

# Module 1 ■ What Are Counties Responsible For?

5 HOURS, 15 MINUTES

## LEARNING OUTCOMES

By the end of this module, the participants will have:

- identified the functions assigned to the national government and county governments, according to the Fourth Schedule of the Constitution;
- examined the division of functions between national and county government, especially for the education, health, and agriculture sectors;
- pointed out gaps in clarity about the functions assigned to national and county government, especially for the education, health, and agriculture sectors;
- reviewed the August 2013 Gazette notice issued by the defunct Transition Authority on the transfer of functions;
- Reviewed the January and February 2016 Gazette notices issued by the defunct Transition Authority on the transfer of specific functions to county governments.
- Reviewed the extent to which the April 2016 gazette notice issued by the defunct Transition Authority clarifies the roles and responsibilities of county governments;
- learned about county revenue sources (national and own revenues)
- studied data at county and ward level from various data sets as a starting point for identifying county priorities; and
- examined an existing county development plan in order to consider how to move from a plan to a budget.

## Introduction to Budget Analysis

### CASE STUDY: COUNTIES SLASH HEALTH CARE BUDGETS?

45 MINUTES

## KEY TAKEAWAYS

GOOD BUDGET ANALYSIS REQUIRES THE ANALYST TO TAKE INTO CONSIDERATION:

- ✓ CHANGES OVER TIME IN ALLOCATIONS TO DIFFERENT SECTORS/ITEMS
- ✓ THE IMPORTANCE OF ALLOCATING BOTH RECURRENT AND DEVELOPMENT(CAPITAL) EXPENDITURE IN ACHIEVING SECTOR OBJECTIVES
- ✓ DIFFERENCES ACROSS COUNTIES IN PRIORITIES AND NEEDS THAT AFFECT ALLOCATION OF RESOURCES

## OBJECTIVE

### ❖ IDENTIFYING STRENGTHS AND WEAKNESSES IN BUDGET ANALYSIS

## RESOURCES NEEDED

- ✓ Flipchart paper, markers, and tape
- ✓ Paul Wafula's articles from The Standard available at:

<http://www.standardmedia.co.ke/lifestyle/article/2000097475/alarm-as-30-counties-slash-health-budgets>

<http://www.standardmedia.co.ke/health/article/2000097556/new-report-reveals-top-and-bottom-counties-in-health-spending>

- ✓ Jason Lakin's article from The Star(optional) available at:

<http://www.the-star.co.ke/news/article-144691/paper-was-wrong-health-budgets> .

## HOW TO RUN THIS TASK

1. Ask participants to read the two articles by Paul Wafula (Participant Manual (PM), page 2) and then ask for volunteers to explain what the stories are about in plenary. Try to focus first on the purpose and logic of the stories, and not on their strengths and weaknesses.
2. After it is clear what the story is about, then try to encourage a discussion about whether the stories make sense and capture important challenges in county budgeting.
3. Certain key points need to come out at a minimum. These are covered here and in point 4 and 5. The first key point is related to budget comparisons. Explain the importance in budget analysis of making comparisons between the previous year and the current year, but also the challenges of doing this in the first year of devolution (There were no counties in 2012/13, but there was data from national government on how much was spent roughly in each county before devolution. This is the basis of the comparison in Wafula's analysis and is laudable, though not fully explained. At the time, maintaining service levels during the transition was important and is still important as counties continue to grow. Thus, assessing whether they were maintaining funding in the first year of devolution at pre-devolution levels for key services like health was an important question).
4. A second key point relates to the difference between recurrent and development expenditure and what this means in the health sector. The key point here is that when making budget comparisons from year to year, and when focusing on service delivery sectors like health or education, it is not possible to draw firm conclusions from looking only at development/capital budgets. First, most service delivery costs in these sectors are recurrent: salaries, supplies, etc. Second, spending on recurrent and development has different patterns from year to year. If a health facility spends X and Y on recurrent and capital respectively in a given year, what can we say about the budget for the next year? If the facility spends less than X in the next year, this likely means fewer staff or fewer drugs, since it is not possible to pay less and maintain salaries and supplies. However, if the facility spends less than Y on capital, this may be perfectly adequate in a number of cases. For example, if Y was spent to buy new equipment in the first year, or to refurbish the maternity wing, it is not necessary to spend Y again in the next year. In fact, we might expect Y to go down and X to go up, because new equipment or facilities now require operational and maintenance costs which are recurrent in nature. Thus we cannot react in the same way to a cut in X and a cut in Y. This is a weakness of the article and a key point about budget analysis.

