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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 recognize the increase in the amount of allocation for the health sector from last year, with a huge increase going to the development budget (45 per cent).** The overall budgetary increase for the ministry of health was about 38.4 per cent.
- 2. We also 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.
- 3. While there have been efforts to improve the budget presentation from the first shift from line item budgeting to PBB in 2013/14, 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.**
- 4. Our suggestions relate to the following areas, which we explain 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.

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 subprogram allocations as well. When the estimates are tabled, Parliament's focus should be on program and subprogram level amendments, which requires a summary table to see where the major proposed shifts are from

year to year. Currently, to see the biggest shifts at program and subprogram level requires one to go ministry by ministry. Elgeyo Marakwet county produced a budget summary table at subprogram level, and the national government can do the same.

Narrative links to budget data

5. The 2015/16 narrative still fails to explain choices about allocations at program or subprogram 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 subprogram, 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.

6. It is difficult to link the narrative to the budget figures of the programmes eg. Equipping and developing health infrastructure of 94 Hospitals (2 per county) on a Managed Equipment Service (M.E.S) contract framework which is mentioned as a priority in the budget narrative but details of the same are cannot be traced from the budget figures provided. Ideally, we would assume this will be under the curative health program, which had the allocation raise to Ksh 16B from Ksh 14 B. In addition, going deeper into the budget figures, we see human resource management taking around Ksh 3B and therefore we would assume this is the money to be used to pay for staff working in the health sector, but comparing to what this received last year, there is a huge decrease of Ksh 1B. It is not clear why this is the case and therefore the budget figures contradict with the policy interventions and priorities mentioned.

7. Narrative fails to explain reasons for making allocations that contradict the health sector report. The allocation for 2015/16 is Ksh 59.1B is lower than the total resource requirement (Kshs. 88.9 Billion) as recommended by the health sector report for the Financial Year 2015/2016. The narrative section in the budget that shows performance overview and background for programme funding should explain the reason for this shortfall between what is needed and what is allocated and whether it is actually dealt with.

8. Generally, the narrative does not tell us how priorities are changing over time. If we look at program level shifts, what do we see? Overall, there is an important decline in the share of total spending going to the Preventive & Promotive Program of about 5%, which is driven by a large drop in the Health Promotion SP and the Non-Communicable Disease SP. This is in spite of a fairly large increase in the Communicable Disease SP also within the same Program. What is happening here?

9. Part of the story is simply due to the shift of Immunization from Health Promotion into its own SP below the Maternal Program, which has resulted in a big increase in that program, but not a real shift in priorities. The same seems to be true for NCD and CDC: some of the items under NCD like HIV, maternal health, TB, malaria, etc. have now been moved, probably correctly, to

CDC, which has led to an increase. From the economic classification for the CDC SP, the big increase is in transfers and “other development.” From the PBB, it appears that another new item in CDC is Global Fund expenditure for TB, malaria, etc. The budgets associated with the Global Fund lines are about Ksh 3.6 billion. The increase in CDC in transfers and “other development” is about 3.5 billion. So it would appear that most of this increase can be linked to the shifting of budget lines from one place to another, rather than a major increase in funding. Where did these items come from before they moved to CDC? They came from NDC.

10. The decrease in NCD is about 1.2 billion while the increase in CDC is about 4.2 billion, however, so this cannot be the full explanation of the shift. This is because these items, such as Global Fund, also did increase substantially this year: the total for the three GF lines increased by roughly Ksh 1.2 billion. So in addition to organizational changes in the budget, there were some important increases in CDC items.
11. Aside from these shifts, there were increases in the Administration Program as a share of available resources for the sector (4 percentage points). What caused this increase? This was driven by increasing weight on the Health Policy SP. And that in turn was caused primarily by the introduction of Health Sector Support Programme Phase II, which is a new 1.2 billion Ksh program, plus an increase in existing rural health programme of about 900 million. In addition, the Division of Mental Health was also moved into this SP. Finally, a major increase in planning and feasibility studies, supported by nearly 2 billion in donor funds, is driving the budget up for this item.
12. Does the narrative actually explain any of this? Not really. There is no mention of the increases in health policy (nor is it obvious why any of these items are actually in the health policy programme).

Indicators and targets

13. **There is introduction of new indicators that are inconsistent with the sector report recommendations.** 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. The budget still has the ALOS of 10.7 days as the target for 2015/16.
14. **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 subprogram, under the delivery unit – environmental health services, the indicator used in 2014/15 was %

of households with latrines, and the target was 70% by the year 2015/16. However, that has been dropped 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 budget are inconsistent with other government sources. Some of these sources, including sector working group reports, show the budget targets were already met last year!

15. In addition, a look at KMTC in the ministry of health's narrative shown below shows that we are graduating almost 22,000 workers, but the target for the 2015/16 budget year is only 21,000 for this year.

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.

16. **Missing indicators which are important.** There is information on the ministry achievements besides sector allocation over the years with information on the budget trends as well as achievements. For instance, HIV prevalence rates reduced from 13.9 % in 2000 to 5.6 % in 2013. However, there is no direct relationship between this information and the indicators and targets. HIV prevalence as an indicator for this sector is missing. Instead, the only indicators available are % of HIV positive mothers receiving care, No. of treat clients and no of patients receiving HIV viral load test.

External funding

17. **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.

Breakdown of economic classification including wage data

18. **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.
19. **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 subprogram level. For instance, in the forensic and diagnostics subprogram, the “other recurrent” receives a Ksh 4.7B allocation while we do not really know what this is for.

Programmes and Objectives

- 20. Programme objectives have been revised and no longer overlap as it was seen 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 go against the PBB manual. The same is true for newly revised maternal health program objective.** As per the PBB manual which 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.

- 21. There is reduction in the number of sub programmes.** For example, in 2014/15 the preventive & promotive programme 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.

Priorities mentioned in the budget highlights versus the actual allocation in the budget

There is a mention of Ksh12.9 billion in the budget highlights for free access to primary health care in dispensaries, maternal health care, leasing medical equipment, and internship program. This is allocated as follows:

- 22. KSh 4.3 billion is for free access to maternal health.** This can be easily tracked under the maternal and child health program. However, our analysis shows that there is only Ksh 308 million increase from last year. Therefore this is not a completely new allocation!
- 23. KSh 3.5 billion for Kenya Medical Training Centers.** We could assume that this is under the health research and development program. However, this has not really increased substantially compared to last year’s figure. There is only about Ksh 330 million increase.
- 24. KSh 9.0 billion for Kenyatta National Hospital and KSh 5.5 billion for Moi Teaching and Referral Hospital is 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, therefore difficult to compare what the two hospitals were getting last financial year. A look at the development and recurrent line item budgets figures give figures which are close to, but not exactly the same as the amounts above (Ksh 9.3B and Ksh 5.8B).

- 25. 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 subprogram was.