REPUBLIC OF KENYA

NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS FY 2015/16

Ministry of Health

National and County Health Budget Analysis FY 2015/16

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DISCLAIMER

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The annual national and county budgets reflect the policy and resource allocation decisions that determine the activities, programmes, and services that will be delivered within a financial year. Tracking these allocations reveals the national and county governments' resource allocation patterns and measures resource allocations' alignment to the governments' health policy priorities.

This report, a sequel to *National and County Health Budget Analysis 2014/15*, continues the interrogation of how public health sector financial resources were allocated in 2015/16. The study used data from appropriate institutions, including the Commission for Revenue Allocation, the Office of the Controller of Budget, the National Treasury, and Ministry of Health; and from the counties.

The findings provide information for national and county policymakers and decision makers to establish the level of resources allocated for public health spending, and can serve as a tool for sourcing additional funding. Policymakers and other decision makers can also use these findings to examine whether allocations to health were directed towards the most efficient programmes and activities.

These findings also include information that can provide benchmarks against which national and county governments can compare themselves with other countries and counties, respectively. The information also contributes towards creating a strong basis for improved health financing for national and county governments and subsequent better health outcomes for the population.

The Ministry of Health is grateful to the institutions that provided access to the data used in this study. The ministry also acknowledges the financial and technical support provided by the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the Health Policy Plus (HP+) project, which made this study possible.

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ACRONYMS AND ABBREVIATIONS

A-in-A	appropriations in aid
BROP	Budget Review and Outlook Paper
CBROP	County Budget Review and Outlook Paper
FY	financial year
GOK	Government of Kenya
MDAs	ministries, departments, and agencies
MOH	Ministry of Health
PBB	programme-based budgeting
PFMA	Public Finance Management Act
SAGAs	semi-autonomous government agencies
SWG	sector working group
TNGB	total national government budget

EXECUTIVE SUMMARY

Budgets are the definitive instruments that detail planned government spending, and are thus the right indicators for the policies, priorities, programmes, and activities to be implemented over the budget period. In Kenya, budgets are required; the process is defined by the Constitution and further elaborated in the Public Finance Management Act of 2012. In the budget process, ministries, departments, and agencies of national and county governments originate budgets following set guidelines, and the budgets are approved by the respective legislative bodies. National and county governments are required to adopt a programme-based budgeting (PBB) approach starting with the FY 2015/16 budget. This study looks at how national and county governments allocated funds to the health sector in FY 2015/16 and what areas these funds cover. The study aims to provide evidence that can help national and county policymakers understand the allocation patterns by different economic and functional areas.

Total Government Budget Allocation to Health

Kenya is gradually increasing the proportion of its discretionary public budget allocated to health. After an initial drop—from the 7.8 percent allocated in FY 2012/13 (before devolution) to 5.5 percent in the combined national and county budget allocation for FY 2013/14—the figure increased steadily to 7.7 percent during FY 2015/16. This growth is due to expanded budget allocations by counties, which increased by 10 percentage points between FY 2013/14 and FY 2015/16.

National Budget Allocations to the MOH in the FY 2015/16

In 2015/16, Kenya's national Ministry of Health (MoH) was allocated Ksh 59 billion out of the Ksh 1,505 billion the national government had discretion to share. This is equivalent to 3.9 percent, an increase from the 3.4 percent the health sector was allocated in 2013/14.

MOH Budget Allocations, FY 2015/16

Internally, the MOH has gradually reduced the proportion of its budget allocated to recurrent expenditure, from 56 percent in FY 2013/14 to 48 percent in FY 2015/16. This is attributed to the fact that most recurrent service delivery functions were devolved to the counties. Since FY 2013/14, allocations for recurrent expenditure grew an average of only 18.5 percent per year, compared with allocations for development expenditure, which expanded at an annual average of 39.0 percent.

The MOH allocated Ksh 28.5 billion to recurrent allocation in FY 2015/16, most of it going to grant transfers to the seven semi-autonomous government agencies (SAGAs) under the ministry, which consumed 70 percent (or Ksh 20 billion), as illustrated in the table below:

Donors contributed 62 percent (or Ksh 19.1 billion) of the MOH development budget of Ksh 30.6 billion in FY 2015/16, up from Ksh 12.2 billion in FY 2014/15. Much of the donor funding was allocated to HIV, reproductive health, immunisation, and health systems support. The Government of Kenya (GOK) health development budget amounted to 38 percent of the MOH development budget allocation (or Ksh 11.6 billion) in FY 2015/16, up from Ksh 9.1 billion in FY 2014/15. Of this amount, the medical equipment services programme and the free maternity care programme were the major beneficiaries, allocated 47 percent and 37 percent of the total health development budget allocation for FY 2015/16, respectively.

Allocations to Health in the County Governments' Budget, FY 2015/16

County governments increased the allocations to health as a percent of total county budgets by 32.8 percent, to 23.4 percent (or Ksh 85 billion) in FY 2015/16 from the previous fiscal year's 21.5 percent (or Ksh 64 billion). This indicates an increased commitment to health by county governments; however, the allocation is still below the pre-devolution levels. The counties that allocate the highest proportion to health include Nyeri, Embu, Baringo, Kiambu, Siaya, Elgeyo Marakwet, Nakuru, Kirinyaga, and Kericho, all of which

allocated 30 percent or more of their budgets to health; conversely, Turkana, Narok, and Laikipia allocated less than 15 percent. However, most counties (39) increased the proportion of their budget allocated to health in FY 2015/16 relative to FY 2014/15.

The recurrent development budget ratios of counties continue to be skewed towards recurrent expenditures, with 72 percent of total county health budgets allocated to recurrent expenditures in FY 2015/16. While this is an improvement from the previous 75 percent in FY 2014/15, it remains lower than the desirable 30 percent allocation for development.

The share of the recurrent budget allocated to personnel expenses continues to dominate and grow in county budgets, to 72.5 percent in FY 2015/16 from 69.7 percent in FY 2014/15. Budget allocation for drugs and other essential medical supplies increased from 9.1 percent in FY 2014/15 to 15.1 in FY 2015/16. Counties should be encouraged to increase resources for health so as to adequately cater for essential health services inputs and balance between personnel, drugs and essential supplies, and operations and maintenance.

Construction and rehabilitation of buildings and medical equipment were allocated the largest share of the development budget in FY 2015/16, indicating that counties prioritise expansion and consolidation of physical infrastructure. This figure increased from 50.1 percent in FY 2014/15 to 63.1 percent in FY 2015/16.

Overall, counties increased their average per capita allocation to health from Ksh 1,479 in FY 2014/15 to Ksh 1,910 in FY 2015/16. Lamu, Isiolo, Taita Taveta, Elgeyo Marakwet, Marsabit, and Tana River have higher per capita allocations at more than Ksh 3,000; while Laikipia, Bomet, Migori, Narok, Bungoma, and Turkana allocated Ksh 1,000 or less during FY 2015/16.

Recommendations

Counties should endeavour to increase resources allocated to health. County governments should also ensure that funds allocated as conditional grants for health are entirely allocated to health.
Counties should improve their budget formulation process and use it as a tool for improving service delivery. In particular, they should strive towards balanced budgets.
The two levels of government should optimally utilise available human resources to increase fiscal space for other inputs.
Whereas the PBB approach and tools are standard requirements for budgeting, it is important that the MOH adapt these tools to a format that can facilitate budget analysis and extend health budgeting capacity to counties.
Close linkages between the MOH and county health budgeting units should be established and maintained during the budgeting process.

INTRODUCTION AND METHODS

This analysis focuses on public sector budgets for national and county governments, respectively, further narrowed down to the health sector and a budget period of one year. Budget analysis provides deeper insight and purposeful enquiry, which can reveal aspects that may not be apparent at first glance. It can also show insufficiency in addressing the original intention of the budget, and can guide actions to address deficiencies in subsequent budgets and budget processes. In particular, analysis of health sector budgets can help diagnose the equitability, efficiency, and sustainability of health systems.

This report first sets the contextual background, covers the objectives of the budget analysis and the methodological approach of the study, and then presents detailed findings and recommendations from the analysis of national and county budgets covering three financial years (2013/14, 2014/15, and 2015/16). It is envisaged that the findings of this analysis, which examine the investment priorities at national and county levels, will be useful in strengthening the devolved health system structures.

Defining Budget

A collection or set of agreed-upon "items" and the funding intended to be spent over a specific period of time

The "items" can be packed in many different forms and dimensions depending on what is under consideration

Budgets and budgetary processes in the public sector are typically institutionalised in formal and legal frameworks

Author's definition

Context

The Constitution of Kenya recognises health as a fundamental right and an important driver in spurring economic growth. This and other major policy documents—such as Kenya Vision 2030 and the Kenya Health Policy framework, 2014–2030—highlight the government's obligation and commitment to ensure that Kenya attains the highest standard of living for its population by providing equitable health services. To meet these obligations, both the national and county governments must allocate, adequately and efficiently, the resources needed for public sector health delivery systems.

The annual health budgets guide how money will be spent in the public health sector in a given year. The budgeting process is provided for within the country's constitutional, legislative, and other public financial legal frameworks. In Kenya, the Constitution (Sections 220–224) requires budgets for national and county governments, and the Public Finance Management Act 2012 defines the roles and responsibilities for various institutions involved in budgeting (including national and county governments), and the procedures to be followed in the process.

Kenyan law also requires that budgets incorporate input from county citizens and other national and county-level stakeholders. Article 201 of the Constitution lays down the principles of public finances and requires openness, accountability, and public participation in the process.

