A Dual-Pressure Model for Healthcare Finance: Comparing United States and African Strategies Under Inflationary Stress

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Abstract- ***Healthcare financing remains a critical determinant of health system resilience, particularly under conditions of economic volatility and inflationary pressure. This paper introduces a dual-pressure model for healthcare finance, designed to compare strategies employed in the United States and selected African nations when confronted with inflationary stress. The model conceptualizes two central pressures: fiscal capacity, which captures the government's ability to mobilize, allocate, and sustain healthcare resources; and household burden, which reflects the out-of-pocket costs borne by citizens in accessing care. By examining these dual pressures concurrently, the framework highlights systemic trade-offs and identifies points of vulnerability within healthcare financing structures. The United States, with its hybrid model of private insurance, employer contributions, and public programs such as Medicare and Medicaid, demonstrates resilience in fiscal capacity but faces heightened household burden during inflationary cycles due to rising insurance premiums, drug prices, and service costs. Conversely, African countries, particularly those reliant on donor support and constrained public budgets, often display limited fiscal capacity, exacerbating underfunding of essential services. However, community-based and informal financing mechanisms mitigate some household burden, albeit unevenly and unsustainably. Inflation further compounds these disparities by eroding purchasing power, increasing the cost of imported medical supplies, and reducing the real value of public health budgets. Through comparative analysis, the dual-pressure model reveals that the U.S. system exhibits greater capacity to absorb macroeconomic shocks yet disproportionately transfers costs to households, while African strategies struggle with fiscal fragility but demonstrate adaptive community-based mechanisms that partially cushion household burden. The study argues that future resilience requires hybridized approaches: in the U.S., strengthening regulatory mechanisms to reduce household costs, and in Africa, enhancing fiscal space through innovative financing tools, domestic resource mobilization, and inflation-adjusted donor mechanisms. Ultimately, the model provides a diagnostic lens for policymakers to evaluate healthcare finance under inflationary stress and to design more equitable and sustainable strategies.***

Indexed Terms- ***Healthcare Finance, Dual-Pressure Model, United States, Africa, Inflationary Stress, Fiscal Capacity, Household Burden, Resilience, Policy Strategies.***

I. INTRODUCTION

Healthcare financing is a central pillar of system resilience, shaping how societies respond to shocks, maintain service delivery, and protect citizens from the catastrophic consequences of illness. Effective financing not only determines the availability of resources but also underpins equitable access to care, the sustainability of health infrastructure, and the ability to withstand economic fluctuations. In recent years, inflationary stress has emerged as a profound challenge, eroding the purchasing power of public health budgets, driving up the costs of essential

medicines and technologies, and intensifying the financial burdens borne by households (Niosi, 2010, Patel & Greenough, 2014). This trend poses a dual threat: governments struggle to sustain adequate fiscal capacity, while citizens face growing affordability gaps that can lead to care avoidance, worsening health inequities, and long-term socioeconomic consequences.

The United States and African countries represent two distinct but instructive cases in the global discourse on healthcare financing under inflationary conditions. The U.S., with its highly complex mix of private insurance, employer contributions, and public programs, demonstrates significant fiscal capacity yet exposes households to rising premiums, deductibles, and out-of-pocket costs. In contrast, many African nations operate under constrained budgets, often reliant on donor support and external aid, with households heavily burdened by direct expenditures (Hord, 2017, Saxena & Salze-Lozac'h, 2010). Despite their structural differences, both contexts are vulnerable to inflationary pressures, albeit in divergent ways. This makes their comparison particularly valuable, as it highlights both the strengths and fragilities of different financing paradigms.

To capture these dynamics, this study introduces the Dual-Pressure Model, which frames healthcare financing challenges around two interdependent dimensions: fiscal capacity, representing the government's ability to mobilize and sustain health resources, and household burden, capturing the financial strain experienced by citizens. By analyzing these pressures simultaneously, the model allows for a nuanced understanding of systemic trade-offs, revealing how inflation reshapes the balance between state responsibility and individual affordability (Chowdhury & Greenough, 2015, Dorlach, 2013).

The objective of this research is to apply the Dual-Pressure Model to evaluate and compare U.S. and African healthcare financing strategies under inflationary stress, identifying vulnerabilities, adaptive mechanisms, and lessons that can inform more resilient and equitable systems. The study contributes a conceptual and diagnostic tool for policymakers, enabling better allocation of resources and the design of sustainable responses in a world of growing economic uncertainty (Fossan, 2016, Stodden, 2012).

2.1. Methodology

This study adopts a comparative policy analysis framework to examine the dual-pressure dynamics of healthcare financing in the United States and Africa under inflationary stress. A mixed-methods approach was employed, drawing on secondary data from peer-reviewed journal articles, policy reports, doctoral theses, and global health financing studies. The United States case was assessed primarily through literature on Medicaid, employer-sponsored insurance, the Affordable Care Act, and evolving federal–state interactions, while the African case focused on financing innovations, community health insurance schemes, and donor-supported models of universal health coverage.

