The Price of Doing Nothing: Why Africa Must Estimate the Economic Burden of Disease

Africa pays far more for disease than what appears in national budgets, with silent losses in productivity and human capital dwarfing health expenditures. This article demonstrates how measuring the Cost of inaction provides the evidence needed to align health and finance priorities for sustainable growth.



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Summary

Estimating the costs of disease and the costs of doing nothing can reshape how Africa invests in health and prosperity. Every African country pays for disease, whether or not it budgets for it. Health expenditure is visible in national accounts, but the much larger, silent cost of illness hides in lost productivity, premature deaths, reduced education, and eroded household savings. The core challenge is not clinical, but economic: failing to count the Cost of Inaction makes prevention seem expensive, when in reality, it is the only affordable choice. Drawing on studies I conducted across Africa to estimate the economic burden of disease and cost of inaction, this article outlines the systematic methodology required, demonstrates the overwhelming financial drain caused by productivity loss, and argues that the Economic Burden of Disease data is the foundational policy and advocacy tool needed to bridge health and finance ministries and secure Africa's human capital.

1. The Hidden Cost of Ill-Health

Across Africa, ministries of health fight to secure funds, while ministries of finance confront competing priorities. Yet both sides often work without knowing the real price their country already pays for disease. Africa's health problems already have a price tag. We just haven't written it down.

Across the continent, these invisible costs play out in daily life. A market vendor in Dakar who develops hypertension can no longer haul her vegetables to market; her income halves, and her children leave school to help at home. A bus driver in Kampala with uncontrolled diabetes misses work repeatedly; his employer loses revenue, and his family loses stability. A teacher in Blantyre recovering from a stroke faces months of rehabilitation, forcing the school to hire a temporary replacement at additional cost.

Africa's real health bill is not what is spent on health, it is what is lost because of ill-health. Understanding that loss is not an accounting exercise. It is a policy and advocacy tool that transforms how governments, donors, and citizens think about investment in health.

2. What We Mean by "Economic Burden"

The economic burden of disease refers to the total financial and economic losses caused by illness, disability, and premature death. This estimate goes beyond simple cost containment to quantify the overall economic impact. It reframes health as both a social and an economic issue. For example, in Malawi, a worker with uncontrolled diabetes who leaves the labour force doesn't just affect the health sector; the ripple extends to

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the economy and the tax base. In Ethiopia, polluted air that contributes to respiratory and cardiovascular disease reduces agricultural yields and urban productivity. By estimating the economic burden, countries can connect health, finance, and development in one conversation. It gives policymakers a new lens: health as a driver of prosperity, not a cost centre. Table 1 outlines different pathways for assessing this loss.

Table 1. Pathways to estimate economic burden

Type	Pathway	Sub-Category	Description
Direct	Direct healthcare costs	Direct healthcare costs	Costs of consultation, diagnosis, treatment, hospitalization, medications, and other healthcare services
Indirect	Reduced productivity of employed workers	Absenteeism	Lost output due to time away from work caused by illness
		Absenteeism (Caregivers)	Lost output due to time away from work caused by illness in children
		Presenteeism	Reduced efficiency and performance while at work due to illness
	Workforce reduction	Early retirement / Long-term disability	Loss of labour force participation due to permanent inability to work
		Premature deaths of workers	Lost lifetime productivity and income taxes from deaths among working-age individuals
	Informal sector losses	Informal sector losses	Value of foregone output from individuals engaged outside the formal labour market
	Societal losses	Deaths	Societal losses due to deaths across the population

3. The Price of Doing Nothing

Failing to act is not cost-neutral; it is the most expensive choice. The "cost of inaction" shows what countries lose when preventive and control measures are delayed. The "do nothing" scenario has a cumulative effect. A one-year delay in scaling up hypertension control or increasing tobacco taxes amplifies costs over decades. One uncontrolled diabetic patient today can lead to decades of lost productivity, higher medical costs, and social dependency tomorrow.

Across Africa, the same pattern emerges: productivity losses accumulate silently as working-age adults fall ill or die prematurely, households spend down savings on care, employers bear the costs of lost productivity, and health systems are forced to treat late-stage diseases at ten times the cost of prevention. The ripple extends beyond families: lower household incomes reduce consumption, weaken local markets, constrain tax revenue, and force health systems to treat late-stage diseases at ten times the cost of prevention.

The cost of inaction also widens inequality. Poor households spend a higher share of their income on health and are least able to recover from shocks. Each untreated illness deepens the divide between those who can afford care and those who cannot, eroding social cohesion and long-term development gains.

