



MINISTRY OF HEALTH

2014/2015 NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS REPORT

July 2015



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This report provides the findings of a study that assessed how national and county governments allocate funds to the health sector and what areas these funds cover. The study compared data from FYs 2014/15 and 2013/14 to help planning officials improve budgeting practices. These findings will enable national and county policymakers to understand the allocation patterns by different economic and functional areas.

The Ministry of Health would like to acknowledge 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 Project (HPP), which made it possible to undertake this study.

The study was conducted by a team led by Geoffrey Kimani, Deputy Chief Economist, Ministry of Health. Technical assistance was provided by HPP through Angela Oloo Akumu, Health Financing Advisor and Thomas Maina, Senior Health Financing Advisor. Stephen Muchiri, the HPP Programme Director provided critical input in the study and report writing.

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EXECUTIVE SUMMARY

Tracking health budget allocations is critical in assessing whether resources allocated in the health sector are aligned to key policy objectives as articulated in policy documents. Kenya's 2010 Constitution established 47 county governments and devolved many of the national government functions out to the counties. The devolved functions are funded through national revenues and the equalisation fund. Money in the equalisation fund is public finance set aside to accelerate the level of services in marginalised areas of Kenya in order to bring them up to par with the rest of the country. The revenue is distributed among counties that have sizeable areas that are classified as marginalised.

The Constitution requires that at least 15 percent of the national revenue be allocated to the county governments to fund the devolved functions, including health.

Since health resources are not earmarked in the transfer from the national level to the county level, it was necessary to assess how counties are prioritising health in terms of budget allocations. The prioritisation of budget allocations for health is one of the keys to sustaining the gains Kenya has made in the health sector over the last decade. The first county health budget analysis was undertaken in 2014 and covered fiscal year (FY) 2013/14. The findings, presented to the counties and other stakeholders, were expected to influence the budget allocations for FY 2014/15.

To analyse the trends in allocations between FYs 2013/14 and 2014/15, and to assess whether the allocations were aligned to national and county level sector priorities a national and county budget analysis for FY 2014/15 was conducted.

Specifically the FY 2013/14 and FY 2014/15 analyses examined:

- i. The national budgets to identify and determine the overall budget allocations to the health sector
- ii. The county budgets to identify and determine the overall budget allocations to the health sector
- iii. The National and county broad and specific health budget line items and distinguished levels of allocation by recurrent and development;
- iv. Allocations to healthcare inputs/categories
- v. Total allocations to key programmes including, but not limited to HIV and /AIDS, tuberculosis, malaria, reproductive health, maternal and child health, and chronic diseases.

The health budget analyses were based on national Ministry of Health budgetary allocations and county health budgets for the two-year period, FYs 2013/14 and 2014/15, obtained from the Controller of Budget.

Main Findings

Analysis of national level health budget allocations

The Ministry of Health budget allocation for FY 2014/15 was KShs 47.4 billion, constituting 4 percent of the national budget, compared to 3.4 percent in FY 2013/14. The KShs 47.4 billion budget allocation included government and development partners' contributions for one year. Overall, the Ministry of Health FY 2014/15 budget allocations increased by 34 percent from what was reported in FY 2013/14. The development health budget for FY 2014/15 accounted for 45 percent of the total Ministry budget, a marginal increase from what was reported in FY 2013/14 (43.9%). The recurrent health budget in FY 2014/15 accounted for 55 percent of the total budget, compared with 56.1 percent in FY 2013/14.

Development partners accounted for 57.1 percent of the total development budget in FY 2014/15, compared with 59.8 percent in FY 2013/14.

A disaggregation of the recurrent health budget for 2014/15 shows that total grants/ transfers to semi-autonomous government agencies, which includes their own locally generated revenues (user fees) accounted for about 75 percent of the total Ministry of Health recurrent budget while personnel emoluments - headquarters staff, Mathari Teaching and Referral Hospital and the National Spinal Injury Hospital staff - accounted for close to 9 percent of the total recurrent health budget with internship programme receiving 6 percent. Drugs and other medical supplies, operations and maintenance, and others accounted for the remaining 10 percent (Figure 3).

Analysis of county level health budget allocations

The counties' health sector budgets increased from 13 percent of total counties' budget in FY 2013/14 to 22 percent in FY 2014/15. However, substantial variations between counties are also noted. In FY 2013/14, 22 counties allocated at least 15 percent of their budget to health, compared with 38 counties in FY 2014/15. The split between recurrent and development health budgets remained constant at 75 percent in FY 2014/15 and 25 percent in FY 2013/14. In FY 2014/15, 69 percent of the recurrent health budget was allocated to personnel emoluments, while 13 percent went to finance operations and maintenance. Medical drugs received only 8 percent of the recurrent budget.

Investment in the construction of facilities was the largest expenditure category in the development budget in FY 2013/14, with an allocation of 51 percent of the total county health budget. During FY 2014/15, construction of facilities was allocated 51 percent of the total county health budget. A further 13 percent was allocated to vehicles, including ambulances. Medical equipment had an allocation of 14 percent, while rehabilitation was allocated 22 percent. It is worth noting that a few counties did not show a disaggregated development budget which made it difficult to determine what projects would be implemented.

Overall, the county health budget per person was KShs 1,567 (US\$18.2) in FY 2014/15 compared to KShs 962 (US\$11) in FY 2013/14. However, there was a wide variation in per capita health budget allocations between counties in FY 2014/15, ranging from KShs 4,102 (US\$47.7 per capita) in Lamu County to KShs 384 (US\$4.5) per capita in Laikipia.¹

Combined national and county health budget allocations

The creation of 47 counties by the new constitution necessitated a revision of the Abuja target estimation process, which now includes an aggregation of the county health budgets and the national Ministry of Health budget. Using this revised methodology, the combined budget allocations (national and county) increased from an estimated 5.5 percent in FY 2013/14 to 7.5 percent in FY 2014/15. However, the latter estimate is lower than the 7.8 percent reported in FY 2012/13, before devolution was implemented.

Recommendations

- i. The Ministry of Health should support counties to develop a standard budget format to facilitate comparisons among the counties; this should be in line with programme-based budgeting.
- ii. Since a large portion of county governments' allocation to health goes to compensating personnel, a necessary component of a productive health system, the National treasury should ensure the sharable funds for county level are sent to counties on timely basis to guarantee payment of salaries of health workers.
- iii. The results of the analysis show predominance of recurrent over development expenditure estimates across the counties. The county budget committee needs to ensure that over the medium term a minimum of 30 percent of the county governments budgets are allocated to the development expenditure as stated in the Public Finance Management Act 2012.

¹ 1 USD = Kshs. 86

- iv. The analysis found an emphasis on new construction and the upgrading of health facilities in the counties. These investments need to be matched with human resources and other inputs so that the facilities are not under-utilised. In expanding infrastructure, counties should first consider the existing pool of health providers, including contracting them if necessary. Equally, any expansion should be harmonised with priorities in the county development fund.
- v. The analysis shows that there are low allocations by counties to some programme activities, including HIV and AIDS, immunization, and family planning, all of which are important to improve health outcomes at the county level. Counties need to complement national budget allocations for these programmes.
- vi. Furthermore, the national government has plans to equip selected health facilities in the counties with specialised medical equipment. In the light of this, the analysis' other findings, and current workloads, The National and county government need to take into account the required human resources, without which these investments could be under-utilised.

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CFSP	County Fiscal Strategy Paper
DLT&LD	Division of Leprosy Tuberculosis and Lung Disease
FY	fiscal year
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
KEMSA	Kenya Medical Supplies Authority
KMRI	Kenya Medical Research Institute
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
KShs	Kenya shillings
MOH	Ministry of Health
MTRH	Moi Teaching and Referral Hospital
NACC	National Aids Control Council
NSIH	National Spinal Injury Hospital
PBB	programme-based budgeting
PFMA	Public Financial Management Act, 2012
SAGA	Semi-Autonomous Government Agencies
TGB	total government budget
US	United States

INTRODUCTION

The 2010 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 to ensure that Kenya attains the highest standard of living for her population by providing equitable health services. To meet these obligations, both the national and county governments have committed to boost spending in the health sector.

The national and county annual budgets reflect the policy and resource allocation decisions that determine the activities, programmes, and services that will be delivered within the financial year. Tracking these allocations can reveal the national and county governments’ resource allocation patterns and indicate whether the allocations align to the governments’ health policy priorities.

