

Status of Domestic Health Financing in Kenya: County Analysis

Introduction

The Kenya Constitution of 2010 guarantees all Kenyan citizens a right to access the highest attainable standard of health, including reproductive health and emergency treatment. Kenya's health sector is working towards achieving the Vision 2030 goal of universal health coverage (UHC), which should enable all individuals to receive equitable, affordable and quality health care without suffering financial hardship.

Kenya has made strides towards achieving UHC and has made commitments that act as the steering wheel to achieve this goal. In 2015, all United Nations member states, including Kenya, committed to the 17 Sustainable Development Goals (SDGs), with SDG 3 promoting good health and well-being for all ages. In 2001, African heads of state, including the Kenyan government, ratified the Abuja Declaration, thereby committing to allocate 15% of the domestic government budgets to health. In 2019, African heads of states, also committed to the Africa Leadership Meeting (ALM) Declaration that aimed at increasing domestic investment in health, improving spending and enhancing efficiencies in health financing systems to achieve UHC.



The Kenyan health sector functions are shared between the national and the 47 County Governments. Counties hold 70% of the health functions, whereas 30% of the health functions are implemented at the national level. There have been incremental gains in health budget allocation at the county level since devolution in 2012, but Kenya is still experiencing challenges in the mobilisation and utilisation of the available health resources. Effective implementation of the Kenya Health Financing Strategy (KHFS) 2020-2030 by national and county Ministries of Health (MoH) will contribute towards increased health investment and maximisation of efficiency and equity in the mobilisation, allocation and use of health resources.

National and County MoH Budget Allocation FY 2012/13-FY2020/21

There has been a progressive increase in budget allocation at the county level over time since the devolution of health services (Figure 1). Nevertheless, Kenya has not attained the Abuja Declaration commitment of allocating 15% of its domestic budget to health hence the need to fast-track the domestic resource mobilisation strategies for the health sector to achieve UHC. Critically, the

government's expenditure on health falls below 50%, leaving more than 50% of health expenditure to be covered by citizens' out-of-pocket (OOP) expenditure, donor aid, and the private sector (Figure 2). Counties have a significant role in the mobilisation and utilisation of resources, given that most of the health functions are implemented at the county level.

