ISSUE PAPER ON Sustainable Financing of Universal Health and HIV Coverage in the East Africa Community Partner States
1.0 BACKGROUND TO THE EAST AFRICAN COMMUNITY

The East African Community (EAC) is a regional inter-governmental organization of the five Partner States, namely; the Republic of Kenya, the Republic of Uganda, Republic of Burundi, Republic of Rwanda and the United Republic of Tanzania, with its Headquarters located in Arusha, Tanzania. (www.eac.int). The five East African countries cover an area of approximately 2.0 million square Kilometres and have an estimated population of nearly 145.5 million (2014) who share a common history, language, culture and infrastructure. These advantages provide the five Partner States with a unique framework for regional co-operation and integration in various political, economic, social and cultural areas of common interest.

Consequently, the various organs and institutions of the East African Community are currently engaged in the promotion and development of various priority areas of regional cooperation. These include: Health, Customs and Trade, Agriculture, Transport and Communications, Monetary and Fiscal Affairs, Environment and Natural Resources, Legal, Judicial and Parliamentary Affairs, Peace and Security, ICT, etc.

This issue paper is based on the Sustainable Financing Analysis of Universal Health and HIV Coverage in the EAC.

In this Analysis HIV/AIDS has been given special emphasis and has been amplified because HIV is heavily dependent on donor funds in all the Partners States countries and will be most affected with the current reduction in donor funding.

1 The Region has recently accepted the Republic of South Sudan into the EAC. The sustainable financing initiative will include South Sudan in the long run.
1.1 SOCIO-ECONOMIC SITUATION

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 GDP growth rate over the period 2005-2013. This growth is anticipated to continue apace, doubling per capita income across the EAC Partner States between 2010 and 2020. In EAC, there is high level of unemployment and poverty levels are still high; these lead to poor access to social services including health and education, safe water supply and sanitation. In addition, most of the population depend on public funded health services and health expenditure per capita is still low across EAC Partner States.

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>GDP PER CAPITA (USD)</th>
<th>GROWTH RATE 2009/10 – 2013/14 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>RWANDA</td>
<td>582</td>
<td>8.2</td>
</tr>
<tr>
<td>UNITED REPUBLIC OF TANZANIA</td>
<td>580</td>
<td>5.9</td>
</tr>
<tr>
<td>UGANDA</td>
<td>560</td>
<td>5.3</td>
</tr>
<tr>
<td>KENYA</td>
<td>1,113</td>
<td>5.0</td>
</tr>
<tr>
<td>BURUNDI</td>
<td>247</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Source: Adopted from the EAC Sustainable financing analysis for universal health coverage.

1.2 HEALTH PROFILE

The EAC Partner States share a common disease burden profile. Much of this burden takes the form of diseases such as malaria, HIV and AIDS, pneumonia, measles, and tuberculosis as indicated in table 2 below which highlights few selected health indicators in each country.

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BURUNDI</th>
<th>KENYA</th>
<th>RWANDA</th>
<th>UGANDA</th>
<th>UR TANZANIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>MATERNAL MORTALITY RATIO</td>
<td>500</td>
<td>488</td>
<td>210</td>
<td>438</td>
<td>432</td>
</tr>
<tr>
<td>UNDER FIVE MORTALITY RATE</td>
<td>96</td>
<td>52</td>
<td>50</td>
<td>90</td>
<td>81</td>
</tr>
<tr>
<td>NEONATAL MORTALITY RATE</td>
<td>36</td>
<td>22</td>
<td>20</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>PREVALENCE OF STUNTING IN CHILDREN UNDER 5 YEARS</td>
<td>58</td>
<td>26</td>
<td>38</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>CONTRACEPTIVE PREVALENCE RATE</td>
<td>22</td>
<td>58</td>
<td>53</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL FERTILITY RATE</td>
<td>6</td>
<td>3.9</td>
<td>4.2</td>
<td>6.2</td>
<td>5.4</td>
</tr>
<tr>
<td>HIV PREVALENCE RATES %</td>
<td>1.3</td>
<td>6.3</td>
<td>3.0</td>
<td>7.3</td>
<td>5.3</td>
</tr>
</tbody>
</table>


1.3 HEALTH AND HIV EXPENDITURE TRENDS

The average real Total Health Expenditure (THE) for 2012/2013 for the EAC region is 45 USD per capita as compared to the 86 USD recommended for UHC with varying spending; Rwanda, 70 USD; Uganda 49USD, Tanzania 42 USD, Kenya 40 USD and Burundi 21 USD per capita. In economic context, THE amounts to 7.9% of the regional GDP. 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 sustainability of health financing in the region.