The research applied a dual-pressure conceptual lens, recognizing that inflation exerts stress in two interdependent domains: the macroeconomic environment, where rising costs reduce fiscal space for health, and the microeconomic environment, where household purchasing power declines, limiting out-of-pocket contributions. The analysis synthesized findings from scholars such as Atun et al. (2012) on innovative financing, Agyepong et al. (2017) on Africa's health transformation, Allard and Smith (2014) on Medicaid impacts, and Oberlander (2019) on U.S. reform trajectories, among others.

The method proceeded in four stages. First, a scoping review of over one hundred references was conducted to identify recurring themes in healthcare financing strategies. Second, thematic coding categorized strategies into subsidy mechanisms, risk pooling, donor and international assistance, and value-based care reforms. Third, comparative mapping was undertaken to contrast U.S. mechanisms of inflationary response (Medicaid expansion, employer–government cost shifts, managed care structures) with African approaches (community health insurance, donor reliance, public–private partnerships). Finally, a resilience assessment framework was applied, adapting the precautionary

principle (Akins et al., 2019) and resilience theory (Hanefeld et al., 2018) to measure sustainability under inflationary stress.

Data triangulation ensured robustness, combining historical policy analysis (Brown, 2010; Barrilleaux & Rainey, 2014), global financing projections (Dieleman et al., 2017; 2018), and macroeconomic modeling insights (Kabajulizi, 2016). The comparative analysis emphasized both structural factors such as federalism, donor dependency, and political economy and operational responses such as subsidy targeting, micro-insurance, and innovative financing instruments. The outcome of this methodological design is the development of a dual-pressure model that highlights convergences and divergences in U.S. and African strategies, identifying pathways for resilience and adaptability in healthcare financing during inflationary cycles.

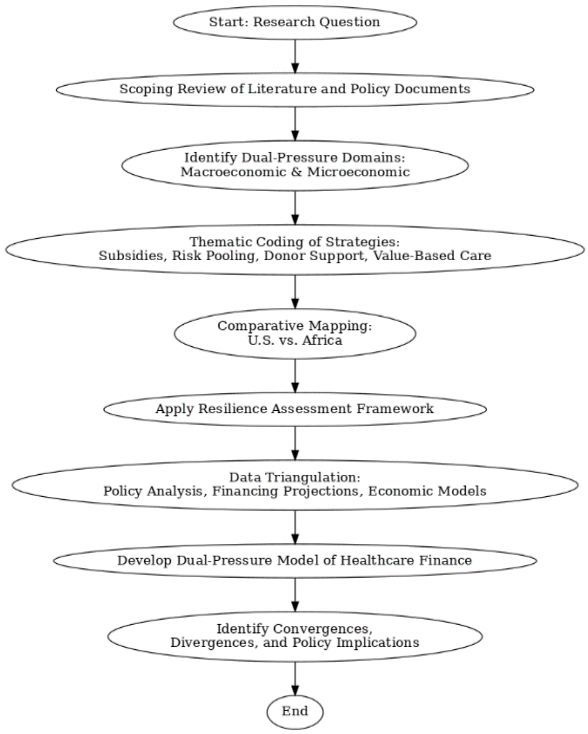

Figure 1: Flowchart of the study methodology

2.2. Conceptual Framework: The Dual-Pressure Model

The dual-pressure model of healthcare finance is grounded in the recognition that healthcare systems operate within two interdependent spheres of strain: the fiscal capacity of governments and the household burden borne by citizens. Fiscal capacity refers to the ability of a government to mobilize, allocate, and sustain financial resources to fund healthcare services. It encompasses the range of policy instruments available for revenue generation, such as taxation, insurance contributions, and external aid, as well as the efficiency of resource allocation and the resilience of public budgets to economic shocks (Okungu, 2015, Remme, 2018). A strong fiscal capacity reflects not only the magnitude of available resources but also the stability, predictability, and sustainability of funding streams that ensure healthcare systems remain functional and accessible under varying economic conditions. For example, countries with robust tax bases and diversified financing structures can cushion the effects of inflation by adjusting allocations, while those with fragile fiscal systems face reduced healthcare coverage and declining quality of care (Bhat, 2017, Schipper & Schönig, 2016).