Figure 1. Trend in National and County Budget Allocation

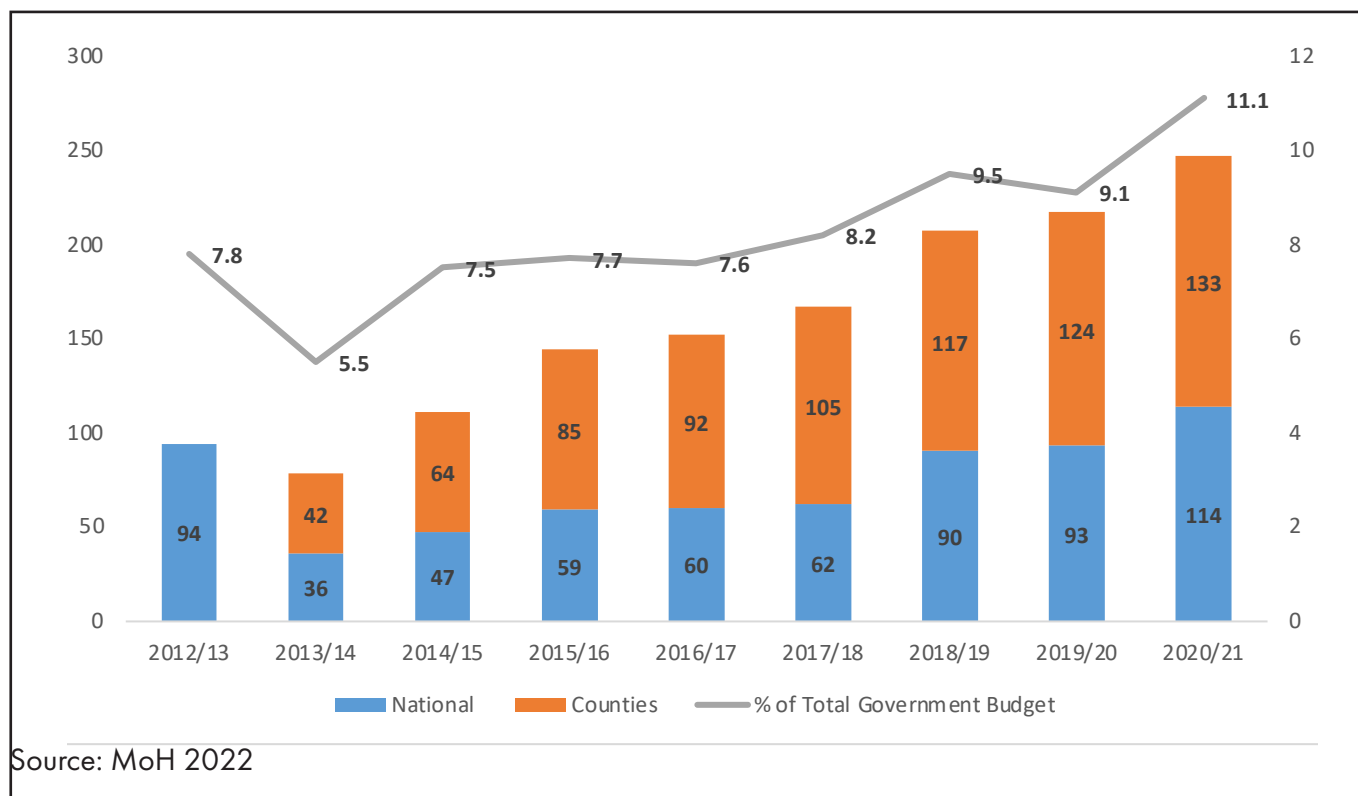
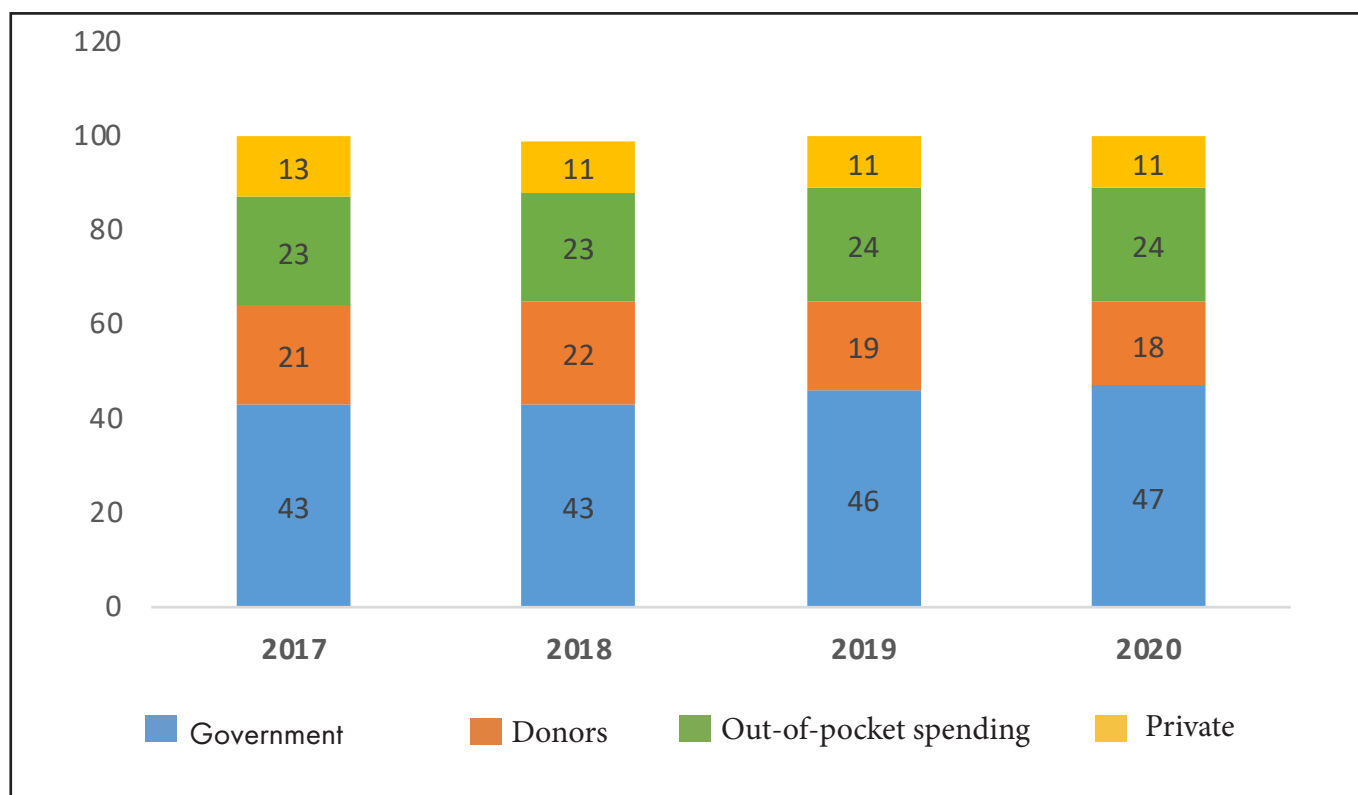