For the region as a whole, the average expenditure to health out of the total public budget has grown from 4% in 2009/2010 to 5.5% in 2012/13. The average total real HIV spending for the EAC region is 123 USD measured as a proportion of the amount spent on the population affected by HIV.

1.4 RATIONALE FOR SUSTAINABLE FINANCING FOR HEALTH AND HIV

Across the EAC governments contribution to health and HIV are not necessarily linked to income, the average spending on HIV accounts for 0.3% of GDP and 1.2% of the budget. Only 15% of all HIV spending in EAC is from government budgets while 13% from the private sector. 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 the region as a whole. The World Bank and the United Nations Population Division and Latest Demographic and Health Surveys of the Respective Partner States.
impact on HIV sector. It is important then to consider how health and HIV expenditures can be linked in an attempt to integrate HIV within the Universal Health Coverage agenda. EAC Partner States will need to significantly increase domestic funding as per their capacity and burden of disease.

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.

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 larger shares of total government expenditure into expenditure on health as their economies grow.

Sustainable Development Goal (SDGs) 3 target 3.8 which is achieving Universal Health Coverage including financial risk protection, access to quality essential health care services and access to safe water, effective, quality and affordable essential medicines and vaccines for all further reaffirms the need to focus on Sustainable and reliable financing which will enable the population regardless of their socio-economic status to access services without financial difficulties in the region. Further, in their 10th ordinary meeting, the EAC Ministers of health urged the EAC Partner States to create a conducive environment for local production and bulk pooled procurement of medicines and other medical/health supplies and commodities in the EAC region. They also urged Partner States to support mechanisms aimed at establishing national and regional sustainable financing for HIV and AIDS, TB and STIs programming in the region. (EAC/Health/ SCM-10/Decision 047)

In the EAC region, out of pocket expenditure ranges from 18% in Tanzania; 20% Rwanda; 27% Burundi; 29% in Kenya; and 39% in Uganda which is above the threshold of 20% recommended by WHO. Catastrophic out of pocket health expenditure in this region leads to impoverishment for families, hinders access to health services, and contribute to observed poverty levels in the region.

2. RESOURCE NEEDS

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 in 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.

The resource needs for Universal Health Care 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 for low income 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.

2.1 RESOURCE GAP

In 2001 African Heads of States signed to Abuja Declaration committing their countries to allocate 15 percent of the government budget to Health. To date almost all African countries have not achieved the target with the exception of Rwanda. As a result the health financing gap is prominently huge across the Partner states.

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 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 resource gap 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 prioritisation in the 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 resource gap 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”.

3. OPTIONS TO BRIDGE THE RESOURCE GAP

This paper explores options available to the EAC Partner States to mobilise additional resources for health and HIV programming. Three policy options to maximise fiscal space for addressing the resource gaps are explored in detail: Reprioritisation of public spending towards health and HIV to reach 15% recommended in the Abuja declaration; additional taxes with proceeds earmarked to health and HIV; and increased efficiency of health and HIV service delivery.

3.1 REPRIORITISATION OF PUBLIC SPENDING TOWARDS HEALTH AND HIV

Reprioritisation of public spending towards health and HIV in EAC Partner States to reach the recommended 15% 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 reprioritisation, the resource gap could fall from 5.5% of GDP to 3.8% pa over the fifteen years. In Kenya, reprioritisation 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.

3.2 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. So far, EAC Partner States can borrow experience from other countries that have introduced specific taxes for health example Botswana, Zimbabwe (AIDS Levy) etc.

3.3 EFFICIENCY SAVINGS

A potential 5 billion USD a year is projected to be captured by efficiency savings in health.
### 3. Recommended Action Framework on Sustainable Financing

<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 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 and expectation; 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 diagnostic-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 flexible 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 levels 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>
<tr>
<td>10. Health interventions: insufficient mix/appropriate level of strategies</td>
<td>Funding high-cost, low-effect interventions when low-cost, high-impact options are unfunded. Inappropriate balance between levels of care, and/or between prevention, promotion and treatment.</td>
<td>Regular evaluation and incorporation into policy of evidence on the costs and impact of interventions, technologies, medicines, and policy options.</td>
</tr>
</tbody>
</table>

4. **CONCLUSION**

If all EAC Partner States implement these three policy options above in combination, the UHC and HIV needs throughout the region could be covered by 2027/2028 except for Burundi and Uganda that will still remain with a resource gap. To bridge the gap the Republic of Burundi and Republic of Uganda will require 10.7% and 2.6% of their respective GDPs to fully reach UHC and HIV needs. We strongly recommend that in addition to the three policy options recommended above, Partner States should implement other innovations such as health insurance schemes to ensure UHC. Further, implementation of the three options will reduce the OOP expenditures levels to the desirable levels of 20% or below.

