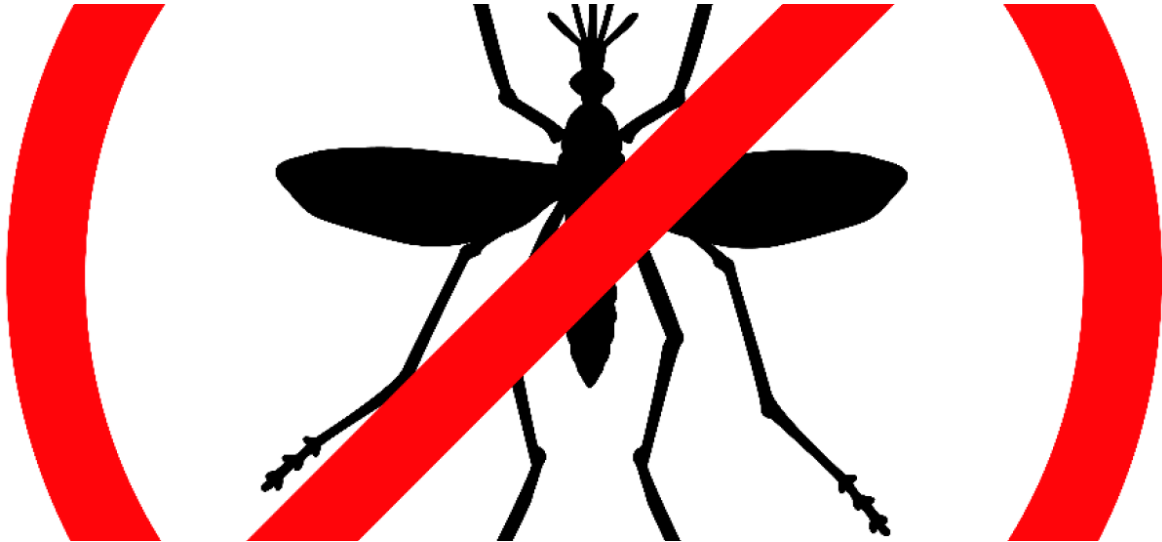


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# Combating malaria in the developing world



## **A plenary session with:**

**Dave de Ferranti, Director Global Health Financing, The Brookings Institution**

**Gina Lagomarsino, Global Health Financing Initiative, The Brookings Institution**

**Robert Sebbag, Vice President for Accessible Medicines, Sanofi-Aventis**

**John Tomaro, Director, Health Programme, Aga Khan Foundation**

Despite many medical advances, malaria still affects 40 per cent of the world's population, especially countries with the lowest incomes. Although increased funding has come in from private sources such as the Bill & Melinda Gates Foundation, those most in need are still not getting the help they require.

At the recent healthcare2020.forum held at INSEAD's Europe campus in Fontainebleau, participants discussed how existing and new resources can be leveraged to promote better health. Taking the case of malaria as an example, the session focused on healthcare financing strategies in developing countries.



**Dave de Ferranti** of The Brookings Institution, the non-profit organisation which organised this plenary session on malaria, set the issue in context. “There are 6.2 billion people in the world and five-sixths are from developing countries. In the next 25 years another 2 billion people will be added to the globe and almost all will be in developing countries,” de Ferranti explains, pointing out the need to focus on the implications of population increase with the subsequent need for more health products, vaccines and medicines. Issues such as R&D, subsequent delivery and financing are also becoming more urgent, he says.

The important question to address, according to de Ferranti, is how the developed world can help “through philanthropic flows, profit flows, public flows, private flows and for-profit flows.”

Funding from new sources such as the Gates and Clinton Foundations helped boost development assistance in health to US\$14 billion from US\$2.5 billion between 1990 and 2006/07, says Tomaro of the Aga Khan Foundation. But this additional funding from large donor pools can create problems, as much of the new funding is targeted at specific diseases or is inconsistent. For example, the share of health aid devoted to HIV/AIDS more than doubled between 2000 and 2004, while the share of funds for primary care fell by almost 50 per cent, he says. Tomaro also argues that the new development assistance is often short term and may not be sustained.

Highlighting the case of Botswana, a developing country with mineral wealth, he says it had received funding from the Clinton foundation as well as global fund for developing countries, and so had all the funding it needed to tackle the 280,000 cases needing treatment. However, only 82,000 people received the necessary drugs, he says. The reason: there are no health workers there. Most of them are recruited by South Africa and the UK.