Figure 2: Sources of Health Expenditure

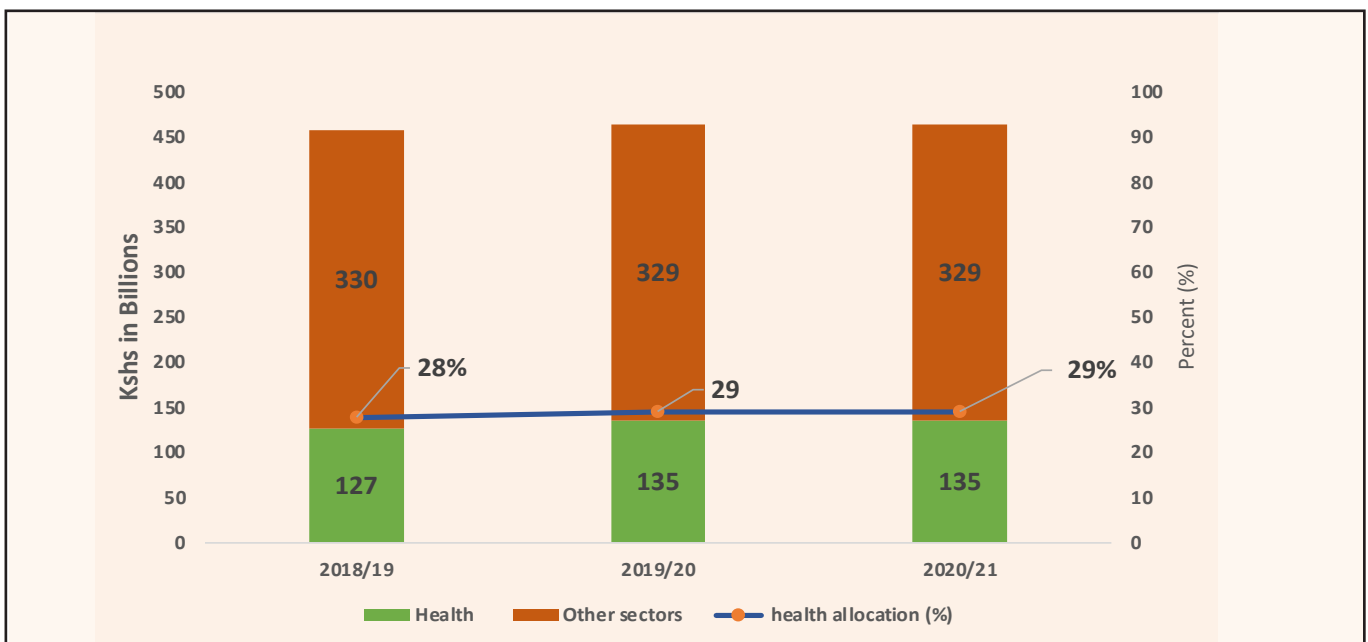


County Allocation to Health Compared to Other Sectors (2018/19-2020/21)

The proportion of counties total budget allocated to health is a reflection of the political goodwill and the priority given to the health sector. The county allocation to health compared to other sectors stagnates between 28% and 29% between FY 2018/19 and FY 2020/21. This is below the 35% pre-devolution allocation to the sub-national level.

