Steps to Read and Analyze A Sector in Your County Budget

May 26, 2016

1. **Choose your sector (department) of interest. Health.**
2. **Look at the programs in that sector.** The program and sub-program breakdown for all departments can be found in the summary at the start of the budget. You can also find the programs in Part C, D, E, F, or G of each ministry's breakdown, along with their further breakdowns. You may find that in some cases there are inconsistencies across all these sections.

Health Programs (Summary)	Programs (Sector Narrative)	Programs (Program Breakdown)
Preventive and promotive	County health management team	Preventive and promotive
Curative care	Preventive and promotive	Curative care
General administration	Curative care	General administration

3. **Compare program allocations in 2015/16 and 2016/17.** Which programs are increasing and which are decreasing? Which are increasing faster than the average for the department? Those that are increasing faster than average will be taking a greater share of the department's budget in 2016/17 than in 2015/16. For example, if the department's budget is growing by 11%, and Program A is growing by 5% while Program B is growing by 15%, then Program B will have a larger share of the 2016/17 budget than it did in 2015/16. This is a sign of an increasing priority. Program A is still growing, but at a rate below the department average, suggesting it is a bit less of a priority in the coming year. These growth rates reflect choices made by the county government about what is most important. You can see from the table below that Program A's share of the budget is falling from 40% to 38%, while Program B's share is rising by 2 percentage points.

Program	2015/16	2016/17	Rate of	Share of	Share of

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	Budget	Budget	Growth	2015/16	2016/17
Department	1000	1110	11%	100%	100%
Program A	400	420	5%	40%	38%
Program B	600	690	15%	60%	62%

There may be cases where the absolute growth in a program is so large that we also want to look at it, even if its share of the budget is declining (like Solid Waste Management in the Nairobi 2016/17 budget).

Program	**2015/16**	**2016/17**	**Growth**	**Share 2015/16**	**Share 2016/17**
Preventive	**1115**	**43**	**-96%**	**16%**	**1%**
Curative	**4174**	**1415**	**-66%**	**61%**	**22%**
Administration	**1509**	**5092**	**237%**	**22%**	**78%**
Total	**6798**	**6550**	**-4%**		

In a case like this, the changes are so stark that it is almost certain that there is a reorganization going on. We will have to investigate further to understand what is happening.

4. **Having established priorities at the program level, we now ask what is driving these choices?** Why are some programs being prioritized over others? To answer this, we first look at the narrative in the sector to see what information it gives us. The narrative should tell us why certain areas are being prioritized over others. To be useful, it must explain this at the program level, because that is the level at which the budget is done. Just listing projects or initiatives that we cannot connect to programs and sub-programs does not help us understand the choices.

   The narrative does not address the priorities going forward at all. It mainly focuses on achievements from the previous year. The Curative program does mention some projects underway, but does not clarify exactly what to expect in the coming year:

   "Plans to operationalize a HDU (High dependant unit) at Pumwani Hospital are at an advanced stage. At Mama Lucy Kibaki Hospital construction of a 66 bed ward block is 44% complete"

   There is no discussion of inter-program trade-offs in the document. There is also no discussion of any reorganization.

5. **After looking at the narrative, look next at the sub-program breakdown for programs that are increasing (decreasing) in priority to understand what specifically is increasing (decreasing).** The sub-program breakdown can be found in the summary table at the top of the document, or in Part F of each sector. Just as we did at program level, we will ask which sub-programs are growing fastest and which are taking a larger share of the available program budget. Those are the sub-program priorities.

   Let's start with where the big increase is, which is administration. Administration has the

following sub-programs:

Administration Program	2015/16 Budget	2016/17 Budget	Change	Share 15/16	Share 16/17
Health policy, planning and financing	29	4190	14300%	2%	82%
Administration	463	179	-61%		
Health commodities	557	480	-14%		
Research, quality assurance, standards	43	42	-2%		
Coroner services	417	201	-5%		
Program Total	1509	5092			

Clearly, the big shift here is a decline in all SPs and a massive increase in Health policy. Why? Whatever the reason, this explains the main increase in the Administration program overall.

6. **To understand what the sub-programs are actually doing, look at two additional parts of the department budget, starting with the economic classification of the sub-program.** The sub-programs are broken down into broad economic classes in Part H. Here we should be able to see whether most of the funds in the sub-program are going to recurrent or development, and particularly for salaries, goods and services, assets, etc. This will give us some general understanding of the sub-program's focus.

   We continue following this thread. It is clear that the Health policy sub-program contains the key to understanding what is changing in the ministry this year. The table below shows the sub-program breakdown.

