Sustainable Financing Analysis of Universal Health and HIV Coverage in the East Africa Community

February 4th, 2015
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The East African Community and its Partner States are committed to the related policy objectives of Universal Health Coverage and Ending AIDS in 2030. However, the funding landscape for health and HIV is set to change dramatically over the coming 10 to 15 years. The policy question this work tries to answer is: How can EAC Partner States achieve the high level policy objective of universal coverage for health and HIV services within a changing fiscal landscape?

To answer this question we first examine the EAC political, epidemiological and economic context. We then determine the cost of achieving UHC and Ending AIDS in 2030, and benchmark that against the fiscal space for health and HIV generated over the next 15 years by the current funding strategies in each of the Partner States. We conclude that this would leave Partner States short of financial resources to achieve universal coverage for health and HIV. We then explore which initiatives Partner States can take to increase fiscal space. Apart from assessing the fiscal dimensions of the health and HIV response, we look into ways to reduce the cost of achieving UHC through focussing on a more limited package of cost-effective services, and ways to deliver these services with maximal efficiency.

Political, Epidemiological and Economic context

1. The EAC is a regional economic community through which Partner States cooperate, negotiate and collectively determine legislation and policy that is nationally binding. EAC legislation takes precedence over similar national laws on matters pertaining to the implementation of the Treaty, including health and HIV.

2. Differences in life expectancy, immunisation coverage, the percentage of births assisted by trained health workers, HIV prevalence and maternal, infant and under-5 mortality reflects the variation across the EAC of both the epidemiological profiles and the capacity of the national health systems to address the population-level burden of disease. The high variability of health outcomes across Partner States implies that the path to universal coverage of health and HIV services will vary across countries.

3. The top 10 causes of death across each of the five EAC Partner States also emphasise that the leading causes of death are shared across the EAC Partner States, strengthening the rational for rational action. These the most common causes of death are: Lower respiratory tract infections, Diarrhoeal disease, HIV and AIDS, Stroke and Malaria.

4. The overall decreasing but still significant levels of HIV incidence requires concerted effort by Partner States, particularly in Uganda. The five EAC Partner States are home to 4,695,000 PLHIV. Adult (15-49 years) HIV prevalence rates vary considerably, from a low of 1.1% in Burundi to a high of 7.3% in Uganda (Kenya: 5.3%, Rwanda: 2.8%, Tanzania: 5.3%). While the incidence of new HIV infections has consistently declined in four of the five Partner States since 2009 the region will contribute 20.1% of the total number of 1.4 million new HIV infections anticipated to occur across Sub-Saharan Africa during 2014. The EAC region accounted in 2014 for 9.9% of the world’s 1.2 million AIDS-related deaths. Across sub-Saharan Africa, on average only 45% of the people living with HIV (aged 15-49) know their HIV status; of these PLHIV, only 39% are accessing ART, and of the PLHIV on ART, only 29% have a suppressed viral load. This significantly hinders the prevention of onward transmission of HIV.

5. Malaria and TB remain important drives of mortality and morbidity in the region. Three EAC Partner States – Kenya, Uganda and Tanzania – feature among the 22 TB high-burden countries globally that account for approximately 80% of all new TB cases arising each year. Malaria is a significant contributor to childhood death across all five partner states and prevalence rates range from a low of 2.8% in Burundi to a high of 5.6% in Uganda.

6. Africa’s economies are growing rapidly and Africa’s economic growth has been remarkably resilient, even in the face of an uncertain global economy. Over the past decade Africa has been the second fastest growing region in the world with an average annual GDP growth rate of 5.1%. In 2006, 13 African countries were categorised as middle-income. By 2013, that number had climbed to 21. Between 2013–2023 Africa’s GDP is expected to grow by an average exceeding 6% per year – outstripping that of any other world. If projected growth is achieved, another 10 countries will attain middle-income status by 2025, raising the total number of Africa’s middle income
countries to 31 of 54 – almost triple that of 2006.

7. Growth in EAC Partner States mirrors the economic growth of the African continent, averaging 4.5% per annum over the decade 2000–2010. Regional GDP growth is expected to exceed an annual average GDP growth rate of 5% in the period up to 2020. All 5 Partner States have almost doubled per capita GDP growth over the period 2005-2013. This growth is anticipated to continue apace, doubling per capita income across four of the EAC Partner States between 2010 and 2020. The only country that will not see a 100% increase on per capita income over this period will be Rwanda, where it would rise by 97.7% instead.

8. As ‘health is wealth’ EAC Partner States should invest the dividends of economic growth into development. Based solely on an economic (‘growth through productivity’) argument, reductions in mortality in low-income and middle-income countries are responsible for about 11% of their recent economic growth. When the intrinsic value of health is factored in (by using a Value of additional Life-Year (VLY) approach), 24% of “full income growth” resulted from additional life years gained across these countries over the period 2000 – 2011. Thus, there is a strong case that EAC Partner States should invest disproportionately larger shares of total government expenditure into government expenditure on health as their economies grow.

9. The real Total Health Expenditure (THE) is 45 USD per capita on average throughout the region in 2012/13 but there’s a high variation between Partner States. Rwanda spends 70 USD per person whilst Burundi spends 21 USD per person. Putting this into economic context, THE amounts to 7.9% of the regional GDP. Rwanda spends 11.2%, and Kenya 5.2% of GDP on health.

10. Overall only 20% of health care financing comes from the public budget, which raises the issue of longer term sustainable domestic financing for health. With 20% coming from governments, and 16% from the private sector (e.g. voluntary health insurance). 28% is from Out Of Pocket (OOP) spending and 35% from external funding. For the region as a whole, the allocation to health out of the total public budget grown from 4% to 5.5% from 2009/10 to 2012/13. Kenya spent on average 7% over the past four years, whereas Tanzania spent 3.1% over the same period.

11. 72% of total HIV spending in the EAC is from the international community, raising serious concerns about sustainability of funding. Only 15% of all HIV spending in EAC is from government budgets, and 13% from the private sector. Total real HIV spending can be measured as a proportion of HIV DALYs in total DALYs; i.e. a measure of the amount spent on the population affected by HIV (where DALY = Disability-Adjusted Life Year). The average for the region is 123 USD. Rwanda spent almost 300 USD, whilst Burundi spent around a tenth of this on their HIV/AIDS patients. EAC governments’ contribution to HIV is not correlated to their income levels. Burundi’s GDP per capita stood at 261 USD in 2012/13, but its government pays for 27% of its HIV expenditures. The government of Kenya – the only middle income country in the group – pays for 18%. Donor contributions for HIV are also not associated to income status. In EAC the average spend on HIV accounts for 0.3% of GDP and 1.2% of the budget. Again it is clear that the level of commitment to HIV is not correlated to the income of a country within the EAC.

12. To protect HIV spending from decreasing donor support, it should be more closely linked to health spending. Across the EAC government contribution to health and HIV are not necessarily linked to income. And spending on health is not necessarily linked in a particular way to spending on

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**THE BUSINESS CASE FOR INVESTING IN HEALTH AND HIV**

1. Spending on health is not only a crucial part of well-being and a fundamental goal of economic development, it is a pre-requisite of development. Research shows that the absence of good health – or indeed the presence of poor health is a threat to development. What is more, empirical evidence points overwhelmingly to the fact that spending on health contributes to economic growth. Indeed, a 2013 Lancet Report (Lancet Global Health 2035) calculated that investments in health can realise returns up to twenty times the level of investment made in health.

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**HEALTH AND HIV EXPENDITURE TRENDS**

- The real Total Health Expenditure (THE) is 45 USD per capita

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2 The calculation is as follows: Total real HIV spending / [(AIDS DALYs/TOTAL DALYs)*country population].
HIV. Donor dependency in HIV is more than double that in health; 72% compared to 35%. Therefore the expected decline in external funding in the coming years is expected to affect all EAC countries to a great extent, and may have a more substantial impact on HIV sector. It is important then to consider how health and HIV expenditures can be linked in an attempt to shelter HIV within the Universal Health Coverage agenda.

RESOURCE NEEDS

13. The projected HIV resource needs amount to an average of 2.3 billion USD per annum across the region, peaking in 2019/20 before declining slightly to 2029/30, but the variability of resources required for HIV is high between Partner States. For HIV resource needs we have used those supplied by UNAIDS covering the period 2015-2030 for each EAC Partner State. This equates to 0.8% of the total GDP for the region, and declines in real terms over the projection period from 1.7% to 0.5%. However, the variability between EAC Partner States is high and for lower income countries HIV resource needs as a share of the economy are higher, for example on average 1.6% of GDP for Burundi but only 0.4% for Kenya.

14. Unlike resource needs for HIV, those for health are projected to continue to rise every year over the next fifteen years: from 15 billion USD to 41 billion by 2029/30, with the higher burden falling onto poor Partner States. For health resource needs we use a normative framework based on recent research that estimates the cost of offering a Universal Health Coverage (UHC) for a basic or essential package of health services, expressed as a double target: either public health funding of 5% of GDP but not less than US$ 86 (2012 dollars) per capita. The latter condition is added in the knowledge that even if some low-income countries do spend 5% of GDP on health, they would not reach US$ 86 per capita. Health resource needs would account for 8.1% of the regional GDP. Disaggregating this by country gives similar findings as the HIV resource needs; i.e. the greatest burden is skewed towards the lower income countries. The UHC needs would cost Burundi 26% of its GDP on average over the fifteen years, and only 5% of Kenya’s GDP, suggesting that poorer countries cannot achieve UHC relying on domestic resources only, and would need external donors to provide financial assistance.

15. The combined health and HIV resource needs are projected to move from 15 billion USD in 2015/16 to 37 billion by 2029/30, with the heavier burden falling onto lower-income Partner States. This would account for 7.6% of the regional GDP over the time period. To create a scenario where HIV resource needs are combined with health resource needs we need to consider how much of the UHC package is HIV-related, and how much of the HIV needs are health related. The combined health and HIV resource needs are less than if simply adding health and HIV needs together as we have attempted to extract any duplication. This means that on average throughout the region the UHC resource needs more than cover the total UNAIDS HIV resource needs.

BUSINESS AS USUAL RESOURCE GAP

16. If EAC Partner States do not take any additional initiative to fund HIV and health, i.e. they would continue to rely on the current sources of funding, they will not mobilise enough resources to meet the HIV, health and combined resource needs, and not be able to meet the UHC and Ending AIDS in 2030 policy objectives.

17. For health, a business as usual funding strategy provides a resource gap which averages 18 billion USD a year over the next fifteen years, reaching 28 billion USD by 2029/30, accounting for 5.6% of the regional GDP and 21.4% of the total governments’ budget across the Partner States. Tanzania has the largest nominal gap; 6.1 billion USD. Relative to the size of the economy Burundi has the greatest burden with the resource gap at 20% of its GDP. Kenya’s gap is lower but still projected to be 11% of the available total public budget.

18. For HIV, the resource gap averages 244 million USD a year over the next six years, and from 2021/22 projections suggest there will be more than enough funds to cover the needs. When in deficit the gap will account for 0.1% of the regional GDP and 0.5% of the total governments’
budget across the Partner states. Kenya has the largest nominal resource gap at 0.4 billion USD pa. In relation to their economy the greatest burden falls on Burundi (1.1% of GDP). Countries indicating the greatest domestic pressures in terms of ability to pay from the budget are Burundi where the gap is 3.8% of the budget.

19. The resource gap for health and HIV combined averages 18 billion USD a year over the next fifteen years, reaching 27 billion USD by 2029/30. This could account for 5.5% of the regional GDP and 21.3% of the total governments’ budget across the Partner states. The burden over time is declining as economies grow. Tanzania has the largest nominal combined HIV and UHC gap in the region; 6.2 billion USD. As a proportion of the economy Burundi has the largest burden with 21% of GDP pa. Burundi's combined HIV and UHC resource gap is projected to equate to more than two thirds of its entire budget – 72% on average over the 15 years. Other countries with a serious challenge to paying for UHC through domestic means, in order of magnitude, are Uganda (41% of budget), Tanzania (26% of budget), and Rwanda (23% of budget). Kenya's gap will be lowest in the region but still high at 10% of its budget.

20. All of the EAC countries will be struggling to provide UHC with or without HIV over the next fifteen years. Some of these countries need to alter their current allocations to ensure UHC is provided; others may need a substantially greater prioritisation of health and HIV to achieve the goal of UHC including HIV.

EAC Regional Combined HIV in UHC Resource Gap (USD, millions) and as percentage of GDP and Budget (2015/16 to 2029/30)

21. While some countries are expected to have enough fiscal space for HIV alone from 2020/21 onwards, the HIV resource needs methodology assumes that expenditure on HIV is frontloaded, i.e. a higher investment is made in the period 2015-2020, in order to maximise population benefits and to keep total costs at a minimum. During this period, all EAC Partner States face a funding gap with a funding strategy of ‘business as usual’.

MAXIMISING FISCAL SPACE RESOURCE GAP

22. EAC as a whole can generate enough additional fiscal space from reprioritisation of public spending towards health and HIV, additional taxes with proceeds earmarked to health and HIV, and increased efficiency of health and HIV service delivery to plug the financing gap, however, for some Partner States individually this won’t be able to generate enough resources to meet the UHC and Ending AIDS 2030 policy objectives. Efficiency savings, budgetary financing (re prioritisation) and earmarked financing could cover the UHC and HIV needs throughout the region by 2027/28. Kenya, Rwanda and Tanzania are in a situation where they can cover their UHC and HIV needs domestically. Resources from the three policies combined will not be sufficient for Burundi and Uganda which still require 10.7% and 2.6% of their respective GDPs to fully reach UHC and HIV needs.

Closing the UHC inclusive of HIV Resource Gap for the EAC Region (USD, millions)

23. Reprioritisation of public spending towards health and HIV follows benchmarks that are both politically and economically feasible. Once these reprioritisation targets are set the new resource gap is 7 billion USD smaller on average per year over the projection period (falling from an annual average of 18 to 11 billion USD). As a proportion of the regional economy the resource gap could fall from 5.5% of GDP to 3.8% pa over the fifteen years. For Kenya this single policy action may almost eradicate the resource gap by 2024/25. For Rwanda and Tanzania reprioritisation of public spending towards health and HIV will reduce the gap to 2% of GDP by 2029/30. But the gap is not being address immediately by this policy, as in the near term it remains at 7% of GDP. For Burundi and Uganda the policy reduces the resource gap significantly over the fifteen years (from 24% to 14% for Burundi, and from 11% to 5% for Uganda).

24. Earmarked taxes, which expand existing tax regimes on
specific sectors, such as alcohol, tobacco, airline and mobile phone industry, or increases in headline personal, corporate and indirect taxes, have the potential to bring 1.8 billion USD a year to the region in the short turn. The policy option to re-prioritise funding shows that over time many countries can be expected to self-fund through general taxation measures as growth and tax reform continues. However, in the short term the current tax systems cannot sustain the needs of the sector for the simple reason that tax reforms, leading to increased revenue collection and increased public expenditure, take time. This is the equivalent of an additional 0.5% of GDP for each country to go towards UHC inclusive of HIV, and so reduces each country’s resource gap by this amount. As the HIV Response relies on front-loading expenditures, to increase effectiveness and efficiency, this option is particularly attractive.

25. A potential 5 billion USD a year is projected to be captured by efficiency savings in health and HIV. Simply defined, inefficiency refers to a failure to obtain maximum outputs for a given level of investment. What is important for efficiency is not simply the cutting of costs but increasing the impact of spending and improving the efficiency with which funds are spent. The emphasis, therefore, is fundamentally on value for money, i.e. containing or reducing costs without reducing outcomes or, better yet, achieving better outcomes for the same level of investment.

EFFICIENCY SAVINGS

26. A common criticism by Ministries of Finance is that Ministries of Health are not sufficiently well armed with evidence of performance efficiency to defend their budget requests or to advocate for greater resources for health, let alone to counter the perception that ‘the available funds are not being used efficiently’. Efforts to improve efficiency are rarely simply about ‘cutting costs’. They are about making better use of existing resources – of increasing the impact of spending as well as improving the efficiency with which funds are spent – so as to expand coverage and access.

27. A 2012 study of the performance efficiency of national HIV&AIDS programmes in low- and middle-income countries found that HIV programmes were on average only 49.8% efficient. Such performance levels provide significant room for countries to improve the outputs of their HIV programmes simply by using resources as efficiently as the best performing countries do. A similar study of overall health sector spending (2014) found that health sector spending provided 21.1% ‘room’ for efficiency savings.

The ten leading causes or sources of inefficiency are summarised in the table below

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<th>#</th>
<th>CATEGORY</th>
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<tr>
<td>1</td>
<td>Medicines</td>
<td>Underuse of generics and higher than necessary prices for medicines.</td>
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<tr>
<td>2</td>
<td>Medicines</td>
<td>Use of sub-standard and counterfeit medicines.</td>
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<td>3</td>
<td>Medicines</td>
<td>Inappropriate and ineffective use.</td>
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<tr>
<td>4</td>
<td>Products and services</td>
<td>Overuse or supply of equipment, investigations and procedures.</td>
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<tr>
<td>5</td>
<td>Health workers</td>
<td>Inappropriate or costly staff mix, unmotivated workers.</td>
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<td>6</td>
<td>Health-care services</td>
<td>Inappropriate hospital admissions and length of stay.</td>
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<td>7</td>
<td>Health-care services</td>
<td>Inappropriate hospital size (low use of infrastructure).</td>
</tr>
<tr>
<td>8</td>
<td>Health-care services</td>
<td>Medical errors and suboptimal quality of care.</td>
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<tr>
<td>9</td>
<td>Health system leakages</td>
<td>Waste, corruption and fraud.</td>
</tr>
<tr>
<td>10</td>
<td>Health interventions</td>
<td>Inefficient mix/ inappropriate level of strategies. (allocative efficiency)</td>
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ESSENTIAL BENEFIT PACKAGE

28. In confronting the decision regarding ‘what interventions to fund as a priority’ Partner States will want to ensure that the chosen resource allocation leads to the best possible results. While the ideal scenario would be for the Ministry of Health to have sufficient resources to implement its desired full package of health and HIV interventions and services, the likely reality is that resources available are not adequate to do so. Agreeing an essential benefit package for health and HIV confronts the prioritisation challenge with a framework that will help Partner States to prioritise interventions on the basis of some objective – usually of achieving specific technical and/or social outcomes – and thereby overcoming entrenched interests and/or historical inertia. EAC Partner States took the decision to prioritise at the 13th meeting of the EAC Technical Working Group on HIV & AIDS, STIs and TB (held in Rwanda from 23-25 June 2014). The TWG recommended “that the EAC adopts a cost effective delivery model i.e. high impact at low cost, with a focus on efficient and effective use of the limited resources”.

