NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS FY 2016/17

Ministry of Health
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ACKNOWLEDGEMENT

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 also measures the alignment of resource allocations to the governments’ health policy priorities.

This report, a follow-on to the *National and County Health Budget Analysis FY 2015/16*, continues the examination of how public health sector financial resources were allocated in fiscal year 2016/17. The study used data from appropriate sources, including the Commission for Revenue Allocation, the Office of the Controller of Budget, the National Treasury, and the Ministry of Health; and from the counties.

The findings provide information that national and county policymakers and other decision-makers can use to establish the level of resources allocated to public health, and can serve as a tool for securing additional funds. Policymakers and other decision-makers can also use these findings to determine 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 others. 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 the *National and County Health Budget Analysis FY 2016/17* 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.

The study was conducted by a Ministry of Health team led by Elkana Onguti, chief economist and Terry Watiri, economist. Technical assistance was provided by Robinson Kahuthu, HP+ senior policy advisor. Technical review was provided by Stephen Muchiri, HP+ Kenya/East Africa project director and Thomas Maina, HP+ senior health financing advisor. Editorial review was provided by Monica Wanjiru, HP+ communications advisor.
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>FY</td>
<td>fiscal year</td>
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<tr>
<td>GOK</td>
<td>Government of Kenya</td>
</tr>
<tr>
<td>Ksh</td>
<td>Kenya shilling</td>
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<tr>
<td>MDA</td>
<td>ministries, departments, and agencies</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>PBB</td>
<td>programme-based budgeting</td>
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<td>PFMA 2012</td>
<td>Public Finance Management Act of 2012</td>
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<td>SAGAs</td>
<td>semi-autonomous government agencies</td>
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<td>TNGB</td>
<td>total national government budget</td>
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<td>USD</td>
<td>United States dollar</td>
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EXECUTIVE SUMMARY

Budgets are definitive instruments that detail planned government spending, and are indicators for the implementation of policies, priorities, programmes, and activities over a specific financial period. In Kenya, government budgets are a legal requirement. The budget process is defined by the Constitution and elaborated in the Public Finance Management Act of 2012. Ministries, departments, and agencies of the national and county governments develop budgets following set guidelines, which are then approved by the respective legislative bodies. Beginning in the 2015/16 fiscal year (FY), both levels of government are required to adopt a programme-based budgeting (PBB) approach. This study looks at how and to what health sector priority areas national and county governments allocated funds in FY 2016/17. The study aims to provide evidence that can help national and county policymakers understand allocation patterns by different economic and functional areas.

Total Government Budget Allocation to Health

The proportion of the combined discretionary public budget allocated to health by national and county governments during FY 2016/17 decreased to 7.6 percent from 7.7 percent the preceding year, below the pre-devolution level of 7.8 percent and below the Abuja declaration target of 15 percent. Previously, there had been a gradual increase from 5.5 percent in FY 2013/14 to 7.7 percent in FY 2015/16. While national government allocations to health flattened to about 7.6 percent over the FYs 2013/14 to 2016/17 period, county governments maintained a gradual increase from 13.5 percent to 25.2 percent over the same period.

National Budget Allocations to the Ministry of Health

In FY 2016/17, the Ministry of Health was allocated Ksh 60 billion out of the national government’s total budget of 1,505 billion. This is equivalent to 3.7 percent, a decrease from the 3.9 percent allocated in FY 2015/16 and 4.0 percent allocated in FY 2014/15. This shift indicates a downward trend in the proportion of government budget allocated to health.

Ministry of Health Budget Allocations

The Ministry of Health has maintained the allocation for recurrent expenditure at 48 percent of its total budget in both FYs 2015/16 and 2016/17, a decrease from the 55 percent allocated in FY 2014/15. The decrease is attributed to the fact that many of the recurrent service delivery functions in health were devolved to the counties. Absolute allocation to the recurrent budget increased by 2 percent between FYs 2015/16 and 2016/17, a decrease from an annual average of 5.7 percent over previous three-year period. As devolution continues, more funding will shift from the Ministry of Health to the county level.

In absolute terms, the Ministry of Health allocated Ksh 29.1 billion to the recurrent budget in FY 2016/17, with most of it going to grant transfers to the seven semi-autonomous government agencies under the ministry, which consumed 70.4 percent (or Ksh 20.5 billion). The two tertiary and specialized care hospitals, Kenyatta National Hospital and Moi Teaching and Referral Hospital, and health training under the Kenya Medical Training College were allocated Ksh 17.2 billion or almost 60 percent of the Ministry of Health’s recurrent budget.

Donors contributed 63.4 percent (or Ksh 19.8 billion) of the Ministry of Health’s development budget of Ksh 30.7 billion in FY 2016/17, up from 62 percent or Ksh 19.0 billion in FY 2015/16. Much of the donor funding was allocated to HIV, reproductive health, immunisation, and health systems support. In contrast, the government’s contribution to the health development budget amounted to 36.6 percent of the Ministry of Health’s development budget allocation (or Ksh 11.4 billion) in FY 2016/17, down from Ksh 11.6 billion in FY 2015/16. In FY 2016/17,
most of this money was allocated to the medical equipment services programme (39%) and the free maternity care programme (38%).

