



EAST AFRICAN COMMUNITY HIGH-LEVEL MINISTERIAL DIALOGUE ON SUSTAINABLE FINANCING FOR UNIVERSAL COVERAGE OF HEALTH AND HIV&AIDS

ARUSHA, UNITED REPUBLIC OF TANZANIA

23RD JUNE 2016





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1.0 Introduction

1.1 Background

The EAC Health Sector over the past few years has been involved in discussions aimed at ensuring Universal Health Coverage (UHC) for the EAC region. This is reflected in Directives EAC/Health/SCM-10/ 010 and EAC/Health/SCM-10/ directive 013 respectively, whereby the EAC Secretariat is expected to develop a strategy, roadmap and implementation framework for Social Health Protection. The EAC Council of Ministers is urged to advocate for UHC. Achieving the goals of UHC will require a significant increase in the level of funding for both Health and HIV and AIDS interventions in the Partner States.

The push for UHC is informed by the changing financing landscape for HIV and Development Aid for Health (DAH) which is declining despite the strong commitment demonstrated by African leaders to offer UHC and stop HIV/AIDS, TB and Malaria. The commitment is exemplified by several continental, regional and international decisions including the Abuja Declaration signed in 2003 and renewed commitment in 2013, and the African Union's Roadmap on Shared Responsibility and Global Solidarity for AIDS, Tuberculosis and Malaria response in Africa (2012-2015), which outlines an innovative framework for delivering equitable and sustainable results across the African continent.

To end poverty and help ensure shared prosperity, all countries need a sustainable, inclusive development strategy built on human capital investments in health, education, and social protection for all. We can end poverty by reducing out of pocket health care expenses by introducing effective models of equitable health financing with strong social protection measures for all members of society. Furthermore, we need to close the gap in access to quality health services for the poorest 40 percent of the population in every country¹. This requires a health system that ensures that health investments and expenditures will contribute to improving health outcomes equitably and sustainably.

¹ Global conference on UHC for inclusive sustainable growth 2013, http://www.mof.go.jp/international_policy/others/UHC_Global_Synthesis_Report.pdf



Information available from the EAC Partner States shows that all five countries are implementing sustainable financing initiatives for Health and HIV and AIDS as top priority in the region. The information indicates that the Partner States are at different levels in regards to establishing mechanisms and identifying suitable options for raising local revenue. Health and HIV & AIDS financing is from various sources including national governments treasury, Development Partners, health insurance schemes, community financing schemes and out of pocket expenditure.

The EAC Secretariat has conducted an analysis of the financing options for Universal Health and HIV coverage for the EAC region*. The analysis report outlines the financing options available to the EAC Partner States, and informs the Issue Paper on Sustainable Financing. The Paper will guide the High-Level Ministerial Dialogue (HLMD) on Sustainable Financing for Universal Coverage for Health and HIV/AIDS for the EAC region. The HLMD will be convened by the EAC Secretariat in collaboration with the EAC Partner States and other key stakeholders. It is expected to bring together the Ministers responsible for Finance and Economic Development and Health in the EAC Partner States.

Note : *The Terms of reference (ToRs) for the study were approved by 10th Ordinary Meeting of the EAC Sectoral Council of Ministers of Health held in October 2014, in Arusha Tanzania (Decision EAC/Health/SCM-10/Decision 053) (footnote)

1.2 Rationale

From the funding sources in table 1 below, show that the biggest percentage of health financing is from development partners. At the East African Community level, 99% of regional health sector interventions are funded and supported, by multilateral and bilateral development partners and foundations including Sida, Norad, GIZ, the Rockefeller Foundation, the World Bank, Bill and Melinda Gates Foundation and KfW among others. (Include all partners)



Table 1: Summary of Percentage of Funding for HIV and AIDS at Partner State level

