African Health Policy Alliance

Health and Revenue Mobilisation in Southern African Countries

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Content

Executive Summary

Health systems in Southern Africa are currently facing significant challenges. Budget constraints are intensifying, epidemiological risks are mounting, and longstanding structural weaknesses are being exposed, which threatens to undermine the progress that has been achieved over the past twenty years. The COVID-19 pandemic placed considerable strain on health service delivery and has contributed to an expected 70% decline in Official Development Assistance between 2021 and 2025. At the same time, debt servicing obligations are projected to reach 81 billion US dollars by 2025. These factors combine to reduce the resources available for essential health functions at a time when greater investment is crucial to sustain service coverage, strengthen resilience, and protect vulnerable populations who are typically the first to be affected when funding becomes unstable or regressive in its impact (Africa CDC, 2025).

Public health financing remains insufficient. The Abuja Declaration recommends allocating 15% of national budgets to health, yet only 6 out of 47 countries achieved this target by 2021. In 23 of 47 countries, public health expenditure represented no more than 1.3% of GDP (WHO, 2025). This persistent shortfall in government funding exists in an environment where out-of-pocket payments frequently account for 30% to 60% of total health expenditures. Such high levels of direct household spending increase the risk of catastrophic expenditures and discourage timely care-seeking, particularly among low-income households. Simultaneously, external assistance is declining, which threatens programmes that depend on development partners for pandemic preparedness, immunisation, maternal and child health, and responses to HIV and other communicable diseases (WHO UHC, 2024), (Africa CDC, 2025) , (Apeagyei, et al., 2024), (Afriyie, et al., 2025).

Structural vulnerabilities are exacerbating these fiscal challenges. The incidence of outbreaks increased by 41% between 2022 and 2024. More than 90% of vaccines, medicines, and diagnostics are imported, which leaves health systems highly exposed to global market fluctuations and supply chain disruptions. Health workforce shortages remain severe, with only 2.3 professionals per 1,000 people, significantly below the World Health Organisation's (WHO) recommended threshold of 4.45. Fewer than 30% of health systems in the region are fully digitised, which restricts real-time surveillance, weakens early warning systems, and slows the transition to data-driven decision-making and accountability. These constraints are reflected in health outcomes. Life expectancy in sub-Saharan Africa is 66 years, compared to a global average of 74. In 2021, health expenditure per capita was only 92 US dollars, compared to the European average of around 4,300 US dollars in 2022 (EU, 2022). Progress toward Universal Health Coverage has stalled, with a service coverage index of 44 in the WHO African Region, well below the global average of 68, and the pandemic has further delayed improvements anticipated since 2015 (Africa CDC, 2025), (WHO UHC, 2024), (WHO Atlas, 2023), (Asante, et al., 2025), (Afriyie, et al., 2025).

Nevertheless, there is compelling evidence from the region that well-designed reforms can expand coverage, improve financial protection, and achieve better outcomes, even in the face of fiscal constraints. Rwanda, for instance, has achieved approximately 90% population coverage through its *Mutuelles de Santé,* resulting in a significant reduction in infant mortality. Ghana has expanded coverage to over 70% via its National Health Insurance Scheme, supported by robust legislation for pooling and purchasing reforms. Other countries are exploring innovative financing approaches, including solidarity levies on airline tickets or imports, health taxes, charges on telecommunications earmarked for health, and financial instruments that involve the diaspora as a long-term investment partner. These strategies tend to be most effective when they are accompanied by strong public financial management, transparent earmarking, and harmonised purchasing mechanisms that minimise fragmentation and direct resources to cost-effective services, particularly in primary health care and essential medicines (Africa CDC, 2025), (Afriyie, et al., 2025), (WHO Atlas, 2023).

A strategic shift in perspective is necessary. Health should be understood as an investment in productive capacity, stable economic growth, and social resilience, rather than merely as a recurrent expense to be minimised. Improved health contributes to higher labour productivity, better educational attainment, increased lifetime earnings, and a more stable tax base. The following sections will analyse the financing landscape in Southern African countries, evaluate the impact of revenue and purchasing decisions on access to essential services, identify the principal barriers to effective resource mobilisation and

expenditure, highlight successful innovations and country examples, compare regional profiles, and conclude with a set of policy recommendations that connect health financing reform to inclusive economic development.

1. Introduction and Context

Southern African health systems are currently facing significant challenges as external financial support declines and domestic fiscal pressures intensify. Projections indicate that Official Development Assistance will decrease by 70% from 2021 to 2025, while governments in the region are expected to confront debt servicing obligations totalling 81 billion US dollars by 2025. This combination of reduced donor funding and mounting debt narrows the fiscal space available for health, making it increasingly difficult for governments to sustain programmes that have historically relied on external assistance. Public health spending in twenty-three out of forty-seven countries was no more than 1.3% of GDP. Persistent underinvestment in health limits the ability of these systems to address emerging risks and hinders progress toward universal health coverage, particularly given that public budgets are strained by rising interest payments and competing priorities (Africa CDC, 2025), (WHO Atlas, 2023).

These fiscal constraints are compounded by a range of systemic and epidemiological pressures. The number of disease outbreaks in the region increased by 41% from 2022 to 2024, rising from 152 outbreaks in 2022 to 213 in 2024. The latest mpox outbreak has resulted in 2862 confirmed cases, including 17 deaths between 14 September and 19 October 2025. Transmission of mpox is active and ongoing in 17 countries in Africa.

The region is heavily dependent on imports for vaccines, medicines, and diagnostics, with more than 90% of these supplies sourced from outside Africa. Such reliance exposes health systems to global supply shocks that can disrupt essential services and drive-up costs. The density of health professionals remains low, at only 2.3 per 1,000 people, well below the WHO's recommended threshold of 4.45. In addition, fewer than 30% of health systems in the region are fully digitised, which weakens disease surveillance, slows the detection of public health threats, and limits the use of data for strategic purchasing and accountability. These structural weaknesses are reflected in health outcomes. Life expectancy in sub-Saharan Africa is 66 years, compared with the global average of 74. The Universal Health Coverage service coverage index for the WHO African Region is 44, significantly below the global average of 68, and the index has stagnated since 2015, with further setbacks resulting from the pandemic. These conditions highlight the urgent need for stronger and more effectively governed domestic financing to build resilient health systems capable of absorbing shocks and improving population health outcomes (Africa CDC, 2025), (WHO UHC, 2024), (Apeagyei, et al., 2024), (Afriyie, et al., 2025).