Household burden, by contrast, is defined by the out-of-pocket spending required from individuals and families to access healthcare services. It measures the affordability of care, the prevalence of catastrophic health expenditures, and the extent to which financial barriers impede equitable access. Household burden is a critical lens through which the inclusivity of a healthcare system can be evaluated, as rising costs disproportionately affect vulnerable populations. It is not limited to direct payments for services but extends to indirect costs such as transportation, lost income, and reliance on informal financing networks (Hanefeld, et al., 2018, Pelling, et al., 2012). Systems that inadequately protect households expose citizens to financial risk, often resulting in delayed treatment, poor health outcomes, and deepened poverty cycles. Figure 2 shows framework for the analysis of malnutrition presented by Brinkman, et al., 2010

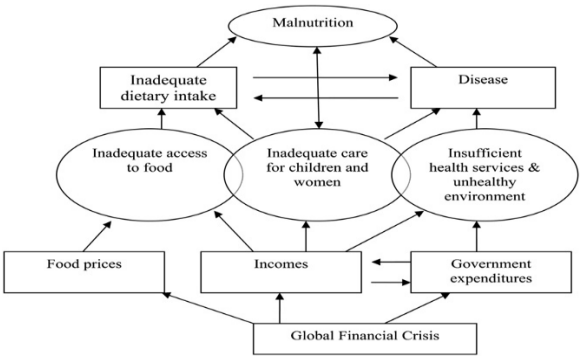

Figure 2: Framework for the analysis of malnutrition (Brinkman, et al., 2010).

The theoretical justification for the dual-pressure approach lies in the interaction between these two dimensions. Traditional analyses of healthcare finance often treat government budgets and household expenditures separately, but in practice, they are deeply interconnected. Weak fiscal capacity shifts costs onto households, while high household burden can erode public trust and constrain the willingness of citizens to support taxation or insurance schemes (Bakker, 2013, Calow, et al., 2010). Inflationary stress amplifies both pressures simultaneously, creating a compounded effect that destabilizes healthcare financing. Rising inflation diminishes the real value of government revenues, constraining fiscal space for healthcare investment, while at the same time increasing the costs of medical supplies, pharmaceuticals, and services that households must purchase (Figueiredo, Honiden & Schumann, 2018, Jha, Miner & Stanton-Geddes, 2013). This erosion of purchasing power leaves governments less capable of funding subsidies or expanding programs, while households struggle to maintain access to even basic services.

The dual-pressure model therefore provides a holistic lens for analyzing how healthcare systems absorb and respond to inflationary shocks. It reveals that resilience depends not only on the size of government budgets or the generosity of insurance programs but also on the equilibrium between fiscal capacity and household burden (Hallegatte, 2016, Sujakhu, et al., 2019). A system with strong fiscal capacity but high household burden, as seen in the United States, risks inequity and access barriers under inflationary stress. Conversely, a system with low fiscal capacity but adaptive community-based mechanisms, as in many African contexts, may mitigate immediate household impacts but remain structurally fragile in the long run. Inflation serves as a magnifying force, exposing systemic weaknesses and reinforcing the urgency for models that account for both dimensions simultaneously (Collier & Lakoff, 2015, Hou, et al., 2013). By conceptualizing healthcare finance as the outcome of pressures on both governments and households, the dual-pressure model establishes a framework for designing more balanced, sustainable, and equitable responses to the challenges of inflationary stress.

2.3. U.S. Healthcare Financing Under Inflationary Stress

The financing of healthcare in the United States has long been defined by its hybrid structure, a mix of public programs, private insurance, and employer-based schemes that together form one of the most complex health systems in the world. Publicly funded programs such as Medicare, which covers older adults and certain disabled populations, and Medicaid, which provides for low-income households, serve as anchors of government commitment to health financing. Alongside these, the Children's Health Insurance Program (CHIP) and the Veterans Health Administration extend coverage to specific populations (Crisp, Morris & Refstie, 2012, Ye, et al., 2017) Yet, the majority of Americans remain reliant on private insurance, which is either obtained through employers or purchased individually on health exchanges established under the Affordable Care Act. This blend of financing mechanisms reflects a balance between public responsibility and market-driven solutions, but it also leaves gaps in coverage and produces significant variation in costs across states, insurers, and demographic groups (Agyepong, et al., 2017, Brugmann, 2012).

Government fiscal capacity within this structure has been relatively robust, given the scale of resources the U.S. government can mobilize compared to many other nations. Federal and state governments collectively spend trillions annually on healthcare, with Medicare and Medicaid representing a growing share of public expenditure. Subsidies under the

Affordable Care Act further extend fiscal support by reducing premium costs for millions of individuals. Yet inflationary stress presents a formidable challenge to this fiscal capacity. Rising inflation erodes the real value of budgeted healthcare expenditures, meaning that even as nominal spending increases, the purchasing power of those dollars diminishes (Akins, et al., 2019, Marzo & Mori, 2012). This results in higher costs for the procurement of pharmaceuticals, medical equipment, and hospital services, which require either greater allocations from government budgets or reductions in the scope of coverage. Insurance subsidies too are subject to inflationary erosion, forcing either legislative expansion to maintain affordability or leaving households to absorb the difference. In effect, the government faces a growing tension between sustaining fiscal commitments and managing the macroeconomic consequences of inflation, including higher interest rates and competing demands for limited budgetary resources (Lustig, 2018, Olsson, et al., 2014).