The purpose of this study was to analyse disaggregated data of the fiscal year (FY) 2014/15 health budget, and to provide pertinent information to policymakers to inform future budgeting.

Background

County budgets are prepared as provided for in Section 129 of the Public Finance Management Act, 2012 (PFMA), which provides that the County Executive Committee Member for Finance shall submit to the County Executive Committee for its approval

- The budget estimates and other documents supporting the budget of the county government, excluding the County Assembly
- The draft bills at the county level required to implement the county government’s budget, in sufficient time to meet the deadlines prescribed

The section further provides that following approval by the County Executive Committee, the County Executive Committee Member for Finance shall

- Submit to the County Assembly the budget estimates, supporting documents, and any other bills required to implement the budget, except the Finance Bill, by the 30th of April in accordance with Section 117 of the PFMA. Ensure that the budget estimates submitted are in accordance with the resolutions adopted by County Assembly in the County Fiscal Strategy Paper (CFSP) which presents the fiscal objectives for the following financial year. The CFSP also details the broad strategic priorities and policy goals that will guide the county governments in preparing their budgets which are founded on the expected flows from the national government and the locally mobilised revenues.

As required by Section 12 of the second schedule of the PFMA, counties must adopt a PBB approach for FY 2014/15. This requirement was changed for FY2015/16 however, following a senate intervention which cited a lack of capacity by counties to undertake budgeting using the programme-based budgeting (PBB) approach. The PBB approach aims to achieve two principle goals:

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

County budgets are therefore prepared in compliance with the 2010 Constitution and PFMA 2012. These 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, which include openness, accountability, and public participation in the process. It is envisaged that the

findings of this analysis, which examine the priorities for investment at the county level, will be useful in strengthening the devolved health system structures.

Objectives of the Budget Analysis

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 2014/15 and 2013/14 to help planning officials improve budgeting practices.

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

- i. The national budgets to identify and determine the overall budget allocations to the health sector;
- ii. The county budgets to identify and determine the overall budget allocations to the health sector;
- iii. The national and counties' broad and specific budget lines to which the allocations on health sector relate, and to be able to distinguish levels of allocation by recurrent and development spending; and
- iv. Allocations to healthcare inputs/economic categories.

In order to provide clarity, this report is divided into the following sections:

- Executive Summary
- Introduction
- Findings (i.e., where the budget allocations are analysed against various dimensions at aggregate and disaggregated levels, and from an economic classification perspective)
- Conclusion and Recommendations
- References

Methodological Approach

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

FINDINGS

This chapter presents the analyses of the national health and county budgets for FY 2014/15, compared with FY 2013/14.

National/MOH Health Budget Allocations

There were substantial increases in MOH budget allocations in nominal terms between FYs 2013/14 and 2014/15, from KShs 36,218 million in FY 2013/14 to KShs 47,362 million in FY 2014/15, an increase of about 31 percent (Table 1).

Table 1: Health Budget as a Percent of the National Government Budget, FYs 2013/14 and 2014/15

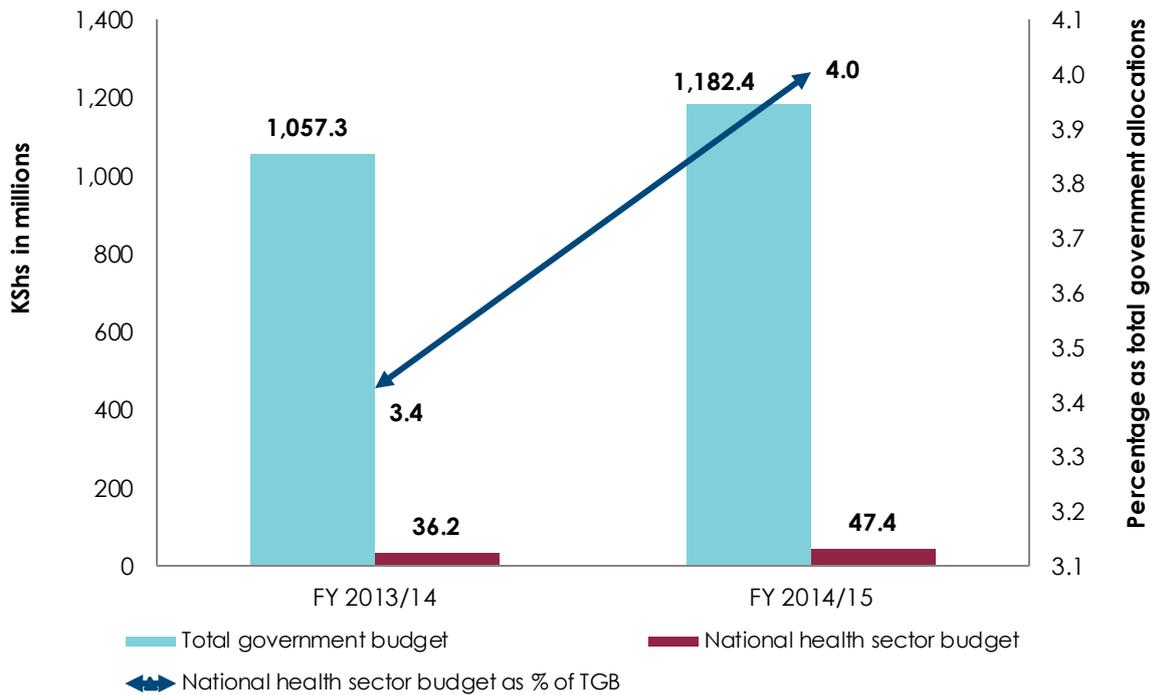
FY		Total Budget (KShs million)		Health budget as a % of total government budget
		Total government Budget (gross) ²	Ministry of Health budget (gross)	
2013/14	Recurrent	610,585	20,325	3.3
	Development	446,689	15,893	3.6
	Recurrent and Development	1,057,274	36,218	3.4
2014/15	Recurrent	687,540	26,061	3.8
	Development	494,892	21,301	4.3
	Recurrent and Development	1,182,432	47,362	4.0

Source: GOK, 2013a; GOK, 2013b; GOK, 2014a; GOK, 2014b

Budget allocation to the national health sector increased slightly from 3.4 percent of the total government budget (TGB) in FY 2013/14 to 4 percent in FY 2014/15. Before the onset of devolution in 2013, the budget allocation to the health sector constituted 6 to 7 percent of the TGB. This decrease reflects the shifting of significant amounts of funds to the county governments following the transfer of service delivery functions from the national government to the counties.

² Gross normally includes government allocations, plus revenues raised internally by the MOH and its semi-autonomous government agencies. Net is therefore total allocations, less internal revenues.

Figure 1: Health Budget Allocation Pattern (FYs 2013/14–2014/15)



Source: GOK, 2013a; GOK, 2013b; GOK, 2014a; GOK, 2014b

MOH budget allocations by recurrent and development votes

The total MOH budget allocation increased from KShs 36.2 billion in FY 2013/14 to 47.4 billion in FY 2014/15, an increase of about 34 percent. Of the total health budget, recurrent budget allocation accounted for 56 percent of the total MOH budget in FY 2013/14, compared to 55 percent in 2014/15. The proportion allocated to development accounted for 44 percent and 45 percent in FY 2013/14 and FY 2014/15 respectively (Table 2).

Table 2: MOH Budget Allocations by Recurrent and Development (KShs in millions)

FY	Total	Recurrent	Development	Share (%) of total	
				Recurrent	Development
2013/14	36,218	20,325	15,893	56	44
2014/15	47,362	26,061	21,301	55	45

Source: GOK, 2013a; GOK, 2013b; GOK, 2014a; GOK, 2014b

As seen in Table 3, development partners’ contribution accounted for 60 percent and 57 percent of the total development budget of MOH in FY 2013/14 and FY 2014/15 respectively. However, the overall MOH budget grew by 31 percent from FY 2013/14 to FY 2014/15.

