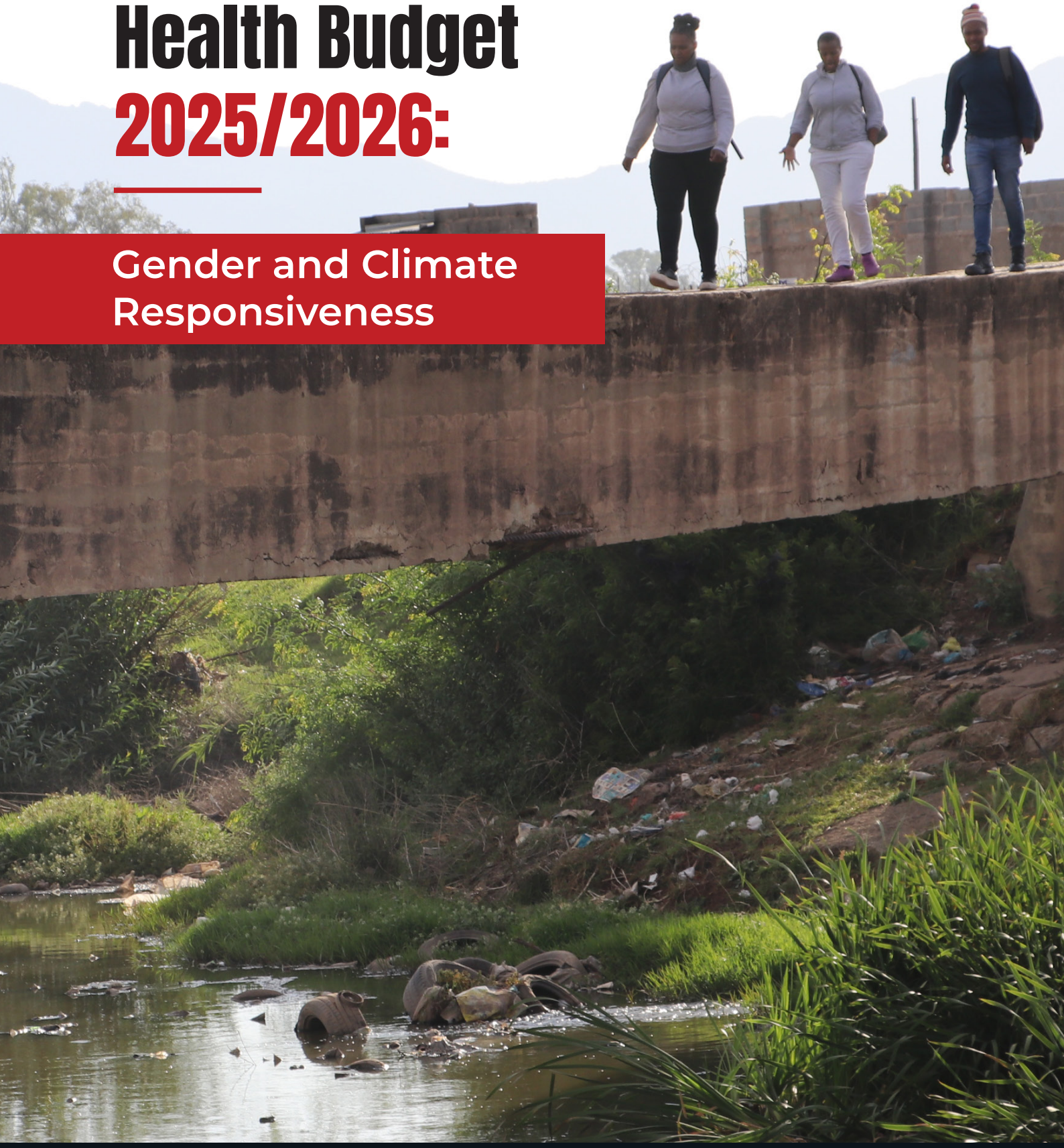
South Africa's Health Budget 2025/2026:

Gender and Climate Responsiveness



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01

Executive Summary



> When the public healthcare system is disinvested, the care still happens.
>
> ***It is just shifted into women's time and labour.***

South Africa's Constitution guarantees the right to access quality healthcare to all. This right was meant to change a system that was built under apartheid to serve a minority, and to build one that works for everyone. The Constitution recognises that this cannot happen overnight and speaks about the progressive realisation of this right. This means the state must take deliberate steps, using its resources, to steadily expand access and improve the quality of care over time. In other words, we should be building, year by year, towards a healthcare system that reaches everyone equitably.

The way that the government allocates public money is a determinant of whether clinics are built in communities, hospitals are adequately staffed and of whether people can access the care they need. It determines whether we are truly moving closer to universal healthcare, or whether the inequalities of the past remain entrenched in people's everyday lives.

For many women in particular, this is where the reality of the health system is felt most sharply. Women are the majority of people who rely on public healthcare (Statistics SA, 2022), and they are also the ones who carry the responsibility of care in their homes and communities (Smout, 2021). Furthermore, poverty in South Africa is gendered, with women, particularly in female-headed households, more likely to experience poverty (Statistics SA, 2021) and to rely on public services (Smout, 2021). When the system is resourced to work for all, it supports everyone including women to live, work, and care with dignity. However, when the public healthcare system is disinvested, the care still happens. It is just shifted into women's time and labour. This is why questions of access to healthcare are also questions of gender, because the failures in the system are carried disproportionately, and most often by women (Smout, 2021). And while certain budget allocations, like maternal health, explicitly target women, this narrow framing of gender fails to address the broader structural conditions that shape women's health and wellbeing.

In this report, we focus on lower-income women not because they are the only ones affected, but because they are at the centre of how health systems and households respond to disinvestment in the system.



Currently, South Africa's health system sits at the intersection of three converging crises: an economy that continues to exclude many people from meaningful work and income; deepening gender inequality; and the accelerating impacts of climate change.

While government has committed to advancing gender-responsive budgeting (Sbusisiwe Sibeko, 2025), current health budget allocations do not yet reflect the scale or urgency of these intersecting challenges. Nor is the Department of Health included in National Treasury's Gender Responsive Budgeting (National Treasury, 2026) pilot.

Furthermore, while the increasing frequency (Godwell Nhamo, 2025) of extreme weather events linked to climate change impact us all; the impact is not gender-neutral. Women, particularly those in low-income and rural communities, experience these most acutely while having the least access to resources to adapt and recover (UN Women, 2024). For women's health in particular, extreme weather events increase illness, disrupt access to care, and place additional pressure (Dumbuya, Chabinga, Ferede & Saber, 2024) on our public health system. This translates into a greater burden of care that, in our gendered society, is most often carried by women.

This is where climate-responsive and gender-responsive budgeting intersect: both recognise that crises are not experienced equally and that public resources must respond to who is most affected. For this reason, this report focuses on women's access to healthcare as a way of strengthening the health system for everyone, including those most marginalised, and in this way ensure that those most exposed to crisis are not left behind. When designed to address the challenges people are facing, budgets can equip the health system to respond to climate-related risks and protect vulnerable women's access to care. However, when constrained, they deepen vulnerability and exclusion in our communities.

This report assesses the gender-responsiveness and climate-responsiveness of South Africa's health budget. It finds that while the public health system is primarily used by low-income households, it is insufficiently responsive to the structural and intersecting realities shaping women's health outcomes.

First, persistent underinvestment in health system infrastructure and service delivery undermines access to quality care, particularly in rural areas. We find that these gaps are not gender neutral. Weak infrastructure, long travel distances and unreliable emergency services disproportionately affect women, especially in relation to maternal health and caregiving responsibilities.

What this means in practice is that inadequate resources invested in public health provision shift the burden of care from the state to households, where it is overwhelmingly absorbed by women.



Second, while certain budget allocations, such as maternal health, explicitly target women, these interventions do not fully respond to the wider social and economic realities that shape women's health and wellbeing. As such, we must demand a gender-responsive budgeting that foregrounds recognising and resourcing the full care economy, including the unpaid labour that sustains households and communities in the face of systemic gaps.

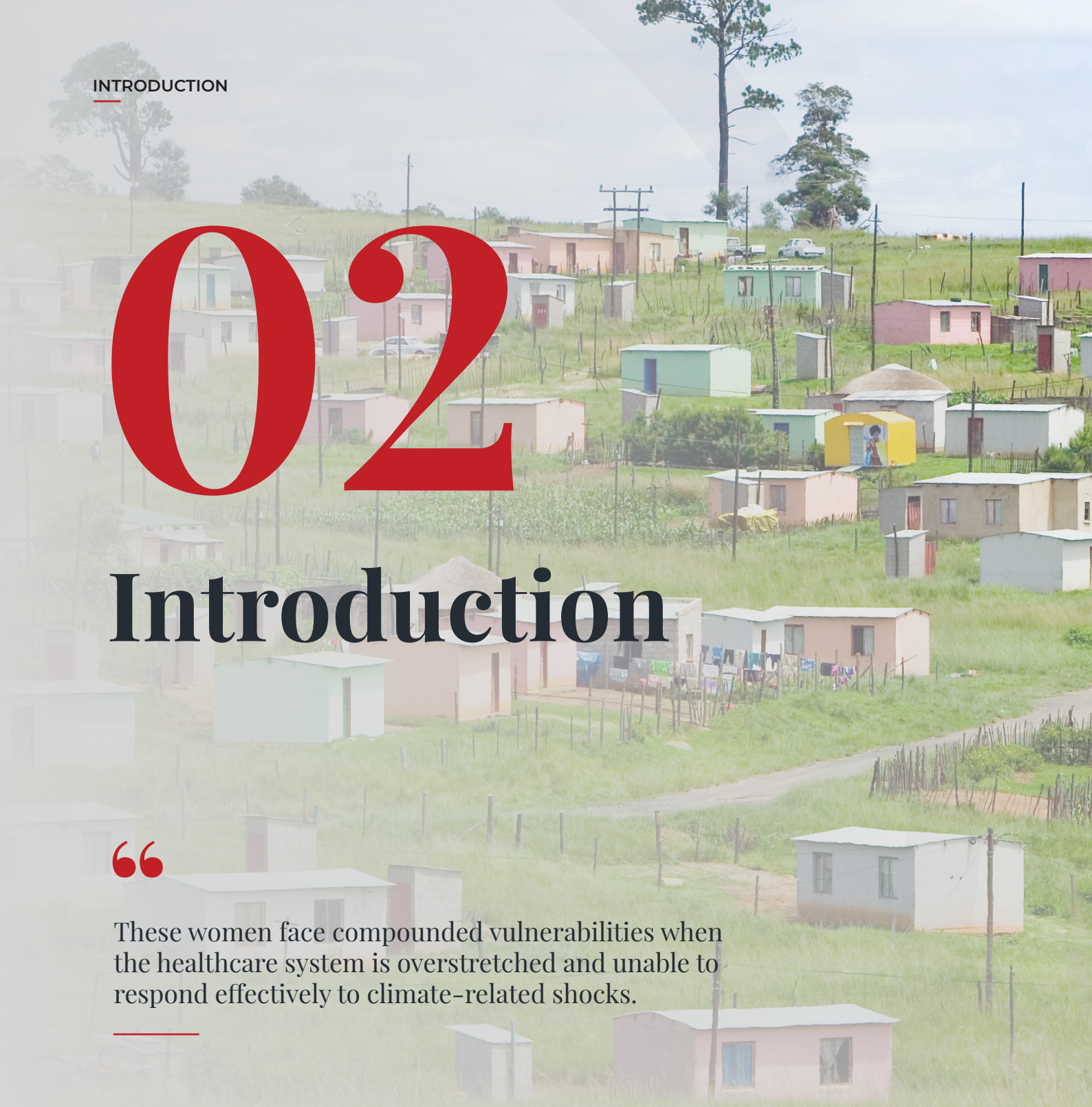
Third, the health budget does not yet meaningfully integrate climate risk into planning and allocation decisions. Despite growing evidence that climate change is already placing a strain on health systems and worsening health outcomes, there is limited evidence of dedicated funding to support climate adaptation in the health sector. This weakens the system's ability to respond to climate-related disasters and disproportionately exposes women to heightened health risks.

Finally, while there are signs of policy commitment to gender-responsive budgeting and climate-responsive budgeting, including public statements and frameworks, these have not yet translated into consistent, adequately resourced budget decisions. In a context of significant fiscal restraint and real-term reductions in health spending, women in South African communities are forced to shoulder the gap between policy intent and budget reality.

Taken together, the findings show that the health budget is not yet adequately aligned with the goal of building a climate-resilient, gender-responsive health system. Thus, we must advocate for meaningful investment in public health infrastructure, workers, and climate preparedness.

Put simply, when the health budget responds to gender and climate realities, it helps people access care, keeps the system working, and ensures that those who are most affected are not left behind. What this report reminds us of is that building a healthy South Africa requires us to invest in the promises we make to our people, and to make budget decisions that speak to the lived realities of women seeking and sustaining care in a time of growing climate pressure.