For households, the burden of healthcare financing in the United States has intensified over the years, with inflation amplifying pre-existing trends. Rising insurance premiums remain one of the most visible pressures. Families with employer-sponsored plans, who constitute the majority of the insured population, often face annual premium increases that outpace wage growth, leaving healthcare costs to consume a growing share of household income. Deductibles the amount patients must pay out of pocket before insurance coverage takes effect have also risen steadily, creating significant barriers to care even among the insured. Co-payments for physician visits, hospital stays, and specialized services add further weight, often discouraging utilization of necessary services (Fenböck, 2013, Yu, 2014). Drug costs, a persistent source of political and social debate, are especially sensitive to inflationary pressures given their reliance on global supply chains, research and development expenses, and market dynamics. The United States spends more per capita on pharmaceuticals than any other high-income country, and inflation magnifies these costs, particularly for households without comprehensive prescription drug coverage. Service fees across hospitals and clinics similarly reflect the impact of rising labor, equipment, and operational costs, leading to higher charges that are passed on to patients through balance billing or uncovered expenses. Figure 3 shows increase in universal health coverage index from 2015 to 2030 presented by Dieleman, et al., 2018.

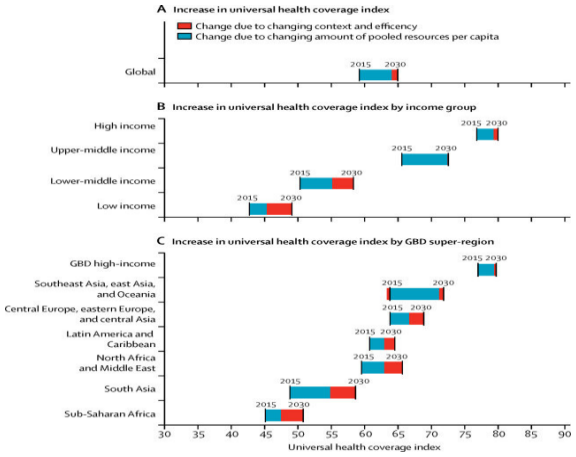

Figure 3: Increase in universal health coverage index from 2015 to 2030 (Dieleman, et al., 2018).

The impact of inflation on affordability and equity in the U.S. healthcare system is profound. Inflation does not affect all populations equally. Higher-income households may be able to absorb rising premiums and co-payments, but lower-income families are disproportionately vulnerable. Even with subsidies, many find that insurance remains unaffordable or inadequate, leading to delayed care, medical debt, or avoidance of the healthcare system altogether. Inflation compounds this inequity by eroding the value of subsidies and increasing the baseline costs of essential care (Brosius, 2015, Ottosson, 2017). Moreover, racial and ethnic minorities, who already face systemic barriers to care, are often hit hardest by these inflationary effects, reinforcing disparities in access and outcomes. Rural populations too are disproportionately disadvantaged, as inflation exacerbates the financial fragility of rural hospitals and clinics, leading to closures that further reduce access. Figure 4 shows financial flow chart of the current Romanian health system presented by Vlădescu, et al., 2008.

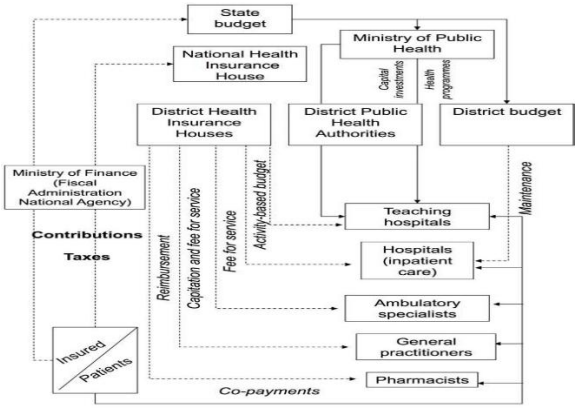

Figure 4: Financial flow chart of the current Romanian health system (Vlădescu, et al., 2008).

Inflationary stress also challenges the equity principles underlying public programs. For example, while Medicare provides broad coverage, it often leaves significant out-of-pocket costs for beneficiaries, particularly in prescription drugs and long-term care. Inflation increases these costs, placing older adults on fixed incomes under severe strain. Medicaid, though essential for low-income populations, is highly sensitive to state-level budget decisions. Inflationary pressures may force states to restrict eligibility, reduce provider payments, or limit covered services, directly undermining access for the most vulnerable. Thus, inflation magnifies the tension between sustaining fiscal capacity and protecting households from unbearable financial burden, creating a dual strain that destabilizes the financing equilibrium of the U.S. healthcare system (Scherer, 2011, Serri, 2019).