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4 The methodology used to estimate the magnitude of potential savings from imposing efficiency measures is based on international comparative performance via a Data Envelope Analysis (DEA) (as discussed in methodology annex).
29. Evidence shows that that a few health conditions matter most in terms of impact on health outcomes. The Commission on Macroeconomics and Health (2001) found that just a small number of conditions accounted for 90% of the difference in the death rate at younger ages between LMICs and high-income countries (2001). The earlier World Health Report 1999 found that almost one-third of all deaths in LMICs were due to communicable diseases, maternal and perinatal conditions, and nutritional deficiencies.

30. Any essential benefit package in the EAC must begin by addressing the leading causes of morbidity and mortality in the region. An overview of disease burden and causes of mortality in the EAC region shows that the most common shared causes of death across EAC Partner States are:

1. HIV and AIDS
2. Lower respiratory tract infections
3. Diarrhoeal disease
4. Stroke
5. Malaria

31. Evidence from Cost Effectiveness Analysis provides a good but insufficient basis for selecting priority interventions under fiscally constrained conditions. Cost-effectiveness Analysis (CEA) is a technique for identifying the most effective use of limited resources by measuring how cost-effective one intervention is in comparison with another.

32. Trust Funds for HIV have become a popular feature in the HIV financing debate in Southern and Eastern Africa. Probably one of the earliest to set up a Trust Fund for HIV was Zimbabwe, but a number of countries have or are planning to follow suit: Uganda, Kenya, Tanzania, Namibia and Botswana. The rationale for setting up a Trust Fund seems to reside in one or both of the following. First it allows politicians to show they are taking initiative in an area that is politically sensitive. Second, in the wake of the realisation that the scale up of HIV programmes would fall short of money, HIV advocates see it as a way to raise additional funding. Not only is it a visible pool of earmarked funding, its institutional characteristics provide it a supposedly stronger governance framework for funds to be spent as intended. This in turn opens the way to attract additional funding from the non-traditional donors such as the private sector and the BRICS.

33. A trust fund can operate either a funded or an unfunded scheme. A funded scheme requires a substantial up-front injection of resources that will accumulate quickly, thereby enabling the scheme to begin paying dividends rapidly. An unfunded scheme receives resources (usually from many sources) over a longer period of time. This unfunded scheme then determines whether (or what proportion) of its resources to invest and what proportion to use on trust fund recurrent expenditure – the fund becomes an operation mechanism for managing and allocating these resources.

34. Trust Funds have draw-backs from a health financing and public finance management point of view. They create yet another pool for a specific disease, taking away some flexibility of both the Ministry of Finance and Health to allocate resources according to relative priority. A Trust Fund brings new implementation modalities which must be integrated in the policy, planning and budgeting cycle of the Ministry of Health, adding to already high levels of planning complexity, in often capacity-poor contexts. In its motivation to set up a Trust Fund, Kenya was therefore explicit that this was a temporary measure, to overcome what is believed to be a temporary shortfall of funding for HIV as long as the National Hospital Insurance Fund is extending its benefit and population coverage.

35. From a purely fiscal perspective, the current funding strategies will not achieve the related policy goals of UHC and Ending AIDS in 2030, but additional initiatives can be taken to decrease the funding gap. The East African Community and the Partner States individually are committed to achieving Universal Health Coverage and Ending AIDS by 2030. However, a combination of reprioritisation of public spending towards health and HIV, earmarking revenue from innovative taxes, and increasing the efficiency with which health and HIV services are delivered, will allow the region to generate enough resources by 2030.

36. However, some countries are not able to mobilise enough fiscal space over the coming 15 years for UHC and Ending AIDS in 2030, and all countries face a funding gap for HIV specifically over the next five years, jeopardising an effective and efficient delivery of the HIV response. While the region as a whole can generate enough fiscal space for UHC and Ending AIDS by 2030, some Partner States (Burundi and Uganda) won’t be able to generate enough financial resources from within their economy. All EAC Partner States face a funding gap for HIV in the short term. This sits at odds with the logic underpinning the Ending AIDS 2030 strategy, which is based on frontloading expenditure, to increase effectiveness and keep overall costs down. HIV and AIDS being the leading cause of mortality in the region begs the question whether particular attention should be given to plugging the HIV funding gap in the short term.

37. Each Partner State will have to develop a vision and approach to achieving UHC and Ending AIDS 2030 proper
to its own circumstances. There are important differences between Partner States in levels of economic development, health and HIV service delivery infrastructure and HIV burden, accentuated by differences in the priority Partner States give to spending on health and HIV out of total public budget.

38. However, the EAC Secretariat can take a number of initiatives that will help individual Partner States to develop national strategies within a regional approach that aims to increase convergence of health systems and outcomes over time:

1. **Defining a package of cost-effective services**
   In an ideal world enough financial resources are available to meet the funding challenges set by the UHC and Ending AIDS 2030 policy objectives. However, it is most likely, certainly in the short term, that fiscal space will be constrained. This implies that choices about which health and HIV services to fund will have to be made. Given that the disease patterns are very similar across the EAC, the EAC Secretariat should support Partner States with an exercise to determine an EAC-wide benefit package starting from the leading causes of mortality and morbidity across the region, and health and HIV interventions according to their cost-effectiveness. This in turn would allow each Partner State to reassess its benefit package, and focus limited resources on those services that have most impact on population outcomes.

2. **Costing a package of cost-effective services**
   To facilitate discussions around allocations of public spending to health and HIV between the Ministry of Finance, the Ministry of Health and the HIV coordinating institutions, it is necessary to have a precise idea of the cost of health and HIV programmes, at different levels of benefit package, and over time. To do this the EAC Secretariat should support Partner States with costing out the benefit package, offering a generic approach, where each Partner State will use unit costs appropriate to the country. Having a precise idea of the cost of achieving UHC and Ending AIDS in 2030 will be helpful in determining the level of public investment over time, striving to be adequate but taking into account fiscal constraints.

3. **Developing a financing strategy for a package of cost-effective services with financial projection**
   Universal Health Coverage as well as Ending AIDS in 2030 require a specific package of cost-effective services to be offered with financial protection to the entire population. This means that the share of household out-of-pocket expenditure in total health expenditure should be around the 20-25% benchmark. The way to achieve this is by either increasing the level of subsidy of public health and HIV services, reducing fees for service and drugs, or by increasing population coverage of mandatory social insurance. The EAC should support Partner States in assessing current financing strategies, and designing ways to adapt them with a view to decreasing the share of out-of-pocket expenditure in total health expenditure.

A financing study is a necessary complement to the costing study, in order to understand the implied levels of public funding required to roll out an affordable essential benefit package.

4. **Delivering a package of cost-effective services with optimal efficiency**
   To further support the dialogue around fiscal space for health and HIV, the EAC can support Partner States with an EAC-wide technical efficiency study. This would entail that the EAC Secretariat designs and develops a generic approach to assessing technical efficiency, actions to improve efficiency, and an estimate of efficiency savings, which is then applied in each of the Partner States individually. This will provide Partner States with a series of priority actions which, when implemented over the medium-term, can provide critical key performance indicators for the Ministry of Finance to release more funding for health and HIV.

5. **EAC-wide debate on fiscal space for UHC and Ending AIDS in 2030**
   The current levels of allocation of public spending to health and HIV vary significantly across the EAC. The EAC Secretariat should support Partner States by organising a debate that brings together the elements from the previous steps, starting from the policy objectives of UHC and Ending AIDS in 2030: essential benefit packages, cost of offering essential benefit packages with financial protection, and efficiency savings. An EAC-wide discussion would involve the Heads of State and representatives of the Ministries of Health, Finance and the HIV coordinating agencies. The aim would be to obtain a long-term funding commitment that will allow to achieve UHC and Ending AIDS within the available fiscal envelope. The detail of such an agreement would comprise specific public spending benchmarks for each Partner State, with a view of convergence across the EAC, specific targets for increased technical efficiency, as well as specific targets for out-of-pocket expenditure, to ensure financial protection and further exploration of the potential of public-private partnerships for health financing and service delivery.
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1. STRUCTURE OF THE REPORT

The next chapter (chapter 2) will examine the political, epidemiological and economic context within which this work is situated – and the challenges as well as opportunities that these contexts provide – for the effort by the EAC and its Members States to achieve the high level policy objective of UHC and HIV services within a changing fiscal landscape. This chapter will be presented in three sub-sections: Political space (political context); Population health and HIV needs (epidemiological context); and Development and economic growth (fiscal context).

The following chapter (chapter 3) sets out the business case for the EAC region to invest the dividends of its anticipated economic growth into health and HIV.

Chapter 4 and 5 set out the objectives respectively methodology and approach to this work.

Chapter 6 will set out the recent trends in the EAC health and HIV sector expenditures. This will include analysis of how health and HIV expenditures are related.

Chapters 7 will provide the projections for available expenditures and resource needs for the health and HIV sectors up to 2029/30. And will then show how these can be combined to provide resource needs for UHC inclusive of HIV.

Chapter 8 will project the combined UHC and HIV resource gap under a ‘business as usual’ scenario; i.e. where current funding policies remain unchanged. Thereafter, in Chapter 9, the report will examine the possibilities of domestic financing to close this gap: increasing budget allocation (inclusive of mandatory health insurance); earmarked taxes; efficiency savings; and borrowing. It also has a section on Trust Funds. The analysis will also outline the potential impacts these financing options have on the macroeconomic stability of each Partner State.

Chapter 10 will provide an overview on health and HIV benefit packages, focussing on both needed and cost-effective services, and provide guidance for a practical way forward in designing affordable benefit packages.

Chapter 11 concludes with a number of policy recommendations.
2. BACKGROUND

This Chapter provides a background to the East African Community (EAC) and the political context; the economic and development context and lastly, the epidemiological context.

2.1 BACKGROUND TO THE EAST AFRICAN COMMUNITY AND THE POLITICAL CONTEXT

The East African Community (EAC) is a regional intergovernmental organisation whose mission it is to widen and deepen economic, political, social and cultural integration of its five constituent Partner States – the Republics of Burundi, Kenya, Rwanda and Uganda and the United Republic of Tanzania.

The five EAC Partner States are home to 145.5 million people (2014). While not homogenous, the Partner States provide significantly more homogeneity than do the countries of, say, the Southern African Development Community (SADC). Moreover, the long history of working towards political federation provides a history of interaction and cooperation. Collectively these provide a real opportunity to integrate and harmonise regional health policy. This effort is further assisted by the efforts of the African Union and by the other Regional Economic Communities (RECs) to coordinate and deepen cooperation at the regional, multi-regional and continental levels.

The cooperation of the EAC Partner States is underpinned by the common vision of deepening regional integration. The objectives of the Community shall be to develop policies and programmes aimed at widening and deepening co-operation among the Partner States in political, economic, social and cultural fields, research and technology, defense, security and legal and judicial affairs, for their mutual benefit. The achievement of this common objective requires that Partner States work together harmoniously on common problems and issues. The structures and institutions of the EAC facilitate such a relationship through several legal and institutional instruments that guide and standardise the work of Partner States.

In accordance with Article 9 of the EAC Treaty, the institutional framework of the EAC consists of Executive, Legislative and Judicial arms. The East African Legislative Assembly constitutes the Legislative arm while the East African Court of Justice comprises the Judicial arm. The Executive arm has three branches: the Summit of the Heads of State (which sets the broad vision of the Community), the Council (which is the policy making organ) and the Secretariat (which is the executive organ of the Community and of the EAC Institutions).

The existence within the EAC of a Legislative arm provides the EAC with the authority to draft regional (EAC) legislation which, in accordance with the powers conferred upon the East African Legislative Assembly by the EAC Treaty (specifically, Article 8 – and especially paragraphs 4 and 5 thereof), once enacted, published and
gazetted are binding on the Partner States. That is, EAC legislation takes precedence over similar national laws on matters pertaining to the implementation of the Treaty.5

What is more, the 4th EAC Development Strategy (2011/12 – 2015/16) commits the EAC to improve the decision-making systems and the policy making mechanisms of the EAC.

Thus, unlike similar regional bodies such as SADC and ECOWAS whose Parliamentary Forums are forums for dialogue and whose authority is limited to submitting recommendations for consideration by the Executive arm or to policy making, the EAC is able to enact legislation at the regional level and for such legislation to be binding upon Partner States6.

Matters relating to health are guided by Chapter 21 of the EAC Treaty – Article 118: Health. In 2002, the EAC Council extended regional collaboration to the field of health through the establishment of an EAC Sectoral Council on Regional Cooperation on Health. The Sectoral Council is responsible for guiding the full Council of Ministers on issues related to the initiation and strengthening of regional collaboration in health (the provisions of Article 118 are set out in Annex A.1).

The EAC has since established a Health Department within the EAC Secretariat and has established an EAC Sectoral Committee on Health comprised of the EAC Health Sector focal points for the five EAC Partner States. In accordance with Article 118, Partner States are required to harmonise national health policies and regulations as well as to exchange information on health matters. (Annex A.2 presents the legislation, frameworks and policy instruments developed in response to regional health challenges by the EAC Health Department).

Following the recommendation of the EAC Sectoral Council on Legal & Judicial Affairs (2011) for Partner States to develop a framework for the harmonisation of national laws on HIV and AIDS the Sectoral Committee on Health developed the Regional HIV and AIDS Prevention and Management Bill in 2012. The Bill was passed by the EALA in 2012 but is a awaiting Partner State assent having thus far been assented to only by Uganda, Burundi and Kenya. The Bill asks that governments ensure that persons living with or affected by HIV and AIDS are protected from all forms of abuse and discrimination, and are provided with appropriate support, care and treatment services. The Bill further seeks to create a common, responsive legal framework for HIV and AIDS in the region by applying a rights-based approach and through incorporating standards of good-practice in HIV prevention, treatment, care and support.

The EAC has adopted a Protocol on Health (2013) whose purpose is to provide guidance on how to govern regional co-operation on health and related matters among Partner States. The principal objective of the Protocol on Health is to establish, harmonise and operationalise regional health policies and legal frameworks and mechanisms in order to facilitate and govern regional cooperation on health and related matters among the Partner States.

Finally, the EAC has conducted “A Comprehensive Analysis of the HIV and AIDS Legislation, Bills, Policies and Strategies in the EAC” (2014). This analysis indicates that Partner States have displayed a strong commitment to combatting HIV and AIDS through the enactment of a range of laws and policies as well as through the establishment of a number of institutions and initiatives. The report shows, however, that while the region continues to display strong emphasis on the enactment of laws and on the drafting of good policies, there is a weakness in the application and the popular dissemination of these laws, policies and strategies. Annex A.3: Regional and Global Political Commitments of EAC Partner States relating to Health and HIV presents the several EAC frameworks, instruments, laws and the EAC Protocol on Health that set out the collective health commitments of EAC Partner States.

2.2 ECONOMIC AND DEVELOPMENT CONTEXT

Mirroring the economic growth of the African continent economic growth across the EAC Partner States has averaged 4.5% per annum over most of the preceding decade (2000-2010).

In 2013, Tanzania recorded the highest economic growth rate of 7.0% followed by Burundi and Kenya with 4.8% and 4.7%, respectively; that of Burundi increased from 4.2% to 4.8% while for Kenya increased from 4.6% to 4.7%. Kenya had the highest per capita income of US$ 1,055.2 while Burundi recorded the lowest at US$ 294.2. Per capita growth almost more than doubled in the period 2005-2013.7

Projected growth is equally strong, with all countries exceeding annual average growth rate of 5% in the period 2015-2020, higher than projects growth in Sub-Sahara Africa and the world.

The previous ten years of integration, including the adoption of the EAC Customs Union, have catalysed the region's trade expansion. Total aggregate output (at current prices) for the EAC region amounted to US$ 110.3 billion in 2013, compared to US$ 99.3 billion in 2012. During 2013, the dominant sector for all the Partner

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5 EAC Treaty:

Article 8 – Paragraph 4: “Community organs, institutions and laws shall take precedence over similar national ones on matters pertaining to the implementation of this Treaty.”

Article 8 – Paragraph 5: “In pursuance of the provisions of paragraph 4 of this Article, the Partner States undertake to make the necessary legal instruments to confer precedence of Community organs, institutions and laws over similar national ones.”

6 EAC: Resume on EAC Legislation

States was agriculture, followed by wholesale and retail trade and manufacturing.\(^8\)

Between 2005 and 2009 alone, intra-EAC trade grew by 40%. Over this period, Uganda’s exports to Kenya increased more than tenfold (from $15.5 million in 2004 to $172 million in 2009), while Tanzania’s exports to Kenya over the same period almost tripled. Between 2010 and 2012, the region experienced a more than 10% average annual increase in the total value of exports from the EAC region. At the country level, the period 2008-2012 saw average annual exports increase by 23% for Rwanda, 18.6% for Burundi and 16.4% for Tanzania.

The growth in trade was complemented by the significant growth in cross-border investment in the services sectors cutting across banking, insurance and tertiary education. Cross-border investment as well as mergers and acquisitions have become major drivers and contributors to growth of investment in the region.

### 2.3 EPIDEMIOLOGICAL CONTEXT

This section provides a brief overview of the main attributes of population health, HIV and AIDS and the overall burden of disease in the EAC Partner States.

#### 2.3.1 DEMOGRAPHIC AND HEALTH PROFILE\(^9\)

The EAC has a population of 145.5 million people and has a high annual rate of population growth averaging 2.7 per annum over the past 10 years.\(^1\) 64.2% of the population in the EAC is aged 0-24 years, with Uganda having the highest percentage of its population under the age of 25 years (70.4%) and Rwanda the lowest (61%).

Across the region, more than 80% of children of primary school-age are enrolled in school.

Although EAC Partner States have made a strong commitment to population health, the state of health across the region presents the EAC region with a significant challenge. Life expectancy in EAC Partners States in 2014 ranged between 50 (Uganda) and 65 (Rwanda) years. Life expectancy has improved significantly over the past decade which could be partly attributed to the falling incidence of new HIV infections and improvements in access to high impact HIV prevention, treatment and care services.