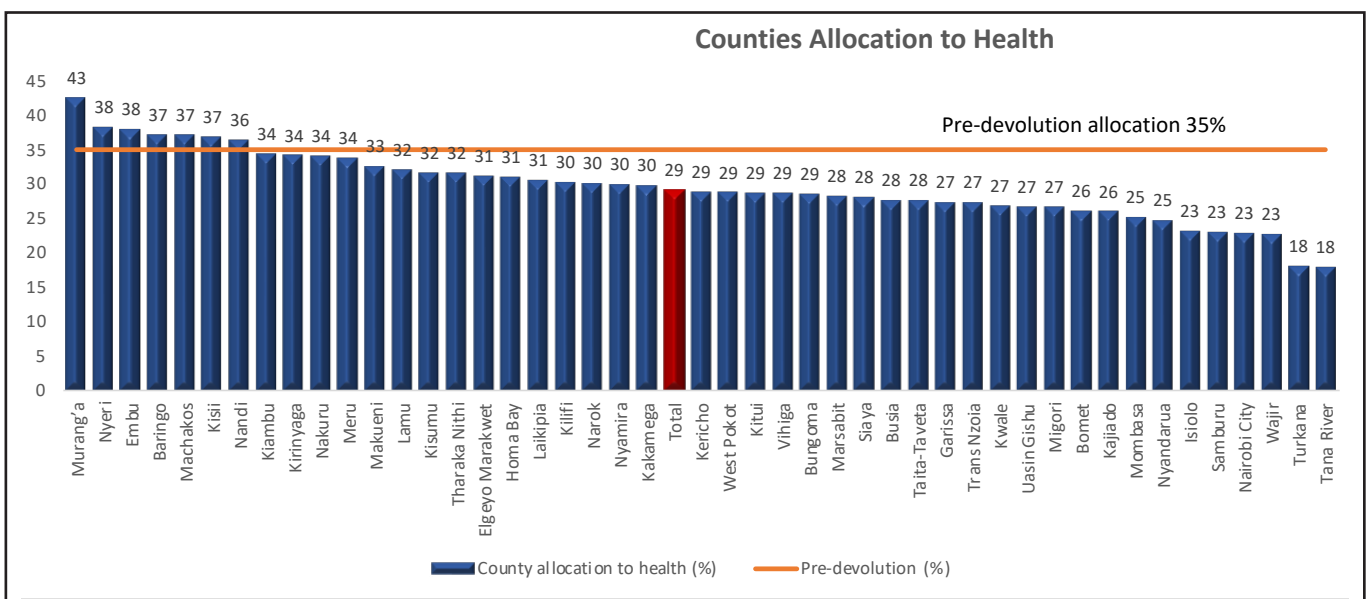
In the financial year (FY) 2020/21, only seven counties attained the 35% pre-devolution allocation to the sub-national health government (Figure 4). Therefore, counties should enhance advocacy for additional resources to health by allocating resources more efficiently to health priority areas that increase value for money (VfM), capitalising on evidence from county-specific budget and expenditure analyses.

Figure 3. County Allocation to Health Compared to Other Sectors (2018/19-2020/21)



Source: MoH 2022

Figure 4. Counties Allocation to Health FY 2020/21



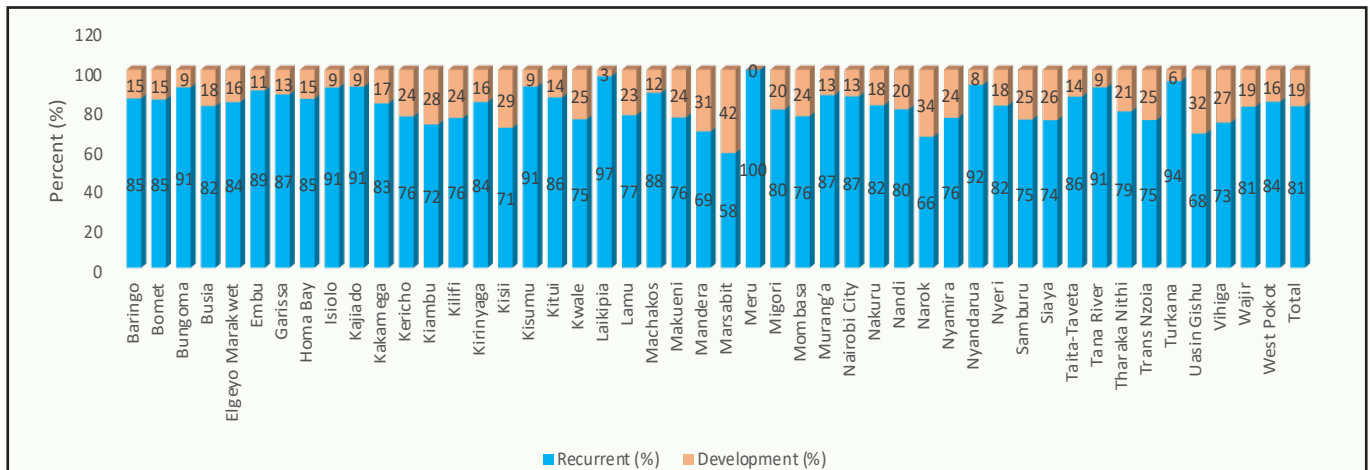
Source: MoH 2022

Recurrent and Development Health Expenditure Absorption Rates 2021/2022

The Public Finance Management (PFM) Act of 2012 recommends the allocation of 30% of the aggregate health budget to development. The average share of county budgets allocated to recurrent expenditures increased from 78.7% in FY 2018/19 to 81.5% in FY 2020/21, compared to the recommended 70%.