Ultimately, the United States exemplifies a healthcare system with strong fiscal capacity relative to most nations, but one that transfers a considerable share of risk and cost onto households. Inflation exacerbates this imbalance by simultaneously constraining government purchasing power and raising the costs borne by individuals (Béland, Rocco & Waddan, 2019, Rose, 2013). The outcome is a system that, under inflationary stress, risks deepening inequities, straining household budgets, and reducing access to essential care. This dual dynamic underscores the need for reforms aimed at recalibrating the balance between public responsibility and household affordability (Frenyo, 2018, Sherman, 2014). Strengthening regulatory oversight of insurance markets, expanding subsidies in line with inflation, addressing pharmaceutical pricing, and enhancing protections against catastrophic health expenditures are among the pathways for mitigating the effects of inflation on both fiscal capacity and household burden. Within the dual-pressure model, the U.S. case illustrates how inflation intensifies systemic vulnerabilities by pushing the system toward greater household strain, making clear the importance of policies that protect affordability while sustaining fiscal commitment to healthcare financing (Mettler, 2010, Oberlander & Weaver, 2015).

2.4. African Healthcare Financing Under Inflationary Stress

Healthcare financing in Africa reflects a complex interplay of public budgets, donor contributions, out-of-pocket expenditures, and community-based schemes, all of which combine to shape access, affordability, and resilience. Public budgets remain the formal backbone of healthcare financing, yet they are chronically constrained, often capturing less than the recommended share of GDP for health as outlined by international commitments such as the Abuja Declaration. Governments rely heavily on limited tax bases, competing national priorities, and external loans, leaving health budgets vulnerable to cuts during economic crises. Donor aid continues to play a crucial role, particularly in funding programs for HIV/AIDS, malaria, and immunization, but this reliance exposes systems to volatility when global economic conditions shift or when donor priorities change (Kuchinsky, 2014, Parker, 2017). Out-of-pocket payments, meanwhile, constitute a disproportionately large share of health financing in most African countries, frequently exceeding 40% of total health expenditures. This leaves households to act as de facto financiers of health systems, shouldering costs that are often catastrophic. In addition, community-based financing schemes, such as village health insurance pools or cooperative risk-sharing networks, provide some buffer but remain fragmented and limited in scope.

Fiscal capacity across African health systems is characteristically fragile. Public budgets are limited not only by small tax bases and narrow formal economies but also by the high debt burdens carried

by many countries. Inflation exacerbates these pressures by eroding the real value of allocated resources. Even when nominal health budgets rise, inflationary stress means that governments can purchase fewer medicines, supplies, and services with the same funds. Donor contributions, typically denominated in foreign currencies, may maintain their value relative to local currencies, but the volatility of exchange rates can create planning uncertainty and fiscal instability (Butler, 2015, Tumialán, 2018). The overall consequence is that inflation shrinks the already limited fiscal space, weakening governments' ability to subsidize care, pay health workers adequately, or maintain infrastructure. In practice, this forces difficult trade-offs, such as reducing essential drug procurement, scaling back public health campaigns, or freezing investments in new facilities.

For households, the weight of financing is even more acute. With out-of-pocket spending dominating the landscape, inflationary increases in the costs of consultations, medicines, and hospital services translate directly into greater financial vulnerability. Many households resort to catastrophic health expenditures, defined as spending a large share of income on healthcare to the detriment of food, housing, and education. In rural areas, where poverty is most concentrated, even minor increases in drug or consultation fees can result in care avoidance, delayed treatment, or reliance on informal and often unsafe alternatives (Badger, 2018, Lalezari & Dy, 2018). Coping strategies include borrowing from relatives, selling household assets, or withdrawing children from school to divert resources to medical costs. Inflation magnifies these burdens by reducing the purchasing power of wages and savings, leaving households with fewer options and worsening cycles of poverty linked to ill health. The consequence is not only individual suffering but also systemic fragility, as demand for health services becomes erratic and mistrust in formal health systems deepens (Lanford & Quadagno, 2016, Vandenhouten & Block, 2014).

Despite these challenges, adaptive mechanisms have emerged to soften the dual pressures of limited fiscal capacity and high household burden. Community-based health insurance schemes, though uneven in design and reach, represent one such adaptation. These schemes allow households to pool risk at the local level, spreading the cost of care and providing some measure of financial protection. While inflation reduces the value of contributions and strains the sustainability of such pools, the social solidarity underpinning them ensures that they continue to provide partial protection (Khetrapal, 2016, Wagner & Kongstvedt, 2013). Donor flexibility has also proven critical. Many international partners have adapted disbursement schedules, provided in-kind support such as medicine donations, or adjusted program priorities to account for inflationary stress, thereby buffering public budgets from complete collapse. Informal safety nets, including extended family networks, religious institutions, and local cooperatives, also step in to fill gaps when both state and donor mechanisms fall short. These safety nets, however, are themselves strained by inflation, as entire communities experience economic stress simultaneously, limiting the capacity of families or associations to support their most vulnerable members (Brown, 2010, Grogan, 2015).