The Budgeting Process

The Public Finance Management Act of 2012 (PFMA 2012) prescribes the roles of various institutions involved in determining budgetary allocations at both levels of government. According to the law, the National Treasury develops indicative aggregate budget proposals for national spending based on economic outlook and expected revenues, other receipts, and fixed commitments of consolidated funds. The aggregate budget constituting of direct government funding, donor resources and revenues generated by operating units is then shared between national and county governments and other independent constitutional bodies, based on a formula developed by the Commission on Revenue Allocation and approved by Parliament. The national and county governments are then given indications for the amounts they can internally allocate for their sectors and institutions, including health. There are significant competing needs for resource allocation

within the various sectors of the national and county government portfolios, and the allocation to health is thus an indication of how the governments prioritises health issues compared to other sectors It is important to note that if the global aggregate is low, the sharable pool will be low and many sectors (including health) may receive less allocation.

The process of budget allocation to respective sectors is the same at the national and county levels. Indicative ceilings for respective sectors originate in county and national treasuries and are contained in the Budget Review and Outlook Paper (or the County Budget Review and Outlook Paper, or CBROP) (BROP/CBROP, September), which must be approved by the respective cabinets and legislatures. It is important to note that the BROP gives the first indication of how much the health sector will receive; therefore, interventions to lobby for more health funding should be done prior to its release.

While the BROP/CBROP provides indicative ceilings for respective sectors around September every year, purposely formed sector working groups (SWG) then guide their respective ministries or departments in preparing three-year rolling budget allocations to proposed programmes and activities. At both national and county levels, the SWGs produce reports, which inform the Cabinet/County Executive Committee in refining the sector ceilings. A strong justification for additional funding may lead to adjustment of the annual ceilings published in the subsequent Budget Policy Statement (BPS) (national) and County Fiscal Strategy Paper (CFSP) released in February of each year after the final ceilings are determined and approved by Parliament at the national level, and by county assemblies.

Ministries and departments have the opportunity to influence amounts allocated to them through effective advocacy in the development of the SWG reports. Despite the fact that ministries in the national government and department in the county governments originate, justify, and lobby for their budget allocation proposals, their respective treasuries and legislative assemblies have the final decision on how much is allocated to health and other sectors.

Although ministries and county health departments determine how their allocated budget is distributed to programmes or activities within their dockets, they are not allowed to transfer funds between approved development and recurrent allocations. They are also required to budget for all existing personnel. However, they have significant flexibility to shape the allocations in the most efficient manner possible, prioritising cost-effective and efficient programmes.

Final budgets are approved by the National Assembly for the national government and by county assemblies for the county governments, with or without amendments. Fewer amendments are required in cases where there has been positive and continuous engagement between the executive and the legislative assemblies during the budgeting process.

The PBB Budgeting Approach

Section 12 of the Second Schedule of the PFMA requires the national government and counties to adopt a PBB approach beginning FY 2014/15. This requirement was changed in FY2015/16 following Senate intervention, which cited lack of capacity in the counties to implement the PBB approach. The PBB approach, according to the same act, aims to achieve two goals:

- Improve the prioritisation of expenditure in the budget to help allocate limited county government resources to those programmes of greatest benefit to the community
- Encourage departments to improve the efficiency and effectiveness of service delivery by changing the focus of public spending from input to output and outcomes

The approach requires that budgets link all financial resources and activities to the outcomes and outputs that will be generated by the budgeting entity. This would ensure a focus more on the targeted outcomes rather than on traditional approaches of incrementing a certain percentage over the existing budget line items.

Study Objectives

The main objective of this study is to assess how national and county governments allocate funds to the health sector and what areas these funds cover. The study aims to provide evidence that can guide national and county policymakers to understand the allocation patterns by different economic and functional areas. It compares data from FYs 2015/16, 2014/2015, and 2013/2014 to help planning officials improve budgeting practices.

Specifically, the study analyses and draws recommendations on the following:

a) The national budgets, to identify and determine the overall budget allocations to the health sector and its application by health care inputs
b) The county budgets, to identify and determine the overall budget allocations to the health sector and its application by health care inputs
c) County comparisons and trend on budget allocations to health
d) National and County Budget allocations to health care inputs

The proportion and volume of government funds allocated to health indicates the level of commitment towards achieving national health goals. Relatively higher public spending on health can lead to improved access to care especially by indigents and vulnerable groups in the society.. It also has the potential to increase the efficiency of healthcare delivery systems if more of the expanded funding is directed towards efficient public health programmes.

Gradual and sustainable health budget expansion is desirable for four reasons:

1) To enable the sector to absorb the impact of expanded administrative costs of devolution and still provide the level of services existing before devolution
2) To realise progress towards achieving the Abuja commitment of allocating 15 percent of the public budget to health
3) To attain faster progress towards realisation of the national goal of universal health coverage
4) To provide a measure of sustainability especially when the expansion is coming from domestic sources

Methodological Approach

This study analysed the national Ministry of Health (MOH) budgetary allocations and county budgets for FYs 2013/14, 2014/15, and 2015/16. The MOH data was obtained from the respective annual estimates, while county budget data was obtained from the Commission for Revenue Allocation, Office of the Controller of Budget; and, in some instances, from the counties. However, the data from other sources have not been validated by the counties and there may be inconsistencies compared with the final actual county budgets. The authors of this study note that, in some instances, gaining access to information in a homogenous form was challenging because counties presented budgets in different formats. For instance, PBBs were completed by just a few counties, and formats are not best suitable to carry out this analysis. To address this issue going forward, there is a need for standard formats for the compilation of health budgets in the counties.

FINDINGS

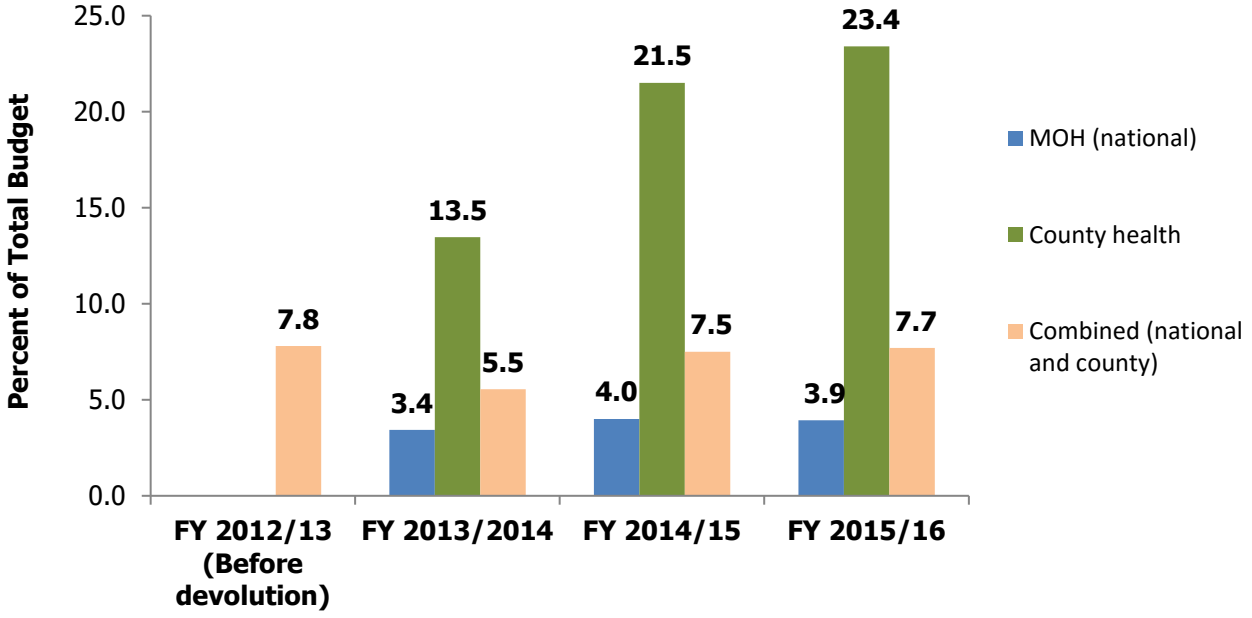
This chapter presents results from the analyses of national and county budgets and allocations to health for fiscal years 2013/14, 2014/15, and 2015/16. It examines how the two levels of government allocated funds to health and how the funds were allocated internally within the health dockets. It also provides comparisons across counties and an analysis of the combined absolute national and county budget allocation to health, including the respective per capita allocations.

Total combined national and county government allocations to health

The national government and each of the 47 counties determine, independently, the amount of funds to be allocated to health from the discretionary budget. While the national government health budget addresses policy-level matters and national strategic programmes, county governments primarily allocate resources for service provision and investment within their localities. An analysis of the combined allocation would therefore provide a complete picture of how budgetary resources are allocated, and would provide an indication of whether the country is moving towards achieving the Abuja Declaration requiring governments to allocate at least 15 percent of their annual budget to health. This section provides an analysis of the combined allocation to health by national and county governments.

The results summarised in Figure 1 show that Kenya is gradually increasing the proportion of its discretionary public budget allocated to health. From 7.8 percent in FY 2012/13, the allocation fell to 5.5 percent in FY 2013/14 at the onset of devolution, and then increased to 7.7 percent in FY 2015/16. This growth is attributed to expanded allocation by counties, which increased by 10 percentage points between FY 2013/14 and FY 2015/16.

Figure 1: Trends in Health Allocations as a Percentage of Total Budget, by Level of Government



National budget allocation to the health sector

The analysis shows that over the last three years, the absolute Total National Government Budget (TNGB) continued to increase, as did the national government's allocation to health. However, the proportion of TNGB allocated to health increased slightly over the same period. Figure 2 presents the TNGB, and the amount and proportion allocated to the MOH over the last three fiscal years.