Even so, it’s clear that funding from private sources is needed. Governments in developing countries just don’t have the resources. “Currently governments cannot meet the cost of care, even with assistance,” Tomaro says, adding that in India 97 per cent of its health budget goes on administration.

While average life expectancy was 78 in 2002 for wealthy countries, it was only 46 in the least developed countries, Tomaro says. “The infant mortality rate is six out of a thousand compared to 100 out of a thousand. The contrast is dramatic – recently Afghanistan recorded the highest ever infant

maternal mortality rate.”

“Per capita health spending is also uneven, with the government funding US\$8billion for the least developed countries, compared to US\$1,766 billion in high income countries. Interestingly as you begin to move towards being a developed country more public money is spent on healthcare.”

While the poor are unable to afford healthcare or health insurance, **Gina Lagomarsino** of The Brookings Institution says pharmaceutical companies



believe the market for anti-malarial drugs is not profitable enough, even though some 500 million people suffer from the disease. She says not enough money is going into product development. “If you look at the real

disease burden there should have been ten times more (money) spent.” In 2004, US\$323 million was spent on malaria R&D, but, she says, given the disease burden, the figure should have been around US\$3billion. In addition, she points out that while some 1,556 new drugs were approved between 1974 and 2004, only eight were for malaria.

“There are already some potential mechanisms that could create incentive for investment, just as product development partnerships evolve with the creation of new organisations focusing on the disease,” she says. “There are also advanced market commitments – the idea is for donor governments or foundations to attempt to create a market for a traditional product from the developed world by signing a legally binding contract that says they will buy a certain product if it meets certain specifications and at a certain price.”

Another option would be to allow pharmaceutical companies which invest in neglected diseases to be compensated by the extension of a patent on a more profitable drug, she says, adding that credit enhancements could also be used to leverage donor money and attract private capital.

### **‘Improved malaria management could impact development’**

If an effective new vaccine were developed, Lagomarsino says, it would significantly improve the control of the disease. “Improved malaria management could impact development in these countries,” she says. “Not only would mortality rates decrease, but productivity would improve by less absenteeism from illness. There are already existing innovations that can be improved such as the insecticide bed nets that now last up to five years and are more cost effective.”

New treatments are being developed. Lagomarsino points out that artemisinin combination therapies (ACTs) derived from a plant are replacing old treatments as malaria-carrying mosquitoes build up resistance.

She says that even though there has been an increase in spending on disease reduction worldwide, more money is still required to deliver basic malaria interventions. However, she says more money would not mean “the end of the problem – it’s delivering the products that last mile to relatively remote villages.”



of Sanofi-Aventis agrees that innovation development is important but says “that’s for tomorrow. What we can do today is the burning issue.” He outlined how his company is trying to make a difference through its Access to Medicine department, which is seeking to mobilise the company’s know-how to develop sustainable programmes against diseases.

The department is looking to develop new anti-malaria treatments, Sebbag says. “We have to be on the ball. Currently we use ACT and it is effective as a treatment but it may become resistant within five years and therefore we have to be ready. We are developing a new compound and also working on a vaccine.” The programme also aims to develop affordable drugs but Sebbag is quick to point out that “it is not a pricing competition between the pharmaceutical companies.”

With hundreds of millions of people suffering from malaria and other diseases, “there is room for many players,” he says. “Novartis, for example, is not going to make money with its compound, and neither are we because we sell it (taking a) no-profit/no-loss approach.”

Training is also key, Sebbag notes. “There is no point in having an effective drug if there is no one to administer it.” Information, education and communication are also important. “There is a need to supply medical information in the diagnosis, but also to teach families and communities about disease prevention as well as how to take the drugs safely.”

The Aga Khan Development Network (AKDN) believes that while finance is important, development must be long term, with a focus on human resource development, management and governance. But the private sector has a role to play in terms of training and governance.

**John Tomaro** of the Aga Khan Foundation believes the current focus on disease control will eventually change and that as communities from





poverty to self-reliance, they will build their own funding sources, reduce the impact of cycles in donor funding and build institutions that last.

He concludes that disease-specific programmes in developing countries “will be no more successful than the previous initiatives. Why? Because of the donors – they are unreliable because legislatures respond to voters. Therefore the emphasis should be on systems that will lead to long-term sustained positive change.

**Find article at**

<https://knowledge.insead.edu/responsibility/combating-malaria-developing-world>

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