1.1 Overview of Current Health Systems

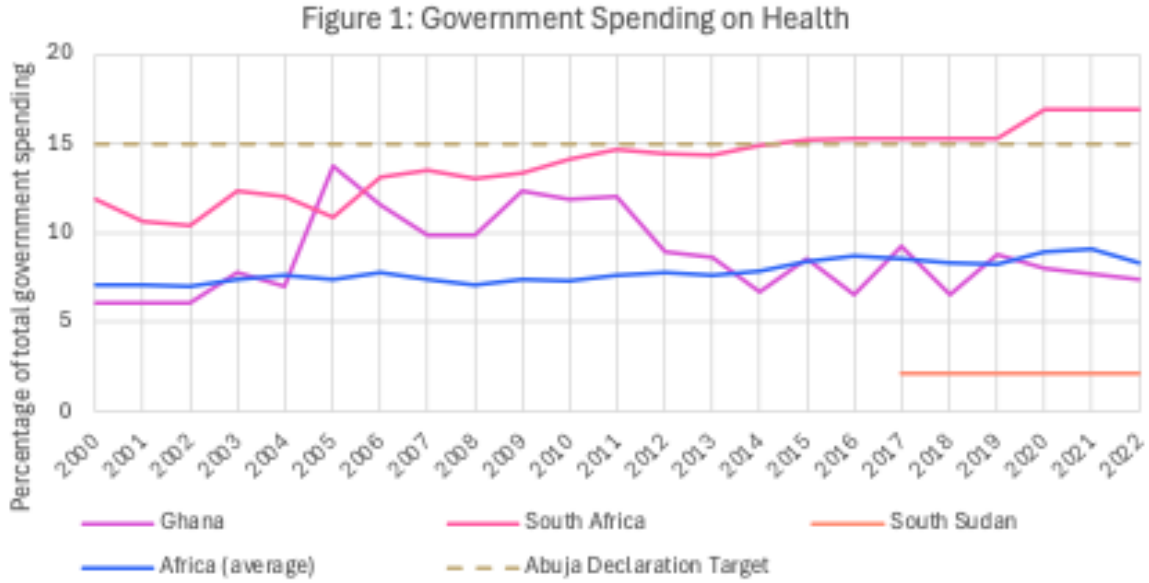
Health expenditure across Southern African nations demonstrates significant variation, both between countries and among income groups. There are notable differences in the proportions of public funding, out-of-pocket expenses, and external support. A considerable number of these countries remains highly dependent on external financing, with official development assistance accounting for more than one third of total health spending in several cases. For many years, this external aid has been crucial in supporting health initiatives targeting HIV, immunisation, maternal and child health, as well as other essential public health areas. Recent projections suggest that growth in development assistance will decelerate through 2050, while domestic public funding is only expected to increase moderately. This scenario is likely to intensify pressure on governments to generate more sustainable domestic revenue and to improve the efficiency of resource utilisation (Africa CDC, 2025), (Apeagyei, et al., 2024).

Public health investment continues to fall short relative to the region's needs. In 23 out of 47 countries with available data, public health outlays are at or below 1.3 % of GDP. At the same time, health systems are contending with both a persistently high burden of infectious diseases and a growing prevalence of noncommunicable conditions. These trends are straining prevention and treatment services throughout all stages of life. Climate-related disruptions such as floods and droughts further complicate service

delivery and can overwhelm already fragile health systems, which often lack adequate buffers in supply chains, workforce, and financing. These ongoing pressures contribute to a persistent gap in the Universal Health Coverage service coverage index, which remains at 44 for the WHO African Region compared to a global average of 68. Since 2015, improvement has been limited, and the COVID-19 pandemic has further impeded progress (Africa CDC, 2025), (WHO Atlas, 2023), (Afriyie, et al., 2025), (Apeagyei, et al., 2024)

2. Main Sources of Health Financing

In Southern African countries, the financing of health systems relies on a diverse combination of government funding, external aid, out-of-pocket expenditures, insurance models, private sector involvement, and increasingly, innovative financing approaches. Each of these financial sources presents unique challenges and opportunities regarding long-term sustainability, the pursuit of equity



The figure is based on (Picci, 2023),using data from (WHO, 2025).

and the ability to deliver essential services at scale.

2.1 Government Budgets

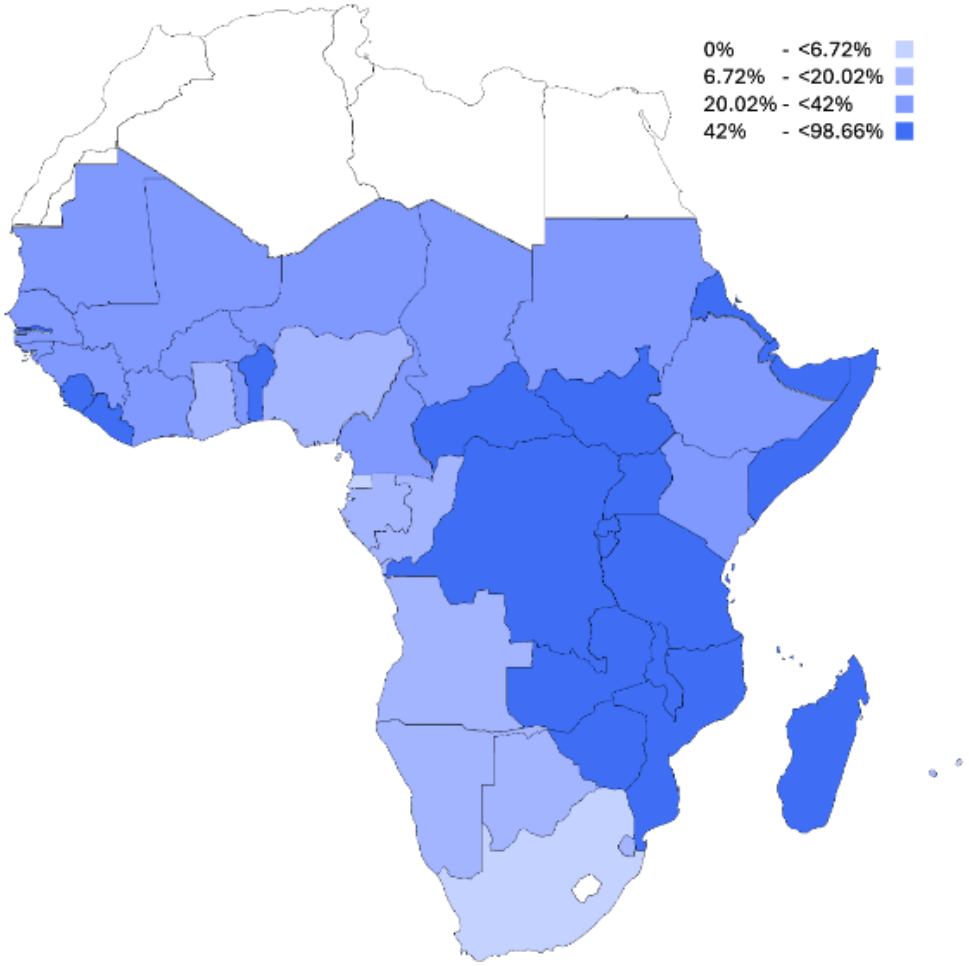
Government budgets, mainly supported through general taxation, continue to serve as the primary source of health financing in the region. The Abuja Declaration established a goal for African Union member states to dedicate at least 15% of their national budgets to health. Despite this, progress has been limited, with only a small number of countries reaching the target. In many instances, government health spending has remained stagnant, and persistent inefficiencies continue to restrict the effectiveness of public investment in improving health outcomes (Apeagyei, et al., 2024).

