Kenya’s Medium Term Expenditure Framework in the Health Sector:
Missed Opportunities, Actions for Revival, and Lessons from Neighbors

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I. Introduction

1. In recent years, an increasing number of governments in sub-Saharan Africa, including Kenya, have embarked on a Medium Term Expenditure Framework (MTEF) as a way of improving their budget. MTEF is essentially a response to past budget failures in which budgeting was reduced to a listing of “wish-list” activities that focused on “needs” rather than “funds availability” causing undue expansion in the public sector. Moreover, government policymaking, planning, and budgeting took place independently of each other such that the budgetary implications of policies and programs were rarely taken into explicit account. Due to these factors, many developing countries experienced inexorable growth in government projects and in civil service employment, resulting in little leeway for the funding of other recurrent costs and in ensuring the sustainability of investments.

2. MTEF attempts to correct these budgetary distortions by providing a 3- to 5-year framework for the funding of priority expenditures under a given and predictable budget constraint, that is, subject to the availability of funds that are within the manageable interest of the government (budgetary funds, extra-budgetary funds such as user fees, and donor resources). An MTEF exercise has three related objectives: to improve government and donors’ allocation and spending of resources to identified priorities within the sector, to increase government and donors’ commitment to the stated policy and to funding predictability, and to provide line ministries with a solid budget constraint that allows them to “contract” with lower level units on the basis of a predictable budget. Viewed in this light, the MTEF is very similar to the objectives of the “sector wide approach” (SWAp) being adopted in the health sector of a number of African countries.

3. This report reviews the status of the Government of Kenya’s (GoK) initiative to develop an MTEF for the health sector. It identifies institutional and technical constraints in the MTEF process, provides recommendations for expediting and improving it, and attempts to share lessons learned from other East African countries that are going through similar budgetary reform exercises. The observations and findings rely on (a) three missions made by AFTH1 staff involved in the preparation of the Kenya health project, the first made from June 1 to 12, 1998, the second from January 18 to 29, 1999 and the third from April 31 to May 5, 1999; (b) review of documents prepared to support Kenya’s MTEF process; and (c) lessons from similar experiences in Uganda, Tanzania, and Malawi which were gathered during missions to these countries in 1998-99. The list of persons met and the references are attached.

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4. This report reiterates the importance of formulating the MTEF firstly in the context of GoK’s stated goal of improving economic governance. The Ministry of Finance (MoF) views the MTEF as an important instrument for instilling fiscal discipline and improving expenditure management at the macro level. Completion of the MTEF exercise with the attendant annual reviews and refinements, therefore, can be viewed as a demonstration of GoK’s serious commitment to better governance of assets and resources. Secondly, the MTEF is central to the Ministry of Health’s (MoH) own performance enhancement objectives. Previous budgets were not performance oriented in that there were too many functions and services chasing too few resources. The MTEF process should force the Ministry to focus on those functions in which there is a demonstrated economic justification for government involvement, for which resources are available, and for which it should be made accountable. Thirdly, the MTEF can be seen as laying the groundwork for a longer term donor involvement in Kenya’s health sector. Donors are keen on using the MTEF as a basis for a future budget support program under a sector-wide approach as laid out in the signed Statement of Intent. Finally, the MTEF is relevant in the preparation of the new IDA credit in health (the Health System Development Project). While the new IDA credit will focus on proven technical interventions in reproductive and child health, the intention is to finance and deliver these services with much stronger underpinnings of improved fiscal discipline and financial management under an increasingly decentralized structure following the principles established under IDA’s Kenya Country Assistance Strategy (CAS).

II. Status

5. The 1997 Kenyan Public Expenditure Review (PER) underscored the nature and magnitude of the fiscal challenge facing the country and the adverse impact it was having on both the public and private sectors. To address this fiscal problem, the MoF felt that a system which provides a medium-term perspective on policy, planning, and budgeting be put in place, the centerpiece of which would be the formulation of an MTEF. The MoH MTEF process started off quite auspiciously along administrative, technical, and strategic fronts in the first quarter of 1998. The MoF issued a circular on April 17th and a letter on the 29th to all Permanent Secretaries and Accounting Officers directing all line ministries to begin immediately the process of developing their respective ministries’ MTEF. The process involves carrying out sector expenditure reviews to be done in two phases over the following six months: Phase 1 involves identification of program adjustments necessary to formulate a credible FY98/99 budget policy including policy options for improved resource allocation which can be raised in the FY98/99 Budget Speech. Phase 2 involves a more detailed review of ministerial priorities, policy framework, and expenditure management program, and other policy adjustments which can be used as inputs into the FY99/00 Forward Budget.