SP 1: Health policy, planning and financing				
	Estimates	Requirements		
Economic Classification	2015/16	2016/2017	2017/2018	2018/2019
Recurrent Expenditure	**28,565,097**	**4,190,000,000**	**4,399,500,000**	**4,619,475,000**
Personnel Costs	28,565,097	4,161,391,917	4,369,461,513	4,587,934,589
Use of Goods & Services	0	28,608,083	30,038,487	31,540,412
Other Recurrent Costs	0	0	0	0
Development Expenditure	-	-	-	-
Acquisition of Assets	0	0	0	0
Development	0	0	0	0
Total Expenditure SP1	**28,565,097**	**4,190,000,000**	**4,399,500,000**	**4,619,475,000**

What is clear is that the main shift here is a massive increase in personnel costs. Why? The answer to this can best be seen by looking at the other sub-programs to see what is happening to their personnel costs. We can see immediately that they are all going to zero. Consider the Health centres SP:

SP 2: Health Centres & Dispensaries				
	Estimates	Requirements		
Economic Classification	2015/16	2016/2017	2017/2018	2018/2019
Recurrent Expenditure	**1,594,834,268**	**137,895,991**	**144,790,791**	**152,030,330**
Personnel Costs	1,464,434,268		0	0
Use of Goods & Services	130,400,000	137,895,991	144,790,791	152,030,330
Other Recurrent Costs	0	0	0	0
Development Expenditure	**403,000,000**	**365,000,000**	**383,250,000**	**402,412,500**
Acquisition of Assets	0	0	0	0
Development	403,000,000	365,000,000	383,250,000	402,412,500
Total Expenditure SP2	**1,997,834,268**	**502,895,991**	**528,040,791**	**554,442,830**

What this tells us is that the payroll is being centralized under the Health sub-policy program. It is not immediately clear why this is happening, or why it is not happening under the Administration/Human resources for health sub-program. This makes it hard to see whether there are really increases or decreases in particular programs, because this shift is so large it affects our perceptions of everything. However, one can see that the development side of the budget would not be affected by this, and we can see a decline in development for SP2 above as well. What would explain this?

This observation might lead us to ask what is happening to the overall capital budget. We

can see that in fact it is going down, when we look at the table on page 60.

VOTE AND ECONOMIC CLASSIFICATION

Expenditure Classification	Estimates 2015/2016	Estimates 2016/2017	Projected Estimates 2017/2018	Projected Estimates 2018/2019
Current Expenditures	**5,038,443,165**	**5,450,000,000**	**5,722,500,000**	**6,008,625,000**
Compensation to Employees	3,673,343,302	4,161,391,917	4,369,461,513	4,587,934,589
Use of goods and services	1,365,099,863	1,288,608,083	1,353,038,487	1,420,690,412
Other Recurrent	0	0	0	0
Capital Expenditure	**1,760,000,000**	**1,100,000,000**	**1,300,000,000**	**1,600,000,000**
Acquisition of Capital Assets	1,760,000,000	1,100,000,000	1,300,000,000	1,600,000,000
Other Development expenditure				
Total Expenditure of Vote	**6,798,443,165**	**6,550,000,000**	**7,022,500,000**	**7,608,625,000**

There is no explanation for this in the document. However, if we look for the SP where the capital budget is falling the most, it is this one:

Program 2: Curative care

SP 1: County Referral Hospitals				
	Estimates	Requirements		
Economic Classification	**2015/16**	**2016/2017**	**2017/2018**	**2018/2019**
Recurrent Expenditure	**1,219,023,228**	**411,700,000**	**432,285,000**	**453,899,250**
Personnel Costs	807,323,228		0	0
Use of Goods & Services	411,700,000	411,700,000	432,285,000	453,899,250
Other Recurrent Costs				
Development Expenditure	**957,000,000**	**500,000,000**	**525,000,000**	**551,250,000**
Acquisition of Assets				
Development	957,000,000	500,000,000	525,000,000	551,250,000
Total Expenditure SP1	**2,176,023,228**	**911,700,000**	**957,285,000**	**1,005,149,250**

7. **Next, to understand in more detail what the SP is actually doing, look at the indicators and targets for that sub-program.** This is available in Part E of each department's budget. The indicators should highlight the key activities that the sub-program will undertake, and the targets should point to what the sub-program will seek to achieve in the coming year and the next two years after that. If there is an increase in the budget for salaries or for capital expenditure in the economic classification, we should be able to find some indication of where that money is going in the indicators. If we cannot, this suggests a disconnect between the budget and the departmental objectives.

What can we learn from the indicators and targets for the Health policy program? None of them seem to relate to any major staff changes. The closest target that relates to staffing is for signing of performance contracts, and this was 100% in 2015/16 and remains 100% in 2016/17, so there is no indication of change here. The other targets all seem truly administrative, and some are confusing:

# of quarterly data review meetings held	4	4	4	4
# of public facilities with integrated established Electronic Medical records	2	15	20	25
# of health workers trained on integrated health information systems	94	199	234	269
# of copies of data collection and reporting tools printed and distributed	23,071	23,080	23,087	24,000
AWP developed	1	1	1	1
County M&E framework developed	0	1	1	1

Consider the target for # of data collection tools. It is not clear what this means, and the numbers seem strange. What explains the very small differences from year to year?