2.2 External Aid

External assistance continues to be crucial in many countries. Official Development Assistance, the Global Fund, and Gavi have contributed significantly to improved immunisation coverage, reduced under-five mortality, and expanded treatment and prevention for human immunodeficiency virus and related conditions. Recently, though, the reliability of this support has declined. In January 2025, the United States began to withdraw from WHO and reduce USAID and PEPFAR operations. These actions are likely to disrupt HIV treatment, immunisation programmes, and maternal and child health services unless rapid solutions are implemented. Academic studies, like the one from Hussein & Samet (Hussein

& Samet, 2025), point to immediate and measurable harms under these circumstances, such as interruptions in treatment, increased risk of outbreaks of vaccine-preventable diseases, and a gradual weakening of health system capacity if these gaps remain unaddressed. To maintain the progress made in recent years, countries must adopt contingency plans that safeguard last mile delivery and supply chains, secure domestic co-financing for effective programs, and engage a broader range of partners to

Figure 2: Percentage of Development Assistance for Health as a Proportion of total Health Spending in 2021.



The figure is based on (Apeagyei, et al., 2024).

support surveillance and response capacity. Transparent transition metrics and clear timelines are also essential. Without proactive planning, recent advances risk being reversed, with the heaviest burden falling on vulnerable populations (WHO UHC, 2024), (Hussein & Samet, 2025).

2.3 Out-of-Pocket Payments

Out-of-pocket payments remain a significant component of total health expenditure in many Southern African countries, often accounting for 30% to 60% of the overall health spending. This heavy reliance on direct payments at the point of service creates a regressive financial burden that disproportionately affects poorer households. As a result, many families are forced to delay or even forgo necessary care, which frequently leads to worse health outcomes and higher long-term costs. To enhance financial protection and encourage earlier, preventive care, it is crucial to reduce the share of out-of-pocket spending while expanding prepayment mechanisms and risk pooling (Apeagyei, et al., 2024), (Afriyie, et al., 2025).

2.4 Insurance Schemes

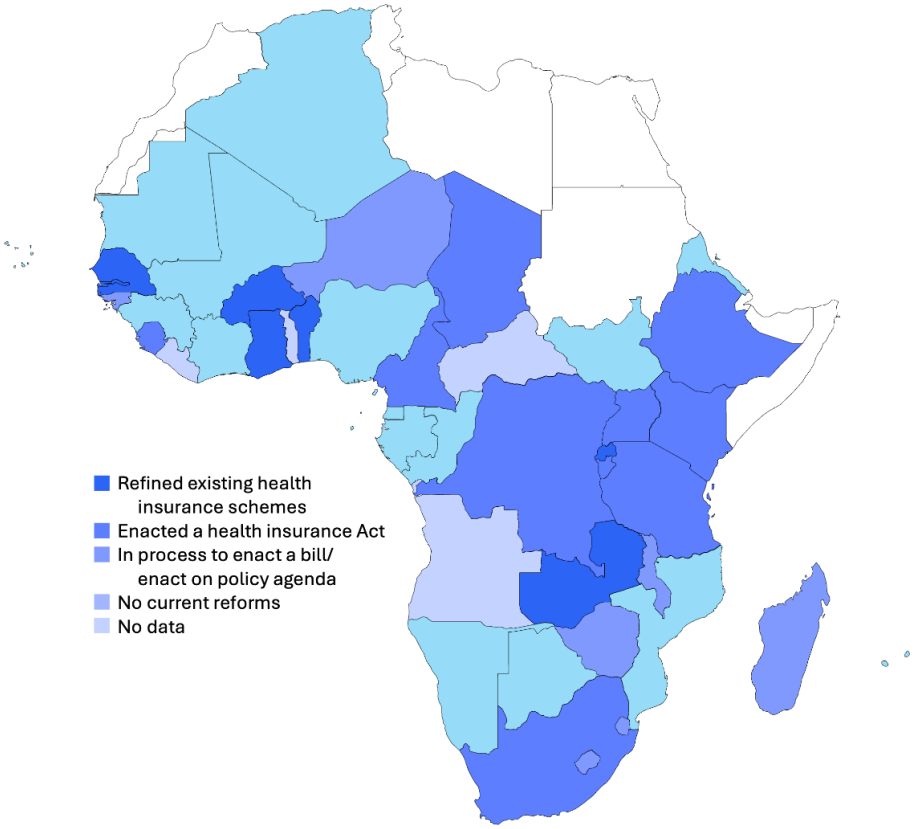
Insurance and other risk-pooling arrangements have demonstrated that substantial progress is possible even within constrained budgets, provided reforms are well designed. Rwanda, for example, achieved approximately 90% population coverage through *Mutuelles de Santé*, which contributed to significant reductions in infant mortality. Similarly, Ghana expanded coverage beyond 70% through its National Health Insurance Scheme, supported by legislative action and improvements in purchasing and benefit structures. There is considerable interest in contributory insurance across the region, with 77% of surveyed countries reporting current or planned reforms. Nevertheless, fragmentation across multiple schemes can undermine the efficiency of pooling and should be addressed through harmonised governance and unified purchasing mechanisms in order to promote equity and value for money (Africa CDC, 2025), (Afriyie, et al., 2025).

