

## Chairman's Notes

### Regional Financing for Malaria Task Force

Hong Kong 12 May 2014

#### *Key messages*

Countries in Asia and the Pacific have a strong self-interest in increasing the level and the quality of expenditure on malaria control throughout the region as they increase connectivity and economic integration. In addition to cumulative productivity gains and treatment cost savings, countries which are close to eliminating malaria would benefit from reduced risks of transmission and/or resurgence from their neighbours.

Private companies producing legitimate drugs and insecticides would also benefit from expanded, high quality malaria programs. Many countries in the region, including and beyond in People's Republic of China and India have aspirations to become quality pharmaceutical manufacturers and all have an interest in health security. In addition, better management of the disease, particularly along border areas, can help maintain the efficacy of the commodities they produce.

The alternative scenario is one where the impressive gains made in malaria control are lost as effort and attention wane, and the efficacy of malaria commodities is eroded through unsuccessful management of the disease. Vulnerable populations suffer an increasingly disproportionate burden of disease, leading to greater inequity and exclusion, exacerbated by growing resistance to front line anti-malarials and pesticides.

The lessons of history are clear: collective action is required. Chloroquine resistant malaria emerged in South East Asia in 1957 and quickly spread globally, imposing large health and economic burdens. Drug resistant malaria, already occurring in five countries of the Mekong would have even larger regional, and global health and economic consequences. Other emerging infectious diseases that disrupt trade and economic growth are believed to have emerged in the region and have spread quickly.

*Additional financing* is urgently needed to achieve elimination of malaria particularly in an environment of falling contributions from traditional donors. *Regional financing* is needed because of the cross-border nature of drug and insecticide resistant malaria. Many countries in Asia have eliminated malaria or are at pre-elimination phase: major national gains that would be undone by a resurgence.

### *Background and context*

The Asia Pacific Leaders Malaria Alliance (APLMA) is a regional alliance of heads of government in Asia and the Pacific. APLMA supports state leaders ‘to reduce and eliminate malaria across the region, particularly in those countries where drug-resistant malaria has emerged or which have a high disease burden from malaria’. The Asian Development Bank hosts the APLMA Secretariat. The 2013 East Asian Summit acknowledged the establishment of a Regional Financing for Malaria Task Force (RFMTF) as part of the APLMA. This task force held its first meeting in Hong Kong on 12<sup>th</sup> May 2014. The aim was to explore options for increasing funding for malaria (and other communicable diseases) with a particular focus on reducing deaths and containing artemisinin resistant malaria. An early priority was to develop malaria financing priorities that could be then tabled at the 9<sup>th</sup> East Asia Summit to be held in Myanmar in November 2014. The RFMTF meeting in Hong Kong involved experts from academia, malaria control programs, multilateral and bilateral agencies, as well as individual experts. The meeting was chaired by Lawrence Greenwood. The following are the informal Chairman’s summary notes from the meeting.

### *Update on the health burden of malaria*

**Despite impressive progress, Asia Pacific remains a hot spot for malaria, especially artemisinin resistant malaria, and other communicable diseases.** Latest estimates for 2012 presented by WHO indicate that there were 45,500 malaria related deaths; 28.2 million malaria cases; and 2.3 billion people at risk of malaria in the Asia Pacific region. Progress in controlling malaria within the region was uneven. On the one hand, malaria mortality rates in the WHO Western Pacific Region had steadily declined since 2000 and five countries in Asia Pacific were now at pre-elimination phase. On the other hand, India, Indonesia, Myanmar and PNG would not reach the MDG goal of reducing malaria by 75% between 1990 and 2015. There was a resurgence of malaria in Lao PDR and high burdens in PNG, Timor Leste and the Solomon Islands: countries that lacked the financial and other resources, and strong health systems, to effectively control the disease. Perhaps most importantly, artemisinin resistant malaria was suspected or confirmed in five countries of the Mekong: Cambodia, Lao PDR, Myanmar, Thailand and Viet Nam. Most sites were on international borders emphasising the need for collective action at a regional level.

Asia Pacific is also vulnerable to other communicable diseases: over three quarters (77%) of the global health burden of Hep B virus, and 58% of the global TB burden occurs in the Asia Pacific region. Dengue is an increasing health and economic burden in 24 countries of the region. New strains of influenza including H5N1 and H7N9 are believed to have emerged in the region. The region needs to address around 17 neglected tropical diseases including lymphatic filariasis.

*Update on the economics, and rationale for investing*

**There are some economic and financing challenges common to all countries in Asia and the Pacific.** The biggest difference between health burdens in developed and developing countries in the region is rates of communicable diseases. Unlike many non-communicable diseases, most communicable diseases have technically feasible, affordable, and cost-effective interventions available now, which due to a variety of factors are not deployed universally.