02 Introduction



> These women face compounded vulnerabilities when the healthcare system is overstretched and unable to respond effectively to climate-related shocks.







South Africa officially adopted gender mainstreaming - the principle that women's realities must be centred in how the state plans, spends, and delivers services - at the Beijing Conference in 1995, alongside United Nations Member States. This framework was established as a way to accelerate gender equality by ensuring that women's rights are reflected in policy, budgeting, and implementation. (UN, 1995). The National Climate Change Response Policy (NCCRP) of 2011 was South Africa's initial framework for its transition to a low-carbon, climate-resilient economy and society (Department of Environmental Affairs, 2011). In recent years, the intersection between gender inequality and climate vulnerability has become increasingly pronounced, particularly within the South African public healthcare sector. Intersectionality, as the grounding framework for this analysis, draws attention to women in marginalised communities, especially those living in rural areas and assuming informal care roles.

These women face compounded vulnerabilities when the healthcare system is overstretched and unable to respond effectively to climate-related shocks. Community Health workers, nurses, and unpaid caregivers are often indispensable players during times of inadequate policy recognition or austere budgetary support, and they often bear the brunt of such system failures. Recognising this, SECTION27 commissioned a comprehensive Gender- and Climate-Responsive Budgeting Analysis of the 2025/26 national health budget to understand how budget decisions respond to women's realities, care needs, and growing climate pressures, and to inform future advocacy.

In this report, we integrate three analytical lenses:

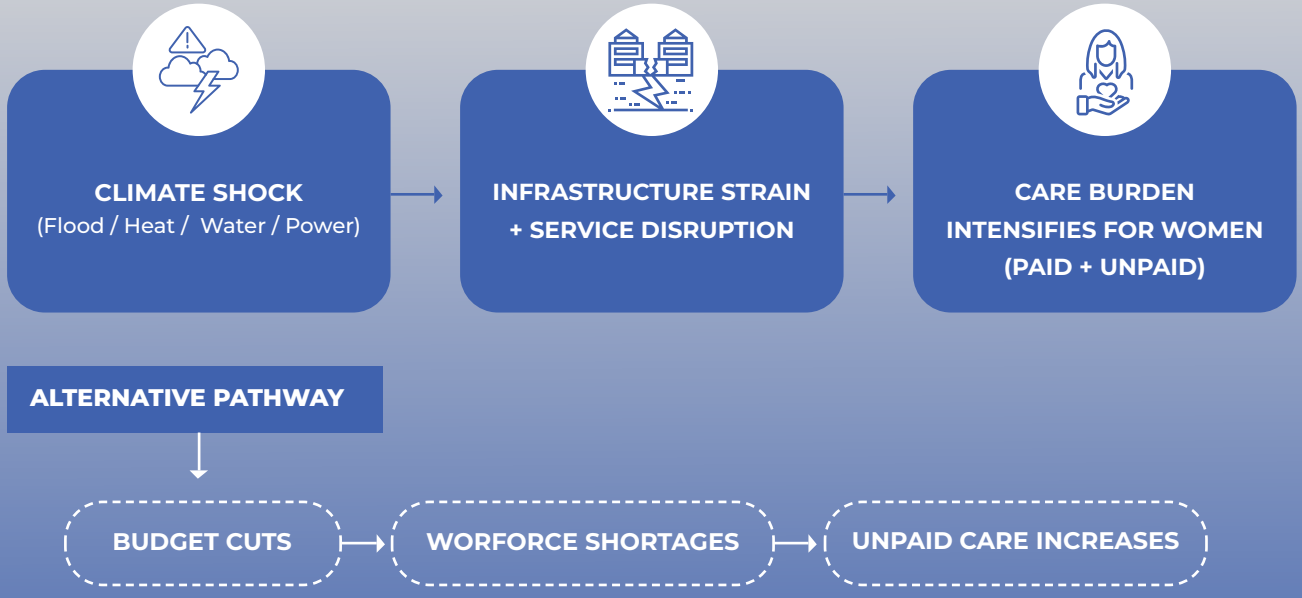
(a) The Social Reproduction Accounting (SRA) lens shows how health budget decisions affect the care economy - the paid and unpaid work that keeps people healthy and supports daily life, including caregiving and domestic work. Choices like hiring health workers or cutting services impact who does the caring, how well it is done, and whether the gap is covered by the women in the lives of those who are sick and in need of care;

(b) An Expenditure and Benefit Incidence Analysis (EIA/BIA) helps us understand who public health spending is reaching in practice, and whether those who need it most are benefiting from it;

(c) We also look closely at recent budget speeches and planning documents to understand the values and priorities shaping health budget decisions. This helps us see who the budget is being designed for, whose realities are missing, and how gender, race, geography, and class influence the stories government tells about spending and care. Together, these methods offer an intersectional feminist macroeconomic interpretation of Vote 18 (the budget for the Department of Health), assessing not only what is spent but who benefits, who carries the cost, and how fiscal policy can be redirected to promote equitable, climate-resilient health systems.

How Gender and Climate Intersect in the Health System

FIGURE 1: Flow Diagram: How Gender and Climate Intersect





Climate-related shocks deepen these pressures by increasing demand for services and intensifying the workload of a

predominantly female health workforce, without sufficient investment in climate resilience.

03

Social Reproduction Accounting Analysis of

Vote 18: Health (South Africa)

3.1 Community Health Workers and Nursing Workforce

KEY FINDINGS:

This section shows that women sustain South Africa's health system through both paid and unpaid care work. Although the budget supports the retention of community health workers (CHWs) and nursing staff, real growth remains too limited to meaningfully expand service coverage or reduce inequalities in access to care. The result is that gaps in the health system continue to be absorbed in households, where women and girls carry the burden of unpaid care. Climate-related shocks deepen these pressures by increasing demand for services and intensifying the workload of a predominantly female health workforce, without sufficient investment in climate resilience.

Paid Care Work Dominated by Women:

The South African paid healthcare workforce is mainly feminised, with 89% of professional nurses being women (South African Nursing Council, 2024), and community health workers are also predominantly women (Malatji et al., 2024).



This aligns with regional statistics indicating that women make up

72%

of the health workforce in Africa

(WHO, 2021).

As a result, allocations such as the district health programmes grant, which is meant to fund an effective response to HIV/AIDS, tuberculosis, and to enable community outreach services, in the Vote 18 directly support women's employment. This grant is projected to achieve nominal growth of 4.8% over the medium term, which will support the retention of community health workers and cover stipend adjustments (National Treasury, 2025).

However, in real terms, assuming an average inflation rate of 4.4% over the 2025/26 to 2027/28 Medium Term Expenditure Framework, based on the Reserve Bank's inflation targeting band and National Treasury projections, this equates to a marginal real growth of just 0.4% (South African Reserve Bank, 2024).

When adjusted for the rising cost of healthcare delivery, which has been estimated to outpace consumer inflation due to increasing patient volumes, chronic disease burdens, and wage-linked input costs, this growth is unlikely to meaningfully expand service coverage or equity.

Per-user health expenditure is projected at approximately

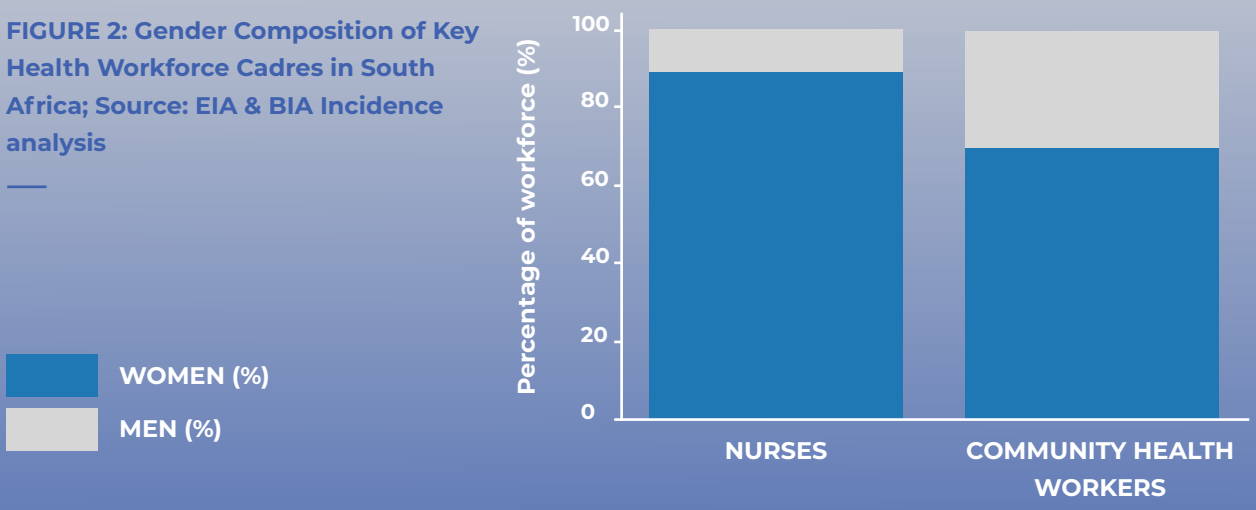
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annually, based on the 2025/26 Vote 18 allocation and an estimated 86% of South Africa's population rely on the public health system (Statistics South Africa, 2023).

While this may appear low, it is a realistic estimate for the national portion of spending, which excludes the majority of frontline delivery costs handled through provincial budgets. Vote 18 largely supports national functions such as programme coordination, infrastructure, CHWs, and disease control, while provinces account for around 86% of total public health spending. Full per-user public health costs are estimated to be significantly higher when national, provincial, and donor contributions are combined, constraining the ability of the public healthcare system to fulfil its constitutional obligation to deliver access to quality healthcare services - at best it maintains the status quo.

Gender Composition of Key Health Workforce Cadres in South Africa

FIGURE 2: Gender Composition of Key Health Workforce Cadres in South Africa; Source: EIA & BIA Incidence analysis



Unpaid Care Spillovers:
Although there are investments toward paid care work, unpaid care work remains widespread and gendered. In South Africa, as elsewhere, women perform more unpaid care and domestic work than men. Harambee Youth Employment Accelerator and International Development Research Centre (2022) notes that

WOMEN PERFORM

30.5 hours

of unpaid care and domestic work per week,

COMPARED TO

12.2 hours **for men.**

STATISTICS SA (2022) STATES THAT

13.4%

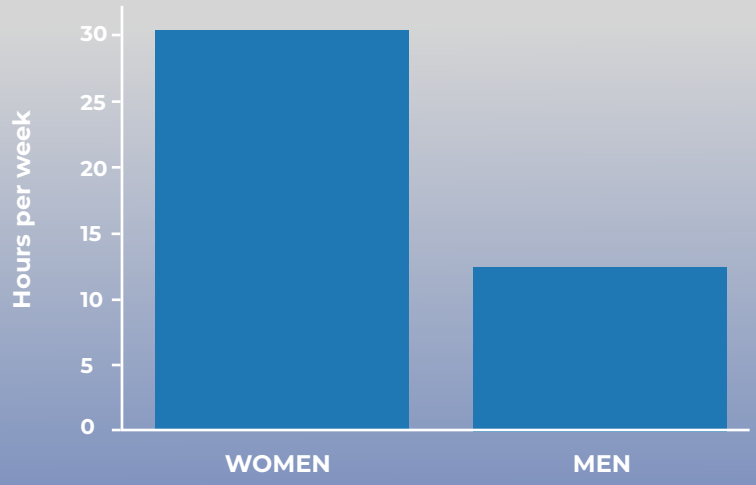
Of young women have indicated family commitments as a cause for leaving school.

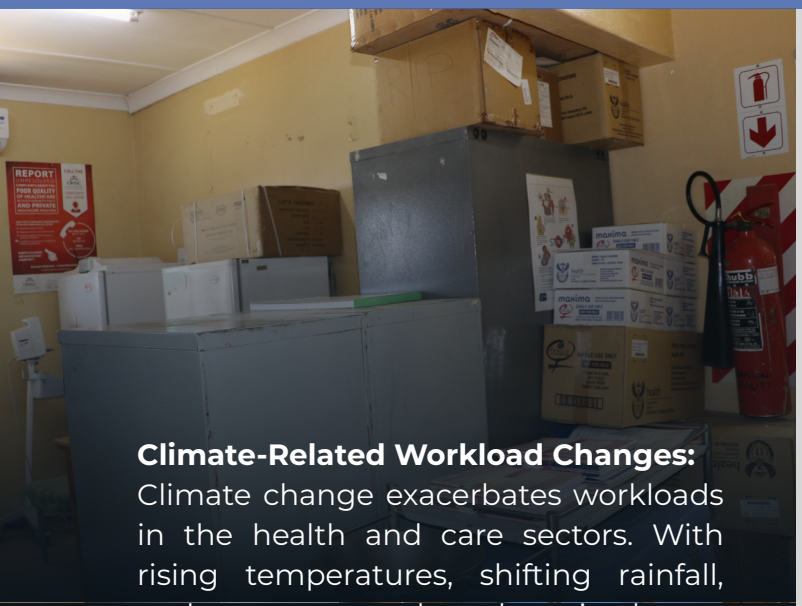
When the healthcare system weakens, such as when there are staff shortages, insufficient clinics and unreliable services, healthcare burdens then spill over to households and mostly fall to the shoulders of women and girls. Expanding CHW outreach, including the "20 million household visits per year by March 2028" as per Vote 18, and further HIV adherence support for men will help to ensure home-based monitoring, support services, as well as delivery of medication (National Treasury, 2025). Nonetheless, unpaid care continues to serve as an "invisible subsidy" that compensates for gaps and failures in the health system.