6. At about the same time (February/March 1998), the donor community in Nairobi (those involved in health, population, and nutrition) started seriously engaging the MoH on the need for greater management of the sector through better partnership. The mutual
understanding would later be written as the Statement of Intent (SoI), eventually to be signed by close to a dozen major donors. Although the SoI did not explicitly deal with the formulation of the MTEF, in spirit and principle, it dealt with crucial issues of economic governance including improved coordination of inputs and actors in the sector, increased certainty with respect to the flow of resources to the sector, increased effectiveness and efficiency in the use of resources, reduction in administrative and managerial requirements with respect to the handling of donor agencies, and enhancing MoH’s ability to guide the use of donors’ inputs to the sector.

7. The SoI was premised on donors’ interest to adopt a SWAp in the health sector, eventually leading to a direct expenditure support program for the MoH and, within a reasonable time period, its decentralized units. Most neighboring countries in East Africa are reconfiguring their current and future health activities along the lines of a SWAp; Tanzania and Uganda, for instance, are in different stages of SWAp planning. A key but often unstated underpinning of a SWAp is a sound and solid medium-term expenditure framework that takes account of all public resources (government budget, extra-budgetary resources, and donor flows). The SoI, therefore, strongly endorsed the carrying out of an MTEF, though this was not stated directly as an intention.

8. The technical underpinnings of the MTEF process were carried out in two fronts: the MoH ministerial PER and a series of analytical studies funded by donors to be used by MoH for programming and policy development. The health sector PER was completed, distributed within the MoH and donors, and reviewed by interested parties. In our view, it was better prepared than other 1998 health PERs in other African countries (Uganda, for instance), but given that Kenya has had a longer PER history and that there were quite a number of supportive analyses that were ongoing or completed, this effort was quite disappointing. It remained, much like its predecessors, more descriptive rather than prescriptive. The intention was to use the health PER to feed into the forward budget, through a Cabinet Memo, and thereby initiate the MTEF process. However, this did not transpire for the following reasons.

9. First, the PER consultants did not seem to have gone through the many analyses that have been produced on Kenya, with the final product having less value added than it could have. Also, the consultants started from a few misdirected premises (e.g., government’s role is to ensure that citizens are healthy), and were largely blaming limited resources as the primary culprit for poor sector performance, instead of using “limited resources” as a given and working out what GoK’s role should be from such a given assumption.

10. Second, it was difficult to gather actionable policy proposals (whatever was useful) from the PER that MoH can use directly as inputs into the ministry’s MTEF process. This would have been salvaged if MoH staff developed a summary table of the

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2 Statement of Intent (SoI), signed by ambassadors, country representatives, heads of delegation, and directors of the following donors, in various dates from February to December 1998: Denmark/DANIDA, British DfID, European Commission, GTZ, the Netherlands, Swedish Sida, USAID, the World Bank, and Unicef.
PER that identified key actions related to the formulation of MTEF, assign responsible persons and units, and agree on timelines for meeting these key actions. The key actions relevant to the MTEF are discussed partially, or merely hinted at, in the 1998 PER including the following: consolidation of the development and recurrent budget, a firmer grip on extra-budgetary revenues, establishment of cost centers, financial tracking, and performance monitoring. No specific guidance or follow-on tasks were proposed.

11. Third, as usual the health PER was prepared by consultants with the attendant problem of MoH staff being peripherally involved in the process and therefore not owning the results. This problem appears to be endemic not only in health but in other ministries as well. However, other sub-Saharan countries seem to have hurdled this problem of translating technical findings into policy, planning and budget work. There are institutional as well as behavioral problems involved in Kenya, an issue that we will revisit in the section on “Constraints”.

12. In the enthusiasm accompanying the adoption of the SoI, health sector donors also provided supportive technical analyses. Although these studies were initially conceived not with the MTEF in mind and were directed more at the planned SWAp that donors were considering, their results could have been used in the MTEF process. To date, this remains an aspiration rather than a fact.