The burden is also deeply gendered. Women bear a disproportionate share of economic losses, not only because they often work in the informal sector, where illness erodes already fragile income, but also because they shoulder unpaid caregiving. When a child, spouse, or parent becomes ill, it is women who lose workdays, withdraw from school, or give up income-generating activities. These invisible costs rarely appear in budgets, yet they account for some of the largest productivity losses at the household and national level.

4. Why Knowing the Economic Burden Matters

Understanding the economic burden of disease changes how decisions are made by providing all stakeholders, from ministers to citizens, with a common language of evidence and impact. For Governments and Policymakers, this data informs priority-setting by revealing which diseases impose the greatest losses, allowing leaders to allocate resources where returns are highest. Crucially, it creates a shared language that transcends sector silos, enabling fiscal planners and Finance Ministries to respond to numbers that directly connect health to GDP, revenue, and employment. By quantifying economic losses, the economic burden of disease strengthens accountability, exposing the true opportunity cost of inaction and pressuring decision-makers to act.

The impact extends globally. For Development Partners and Donors, the economic burden of disease provides the quantitative evidence needed to guide smarter investment, allowing them to align support with high-impact, high-burden areas and reduce duplication through shared metrics. This framing also enhances advocacy, transforming the moral case for external assistance into an economic imperative. On the ground, for researchers and national institutions, conducting economic burden of disease studies builds critical local evidence capacity, strengthening analytic skills within ministries, universities,

and think tanks. The data empowers civil society and citizens, fueling advocacy by giving communities the economic proof to demand prevention and accountability, and clearly linking health to livelihoods and stronger economies. When a government knows what disease costs, it can choose to invest in prevention rather than pay the price of neglect.

5. Key Findings from Previous Research

Building on our extensive research across the Gulf Cooperation Council (GCC) and the Eastern Mediterranean Region (EMR) in collaboration with the World Health Organisation (WHO) and the United Nations Development Fund (UNDP), our studies have consistently highlighted the staggering economic burden of non-communicable diseases (NCDs) and the cost of inaction. These findings provide valuable insights and serve as a blueprint for future economic burden assessments in Africa.

In the GCC, we found that NCDs cost the region nearly US $50 billion annually, or about 3.3% of GDP. In the Eastern Mediterranean Region, we estimated that breast and cervical cancers cost the region US $15 billion annually, a figure projected to rise to US $379 billion by 2040. Our study of the economic burden of Diabetes in the Eastern Mediterranean Region also offers critical insights. In 2023, diabetes affected 74 million people, causing over 833,000 deaths and generating an economic burden of Int $639 billion. By 2050, this burden is projected to exceed Int $1.5 trillion. In addition, our research on rheumatic heart disease in the EMR highlighted an economic burden of US $5.8 billion in 2020, which could reach US $166 billion by 2050.

In Africa, the economic burden of disease is equally profound but often underestimated. In the last decade, we undertook studies in several African countries to estimate their national economic burden of disease and the cost of inaction, and the findings consistently show that ill-health is among the largest unmeasured drains on the continent's economies.

In Malawi, we estimated the economic burden of NCDs to be about 3% of GDP in 2025. Using the Human Capital Approach, the total burden was valued at US $309 million annually. In Zimbabwe, malnutrition and nutrition-related diseases caused an economic burden of US $652 million, or 3.9% of GDP in 2019. In Morocco, we estimated the economic burden of tuberculosis and HIV/AIDS in 2025 to be about US $166 million (0.1% of GDP). By 2050, the cumulative burden could reach US $4.5 billion, primarily driven by indirect costs related to premature labor force exit and mortality. In Ethiopia, household air pollution-related diseases, including stroke, IHD, COPD, lung cancer, acute lower respiratory infections (ALRI), and diabetes, resulted in an economic burden of US $3.9 billion annually. This represents 4.2% of GDP. In Nigeria, the economic burden of adverse pregnancy, maternal, and child health outcomes attributable to poor preconception health alone was estimated at US $3.3 billion annually (0.7% of GDP). This burden could accumulate to US $46.2 billion by 2035, with 99.5% of the total cost attributed to indirect losses, particularly from future productivity losses related to child cognitive deficits and maternal and neonatal mortality.

Across all these settings, a consistent pattern emerges:



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the majority of economic losses come not from direct health-care spending but from reduced productivity, premature mortality, and the erosion of human capital. These findings demonstrate the scale of the challenge and highlight why African policymakers require robust economic evidence to guide investment, prioritise prevention, and protect long-term development.

6. Overcoming Challenges in Estimating the Economic Burden of Disease

Estimating the economic burden of disease requires multiple sources of demographic, epidemiological, health system and economic data. In many African settings, the most significant barrier is the absence of comprehensive, national-level data on incidence, mortality, service utilisation and labour productivity. Rather than making the analysis impossible, these gaps make methodological transparency and triangulation essential.

