Invest in malaria is to invest in development? What is the correlation at the national level

Professor William Brieger discusses the economic benefits of successful investment against malaria

World Malaria Day 2015 is continuing a 3-year theme of promoting continued financial resource commitment to control and eliminate the disease.[1] Investing in malaria can take many forms, the most obvious of which is the large donor agency grants from the Global Fund (GFATM), the US President's Malaria Initiative (PMI), the Department for International Development, and the World Bank Malaria Booster Programme, to name a few. International and local businesses and corporations also provide a share usually through their corporate social responsibility and employee health projects.[2]

The global financial crisis that began in 2008 lingers in many corners of the world, and has caused thoughtful concern since then about how global disease control efforts can be sustained. In relation to malaria, this concern must take account of the fact that when interventions (insecticide-treated nets, artemisinin-combination therapies (ACTs), rapid diagnostic tests, and intermittent preventive treatment) are scaled-up and sustained, incidence will drop, and the nature of programming and financial commitments will change. A greater emphasis on surveillance, identification of hotspots, response to epidemics, and import of cases from neighbouring countries will take the foreground. All this will still require financial support, but where will it come from?

Many of the frontline malaria elimination countries in Africa do not receive external financial support, but rely on their own national treasury. As incidence in other endemic countries drops, will the same be expected of them? It is important therefore to look at the current pattern on national commitment to funding malaria control and eventual elimination.

This review should be also viewed in the light of the Abuja Declaration, wherein African countries were called upon to devote 15% of their annual budgets to health.[3] Ten years after the 2001 Declaration 'only Rwanda and South Africa have achieved the Abuja Declaration target'.

One of the largest sources of funding for health at the national level is out-of-pocket (OOP) payments from households. In a 2005 study of national health accounts (NHA) in Nigeria, Soyinbo et al[4] found that governments at all levels accounted for only 26% of overall health financing, international donor accounted for 4%, and healthcare provided by firms and businesses equalled 3%. Households were responsible for 67%. Studies of healthcare-seeking for malaria in Nigeria confirms that private sources, including medicine shops, was a major source of care that had to be purchased by households.[5] Onwujekwe et al[6] found that costs of malaria amounted to almost half of total household curative costs, and this study was done before more expensive ACTs were introduced. This heavy reliance on individuals and households to pay for malaria services is ironic given that Nigeria is now Africa's biggest economy.[7]

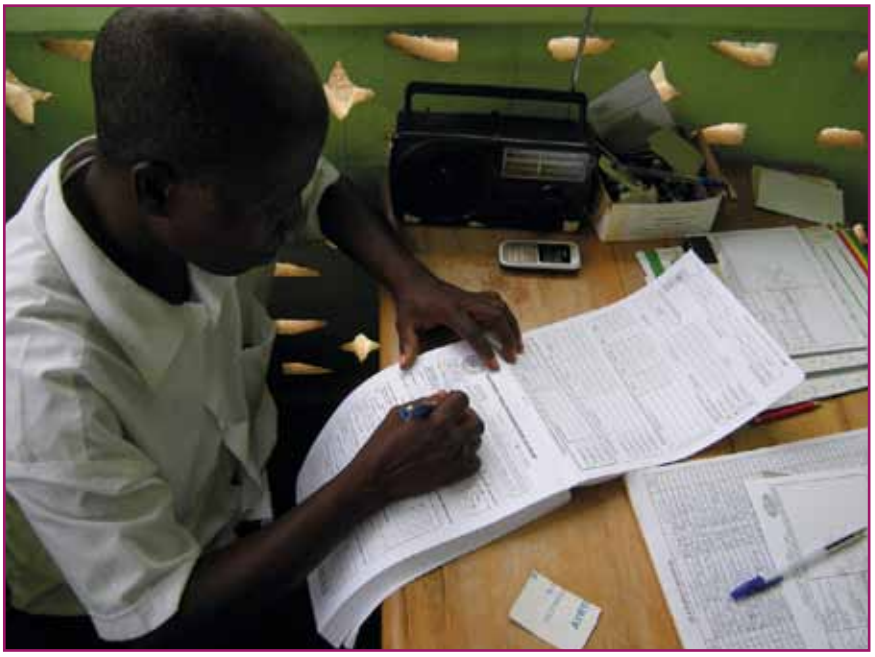
Obtaining care from public sources does not necessarily reduce OOP costs. Burkina Faso is among countries that have a modest cost-recovery scheme at their primary care centres, but for poor families this results in greater costs than home or self-care.[8] In Uganda, it is the public sector that attracts more clients and greater costs to the household.[9] OOP in Uganda was divided among medicine (54.0%), consultation (26.0%), transport (15.2%) and hospitalisation (2.9%). Urban households spent on average US$7.26, while rural spent $3.39.