5. A final point in this discussion is about comparison across units. Comparison across time and comparison across units are both important, but they must also be done carefully. In the case of comparing across units, we need to understand the needs of each unit first before we decide whether to compare them. For example, it would not make sense to say that a county with many facilities and few doctors should continue to spend more on capital rather than recurrent as might be the case in a county with few facilities and many personnel.
6. After completing the discussion, if there is time, ask the participants to look at the rejoinder article by Jason Lakin.

### **BACKGROUND INFORMATION**

- **Recurrent expenditure:** Expenditure that does not result in the acquisition of long-term assets. It consists mainly of expenditure on salaries, goods and services (like medicines), etc.
- **Capital expenditure:** Funds spent for the acquisition of a long-term asset; the total spending on such assets would be divided over several years. This includes expenditure on equipment, land, buildings, etc.
- Example of the recurrent and development expenditure in the health sector is paying for workers and building hospitals, respectively. Increasing development from year to year does not necessarily relate directly to quality of services in that year, though it should have some impact over time if the assets are productive.

**Note: In Kenya, traditionally “development” expenditure has included both capital and recurrent expenditure (the latter was often included if it was funded by “development partners”). The PFM Act, 2012 actually defines development expenditure as “capital” expenditure, so eventually the two should mean the same thing in Kenyan budget documents. However, there continues to be a fair amount of confusion about this matter. At the same time, it is important to understand that there is no perfect line between capital and recurrent (or what is sometimes called current) spending. For example, money spent on an asset like a road or building will involve paying wages to construction workers. Normally, wages are considered recurrent, but a wage in service of developing an asset is part of capital expenditure.**

- It is essential for one to know their county well and the fact that every county is different with its own needs. A common assumption is that spending more on capital/development is always better, but this is frequently not the case. It is also not as easy to compare per capita development expenditure as it is to compare per capita recurrent spending. This is partly due to the ongoing and consistent relationship between population and many services, such as health or education. For example, for every 30 students, a new teacher may be needed, or additional surgical gloves, but a new road or bridge may only be needed for every 1000 additional people, and even then, we might not need a new road (capital) but just more and better maintenance (recurrent). Because every additional person has a closer link to recurrent spending than to capital spending, per capita recurrent spending is more useful than per capita development spending.

## DISCUSSION

For journalists, the focus of the discussion should be:

1. Is the story framed properly? Is there really a “crisis”?
2. What contextual information is included and what is missing?
3. What are the sources for the story and how could these have been used better?
4. How would you write the story differently?

For CSOs, the focus of the discussion should be:

1. Is this type of analysis useful for advocacy? How would you use it in your own county?
2. What other information would you need for a successful advocacy campaign on this issue?
3. How would you structure an advocacy piece or short policy brief to achieve your goals?

Analysis

- Strengths of the analysis include the fact that it tries to look at previous year spending and compare to the current year to determine whether services are expanding or contracting, and tries to compare per capita expenditure across counties.
- A major weakness is that the analysis is limited to development spending and therefore misses the key issues in the health sector. It also does not clearly state this at the outset, giving the impression that budgets as a whole are falling when only development is referred to. Health is a sector where recurrent and operational costs are the main driver of expense. While investing in new facilities is also important, such spending is not necessary in a given year to be able to maintain services.
- Moreover, recurrent spending and development spending have different properties. If recurrent spending falls in a given year, it is likely going to lead to firing of staff or severe contractions in medicines, etc. But the development budget can go up and down depending on project cycles for infrastructure projects.
- The series confuses these two things and focuses on a “crisis” in the sector that is actually only about development, not recurrent, expenditure, and is therefore not a crisis. The title is misleading.
- Why doesn’t the article look at recurrent spending? Partly because county budgets were not transparent in 2013/14 and it was very difficult to find health worker salaries in many budgets. This being the largest part of the recurrent health budget, it made it difficult to do proper analysis. This issue continues to be a challenge even today in many counties, and not only in the health sector.

