REPUBLIC OF KENYA

NATIONAL AND COUNTY HEALTH BUDGET ANALYSIS

FY 2018/19

MINISTRY OF HEALTH

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Annual national and county budgets reflect the policy and resource allocation decisions that determine the activities, programmes, and services that will be delivered within a financial year. Tracking these allocations and utilisations reveals national and county governments' resource allocation patterns, and measures the alignment of these allocations with regard to governmental health policy priorities.

This report, a follow-on to the *National and County Health Budget Analysis 2017/18,* examines how public health sector financial resources were allocated over the 2018/19 fiscal year in comparison to the allocation patterns of the preceding two years. The study used data from appropriate sources, including two previous budget analysis reports, the Office of the Controller of Budget, the National Treasury, the Ministry of Health, and county government offices to compile the final report.

The findings provide information that policymakers and other decision-makers from national and county levels can use to estimate resources currently allocated to public health, and serve as a tool for securing adequate health funding. These findings also can be used to advocate for increased allocation to health.

The Ministry of Health (MOH) is grateful to the institutions that provided access to the data used in this study. The ministry acknowledges the financial and technical support provided by the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the Health Policy Plus (HP+) project, which made this analysis possible.

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ABBREVIATIONS

AIA	Appropriation in Aid
ARV	Antiretroviral
BPS	Budget Policy Statement
CDOH	County Department of Health
CHSP	County Health Strategic Plan
CIDP	County Integrated Development Plan
FY	Fiscal or Financial Year
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
KAIS	Kenya AIDS Indicator Survey
KDHS	Kenya Demographic and Health Survey
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Authority
KHSSP	Kenya Health Sector Strategic Plan
KMTC	Kenya Medical Training College
KNH	Kenyatta National Hospital
Ksh	Kenya Shilling
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTRH	Moi Teaching and Referral Hospital
O&M	Operations and Maintenance
PBB	Programme-based Budgeting
PFMA	Public Finance Management Act of 2012
SAGAs	Semi-autonomous Government Agencies
TB	Tuberculosis
TGB	Total Government Budget
UHC	Universal Health Coverage

EXECUTIVE SUMMARY

Budgets are definitive instruments that detail planned government spending and can act as an indicator of policy, priority, programmes, and activity implementation over a specific financial period. In Kenya, the existence of government budgets is a legal requirement. The budget process is defined by the country's constitution and elaborated in the Public Finance Management Act of 2012 (PFMA). The ministries, departments, and agencies of national and county governments develop budgets following set guidelines, which then are approved by the respective legislative bodies. Beginning in fiscal year (FY) 2015/16, both levels of government are required to adopt a programme-based budgeting approach. This report examines which health sector priority areas were allocated funds by national and county governments in FY 2018/19 in comparison to allocation patterns of the preceding two years. Findings provide evidence that can help national and county policymakers understand allocation patterns by different economic and functional areas.

Total Government Budget Allocation to Health

In FY 2018/19, the proportion of the combined discretionary public budget allocated to health increased from 8.2 percent the preceding year to 9.2 percent, but fell far below the Abuja declaration target of 15 percent. The public sector health budget expanded from Kenya shilling (Ksh) 94 billion in pre-devolution FY 2012/13 to Ksh 207 billion in FY 2018/19—more than a two-fold expansion. Over the last three years, Kenya's health budget expanded from Ksh 152 billion to Ksh 207 billion. The national government allocated 5.1 percent of its budget in FY 2018/19, whereas counties increased their allocation to 27.2 percent, indicating that the latter are primarily responsible for the rapid budget expansion.

National Budget Allocation to the Ministry of Health

In FY 2018/19, the Ministry of Health (MOH) was allocated Ksh 90 billion—up from the Ksh 60 billion allocated during each of the two preceding years. This sum constituted 5.1 percent of the national government budget—a significant increase from the 3.7 percent allocated during each of the two preceding years. The MOH absolute budget increased by 50 percent over the three-year period.

Ministry of Health Budget Allocation

The MOH increased the share of recurrent expenditure to 55 percent from 49 percent in FY 2017/18 and 48 percent in FY 2016/17. In absolute terms, the MOH allocated Ksh 49.1 billion to the recurrent budget in FY 2018/19, with most of this amount allocated to grant transfers to the seven semi-autonomous government agencies under the ministry, which consumed 58.9 percent of the budget (or Ksh 26.9 billion). Semi-autonomous government agencies were expected to raise 19 percent of their budgets from internal revenues. Universal health coverage (UHC) transfers, including free primary care services, constituted 11 percent of the recurrent budget. Allocation to personnel emoluments increased from 5.7 percent in FY 2016/17 and 2017/18 to 7.9 percent of recurrent budget in FY 2018/19.

Donors contributed 58 percent (or Ksh 23.7 billion) of the MOH development budget of Ksh 40.9 billion in FY 2018/19, down from 68 percent (Ksh 17.9 billion) in FY 2017/18, indicating a decline in donor funding to the MOH development budget. Much of the donor funding was allocated to HIV, reproductive health, immunisation, and health systems support. In contrast, the government's contribution to the development budget amounted to 42 percent of the MOH development budget

allocation (or Ksh 17.2 billion) in FY 2018/19, up from Ksh 13.0 billion in FY 2017/18. In FY 2018/19, most of this money was allocated to programmes related to medical equipment (54 percent) and the Free Maternity Care Programme (25 percent).

The proportion of the FY 2018/19 MOH budget allocated to the curative services programme remained the highest, at 45 percent, after expanding by 71 percent between FY 2016/17 and FY 2018/19. The proportionate allocation for the preventive and promotive programme stagnated at about 11 percent over the three-year period.

County Government Allocations to Health

In FY 2017/18, county governments increased their allocations to health as a percentage of total county budgets to 27.2 percent (or Ksh 121 billion), up from 27.0 percent (or Ksh 105 billion) in the previous year. Although this change indicates an increased commitment to health by county governments, the allocation is still below estimated pre-devolution levels of 35 percent. The top five counties that allocated the highest proportion to health were Elgeyo Marakwet, Laikipia, Kiambu, Tharaka Nithi, and Machakos. The lowest five were Mandera, Bomet, Turkana, Tana River, and Wajir. However, 18 counties increased the proportion of their budgets allocated to health between FY 2017/18 and FY 2018/19. The average share of the county's health budget allocated for recurrent expenditure increased from 79 percent in FY 2016/17 to 82 percent in FY 2017/18 and then decreased to 79 percent in FY 2018/19, compared to the recommended 70 percent; in FY 2018/19, 38 counties were noncompliant regarding the recommended percentage.

A further breakdown of the data shows an increase in the proportion of the recurrent budget allocated to personnel expenses, from 71.9 percent in FY 2017/18 to 75.8 percent in FY 2018/19. Under the development vote, allocation to grants and transfers expanded from 15.8 percent in FY 2017/18 to 44.1 percent, overtaking allocation for the construction and rehabilitation of buildings, which declined from 43 percent to 30.7 percent over the same period.

Overall, counties increased their average per capita allocation to health from Ksh 2,227 in FY 2017/18 to Ksh 2,532 in FY 2018/19. In FY 2018/19, the five counties with the highest per capita allocation were Lamu, Isiolo, Marsabit, Laikipia, and Embu; the bottom five were Bomet, Bungoma, Nairobi City, Uasin Gishu, and Migori. Overall, 18 out of 47 counties increased their per capita health budget allocations.

Conclusions and Recommendations

The findings indicate that, overall, national and county governments are allocating more funds in absolute terms and increasing the public budgetary resources available to the health sector. The findings also draw other conclusions, including the following:

- Donor funding to MOH is declining, and the national government's reliance on this source of funding is not sustainable.
- County health budgets are still low. They fall below the recommended proportion of 35 percent in the pre-devolution period and continue to be dominated by recurrent expenditure, most of which goes to personnel emoluments, raising concerns about efficiency in service delivery.

- The county comparisons show that counties do have the capacity to increase the proportion of their budgets allocated to health, as evidenced by the 18 counties that increased such allocation between FY 2016/17 and FY 2018/19.

In the light of these findings and conclusions, the key recommendations of this study are as follows:

- The overall health budget needs to be expanded for two reasons:
    - To reduce over-reliance on donor resources for key programmes, including those related to HIV, tuberculosis (TB), and malaria, and enhance domestic resource mobilisation for key programmes
    - To extend coverage and access to county-specific health priorities
- The MOH needs to align resource allocation to policy priorities, especially funding for preventive and promotive health services, including key strategic programmes, whose proportion of allocation has stagnated over the previous three years.
- The MOH should also immediately lay down mechanisms stipulated in the recently enacted Health Law to ensure that resources disbursed for free care at primary care facilities are used at the facilities to increase access and their quality of services.
- Counties are constitutionally obliged to deliver most healthcare services and thus should allocate more resources to health—current resources are still inadequate. The focus for increases in health resource allocation should be those counties below the overall county average. Planning, budgeting, and advocacy capacities for those counties should be enhanced.
- As budgets expand, counties should strive to achieve technical efficiency by optimising allocations to critical health inputs.

The MOH and partners should provide more technical support to counties because health budget allocations remain below the proportion allocated for services before devolution, even five years after devolution.

INTRODUCTION AND METHODS

The constitution of Kenya recognizes health as a fundamental right and an important driver in spurring the country's economic growth. The constitution and other major policy documents—including Vision 2030, the Kenya Health Policy (2014–2030), respective county integrated development plans (CIDPs), and county health sectoral plans (CHSPs)—often highlight the government's obligation and commitment to ensure that Kenya attains the highest standard of living for its population by providing equitable health services. This achievement requires the provision of equitable health services with respect to geographical, gender, and economic conditions; thus, the national and county governments are required to create an enabling environment for public and private sector investments for health service delivery.

Budgets are essential instruments for implementation of national and county policies and strategies. National and county governments thus are expected to structure their respective budgets towards achievement of the policy commitments outlined in their respective guiding documents. At the national level, the 2018 Budget Policy Statement (BPS), the current Kenya Health Sector Strategic Plan (KHSSP III), and the Medium Term Expenditure Framework (MTEF) highlight infrastructure, education, health, and social safety nets as the priority focus areas of the government for fiscal year (FY) 2018/19, whereas the KHSSP III articulates the government's commitment to continue increasing funding to the health sector as part of its endeavour to achieve the Abuja target. Counties usually align their respective medium-term planning and budgeting frameworks to national strategies while considering localised priorities. Analysing national and county health budgets therefore interrogates the appropriate budgets against national and county priorities.

This budget analysis covers FY 2018/19 and compares with the previous two financial years; it also examines how the national and county governments allocate their health budgets. The analysis also assesses how the country has attempted to prepare for implementation of universal health coverage (UHC) in the Kenya government's big four national medium-term development agenda and respond to dwindling donor funds, and explores whether the government has made efforts to align the budget to accommodate its expected takeover of funding of donor-funded programmes.

The analysis briefly reviews the health policy priorities that the various governments intend to address, as well as the macroeconomic settings. It then reviews data on MOH and county health allocations from FY 2016/17 to FY 2018/19 to assess how the funds align to health priorities. The study also includes a trend analysis to show investments in the public health sector and the progress towards increasing domestic resources for health. It also analyses the MOH and county health budgets by recurrent and development categories, and economic categories and programmes, focusing on key programmes and sub-programmes when information is available.

Macroeconomic Context

Budget allocations to the health sector are analysed within Kenya's macroeconomic context, because, according to the Economic Survey 2018, a country's growth rate is thought to influence the allocations to different sectors of the economy. Kenya's economy remained robust in the face of the global economic slowdown. The country has enjoyed significant economic expansion from a reported growth rate of 4.9 in 2017, although this rate was lower than in 2015, when it was 5.7 percent. This growth rate is attributed to the increased budgetary allocation to infrastructural projects and agriculture and rural development. In the medium term, the economy is projected to expand further by 6.1 percent in 2017 and 6.5 percent by 2020, supported by strong output from

agriculture and the completion of key road, rail, and energy generation projects. In addition, strong consumer demand and private sector investment, as well as a stable macroeconomic environment, will help reinforce the projected growth.

Economic growth is expected to translate into increased government revenues. Thus, in an ideal scenario, the growth of the economy should have a bearing on available resources and allocations to the country's priority sectors, including the health sector.

Performance of Selected Health Priority Areas

The health sector is a key component of Vision 2030's social pillar, which promises to develop a healthy and productive population able to fully participate in and contribute to other sectors of the economy. Currently, however, results from the Kenya AIDS Indicator Survey 2012 (KAIS) and the Kenya Demographic and Health Survey (KDHS) of 2014 show mixed progress against national health targets. For instance, the KDHS notes remarkable declines in under-5 and infant mortality rates since 1998, from 112 to 52 and 74 to 39 per 1,000 live births, respectively. The proportion of fully immunised children increased from 64 percent in 2005 to 68 percent in 2014. These gains are attributed to improved health service delivery, intensified immunisation campaigns, and widespread distribution of insecticide-treated bed nets.

Gains have also been realized in the management and control of HIV. Recent data from the KDHS of 2014 indicate that the HIV prevalence among adults 15–49 years of age has declined to 6 percent, down from 7.4 percent in 2007 and 6.7 percent in 2003 (Kenya Aids Indicator Survey 2012). Kenya also has had relative success in scaling up access to antiretroviral (ARV) treatment, with 1,245,107 Kenyans on ARVs in 2015, up from 500,000 reported in 2012. If these gains can be sustained through increased health spending targeting specific programmes, Kenya would be on track to realizing some of its national health goals.