Average Weekly Unpaid Care Work Burden by Sex in South Africa

FIGURE 3: Average Weekly Unpaid Care Work Burden by Sex in South Africa





Climate-Related Workload Changes: Climate change exacerbates workloads in the health and care sectors. With rising temperatures, shifting rainfall, and extreme weather, there is also an increase in the incidence of diarrheal disease, respiratory illness, malaria, and flood-related injuries (Brink et al., 2024). Community health workers and nurses, roles predominantly occupied by women, are often the first point of contact during climate-related health shocks and experience increased workloads during outbreaks, heatwaves, floods, and droughts while working in chronically under-resourced facilities and community settings.

Climate Shocks and Health System Failures in South Africa (2021–2025)

FIGURE 4: Climate Shocks and Health System Failures in South Africa (2021–2025)

- **2021-2022: Eastern Cape load shedding** (-127 hours/month)
- **2022: KZN floods** (85 Health facilities damaged)
- **2023-ongoing: Heatwaves and dorughts** (Increased diarrhoeal and Malaria burden)
- **2025: All Saints Hospital water failure** (3 weeks)

In recent years, South Africa has experienced ongoing water shortages, and during droughts and heatwaves, facilities are strained, and service delivery is disrupted (de Villiers, 2021). Frontline workers, particularly community-based workers, sustain continuity by ensuring vulnerable patients are attended to and provided with medication during climate-related disasters. Similarly, energy shedding also intensifies work, requiring nurses to manually ventilate patients or protect temperature-sensitive vaccines (Nanji, 2022). Despite all these risks, Vote 18 (National Treasury, 2025) currently does not explicitly earmark climate adaptation training nor allocate resources for protection. The climate resilience of the public healthcare system is imperative. Due to increasingly frequent climate-related shocks that raise demand for health services while simultaneously undermining the infrastructure on which service delivery depends, climate resilience is a structural requirement for South Africa's public healthcare system. Furthermore, to protect frontline workers, such an allocation for backup power, water security and protective gear would support a sector that is predominantly female.

3.2 Care-Infrastructure Vulnerabilities

KEY FINDINGS:

This section finds that failures in health infrastructure directly undermine the delivery of safe and dignified care, with disproportionate impacts on women as frontline workers, maternity patients, and caregivers in families. Breakdowns in water and electricity systems increase infection risks, disrupt critical services, and intensify the labour of care within both facilities and households. Climate-related shocks such as floods, droughts, and heatwaves are compounding these failures by damaging already fragile infrastructure and increasing demand for care. Sustained investment in climate-resilient health infrastructure is therefore essential to protecting women's health and building a stronger public health system.





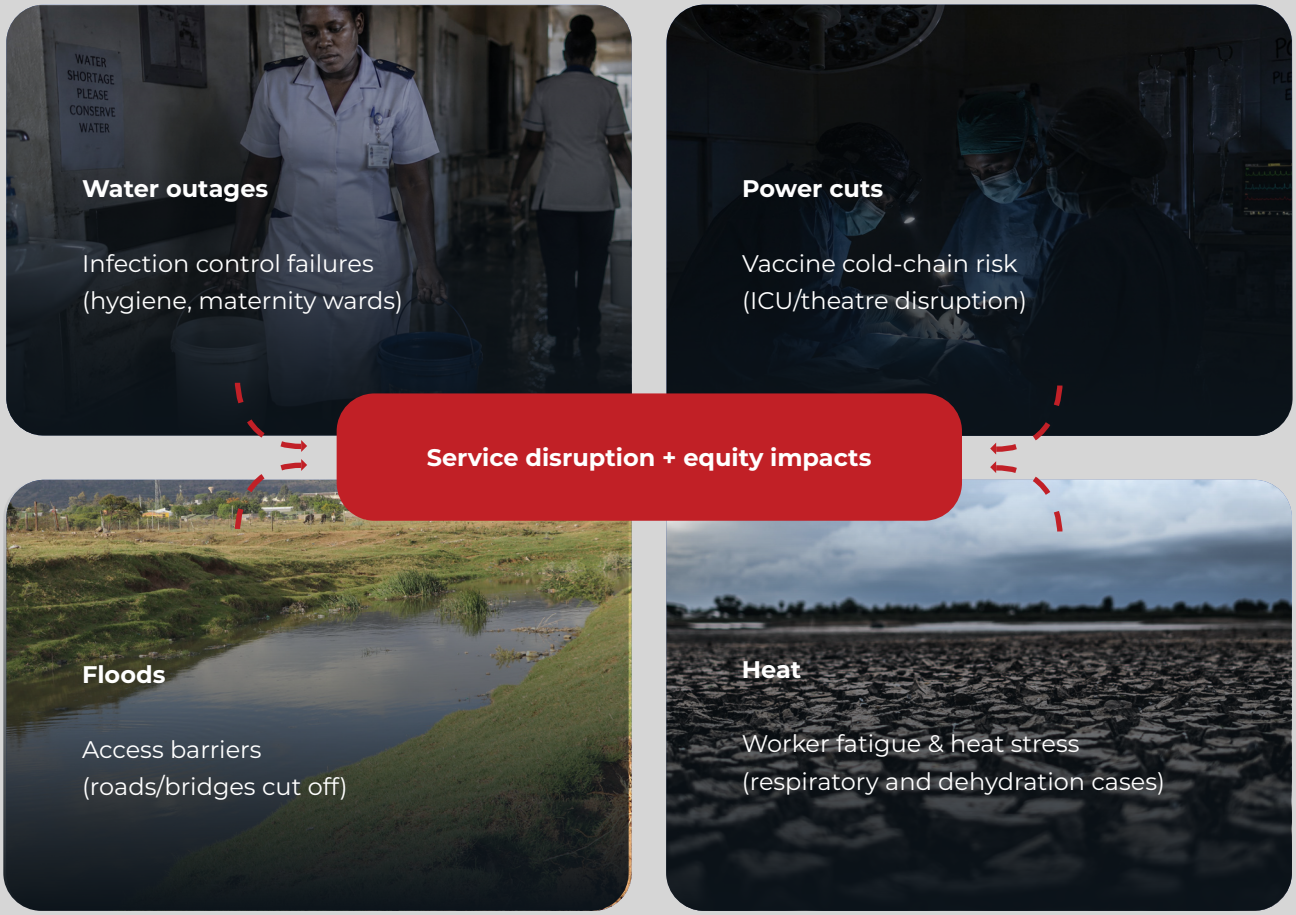
Infrastructure, particularly related to healthcare, is vital to caregiving, and when failures in this infrastructure occur, the impact disproportionately harms women, both on the front lines and as caregivers in families (Akintola, 2009). In October 2025, the water pumps at the All-Saints Hospital in the Eastern Cape were vandalised, leaving the facility without water for three weeks and forcing nurses and patients to haul buckets from storage tanks for bathing and toilet use (Sobuwa, 2025). This resulted in severe hygiene risks, where sewage odours permeated throughout the hospital, infection control was compromised, creating unbearable conditions for maternity patients.

This is a classic case of how women bear the brunt of infrastructure breakdown be it nurses ferrying water or a woman caring for a hospitalised loved one under these conditions. It also highlights the health risks to all marginalised patients in under-resourced facilities, with women facing peculiar dangers, for example, postpartum mothers are at higher risk of infection when there is no running water. Between September 2021 and February 2022, a rural district hospital in the Eastern Cape experienced load shedding of up to 127 hours per month, including a 48-hour continuous outage. As a result, the hospital relied on expensive diesel backups (Nanji, 2022).

Two main indicators here:
firstly, the use of diesel as backup; diesel generators emit pollutants during combustion, contributing to air pollution and climate change (Wright et al., 2024).

Secondly, power outages damage medical equipment and compromise Intensive Care Units (ICUs) and theatres; as a result, nurses and doctors often must do their level best to save people's lives mid-surgery during load shedding (Office of the Health Ombud, 2022). Electricity failures disrupt maternity care, vaccine cold chains, electronic systems, and routine services, again showing how energy failures also result in gendered impact on care.

Figure 5: Health System Vulnerabilities Under Climate Change



Climate change worsens these stresses. Heatwaves and droughts lead to water shortages across the healthcare system. When floods occurred in KwaZulu-Natal in 2022, more than 80 clinic buildings were damaged, and the water supply was contaminated, leading to an increase in diarrheal disease (KwaZulu-Natal Department of Health, 2022). Few facilities across the country have robust backup water and energy systems. Some of the needs for these are partly being addressed through the foreign-funded Clinton Initiative. The new initiative, launched in early 2025 to equip thousands of African clinics with solar energy (Clinton Health Access Initiative, 2025), and, equally, the national investments under Vote 18 towards the health facility revitalisation grant (HFRG), a ring-fenced grant meant to address backlogs and deficiencies in healthcare infrastructure (National Treasury, 2025), present an opportunity to embed climate-resilient infrastructure (solar, batteries, drainage, rainwater systems). Such improvements can benefit women, who face heightened risks during maternity care and shoulder unpaid care when health systems fail.

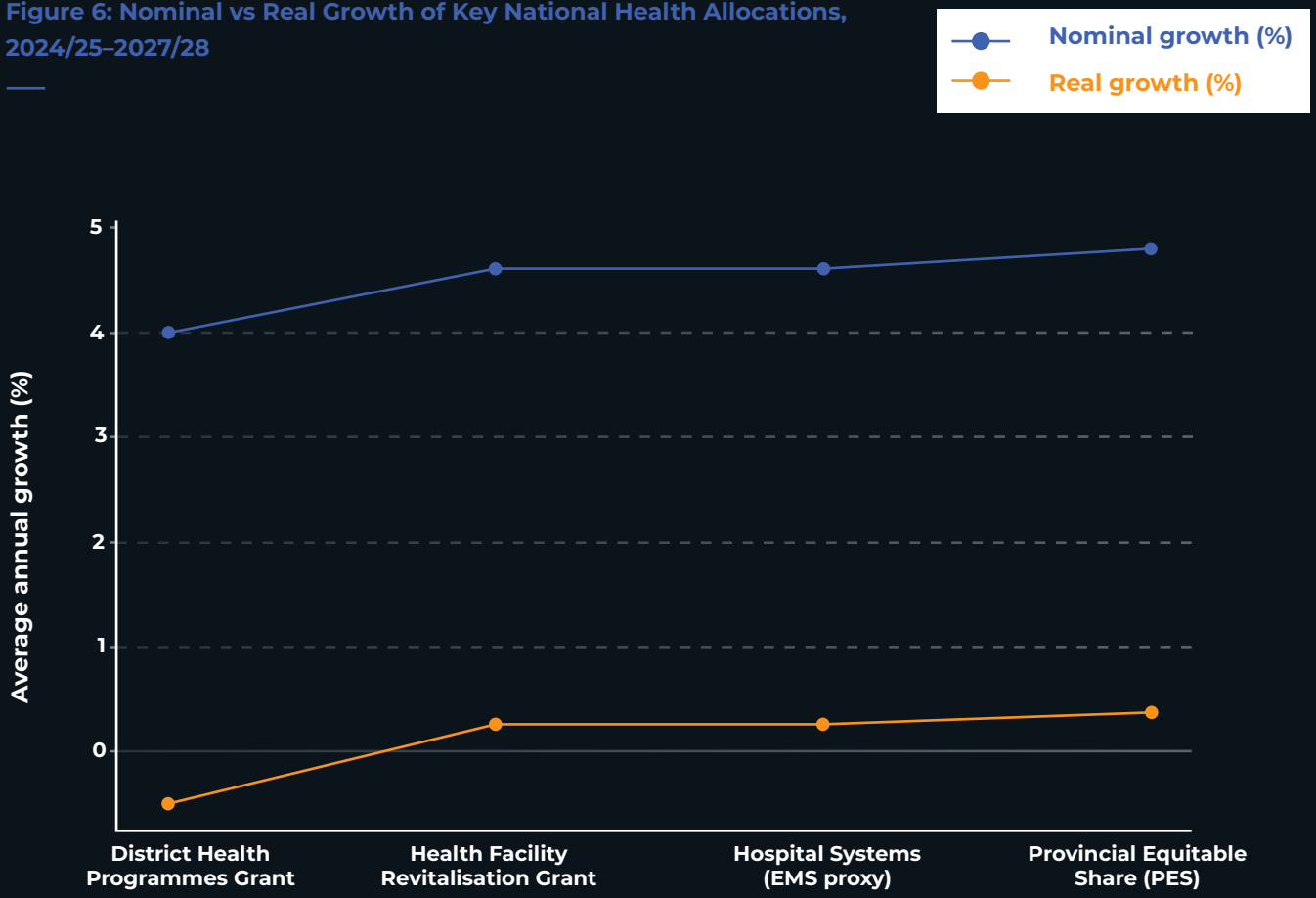
3.3 Conditional Grants Analysis (Gender & Climate Lens)

