Health Budget Brief

Preface

This budget brief is among five (5) budget briefs which seek to identify the extent to which the needs of children are addressed by the national and social sector budgets in Kenya. The brief presents the size and composition of 2013/14-2017/18 budget and how the budget allocation to the sector is likely to affect children. The brief is organized into the following sections: Introduction; Education and Training Spending Trends; Composition of Spending; Budget Credibility; Decentralisation and Education and Training Spending; Equity in Education and Training Spending; and Financing Sources.

Key Messages and Recommendations

1. Kenya has recorded improvements in health indicators such as under-5 child mortality rates and skilled birth attendance, but not all indicators are moving in a positive direction. The government needs to ensure that investments in the health sector are sufficient to provide basic health services to all people, including minimum medical staffing requirements, and availability of vaccine and essential medicines to all persons.

2. Universal health coverage (UHC) is a high priority for the government, but out-of-pocket spending remains around twice the recommended level (26.1% against the 12-15% target under UHC). In a context of declining donor funding, it will be important for the government to progressively increase the share of the budget going to health if UHC is to be achieved.

3. The health sector continues to face challenges with budget execution, which has increased in recent years but only reached 81 per cent in 2016/17. Disbursement delays from the National Treasury, and lengthy and cumbersome procurement procedures need to be addressed so that approved budgets are fully utilized.

Introduction

Policy, strategy and framework

The Constitution of Kenya guarantees all Kenyans to the right to life and the highest attainable standard of health. This includes the right to quality health care services; reproductive health; emergency care; clean, safe and adequate water for all Kenyans; reasonable standards of sanitation; food of acceptable quality; and a clean healthy environment. Further, the Constitution under the Bill of Rights has made access to equitable health care a right to every Kenyan, including children. Good health is a prerequisite for enhanced economic growth and a precursor to realization of the health sector goals.

Other strategic frameworks guiding the health sector include: the Sustainable Development Goal (SDG) Goal No. 3 aimed at ensuring healthy lives and promoting well-
being for all at all ages, the Kenya Vision 2030 under the social pillar, the Medium-Term Plan 2018-2022 of the Vision 2030 in which the Universal Health Coverage (UHC) under the government “Big Four” agenda is emphasized, the Kenya Health Sector Strategic Plan 2018-2023, and the County Health Strategic Plan 2018-2023.

**Disease profile**

**Poor child health is one of the major public health and developmental problems facing Kenya.** The epidemiological profile indicates that disease burden among children is still high. The life expectancy of Kenyans is averaged at 61 years; it has been increasing slowly but has been hampered due to the relatively high under-5 mortalities.

**Kenya is experiencing an epidemiological transition in its disease burden from infectious to non-communicable diseases (NCDs).** NCDs contribute to over 50 per cent of inpatient admissions and 40 per cent of hospital mortality, causing substantial financial burden and pushing individual’s households and communities into poverty and slowing down economic progress of the nation.

**Figure 1: Epidemiology of communicable, non-communicable diseases and injuries in Kenya**

![Epidemiology of communicable, non-communicable diseases and injuries in Kenya](image)

*Source: Ministry of Health*

In 2016, diarrhoea was the leading cause of death among children followed by HIV and AIDS and lower respiratory infections. The main reason why diarrhoea was the leading cause of death could be explained by low investments in preventive health and low level of improved hygiene, inadequate sanitation facilities especially in urban informal settlements and in rural areas which reported the highest number of children under-five years suffering from diarrhoea. The proportion of the population accessing sanitation facilities in urban areas was 31.2 per cent compared to 29.7 per cent in rural areas, which was 30.1 per cent of the total general population. Further, those who were able to access unimproved sanitation facilities in urban areas was 68.8 per cent compared to 70.3 per cent in rural areas, which is equivalent to 69.9 per cent of the total general population.
Malaria as a main cause of death was ranked fourth in 2005 and eleventh in 2006. The improvement was partly due to an increase in the number of children under-5 and pregnant mothers sleeping under Long Lasting Insecticide Treated Nets and an increase in the number of children under-5 who were treated with anti-malarial drugs over the period.

### Under-5 mortality rate

The under-5 mortality rate per 1,000 reduced from 56 in 2013 to 49 per 1000 live births in 2016. This was because of the introduction of flagship programmes such as “Linda Mama” and “Beyond Zero” which targeted maternal and child health. The programmes have mainly contributed in reduction of the under-5 mortality rate.