Figure 2: National Government Budget and Allocation to the MOH, FY 2013/14–2015/16 (excludes Consolidated Fund Services)

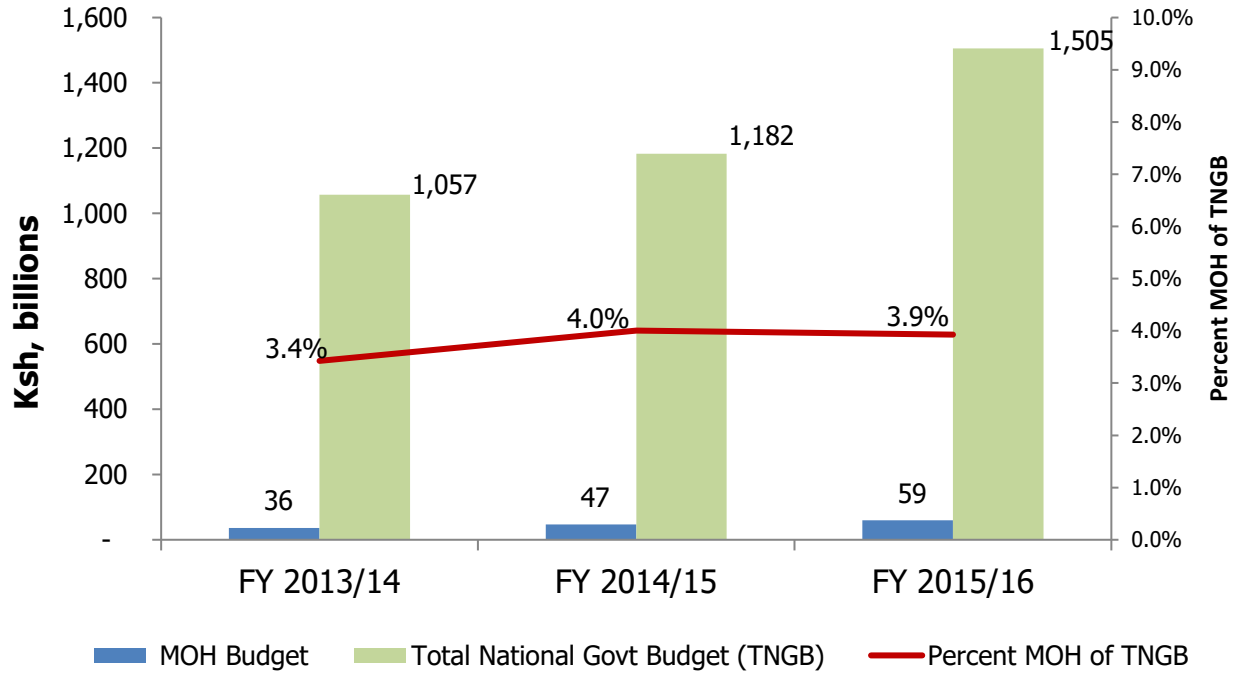


Figure 2 shows that allocation to health by the national government expanded gradually and almost proportionate to the expansion of the national government budget. While the TNGB rose from Ksh 1,057 billion in FY 2013/14 to Ksh 1,182 billion in FY2014/15 and to Ksh 1,505 billion in FY 2015/16, allocation to health increased from Ksh 36 billion in FY 2013/14 to Ksh 47 billion in 2014/15 and to Ksh 59 billion in FY 2015/16. This represents an increase in the proportion allocated to health, at 3.4 percent, 4.0 percent, and 3.9 percent of the total national government budget over the same period.

While the TNGB expanded by 12 percent from FY 2013/14 to FY 2014/15 and by a further 27 percent between FY 2014/15 and FY 2015/16, the total MOH allocation expanded by 31 percent and 25 percent respectively over the same period. This depicts an annual average growth of 28 percent for the health budget, as compared with 20 percent for the national government budget as shown in Table 1.

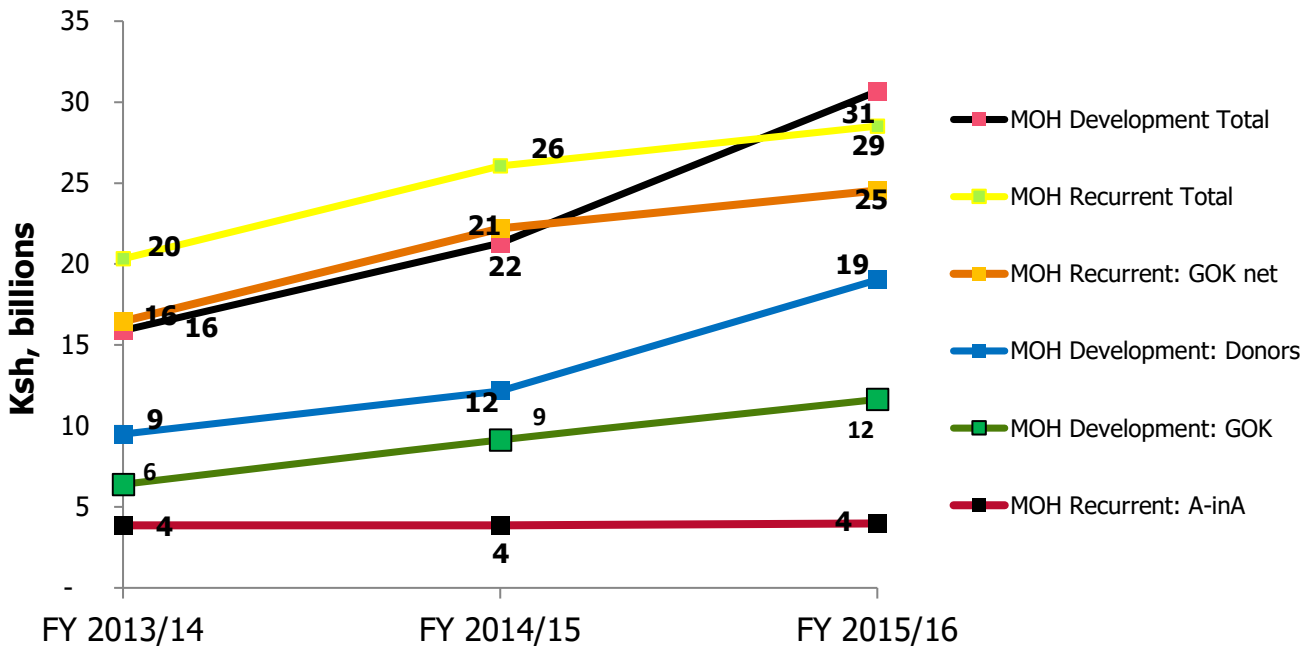
Table 1: Growth of National and MOH Budgets, FY 2013/14–2015/16

	Ksh, millions			Increase in budget allocation (%) between FYs 2014/15 and 2015/16	Average Annual Growth
	2013/14	2014/15	2015/16		
MOH	36,219	47,363	59,184	25 %	28 %
National government	1,057,274	1,182,432	1,505,492	27 %	20 %

MOH Allocation to Recurrent and Development Expenditure

The national government allocates its resources to ministries and other spending units in two budget categories (votes): namely, recurrent and development. The recurrent budget finances recurring costs, including personnel remunerations and operational inputs, while the development budget finances capital formation and investments such as infrastructure, equipment, and (in some cases) capacity development. The recurrent budget is usually funded by the GOK and from the amounts realised internally (appropriations in aid) by the spending units, while the development budget is primarily financed by both GOK and donors. Figure 3 shows the trend in allocation of the MOH budget to recurrent and development budgets, including the amounts sourced from appropriations-in-aid and from donor resources over the FY 2013/14–2015/16 period.

Figure 3: MOH Budget Allocation to Recurrent and Development Expenditure



The MOH was allocated Ksh 20.3 billion, or 56 percent of its proposed total spending, to finance recurrent expenditures during FY 2013/14; Ksh 26.1 billion, or 55 percent, in FY 2014/15; and Ksh 28.5 billion, or 48 percent, in FY 2015/16. Development was allocated 44 percent, 45 percent, and 52 percent of the total health budget during the same fiscal years, respectively. As shown in Table 2, allocation to the development vote is expanding more rapidly compared with the recurrent vote, indicating that additional resources to the MOH are primarily channelled towards development.

Table 2: Percent Increases in MOH Recurrent and Development Allocations, FY 2013/14–FY 2015/16

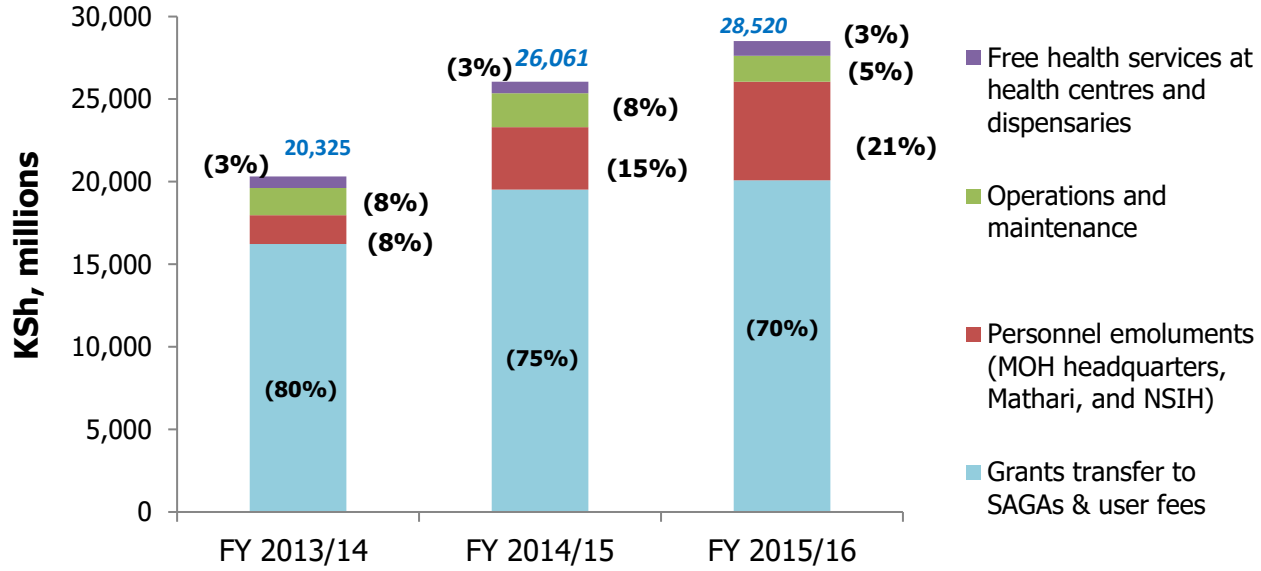
Budget Category Figures in Ksh millions	Financial Year (percent of MOH total)			Increase in budget allocation (%) between FYs 2014/15 and 2015/16	Average Annual Growth
	2013/14	2014/15	2015/16		
Recurrent: all (Percent of MOH total)	20,325 (56%)	26,061 (55%)	28,520 (48%)	9%	18.5%
Recurrent: net	16,463	22,199	24,542	11%	23%
Recurrent: A-in A	3,862	3,862	3,978	3%	1.5%`
Development: all (Percent of MOH total)	15,893 (44%)	21,302 (45%)	30,664 (52%)	44%	39%
Development: GOK	6,395	9,137	11,639	27%	35%
Development: donors	9,498	12,165	(19,025	57%	42%
MOH total	36,219 (100%)	47,363 (100%)	59,184 (100%)	25%	28%