2.5 Private Sector and Public–Private Partnerships

The private sector plays a significant role in public–private partnerships and blended finance solutions, particularly in areas such as diagnostics, facility infrastructure, and supply chain management. These approaches can attract additional financial resources and managerial expertise to the health sector. Nonetheless, the effectiveness of such collaborations depends on the presence of robust regulatory and contractual frameworks to safeguard public interests, quality, and equity. Achieving an appropriate balance between public oversight and private involvement is contingent on transparent regulations, reliable performance data, and credible mechanisms for accountability (Africa CDC, 2025)

2.6 Innovative Financing Mechanisms

Figure 3: Reforms related to contributory health insurance schemes in the WHO African Region.



The figure is based on (Afriyie, et al., 2025).

2.6.1 Solidarity Levies and Import Charges

Solidarity levies, such as those imposed on airline tickets and import charges allocated specifically for regional health initiatives, are being utilised to establish predictable revenue streams for public health goods. For instance, the Economic Community of West African States applies a 0.5 % import levy (community levy), which contributes to financing the West African Health Organisation. This pooled financing model may serve as an example for similar initiatives in Southern Africa, particularly for surveillance, preparedness, and joint procurement efforts. Clear earmarking of funds and transparent public reporting are essential to maintain legitimacy and maximise the impact of these mechanisms (Africa CDC, 2025).

2.6.2 Excise Taxes on Alcohol, Tobacco, and Sugar-Sweetened Beverages

Excise taxes on alcohol, tobacco, and sugar-sweetened beverages function both to generate revenue and to discourage harmful consumption patterns. When these taxes are designed equitably, they can contribute to stable health financing and improved health outcomes at the population level.

2.6.3 Diaspora Bonds and Remittances

Diaspora bonds and remittance flow present opportunities as development finance for investment in health infrastructure, laboratory systems, supply chains, and digital health platforms. Countries such as Nigeria and Ethiopia have already issued diaspora bonds, channelling remittances toward priority health projects. Valuable lessons can be learnt from other global south economies on how to transform remittance flows into broad-based growth.

Remittance inflows to Africa have increased from approximately US$53 billion in 2010 to US$95 billion in 2024, an increase in its share of the continent's GDP from 3.6% to 5.1%, making remittances one of Africa's largest and most stable sources of external finance.

This represents a substantial and stable source of underutilised external finance.

Southern African countries are considering similar instruments that could supplement existing budget resources and reduce dependence on external aid, provided that governance is credible and the use of proceeds is transparent and well-communicated (Africa CDC, 2025).

2.6.4 Telecommunications Charges

Some countries are exploring the imposition of charges on telecommunications services to support digital health infrastructure. By earmarking revenue from telecommunications fees, these states can fund the development and maintenance of health information systems and digital tools that enhance access, reporting, and accountability within the health sector.

2.6.5 Performance-Based Financing and Digital Innovation

Performance-based financing and the adoption of digital innovations, such as DHIS2 dashboards and Africa CDC scorecards, can improve transparency and enable timely adjustments to spending. These strategies make funding allocations more results oriented. When strategic purchasing is informed by real-time data and focuses on primary health care and essential medicines, limited resources can be directed toward high-value services that yield measurable improvements in access and quality.

2.7 Efficiency and Sustainability of Financing Sources

Maximising health outcomes for every unit of expenditure relies on the careful and strategic allocation of resources. Effective governance and robust public financial management are critical, especially when combined with transparent monitoring systems and purchasing models that incentivise performance. The routine application of digital tools such as DHIS2 dashboards and Africa CDC scorecards significantly enhances the visibility of spending, enables timely adjustments, and guides decision makers

in channelling funds toward interventions with the highest impact. When performance-based financing and strategic purchasing are grounded in credible budgeting, prompt disbursement, and clear accountability, both coverage and quality of care improve. Additionally, digital solutions and real-time data enable more granular measurement and responsive purchasing, fostering a cycle where transparency encourages trust and sustained domestic investment (Africa CDC, 2025), (Afriyie, et al., 2025).

Sustainability remains a key concern. Fluctuations in Official Development Assistance highlight the urgent need for mobilising domestic resources, yet many nations contend with limited tax bases, slow growth in public spending, and increasing debt service obligations. Expanding fiscal space requires a blend of revenue-raising initiatives and efficiency improvements. The Abuja target serves as a political commitment to prioritise health in national budgets. Broadening tax bases, implementing fair excise taxes on alcohol, tobacco, and sugar-sweetened beverages, introducing solidarity levies designated for public health, and strengthening tax administration can all help stabilise funding. Concurrently, reforms aimed at reducing financial leakage and enhancing procurement, supply chain management, and workforce productivity are necessary to ensure that additional revenues are directed toward expanding coverage and improving outcomes, rather than being lost to inefficiency. Building a credible and sustainable financing system depends on both reliable resource mobilisation and responsible use, which is fundamental to managing external shocks and maintaining progress towards Universal Health Coverage (Apeagyei, et al., 2024), (Africa CDC, 2025).

2.8 How Revenue Strategies Impact Access to Essential Health Services

The way health systems generate and allocate revenue plays a fundamental role in determining who can access essential health services and who cannot. Heavy reliance on out-of-pocket payments at the point of care often acts as a barrier, discouraging early use of primary and preventive services. As a result, households may delay seeking care for common conditions, which can lead to complications that are more costly to manage and may result in avoidable loss of life and productivity. This financial burden is not distributed equally, as lower-income and rural households are particularly vulnerable to catastrophic health expenditures and may forgo care due to cost (Apeagyei, et al., 2024), (Afriyie, et al., 2025).

Conversely, expanding insurance coverage and other risk-pooling mechanisms reduces financial barriers and increases the use of maternal and child health services, while also supporting continuity of care for chronic conditions. Rwanda serves as a notable example, where widespread enrolment in *Mutuelles de Santé* has been associated with significant reductions in infant mortality. Similarly, Ghana has demonstrated that a national health insurance scheme can achieve substantial population coverage and direct resources toward high-value services. These cases suggest that pooling resources and strategic purchasing can improve both access and financial protection, even in contexts with limited fiscal space, provided that subsidies effectively target the poor and that benefits are aligned with national priorities, such as primary health care and access to essential medicines (Africa CDC, 2025), (Afriyie, et al., 2025).

In addition, earmarked revenue measures can support access to essential services when designed and managed appropriately. For example, health taxes not only generate government revenue but also serve public health by reducing harmful consumption. Solidarity levies on airline tickets or import charges that are dedicated to regional public goods, such as disease surveillance and cross-border preparedness, can provide stable funding that is less vulnerable to annual budget fluctuations or external shocks. Diaspora bonds and dedicated funds can also facilitate capital investments in critical infrastructure, such as laboratories, supply chains, and digital systems necessary for reliable service delivery. Across all these approaches, effective public financial management, clear earmarking, and regular public reporting are essential to ensure that resources reach frontline services and produce measurable results (Africa CDC, 2025).