**County Governments Allocation to Health**

In FY 2016/17, county governments increased allocations to health as a percent of total county budgets to 25.2 percent (or Ksh 92 billion), up from the previous year’s 23.4 percent (or Ksh 85 billion). While this indicates an increased commitment to health by county governments, the allocation is still below pre-devolution levels. The top five counties that allocated the highest proportion to health include Elgeyo Marakwet, Nakuru, Kiambu, Baringo, and Siaya. The lowest five are Mandera, Bomet, Turkana, Samburu, and Wajir. However, most counties (33 out of 47) increased the proportion of their budget allocated to health between FYs 2015/16 and 2016/17. The share of the county health budget allocated for recurrent expenditure increased from 72 in FY 2015/16 to 79 percent in FY 2016/17 against the recommended 70 percent.

A further breakdown of the data shows that there was a decrease in the proportion of the recurrent budget allocated to personnel expenses from 72.5 percent in FY 2015/16 to 70.6 percent in FY 2016/17. The allocation to drugs and other essential medical supplies decreased from 15.1 percent in FY 2015/16 to 14.6 in FY 2016/17. Construction and rehabilitation of buildings and medical equipment received the largest share of the development budget in FY 2016/17, indicating that counties give priority to expansion and consolidation of physical infrastructure.

Overall, counties increased their average per capita allocation to health from Ksh 1,910 in FY 2015/16 to Ksh 2,020 in FY 2016/17. In FY 2016/17, the five counties with the highest per capita allocation were Lamu, Isiolo, Marsabit, Elgeyo Marakwet, and Baringo while the bottom five were Bomet, Bungoma, Meru, Nandi, and Mandera. Overall, 30 out of 47 counties increased their per capita health budget allocation.

**Conclusions and Recommendations**

The results of the budget analysis show that national and county governments are allocating more funds in absolute terms and increasing the public budgetary resources available to the health sector. However, donor funding for key programmes like HIV, tuberculosis, and malaria decreased in absolute terms in FY 2016/17 from previous levels and the national government’s reliance on this source of funding is not sustainable.

County health budgets are still low, rest below the recommended proportion of 35 percent in the pre-devolution period, and continue to be dominated by recurrent expenditure, most of which goes to personnel emoluments, raising concerns about efficiency in service delivery. The county comparisons show that counties do have the capacity to increase the proportion of the budget allocated to health. However, counties also appear to have capacity and structural challenges in the budget making process, as observed from the budgets submitted for FY 2016/17.

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

- National and county governments should increase allocations to health to surpass the pre-devolution levels and move closer to Abuja targets. There is more space for health budget expansion in the counties, which county governments should use to increase health budgets.
- At the national level, the Ministry of Health should increase the development budget allocations from Government of Kenya resources to reduce over-reliance on donors and reduce the gaps arising from decreasing donor funding. This is especially true for HIV, tuberculosis, and malaria programmes.
• Counties should continue increasing the proportion of the budget allocated to health, especially in Mandera, Bomet, Samburu, Wajir, Tana River, Narok, Nyandarua, Busia, and Marsabit counties.

• Counties need to increase allocations to development, especially the six counties of Muranga, Nyeri, Taita Taveta, Bomet, Embu, and Kericho, which had the lowest allocations to development.

• Although it may be difficult to accomplish in the short run, counties must strategise how to bring down the allocation to personnel emoluments to the recommended 50 to 60 percent of the recurrent budget.

• County governments need to rationalise their development budgets to limit the growth observed in allocation for construction.

• The National Treasury and the Office of the Controller of Budget should ensure that budget information is standardised across counties for ease of comparison. They should also strengthen the capacities of counties in budgeting in order to bridge the serious capacity gaps observed.
INTRODUCTION AND METHODS

This analysis focuses on the public health sector budgets for national and county governments for fiscal year (FY) 2016/17 and compares them with FYs 2014/15 and 2015/16. Budget analysis provides deep insights and purposeful enquiry, which can reveal inadequacies and inefficiencies 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 the health sector budgets can help diagnose the equitability, efficiency, and sustainability of the health system.

This report first sets the contextual background, covers the objectives of the budget analysis and the methodological approach, and then presents detailed findings and recommendations from the analysis, with the aim of strengthening the devolved health system structures.

**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 (Kenya Vision 2030 and the Kenya Health Policy, 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 adequately and efficiently allocate the resources needed for public sector health delivery systems.

National and county governments’ annual health budgets guide how money is spent in the public health sector in a given year. The budgeting process is provided for within Kenya’s constitutional, legislative, and other public financial legal frameworks. The Constitution (Sections 220–224) requires budgets for national and county governments and the Public Finance Management Act 2012 (PFMA 2012) defines the roles and responsibilities of the various institutions involved in budgeting and the procedures to be followed in the process. The law also requires that budgets incorporate input from the public and other national- and county-level stakeholders. Article 201 of the Constitution outlines the principles of public financing and requires openness, accountability, and public participation in the process.

**The Budgeting Process**

According to the PFMA 2012, the National Treasury develops indicative, aggregate budget proposals for national spending based on the economic outlook and expected revenues, other monies anticipated as appropriations in aid, and fixed commitments of consolidated funds. The aggregate budget, which is composed of government revenues, donor resources, and revenues generated by operating units, is then shared between national and county governments and other independent constitutional bodies, based on agreed proposals made by the Intergovernmental Economic and Budget Council and approved by Parliament. The national and county governments are given indications for the amounts they can allocate for their sectors and institutions, including health. Inter-county allocations are determined by a
formula developed by the Commission on Revenue Allocation and approved by Parliament every five years. Figure 1 presents the overall resource sharing framework.

