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2014 Ebola Outbreak Exposes Large Gaps in Financing Adequate Healthcare in West African Countries

by Robtel Neajai Pailey, Department of Development Studies, SOAS

Introduction

According to a report in the *New England Journal of Medicine*, the recent outbreak of the Ebola Virus Disease (EVD) in West Africa might have originated in a toddler from the rural village of Meliandou, Guinea. After the child's mysterious death in December 2013, symptoms, including high fever, diarrhoea, vomiting and organ failure, emerged in family members who subsequently passed away.

It is unclear how the 2-year-old, referred to as patient zero, was infected, yet his case has led currently to nearly 5,000 reported deaths and more than double the number of confirmed, probable and suspected infections in Guinea, Liberia and Sierra Leone—the three countries most affected by Ebola. Because of porous borders, transborder trade and travel and, importantly, fragile healthcare systems, the current epidemic has spread rapidly into capital cities such as Conakry, Monrovia and Freetown.

Assessing Ebola from a political economy perspective, this Development Viewpoint contends that while the countries most affected have been urged in the past to prioritise conventional macro-economic policies of liberalisation, privatisation and deregulation, they have not been similarly supported to build strong public health systems as a development imperative.

The Political Economy of Ebola

The Ebola outbreak spiralled out of control in Guinea, Liberia and Sierra Leone because of their similar political economy trajectories. The three countries are members, for example, of the Mano River Union (MRU), established in 1973 to increase regional economic integration. Yet all three countries have been recovering from recent major ruptures in their socio-political and economic systems. For instance, Liberia and Sierra Leone experienced more than a decade of armed conflict pre-Ebola.

The three MRU nations could have benefitted more meaningfully from large reserves of mineral deposits that attracted billions of dollars in foreign direct investment. Nevertheless, investments have been largely isolated in the extractive industries, without stimulating other vital sectors in their economies.

The critical point is that any economic gains made in the past decade in these three countries have been quickly reversed because of a lack of financing of basic quality healthcare. With the closure of borders, suspension of international flights and the evacuation of concession-company personnel, the three MRU nations have experienced inflation in commodity prices—particularly in fuel and food—decreases in agricultural productivity, low revenue collection and exchange rate volatility, bringing their economic activity to a virtual standstill.

According to World Bank preliminary projections, the short-term impacts of the Ebola outbreak would lead to significant decreases in economic growth rates between 2014 and 2015—from 4.5% to 2.4% in Guinea, from 5.9% to 2.5% in Liberia and from 11.3% to 8.0% in Sierra Leone.

Even if there were some containment of the disease by the end of 2014, the Bank estimates that the three countries would still lose US$97 million worth of GDP in 2015 alone. If there is little or no containment by end-2014, the GDP loss for 2015 could rise to a total of US$809 million. Although these projections are speculative, they emphasise the importance of taking urgent action now to contain the epidemic as well as following up with long-term structural changes in the financing of quality healthcare.

Healthcare before Ebola

Infrastructure to support the provision of quality healthcare was a challenge before the outbreak of Ebola in all three MRU countries. According to the World Health Organisation's Global Health Observatory Data Repository, Guinea, Liberia and Sierra Leone hovered at the bottom of most tables on health indicators and the quality of health systems pre-Ebola.

For instance, healthy life expectancy (HALE) at birth for both sexes in 2012 was only 39, 49 and 52 years for Sierra Leone, Guinea and Liberia, respectively, while the global average was 62. While Sierra Leone's HALE was the lowest in the world, the HALEs of Liberia and Guinea ranked only slightly higher. The Table shows that the HALEs in 2012 for the three MRU nations were all lower than the average for all low-income countries, i.e., 53.

HALE 2012 Figures

World Bank Income Group	HALE for both sexes
Low-income	53
Lower-middle-income	57
Upper-middle-income	66
High-income	70
Global	62

Source: WHO Global Health Observatory Data Repository: http://apps.who.int/gho/data/view.main.700?lang=en

Centre for Development Policy and Research
SOAS, University of London
Thornhaugh Street, Russell Square, London , WC1H 0XG, UK

www. soas.ac.uk/cdpr
Email: cdpr@soas.ac.uk
Telephone: +44 (0) 207 898 4316

As additional evidence, estimates for physicians per 1,000 people generated for 67 countries in 2004 show that while Guinea ranked 46th with 0.11 per 1,000, Liberia and Sierra Leone were tied at 62nd, recording a mere 0.03 physicians per 1,000 people. Tellingly, there are more Sierra Leonean healthcare professionals in the UK than in the country itself. These statistics suggest that investments in quality healthcare do indeed matter.