However, reproductive and maternal health indicators are less positive. Although contraceptive prevalence increased from 39 percent in 2003 to 61 percent in 2014, it is still far below the FP2020 target of 70 percent provided by Kenya's family planning strategy document (Kenya CIP 2017–2020). Use of antenatal care services remains steady at 91.5 percent, but skilled birth attendance stands at 61 percent and still remains below the target of 90 percent (KHDS 2014).

The Budgeting Process

According to the Public Finance Management Act of 2012 (PFMA 2012), the National Treasury develops indicative, aggregate budget proposals for national spending based on the economic outlook and expected revenues, other monies anticipated as appropriations in aid, and fixed commitments of consolidated funds. The aggregate budget, which includes composed government revenues, donor resources, and revenues generated by operating units, is then shared between the national and county governments and other independent constitutional bodies, based on agreed proposals made by the Intergovernmental Economic and Budget Council, and approved by Parliament. The national and county governments are given indications of the amounts they can allocate for their sectors and institutions, including health. Inter-county allocations are determined by a formula proposed by the Commission on Revenue Allocation and approved by Parliament every five years.

There are significant competing needs for resource allocations between the various sectors at both the national and county levels. Allocation to health is therefore an indication of what priority the

governments place on health issues compared to other sectors. If the national aggregate is low, the sharable pool will be low, and many sectors (including health) may then receive a smaller allocation.

The process of budget allocation to the respective sectors is the same at the national and county levels. The county and national treasuries communicate the indicative budget ceilings to the various sectors through the *Budget Review and Outlook Paper* or the *County Budget Review and Outlook Paper*, which are released in September and must be approved by the Cabinet and legislative assembly at each level of government. The *Budget Review and Outlook Paper* provides the first indication of how much the health sector might receive; thus, interventions to advocate for more health funding should be done before its release.

Sector working groups guide their respective ministries or departments in preparing three-year rolling budget allocations to proposed programmes and activities. At both the national and county levels, these groups produce reports that inform the Cabinet/County Executive Committee in refining the sector ceilings. A strong justification for additional funding may lead to an adjustment of the annual ceilings, which are published in the subsequent *Budget Policy Statement* (national) and *County Fiscal Strategy Paper* (county). These publications are released in February of each year and determine the final ceilings; they are approved by Parliament at the national level and by the county assemblies at the county level.

National ministries and county departments have the opportunity to influence the amounts allocated to them through effective advocacy during the development of the sector working group reports. Despite ministries and departments originating, justifying, and advocating for their budget allocation proposals, it is their respective treasuries and legislative assemblies that make the final decision on how much is allocated to the health and other sectors.

It is important to note that although national ministries and county health departments determine how their allocated budgets are distributed to programmes or activities within their dockets, they are not allowed by law to transfer funds between approved development and recurrent allocations. They are also required to budget for all existing personnel. However, they have significant flexibility in shaping the allocations in the most efficient manner possible by prioritising the most cost-effective and efficient programmes.

Final budgets are approved by the National Assembly for the national government and county assemblies for the county governments, with or without amendments. Fewer or no amendments are made when positive and continuous engagement occurs between the executive and the legislative assemblies during the budgeting process.

The Programme-based Budgeting Approach

The PFMA 2012 (Section 12 of the second schedule) required the national government and counties to adopt a programme-based budgeting (PBB) approach beginning in FY 2014/15. So far, although the national government has fully adopted the approach, counties are struggling to fully entrench the system, especially in disaggregating personnel expenses by programmes and sub-programmes. The PBB approach, according to the PFMA 2012, aims to achieve two goals:

- Improve the prioritisation of expenditures in the budget to help allocate limited county government resources to those programmes of greatest benefit to the community.

- Encourage county government departments to improve the efficiency and effectiveness of service delivery by changing the focus of public spending from inputs to outputs and outcomes.

The approach requires that budgets link all financial resources and activities to the outcomes and outputs generated by the budgeting entity, thus ensuring a greater focus on targeted outcomes rather than traditional approaches of incrementing a certain percentage over the existing budget line items.

Study Objectives

The main objective of this analysis was to characterise national and county governments' budget allocations to the health sector over the period FY 2016/17 through FY 2018/19. It is anticipated that the results from this assessment will be used to inform planning and budgeting processes at both the national and county levels.

Specifically, the study examines these four allocations:

1. Total government budget (TGB) allocations to health
2. National and county budgets' allocations to health
3. County comparisons and trends for budget allocations to health
4. National and county budget allocations to healthcare inputs

The proportion and volume of government funds allocated to health indicates the level of commitment towards achieving national health goals. When allocated and used efficiently, a relatively higher amount of public spending on health can lead to improved access to care, especially for indigent and vulnerable groups. It also has the potential to increase the efficiency of healthcare delivery systems if a greater proportion of the expanded funding is directed towards more efficient public health programmes.

In Kenya, a gradual and sustainable expansion of the health budget is desirable for four reasons:

1. To enable the sector to absorb the impact of the expanded administrative costs of devolution while still providing the level of service that existed before devolution
2. To realise progress towards achieving the Abuja commitment of allocating 15 percent of the public budget to health
3. To move more quickly towards the national goal of UHC
4. To provide a measure of sustainability, especially when expansion comes from domestic sources

Analysis Methods

This study analysed the national (MOH) and county budgetary allocations to the health sector for FY 2016/17, FY 2017/18, and FY 2018/19. The MOH data were obtained from the annual estimates for each year, whereas county budget data were obtained from the Commission for Revenue Allocation; the Office of the Controller of Budget; and, in some instances, the counties. However, data from the Commission for Revenue Allocation and the Office of the Controller of Budget have not been validated by the counties, indicating possible inconsistencies compared with the final county

budgets. The authors of this study note that, in some instances, gaining access to information in a homogenous form was challenging because counties presented budgets in different formats and did not strictly adhere to the standard Charter of Government Accounts. For instance, some counties have not adopted the PBB approach; also, in some cases, the budget data available were in formats not suitable for this analysis.

The analysis breaks down the budget into a recurrent budget (for expenditures on personnel and operations and maintenance [O&M]) and a development budget (for capital investments). Weaknesses have been noted in counties' classification between recurrent and development. This analysis has attempted to correct this mistake to the extent possible. For each of these budgets, there is a gross budget, which includes appropriation in aid (AIA)—external and local, revenues from local taxes, and foreign assistance. This analysis does not include the off-budget resources provided by donors that do not pass through the country's budget system and thus are not captured in the county printed estimates; for this reason, the analysis does not present all resources employed in the health sector.

This report first sets the contextual background, covers the objectives of the budget analysis and the methodological approach, and then presents detailed findings and recommendations from the analysis with the aim of strengthening health system structures.

KEY FINDINGS

Combined Health Budget Allocations Pre- and Post-devolution

The Kenya Constitution of 2010 introduced devolution, transferring most health service delivery functions to the 47 counties. Devolution was implemented after the general elections in March 2013, and the transfer of functions and funding to the counties began in the budget for FY 2013/14. Figure 1 shows budget allocations to health for the period FY 2012/13 through 2018/19.

Figure 1: Pre- and post-devolution budget allocations to health

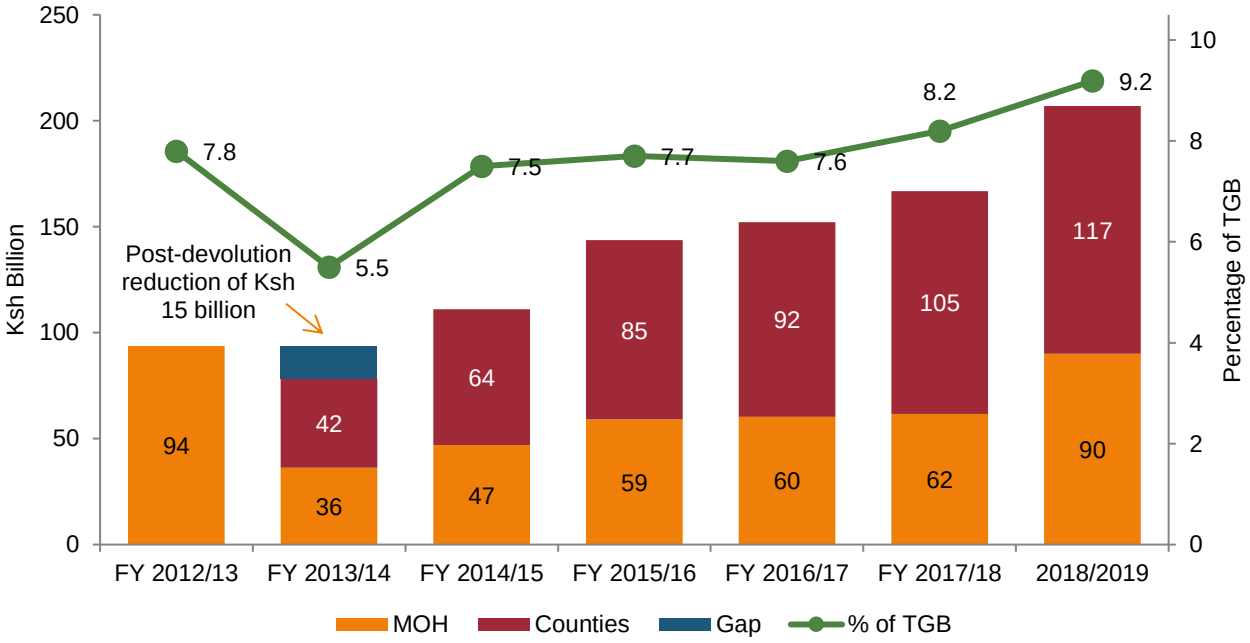


Figure 1 shows that the MOH budget of FY 2012/13 (pre-devolution) was Ksh 93.6 billion (7.8% of TGB), which included the funding for health functions devolved to the counties after the March 2013 elections. The allocation to the MOH dropped to Ksh 36.2 billion in the first year of devolution (FY 2013/14), as the newly formed counties made their own budgets and took up functions formerly funded through the MOH. In the same year, counties collectively allocated Ksh 42.1 billion, making a total of Ksh 78.3 billion allocated to health by both levels of governments—equivalent to 5.5 percent of the TGB. The budget allocated to health thus decreased by Ksh 15.3 billion (from Ksh 93.6 billion to 78.3 billion) and 2.3 percentage points (from 7.8 to 5.5 percent) of total government budget with devolution.

Combined budget allocations to health continued to expand gradually in absolute terms, from the Ksh 78 billion allocated in FY 2013/14 to the current Ksh 207 billion in FY 2018/19 (a 165% expansion). This increase was attributable mostly to county health budgets expanding faster than the MOH budget (increasing from Ksh 42 billion to Ksh 117 billion over the same period, a 178% expansion). In contrast, the MOH budget increased from Ksh 36 billion in FY 2013/14 to Ksh 90 billion in FY 2018/2019, a 149 percent expansion.

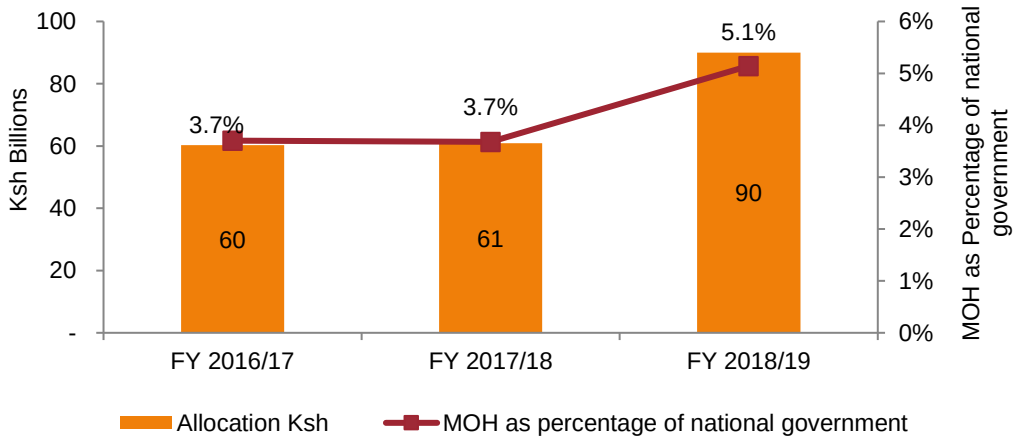
The proportions of TGB allocation to health for both the national and county levels has shown improvements during FY 2017/18 and FY 2018/19, after stagnating at about 7 percent over the

period FY 2014/15–FY 2016/17, and reaching a high of 9.2 percent in FY 2018/19. These percentages indicate that Kenya is gradually moving towards the Abuja target of 15 percent; much of that progress is attributable to counties expanding their health budgets.

National Government Budget Allocation to the Ministry of Health for FY 2016/17–FY 2018/19

In the past few years, the national government budget allocation to the MOH increased significantly, from a level of about Ksh 60 billion during FY 2016/17 and FY 2017/18 to Ksh 90 billion in FY 2018/19. Likewise, the national government also significantly increased the proportion of its budget allocated to health, from a low of 3.7 percent in the preceding two years to a high of 5.1 percent in FY 2018/19, as shown in Figure 2.

Figure 2: National government budget allocation to the MOH, FY 2016/17–FY 2018/19



As Figure 2 shows, the national government increased the budget to the MOH by a large margin of 48 percent between FY 2017/18 and FY 2018/19, which indicates the national government's commitment to enhancing funding for health and supporting the newly enacted UHC national agenda among the big four priorities.