![Figure 2: Main causes of disability adjusted life years (DALYS) among children under-5, 2005 and 2016](image)

<table>
<thead>
<tr>
<th>2005 Ranking</th>
<th>2016 Ranking</th>
<th>% change 2005-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV/AIDS</td>
<td>1. Diarrhoea</td>
<td>-13.5</td>
</tr>
<tr>
<td>2. Diarrhoea</td>
<td>2. HIV/AIDS</td>
<td>-61.5</td>
</tr>
<tr>
<td>3. Low respiratory Infection</td>
<td>3. Low respiratory infections</td>
<td>-11.1</td>
</tr>
<tr>
<td>4. Malaria</td>
<td>4. Ischami Heart Disease</td>
<td>37</td>
</tr>
<tr>
<td>5. Cerebrovascular Disease</td>
<td>5. Cerebrovascular Disease</td>
<td>20.9</td>
</tr>
<tr>
<td>6. Tuberculosis</td>
<td>6. Tuberculosis</td>
<td>22.2</td>
</tr>
<tr>
<td>7. Ischami Heart Disease</td>
<td>7. Neontal Encephalopathy</td>
<td>-10.7</td>
</tr>
<tr>
<td>9. Protein-energy Malnutrition</td>
<td>9. Menegitis</td>
<td>8.6</td>
</tr>
<tr>
<td>10. Protein-energy Malnutrition</td>
<td>10. Malaria</td>
<td>-58.1</td>
</tr>
<tr>
<td>11. Menegitis</td>
<td>11. Malaria</td>
<td>-58.1</td>
</tr>
</tbody>
</table>

Source: Institute of Health Metrics and Evaluation

![Figure 3: Under-5 mortality rate, 2013-2016](image)

To reduce child mortality, the government has invested on key interventions such as immunization. Immunization coverage for all vaccines in the country is 84 per cent of children vaccinated for DPT and 86 per cent vaccinated against polio in 2016. The immunization rate over the four years of analysis shows that there has been slight changes between 2014 and 2016 as shown in Figure 4.

The decrease in full immunization coverage during the period 2013-2017 is attributed to frequent industrial actions by health workers. Figure 5 shows a positive correlation between the trend in immunization coverage and under-5 mortality rate. The percentage of fully-immunized children (FIC) under the age of 5 decreased from 76 per cent to 69 per cent across the years 2013-2017.
Health Workforce in Kenya

The lack of adequate human resources in the health sector represents a major barrier to scaling up integrated approaches to maternal, newborn and child survival, health and nutrition at the community level. Kenya performs well compared with other countries in the region in all health worker cadres. The country has a high number of nurses and midwives compared to the number of physician which is key in community health.

Skilled birth attendance

Skilled birth attendance is one of the most effective ways of combating maternal and neonatal mortalities. It is often used as an indicator of access to health services by clients. Kenya has made significant progress in increasing skilled birth attendance from 42 per cent in 2009 to 62 per cent in 2013. This is above most Sub-Saharan African (SSA) countries as shown in Figure 7. However, the country needs to increase the rate to match other high achieving countries such as Botswana and Namibia.
Health Spending Trends

Nominal and real spending on health

After 2013, the health function was devolved to county governments, with most of the roles and responsibilities being carried out by county governments. Over the years, real health expenditure has been lower compared to nominal spending. The nominal expenditure and the real expenditure have exhibited an increasing trend. However, the sector experienced a dip in 2017/18. The decline is attributable to the electoral effects and the health workers unrest which affected health outcomes and service delivery in the sector.

Figure 8: Nominal and real expenditure on health, 2014/15 -2017/18

Figure 9: Health sector budget and spending, 2014/15-2017/18
Spending by priority programmes

Since the advent of devolution, health care budget at the county and national government has been increasing. During 2016/17, the health budget increased to 7.0 per cent from 6.0 per cent in 2015/16 financial year (Figure 9). Despite the increase in health spending, the country is yet to achieve the Abuja Declaration target of 15 per cent.

Health spending per capita and as a per cent of GDP

Kenya spends about US$ 78 per capita on health as per the National Health Accounts 2015. This falls short of the World Health Organization (WHO) recommended rate of US$ 86 per capita, which is the estimated minimum requirement to provide basic health services to a population. Kenya could learn from countries such as Swaziland which has managed to achieve health sector spending targets both in terms of budget prioritization and spending levels.

