STATUS OF HEALTH FINANCING IN EAST AFRICA

This information sheet makes a comparative analysis of spending on health for the five East African countries in the East African Community namely Burundi, Kenya, Rwanda, Tanzania and Uganda. It teases out issues for consideration by Health Policy Makers. The information is based on the Health Financing Data obtained from World Health Organization National health Accounts Website, Country Ministry of Health offices and websites and National Budgets.

Key Messages

- Address high levels of out of pocket expenditure in order to protect households from catastrophic spending by broadening pre-payment mechanism such as Social Health Insurance. This is in line with World Health Assembly resolution of 2005 on universal coverage and sustainable health financing and: Revisiting the Paris Declaration 2001: Greater Investments in the Health Sector: Health Insurance and Financing
- Increase government investment in health towards meeting the Abuja Declaration target and reduce the dependence on external resources to finance healthcare. This is especially more critical now given the macro-economic challenges facing most industrialized countries, which may affect the flow of donor funding, rendering it more unsustainable.
- Strengthen government's stewardship role in coordinating donors and ensuring alignment to country strategies in line with the Paris Declaration principles, and towards more effective aid. Development of strategic partnerships which allow for predictability of funds over a longer period will ensure sustainability of funding.
- Explore alternative ways of mobilizing domestic resources to improve financial sustainability including the improvement of efficiency in resource use.
- Develop comprehensive health financing strategies and institutionalize National Health Accounts as a tool to track progress in the implementation of the strategies.

What is the purpose of this document?

To raise awareness on the need to improve the financing of health services in the EAC region

What is it about?

A summary of the health financing profiles of 5 countries in the EAC region and key Messages to policy makers and implementers on improvement of the health financing Status

Increasing interest in Health financing is attributed to the ever growing gap between resources and needs, which has led to pressure on the health care system for additional resources. It is worth noting that higher per capita expenditure on health coupled with efficient use of those resources is likely to translate into better health outcomes. This fact sheet presents the resource availability and sources of funds to health in the five East African community Countries.

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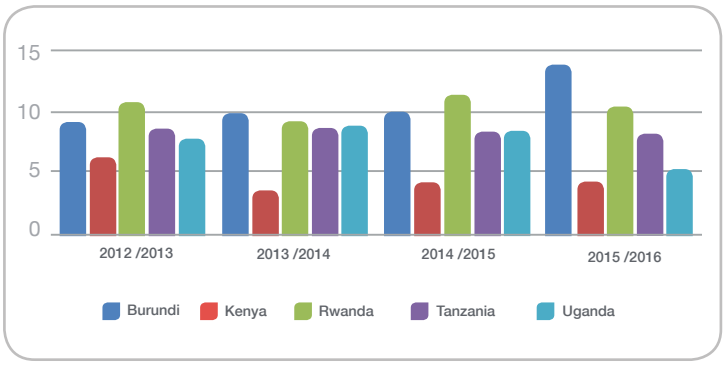
Sources of Funds: Who Finances Health?

Government Funds

Government tax funds are one of the main sources of funding for health. Government income tax is usually progressive, where higher income individuals contribute a larger proportion of their income towards the tax. Government funding is therefore viewed as one equitable mechanism of raising health funds, given that individuals contribute according to their ability to pay. It also allows for the pooling of risk and cross-subsidization, given that the utilization of publicly funded health services normally depends on health needs and not necessarily on socio-economic factors. It is for these reasons, among others that governments are encouraged to allocate an adequate share of domestic resources from their budget towards health. African Governments committed, through the Abuja Declaration, to allocate and spend at least 15 percent of government funds to health. In June 2015, Countries in the East African Community concurrently released their National budgets for the Financial Year 2015/2016.

Figure 2 below shows the proportion of government expenditure that went towards health in East African countries. This is analyzed in relation to the Abuja Declaration target.

FIGURE 1: GOVERNMENT HEALTH BUDGET AS A PERCENTAGE OF GENERALGOVERNMENT BUDGET (2012 AND 2015)



Source: EAC Countries Ministries of Health, EAC Countries Budget Speeches 2012-2015

The graph below shows the Government Health Expenditure as a percentage of General Government Expenditure for the years 2013-2015.

The above data shows that none of five countries spent more than 15 percent of government domestic resources on health between 2012 and 2015. In 2015, Burundi allocated the highest percent of total government expenditure on health. It is worth noting that there is inconsistency in all East African Countries in terms of moving towards achieving Abuja Declaration target of 15% government spending on health. Kenya has had the lowest percentage of the government expenditure spent on health while Uganda has had a drastic decline in its budget to health in 2015. The trend is not consistent with the Abuja Declaration commitment.