**Figure 1: Kenya’s Financial Resources Sharing Framework**

There are significant competing needs for resource allocation within the various sectors at national and county levels, and the allocation to health is therefore an indication of what priority the governments place on health issues compared to other sectors. If the national aggregate is low, the sharable pool will be low and many sectors (including health) may receive less allocation.

The process of budget allocation to the respective sectors is the same at the national and county levels. The county and national treasuries communicate the indicative budget ceilings to the various sectors through the *Budget Review and Outlook Paper* or the *County Budget Review and Outlook Paper* which is released in September and must be approved by the Cabinet and legislative assembly at each level of government. The *Budget Review and Outlook Paper* gives the first indication of how much the health sector will receive; therefore, interventions to advocate for more health funding should be done prior to its release.

Sector working groups 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 sector working groups produce reports which inform the Cabinet/County
Executive Committee in refining the sector ceilings. A strong justification for additional funding may lead to an adjustment of the annual ceilings, which are published in the subsequent *Budget Policy Statement* (national) and *County Fiscal Strategy Paper* (county), which are released in February of each year after the final ceilings are determined and approved by Parliament at the national level and by the county assemblies.

National ministries and county departments have the opportunity to influence the amounts allocated to them through effective advocacy during the development of the sector working group reports. Despite the fact that ministries and departments originate, justify, and advocate 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.

It is important to note that although national ministries and county health departments determine how their allocated budget is distributed to programmes or activities within their dockets, they are not allowed by law 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 or no amendments are made in cases where there has been positive and continuous engagement between the executive and the legislative assemblies during the budgeting process.

**The Programme-based Budgeting Approach**

The PFMA 2012 (section 12 of the second schedule) requires the national government and counties to adopt a programme-based budgeting (PBB) approach beginning in FY 2014/15. However, the commencement date was later changed to FY 2015/16, following a Senate intervention that cited a lack of capacity in the counties to implement the new approach. The PBB approach, according to the PFMA 2012, 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 county government 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.
Box 2: 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

The main objective of this study was to assess how national and county governments allocate funds to the health sector and what health interventions 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 2016/17, 2015/16, and 2014/2015 to also help planning officials improve budgeting practices.

Specifically, the study examines:

1. Total government budget allocation to health
2. The national and county budgets to identify and determine the overall budget allocations to the health sector
3. County comparisons and trend on budget allocations to health
4. National and county budget allocations to healthcare 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 indigent and vulnerable groups. It also has the potential to increase the efficiency of healthcare delivery systems if a greater proportion of the expanded funding is directed towards more efficient public health programmes.

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

1. To enable the sector to absorb the impact of the expanded administrative costs of devolution while still providing the level of service that existed 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 the national goal of universal health coverage.
4. To provide a measure of sustainability, especially when expansion is coming from domestic sources.
Methodology and Limitations

This study analysed the national (Ministry of Health) and county budgetary allocations to the health sector for FYs 2014/15, 2015/16, and 2016/17. The Ministry of Health (MOH) data was obtained from the annual estimates for each year, while county budget data was obtained from the Commission for Revenue Allocation, the Office of the Controller of Budget, and in some instances from the counties. However, data from the Commission for Revenue Allocation and the Office of Controller of Budget have not been validated by the counties and there may be inconsistencies compared with the final 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, some counties have not adopted the PBB approach and in some cases the budget data available were in formats not suitable for this analysis. To address this issue going forward, there is a need for greater standardisation of health budget formats in the counties.
This chapter presents results from the analyses of national and county budgets and allocations to health for FYs 2014/15, 2015/16, and 2016/17. It examines how the two levels of government allocated funds to health in those years and how those funds were then 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.

**Combined Total Government Allocations to Health**

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

The results summarised in Figure 2 show that the combined allocation to health in Kenya has remained almost constant at between 7.5 – 7.7 percent of total government budget over the last three fiscal years. After an initial drop to 5.5 percent in FY 2013/14 with the onset of devolution, the allocation to health increased to 7.5 percent in FY 2014/15 and has remained almost the same since then.

![Figure 2: Trends in Health Allocations as a Percentage of Total Government Budget and Level of Government](image)

Partly as a result of devolution, the national government has gradually been reducing its share to health over the last three fiscal years. After an initial increase from 3.4 percent in FY 2013/14 to 4.0 percent in FY 2014/15, the national government’s allocation reduced in FYs

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1 Total government budget includes both national and county government allocations.
2015/16 and 2016/7 to 3.9 percent and 3.7 percent respectively. In contrast, counties increased their allocation from 13.5 percent in the first devolution budget (FY 2013/14) to 21.5 percent in FY 2014/15, and to 23.4 percent and 25.2 percent in FYS 2015/16 and 2016/17. Prior to devolution, health had the largest budget allocation at 35 percent of shareable revenue in FY 2012/13. Given that health is the most devolved function, it is expected that counties will allocate the sector a similar proportion of funds, but this analysis found that most counties are yet to reach this level.

**National Budget Allocation to the Health Sector**

Government resources, as well as donor resources provided through the government and resources generated through the provision of services that are intended to fund health at the national level, are primarily allocated through the vote for the MOH by Parliament. After the finalisation of a revenue-sharing agreement between national and county governments, the national government allocates specific amounts for its ministries, departments, and agencies (MDAs) through an elaborate budgeting process that confers a fair amount of discretion as to how much each MDA receives. This analysis excludes monies allocated to Parliament and the Judiciary, which are usually appropriated separately from national and county governments’ budget appropriation.

