



29 May 2015

**PARLIAMENTARY COMMITTEE ON HEALTH
NATIONAL ASSEMBLY
KENYA**

MEMORANDUM TO THE PARLIAMENTARY HEALTH COMMITTEE OF THE NATIONAL ASSEMBLY

This memorandum summarizes our recommendations for improving the presentation of the FY 2015/16 Program-Based Budget with a focus on the Ministry of Health Budget. We also attach handouts that clearly explain our suggestions for improvement. For further information, please contact Dr. Jason Lakin at 0729937158 or jason.lakin@gmail.com.

1. **We applaud the efforts of the National Treasury to greatly improve the Program-Based Budget (PBB) from last year.** The 2014/15 PBB was a major advance over the 2013/14 version, and demonstrated serious commitment by Treasury to enhance the transparency and usefulness of national budget documents.
2. **In spite of these improvements, we believe the 2015/16 budget could have gone farther to improve transparency.** We make some very specific suggestions for further improvements in the Ministry of Health budget.
3. **Our suggestions relate to the following areas, which we explain further below:** Summary table; narrative links to budget data; indicators and targets; AIA/external funding; and breakdown of economic classification, including wage data and programs with clear objectives.

A. Summary table

The summary table at the beginning of the budget should show prior year allocations at program level, and should be accompanied by a table showing sub-program allocations as well. When the estimates are tabled, Parliament's focus should be on program and sub-program level amendments, which requires a summary table at sub-program level to see where the major proposed shifts are from year to year. Currently, to see the biggest shifts at program and sub-program level requires one to go ministry by ministry. Elgeyo Marakwet County produced a budget summary table at sub-program level, and the national government can do the same.

B. Narrative links to budget data

- 1. It is generally difficult to link the narrative to the budget figures for the programs.** For example, "Equipping and developing health infrastructure of 94 Hospitals (2 per county) on a Managed Equipment Service (M.E.S) contract framework" is mentioned as a priority in the budget narrative, but details of the same cannot be traced easily in the budget figures provided.
- 2. The 2015/16 narrative still fails to explain choices about allocations at program or sub-program level, which is the main purpose of a budget narrative.** For example, the biggest change in the health sector this year is the increase in funding for the Health Policy sub-program, but this is not mentioned in the budget narrative at all, while items mentioned in the narrative, such as the Health Insurance Subsidy Program, cannot be found in the budget allocations. It is hard to understand the choices that are being proposed in the sector.
- 3. Generally, the narrative does not tell us how priorities are changing over time.** Shifting of expenditure items between programs and sub-programs has created the impression that priorities are shifting when in fact much of this is simply due to reorganization of the budget presentation. For example, there is a decline in the share of total spending going to the Preventive & Promotive Program of about 5 percent, which is driven by a large drop in the Health Promotion sub-program and the Non-Communicable Disease sub-program. This is largely because there is a shift of Immunization from the Health Promotion sub-program into its own sub-program in the Maternal Program. This in turn has resulted in a big increase in that program, but not a real shift in priorities. The same seems to be true for the two sub-programs – Non-Communicable Disease (NCD) and Communicable Disease (CDC), where some items in the NCD like HIV, maternal health, TB, and malaria have now been moved (probably correctly) to CDC, which has led to an increase in its allocation due to reorganization, but no actual change in priorities.

C. Indicators and targets

- 4. Indicators and targets continue to be less useful than they should be. In 2015/16, they still lack baselines making it impossible to know how realistic the targets are. In addition, there is introduction of new indicators and targets over the years, with some being dropped and some replaced without any explanation.** For example, in the health promotion sub-program, under the delivery unit "environmental health services," the indicator used in 2014/15 was "% of households with latrines," and the target was 70 percent by the year 2015/16. However, that has been dropped this year and the same unit now has a new indicator – National Aflatoxin Management, with no target for the year 2015/16. Why?