Table 2 also indicates that, although the MOH recurrent budget in absolute figures had annual growth of 18.5 percent, it tends to level to about 9 percent growth in the last year. This indicates that the MOH is not focused on expanding operations since most operations were devolved to the counties. Likewise, the development budget expanded at an annual average growth of 39 percent, with this increase arising from a rapid increase in donor resources, which rose by 57 percent between FY 2014/15 and FY 2015/16.

Analysis of MOH Recurrent Budget Allocations

Approximately Ksh 28.5 billion was allocated to the MOH for recurrent expenses in FY 2015/16, up from Ksh 26 billion allocated in FY 2014/15 and Ksh 20.3 billion in FY 2013/14. Figure 3 shows the allocation of the recurrent budget across four major expenditure items over the three fiscal years.

Figure 3: Allocation of Recurrent Budget by Expenditure Category



Grant transfers to semi-autonomous government agencies (SAGAs), together with user fees (collected by these entities), were allocated Ksh 20.1 billion in FY 2015/16, which constitutes about 70 percent of the total MOH recurrent budget. The figure has risen steadily in absolute terms over the previous two years, from Ksh 16 billion (or 80% of total MOH recurrent) in FY 2013/14 to about Ksh 20 billion (reduced to 75% in relative terms) in FY 2014/15. There was a notable expansion of the budget allocation for personnel emoluments, which increased from 8 percent in FY 2013/14 to 15 percent in FY 2014/15, and then to 21 percent during FY 2015/16. This was because the GOK began paying medical interns across the country, in addition to giving emoluments to staff at the MOH headquarters, the Mathari Referral Hospital, and the National Spinal Injury Hospital. Allocations to operations and maintenance, including training, decreased significantly for FY 2015/16 after an initial increase over the previous two years, perhaps due to scale-down of operations as devolution takes root.

Budget allocations to free services at primary care facilities intended to support abolition of user fees in these facilities increased marginally, to Ksh 900 million in FY 2015/16 from the Ksh 700 million allocated in the previous two years. This increase was intended to upgrade facilities and construct new ones. However, it should be noted that these funds are directly transferred to the counties' revenue accounts and are captured in some county budgets, which may lead to double counting.

SAGAs under MOH

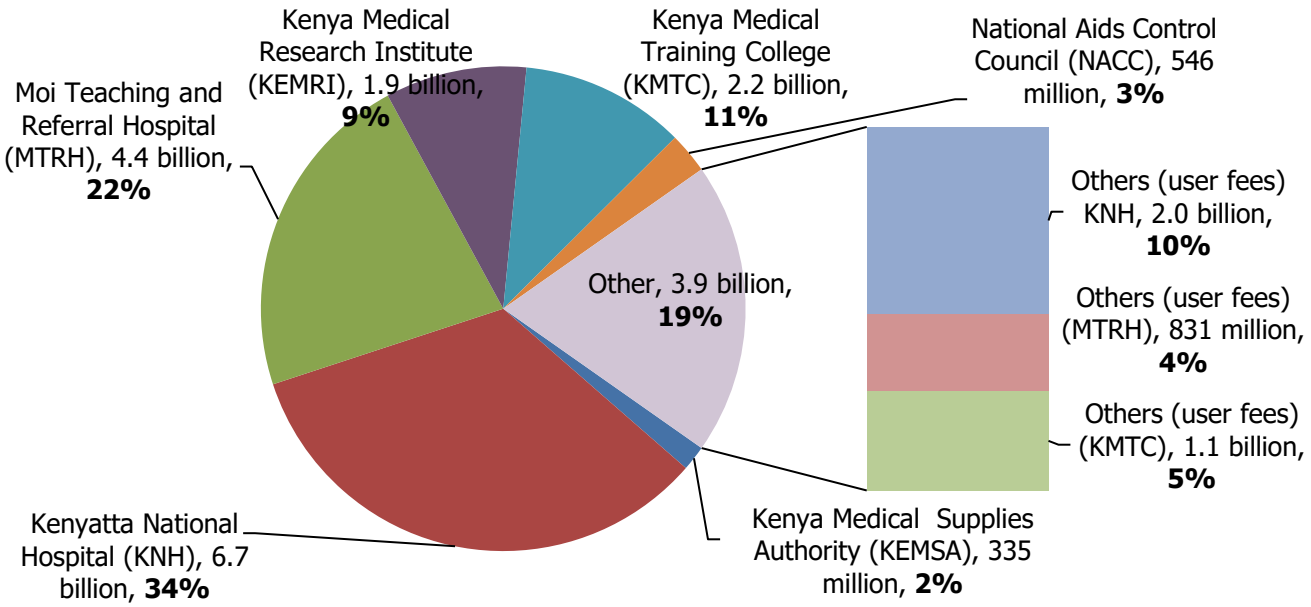
- Kenyatta National Hospital
- Kenya Medical Research Institute
- Kenya Medical Training College
- National AIDS Control Council
- Moi Teaching and Referral Hospital
- Kenya Medical Supplies Authority

Analysis of Recurrent Allocations for SAGAs under the MOH

The recurrent expenditures vote for the MOH also includes the budget for the six SAGAs under the ministry. However, the SAGAs have discretion as to how they can allocate this budget, so long as they remain within the ceiling provided by the MOH, and within the ministry's overall ceiling.

Grants from the government contributed 80.5 percent of the Ksh 20.1 billion allocated by the MOH to SAGAs in FY 2015/16, while the remainder was to be realised from user fees (19.5%). This closely compares to the FY 2014/15 allocation, in which 80 percent of the Ksh 19.1 billion was comprised of grants from the government, while locally generated revenues accounted for 20 percent (Ministry of Health, 2015). Figure 4 below shows the MOH allocation of recurrent budget to SAGAs in FY 2015/16.

Figure 4: MOH Recurrent Budget Allocations to SAGAs FY 2015/16



As seen in Figure 4, Kenyatta National Hospital received the largest allocation (34% grants and 10% user fees), accounting for 44 percent of the total grants to SAGAs during FY 2015/16, followed by Moi Teaching and Referral Hospital (22% grants, 4% user fees). Both hospitals are key deliverers of national referral services (a mandate of the national government), and constituted over 40 percent of all MOH allocations.

Kenya Medical Training College was allocated 11 percent and received 4 percent in A-in-A, for a total of 15 percent of all allocations to SAGAs. Among all SAGAs, this hospital had the highest grant to A-in-A ratio, where the institution was expected to raise 33 percent of the proposed expenditure.

The Kenya Medical Supplies Agency received the smallest allocation, at only 2 percent. These funds are primarily intended to support personnel and operational costs, rather than the stocks of drugs and supplies that are budgeted under purchasing institutions.

MOH Development Budget

The MOH development budget includes both funds provided by the national government and loans and grants from donors. The amounts and proportions contributed from each source between FY 2013/14 and FY 2015/16 are presented in Table 3.

Table 3: MOH Development Budget Appropriation, FY 2013/14–2015/16

Sources	*FY 2013/14*	*% of total*	*FY 2014/15*	*% of total*	*FY 2015/16*	*% of total*
GOK	6,395,355,964	40%	9,137,000,000	43%	11,639,519,940	38%
Donors	9,498,000,000	60%	12,164,511,786	57%	19,024,846,894	62%
Loans	2,303,000,000	14%	1,704,000,000	8%	5,176,445,000	17%
Grants	7,195,000,000	45%	10,461,000,000	49%	13,848,401,894	45%
MOH development total	15,893,355,964	100%	21,301,511,786	100%	30,664,366,834	100%

Overall, donors' contribution to the MOH development budget increased from 60 percent in FY 2013/14 to 62 percent in FY 2015/16. Conversely, the GOK contribution decreased overall, from 40 percent to 38 percent, during the same period. Data in Table 3 highlights the rapid increase in loan contributions, from 8–17 percent from FY 2014/15 to FY 2015/16.