Ministry of Health Budget Allocation to Recurrent and Development for FY 2016/17–FY 2018/19

As illustrated in Table 1, the MOH allocation to the recurrent budget increased marginally, from Ksh 29.0 billion in FY 2016/17 to Ksh 29.6 billion in FY 2017/18 and then expanded rapidly to Ksh 49.1 billion in FY 2018/19. Allocation to development ranged from Ksh 31.2 billion to 31.3 billion over the same period and likewise expanded to Ksh 40.9 billion in FY 2018/19. The proportional allocation to development compared to recurrent was 52, 51, and 45 percent, respectively, of the total MOH budget over the same period.

Table 1 also shows that the government—through the recurrent budget—is the main contributor of the increase in the health budget, which expanded by 65.8 percent over FY 2017/18–FY 2018/19. A notable shift occurred in the recurrent/development ratio; more resources were allocated to recurrent in FY 2018/19, at 54.6 percent of the MOH budget, unlike FY 2017/18, when the recurrent budget was allocated 48.6 percent of the MOH budget.

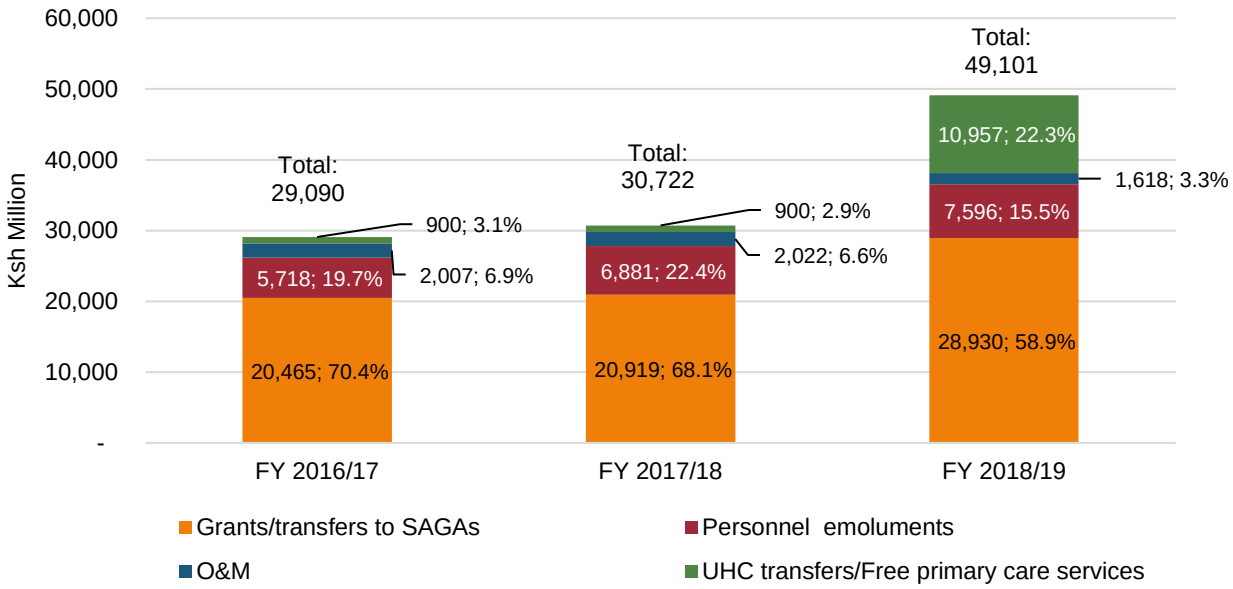
Table 1: MOH budget allocation to recurrent and development, FY 2016/17–FY 2018/19

Vote (Ksh billion)	2016/17	2017/18	2018/19	% increase FY 2017/18–2018/19
Recurrent (all GOK)	29.0	29.6	49.1	65.8%
Recurrent as % of MOH budget	*48%*	*49%*	*55%*	
Development (GOK + Donor)	31.2	31.3	40.9	30.8%
Development as % of MOH budget	*52%*	*51%*	*45%*	

Allocation of the Ministry of Health Recurrent Budget by Spending Categories

Figure 3 represents the breakdown of the recurrent budget across the key spending items, including personnel emolument; reimbursements for removal of user fees at facilities, which has been combined with UHC transfers; O&M; and grants and transfers to the six semi-autonomous government agencies (SAGAs) under the MOH for the period FY 2016/17–FY 2018/19.

Figure 3: MOH recurrent budget allocation by major classification, FY 2016/17–FY 2018/19



The allocation for grant and transfers to SAGAs increased from about Ksh 20 billion of the MOH recurrent budget over FY 2016/17–FY 2017/18 to Ksh 29 billion in FY 2018/19. Despite the increase, the transfers amounted to 58.9 percent of the MOH budget in FY 2018/19, having decreased from the 70 percent observed in the previous two years. Personnel emoluments and O&M remained fairly constant in allocation over FY 2016/17 and FY 2017/18, but registered a reduction in the proportion of the MOH budget allocated to the two items.

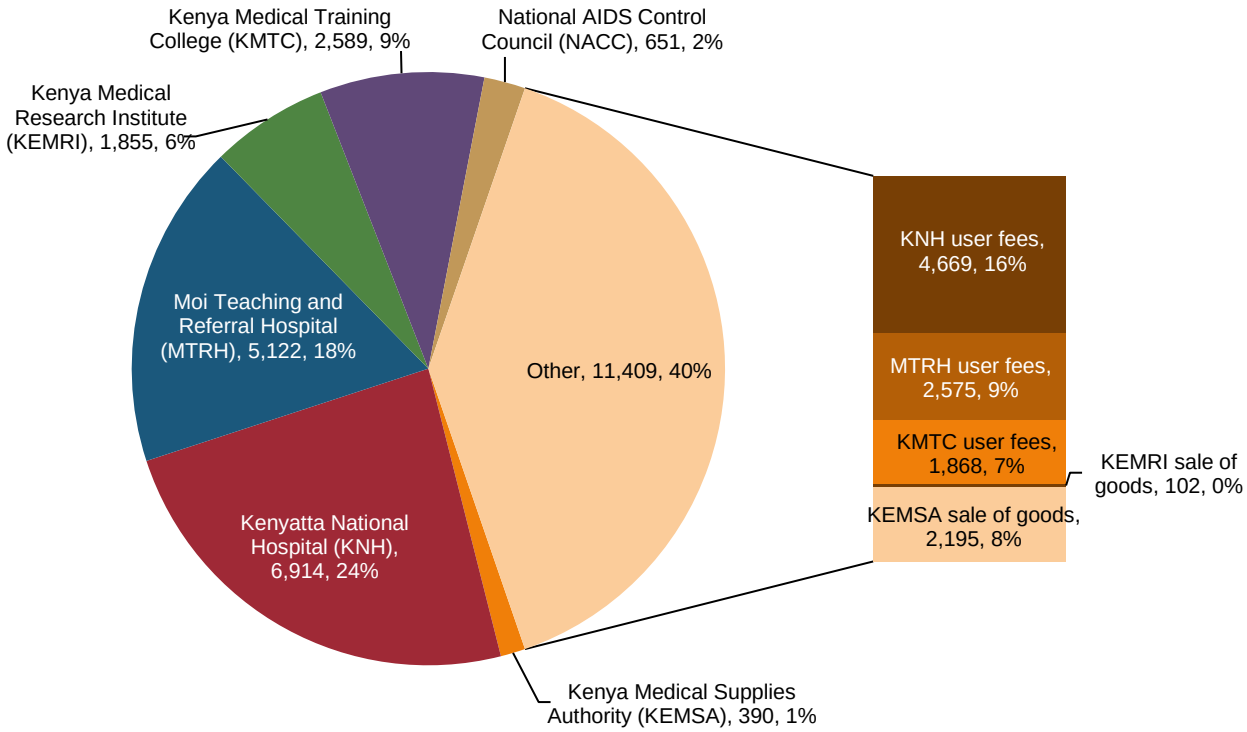
During FY 2018/19, the MOH introduced and allocated approximately Ksh 11 billion, or 22.3 percent of its budget, to transfers to UHC and discontinued allocation for the free primary healthcare programme after allocating Ksh 900 million in the two previous years.

Ministry of Health Recurrent Budget Allocations to Semi-autonomous Government Agencies in FY 2017/18

The analysis results show that of the Ksh 28.9 billion allocated to SAGAs by the MOH in FY 2018/19, 60.6 percent was in the form of government grants, with 39.4 percent from revenues generated internally by the institutions. These proportions represent significant increases from the previous FY, which had a total allocation to SAGAs of Ksh 20.5 billion, with government grants constituting 81 percent and generated revenues 19 percent. The budget expansion thus was driven by increases in revenues of respective SAGAs. Figure 4 shows the breakdown of the recurrent budget allocation to the six SAGAs under the MOH in FY 2018/19.

As the results show, two hospitals—Kenyatta National Hospital (KNH) and Moi Teaching and Referral Hospital (MTRH)—accounted for about 66.6 percent of the MOH recurrent budget allocations to SAGAs. KNH received the largest allocation at 40 percent (24% grants and 16% user fees), followed by MTRH at 27 percent (18% grants and 9% user fees). The Kenya Medical Training College (KMTC) was allocated 9 percent and a further 7 percent in appropriations in aid, for a combined 19 percent. The Kenya Medical Supplies Authority (KEMSA) was allocated 1 percent but was expected to raise a further 8 percent from sales of goods to constitute 9 percent of the MOH recurrent allocation to SAGAs.

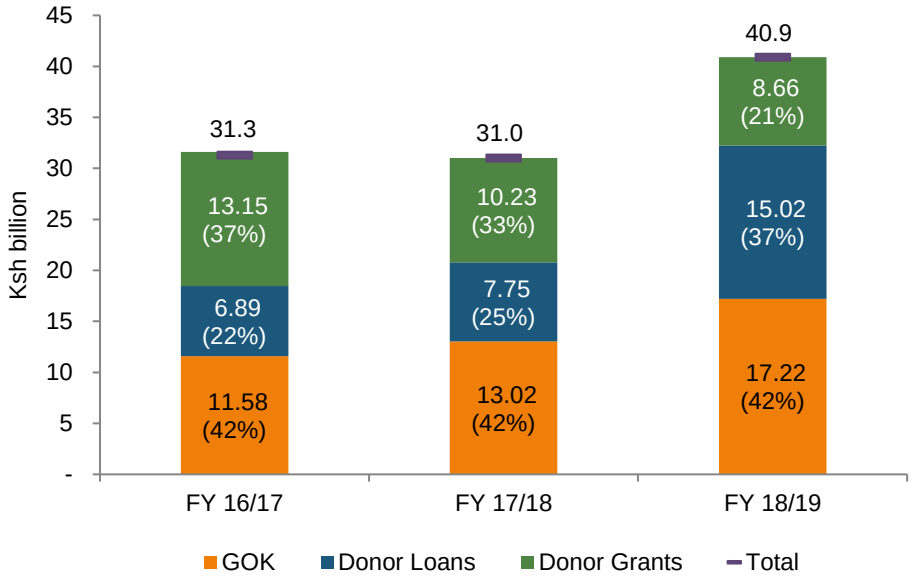
Figure 4: MOH recurrent budget allocations to SAGAs, FY 2018/19 (Ksh millions)



Sources of Ministry of Health Development Budget for FY 2016/17–FY 2018/19

The MOH's development budget includes funds provided by the national government and donors through loans and grants. The amounts and share contributed from each of the sources between FY 2016/17 to FY 2018/19 are presented in Figure 5.

Figure 5: Composition of development budget, FY 2016/17–FY 2018/19

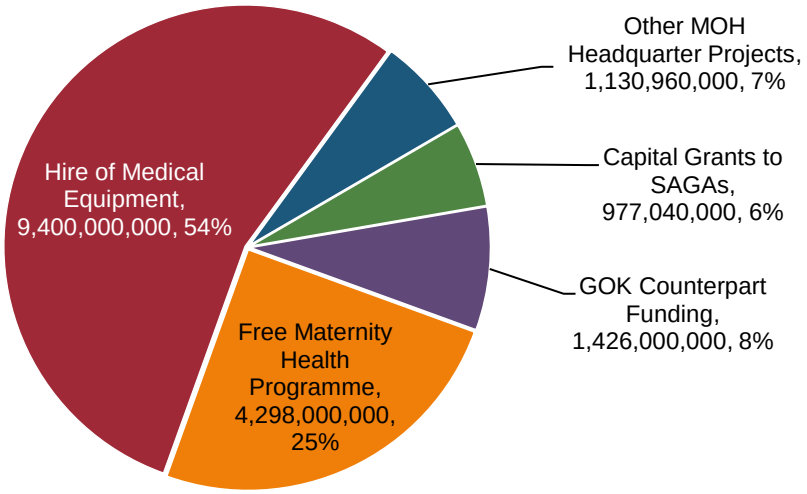


As illustrated in Figure 5, the MOH development budget increased significantly, to Ksh 40.9 billion in FY 2018/19, as compared to the previous two years, when it stayed almost constant at about Ksh 31 billion. The increase in FY 2018/19 is attributed to the Government of Kenya (GOK) contribution, which increased from 11.6 billion in FY 2016/17 to Ksh 17.2 billion, and donor loans expansion from Ksh 6.9 billion in FY 2016/17 to Ksh 15 billion in FY 2018/19. Donor grant contributions decreased over the period, going from Ksh 13.1 billion to Ksh 8.7 billion by FY 2018/19. However, the proportion of the GOK contribution remained constant at 42 percent, whereas the contribution from donor loans expanded from 22 percent to 37 percent by FY 2018/19, with a corresponding decrease in the contribution from donor grants. Donors are therefore reducing their contributions to the MOH budget through grants or possibly channelling them through off-budget support mechanisms. The trend also indicates that the MOH is substituting donor grants with loans and GOK resources, which are more predictable as sources of financing, but is not expanding its development budget.