Malaria control is widely recognized as one of the ‘best buys’ in public health; under-investment imposes significant further costs at the national and macroeconomic level. It reduces worker productivity and makes malaria endemic areas hostile to agriculture or tourism. Estimates suggest GDP growth can be reduced by 1 to 2 percentage points as a result of malaria. The disease imposes costs on individuals and households as well, reducing participation in employment and education for those directly and indirectly affected. In Asia, high levels of out of pocket expenditure push or keep vulnerable households in poverty. The poorest countries with highest malaria burden have least capacity to finance healthcare, in particular to raise public funds. Virtually all countries in the region have scope to improve the allocative (‘doing the right things’) and technical (‘doing things right’) efficiency of government expenditure. Affordable and cost-effective interventions are currently available for all countries in the region, although actual interventions vary depending upon specific burdens and costs.

**There are also important differences between countries.** Much of the health expenditure on malaria and other services in Asia is funded directly out of pocket, whereas in the Pacific the government (often supported by donors) finances and provides health services. Most of the private expenditure in Asia is by the richer quintiles. The lowest income groups in Asia – which may well have the highest exposure and risks of malaria – are often unable to afford the treatment they need or, if they do, then incur debt and further risk of poverty. Several poor countries are highly aid-dependent, but aid funding is not always 100% additional to expenditure efforts. Most Asian countries have the potential to increase tax revenues given their economic growth and potentially broad tax base. This is more difficult in the small island economies.

**There is clearly an existing financing gap in controlling malaria.** Lack of good data means it is hard to know how much government, or households, are actually spending on diseases such as malaria: itself an important area for future research. Nevertheless, it is clear that current funding is disproportionately low compared to the health and economic burden of malaria, and especially drug resistant malaria. The cost of containing artemisinin resistance is estimated to be around \$180 million for the Asia Pacific region or

around 4% of the \$4.78 billion total malaria investment for the region between 2012 – 2015. It is 0.5% of the total investment estimated to eliminate malaria in 19 countries of the region by 2030. Despite uncertainties around specific numbers, several experts referred to the need to double anti-resistance expenditure to around \$400 million.

**The financing gap is increasing due to reductions in available external financing.** The Global Fund to Fight AIDS, TB and Malaria (GFATM) is an important source of financing. But even with its funding envelope of \$16 billion for 2014-17 it could never meet the financing needs of a region as large as Asia and the Pacific. In any event, GFATM faces high demands for financing the low income countries of Africa, and an inevitably uncertain outlook in terms of future replenishments that might be deployed to the region. Most countries in Asia and the Pacific will likely face a flat or declining GFATM commitment over coming years compared to previous years. The new funding model of GFATM could be helpful, at the margin, to countries because of the potential for increased flexibility. However, countries in Asia and the Pacific should not assume GFATM will be a source of significant additional financing. Under the new model, Solomon Islands will likely face a financing gap of around 63% of current needs, and PNG a financing gap of around 74%.

**There is also a financing gap in terms of regional and collective action by countries, and a financing gap in terms of financing by the private sector.** Countries in the region may underinvest in malaria control given competing priorities, particularly as part of the benefits of malaria reduction and elimination are accrued to other countries. There is therefore a ‘collective action’ problem: all countries would benefit from greater attention to malaria within the region, but if one country is unwilling or unable to fully finance its program, all will suffer. It is also clear that there is a substantial financing disconnect between government efforts and the private sector. The private sector in Asia is very large. It is a large producer of drugs to contain malaria – albeit in a small number of cases counterfeit. But the private sector is also a *victim* of malaria including through malaria induced absenteeism, and indirectly through reduced purchasing power of consumers. In addition, maintaining the efficacy of malaria drugs, such as artemisinin, benefits malaria programs – and legitimate malaria drug producers.

#### *Options for increasing and prioritizing financing*

**Some themes emerged that were common to all countries of Asia and the Pacific.** Several papers and presentations canvassed options about financing. There were some interesting and innovative examples from other parts of the world including results based financing and malaria bonds. However it is clear that the vast size and varied nature of Asia and the Pacific meant that domestically developed solutions were

needed. Discussion identified some preliminary areas that would appear to be common messages and priorities for all countries in the Pacific.

These included the following.

- The critical importance of **collective action in a regional approach**, especially to contain and eliminate drug resistant malaria. The lessons of history are clear: past investments and successes will be undone under a ‘business as usual’ approach that does not involve a region wide strategy. The potential role of the Asian Development Bank was noted as it may be well placed to support collective action of this nature. Presentations made at the meeting and ensuing discussion suggested it has a specific mandate to foster regional cooperation and integration in Asia; has convening power with Ministries of Finance and other ministries across all of Asia and the Pacific; it can finance regional public goods over the long time horizons that would be required to completely eliminate drug resistant malaria in the region; it has in the past and can in the future design and implement innovative new financial instruments that could, for example, access the large pension funds of Asia. The existing financing architecture was also discussed, together with the need for a clear business case to support new approaches.
- It is in the **region’s economic self-interest to urgently invest** more in malaria control, especially now given countries commitment to expanding regional connectivity and the introduction of regional free trade agreements in Asia. The potential economic benefits of increased connectivity could well be undermined by the consequent spread of drug resistant malaria and other communicable diseases.
- The **challenges are essentially political and financial: not technical**. Affordable, cost-effective and even cost-saving interventions are available to the region. The East Asia Summit therefore provides a good opportunity for a bold commitment (perhaps even eliminating malaria from the region). However the Pacific Island countries need to be included, given high malaria incidence in several countries, within the framework for regional malaria as they were not represented at the East Asia Summit.

