A turn for the worse: The impact of deteriorating healthcare spending in South Africa

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The November 2023/2024 national health budget cuts represent the largest reduction in public health expenditure in South Africa's post-apartheid history. This article critically examines the implications of these budget cuts within the context of the country's post-apartheid health system reforms and macroeconomic strategies. Specifically, it documents the historical evolution of fiscal policies and health expenditure across three distinct periods: the 2008 - 2013 period, which witnessed a counter-cyclical fiscal strategy that improved healthcare access and began addressing apartheid-era disparities; the years 2013 - 2023, marked by economic and political instability, culminating in a national debt crisis exacerbated by COVID-19, which eroded health system resilience under fiscal consolidation policies; and the post-November 2023/2024 period, which represents a distinct threat to two decades of progress in health equity and outcomes under further fiscal consolidation measures. The article discusses the impact of these austerity measures on healthcare workers and patient populations and the implementation of the National Health Insurance, while exploring the ethical and legal implications. It concludes by proposing recommendations for system-wide reforms to mitigate the negative effects of these budget cuts and prevent systemic collapse.

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The November 2023 budget cuts, announced by South Africa (SA)'s National Treasury, marked an unprecedented reduction in health expenditure, representing a defining moment in the country's health policy.[1] The budget saw a ZAR4.4 billion reduction in National Department of Health (NDoH) spending, from ZAR64.5 billion in 2022/2023 to ZAR60.1 billion in 2023/2024, representing an expenditure decline of just >7% in a single year.[2] The public sector, which serves 84% of the population through general tax revenue, with budget allocations determined by the NDoH, bears the brunt of these cuts.[3] By contrast, privately funded healthcare – serving only 16% of the population – remains largely insulated, financed through private medical schemes and out-of-pocket payments.[3] These cuts result from a multitude of factors: SA's persistent economic vulnerability as the country faces slow economic growth; high debt services and declining tax revenues; an unfunded wage bill increase negotiated in 2022/2023, which placed financial pressure on all government departments; the tapering off of COVID-19 emergency fund allocations, including cuts to vaccine programmes and COVID-19 conditional grants to provinces; and persistent inefficiencies, including underspending, irregular expenditure and poor procurement oversight.[4] Further projections indicate that over the next 5 years, inflation will continue to exceed health budget allocations, threatening to deepen losses in a system already facing a ZAR11 billion funding gap.[2] These cuts strike at a time when the health system is already fragile, risking the progress achieved in expanding health equity over the past two decades and potentially destabilising future reforms. This article aims to contextualise SA's long-term health spending trends within its history of persistent economic and social constraints across three distinct periods. It highlights how the 2023/2024 budget cuts represent a turning point for health equity and service delivery. By examining the cascading effects of recent austerity on patients, healthcare workers and National Health Insurance (NHI) implementation, this article seeks to inform a critical health policy debate. It offers evidence-based caution on the enduring consequences of underinvestment, advocating for system-wide reform to safeguard public health gains and prevent further erosion of SA's constitutional right to healthcare. The article draws on primary government documents, including national budget statements, policies and parliamentary speeches, as well as publicly available epidemiological and budget data and secondary academic literature.

Healthcare reform successes and counter-cyclical fiscal policy

SA's early democratic years witnessed significant healthcare reforms aimed at addressing the inequality, discrimination and underdevelopment entrenched by apartheid. Healthcare reform successes in this period can be attributed to multiple factors, including legislative reforms, the implementation of key health programmes in the early 2000s and the 2008 counter-cyclical fiscal stance, which enabled increased healthcare spending.[5] Legislatively, progressive healthcare reforms were evident in the implementation of section 27 of the Constitution[6] in 1996, which enshrined the universal right to access to healthcare services. Various white papers introduced in 1997 cemented these intentions, decentralised health management and allowed for greater investment in the healthcare system.[5,7] Furthermore, the implementation of targeted health programmes in the early 2000s played an influential role in reducing previously rising infant and maternal mortality rates.[8] Most prominently, this included the antiretroviral therapy (ART) roll-outs for HIV