#### Table 1: Population and Life Expectancy in East Africa Partner States

<table>
<thead>
<tr>
<th>PARTNER STATE</th>
<th>MID-YEAR POPULATION FOR 2014 (MILLIONS)</th>
<th>LIFE EXPECTANCY IN 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>BURUNDI</td>
<td>9.7</td>
<td>52</td>
</tr>
<tr>
<td>KENYA</td>
<td>43</td>
<td>59</td>
</tr>
<tr>
<td>RWANDA</td>
<td>10.9</td>
<td>65</td>
</tr>
<tr>
<td>UGANDA</td>
<td>34.7</td>
<td>50</td>
</tr>
<tr>
<td>TANZANIA</td>
<td>47.2</td>
<td>62</td>
</tr>
<tr>
<td>EAST AFRICA</td>
<td>145.5</td>
<td>58</td>
</tr>
</tbody>
</table>

Infant Mortality Rate (IMR) in EAC is estimated to range from 32 deaths per 1,000 live births in Rwanda to 67 deaths per 1,000 in Burundi in 2014 while the under 5 mortality rate is estimated at 82/1,000 in Burundi, 52/1,000 in Kenya, 50/1,000 in Rwanda, 49/1,000 in Tanzania and 55/1,000 in Uganda. The leading causes of childhood death are similar across the region and include pneumonia, malaria, diarrhoea, malnutrition or neonatal causes including sepsis, birth asphyxia and complications of preterm birth. Most of these are preventable with the existing interventions.

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\(^8\) East African Community Secretariat: Facts and Figures, 2014.


\(^1\) East African Community Secretariat: Facts and Figures, 2015.
Immunization coverage in the region is quite high and exceeds 85% across all partner states with the exception of Uganda, where coverage for three doses of DPT3/Pentavalent Vaccines is 66%.

Nutritional status is an area of concern. Low birth weight, a leading cause of neonatal mortality, ranges from 7.1% in Rwanda, 8.0% in Kenya, 8.4% in Tanzania, 11.9% in Uganda and 12.9% in Burundi. The rates of ‘moderate to severe stunting’ is lowest in Uganda at 33.4% and highest in Burundi at 57.7%.

Playing a contributory role in child morbidity and mortality is access to safe drinking water. Access to safe drinking water is 79% in Burundi, 74% in Tanzania, 73% in Uganda, 60% in Kenya and 74% in Rwanda.

Maternal Mortality Ratio (MMR) is relatively high in all Partner States: 500/100,000 live births in Burundi; 410/100,000 in the United Republic of Tanzania; 360/100,000 in Kenya, 360/100,000 live births in Uganda and 291/100,000 in Rwanda. Most of the maternal deaths are due to preventable conditions such as haemorrhage, high blood pressure, unsafe abortion, infection and obstructed labour – for which high-impact-low-cost interventions exist. This points to an urgent need to increase the coverage of and quality of care during pregnancy, childbirth and postnatal care.

The percentages of deliveries assisted by trained health workers in health facilities is as follows: 76% in Burundi; 61% in Kenya; 91% in Rwanda; 57% in Uganda and 50% in Tanzania.

With the exception of Kenya and Rwanda whose total fertility rates are 3.9 and 4.2 children per woman respectively, the rates in Burundi, Uganda and the United Republic of Tanzania are in excess of 5 children per woman. The proportion of the population that demanded and received family planning services was 47% in Burundi, 52% in Uganda, 62% in the United Republic of Tanzania, 70% in Kenya and 72% in Rwanda.

Adolescent birth rate is generally high with more than 10% of women aged 15-19 years giving birth in Kenya, Uganda and in the United Republic of Tanzania - the adolescent birth rate is highest in Uganda, at 146 births per 1,000 women aged 15-19 years (or 14.6%).

Only Rwanda, Tanzania and Uganda attained MDG 4 on child health, only Rwanda attained MDG 5.

2.3.2 LEADING CAUSES OF MORTALITY AND MORBIDITY IN THE EAC

The EAC like other regions of low and lower-middle income countries is experiencing a triple burden of disease namely, i) communicable infections, undernutrition, and maternal mortality; ii) the emerging challenges of non-communicable diseases (NCDs), such as cancer, diabetes, heart disease, and mental illness, and iii) the problems directly related to globalization, like pandemics and the health consequences of climate change. Figure 2 below shows primary cause of mortality in low and middle income countries, and compares these with those in the EAC.

Table 2: Top Causes of Death, in EAC and low-come countries in 2012

<table>
<thead>
<tr>
<th>EAC</th>
<th>LOW-INCOME COUNTRIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 HIV AIDSD</td>
<td>LOWER RESPIRATORY TRACT INFECTIONS</td>
</tr>
<tr>
<td>2 MATERNAL NEONATAL AND NUTRITIONAL COMPLICATIONS</td>
<td>HIV AND AIDS</td>
</tr>
<tr>
<td>3 LOWER RESPIRATORY TRACT INFECTIONS</td>
<td>DIARRHOEAL DISEASE</td>
</tr>
<tr>
<td>4 DIARRHOEAL DISEASE</td>
<td>STROKE AND OTHER NON-COMMUNICABLE COMPLICATIONS SUCH AS HYPERTENSION AND HEART DISEASES</td>
</tr>
<tr>
<td>5 STROKE AND OTHER NON-COMMUNICABLE COMPLICATIONS SUCH AS HYPERTENSION AND HEART DISEASES</td>
<td>MALARIA</td>
</tr>
<tr>
<td>6 MALARIA</td>
<td>PRETERM BIRTH COMPLICATIONS</td>
</tr>
</tbody>
</table>


2.3.3 HIV AND AIDS IN THE EAC

Sub-Saharan Africa (SSA) remains the region most severely affected by the HIV epidemic, with nearly 1 in every 20 adults (4.9%) living with HIV and accounting for nearly 70% of the people living with HIV worldwide - 25.8 (69.9%) million of the 36.9 million people living with HIV (PLHIV) globally live in Sub-Saharan Africa. Three of the ten (10) countries that account for 81% of all people living with HIV in SSA are EAC Partner States namely Uganda at 6th and the United Republic of Tanzania at 7th (both with approximately 1.5 million PLHIV) and Kenya at 8th (with approximately 1.4 million PLHIV). Rwanda is home to 210,000 PLHIV and Burundi 85,000. Figure 3 below shows the estimated number of people living with HIV in all the EAC Partner States.

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12 Latest Demographic and Health Surveys of the Respective Partner States
Cumulatively, there are approximately 4,695,000 PLHIV across the five EAC Partner States. Adult HIV prevalence rates (15-49 years) varies considerably from a low of 1.1% in Burundi to a high of 7.3% in Uganda (Kenya: 5.3%, Rwanda: 2.8%, Tanzania: 5.3%). In 2012, nearly 2 million of these PLHIV were eligible for ART (but only 75% of these were receiving treatment). Trends in HIV prevalence over time (1990-2013) is depicted in figure 4 below which shows that HIV prevalence in the region is relatively stable and below 10%.

Globally, AIDS-related deaths have fallen by 42% since their peak in 2004. The number of AIDS-related deaths in sub-Saharan Africa fell by 39% between 2005 and 2013. Countries that recorded major declines in AIDS-related deaths include Rwanda (76%), Eritrea (67%), Botswana (58%), Burkina Faso (58%), Ethiopia (63%), Kenya (60%), Zimbabwe (57%), Malawi (51%), South Africa (48%) and the United Republic of Tanzania (44%). This success is directly due to the rapid increase in the number of people on antiretroviral therapy.

2014 saw 1.2 million people die from AIDS-related causes worldwide. Approximately 118,900 of these deaths occurred in the 5 Partner States (3,900 in Burundi; 33,000 in Kenya; 3,000 in Rwanda; 33,000 in Uganda and 46,000 in United Republic of Tanzania) – or 9.9% of total global AIDS-related mortality. This is down significantly even from the 210,000 deaths estimated to have occurred in 2012.

As of March 2015 there were approximately 15 million people accessing antiretroviral therapy worldwide. This breaks down as approximately 41% [38%-46%] of all HIV positive adults accessing treatment and 32% [30%-34%] of all HIV positive children accessing ART.
However, while access to ART expands, significant gaps remain. Chief among these is that only 45% of people living with HIV know their HIV status, underscoring the need to increase HIV knowledge and expand testing. Retention on ART 12 months after initiation is presented in below while presents an abbreviated ‘HIV treatment cascade’ in sub-Saharan Africa for adults aged 15 - 49 years. The latter shows that across the sub-Saharan Africa region, on average only 45% of the people living with HIV (aged 15-49) know their HIV status, that of these PLHIV only 39% are accessing ART, and that of the PLHIV only 29% have a suppressed viral load – preventing the onward transmission of their HIV.
3. RATIONALE/INVESTMENT CASE FOR HEALTH AND HIV

This brief constructs a business case for the EAC region to invest the dividends of its anticipated economic growth into health and HIV. It also shows how per capita health and HIV spending varies widely across Partner States, as a combined result of differences in economic development and political priorities.

KEY HIGHLIGHTS

- Research shows that the absence of good health – or indeed the presence of poor health is a threat to development. What is more, empirical evidence points overwhelmingly to the fact that spending on health contributes to economic growth.
- The Report "Lancet Global Health 2035" estimates that investments in health can realise returns up to twenty times the level of investment made in health; reductions in mortality in low-income and middle-income countries are responsible for about 11% of their recent economic growth; 24% of "full income growth" resulted from additional life years gained across these countries over the period 2000 – 2011.
- In recognition of importance of investing in health Development Assistance for Health increased at a rate of over 10% from 1990 to 2010 reaching 25% of the total Development Assistance on Health in 2011.
- Patterns of the DAH have however been changing with a fall in quantity registered in 2013 and 2014 and as some African countries graduate to middle income, the funding to them has reduced. While the funding is increasingly becoming conditional DAH for HIV has remained static.
- In light of decreasing DAH & increasing conditionality, it is imperative that the member countries adopt a value for money approach in their Health and HIV responses alongside increasing budgets and expenditures from domestic resources.

3.1 RECOGNITION OF THE IMPORTANCE OF HEALTH TO DEVELOPMENT

The movement of health up the global political and economic agendas began with the Alma Ata declaration adopted at the International Conference on Primary Health Care in September 1978 (Alma-Ata, now Almaty, Kazakhstan). This called for ‘health for all’. The Alma Ata declaration did not have much impact outside the health sector, however it led to the 1993 World Bank World Development Report entitled ‘Investing in Health’. Under the subheading “Why health matters” the report stated: “Good health, as people know from their own experience, is a crucial part of well-being, but spending on health can also be justified on purely economic grounds. Improved health contributes to economic growth”.

In 2000 the Millennium Development Goals (MDGs) were established following the Millennium Summit of the United Nations. There were three specific health MDGs: Goal 4 to reduce child mortality; Goal 5 to improve maternal health; and Goal 6 to combat HIV/AIDS, malaria, and other diseases. In the same year the importance of AIDS was underlined when the UN Security Council passed Resolution 1308, stating: “the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security.”

In 2001 the WHO released the report of the Commission on Macroeconomics and Health. The purpose of the Commission was to assess the contribution of health to global economic development. Not only did the report of the commission serve to increase global attention to health, it concluded that health is a creator and prerequisite of development: “Improving the health and longevity of the poor is an end in itself, a fundamental goal of economic development. But is also a means to achieving other development goals.” Its third key finding (of ten) was: “The HIV/AIDS pandemic is a distinct and unparalleled catastrophe in its human dimension and its implications for economic development. It therefore requires special consideration.”

Health was not just desirable on an individual and national economic level, but the absence of health – or indeed the presence of poor health (including the AIDS epidemic) – had come to be seen as a threat to development.

Within this climate and with the intention of tackling these diseases for the threat they pose to development, The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) was established in January 2002 as a partnership between governments, multilateral development agencies, the private sector and civil society. It has since become one of the world’s largest funds for Global Health Initiatives (GHI), committing USD $4 billion in 2013.

Further evidence of the shift to consider disease as a threat to development was provided in 2003 when UN Secretary General Kofi Annan established The Commission on HIV/AIDS and Governance in Africa (CHGA), with its Secretariat located at the Economic Commission for Africa. The CHGA’s task was to clarify the impact of HIV & AIDS on state structures and economic development, and to examine, design and implement policies and programmes through which to govern the epidemic.

Thirty-five years since Alma Ata, we have reached the point where the idea that a healthy population is a pre-requisite for reducing poverty and for achieving sustainable economic growth has universal acceptance. In accordance with this idea the last two decades have
seen astounding progress in public health, particularly on the African continent.27 This progress has, according to a recent Lancet Global Health 2035 report, brought the world to the point where:

“For the first time in human history, our generation has the financial and technical capacity to eliminate health disparities between poorer and wealthier nations”28

The Lancet Global Health 2035 report made the case that with a wider set of interventions and greater domestic financing for health we can achieve dramatic gains in global health and, moreover, that these gains will contribute to economic growth and development and realise returns up to twenty times the level of investment made in health.

On September 25th 2015, countries adopted a set of goals to end poverty, protect the planet, and ensure prosperity for all as part of a new sustainable development agenda. Goal number 03 of the Sustainable Development Goals (SDGs) is dedicated to ensuring healthy lives and promote well-being for all at all ages with a focus on child health, maternal health, HIV/AIDS and other diseases.

Here below are the specific Health Sector SDGs and respective targets.

1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
4. By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
5. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
6. By 2020, halve the number of global deaths and injuries from road traffic accidents
7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
9. By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
10. Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate
11. Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration.
12. Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries
13. Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

Attainment of the SDGs calls for increased investment in health.

3.2 GROWING FINANCING FOR HEALTH

The rhetoric calling for increased investment in health was, unusually, matched by significant resources. The last twenty-five years have seen a dramatic escalation in development assistance for health (DAH). Funding increased at a rate of over ten per cent per year from 1990 to 2010, peaking at $US 28.2 billion. During this period a significant percentage of funds were raised for three specific communicable diseases (HIV/AIDS, tuberculosis (TB) and malaria). In 2001 Kofi Annan, called for spending on AIDS to be increased tenfold in developing countries, and the Global Fund for AIDS, TB and Malaria was established. In 2003 US President George W. Bush pledged $15 billion toward the Presidents Emergency Plan for AIDS Relief (PEPFAR), and the WHO launched the “3 × 5” campaign to have 3 million people on treatment by 2005.

By 2011, funding for HIV and AIDS accounted for approximately a quarter of all DAH. However, since 2010 the level of international funding for HIV has remained static, but an increase in domestic health investments and private philanthropic contributions have offset this reduction. There is a general consensus that the pattern and quantity of DAH has changed.29 There was a fall of 1.6 percent in disbursements of DAH between 2013 and 2014 – the total was $35.9 billion in 2014. While HIV and AIDS received the largest amount of DAH in 2014 ($10.9 billion) the rate of growth between 2010 to 2014 was just 0.7 percent. TB with $1.4 billion and growth...
of 1.7% and malaria $2.4 billion and 0.9% were similarly stagnant. Child health and maternal health stood at $6.6 billion and $3 billion in 2014 a growth of 7.1% and 4.2% respectively between 2010 and 2014. NCDs received the least amount of DAH in 2014 ($611.2 million) but saw significant growth of 6.6%.

The first decade of the new century saw an unprecedented increase in funding. According to the Kaiser Foundation, at the peak, in 2011, annual HIV assistance commitments were $8.8 billion, falling to $8.3 billion in 2012 and $8.1 billion in 2013. Although the amount of “new money” decreased, disbursements – the amount of money being “moved out of the door” of agencies – was at the highest recorded level in 2013. The cost of drugs plummeted dramatically, falling to US$115 per person per year for first-line ART therapy. Partly as a result the number of patients on ART rose rapidly and at the end of 2014, exceeding 14 million people. As such, countries are faced with a “double squeeze” of 1.) rising HIV programme costs to meet higher programme coverage targets for increased access to prevention and treatment services; 2.) shrinking donor support for HIV. Yet HIV in particular represents a long-term financial burden, making it all the more crucial that countries adopt a ‘value for money’ approach in their responses, alongside increased spending from domestic sources. That notwithstanding the middle-income countries will still need support.

If economic growth is maintained as expected to 2025, another 10 countries will attain middle-income status, and 31 of Africa’s 54 countries would then be considered “middle income”. Providing them with the possibility of increasing domestic investment in HIV. At the same time it will be important to increase efforts to deliver health and HIV services with the best possible value for money. The graduation of African countries to middle income status and the projected increase of investments in HIV notwithstanding, the countries still need support to deliver health services and attain SDGs amid increasing populations, rise of NCDs and changing disease patterns. It is this belief that the global health community is on track to provide a “wider net of interventions”, and that countries in the region have shown the commitment to investing some of the returns of greater economic growth into health and social development, that underpins the view that the African region can be on the verge of achieving even more dramatic gains in health. However it is vital that these efforts and levels of financing are sustained, within a changing funding landscape.

3.3 CHANGING PRE-REQUISITES FOR INCREASED FINANCING FOR HEALTH AND HIV

There are a number of global trends that must be considered. First is the rapid economic growth in many of the formerly Low-Income Countries (LIC). As these economies transition to middle-income status they become either ineligible for development assistance or less likely to receive it. For example, the UK Department for International Development (DFID) announced in 2013 that it would end its assistance to South Africa and India. The United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) programme has made similar announcements, implementing ‘transition programmes’ to redirect funding to less well-endowed economies as the size of the programme levels off. Second the financial crisis of 2008 left some traditional donors struggling to justify overseas development assistance in the face of domestic economic hardship. Despite promises made it is unlikely that countries such as Greece, Italy and Spain will fulfil existing pledges let alone increase their development assistance.

Third in addition to changing quantities of assistance there is evidence to suggest that development assistance will be more conditional. Finally the funding climate has transitioned to place more stringent “counterpart funding” requirements upon recipient countries. Counterpart funding requirements in the area of AIDS, TB and malaria have been accelerated in recent years. In the case of the Global Fund, for example, countries are required to meet certain ‘minimum counterpart financing thresholds’ that are determined upon the basis of their ‘income level’. Eligibility also requires that countries increase government contributions to disease programmes and to the health sector in general. The withdrawal of donor funding as countries transition to middle-income status, a constrained donor funding climate following the global recession, the increased conditionality of funding and increasing domestic funding requirements all point to a need to improve the ‘value for money’ of health programmes. Ministries of Finance will only be convinced to increase domestic resources in health and HIV, if Ministries of Health can demonstrate the efficiency and effectiveness of their programmes.