Allocation of the Government of Kenya Development Budget by Key Areas/Programmes in FY 2018/19

Figure 6 shows the distribution of the MOH development resources provided by the national government for FY 2018/19 by key areas, amounts, and percentages.

Figure 6: Allocation of GOK development budget to key areas, FY 2018/19



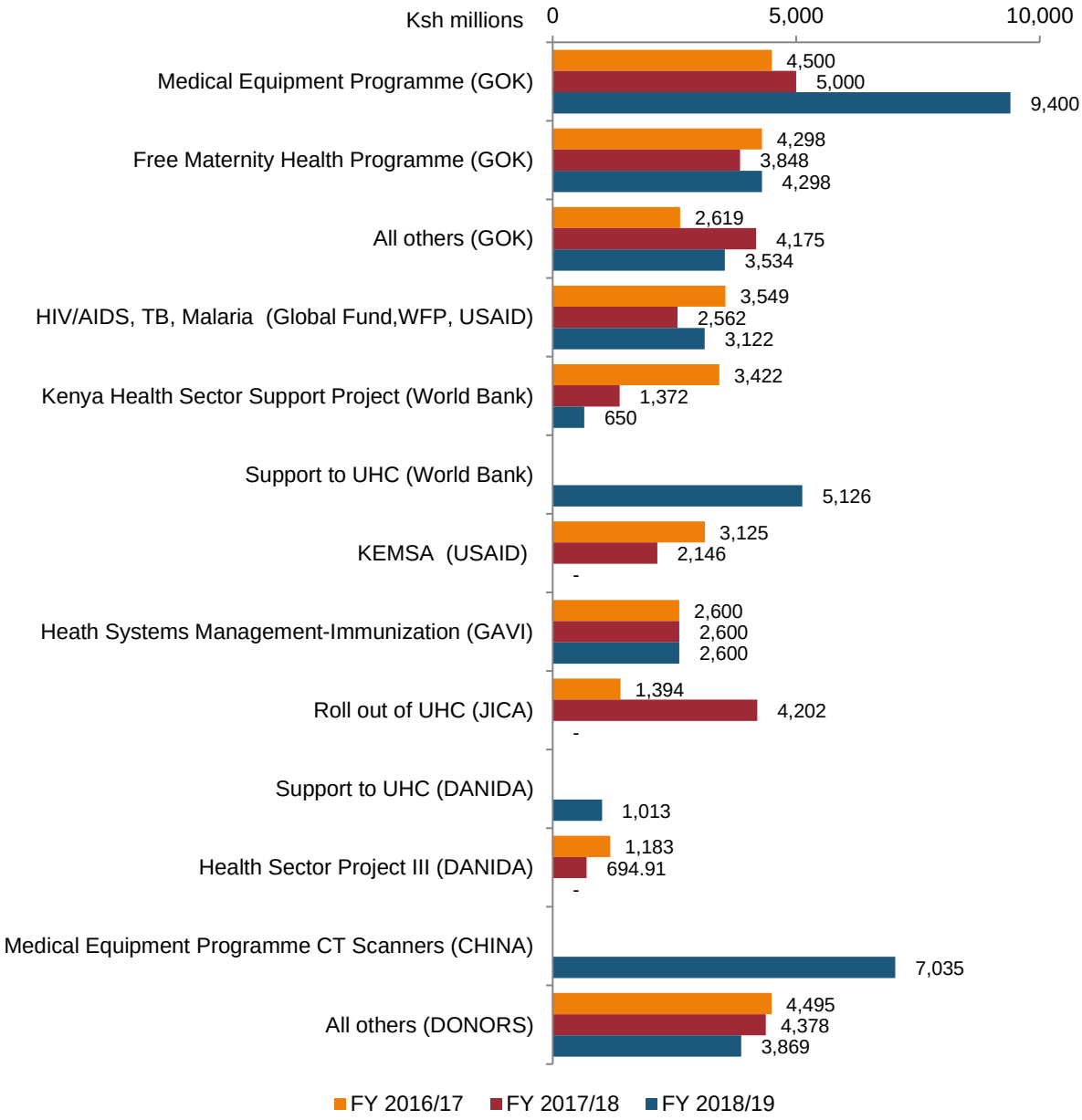
The MOH earmarked the largest proportion of GOK funding to development for the category of Hire of Medical Equipment, at 54 percent, and the Free Maternity Services programmes, at 25 percent, indicating that the MOH places a high priority on these programmes. These funds go towards purchasing modern equipment for Level 4 and 5 hospitals, and improving access to high-quality diagnostic and curative care. Funding for the Free Maternity Services Programme is earmarked to cover reimbursements to facilities providing free maternity care in FY 2018/19 through the National Health Insurance Fund.

The rest of the development budget was earmarked for GOK capital grants to SAGAs (6%), the government's contribution to donor-funded programmes (counterpart funding at 8%), and other capital development projects under the national government (7%).

Allocations to Programmes under Development in FY 2016/17–FY 2018/19

Figure 7 presents a summary of allocations to various programmes of the total development budget of the MOH (national government and donor sources) in FY 2016/17, FY 2017/18, and FY 2018/19, by programme and source. The results of the analysis (Figure 7) show that providing funds for the Medical Equipment Programme continues to be the MOH's highest priority. The programme was allocated Ksh 4.5 billion in FY 2016/17, Ksh 5 billion FY 2017/18, and then significantly increased to Ksh 9.4 billion. An additional Ksh 7 billion was provided from donor resources (China loan), resulting in a total allocation of Ksh 16.4 billion for the equipment-related budget. This allocation calculates to 40 percent of the entire MOH development budget.

Figure 7: MOH development budget allocations to programmes, FY 2016/17–FY 2018/19



Allocation for the Free Maternity Services Programme decreased from Ksh 4.3 billion in FY 2016/17 to Ksh 3.9 billion in FY 2017/18, and then increased to Ksh 4.3 in FY 2018/19. However, more funding for other maternal and reproductive health-related activities is provided under the all others (GOK) and all others (Donor) categories in amounts smaller than can be presented in the figure.

Allocation to UHC was Ksh 5.1 billion from donor resources in FY 2018/19, ranking as the second-highest priority among all programmes, after equipment. If combined with the Free Maternity Health Programme as a UHC access-enhancing programme, the total allocation for UHC becomes Ksh 9.4 billion, or 23 percent of the entire MOH development budget.

The largest contribution to the HIV/AIDS, Tuberculosis, and Malaria Programme came from the Global Fund to Fight HIV and AIDS, Malaria, and Tuberculosis, followed by the World Food Programme, and the U.S. Agency for International Development. However, the study found an

overall decline in the combined resources allocated to HIV by donors, from Ksh 3.6 million in FY 2016/17 to Ksh 3.1 billion in FY 2018/19.

Immunisation and related health systems support was allocated Ksh 2.6 billion from the Global Alliance for Vaccines and Immunization annually for FY 2016/17, FY 2017/18, and FY 2018/19. The GOK allocated Ksh 703 million to the programme in each of these financial years.

Figure 7 also indicates that the World Bank, Japan International Cooperative Agency and Danish International Development Agency appear to be decreasing their funding of Health Sector Support programmes over the review period, and most probably may be directing those resources to the counties.

Analysis of Ministry of Health Allocations to Programmes

The MOH designates five programmes for delivering on its mandate. Figure 8 shows the MOH budget allocation to programmes for FY 2016/17 through FY 2018/19, which includes the recurrent and development budgets. Figure 8 also shows growth over the period and the proportion of the programme allocation to the MOH budget.

Figure 8: MOH budget allocations to programmes FY 2016/17–FY 2018/19

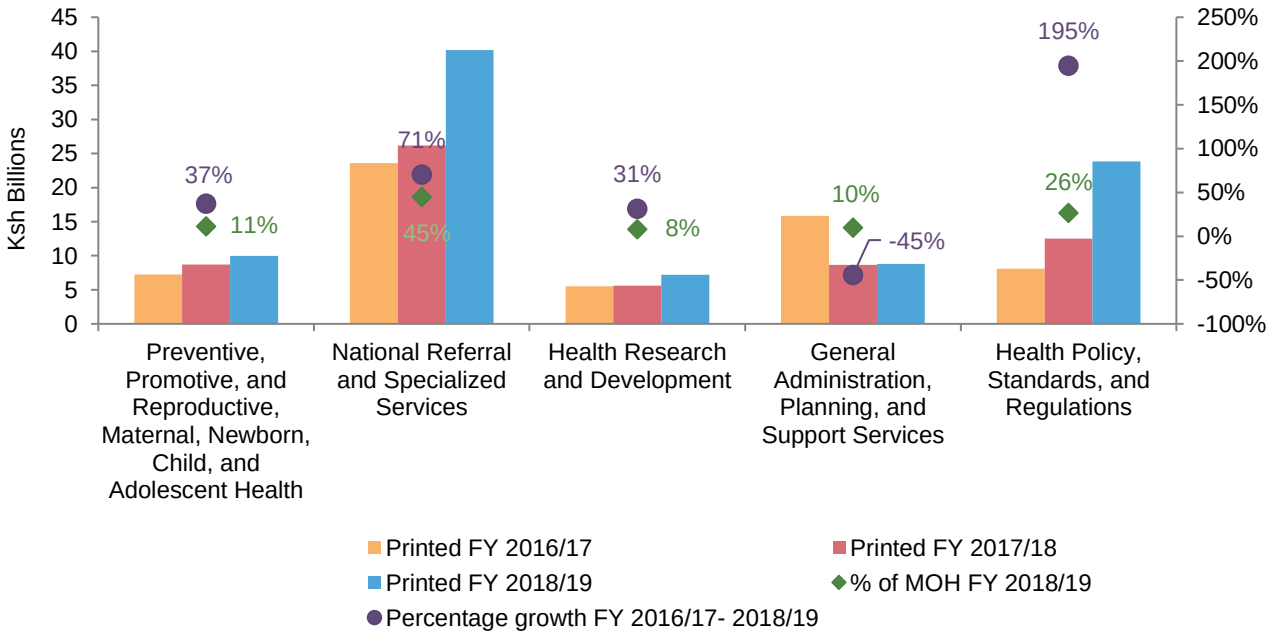


Figure 8 shows an increasing absolute allocation to all programmes except the general administration programme, which recorded a decrease over the period FY 2016/17–FY 2018/19. Significantly large proportionate increases in allocations also are shown for the health policy standards and regulations, and the national referral and specialized services programmes, at 195 and 71 percent, respectively. The same two programmes were allocated the highest percentages of the MOH budget in FY 2018/19, with national referral receiving 45 percent and health policy at 26 percent.

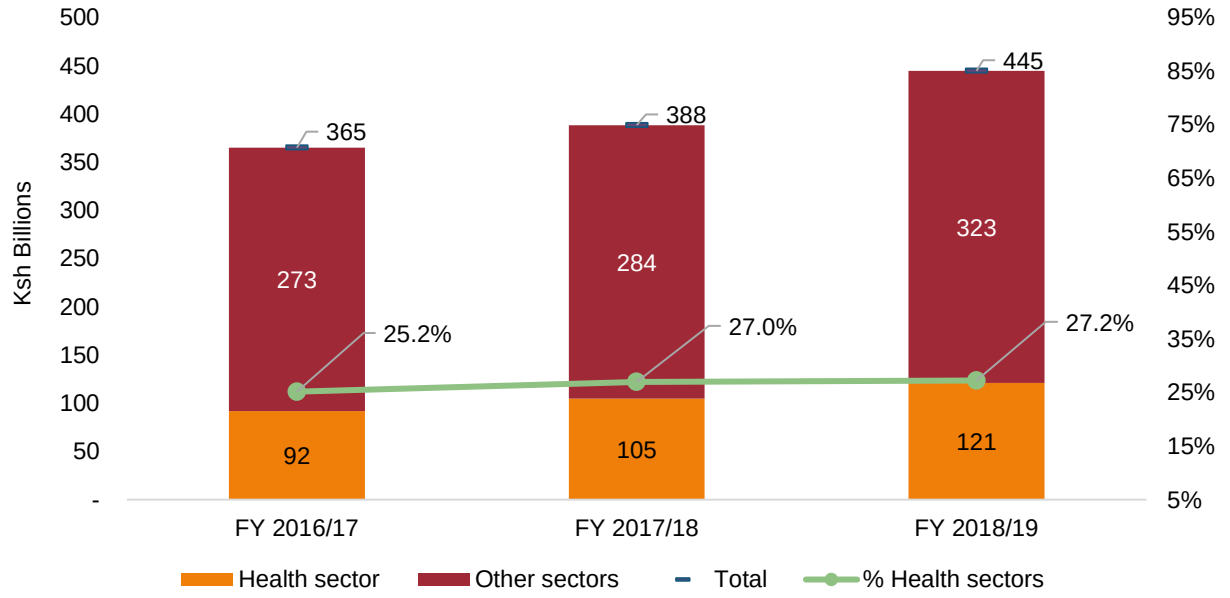
County Allocations to Health

Since the onset of devolution in FY 2013/14, the counties continue to provide a range of health services through primary healthcare facilities, dispensaries, health centres, and some hospitals in their respective areas of jurisdiction. The principal source of financing continues to be transfers from the national revenues, which are shared among counties based on a legal formula that considers counties' population, poverty levels, land area, and level of development. Counties also raise additional revenues from user fees for services provided at public health facilities (among other levies). Although the PFMA 2012 provides guidelines to counties on how to allocate their global budgets between recurrent and development expenditures (70% to recurrent and 30% to development over the medium term), allocation to specific sectors such as health remain the prerogative of the respective counties, depending on their priorities. This section analyses the budgets for the 47 counties and presents findings on how they allocated funds to health over the review period of FY 2016/17 through FY 2018/19.