When it comes to the declining capital budget for hospitals, can we see any implication for targets? Not really.

SP1: County Referral Hospitals	County Referral Hospitals	Provision of specialized curative diagnostic interventions	**#** of public health facilities with specialized diagnostic services	2	3	4	5
			# of fully equipped Ambulances in the County	0	3	7	9
			# of facilities offering medical rehabilitation services	7	10	12	15
			# of functional Ambulances in the County				
			# of health facilities with specialised services (MDR, peadtric, mental menthadol, SGBV)	0	3	4	5

Some of these items seem likely to be capital in nature, and all the targets are rising. What is the impact or meaning of the declining capital budget?

When we look at other targets, other questions arise. For example, we can see that although the budget for health commodities is falling above, we can see that the target continues to rise:

SP 3: Health Commodities	**Health Commodities Unit**	Commodity security enhanced	% achievement of commodity security	30%	60%	70%	80%
SP 4:	**Research**	Research Unit	Research coordination	0	1	1	1

8. **At this point, turn to the line-item budget for the department to see if there is additional information that can explain the department's priorities.** Most departments have some capital expenditure breakdown which may be useful. The recurrent breakdown into line items may or may not shed light on what the department hopes to do. For example, it may be possible to identify the particular sub-department where salaries are being increased, or to find out more specifics about which buildings are being constructed.

   We do not have a line item budget that is updated to match the updated PBB. However, we can look at the line budget to get some idea about salaries and capital projects.

		Proposed Estimates 2016/2017
Health policy planning and financing	Basic Salaries - Permanent - Others	1,840,618,004
	Casual Labour - Others	
	House Allowance	868,092,244
	Transport Allowance	181,476,775
	ACTING ALLOWANCE	571,340
	Provision for uniforms for medical personell	16,000,000
	Extraneous Allowance	486,672,000
	Non- Practicing Allowance	80,142,000
	Leave Allowance	63,807,063
	Risk Allowance	77,913,813
	Emergency Call Allowance	81,720,000
	Employer Contribution to Staff Pensions Scheme	464,378,679
	Total Personel	**4,161,391,917**

This does not tell us much more than what we knew, though we can see that a major driver of cost is the house allowance, which we might not have realized. The large extraneous allowance might also raise questions: what is that for exactly?

On the development side, we can see a large share going to rolled over projects:

Sector	**Project description**	**2016/2017**
Curative care	· Purchase and Installation of Oxygen Plants	50,000,000
County Referral Hospitals		
	· Completion of building	100,000,000
	Rolled over projects (Hospitals)	190,000,000
Health Centres & Dispensaries	· Painting	15,000,000
	· Replacement of roof	
	· Replacement of broken down door locks &	
	· Perimeter wall, guard house and main gate	
	· Perimeter wall, guard house and main gate.	15,000,000
	· Repair of roof	
	· Painting	
	· Replacement of broken down door locks	

These are not detailed in the soft copy of the budget. Note that there is no 2015/16 data to allow us to see whether specific projects are going up or down, which might explain the decline in development spending (related to project cycles).

9. **With this information, analyse the priorities.** The remaining task is to synthesize this information into an analysis of the government's priorities. Answer the following questions:

Question	Notes	Nairobi
Are the government's priorities at program and sub-program level CLEAR?	This is a basic transparency question about the budget presentation. Can we understand the priorities or not? With the health sector in many counties, this is difficult due to centralization of health worker salaries.	No. They are not explained at this level and it is not possible to understand the priorities well at program level given the centralization of health staff
Are the program priorities JUSTIFIED?	We need to decide whether the narrative information and our own knowledge of the county's needs can justify the decisions that appear to be being made to focus on particular areas or not.	There is no justification in the document.
What alternative priorities might the government have focused on and WHY?	In case we are not convinced that the county's choices are justified, what do we recommend as focus areas at program and sub-program level in the budget?	
Do the indicators and targets appear to capture the most important ACTIVITIES of government or are there key activities missing?	What gets measured gets done. We want to make sure that if we think government should be doing certain things, that these are captured in an indicator or set of indicators.	It is hard to link the programs and the targets to understand well whether they are measuring everything that is happening in a given program or SP.
Are the TARGETS realistic given what we know about current performance?	We can only link budget to performance if we have realistic targets, otherwise we will never meet them and never know whether this is because we did not spend well or because they were impossible targets to meet. We should use available resources to question the targets	

	before they are approved.	
Are the ALLOCATIONS realistic given past budget performance?	We would ideally want to look at past implementation reports to know whether the various departments and programs have actually been able to spend what they were given before increasing their funding. This requires us to look at Controller of Budget reports (or county implementation reports if available) to see which departments have been able to spend and which have not. Those that have not spent should not be given increments unless they have shown that they have addressed their implementation challenges.	