Concern about OOP extends from the challenge of achieving equity in the control and elimination of malaria from a country. There are other countries where OOP is a lesser factor. Summarising the period 2006–2010, Roll Back Malarian (RBM) estimated that households accounted for 27% of malaria financing, government 16% and donors 54% (other sources such as employers stood at 3%).[10]

An example of National Health Insurance Scheme member cards from Ghana

William R Brieger is a Professor for the Department of International Health, the Johns Hopkins Bloomberg School of Public Health, and Senior Malaria Specialist, Jhpiego, an affiliate of the Johns Hopkins University.

Of long-term interest is the balance between domestic government and external donor financial support of malaria programmes. Inflows of donor funds vary by year, but for example, in the most recently reported years to the World Health Organization, donor financing accounted for around 75% of formal sector malaria funds in 2010, and over 95% in 2012 in Malawi.[11] In Zambia over the past five years, domestic government financial inputs barely registered on graphs seen in the World Malaria Report.[12] As noted, these figures pose a challenge to sustainability of malaria control, especially as surveillance systems need to be in place long after malaria cases become rare.



Checking national health insurance authority register at a Community Health Partnership in Ellembelle Ghana

South Africa is an example of a frontline of malaria elimination country that bears the bulk of costs for its malaria efforts. A RBM Progress and Impact Series report on South Africa informs that: 'Funding for malaria control programmes in South Africa has been solely through governmental sources, with limited support from partners for workshops, reviews and technical assistance. The national budget for malaria control increased significantly between 2007 and 2008, reaching an average of US$25 million annually between 2009 and 2012. A malaria elimination plan was developed focusing on the key intervention areas, but there is a gap to fully fund elimination strategies around vector control, surveillance and health promotion. Innovative funding mechanisms are required to close the financial gap for malaria elimination, either through a governmental intersectoral approach for interventions such as surveillance, case management and health promotion, or for securing local funding from private sector partners and funding agencies.'[13]

The bulk of funding for malaria from the formal sector in Botswana, another frontline malaria elimination state, is also funded nearly totally from government sources.[14] Likewise in the most recent years, Namibia has been covering over 90% of its malaria programme from government sources.[15]

As we move towards greater use of domestic funds, several issues arise, including the ability of countries to raise needed funds, good governance in the management of funding sources, and accountability for remaining donor support. The World Tax Summit gave Oxfam the opportunity to raise the issue of corporate tax dodging as a driver of poverty and inequality. They explained that, 'Liberia, Sierra Leone and Guinea - the three countries worst affected by the Ebola virus - lost an estimated $287.6 m[illion] through corporate tax dodging in 2011 and spent just $237 m[illion] on health. This money could save lives in the fight against Ebola in the short-term'.[16]

Then there is the issue of 'Illicit Financial Flows from Developing Countries' as published by the Global Financial Integrity Project,[17] wherein it was estimated that the 'cumulative illicit financial outflows over the decade between 2002 and 2011 [was] US$5.9 trillion'. Africa 'has the highest average illicit outflows to GDP [gross domestic product] ratio [5.7 per cent], suggesting that the loss of capital has an outsized impact on the continent'. This impact, though not stated explicitly, includes depressing the ability of malaria endemic countries in the region to control the disease.