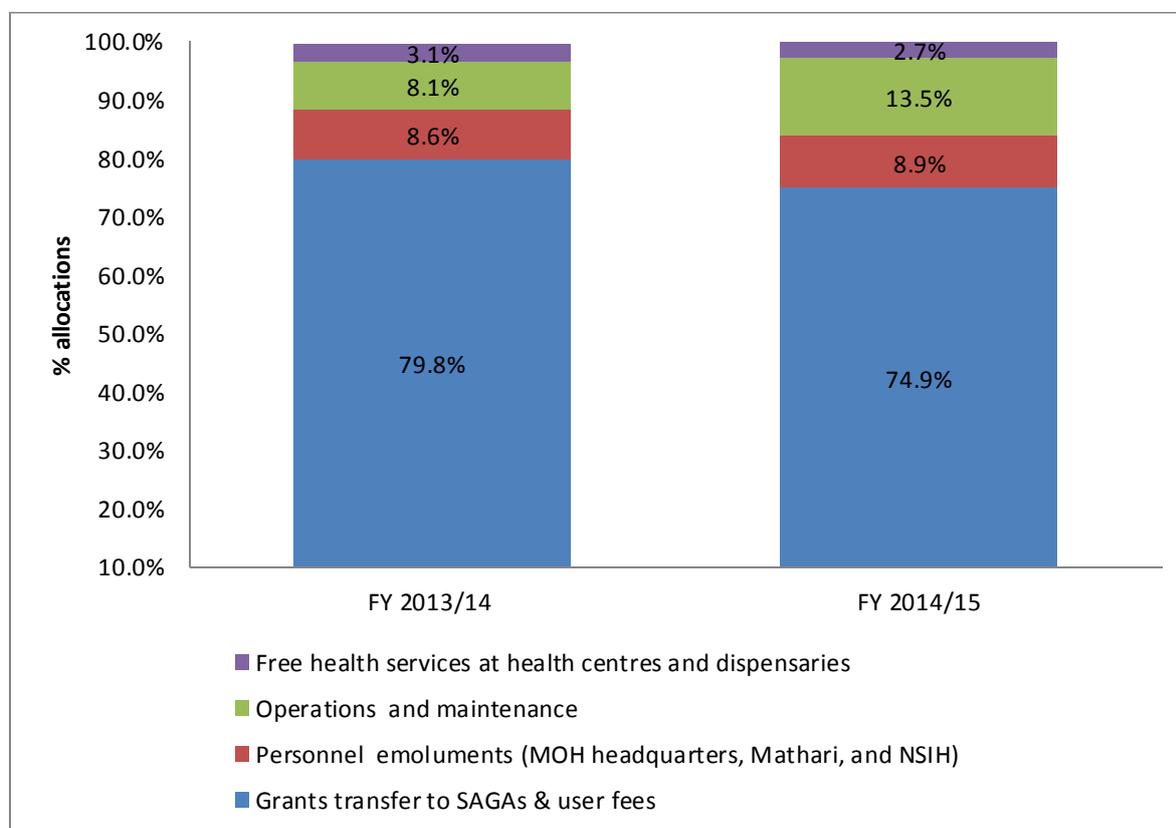
Table 3: National Health Budget by Source, FYs 2013/14 and 2014/15

Source	FY 2013/14		FY 2014/15		Increase in budget allocation (%) between FYs 2013/14 and 2014/15
	National health budget (KShs million)	%	National health budget (KShs million)	%	
MOH budget	36,218	100	47,362	100	30.8
Recurrent	20,325	56	26,061	55	28.2
Development	15,893	44	21,301	45	34.0
Development partners	9,498	60	12,164	57	28.1
GOK	6,395	40	9,137	43	42.9

Source: GOK, 2013a; GOK, 2013b; GOK, 2014a; GOK, 2014b

As illustrated in Figure 2, grants/transfers to semi-autonomous government agencies (SAGAs) and their internal revenues from user fees accounted for three quarters (75%) of the total MOH recurrent budget in FY 2014/15. Grants to the SAGAs mainly cover personnel-related expenditures. In FY 2014/15, other major categories (but with relatively lower allocations) were personnel compensation, specifically for MOH headquarters, the Mathari Referral Hospital, and the National Spinal Injury Hospital (NSIH). Reimbursements to county health centres and dispensaries for providing free healthcare services under the abolition of user fees policy accounted for 2.7 percent. Comparative analysis shows decreases in allocations to SAGAs in FY 2014/15 over FY 2013/14, as well as notable increases in allocations to operations and maintenance, mainly because of the internship programme and personnel emolument (Figure 2).

Figure 2: MOH Health Recurrent Budget by Major Classification (%), FYs 2013/14 and 2014/15

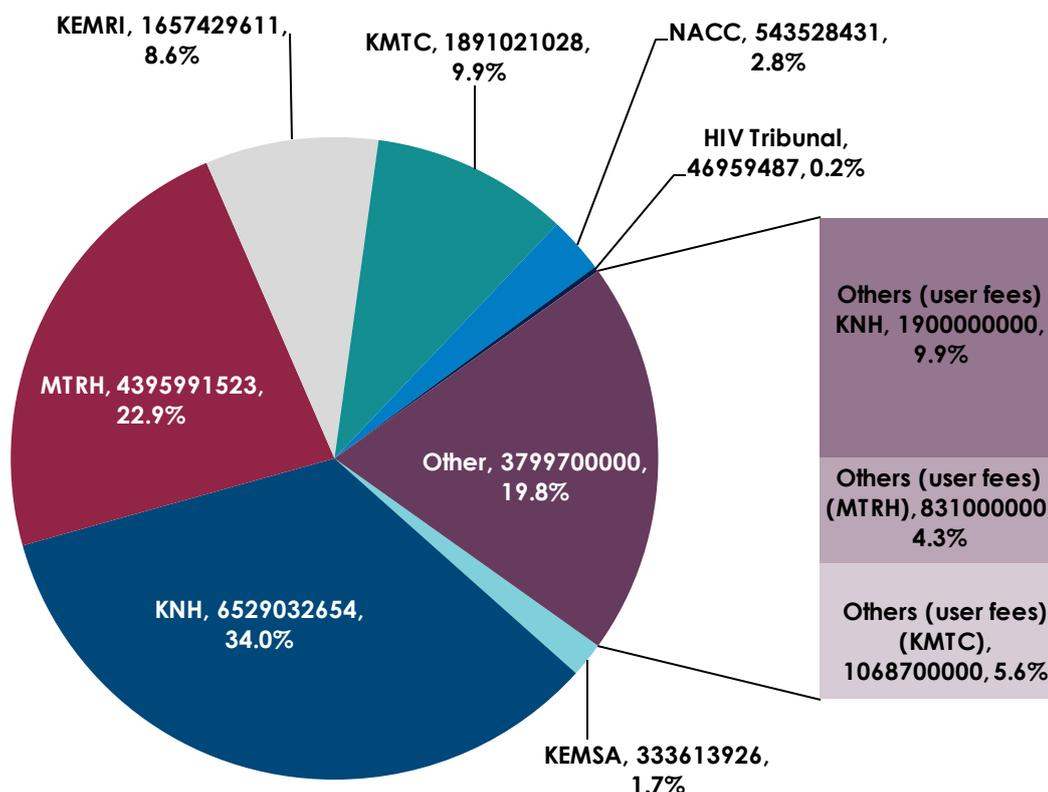


Source: Authors' calculations

Recurrent allocations for SAGAs under the MOH

Of the KShs 19.1 billion allocated to SAGAs in FY 2014/15, grants from the government accounted for 80 percent while locally generated revenues accounted for 20 percent of total resources allocated to SAGAs. As seen in Figure 3, Kenyatta National Hospital (KNH) received the largest allocation (34% grants and 9.9% user fees), accounting for 43 percent of the total grants to SAGAs during FY 2014/15, followed by Moi Teaching and Referral Hospital (MTRH) at 27 percent.