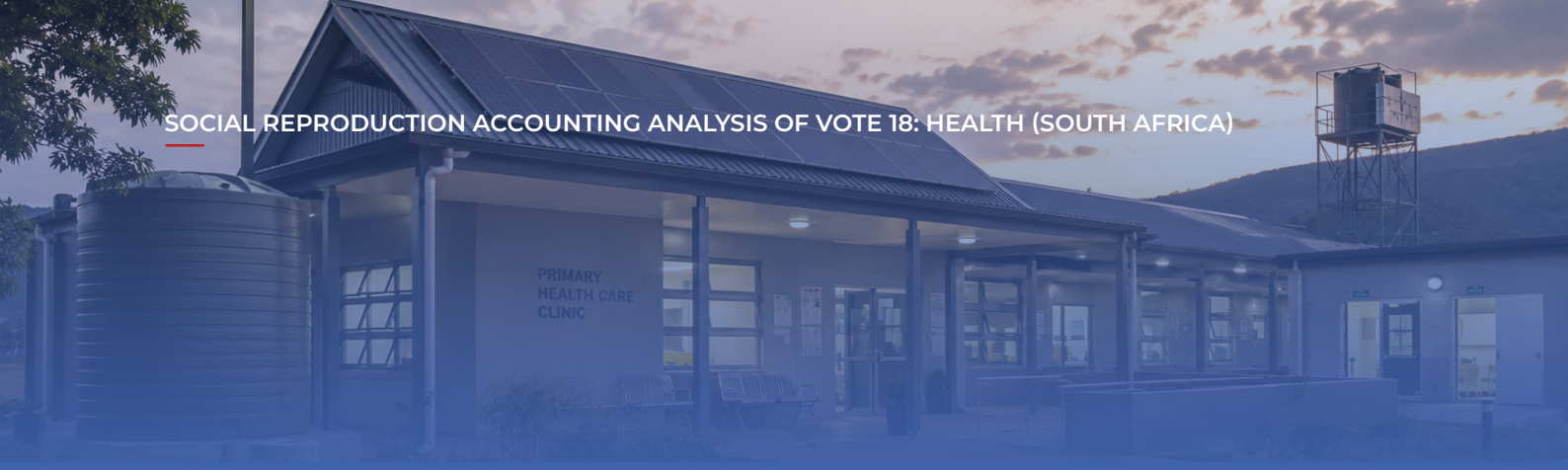
Before turning to individual conditional grants, it is important to situate these allocations within the broader fiscal context. Although headline allocations in Vote 18 show nominal increases over the medium term, these increases largely fail to keep pace with inflation. Figure 6 illustrates the divergence between nominal and real growth across key health allocations, highlighting the persistence of real-term stagnation or decline in core health system funding.

While nominal allocations increase modestly over the medium term, real growth is flat or negative once inflation is accounted for. This indicates continued fiscal constraint in district health services, emergency medical capacity, health infrastructure investment, and the provincial equitable share, all of which are central to gender equity and climate resilience.

Nominal vs Real Growth of Key National Health Allocations, 2024/25–2027/28

Figure 6: Nominal vs Real Growth of Key National Health Allocations, 2024/25–2027/28





Health Facility Revitalisation Grant

VOTE 18 ALLOCATED

R7.16 Billion **in 2024/2025 towards HFRG,**

with an expected increase to R8.2 billion in 2027/28 (National Treasury, 2025). A nominal increase of 14.6% over three years, an inflation rate of 5% is assumed based on South Africa's recent average consumer price trends and the South African Reserve Bank's target range, providing a realistic benchmark to adjust nominal figures and assess the health budget's real value over time (Statistics South Africa, 2025) and considering rising infrastructure costs, the real increase in capacity will likely be minimal, possibly zero or negative. Given the large infrastructure deficits, deferred maintenance, and broad scope required (new builds, repairs, climate resilience), this level of funding is probably insufficient to meaningfully "catch up." For women who dominate the nursing staff and are primary users of healthcare services, this infrastructure is vital in improving safety, dignity and the quality of care. The HFRG is also an avenue to build climate-resilient infrastructure. The grant's scope explicitly includes "maintenance, renovations, upgrades, additions and construction of infrastructure, including replacement of health technology" (National Treasury, 2025). This should encompass climate-proofing measures, for example, installing solar panels and battery storage for backup power, rainwater harvesting, etc. Projects like the new Limpopo Academic Hospital (South African Government News Agency, 2023) bring obstetric and neonatal services closer to underserved women by expanding access to specialized maternal and newborn care in a region that has historically lacked sufficient tertiary-level health infrastructure. These facilities are critical for reducing maternal and infant mortality, managing high-risk pregnancies, and ensuring safe deliveries, particularly in rural areas where women often face long travel times, poor transport networks, and delayed emergency care. By locating advanced services within or near communities that were previously underserved, such projects help close the spatial and socio-economic gap in access to quality healthcare, while also easing the burden on over-capacitated urban hospitals. This approach supports gender equity by responding directly to the health needs of women, who are disproportionately affected by the weaknesses in public health infrastructure, especially during pregnancy and childbirth.











District Health Programmes Grant (HIV/TB & District Services)

The District Health Programmes Grant is the largest grant at R89 billion over the Term Expenditure Framework (MTEF) (National Treasury, 2025). This grant supports 6.5 million people on Antiretroviral Therapy (ART) by 2027/28, Human Papillomavirus (HPV) vaccinations for girls, Tuberculosis (TB) and malaria programmes (National Treasury, 2025). This will be delivered by the predominantly female community health workers. This reduces unpaid care burdens on women while strengthening household resilience. Climate-related disease risks (TB ventilation issues, shifting malaria zones) heighten the importance of this programme. This grant also supports the Central Chronic Medicine Dispensing and Distribution, which safeguards the continuity of chronic medication during floods or disasters (South African Government Official Information and Services, 2023).

Emergency Medical Services (EMS)

SOUTH AFRICA IS CURRENTLY EXPERIENCING A

2 221 Vehicle shortage in ambulances, (Frimedia, 2025)

with delays especially acute in rural areas where low-income families lack private alternatives. The Emergency Medical Services gets a very low allocation, only 0.3% of programme 3: primary healthcCare service programme in 2025/2026. Its nominal budget growth of 2% is exceeded by 4.4% inflation, resulting in a real annual decrease of about 2.2%.

This low level of investment says that EMS is not seen as a national priority, despite the fact that it is vital in supporting gender-responsive and climate-resilient health systems. While its underinvestment may reflect devolution to provincial governments, the decline in real terms raises grave concerns about equity and access, particularly for marginalised groups during emergencies. Women in labour face life-threatening delays; disability and preventable mortality have resulted from hour-long response gaps (Frimedia, 2025). A constrained budget limits the fleet expansion. Strengthening EMS is a gender-equitable and climate-adaptation priority, particularly as floods and heatwaves increase rescue needs.





Provincial Equitable Share

According to Statistics SA (2023), provincial health spending accounts for 30-35% of the Provincial Equitable Share. This grant funds the salaries of predominantly female human capital. About two-thirds of provincial spending goes to compensation of employees (Statistics SA, 2023). Austerity measures have led to hiring freezes, unemployed medical graduates awaiting posts and understaffed clinics and hospitals (Senkubuge et al., 2025). As a result, women's workloads increase, and care burdens shift back into households.



More than 80% of households in poverty-stricken provinces, such as Limpopo and Eastern Cape, rely on public healthcare (South African Government Official Information and Services, 2023), making equitable PES allocation critical.

National Tertiary Services Grant

The National Tertiary Services Grant is one of the largest conditional grants under Vote 18, specifically designed to fund advanced and highly specialised health services. These include oncology, intensive neonatal care, specialist obstetrics, and other critical services that are not uniformly available across all provinces. The grant plays a central role in facilitating referral-based access and supporting regional equity by compensating provinces that host tertiary facilities used by patients from beyond their borders (National Treasury, 2025).

ACCORDING TO THE 2025 ESTIMATES OF NATIONAL EXPENDITURE, THE NTSG IS ALLOCATED:

IN 2024/25 **R15.3 Billion**

IN 2025/26 **R16.0 Billion**

IN 2026/27 **R16.7 Billion**

(National Treasury, 2025).

0.2%

real growth per year when adjusted for inflation using an **average rate of 4.4%.**

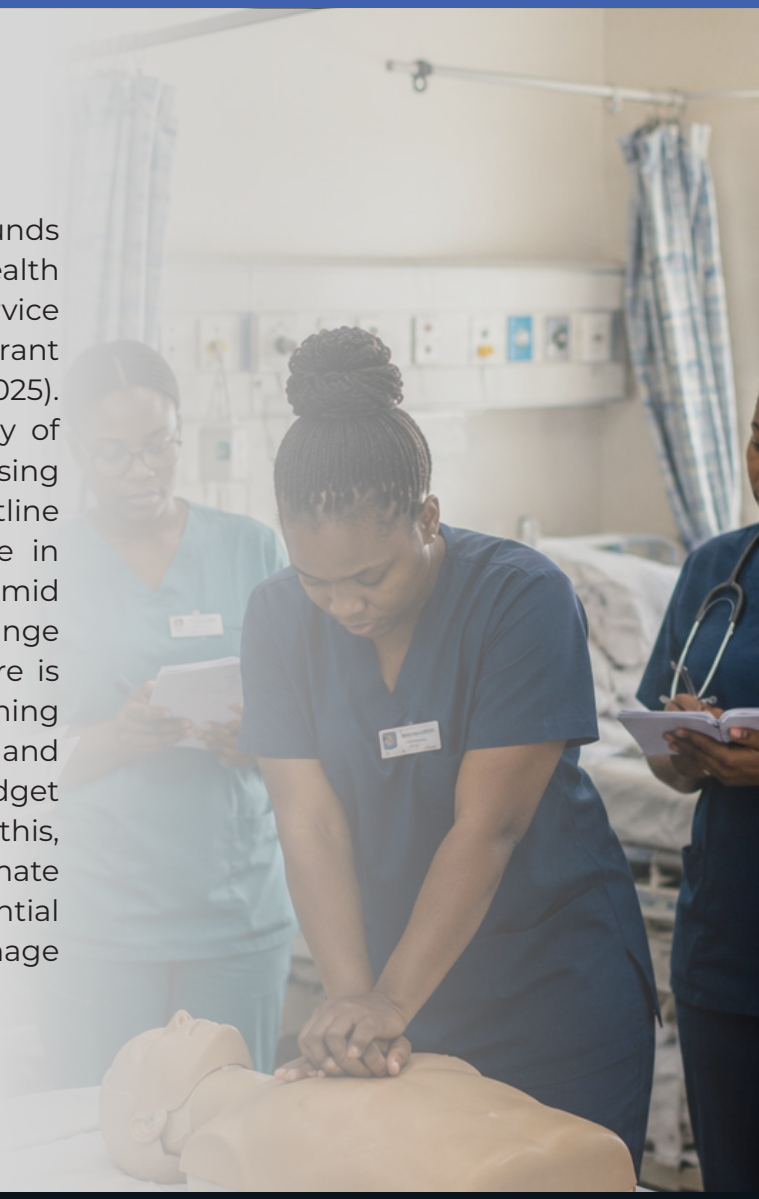
This translates to an average nominal growth rate of approximately 4.6% over the Medium-Term Expenditure Framework (MTEF). However, when adjusted for inflation using an average rate of 4.4%, this reflects only 0.2% real growth per year, effectively a plateau in the grant's purchasing power. Given that the NTSG funds highly resource-intensive services, the stagnation in real terms is concerning. Tertiary hospitals face rising operational costs, including the cost of specialised equipment, medicines, skilled personnel, and energy. Moreover, demand for these services is increasing due to demographic pressures (e.g. growing urban populations and aging patients), as well as epidemiological shifts such as higher chronic disease burdens, including cancer and diabetes.

