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Pandemic Preparedness, Morocco, and Africa

By Uri Dadush

Abstract

Preparedness for the next pandemic is an essential investment. To get it right, countries must stay flexible and reinforce their international health networks, not abandon them. With its new health law, Morocco has taken a step in the right direction.

INTRODUCTION

The COVID-19 catastrophe has already caused more than 3 million deaths worldwide, accompanied by enormous economic damage, equal to several months of global GDP. Morocco has not been spared. It is estimated that nearly 9000 Moroccans have died and over 500,000 have tested positive for the virus. In 2020 the Moroccan economy suffered the worst contraction since independence, shrinking by 7%. The pandemic is far from over, but the arrival of remarkably effective and safe vaccines, and their relatively rapid deployment in Morocco, is a reason for hope.

Attention in Morocco and around the world is now turning towards preventing the next pandemic or—if prevention fails—preparing a better response for next time. A new health reform, which envisages extending health insurance to all Moroccans in defined stages, represents a first important step in that direction.

Amid the shortages caused by the pandemic, many in Morocco have advocated 'medical independence', which entails using a combination of government subsidies and protective tariffs to build factories that make personal protective equipment (PPE) and medicines, while accumulating large stocks of ventilators, vaccines and other essentials. Others argue instead for increased international cooperation. The new health law in Morocco is in that spirit since it opens the medical sector to foreign service providers and their state-of-the-art techniques.

How should the debates about preparedness for pandemics be resolved? How should Moroccans, and others in Africa, think about preparedness?

They should start by recognizing that pandemic preparedness—important as it is—is like any other investment by the public. Given high debt levels, made much worse by the pandemic, and limited fiscal resources, the investment that goes into preparedness

must balance risk and return. The prize is the avoidance or mitigation of an extremely damaging event. At risk are the resources required to prepare. For example, will new factories that produce ventilators be of use once this pandemic ebbs, and will dealing with the next pandemic require large numbers of ventilators?

Four Truths

Here are some facts drawn from the experience with COVID-19 which I believe help chart the right policy course.

The cost of preparedness is likely to be small compared to the devastation caused by pandemics.

Even if a country opts for a high level of preparedness, entailing stockpiling of medical equipment, establishing a comprehensive early-warning and disease monitoring system, and creating contingent field-hospital capacity, and even if it builds new factories to produce medical equipment and medicines, the cost of doing so is likely to be small compared to the effect of avoiding or mitigating a pandemic. This should not be read as saying that any investment in preparedness is justified or even useful.

McKinsey has estimated that an effective preparedness strategy at the global level—involving all countries—would cost $20 billion to $30 billion in upfront investment over two years, followed by an annual outlay of $5 billion to $10 billion. In the scenario explored by McKinsey, preparedness would include an early warning and investigation system in every region, the building of emergency operation centers for crisis management, stockpiling of equipment and medicines, and regular simulations of rapid response scenarios. Considering the damage inflicted by a pandemic can reach tens of trillions of dollars, the likely return on investment in preparedness is high even if the mitigation is only minimally effective.

By definition, pandemics are global. But this does not mean that preparing for pandemics is mainly a global responsibility. Pandemics affect families, villages, provinces, and whole nations; it is at the local and national level that they devastate the economy and harm people, and that is where action must be taken to prevent and contain them.

The policy implication is that all countries, even the poorest in Africa, must invest in preparedness. There are many valid reasons why poor countries should receive more aid—for example, to deal with the economic fall-out of the pandemic—but they do not (or should not) require financial incentives from abroad to prepare for pandemics, because it is in their vital interest to do so. The bigger question is, however: prepare for what, exactly?

Pandemics are rare and impossible to predict

There have been many epidemics—which affect certain regions or groups and have been contained within boundaries—but few pandemics. The last pandemic comparable to COVID-19 was the Spanish Flu of 1918, which was far more deadly, partly because the world was, compared to today, entirely unequipped to deal with it, with fewer medical resources, no antibiotics, no anti-viral medicines, no vaccine, and no real-time sharing of medical information or data. The Spanish flu and the many epidemics that have occurred since each had distinct characteristics, requiring different therapies and vaccines. The polio virus eventually succumbed to global vaccination, but no vaccine has been developed for malaria or HIV-Aids, for example, though effective therapies have been found for them after many years of trying. In macroeconomic policy we learnt at great cost that 'every crisis is different'—clearly every epidemic is different, too.