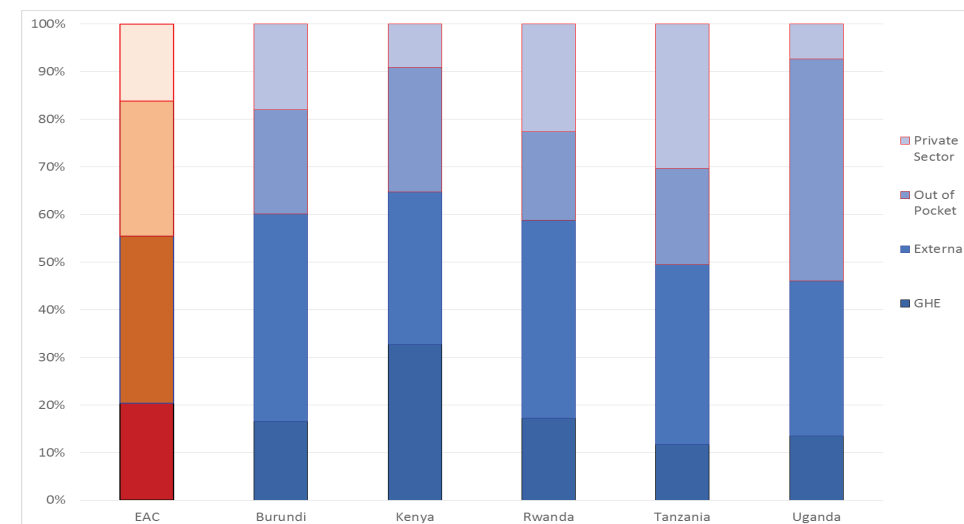
Country and Year of NASA Study	Sources of Funding			TOTAL
	Public	Private	International	
Burundi (2009 & 2010)	5.3	0.4	94.3	100
Kenya (2006/07 & 2008/09)	18.9	6.0	75.1	100
Rwanda (2006)	5.0	2.6	92.0	100
Uganda (2008/09 & 2009/10)	10.8	21.6	67.6	100
Tanzania (NHA 2009/10)	11.5	18.3	70.3	100

Source: NASA Studies for years shown in first column.

In the EAC Partner States, only 36% of health care financing comes from 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 funding². This poses a challenge of the sustainability of health financing in the region. In addition the average spending on HIV accounts for 0.3% of GDP and 1.2% of the budget. It is clear that the level of commitment to HIV is not correlated with the income of the Partner States. Only 15% of all HIV spending in EAC Partner States is from government budgets. 72% is from the international community and 13% from the private sector.

² Report on Sustainable financing analysis for Universal health and HIV coverage for the EAC region, 2016

Figure 1: Total Health Expenditure by source for EAC Partner States



Source: Report on Sustainable financing analysis for Universal health and HIV coverage for the EAC region, 2016

Most African countries recognize the need to diversify and expand the sources of funding for health HIV responses and specifically reduce their dependence on external funders. Measures taken include quantifying the country-level funding gap (e.g. financial gap analysis for malaria for 2013 – 2016 done by all malaria endemic countries), identifying policy options to increase resources, increased financial commitment by the private sector, and inclusion of health, malaria and HIV services in different forms of health insurance and other health financing schemes. Partner States encouraged developing financial investment plans for health, including AIDS, TB and Malaria, showing how national programme costs will be covered with domestic and external funding and annual increases in share of domestic funding. Further, individual EAC Partner States have developed different funding mechanisms including HIV Trust Funds and The National Health Insurance Fund (NHIF) for the Republic of Kenya, Uganda, Tanzania and Burundi; Community Based Health Insurance



(CBHI) in Rwanda and Tanzania to enable the countries to have reliable and sustainable financing for health especially to support HIV and AIDS interventions.

With the information provided above, it is clear that there is need to develop strategies that will enable the Partner States harness/tap into existing alternative domestic financing options for health and HIV and AIDS. This calls for bold discussions at the regional level on existing financing options for health in the EAC Partner States. The East African Community Secretariat in partnership with the EAC Partner States and development partners has organized a one-day high level dialogue meeting to discuss sustainable domestic Financing for Health and HIV and AIDS in the East African Community.

2.0 Objective of the High Level Dialogue Meeting

The main objective of the HLMD is to consider the recommendations as contained in the Report on Sustainable Financing Analysis for Universal Health and HIV coverage for the EAC region for adoption by the EAC Partner States.

Specifically the HLMD will:

- i. Receive and consider the report on Sustainable Financing Analysis for Universal Health and HIV coverage for the EAC region and Share Partner States experiences on Sustainable Financing for Health and HIV and AIDS
- ii. Share information on innovative financing mechanisms from other African countries;
- iii. Recommend sustainable financing options for adoption and implementation by the Partner States

3.0 Participants

The dialogue meeting will be attended by:

- Partner States' Ministers responsible for health and their Permanent Secretaries/Principal Secretaries, Head/Director policy and planning
- Partner States' Ministers of Finance and Economic Development: their Permanent / Principal Secretaries and Head/Director responsible for taxation, budget
- Executive Directors of the National AIDS Councils and Commissions
- Regional Civil Society Organisation (EANNASO)
- East African Health Platform
- East African Business Council
- SADC
- IGAD
- WAHO
- ECOSA
- NEPAD
- UNDP
- UNAIDS
- WHO
- Development Partners



- East African Legislative Assembly (EALA) Speaker, head of GPC
- East African Community organs and institutions
- East African Development Bank
- Representative from the media houses
- Representatives of the African Union Commission
- Think Tank SF (1/PS)
- EWG SF (1/ PS)

4.0 Preparation for the meeting

As part of the preparation, the EAC Secretariat constituted an Expert Working Group (EWG) on sustainable financing for health that has been guiding the analysis in financing options for universal health and HIV coverage in the EAC region. The EWG members will contact relevant Ministries in the Partner States, through the EAC Deputy Secretary General (Productive and Social Sectors) requesting each country to participate in the High Level Dialogue Meeting. The United Republic of Tanzania will chair the meeting, and the Republic of Uganda will be the rapporteur.

The Permanent Secretary Ministry of Health, Children and Elderly in the United Republic of Tanzania will present the Issues Paper to the Ministers, highlighting the issues for discussion and a keynote address will be given by a reknown expert on sustainable financing issues from the World Bank.

5.0 Convening of the meeting

The HLD meeting will be convened as a side event during the 12th Ordinary Meeting of the Sectoral Council of Ministers of Health on 23rd June 2016 to ensure appropriate participation. The meeting will start with the Senior Officials Session, followed by the Permanent Secretariats/Principal Secretariats Session and will be concluded with the Ministerial session.

6.0 Logistics for the meeting

The air ticket and upkeep for the experts participating in the experts meeting and the EAC regional high level ministerial dialogue on sustainable financing for health and HIV and AIDS will be covered by the EAC HIV and AIDS project with funding from SIDA.

7.0 Expected outputs

- i. Adoption of the key policy recommendations and proposed Framework of Action (FOA) towards Sustainable Financing for the EAC region;
- ii. Road map towards sustainable domestic financing for the East African Community region, and
- iii. Meeting report with issues for consideration / Communiqué





EAST AFRICAN COMMUNITY HIGH-LEVEL MINISTERIAL DIALOGUE ON SUSTAINABLE FINANCING FOR UNIVERSAL COVERAGE OF HEALTH AND HIV&AIDS

ISSUE PAPER

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 infrastructure¹. 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 1: GDP Statistics for individual countries)

Country	GDP per capita (USD)	Growth Rate 2009/10 – 2013/14 %
Rwanda	582	8.2
United Republic of Tanzania	580	5.9
Uganda	560	5.3
Kenya	1,113	5.0
Burundi	247	6.7

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 2: Selected Health Indicators in each Partner State²

Indicator	Burundi	Kenya	Rwanda	Uganda	Tanzania
Maternal Mortality Ratio	500	488	210	438	432
Under five mortality rate	96	52	50	90	81
Neonatal mortality rate	36	22	20	27	21
Prevalence of Stunting in Children Under 5 years	58	26	38	33	42
Contraceptive Prevalence Rate	22	58	53	30	34
Total Fertility Rate	6	3.9	4.2	6.2	5.4
HIV Prevalence rates %	1.3	6.3	3.0	7.3	5.3

Adopted from Trends in Maternal Mortality: 1990 to 2013. "Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division and Latest Demographic and Health Surveys of the Respective Partner States"

² Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division and Latest Demographic and Health Surveys of the Respective Partner States



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 HIV³.

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 HIV sector.

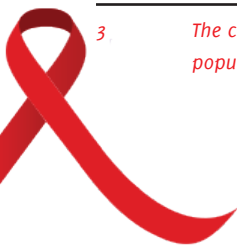
³ The calculation is as follows: Total real HIV spending / [(AIDS DALYs/TOTAL DALYs)*country population].

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.

2.0 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 countries.

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 com-



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'.

3.0 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 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).

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.