Overall Allocations to Health by County Governments

The proportion of the county health budget in relation to the total county government budget indicates the level of priority that county governments place on the health sector and their commitment to improving their health indicators. This section examines county health allocations against the overall total county budgets from FY 2016/17, FY 2017/18, and FY 2018/19. Figure 9 provides county governments' budgets allocated to the health sector in those three years.

Figure 9: County governments' allocation to health, FY 2016/17–FY 2018/19[1]



Counties' budgets expanded from Ksh 365 billion in FY 2016/17 to Ksh 388 billion in FY 2017/18 and Ksh 445 billion in FY 2018/19, representing an increase of 22 percent over the three-year period (and a 14.7% increase between FY 2017/18 and FY 2018/19). Allocations to health increased from Ksh 92 billion in FY 2016/17 to Ksh 105 billion in FY 2017/18 and Ksh 121 billion in FY 2018/19, an

[1] The amount Ksh 121 billion of county health budgets differs from the Ksh 109 billion reported earlier because it includes the transfers received from the MOH. These funds are received through the County Revenue Fund and allocated according to county budget allocation mechanisms.

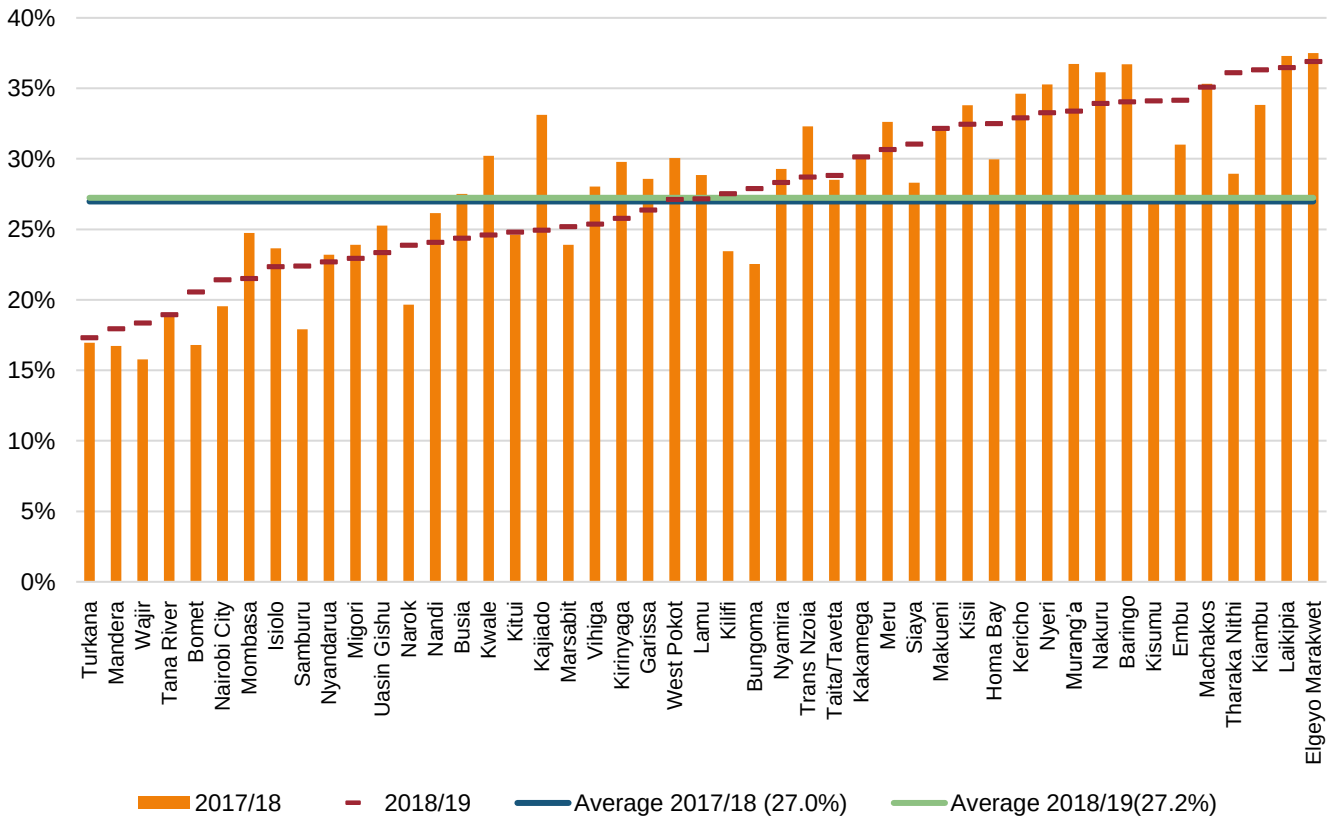
expansion of 31 percent during the same period (and an increase of 15% between FY 2017/18 and FY 2018/19).

The data show that, overall, the county governments' allocations to the health sector as a percentage of total county governments budgets increased from 25.2 percent in FY 2016/17 to 27.0 percent in FY 2017/18, and 27.2 percent in FY 2018/19. This finding suggests that, on average, health is a priority sector for the county governments.

Allocations to Health by County, FY 2016/17 and FY 2017/18

Figure 10 shows the percentages of the budgets allocated to health in the respective counties in FY 2017/18 and FY 2018/19, and the averages across all 47 counties as drawn from available data. Figure 10 indicates that allocation to health increased marginally, from an average of 27 percent in FY 2017/18 to 27.2 percent in FY 2018/19, with 18 out of 47 counties increasing the proportion of their budget allocations to health in FY 2018/19. Five counties reached the estimated pre-devolution allocation of 35 percent in FY 2018/19. This finding shows that counties continue to face challenges in increasing their budget allocations to health. Importantly however, the data shown in Figure 10 do not indicate any particular regional differences between well-performing and less well-performing counties, meaning that low-performing counties have the potential to increase their proportionate allocations to health.

Figure 10: County health budget allocation as a percentage of total county budget by county, FY 2017/18 and FY 2018/19



County Health Sector Budget Allocations: Recurrent vs. Development Budget, FY 2016/17–FY 2018/19

County governments determine the proportion of funds to be allocated to recurrent and development activities through sector budget submissions. The PFMA 2012 recommends that over the medium term, counties allocate at least 30 percent of their budgets to development and 70 percent or less to recurrent, so as to consistently invest in the sector's expansion and yet maintain service provision. This section analyses how counties allocated funding for recurrent and development activities over the FY 2016/17–FY 2018/19 period.

Overall County Recurrent and Development Expenditure Allocations

Table 2 presents the amounts and proportions that counties allocated to their recurrent and development budgets. The table shows that the counties increased their allocations to health in absolute terms, from Ksh 91.8 billion in FY 2016/17 to Ksh 104.8 billion in FY 2017/18, and Ksh 121.1 billion by FY 2018/19. This increase was driven mainly by increases in recurrent budget allocations, which have remained consistently high, at an average of 79.8 percent—significantly above the 70 percent threshold. The counties are far from achieving the PFMA requirements.

Table 2: Recurrent and development allocations, health sector, FY 2016/17–FY 2018/19

Vote	Allocation Ksh (% of total county health budget)		
	FY 2016/17	FY 2017/18	FY 2018/19
Recurrent	72,297,833,991 (78.8%)	85,795,473,875 (81.9%)	95,295,938,788 (78.7%)
Development	19,489,223,722 (21.2%)	18,980,837,655 (18.1%)	25,793,427,753 (21.3%)
TOTAL	91,787,057,713 (100%)	104,776,311,530 (100%)	121,089,366,541 (100%)

Proportion of Health Budget Allocations to Development by County, FY 2018/19

The amount and proportion of funds allocated for the development budget indicates the level of capital investment in the health sector and the overall expansion of longer-term infrastructure. There are significant variations among counties in the proportion of their budget allocations to development, regardless of the absolute amounts allocated to health. Figure 11 presents the pattern of development allocations per county for FY 2018/19, showing the total allocation to health, broken down to recurrent and development, and the proportion of the development allocation to the total budget.

Figure 11 shows that health budget allocations ranged from Ksh 1.05 billion in Isiolo to Ksh 6.92 billion in Nairobi City, and the proportion allocated for development ranged from 5.8 percent in Bungoma to 43.6 percent in Kwale counties, with no observable pattern linking the total amount allocated to health to the proportion allocated to development. Although the counties are allocating 79.8 percent on average to the recurrent budget, Table 3 shows the proportion of the respective counties' allocations to recurrent. Table 3 lists 38 counties that allocated between 71 and 90 percent of the health budgets to recurrent expenditures and thus exceeded the recommended threshold of 70 percent, whereas nine counties managed to allocate within that threshold, with no unusual regional variations observed across the counties to explain the differences. This finding implies that other counties have the potential to allocate a higher proportion of funds to the development budget.

Figure 11: Budget allocation to recurrent and development by county, FY 2018/19

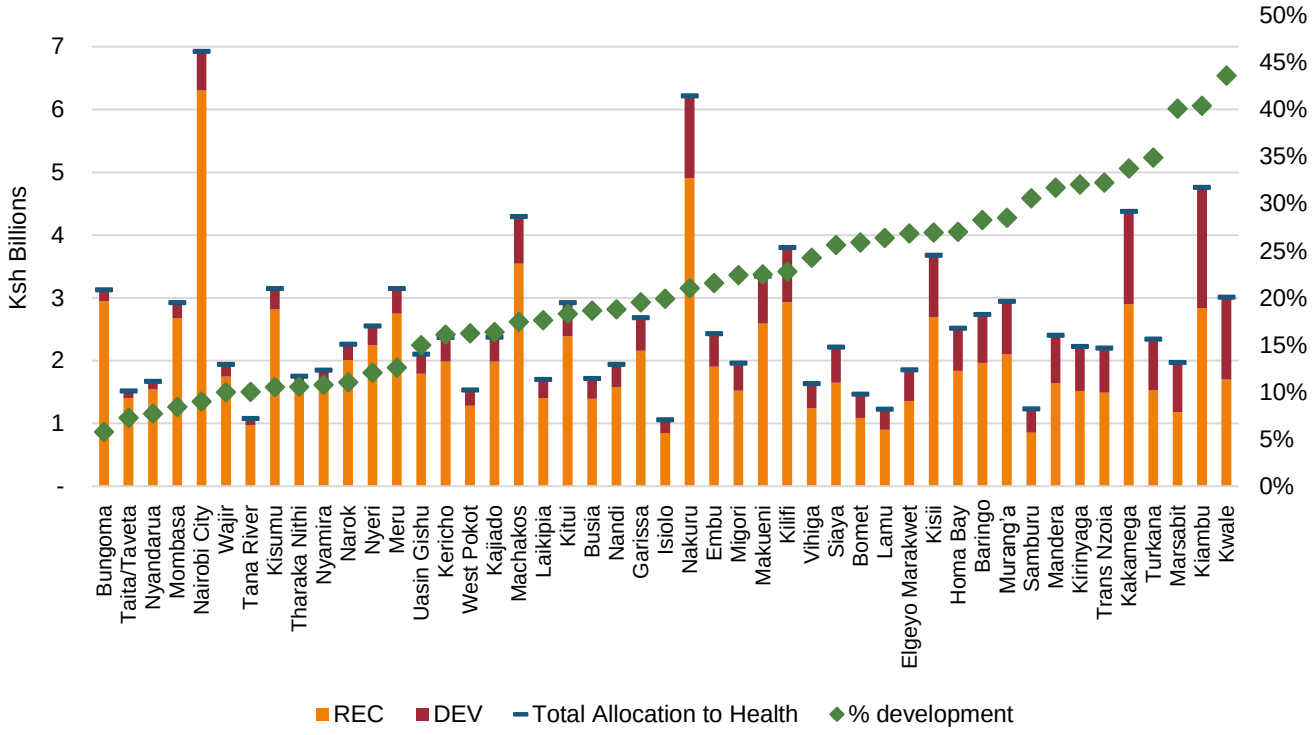


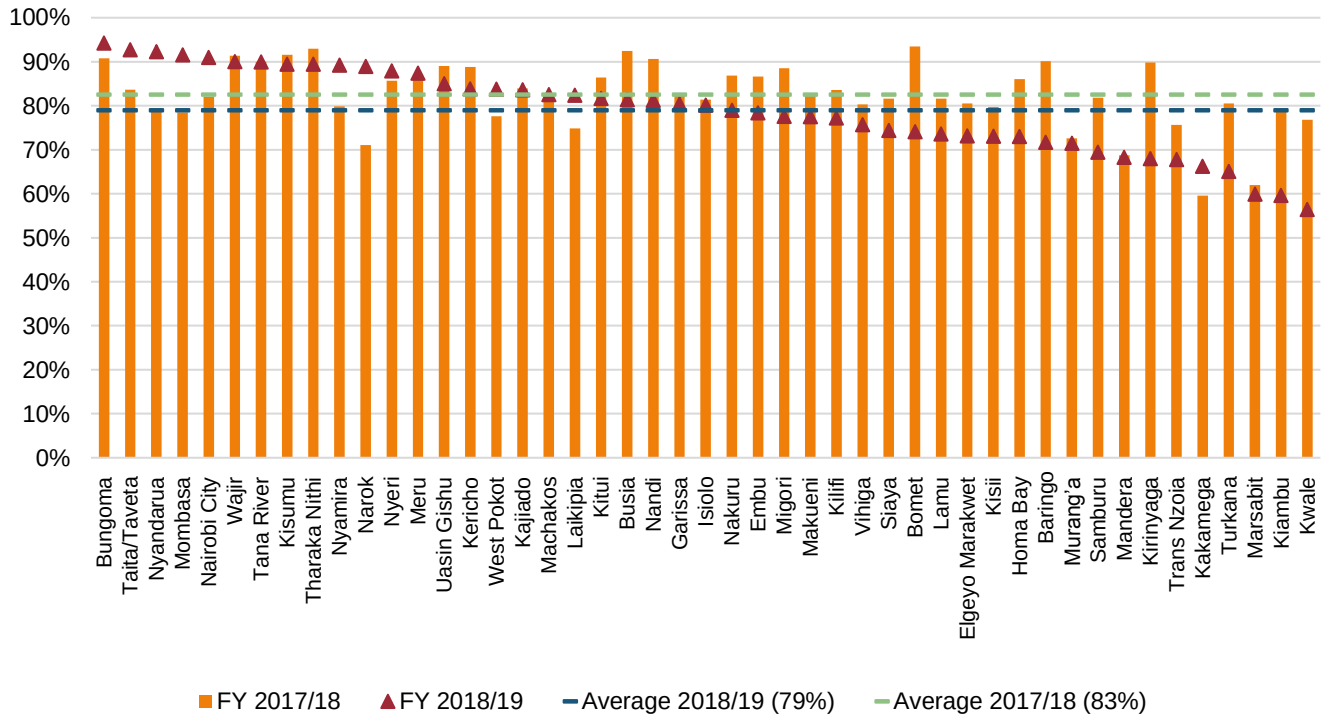
Table 3: Recurrent allocations by counties as a percentage of their total health allocations in FY 2018/19