3. Barriers to Effective Health Financing and Revenue Collection

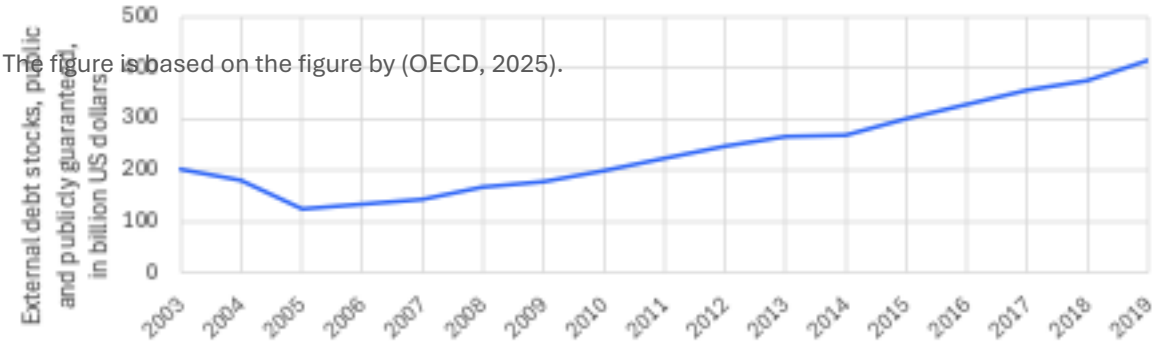
Despite some progress, countries in Southern Africa still encounter numerous obstacles that limit the effectiveness of health financing and revenue collection. These challenges are diverse, including financial limitations, governance issues, infrastructural deficits, and socio-cultural factors.

3.1 Fiscal Constraints

Domestic fiscal limitations further restrict the capacity of governments to finance health. A small tax base, sluggish growth in domestic spending, and substantial debt servicing obligations all reduce the resources available for health care. These fiscal pressures are often intensified by competing demands from other sectors, which can result in health being deprioritised in national budgets (Africa CDC, 2025), (Apeagyei, et al., 2024).

Research by Eric Toussaint and Milan Rivié indicates that the total external debt of developing countries more than tripled in constant values between 2000 and 2019, with a significant acceleration after 2008 coinciding with increased private capital inflows and a rise in debt held by private creditors. By 2021, factors such as falling commodity prices, currency devaluation, and decreased reserves contributed to an unsustainable debt burden for many developing countries.

Figure 5: Evolution of the total Debt Stock



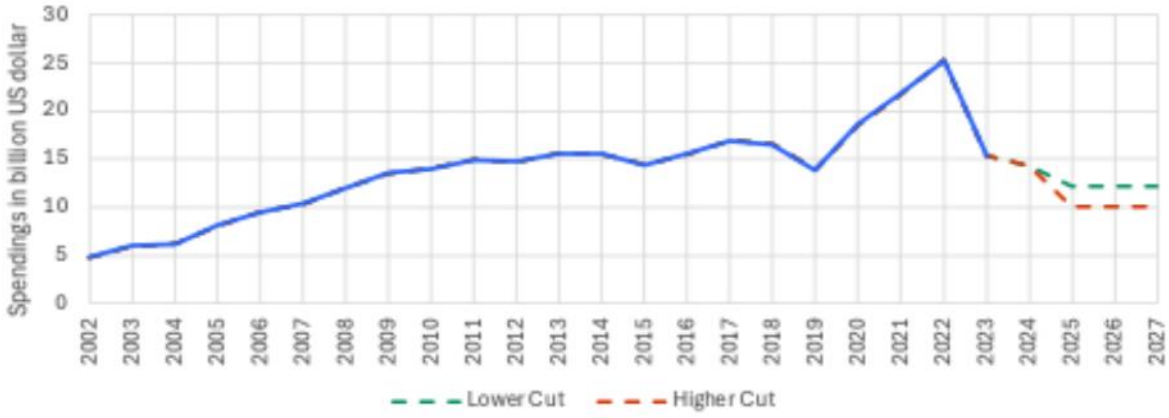
The figure is based on the figure by (OECD, 2025).

The figure is based on the figure by (Toussaint & Rivié, 2021).

3.2 Donor Dependency and Volatility

Many countries in this region remain heavily reliant on external aid to sustain essential health programs such as HIV prevention, immunisation, and maternal and child health initiatives. The main issue is that

Figure 4: Projections of Official Development Assistance



international funding is often unpredictable. Recent declines in Official Development Assistance have made this volatility even more pronounced, leaving health systems vulnerable and making long-term planning increasingly difficult (Africa CDC, 2025), (Apeagyei, et al., 2024)

3.3 Governance Challenges

Weaknesses in governance and public financial significantly hinder effective health financing. Persistent issues such as corruption, financial leakages, and poor strategic planning remain widespread. Approximately two-thirds of countries in the region do not have comprehensive National Health Development Plans or National Health Financing Plans, both of which are crucial for coordinated and accountable resource allocation. The lack of system interoperability and limited mechanisms to ensure accountability and transparency make these problems even more pronounced. Addressing these weaknesses will require substantial reforms in public financial management (Africa CDC, 2025)

3.4 Infrastructural Barriers

Infrastructural limitations pose another set of barriers. Deficits in digitalisation and supply chain management are particularly problematic. Less than 30% of health systems in the region are fully digitised, which restricts the effectiveness of disease surveillance, monitoring, and early warning systems. In addition, fragile supply chains and persistent shortages of healthcare workers continue to undermine the ability of health systems to consistently deliver essential services (Africa CDC, 2025) (WHO Atlas, 2023).

3.5 Mixed Mechanisms and the Need for Harmonisation

The current landscape of health financing mechanisms is highly fragmented, with multiple models such as public-private partnerships, donor funding, and performance-based financing operating simultaneously. This fragmentation leads to inefficiencies and makes it difficult to realise the full benefits of diverse funding sources. Harmonised frameworks for governance and coordination are necessary to optimise resource use and support progress toward Universal Health Coverage (Afriyie, et al., 2025), (Africa CDC, 2025).

3.6 Socio-Cultural Factors

Socio-cultural factors also play a substantial role in shaping health financing outcomes. Political resistance to new levies, widespread mistrust of authorities, low levels of public awareness, and opposition to insurance products all impede the adoption of innovative financing mechanisms (Africa CDC, 2025). Building public trust and strengthening political will are essential for supporting the reforms required to advance health system financing.

