Malaria Finance Report

Financing for impact: Meeting Milestone Malaria Targets through Innovation and Collaboration

Since 2000 global malaria death rates have been cut by over 60%, saving nearly 7 million lives and adding an estimated 2 trillion to malaria-affected country economies.[1] This historic progress has been made possible thanks to political will and significantly increased global financing to expand access to simple, effective health tools such as mosquito nets, sprays, diagnostic tests and medicines.

However, we now face significant challenges to sustain and build on this remarkable progress:

- Malaria burden remains high: A child still dies of this preventable, curable disease every two minutes; it keeps children out of school and can drain up to 25% of a household's income, perpetuating cycles of poverty.
- Increased coverage needed: Millions at risk still lack access to proven prevention, testing and treatment tools due to insufficient resources.
- Future funding uncertain: More resources needed, but donor funding – which makes up more than two thirds of total financing to fight malaria – has plateaued; meanwhile domestic health and malaria funding is not significantly increasing.
- Rapid resurgence risk: As recent examples from Africa have shown, malaria surges back with deadly consequences when interventions and financing are not sustained.
- Growing drug and insecticide resistance: If we don't act now resistance could render current tools ineffective and reverse progress achieved so far.

The key to addressing each of these challenges, and achieving the next malaria targets, is political will and sufficient, sustained financing.

The international community has signalled its collective ambition to accelerate progress towards a malaria free world, including the Sustainable Development Goal (SDG) aim to end the epidemic of malaria by 2030. This is backed by the World Health Organization's Global Technical Strategy for Malaria 2016–2030, aiming to cut malaria cases and deaths by a further 90% and eliminate malaria in at least 35 more countries by 2030.[2] The deadly history of malaria resurgence demonstrates why we cannot afford to leave the job of malaria elimination half done.[3] Only by meeting these ambitious targets can the lives of billions of people be saved and improved.

RBM Partnership To End Malaria

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Malaria financing is, however, precarious. Without concerted effort we are in danger not only of not increasing resources sufficiently to reach these targets, but also of backsliding on current intervention coverage levels – threatening a reversal of the gains achieved to date.

There is a critical need for more resources to be invested in the malaria fight without delay. Donor and domestic public health investment must increase together with identifying efficiencies and new financing mechanisms to meet the funding gap:

Key Recommendations:

1. Donors must keep promises to provide Overseas Development Assistance (ODA) to fund effective malaria prevention, case management and R&D, including increased contributions to effective multilateral mechanisms such as the Global Fund.

2. Malaria-affected countries must prioritise investment in health and tackling malaria in their National Development Plans, driving down mortality and morbidity and enabling improved productivity and economic growth.

3. National governments should maximise and prioritise public resources for health while reducing out-of-pocket spending by the poorest, including for malaria services.

4. National governments and donors should explore potential innovative and leveraged mechanisms to increase health sector financing as well as opportunities to highlight and share learning and encourage cross-country collaboration.

1. The vital role of Overseas Development Assistance in combatting malaria

Following significant growth since 2005, donor financing for malaria has plateaued over the last few years. Analysis of future trends in overall ODA shows that aid allocations to partner countries are predicted to remain constant at 2015 levels until at least 2019.[4] These trends imply future real term reductions in funds for essential development efforts, such as in-country healthcare. To date, ODA remains by far the biggest source of malaria financing, and recent successes in combating malaria have been largely due to increased ODA. Given the link between malaria and poverty, alternative sources of financing need to be additive rather than substitutive if we are to achieve the next global targets. Therefore, notwithstanding the potential for domestic revenue raising and innovative financing, international donors must continue to provide funding for malaria prevention, case management and R&D, including increased contributions to effective multilateral mechanisms such as The Global Fund.

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2. Prioritising Universal Health Coverage and tackling malaria within National Development Plans

The WHO has long advocated the importance of Universal Health Coverage (UHC) and the critical need for governments to devote sufficient funding to achieve it. Institutions providing policy guidance to government, such as the IMF, have also shifted their approach in recent years, advocating that essential services like health care are maintained even when fiscal space is constrained.[5]

An increasing number of countries, such as Botswana, Gabon, Ghana, Rwanda and Senegal, are introducing universal health systems. The common framework is that the poorest and most vulnerable are covered by free care, funded through wider taxation, with public health insurance schemes available for the rest of the population. As part of this investment in UHC, the benefits of controlling or eliminating malaria are clear. High burden countries, in particular could significantly reduce morbidity and mortality rates and unlock economic productivity and growth through sustained investment in reducing their malaria burden. To finance UHC, each country needs to develop its own integrated financing framework; each country faces differing challenges and an assessment on a country by country basis is required. It is vital that National Development Plans prioritise

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investment in health and tackling malaria, ensuring long-term strategies are linked to core priorities within Integrated National Financing Frameworks.

3. Maximising public resources for health and malaria, and protecting the poorest

Malaria-affected countries governments can also take advantage of donor incentives and leverage opportunities to support sustainable financing for National Development Plans that include a commitment to UHC and to tackling malaria such as:

Leveraging Global Fund Financing
The Global Fund is aiming to incentivise governments across income and burden groupings to increase investments in health and disease-specific programmes through its 2017–2019 'Sustainability, Transition and Co-Financing Policy'.[6]

This co-financing links domestic health financing to donor funding, aiming to support increased overall government allocations to the health sector over time, even in the lowest incomes countries, with the goal of ending the epidemics of HIV, TB and malaria and achieving UHC.