Figure 3: Recurrent Allocations for SAGAs FY 2014/15



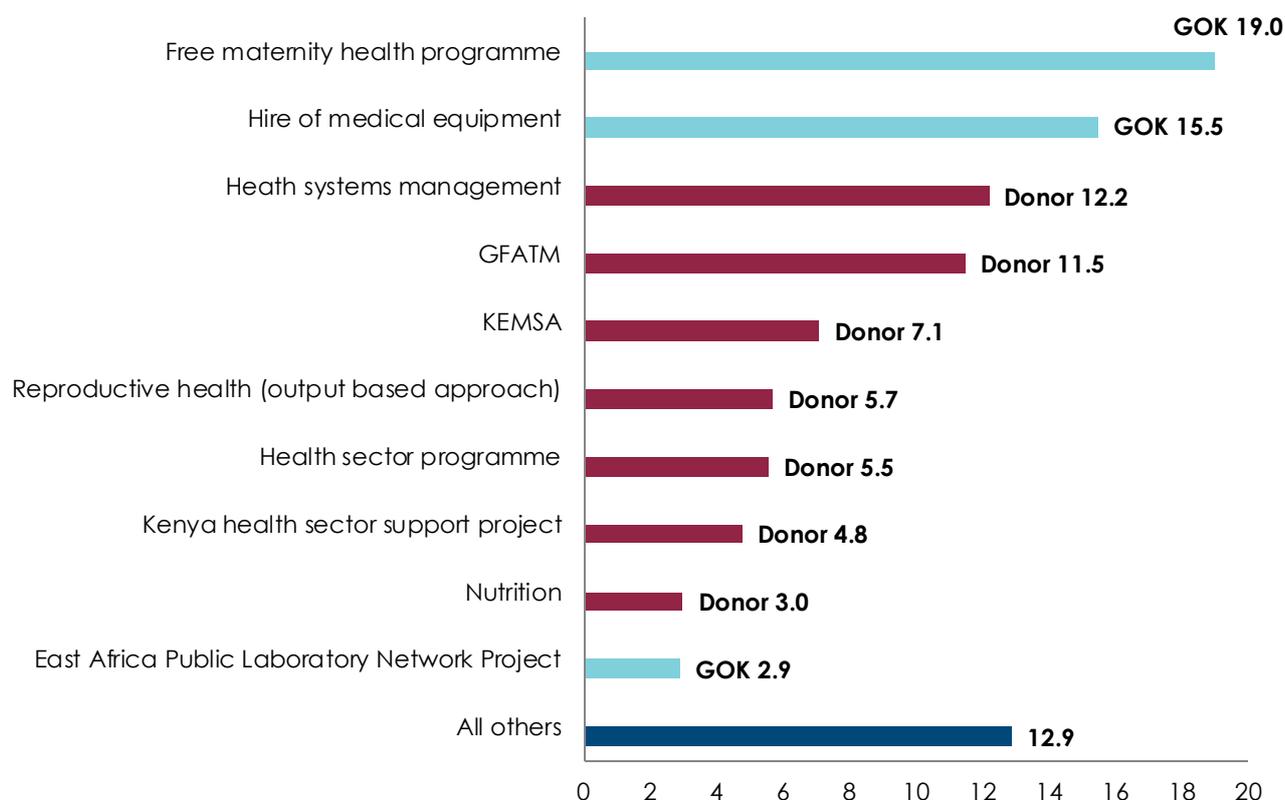
Source: Authors' calculations

Development vote allocations

The FY 2014/15 MOH development budget allocation (development partners plus government of Kenya (GOK) contribution) amounted to KShs 21.3 billion and focused on projects enumerated in Figure 4. The analysis shows that the free maternity health programme³ in public facilities accounted for almost a fifth (19%) of total MOH development budget allocations, while hiring of medical equipment accounted for 16 percent. A further 12 percent went to national HIV and AIDS, tuberculosis, and malaria programmes and was comprised of funds from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) (MOH, 2012).

³ The Free Maternal Health Policy is voted under the development budget while the abolition of user fees is voted under the recurrent budget.

Figure 4: Percent Allocations to Key Programmes/Projects Under MOH Development Budget, FY 2014/15



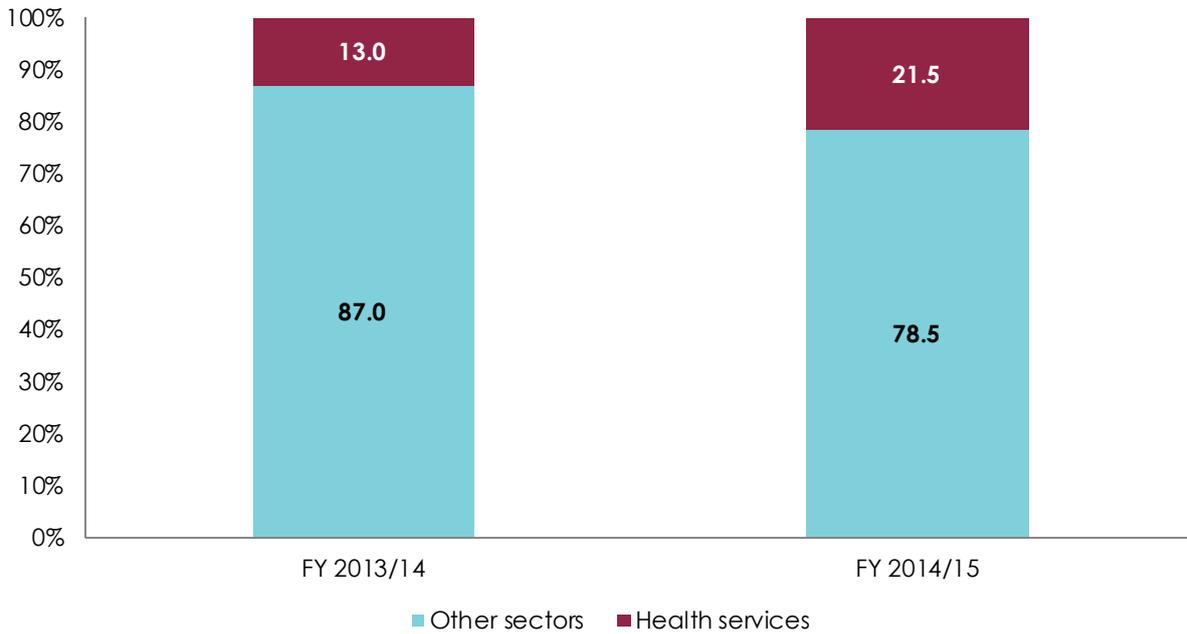
Source: Authors' calculations

County Allocation to Health

This section examines county health budget allocations against the overall total county budgets for FYs 2013/14 and 2014/15. The ratio of health budget to total budget measures the county governments' priorities and commitment towards the health sector and the improvement of health indicators. Figure 5 provides the proportion of the health budget as a percent of the county budgets for the two periods (FYs 2013/14 and 2014/15).

The data show that, in general, counties' health sector budgets in absolute numbers increased from KShs 42.1 billion in FY 2013/14 to KShs 64 billion in FY 2014/15, an increase of about 8.5 percent. In addition, the county health budget, as a percent of total county budget, increased from 13 percent in FY 2013/14 to 21.5 percent in 2014/15 (Figure 5). This suggests that county governments have given priority to the health sector despite many competing needs from other sectors, including agriculture, water, roads, and transportation.