Personnel emoluments constitute the largest share of the recurrent budget hence the need to retain it at the minimum level. The county budget allocation in the FY 2020/21 shows that only four counties allocated more than 30% of their health budget to development. Counties are encouraged to allocate more to development to increase health systems resilience.

Figure 5. Recurrent versus Development Health Allocation 2020/2021



Source: MoH 2022

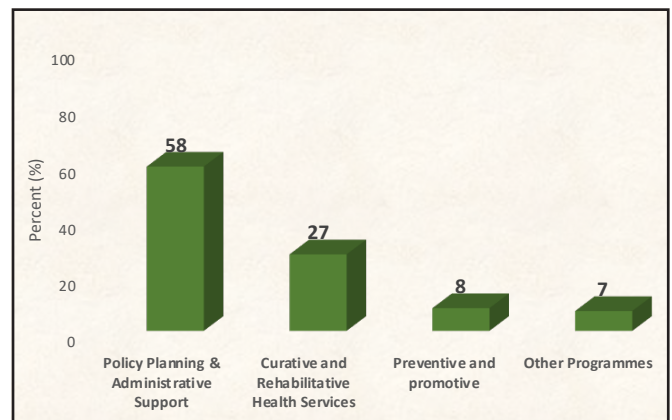
County Health Allocation by Programme

The funding structure at the county level is mainly focused on curative and rehabilitative health services and allocates limited resources to preventive and promotive health services. Counties have a huge mandate in primary health care (PHC), which has been shown to reduce the incidence of preventable diseases and mortality arising from maternal and child health, communicable and non-communicable diseases (NCD), and reproductive health. Earmarking a specific budget for PHC makes the interventions more targeted. Some counties such as Nakuru, Kilifi, Lamu, Migori, and Tharaka Nithi earmark specific budgets for PHC.

The FY 2021 county allocation to the programme indicates that only 8% of the domestic budgets in counties are allocated to preventive and promotive health services. Recent evidence in Kenya shows that every \$1 investment in PHC saves up to \$16 in spending on conditions such as TB, malaria, stunting and maternal and child health morbidity in a period of five years reference. Therefore, a paradigm shift

is required to invest more resources in cost-effective preventive and promotive health services, which form a large component of PHC, in order to achieve UHC.

Figure 6. County Health Allocation by Programme 2020/2021



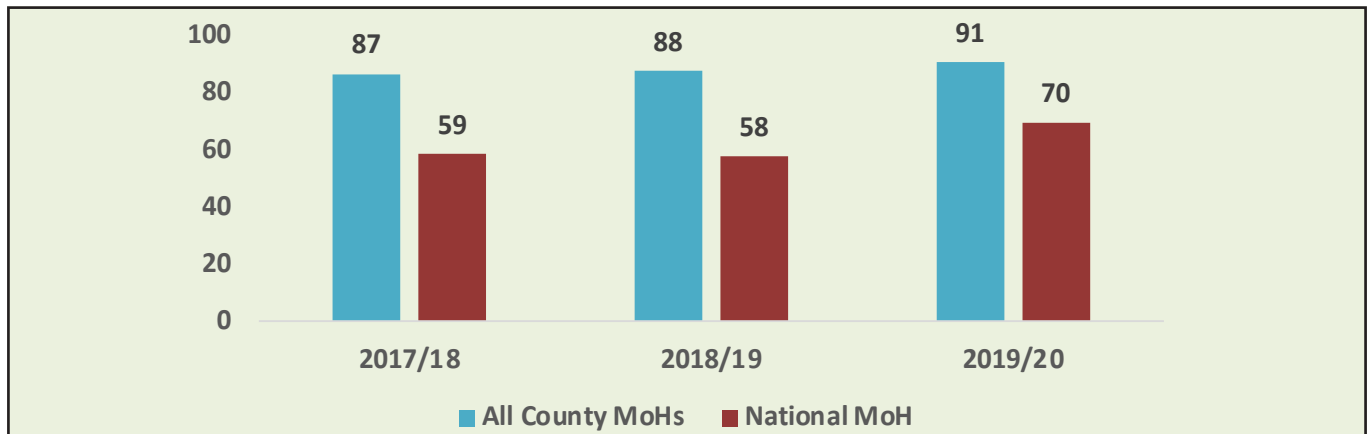
Source: MoH 2022

Persistent Underspending of Health Budgets

Despite the budget allocated to health being inadequate, the county and national MoHs do not spend all the budgets that are allocated. This is attributed to the delays in the release of funds by the Treasury and inefficiencies caused by complex PFM procedures and weak capacities in understanding

PFM processes. Therefore, deliberate efforts should be made to address the delays in the disbursement of funds and the PFM challenges that affect the absorption rate of health budgets.