55–60%	61–70%	71–80%	80–90%	Over 90%
Kwale: 56.4% Kiambu: 59.6% Marsabit: 59.9%	Turkana: 65.1% Kakamega: 66.3% Trans Nzoia: 67.8% Kirinyaga: 68.0% Mandera: 68.3% Samburu: 69.4%	Murang'a: 71.5% Baringo: 71.7% Homa Bay: 73.0% Kisii: 73.1% Elgeyo Marakwet: 73.2% Lamu: 73.6% Bomet: 74.1% Siaya: 74.4% Vihiga: 75.8% Kilifi: 77.2% Makueni: 77.5% Migori: 77.6% Embu: 78.4% Nakuru: 79.0%	Isiolo: 80.1% Garissa: 80.5% Nandi: 81.2% Busia: 81.4% Kitui: 81.7% Laikipia: 82.4% Machakos: 82.6% Kajiado: 83.7% West Pokot: 83.8% Kericho: 83.9% Uasin Gishu: 85.0% Meru: 87.4% Nyeri: 88.0% Narok: 89.0% Nyamira: 89.2% Tharaka Nithi: 89.5% Kisumu: 89.5% Tana River: 90.0% Wajir: 90.0%	Nairobi City: 91.0% Mombasa: 91.6% Nyandarua: 92.3% Taita/Taveta: 92.8% Bungoma: 94.2%

Trends in Recurrent vs. Development Allocations by County, FY 2017/18–FY 2018/19

Figure 12 presents the trends of recurrent health budget allocations by county as a percentage of their total health allocations over FY 2017/18 and FY 2018/19. Figure 12 shows that, on average, the proportion of county health budgets allocated to recurrent decreased slightly, from 83 percent in FY 2017/18 to 79 percent in FY 2018/19. The greatest decreases in recurrent allocations between FY 2017/18 and FY 2018/19 were observed for Kwale, Kiambu, Turkana, Kirinyaga, Samburu, Baringo, Homa Bay, Bomet, Embu, Nakuru, Isiolo, Migori, Busia, and Nandi counties, whereas unfavourable trends in which the proportion of the recurrent budget increased included Bungoma, Taita Taveta, Nyandarua, Mombasa, Nyamira, Narok, West Pokot, and Laikipia.

Figure 12: Recurrent allocations as a percentage of health allocations by county



County Health Sector Budget Allocations by Economic Categories

As counties move towards implementing the PBB approach, which classifies allocations according to specific economic categories and input items, it is prudent to analyse budget allocations by key health inputs. This is the case because PBB formats provide an indicative assessment of whether health inputs are balanced and positioned to achieve technical and operational efficiency in service delivery. This section examines how counties allocated their recurrent and development budgets by economic categories.

Health Recurrent Budget Allocations by Economic Categories

Whereas PBB guidelines propose the disaggregation of the recurrent budget into the four economic categories—personnel emoluments, O&M, current transfers to government agencies, and "other" recurrent expenses—health sector budgets are more informative if inputs critical for service delivery, such as drugs, are identified and analysed based on the O&M category. Figure 13 presents the pattern and trends in counties' disaggregated health recurrent budget allocations by those economic categories relevant in the health sector.

Figure 13: County health recurrent budget allocations (%) by economic category, FY 2016/17–FY 2018/19

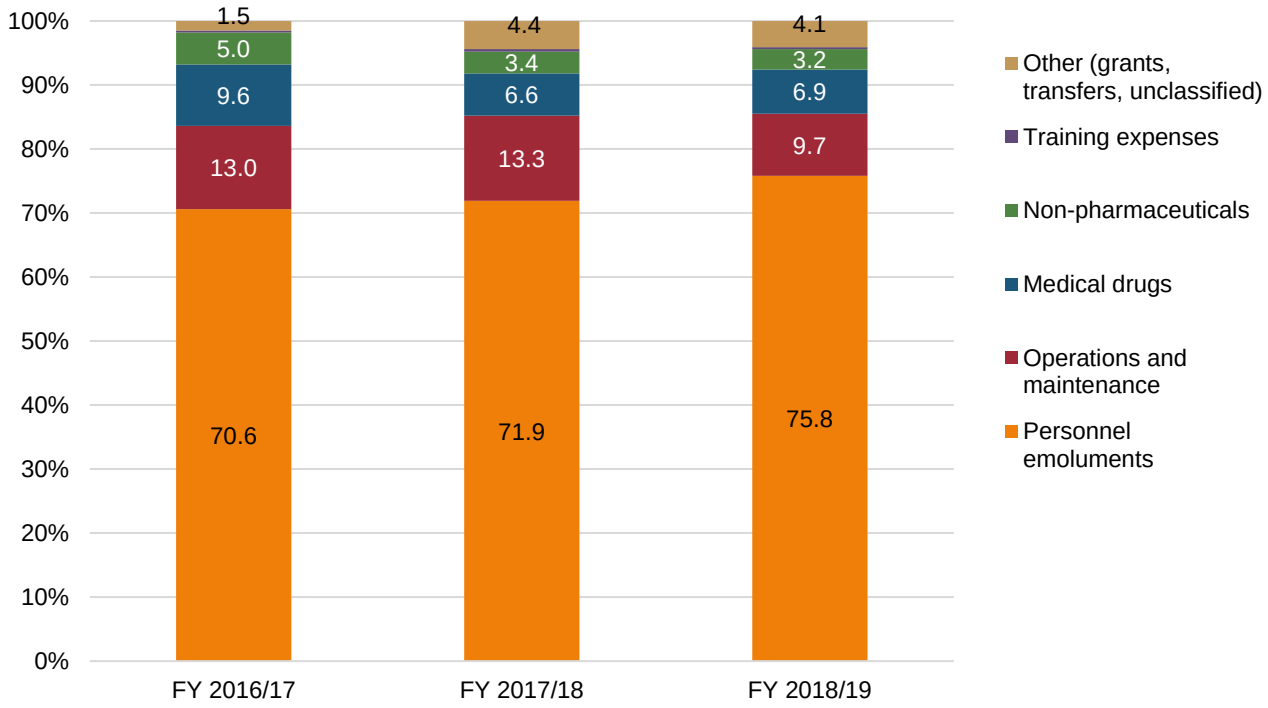


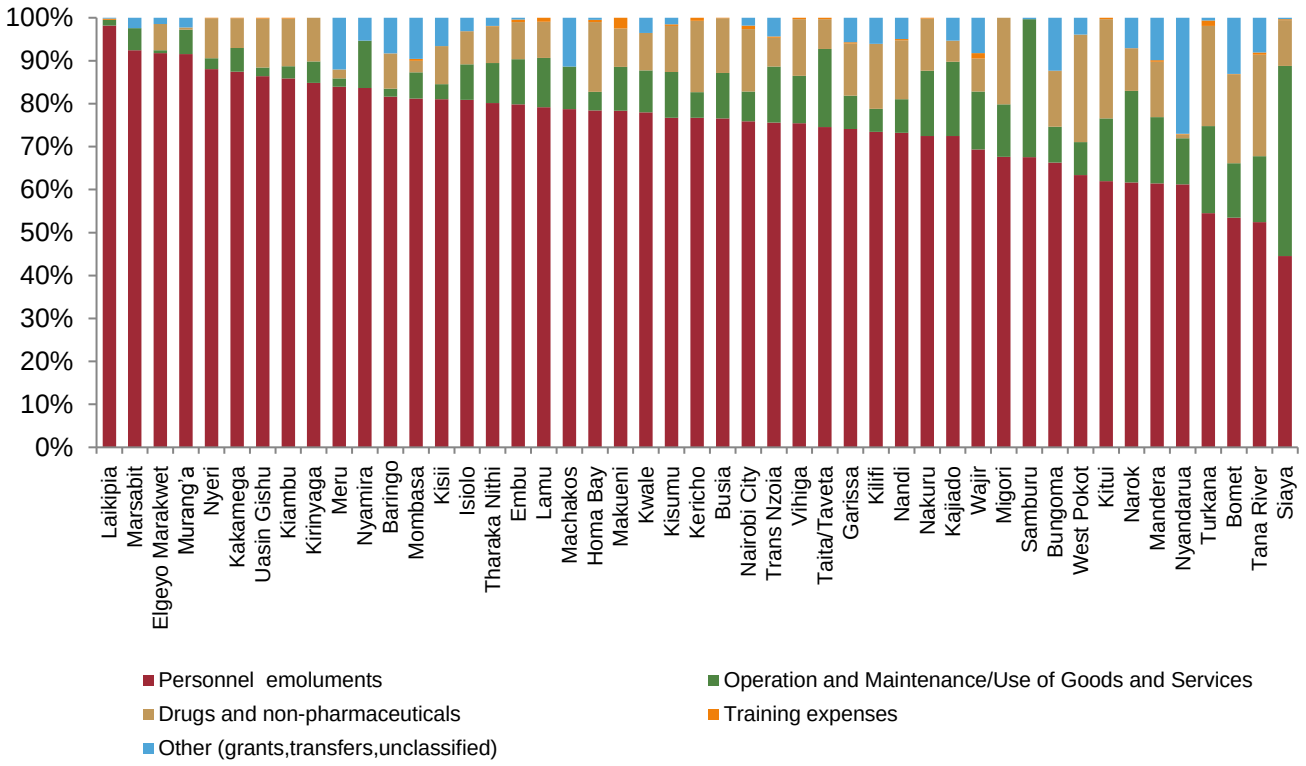
Figure 13 shows that allocations for the Personnel emoluments category take up the largest share of the recurrent budget, accounting for 70.6 percent in FY 2016/17, increasing to 71.9 percent in FY 2017/18, and then to a significant 75.8 percent in FY 2018/19. Figure 13 also shows an increase in the proportion of budgets allocated to O&M, from 13.0 percent in FY 2016/17 to 13.3 percent in FY 2017/18, followed by a decrease to 9.7 percent in FY 2018/19.

Allocations for medical drugs and non-pharmaceutical supplies, considered essential health inputs, have been decreasing. The two items combined were allocated at 14.6 percent in FY 2016/17 and decreased to 10.1 percent by FY 2018/19. Allocations for other recurrent expenses, including grants transfers, increased from 1.5 percent in FY 2016/17 to 4.4 percent in FY 2017/18 before decreasing marginally to 4.1 percent in FY 2018/19.

Health Recurrent Budget Allocations by Economic Categories by County, FY 2018/19

Individual counties allocated their FY 2018/19 recurrent budgets to economic categories differently. Figure 14 shows individual counties' allocations to personnel emoluments; drugs and other non-pharmaceuticals; training; and the "Other" category, which includes grants, transfers, and unclassified expenditures.