In conclusion, overcoming these challenges will require a comprehensive and multi-faceted approach. Key steps include strengthening domestic resource mobilisation, improving governance and transparency, investing in both digital and physical infrastructure, and engaging communities throughout the reform process. Such efforts are critical for creating more resilient and sustainable health financing systems in Southern Africa.

4. Case Studies

Several Southern African countries have responded to ongoing challenges in health financing by adopting a range of innovative strategies to diversify funding streams, increase efficiency, and broaden access to essential health services (citation). These approaches include health insurance schemes, solidarity levies, diaspora bonds, performance-based financing, digital tools, and public-private partnerships. Each of these mechanisms has generated valuable insights that can inform wider adoption, provided they are supported by strong public financial management and transparent governance.

4.1 Ghana

Ghana's experience with health financing reforms offers a nuanced picture of progress and ongoing challenges in the pursuit of Universal Health Coverage (UHC). The National Health Insurance Scheme (NHIS), launched in 2003, has been the cornerstone of the country's strategy to reduce financial barriers and broaden access to essential health services. It is financed through a blend of value-added tax (VAT) levies, payroll taxes, direct government funding, and member premiums, with targeted exemptions for vulnerable groups (Saleh, 2013), (Achiaw, et al., 2025).

While initial data suggested that over 50% of the population registered for NHIS, household surveys indicate that effective coverage is lower, particularly among rural and low-income communities (Saleh, 2013). Private health insurance schemes (PHISs) have emerged as a supplement to the NHIS, offering customised benefits and flexible payment options, but their reach is mostly confined to urban and higher-income groups (Asante, et al., 2025).

The scheme has contributed to improved financial protection by reducing out-of-pocket (OOP) payments as a proportion of total health spending. Nevertheless, OOP expenses remain above recommended levels, and affordability issues persist for services not covered by NHIS (Saleh, 2013), (Asante, et al., 2025). The NHIS has been linked to increased use of maternal and child health services and better detection of noncommunicable diseases, yet there are still significant difficulties in managing chronic illnesses (Achiaw, et al., 2025).

Despite expanded access, quality of care varies. There are persistent shortages of skilled health workers, especially in rural regions, and disparities in the distribution of facilities and equipment (Saleh, 2013). PHISs may provide faster claims processing and more tailored benefits, but their limited coverage can worsen inequities (Asante, et al., 2025). The PHIS sector operates under the regulatory framework of the National Health Insurance Authority (NHIA) and has grown due to demand for higher-quality care, shorter wait times, and coverage for services the NHIS does not include. However, PHISs also face obstacles related to regulation, premium collection, and equitable access. Their expansion has been influenced by health concerns during the COVID-19 pandemic and by new investments and partnerships (Asante, et al., 2025).

Operational and sustainability challenges continue to hinder progress. The NHIS is under financial strain, with expenditures exceeding revenues and actuarial studies warning of potential insolvency (Dzupire, et al., 2024). Claims processing is often delayed by manual procedures and weak integration of information systems. Adverse selection, low renewal rates, and challenges in identifying and enrolling the poorest populations further limit the scheme's ability to pool risk and promote equity (Dzupire, et al., 2024), (Saleh, 2013).

Ghana's financing reforms include progressive policy tools such as VAT and payroll taxes, targeted exemptions, and public–private partnerships to extend services into underserved areas (Saleh, 2013). More recent strategies focus on better targeting, stronger administrative capacity, and improved risk management to sustain the system and support equity (Dzupire, et al., 2024), (Asante, et al., 2025). The Ghanaian experience highlights the need for sustained political and fiscal commitment, strong governance, and continual adjustment of provider payment systems and benefit packages.

Recent studies emphasise the importance of risk management for ensuring the long-term sustainability of health insurance schemes. In Ghana, most NHIS members rely exclusively on the scheme for their health coverage, leaving them highly vulnerable if the scheme were to fail (Dzupire, et al., 2024). Inadequate funding, shortages of medical staff and infrastructure, and persistently high OOP payments even among the insured pose significant risks. Research shows that 62% of NHIS members would be seriously affected by a collapse of the scheme, with limited alternative options available (Dzupire, et al., 2024).

In summary, Ghana shows that well-designed health financing reforms can expand coverage and improve financial protection, but ongoing challenges related to equity, sustainability, and operational efficiency demand continued attention. Lessons from Ghana underscore the critical role of strategic

pooling, innovative financing, and robust public financial management as foundations for resilient health systems in the region (Asante, et al., 2025), (Saleh, 2013), (Achiaw, et al., 2025), (Dzupire, et al., 2024).

4.2 South Africa

South Africa, just like Ghana also has a "dual health care system". The tax-funded public sector is serving approximately 80–84% of the population and a private sector, financed largely through insurance, catering to the remaining 16–20%. Despite similar overall expenditures, the private sector absorbs nearly half of total health spending, resulting in big disparities in per capita expenditure and access to care. The public sector, while providing essential services to the majority, is chronically under-resourced and faces persistent challenges related to infrastructure, workforce, and management (Mayosi & Benatar, 2014), (Abbott & Sigamoney, 2024), (Mckenzie, et al., 2023).

The burden of disease in South Africa is shaped by a "quadruple burden": high rates of communicable diseases (notably HIV/AIDS and tuberculosis), a rising prevalence of non-communicable diseases, significant maternal and child mortality, and a high incidence of trauma and violence. These factors, compounded by deep socioeconomic inequalities, drive health costs and strain the capacity of the public sector. The Gini coefficient remains among the highest globally, and poverty is particularly acute in rural areas, where access to health services is further constrained (Mayosi & Benatar, 2014), (Mckenzie, et al., 2023).

Efforts to address these challenges have included the introduction of the National Health Insurance (NHI), a major reform aimed at pooling resources and providing universal health coverage (UHC) through a single, centrally managed fund.

Implementing UHC via NHI in South Africa faces significant economic challenges**.** Chief among them is the question of financial feasibility and fiscal space. While the NHI promises to extend comprehensive services to the entire population, the cost of doing so is substantial. Estimates of the NHI's price tag vary, but all suggest that a large increase in health spending will be required. (Kenneth Jacobs, AHPA, https://www.africanhealthpolicyalliance.com/)

Such an expansion of health financing by hundreds of billions of rand poses a huge fiscal challenge, especially in a context of modest economic growth and heavy existing budget pressures. (Kenneth Jacobs, AHPA)

The NHI is being implemented in a phased manner with full implementation targeted for 2030. Its success will depend on overcoming significant barriers, including the legal challenges to the NHI Act, inadequate workforce, freezing of posts in the health sector, austerity measures, improvement and modernisation of health facilities. Further challenges include modernisation of digital infrastructure, integration of health information systems, and the development of robust governance and accountability mechanisms (Abbott & Sigamoney, 2024), (Mckenzie, et al., 2023).