## Wafula Article 1

### Alarm as 30 counties slash health budgets

Updated Tuesday, November 12th 2013 at 00:00 GMT +3

By Paul Wafula

**Kenya:** Thirty counties will spend less on health this year, compared to what the national government spent on citizens in 2012. In their rush to beat the June 30, 2013, deadline set by the Public Finance Management Act, many counties ended up under-budgeting on health, a move that could drastically affect service delivery and create a national health crisis.

Tharaka Nithi, Nyeri, Homa Bay, Kitui and Kericho top the list of counties that slashed their budgets by more than half, compared to what the Ministry of Health previously spent in each of the areas before the advent of devolution. But there are also counties that before the advent of devolution. But there are also counties that doubled their health development expenditure, a move that could improve health services in these areas. These include Kisii, Bomet, Laikipia, Kakamega and Turkana. However, only 17 counties increased their development expenditure, money which goes directly into improving infrastructure to boost service delivery. The revelation will hurt the expectations of many Kenyans who had hoped that devolution would solve their most pressing problems that the central government had ignored for decades. More than six months on the devolution road, an examination of the county health budgets and priorities reveals that most county governments may be failing the test of investing innovatively for the health of the people.

It is conceivable that many of the counties that were already doing badly before devolution will have slim chances of improving. Some counties have invested as little as Sh24 per person in developing health, while the best spenders are counting on donors to honour their promises to supplement funds.

### Failure

Starting Tuesday November 11, The Standard will provide comprehensive coverage of devolution of health services to help Kenyans visualise the state of health in their counties and know what the local governments are doing to improve healthcare.

Our two-month investigation reveals that the race by most of the 47 new county governments to prepare budgets to beat the deadline by the central Government may inadvertently have set them up for failure.

Our investigation reviews how much each county is spending on your healthcare and the challenges faced in service delivery to deal with neglected diseases such as trachoma in West Pokot and elephantiasis in and Kilifi. Finally we will look at the challenges of politics and priorities in Tharaka Nithi.

## Wafula Article 2

### NEW REPORT REVEALS TOP AND BOTTOM COUNTIES IN HEALTH SPENDING

*Last updated on 13 Nov 2013 00:00*

**By Paul Wafula**

**Kenya:** Kisii is the top spending county on health per person in the ranking that saw Tharaka Nithi become the least spender among the 47 counties. A breakdown of the development budgets by the Commission on Revenue Allocation (CRA), County Budgets: 2013-2014 report, shows that Kisii County will spend Sh 2,555 on each of its residents to improve their health infrastructure. This is 10 times more than what the bottom five counties combined plan to spend per person in developing health services in what has seen most counties miss their first opportunity to fix the ailing healthcare system.

### **Invest less**

It comes at a time when it is becoming clearer that most counties will invest less in healthcare than what the National Government did the previous years before the onset of devolution.

Before devolution, the National Government spending saw Nairobi, Kiambu and Nakuru counties take the lion's share of the development budget, spending that explains the better health infrastructure in these regions. To earn the top spot, Kisii will spend Sh3.2 billion, which is about 10 per cent of its entire budget, on its 1.2 million citizens as projected in June 2013. But CRA notes that Kisii is among a host of other counties, including Mombasa, that are relying on huge unexplained external sources to boost their budgets, a pointer that its generous spending is influenced largely by its muscle in sourcing for health development partners.