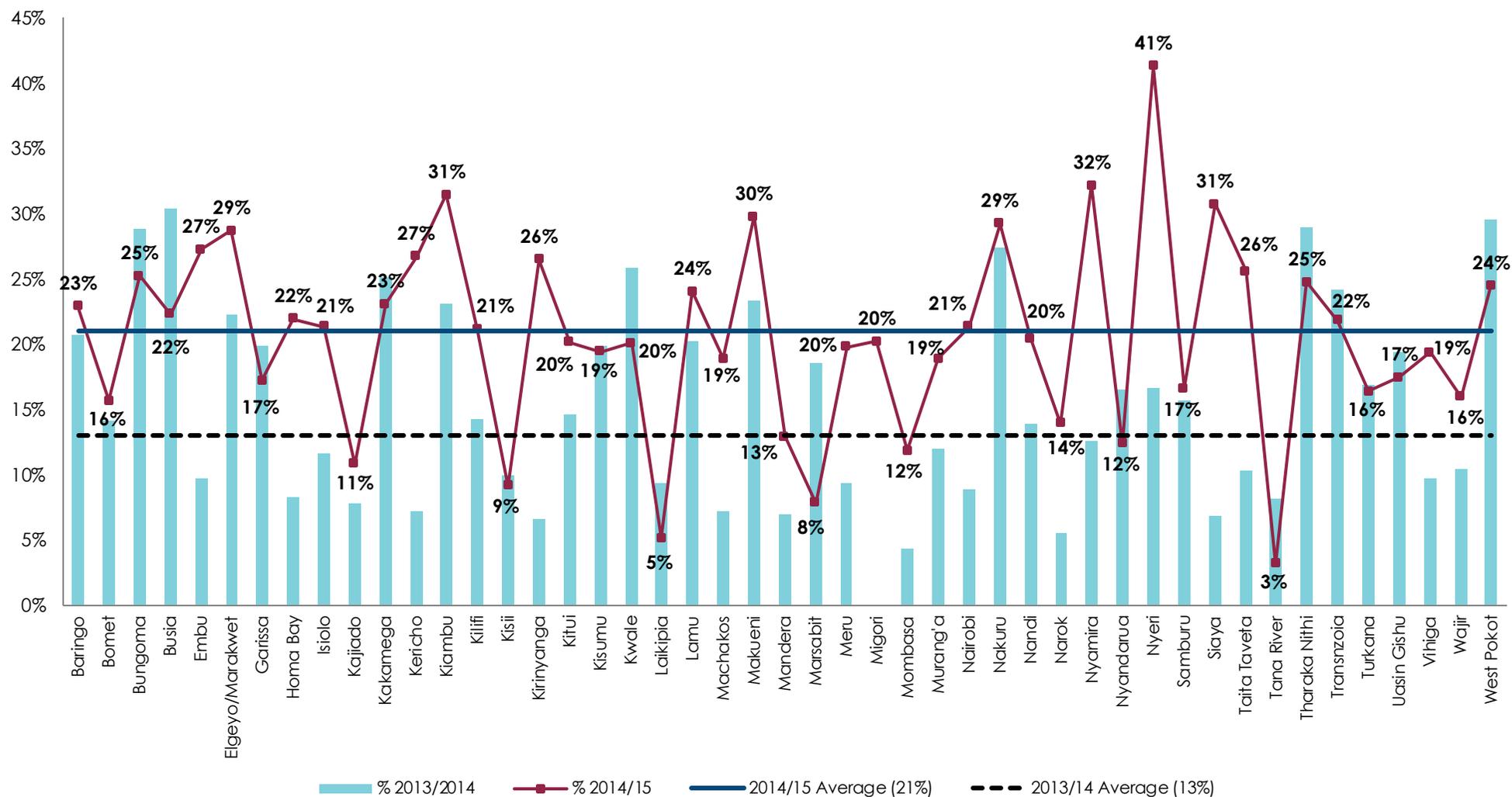
Figure 5: Health Services Allocations as Percent of County Budgets, FYs 2013/14 and 2014/15



Source: Authors' calculations

Compared with FY 2013/14, most of the counties have increased their allocations to the health sector relative to other sectors in FY 2014/15 (Figure 6). However, there is substantial variation in the health budgets between counties. For example, in the FY 2013/2014, only 22 counties allocated at least 15 percent of their budget to health. In FY 2014/15 this number increased to 38 percent.

Figure 6: County Health Budget Allocation as a Percentage of Total County Budget by County, FYs 2013/14–2014/15



Source: CRA, 2013; CRA, 2014

County health sector budget allocations: recurrent vs. development budget

Under devolution, county governments became responsible for a range of health services, including primary healthcare facilities, dispensaries and health centres, and level 4 and 5 hospitals. The major source of financing for counties remains transfers from the national revenues, which are shared among counties on needs-based formulae.

Overall County Recurrent and Development Expenditure Allocations

The counties’ recurrent budgets for health services have been consistently high. Although in nominal terms there was an increase in recurrent and development allocations in FY 2014/15, compared with FY 2013/14 (Table 4). These accounted for 75 percent and 25 percent of total county health budget respectively during FY 2013/14 and FY 2014/15. Overall, allocating almost a quarter of the health budget to development might reflect the counties’ determination to invest more in physical capital. These investments include refurbishing the existing stock of physical infrastructure as well as constructing new facilities and providing medical equipment stock.

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

Vote	FY 2013/2014		FY 2014/2015	
	KShs	%	KShs	%
Recurrent	31,601,918,024	75.1	48,052,151,334	75
Development	10,487,449,944	24.9	15,964,343,735	25
Total	42,089,367,968	100.0	64,016,495,069	100.0

Source: CRA, 2013; CRA, 2014

Recurrent versus development county health budget

The recurrent-to-development budget ratio is an important tool to measure the county governments’ effort to balance development with the recurrent component of the health sector budget for the effective delivery of services.

Table 5 provides the recurrent allocations by counties as a percentage of their total health allocations in FY 2014/15. The results show that 28 counties have allocated between 71 and 90 percent of the health budget to recurrent expenditure.

However, at one extreme, two counties, Kisumu and Kisii, allocated in excess of 90 percent of their health budget to recurrent expenditure (Kisumu at 91% and Kisii at 92%). At the other extreme, six counties (listed in the first column of Table 5) had relatively low recurrent allocations of 50 percent or below.

Table 5: Recurrent Allocations as a Percentage of Total Health Allocations by County, FY 2014/15⁴

Less than 50%		51 – 60%		61 – 70%		71 – 80%		81 – 90%		Over 90%	
Laikipia	24	Bomet	53	Garissa	62	Narok	71	Kwale	81	Kisumu	91
Mombasa	36	Kirinyaga	54	Wajir	63	Kiambu	73	Kericho	81	Kisii	92
Meru	41	Kajiado	56	Nandi	66	Kitui	73	Trans Nzoia	81		
Turkana	43			Machakos	67	Kakamega	74	Embu	82		
Marsabit	45			Lamu	70	Samburu	74	Vihiga	83		
Mandera	50			Murang'a	70	Tana River	74	Elgeyo			
				Kilifi	70	West Pokot	76	Marakwet	83		
						Uasin Gishu	76	Nakuru	85		
						Taita Taveta	76	Nairobi	85		
						Migori	76	Baringo	85		
						Isiolo	77	Siaya	86		
						Busia	77	Makueni	87		
						Bungoma	78	Nyeri	89		
						Tharaka Nithi	79	Homa Bay	90		
								Nyamira	90		