3.4 PROSPECTS FOR GREATER INVESTMENT IN HEALTH IN THE EAC REGION

The economic prospects of EAC Partner States hold vast opportunity for the EAC Region to make a real breakthrough in improving population health and HIV outcomes. However, this opportunity can be squandered if governments fail to convert the additional fiscal space from economic growth into increased expenditure in effective health programmes.

Yet the case for doing so is strong from both an economic and...
from a welfare perspective: reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries as measured by national income accounts. Moreover, in addition to economic growth through productivity, health also has an intrinsic value – being valuable in and of itself. Taking this into account using a Value of additional Life-Year (VLY) approach, 24% of full income growth (income growth measured in national income accounts plus the VLYs gained) resulted from additional life years gained in the period 2000 and 2011. This entails that health policy development goes in tandem with socio-economic development and that health outcomes are not narrowly defined as resulting from an effective health system, but are equally impacted by social and economic determinants. Across the world governments understand that ‘health is wealth’ and the imperative for increased health investments, as they more than proportionally increase the share of government health expenditure in total government expenditure as the economy grows.

Thus, there is a strong argument to be made for EAC Partner States to individually and collectively invest the dividends of the anticipated strong economic growth invested into health – not only for their intrinsic value of improving population health and HIV outcomes but to underpin and drive future growth and development. The case for strong investment in health and HIV has been recognised by the EAC and its individual Partner States, as illustrated by the international agreements, commitments and declarations that have been made in this area (see Annex A.3 and A.4).

4. OBJECTIVES

The East African Community and its Partner States are strongly committed to improving health and HIV outcomes. A number of recent evolutions in the global policy and financing landscape such as those indicated below throw up questions about how this policy objective can be achieved:

- Adoption of the Sustainable Development Goals (SDGs) and other global health security frameworks. The SDGs under goal 3 aims to ensure healthy lives and promote well-being for all at all ages. Examples of targets under this goal include ending of the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases; end preventable mortality and enable women, children and adolescents to enjoy good health while playing a full role in contributing to transformative change and sustainable development. The international HIV policy agenda aims to End AIDS by 2030. The International Health Regulations (IHR) - an international legal instrument that is binding on 196 countries across the globe, including all the Member States of WHO of preventing and responding to acute public health risks that have the potential to cross borders and threaten people worldwide.

- However, the East African Partner States’ economies are relatively small and are thus heavily donor dependent for health and HIV funding. While donor contributions are still significant globally, the expectation is that these will at best level-off (remain at the same nominal level in the future) or decrease as domestic economies grow.

- Universal Health Coverage (UHC) is gaining attention globally, and in each of the EAC Partner States individually. They are also part of the SDGs. UHC implies that governments commit themselves to offering their populations access with financial protection to a defined package of quality health and HIV services. The precise content of the package will vary across Partner States, but the policy agenda will require additional investments for health and HIV in the short, medium and longer term.

This study sought to answer the policy question “how can EAC Partner States achieve the high level policy objective of universal coverage for health and HIV services within a changing fiscal landscape?” In answering this policy question, the TOR for this study set out the main objectives as follows:

37 Every Woman Every Child . 2015. The global strategy for women’s, children’s and adolescents’ health (2016-2030)
38 WHO. 2015. International Health Regulations (IHR) http://www.who.int/topics/international_health_regulations/en/
(i) Develop a position paper to inform and guide policy makers during a high level dialogue on sustainable financing;

(ii) Explore current financing arrangements and identify issues, risks and innovate options for sustaining the response;

(iii) Assess macroeconomic trends and their impact to capacity of EAC Partner States to expand domestic resources;

(iv) Design actionable interventions to improve allocation and use of available resources; and

(v) Propose recommendations to sustain national and regional health and HIV/AIDS responses within the context of changing financing landscape.

5. METHODOLOGY

The Report on Sustainable Financing Analysis of Universal HIV and Health Coverage for the East Africa Community is based on review of relevant global, regional and national literature. The literature review was conducted between May and July 2015. The first and second drafts of the report were subsequently reviewed by the EAC Expert Working Group on Sustainable Financing in July and December 2015 respectively. The final draft was further reviewed by the Expert Working Group and validated by Partner States during country consultations held in February 2016. The Report was finally validated at a regional workshop held in Arusha and subsequently approved by the Sectoral Council of Ministers of Health in March 2016.

The full methodology and comments on data sources are set out in Annex. This section provides an outline of the main data sources and how we use these to create financial projections for health and HIV within a macroeconomic framework.

Macro - Underlying any assessment of resource availability is the macroeconomic context within which the health sector operates. The analysis presented in this report is supported by a macroeconomic framework ensuring consistency in the projections and capturing some of the interactions between health spending and the economy. The macro economic data are primarily from IMF and medium term data is aligned with official government projections. Longer term projections are in line with SADC convergence criteria goals.

Health – The framework looks at all sources of revenue for health expenditures this includes national budgets (public expenditure), donors, private sector, and households (what is termed Out Of Pocket (OOP)). This contains mandatory and voluntary health insurance. The main data source used is the National Health Accounts (NHA) which give health expenditure data that is comparable across the EAC region. NHA data clearly identify three different dimensions of every financing transaction in the health system, which include:

- The financing source, which may be public funds, private funds or external funds
- The financing agent (who manages the funds), which may be government, private sector, households or “rest of world”
- The beneficiary, which is typically classified by disease category, or by the types of interventions

NHAs are therefore able to distinguish between domestic and external financing, and between the activities of the public and private sectors. NHA data are found on the World Health Organisation (WHO) Global Health Expenditures Database.

HIV/AIDS – Again the framework examines at all sources of revenue for HIV/AIDS expenditures: national budgets (public expenditure); donors; private sector; and households (OOP). The preferred data source for this is the National AIDS Spending Assessment (NASA) publications by UNAIDS where available, or the Global AIDS Response Progress Report publications by UNGASS. Again this data is comparable for all EAC countries.

Resource Needs – The best international comparable empirical evidence was used to arrive at an estimate of how much Universal Health Coverage (UHC) would cost. These are set for each country to reflect the maximum of three things as per current international health financing norms. This would raise the country to the global average for health spending and are as follows:

<table>
<thead>
<tr>
<th>Minimum Level Resource Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>$86 per-capita</td>
</tr>
<tr>
<td>5% of GDP</td>
</tr>
<tr>
<td>Current total health spending</td>
</tr>
</tbody>
</table>

HIV/AIDS resource needs were obtained from UNAIDS, and provide a comparable benchmark for each of the Partner States. Finally, a health and HIV resource need was obtained. This is explained in more detail in Section 7.

Financing Gap - This sustainable financing study presents a number of scenarios for investing in health and HIV. It takes the expenditures and resource needs for health and HIV, and combined health and HIV, as discussed above, and a resultant resource gap is found. Projections are presented for a first scenario assuming no specific
policy measures are taken: the ‘Business As Usual’ case. Then an exploration of the sources from which additional resources could be raised, namely: 1) increased budget allocations; 2) innovative funding mechanisms; 3) efficiency gains; and 4) borrowing. This is the ‘Maximising Fiscal Space Resource gap’.

6. HEALTH AND HIV EXPENDITURE TRENDS

This section gives an overview of recent trends in health and HIV spending over the five EAC countries. It provides an understanding of the current levels of prioritisation in these sectors and the interlinkages between health and HIV expenditures.

KEY HIGHLIGHTS

- The average real Total Health Expenditure (THE) for 2012/2013 for the EAC region is 45 USD per capita with varying spending: Rwanda, 70 USD; Uganda 49USD; Tanzania 42 USD, Kenya 40 USd and Burundi 21 USD per capita. Putting this into economic context, THE amounts to 7.9% of the regional GDP. Rwanda spends 11.2%, and Kenya 5.2% of GDP on health.

- In the EAC region, only 36% of health care financing comes from sustainable domestic sources, with 20% coming from governments, and 16% from the private sector (e.g. voluntary health insurance). 28% is from Out Of Pocket (OOP) spending and 35% from external funding. This poses a challenge of the sustainability of health financing in the region.

- For the region as a whole, the average expenditure on health out of the total public budget has grown from 4% in 2009/2010 to 5.5% in 2012/13. Kenya spent on average 7% over the past four years, whereas Tanzania spent 3.1% over the same period.

- The EAC spent on average 123 USD per capita affected by HIV1. Rwanda spent almost 300 USD, whilst Burundi spent around a tenth of this on their HIV/AIDS patients.

- EAC governments’ contribution to HIV is not correlated to their income levels. Burundi with a GDP per capita of 261 USD in 2012/13, contributes 27% of its HIV expenditures, the government of Kenya, the only lower middle income country in the region contributes only 18%.

- In the EAC region, the average spending on HIV accounts for 0.3% of GDP and 1.2% of the budget. Again it is clear that the level of commitment to HIV is not correlated to the income of a country within the EAC. Only 15% of all HIV spending in EAC is from government budgets. 72% is from the international community and 13% from the private sector.

6.1 HEALTH EXPENDITURES

The average real Total Health Expenditure (THE) is 45 USD per capita on average throughout the region in 2012/13 (last official data point available). As Figure 21 shows there is much diversity around this with Rwanda spending 70 USD per person whilst Burundi spends 21 USD per person.

Putting this into economic context, THE amounts to 7.9% of the regional GDP. Rwanda spends the most at 11.2%, followed by Burundi and Uganda at 8.1%, Tanzania spends 6.7%, and Kenya 5.2% of GDP on health.

Figure 7: Nominal per capita THE in 2012/13 (USD)

- Across the EAC governments contribution to health and HIV are not necessarily linked to income. And spending on health is not necessarily linked in a particular way to spending on HIV. Donor dependency in HIV is more than double that in health; 72% compared to 35%.

- The expected decline in external funding in the coming years is expected to affect all EAC countries to a great extent, and may have a more substantial impact on HIV sector. It is important then to consider how health and HIV expenditures can be linked in an attempt to shelter HIV within the Universal Health Coverage agenda.

- Breaking THE down by sources of funding provides an overview of how donor dependant EAC countries are and how sustainable domestic funding is currently.

- OOP spending on health is high at “catastrophic” levels – i.e.
over 20% of all THE. With Ugandan households paying 47% of THE from OOP.

Figure 22 shows that for EAC overall only 36% of health care financing comes from sustainable domestic sources, with 20% coming from governments, and 16% from the private sector (e.g. voluntary health insurance). 28% is from Out Of Pocket (OOP) spending and 35% from external funding. This raises the issue of longer term sustainable domestic financing for health as an important challenge in the region.

OOP spending on health is high at ‘catastrophic’ levels – i.e. over 20% of all THE. With Ugandan households paying 47% of THE from OOP.

Figure 22 also looks at THE by source for each country. This shows that the problem of domestic sustainability is a problem for all EAC Partner States:

- Regardless of income status - Kenya as a middle income country still relies on a third of its health expenditures from external donors.

Figure 23 looks more closely at how much governments allocate out of the national budget to health in each EAC country. For the region as a whole budget allocation to health has grown from 4% to 5.5% from 2009/10 to 2012/13.

- The Kenyan government has consistently spent more on health as a proportion of its total budget averaging 7% over the past four years.
- However, the Rwandan Government health commitment has risen sharply from 2.8% of the national budget in 2009/10 to 7.8% in 2012/13.
- The Burundian government has also increased budget allocation to health doubling the 2.1% in 2009/10 to 4.2% in 2012/13.
- The Ugandan Government has remained relatively consistent allocating around 6% of its total budget to health.
- And the Tanzanian government allocation to health has remained consistently low averaging 3.1% over the four year period.

Figure 10: Real HIV Expenditure as Proportion of HIV Infected Population in 2012/13 (USD)

6. 2 HIV EXPENDITURE

Total real HIV spending can be measured as a proportion of HIV DALYs in total DALYs; i.e. a measure of the amount spent on the population affected by HIV, where DALY = Disability-Adjusted Life Year. The average for the region is 123 USD, and as can be seen in Figure 24 there is great variability across the EAC countries. Rwanda has relatively high expenditures at almost 300 USD, whilst Burundi spends around a tenth of this on their HIV/AIDS patients.

Figure 10: Real HIV Expenditure as Proportion of HIV Infected Population in 2012/13 (USD)
Notes: This indicator is calculated as follows: Total real HIV spending / \([AIDS DALYs/TOTAL DALYs]*country population\).

How much of this expenditure on HIV comes from domestic sustainable resource? Figure 25 shows that only 15% of all HIV spending in EAC is from government budgets. 72% is from the international community and 13% from the private sector. Two important points are clear from Figure 25:

- EAC governments contribute to HIV is not correlated to their income levels. Burundi is the poorest EAC country (261 USD per capital in 2012/13) but its government pays for 27% of its HIV expenditures. The government of Kenya – the only lower middle income country in the group – pays for 18% which is on par with Tanzania which has an income per capita at half the amount of Kenya. The governments of Rwanda and Uganda - with middling incomes within the group - spend the least at 8-9%.

- Donor dependence is also not attributable to income status. The poorest and richest in the region – Burundi and Kenya – both receive around 70% of their HIV expenditures from external sources. Rwanda is the most heavily dependent at 91% of HIV spending sourced externally. Tanzania receives 77% of its HIV expenditures from donors, and Uganda receive 66%.

6.2.1 HIV expenditure as proportion of the general health expenditure

For the period 2008/2009 to 2012/2013, Partner States in EAC region spent on average 29% of their GHE on HIV, while Development Partners spent 57%. The expenditure on HIV as proportion of the GHE ranges from 16% in Rwanda to 27% in Tanzania as shown in table XxX.... In all 5 EAC Partner States, there is a high dependency on Development Partners for implementation of HIV programs. As development partner funding towards health decreases, the proportion of funds available for HIV programming is likely to be affected more than any other health related programs. Given the forgoing, EAC Partner States need to put in place mechanisms that address sustainability of the health and HIV response in the region.

The DIPI allows a comparison of the relative priority given to HIV across countries. The DIPI, developed by UNAIDS, is based on two main assumptions: 40:

1. A country’s ability to pay for HIV from domestic public sources is dependent on the overall size of the government expenditure budget, which is a proxy for the available resources
2. A country’s need to pay for HIV from domestic public sources is related to the number of people living with HIV, which is a proxy for the HIV-related disease burden

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A country’s ability-to-pay for each person living with HIV is likely to be related to the total government budget per capita (i.e., for each person living in the country). The ratio between the two constitutes the index:

\[
\text{DIPI} = \frac{\text{Domestic expenditure per PLHIV}}{\text{Government budget per capita}}
\]

Both the numerator and denominator of this expression are larger in a country with higher available income. The value of the DIPI is expected to be stable with relation to changes in income (ability to pay) or disease burden (need to pay). Under these assumptions, the value of the DIPI index should not differ markedly between small and large countries, between poor and rich countries, or between low and high-prevalence countries. The differences in DIPI values therefore have a normative interpretation — expressing the “level of effort” or priority accorded to HIV in a country. A simple measure of DIPI is calculated as follows:

\[
\text{DIPI} = \frac{\text{GAE / GGE}}{\text{Population Prevalence} \times \text{Population}}
\]

It is clear there is a wide diversity in prioritisation of HIV throughout EAC: Rwanda at 0.05, Burundi 0.02, and Kenya, Tanzania and Uganda at less than 0.01. And being a lower middle income country does not seem to have improved the investment levels for HIV in Kenya.

6.3 INTER-LINKAGE BETWEEN HEALTH AND HIV EXPENDITURES

In general we have seen that government contribution to health and HIV are not necessarily linked to income. And spending on health does not necessarily equate to spending on HIV: Governments of Rwanda and Kenya spend relatively more on health but Tanzania and Uganda proportionally more on HIV – vis-a-vis their budgets. Donor dependency in HIV is more than double that in health; 72% compared to 35%. Therefore the expected decline in external funding in the coming years (see Annex for more details) is expected to affect all EAC countries to a great extent, and may have a more substantial impact on HIV sector which is heavily reliant on these funds. It is important then to consider how health and HIV expenditures are linked in an attempt to shelter HIV within the Universal Health Coverage agenda.

7. RESOURCE NEEDS

This section describes resource needs required for Health, HIV and Health and HIV combined for the period covering 2015-2030.

KEY HIGHLIGHTS

- The projected HIV resource needs compiled using UNAIDS estimates for the period 2015-2030 amount to an average of 2.3 billion USD per annum across the region, peaking in 2019/20 before declining slightly to 2029/30. This equates to 0.8% of the total GDP for the region, and declines in real terms over the projection period from 1.7% to 0.5%.
- However, the variability between EAC Partner States is high and for lower income countries HIV resource needs as a share of the economy are higher, for example on average 1.6% of GDP for Burundi but only 0.4% for Kenya.
- Unlike resource needs for HIV those for health are projected to continue to rise every year over the next fifteen years: from 15 billion USD to 41 billion by 2029/30. This would account for 8.1% of the regional GDP.
- Disaggregating this by country gives similar findings as the HIV resource needs; i.e., the greatest burden is skewed towards the lower income countries. The UHC needs would cost Burundi 26% of its GDP on average over the fifteen years, and only 5% of Kenya’s GDP, suggesting that poorer countries cannot achieve UHC relying on domestic resources only, and would need external donors to provide financial assistance.
- The combined health and HIV resource needs are projected to move from 15 billion USD in 2015/16 to 37 billion by 2029/30. This would account for 7.6% of the regional GDP over the time period.
- As is expected, the heavier burden of the combined health and HIV resource needs falls upon the lower income counties.

1 While each EAC Partner State has HIV resource needs projections of its own, these only cover a period of maximum 5 years, and they are obtained using non-comparable methodologies. For these reasons they are deemed not suitable for an EAC-wide analysis that is geared towards a set of policy recommendations that can be taken at regional, as opposed to national level.