Figure 7. Absorption rates for health budgets (%)



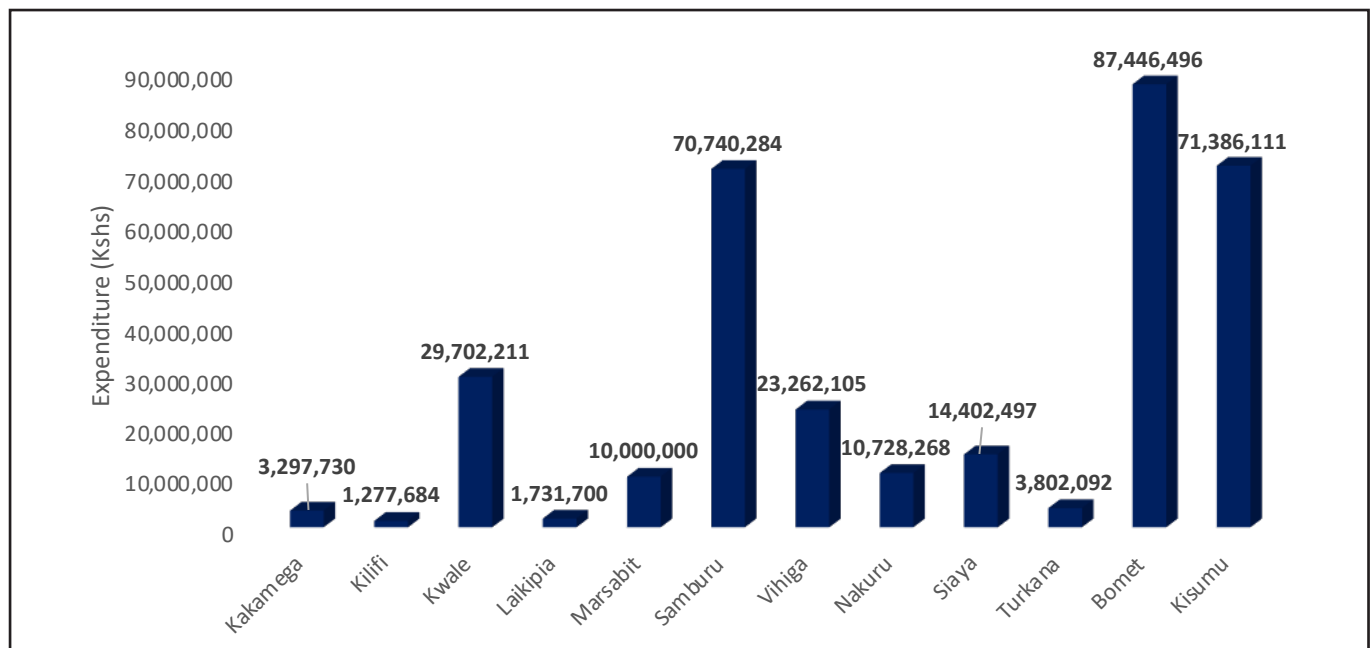
Source : MoH 2022

Expenditure in Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) FY 2020/21

Some counties allocate specific line budgets for RMNCAH (Figure 7). This is an indication that they are deliberate in reducing maternal and child-related deaths. Ending preventable RMNCAH

deaths and diseases remains at the top of the global agenda. Addressing the inequalities that affect health outcomes is fundamental in the achievement of UHC.