From a gender equity perspective, the grant is essential. It supports services that are disproportionately accessed by women, especially breast and cervical cancer care, high-risk obstetric units, and neonatal ICUs. Therefore, a stagnant grant may hinder the expansion or quality of these gender-sensitive services, especially in underserved areas. Additionally, in the context of climate resilience, tertiary hospitals are pivotal in national disaster and emergency response systems. Yet, the current formulation of the NTSG does not allocate funding for climate adaptation infrastructure. Investments such as solar-backup systems, water resilience, and flood-proof design are necessary to ensure continuity of care in the face of increasingly frequent extreme weather events.

In sum, while the NTSG remains a vital funding stream for specialist care and national health system functionality, its flat real growth trajectory and lack of climate- or equity-linked conditions risk undermining its strategic intent. Policy adjustments may be required to ensure it can support both current demands and future shocks.

Human Resources and Training Grant

The Human Resource and Training Grant funds critical human resources in the public health system, including internships, community service posts, and specialist training. In 2024/25, the grant was allocated R5.5 billion (National Treasury, 2025). It enables young health professionals, many of whom are women, to enter the workforce, easing pressure on overburdened nurses and frontline staff. The grant has also played a key role in absorbing unemployed medical graduates amid fiscal constraints. However, as climate change increasingly drives health emergencies, there is a growing need for climate-responsive training in areas such as environmental health and emergency response. While the current budget does not explicitly earmark funding for this, increased investment and integration of climate modules into existing programmes are essential to strengthen provincial capacity to manage climate-related health shocks.



04

Who Benefits from Key Health Budget Allocations in South Africa?

Distributional Incidence of Key Health Budget Allocations in South Africa

4.1 Introduction and Methodology

This analysis applies Expenditure Incidence Analysis (EIA) and Benefit Incidence Analysis (BIA) to estimate who benefits from major allocations in South Africa's health budget. The focus is on CHWs and the nursing workforce, healthcare infrastructure investments, and key conditional grants. Benefits are assessed across sex (women vs men), income quintiles, provinces, and rural vs urban populations.

The analysis draws on official budget documents (including Vote 18: Health and the National Department of Health's Annual Performance Plan), national surveys, and program data. Where direct beneficiary data are unavailable, logical proxies are applied and assumptions are clearly stated. Expenditure Incidence Analysis (EIA) is used to allocate spending based on intended service provision, while Benefit Incidence Analysis (BIA) reflects actual service utilisation. In practice, both approaches are combined using available budget allocations and utilisation data (e.g. clinic visit rates by income group). The full EIA methodology and estimates are presented in Appendix A. Results from this analysis are used throughout this section to evaluate the distributional impact of specific line items.

This methodology also applies an intersectional lens, considering geography, gender, income, and climate vulnerability, to assess equity in public health spending.

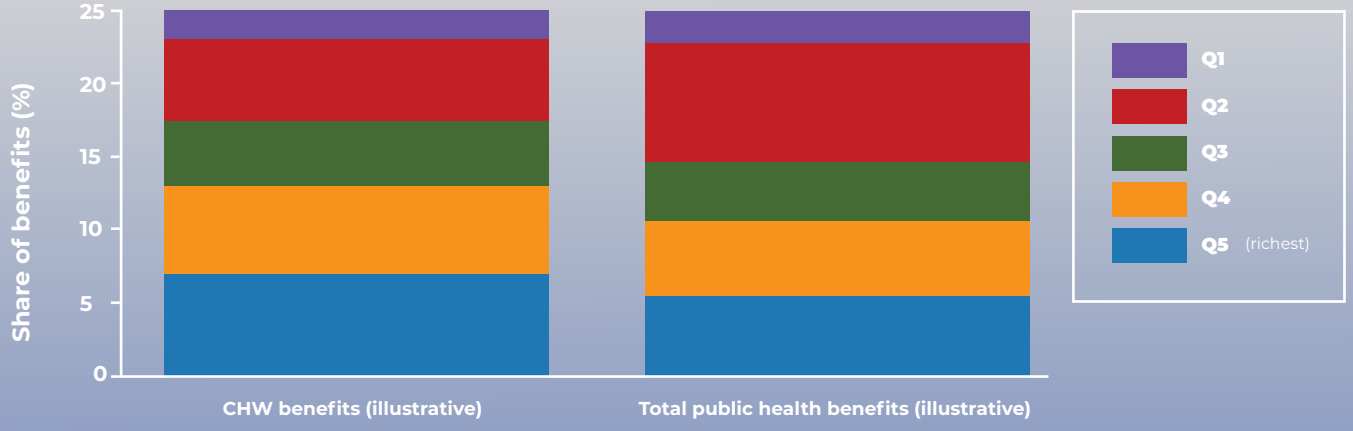
4.2 Community Health Workers and Nursing Workforce

Community Health Workers and nurses are integral to the healthcare system; an investment in this human resource is an investment towards the wellbeing of primarily poor, rural populations, since CHWs have easier access to households. This means the targeted 20 million visits per year (National Treasury, 2025) will primarily benefit women and children, and that about 60% of direct beneficiaries are female. Men also benefit, though men historically underutilise primary care, often due to gender norms that discourage help-seeking, perceptions of health services as feminine space, or work patterns that limit their access to clinics during operating hours. A genuinely gender-responsive budgeting approach must therefore respond to these barriers as part of a system-wide strategy to improve access and utilisation, though this is beyond the scope of this report. Women benefit in two ways: first, as patients; and second, as CHWs and nurses. In mid-2025, Health Minister Aaron Motsoaledi announced a formalisation of 27,000 CHWs after years of volunteering (Saidu, 2025). These are women who were previously earning a minimum wage stipend of R3500 and should now receive better pay and benefits, supporting both livelihoods and service stability (Saidu, 2025).

Given that 84–86% of South Africans are uninsured (Oxfam, 2020), public health expenditure is inherently pro-poor. CHW and nursing services are heavily concentrated in informal settlements and rural districts. The poorest 20% likely receive 25–30% of CHW benefits, while the wealthiest receive <5%, consistent with Biodiversity Impact Assessment? (BIA) findings showing that the bottom 50% of the population receives around 50% of public health benefits despite accounting for only 3% of national income.

Benefit Incidence by Income Quintile (Illustrative)

Figure 7: Benefit Incidence by Income Quintile



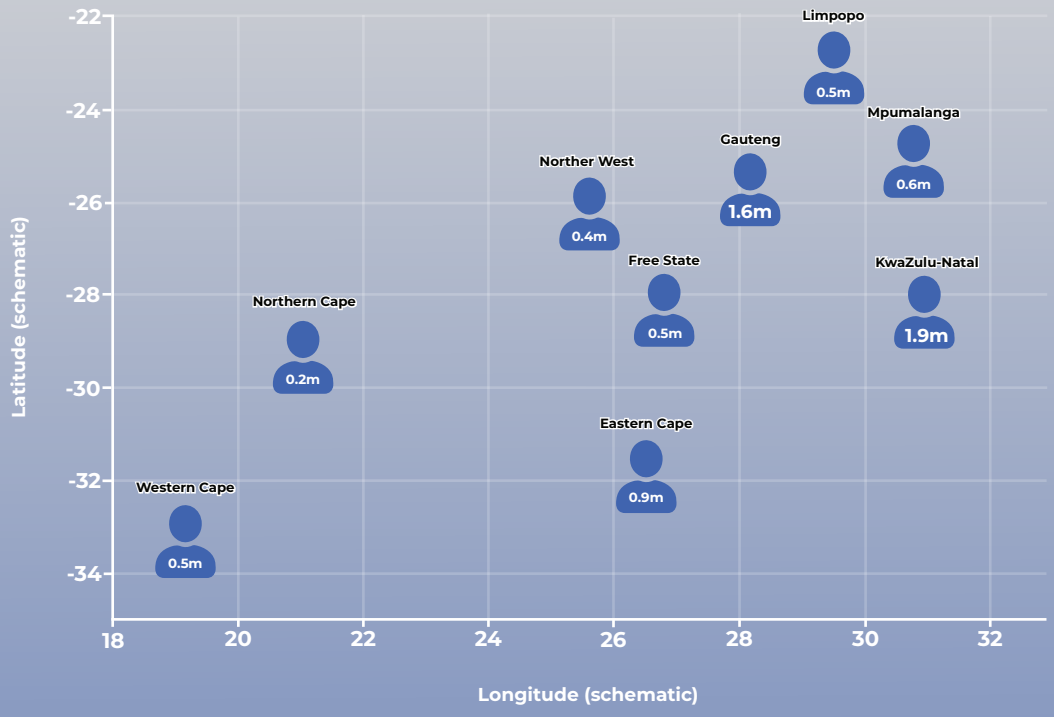
Public health spending in South Africa is broadly progressive, with poorer households receiving a larger share of benefits. Community health worker (CHW) services are particularly pro-poor, with the poorest quintile receiving an estimated 25–30% of benefits. However, higher-cost services remain less progressive, highlighting the importance of protecting and expanding primary-level and community-based care.

Provincially, all nine provinces deploy CHWs and nurses, but rural districts depend on them most. In rural areas, nurse-led clinics are the main providers of healthcare, doctors are in short supply and CHWs often fill gaps (Michel et al., 2018). A CHW may conduct two household visits per day in Gauteng and up to 10 in Limpopo, indicating the highest reliance on CHWs in these provinces (Murphy et al., 2020). Rural health systems are highly vulnerable; they face ongoing nurse shortages, high turnover, and reluctance among young professionals to remain in rural posts after mandatory service, citing isolation and poor working conditions (Abrahams & Parumasur, 2025).

To sustain long-term benefits, there needs to be more rural incentives, which include financial support such as rural allowances and housing stipends, improved clinic infrastructure, family support services and professional development opportunities, to attract and retain healthcare workers in underserved areas and delivery quality healthcare services for all.

Distribution of People Living with HIV (PLHIV) by Province (Schematic)

Figure 8: Distribution of HIV/TB Burden by Province (Map visual)



The burden of HIV is unevenly distributed across provinces, with KwaZulu-Natal and Gauteng carrying the largest number of people living with HIV, followed by the Eastern Cape, while the Northern Cape has the lowest burden. This uneven epidemiological profile underscores the need for pro-poor, pro-burden allocation of HIV and TB resources across provinces.

Note:
Figure 8 is schematic and intended to illustrate relative provincial burden rather than precise geographic boundaries.



CHWs and nurses also play a critical role in climate vulnerability. During floods or storms, they may be the only link to care when roads are cut off. In KwaZangashe (Eastern Cape), a swollen river with no bridge left a village inaccessible for three days, during which a patient died awaiting help (Sobuwa, 2024). CHWs often provide interim care in such conditions, meaning that strengthening this workforce also strengthens climate resilience. Nonetheless, impassable infrastructure can limit even the most effective CHW networks.

Key assumptions:
Due to limited data, precise CHW uptake by quintile or gender is unavailable; therefore, the estimates rely on known utilisation patterns, such as clinic visits being highest among people experiencing poverty (Gethin, 2025) and women. The varied CHW formalisation in different provinces affects service quality. The analysis also assumes that full and sustainable funding for CHW stipends is provided through the District Health Services grant; underfunding would reduce the realised benefits.

4.3 Care-Infrastructure Vulnerabilities and the Health Facility Revitalisation Grant

In this section, we evaluate who benefits from healthcare infrastructure spending, particularly through the Health Facility Revitalisation Grant. Decades of underinvestment in infrastructure and a maintenance backlog have left many healthcare facilities, particularly in peripheral and rural areas, undermined, unsafe, highly vulnerable to climate shocks, and under-resourced (Baduza & Lencoasa, 2023). Infrastructure is vital to ensuring quality healthcare services.

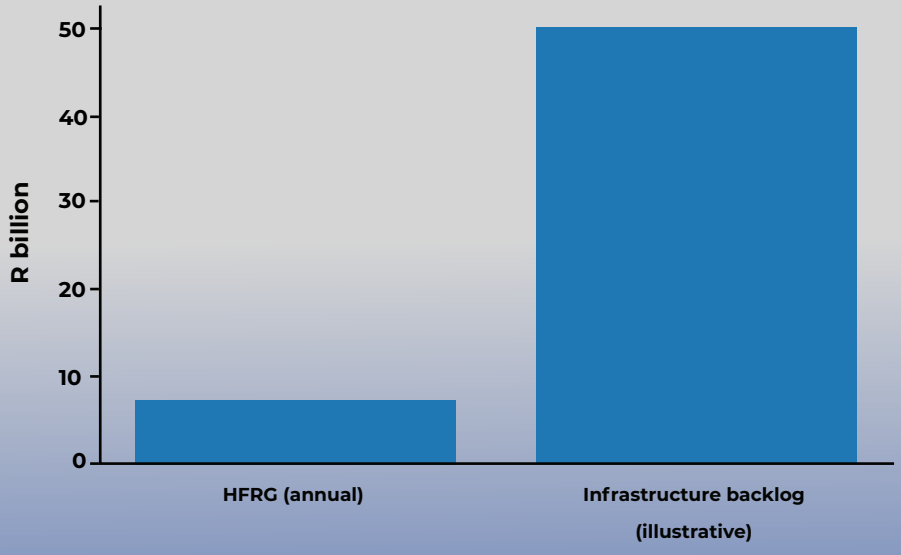
The HFRG funds provinces to upgrade, maintain, and build various healthcare facilities, including hospitals, equipment, and other related healthcare infrastructure.