Domestic Healthcare Financing

In April 2001, the Organisation of African Unity (now African Union) convened in Abuja, Nigeria, "to address the exceptional challenges of HIV/AIDS, Tuberculosis, and other related Infectious Diseases." The participating countries pledged to allocate at least 15% of their national budgets to improve their health sectors.

From 2001 to 2011, health budgets across the continent did increase, on average, from 9% to 11%, but they were still lower than the committed level. While six member states—namely, Liberia, Madagascar, Malawi, Rwanda, Togo and Zambia—increased healthcare financing to the desired level and above, the 15% target is still far from being met by most African nations.

The reports of the World Health Organisation on the health expenditures of the three MRU countries at the epicentre of Ebola are revealing. According to the 2012 Health Systems Financing Country report, Guinea spent US$32 per capita on health—with 67% of this total spent by households, 28% spent by government and 5% spent by other sources. Compared to the expenditures of other low-income countries in Africa, the share of Guinea's total government expenditures allocated to healthcare was low, i.e., only 7%.

In 2012 Sierra Leone spent US$96 per capita on health, but 76% of this total was accounted for by households and a mere 17% by government. However, Sierra Leone's share of total government spending allocated to healthcare was 12%, a median range within Africa.

2012 statistics on health spending in Liberia give a mixed picture. Although it spent less per capita than Sierra Leone, namely, US$65 versus US$96, the share of government's total budget spent on health was higher, 19% versus 17%. The irony is that although Liberia had higher public-sector healthcare financing, it has still recorded half of the current Ebola fatalities. Clearly, increasing financing, though important, is not enough.

Important Lessons

The Ebola outbreak has demonstrated that healthcare should definitely account for a larger share of government expenditure in countries facing grave crises, such as Guinea, Liberia and Sierra Leone. However, emphasis must be placed on improving the provision of quality healthcare, rather than simply increasing the quantity of financing itself.

Such an approach will require investing in a comprehensive healthcare infrastructure that supports trained and well-paid staff, healthcare centres located beyond urban metropolises, adequate supplies and equipment as well as sustained and relevant local medical research.

The need to overhaul entire healthcare systems is a major long-term lesson for averting an Ebola epidemic of this scale and magnitude. Nigeria, which reported 20 cases and 8 deaths in the recent outbreak, serves as an example to emulate. It was able to contain the spread of the disease by employing systems already established to eradicate polio. It is also no coincidence that Nigeria spent US$94 per capita on healthcare in 2012, with 31% of such spending accounted for by the national government.

Concluding Remarks

The World Bank has committed a US$400 million emergency stimulus package for Guinea, Liberia and Sierra Leone to help them stabilise their economies in the short- and medium-term. While some of the money will be in the form of grants, a portion will be concessional loans. Yet, for the three MRU countries, there is clearly a need to curb loans that can lead to heavy debt servicing. Such conditions may compromise future investments in quality healthcare.

First and most importantly, public-sector healthcare financing per capita must be increased in the affected countries in order to lessen the burden on households. Governments must also demand that concession companies and private-sector actors fulfil their corporate social responsibility by financing vital social services such as health and education. Donors contributing to healthcare must also channel funds directly through domestic budgets in order to strengthen aid coordination, transparency and effectiveness.

Second, improved healthcare financing should facilitate the training of more health workers and increase the incentives for the limited number who are currently serving in the affected countries—compensating them, at least, with a living wage and adequate social benefits. The death toll among health care workers alone has already exceeded 200 in the recent and on-going outbreak of Ebola.

Endnotes

1 Named after a river in the Democratic Republic of Congo (DRC), Ebola was first discovered in 1976. It spreads through contact with the bodily fluids of a symptomatic person.

2 HALE is a population health measure that estimates expected years of life in good health for persons at a given age.

Centre for Development Policy and Research
SOAS, University of London
Thornhaugh Street, Russell Square, London , WC1H 0XG, UK

www. soas.ac.uk/cdpr
Email: cdpr@soas.ac.uk
Telephone: +44 (0) 207 898 4316