We have seen that there are great differences in how much a country spends on health and HIV. This is a global phenomenon and there is no ‘correct’ level of spending. However, to identify how much a country may need to spend on health and HIV is possible to estimate and project over time.
7.1 HEALTH

Estimating the resource needs for health is less simple than HIV. Country-specific total health costing analysis is difficult to obtain (costly and time consuming). Therefore this framework uses international health needs norms as developed by OPM using research within a recent paper by McIntyre and Meheus (2014). The framework estimates the requirements focused on Universal Health Care (UHC) for a essential package of health services. The McIntyre and Meheus (2014) paper examines the funding requirement to offer an essential package of services with financial protection to the entire population. The ‘financial projection’ requirement implies that the population should be able to access these services without risk of financial impoverishment. The authors suggest a double target: either public health funding of 5% of GDP but not less than $86 (2012 dollars) per capita. The latter condition is added in the knowledge that even if some low-income countries do spend 5% of GDP on health, they would not reach US$ 86 per capita. These cases make a compelling argument for additional contributions from international donor sources. Practically, country resource needs are set for each country individually, to reflect the maximum of three things:

1. $86 USD per capita;
2. 5% of GDP; or
3. Current total health spending.

As can be seen in Figure 29, unlike resource needs for HIV those for health are projected to continue to rise every year over the next fifteen years: from 15 billion USD to 41 billion by 2029/30. This would account for 8.1% of the regional GDP.

Figure 13: Total Health Resource Needs in EAC (M USD) and by Partner State (as % GDP)

Disaggregating this by country gives a similar findings as the HIV resource needs; i.e. the greatest burden is skewed towards the lower income countries. The UHC needs would cost Burundi 26% of its GDP on average over the fifteen years, and only 5% of Kenya’s GDP.

7.2 HIV

UNAIDS have supplied the fifteen year projections for total resource needs for each EAC Partner State. This is projected at 2.3 billion USD per annum, peaking in 2019/20 before declining slightly to 2029/30. This equates to 0.8% of the total GDP for the region, and declines in real terms over the projection period from 1.7% to 0.5%.

However, the variability can be seen in Figure 28 where the resource needs for lower income countries is a much greater burden on their economies – averaging 1.6% of GDP for Burundi but only 0.4% for Kenya.

Figure 14: Total HIV Resource Needs in EAC (M USD) and by Partner State (as % GDP)

7.3 HEALTH AND HIV

To create a scenario where HIV needs are combined with health needs we need to consider how much of the UHC package is HIV-related, and how much of the HIV needs are health related.

1. For UHC Resource Needs a recent analysis on this topic found that: “The CMH, WHO norm and MBB each allocated between 12% and 18% of the total cost of UHC to HIV/AIDS response interventions. UNAIDS estimated fiscal need for HIV/AIDS interventions is between 14% and 15% of estimated government plus donor expenditure on health between 2015 and 2019” (Alex CJ OPM 2015, page 34).

2. For HIV Resource Needs – Estimation of the line items associated with health spending and those not directly

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41 Where CMH = Commission on Macroeconomics and Health, MBB = Marginal-Budgeting for Bottlenecks (approached used by the High Level Task Force on Innovative International Financing for Health Systems), and WHO = World Health Organisation.
health related were made. The resultant estimate of Health and Non-Health related UNAIDS HIV Resource Needs are set out in the annex Table A.7. Past expenditures in these needs categories suggest that in the EAC region 86% were identified as directly health related, the remaining 14% not. Country specific results have been used as shown in Figure A.1 in the annex.

Therefore, this study will use these finding as follows:

• Take 15% off of Health Resource Needs to give ‘Non-HIV/AIDS Health Resource Needs’.

• Remove 14% of the Non-Health related HIV needs to give ‘Health-Only HIV/AIDS Resource Needs’, (using the UNAIDS HIV Resource Needs as these are based on country-specific unit costs and can range from 20% in Kenya and 4% in Tanzania).


• A Health and HIV/AIDS Resource Needs with no duplications and no non-health costs.

The results of these calculations are presented in Figure 30. They are projected to move from 15 billion USD in 2015/16 to 37 billion by 2029/30. This would account for 7.6% of the regional GDP over the time period.

These are less than if simply adding health and HIV needs together as we have attempted to extract any duplication. However, over the longer term they are also less than simply health resource needs which are projected to reach 41 billion USD in 2029/30. This means that on average throughout the region the UHC has enough to cover the total UNAIDS HIV health needs; i.e. the estimated 15% of UHC allocated to HIV is more than the UNAIDS country-specific cost estimated for HIV resource needs.

As is expected, and seen in the HIV and health resource needs, the heavier burden falls upon the lower income counties.

Figure 31 shows the country specific differences between the UNAIDS resource needs and the 15% allocation to HIV. It is clear that all EAC countries will be able to accommodate their HIV needs within the UHC package.

It must be noted that these combined resource needs do not include non-health related HIV needs.

Note: Positive values = UHC has enough resource needs to cover UNAIDS estimated HIV/AIDS health needs, Negative = Needs more than 15% of UHC to cover the UNAIDS estimated HIV/AIDS health needs.
8. BUSINESS AS USUAL RESOURCE GAP

This section addresses the policy question “would the EAC, and each Partner States individually, mobilise enough resources to meet the HIV, health and combined resource needs as set out in the previous section” and if they would continue to rely on the current sources of funding if they would not take any additional initiative to fund HIV, and health. Three gaps will be presented: one for health, one for HIV and the third will combine the two to give an estimate of UHC with HIV. For this analysis, only government budgetary expenditures on health and HIV and the external funding are considered. Out Of Pocket expenditure (OOP) and the private sector are excluded in the analysis.

KEY HIGHLIGHTS

- The resource gap for health under the business as usual scenario is an average of 18 billion USD a year over the next fifteen years, reaching 28 billion USD by 2029/30 which accounts for 5.6% of the regional GDP and 21.4% of the total governments’ budget across the Partner States. Tanzania has the largest nominal gap of 6.1 billion USD over a period of 15 years while Rwanda and Burundi have a gap of about 1.3 billion.

- Burundi has the greatest health burden with the resource gap at 20% of its GDP; Uganda has a gap equivalent to 8.5% of GDP; Tanzania 7.1%; Rwanda 6.6% and Kenya has a significantly lower burden of only 2.9% of GDP

- The HIV resource gap will reach an average of 244 million USD a year over the next six years. and 2021/22 projections suggest that Partner States will have adequate funds to cover their HIV needs. Countries indicating the greatest domestic pressures in terms of ability to pay from the budget are Burundi where the gap is 3.8% of the budget.

- Kenya and Rwanda are the only countries to have a surplus for HIV, averaging 0.3% of GDP pa. This means that technically there are enough funds to cover HIV needs but this will depend upon allocation.

- The combined health and HIV resource gap will reach an average of 18 billion USD a year over the next fifteen years, and 27 billion USD by 2029/30. This could account for 5.5% of the regional GDP and 21.3% of the total governments’ budget across the Partner States. As the economies of EAC Partner States grow, the HIV burden will decline over time. Tanzania has the largest nominal combined HIV and UHC gap in the region: 6.2 billion USD. As a proportion of the economy Burundi has the largest burden with 21% of GDP pa, Burundi’s combined HIV and UHC resource gap is projected to equate to more than two thirds of its entire budget – 72% on average over the 15 years. Other countries with a serious challenge to paying for UHC through domestic means, in order of magnitude, are Uganda (41% of budget), Tanzania (26% of budget), and Rwanda (23% of budget). Kenya’s gap will be lowest in the region but still high at 10% of its budget.

- In sum, all of the EAC countries will be struggling to provide UHC with or without HIV over the next fifteen years. Some of these countries need to alter their current allocations to ensure UHC is provided; others may need a substantially greater prioritisation of health and HIV to achieve the goal of UHC including HIV.

- While some countries are expected to have enough fiscal space for HIV alone from 2020/21 onwards, the HIV resource needs methodology assumes that expenditure on HIV is frontloaded, i.e. a higher investment is made in the period 2015-2020, in order to maximise population benefits and to keep total costs at a minimum. During this period, all EAC Partner States face a funding gap with a funding strategy of “business as usual”.

8. 1 HEALTH

For health we use the health expenditures as described above but remove any HIV expenditures within this. The methodology annex provides more details of the calculations. Each EAC Partner State will have its own country proportions applied.

Table 4: Proportion of HIV Expenditures compared to Health Expenditure (5 year average 2008/09 - 2012/13)

<table>
<thead>
<tr>
<th>Country</th>
<th>GOVERNMENT: GAE WITHIN GHE</th>
<th>DONORS: HIV ODA WITHIN HEALTH ODA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>22%</td>
<td>25%</td>
</tr>
<tr>
<td>Kenya</td>
<td>18%</td>
<td>65%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>16%</td>
<td>60%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>48%</td>
<td>50%</td>
</tr>
<tr>
<td>Uganda</td>
<td>27%</td>
<td>58%</td>
</tr>
<tr>
<td>EAC Average</td>
<td>29%</td>
<td>57%</td>
</tr>
</tbody>
</table>

Note: Calculated from NHA and NASA for Government Expenditure, and OECD DAC CRS for Donors. But to provide a picture for the average regional impact the health expenditures will be calculated as follows:
• Government spending on health reduced by 29% to remove HIV expenditures; and

• Donor funding for health reduced by 57% to remove HIV financing.

These expenditures are set against the health resource needs (removing any HIV expenditures are per section 4.3). This provides a resource gap for health which averages 18 billion USD a year over the next fifteen years, reaching 28 billion USD by 2029/30, see Figure 32. Accounting for 5.6% of the regional GDP and 21.4% of the total governments’ budget across the Partner States. The average for each country over the fifteen years is provided in Figure 33. Some noteworthy points:

• Tanzania have the largest nominal gaps; 6.1 billion USD. Burundi and Rwanda are much smaller at around 1.3 billion USD is a function of their small population.

• Relative to the size of the economy Burundi has the greatest health burden with the resource gap at 20% of its GDP. Uganda has a gap equivalent to 8.5% of GDP. Tanzania 7.1%, Rwanda 6.6% and Kenya has a significantly lower burden of only 2.9% of GDP.

• In terms of a governments’ national budgets Burundi and Uganda have substantial health burdens accounting for more than two thirds of the projected available budget for Burundi and 40% in Uganda. The gaps for Rwanda and Tanzania are 25% of their budgets. Kenya is lower but still projected to be 11% of the available budget.

8.2 HIV

For HIV we use the HIV expenditures as described above but remove any non-health expenditures within this. The methodology annex provides more details of the calculations. Each EAC Partner state will have its own country proportions applied. But to provide a picture for the average regional impact the HIV expenditures will be calculated as follows:

• Government spending on HIV reduced by 9% to remove non-health expenditure; and

• Donor funding on HIV reduced by 15% to remove non-health monies.

Table 5: Proportion of HIV Expenditures related to Health

<table>
<thead>
<tr>
<th></th>
<th>HEALTH RELATED HIV EXPENDITURES BY GOVERNMENT</th>
<th>HEALTH RELATED HIV EXPENDITURES BY DONORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>99%</td>
<td>87%</td>
</tr>
<tr>
<td>Kenya</td>
<td>82%</td>
<td>79%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>100%</td>
<td>87%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>99%</td>
<td>91%</td>
</tr>
<tr>
<td>Uganda</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>EAC TOTAL</td>
<td>91%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Note: Based on UNAIDS GARPR data.
The table above shows that over the analysis period, the EAC Partner States spent on average 9% of the total HIV budget on non-health expenditure.

These expenditures are set against the HIV resource needs (removing any non-health expenditures). This provides a resource gap for HIV which averages 244 million USD a year over the next six years, and from 2021/22 projections suggest there will be more than enough funds to cover the needs, see Figure 34. When in deficit the gap will account for 0.1% of the regional GDP and 0.5% of the total governments’ budget across the Partner states.

The average for each country over the fifteen years is provided in Figure 20. Some noteworthy points:

- Kenya and Rwanda are the only countries to have a surplus for HIV, averaging 0.3% of GDP pa. This means that technically there are enough funds to cover HIV needs but this will depend upon allocation.
- Kenya has the largest nominal resource gap at 0.4 billion USD pa.
- In relation to their economy the greatest burden falls on Burundi (1.1% of GDP), followed by Uganda (0.3%) and Tanzania (0.2%).
- Countries indicating the greatest domestic pressures in terms of ability to pay from the budget are Burundi where the gap is 3.8% of the budget. Uganda is 1.6%, and Tanzania is 0.6%.

Figure 19: EAC Regional HIV Resource Gap M USD and as percentage of GDP and Budget (2015/16 to 2029/30)

Adding these two gaps together we can have an idea of how HIV can be incorporated into UHC, as shown in Figure 21. The resource gap for HIV within UHC averages 18 billion USD a year over the next fifteen years, reaching 27 billion USD by 2029/30. This could account for 5.5% of the regional GDP and 21.3% of the total governments’ budget across the Partner states. The burden over time is declining as economies grow.

The average for each country over the fifteen years is provided in Figure 22. Some noteworthy points:

- Tanzania have the largest nominal combined HIV and UHC gaps in the region; 6.2 billion USD.
- As a proportion of the economy Burundi has the largest burden with 21% of GDP pa projected to be not payable out of current budget allocations and donor funds. Uganda, Tanzania and Rwanda have a resource gap of 8.8%; 7.3% and 6.3% of their respective GDPs. Kenya’s combined UHC and HIV gap is projected to be 2.7% of GDP.
- Burundi’s combined HIV and UHC resource gap is projected to equate to more than two thirds of its entire budget – 72% on average over the 15 years. Other countries with a serious challenge to paying for UHC through domestic means, in order of magnitude, are Uganda (41% of budget), Tanzania (26% of budget), and Rwanda (23% of budget). Kenya’s gap will be lowest in the region but still high at 10% of its budget.

In sum, we can say that UHC has the potential to include HIV within a package of essential services across EAC – in that the UNAIDS estimated resource needs are not substantially different from 15% of the allocation to HIV in UHC. However, all of the EAC countries will be struggling to provide UHC with or without HIV over the next fifteen

8.3 HEALTH AND HIV

Note: Includes only government and donor health related HIV expenditures and resource needs.
years. Some of these countries need to alter their current allocations to ensure UHC is provided; others may need a substantially greater prioritisation of health and HIV to achieve the goal of UHC including HIV. However, there will need to be continued support from the international community to be able to achieve anywhere near the goals. More on what possible policy options and financing mechanisms are set out in the next chapter.

Figure 21: EAC Regional Combined HIV in UHC Resource Gap M USD and as percentage of GDP and Budget (2015/16 to 2029/30)

Note: Includes only government and donor health and ‘health-only HIV’ expenditures and resource needs.

Figure 22: Country Combined HIV in UHC Resource Gaps M USD and as a proportion of GDP and Budget (Annual Average 2015/16 - 2029/30)

9. MAXIMISING FISCAL SPACE RESOURCE GAP

This section explores options available to the EAC Partner States to mobilise additional resources for health and HIV and examines if the additional funding from these sources would be adequate to address the business as usual funding gap. Three policy options are explored in detail: Reprioritisation of public spending towards health and HIV, additional taxes with proceeds earmarked to health and HIV, and increased efficiency of health and HIV service delivery.

KEY HIGHLIGHTS

• Reprioritisation of public spending towards health and HIV
• Reprioritisation of public spending towards health and HIV in EAC Partner States reduces the resource gap to 7 billion USD per year over the projection period, falling from an annual average of 18 to 11 billion USD. As a result of reprioritization, the resource gap could fall from 5.5% of GDP to 3.8% pa over the fifteen years.
• In Kenya, reprioritization could eliminate the resource gap by 2024/25, while it would reduce the gap to 2% of GDP by 2029/30 for Rwanda and Tanzania.
• For Burundi and Uganda, the reprioritization policy reduces the resource gap significantly from 24% to 14% for Burundi, and 11% to 5% for Uganda.
• Earmarked Funds
• Earmarked taxes, which expand existing tax regimes on specific sectors, such as alcohol, tobacco, airline and mobile phone industry, or increases in headline personal, corporate and indirect taxes, have the potential to bring 1.8 billion USD a year to the region in the short turn. This is the equivalent of an additional 0.5% of GDP for each country to go towards UHC inclusive of HIV, and so reduces each country’s resource gap by this amount. The success of this policy action is contingent on the EAC PSs implementing tax reforms that improve revenue collection in the short term.
• Efficiency savings
• A potential 5 billion USD a year is projected to be captured by efficiency savings in health and HIV1.
• If EAC Partner States implement these 3 policy options above in combination, the UHC and HIV needs throughout the region could be covered by 2027/2028 except Burundi and Uganda will still require 10.7% and 2.6% of their respective GDPs to fully reach UHC and HIV needs.

1 The methodology used to estimate the magnitude of potential savings from imposing efficiency measures is based on international comparative performance via a Data Envelope Analysis (DEA) (as discussed in methodology annex).
9.1 PUBLIC SPENDING

As we have seen above the level of public spending on health and HIV varies across countries. We will discuss each in turn and provide explanations for targets used. Social Health Insurance (SHI) is included within these data under public spending.

The role of out-of-pocket expenditure and private sector (financial) contributions to the health system is generally important, although OOP in the region is comparatively low as is the input from private firms and companies. Through direct contributions households and firms finance health services. However, these are generally not taken into account for universal health coverage, which strives to offer the entire population access to a defined package of health services with financial protection. Because they depend on the ability to pay of each individual household, out-of-pocket expenditure cannot be a source of funding for UHC: it does not guarantee access of all households, nor does it guarantee financial protection. The same logic applies to financial contributions from firms: these are for specific population groups, and will also depend on the capacity to pay of individuals firms. However, contributions from households and firms toward mandatory health insurance are considered a source of funding for UHC, and have, for simplicity, added to public expenditure.

9.1.1 HEALTH – GHE

There are international goals for health spending such as the Abuja Declaration which each EAC country has signed up to. This has a target of raising the GHE:GGE ratio to 15%. The projections allow a timeframe of ten years, starting in 2015/16, of incremental annual growth in the allocation to health towards these targets to be achieved by 2024/25 and maintained up to 2029/30. It assumes no new taxation measures, simply a re-prioritisation of the national budget to health to achieve UHC.

9.1.2 HIV – GAE

For HIV we calculate fair shares as per Resch’s approach to government financing of HIV. This was discussed above and the target for HIV/AIDS spending (as a ratio to health spending) is 0.5. This is calculated by:

\[
Resch \ DIPI = \frac{GAE \ / \ GHE}{AIDS \ DALYs/ \ TOTAL \ DALYs}
\]

This means, for example, a country where 10% of the total disease burden is due to AIDS would be expected to spend at least 5% of its health budget on AIDS programs. The Resch DIPIs for all EAC Partner States are above 0.5 and the regional as provided by the figure above average is 2.2. As noted all EAC countries are already above the 0.5 ‘fair share’ but are not able to meet their resource needs for Health and HIV/AIDS in the short term.