### **Second and third**

Lamu County came in second having set aside Sh 1,659 to develop health for each of its citizens, while Isiolo was third with Sh 1,484 per person. The calculations are limited to what counts intend to spend on development expenditure. Also in the list of the top five spenders are Laikipia and Marsabit counties which plan to spend Sh 1,159 and Sh734 per person, taking the fourth and fifth positions respectively. Three counties from the Western region followed closely in the top 10 big spenders on health per person. Busia County was sixth after it set aside Sh734 per person, while Kakamega and Bungoma Counties set aside Sh689 and Sh671 on each of its citizens. Kakamega was seventh followed closely by Bungoma County. Kakamega and Bungoma counties are also in the top five of the populous counties in Kenya. Busia County is also the only county whose health development expenditure is over 15 per cent of its overall budget. To complete the list of the top 10 spenders on health are Bomet and Mombasa counties, at position nine and 10 respectively. Bomet County will spend about Sh654 per person while a resident in Mombasa County will have Sh498 set aside to improve his or her health this financial year. Some counties that are the least spenders ironically have bigger disease burdens and more pressing health issues.

It was expected that after devolution, county governments would be best placed to address local challenges, but it appears most counties are yet to fill this given that their spending priorities may not give them the financial headroom to start fixing the healthcare system. At the bottom, Tharaka Nithi, Nyeri, Homa Bay, Narok and Siaya counties which spend Sh24, Sh32, Sh57, Sh85 and Sh93 respectively. Also in the list of the bottom 10 counties are Siaya (Sh102), Kericho (Sh109), Kajiado (Sh118), Mandera (Sh140) and Nandi (Sh150). Tharaka Nithi's total development budget is at Sh1.3 billion. Agriculture, livestock and water services had Sh312 million, roads, public works, transport and legal affairs took the lion share of Tharaka Nithi's development budget, receiving Sh911 million.

### **Public hospital**

This has made it the least spenders on health despite having only one major public hospital at Chuka, the other being a church-sponsored institution. An analysis of the data shows disconnect between what counties plan to spend against their manifestos and strategic plans. A look at the various county strategic plans and manifestos show that though most counties seem to have appreciated their health challenges, they have begun on a the wrong footing in terms of using hard data and facts to support their expenditure. Nairobi County, the heart of Kenya's healthcare system, had huge plans to build more health facilities and pharmacies, create ambulance services, promote primary health care, license and control outlets that sell food to the public, create and improve cemeteries, funeral parlours and cremations and show great leadership in liquor licensing. But it is not among the top 10 health spenders in the country. It is at position 33, after it allocated only Sh249 to be spent on developing health for each of its 3.4 million people. This is just about 3.5 per cent of its overall budget. Mombasa County had bigger plans for its health sector. According to its governor's website, there were plans to have every wards to have a modern health centre that is well equipped and staffed.

### **Total budget**

But the county has allocated Sh498 to be spent on developing health for each of its citizens, bringing its total health development budget to Sh520 million. This is less than 3 per cent of its total budget. Mombasa is ranked position 16 in terms of spending per person in out of the 47 devolved units.

Machakos County, which is emerging as a model county due to its speed in implementing its strategic plans, however, has not allocated money that would roll out its ambitious plan of converting every dispensary in every sub-location to a community hospital to meet World Health Organisation (WHO) standards of a hospital every 5 kilometres. It also plans to add a few rooms in every health centre for bed wards, maternity, mini-theatre, laboratory and x-ray. Information on the Machakos County website also gives an insight of their plans to build doctors and nurses quarters to attract health care personnel and give an allocation of Sh300 million to purchase and equip ambulances for every location to ensure that no patient will ever be carried on wheelbarrows to hospitals. According to the CRA report, Alfred Mutua's administration allocated Sh420 million was to health development. This is about 5 per cent of its overall budget. This puts the county at position 24.

Counties are counting on donors to support health services, a factor that partly explains the little allocation to health services despite being ranked as one of the top three priorities in most counties.