- The importance of **investing in surveillance and demonstrating program effectiveness**. Good epidemiological surveillance – often using existing routine surveillance – was essential to track risks and outbreaks. Measuring program effectiveness was essential to convince governments and their development partners that funding malaria control was providing value for money.
- The importance of the **private sector**. Opportunities exist for legitimate drug manufacturers in People’s Republic of China and India to expand market share, especially at the expense of counterfeit and sub-standard drugs.
  - One option for encouraging the expansion of legitimate producers would be to explore the option of an Affordable Medicines Facility for malaria (AMFm). Providing a clear, predictable, subsidized, price to legitimate manufacturers would have the potential benefit of providing affordable essential medicines to the public; would enable legitimate producers to expand production; and could, in so doing, help to drive out counterfeit sales. There was support for examining the feasibility of an AMFm in Asia, bearing in mind the decision not to continue the AMFm in Africa, and the significant differences between Asia and Africa
  - Identifying which industries were most vulnerable to malaria related absenteeism would also be a strategic investment in building the evidence base for policy.
  - India and Myanmar’s experience of identifying for larger private sector firms the nearby catchment pool of those vulnerable to malaria was also an innovative way of potentially engaging the private sector.

**There are also differences that need to be recognised between and within countries in the region.** The financing needs and capacities to generate additional resources vary within the region: a differentiated approach will be required between Asia and the Pacific. More specifically, large fast growing countries in Asia will need to mobilise their own resources to help preserve the benefits of past investments in malaria reduction and safeguard future gains. Raising taxes on tobacco, as the Philippines has done to fund Universal Health Coverage, is one possibility to explore. However several smaller high burden countries in the Pacific such as Solomon Islands are likely to be dependent on external financing for extended periods: ensuring “additionality” of financing and strengthening absorptive capacity would be important. It is important to explore the possibilities of newly emerging economic powers such as People’s Republic of China and India investing in regional malaria control.

### *Next steps*

It will be important to have some clear, crisp, messages and endorsements for future action that the Leaders of the East Asia Summit can endorse, with opportunities identified to also engage Pacific Leaders. To achieve that, it will be necessary for the Task Force to further refine key messages and options **by July this year**. The APLMA Secretariat will be organising another virtual meeting in 4 – 6 weeks to progress this work. Efforts will continue to be made to engage People’s Republic of China, India, Japan, the Republic of Korea, and private sector firms in future meetings.

The Secretariat may wish to use the following conclusions of the Chair to help mobilise action over the coming weeks:

- Financing to tackle drug and insecticide resistance is a clear regional and global priority, given the potential for drug resistance to reverse decades of progress in fighting malaria. Filling the gaps in national budgets for control and elimination is another priority. More work needs to be done to identify more accurately the gaps for both drug resistance and control/elimination. Having a clearer, common, understanding of financing gaps and donor funding is important so as to avoid gaps and duplication. While important, this work should be done quickly given the urgency of scaling up efforts.
- New regional financing, and likely a new regional fund is needed to maintain and/or increase investment in national programs for malaria control and eventual elimination, as well as to finance strategic regional activities, such as cross-border programs to control artemisinin-resistant infections, that may not otherwise be addressed by individual countries. That financing would at the very least address drug resistance, and would to the extent possible help fill gaps in financing for control and elimination. A fund could also finance activities that are by their nature beyond the scope of national action, such as infections among migrant workers who work on the borders, tracking and evaluation, and procurement pooling. More work needs to be done on the scope (e.g. how would the fund position itself on the broader elimination issue?) preliminary TOR and governance structure of such a fund.
- The fund would still try to engage traditional donors (such as the Global Fund, Australia, US and the UK) but would need to rely more heavily on new regional donors and innovative financing mechanisms. More work needs to be done on how to reach out to new donors and how to design governance in a way that would be more attractive to them.

- It needs to be recognised that a regional fund is in no way an end in itself. Noting the recently established ADB Malaria and Other Communicable Disease Threats Trust Fund and of course the GFATM; any addition to a complex landscape requires a clear business case and wide consultation to ensure a balanced view and prevent duplication.
- Innovative ways of mobilizing and deploying financing should be explored, in particular cash-on-delivery, programs that blend loans and grants, and social bonds. More work needs to be done to narrow down, and flesh out possible innovative financing options.
- The private sector needs to be involved, as a donor and as a service provider. On the latter, more work needs to be done to determine options, focusing initially on the AMFm model (subsidies to manufacturers) and the social marketing model (subsidies to the distributors).