and AIDS, starting in 2004 – the largest programme at the time to target the high burden of HIV infection and its associated morbidity and mortality.[9] International donor support, such as the US President's Emergency Plan for AIDS Relief (PEPFAR), and healthcare worker expansion through the occupation-specific dispensation, improved salaries and retention, enhancing service delivery.[10] Finally, the counter-cyclical fiscal stance adopted following the 2008 recession not only promoted economic stability, but also doubled the real value of health spending between 2002 and 2012, supporting significant health reform gains.[11] Over 1 500 projects were introduced to build new healthcare facilities, increase recruitment of healthcare personnel, drive primary healthcare service delivery through the district health system, increase salaries and implement legislative reforms, which nullified fees for children aged <6 years, disabled people and pregnant women.[5] Ultimately, the culmination of legislative reforms, fiscal policies and targeted healthcare programmes in the two decades following democracy produced significant healthcare reforms, evident in improved key health indicators: the infant mortality rate dropped by 33% between 2004 and 2012, the maternal mortality ratio dropped by 25% over the same period,[12,13] life expectancy increased by 25 years, under-five mortality rates decreased by 48% and mother-to-child HIV transmission fell from 10.9% in 2009 to 1.5% in 2015.[11]

Fiscal consolidation and the debt crisis

The period from 2012/2013 to 2023 illustrates how the confluence of fiscal consolidation policies, implemented in response to rising debt and stagnant growth, served to threaten previous health gains. While there was some contraction in real health spending between 2000 and 2004, the country entered a period of sustained increases in real health spending from 2007 to 2020, largely driven by targeted investments in HIV, tuberculosis (TB) and maternal and child health.[14] However, following the fiscal expansion necessitated by the COVID-19 pandemic, SA entered a period of marked austerity, during which real health spending declined by 13% from 2020 to 2023.[14] Public health outcomes, previously buoyed by investments in HIV and TB programmes, began suffering setbacks, as evidenced by fluctuating maternal mortality rates and a lower rate of decline in infant mortality rates over the 2013 - 2023 period.[14,15]

SA's debt crisis is particularly severe compared with its regional peers.[15] The country's debt-to-gross domestic product (GDP) ratio averaged 54% over the decade leading up to 2022, nearly 10% higher than the average of neighbouring sub-Saharan African countries and higher than that of many other middle-income countries.[15] This ratio reached 73% by 2022/2023.[15] At a macroeconomic level, such high debt levels can have severe, long-lasting consequences. When the debt-to-GDP ratio exceeds 64%, each additional percentage point reduces real annual growth by 0.02%.[16] For SA, this translates to ~ZAR11.4 billion in lost income – equivalent to just <20% of the 2023/2024 NDoH health budget.[2] Consequently, fiscal austerity measures during this period, compounded by economic stagnation, rising debt levels and epidemiological pressures such as COVID-19, simultaneously weakened previous health outcome gains, raising urgent questions about the sustainability and equity of current health financing strategies.

A brief cross-country comparison

Evidence from other low- and middle-income countries (LMICs) in the African context demonstrates similar findings to those observed in SA regarding health spending and significant improvements in health outcomes.[17] For example, following a significant rise in per capita health expenditure over the past two decades, Rwanda achieved notable reductions in under-five mortality and expanded service coverage.[18,19] Similarly, a World Health Organization review of African health financing found that targeted health spending on primary healthcare services lowered maternal and child mortality and improved access to care.[20] However, increased spending alone is insufficient without effective public financial management. Tanzania's health spending trends in the early 2000s illustrate this point: despite significant increases in health spending, health outcomes improved only modestly owing to inefficiencies and poor financial management.[21] By contrast, Rwanda's concurrent health spending and health reforms enabled superior health indicator outputs despite lower absolute spending. This reinforces the idea that reforms improve budget execution, procurement and accountability, thereby enhancing outcomes even under budget constraints.[22] These comparisons highlight that while increased health spending is important, it is not sufficient on its own. For SA, the lesson is clear: the effective use of available funds is just as critical as the quantum of spend.