It is important to note that in low income countries where government budgets are seriously constrained, achievement of the Abuja Declaration target may not result in a significant change in the health financing situation, because it is based on a relatively small GDP. The target is however relevant and maybe viewed as a proxy of government commitment to increased health investment.

TABLE 1: GOVERNMENT HEALTH BUDGET AS A PERCENTAGE OF GENERALGOVERNMENT BUDGET (2012 AND 2015)

Country	2012/2013	2013/2014	2014/2015	2015/2016
Burundi	9	10	10	13.8
Kenya	6.1	3.4	4.0	4.0
Rwanda	10.8	9.2	11.3	10.2
Tanzania	8.5	8.5	8.0	8.0
Uganda	7.7	8.6	8.4	5.3

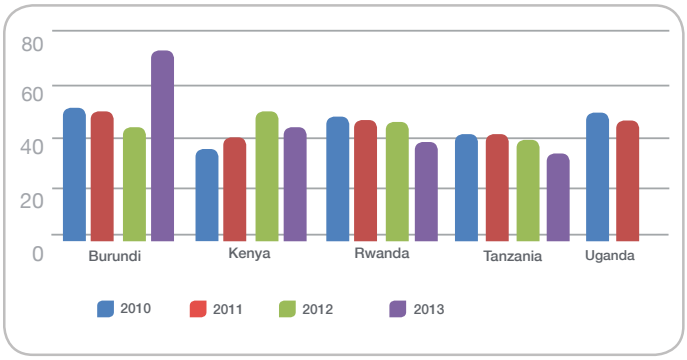
Source: EAC Countries Ministries of Health, EAC Countries Budget Speeches 2012-2015

External Funds

Besides the domestically generated funds described above, most low and middle income countries complement these sources of funds with aid, which originates outside the country from various development partners. Given the constraints in lower income countries to raise sufficient domestic resources for the provision of health services, external funds have always played a significant role in the financing of health services. External funds however flow in time-limited cycles, usually with no guarantee for continuation beyond a particular cycle, due to the ever changing development assistance landscape. The flow of external development assistance is also dependent on a multiplicity of factors, some of which are beyond the control of the health sector.. In this regard, the financing of health services from external sources is considered to be unsustainable in the long-term. In addition, the absence of strong stewardship and coordination of the external funds may render the development aid less effective. The figure below shows external resources as a percentage of total health expenditure for the years 2010-2013.

The data below shows a trend of external funding in the five East African Countries between 2010- 2013 except for Uganda where only data for 2010 and 2011 data is available. A drastic increase in external funding as a percentage of Total Health expenditure in Burundi in 2013 is an issue of major concern. The level of external funding in all East African Countries remains relatively high over the 4 years.

FIGURE 2: EXTERNAL RESOURCES AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURE (2010-2013)



Source: (Health expenditure series, World Health Organization, Geneva, February 2009 (latest updates are available on http://www.who.int.nha/country/en/index.html)

The Resource Envelope. How much is available?

Current Health Expenditure measures the economic resource spent by a country on health services and goods. The total expenditure on health per capita provides information on the overall availability of resources for health care. Table one below compares per capita expenditure on health of East African Countries in US $ for the four years 2010-2013

The table right shows that Health per capita spending ranged from the lowest of US 46 in Tanzania to the highest of US $ 95 in Rwanda in the year 2013. It also shows an increasing trend in per capita spending on health though percentage greatly varies from country to country. All East African Countries are above the conservative 30-40 US$ per capital expenditure on health recommended by the Commission on Macro-Economics of Health. Tanzania and Uganda are below the WHO recommended minimum level of US $60 per capita expenditure on health for low developing countries.

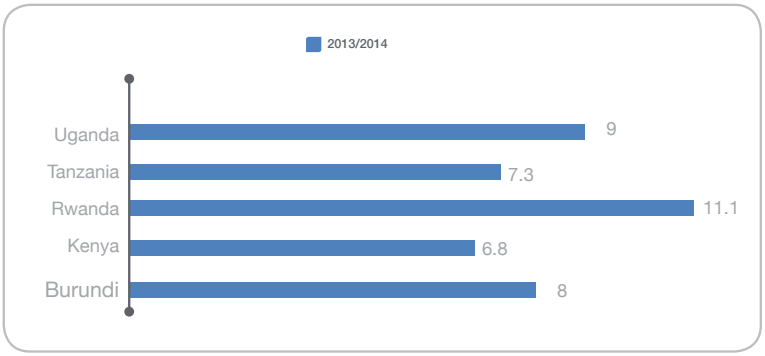
Differences are also noted in health spending in relation to Gross Domestic Product.