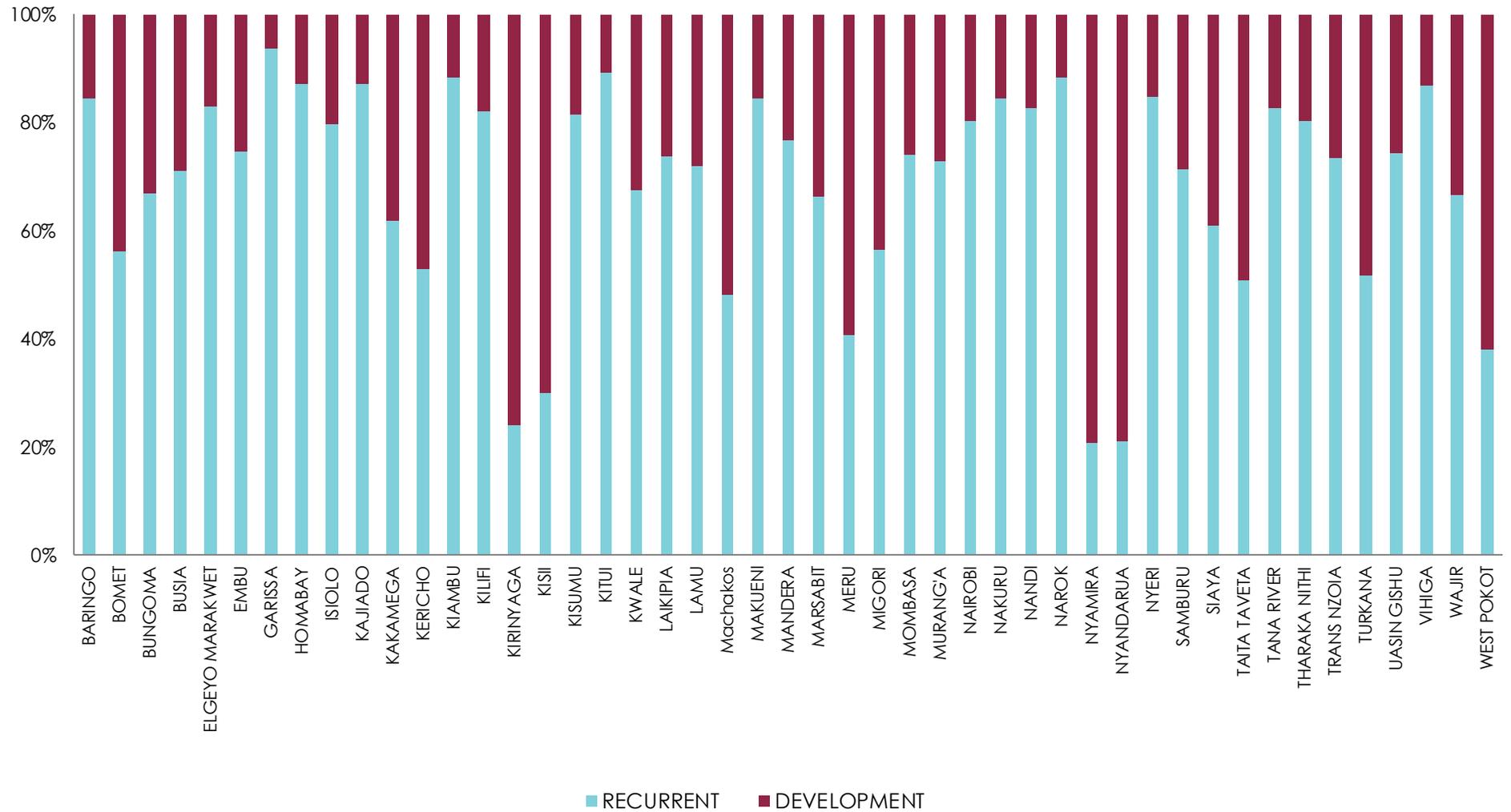
Source: Authors' calculations

There is also substantial variation in the allocation of budgets to the two major classifications (recurrent and development) among the different counties.

Figure 7 shows a predominance of recurrent expenditure over development estimates across the counties in FY 2014/15. Garissa, Kitui and Kiambu counties allocated the highest budget share to recurrent estimates (or lowest budget share of development expenditure estimates), while Nyamira, Nyandarua and Kirinyaga counties had the lowest (or highest budget share of development expenditure provisions). Figure 8 shows a similar pattern in FY 2013/14.

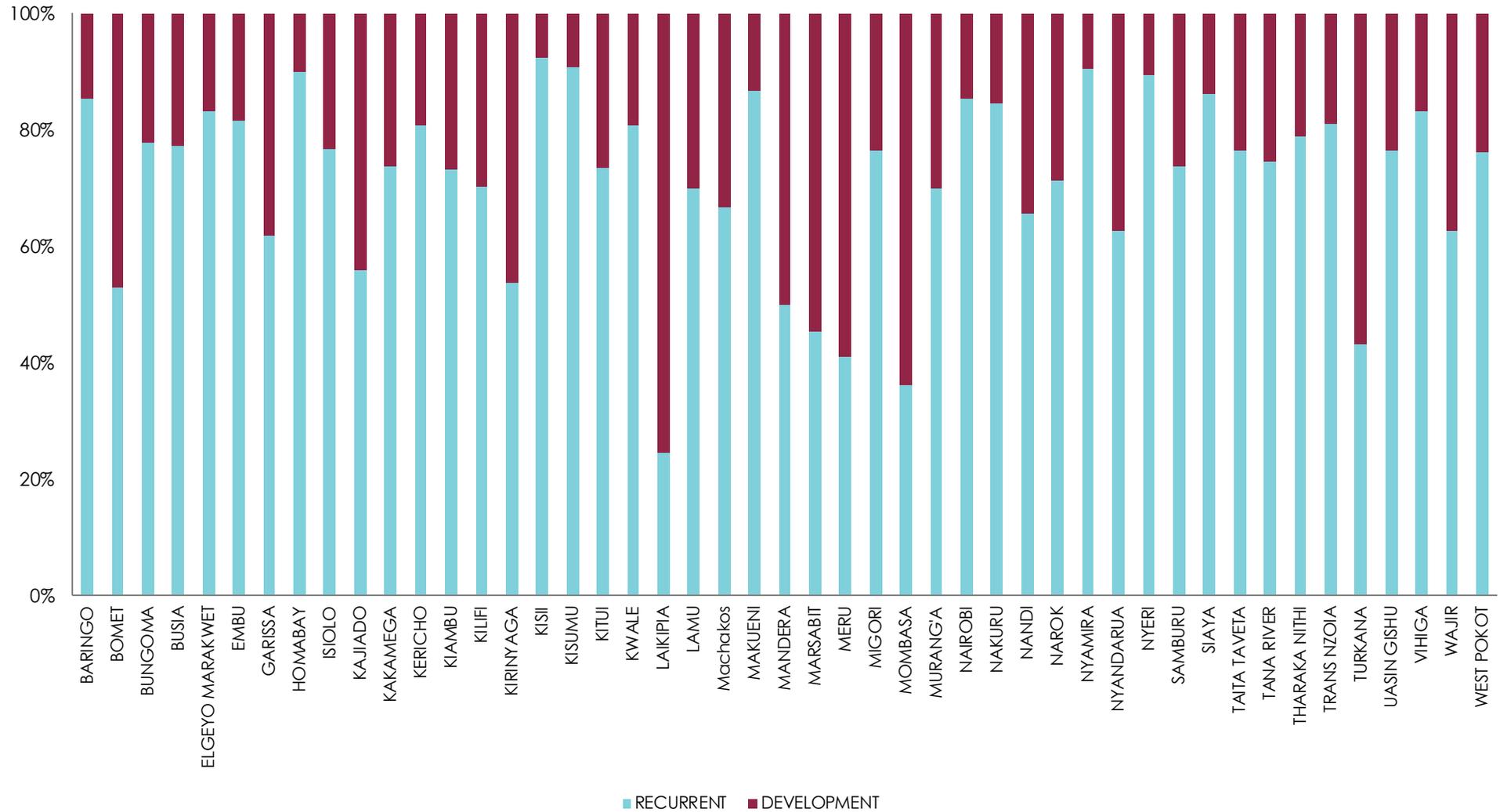
⁴ Figures in parentheses indicate the recurrent allocations as a percentage of total health allocations.

Figure 7: County Health Recurrent and Development Budgets, FY 2014/15



Source: Authors' calculations

Figure 8: County Health Recurrent and Development Budgetary Allocations, FY2013/14



Source: Authors' calculations

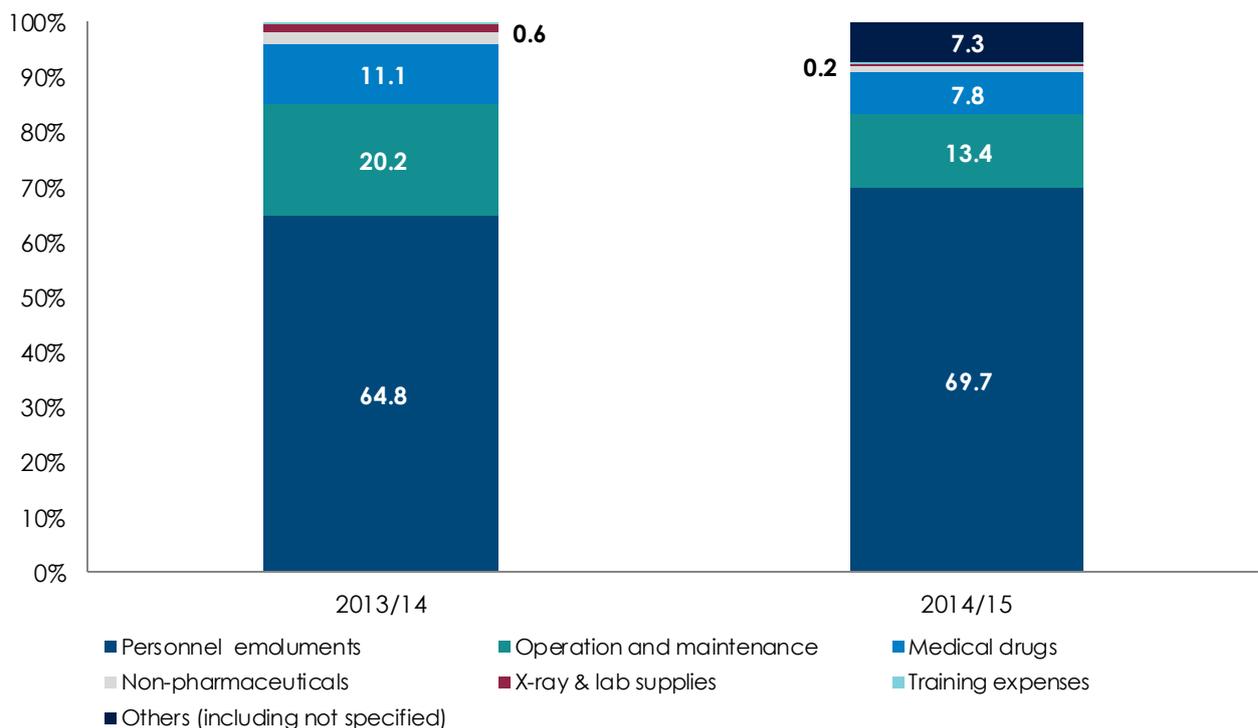
County health sector budget allocations by economic categories

Allocations to the health sector by county governments can also be analysed by economic classification. However, while development allocations may be seen as resources meant to finance capital projects like infrastructure, in many counties, drugs and non-pharmaceuticals were included in the development budget along with the more conventional capital project allocations. For the purpose of this analysis, such allocations that included drugs and non-pharmaceuticals were harmonised by moving them to the recurrent budget in order to accurately compare FY 2014/15 recurrent and development budgets to FY 2013/14 health budgets.