We observe that over the 2025 MTEF, this grant totals R23 billion; however, the 2025/2026 allocation increased by only 1.3% nominally (a real cut of 2.75%) (SECTION27, 2025). This is despite the widespread infrastructure backlogs. All users of the public health system benefit from this grant; however, targeting is important given the existing inequalities across provinces. Recently, investments have been prioritised to historically underserved provinces such as Limpopo, where R3 billion has been allocated to build an Academic hospital and Siloam District hospital, to increase access in a province where over 90% of its population depends on the public sector (Parliament of the Republic of South Africa, 2025). Similarly, these funds are also used to fix hospitals in rural Eastern Cape and KwaZulu-Natal, meaning rural and poorer communities gain the most, helping reduce geographic inequality.

HFRG Allocation vs Infrastructure Backlog

Figure 9: HFRG Allocation vs Infrastructure Backlog





Urban areas also benefit from this grant, which funds upgrades to tertiary hospitals. Thirty-five nationwide public hospitals provide tertiary services (South African Government Official Information and Services, 2023), mainly located in urban centres, and many of these hospitals need renovations. This grant works in tandem with the National Tertiary Services Grant, which helps build specialist capacity in smaller provinces. An example is the purchase of new equipment in Mpumalanga hospitals (Motsoaledi, 2025).

A geo-gap persists, with differences between rural and urban clinics. Rural clinics often lack reliable water, electricity and experience difficulties with road access. In rural clinics, even basic repairs such as roof repairs, solar power installations, and borehole installations make a huge difference in improving care. Climate vulnerability exacerbates these gaps, for example, when heavy rains in the Eastern Cape washed out roads, isolating villages from clinics and ambulances and compromising healthcare service delivery (Sobuwa, 2024). Another case describes how a community cut off by a flooded river with no bridge led to a preventable death (Sobuwa, 2024). This indicates how vital resilient infrastructure is; bridges, all-weather roads, and flood-resistant buildings directly save lives.

The National Infrastructure Plan 2050 recognises this and calls for resilient healthcare facilities that support long-term healthcare needs (Department of Public Works and Infrastructure, 2022). New clinics and hospitals must meet updated norms and standards, including climate-resilient design. Although specifics such as flood mitigation or green building are not detailed in the budget, they are areas of need. Programmes such as the Ideal Clinic initiative promote infrastructure that can withstand service interruptions, such as generators or solar power (Department of Health, 2022).

The limitations observed include risks of underspending, delays, and incomplete projects; these problems have been repeatedly flagged by civil society (SECTION27, 2025). Due to limited published data, rural-urban allocations are often inferred from project descriptions. Climate resilience benefits are also inferred; future analysis should map facility exposure to climate risk more systematically to better target investments.

4.4. Conditional Grant

District Health Programmes (HIV & TB)

By gender, this grant benefit incidence reveals the epidemics of gender patterns. In terms of spending towards HIV, women are the major beneficiaries with about

5.2 million

WOMEN

VS

2.6 million

MEN

living with HIV benefiting in 2024 (Low, 2025),

and of the

6.2 million

people on ART, about

60% **of them are women** (Low, 2025).

This indicates that the HIV component is largely pro-women, thereby improving the lives of both women and children by equally preventing mother-to-child transmission. With that said, TB spending tilts towards men: the incidence is 1.6x higher in men and the mortality was 1.7x higher according to the incidence analysis, with 56% of men treated for drug-susceptible TB between 2009 and 2016 (Osman et.al., 2021). Overall, we estimate the grant's benefits for 55% of women and 45% of men.

Real-term cuts in 2025 at −3% after inflation risk gender-differentiated harms, and stakeholders argue any ARV "savings" should be reinvested, given ongoing infections and the new NSP focus on vulnerable groups (SECTION27, 2025).



settlements and prisons and is often understood as a disease which affects the poor mostly. We infer the poorest 20% receive 25%+ of grant benefits, while the richest 20% receive <10%, consistent with broader evidence that the poorest 50% capture about half of public health spending (Gethin, 2025). Given the nature of these diseases, their spending may very well be even more progressive than the overall health expenditure.

Provincially, allocations roughly follow HIV/TB burden: KZN (1.8–2 million PLHIV, high TB), Gauteng and the Eastern Cape receive the largest shares (Spotlight, 2019); Mpumalanga and the Free State also receive substantial amounts; the Northern Cape gets the smallest. The grant aims to equalise access by ensuring that poorer provinces can fund ART and TB programmes, enabling patients in Limpopo to access the same ARV regimens as in Gauteng. Rural-urban gaps persist due to the under-resourcing of human resources and access challenges. This grant funds CHW and testing outreach and Central Chronic Medicine Dispensing and Distribution (CCMDD), helping 40% of ART patients access their medication at external pickup points (Department of Health, 2025). This benefit is available to working urban patients and to patients in villages with pickup points; however, very peripheral rural populations often struggle to access it owing to transport barriers and the absence of pickup points (Sobuwa, 2024).

Climate linkages are indirect but real. The grant partly funds malaria control in endemic areas, which is becoming increasingly important as climate change shifts transmission zones. Climate shocks that cause displacement and overcrowding, like floods, can worsen TB risk. Overall, a robust HIV/TB programme enhances general health system resilience, as a healthier population is better able to cope with disasters.

Key assumptions/limitations include treating funded services as equally accessible across groups, despite uptake gaps (e.g. young men's lower testing and ART uptake); assuming continued complementary donor funding (PEPFAR, Global Fund), although cuts such as recent USAID reductions (SECTION27, 2025) could erode coverage; and also not disaggregating by key populations, which is beyond scope.



Emergency Medical Services

Theoretically, the Emergency Medical Services should benefit every person in need; however, in practice, the benefits are uneven. Coverage favours urban areas and more advanced provinces, with rural and poor communities often receiving little or no service, making EMS an outlier compared with more progressive health programmes.

Urban centres and wealthier provinces, such as Gauteng and the Western Cape, have more ambulances and better response times.

The national standard is

1 AMBULANCE
per 10,000 people;



however, in the Eastern Cape, the ratio is

0.4 **per 10,000** (Sobuwa, 2024),

with vehicles crowded in towns and favouring more urban centres.

The rural population often reports having to wait many hours or days for an ambulance, and sometimes the ambulance does not arrive at all.

One case in the Eastern Cape involved a 72-hour wait, after which the patient died, and a funeral parlour retrieved the body within an hour (Sobuwa, 2024).

We estimate that only about

30%



of the public EMS responses reach rural residents, while

70%



of the ambulances serve urban and peri-urban areas.





Gender incidence is roughly 50/50. Men are somewhat over-represented in trauma (accidents, violence); women are in obstetric emergencies and inter-facility transfers. The workforce has historically been male dominated, though female paramedic participation is growing.

EMS is vital for climate adaptation, yet climate events expose system vulnerabilities. When there are floods and bridges are washed out, ambulances find it hard to reach patients, as is the case with the unbridged Eastern Cape River (Sobuwa, 2024). Disasters like the 2022 KZN floods were in dire need of emergency response, and in poor communities, the EMS was already overstretched. Strengthening EMS through more 4×4 vehicles, better communication, and surge capacity is thus central to climate-resilient health systems.

EMS faces stagnant or declining funding in terms of the state budget. SECTION27 notes a 2.4% real-term cut to EMS allocations in 2025 (SECTION27, 2025), and South Africa is estimated to be short by 2,200 ambulances (37% below norm) (Panchia, 2025), with the worst of shortages in rural provinces and peripheral areas. Without dedicated conditional grants or strong ring-fencing, EMS competes with other health priorities in provincial budgets; wealthier provinces cope better, poorer ones fall further behind. Our incidence estimates rest on qualitative evidence and known disparities, and they reflect utilisation, not unmet need, which is far higher among rural poor households.

Provincial Equitable Share for Health

The Provincial Equitable Share is the backbone of health financing, covering most costs for public clinics and hospitals (staff, medicines, operations). The PES health component, 27% of total PES, effectively drives the benefit incidence of the entire public health system (Bidzah, 2015). Although it is important to note that the PES is an unconditional allocation, thus provinces have the leeway to allocate funds from it as they see fit, and are not required to follow the ratios in the formula.

PES-financed services mainly benefit low-income groups.

Most low-income households use public health facilities, while wealthier people often choose private care. Data shows that the poorest groups visit public providers more often; over half of adults in the poorest quintile reported a public health visit in the past three months, and use of public providers drops as income increases (Gethin, 2025). The poorest 50% of people receive about half of public health spending, which matches their share of the population and suggests a neutral or slightly progressive effect. For example, Quintile 1 may get 15–20% of benefits, Quintile 2 a similar or higher share, the middle quintile about 20%, and the top quintile less than 10%. This pattern helps reduce inequality by providing more in-kind health benefits to the poor, thereby narrowing the income gap.



Because those who can afford to do so mainly opt out of the public system altogether, even the expensive tertiary public hospitals largely serve low- and middle-income groups, for example, when an unemployed patient undergoes a complex surgery in a central hospital. Thus, adding all services together, the bottom quintile may get around 22% of health benefits vs 12% for the top quintile, illustrative figures consistent with a pro-poor tilt.



By sex, women often use public services more than men, particularly for reproductive and child-related care. Women equally have more contact points from family planning, childbirth, postnatal visits, antenatal care, to taking their children to clinics, whereas men often delay care-seeking. Given women's longer life expectancy, this means more years of service utilisation. We estimate women receive 55-60% of public health benefits, reflecting both needs (maternal health) and behavioural patterns, rather than discrimination against men. Policy efforts increasingly aim to draw men into earlier and preventive care.

The distribution of resources at a provincial level is governed by an accounting system that takes into account population size, the uninsured rate, and health risks (children and the elderly) (Mthimkhulu and Dev, 2024). Poorer provinces with a higher uninsured rate (Limpopo,

Eastern Cape) receive relatively more per capita, while wealthier provinces such as Gauteng and Western Cape receive more moderate shares due to larger insured populations. PES thus aims to equalise provinces' ability to deliver a basic package of services. Yet actual per capita spending and outcomes still differ; for instance, the Western Cape typically spends more per person and achieves better results, while poorer provinces typically underspend and struggle with capacity. All provinces provide free public care, but the quality of service varies across waiting times, drug supply, and staff ratios.

Given this uneven rural–urban pattern, budget allocations to districts are a provincial choice. Tertiary hospitals often absorb a large share and often favour urban residents. Rural clinics, on the other hand, endure under-resourcing, with fewer doctors and nurses per capita. We therefore assume urban residents capture around 60% of spending and rural residents 40%, roughly mirroring the population but with an urban bias due to more resource-intensive services.

Climate risks are not explicitly built into the PES formula, though geography and climate clearly affect costs (e.g., maintaining flood-prone facilities and serving scattered rural populations). Provinces must fund climate-related damage, such as storm-damaged roofs and flood-damaged hospitals (as in KZN) from within existing envelopes, potentially crowding out other services. As climate change increases disease burdens, PES may come under further pressure unless complemented by dedicated resilience financing.

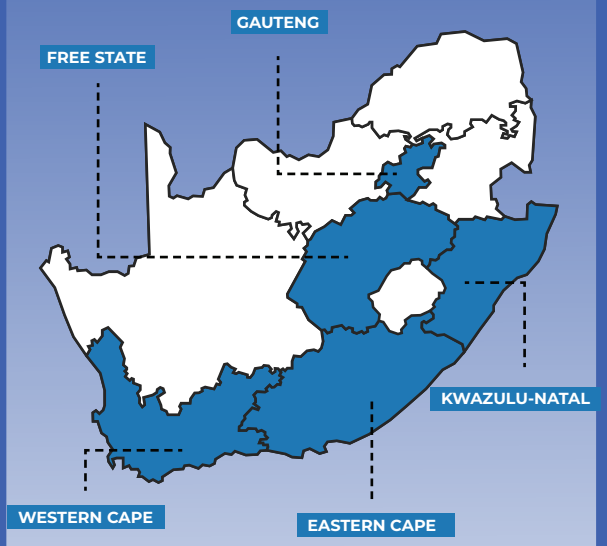
Key assumptions include stable utilisation patterns, no explicit quality adjustment, and continued partial exit of middle classes to private care. This makes the system more pro-poor on paper, but risks weakening political support for public health if quality declines.



National Tertiary Services Grant

The NTSG funds specialised tertiary services (ICU, oncology, surgery, transplants) provided by provincial hospitals. Over the medium term, it allocates about R50.2 billion, growing 4.7% annually within the Hospital Systems programme (Department of Health, 2025). It compensates provinces that deliver tertiary care to referred patients and helps maintain a national standard of advanced care.