The discretionary national government budget is shared among 46 MDAs and constitutional offices, including the MOH. There are significant competing needs for resources among the various sectors of the national government’s portfolio, and thus the proportion of the budget allocated to health is an indication of the priority given to the health sector, compared to other sectors.

Over the last three years, the absolute national government budget continued to increase and so did the national government’s absolute allocations to health. However, there was a gradual decrease in the proportion of the total national government budget allocated to health over the same period. Figure 3 presents the total national government budget amount and proportion allocated to the MOH over the last three fiscal years.

**Figure 3: National Government Budget and Allocation to MOH FYs 2014/15–2016/17 (excludes Consolidated Fund Services)**
As shown in Figure 3 above, the national government’s allocation to health increased minimally in absolute terms and disproportionately with the expansion of the national government budget. While the total national government budget rose from Ksh 1,182 billion in FY2014/15 to Ksh 1,505 billion in FY 2015/16 and Ksh 1,627 billion in FY 2016/17, allocation to health increased from Ksh 47 billion in 2014/15 to Ksh 59 billion in FY 2015/16 and Ksh 60 billion in FY 2016/17. This represents a gradual decrease from 4.0 percent to 3.9 percent and 3.7 percent of the total national government budget over the same period. Additionally, while the total national government budget expanded by 8 percent between FY 2015/16 and FY 2016/17, the total MOH allocation expanded by only 1.8 percent over the same period, and the same unfavorable pattern is observed on the average annual growth over the three-year period as shown in Table 1.

### Table 1: Growth of Total National Government and MOH Budgets, FYs 2014/15-2016/17

<table>
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<tr>
<th>Budget Category</th>
<th>Fiscal Year (Ksh million)</th>
<th>Increase in Budget Allocation (%) between FYs 2015/16 and 2016/17</th>
<th>Average Annual Growth (%)</th>
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<tbody>
<tr>
<td>MOH</td>
<td>FY 2014/15 47,363</td>
<td>FY 2015/16 59,184</td>
<td>FY 2016/17 60,270</td>
</tr>
<tr>
<td>Total National Government</td>
<td>FY 2014/15 1,182,432</td>
<td>FY 2015/16 1,505,492</td>
<td>FY 2016/17 1,626,902</td>
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**MOH allocation to recurrent and development expenditure**

The national government allocates its resources to ministries and other spending units to finance recurrent or and development budgets. The recurrent budget finances running costs, including personnel remunerations and operational inputs, while the development budget finances capital formation, including infrastructure and major equipment. Donor funding is factored in under the development budget. Recurrent budget is primarily funded by the Government of Kenya (GOK) from domestic taxes and from the amounts raised by the spending units in the course of providing chargeable services, while the development budget is financed by both GOK and donors. Figure 4 shows the trend in allocation of MOH budget to recurrent and development, including the amounts raised from appropriations in aid and donors over the FY 2014/15–2016/17 period.
The MOH allocated Ksh 26.1 billion or 55 percent of its total budget to finance recurrent expenditures during FY 2014/15, Ksh 28.5 billion or 48 percent in FY 2015/16, and Ksh 29.1 billion or 48 percent in FY 2016/17. Development was allocated 45 percent, 52 percent, and 52 percent of total health budget during the same fiscal years respectively. As shown in Table 2, allocation to the development vote expanded initially, and then leveled out in the last two years.

Table 2 also indicates that in absolute figures, the MOH recurrent budget grew on average by 5.7 percent annually over the three year period, but that growth in the same budget decreased
to a low of 2.0 percent in FY 2016/17, indicating that the MOH is not focusing on expanding operations since most operations’ mandates were devolved to the countries. Likewise, the development budget expanded at an annual average growth of 22.8 percent, but the growth declined substantively to 1.7 percent during FY 2016/17. The budget contribution by donors also substantially reduced from an overall annual growth rate of 30 percent to 3.9 percent between FYs 2015/16 and 2016/17.

**Analysis of MOH recurrent budget allocations**

Figure 5 presents a breakdown of the allocation of the MOH’s recurrent budget across four major expenditure items over three fiscal years. The vote includes the budget for the six semi-autonomous government agencies (SAGAs) under the Ministry.

**Figure 5: MOH Recurrent Budget Allocations, FYs 2014/15-2016/17**

![Budget Allocation Chart]

Grant transfers to SAGAs and reimbursements for user fee waivers (monies collected by these entities for services provided) were allocated about Ksh 20.5 billion in FY 2016/17, which is about 70 percent of the total MOH recurrent budget. The results show that this figure has almost leveled in absolute figures, from Ksh 19.5 billion (which was 75% of total MOH recurrent) in FY 2014/15 to about Ksh 20 billion (reduced to 70% in relative terms) in FY 2015/16.

The proportion of the MOH recurrent budget allocated to personnel emoluments increased from 15 percent in FY 2014/15 to 21 percent in FY 2015/16, and then dropped marginally to 19 percent in FY 2016/17. The notable increases in FY 2015/16 and FY 2016/17 can be attributed to the MOH deciding to pay newly-graduated medical staff during their internship period. The budget allocation for operations and maintenance decreased from 8 percent of the total MOH budget in FY 2014/15 to 5 percent in FY 2015/16, with an increase to around 7 percent in FY 2016/17.