The spending per person was calculated using data is contained in a CRA booklet presented to the Inter-Governmental Budget and Economic Council Meeting of August 12, 2013. The CRA booklet also contains a breakdown of intergovernmental transfers by county, revenue generated at county-level, and expenditure estimates. "An aggregation of county budgets shows that 69 per cent of revenues will come from National Government transfers while 31 per cent will be generated from own revenue sources," CRA chairman Micah Cheserem notes in the report.

The article was retrieved from the Standard Digital News.

<http://standardgroup.co.ke/m/story.php?id=2000097556&pageNo=1> Accessed on 2/2/2014

**Rejoinder Article by Jason Lakin, PhD**  
**WHY THE PAPER WAS WRONG ON HEALTH BUDGETS**

THE STAR  
By JASON LAKIN  
FRIDAY, MARCH 28 2014

Last week, the Standard generated considerable heat with a series on county health budgets. One article was titled “Alarm as 30 Counties Slash Health Budgets.”

Another lauded Kisii county for high spending and skewers Tharaka Nithi, Nyeri and Homa Bay for stinginess in their health allocations.

The Standard deserves commendation for actually writing any story at all comparing county budgets.

This story is several months overdue and no other major news outlet has done the hard work of collecting and analyzing the available budget information and comparing to estimates of how much was spent last year in each county. That, unfortunately, is where the praise for this series must end.

The journalists involved in this effort did not analyze the entire health budgets of the counties they are looking at. Rather, they analyzed only the development (or capital) budget.

They proceeded to write a headline (and story) that implies that counties are cutting their total health budgets. This is misleading.

Quite a substantial share of health spending goes to pay health workers and is captured under the recurrent part of the budget, along with money spent on drugs and supplies.

By my estimates (using Treasury data), this was about 70 percent of total health spending in 2012/13. Development spending was less than 1/3 of total health spending. Ignoring the majority of health spending and then claiming that counties have “slashed” their health budgets is poor journalism.

The analysis goes on to justify the focus on development spending in terms that are at odds with basic public finance. First, the report consistently refers to money spent on “developing health.”

It is not clear what this means, but seems to be a corruption of “development” spending. Yet developing health, like developing education, depends heavily not only on investment but health care workers. For many counties, their focus will need to be on recruiting more and better workers rather than new buildings.



Second, the report seems to miss the different logics between recurrent and development spending. Recurrent spending, for wages and supplies, must happen every year in order to keep the health system running.

A substantial drop in a given year in recurrent spending suggests that health workers may be laid off, facilities closed, or drugs out of stock.

But development spending works differently. Suppose that a county decides that it needs 5 new health facilities. It builds these facilities over three years.

For three years, we will see a large development budget, but in the fourth year, this budget should fall, because the facilities are completed.

Now the focus shifts to operations and maintenance (recurrent spending). So for development spending, the budget can rise and fall each year without endangering the health system, if it is linked to the start and completion of projects.

The problem with many county budgets is that it is not easy to tell if this is happening, because they do not offer multi-year projections for their development expenditures and there is insufficient detail to know what projects are really being proposed or how much they cost.

That is what needs to be questioned. A drop from last year in development spending is not in and of itself a cause for alarm. The problem is that it is not clear where the money is going.

Indeed, one of the reasons why it is effectively impossible to actually analyze the full health budgets for counties, using both recurrent and development expenditure, is because most counties made a major blunder in compiling their budgets this year.

The majority put all staff costs for each sector under a single budget line, such as “executive services,” or “public service.” Thus, all wages for health workers, extension officers, ECD teachers, and so on are under a single budget line.

This is bad budget practice and makes it impossible to know how much each county is spending on each sector. This is the major story this year: not that counties slashed health budgets, but that we cannot even know if they slashed health budgets.

A good investigative story would be to ask county finance officers how they came up with the figures that are contained in that single budget line for staff costs.

There is a good chance that some counties did not budget enough for health workers. Nairobi, for example, one of few counties which has provided sector figures, seems to have cut its recurrent health budget to less than half of last year’s allocations. But more digging is required to determine how widespread this problem really is.