The analysis shows that the largest share of recurrent budget allocations go to finance compensation to employees - salaries and allowances. As seen in Figure 9, in FY 2013/14, 65 percent of the county health sector budget went to personnel, increasing to 70 percent in FY 2014/15. The remaining funds covered operation and maintenance (20% in 2013/14 and 13% in FY 2014/15).

The distribution of county recurrent health budget by economic categories therefore shows glaring inefficiencies in the way counties are allocating resources. A larger share of resources is covering the costs of employee compensation, while an insignificant share is being allocated to essential medical supplies like medicine. This suggests allocative inefficiencies.

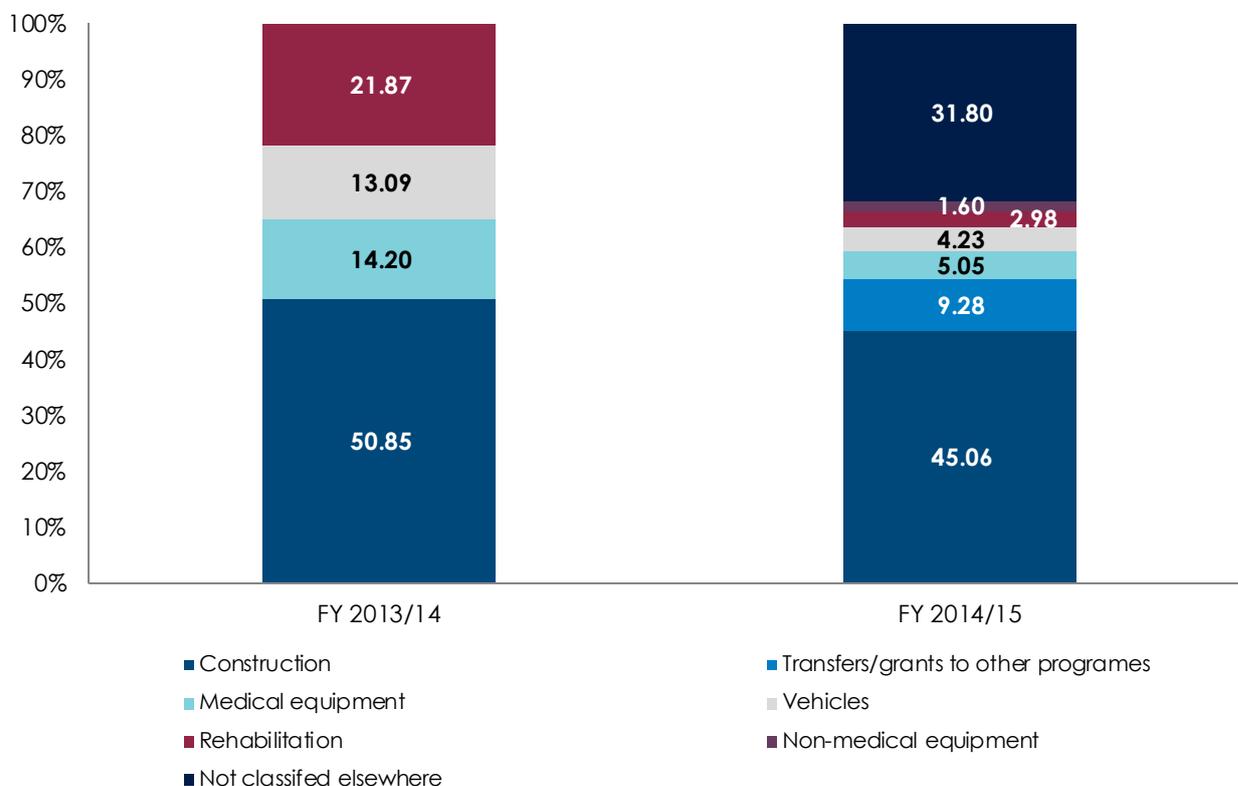
Figure 9: County Health Recurrent Budget Allocations (%) by Economic Category, FYs 2013/14 and 2014/15



Source: Authors' calculations

On the development budget, the largest expenditure category in FYs 2013/14 and 2014/15 were investment in construction projects that accounted for about 51 percent and 45 percent of the development budget in FY 2013/14 and FY 2014/15 respectively (Figure 10). Vehicles also received a higher allocation in FY 2013/14 with procurement of ambulances and other vehicles accounting for 13 percent, however, this allocation was only 4 percent in FY 2014/15. Allocation to medical equipment comprised 14 percent in FY 2013/14 and 5 percent in FY 2014/15.

Figure 10: County Health Services Development Budget Allocations (%) by Economic Categories, FYs 2013/14 and 2014/2015