Budget allocation to cover facility reimbursements for free services at primary care facilities increased marginally to Ksh 900 million in both FYs 2015/16 and 2016/17 from Ksh 700
million in FY 2014/15, to cater for upgraded and new facilities. These funds are transferred directly to counties’ revenue accounts and may not necessarily be included in the county allocation to the health sector.

Analysis of recurrent allocations for SAGAs under the MOH

The six SAGAs under the MOH have discretion as to how they internally allocate their recurrent budget, as long as they remain within the ceiling provided by the Ministry. Exactly 81.3 percent of the Ksh 20.5 billion that the MOH allocated to SAGAs in FY 2016/17 came from government grants, while the remainder (18.7%) came from user fees. The amount and allocation pattern compares closely with the FY 2015/16 allocation of Ksh 20.1 billion, where government grants accounted for 80.5 percent, while user fees accounted for 19.5 percent. Figure 6 below shows the MOH allocation of recurrent budget to SAGAs in FY 2016/17.

Figure 6: MOH Recurrent Budget allocations to SAGAs, FY 2016/17

As illustrated in Figure 6, two hospitals—Kenyatta National Hospital and Moi Teaching and Referral Hospital—constituted over 70 percent of all MOH recurrent allocations. Kenyatta National Hospital received the largest allocation (32% grants and 10% user fees), accounting for 42 percent of the total grants to SAGAs during FY 2016/17, followed by Moi Teaching and Referral Hospital at 23 percent and 4 percent of grants and user fees, respectively. Both hospitals constituted over 70 percent of all MOH recurrent allocations and are the key deliverers of national referral services, which is among the Ministry’s constitutional function.

The Kenya Medical Training College was allocated 12 percent of the MOH recurrent budget and a further 5 percent in appropriations in aid for a combined 17 percent of all recurrent budget allocation to SAGAs. Among all SAGAs, the Kenya Medical Training College had the highest grant to appropriations-in-aid ratio where the institution was expected to raise 33 percent of the proposed expenditure. The Kenya Medical Supplies Authority was allocated 3
percent of the MOH recurrent allocation to support personnel and operational costs. The costs for drugs and supplies stock are budgeted under the purchasing institutions.

**MOH development budget**

The MOH’s development budget includes funds provided by the national government and donors through loans and grants. The amounts and proportions contributed from each of the sources between FY 2014/15 to FY 2016/17 is presented in Table 3. As illustrated, donors’ contribution increased overall from 57 percent of the development budget in FY 2014/15 to 63.4 percent in FY 2016/17, while the GOK contribution decreased overall from 43 percent to 36.6 percent during the same period. There was a rapid increase in loan contribution from 8 percent to 21.6 percent between FY 2014/15 and FY 2016/17.

**Table 3: MOH Development Budget by Source, FYs 2014/15–2016/17**

<table>
<thead>
<tr>
<th>Sources</th>
<th>FY 2014/15</th>
<th>% of total</th>
<th>FY 2015/16</th>
<th>% of total</th>
<th>FY 2016/17</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOK</td>
<td>9,137,000,000</td>
<td>43%</td>
<td>11,639,519,940</td>
<td>38%</td>
<td>11,411,000,000</td>
<td>36.6%</td>
</tr>
<tr>
<td>Donors</td>
<td>12,164,511,786</td>
<td>57%</td>
<td>19,024,846,894</td>
<td>62%</td>
<td>19,768,819,184</td>
<td>63.4%</td>
</tr>
<tr>
<td>Loans</td>
<td>1,704,000,000</td>
<td>8%</td>
<td>5,176,445,000</td>
<td>17%</td>
<td>6,736,614,735</td>
<td>21.6%</td>
</tr>
<tr>
<td>Grants</td>
<td>10,461,000,000</td>
<td>49%</td>
<td>13,848,401,894</td>
<td>45%</td>
<td>13,032,204,449</td>
<td>41.8%</td>
</tr>
<tr>
<td>Total</td>
<td>21,301,511,786</td>
<td>30,664,366,834</td>
<td>31,179,819,184</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allocation of MOH development budget to programmes**

Figure 6 shows the distribution of the GOK resources under the development budget for FY 2016/17 by key areas, amounts, and percentages.
The MOH earmarked a significant proportion, 77 percent of the development budget from GOK resources, to the medical equipment and free maternity services programmes. Allocations to the medical equipment programme (39% of the development budget) aim to equip 94 Level 4 and 5 hospitals (two per county) with equipment, in order to improve access to high-quality curative care. A further 38 percent of the GOK development budget is directed towards the Free Maternity Health Programme, intended to reimburse facilities for providing free maternity care with the aim of increasing access to facility-based skilled deliveries (equity) to mitigate the high national maternal mortality rates.

The rest of the development budget (23 percent) was earmarked for GOK capital grants to SAGAs (about Ksh 247 million), government’s contribution to donor-funded programmes (Ksh 610 million), and other capital development projects under the national government (Ksh 1,369 million).

