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Sharing the pie: what can be done to improve priority setting for healthcare at the county level in Kenya?

Key points

- County level planning and budgeting processes are misaligned, meaning that budgets are not informed by health priorities and plans are unlikely to be implemented.
- Political interests dominate decision-making, resulting in inequitable and inefficient allocation of resources.
- There are few opportunities for meaningful involvement of stakeholders and frontline health managers in decision-making processes.

Introduction

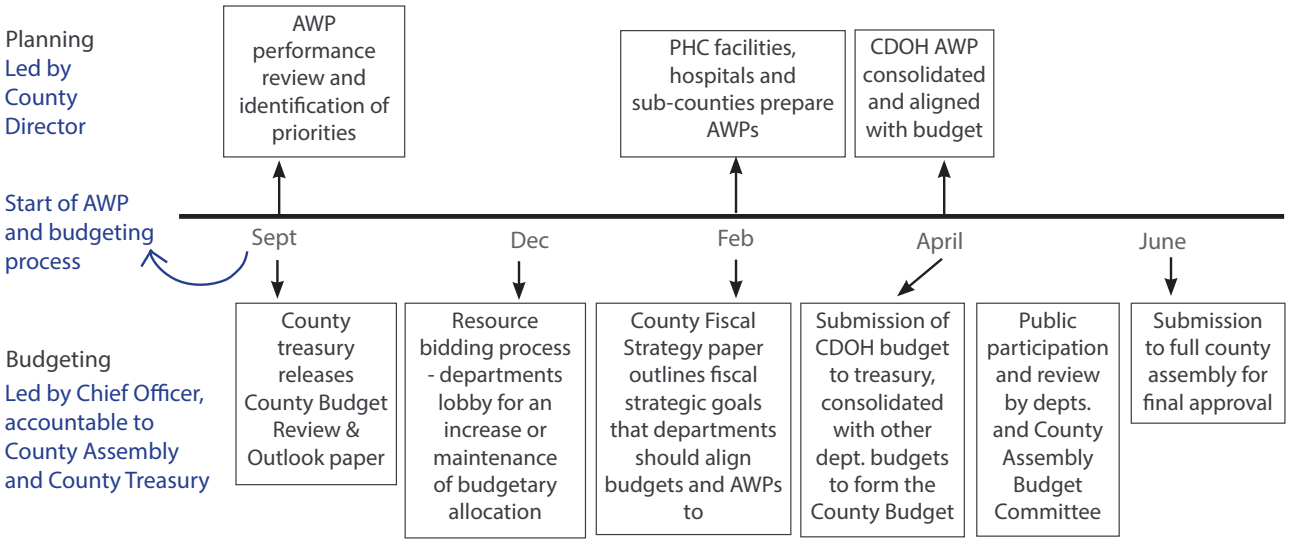
County departments of health (CDOH) play a critical role in the Kenyan health system. Since devolution in 2013, they have been responsible for the provision of preventive and curative, primary and secondary care health services. They now control the biggest proportion of healthcare resources in the country, with collective budgets amounting to KES 90 billion (USD 900 million) in 2016/2017. To effectively deliver health services, it is imperative that CDOH have strong and systematic budgeting, planning and priority-setting processes so that scarce resources are optimally used.

KEMRI-Wellcome Trust has undertaken research that examines the planning and budgeting as the main priority setting activities at the county level in Kenya. Similar research has taken place within hospitals and at the national level revealing significant misalignment in planning and budgeting and priority-setting practices based on informal considerations[12]. This brief summarises the key findings from the research and concludes with recommendations for county policymakers.

Ideal planning and budgeting process at the county level

As part of their responsibilities after devolution, CDOH are required to prepare an Annual Work Plan (AWP) that identifies activities to be implemented in the coming fiscal year, and to develop quarterly budgets that allocate resources against these activities. Figure 1 shows a timeline of the planning and budgeting process as it is meant to happen.

Figure 1: Formal planning and budgeting process



Key findings - planning and budgeting in practice

1. The planning and budgeting process of County Departments of Health are not aligned

CDOH prepared their AWP at least one quarter late, meaning that budgets were prepared prior to the AWP and not informed by the priorities laid out in the AWP. Misalignment is a recurrent occurrence in the health sector because planning and budgeting are driven by different actors: a Chief Officer leads the budgeting process, whilst a County Director leads the planning process. In practice, AWP timelines depend more on the timelines of donors that are supporting healthcare in Kenya.

Lack of alignment weakens the effectiveness of planning processes because it is likely that plans, which should reflect county priorities, are not backed up by budgets and hence are unlikely to be implemented.

2. Country health priorities are significantly influenced by political and donor interests

Kenya's devolution has resulted in the establishment of a local political structure that has direct influence on healthcare priority-setting decisions.

"We had planned to procure 35 motorbikes for the rural public health officers to go to the field, but the budget was cut down because the governor came and said that he had promised people that he will do a different activity but did not have the funds to do it. So, he said he will use the funds allocated to motorbikes to do what he promised people he would do." Senior manager

The use of informal considerations in decision-making rather than formal criteria such as essential services or need, could lead to perceptions of unfairness. Further, without adequate safeguards, the influence of political interests could result in inequitable allocations, for example, by prioritizing sub-county regions with the most vocal or powerful political representatives, or regions that have demonstrated political support for current political leaders.

Donors and health partners' priorities also influence planning decisions due to their ability to fund and support activities carried out by the CDOH. This was found to be the case even when donor interests were not a priority for the department.

3. There is no systematic attempt to incorporate efficiency and equity in decision making

Efficiency considerations, i.e. seeking to maximise outcomes within the constraint of available resources, were not incorporated into decision-making processes. There are several reasons for this including limited technical capacity and a perception amongst healthcare managers that public sector operations are not compatible with the use of efficiency criteria in decision making. Similarly, equity didn't feature in decision making due to a lack of involvement of all relevant stakeholders, and most prominently, political interference.

4. Senior managers dominate decision making processes, with limited opportunity for wider stakeholder involvement

There is a lack of genuine commitment to engage stakeholders effectively in the planning and budgeting process, in particular facility managers. This could be interpreted as a manifestation of power and a means by senior managers to avoid scrutiny of their decisions. When facility and mid-level managers were involved in discussions, they felt that their contributions were not taken seriously and their participation was to "rubber-stamp" the county managers' decisions.

Recommendations for county decision makers

1. The planning and budgeting process should be harmonized through:
   - Strict adherence to planning and budgeting activities and timelines as outlined in policy and legal documents.
   - Actors involved in driving the two processes should have similar and uniform reporting and accountability relationships so that they act in unison.
2. Develop and implement a systematic priority-setting process with explicit resource allocation criteria. This could also incorporate efficiency and equity considerations.
3. Improve the inclusivity of the planning and budgeting process by including the public and frontline managers in planning, and frontline managers and middle-level managers in budgeting.
4. Create awareness amongst all stakeholders of the importance of AWPs and their role in the budgeting process.
5. Strengthen and improve existing channels for incorporating community values in decision making e.g. by involving hospital and facility health committees in the AWP process.

About the brief

Based on

Dennis Waithaka, Benjamin Tsofa, Evelyn Kabia, Edwine Barasa: Describing and evaluating healthcare priority setting practices at the county level in Kenya International Journal of Health Planning and Management: 2018;1-18

References

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2. Improving priority setting practices in Kenya's hospitals: recommendations for county decision-makers and hospital managers. RESYST policy brief; 2016

Further information

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