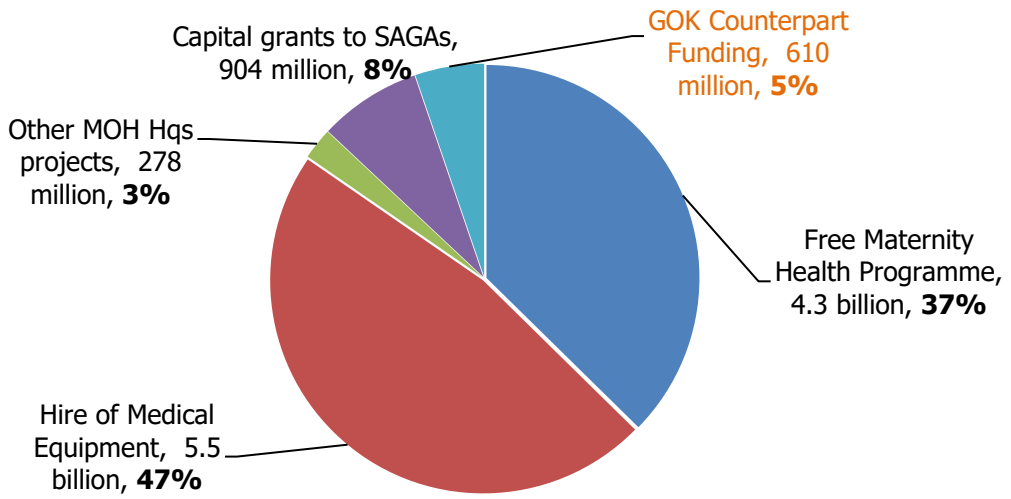
Even if GOK resources contribute only 38 percent of the development budget, they represent a more reliable and stable source of resources than donor funds, which are dependent on various funding agreements and whose frequency and timing may be unpredictable. Development programmes funded through GOK resources are therefore more likely to be sustainable as long as they remain a priority in the government's agenda.

MOH Development Budget Allocation to Programmes

Allocation of GOK Development Resources

Figure 5 shows the key areas, amounts, and percentages for which GOK resources were allocated under the development budget for FY2015/16.

Figure 5: GOK Development Budget Allocation to Key Areas in FY 2015/16



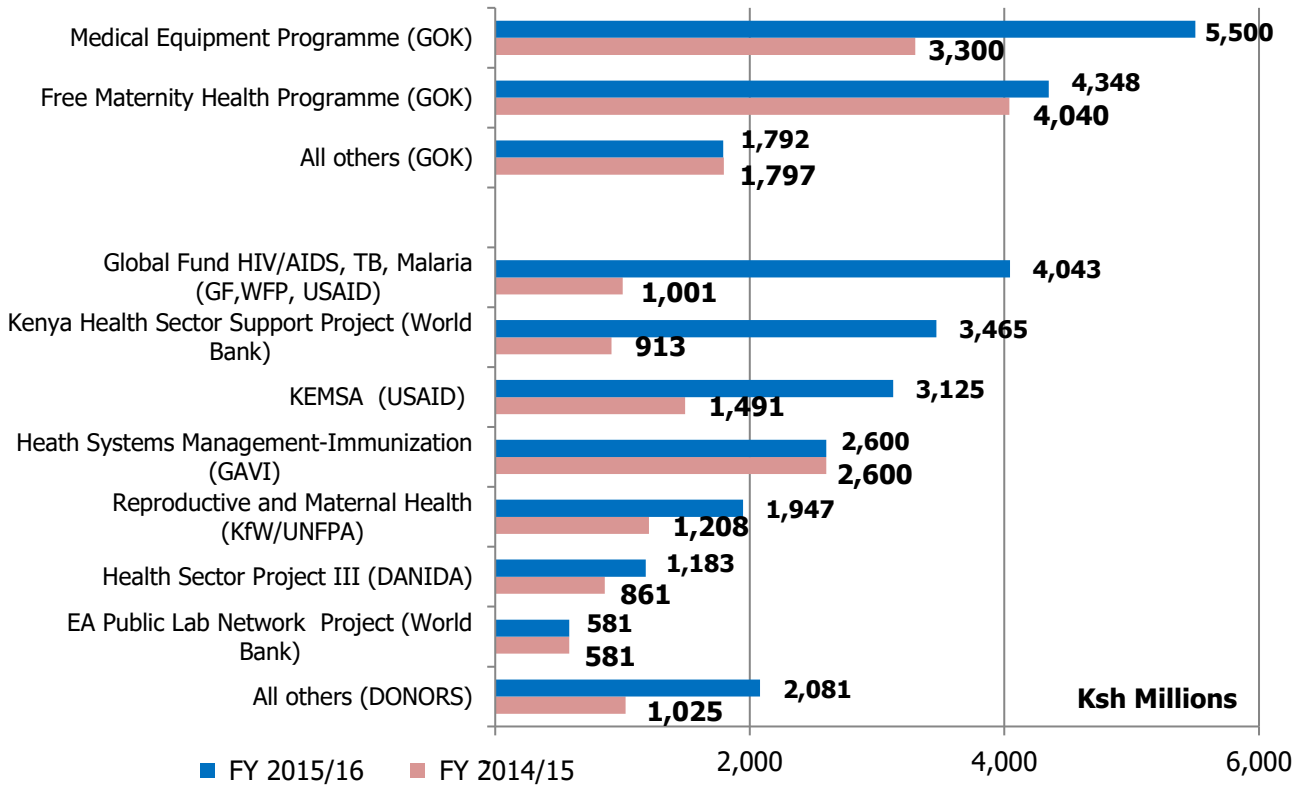
The MOH earmarked a significant proportion (84 percent) of the GOK development budget to the medical equipment and free maternity services programmes. The medical equipment programme, allocated 47 percent of the budget, intends to equip 94 hospitals (two per county in levels 4/5) with equipment to improve access to high-quality healthcare. The allocation to the free maternity health programme (37 percent) is intended to reimburse facilities that provide free maternity care, in order to increase access to facility-based skilled deliveries (equity) and mitigate high national maternal mortality rates.

The remaining 16 percent was earmarked for GOK capital grants to SAGAs (Ksh 904 million), the government's contribution to donor-funded programmes (counterpart funding) (Ksh 610 million), and capital development projects under the MOH headquarters (Ksh 228 million).

MOH Overall Allocations to Programmes, FY 2014/15 and FY 2015/16

Figure 6 (overleaf) presents the MOH overall development budget allocations to various programmes, sources of funding, and a comparison of the amounts provided in FYs 2014/15 and 2015/16.

Figure 6: MOH Development Budget Allocations to Programmes, FY 2014/15 and FY 2015/16



From the analysis presented in Figure 6, it can be observed that

- Combined allocation to reproductive and maternal health programmes, including the free maternity care programme, increased from Ksh 5.3 billion in FY 2014/15 to 6.3 billion in FY 2015/16. These figures represent 27.9 percent and 20.5 percent, respectively, of all GOK and donor resources budget allocations over the same period. This is an indication of the MOH's high prioritisation of and commitment to the improvement of maternal health.
- Allocation for medical equipment increased from Ksh 3.3 billion in FY 2014/15 to Ksh 5.5 billion in FY 2015/16. The programme received a relatively high development budget allocation, and is the leading priority for the government-provided development budget for the MOH. Allocation for the programme constitutes 17.5 percent and 17.9 percent of the entire development budget in FYs 2014/15 and 2015/16, respectively.
- HIV is also a leading priority and ranks third in budget allocation among other programmes. The combined allocation for HIV, tuberculosis, and malaria increased from Ksh 1.0 billion to Ksh 4.0 billion from FY 2014/15 to 2015/16, constituting 5.3 percent and 13.3 percent of the entire development budget in the two years, respectively. However, the entirety of the funding came from the Global Fund, the World Food Programme, and USAID.
- Immunisation and related health systems support receives priority in budgeting, with a steady allocation from the Global Alliance for Vaccines and Immunization initiative of Ksh 2.6 billion during the two financial years. This constitutes 13.8 percent and 8.5 percent of the total MOH development budget for FYs 2014/15 and 2015/16, respectively.

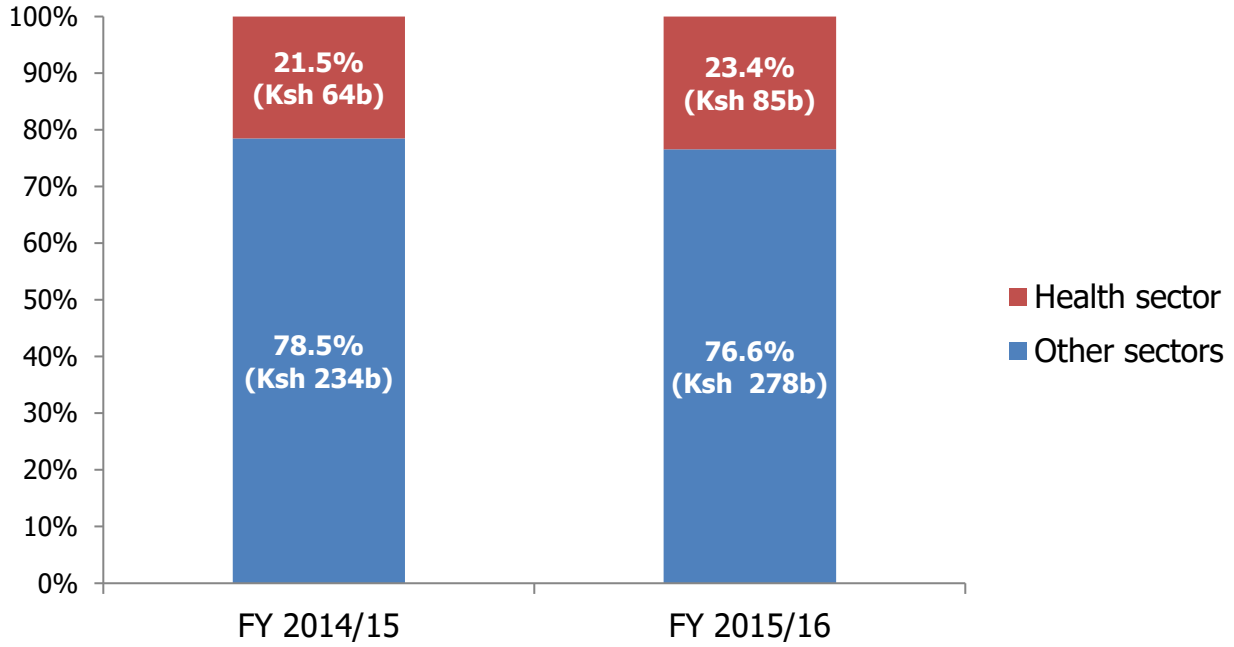
Counties budget allocation to the health sector Under devolution, county governments became responsible for a range of health services, including primary healthcare facilities, dispensaries and health centres, and some hospitals. The major source of financing for counties remains transfers from the national revenues, which are shared among counties on a needs-based formula. Additional revenues are realised from user charges on services provided at public health facilities (among other levies) at the county level. Counties are

informed by PFMA guidelines on how to allocate between recurrent and development expenditures on their global budgets (30/70), but such allocation within the health docket is not bound by these guidelines. This section presents results from the analysis on how counties allocate funds to health.