**RECOMMENDATIONS**

The EAC regional Think Tank on Sustainable Financing response recommends to the Ministers of Finance and Ministers of Health to consider the proposed EAC Action Framework on Sustainable Financing in the table 4 below.

The Ministers of Finance and Ministers of health approve the framework operationalizing the recommendations (1 to 4) above, and direct the EAC Secretariat to work with the Partner States and all relevant stakeholders to implement the EAC Action Framework on Sustainable Financing for Universal Health Coverage and HIV and AIDS.
<table>
<thead>
<tr>
<th>RECOMMENDATION</th>
<th>PROPOSED STRATEGIC ACTIONS</th>
</tr>
</thead>
</table>
| **1. COMMIT TO INCREASE NATIONAL HEALTH BUDGETS TO COVER RESOURCE REQUIREMENTS** | 1. Commit to increase national health budgets for UHC  
2. Each Partner State develops a strategy to achieve UHC and ending AIDS by 2030  
3. Expand fiscal space towards reducing the proportion of total health expenditure that is out of pocket expenditure to less than 20% in all Partner States  
4. The EAC Secretariat to support Partner States to develop investment cases for HIV and health to be used in advocacy for UHC financing  
5. Ministry responsible Health in the Partner States to conduct national dialogue on earmarked taxes to address Universal Health and HIV&AIDS financing. Each Partner State should explore additional financing sources for health  
6. The EAC Secretariat to facilitate sharing of best practices at regional level and promoting their adoption and scale up by the Partner States  
7. EAC Secretariat to facilitate advocacy activities for increased investment in Universal Health and HIV&AIDS coverage in the region |
| **2. COMMIT TO DEVELOP AND IMPLEMENT A COST EFFECTIVE UNIVERSAL HEALTH AND HIV & AIDS REFERENCE PACKAGE IN EACH OF THE PARTNER STATES** | 1. Development of a regional reference package for Universal Health and HIV & AIDS coverage to guide country specific processes  
2. Adopt/adapt a country specific package of services for Universal Health and HIV&AIDS coverage from the regional reference package  
3. Cost the country specific package for Universal Health and HIV&AIDS coverage  
4. Implement the costed country specific reference package for Universal Health and HIV & AIDS coverage |
| **3. EXPLORE INNOVATIVE FINANCING MECHANISMS TO EXPAND THE FISCAL SPACE FOR UHC AND ENDING AIDS BY 2030** | 1. All Partner States develop and implement innovative financing mechanisms including (consumption taxes, resource taxes, sin taxes)  
2. Develop and implement a PPP policy framework for mobilising resources for health  
3. Partner States establish/strengthen mechanism to enforce integration of HIV, Health and gender into the Environmental Impact Assessments (EIAs) for all capital projects  
4. Develop a mechanism to ensure utilisation of resources allocated for health in capital projects  
5. EAC Secretariat to develop a regional financing strategy for health and HIV  
6. All EAC Partners States develop and approve national financing strategy for universal health and HIV coverage by 2017  
7. All EAC Partner States fully institutionalise and routinely carry out resource tracking/monitoring/mapping by June 2018  
8. All EAC Partner States adopt and implement financing mechanisms (including insurance) that improve access, quality and financial protection by December 2018 (consider portability of health insurance cover across borders) |
| **4. PRIORITIZE AND IMPLEMENT MEASURES TO IMPROVE EFFICIENCY IN THE ALLOCATION AND USE OF HEALTH RESOURCE** | 1. Finalise development of EAC medicines manufacturing regulation including a compulsory licensing framework by December 2018 (Consult Rogers)  
2. Finalise development of EAC pooled-bulk procurement and generic substitution framework by December 2018  
3. Develop 2 yearly national and regional essential medicines and health product indicative price lists by December 2017.  
4. Develop EAC health worker remuneration and incentive guidelines/framework for equitable distribution of health workforce and the right skills mix  
5. Partner States to prioritise harmonisation and linkage of HRH information systems in their budgets to expand its coverage and integrate it with the medicines logistics and financial management information systems  
6. All EAC Partner States adopt and implement National Development Cooperation Frameworks for the Health Sector (including both the public and private sectors, CSOs and International NGOs) to improve governance and accountability by December 2018 (revise it within the accountability agenda) (Rogers)  
7. Conduct national and regional level efficiency studies to inform strategies to minimise wastage in the health sector, including development of EAC regional indicators, conduct annual monitoring of indicators and support implementation in the Partner States |