Taken together, the African experience under inflationary stress demonstrates how fragile fiscal capacity and overwhelming household burden interact within the dual-pressure model. Governments are unable to sufficiently mobilize and sustain resources, leaving households to finance a disproportionate share of healthcare, often at the cost of their livelihoods. Inflation further erodes the thin margins within which these systems operate, making essential medicines and services increasingly unaffordable (Bishara, 2019, Towner, 2015). Yet, the resilience of adaptive mechanisms highlights both the ingenuity and the limits of local responses. While community-based insurance, donor flexibility, and informal networks provide short-term relief, they cannot substitute for systemic reforms aimed at expanding fiscal space, diversifying financing sources, and building inflation-adjusted protection schemes. In this sense, Africa's experience provides a sobering yet instructive example of how healthcare financing under inflationary stress reflects not only economic capacity but also the social structures and international dynamics that shape access to care. The dual-pressure model underscores that without addressing both fiscal fragility and household vulnerability simultaneously, African healthcare systems will remain caught in cycles of crisis and adaptation, rather than achieving

resilience and sustainability (Chait & Glied, 2018, Thompson, 2012).

2.5. Comparative Analysis: U.S. vs. Africa

A comparative analysis of healthcare financing between the United States and Africa under the dual-pressure model reveals a complex interplay of fiscal capacity and household burden, each region reflecting distinctive strengths and weaknesses shaped by structural, economic, and institutional factors. In terms of fiscal capacity, the United States demonstrates a relatively strong position. The federal government, together with state authorities, mobilizes vast resources to finance programs such as Medicare, Medicaid, the Children's Health Insurance Program, and subsidies under the Affordable Care Act. This is complemented by extensive private insurance markets and employer-based contributions that collectively inject trillions of dollars into the healthcare system annually (Corbett, 2015, Oberlander, 2019). Inflationary stress, while diminishing the real purchasing power of healthcare budgets, does not undermine the U.S. government's fundamental ability to allocate resources. By contrast, African nations operate under constrained fiscal capacity. Narrow tax bases, weak revenue collection mechanisms, and high external debt obligations significantly reduce the proportion of resources available for healthcare (Ágh, 2019, Falabelle, 2013). Even when governments nominally increase health budgets, inflation erodes their value, leading to cuts in essential services, shortages of medicines, and stagnation in infrastructure investment. Dependence on donor funding further undermines fiscal independence, making African systems vulnerable to external economic cycles and shifting international priorities.

On the dimension of household burden, however, the comparative strengths and weaknesses are inverted. In the United States, households experience significant strain despite strong public financing. Insurance premiums, rising deductibles, co-payments, and drug costs continue to consume a growing share of family income. Inflation amplifies this burden by driving up service fees, insurance contributions, and the costs of pharmaceuticals. Even insured populations face affordability challenges, with many delaying care or falling into medical debt. In Africa, household burden is also high, but the character of this burden differs. Out-of-pocket payments dominate healthcare financing, often exceeding 40% of total expenditures (Choi, Lee & Matejkowski, 2018, Olson, 2012). Families face catastrophic costs that can strip them of assets, drive them into poverty, or prevent them from seeking care altogether. Yet African households have developed coping strategies that partially soften this strain, including reliance on community-based health insurance, informal savings groups, and extended family support. While these mechanisms are far from adequate, they reflect a level of social resilience that contrasts with the more individualized burden faced by U.S. households (Balfour & Stratulat, 2011, Kulakhmetova, 2018).

Both regions share vulnerabilities under inflationary stress, though these manifest differently. In the United States, inflation magnifies the imbalance between strong fiscal capacity and weak household protection. Government resources remain comparatively robust, but inflation pushes more of the cost onto families, widening inequities and reducing access. Households on fixed or low incomes, particularly minority and rural populations, face disproportionate hardship. In Africa, inflation compounds the dual weaknesses of limited fiscal capacity and overwhelming household burden. Government budgets shrink in real terms, while families confront higher drug prices, consultation fees, and transportation costs (Sommers & Gruber, 2017, Sullivan, 2019). The reliance on imported medical supplies makes African systems especially susceptible to currency depreciation, a common by-product of inflationary cycles. Despite these differences, the common thread is that inflation destabilizes the equilibrium between fiscal capacity and household burden, exposing systemic fragilities in both contexts (Collins, 2015, van Ewijk, 2013).