County Governments' Allocation to Health

The ratio of health budget to total county budget indicates the level of priority that county governments place on the health sector and how committed they are to improving health indicators in their counties. This section examines county governments' allocations to health against the overall total county budgets for FYs 2014/15 and 2015/16. Figure 7 provides the proportion of the total health budget as a percent of the total county budgets for FYs 2014/15 and 2015/16.

Figure 7: County Governments' Allocation to Health versus Other Sectors, FYs 2014/15 and 2015/16

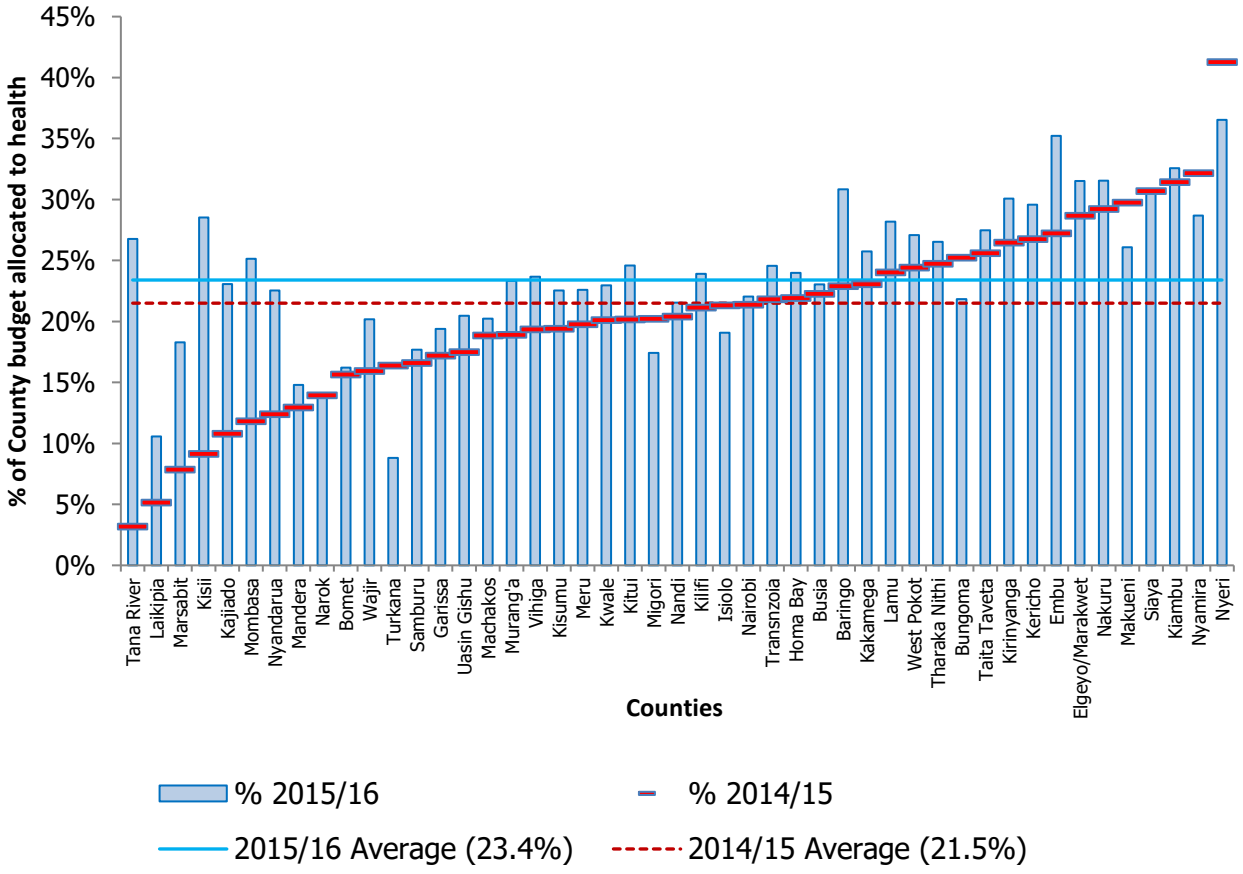


As shown in Figure 6, county governments' health budgets increased from Ksh 64 billion in FY 2014/15 to about Ksh 85 billion in FY 2015/16, an increase of 32.8 percent. Additionally, counties increased the proportion of their total budgets allocated to health, from 21.5 percent in FY 2014/15 to 23.4 percent in FY 2015/16. This indicates that county governments increasingly prioritise health despite competing needs from other sectors.

Allocations to Health by County

The analysis found differences in the levels of county budgets allocated to health. Figure 8 (overleaf) presents the percentages of total budgets allocated to health in different counties in FY 2014/15 and FY 2015/16, drawn from available data.

Figure 8: Percentage of Total County Budgets Allocated to Health by County, FYs 2014/15 and 2015/16



On average, 23.4 percent of county budgets were allocated to health in FY 2015/16, an increase from the previous year's allocation of 21.5 percent. 40 out of 47 counties increased the percentage allocated to health over the two-year period. These results show that the top five counties (Baringo, Embu, Mombasa, Kisii, and Tana River) increased their health budgets by more than 5 percentage points. Seven counties (Turkana, Migori, Isiolo, Bungoma, Nakuru, Nyamira, and Narok) reduced their percentage allocation to health from FY 2014/15 to FY 2015/16, with three (Turkana, Migori, and Isiolo) allocating below the national average.

Recurrent versus Development Allocations

Aggregate County Recurrent and Development Budget Allocations

Counties' recurrent budgets for health services have been consistently high over the last three fiscal years. There were, in nominal terms, increases in both recurrent and development allocations in FY 2015/16 compared with FY 2014/15 (Table 4). However, counties increased the percentage allocated to the development vote as a percent of their total county health budgets, from 25 percent in FY 2014/15 to 28 percent in FY 2015/16. Overall, allocating nearly one-quarter of the health budget to development reflects the counties' determination to invest more in health.

Table 4: Levels and Shares of Allocations to County Health Services by Year

Vote	FY 2014/15		FY 2015/16	
	Ksh millions	% of total county health budget	Ksh millions	% of total county health budget
Recurrent	48,052	75	60,592	72
Development	15,964	25	23,916	28
Total	64,017	100.0	84,508	100

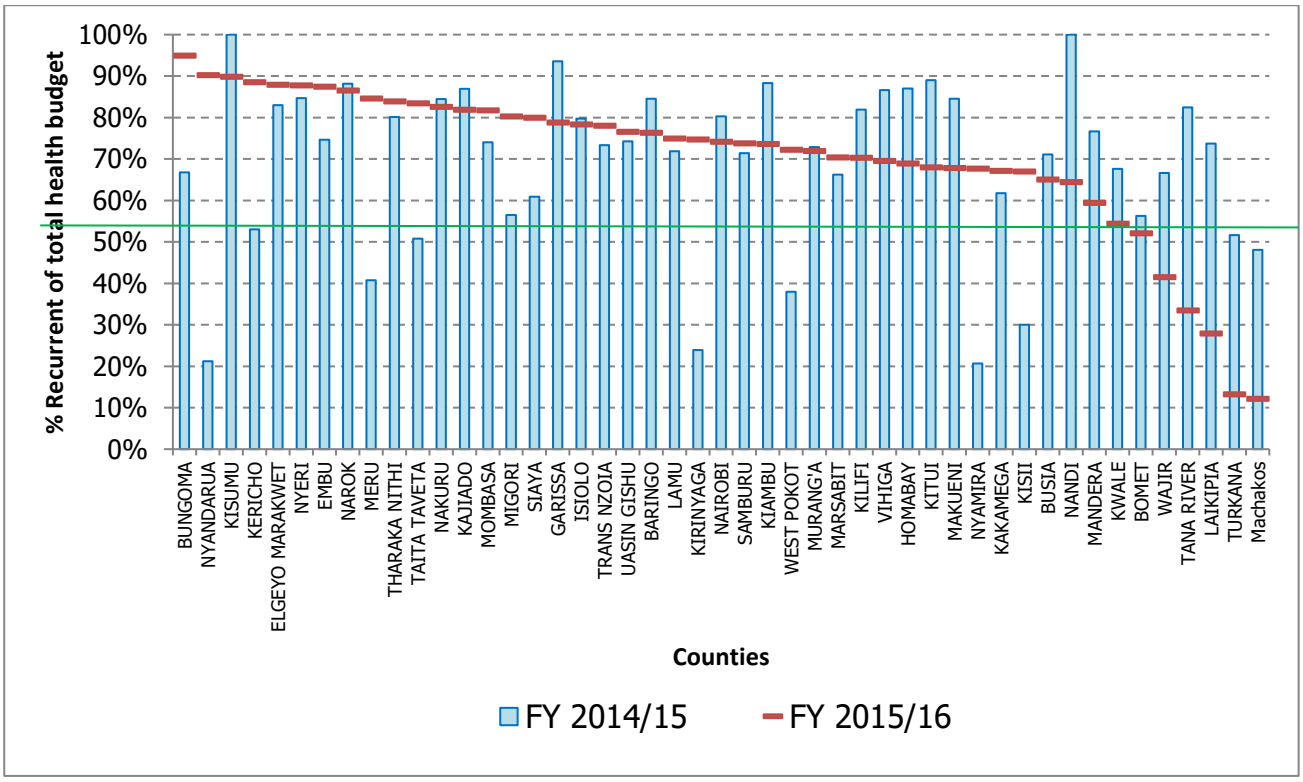
Source: Republic of Kenya, Office of Controller of Budget. 2015. *County Budgets 2013/14 and 2014/2015 and Budget Implementation Review Report 2015/16*. Nairobi: Republic of Kenya.