Specifically in 2014, the United Nations Economic and Social Council's Economic Commission for Africa of the African Union issued a 'Progress report of the High-level Panel on Illicit Financial Flows from Africa'.[18] The meetings recognised that while the process of actually transferring money out of a country is technical, the context is political and will not be solved until adequate political will is mustered. Some of these transfers are 'commercial' as per the issue of tax evasion noted above, while others are clearly criminal.

The challenge of accountability for both finance and programme indicators has led to a crisis of confidence in Non-Government Organisation (NGO), foundation and government approaches to aid and development.[19] New frameworks are needed to address the variety of partners on the international and local scene, and their relationships.

Although the financial tools and data are better able today to address the metrics of accountability in resource allocation, the financial landscape today is more complex, yielding multiple concepts of the accountability process. Bruen and colleagues point out that a traditional vertical foreign aid system where recipients are accountable to donors has been replaced by a variety of partners and relationships.[20]

There are still key players like the GFATM that have an elaborate system of accountability for programmatic

indicators (both prevention and treatment), and use of funds to achieve those. Principal Recipients have had their grants suspended or cancelled due to financial improprieties. Based on the heavy reliance on such donors among highly endemic countries, this threat to a main source of funding is worrisome to national malaria programmes. Accountability today not only refers to relationships with multiple donors and recipients within a country, but also to the relationship between the health and development services and the citizens they are expected to help. Thus accountability takes on a decidedly political nature according to Bruen et al.

Donor aid models vary from source to source. Some agencies take a 'basket' or 'sector-wide' approach and provide money directly to countries and governments at different levels (national, provincial, district). Others spend through intermediaries such as international NGOs. Pressure is on for more direct financing and fewer intermediaries. In that context donors worry that by 'directly supporting local governments and institutions, the risks of corruption are higher'. This problem is equally true when funds come from national governments themselves.[21]

Finally, there is an important form of local investment that involves communities, families, health services and governments in the financing of healthcare in general, and malaria care in particular, and that is health insurance. Ghana's National Health Insurance Scheme (NHIS) was established in 2003 and as long as public and private health providers meet standards of service, they can claim reimbursement from the scheme. Reviews of coverage vary, but a recent study in the Volta Region found that about half of respondents were currently enrolled; a third had been formerly enrolled while the remainder had never participated.[22] Premiums range between US$5 and $30, are deducted from civil servant salaries and paid directly by others.[23] The payments are seen as regressive. In particular people have difficulty comprehending and paying for NHIS renewals. While the coverage level is better than in many countries in the region, 'For Ghana to attain an equitable health system and fully achieve universal coverage, it must ensure that the poor, most of whom are not currently covered by the NHI, are financially protected, and it must address the many access barriers to health care'.[24]

Rwanda on the other hand operates a system of community based insurance schemes called the mutuelle.[25] Mutuelles are highly subsidised through government and donor support in order to achieve high levels of coverage. Not surprisingly premiums and co-payments generate a very small portion of overall mutuelle operations. High coverage has led to improved health indicators, but the issue of sustainability if subsidies become infeasible is raised.

Ultimately, the challenges of political accountability for results and financial management within countries to citizens, domestic civil society, and other non-state actors must be resolved if governments are going to take on a growing role for eliminating the malaria burden within their borders. Monetary investments alone cannot eliminate malaria. Political will must also be invested to close financial gaps, mobilise resources from various sectors, and create a true partnership to end malaria.