Figure 14: Individual counties' health recurrent budget allocations (%) by economic category, FY 2016/17–FY 2018/19

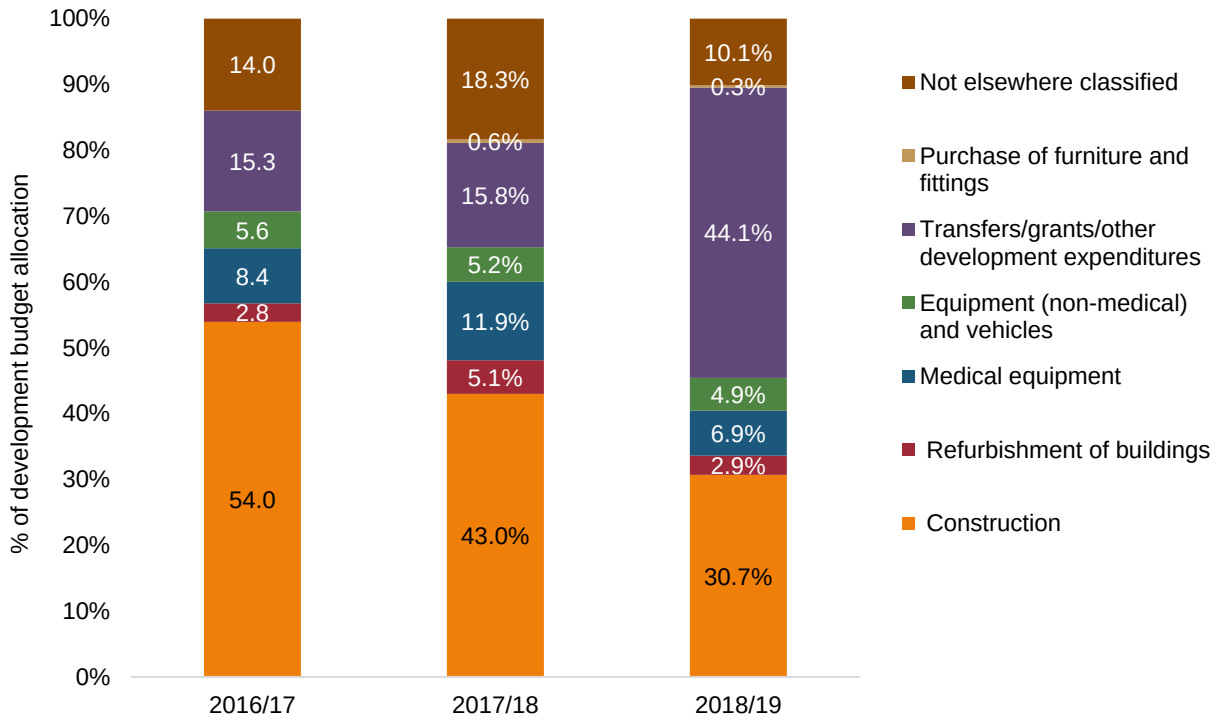


A high proportionate allocation of recurrent budget to personnel emoluments means that a county is reserving fewer resources for other critical health inputs essential for delivery of care. Figure 14 shows that during FY 2018/19, the five counties allocating the highest proportion of recurrent budget to personnel emoluments were Laikipia, Marsabit, Elgeyo Marakwet, Muranga, and Nyeri; Siaya, Tana River, Bomet, Turkana, and Nyandarua allocated the lowest proportion.

Health Development Budget Allocations by Economic Categories

As noted in Table 2, counties are gradually increasing the absolute amount and proportion of their health budgets allocated to development, from Ksh 18.9 billion (18.1% of the total health budget) in FY 2017/18 to Ksh 25.8 billion (21.3%) in FY 2018/19. Figure 15 shows the disaggregated development budget across economic categories.

Figure 15: County health services development budget allocations (%) by economic categories, FY 2016/17–FY 2018/19



The largest expenditure categories in FY 2016/17 and FY 2017/18 were investment in construction projects, accounting for about 54 percent and 43 percent of the development budget, respectively. This allocation decreased significantly to 30.7 percent in FY 2018/19; the funds accounting for this decline appear to have been reallocated to the transfers/grants/other development category, whose proportion increased from 15.3 percent in FY 2016/17 to 15.8 percent in FY 2017/18 and 44.1 percent in FY 2018/19. Allocations to medical equipment accounted for 8.4 percent in FY 2016/17, increasing to 11.9 percent in FY 2017/18 and then decreasing to 6.9 percent in FY 2018/19.

Health Development Budget Allocations by Economic Categories by County, FY 2018/19

Likewise under development, individual counties allocated their FY 2018/19 development budgets to economic categories differently. Figure 16 shows individual counties' allocations to economic inputs grouped into buildings, equipment and furniture, and grants, transfers, and other development expenditures not specifically classified.

Figure 16: Individual counties' health development budget allocations (%) by economic category, FY 2016/17–FY 2018/19

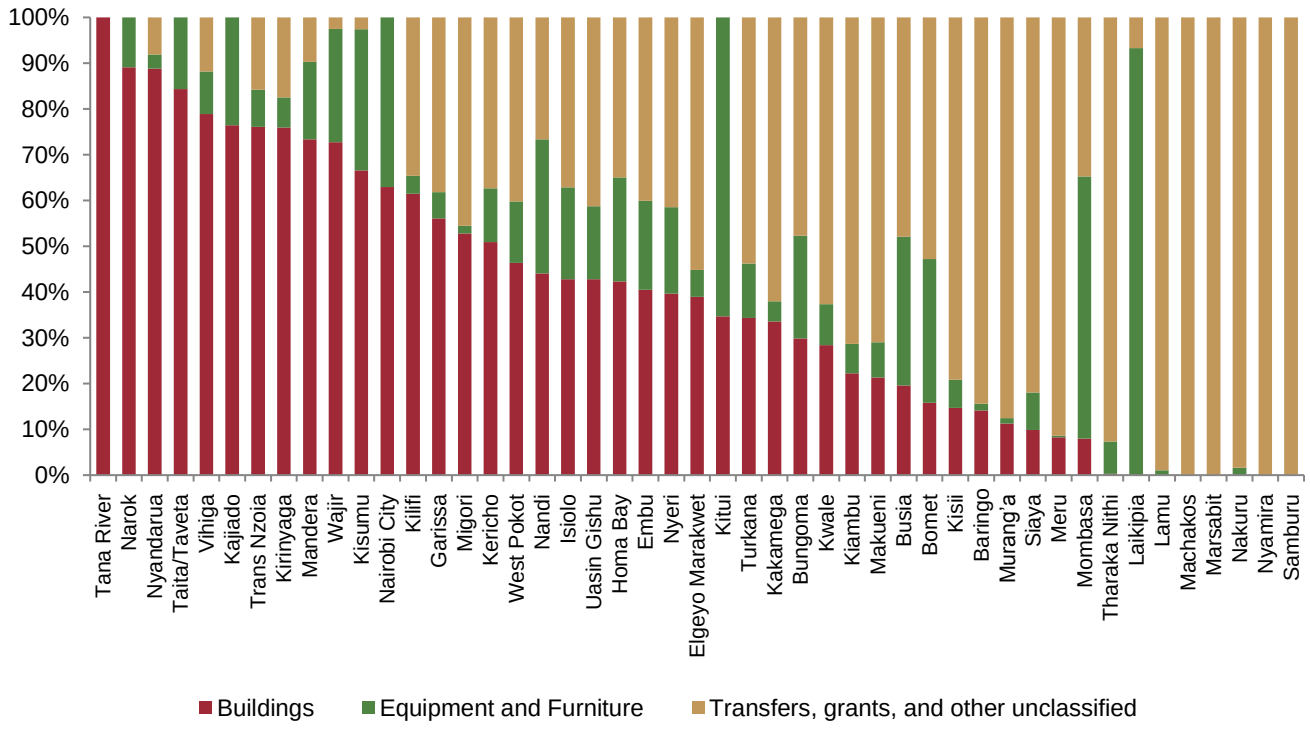


Figure 16 shows that the top five counties with the highest budget allocated for buildings are Tana River, Narok, Nyandarua, Taita Taveta, and Vihiga, while data shows that the six counties of Lamu, Machakos, Marsabit, Nakuru, Nyamira, and Samburu did not allocate any development funds for buildings. However, counties that seem to allocate nil or a minimum amount for buildings reported the highest allocation of the development budget under the category of transfers, grants, and unclassified, which may incorporate elements of other categories as well.

Per Capita Allocations to Health by County, FY 2017/18 and FY 2018/19

Counties must serve different population sizes through the allocations provided for health. Weighting the allocation against the population served provides a measure of the intensity of the resources allocated. In addition, the World Health Organization has found that countries that attained UHC allocated at least $86 (approximately Ksh 8,600) per person per year, meaning that counties can estimate the amount allocated per capita directly through the national government and use their allocations to evaluate themselves against this indicator. Figure 17 provides the per capita allocation by county for the period FY 2017/18 and FY 2018/19.

Figure 17: County per capita budget allocations, FY 2017/18 and FY 2018/19

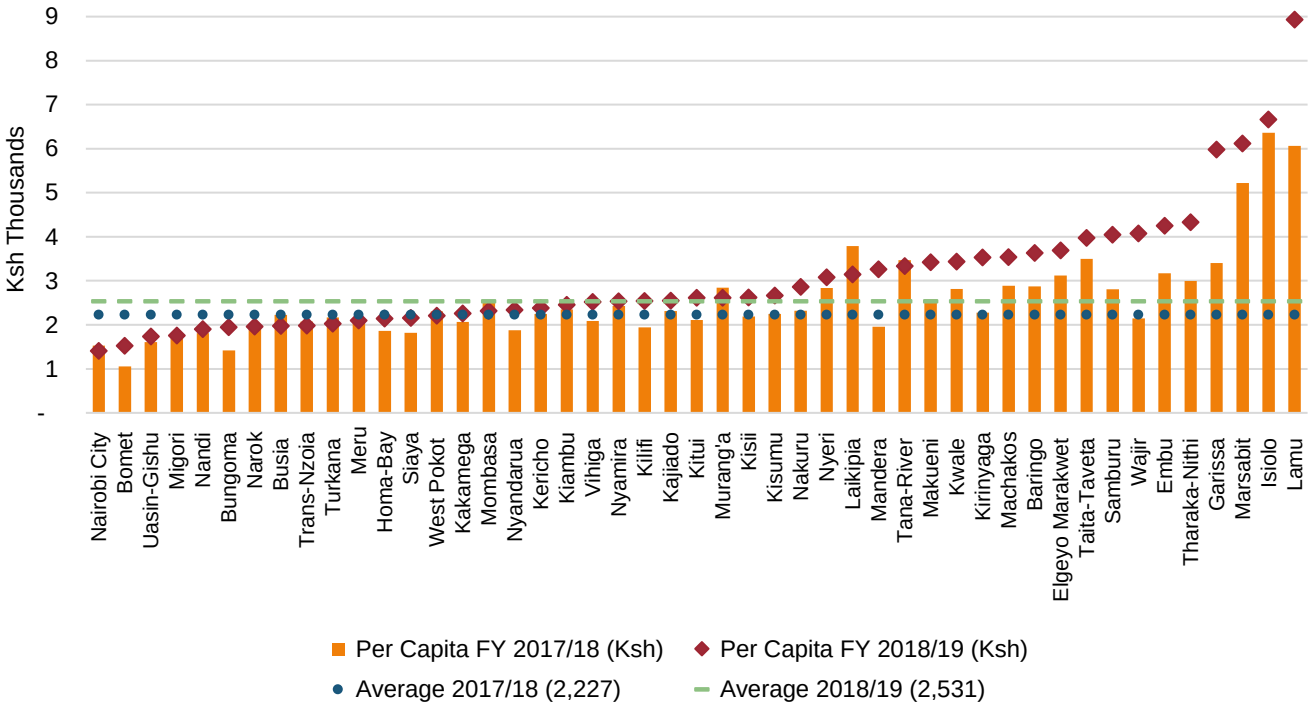


Figure 17 shows that counties increased their per capita budget allocations from Ksh 2,227 in FY 2017/18 to Ksh 2,531 in FY 2018/19, computing to a 13.7 percent increase. However, the figure also shows that the per capita allocation varied across counties, ranging from Ksh 1,401 for Nairobi County in FY 2018/19 to a per capita allocation of Ksh 8,928 in Lamu County during the same year.

CONCLUSION AND RECOMMENDATIONS

This study sought to explore budget resource allocations to the MOH and counties' health departments, and whether these resources are allocated efficiently to achieve intended health priorities over the period FY 2016/17 to FY 2018/19, with a view to inform resource allocation policies in the health sector. The study findings lead to the following conclusions and recommendations.

Conclusions

- The continuous expansion of the total government budget, taking into consideration a projected favourable macroeconomic environment in which government revenues are expected to increase, indicate a fiscal space for the national government to allocate more resources to the MOH. These additional resources could be applied towards expanding the reach of core national programmes, including maternal care, immunisations, HIV treatment and prevention, and other subsidies. The GOK has the potential for expanding funding for health and need to allocate more resources to the MOH, including more provisions for conditional grants extended to the counties.
- Donors still are contributing the largest proportion of the development budget, at 58 percent, and are the main financers of core programmes, such as HIV, TB, and Malaria, even though the donor allocation for this programme declined from Ksh 3.6 billion in FY 2016/17 to Ksh 2.6 billion by FY 2017/18. Thus, a high dependence on donors for financing key programmes still exists, raising issues of ownership and sustainability.
- Even though the budget allocation for the Free Maternity Services Programme declined from Ksh 4.3 billion in FY 2016/17 to Ksh 3.9 billion in FY 2017/18, the funding delivery mechanism changed from an MOH disbursement to using the National Hospital Insurance Fund mechanism; the expectation is that this mechanism will be innovative and efficient, and will reach nongovernment providers.
- This analysis clearly shows that county governments are committed to increasing—in absolute and relative terms—their budgetary allocations to health. Overall county health sector budgets have been increasing gradually over the last three years, indicating that counties are prioritising health in their budget allocations by increasing its allocation from 25.2 percent in FY 2016/17 to 27.2 percent in FY 2018/19. Although there were noticeable variations between counties, the results reflect the high priority given to health.
- The number of counties allocating more than 30 percent of their budgets to the health sector also significantly increased, from seven counties in FY 2016/17 to 19 in FY 2017/18 and 17 in FY 2018/19. County governments must continue prioritising the health sector in budget allocations to successfully implement their planned projects.
- The analysis also found increasing allocations to recurrent over development expenditure estimates in most counties. This trend in the counties' recurrent budget allocations suggests that counties continue to increase allocations to personnel emoluments instead of shifting resources to other critical inputs. The percentage allocated to personnel emoluments still remains high, at 76 percent, as opposed to the recommended 50 to 60 percent.