Geographically, NTSG is concentrated in provinces with tertiary hospitals:





(e.g. Chris Hani Baragwanath, Groote Schuur, Inkosi Albert Luthuli, Universitas, Walter Sisulu).

Smaller provinces (Limpopo, Northwest, Mpumalanga, Northern Cape) historically had limited tertiary capacity and referred to big centres, receiving smaller grants largely to purchase services. Recent policy shifts earmark part of NTSG to develop tertiary capacity in under-resourced provinces and "minimise interprovincial referrals" Department of Health, 2025). Over time, this should increase benefits for populations in provinces like Limpopo and Mpumalanga.

Rural vs urban and income:
Tertiary care inherently favours those who can reach and navigate the referral system. Urban residents near tertiary hospitals enjoy proximity advantages, while rural patients face distance and cost barriers and may never be referred. However, within the public system, tertiary hospital patients are still largely low- and middle-income; the wealthy generally use private specialists and hospitals. The top quintile likely receives 5% or less of NTSG benefits. The very poorest rural people are under-represented because they may never reach tertiary facilities. Overall, tertiary spending is progressive, though less strongly pro-poor than primary care.

Gender incidence is roughly balanced (50/50). Women may be slightly over-represented due to longevity and complex obstetric cases managed at the tertiary level; men dominate certain trauma and occupational disease caseloads. On aggregate, utilisation aligns with the segment of the population that reaches older ages, where women are more numerous.

NTSG's core benefit is financial and health protection: it makes catastrophic, high-cost care available in the public system, preventing households from falling into poverty due to severe illness. Marginalised patients gain the most from this risk protection, as they cannot self-finance specialised care.

In the event of climate disasters, tertiary centres must provide surge capacity to handle mass casualties and outbreaks. Yet many tertiary hospitals are old and vulnerable to power cuts, water shortages, and floods (e.g., Durban hospitals were hit during the 2022 floods). Ideally, NTSG and HFRG together would climate-proof these apex facilities to ensure backup power, water, and flood defences, but current documents emphasise service expansion over climate adaptation.

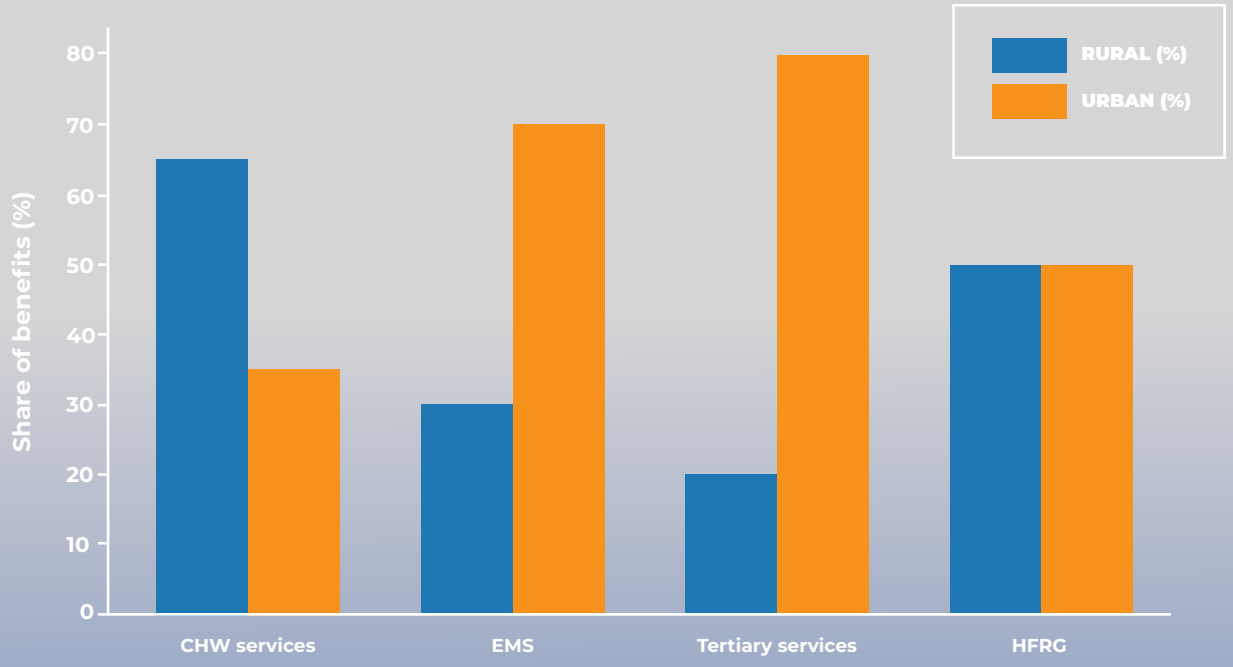
Assumptions include stable referral patterns and full utilisation of allocated funds. Staff shortages, long waiting lists, or underused theatres can reduce the actual benefit per Rand spent. Better data on patient origin (by province, rural/urban, income proxy) would sharpen the incidence estimates; here, we rely on qualitative patterns and known system features.





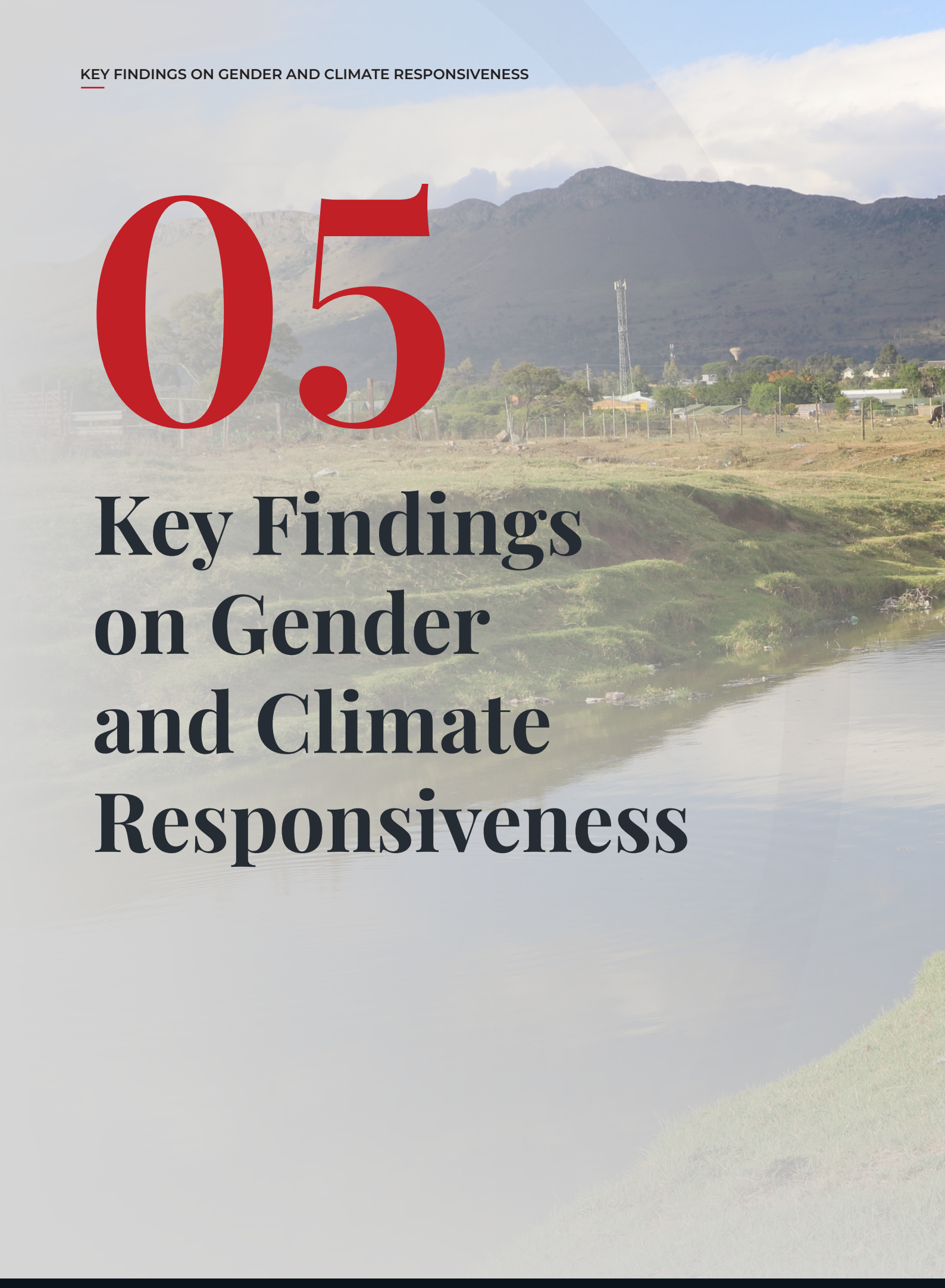
Rural vs Urban Benefit Incidence by Health Programme

Figure 10: Rural vs Urban Benefit Incidence by Health Programme



Public health spending in South Africa is broadly progressive, with poorer households receiving a larger share of benefits. Community health worker (CHW) services are particularly pro-poor, with the poorest quintile receiving an estimated 25–30% of benefits. However, higher-cost services remain less progressive, highlighting the importance of protecting and expanding primary-level and community-based care.





05

Key Findings on Gender and Climate Responsiveness

Gender Equity in the Budget Narrative

The 2025/26 health budget continues to frame women's health in narrow ways, focusing mainly on maternal and girls' health programmes. The highlights in the Estimates of National Expenditure (ENE) include objectives such as achieving 90% HPV vaccination coverage for girls aged 9 to 4 (National Treasury, 2025). The report also notes the existing women's Maternal and Reproductive Health subprogramme (National Treasury, 2025). Even with all this, neither the ENE nor the budget speech explicitly adopts a broader "gender equity" framing. Instead, as has previously been the case, the framing omits critical elements such as gender-based violence, women's decision-making power in healthcare, and gendered social determinants of health (Lencoasa, 2024).

These omissions have severe consequences for poor black women, who disproportionately rely on public healthcare and often bear the heavier burden of disease, including higher HIV prevalence (HSRC, 2023).



During austerity measures, therefore, black women are impacted the most, leading to increased unpaid caregiving responsibilities (Razavi, 2007). Yet, the budget continues to regard health allocations as gender-neutral. The small women's health subprogramme is the only one that stands out and accounts for just 0.1% of total health spending (National Treasury, 2025a). Analysts have repeatedly urged the Treasury to implement gender-tagging mechanisms to highlight which programmes benefit women (Budlender, 2002).

Many of the earlier budget cycles have this narrow positioning, which equates gender and health primarily with maternal health or HIV-related interventions for women. A highlight of the 2025 minister's speech is that he does not mention maternal health or HIV at all, instead prioritising system issues such as infrastructure, staffing, and NHI implementation (National Treasury, 2025b). The result is that women's health issues remain absent from the policy discourse. In the main, women continue to be positioned as passive recipients of specific health services rather than individuals with rights within and interest in a well-functioning and transforming health system, leaving questions of gender equity, systemic bias, and care burdens unresolved.

Climate Resilience in the Health Budget Discourse

The 2025/26 health budget revealed a blind spot in that neither the minister's budget speech nor the ENE made any reference to climate change, climate resilience, adaptation, or environmental health risks (National Treasury, 2025). This exclusion continues a long-standing pattern where South Africa's healthcare budgets rarely recognises climate risks, despite well-documented impacts.

During the KwaZulu-Natal floods in April 2022

85

healthcare facilities were destroyed,

and this disrupted service delivery across the province (Department of Health, 2022). Extreme weather events, such as floods, heatwaves, and droughts, are projected to become more frequent and intense over time. This not only threatens to damage critical health infrastructure but also increases the incidence of climate-sensitive diseases such as malaria, diarrheal illnesses, and heat-related conditions (IPCC,2022). Yet Vote 18 does not frame climate resilience as a priority, and the Environmental and Port Health subprogramme remains focused on routine regulation rather than climate adaptation (National Treasury, 2025).

This climate omission is consequential. Civil society research has consistently stated that budget cuts and underinvestment limit the healthcare system's ability to respond to climate shocks, especially those directly affecting women (SECTION27, 2024).



Climate risk is not gender-neutral, it disproportionately affects poor and rural women and by failing to incorporate climate adaptation into the health budget, these intersecting vulnerabilities remain unaddressed (SECTION27, 2024).

In spite of the commitments to erect new hospitals and upgrade clinics, the minister's budget speech for 2025 did not make mention of facilities that can withstand extreme weather events or rely on water and energy system backups during climate shocks. This omission is striking given the recurrent electricity cuts and water shortages across health facilities in the country (National Treasury, 2025).