Impact on healthcare workers

The health budget cuts pose severe consequences for the healthcare workforce, with long-term effects that undermine both healthcare reforms and economic growth. Core challenges include mismatches in the supply of and demand for healthcare workers, high unemployment levels and deteriorating work environments. The discrepancy between qualified professionals and available posts is further exacerbated by the fivefold increase in the number of interns from 2015 to 2022, despite widespread post-freezing.[23] In 2023, an estimated 63% of the total provincial health budget was allocated to compensation of employees. While this is consistent with spending in other LMICs, the persistent problem remains the shortage of available posts.[24,25] In 2024, >700 newly qualified doctors remained unemployed because 2 000 vacant posts were frozen.[23] Furthermore, despite a further ZAR3.7 billion boost from the National Treasury in an attempt to alleviate pressure on the healthcare system due to the unfunded wage bill, staff shortages, resource constraints and forced shutdowns of essential healthcare services remain imminent.[26] Moreover, the backlog in patient care previously deferred during the COVID-19 pandemic places additional strain on healthcare workers. This has resulted in an overstretched list of healthcare duties, manifesting in delays in HIV and TB treatment and elective surgeries, further burdening the healthcare setting.[27,28] For remaining healthcare staff, the burden is immense, reflected in rising stress levels, worsening mental health and an overwhelming sense of hopelessness.[29] In 2024, >70% of young primary healthcare doctors reported symptoms of burnout.[29] This may ultimately drive professionals from the public sector and country, exacerbating brain drain and threatening economic growth, serving as a long-term threat to both healthcare delivery and economic stability.

Threat to patient populations

In addition to the impact on healthcare workers, budget cuts pose a significant threat to patient populations and overall health outcomes. Financial burdens increase as hospitals restrict essential services, including the after-hours closure of primary healthcare clinics in community settings. This forces patients to pay out-of-pocket for private transport to reach more distant hospital facilities, with estimated costs ranging from ZAR250 to ZAR1 000 per visit.[30] Such 'catastrophic health costs' force patients to sacrifice essential needs, deepening cycles of poverty and poor health outcomes.[30] With budget cuts threatening an already vulnerable primary healthcare system, vacant healthcare worker posts have reduced access to

immunisations, antenatal care and chronic disease management. This, in turn, worsens patient outcomes and places additional pressure on secondary and tertiary healthcare institutions.[29] Surgical backlogs resulting from the COVID-19 pandemic, compounded by ongoing resource constraints, have also had serious consequences for patients.[31] Prolonged delays in receiving specialist care can result in disease progression, increased pain, loss of function and avoidable complications. For many patients, these delays may necessitate more invasive procedures and longer recovery periods, significantly affecting quality of life and increasing the risk of adverse outcomes.[31]

Threat to NHI implementation

Austerity measures may hinder the implementation of the NHI through systemic and infrastructural deterioration. First, failures in patient documentation – essential for the diagnosis-related group (DRG) payment system, under which hospitals receive a fixed payment based on diagnosis regardless of actual treatment costs – pose a significant obstacle to NHI implementation.[32] Designed to promote cost control and transparency, the DRG model depends on accurate documentation. However, studies conducted between 2016 and 2019 found that only 43% of patient records included complete ICD-10 codes, and only 66% had discharge summaries, leading to significant inefficiencies and potential financial losses for hospitals.[32] These challenges are likely to worsen under recent austerity measures, which hinder the establishment of essential digital systems and the facility upgrades required to implement DRG payments effectively.