Figure 7: Expenditure in RMNCAH FY 2020/21



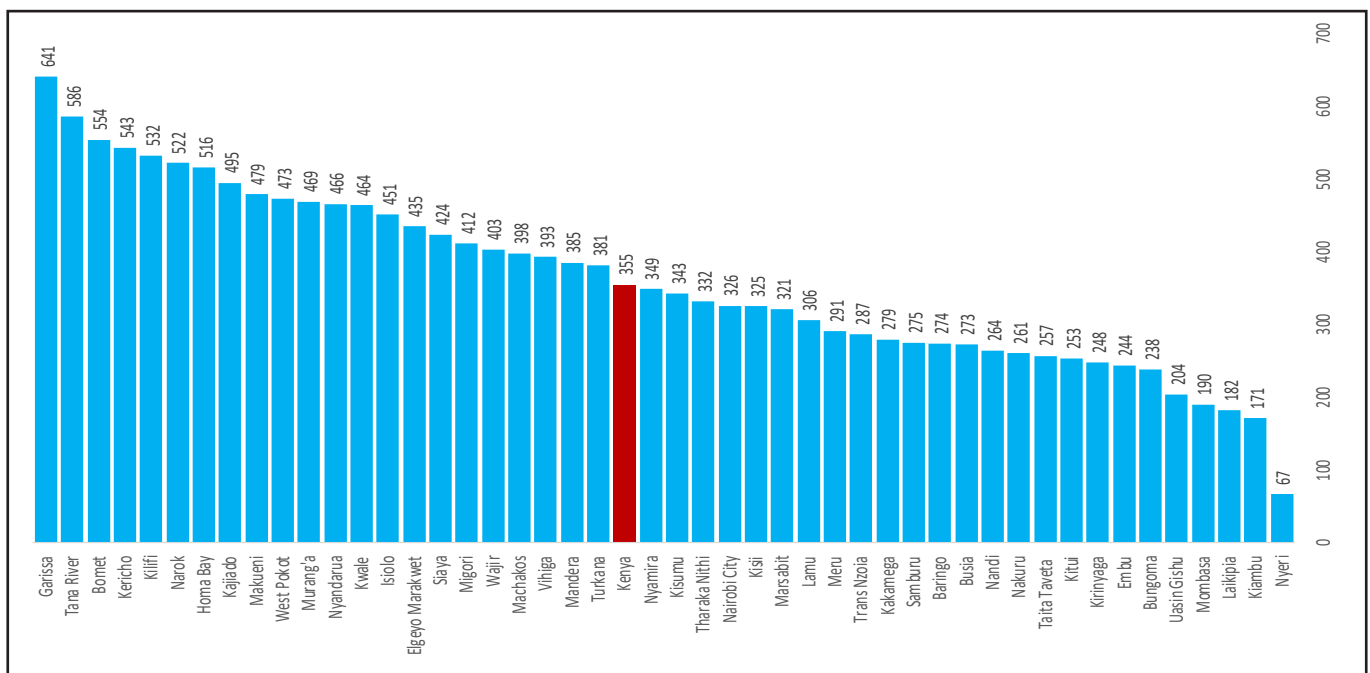
Source: Economic Survey 2022

Maternal Mortality by County

SDG 3.1 targets to reduce the maternal mortality ratio to less than 70 per 100,000 live births globally. Based on the 2019 Kenya Population and Housing Census (KPHC), maternal mortality in Kenya stands at 355 maternal deaths per 100,000 live births². Most maternal deaths are preventable through adherence to the health care solutions that prevent and manage complications. Counties play a pertinent role in reducing maternal, neonatal and

infant mortality due to their role in the provision of PHC in level 1, 2 and 3 facilities. The figure below shows that almost all the counties have not attained the maternal mortality target. Counties need to enhance maternal and newborn health by providing accessible and quality healthcare during pregnancy, delivery and after childbirth to reduce maternal mortality and morbidity.

Figure 9. Maternal Mortality per 100000 Live Births

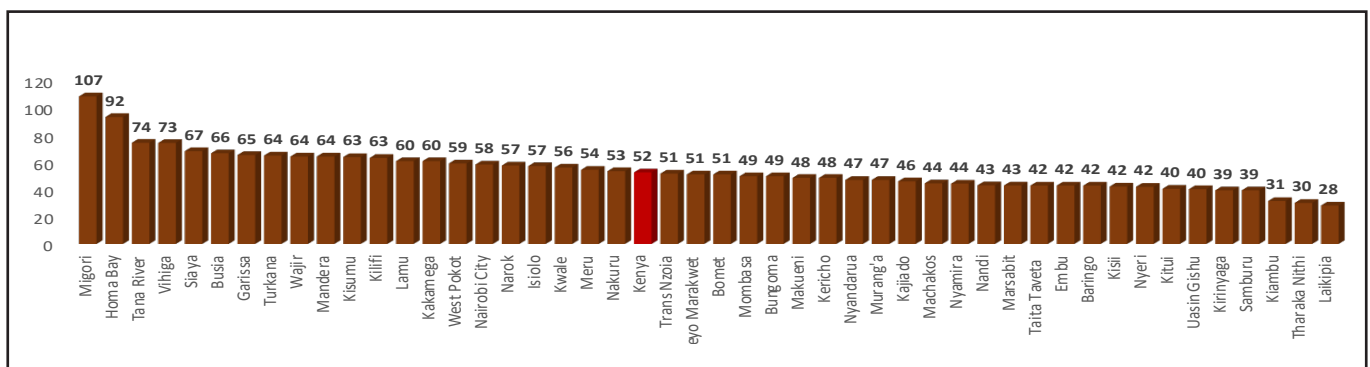


9. Under-Five Mortality Per 1000 Live Births

SDG 3.2 targets to reduce under-five mortality to as low as 25 per 1000 live birth. Based on the 2019 KPHC statistics, under-five mortality in Kenya stands at 52 live births. Counties have a key role in ending

preventable deaths of children under five years by enhancing investment and efficiencies in PHC.

