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Falling Behind the Promise
Analysis of the Health Sector Budget for FY 2011/2012

Kenya Vision 2030 and other national development blue prints recognize the need to prioritize health investments to ensure a healthy and productive population. Policy documents derived from this Vision such as the Kenya Health Policy Framework 2012-2016 and the third National Health Sector Strategic Plan 2013-2017, all recognize the need to scale up investment in health in terms of increased budget allocations and also to priority issues related to the health workforce.

This position paper summarizes the outcomes of a systematic analysis of the MOH budget for FY 2011-2012 with a view to identifying trends and areas where adjustments may be needed to improve both quantity and quality of allocations to address health workforce issues. The Analysis revealed among others the inherent challenges of tracking allocations to the HRH priorities given that these items are lumped up with other administrative costs.

Introduction

Increased allocation of resources to the health sector is critical to the achievement of sustained social and economic development. In an ideal world, national budgetary allocations are the conventional expression of government commitment in addressing social and economic challenges facing its people.

Overwhelming evidence exists to show that countries that prioritise the health of its citizen through increased spending on health care have better health outcomes (Akinkugbe and Mohanoe, 2009). However, in Kenya, like many countries in the SSA region, the level of spending in public health remains below the Abuja Declaration threshold of 15% of the total national expenditure1 (Organisation of African Unity - OAU, 2001). This is despite the continent having the biggest share of the burden of disease due to malaria, HIV/AIDS, tuberculosis and other infectious diseases.

Allocations to health have traditionally comprised a large portion of personnel emoluments.

The Government of Kenya (GoK) has made a commitment to prioritize health in the Economic Recovery Strategy and followed this in the Vision 2030. In addition, as a signatory to the Abuja Declaration in 2001, Kenya made a commitment to increase health allocations to 15 percent of total government allocations. The budget is therefore a crucial indicator of the commitment of any government to the implementation of national policies for a particular sector.

Against this background, the specific objectives of the assignment were to:

- Review the FY 2011/12 health sector budget and critically examine:
  - the proportion of budget allocated for promotive/preventive health care versus rehabilitative/curative health care
  - ***'Tease out'*** development versus recurrent expenditure for health care
- Analyze the FY 2011/12 health sector budget against:
  - the Ministries of Health Annual Operation Plan (AOP) 7
  - the priorities of the National Health Sector Strategic Plan II
- Carry out a trend analysis-from FY 2001/2 to 2011/12-of the GOK Budget allocation to the health sector (in nominal per capita amounts and as a percentage of budget)

Findings

Macroeconomic Overview and analysis

The budget allocations to the health sector should be analyzed within the macro-economic context as the economic growth rate is ideally thought to influence the resource allocation to the priority areas of the sectors of the economy.

The overall total budget for 2011/12 was estimated at Kshs. 1.6 Trillion. This is an increase of 15.6% when compared with the budget for 2010/11 with recurrent allocations accounting for 69% of the total budget and development allocations accounting for 31%. The development budget increased by 31.2% compared to the recurrent budget which grew by 8.5%. These shows an indication that the government is making efforts to contain recurrent expenditure while expanding development expenditures.

Table 1: Total health budget for 2010/11 and 2011/2012 (Net expenditure)

Medical Services		Public Health & Sanitation		Total Health Budget		
2010/2011	2011/2012	2010/2011	2011/2012	2010/2011	2011/2012	Grand total
Recurrent	23,266,018,000	23,725,974,090	10,059,441,500	10,698,637,030	33,325,459,500	34,424,611,120
Development	2,440,523,750	2,036,000,000	9,955,040,400	13,254,515,110	12,395,564,150	15,290,515,110
Total health Budget	**25,706,541,750**	**25,761,974,090**	**20,014,481,900**	**23,953,152,140**	**45,721,023,650**	**49,715,126,230**

Source: Printed Budget Estimates 2011-2012

Budget allocations to sectors in 2011/12 remained largely similar to 2010/11 allocations with the biggest share of the resources (25%) being allocated to Physical infrastructure sector which includes roads and other public works. This was followed closely by Human Resources Development which consumed 24% of the total resources for distribution. These two sectors accounted for 48* of budgetary allocations in 2010/11 and 49%in 2011/12. This is a confirmation of the government commitment towards investment in physical infrastructure to spur economic growth and investing in the people of Kenya so as to achieve equitable social development by focusing on human resource development as articulated by the Vision 2030.

