

Summary of the Health Sector Analysis

Allocations-comparison between the years
Program Based Budget presentation

Allocation comparison between years

There seem to be an increase in the amount of allocation of the health sector from last year, which a huge increase going to the development budget with 45.6%. The overall increase in the budgetary allocation was about 38.4%.

FY 2014/15 (Million)	FY 2015/16
Recurr(26,311) Develop (21,051) Tot(47,362)	Rec (28,519) Dev (30,664) Tot (59,183)
Rec(2,208) Dev(9,613) Tot(1,821)	
(Rec 8.3%, Dev 45.6% Tot 38.4%)=% increase in sector allocation	

Summary by vote and expenditure of programmes

- The lion share of the recurrent allocation goes to curative health programme (16.3Bn) and (9.5bn) for development expenditure with the General administration planning and support program receiving the highest share for FY 2015/16. The increased funding goes in line with the budget priorities identified in the narrative section of the health ministry – scaling up policy interventions to ensure equitable access to health care.
- However, 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.

Program Based Budget presentation

Budget Narrative

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.

A look also at KMTC in 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.

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.

More generally, the focus areas for the year are not given as program or Subprogram level items making it difficult to connect. There is a mention of some priorities in the narrative section but no further details on the same under the disaggregation of programmes e.g. Health Insurance Subsidy Program (HISP) seems to be missing in the subprograms.

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 16B from 14 B.

The problem is the mental and spinal injury subprograms were combined into one subprogram – national referral services and therefore makes it difficult to trace where exactly the allocation went to in the program based budget. However, a look at the line item budget under the Curative Services, one can see the increased allocation to 4.7 billion for rental of produced assets.

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?

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.

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.

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.

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).

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. In addition, some indicators have been dropped and/or replaced with new ones despite the targets for the previous years not achieved. For example, in the year 2014/15 under the health promotion subprogram, the delivery unit environmental health had an indicator % of households with latrines with targets 34% and 70% to be achieved respectively in the years 2014/15 and 2015/16. This is now replaced by an indicator “National Aflatoxin Management”.

Programmes and Objectives

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 goes 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.

There is reduction in the number of sub programmes eg in 2014/15 the preventive & promotive programme had 5 SPs but this reduced to 3 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

KSh12.9 billion for free access to primary health care in dispensaries, maternal health care, leasing medical equipment, and internship program. This is allocated as follows:

KSh 4.3 billion is for free access to maternal health – can be easily tracked under the maternal and child health program. However, there is only KSh 308 million increase from last year. This is not a completely new allocation.

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 years figure. There is only about Ksh 330 million increase.

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 (9.3 and 5.8).

KSh 1.0 billion for slum health care program – difficult to trace this in the budget figures