Second, failure to invest in infrastructure undermines the prerequisites of the NHI. Between 2013 and 2023, fiscal consolidation led to a 6% decline in health infrastructure spending.[11] Consequently, approximately only two-thirds of public health facilities met the minimum standards for adequate staffing and resources in 2021/2022, and many of the most vulnerable hospitals and clinics failed to meet the Office of Health Standards Compliance requirements – a prerequisite for the NHI.[29] Despite National Treasury claims of ongoing infrastructure investment, health spending continues to decline, including a ZAR1.1 billion cut from facility revitalisation grants (2024 - 2027).[33] Collectively, these austerity-driven reductions threaten the development of infrastructure needed for implementation of the NHI, threatening efforts to address healthcare disparities in SA.

Ethical, legal and justice implications

The 2023 budget cuts have threatening ethical, legal and justice implications, potentially violating section 27 of the Constitution and perpetuating the legacy of spatial apartheid, thereby entrenching SA's two-tiered healthcare system.[6] Section 27(2) requires the state to take reasonable measures, within its available resources, to ensure the progressive realisation of the right to access to healthcare services.[8] Moreover, as outlined by General Comment No. 14 of the United Nations Committee on Economic, Social and Cultural Rights and the Limburg Principles, progressive realisation demands immediate steps towards ensuring minimum core healthcare services, and cannot justify prolonged inaction.[34,35] Therefore, austerity measures that continue to disproportionately affect under-resourced rural and township-based communities undermine these standards. The Constitutional Court ruled in Minister of Health and Others v Treatment Action Campaign and Others 2002 (2) SA 721 and Government of the Republic of South Africa and Others v Grootboom and Others 2000 (1) SA 46 that equity and inclusion are essential to the 'reasonableness' of state action, especially where the most vulnerable are concerned.[36] The disproportionate impact of austerity on rural and township-based facilities, where services are already under-resourced, arguably fails this reasonableness test. While fiscal consolidation may be necessary amid the debt crisis, its severe impact on marginalised communities cannot be overlooked. This raises broader health-economic justice questions, which can be further investigated using Rawls' theory of justice[37] and Sen's capability approach.[38] Under the Rawlsian model of justice, inequalities are justified only if they benefit society's least advantaged.[37] Austerity-driven neglect of healthcare service refurbishment in outlying areas, and the failure to address the spatial injustices of apartheid, challenge this theory. Similarly, Sen's capability approach argues that justice should be evaluated according to individuals' capabilities to lead valued lives.[38] The ongoing underfunding of healthcare in marginalised communities strips residents of their capabilities, effectively trapping them in cycles of poverty and poor health. The failure to address enduring structural inequalities bound to healthcare underscores the urgent need for solutions that balance fiscal limits with a commitment to health and economic justice.

Towards tentative policy solutions

Severe budget cuts in SA's healthcare sector demand urgent, targeted reforms to prevent systemic collapse. Key interventions should include fiscal oversight, curbing wasteful spending, tackling corruption and strengthening the primary healthcare workforce. Although filling 2 000 critical healthcare vacancies would cost ZAR2.4 billion, irregular expenditure between 2015 and 2021 exceeded ZAR6 billion annually, illustrating substantial resource misallocation.[39] Fig. 1 demonstrates the significant financial burden imposed by irregular expenditure on SA annually. Additional inefficiencies include ZAR350 million lost to medicolegal claims in Gauteng Province in 2023, ZAR150 million lost through poor procurement practices in 2015 and ZAR304.5 million lost in irregular spending at a hospital in KwaZulu-Natal Province in 2014.[39] Corruption further diverts funds, as evidenced by the ZAR150 million 'Digital Vibes' scandal and an estimated ZAR3 billion in losses at Tembisa Hospital.[40,41] Robust oversight, transparency and accountability are critical to redirect funds towards essential services. Stabilising the primary healthcare workforce in SA offers a dual benefit: enhancing healthcare delivery while addressing broader socioeconomic challenges. Community health workers (CHWs) play a critical role in improving health outcomes by providing education, promoting preventive care and facilitating early disease detection, particularly among vulnerable groups such as mothers, children and those managing chronic diseases. These contributions by CHWs can yield significant health cost savings in the long run. Additionally, expanding CHW programmes creates employment in marginalised communities, reducing poverty, addressing socioeconomic inequities and fostering economic growth through job creation and increased economic activity. Macroeconomic reforms that stimulate GDP growth and reduce debt-to-GDP ratios are also essential, as austerity risks exacerbating healthcare disparities and the legacy of apartheid. To ensure fiscal discipline while maintaining equitable healthcare provision, primary healthcare funding should be prioritised to prevent costly interventions, and investment in health information systems should support data-driven policies. Ultimately, sustainable reform requires a strategic approach that upholds equity, justice and resilience in the public healthcare system.