Recurrent Versus Development County Health Budget

The recurrent-to-development budget ratio is an important tool to measure county governments' efforts to balance development and recurrent components of health sector budgets for the most effective delivery of services. PFMA 2012 recommends that counties allocate at least 30 percent of their budgets to development and 70 percent or less to recurrent budgets.

Figure 9 presents the recurrent allocations by counties as a percentage of their total health allocations for FY 2014/15 and FY 2015/16. Data sources—particularly for some counties which included personnel emoluments for health workers in the budget of other departments—may explain the extremely low percentage of the total given to recurrent budget allocations in FY 2015/16.

Figure 9: Recurrent Allocations as a Percentage of Health Allocations by County, FYs 2014/15 and 2015/16



For FY 2015/16, 28 counties allocated more than the recommended threshold of 70 percent to recurrent expenditures, with 13 exceeding 80 percent. This may imply that inadequate resources were allocated for health investment. On the other hand, five counties allocated less than 50 percent of their health budget to recurrent expenditures, thus dedicating over 50 percent to development.

Bungoma, Kisumu, and Nyandarua counties allocated the highest estimated budget share to recurrent expenditures (or the lowest share to development expenditures), while Machakos, Turkana, and Laikipia counties had the highest budget share for development expenditure provisions. However, compared with FY 2014/15, more counties in FY 2015/16 moved towards reducing the share of their budgets allocated to the recurrent vote.

Allocations by Economic Categories

While county health departments do not directly determine the aggregate amounts to be allocated to health, these units have a significant role in determining allocations within the department to specific input items. An analysis of budgetary allocations by key health inputs provides an indicative assessment of whether health inputs are balanced to achieve technical and operational efficiency in service delivery. Further, counties are gradually moving towards implementing the programme-based approach (and formats) in the budget-making process, where allocations (among other things) are classified according to specific economic categories and input items. This section examines how counties allocated health recurrent and development budgets to selected health inputs.

Data obtained from county budgets indicate that counties face challenges in disaggregating and presenting their budgets by programme, as prescribed:

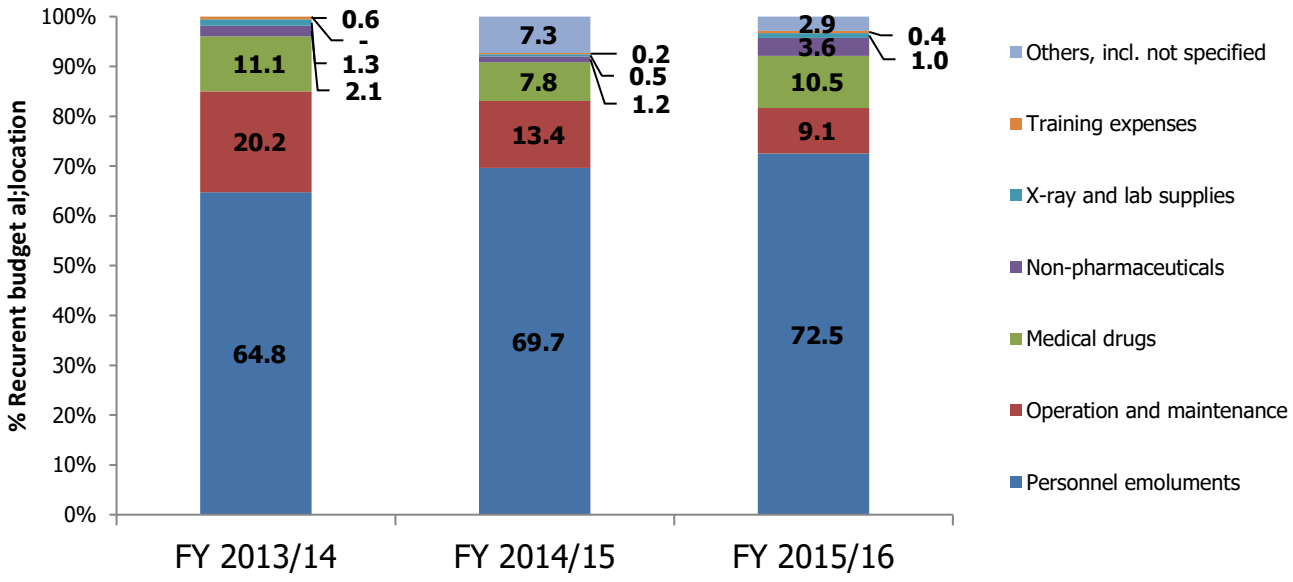
1. Within their health budgets, counties pool essential health inputs like drugs and other essential medical supplies under "Operations and Maintenance/Use of goods and services." Even though this is a standard classification item under the PBB approach, counties are expected to break down the item further and present an itemised budget. In order to compare the results with previous analyses without affecting their validity, this analysis excluded 11 counties (Bungoma, Kakamega, Marsabit, Mombasa, Nakuru, Nyandarua, Samburu, Siaya, Taita Taveta, Tharaka Nithi and Trans Nzoia) whose drugs and medical supplies items were lumped under the operations and maintenance items.
2. Misclassification between recurrent and development: In order to be comparable with previous fiscal years' analyses for the purpose of this analysis, allocations that included drugs and non-pharmaceuticals were harmonised by moving them to the recurrent budget, with capital items moved to development budgets.

To present an accurate situation regarding county budget allocations by economic categories, budgets from 27 counties whose data was appropriately broken down, complete and can compare with previous' years analysis was used for the analysis.

Allocations of Recurrent Budget to Economic Categories

Figure 10 presents the pattern and trend of county governments' health budget allocations to economic categories for FYs 2013/14, 2014/15, and 2015/16. The data shows that personnel emoluments got the largest share of counties' recurrent budgets, and that the proportion has gradually expanded to reach 72.5 percent in FY 2015/16. Budget allocations for drugs and other essential health supplies (e.g., x-rays and non-pharmaceuticals) as a percent of the total health recurrent budget dropped from 14.5 percent in FY 2013/14 to 9.5 percent in FY 2014/15, before rising to 15.1 percent in FY 2015/16. Allocations for operations and maintenance as a percent of the total health recurrent budget declined from 20.2 percent in FY 2013/14 to a low of 9.1 percent by FY 2015/16. This drop, and the increased allocation to drugs, may be due to improved classification of allocations to specific items (from operations and maintenance and from the "Unspecified/Other" category).

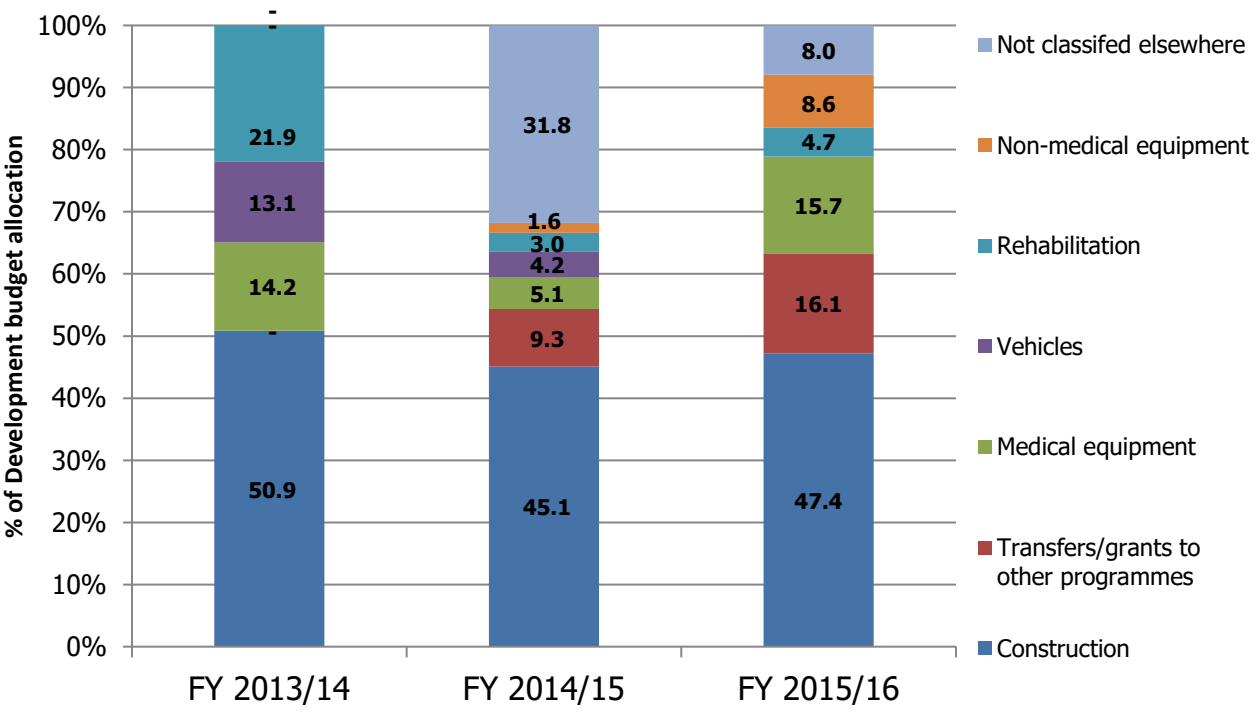
Figure 10: County Health Recurrent Budget Allocations (%) by Economic Category, FYs 2013/14, 2014/15, and 2015/16



Allocation of Development Budget by Economic Categories

The development budget is envisaged to cater to non-recurrent capital items such as construction, equipment, and other items whose utilisation is long-term. Figure 11 presents findings on how counties allocated the health development budget over a three-fiscal years period, shown by economic categories.