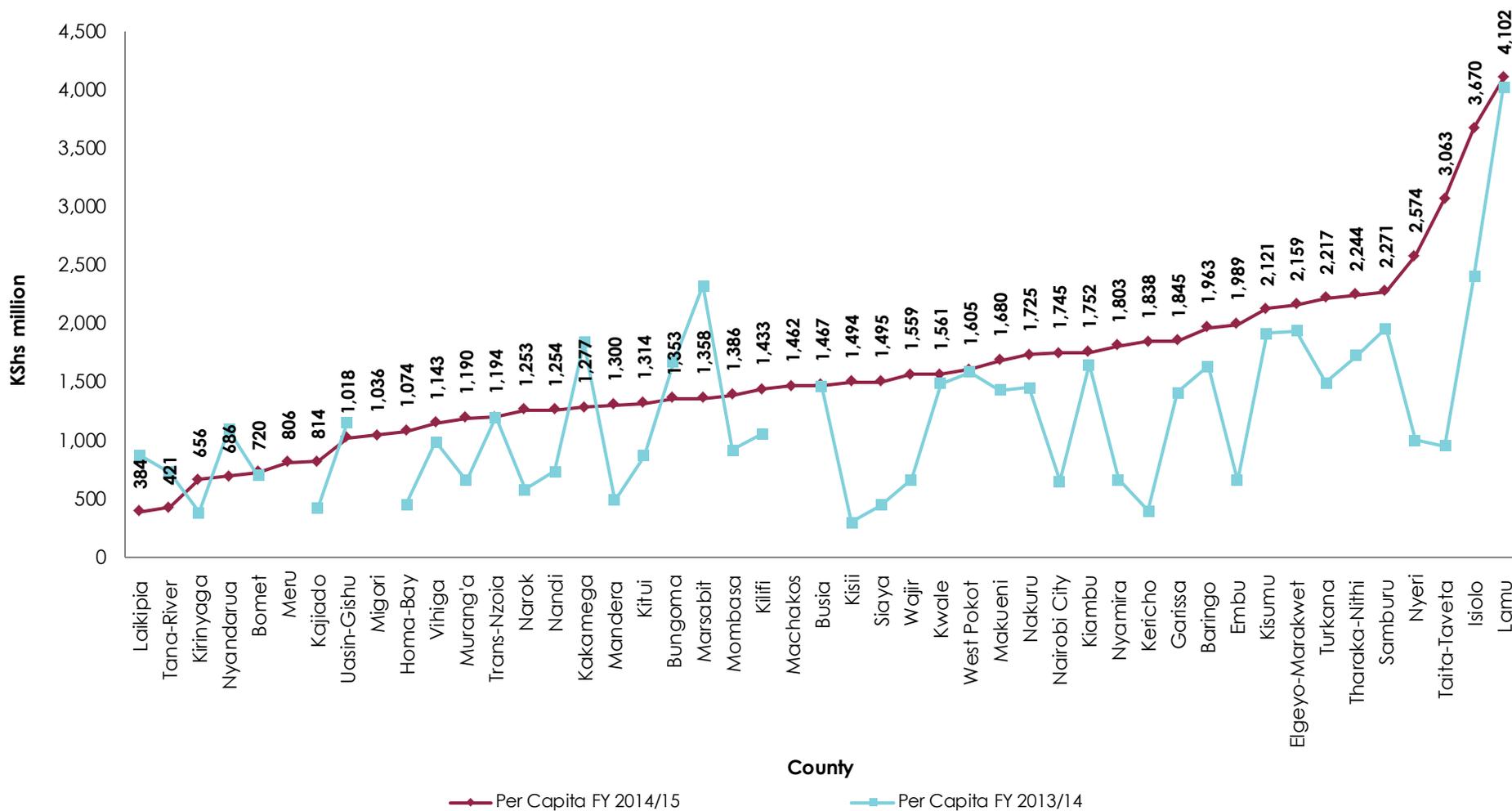
Source: Authors' calculations

In FY 2013/14, information on transfers/grants to other programmes, non-medical equipment, and allocations not classified elsewhere were not provided. They were, however, provided in the FY 2014/15 budget.

Per capita health services budgetary allocations by county

The analysis shows that the counties' health services budget allocation per person in FY 2014/15 was KShs 1,567 (US\$18.2). However, the allocation is skewed, with a range between KShs 4,100 (US\$47.7) in Lamu County, followed by Isiolo County KShs 3,670 (42.7) to a low of KShs 384 (US\$4.5) per capita in Laikipia County (Figure 11). Overall, there were improvements in per capita allocations in FY2014/15, especially among counties that had low allocations in the previous year.

Figure 11: Per capita Health Budget Allocations (KShs millions) by County, FYs 2013/14 and 2014/15

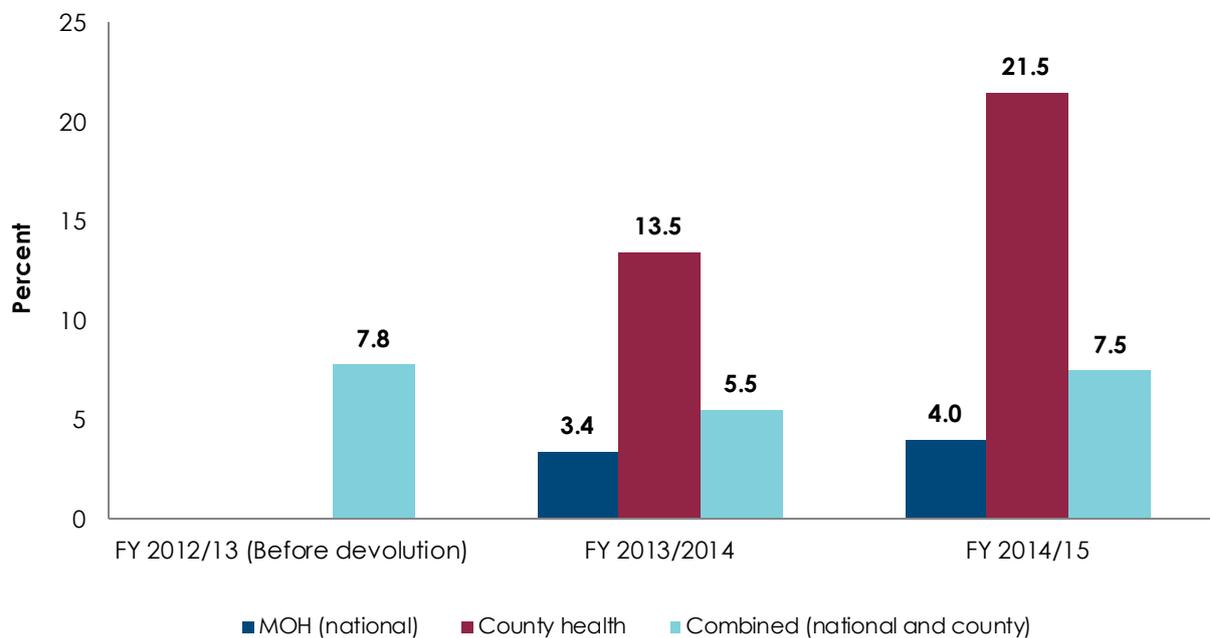


Source: Authors' calculations

Combined National and County Government Budget Allocations to Health

With the creation of 47 independent county governments, Kenya needs to revise the methodology it uses to estimate the targets required to achieve its commitment to the Abuja Declaration. The Abuja Declaration requires countries to allocate at least 15 percent of their total national budget to the health sector. The revised methodology should involve aggregation of health budgets of the 47 county governments and the MOH. Using this approach, the combined (national and county) allocations to health by Kenya is estimated to have increased from 5 percent in FY 2013/14 to 7.5 percent in FY 2014/15. However, both the FYs 2013/14 and 2014/15 estimates are lower than the 7.8 percent reported in FY 2012/13, before devolution was implemented. With the new estimates, Kenya is far from achieving the Abuja target.

Figure 12: Trends in Health Allocation Estimates as Percent of Total Budget by Level of Government



Source: Authors' calculations

CONCLUSION AND RECOMMENDATIONS

Conclusion

At the national level, there has been an increase in the health budget allocations between FYs 2013/14 and 2014/15. This is reflected in the increases in both the recurrent and development budgets. However, contributions from development partners have decreased between FYs 2013/14 and 2014/15. The overall county health sector budgets increased between the two years. The number of counties allocating more than 15 percent of their budgets to health sector also significantly increased between FYs 2013/14 and 2014/15. It is important for the national and county governments to continue giving priority to the health sector in budget allocations, not only to achieve the Abuja target, but also to successfully implement planned projects.

The distribution of county health budget by economic categories shows glaring inefficiencies in the way counties are allocating the limited resources at their disposal. The bigger share of county health budgets are going to finance personnel costs, while essential items like medicine are receiving limited attention in terms of resource allocation. These therefore suggest allocative inefficiencies.

Recommendations

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

- i. The MOH should support counties to develop a standard budget format to facilitate comparisons among the counties; this should be in line with programme-based budgeting.

Box 1: Programme-Based Budgeting

Programme-Based Budgeting 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, programme-based budgeting has many advantages. Specifically, PBB

1. Helps policymakers focus on goals and helps bring clarity around programme- and evidence-based policy choices
2. Allows managers to work with clearly defined expectations; 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 the economy, efficiency, and effectiveness
 - c. Make performance measurement central to budgeting.

Source: Authors

- ii. Since a large portion of county governments' allocation to health goes to compensating personnel, a necessary component of a productive health system, the National treasury should ensure the sharable funds for county level are sent to counties on timely basis to guarantee payment of salaries of health workers.
- iii. The results of the analysis show predominance of recurrent over development expenditure estimates across the counties. The county budget committee needs to ensure that over the

medium term a minimum of 30 percent of the county governments budgets are allocated to the development expenditure as stated in the PFMA.

- iv. The analysis found an emphasis on new construction and the upgrading of health facilities in the counties. These investments need to be matched with human resources and other inputs so that the facilities are not under-utilised. In expanding infrastructure, counties should first consider the existing pool of health providers, including contracting them if necessary. Equally, any expansion should be harmonised with priorities in the county development fund.
- v. The analysis shows that there are low allocations by counties to some programme activities, including HIV and AIDS, immunization, and family planning, all of which are important to improve health outcomes at the county level. Counties need to complement national budget allocations for these programmes.
- vi. A need-based formulae to guide the allocation of resources at the county level is one of the keys to ensuring priority areas/programmes like HIV/AIDS, malaria, and others receive much needed attention in terms of resource allocation.

Further, it is noted that the national government has plans to equip selected health facilities in the counties with specialised medical equipment. In the light of this and the other findings presented here, it is recommended that the two levels of government take into account the required human resources and current workloads. Without which these services could be under-utilised.

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