**MOH overall allocations to programmes in FYs 2015/16 and 2016/17**

The MOH overall development budget allocations to various programmes, sources of funding, and a comparison of amounts provided in FYs 2015/16 and 2016/17 is presented in Figure 7.
As demonstrated by Figure 7, allocation for medical equipment continues to be the MOH’s highest priority, although the allocation decreased from Ksh 5.5 billion in FY 2015/16 to Ksh 4.5 billion in FY 2016/17. However, in FY 2016/17 the allocation accounts for 39.4 percent of MOH government development budget up from 14.7 percent in FY 2015/16. The results of the analysis also show that allocation for the free maternity services programme decreased from about Ksh 4.4 billion in FY 2015/16 to about Ksh 4.3 billion in FY 2016/17. However, additional funding for maternal and reproductive health is provided under the “All Others (GOK)” and “All Others (Donor)” categories (see Figure 7).

Allocation for HIV and AIDS, tuberculosis, and malaria amounted to 11.4 percent of the FY 2016/17 budget, indicating that HIV is among the highest priorities of the MOH. All of the funding for these programmes came from the Global Fund to Fight Aid, Malaria, and Tuberculosis, the World Food Programme, and the United States Agency for International Development. However, funds decreased from Ksh 4,043 million in FY 2015/16 to Ksh 3,549 million in FY 2016/17, a decrease of 12.2 percent, indicating a need for Kenya to explore other options to cover the declining donor resources. Immunisation and related health systems support received Ksh 2.6 billion from the Global Alliance for Vaccines and Immunization in FYs 2015/16 and 2016/17, and Ksh 700 million and Ksh 410 from GOK in FYs 2015/16 and 2016/17.

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2 WFP = World Food Programme, USAID = United Agency for International Development, GAVI = Global Alliance for Vaccines and Immunization, JICA = Japan International Cooperation Agency, DANIDA = Danish International Development Agency
2016/17, respectively. The allocations constitute an increase of 10.6 percent and 9.9 percent of
total MOH development allocation between FYs 2015/16 and 2016/17.

**County Allocations to Health**

Under devolution, county governments became responsible for a range of health services,
including primary healthcare facilities, dispensaries, health centres, and some hospitals. The
major source of financing for counties continues to be transfers from the national revenues,
which are shared among counties based on a legal formula that takes account of counties’
population, poverty levels, land area, and level of development. Counties also raise additional
revenues from user fees for services provided at public health facilities (among other levies).
Although the PFMA 2012 provides guidelines to counties on how to allocate their global
budgets between recurrent and development expenditures (70% to recurrent and 30% to
development), the county health sector is not necessarily bound by these guidelines. This
section presents findings on how counties allocated funds to health over the review period,
FYs 2014/15 to 2016/17.

**Overall allocation to health by county governments**

The proportion of the county health budget in relation to the total county government 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 compared with the total county government budgets
for FYs 2014/15, 2015/16, and 2016/17. Figure 8 provides the proportion of the total health
budget as a percent of the total county government budgets for each of the three years.

**Figure 9: County Governments’ Allocation to Health versus Other Sectors,
FYs 2014/ 15– 2016/ 17 (Ksh billion)**

<table>
<thead>
<tr>
<th></th>
<th>FY 2014/15</th>
<th>FY 2015/16</th>
<th>FY 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other sectors</td>
<td>78.5% (Ksh 234b)</td>
<td>76.6% (Ksh 278b)</td>
<td>74.8% (Ksh 273b)</td>
</tr>
<tr>
<td>Health sector</td>
<td>21.5% (Ksh 64b)</td>
<td>23.4% (Ksh 85b)</td>
<td>25.2% (Ksh 92b)</td>
</tr>
</tbody>
</table>

As shown in Figure 8, counties increased the proportion of their total budgets allocated to
health from 23.4 percent in FY 2015/16 to 25.2 percent in FY 2016/17. In absolute terms, the
allocation increased by 8.2 percent from Ksh 85 billion in FY 2015/16 to about Ksh 92 billion
in FY 2016/17. In contrast, the absolute allocation to other sectors reduced slightly from Ksh
278 billion in FY 2015/16 to Ksh 273 billion in FY 2016/17, a negative growth.
**Allocations by county**

Figure 9 shows the percentages of total budgets allocated to health in the different counties in FY 2015/16 and FY 2016/17, drawn from available data.

**Figure 10: Percentage of Total County Budgets Allocated to Health by County, FYs 2015/16 and 2016/17**

On average, counties allocated 25.2 percent of their budgets to health in FY 2016/17, an increase from 23.4 percent in FY 2015/16. Over two thirds (66%) of the 47 counties increased the percentage of county budgetary resources allocated to health over the two-year period. At the same time, eight counties (Busia, Kericho, Nyandarua, Samburu, Taita Taveta, Tana River, Bomet, and Wajir) reduced the proportion of allocation to health, to levels below the pre-devolution 35 percent and below the average for all counties between FYs 2015/16 and 2016/17. Another eight counties (Elgeyo Marakwet, Nakuru, Kiambu, Baringo, Siaya, Kirinyaga, Lamu, and Trans Nzoia) allocated at least 30 percent of the resources to health, indicating that it is possible for counties to increase their percent allocation to health to the recommended levels.

**Recurrent versus development allocations**

**Aggregate county recurrent and development budget allocations**

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

Since devolution was implemented, the budgets for recurrent expenditures for health services in the counties have been consistently and substantially higher than for development. The results of this study show that there were, in nominal terms, increases in both recurrent and development allocations in FY 2016/17, compared with FY 2015/16 (Table 4). However, the percentage allocated to development as a percent of total county health budgets decreased from 28 percent in FY 2015/16 to 21 percent in FY 2016/17, while the recurrent budget allocation increased from 72 percent to 79 percent.