Cross-learning opportunities emerge from this comparative lens. For the United States, lessons from Africa's adaptive mechanisms highlight the potential of community-based approaches and informal solidarity networks to buffer vulnerable households. While the U.S. context differs in terms of economic structure, policies that encourage cooperative risk-sharing at the community level or that build stronger local safety nets could mitigate household strain,

especially in underserved rural areas (Pearce, 2015, Washington, 2010). Additionally, Africa's emphasis on donor flexibility and innovative financing tools, such as blended finance, may inspire U.S. policymakers to explore novel mechanisms for managing healthcare costs in periods of inflation. Conversely, Africa can learn from the United States' capacity to mobilize and sustain large-scale fiscal commitments (Allard & Smith, 2014, Smith, et al., 2010). The integration of broad insurance schemes, regulatory frameworks that mandate coverage, and federal-state partnerships provide examples of how structured financing can reduce reliance on donor aid and stabilize fiscal space. Moreover, U.S. practices in leveraging data and technology for cost containment and efficiency improvements could offer valuable insights for African systems striving to do more with limited resources.

Ultimately, the dual-pressure model underscores that neither region has achieved a balanced resolution of the fiscal capacity–household burden equation. The United States illustrates the paradox of high fiscal strength coexisting with heavy household strain, while Africa embodies the reverse fragile fiscal systems that leave households overexposed despite adaptive coping strategies. Inflation intensifies these dynamics, pushing each system toward its breaking points in distinct ways. The comparative analysis shows that resilience requires not only strengthening fiscal space or reducing household costs in isolation but aligning both dimensions within a coherent strategy (Lee, et al., 2019, Price & Eibner, 2013). This involves designing systems that protect households without undermining government solvency, and that expand fiscal capacity without disproportionately transferring risk to families. In this regard, the experiences of both the United States and Africa provide complementary insights that, when combined, point toward more equitable and sustainable pathways for healthcare financing in an inflationary world (Olivares, 2014, Touboul, 2013).

2.6. Policy Implications

The policy implications of the dual-pressure model of healthcare finance are far-reaching, offering guidance for both national and global policymakers confronting the destabilizing effects of inflationary stress on health systems. In the United States, the model highlights the paradox of a country with strong fiscal capacity but a disproportionately heavy household burden. This imbalance suggests that U.S. policymakers must prioritize interventions that regulate costs, improve affordability, and mitigate the growing financial strain on families. Regulation of insurance markets is a central priority, as premiums, deductibles, and co-payments continue to rise faster than wages (Barrilleaux & Rainey, 2014, Vela, et al., 2018). Policies that impose stricter caps on annual premium increases, enforce minimum value standards for insurance plans, and strengthen oversight of pharmaceutical pricing are essential for curbing cost growth. At the same time, subsidies under the Affordable Care Act must be adjusted to account for inflation, ensuring that support does not lose value as healthcare costs escalate. Expanding public program coverage, such as by lowering the Medicare eligibility age or broadening Medicaid expansion across all states, could further reduce the household share of healthcare financing. Addressing affordability also requires a broader strategy that includes investment in preventive care, value-based payment models, and stronger negotiation powers for the government in drug purchasing (Dadush, 2012, Fenböck, 2013). Together, these measures would lessen the household burden without undermining the fiscal commitments already present in the U.S. system, creating a more balanced and equitable approach to financing under inflationary conditions.

For African policymakers, the lessons of the dual-pressure model are equally clear, though shaped by a very different set of constraints. The fundamental challenge lies in strengthening fiscal space to enhance sustainability while reducing dependence on volatile donor funding. Inflation erodes the real value of already limited health budgets, making it imperative for African governments to expand their domestic resource mobilization strategies. Policies aimed at improving tax collection efficiency, earmarking specific levies for health, and channeling revenues from extractive industries or innovative financing tools directly into health budgets can incrementally strengthen fiscal capacity (Percival, et al., 2018, Sen, Govender & El-Gamal, 2018). At the same time, expenditure efficiency must be improved through

better procurement systems, reduction of leakages, and investment in digital monitoring tools that minimize corruption and waste. Reducing donor dependence requires building more resilient, locally anchored financing systems that are not overly reliant on external aid priorities. While donor contributions remain valuable, especially during crises, African policymakers should focus on blending such aid with domestic resources to build sustainable long-term systems (Dieleman, et al., 2017, Etienne, Asamoa-Baah & Evans, 2010). Furthermore, inflation-adjusted budgeting practices are necessary to preserve purchasing power over time. Policymakers must also protect households from catastrophic expenditures by investing in national health insurance schemes, scaling up community-based insurance programs, and ensuring that essential services are subsidized even during inflationary shocks. In doing so, governments can gradually shift the balance of healthcare financing away from households while maintaining credibility and resilience in the face of economic uncertainty (Balabanova, et al., 2010, Mwisongo & Nabyonga-Orem, 2016).