Many of the targets in the 2015/16 budget are inconsistent with other government sources. Some of these sources, including sector working group reports, show that the budget targets were already met last year!

For instance, the average length of stay (ALOS) in Kenyatta National Hospital for inpatient decreased from 10.7 days in FY 2012/2013 to 9.5 in FY 2013/2014, according to the Health Sector Report for the year 2014/15. However, the budget still has the ALOS of 10.7 days as the target for 2015/16.

In addition, a look at KMTC in the ministry of health's narrative below shows that we are already graduating almost 22,000 workers, but the target for the 2015/16 budget year is only 21,000. The lack of seriousness in setting indicators/targets makes it difficult for Parliament to exercise oversight over whether spending is leading to service delivery objectives.

Figure 1: Snippet from the ministry of health budget estimates 2015/16

In its core mandate of Training health workers, Kenya Medical Training College graduated 21,853 health workers of different cadres while its student population increased from 19,000 to 23,000. KMTC has now 34 campuses countrywide.

D. External funding

- 5. In the 2015/16 PBB, there is still no information provided on Appropriations in Aid, meaning there is no information on external funding of the budget.** Given an increase in external funding apparent from the line-item budget this year of 87% (over Ksh 160 billion increase), this is a major omission from the PBB. Information on external funding is important for several reasons, including the fact that sectors with heavy external funding tend to have more trouble actually spending their budgets. The health sector is slated to receive a total of Ksh 11B in AIA for health in the development budget this year, but these funds cannot be seen in the PBB.

E. Breakdown of economic classification including wage data

- 6. Both 2014/15 and 2015/16 PBBs lack adequate breakdown of economic classification, including information about staff compensation.** The budget provides only a gross figure for staff compensation at the sub-program level, and no information on the number, type of employees or job group is provided.
- 7. The continued use of vague categories, such as "other development" and "other recurrent," for major allocations undermines transparency.** These are intended as residual categories but sometimes take the largest share at sub-program level. For instance, in the forensic and diagnostics sub-program, "other recurrent" receives a Ksh 4.7B allocation. It is impossible to know what this is for.

F. Programs and Objectives

- 8. Program objectives have been revised and no longer overlap as in the 2014/15 budget.** For instance, the preventive and promotive health program no longer overlaps with the curative health program. One emphasizes preventive while the other specialized care. **However, they do not aim at achieving outcomes, but only outputs, which is inconsistent with the government's own PBB manual. The same is true for the newly revised maternal health program objective.** The PBB manual states that:

Program objectives should be explicit and brief. Ideally program objectives should be succinctly stated in one sentence. Program objectives are often poorly defined. Oftentimes they are too wordy and unclear. It is not unusual to find program objectives which focus entirely on the output (service) which the program delivers to the public, or on program activities/processes, with no reference to the intended outcomes.

The overarching program objective should indicate the key outcome(s) the program seeks to achieve. This is important not only for clarity in program definitions, but also to provide a framework for the derivation of program performance indicators and targets.

- 9. There is reduction in the number of sub-programs making it difficult to track spending over time.** For example, in 2014/15 the preventive & promotive program had five SPs but this reduced to three SPs in 2015/16 thus making it difficult to track and evaluate the achievement of targets and indicators over the years.
- 10. The priorities mentioned in the simplified citizen version of the budget, "Budget Highlights," do not fully align with the allocations in the full budget.** KSh 9.0 billion for Kenyatta National Hospital and KSh 5.5 billion for Moi Teaching and Referral Hospital are mentioned in the highlights but difficult to link in the budget figures in the PBB. There is only one block figure of Ksh 16 billion to national referral hospital. A look at the development and recurrent line item budgets give figures which are close to, but not exactly the same as the amounts above (Ksh 9.3B and Ksh 5.8B respectively). There is also a mention in the highlights of KSh 1.0 billion for slum health care program. It is difficult to trace this allocation in the budget figures. Last year, this was also the case. It was mentioned in the narrative, but was difficult to track exactly under which program or sub-program was.