factors contributing to poor health exists outside the healthcare system, such as inadequate nutrition and lack of education. These issues impact health significantly before individuals seek medical attention.

Consequently, improving health is a “shared responsibility” that involves everyone. In the Global South, this collective responsibility is particularly crucial, given that governments and health systems often have limited resources.

Figure 12. A whole-of-society approach to improve health



Source: WHO (2020). Everyone’s business

Government should coordinate national, regional, and local efforts to balance healthcare supply and demand. Both private and public sectors can enhance services by investing in hospitals, training health workers, and improving information systems. Civil society can mobilise communities for quality care, advocate for better policies, and ensure transparency. Involving all sectors creates ownership and commitment to tackling issues like chronic diseases and demographic changes. This results in better health and broader societal benefits.

6.2 Primary Healthcare

A whole-of-society approach involves transitioning healthcare from hospitals and specialists to community-based and outpatient services. Primary Healthcare (PHC) plays a crucial role in facilitating this transition. PHC enhances prevention and well-being by delivering healthcare within everyday environments such as communities, schools, and workplaces. It encompasses care ranging from health promotion to treatment, rehabilitation, and end-of-life support.

PHC services encompass a range of essential interventions, including vaccinations, child health programmes, antenatal care, general consultations, and routine treatments.

For effective patient assessment, primary care practitioners must be trained in screening and diagnostic techniques as part of their clinical competencies as generalists. These competencies include risk identification, counselling skills, expert clinical examination, interpretation of basic x-rays, minor surgical skills, interpreting blood tests, and point-of-care ultrasound.[55] Against a backdrop of ongoing budget constraints, consumables and equipment needed for diagnosis should be readily available and referral pathways for patients and specimens should be clearly defined and resourced.

An example of PHC in practice can be observed in clinics that provide immunizations, prenatal check-ups, and chronic disease management. PHC reduces costs significantly. According to WHO 90% of key UHC services can be provided through PHC[56]. Each additional PHC visit saves $721 per year, with the first visit saving nearly $4,000. Among high-risk patients, savings can exceed $16,000 annually[57].

LMICs spend $15 to $60 per person on PHC[58], but achieving 80% coverage would require a spend of $97 per person[59]. Scaling up PHC in LMICs could save 60 million lives and increase average life expectancy by 3.7 years by 2030[60]. Stronger PHC systems could also deliver up to 75% of health improvements linked to the Sustainable Development Goal.[61]

7. Conclusion

The gap between healthcare supply and demand in the Global South is increasing. This growing imbalance is leaving many countries too sick to grow. In many places, already fragile health systems face the risk of collapse.

Improving health in LMICs is an investment in the future. Countries that act now can reduce health issues and establish a foundation for higher productivity, stronger fiscal stability, and more inclusive social and economic development in the future.

Addressing the health crises requires collective action from governments, private sectors, and communities. Using a whole-of-society approach, governments should unite all stakeholders.

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55 Ras T. et al. (2023). The role of primary care practitioners in cancer control in South Africa: a systems-based case study

56 WHO (2023). WHO UHC Global Roadmap

57 Gao J. et al. (2022). The Effect of Primary Care Visits on Total Patient Care Cost: Evidence from the Veterans Health Administration

58 Vande M. N. et al. (2019). Measuring primary healthcare expenditure in low-income and lower middle-income countries

59 Stenberg K. et al. (2019) Guide posts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study

60 WHO (2023). WHO UHC Global Roadmap

61 WHO (2023). WHO UHC Global Roadmap

LMICs should focus on solutions that reduce healthcare gaps without extensive infrastructure. For instance, private investment in digital health can expand access and improve quality. Implementing risk- and harm-reduction strategies for smoking, alcohol, unhealthy diets, and gambling can decrease harmful consumption and prevent illness, easing system pressure. Enhancing health literacy can promote prevention and reduce dependence on hospitals. These low-cost, high-impact methods can relieve overburdened systems and balance healthcare provision.

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