Table 3: World Health Report 2010 – Leading sources of inefficiency with common causes and ways to redress⁴

Table 4.1. Ten leading sources of inefficiency

Source of inefficiency	Common reasons for inefficiency	Ways to address inefficiency
1. Medicines: underuse of generics and higher than necessary prices for medicines	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.	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.
2. Medicines: use of substandard and counterfeit medicines	Inadequate pharmaceutical regulatory structures/mechanisms; weak procurement systems.	Strengthen enforcement of quality standards in the manufacture of medicines; carry out product testing; enhance procurement systems with pre-qualification of suppliers.
3. Medicines: inappropriate and ineffective use	Inappropriate prescriber incentives and unethical promotion practices; consumer demand/expectations; limited knowledge about therapeutic effects; inadequate regulatory frameworks.	Separate prescribing and dispensing functions; regulate promotional activities; improve prescribing guidance, information, training and practice; disseminate public information.
4. Health-care products and services: overuse or supply of equipment, investigations and procedures	Supplier-induced demand; fee-for-service payment mechanisms; fear of litigation (defensive medicine).	Reform incentive and payment structures (e.g. capitation or diagnosis-related group); develop and implement clinical guidelines.
5. Health workers: inappropriate or costly staff mix, unmotivated workers	Conformity with pre-determined human resource policies and procedures; resistance by medical profession; fixed/inflexible contracts; inadequate salaries; recruitment based on favouritism.	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.
6. Health-care services: inappropriate hospital admissions and length of stay	Lack of alternative care arrangements; insufficient incentives to discharge; limited knowledge of best practice.	Provide alternative care (e.g. day care); alter incentives to hospital providers; raise knowledge about efficient admission practice.
7. Health-care services: inappropriate hospital size (low use of infrastructure)	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.	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).
8. Health-care services: medical errors and suboptimal quality of care	Insufficient knowledge or application of clinical-care standards and protocols; lack of guidelines; inadequate supervision.	Improve hygiene standards in hospitals; provide more continuity of care; undertake more clinical audits; monitor hospital performance.
9. Health system leakages: waste, corruption and fraud	Unclear resource allocation guidance; lack of transparency; poor accountability and governance mechanisms; low salaries.	Improve regulation/governance, including strong sanction mechanisms; assess transparency/vulnerability to corruption; undertake public spending tracking surveys; promote codes of conduct.
10. Health interventions: inefficient mix/ inappropriate level of strategies	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.	Regular evaluation and incorporation into policy of evidence on the costs and impact of interventions, technologies, medicines, and policy options.

4.0 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 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.

4 WHO: World Health Report 2010; Table 4.1; 2010



Table 4: Recommendations for Sustainable Financing for Health, HIV & AIDS

Recommendation	Proposed strategic actions
1. Commit to increase national health budgets to cover resource requirements for Universal Health Coverage	1.1. Commit to increase national health budgets for UHC 1.2. Each Partner State develops a strategy to achieve UHC and ending AIDS by 2030 1.3. 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 1.4. The EAC Secretariat to support Partner States to develop investment cases for HIV and health to be used in advocacy for UHC financing 1.5. 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 1.6. The EAC Secretariat to facilitate sharing of best practices at regional level and promoting their adoption and scale up by the Partner States 1.7. 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	2.1. Development of a regional reference package for Universal Health and HIV & AIDS coverage to guide country specific processes 2.2. Adopt/adapt a country specific package of services for Universal Health and HIV/AIDS coverage from the regional reference package 2.3. Cost the country specific package for Universal Health and HIV/AIDS coverage 2.4. Implement the costed country specific reference package for Universal Health and HIV & AIDS coverage

Recommendation	Proposed strategic actions
3. Explore innovative financing mechanisms to expand the fiscal space for UHC and Ending AIDS by 2030	3.1. All Partner States develop and implement innovative financing mechanisms including (consumption taxes, resource taxes, sin taxes) 3.2. Develop and implement a PPP policy framework for mobilising resources for health 3.3. Partner States establish/strengthen mechanism to enforce integration of HIV, Health and gender into the Environmental Impact Assessments (EIAs) for all capital projects 3.4. Develop a mechanism to ensure utilisation of resources allocated for health in capital projects 3.5. EAC Secretariat to develop a regional financing strategy for health and HIV 3.6. All EAC Partners States develop and approve national financing strategy for universal health and HIV coverage by 2017 3.7. All EAC Partner States fully institutionalise and routinely carry out resource tracking/monitoring/mapping by June 2018 3.8. 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)



Recommendation	Proposed strategic actions
<p>4. Prioritize and implement measures to improve efficiency in the allocation and use of health resource</p>	<p>4.1. Finalise development of EAC medicines manufacturing regulation including a compulsory licensing framework by December 2018 (Consult Rogers)</p> <p>4.2. Finalise development of EAC pooled-bulk procurement and generic substitution framework by December 2018</p> <p>4.3. Develop 2 yearly national and regional essential medicines and health product indicative price lists by December 2017.</p> <p>4.4. Develop EAC health worker remuneration and incentive guidelines/framework for equitable distribution of health workforce and the right skills mix.</p> <p>4.5. 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.</p> <p>4.6. All EAC Partner States adopt and implement National Development Cooperation Frameworks for the Health Sector (involving 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)</p> <p>4.7. 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</p>

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.