9.1.3 UHC INCLUSIVE OF HIV - INTERACTIONS BETWEEN GHE AND GAE

Within this framework the level of spending on health affects the spending on HIV. As allocation to health rises automatically HIV should gain extra resources – whether these are for directly HIV specific drugs and interventions, or a general improvement in health systems etc. This is discussed in greater detail in the data and assumptions section of the methodology annex, specifically the subsection ‘Linkages between Government Spending on Health and HIV’. In sum, it’s important to note that the framework used for this study allows for these types of inter-linkages as the EAC countries move forward to a UHC service.

9.1.4 IMPACT OF RAISING BUDGETARY ALLOCATIONS TO HEALTH AND HIV

Once these targets are set the new resource gap is found which is 7 billion USD smaller on average per year over the projection period (falling from an annual average of 18 to 11 billion USD). As a proportion of the regional economy the resource gap could fall from 5.5% of GDP to 3.8% pa over the fifteen years. Figure 38 shows these results for each year and suggests that:

• For Kenya this single policy action of raising budgetary allocation may almost eradicate the resource gap by 2024/25. The average gap in the last five years is only 0.2% of GDP.

• For Rwanda and Tanzania the policy to raise the health and HIV budgets will reduce the gap to 2% of GDP by 2029/30. But the gap is not being addressed immediately by this policy, as in the near term it remains at 7% of GDP.

• For Burundi and Uganda the policy reduces the resource gap significantly over the fifteen years- (from 24% to 14% for Burundi, and from 11% to 5% for Uganda. However, these gaps – especially for Burundi - remain a significant burden and there simply is not enough money in national budgets to meet the combined UHC and HIV resource needs.

Figure 23: EAC Combined Resource Gap with Targeted Budgets (M USD) and by Partner State (as proportion of GDP)
9.2 EARMARKED FUNDS

General taxation reform takes time. To raise general taxes to increase domestic budget spending can be a lengthy process. As we’ve seen from the section above the incremental rise in budget allocation to health and HIV makes a significant reduction in the resource gap by 2029/30, but over the short to medium term some countries simply do not have the capacity to raise the financing required. However, most of the EAC countries are not operating at their optimal taxation incidence, as we have seen in the macroeconomic section above there is fiscal space to increase taxation and this can be done in the near term by implementing earmarked taxes.

Earmarking tax revenue pays an important role in ensuring the political acceptability of governments’ priorities. This is particularly the case where the taxes are put to a clearly defined social benefit (such as health services) or linked to particular social dis-benefits (e.g. sin taxes). The financing of health and HIV is characterised by the need for sustained expenditure well into the future, high donor dependency and uncertainty around future donor support caused by a tight fiscal climate globally. Many governments are therefore confronted with the certainty of important expenditure for health and HIV into the future but uncertainty about how to finance their programmes.

The recent strong growth in EAC countries could be taken to imply that the country should be able to generate its own resources for UHC. However, this growth has not yet translated into a wider tax base whereby revenues can cover expenditures. In the previous section we have seen that over time many countries can be expected to self-fund through general taxation measures as growth and tax reform continues. However, in the short term the current tax systems cannot sustain the needs of the sector. Within the context of dwindling external resources countries need to take ownership of the sector. Given the limitations of the general taxation system it is therefore essential that the health and HIV sectors increases fiscal space and investment for UHC outcomes through alternative funding sources.

This report has analysed six different potential earmarked taxes and levies for EAC countries to consider. These are set out in Table 12 in order of their score within selection criteria to assess their effectiveness as sources of funding for UHC inclusive of HIV. Each has been measured on a five-point scale: 1) sustainability of resource flows over time; 2) stability of funding; 3) progressiveness (i.e. impact on equity); 4) administrative efficiency (how costly it would be to set up and maintain the levy); and 5) any potential side effects.

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Sustainability</th>
<th>Stability</th>
<th>Progressivity</th>
<th>Administrative Efficiency</th>
<th>Side Effects</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airline levy</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
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<tr>
<td>Public Sector Mainstreaming</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>18</td>
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<tr>
<td>Sin tax – Alcohol</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>17</td>
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<tr>
<td>Remittances levy</td>
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<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Private Sector Mainstreaming</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>16</td>
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<tr>
<td>Airtime levy</td>
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<td>4</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>15</td>
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<tr>
<td>Health bonds</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 6: Overview of the Costs and Benefits of Innovative Funding Mechanisms

Source: Adapted from Lievens (2012)

Note: * = Summarises findings from countries that have implemented, or carried out analysis on these earmarked taxes. Figure 39 adds the impact of raising budgets and implementing an earmarked tax for UHC inclusive of HIV. The average gap over the period has now declined from 18 to 9 billion USD a year.

Earmarked taxes here have the potential to bring 1.8 billion USD a year to the region. This is the equivalent of an additional 0.5% of GDP for each country to go towards UHC inclusive of HIV, and so reduces each country’s resource gap by this amount.

Figure 24: EAC Combined Resource Gap with Targeted Budgets and Earmarked Taxes (M USD) and by Income Status (as proportion of GDP)
9.3 TRUST FUNDS

9.3.1 FUNDING MODALITIES

There are two ways in which such a trust fund could operate; funded and unfunded.

In an unfunded scheme, the government amongst other funders would allocate resources to the fund each year. These may be in the form of either direct transfers from the government budget (as may currently happen for a statutory body, for example) or as revenues that go directly to the Fund without passing through the government budget. The fund would then conduct expenditure on HIV in an amount equal to the sum received that year. In these circumstances, from a purely financial point of view, the fund operates no differently to the government in terms of the size and sustainability of the HIV resources and expenditures. The fund is therefore purely an operation mechanism for managing and allocating these resources.

In a funded scheme, the fund receives an initial endowment and the balance of the fund is allowed to accumulate by investing in financial assets. Once a certain level has been reached, the fund can then allocate the interest earned on its value each year to expenditure on HIV and AIDS. This is clearly a more sustainable situation over the long term, as it reduces the reliance on the annual allocation to the fund by the government and/or the revenue streams allocated to the fund.

However, to establish a funded scheme requires an initial injection of resources. This endowment must be fairly substantial to allow the fund to quickly accumulate to a sustainable level at which it can start to pay out for HIV expenditure. It is therefore easiest to establish such a fund in a country that has recently enjoyed, or expects to enjoy, a sudden increase in revenues – typically as a consequence of exploiting a natural resource (e.g. oil). In such circumstances, there are strong macroeconomic reasons for establishing a fund to receive the “excess” revenues, to avoid Dutch disease effects and inflation.

9.3.2 OPERATIONAL MODALITIES

Apart from the core motivation of raising funds for HIV/AIDS the trust fund is often expected to have additional qualities. Two important ones are the idea that the trust fund can operate as a coordination mechanism for HIV/AIDS and be a flagship for good governance.

Coordination – With a central depository of funding the trust fund carries with it the responsibility of prioritising the funds. As donors phase out their activities, the trust fund remit would be expanded. Through the role of an active purchaser, this could be an opportunity to improve efficiency in service delivery and improve prioritisation on a national level. Capacity would need to be developed to deal with resource allocation and implementation issues.

The trust fund could act as a strengthening institution to improve policy dialogue with stakeholders as they would be required to liaise with one central agency. This along with the reduction in fragmentation of services could reduce transactions costs in the sector and help improve management.

Good governance – HIV funding is characterised by fragmentation of funding and service provision. This can be partly explained by donors concerns over corruption and a general mistrust of government institutions’ accountability mechanisms. The establishment of a new independent HIV/AIDS trust fund with inbuilt accountability and transparency mechanisms could rebuild trust. Over time donors may be convinced to disburse their funding through the trust fund. This would further assist in alignment of HIV/AIDS services.

There will need to be provisions within the legislature to establish a (semi) autonomous fund. It will need to have effective powers to develop its budgets and release expenditures that are aligned with the national plans for HIV/AIDS. There will need to be a thorough monitoring and evaluation and publication of annual accounts to help facilitate this agenda for good governance.

The criteria and procedures that need to be fully developed and legislated for include:

- Objectives, expected outcomes, beneficiaries, programme areas
- Budget formulation, adoption, execution and monitoring
- Financial operating procedures
- Contracting and procurement procedures
- Communication strategy

Also, independent auditing may be required to ensure accountability and there is a need transparency of public records. There would also be a need for legislation for the inclusion of donor funds in the medium term if they find the trust fund to be an efficient and effective method of financing HIV/AIDS.
GOOD PRACTICE 1 – SUMMARY:
RESOURCE MOBILISATION INNOVATION – HEALTH ENDOWMENT / TRUST FUND

WHAT IS THE HEALTH FINANCING MECHANISM?
• An HIV & AIDS, TB, Malaria or general health Endowment Fund.
• The idea behind an HIV & AIDS, TB, Malaria or general health Endowment Fund is that once the fund has reached a certain level of capitalisation the return on that capital would, for example, cover the country’s HIV expenditure.

CASE STUDY: AIDS TRUST FUND IN THE UNITED REPUBLIC OF TANZANIA

WHY – WHAT IS THE SITUATION IN TANZANIA?
• 60% of Tanzania’s response to AIDS, TB and Malaria is sustained through external funding.
• Canada and Denmark are two of the largest bilateral donors of the country’s HIV & AIDS response, but have both announced the withdrawal of funding by the year 2015.
• At the same time, the updated WHO ART Treatment Guidelines have increased ART eligibility, with at least one million people in need of treatment under the new guidelines, in addition to the 566,460 who are currently receiving ART.
• Tanzania is also the second largest recipient of grants from the Global Fund for AIDS, TB and Malaria (GFATM) – the world’s largest funder of the global response to these three epidemics.
• There is no GFATM commitment to health financing beyond the 2015 deadline.

WHAT RESULTS DOES THE TANZANIAN AIDS TRUST FUND SEEK TO ACHIEVE?
• This led the Global Fund in 2013 to urge Tanzania “to fast-track efforts to establish a multimillion-dollar health trust fund aimed at sustaining the country’s campaign to fight HIV & AIDS, tuberculosis and malaria.”
• Analysis by the Tanzania Commission for AIDS (TAC AIDS) show that foreign assistance for HIV has declined by nearly 50%, and is projected to decline further.
• Establishing the Tanzanian AIDS Trust Fund
• In the face of this the government of Tanzania first mooted the idea of establishing a trust fund in 2012. Government has been considering the introduction of either an AIDS Trust Fund (ATF) or a Health Trust Fund (HTF) in order to raise financial resources to bear costs of responding, in particular, to the epidemics of HIV & AIDS, Malaria and Tuberculosis.
• In February 2014 it was announced that Cabinet had approved the establishment of an AIDS Trust Fund, and that it would be established in the 2014/2015 financial year.
• Executive Chairperson of TAC AIDS, Dr Fatma Mrisho, has confirmed that government has ratified the allocation of funds for the programme, that TAC AIDS is working to prepare regulations for its operations and that establishing the AIDS Trust Fund will be among her top 3 priorities next year.

• The purpose behind the establishment of the Tanzania AIDS Trust Fund (ATF) is to mobilise and distribute domestic resources to fight against the disease in order to reduce dependence on donor financing while at the same time sustaining HIV & AIDS the interventions.
• A sessional paper on the establishment of the AIDS Trust Fund tabled for discussion in Parliament noted that government would allocate approximately 1% of its total revenue to the fund and that the Fund would reduce donor dependency by 34%.
KENYA. In its meeting of December 2012 Cabinet decided to establish a Trust Fund for HIV and priority non-communicable diseases. Although the initial proposal was to allocate up to 1% of ordinary government expenditure to the Fund, the Cabinet’s approval went not that far.

ZIMBABWE. The Zimbabwe National AIDS Trust Fund (ZNATF) was financed by a levy of 3% on the taxable income of individuals and firms. Due to Zimbabwe’s economic problems, which led to the collapse of most of the formal sector of the economy, this has not been particularly successful – in 2009 it was reported to have raised only 5.1 million USD. The levy was reported to be highly unpopular, due to a combination of resentment at the effective increase in tax rates at a time when incomes were under stress, as well as concerns about transparency and accountability in the use of ZNATF resources.

In BOTSWANA a similar approach is being considered involving a levy on the taxable income of non-mining firms. This could be achieved by increasing the top rate of income tax from 25% to 26%. The incidence of this would fall roughly equally on individual and corporate taxpayers. Such a levy would be relatively easy to collect. As in Zimbabwe, however, it would most likely unpopular, given the recent stress resulting from stagnating or declining real incomes in much of the economy. There may also be resistance from government to raising effective tax rates due to the potential impact on investment and growth.

In SOUTH AFRICA the National AIDS Trust was established in 2002 to support the South African National AIDS Council (SANAC). However this is an advisory body and has no statutory status. It is a funded scheme and the objective of the board of trustees is to secure funding for SANAC activities.

In TANZANIA the Vice President announced the establishment of an HIV/AIDS trust fund. This has been decided under similar conditions to Kenya, i.e. high dependency on donor funding, and the realisation of a need to have full insurance coverage in the longer term for sustainable financing. The Tanzania Commission for AIDS is responsible for the Fund.

There are also trust funds led by the private sector or civil society with various goals for HIV/AIDS. For example in Namibia a private fund aims to tap the corporate social responsibility budgets of companies. They aim to avoid duplication by primarily funding existing HIV/AIDS initiatives. Also in Namibia there is a local entertainment organisation that has set up a trust fund for HIV/AIDS orphans and underprivileged children.

9.4 EFFICIENCY SAVINGS

Simply defined, efficiency refers to ability to fully exploit available resources. At its most basic level, efficiency gains can be thought of as achieving one of two things:

- Better health and HIV outcomes for the same level of investment; or
- The same health and HIV outcomes at a reduced level of investment.

The purpose of improving the efficiency of the health system, however, is rarely simply about ‘cutting costs’. More often it is about making better use of existing resources – of using them more efficiently – so as to expanding coverage and access. Efforts to improve efficiency, then, should be considered in order to increase the domestic resources available for health and to help countries to manage those precious resources more effectively so that more people can access those services or so that the range of services on offer can be increased.

At their most basic level efficiency gains refer to the gap between coverage levels and health outcomes that countries achieve and what they could potentially achieve using the same resources. Rather than simple cost-cutting, efficiency gains refer to increasing the impact of spending (spending funds in a manner that derives the greatest impact) as well as to improving the efficiency with which funds are spent (spending in the most efficient manner). The emphasis is on value for money. Thus, while efficiency gains may reduce the costs of service delivery the objective is to contain costs without reducing health outcomes. Efficiency, therefore, includes a measure of both the quality and the quantity of outputs (i.e. health outcomes or services) for a given level of input (i.e. cost).
Efforts to improve efficiency can impact on programmes in one of two ways: (1) Improving the allocation of resources so that interventions are implemented in the most efficient manner (termed allocative efficiency), and (2) Improvements that optimise implementation so that interventions are implemented more efficiently (termed technical efficiency). It is on the latter – on technical efficiency – that this study will focus: on presenting an analysis of the areas of HIV programme implementation within which efficiencies can be generated. In other words, the study will present an analysis of how to generate efficiency savings within the HIV service delivery interventions that are being implemented.

‘Technical efficiency’ relates to improving the sub-optimal or even unnecessary use of resource inputs for a defined outcome in order to extract maximum benefit from those inputs. It is concerned with improving the way in which health care inputs are used: with using less resources for a particular intervention without reducing outcomes.

‘Allocative efficiency’ is concerned with the mix of services or interventions, both within diseases (such as prevention versus treatment within, say, HIV) as well as across them (such as spending less on HIV and more on, say, malaria), in order to maximise health outcomes. Thus there is an interest in health outcomes and in how such outcomes are distributed across the population, with a view to adjusting the mix of services and interventions provided in order to achieve better outcomes.

II. MEDICINES

The costs of diagnostic tests and prescription drugs typically constitute the second largest budget items in a health system and, as such, offer opportunities for inefficient spending. Referred to as ‘medicines’ for the sake of simplicity, inefficiencies within the prescription of drugs and the use of diagnostic tests are divided into four main cost-driving categories: 1) Underuse of generics; 2) Higher than necessary prices for medicines; 3) Use of sub-standard and counterfeit medicines and 4) Inappropriate and ineffective use; 5) poor quantification and forecasting for medicines and health products; 6) low domestic production capacity for medicines leading to reliance of external supply through importation; and 7) Individual individualized procurement of medicines and medical products by partner States. Some of the procurements do not follow national procurements mechanism and these donor procurements pose inefficiencies.

Generic (as opposed to ‘branded’) medicines have equivalent efficacy and are substantially cheaper to procure, yet they are vastly underutilised. A study undertaken in Cameroon (please insert reference) analysed the current use of branded as opposed to generic medicines and found that tens of millions of (US) dollars could be saved by switching to generic versions of 17 commonly used drugs in public hospitals alone in each of a range of developing countries.

Countries also commonly pay far higher than necessary prices for medicines. Two avenues for addressing this involve regional pharmaceutical manufacturing (which is under discussion by the EAC) and explore alternative procurement options (for which global expertise exists to assist countries in considering the variety of alternative pooled procurement options available).

III. HOSPITALS

Hospital care is a critical component of a comprehensive health service but as with staff and medicines it too constitutes a major cost item for any health system. Tertiary health facilities – hospitals – are the top rung in any three-tiered health system and bring together various resource inputs, including physical (buildings), human (health and administrative personnel), medicines and equipment (Chisholm and Evans, 2010).

- **INAPPROPRIATE HOSPITAL ADMISSIONS AND LENGTH OF STAY:**

Chisholm and Evans (2010) cite four separate studies of adult inpatients in Canada where 24-90% of admissions and 27-66% of inpatient days were inappropriate. Moreover, the literature abounds with examples of excessive inpatient admissions and overly long lengths of stay (see McConagh et al, 2000). These ‘inappropriate hospital admissions and length of stay’ are commonly due to...
insufficient incentives to discharge, a limited knowledge of best practice, or a lack of alternative care arrangements.

**INAPPROPRIATE HOSPITAL SIZE (LOW USE OF INFRASTRUCTURE):**

Inappropriate hospital size is commonly due to too many hospital and inpatient beds in some areas while not enough in others. Excessive or insufficient hospital size often reflects a lack of planning for health service infrastructure development. “While it may make good economic sense to enlarge the size and scope of a hospital in order to make better use of available expertise, infrastructure and equipment, there comes a point where a hospital departs from its optimal level of efficiency and begins to exhibit diseconomies of scale; at the other end of the scale, small hospitals may also be inefficient because the fixed infrastructural and administrative costs are shared across too small a caseload, thereby pushing up the cost of an average hospital episode” (see McConagh et al, 2000).