Health sector policy and planning framework

<u>The budgetary process in Kenya</u>

The budgetary process in Kenya follows the Medium Term Expenditure Framework (MTEF), a three year rolling budget framework that was introduced in the year 2000 as part of the Public Expenditure Management Reforms (PEM). MTEF seeks to translate government policies and plans into an expenditure programme within a coherent multi-year macro framework. Formulation of the annual budgets is usually preceded by the National and District Development plans which should inform the budgets. The budget preparation process starts with the issuance of a Treasury circular around the month of August to all Permanent Secretaries with instructions and guidelines on how preparation of the budget should be undertaken. Following the issuance of the Treasury circular, Sector Working Groups (SWGs) are launched and Ministerial Public Expenditure Reviews (MPERs) commence. Meanwhile, the Ministry of Finance prepares the Budget Outlook Paper (BOPA) which gives the medium – term fiscal framework. Finally, ministries and departments that make up a sector bid for resources from the sectoral resource envelope through negotiations where tradeoffs are made between different activities. After negotiations the budget Steering Committee prepares the Budget Strategy paper (BSP) which provides firm ministerial ceilings and spending priorities to be included in the budget. Allocations will then be made in accordance with the BSP as approved and ratified by Parliament. After the negotiations, the Minister for Finance presents the Estimates to the cabinet for approval. When the approval is granted, the Ministry of Finance then proceeds to prepare the Printed estimates. The next phase is the debate and approval of the budget by Parliament. During this phase the Minister for Finance will present the Annual Budget to parliament in the form of a budget speech accompanied by the spending proposals in the Appropriation Bill and taxation proposals in the Finance bill by 20th of June every year. To ensure continuity of public service delivery, parliament interrupts debate on the policy statement to pass the Vote on Account which allows the ministries and government departments to spend up to 50%

of their budgetary allocations pending the approval of their budgets by parliament.

During the implementation Phase, the Treasury issues spending units with Authority to Incur Expenditure (AIE) which allows the heads of departments to utilize funds as approved by parliament.

The final phase is the budget oversight which involves monitoring of the budget to ensure resources are utilized prudently and for the purposes intended.

Health policy framework

There are two national policy documents that have guided the health development in the country. For the period between 2003 and 2007, the policy framework for sectoral policies was provided by the Economic Recovery Strategy for Wealth and Employment Creation 2003 – 2007 (ERS). ERS outlined three main policy objectives, namely economic growth, improved equity and reduced poverty and enhanced governance. At the sectoral level, two policy documents are important in terms of shaping the health policy. These include the Second National Health Sector Strategic Plan 2005/06 – 2009/10 (NHSSP II) and the Health Policy Framework of

1994-2010 that is popularly referred to as the foundation for health policies in Kenya. These two plans are however heavily informed by NHSSP II with the specific indicators in this two strategic plans having been pulled out from the NHSSP II. NHSSP II plan outlines five major strategic policy objectives; Increase equitable access, improve service quality and responsiveness, improve efficiency and effectiveness, foster partnership and improve financing.

Overview of the health budget

The health budget is broken down into recurrent and development budget. Recurrent budget is resources meant to cater for expenditures of recurrent and ongoing nature while development budget that caters for expenditures of development or investments nature. A clear picture of the public health budget can only be presented when both the Kenyan government and development partners' resources are considered and also

Table 2: Budget for HSSF Allocations 2011/12

Facility ownership	Total Amount Dispensaries	Total Amount Health Centres	Total Amount DHMTs	GRAND TOTAL
GoK facilities	462,000,000	452,250,000	138,510,000	1,052,760,000
FBOs Facilities	24,750,000	67,500,000	-	92,250,000
Grand total	**486,750,000**	**519,750,000**	**138,510,000**	**1,145,010,000**

net of what the ministries have generated internally. The overall allocations(recurrent and development) as a proportion of the total government expenditure has reduced from the 6.3% of total government expenditure in 2010/11 to 5.48% of total Government expenditures in 2011/12 which is below the Abuja declaration target of 15% and the Economic Recovery Strategy (ERS) target of 12% of total Government allocations.

When compared with fiscal year 2010/11, the health budget for 2011/12 increased from Kshs.45.7billion (2010/11) to Kshs. 49.7 billion, an increase of approximately 4 billion which translates to an 8.8% increase. Regarding the allocation within the health sector there are two major shifts. The first shift from curative to preventive and promotive and the second is a shift in allocation from the Recurrent Budget to the Development Budget.

Preventive and promotive sub-vote

Generally, budgetary allocations to these key programmes are channelled through the two ministries responsible for

Table 1: Allocations under Preventive and Promotive programmes

Priority Program	2010/2011	Percent	2011/2012	Percent
Family Planning Maternal and Child Health	1,322,814,520	15	2,473,053,614	14.7
Nutrition	711,468,597	8	681,249,685	4.1
Malaria control	338,126,421	4	497,895,587	3.0
KEPI	811,860,500	9	6,350,413,854	37.9
TB and Leprosy	204,549,070	2	1,046,133,582	6.2
NASCOP	923,093,236	11	926,042,773	5.5
Environmental health	3,694,378,751	43	3,746,283,996	22.3
Communicable disease control	115,982,164	1	121,049,391	0.7
Non-Communicable diseases	154,112,164	2	161,898,791	1.0
Health education	55,748,949	1	59,123,862	0.4
Port health control	55,703,047	1	58,720,767	0.4
National Public Health Labs (NPHLS)	239,882,189	3	466,741,675	2.8
Special Global Fund	48,315,537	1	141,120,604	0.8
Vector borne diseases	8,837,500	0	38,196,673	0.2
Total	**8,684,872,645**	**100**	**16,767,924,854**	**100.0**

health care delivery - MoPHS and MoMS- with all the key programmes resources being channelled through MPH&S apart from NASCOP where the two Ministries are dominant. The budget for preventive and promotive grew by 48.2% between 2010/11 and 2011/12 confirming the ministries commitment to shift resources from curative to prevention and promotive health services.