EAST AFRICAN COMMUNITY

EAST AFRICAN COMMUNITY HIGH-LEVEL MINISTERIAL DIALOGUE ON SUSTAINABLE FINANCING FOR UNIVERSAL COVERAGE OF HEALTH AND HIV&AIDS

DRAFT PROGRAMME

Time	Activity & Location	Responsible Person
Wednesday, 22 nd June 2016 06:30 – 9:30 pm	Welcome Reception & Buffet Dinner at Mount Meru Hotel, Arusha, Tanzania	Hosted by Secretary General of East African Community
Thursday, 23 rd June 2016	High Level Dialogue on Sustainable Financing of Universal Health and HIV Coverage in the East Africa Community, Main Conference Room, EAC Headquarters, Arusha, Tanzania	
OPENING SESSION		
Time	Activity	Speaker
08:30 – 08:50 am	Delegates seated & arrival of Guest of Honour	Organizing Committee
08:50 – 09:00 am	EAC Anthem	All
09:00 – 09:20 am	Welcome Remarks & Introductions	Secretary General, East African Community (EAC)
09:20 – 09:30 am	Welcome Statement by the Chairperson of the EAC Sectoral Council of Ministers responsible for Health	Hon. Chairperson of the EAC Sectoral Council of Ministers responsible for Health of The United Republic of Tanzania
09:30 – 09:40 am	Welcome Statement by the Chairperson of the EAC Sectoral Council of Ministers responsible for Finance	Hon. Chairperson of the EAC Sectoral Council of Ministers responsible for Finance and Minister responsible for Finance of the United Republic of Tanzania
09:40 – 09:50 am	Official Opening Speech	Hon. Chairperson of the EAC Council of Ministers and Minister Responsible for EAC Affairs of The United Republic of Tanzania



Time	Activity & Location	Responsible Person
09.50 – 9.55am	Remarks from the Director UNAIDS RST	Prof. Sheila Tlou
09:55 - 10:35 am	Presentation of the Regional Issue(s) Paper on Sustainable Financing Analysis for Universal Health and HIV Coverage in the East African Community Partner States	Permanent Secretary - Health, Ministry of Health, Community Development, Gender, Elderly and Children, The United Republic of Tanzania
10:35 – 11:00 am	REFRESHMENTS, GROUP PHOTOGRAPH	
11:00 – 12:00 pm	Overview of the current status and progress of implementation of sustainable financing for Universal Health and HIV Coverage in each EAC Partner State	<ul style="list-style-type: none"> Hon. Minister Responsible for Finance in the Republic of Burundi Hon. Minister Responsible for Finance in the Republic of Kenya Hon. Minister Responsible for Finance in the Republic of Rwanda Hon. Minister Responsible for Finance in The United Republic of Tanzania (Mainland) Hon. Minister Responsible for Finance in the Republic of Uganda

Time	Activity & Location	Responsible Person
12:00 – 12:45 pm	High Level discussion with EAC Hon Ministers responsible for Health and EAC Hon Ministers responsible for Finance	Session moderated by Chair
12:45 - 01.00 pm	Resolutions and Recommendations	All Delegates
01:00 - 01:30 pm	Review and signing of Joint Communiqué on Sustainable financing for Universal Health and HIV Coverage in EAC Partner States”	Hon. Ministers Responsible for Finance and Hon. Ministers Responsible for Health from the EAC Partner States
01:30 – 01:50 pm	Closing Remarks	Secretary General of East African Community
01:50 – 02:30 pm	Press Conference (Main Hall)	All EAC Hon Ministers, Chair of the High Level Ministerial dialogue shares the communiqué.
02:30 – 03:30 pm	LUNCH BREAK	
03:30 pm	DEPARTURE	

Chair: Chairperson of the EAC Sectoral Council of Ministers of Finance and Minister Responsible for Finance of The United Republic of Tanzania

Rapporteur: Rapporteur of the EAC Sectoral Council of Ministers of Finance, Minister of Finance, The Republic of Uganda





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