- Likewise, counties' allocations for medical drugs, an essential health input, continues to decrease. Also, a huge proportion of their development budget is unclassified. These cases illustrate inefficiencies in their budgets and budgeting.
- Counties are gradually increasing their allocation to health, both in absolute terms and relative to other sectors, which is encouraging; however, the number of counties that demonstrated an increase in their health budgets was significantly lower in FY 2018/19 than in FY 2017/18—an indicator that even those counties with lower allocations have the potential to increase health funding, if appropriately prioritised.
- Counties need to increase allocations to development, especially those allocating almost their entire budgets to recurrent, including Nairobi, Mombasa, Nyandarua, Taita Taveta, and Bungoma.
- Likewise, county development budgets are mostly allocated to new infrastructure, whereas only a minimal amount is allocated to rehabilitation. Rapid expansion of facilities demands more allocations to the recurrent budget in the future; counties should rationalise this rapid expansion.
- Counties' per capita allocations are still low, averaging Ksh 2,53, compared to the recommended World Health Organization figure of US$86 (approximately Ksh 8,600).

Recommendations

In the light of these findings, this study makes the following recommendations:

- The MOH budget must be expanded for two reasons:
    - To reduce over-reliance on donor resources for key programmes, including HIV, TB, and malaria, and enhance domestic resource mobilisation for key programmes
    - To extend coverage and access to priority national-level programmes, such as maternity care, immunisation, family planning, and subsidies for free care at primary care facilities
- The MOH needs to align resource allocation to policy priorities, especially in funding for preventive and promotive health services, whose proportion of allocation is comparatively low.
- The MOH should also immediately develop the mechanisms stipulated in the recently enacted Health Law to ensure that resources disbursed for free care at primary care facilities are ring-fenced and used to increase access to and quality of services at those facilities.
- Counties are constitutionally obliged to deliver most healthcare services and thus should allocate more resources to health; such allocations are still inadequate. Specifically, those counties below the overall county average should be encouraged to do so. Planning, budgeting, and advocacy capacities for those counties should be enhanced.
- As budgets expand, counties should strive towards allocating resources more efficiently by balancing allocations to critical health inputs, especially for drugs and related supplies.
- The MOH and its partners should provide more technical support to counties, given that budget allocations for health remain below the proportion allocated for such services before devolution and continue to be so five years after devolution.

- Given that a large portion of county health allocations go to personnel emoluments, it is important that rational deployment plans, as well as initiatives to enhance productivity, are put in place.
- Study results show the predominance of recurrent over development expenditure estimates across counties. There is a need to ensure that over the medium term, a minimum of 30 percent of county governments' budgets is allocated to development expenditure, as stated in the PFMA. However, it should be noted that unless counties receive sufficient allocations for health, it will remain difficult for them to allocate to their development budgets before meeting the needs of their recurrent budgets.
- Counties should continue increasing the amount they allocate to health, as they are yet to realise the recommended 30 percent average. Counties ranked lowest in allocating funds to health should be encouraged and given the capacity to increase these allocations.

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ANNEX 1: COUNTY HEALTH BUDGET ALLOCATION FY 2018/19

Total budget and health allocation

County	Total Budget	Health Allocation		
		Total	Recurrent	Development
Baringo	8,029,370,014	2,734,848,431	1,962,222,769	772,625,662
Bomet	7,116,909,002	1,464,348,401	1,085,589,252	378,759,149
Bungoma	11,213,060,757	3,127,885,081	2,947,853,461	180,031,620
Busia	7,026,121,806	1,713,638,895	1,394,193,157	319,445,738
Elgeyo Marakwet	5,020,012,841	1,852,951,675	1,355,873,746	497,077,929
Embu	7,107,296,920	2,428,167,557	1,904,412,841	523,754,716
Garissa	10,162,735,255	2,681,472,229	2,157,972,229	523,500,000
Homa Bay	7,732,086,904	2,514,078,080	1,835,434,262	678,643,818
Isiolo	4,727,633,637	1,057,500,530	847,270,700	210,229,830
Kajiado	9,514,040,462	2,372,881,866	1,984,975,066	387,906,800
Kakamega	14,507,750,502	4,374,733,790	2,899,873,640	1,474,860,150
Kericho	7,184,116,063	2,365,396,294	1,984,539,209	380,857,085
Kiambu	13,101,258,545	4,758,735,909	2,836,752,920	1,921,982,989
Kilifi	13,807,774,484	3,801,491,894	2,935,567,977	865,923,917
Kirinyaga	8,634,442,271	2,226,984,858	1,513,784,858	713,200,000
Kisii	11,327,000,000	3,675,958,458	2,686,149,943	989,808,515
Kisumu	9,217,889,213	3,145,827,056	2,815,045,182	330,781,874
Kitui	11,775,231,412	2,922,385,058	2,387,774,745	534,610,313
Kwale	12,232,755,516	3,010,267,420	1,698,103,384	1,312,164,036
Laikipia	4,663,400,000	1,700,750,406	1,401,250,406	299,500,000
Lamu	4,502,378,109	1,223,599,906	900,956,372	322,643,534
Machakos	12,231,106,619	4,293,811,773	3,545,367,364	748,444,409
Makueni	10,400,508,264	3,345,021,905	2,592,616,891	752,405,013
Mandera	13,378,745,394	2,402,879,900	1,641,523,900	761,356,000
Marsabit	7,820,538,914	1,971,322,500	1,181,072,500	790,250,000
Meru	10,260,317,505	3,146,274,398	2,750,226,898	396,047,500
Migori	8,540,007,356	1,960,058,055	1,520,858,055	439,200,000
Mombasa	13,591,771,891	2,923,643,133	2,678,037,579	245,605,554
Murang'a	8,810,779,834	2,942,858,292	2,104,277,697	838,580,595
Nairobi City	32,310,240,815	6,924,938,618	6,301,646,802	623,291,816
Nakuru	18,315,751,744	6,214,866,638	4,908,385,628	1,306,481,010
Nandi	8,046,964,890	1,939,050,605	1,575,050,605	364,000,000
Narok	9,472,053,231	2,261,922,134	2,012,255,615	249,666,519
Nyamira	6,526,425,651	1,848,548,102	1,649,548,102	199,000,000

County	Total Budget	Health Allocation		
		Total	Recurrent	Development
Nyandarua	7,346,070,488	1,667,687,708	1,539,237,708	128,450,000
Nyeri	7,672,055,820	2,553,300,734	2,245,729,954	307,570,780
Samburu	5,493,647,720	1,231,158,752	854,783,378	376,375,374
Siaya	7,129,591,194	2,214,582,739	1,647,375,558	567,207,181
Taita/Taveta	5,252,863,879	1,514,455,189	1,404,799,680	109,655,508
Tana River	5,693,857,764	1,078,876,054	971,076,054	107,800,000
Tharaka Nithi	4,844,778,431	1,750,167,000	1,565,667,000	184,500,000
Trans Nzoia	7,651,764,487	2,196,553,641	1,488,912,665	707,640,976
Turkana	13,535,455,447	2,344,074,357	1,526,031,227	818,043,130
Uasin Gishu	9,007,239,941	2,104,476,595	1,789,257,710	315,218,885
Vihiga	6,440,640,905	1,634,944,844	1,238,471,924	396,472,920
Wajir	10,556,115,190	1,938,607,307	1,745,407,307	193,200,000
West Pokot	5,645,490,960	1,531,381,775	1,282,724,868	248,656,907
Total	444,578,048,046	121,089,366,541	95,295,938,788	25,793,427,753

Recurrent and development budget breakdown

County	Recurrent breakdown					Development breakdown		
	Personnel emoluments	Operation and maintenance	Drugs and medical supplies	Training expenses	All other recurrent	Buildings	Equipment and furniture	Grants, transfers, and other unclassified
Baringo	1,601,946,172	36,387,718	159,934,500	1,157,782	162,796,597	109,345,533	11,208,058	652,072,071
Bomet	580,224,711	137,432,841	225,000,000	931,700	142,000,000	60,000,000	118,759,149	200,000,000
Bungoma	1,953,635,172	245,248,614	382,728,771	3,041,097	363,199,807	53,759,825	40,400,000	85,871,795
Busia	1,067,348,500	147,932,854	176,994,743	1,917,060	-	62,591,000	103,852,440	153,002,298
Elgeyo Marakwet	1,243,914,029	9,636,173	82,300,000	-	20,023,544	193,747,084	28,991,926	274,338,919
Embu	1,520,722,662	200,416,255	164,651,756	10,882,753	7,739,415	212,116,550	101,638,166	210,000,000
Garissa	1,600,000,000	165,978,604	262,000,000	7,668,000	122,325,625	293,500,000	30,000,000	200,000,000
Homa Bay	1,440,160,805	79,070,457	298,000,000	9,703,000	8,500,000	287,385,996	154,170,000	237,087,822
Isiolo	685,110,586	70,158,500	78,660,000	1,250,000	12,091,614	90,000,000	42,191,748	78,038,082
Kajiado	1,438,404,477	343,359,533	97,499,633	-	105,711,423	296,500,000	91,406,800	-
Kakamega	2,535,479,652	160,963,621	199,277,908	4,152,459	-	495,000,000	65,476,373	914,383,777
Kericho	1,521,922,656	118,321,350	330,475,203	13,820,000	-	194,000,000	44,784,072	142,073,013
Kiambu	2,437,088,400	79,326,160	314,608,000	5,730,360	-	426,968,000	124,719,600	1,370,295,389
Kilifi	2,154,779,543	159,405,248	601,383,186	-	20,000,000	532,493,917	33,630,000	299,800,000
Kirinyaga	1,284,164,858	75,620,000	153,500,000	500,000	-	541,818,973	46,636,630	124,744,398
Kisii	2,176,908,406	94,910,000	238,000,000	-	176,331,537	145,295,000	61,000,000	783,513,515
Kisumu	2,159,558,989	300,649,393	301,400,000	10,300,000	43,136,800	220,258,561	102,023,313	8,500,000
Kitui	1,480,001,266	348,018,958	551,306,877	8,447,644	-	185,492,462	349,117,851	-
Kwale	1,324,077,003	165,259,092	147,967,289	800,000	60,000,000	372,520,208	117,378,348	822,265,480
Laikipia	1,375,650,406	18,600,000	-	4,000,000	3,000,000	-	279,500,000	20,000,000
Lamu	713,526,372	103,340,000	76,000,000	8,090,000	-	-	3,390,000	319,253,534
Machakos	2,792,181,364	351,186,000	-	-	402,000,000	-	-	748,444,409
Makueni	2,032,207,198	263,560,000	231,849,693	65,000,000	-	160,461,658	57,746,833	534,196,522
Mandera	1,008,309,515	253,733,019	210,952,927	6,039,936	162,488,503	558,514,000	128,792,000	74,050,000

County	Recurrent breakdown					Development breakdown		
	Personnel emoluments	Operation and maintenance	Drugs and medical supplies	Training expenses	All other recurrent	Buildings	Equipment and furniture	Grants, transfers, and other unclassified
Marsabit	1,091,836,286	60,520,000	28,716,214	-	-	-	-	790,250,000
Meru	2,307,527,313	53,969,575	56,500,000	890,000	331,340,010	32,810,000	1,237,500	362,000,000
Migori	1,028,461,393	185,493,278	306,903,384	-	-	232,000,000	7,200,000	200,000,000
Mombasa	2,173,454,745	165,231,222	70,093,771	12,350,420	256,907,421	19,643,774	140,611,780	85,350,000
Murang'a	1,926,099,552	119,017,750	9,000,000	2,000,000	48,160,395	94,500,000	10,000,000	734,080,595
Nairobi City	4,783,604,149	435,198,920	1,032,945,833	49,897,900	-	392,356,000	230,935,816	-
Nakuru	3,558,063,051	743,653,562	598,119,015	8,550,000	-	-	20,907,500	1,285,573,510
Nandi	1,153,189,355	122,650,000	217,000,000	4,000,000	78,211,250	160,500,000	106,500,000	97,000,000
Narok	1,241,437,045	427,707,862	338,650,799	4,358,372	101,538	222,513,894	27,152,625	-
Nyamira	1,379,240,892	183,005,472	87,301,738	-	-	-	-	199,000,000
Nyandarua	942,228,091	165,485,717	13,900,000	1,890,478	415,733,422	114,100,000	3,950,000	10,400,000
Nyeri	1,977,124,839	56,381,115	210,424,000	1,800,000	-	122,000,000	58,000,000	127,570,780
Samburu	577,153,509	274,629,869	-	-	3,000,000	-	-	376,375,374
Siaya	733,420,166	728,943,392	176,012,000	4,000,000	5,000,000	56,050,270	46,156,911	465,000,000
Taita/Taveta	1,047,722,124	254,499,819	97,694,566	4,883,172	-	92,515,000	17,140,508	-
Tana River	508,991,286	148,939,924	229,754,612	4,630,000	78,760,232	107,800,000	-	-
Tharaka Nithi	1,254,433,000	145,895,881	133,900,000	1,220,000	30,218,119	500,000	13,000,000	171,000,000
Trans Nzoia	1,125,834,898	193,588,890	100,000,000	4,600,000	64,888,877	538,322,334	57,318,642	112,000,000
Turkana	832,000,000	309,231,227	355,500,000	19,300,000	10,000,000	280,850,680	97,405,059	439,787,390
Uasin Gishu	1,545,971,699	35,630,000	204,656,011	3,000,000	-	134,833,176	50,300,000	130,085,709
Vihiga	934,430,356	136,471,784	163,269,784	4,300,000	-	312,792,818	36,800,000	46,880,102
Wajir	1,210,168,371	235,591,939	133,550,000	22,632,000	143,464,997	140,510,000	47,890,000	4,800,000
West Pokot	813,330,206	98,519,929	320,495,770	-	50,378,964	115,356,907	33,300,000	100,000,000
Total	72,273,045,067	9,208,771,516	10,168,877,983	317,734,133	3,327,510,089	8,661,723,620	3,142,619,649	13,989,084,484