The policy implication is that the stockpiles of equipment or medicines that were needed in the last pandemic may not be of much use in the next. What matters instead is the ability to identify the disease early on and to be able to adjust in real time before it spreads out of control. Rapid identification and response both point to investment in research on pathogens, which is the comparative advantage of the most technologically advanced nations. The scientific advances that paved the way to mRNA vaccines have proved essential in the COVID-19 pandemic, and the more we know the more likely it is we can respond better in the future. The need to respond rapidly also requires filling the gaps in the coverage and quality of the healthcare system, gaps the pandemic has exposed. But this is something countries need to do anyway, not only to deal with pandemics.

Above all, pandemic preparedness and response require sound governance.

The differences between countries in COVID-19 infection and death rates are remarkable.

To the surprise of many, poor country outcomes have been generally better than those of richer countries (Table 1). Some of the difference in severity can be accounted for by factors including urban density, climate and seasonality, insularity, and age structure of the population, since younger populations were less affected.

Table 1: Incidence of COVID-19

Table : Incidence of COVID-19 and contributing factors: selected countries	Cases per 100000 population	Deaths per 100000 population	Share of population over 65	Medical doctors per 1000 population	Estimated GDP growth in 2020 (IMF)
European Union	5095.8	108.1	20	3.7	-6.1
USA	9296.9	167.4	16	2.6	-3.5
Morocco	1359.2	24.1	7	0.7	-7
Tunisia	2287	78.1	9	1.3	-8.8
South Africa	2626.1	89.8	5	0.9	-7
Nigeria	79.4	1	3	0.4	-1.8
Algeria	270	7.1	7	1.7	-6
Ethiopia	197.7	2.7	4	0.1	6

But these are structural features over which countries have limited control. In my view, after those factors, the most important variable determining pandemic outcomes is the quality of the government response. In countries where the disease was recognized early and taken seriously from the outset—China, Japan, New Zealand, Denmark, Morocco, to name a few—relatively few people died, even though the economic impact—due in part to the global contraction—was severe. In countries where the danger of the disease was persistently minimized—especially when that happened at the top of the governing hierarchy—and where experts were ignored (or ridiculed and threatened), as in Brazil and the United States, many people died, and the economic devastation was, if anything, worse.

Moreover, the disease had a bigger impact on the poorest and more vulnerable in society, and high inequality—especially in access to health care as in Brazil and the United States—contributed to the severity of outbreaks and led directly to high death rates. Unequal access to healthcare across geographies and social classes is, of course a feature in Morocco, even though—as discussed below—major efforts were made to ensure that those who fell ill with COVID-19 received care. Across most of sub-Saharan Africa, access to quality healthcare is precarious for all except a privileged few. The policy implication is that more must be done to fight inequality, especially in access to healthcare.

Does one also need to make the obvious point that leaders must care, must be ready to give bad news, and must believe in science?! The answer, unfortunately, is yes. Still, voters are clearly taking note: Donald Trump would, I believe, still be president today if the pandemic in the United States, which has killed over 560,000 people, had been better managed.

Globalization helps prepare for and respond to pandemics

Pandemics have been with us since ancient times, long before people spoke of globalization. The Black Death outbreak of bubonic plague wiped out much of the population of Europe, North Africa and Eurasia in seven years starting in 1346, when the predominant mode of transportation was the horse-drawn cart. As Yuval Harari has argued, to avoid pandemics it is not enough to stop or slow globalization—a current fad in many countries, including in Morocco. Instead, humanity would have to revert to the Stone Age when long-distance travel was by foot.

Contrary to the views of some, without globalization, and the international trade and scientific exchange associated with it, it would have been impossible for any country acting in isolation to have acquired so quickly enough masks, gloves, and ventilators, or to have developed vaccines and tested them so quickly, or to have produced

them in massive quantities drawing on sophisticated supply chains requiring hundreds of ingredients.