Conclusion

SA's healthcare system faces a critical juncture, with the 2023 real budget cuts threatening decades of progress. These cuts pose substantial risks to healthcare workers, patient populations and the implementation of the NHI scheme, while also raising ethical-justice questions and perpetuating apartheid-era health inequities.

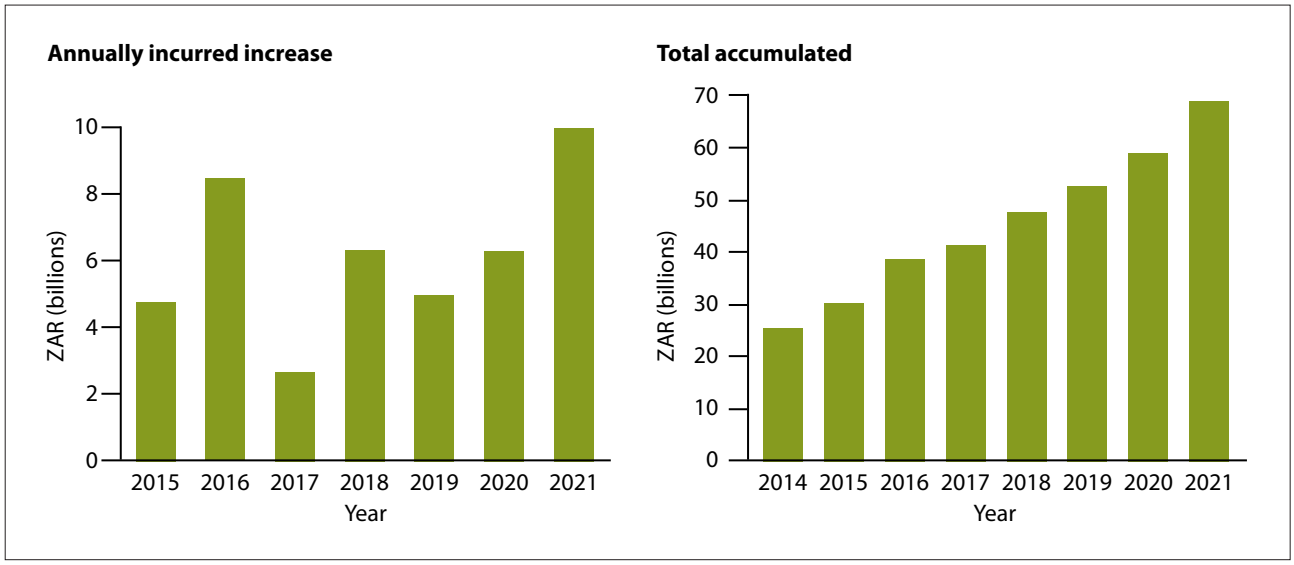

Fig. 1. Irregular expenditure in South Africa: Annualised and accumulated (2014 - 2021).[39]

Addressing these challenges requires balancing fiscal responsibility with maintaining public health services. This can be achieved through enhanced efficiencies, improved financial management, corruption prevention and economic reforms that stimulate growth without compromising social progress. Only through such a multifaceted strategy can the nation preserve past gains, address current challenges and build a more resilient and equitable healthcare system.

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