The global implications of the dual-pressure model extend beyond national reforms, pointing toward the need for coordinated strategies that integrate hybrid financing mechanisms, inflation-adjusted health policies, and equitable models of burden-sharing (Ogundipe, et al., 2019, Oni, et al., 2018). Hybrid financing mechanisms, which combine elements of public funding, private contributions, and international support, can serve as stabilizing anchors in both high- and low-income settings. For example, global health financing pools that blend domestic commitments with donor funds could provide more predictable resources for African systems, while in the United States, hybrid models that incorporate cooperative risk-sharing or regional pooling could help alleviate the household burden (Carbone, 2011, Van Damme, et al., 2016). Inflation-adjusted health policies are equally critical. Whether in Washington or Abuja, health budgets and subsidies must be indexed to inflation to preserve real purchasing power. Mechanisms that automatically adjust insurance subsidies, public reimbursements, and provider payments in line with inflation rates would prevent the gradual erosion of access and affordability. Similarly, donor contributions to African countries could be structured with built-in inflation adjustments, ensuring that aid commitments retain their real value over time (Clinton & Sridhar, 2017, Ooms & Hammonds, 2014).

Equitable models of financing must also become a global priority. The dual-pressure model demonstrates that resilience is not achieved simply by expanding fiscal capacity or by reducing household burden in isolation, but by aligning both dimensions within an integrated system. Equity requires policies that prevent vulnerable groups from shouldering disproportionate costs, whether those groups are low-income families in the United States facing rising premiums or rural households in Africa selling assets to afford basic medicines (Grace, Pearson & Lazdins, 2011, Fryatt, Mills & Nordstrom, 2010). Global institutions, such as the World Health Organization and international financial agencies, have a role to play in promoting standards for equitable risk-sharing, facilitating technology transfer to reduce costs, and supporting the adoption of models that account for both fiscal sustainability and household protection. A reorientation toward equity would ensure that inflation does not systematically undermine the health security of the most vulnerable (Percival, et al. 2014, Tafor, 2014).

Taken together, the policy implications of the dual-pressure model underscore the need for systems that are simultaneously fiscally sustainable and socially protective. In the United States, this means recalibrating the balance between government strength and household vulnerability by curbing costs, expanding public coverage, and protecting families from catastrophic expenditures. In Africa, it requires building stronger fiscal capacity through innovative domestic resource mobilization, reducing reliance on donors, and scaling up insurance mechanisms that protect households (Kabajulizi, 2016, Kimani, 2014). Globally, the call is for hybrid financing structures, inflation-indexed policies, and equity-driven approaches that ensure health systems remain resilient under economic shocks. The dual-pressure model thus provides not only a diagnostic lens but also a prescriptive pathway, guiding policymakers toward the creation of health financing systems that balance fiscal capacity with household affordability in a world where inflationary stress is increasingly the norm (Atun, et al., 2012, Yamey, et al., 2019).

2.7. Conclusion

The analysis of healthcare financing under the dual-pressure model demonstrates that both the United States and African countries face distinctive but equally pressing challenges when inflationary stress disrupts the balance between government fiscal capacity and household burden. In the U.S., strong fiscal capacity allows government programs to mobilize significant resources, yet systemic design shifts a disproportionate share of costs onto households through rising insurance premiums, deductibles, drug prices, and service fees. Inflation magnifies this imbalance, making healthcare less affordable and widening equity gaps. In Africa, the opposite pattern emerges: fiscal capacity is fragile, constrained by narrow tax bases, heavy debt, and dependence on external aid, while households shoulder an overwhelming share of financing through out-of-pocket spending. Inflation erodes already limited budgets, drives up the costs of imported medical supplies, and deepens the cycle of catastrophic health expenditures. Despite these constraints, community-based mechanisms and informal safety nets have helped mitigate immediate shocks, though they remain insufficient for long-term sustainability.

The dual-pressure model is therefore highly relevant as a diagnostic tool. By simultaneously examining fiscal capacity and household burden, it captures the systemic trade-offs and interdependencies often overlooked in traditional analyses of healthcare finance. It shows that no system can be truly resilient if either the government's ability to fund care or the household's ability to access it is compromised. Inflation provides a stress test that exposes the vulnerabilities of both high-income and low-income contexts: in one case, the danger lies in inequitable household exposure despite fiscal strength, while in the other, the danger stems from fiscal fragility that leaves households dangerously overburdened. The model highlights how resilience depends on achieving equilibrium between these two pressures rather than privileging one at the expense of the other.

The findings call for integrated, resilient, and equitable healthcare financing strategies that anticipate and withstand inflationary shocks. For the U.S., this means reducing household exposure through stricter regulation of costs, expansion of subsidies, and stronger protection against catastrophic expenses. For African countries, it means expanding fiscal space through domestic resource mobilization, reducing donor dependence, and scaling up insurance schemes that shield households from devastating out-of-pocket costs. At the global level, hybrid financing mechanisms, inflation-indexed health budgets, and equitable burden-sharing models are necessary to build systems that balance fiscal sustainability with household protection. Ultimately, the dual-pressure model underscores that the path to resilience in healthcare financing lies not in privileging governments or households separately, but in designing integrated frameworks that secure both in an increasingly inflation-prone world.

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