**MEDICAL ERRORS AND SUBOPTIMAL QUALITY OF CARE:**

Medical errors and suboptimal quality of care is commonly due to insufficient knowledge or application of clinical-care standards and protocols; a lack of guidelines; inadequate supervision; and to inadequate disease prevention and control. These can be overcome by improving hygiene standards in hospitals; by providing more continuity of care; by undertaking more clinical audits; and by monitoring hospital performance.

**IV. HEALTH SYSTEM LEAKAGES (CORRUPTION AND WASTE):**

Further inefficiencies that diminish the flow of inputs into the health system and, consequently, compromise the capacity of the health system to deliver on its goals are those ‘leakages’ out of the health system as a result of fraud and corruption. The following areas are key sources of corruption in health: embezzlement and theft from health budgets or user-fee revenues; corruption in procurement; corruption in payment systems; corruption in the pharmaceutical supply chain; and corruption at the point of health service delivery, especially charging fees for services that are meant to be free. ‘Leakages’, on the other hand, commonly result from: unclear resource allocation guidance; lack of transparency; poor accountability and governance mechanisms; and low salaries. By way of example, a 1999 review by PWC (Price Waterhouse Coopers) estimated the rate of leakage in Tanzania at 40%, and this is not uncommon in the other EAC Partner States. There is a great deal that countries can do to significantly reduce leakage as well as fraudulent practices in the health sector. The key to success is improved health system governance, key principles of which include accountability, transparency and the rule of law.

**V. HEALTH INTERVENTIONS: INEFFICIENT INTERVENTION MIX**

Inefficiencies here refer to the sub-optimal mix of services and interventions provided by the health sector (i.e. to allocative efficiency). As this review is concerned with ‘technical efficiencies’ this area of inefficiency is not considered.

These leading causes of inefficiency within health service delivery are presented in Table 7... below. Between 20% and as much as 40% of all investment in health is wasted every year and it is in these ‘sources of inefficiency’ examined above that the largest health programme efficiency improvements are to be gained.

Overuse or supply of equipment, investigations or procedures; and the prevalence of medical errors due to staff not following protocols or clinical care standards.

**9.4.2 LEADING SOURCES OF INEFFICIENCY – HIV**

As with Health in general, the largest budget items in HIV service delivery are human resources (staff costs) and medicines. As with the leading sources of inefficiency in health services in general, these two areas consume the largest proportion of the HIV response budget and provide ample opportunity for efficiency improvements. Table 17 below presents the ten leading causes or sources of inefficiency in HIV programmes.

The emphasis, therefore, is fundamentally on value for money, i.e. containing or reducing costs without reducing outcomes or, better yet, achieving better outcomes for the same level of investment. Efficiency, therefore, includes a measure of both the quality and the quantity of outputs (i.e. health and HIV outcomes or services) for a given level of input (i.e. cost).

In this way, while inefficiency is traditionally thought of as involving excessive spending it may, counter intuitively, result from insufficient spending. For example, low salaries for public sector health workers can result in these workers supplementing their income with second jobs during the hours of their primary employment, detrimentally affecting the quality of care delivered by the public health system.

The methodology used to estimate the magnitude of potential savings from imposing efficiency measures is based on international comparative performance via a Data Envelope Analysis (DEA) as discussed in the chapter on methodology. A potential 5 billion USD a year is projected to be captured by efficiency savings in health and HIV.

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44 Transparency International: 2006
45 PriceWaterhouseCoopers, 1999

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Table 7: World Health report 2010 – Leading sources of inefficiency with common causes and ways to redress

<table>
<thead>
<tr>
<th>Source of inefficiency</th>
<th>Common reasons for inefficiency</th>
<th>Ways to address inefficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicines: underuse of generics and higher than necessary prices for medicines</td>
<td>Inadequate controls on supply-chain agents, prescribers and dispensers; lower perceived efficacy/safety of generic medicines; historical prescribing patterns and inefficient procurement/distribution systems; taxes and duties on medicines; excessive mark-ups.</td>
<td>Improve prescribing guidance, information, training and practice. Require, permit or offer incentives for generic substitution. Develop active purchasing based on assessment of costs and benefits of alternatives. Ensure transparency in purchasing and tenders. Remove taxes and duties. Control excessive mark-ups. Monitor and publicize medicine prices.</td>
</tr>
<tr>
<td>2. Medicines: use of substandard and counterfeit medicines</td>
<td>Inadequate pharmaceutical regulatory structures/mechanisms; weak procurement systems.</td>
<td>Strengthen enforcement of quality standards in the manufacture of medicines; carry out product testing; enhance procurement systems with pre-qualification of suppliers.</td>
</tr>
<tr>
<td>3. Medicines: inappropriate and ineffective use</td>
<td>Inappropriate prescriber incentives and unethical promotion practices; consumer demand/expectations; limited knowledge about therapeutic effects; inadequate regulatory frameworks.</td>
<td>Separate prescribing and dispensing functions; regulate promotional activities; improve prescribing guidance, information, training and practice; disseminate public information.</td>
</tr>
<tr>
<td>4. Health-care products and services: overuse or supply of equipment, investigations and procedures</td>
<td>Supplier induced demand; fee-for-service payment mechanisms; fear of litigation (defensive medicine).</td>
<td>Reform incentive and payment structures (e.g. capitation or diagnosis-related group); develop and implement clinical guidelines.</td>
</tr>
<tr>
<td>5. Health workers: inappropriate or costly staff mix, unmotivated workers</td>
<td>Conformity with pre-determined human resource policies and procedures; resistance by medical profession; fixed/inflexible contracts; inadequate salaries; recruitment based on favouritism.</td>
<td>Undertake needs-based assessment and training; revise remuneration policies; introduce flexible contracts and/or performance-related pay; implement task-shifting and other ways of matching skills to needs.</td>
</tr>
<tr>
<td>6. Health-care services: inappropriate hospital admissions and length of stay</td>
<td>Lack of alternative care arrangements; insufficient incentives to discharge; limited knowledge of best practice.</td>
<td>Provide alternative care (e.g. day care); alter incentives to hospital providers; raise knowledge about efficient admission practice.</td>
</tr>
<tr>
<td>7. Health-care services: inappropriate hospital size (low use of infrastructure)</td>
<td>Inappropriate level of managerial resources for coordination and control; too many hospitals and inpatient beds in some areas, not enough in others. Often this reflects a lack of planning for health service infrastructure development.</td>
<td>Incorporate inputs and output estimation into hospital planning; match managerial capacity to size; reduce excess capacity to raise occupancy rate to 80–90% (while controlling length of stay).</td>
</tr>
<tr>
<td>8. Health-care services: medical errors and suboptimal quality of care</td>
<td>Insufficient knowledge or application of clinical-care standards and protocols; lack of guidelines; inadequate supervision.</td>
<td>Improve hygiene standards in hospitals; provide more continuity of care; undertake more clinical audits; monitor hospital performance.</td>
</tr>
<tr>
<td>9. Health system leakages: waste, corruption and fraud</td>
<td>Unclear resource allocation guidance; lack of transparency; poor accountability and governance mechanisms; low salaries.</td>
<td>Improve regulation/governance, including strong sanction mechanisms; assess transparency/ vulnerability to corruption; undertake public spending tracking surveys; promote codes of conduct.</td>
</tr>
</tbody>
</table>

1 WHO: World Health Report 2010; Table 4.1; 2010
47

Figure 25: EAC Combined Resource Gap with Targeted Budgets, Earmarked Taxes, and Efficiency Savings (M USD) and by Partner State (as proportion of GDP)

These potential efficiency savings, added to the budgetary and earmarked financing could cover the UHC and HIV need throughout the region by 2027/28. The potential impact on the resource gap is shown in Figure 40, and shows Kenya, Rwanda and Tanzania in a situation where they can cover their UHC and HIV needs domestically. The three policies will not be sufficient for Burundi and Uganda which still require 10.7% and 2.6% of their respective GDPs to fully reach UHC and HIV needs.

The sum of these three policies – raising budgets, levying earmarked taxes and introducing efficiency savings - are as follows:

• Kenya, Rwanda and Tanzania would be able to cover their resource needs domestically by 2029/30.

• Burundi and Uganda will need to additional sources of financing if they are to ensure UHC inclusive of HIV.

Yet, due to time lags in policy implementation and effect mostly, if not all five, EAC countries will require financing from additional sources in the near term.
9.5 BORROWING

Borrowing is a last resort financing mechanism available to governments. Once all other domestic financing options are exhausted countries have a last option to borrow to fund UHC needs.

Why and how would a country borrow to pay for UHC and HIV expenditures? Resources could be accessed by issuing a health (or HIV) bond. Bond financing is predictable and can be utilised with minimum delay. Bonds would be taken up by individuals and institutions and the government would use the money raised for health services. The private sector may see this as a method through which to improve corporate social responsibility (and can also benefit in terms of the raising of the non-disabled life years of private sector employees). Therefore, a health-specific government bond could be issued at a lower rate of interest than other government bonds.

A domestic health bond would involve creating national, sovereign savings bonds like those in, for example, the UK. It would require national governments to commit to participation, to implement the bonds in their country, and to earmark revenues for health initiatives. In the case of health bonds issued by low- and middle-income countries it would be reasonable to expect that international institutions such as the World Bank or the regional development banks would extend the guarantees provided by the national governments. A health bond backed by the government with supplementary last-resort backing from international institutions, carefully designed and issued by a specialized financial institution, to finance time-limited cost-effective investment framework activities, seems to have all the characteristics of a feasible and potentially successful financing option.

The purpose of government borrowing is to adjust the timing of government expenditure. Instead of spending a sum each year on a particular expenditure, a government bond brings all the expenditure to the current year in return for a future stream of repayments. As such, government borrowing is simply an inter-temporal reallocation of expenditure. However, in addition to the future stream of repayments, government must also pay interest on its borrowing. For this reason, it is generally accepted that government borrowing should only be used for capital expenditure, where the future returns from an investment will outweigh the cost of borrowing. Under this thinking, government borrowing should not be used to finance a permanent increase in current expenditure.

A study carried out to assess the applicability of an HIV bond found that HIV expenditures, although classified as current expenditure, were actually ‘time-limited’. The authors claim that the cost–benefit analysis of these expenditures is positive, with the cost per life year saved lower than many economic valuations of a life year would suggest. Therefore, while far from a typical ‘capital’ investment, a HIV bond – and potentially a health bond – represents a cost-effective time-limited expenditure and so has characteristics that could warrant financing through borrowing.

Thus, for countries that do not already have high levels of debt, particularly those with high levels of growth, there is considerable potential to raise funds from borrowing. However, unlike the other mechanisms this source of innovative financing must be repaid.

In total the region would need to borrow 5.7 billion USD a year on average to meet the needs for UHC and HIV, see Figure 41. This accounts for 2.3% of the regional GDP. On average then this seems a manageable debt to undertake. However, as we have seen each country has varying capacities to finance UHC domestically, and they also have greatly divergent debt profiles.

Figure 26: EAC Borrowing Requirements (M USD and As a Proportion of GDP)

Table 13 provides the annual nominal borrowing requirement for each EAC country, as well as the fifteen year average as a proportion of GDP. The countries are divided into three categories:

- Green indicates low levels of borrowing required in the short term (less than 0.5% of GDP). This refers to Kenya only.
- Blue indicates a more substantial borrowing need over the short to medium term (between 0.5% and 3% of GDP). This refers to Rwanda and Tanzania.
- Red indicates a long term borrowing requirement (greater than 3% of GDP). This refers to Burundi and Uganda.

It seems that those who cannot afford to cover their UHC needs domestically can neither afford to borrow as this would mean long term annual borrowing rather than a one off or short term financing policy. This is underscored by the debt:GDP ratios which may occur if borrowing for UHC was undertaken to close the resource gap, as seen in Figure 42: Potential Debt:GDP Ratios if borrow for UHV inclusive of HIV (15 Year Average).

Figure 42.

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46 An exception to this rule is the use of borrowing for temporary counter-cyclical fiscal policy during periods of recession. However, good fiscal policy dictates that any such borrowing must be repaid during the subsequent years of higher growth.

Here we see that:

- Only one EAC country could comfortably borrow for their full UHC needs; Rwanda.

- Of the countries that need to borrow large amounts over the long term – Burundi and Uganda - both would suffer Debt:GDP ratios over the recommended sustainable level of 40%.

- Even Kenya with a higher income and low borrowing requirements may struggle to accommodate the extra debt burden.

More country-specific information on debt is discussed in the Country Annex report.

Figure 27: Potential Debt:GDP Ratios if borrow for UHV inclusive of HIV (15 Year Average)

This section will summarise the four policy options whereby countries can attempt to cover their UHC and HIV needs through domestic means. Figure 43 depicts the potential impact for the region as a whole to reduce the “business as usual” resource gap (dark red bar chart).

The first step to closing the resource gap would be for governments to reallocate budgetary finances towards health, and within health allocating the “fair share” to HIV. This is shown in by the second bar chart (orange) where the gap by 2029/30 has been more than halved compared to the “business as usual” scenario. Over the fifteen year period the incremental rise in budgetary financing could reduce the annual gap by 49%.

There is a large potential for EAC countries to gain additional revenues for UHC and HIV through earmarked taxes. The third bar chart (gold) shows that if an earmarked levy could raise 0.5% of GDP the gap could be reduced by a further 10%. In conjunction with the rise in budgetary share this equates to a gap of only 9 billion USD a year. This would be a good policy option for those countries with a low tax effort vis-à-vis their estimated capacities.

On average efficiency savings bring significant fiscal space for countries to supply services to citizens. Over the entire group if efficiency was made a priority the resource gap could be closed by 2027/28 (in conjunction with the budgetary and earmarked tax measures).

These average charts show that the resource gap can be closed over the region. But it must be noted that for all of these countries some borrowing will be required to fully close this gap, as discussed above.

Before we close this chapter it is important to look at the macroeconomic implications of prioritising health under these assumptions and policy options. The next section will give an overview of the key macroeconomic indicators and also the cost of not investing in health.
9.7 EFFECTS OF GREATER HEALTH PRIORITISATION ON THE MACRO ECONOMY

This section compliments the general comments on the macroeconomic environment in chapter two and examines the projected results for key indicators for the EAC. It will look at the impact of investing in health for the macro economy in four areas: tax burden, fiscal deficit, debt to GDP ratio and what could happen to health outcomes if the financing gap was not filled.

Macroeconomic indicators are set out like before but with an additional column relating to the potential impact of increasing monies to the health sector. This section will compare the last two columns from assumptions under the baseline scenario ‘business as usual’ and the secondary ‘maximising health financing’ scenario and their impact on macroeconomic fundamentals.

### Table 10: Macroeconomic Indicators

<table>
<thead>
<tr>
<th></th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
<th>21/22</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BURUNDI</strong></td>
<td>805</td>
<td>803</td>
<td>813</td>
<td>831</td>
<td>852</td>
<td>866</td>
<td>881</td>
</tr>
<tr>
<td><strong>KENYA</strong></td>
<td>1,351</td>
<td>1,119</td>
<td>858</td>
<td>547</td>
<td>199</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>RWANDA</strong></td>
<td>695</td>
<td>700</td>
<td>671</td>
<td>644</td>
<td>570</td>
<td>477</td>
<td>383</td>
</tr>
<tr>
<td><strong>TANZANIA</strong></td>
<td>3,478</td>
<td>3,373</td>
<td>3,229</td>
<td>3,052</td>
<td>2,822</td>
<td>2,396</td>
<td>1,902</td>
</tr>
<tr>
<td><strong>UGANDA</strong></td>
<td>2,781</td>
<td>2,894</td>
<td>2,992</td>
<td>3,089</td>
<td>3,023</td>
<td>2,889</td>
<td>2,750</td>
</tr>
</tbody>
</table>

### 9.7.1 Tax Burden

The model assumes that the increased budget allocation to health is created through redistribution of current resources rather than increased national tax levels. As such there would be no increased tax burden from this.

However, the total of all new alternative funding mechanisms is expected to increase the tax burden by 0.4 percentage points. From a tax:GDP ratio of 18.2% to 18.6%, although it is unlikely that all of these would be implemented simultaneously.

Therefore there is little negative economic impact in the way of an ‘over-burdening’ of tax for the population through these measures. Other country findings show that there is little impact on the industries involved from these taxes, and therefore there would not be expected to be a knock on effect of reduced corporation tax and so forth.

Chapter 2 provided an overview of the prospects of tax growth in EAC. This framework has an underpinning assumption that the tax:GDP ratio will rise to the middle income average of 24% (low income average of 17% for Burundi). The current 14% tax:GDP ratio means that there is certainly room for earmarked taxes for health and HIV in the medium term before governments implement wider tax reforms to strengthen the tax base. In sum this analysis finds that there would be little taxation pressures if domestic revenues were moved to health and HIV and/ or earmarked taxes were implemented. There is fiscal space within the current taxation system.

### 9.7.2 Debt:GDP Ratio

This was discussed in section 6.4. To summarise, the debt-to-GDP ratios for Burundi, Rwanda and Uganda are currently within the recommended 40% limit, whilst Kenya and Tanzania are around 42% (2012/13). However, to close the combined health and HIV resource gap in its entirety each country would require borrowing. This would
raise all, but Rwanda’s, tax:GDP ratios above the 40% limit.

The potential size of borrowing in any given country must be set in the context of maintaining a sustainable debt stock. The IMF/World Bank Debt Sustainability Framework proposes a limit for the Net Present Value of external debt of 40% of GDP. If above this ratio this is not necessarily a problem in itself. Some countries have a strong public management system that ensures projects go as planned and so repayment schedules are not in question, as well as a conducive macro environment. If above the ratio and with weak public management there is a greater chance of debt instability and increasing debt for health would not be advised.

Borrowing is therefore a policy option that each EAC country would need to consider carefully given their own debt dynamics – these are discussed in the country annex. However, outside of this borrowing for health and HIV option the other domestic financing options would not derail the debt ratio.

9.7.3 FISCAL BALANCE

The average EAC fiscal deficit is projected to remain stable at around 4% of GDP. As was touched on above, the model is somewhat passive in its assumptions and so the financing found for health and HIV will be as a result of redistribution rather than creating additional fiscal pressures. As a result, the projected path for the fiscal balance is not disrupted in the second scenario. At present the commitment to retain the fiscal deficit within the 3% limit is not expected to be met over the medium term due to investment commitments for longer term growth needs.