Co-financing is flexibly tailored to enable low income countries to have a broad application focus for its health financing. However, the focus for middle income countries is on co-financing for specific disease programmes with the aim of transitioning towards national health financing.

Financing Facility for Central America and the Caribbean
To help incentivise malaria elimination efforts in Central America and the Caribbean, the Inter-American Development Bank is designing a programme that commits loans and donor funding from 2018 to 2022 to work alongside domestic public resources. If governments are successful in eliminating malaria, then a bonus contribution would be made by donors, which would cover loan interest payments and some of the governments' contributions to the programme.

This programme is still being designed and undergoing feasibility assessment, however, the concept shows the potential for development resources to be pooled in ways that both incentivise delivery of outcomes and leverage ongoing funding.

Supporting increased domestic tax revenue collection
Donors who are members of the Addis tax initiative have stated that they will double support towards domestic public resource mobilisation by 2020.[7]

Though contexts vary, it is generally held that governments need to collect the equivalent of 15% of GDP in non-grant revenue to provide basic services.[8] Countries with lower percentages create a 'tax gap', which indicates likely spending shortages and acts as a crude measure of countries' potential to increase domestic revenue collection.

Analysing this potential tax gap in the context of countries' malaria status reveals wide variation in non-grant revenue as a proportion of economic output between high and low burden countries. Though most malaria-affected countries do not have a tax gap, in 2015 a total of 21 did (of which 13 were considered high burden). Of those, nine countries had non-grant revenues lower than 12% (of which seven were high burden). This suggests that there may be potential within the highest burden countries to scale up domestic public resources to support increased health expenditure.

Governments also need to assess the impact of their tax regimes on the poorest and, where necessary, correct imbalances through targeted tax exemptions or spending programmes (e.g. social protection programmes, subsidies or free access to health services). User fees, unless means-tested exemptions are applied, can negatively affect the poorest who are often unable to afford access to care. Conversely, innovative tax revenue generation can enable additional resources to be syndicated, i.e. specifically earmarked for health sector financing, such as the special VAT and mobile top up taxes employed by Ghana, Zimbabwe and Gabon to finance national health insurance schemes. National governments should maximise and

prioritise public resources for the health sector while reducing out-of-pocket spending by the poorest, including for malaria services.

4. Exploring potential innovative sources of funding

In addition to innovative national tax revenue opportunities, there are several well established innovative funding arrangements for health and malaria. UNITAID is largely funded through airline levies.[9] The Global Fund is one of the best examples of resource pooling, including successfully reducing commodity costs by increasing scale and predictability of financing. Other Public Private Product Development Partnerships (PPPs / PDPs) such as Medicines for Malaria Venture (MMV), IVCC, FIND and PATH MVI have been a highly successful in re-energising the R&D pipeline for malaria tools.[10] Other targeted initiatives such as the Global Fund's Debt2Health and the BMGF/ Islamic Development Bank's Lives and Livelihood Fund are examples of innovative finance aimed at enabling governments access additional capital to help deliver malaria outcomes.[11,12]

Other innovative financing mechanisms being tried in some areas include Development Impact Bonds, performance-based contracts that set out desired development outcomes with private investors providing funding for a set of interventions aimed to achieve them. These have proved tricky in practice but one example being pursued after a successful pilot is the Mozambique Malaria Performance Bond, a collaboration between the Mozambique Ministry of Health, Anglo American, Nando's and Dalberg Global Development Advisors.[13]

Another mechanism designed to stimulate private investment in malaria – and other health – outcomes involves Credit Exchange. Aiming to attract a wider range of investors, selected high-impact health interventions are assigned a certain number of "exchange credits", based on the specific characteristics of the health interventions. Companies then invest by purchasing credits and directing them towards interventions that align with their areas of interest (they get a tax benefit when purchasing credits). Credits are then pooled and invested in socially-responsible, publicly-listed securities. When interventions achieve agreed performance metrics, credits are paid out; if performance metrics are not reached, companies can shift their credits to other interventions. An example is the Health Credit Exchange (HCX) financing mechanism launched at the Financing for Development summit in 2015 by GBCHealth.[14]

Innovative finance is often complicated, context specific and tends to work better in middle-income than low-income countries – in part due to their complex arrangements, high structuring costs and administrative burdens. This may mean that innovative finance to leverage the private sector for malaria is most effective in low burden or eliminating country contexts. Or, at least, that the proportion of costs and risk borne by international public finance actors will remain considerably higher where the malaria burden is greatest.

In summary, national governments, public and private sector donors need to proactively collaborate in exploring mechanisms to effectively promote and incentivise increased, sustainable health sector investment. They should also maximise opportunities to share learning and promote cross-country and cross-sector collaboration, leveraging regional and global networks such as the AU, ASEAN, UNGA, G7, G20, TICAD, FOCAC, and the Commonwealth of Nations amongst others.

We know healthy Lives are key to achieving the SDGs and, for many countries, reducing malaria is a key to unblocking congested health systems and improving health outcomes, increasing productivity and stimulating economic growth.

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Endnotes

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