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

<table>
<thead>
<tr>
<th>Budget Category</th>
<th>FY 2015/16</th>
<th>FY 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ksh million</td>
<td>% of total county health budget</td>
</tr>
<tr>
<td>Recurrent</td>
<td>60,592</td>
<td>72%</td>
</tr>
<tr>
<td>Development</td>
<td>23,916</td>
<td>28%</td>
</tr>
<tr>
<td>Total</td>
<td>84,508</td>
<td>100%</td>
</tr>
</tbody>
</table>


Recurrent versus development health budget by county

Figure 10 presents the recurrent allocations by counties as a percentage of their total health allocations for FY 2015/16 and FY 2016/17. However, it should be noted that a number of counties are still experiencing challenges with classification of budget line items between recurrent and development and therefore the information illustrated in Figure 9 should be considered as indicative.
Overall, counties increased the percent of budget allocated to recurrent expenditure to 79 percent in FY 2016/17, up from the 72 percent allocated in the previous fiscal year. Thirty-seven of the counties allocated more than the recommended 72 percent to recurrent expenditure, implying that counties significantly reduced the amount allocated for health investment. Seven counties (Machakos, Bomet, Tana River, Kwale, Wajir, Turkana, and Laikipia) significantly increased the percent allocated to recurrent expenditure between FYs 2015/16 and 2016/17.

On the other hand, nine counties (Turkana, Mandera, Garissa, Kiambu, Nandi, Marsabit, Kakamega, Wajir and Trans Nzoia) allocated less than 72 percent of their health budget to recurrent expenditures, dedicating over 28 percent to development. Recurrent expenditure is probably given priority in health allocation due to the service-delivery nature of county health functions and, unless adequate allocation is provided to health, the allocation to development is likely to remain small. The results illustrated in Figure 10 suggest that, other factors aside, counties are shifting to a consolidation of service delivery rather than an expansion of infrastructure.

**Allocations by economic categories**

While county health departments do not directly determine the aggregate amounts allocated to health, they have a significant role in determining allocations to programmes and specific input items within the department. An analysis of budget allocations by key health inputs provides an indicative assessment of whether health inputs are balanced and positioned to achieve technical and operational efficiency in service delivery. Further, counties are gradually moving towards implementing the programme-based approach (and formats) to budgeting, where allocations (among other things) are classified according to specific economic categories and input items.
While this section examines how counties allocated the recurrent and development budgets, the study faced the following limitations regarding the county data:

1. Counties pool essential health inputs, such as drugs and other essential medical supplies, under “Operations and Maintenance/Use of Goods and Services” category in their budgets. Even though this is a standard classification under the official PBB guidelines and approach, counties are expected to break down this category further and present an itemised budget. In order to compare the results with previous analyses without affecting their validity, this analysis has excluded six counties (Turkana, Garissa, Kisumu, Laikipia, Nairobi, and Wajir), whose drugs and medical supplies items were lumped under the operations and maintenance category.

2. Misclassification between recurrent and development. In order to be comparable with previous fiscal years’ analyses, allocations that included drugs and non-pharmaceuticals presented in some county budgets as development were harmonised by moving them to the recurrent budget, and capital items moved to development budgets respectively.

To present an accurate situation regarding county budget allocations by economic categories, budgets from 41 counties whose data was appropriately broken down, complete, and could be compared with previous’ years analysis was used for this section’s analysis.

**Allocations of recurrent budget to economic categories**

Figure 11 presents the pattern and trend of county governments’ allocation to recurrent health budget by economic categories for FYs 2014/15, 2015/16, and 2016/17. The data shows that personnel emoluments got the largest share of counties’ recurrent budgets and that the proportion gradually expanded to reach 72.5 percent in FY 2015/16 before dropping to 70.6 percent in FY 2016/17. Allocations for medical drugs, as a percent of the total health recurrent budget, increased from 7.8 percent in FY 2014/15 to 10.5 percent in FY 2015/16 before dropping to 9.6 percent in FY 2016/17. Allocations for operations and maintenance declined from 13.4 percent of the total health recurrent budget in FY 2014/15 to a low of 9.1 percent by FY 2015/16, and then increased to 13 percent in FY 2016/17. Counties also increased recurrent budget allocation to non-pharmaceuticals, reaching 5 percent in FY 2016/17 from the 1.6 percent allocated in FY 2014/15.

**Figure 12: Recurrent Budget Allocations (%) by Economic Category**
These data indicate that counties did not direct all increments in the health budget to personnel emoluments during FY 2016/17, but to other essential health inputs. The data also indicate that counties are gradually improving budgeting as demonstrated by the reducing percentage of the budget allocated to “Other” and unspecified items.

**Allocation of development budget by economic categories**

The development budget is intended to finance non-recurrent capital items such as construction, equipment, and other long-term use items. Figure 12 presents findings on how counties allocated the development budget for health over the three fiscal years, shown by economic categories.

![Figure 13: County Health Services Development Budget Allocations (%) by Economic Categories, FYs 2014/15–2016/17](image)

The data shows that counties have increased the allocation to construction, which increased from 45.1 percent in FY 2014/15 to 47.4 in FY 2015/16 and to 54.0 percent in FY 2016/17. The results also show minimal allocation to rehabilitation of existing infrastructure, implying that in the three-year period counties focused on putting up new infrastructure. The allocation to medical equipment increased from 5.1 percent in FY 2014/15 to 15.7 percent in FY 2015/16, before dropping to 8.4 in FY 2016/17.