Figure 10: Per capita and expenditure health spending in selected countries


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Figure 11: Sector spending by institutions as a % of sector budget, 2016-2018

Source: Ministry of Health (Various), Health Sector MTEF Working Group Reports
Composition of Health Spending

Spending by health institutions

The national government through the Ministry of Health invests mostly on preventive and curative programmes. Further, health institutions in the country also invest heavily in preventive health care unlike research health institutions which have been allocated lower amount of funds since 2016. In 2016, the Kenya Medical Supplies Agency (KEMSA) was allocated 7 per cent which further declined to 6 per cent in 2018. Allocations to the national referral health facilities have remained constant over time, with marginal increases reported for Moi Referral Training Hospital (MRTH) from 20 per cent in 2016 increasing to 22 per cent in 2017 and 2018. Kenyatta National Hospital (KNH), the largest referral hospital, allocated 37 per cent in 2016 to 34 per cent and 35 per cent in 2017 and 2018, respectively.

Spending by economic programmes

Compensation of employees takes the largest share of government health expenditure followed by transfers to goods and services to agencies that have been mandated to deliver health services on behalf of the government. Generally, current transfers and compensation of employees increased, unlike the use of goods and services. This is attributable to the electoral political environment in 2017/2018, and the doctors and nurses strikes which affected service delivery. The government had to result to hiring of Cuban doctors to ameliorate the effects of workers unrest. In health spending, care should be taken when dedicating financing to the development budget as the sector is labour intensive and relies more on an efficient and skilled workforce rather than development of capital. The country needs to invest in equipping health facilities with the required medical equipment and commodities.

Health spending by programmes

Much of the health budget in Kenya is dedicated to preventive and promotive health services, indicating the desire by the government to reduce the disease burden. This could explain why these services are receiving the highest proportion of resources. The...
efforts of the government to curb non-communicable diseases (NCDs) and communicable diseases (CDs) have benefited all aimed at reducing epidemics in the country. Expenditure on maternal and child health has been increasing over time, indicating the government’s commitment to reduce maternal and child mortality and improve health outcomes among children, especially through the *Linda Mama* Programme and Beyond Zero Campaign.
In 2014, the approved health budget was Ksh 45,502 (in billions) and the budget outturn was Ksh 47,362 (in billions), indicating an overspend by 4 per cent. This is attributable to the devolution of health functions, which faced challenges in 2013/14. Nevertheless, there has been concern over decreasing out-turn since 2015, perhaps due to workers unrests, which could have led to poor service delivery in most of the government facilities.

There was a high discrepancy of utilization of funds by economic classification. Budget out-turn has been on the decline over the years since 2014, with 2016 having the largest share of un-utilized funds by economic classification. This may be due to delayed disbursement of funds from the National Treasury.
Credibility by economic classifications

Compensation to employees and subsidies has consistently performed well, while transfers to government agencies and non-financial assets have been characterized by severe under-spending in recent years. One of the major causes is delayed disbursements from the National Treasury.

Figure 17: Per capita health spending in counties and deliveries in health facilities, 2016/17

Source: Ministry of Health (2018)

Decentralization and Health Spending

Devolution overall

There has been tremendous rise in the county health budget since 2014, due to increased allocations from the national level. After devolution, most health functions were transferred to county governments, which is why spending has increased minimally at the national level when compared to the county level.

Figure 18: Per capita health spending in counties and immunization coverage, 2016/17

Source: Ministry of Health (2017)
Decentralization by regions
Most counties allocated a high proportion of their overall budgets to health. On average, about 19 per cent of county budgets are invested in health services. Tana River County gives the highest priority to health, with around 50 per cent of its budget, although it also has the lowest per capita values of health spending indicating that its overall budget envelope is very small. Other counties with the lowest per capita

Figure 20: Per capita health spending and child poverty rates, 2016/17

Source: Ministry of Health

spending on health include Kwale, Kilifi, Nyandarua and Kajiado while those with the highest include Isiolo, Laikipia, Embu, Garissa, and Taita Taveta.

Equity of Health Spending

Equity by sector indicator
There is little connection between more funding and improved health performance at the county level. Some of the worst performing counties in terms of deliveries that take place in a health facilities receive the largest amount of funding once adjusted for population sizes (e.g. Embu, West Pokot) (Figure 17). At the same time, the figure also

Figure 21: Main sources of financing the health sector, 2014-2018 average

Source: Country Health Budget Analysis (2018)
shows that some of the poorest counties are receiving more health resources (e.g. Garissa), which signals that resources are targeting the neediest areas in some cases. The performance of spending also varies when looking at other indicators. For instance, Nyamira County has the highest immunization coverage of any county even though its per capita spending on health is relatively low at Ksh 1,170. A check on the effectiveness and efficiency in utilization of funds is essential for Samburu and West Pokot counties, which have very high per capita spending with very low immunization coverage. Counties with low per capita spending and low immunization rate could focus on proper utilization of their budgets to improve the critical health indicators.