Especially given the impossibility of predicting the nature and timing of the next pandemic, the key to preparedness will be flexibility and the ability to tap global know-how. In policy terms, that means nurturing medical networks (equipment, medicines, services, expertise, data, and information) across open borders, not cutting them off.

Country Strategies

In summary, countries that want to contain the next pandemic must establish an early warning system—which represents a modest but critical investment in diagnosis, information gathering, and reporting. This is especially important in Africa and other poor countries which have limited medical capacity to deal with outbreaks once the disease has taken hold. Above all, countries must retain flexibility because pandemics are unpredictable. To do so, they should refute the siren song of 'medical independence' and instead nurture international networks in all aspects of healthcare, including in the supply chain for medicines, equipment, and know-how.

Many countries, beginning with those in Africa, need to do more to improve the quality and inclusiveness of their health systems, which they should do anyway to fight all disease, not only pandemics. The number of doctors in large population countries in sub-Saharan Africa ranges from 0.1 per thousand population to 0.9 per thousand population. In Morocco, there are just 0.7 per 1000 population. This compares with 2.6 per thousand in the United States and 3.5 per thousand in the European Union. The poorest countries need more aid to invest in better healthcare and to deal with the economic fall-out from the crisis, but they do not—or should not—need new incentives to control pandemics, which is in their vital interest anyway. As in all fields of policy, the quality of governance is critical to success in preparedness.

Morocco's new framework law on social protection and health reform provides an interesting example of what can be done even in a constrained fiscal environment. The law aims to expand support for families (child allowance) and to move in stages towards compulsory universal health insurance in Morocco, eventually to cover an additional 22 million Moroccans. Application of the new law is expected to cost 51 billion Dirhams per year (approximately $5.1 billion), of which 23 billion Dirhams (approximately $2.3 billion) will be covered by the government and the remainder by social and healthcare contributions from the workers covered by the scheme. The law also envisages making more use of international medical resources, including recognition of degrees and competencies acquired abroad, and encouragement of foreign investment in Morocco's health system.

International Coordination

International coordination has benefits, such as ensuring that countries with less resources don't get elbowed out of the way, but it is not a panacea. As shown in the relatively slow vaccine rollout in the European Union, coordination also carries costs and risks in the form of bureaucratization, slowness, and minimum-common-denominator solutions which do not work in a crisis.

That said, the international community has a significant role to play in controlling pandemics. The World Health Organization (WHO), the World Bank and the African Development Bank—to name the leading actors in the poorest countries—can contribute to improving preparedness in at least three ways: they can help identify best practices in preparedness and disseminate them across the world; they can strengthen mechanisms for global surveillance (for example to identify new virus strains) and share data on the progress of diseases internationally, a facility which already exists in the WHO; most important, working with the private sector and health ministries, they can encourage more international collaboration in the development of therapies and vaccines. Especially important are investments in techniques that enable the quick development of medicines, as well as protocols that promote their rapid testing and deployment.

In the end, however, the primary responsibility for pandemic preparedness lies with countries. Morocco's rapid deployment of vaccines, and its just-announced health reform are only a start, but they point the way for the rest of Africa.

About the author
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Uri Dadush is a Senior Fellow at the Policy Center for the New South, previously known as OCP Policy Center in Rabat, Morocco and a non-resident scholar at Bruegel. He is based in Washington, DC, and is Principal of Economic Policy International, LLC, providing consulting services to the World Bank and to other international organizations as well as corporations. He teaches courses on globalization and on international trade policy at the OCP Policy School and at the School of Public Policy at the University of Maryland. He was previously Director of the International Economics Program at Carnegie and, at the World Bank, Director of the International Trade, Economic Policy, and Development Prospects Departments. In the private sector, where he was President of the Economist Intelligence Unit, Group Vice President of Data Resources, Inc., and a consultant with Mc Kinsey and Co.

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The PCNS advocates the concept of an open, responsible and proactive « new South »; a South that defines its own narratives, as well as the mental maps around the Mediterranean and South Atlantic basins, within the framework of an open relationship with the rest of the world. Through its work, the think tank aims to support the development of public policies in Africa and to give experts from the South a voice in the geopolitical developments that concern them. This positioning, based on dialogue and partnerships, consists in cultivating African expertise and excellence, capable of contributing to the diagnosis and solutions to African challenges.

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