9.7.4 FALLING HEALTH EXPENDITURE PER CAPITA: HOW WILL HEALTH OUTCOMES BE SUSTAINED?

The projected trends for nominal expenditures per capita are shown in Table 15 for the EAC; i.e. it gives the spending on health and HIV for each EAC citizen across the five countries from government and donor sources only. Some key points to note from this table:

- Total Combined UHC and HIV Expenditures from Government and Donors - The ‘maximising financing’ scenario shows a large impact in the rise of per capita spending by the EAC governments, from the baseline of 9 to 93 USD per capita in 2029/30. This is compared to the 33 USD per capita projected if no prioritisation of health and HIV is undertaken to offset the decline in donor funding.

Table 15: Spending per capita from government and donor sources across the EAC.

<table>
<thead>
<tr>
<th>Year</th>
<th>Average as % GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>22/23</td>
<td>15.2%</td>
</tr>
<tr>
<td>23/24</td>
<td>0.3%</td>
</tr>
<tr>
<td>24/25</td>
<td>2.5%</td>
</tr>
<tr>
<td>25/26</td>
<td>2.7%</td>
</tr>
<tr>
<td>26/27</td>
<td>5.7%</td>
</tr>
<tr>
<td>27/28</td>
<td>10.9%</td>
</tr>
<tr>
<td>28/29</td>
<td>11.2%</td>
</tr>
<tr>
<td>29/30</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

Note: See World Bank (2009). In fact, this limit is for countries with a medium-level quality of policies and institutions, as measured by the Country Policy and Institutional Assessment. A lower quality of policies and institutions would imply a lower limit.
Table 11: Combined UHC and HIV Public and Donor Expenditures (USD per capita)

<table>
<thead>
<tr>
<th></th>
<th>BASELINE 2013/14</th>
<th>BUSINESS AS USUAL PROJECTIONS 2029/30</th>
<th>MAXIMISING FINANCING PROJECTIONS 2029/30</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMBINED UHC &amp; HIV PUBLIC AND DONOR EXPENDITURES</td>
<td>26</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>OF WHICH: PUBLIC</td>
<td>9</td>
<td>33</td>
<td>93</td>
</tr>
<tr>
<td>OF WHICH: DONORS</td>
<td>17</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>DONOR DEPENDENCE</td>
<td>66%</td>
<td>18%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Note: Authors Own Calculations.

In neither of these scenarios does the EAC government per capita spending reach sufficient levels to meet the costing needs for UHC inclusive of HIV. Once donors remove their funding the EAC will have a serious challenge in meeting current health standards of service, and this is expected to continue.

10. BENEFIT PACKAGE

KEY HIGHLIGHTS

• While the ideal scenario would be for the Ministry of Health to have sufficient resources to implement its desired full package of health and HIV interventions and services, the likely reality is that resources available are not adequate to do so. Agreeing an essential benefit package for health and HIV confronts the prioritisation challenge with a framework that will help Partner States to prioritise interventions on the basis of some objective – usually of achieving specific technical and/or social outcomes – and thereby overcoming entrenched interests and/or historical inertia.

• The earlier World Health Report 1999 found that almost one-third of all deaths in LMICs were due to communicable diseases, maternal and perinatal conditions, and nutritional deficiencies. Lately, non-communicable diseases such as stroke and cardiovascular diseases and cancers are increasingly becoming important. Evidence shows that the number of conditions that cause the most burden of disease are few.

• The most common shared conditions contributing to the burden of disease across EAC Partner States are:
  - Maternal, neonatal and nutritional complications
  - HIV and AIDS and Tuberculosis
  - Lower respiratory tract infections
  - Diarrhoeal disease
  - Malaria
  - Stroke and Cardiovascular diseases

• The set of interventions carefully selected within today’s medical technology to address the most common causes of morbidity and mortality and achieve the technical and social objectives constitutes the Basic Benefits Package.

• EAC Partner States can rely on various approaches including OPTIMA for HIV and cost-effectiveness analysis for a health and HIV benefit package.

• Given the high prevalence of HIV in the region, any appropriate benefit package construed under resource constraint will comprise essential HIV services.

This section describes a practical approach to developing an essential benefit package under a scenario of resource constraint. While the ideal scenario is for Partner States (government through the
ministry of health and other stakeholders) to have sufficient resources to implement the full complement of interventions and services that the population requires (what one would term an optimal resource scenario), the reality is that the resources available are more likely lower than optimal.

In such a scenario we can anticipate funding gaps even when fiscal space has been maximised. Thus, Partner States are faced with a choice of what to fund. But because resources are limited, Partner States will want to ensure that the chosen resource allocation leads to the best possible results. In other words, there is a desire to maximise the outcomes of each choice. To do this, Ministries of Health will need to make trade-offs between certain types of activities as greater spending on one will result in lower spending on another.

Making these trade-offs – or prioritising health services – is often accompanied by the possibility of ‘rationing care’ to the extent that some services might not be provided or some people might not receive care. Often the response to this can be negative, arguing that who gets care and who does not treads on moral and ethical grounds of making decisions that may mean the difference between life and death.

It is important to recognise, however, that prioritisation already takes place, it just takes place implicitly or in a non-transparent manner. Engaging in a process of prioritisation is intended to ensure that such decisions are now made explicitly and transparently.

It is also important for processes of prioritisation to recognise that decisions about health financing are not made in a vacuum. Health spending routinely follows the same pattern, regardless of whether the allocation matches the health problems facing the country. Annexure A.9: Why does health spending follow entrenched patterns? presents an overview of the most common reasons why health spending follows entrenched patterns. These include: historical-based budgeting; inappropriate incentives; political and administrative processes; a lack of information; a variety of costs; and social and political power.

There is no avoiding the fact that prioritisation is difficult and that agreeing an essential benefit package for health and HIV will require overcoming historical inertia and entrenched interests. The first step then is to take the decision to prioritise. The question then becomes how should Partner States (government through the ministry of health and other stakeholders) make the choice regarding what interventions to include as essential to an essential benefit package for health and HIV and which interventions would go unfunded in a constrained resource scenario? The policy question this section seeks to address is which services should Partner States prioritise if not all desired services can be funded in order to address the priority health and HIV needs of the population.

10.1 ALLOCATIVE EFFICIENCY

The section above focussed on ‘technical efficiency’ – on improvements that optimise the implementation of currently implemented interventions so that they are implemented most (or at least more) efficiently. The task of determining which interventions to fund in a scenario of resource constraint refers instead to ‘allocative efficiency’ – to improving the allocation of resources so that the health service implements a mix of services that, collectively, maximise health outcomes.

Within health spending the most commonly recommended areas for improving allocative efficiency are (Tandon & Cashin; 2010):

1. Improved geographic targeting using resource allocation formulas that reduce spending gaps across regions and the typical bias of spending toward urban areas;
2. Changing the allocation of spending across care levels;
3. Targeting specific programmes that yield high returns to spending;
4. Aligning government health expenditures to identified health needs and strategic plans.

Other common sources of inefficiency include rigid public finance systems that have inadequate flexible funds and impede reallocation of funds to areas of highest need; imbalances in input use, particularly excessive expenditures on wages; corruption; low capacity to utilise existing funds; weak management capacity of decentralised units; and leakages from the system, including absenteeism among public sector workers.

10.2 DEFINING AN ESSENTIAL BENEFIT PACKAGE

An essential package of health services has three main distinguishing features:

- It typically contains a limited subset of all health care interventions made possible by today’s medical technology.
- Interventions are not randomly assigned to the package; rather, they result from a process of prioritisation with the objective of achieving specific technical and/or social objectives.
- Interventions within the package are not independent.

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50 'Allocative efficiency' is concerned with the mix of services or interventions, both within diseases (such as prevention versus treatment within, say, HIV) as well as across them (such as spending less on HIV and more on, say, malaria), in order to maximise health outcomes.

from each other. In fact, many are chosen specifically to complement or reinforce each other so that there is synergism among them.

10.3 WHAT ARE THE DISEASES AND CONDITIONS THAT MATTER MOST IN EAC

A background paper prepared by Working Group 5 of the WHO Commission on Macroeconomics and Health (2001) found that just a small number of conditions accounted for 90% of the difference in the death rate at younger ages between LMICs and high-income countries (2001). These ‘primary causes of this avoidable mortality’ were: “maternal and perinatal mortality, vaccine-preventable diseases, acute respiratory infection and diarrhoea, protein-energy and micronutrient malnutrition, malaria, tuberculosis, tobacco-attributable disease, and HIV/AIDS”53.

Going back slightly further in time, in 1998 the WHO found that almost one-third of all deaths in LMICs were due to communicable diseases, maternal and perinatal conditions, and nutritional deficiencies54.

Section 3 of this paper provided an overview of disease burden and causes of mortality in the EAC region and a list of the top 10 causes of death per each of the five EAC Partner States. As we have seen, the most common shared causes of death are:

1. HIV and AIDS
2. Maternal, neonatal and nutritional complications
3. Lower respiratory tract infections
4. Diarrhoeal disease
5. Stroke
6. Malaria

10.4 A ESSENTIAL BENEFIT PACKAGE OF HEALTH AND HIV SERVICES

Three large costing studies have estimated the absolute cost of providing Universal Health Coverage (UHC) in low income countries. The first of these was the WHO-led Commission on Macroeconomics and Health in 2001. The second and third were conducted by the High Level Taskforce on Innovative International Financing for Health Systems in 2005. While the focus of these studies was on financing UHC, the costing estimates were based on an essential package of health services and are thus useful for the purposes of defining a essential benefits package. These are discussed in more detail in Annex.

10.5 SELECTING THE COMPONENTS OF A ESSENTIAL BENEFIT PACKAGE ESSENTIAL BENEFIT PACKAGE IN A RESOURCE CONSTRAINED ENVIRONMENT

The fiscal space analyses conducted earlier in this paper provide EAC Partner States with a much clearer view of their individual ability to finance the various components of the array of essential benefit packages presented above. Now, given the amount of resources available, which services will Partner States choose to prioritise if the fiscal space analysis reveals that not all desired services can be funded while at the same time addressing the priority health and HIV needs of their respective populations?

To the extent that there will be resource gaps for the Health and HIV agendas, countries will have to choose which interventions to prioritise. The remainder of this section will address the question of ‘how’ countries should choose. It will do so by presenting a variety of tools for conducting such an analysis – including OPTIMA and the Cost Effectiveness Analysis (CEA), which are explained in more detail in Annex. The purpose of using tools to assist in making allocation decisions is that they create an objective framework through which to engage in decision making, enabling selection to be based on the attainment of set targets while at the same time avoiding historical inertia or misaligned incentives to determine the components of the essential benefit package that is selected. (Annexure A.9: Why does health spending follow entrenched patterns? presents an overview of the most common reasons why health spending follows entrenched patterns).

10.6 APPLYING CEA TO ANALYSE THE BENEFITS AND OPPORTUNITY COSTS OF 111 DIFFERENT HIV/ AIDS INTERVENTIONS IN LOW INCOME COUNTRY.

In a recent report (April 2015) Oxford Policy Management has attempted to summarise the evidence on the cost effectiveness of health sector interventions in low income countries, drawing upon (and updating to 2015 US $ prices) the World Bank Disease Control Priorities report and the seminal Lancet 2013 publication ‘Global health 2035: a world converging within a generation’55. The OPM report considers 111 interventions and ranks them according to their cost (in US $) per DALY. (See Annexure A.10:The full list of 111 interventions included in the example CEA)

Figure 47 ranks these 111 different interventions according to their cost/DALY (in US$56). The orange dots are HIV/AIDS prevention interventions and the grey dots are HIV/AIDS treatment interventions.

53 Commission on Macroeconomics and Health: Improving the Health of the Global Poor; Science; Vol.295; 15 March 2002.
56 OPM analysis of 2001$ estimates from (Jamison, et al., 2006)). These have been inflated to 2015 $ according to the emerging market and developing economy inflation rate.
The dark blue dots represent a selection on 111 general health interventions for which CEA has been done in low income countries. In addition to the HIV/AIDS prevention and treatment interventions, they include TB, malaria, nutrition/stunting/wasting, diarrheal disease and vaccine preventable disease care as well as maternal and new born care – all of which address the health priorities of the SADC Member States as set out at the beginning of this section.

Figure 47 illustrates two key points. First, HIV/AIDS prevention interventions have a wide range of cost effectiveness ratios, spread evenly from cheap to expensive. The less efficient prevention interventions were either in the Americas, or in places with low disease burden. More efficient results included peer to peer programmes, or programmes in areas with high HIV prevalence rates.

Second, HIV/AIDS treatments also have a wide range of cost effectiveness ratios, however they are bunched slightly more towards the less efficient side. Part of the reason prevention strategies are often so cost effective is because they decrease the need to spend on expensive HIV/AIDS treatment later on. (It is therefore imperative that CEA of HIV prevention strategies captures this as a benefit, otherwise the cost-effectiveness will be underestimated).

This sort of analysis can be a starting point for allocating resources between HIV/AIDS interventions and other interventions in an integrated health financing system given limited resources. Given a budget, a health sector can provide interventions to populations in need, working from left to right across the interventions. When its budget constraint is reached, the health sector does not provide the next intervention. In this way an integrated benefits package is defined, and the highest health output possible is achieved given the limited resources.

11. RECOMMENDATIONS AND ACTIONS

The East African Community Secretariat and the Partner States individually are committed to achieving Universal Health Coverage and Ending AIDS by 2030. From a purely fiscal perspective, the current funding strategies will not achieve these policy goals.

However, a combination of reprioritisation of public spending towards health and HIV, earmarking revenue from innovative taxes, and increasing the efficiency with which health and HIV services are delivered, will allow the region to generate enough resources by 2030.

There are, however, two caveats:

1. While the region as a whole can generate enough fiscal space for UHC and Ending AIDS by 2030, some Partner States (Burundi and Uganda) won’t be able to generate enough financial resources from within their economy;

2. All EAC Partner States face a funding gap for HIV in the short term. This sits at odds with the logic underpinning the Ending AIDS 2030 strategy, which is based on frontloading expenditure, to increase effectiveness and keep overall costs down. HIV and AIDS being the leading cause of mortality in the region begs the question whether particular attention should be given to plugging the HIV funding gap in the short term.

There are important differences between Partner States in levels of economic development, health and HIV service delivery infrastructure and HIV burden, accentuated by differences in the priority Partner States give to spending on health and HIV out of total public budget. This implies that each Partner State will have to develop a vision and approach to achieving UHC and Ending AIDS 2030 proper to its own circumstances.

However, the EAC Secretariat can take a number of initiatives that will help individual Partner States to develop national strategies within a regional approach that aims to increase convergence of health systems and outcomes over time. These are discussed in turn below.

11.1 DEFINING AND COSTING A PACKAGE OF COST-EFFECTIVE SERVICES

In an ideal world enough financial resources are available to meet the funding challenges set by the UHC and Ending AIDS 2030 policy objectives. However, it is most likely, certainly in the short term, that fiscal space will be constrained. This implies that choices about which health and HIV services to fund will have to be made. Given that the disease patterns are very similar across the EAC, the EAC Secretariat should support Partner States with an exercise to determine an EAC-wide benefit package starting from the leading causes of mortality and morbidity across the region, and health and HIV interventions according to their cost-effectiveness. This in turn
would allow each Partner State to reassess its benefit package, and focus limited resources on those services that have most impact on population outcomes.

To facilitate discussions around allocations of public spending to health and HIV between the Ministry of Finance, the Ministry of Health and the HIV coordinating institutions, it is necessary to have a precise idea of the cost of health and HIV programmes, at different levels of benefit package, and over time. To do this the EAC Secretariat should support Partner States with costing out the benefit package, offering a generic approach, where each Partner State will use unit costs appropriate to the country. Having a precise idea of the cost of achieving UHC and Ending AIDS in 2030 will be helpful in determining the level of public investment over time, striving to be adequate but taking into account fiscal constraints.

11.2 DEVELOPING A FINANCING STRATEGY FOR A PACKAGE OF COST-EFFECTIVE SERVICES WITH FINANCIAL PROJECTION

Universal Health Coverage as well as Ending AIDS in 2030 require a specific package of cost-effective services to be offered with financial protection to the entire population. This means that the share of household out-of-pocket expenditure in total health expenditure should be around the 20-25% benchmark. The way to achieve this is by either increasing the level of subsidy of public health and HIV services, reducing fees for service and drugs, or by increasing population coverage of mandatory social insurance. The EAC Secretariat should support Partner States in assessing current financing strategies, and designing ways to adapt them with a view to decreasing the share of out-of-pocket expenditure in total health expenditure.

11.3 DELIVERING A PACKAGE OF COST-EFFECTIVE SERVICES WITH OPTIMAL EFFICIENCY

To further support the dialogue around fiscal space for health and HIV, the EAC should support Partner States with an EAC-wide technical efficiency study. This would entail that the EAC Secretariat designs develops a generic approach to assessing technical efficiency, actions to improve efficiency, and an estimate of efficiency savings, which is then applied in each of the Partner States individually. This will provide Partner States with a series of priority actions which, when implemented over the medium-term, can provide critical key performance indicators for the Ministry of Finance to release more funding for health and HIV.

11.4 EAC-WIDE DIALOGUE ON FISCAL SPACE FOR UHC AND ENDING AIDS IN 2030

The current levels of allocation of public spending to health and HIV vary significantly across the EAC. The EAC should support Partner States by organising a dialogue that brings together the elements from the previous steps, starting from the policy objectives of UHC and Ending AIDS in 2030: essential benefit packages, cost of offering essential benefit packages with financial protection, and efficiency savings. An EAC-wide discussion would involve the Heads of State and representatives of the Ministries of Health, Finance and the HIV coordinating agencies. The aim would be to obtain a long-term funding commitment that will allow to achieve UHC and Ending AIDS within the available fiscal envelope. The detail of such an agreement would comprise specific public spending benchmarks for each Partner State, with a view of convergence across the EAC, specific targets for increased technical efficiency, as well as specific targets for out-of-pocket expenditure, to ensure financial protection, and further exploration of the potential of public-private partnerships for both financing and service delivery.
12. REFERENCES


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13. Reference List: Applying Cost-Effectiveness Analysis