**Equity by poverty rate**

It is imperative for counties with high child poverty rates and low per capita health spending to better prioritize health spending. Some of the counties with high child poverty rate and low per capita include Turkana, Wajir, Migori, Kwale, and Tharaka Nithi with a child poverty rate of 85 per cent, 81 per cent, 68 per cent, 68 per cent and 57 per cent, respectively.

**Figure 22: Sources of health financing in Kenya, 2001/02-2015/16**

Source: Ministry of Health (2017), National Health Accounts

Source: WHO Global Health Expenditure database
Financing the Health Sector

Donor financing

Dependency on donor financing in the health sector has been decreasing in the last five years. Development partners are key contributors to the growth of the Kenya health systems and service provision through their continued support, either directly in-service provision or through the government. Nonetheless, while public spending on health care in the country has been increasing by both the national and county governments, donor spending has been declining in the last five years. This could be explained partly by increased allocation to health by the national and county governments and a decline in donor funding following the rebasing of the economy to a middle income country.

Role of Private Financing

Public and private health financing trends

Private health financing has dominated the health sector over the years, but the trend has been shifting to public financing due to increase in uptake of health insurance through the National Health Insurance Fund (NHIF). The NHIF realized an increase in membership from 2.6 million in 2012/2013 to 6.8 million in 2016/17 and aims to achieve 100 per cent coverage by 2022. The national government also increased budget allocation to the Ministry of Health due to devolution of health functions and to make the UHC agenda a reality. The government purposes to assist poor households, the elderly and the disabled through the Health Insurance Subsidy Programme (HISP) and was able to reach 21,525 poor households, and 198,752 elderly and disabled by 2017.

Kenya ranks the best on health contribution to the GDP in comparison to the other East African countries but lags behind countries in other regions. There is need to shift financing focus from the private to public to enhance sustainability and ensure the realization of UHC.
Out-of-pocket expenditure

The government aims to achieve UHC by 2022 to reduce the risk of families suffering from catastrophic expenditures and poverty in occurrence of disease, which is as a result of out-of-pocket expenditure on health care services. Out-of-pocket expenditure by households in Kenya has been on a decline from 50.2 per cent in 2010 to 26.1 per cent in 2014. However, increased budgetary allocations are still required to reduce the out-of-pocket expenditures to the recommended rates of 12-15 per cent as issued by the WHO.

### Implementation Strategy of Key Issues

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<tr>
<th>Issue</th>
<th>Recommendation</th>
<th>Action (Responsibility)</th>
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<tbody>
<tr>
<td>High under-5 child mortality ratio</td>
<td>Intensify immunization activities including mass campaigns, early detection and case management of diseases, and increase in the proportion of birth assisted by skilled health providers during delivery</td>
<td>Ministry of Health</td>
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<td>County governments</td>
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<tr>
<td>Reduced immunization coverage</td>
<td>Intensify immunization activities in all counties</td>
<td>Ministry of Health</td>
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<td>County governments</td>
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<tr>
<td>Low government health expenditure</td>
<td>Increase government expenditure for health since it has remained low compared to the 15% Abuja Declaration</td>
<td>National Treasury</td>
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<td>Ministry of Health</td>
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<td>County governments</td>
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<tr>
<td>High out-of-pocket (OOP) expenditure by households</td>
<td>Reliance on OOP to finance health care is regressive</td>
<td>National Treasury</td>
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<td></td>
<td>Increase spending on health to around 5% of GDP to be able to generate adequate resources, and thus achieve the goal of UHC by 2021</td>
<td>Ministry of Health</td>
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<td>County governments</td>
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<tr>
<td>Low budgetary execution</td>
<td>Improve budgetary execution through streamlined procurement planning</td>
<td>National treasury, MOH and county governments</td>
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<td>Frequent health workforce unrests in the sector</td>
<td>Continue hiring more workforce and redistribute health workers to achieve equity and efficiency</td>
<td>Ministry of Health</td>
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<td>County governments</td>
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<tr>
<td>High catastrophic health spending and under-utilization of health services</td>
<td>Roll out Universal Health Coverage programme in all counties</td>
<td>Ministry of Health</td>
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<td></td>
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<td>National Treasury</td>
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<tr>
<td>Stock-outs of medical commodities in public health facilities</td>
<td>Roll-out of the pull system of commodities management at KEMSA and increase funding for commodities</td>
<td>KEMSA</td>
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<td></td>
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<td>Ministry of Health</td>
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<td></td>
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<td>County governments</td>
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<tr>
<td>Equity in health spending compared to health indicators is quite low in majority of the counties</td>
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<td>Ministry of Health</td>
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<td>County governments</td>
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