The data show significant variation in “Not Classified Elsewhere” and “Transfers/Grants to Other Programmes,” whose combined allocations decreased from about 41.0 percent in FY 2014/15 to 24.1 percent in FY 2015/16 and then increased again to 29.3 percent in FY 2016/17. Given the fact that these expenditures are eventually allocated to other categories, counties need to eliminate these categories in future budgets and allocate them appropriately from the start.
Per capita allocations on health, by county

The data show that county governments allocated Ksh 2,020 (20 USD) per person in FY 2016/17, compared to Ksh 1,910 (20 USD then) in FY 2015/16, an increase of just 6 percent in Kenya shillings, but reflective of no change in dollar terms. Even with the small increase, there were variations within counties in per capita health budget allocations during FYs 2015/16 and 2016/17 as shown in Figure 13.

Figure 14: Counties’ per Capita Allocation to Health, FYs 2015/16–2016/17

The data show that out of the 47 counties, 30 increased their per capita health budget allocation for FY 2016/17, while 17 allocated less than what was allocated the previous year. Five counties (Baringo, Elgeyo Marakwet, Marsabit, Isiolo, and Lamu) not only increased their allocation, but also allocated significantly more (over Ksh 3,000) than the Ksh 2,010 average in FY 2016/17. Ten counties (Migori, Narok, Muranga, Trans Nzoia, Machakos, Garissa, Elgeyo Marakwet, Marsabit, and Lamu) increased their per capita health allocation by over Ksh 500 between FYs 2015/16 and 2016/17, which suggests that these counties have realised that they had previously under-funded health.

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3 United States dollar (USD) = Ksh 101 in July 2016 and was Ksh 95.5 in July 2015
CONCLUSION AND RECOMMENDATIONS

Conclusion

This analysis clearly shows that both the national and county governments are committed to increasing—in absolute and relative terms—their budgetary allocations to health. Although there were noticeable variations between counties, the results reflect the high priority given to health by both levels of government 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. The allocation trend appears favourable towards health, although the expansion was less rapid than in the previous analysis, National and County Health Budget Analysis FY 2015/16.

Despite the expansion from FY 2014/15 to FY 2016/17, the national government’s allocation to health appears to have levelled out, except for the minor increase in donor financing. The health sector budget is, therefore, expanding more slowly than the national-level budget and this might indicate that government funding to national health functions may have reached saturation. The analysis also shows that donor contributions to the national development budget for health grew over the review period, with GOK sources almost stagnating. This indicates an over reliance on donor funding for programmes of national priority and raises concerns about the predictability and sustainability of these programmes.

Additionally, donor funding for HIV and AIDS, as reflected in the national government allocations, declined over the FY 2015/16–2016/17 period from Ksh 4.0 billion to Ksh 3.66 billion. The analysis also found increasing allocations to recurrent over development expenditure estimates in most counties against the trend observed in the FY 2015/16 analysis. The trend in the counties’ recurrent budget allocation suggests that counties may have contained growth in personnel emoluments and are shifting resources to other critical inputs. However, the percent allocated to personnel emoluments still remains high at 71 percent, against the recommended 50-60 percent. Overall, counties increased their per capita allocations to health, but at a slightly lower rate than was found in the FY 2015/16 analysis.

This study observed that counties appear to have problems with the 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. The failure by counties to use the same approach in allocation poses challenges to cross-sectional data comparisons and analysing the trends.

Recommendations

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

National level

- National and county governments should strive to increase allocations to health to surpass pre-devolution levels and move closer to Abuja targets. This is especially important for counties because there is more space for health budget expansion at the county level.
- At the national level, MOH should increase the development budget allocations from GOK resources to reduce over-reliance on donor resources and reduce the gaps arising from declining donor funding; this is especially so for HIV, tuberculosis, and malaria programmes.
County level

- Counties should continue increasing the amount allocated to health as they are yet to realise the recommended 30 percent average. Counties that are ranked lowest in allocating funds to health should be encouraged and given the capacity to increase allocation to health. These include Mandera, Bomet, Samburu, Wajir, Tana River, Narok, Nyandarua, Busia, and Marsabit.

- Despite the need to consolidate health services delivery with adequate recurrent budgets, the trend indicates further reduction in the budget allocated to development. Counties need to increase allocations to development especially those counties that are allocating almost the entire budget to recurrent. These include Muranga, Nyeri, Taita Taveta, Bomet, Embu, and Kericho.

- Although it may be difficult to accomplish in the short run, counties must strategise how to reduce allocation to personnel emoluments to the recommended 50-60 percent of recurrent budget.

- Likewise, county development budgets are mostly allocated to new infrastructure and the proportion of the budget allocated to infrastructure is growing. Meanwhile, only a minimal amount is allocated for rehabilitation. Rapid expansion of facilities demands more in terms of the recurrent budget in the future and counties should rationalise this rapid expansion.

Overall

- National government should endeavour to further strengthen the capacity of counties in budgeting, especially in health budgeting, to bridge serious capacity gaps observed when reviewing county budgets. The MOH should also enhance standardisation and establish formal channels for obtaining county health budgets and the sharing of budget information across counties so that lower-ranking counties can learn from better performing counties on budgeting issues. MOH should also support counties with mentorship during the budget-making process with a view towards providing support for resource advocacy.

- 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. 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 a supplementary allocation, which has not been the case.
REFERENCES