Figure 11: County Health Services Development Budget Allocations (%) by Economic Categories, FYs 2013/14 and 2014/2015

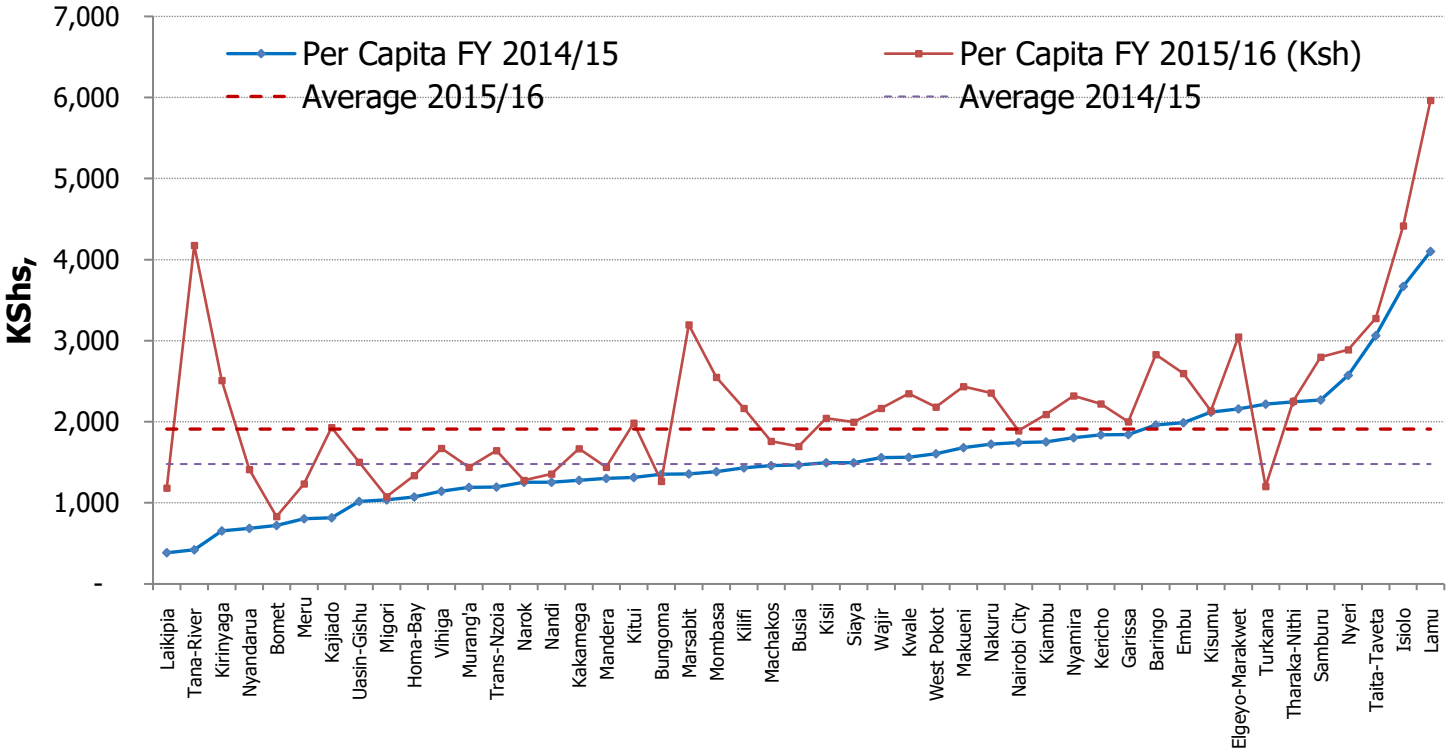


From FY 2014/15 to FY 2015/16, counties significantly expanded their allocations to construction and medical equipment. The proportion allocated to these two items increased from 50.1 percent of the total health development budget in FY 2014/15 to 63.1 percent in FY 2015/16. There was also rapid growth in the proportions allocated to non-medical equipment (including vehicles for FY 2015/16) and staff transfers.

Per Capita Allocations on Health, by County

The analysis shows that county governments' health budget per person in FY 2015/16 was Ksh 1,910 (US$20[1] then), an increase of 29 percent from KSh 1,479 (US$17.2) in FY 2014/15. While this increase is commendable, there were variations within counties in FY 2014/15 and FY 2015/16 (Figure 12).

Figure 12: Counties' Per Capita Allocation to Health



The data shows that most counties increased their per capita allocation from FY 2014/15 to FY 2015/16. Specifically:

- Nine counties (Machakos, Lamu, Isiolo, Taita Taveta, Nyeri, Elgeyo Marakwet, Samburu, Tharaka Nithi, and Turkana) allocated over Ksh 2,000 per capita during FY 2015/16.
- Six counties (Tana River, Kirinyaga, Kajiado, Laikipia, Marsabit, and Nyandarua increased their per capita allocation to health by over 100 percent from FY 2014/15 to FY 2015/16. These six counties, with the exception of Marsabit, had previously allocated quite low per capita amounts (below Ksh 1,000). This may indicate that these counties have realised that they previously under-funded health.
- Eight counties (Bungoma, Garissa, Kisumu, Migori, Nairobi City, Narok, Taita Taveta, and Turkana) registered minimal percent increases, or decreases, in per capita allocation. With the exception of Taita Taveta and Turkana, these counties allocated, on average, Ksh 1,910 per capita.

[1] US$ = Ksh 95.5 in July 2015, and Ksh 86.0 in July 2014

CONCLUSION AND RECOMMENDATIONS

Conclusion

From this analysis, it is evident that both national and county governments were committed to increasing—in absolute and relative terms—their budgetary allocations to health, and thus increasing the amount of public funding for the health sector during the review period. Although there were noticeable variations between counties, over all this reflects ... the high priority given to health by the governments in general, and the place that health now occupies in the national debate. Increasing public health spending has value for both equity and efficiency if properly targeted. From the analysis, the allocation trend appears favourable and may this may persist into the near future (at-least going by the recent trends).

The analysis also shows that donor contributions to the national development budget for health grew over the review period, all going specifically to priority programmes. This indicates overt reliance on donor funding for programmes of national priority, and raises concerns about the predictability and sustainability of these programmes. The results also show low allocations by counties to activities implemented under national programmes such as HIV and AIDS, immunisation, and family planning—all of which are important to the improvement of health outcomes at the county level but remain almost entirely donor-funded.

The analysis also found a predominance of recurrent over development expenditure estimates across the counties, but there are indications that counties are moving further towards expanding and consolidating health services in their locales. Overall, counties increased their per capita allocations to health. As the results show, most of the counties' recurrent budget is locked to personnel emoluments, leaving little to support other essential inputs to health service delivery. In order to achieve the Abuja target and successfully implement planned projects, it is important for the national and county governments to continue prioritising the health sector in budget allocations. Counties also appear to have problems with classification of budget allocations across recurrent and development categories and across expenditure categories, which may be the result of a lack of clarity or adherence to official budgeting guidelines. Such failure by counties to use the same approach in allocation poses challenges to a cross-sectional data comparisons and in analysing the trends.

Recommendations

In the light of these findings, this study makes the following recommendations:

a) National and county governments should strive to increase allocations to health to surpass the pre-devolution levels and edge closer to Abuja targets.
b) Counties, as the principal public health service delivery agents, should endeavour to increase resources allocated for health. County governments should also ensure that funds allocated as conditional grants for health are fully allocated to that sector as supplementary allocation, which has not been the case.
c) Counties should improve their budget formulation process and use it as a tool for improving service delivery; in particular, they should strive towards balanced budgets.
d) To improve the budgeting process and build the capacity of counties, the MOH should adapt the PBB approach and tools to a format that can facilitate budget analysis. Close linkages between the Due to the inherent weak budgeting at the county levels, MOH and county health budgeting units should be established and maintained during budgeting process for two purposes:

    - To share information, approaches, and tools on health budgeting and facilitate joint assessment and compilation of public health sector budgeting status
    - To support counties with mentorship during the budget-making process with a view towards providing support for resource advocacy

Concerning personnel emoluments, the data shows that proportions allocated are high and have been expanded gradually to reach 72.5 percent in FY 2015/16. However, this study notes that these costs are fixed and counties have little flexibility to reduce this proportion in the short run.

Box 1: Programme-based Budgeting

Programme-based budgeting (PBB) refers to a budget organised around a set of programmes. A programme is a group of government activities that help to achieve a common objective. In general, PBB has many advantages. Specifically, it

1. Helps policymakers focus on goals and brings clarity around programme- and evidence-based policy choices
2. Allows managers to work with clearly defined expectations, and have flexibility for innovation and performance
3. Shifts the focus from inputs to outputs/outcomes
4. Focuses on performance information
5. Helps justify choices among competing priorities
6. Enables the public to link public funds and provided services
7. Gives programme management a tool to
    a. Integrate resources and objectives
    b. Focus on economy, efficiency, and effectiveness
    c. Make performance measurement central to budgeting

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