The COVID-19 pandemic exposed and exacerbated existing weaknesses in the health system but also accelerated innovation. The government's response was marked by centralised coordination, rapid mobilisation of resources, and the deployment of community health workers for testing, tracing, and medication delivery. However, the pandemic led to a decline in the utilisation of routine services, particularly immunisations and chronic disease management, and widened existing inequalities. Notably, the crisis prompted improvements in health information systems and fostered greater collaboration between the public and private sectors (Mckenzie, et al., 2023).

South Africa's debt-to-GDP is around 75–76% (*African Union, 2025*) (76,1% in September 2024 according to CEICC Data and is projected to stabilise at 76, 2% of GDP in the fiscal year 2025/26), and the government's ability to raise taxes is constrained by an already small tax base (only a few million individual taxpayers in a population of 60+ million). The International Monetary Fund has cautioned that any new large expenditure like NHI must be matched by new revenue sources or spending cuts elsewhere to avoid unsustainable deficits (*IMF, 2024*). In practical terms, to finance NHI, government would likely need to increase taxes significantly. The NHI Act anticipates new taxes (VAT, income tax surcharge and payroll tax),

Economic experts also point out the opportunity cost: committing a very large share of national resources to health means less fiscal room for other priorities (education, housing, etc.), so NHI must demonstrate value for money. In summary, the financing of NHI is a delicate balancing act that demands raising substantial new revenues in a sluggish economy and ensuring those funds are efficiently and transparently spent. Careful phasing of benefits, cost containment strategies (like price negotiations and gatekeeping referrals), and perhaps a realistic benefit package (starting with primary and essential services) will be necessary to align aspirations with economic reality. (Kenneth Jacobs, AHPA)

Persistent challenges remain. The public sector continues to grapple with shortages of skilled health professionals, outdated infrastructure, fragmented data systems, and inefficiencies in procurement and supply chain management. The migration of health workers to the private sector and abroad further undermines capacity. While the private sector is technologically advanced and profitable, its reach is limited to higher-income groups, and integration with public health objectives is still insufficient (Mayosi & Benatar, 2014), (Abbott & Sigamoney, 2024).

Looking ahead, the realisation of universal health coverage in South Africa will require sustained investment in digital transformation, human resources, and governance reforms. Strengthening public-private partnerships, enhancing data interoperability, and ensuring equitable resource allocation are essential to bridging the divide between sectors and improving health outcomes for all South Africans (Mayosi & Benatar, 2014), (Abbott & Sigamoney, 2024), (Mckenzie, et al., 2023).

4.3 South Sudan

South Sudan's health system remains one of the most fragile and under-resourced globally, shaped by decades of conflict, chronic underfunding, and a heavy reliance on international donors. Despite the government's commitment to universal health coverage, only about 2% of the national budget is allocated to health (HPF, 2020), (Atem & Anguei, 2022). As a result, non-governmental and faith-based organisations provide over 80% of health services, and most health facilities are supported by external partners (Atem & Anguei, 2022), (Malel, et al., 2024).

Access to health care is severely limited: only 44% of the population lives within 5 km of a health facility, and physical barriers such as poor road infrastructure, seasonal flooding, and insecurity further restrict access, especially for rural and marginalised groups (HPF, 2020), (Atem & Anguei, 2022). The country faces some of the world's worst health indicators, with a maternal mortality ratio of 1,150 per 100,000 live births and an under-five mortality rate of 99 per 1,000 live births. One in ten children dies before their fifth birthday, and preventable diseases such as malaria, pneumonia, and diarrhoea account for most child deaths (Atem & Anguei, 2022), (UNICEF, 2023), (UNICEF, 2021).

The health system is further strained by a critical shortage of trained health workers. There are only about 1.5 doctors and 2 nurses per 100,000 population, far below WHO recommendations (230 per 100,000 people). Frequent stock-outs of essential medicines, inadequate infrastructure, and limited diagnostic capacity are pervasive challenges (HPF, 2020), (Atem & Anguei, 2022).

To address these gaps, the government launched the Boma Health Initiative (BHI) in 2017, aiming to strengthen community-based health services and improve access in hard-to-reach areas. Boma Health Workers (BHWs), selected from within their communities, are trained to deliver a package of preventive, promotive, and selected curative services, including health education, malaria treatment, immunisation mobilisation, and referral for maternal and child health services (HPF, 2020), (Atem & Anguei, 2022). The BHI has been effective in expanding access to basic health services, particularly for women and children, and has contributed to improved immunisation coverage and reductions in out-of-pocket expenditures for rural households (Atem & Anguei, 2022).

Despite these achievements, the BHI faces significant challenges. The number of BHWs remains insufficient relative to the population and geographic coverage required, and many BHWs report low or delayed incentives, leading to high attrition rates. Stock-outs of medicines and supplies are frequent, and BHWs often lack adequate training and supervision. Gender disparities persist, with women underrepresented among BHWs due to lower educational attainment and cultural barriers (Atem & Anguei, 2022).

Community health workers are widely recognized as a critical link between health facilities and remote communities, providing health education, basic treatment, and referrals. However, their effectiveness is hampered by logistical challenges, limited resources, and the need for better integration with other community-based health programs (HPF, 2020), (Atem & Anguei, 2022).

Patient satisfaction with health services is generally high in donor-supported facilities, with studies reporting satisfaction rates above 80%. Key factors associated with positive experiences include respectful provider attitudes, technical competence, adequate consultation time, and the availability of medicines (Malel, et al., 2024). However, long waiting times, lack of privacy, and informal fees remain concerns, particularly in facilities not supported by NGOs (HPF, 2020), (Malel, et al., 2024).

The COVID-19 pandemic and ongoing humanitarian crises, including mass displacement, flooding, and food insecurity, have further strained the health system, increasing the risk of malnutrition, disease outbreaks, and preventable deaths among children (UNICEF, 2023), (UNICEF, 2021).

Looking ahead, South Sudan's path toward universal health coverage will require sustained investment in health infrastructure, workforce development, and supply chain management, as well as strengthened government leadership and coordination among partners. Expanding the BHI, improving incentives and training for community health workers, and addressing gender and equity gaps are essential for building a more resilient and inclusive health system (HPF, 2020), (Atem & Anguei, 2022).