Figure 10: Under-five mortality Per 1000 live Births



Source: Economic Survey 2022

Neonatal Mortality per 1000 Live Births

SDG 3.2 targets to reduce neonatal mortality to as low as 12 per 1000 live birth. Basing on the 2019 KPHC statistics, neonatal mortality in Kenya stands at 36 per 1000 live births. Counties have a key role in ending preventable deaths of infants by enhancing investment and efficiencies in PHC. Sensitisation of the community on the essence of attending all antenatal care (ANC) visits and the use of skilled health personnel during delivery will play a huge role in preventing neonatal deaths.

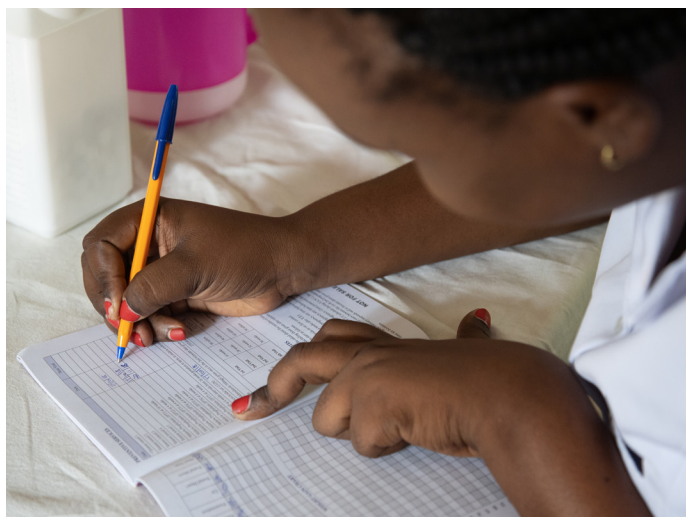
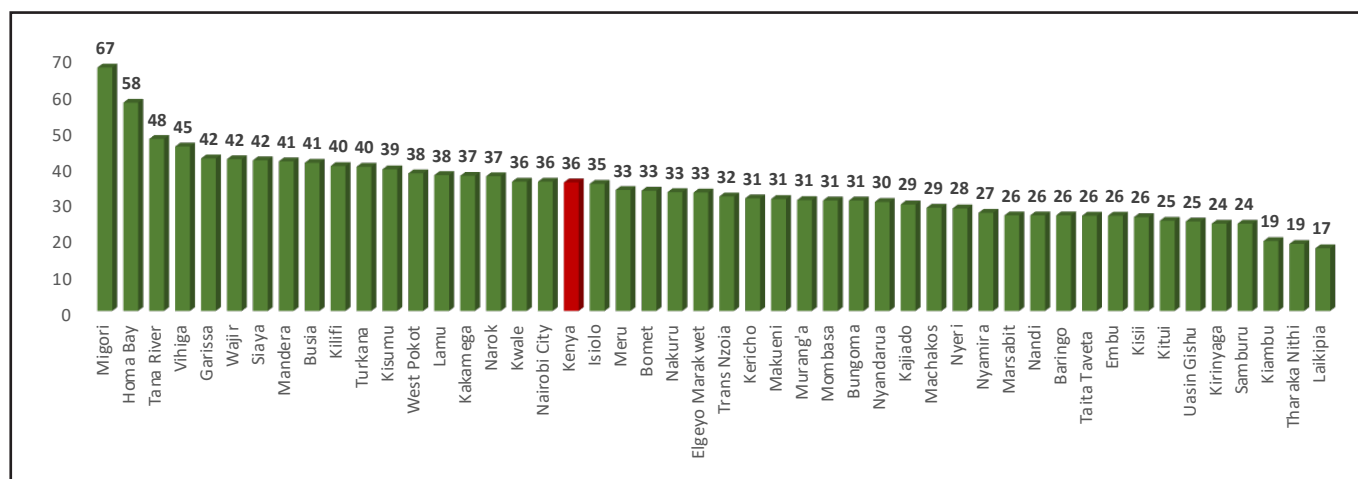


Figure 11: Neonatal Mortality per 1000 Live Births



Source: Economic Survey 2022

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Advance Domestic Health Financing promotes increased and efficient use of domestic health finance with a focus on primary health care and women's and girls' health.

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