06

Recommendations for Civil Society Advocacy and Further Research



Towards a Health Budget that Protects Life, Care, and Ecological Survival

The findings of this analysis point to a central contradiction in South Africa's health budget: while the state acknowledges inequality, gender injustice, and climate risk in rhetoric, fiscal decisions continue to reproduce structural underfunding, spatial exclusion, and the privatisation of care. Therefore, civil society has a critical role to play in contesting austerity, resisting the displacement of social costs onto households, and advancing a redistributive vision of health budgeting rooted in social justice, gender equality, and climate resilience. The following recommendations outline priority areas for advocacy and further research.

Protect and Expand Pro-Poor Health Funding

Civil society must foreground advocacy for public budgets that adequately resource South Africa's healthcare system to deliver quality, accessible, and equitable services.

This includes advancing a fiscal approach that recognises health spending as productive social investment rather than discretionary consumption, particularly in a context of persistent inequality, climate stress, and declining external financing.

Within this framework, sustained investment in core programmes that underpin system performance and protect access for poor, working-class, and marginalised communities remains essential.

The HIV/TB conditional grant, which is strongly pro-poor and central to population health outcomes, remains a cornerstone of the public health system and requires full and predictable funding, particularly as international donor support such as PEPFAR declines. Any fiscal consolidation measures affecting this grant must be subject to rigorous public scrutiny to ensure that savings are not achieved through service retrenchment, workforce erosion, or the quiet shifting of costs onto households. Evidence demonstrates that investment in HIV services is not only socially necessary but economically rational: estimates suggest that every US dollar invested in HIV in South Africa between 2022 and 2030 generates approximately seven dollars in economic returns through improved health outcomes, sustained productivity, and reduced future treatment costs (HE2RO, 2023).

Civil society advocacy should therefore challenge narrow framings of health expenditure and instead assert health funding as a form of social investment that underpins system resilience, gender equity, labour reproduction, and long-term economic participation.



Ensuring the quality and effectiveness of health budget execution

Beyond the level of allocations, civil society should prioritise scrutiny of how health budgets are executed, recognising that the effectiveness of public spending depends on whether funds translate into real improvements in service delivery.

In the context of climate stress, infrastructure fragility, and workforce shortages, every rand allocated to healthcare must be protected from underspending, misallocation, leakage, and corruption, and must be directed towards strengthening service delivery capacity. Poor spending outcomes weaken the health system's ability to respond to rising demand, erode public trust, and undermine the realisation of health rights, particularly for those who rely exclusively on public services.

When allocated funds fail to reach clinics, facilities, and frontline workers, the costs are displaced onto households and unpaid caregivers, deepening gendered burdens of care.

Civil society advocacy should consequently prioritise transparency, accountability, and implementation capacity within health budgets, to ensure that public resources deliver tangible improvements in quality of care, workforce conditions, and system resilience.

Advance Rural Health Equity and Spatial Redistribution

Persistent rural–urban inequalities in access to emergency care, infrastructure, and specialist services reflect long-standing patterns of spatial injustice and uneven development. Civil society should campaign for targeted redistributive interventions to close this gap, including dedicated rural health equity funding through ring-fenced allocations or a conditional grant focused on rural EMS capacity, clinic rehabilitation, and workforce retention. This could include investment in ambulances in remote districts, upgrading dilapidated facilities, and providing meaningful incentives, such as housing, rural allowances, and career progression, to attract and retain health workers in underserved areas. Tragic and avoidable outcomes, including documented cases of patients dying while waiting for ambulances in provinces such as the Eastern Cape (Sobuwa, 2024), should be amplified as evidence of systemic failure rather than individual misfortune. Partnering with organisations with a rural health focus such as the Rural Health Advocacy Project can help sustain pressure on the state to address rural health as a matter of justice, not charity.

Embed Gender-Responsive Budgeting as a Material Practice

Gender-responsive budgeting in the health sector must move beyond symbolic commitments and be translated into concrete fiscal decisions. Civil society should advocate for the Department of Health and National Treasury to explicitly tag, allocate, and report on funding for women's health priorities and for interventions that reduce gendered inequalities in access to care. This includes dedicated resources to improve the quality of maternal health services, address persistently high maternal mortality, and strengthen health-system responses to gender-based violence. At the same time, a feminist approach to health budgeting must also address areas where men are structurally underserved, such as lower uptake of HIV and TB services, through targeted outreach and service design within primary healthcare. A genuinely gender-responsive health budget recognises that advancing women's health and reducing unpaid care burdens benefits society as a whole, but only if backed by deliberate allocations rather than implicit assumptions.

Build Climate Resilience into Health Spending

The health system is already experiencing the impacts of climate breakdown through floods, heatwaves, droughts, water shortages, and electricity disruptions, yet climate adaptation remains marginal within health budgeting. Civil society should push for climate risk to be systematically incorporated into health planning and financing, including routine climate-risk assessments and dedicated adaptation funding. All new facilities funded through the Health Facility Revitalisation Grant should be required to meet climate-resilient standards, such as solar power, water backup systems, and heat-appropriate design. Advocacy should also support the creation of a modest but targeted climate-adaptation envelope within the health budget to retrofit existing facilities in high-risk areas, through measures such as raised clinic platforms, rainwater harvesting, boreholes, and backup power. These investments should be framed as collective insurance against service collapse, rather than optional add-ons. Strengthening emergency preparedness through expanded EMS capacity, stockpiles of supplies, and climate-responsive training for health workers is equally critical. Further research mapping health facilities against climate risk can help direct adaptation resources to where they are most urgently needed.



Integrate Climate Risk into the Provincial Equitable Share

Climate risk is entirely absent from the Provincial Equitable Share formula, even though geography, environmental exposure, and ecological degradation fundamentally shape the cost of delivering health services. Provinces most exposed to floods, droughts, heat stress, water insecurity, and extreme weather are forced to absorb higher operating and infrastructure costs within an allocation framework that treats unequal conditions as neutral. This reproduces structural underfunding in climate-vulnerable, largely rural and working-class areas, while shifting the costs of climate adaptation away from the fiscal centre and onto provincial systems and households. In practice, this deepens gendered and classed inequalities, as women compensate for service failures through unpaid care work. Civil society should advocate for a climate-vulnerability adjustment within the PES health component, using explicit weighting for environmental risk and remoteness, as a redistributive intervention aligned with climate justice and the constitutional obligation to deliver healthcare equitably.

Support the Health Workforce and the Care Economy

Sustained investment in the health workforce is essential to reversing service deterioration and reducing unpaid care spillovers, which disproportionately impact women. While the 2025/26 budget's hiring commitments represent a partial shift away from austerity, civil society must monitor implementation



closely, tracking whether community health workers are actually hired, paid on time, and deployed where need is greatest, and whether new clinical staff reach high-burden districts. Advocacy should emphasise that care work is socially necessary labour that must be valued, protected, and adequately resourced. This includes decent working conditions for nurses and CHWs, access to training, safety protections, and mental-health support, particularly as climate shocks and public-health crises intensify workloads. Budget advocacy could also extend to measures that directly reduce unpaid care burdens, such as expanding community-based services or introducing caregiver support mechanisms (for example, transport vouchers for rural caregivers). Further research quantifying the economic value of unpaid care substituted for public health failures would strengthen the case for sustained public investment.

Monitor Equity Outcomes and NHI Readiness

As South Africa moves toward National Health Insurance (NHI), civil society and researchers must track whether health financing is genuinely becoming more equitable in practice. Building on this distributional analysis, baseline indicators should be established now and monitored annually. Key questions include whether benefit incidence improves for poorer quintiles and rural areas, whether gender gaps in access and outcomes narrow, and whether NHI funding reallocates resources toward provinces and populations with the greatest need. Independent oversight will be essential to prevent NHI from reproducing existing inequalities under a new institutional form. Priority research areas include district-level mapping of spending and outcomes, evaluation of the local impact of new infrastructure investments, and geospatial analysis of health facilities against climate risk. Establishing a tight research–advocacy feedback loop will ensure that evidence generated through monitoring and analysis directly informs future budget campaigns and policy interventions.

By advancing these demands, civil society can push the health budget beyond rhetorical commitments toward a genuinely redistributive, gender-responsive, and climate-just financing framework. The 2025/26 budget signals a tentative break with deep austerity; sustained pressure is now required to convert this opening into structural change that centres the needs of the poorest, the care economy, and communities on the frontlines of climate crisis.

Leveraging Community Health Workers for Climate-Health Surveillance

As part of the Department of Health's (DoH) climate adaptation strategy, there is an urgent need to improve data collection on the health impacts of climate change. Community Health Workers (CHWs) are uniquely placed to support this goal. Embedded within vulnerable communities and already involved in outreach and service delivery, CHWs could be trained to observe and report key climate-sensitive health indicators, such as spikes in respiratory illness during wildfire events, diarrhoeal outbreaks following floods, or access disruptions during extreme weather. Integrating these data into existing health information systems would strengthen local early warning and response capacity. This intervention would not only enhance national surveillance efforts but also support CHW professionalisation by expanding their scope of work and skillset. The Department could consider piloting this approach in high-risk districts, in collaboration with academic and climate-health stakeholders, with a view to scaling it nationally as part of South Africa's climate-resilient health system.



APPENDIX A:

Expenditure Incidence Analysis and Benefit Incidence Analysis

This analysis uses Expenditure Incidence Analysis (EIA) and Benefit Incidence Analysis (BIA) to estimate who benefits from selected South African health budget allocations. We focus on Community Health Workers (CHWs) and the nursing workforce, healthcare infrastructure investments, and major health conditional grants. Benefits are assessed across sex (women vs men), income groups (quintiles), province, and rural vs urban status. We draw on official budget documents (e.g. *Vote 18: Health* and the National Department of Health's Annual Performance Plan), as well as national surveys and program reports. Where precise beneficiary data are unavailable, we use logical proxies and clearly state assumptions and limitations.

EIA vs BIA: In this context, EIA allocates government health spending to population groups based on service provision, while BIA considers the actual utilisation of health services by those groups. For example, if R100 million is spent on a program, EIA would distribute that spending across quintiles based on intended coverage, whereas BIA would distribute the benefits based on who actually uses the services (often derived from survey data). In practice, we combine these approaches: using budget allocations alongside data on service utilization (e.g. clinic visit rates by income group). All assumptions are documented. Table 1 summarises the estimated incidence (share of benefits) of each budget item by key groups.

Table 1. *Approximate Benefit Incidence (%) of Key Health Budget Items by Group.* (Values indicate the estimated share of program benefits accruing to each group.)

Programme / Allocation	Women	Men	Poorest Quintile	Richest Quintile	Rural	Urban
Community Health Workers & Nursing	90% ♀ (Nurses) / ~70% ♀ (CHWs)	90% ♀ (Nurses) / ~70% ♀ (CHWs)	90% ♀ (Nurses) / ~70% ♀ (CHWs)	90% ♀ (Nurses) / ~70% ♀ (CHWs)	90% ♀ (Nurses) / ~70% ♀ (CHWs)	90% ♀ (Nurses) / ~70% ♀ (CHWs)
Health Infrastructure (HFRG)	~50% ♀	~50% ♂	~25%	~10%	~60%	~40%
HIV & TB Programs (District Grant)	~55% ♀	~45% ♂	~25%	~10%	~50%	~50%
Emergency Medical Services	~50% ♀	~50% ♂	~30%	~5%	~30%	~70%
Provincial Health Services	~55% ♀	~45% ♂	~40% (bottom 50% ≈50%)	~10%	~40%	~60%
Tertiary Hospital Services (NTSG)	~50% ♀	~50% ♂	~20%	~5%	~20%	~80%
HR Training & Dev. (Workforce)	~70% ♀**	~30% ♂**	n/a†	n/a†	~50%**	~50%**

Notes: Estimates are illustrative, based on available data and logical assumptions. "♀" and "♂" denote female and male shares. *Tertiary services are located mostly in urban centers, so urban residents benefit more directly; however, patients from rural provinces are referred to urban hospitals, partially redistributing benefits. **The health workforce is predominantly female (especially nurses), so wage benefits largely accrue to women; however, training programs benefit all provinces via new placements (community service) roughly equally (assumption). †For the HR Training grant, incidence by income quintile is not directly applicable; benefits accrue through improved service delivery and workforce distribution rather than direct service use by a particular income group.

This incidence analysis is referenced in section 3 of this report. In the section, we provide detailed analysis for each category, including data sources, assumptions, and key patterns (especially related to gender and climate vulnerability). Where data is limited, we use proxies (e.g. population health indicators or service usage rates) and flag the associated uncertainties. Despite data gaps, clear patterns emerge – notably that public health spending in South Africa is progressive, benefiting lower-income and vulnerable groups disproportionately, and that women tend to benefit strongly (both as patients, especially in HIV programs, and as health sector employees). We also highlight climate-related vulnerabilities in health service delivery (e.g. infrastructure in flood-prone rural areas).

APPENDIX B:

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