References

1. Roll Back Malaria Partnership. World Malaria Day 2015. *Invest in the future: defeat malaria*. http://rbm.who.int/worldmalariaday2015/index.html
2. Mouzin E, et al. *Business investing in malaria control: economic returns and a healthy workforce for Africa.* Roll Back Malaria Partnership, Progress and Impact Series Number 6. Geneva: WHO, 2011.
3. World Health Organization. *The Abuja Declaration: Ten Years On.* Geneva: WHO, 2011. http://www.who.int/healthsystems/publications/Abuja10.pdf
4. Soyibo A, Olaniyan O, Lawanson AO. *Nigeria's 2003–2005 National Health Accounts update.* Paper presented at the stakeholders' meeting of the Special Programme of Research and Training in Tropical Diseases (TDR) of UNDP/World Bank/WHO/UNICEF; Abuja, 2009.
5. Salako LA, Brieger WR, Afolabi BM, et al. Treatment of childhood fevers and other illnesses in three rural Nigerian communities. *Trop Pediatr* 2001; 47: 38–46.
6. Onwujekwe O, Chima R, Okonkwo P. Economic burden of malaria illness on households versus that of all other illness episodes: a study in five malaria holo-endemic Nigerian communities. *Health Policy* 2000; 54(1): 143–59.
7. BBC News, Business. *Nigeria becomes Africa's biggest economy.* 6 April 2014. http://m.bbc.com/news/business-26913497
8. Wouterse F, Tankari M. Household out-of-pocket expenses on health: does disease type matter? *J Afr Econ* 2015; 24: 1–23.
9. Orem JN, Mugisha F, Okui AP, et al. Health care seeking patterns and determinants of out-of-pocket expenditure for Malaria for the children under-five in Uganda. *Malaria J* 2013; 12: 175. http://www.malariajournal.com/content/12/1/175
10. Roll Back Malaria Partnership. Progress & Impact Series, focus on Malawi. Country Reports number 6. Geneva: WHO, April 2013.
11. World Health Organization, Global Malaria Program. Malawi (country profile). World Malaria Report 2014; p.119.
12. World Health Organization, Global Malaria Program. Zambia (country profile). World Malaria Report 2014; p.164.
13. Roll Back Malaria Partnership. Progress & Impact Series, focus on South Africa, Country Reports number 8. Geneva: WHO, 2013.
14. World Health Organization, Global Malaria Program. Bostwana (country profile). World Malaria Report 2014; p.78.
15. World Health Organization, Global Malaria Program. Namibia (country profile). World Malaria Report 2014; p.127.
16. Oxfam. Corporate tax dodging drives poverty and inequality. (Seen on 1/29/2015 1:19 PM) https://act.oxfam.org/international/en/actions/world-tax-summit
17. Kar D, LeBlanc B. *Illicit financial flows from developing countries: 2002–2011*. Global Financial Integrity Project, December 2013.
18. United Nations Economic and Social Council, Economic Commission for Africa, African Union. Forty-seventh session of the Economic Commission for Africa. Progress report of the High-level Panel on Illicit Financial Flows from Africa. E/ECA/CM/47/6. AU/CAMEF/MIN/6(IX), 3 March 2014.
19. Hickel J. The death of international development: the development industry needs an overhaul of strategy, not a change of language. *Al Jazeera* 2014. http://www.aljazeera.com/indepth/opinion/2014/11/death-international-developmen-201411199142665285.html
20. Bruen C, Brugha R, Kageni A, et al. A concept in flux: questioning accountability in the context of global health cooperation. *Global Health* 2014; 10: 73. http://www.globalizationandhealth.com/content/10/1/73
21. Luke C. With shift to local aid, corruption a rising challenge. Devex.com. 09 February 2015. https://www.devex.com/news/with-shift-to-local-aid-corruption-a-rising-challenge-85024
22. Boateng D, Awunyor-Vitor D. Health insurance in Ghana: evaluation of policy holders' perceptions and factors influencing policy renewal in the Volta Region. *Int J Equity Health* 2013, 12: 50. http://www.equityhealthj.com/content/12/1/50
23. Amporfu E. Equity of the premium of the Ghanaian national health insurance scheme and the implications for achieving universal coverage. *Int J Equity Health* 2013; 12:4. http://www.equityhealthj.com/content/12/1/4
24. Akazili J, Garshong B, Aikins M, et al. Progressivity of health care financing and incidence of service benefits in Ghana. *Hlth Pol Planning* 2012; 27: i13–i22.
25. Dhillon RS. A closer look at the role of community based health insurance in Rwanda's success. *Glob Health Check* 2011. http://www.globalhealthcheck.org/?p=324