TABLE 2: PER CAPITA EXPENDITURE ON HEALTH IN U.S $ FOR THE YEARS 2010-2013 IN EAST AFRICAN COUNTRIES

Country	2010	2011	2012	2013
Burundi	54	51	56	64
Kenya	56	60	62	67
Rwanda	77	85	93	95
Tanzania	41	45	46	46
Uganda	52	50.1	-	-

Source: Health expenditure series, World Health Organization, Geneva, February 2009 (latest updates are available on http://www.who.int.nha/country/en/index.html)
Uganda National Health Accounts FY 2008/09 and 2009/10, March 2013
Kenya National Health Accounts FY 2012/2013

FIGURE 3: HEALTH EXPENDITURE AS A PERCENTAGE OF GDP 2013



Source: Health expenditure series, World Health Organization, Geneva, February 2009 (latest updates are available on http://www.who.int.nha/country/en/index.html)

The data left shows that Rwanda spent more than 10% of GDP on health while all the other countries spent less than 10%. There is no benchmark against which to compare a country's health spending as a proportion of GDP. However, health financing evidence points to a strong relationship between the GDP of a country and its health spending. The proportion of a country's GDP spent on health is an indication of prioritization of healthcare.

Household Out-of-Pocket Expenditure

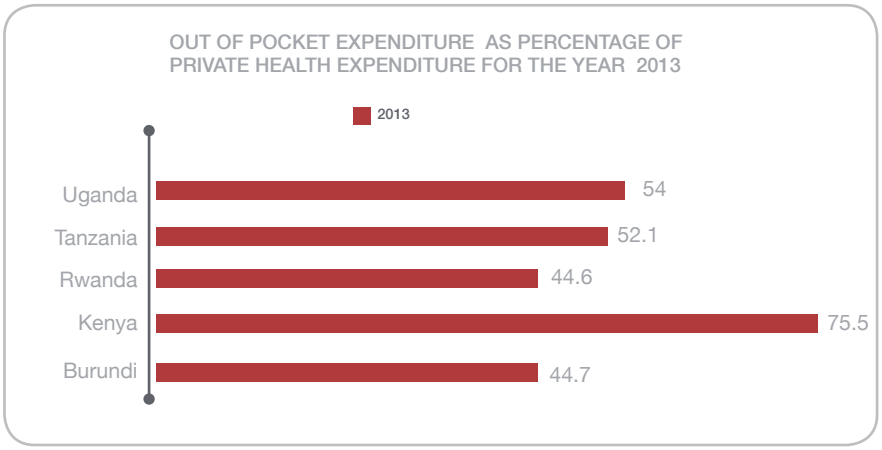
In most low and middle income countries, households are a significant source of funds for health. Households pay for healthcare through subscriptions to health insurance schemes and direct out-of-pocket payment as they utilize services. Out-of- pocket payment is generally considered to be the least preferred mode of paying for healthcare. This is due to the fact that there is no pooling of risk and cross subsidization between individuals with varying health care needs. Individuals with greater health care needs bear the heaviest financial burden, irrespective of their ability to pay. As such, there is no equity in paying for health care.

Out-of-pocket payments also expose households to the risk of catastrophic expenditures. This is a situation where a household spends a large proportion of income on healthcare, at the expense of other needs such as clothing and education for children.

It may also drive a household into selling valuable assets and depleting savings, leading to impoverishment.

Out-of-pocket expenditure accounted for more than 40 percent of private expenditure on health in all the five countries. Evidence from various studies suggests that the incidence of catastrophic expenditures in households increases significantly when out-of-pocket expenditure exceeds 15 percent of total health expenditure. It is therefore quite likely that households in the countries, whose out-of-pocket expenditure is above the 15 percent of total health expenditure, could be experiencing financial catastrophe with impoverishing consequences. Please note that the above are percentages of private health expenditure. The magnitude of this catastrophe may be ascertained with further studies

FIGURE 4: OUT-OF-POCKET EXPENDITURE AS PERCENTAGE OF PRIVATE EXPENDITURE ON HEALTH (2013)



Source: Health expenditure series, World Health Organization, Geneva, February 2009 (latest updates are available on http://www.who.int.nha/country/en/index.html)

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