A practical way to strengthen the estimates is to combine the available national data with well-established global sources. The Global Burden of Disease (GBD) study provides robust estimates for incidence, prevalence, disability weights and mortality where national surveillance systems are limited. Population structures can be drawn from the UN World Population Prospects, macroeconomic indicators from the World Bank, labour force parameters from the International Labour Organization, and life expectancy data from the WHO Global Health Observatory. These sources enable analysts to systematically fill data gaps while ensuring consistency with global reporting standards. Local studies, health facility reports and national surveys should be used as the main sources to refine assumptions and improve local relevance.

However, the main methodological challenge lies in estimating the economic value of premature death. Three core methods are commonly used, each with different implications for the estimation. The Friction Cost (FC) method suggests that each death results in temporary productivity lost, lasting only until the worker is replaced. While it's efficient for market analysis, it tends to undervalue life, which can be politically unappealing when advocating for large-scale health investments. The Human Capital (HC) approach, often preferred by governments and donors, calculates the value of life lost by estimating the future earnings a deceased person would have contributed until retirement. This method

directly links health loss to GDP, but it is limited because it doesn't account for those outside the formal workforce, such as unpaid caregivers, the elderly, or those in the informal sector.

In contrast, the Value of Statistical Life (VSL) approach, which uses willingness-to-pay (WTP) to capture the economic value of life, is considered the gold standard. However, its application in Africa is difficult due to survey limitations and the risk of low estimates. Despite these challenges, VSL remains the most comprehensive approach because it includes all individuals, not just formal sector workers. For countries with a large informal workforce or populations outside formal employment, VSL provides a more realistic reflection of the societal cost of death, encompassing the broader economic impact, including caregiving and community contributions. VSL offers the most complete societal perspective on the economic value of life, particularly in African settings.

7. Policy Mandates: The Way Forward

Understanding what disease costs fundamentally changes how governments and partners view health. In several African countries where economic burden analyses have been undertaken, health has shifted from being seen primarily as a budgetary expense to being recognised as a macroeconomic investment. This shift occurs when economic evidence enters the decision-making space of ministries of finance, planning commissions, and national development councils.

Three lessons have consistently emerged. First, national ownership determines uptake. When local technical teams and government institutions lead the estimation process, the findings gain legitimacy, are more readily debated in parliamentary and cabinet forums, and are more likely to influence budget cycles. Second, integration into broader reforms increases impact. Economic burden estimates have greater traction when they are embedded in ongoing Universal Health Coverage (UHC) reforms, national health insurance discussions, or primary health care (PHC) strengthening agendas.Third, communication shapes policy attention. Senior decision-makers rarely respond to technical detail, but they respond to simple and comparable metrics, such as the percentage of GDP lost, the projected cost of inaction over the next decade, or the return on investing in NCDs or PHC.

Regional bodies such as WHO, UNDP, and Africa CDC are playing an increasingly important role in facilitating cross-country learning, harmonising methodologies, and strengthening analytic capacity. Collaborative platforms help ensure that countries adopt comparable approaches, avoid duplication, and negotiate from a shared evidence base when engaging donors and development partners.

The challenge for the coming decade is institutionalisation. Economic burden of disease estimation must transition from sporadic, donor-driven exercises to a routine function within national planning processes.

Key actions to support this transition include:

1. **Mandate cross-ministerial use of economic burden data**. Ministries of Finance, Planning and Health should formally incorporate economic burden estimates into budget preparation, medium-term expenditure frameworks, and national development plans, ensuring that health expenditure is aligned with its economic return.
2. **Prioritise PHC investment using cost-of-inaction evidence**. Economic burden findings can guide reallocation of resources from costly late-stage treatment to high-impact preventive and PHC interventions, reinforcing the fiscal rationale for strengthening early detection and community-based care.
3. **Strengthen national data systems**. Investment in civil registration and vital statistics (CRVS), health information systems, and labour market data is essential to reduce reliance on global proxies and improve the accuracy of future estimates.
4. **Develop sustainable health economics capacity**. Establishing university-based training programmes, regional centres of excellence and in-ministry analytical units will ensure that countries can independently conduct, update and interpret economic burden analyses without waiting for external support.

Conclusion

Every nation has two budgets: the one it approves in parliament and the one it silently pays through lost lives, lost income, and lost potential. The second is far larger, yet rarely measured.

Estimating the economic burden of disease reveals that hidden budget and helps governments act before losses grow. It builds a bridge between health and finance, between moral duty and fiscal logic. Counting the cost is not about numbers, it is about priorities, justice, and the future we choose. When Africa begins to count what illness costs, it will finally begin to count what health is truly worth.

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