The Economic Stimulus Programme

The health sector has benefitted from the Economic Stimulus Program, recently renamed Economic Recovery and Poverty Alleviation Programme that was channeled through the Ministry of Public Health and Sanitation. This program was introduced in the Financial Year 2009/2010 to spur economic growth in the country under the MPH&S, the following activities were scheduled for implementation in FY 2009/2010; Recruitment of nurses (20 Nurses per constituency), Construction of one model health centre in each of the 210 constituencies, Procurement of 5 motor cycles and 20 bicycles and procurement of drugs and non-pharmaceuticals.

Hospital Management Services Fund (HMSF)

The ministry of Medical Services operationalized the Hospital Management Services fund (HMSF) in line with Legal Notice No: 155 of 16th October, 2009 in July 2010. The objective is to streamline the flow of financial resources for medical supplies, support capacity building in management of health facilities; and improve the quality of health care services in the health facilities.

Health Centres- Health Sector Service Fund (HSSF)

HSSF is one of the MoPHS flagship projects that was established under legal Notice No. 401, under the Kenya Gazette Supplementary No. 123 of December 21st 2007. The fund was set up to pool resources from the development partners and the government through the sector wide approach (SWAp) and then availing the resources directly to health facilities for implementation of health interventions. The HSSF aims to ensure equitable access to health services, addressing quality and responsiveness of the health systems and services to the needs of Kenyans, reducing the bureaucracies in the disbursement of funds to the lower levels. Table 2 below shows the budget for the HSSF fund for 2011/2012

Donor support to the health sector

The development budget provides estimates for allocation in aid (AIA) – grants and loans. The biggest amount of AIA for 2011/12 goes to the Development Budget of MPH&S and is used to finance the vertical programmes where programmes like environmental health, family planning, maternal and child health, HIV/AIDS programme and nutrition are voted. The major part of the MOMs resources under development vote goes to the construction and rehabilitation of buildings at the district level. However, not all donors pass their contribution through the government budget system and therefore not reflected in the government budget. The USG resources constitute the biggest share off the budget resources contributing 84% of the total resources.

Conclusion and policy recommendations

The government of Kenya has consistently underfunded the health sector for a long period of time with the government expenditure on health as a total government spending percent of GDP remaining consistently below 8% between 2001 and 2009. Government expenditure on health as a percentage of total government was reported at 5.4% in 2009 which makes Kenya far from achieving the Abuja target of 15%.

External resources on health in Kenya has also been increasing over the years without proportionate increase from the central government expenditures and therefore putting the country in a precarious scenario since relaying on external resources to finance health care is not sustainable. With increased resources from development partners, donor coordination, alignment and harmonization need to be prioritized to ensure external resources are used to fund critical and priority areas as per the health plans.

The Government of Kenya should therefore increase resources to the health sector and also hasten the introduction of the social health insurance system so as to increase resources to the health sector and also protect the households from excessive costs from private health providers.

Recommendations

There is need for CSOs and other citizens groups to advocate for;

- Increased resource allocation to the health sector to meet and exceed the Abuja target of 15% and other international commitments like the Maputo Plan of Action.
- Shift focus of the budget from curative to preventive to allow more resources to go to vertical programmes and lower level health facilities leading to more impact on child and maternal health (MDG 4 and 5).
- Increase resources to Drugs and other medical supplies so as to address the frequent stock outs and therefore improve access to health care services directly.
- Adopt a budget that is more transparent by creating clear line items for human resources issues, drugs and other medical supplies and also create a line item for ARVs for facilitate monitoring by CSOs
- Increase budget allocation to address specific health priorities like maternal child health and other community level health priorities. The 2011-2012 budget dies not delineate these items.

Reviewers:

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References:

1. GoK 2012, Health Sector Working Group Report, MTEF
2. Demrey, I. and Gaddis I.„Social Spending, Gender Inequality And Kenya´s Poor: A Policy Brief", 2009, p.17, GTZ.
3. The African Union Commission, 2006, „Plan of actions on sexual and reproductive health and rights (Maputo Plan of Action)
4. GoK 2012, Health Sector Working Group Report, MTEF

About the HRH Advocacy Project

The Human Resources for Health (HRH) Advocacy project was funded by the European Union through World Vision Austria, and implemented by World Vision Kenya (WVK), the Kenya Health NGOs Network (HENNET) and African Medical and Research Foundation (AMREF) in Kenya. The Project seeks to enhance access to primary healthcare countrywide through advocacy for increased human resources for health (HRH) and effective community level demand side accountability from primary health delivery institutions.

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