5. Policy Recommendations

Strengthening health financing and service delivery in Southern Africa requires a coherent package that links domestic resource mobilisation, effective pooling and purchasing, robust public financial management, and people-centered primary health care. The recommendations below synthesise regional evidence and generalisable elements from community health reforms.

5.1 Institutionalise Abuja Commitments

Legislate a minimum allocation of 15 % of national budgets to health and anchor this in costed, time-bound National Health Development Plans and National Health Financing Plans with annual public reviews. Link budget execution to measurable outputs and outcomes (Africa CDC, 2025), (Afriyie, et al., 2025), (WHO Atlas, 2023).

5.2 Expand risk pooling and strengthen strategic purchasing

Scale contributory and tax-financed schemes with subsidies for the poor, reduce fragmentation by consolidating pools, and adopt provider payment mechanisms that reward access, quality, and efficiency. Align benefits to primary health care and essential medicines. Evidence from Rwanda and Ghana indicates gains are possible under fiscal constraints. (Africa CDC, 2025), (Afriyie, et al., 2025).

5.3 Mobilise domestic revenue with health taxes and solidarity levies

Broaden tax bases, strengthen tax administration, and implement equitable excise taxes on alcohol, tobacco, and sugar-sweetened beverages. Consider solidarity levies on airline tickets or imports for regional public goods such as surveillance and cross-border preparedness. Publish reports that link revenues to results (Africa CDC, 2025), (Apeagyei, et al., 2024).

5.4 Apply innovative financing under strong governance

Establish legal and operational frameworks for diaspora bonds and dedicated funds to channel remittances into laboratories, supply chains, and digital platforms. Use blended finance and public-private partnerships for targeted functions with transparent contracts and equity safeguards (Africa CDC, 2025).

5.5 Strengthen public financial management and transparency

Integrate financial and service data, ensure timely disbursements to facilities, and institutionalise routine health management systems and performance dashboards such as HMS2, DHIS2,and scorecards. Enforce anti-corruption measures and citizen oversight to reduce leakage and improve value for money, (Africa CDC, 2025), (WHO UHC, 2024), (WHO Atlas, 2023).

5.6 Institutionalise community health platforms within primary health care

Formalise and fund community health worker systems as extensions of facilities. Standardise training, supervision, and incentives, adapt materials to local languages and literacy levels, and finance stable remuneration through government budgets to expand coverage in hard-to-reach areas (Africa CDC, 2025), (HPF, 2020), (Atem & Anguei, 2022).

5.7 Close human resources and gender gaps

Recruit and retain female and underrepresented cadres, invest in literacy and skills for community and facility workers, and apply gender-transformative approaches to improve trust, maternal and child health uptake, and continuity of care (WHO UHC, 2024), (Atem & Anguei, 2022).

5.8 Modernise supply chains and last-mile logistics

Adopt demand-driven quantification, routine stock monitoring, and basic digital reporting where feasible. Build capacity for procurement, warehousing, and distribution at all levels and use pooled procurement to lower prices and reduce stockouts (HPF, 2020), (Atem & Anguei, 2022).

5.9 Invest in digital infrastructure, data use, and accountability

Prioritise interoperable health information systems for surveillance, claims, and purchasing. Expand connectivity and hardware for facilities and community platforms and institutionalise community feedback mechanisms for responsive, data-driven decisions (Afriyie, et al., 2025), (WHO Atlas, 2023), (Atem & Anguei, 2022).

5.10 Coordinate actors and safeguard essential programmes during funding transitions

Align government, partners, private providers, and community structures under a unified results framework and clear division of roles. Develop transition plans that protect last-mile delivery for HIV, immunisation, maternal and child health, and preparedness, with explicit metrics and timelines for domestic co-financing (Africa CDC, 2025), (WHO UHC, 2024), (Apeagyei, et al., 2024).

Collectively, these measures position health as an investment that advances productivity, inclusive growth, and social resilience while creating a financing architecture that is predictable, equitable, and shock responsive.

6. Conclusion and Future Directions

Southern African countries are navigating a period of fiscal tightening, external assistance volatility, and persistent structural constraints that together threaten recent gains in health outcomes. The evidence presented in this report shows that these pressures are neither uniform nor insurmountable. Countries that have prioritised predictable public financing, expanded risk pooling, strengthened purchasing, and modernised public financial management have protected essential services and improved financial protection, even where overall resources have been limited. The experience of Ghana and South Africa illustrates that measurable advances are possible when reforms are sequenced, data-informed, and anchored in primary health care.

The central conclusion is that health must be treated as a productive investment that supports growth, resilience, and social stability. This requires a financing architecture that is both adequate and reliable, with clear rules for allocation and strong accountability for results. Expanding fiscal space through fair health taxes, solidarity levies, and credible innovative instruments is necessary but not sufficient. These revenues must be pooled to promote equity, channelled through strategic purchasing that rewards access and quality, and managed within transparent systems that link funds to outputs and outcomes. In parallel, efficiency gains must be realised through better procurement, supply chain performance, and workforce productivity, supported by routine use of digital tools and interoperable information systems.

Future progress depends on disciplined implementation and coordination. Governments should institutionalise Abuja commitments within costed national plans, consolidate fragmented pools, and safeguard last-mile delivery for programmes that remain vulnerable to external funding shifts. Regional bodies can accelerate resilience by expanding pooled procurement, advancing regulatory harmonisation, and supporting joint investments in surveillance, preparedness, and local manufacturing of essential health products. Public-private collaboration should be used selectively for defined functions under contracts that protect equity and quality.

A focused learning and accountability agenda is also needed. Countries should adopt standardised indicators that connect revenue, pooling, and purchasing decisions to service coverage, financial protection, and quality. Annual public expenditure reviews and performance dashboards can make deviations visible and enable midcourse corrections. Priority research should assess the distributional

effects of health taxes, the performance of provider payment reforms, and the conditions under which diaspora instruments and blended finance deliver value for money. These efforts will strengthen legitimacy, guide resource allocation, and build public trust.

In sum, the region faces real constraints but also has a clear pathway to durable gains. By mobilising predictable domestic resources, pooling risks more effectively, purchasing strategically, and governing transparently, Southern African countries can stabilise service coverage, protect vulnerable populations, and advance toward universal health coverage. The reforms outlined in this report are feasible within current fiscal realities when anchored in primary health care, supported by digital and supply chain upgrades, and monitored through consistent, publicly reported metrics. With sustained political commitment and coherent execution, health systems can become more equitable, resilient, and growth-enhancing over the next decade.

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