13. The Budget Analysis study, funded by DfID, was a retrospective look at the MoH budget. Phase I of the study, with a draft produced in August 1998, looked at the planning, budgeting, disbursement and accounting system of the MoH; described the structure of the MoH budget, its limitations and potentials, and the proposed budget reclassifications; and analyzed trends in public health sector spending. The study highlighted the following:

- The Public Investment Program (PIP), introduced in FY90/91 to improve budgeting, has not been accorded the importance it deserves. It is not binding on the Treasury nor on the MoH and in the past opened the room for unplanned projects to get into the budget cycle. In addition, the “annex system” that is supposed to link district plans to the PIP and thence to the forward budget has not been streamlined, with the districts providing their annexes at the wrong planning stage. Finally, on hindsight, many now view the PIP as too centrally-oriented, with little link to bottom-up planning emanating from districts.

- There is no widely agreed formula of allocating funds to different districts. This problem is compounded by poor planning and poor management information system linking districts to the central MoH. Moreover, while there are clear guidelines on how district funds should be handled, reallocations are problematic and these are often done at the central level with little involvement of district managers. The tight liquidity throughout most of the 1990s merely complicated these district financing problems.

- Although donors are reputed to account for 90 percent of the development budget, GoK is unable to account for all these donor expenditures and to integrate,
harmonize, and report these flows following GoK procedures. Trend data on health expenditures show many discrepancies and deviations, mainly because of GoK accounting system’s inability to capture all relevant donor data.

- While the recurrent budget is fairly comprehensive, the development budget – under which most donor projects are supposed to be reported – is not. Moreover, while the recurrent budget is relatively consistent in its accounting disaggregation, the development budget is not.

- The budget coding system is inappropriate for performance evaluation. The distinction between curative, preventive, and rural health services is ambiguous, thus undermining the possibility of assessing the extent to which policy objectives have been met. The number of budget items could be reduced and re-organized into five major categories based on economic classifications (personnel, drugs and supplies, utilities, transport maintenance and replacement, and grants and other expenditures).

- The accounting system is overwhelmingly manual which inhibits facilitation and dissemination of financial information. It is tailored for control and audit functions rather than for planning and management. There is no comprehensive and consistent system of financial and performance reporting (running from headquarters to provincial administrations to districts).

14. Although it was not mentioned in the study, MoH staff also pointed to the heavily centralized nature of ministerial budgeting, with the districts barely involved in the process. The District Development Committees (DDC), which are the mandated management structure in the districts, appear to be merely passive recipients of resources from the center under what one MoH staff described as a “central supply system” of funds. Districts’ apparent lack of involvement is compounded by central HQ’s insufficient ability to provide solid budget ceilings to districts that they can work on. Being multisectoral, the DDCs report to the Office of the President and not to specific technical ministries, a bifurcation that may also have implications on performance accountability.

15. The Budget Analysis study, Phase II was intended to link resource allocation with output performance, with field work planned to derive standard workload and output measures based on cost and physical achievement figures from a sample of 37 public health facilities (from 5 provinces, 12 districts, 12 health centers, and 12 medical training centers). The aims of the study are to carry out a detailed analysis of resource availability and utilization, to assess the extent to which policies and priorities are being met at various levels, and to identify potentials for resource reallocations and savings.

16. The study intended to analyze the following variables: number and distribution of personnel, personnel costs (salaries, allowances and gratuities), cost of drugs and supplies, cost of maintenance, and administrative costs. The intention was to generate standard cost and output measures for the Provincial Medical Office, general hospital, district hospital, and health centers/dispensaries, and to apply these in the formulation of
a more rational budget. The analysts were also interested in the possibility of using some of these unit cost and other data for the formulation of block grants to districts. Initial results indicated that block grants could be allocated on the basis of district annual workplans tailored to conform to GoK annual budgetary codes, audit, and monitoring requirements. Five cost categories (collapsed from the existing 43-odd budget items) were proposed:

- Personnel Costs category – subcategories for personnel emoluments, allowances, special allowances;
- Drugs and Supplies category – subcategories for drugs and vaccines, medical supplies, nonmedical supplies, patients’ food;
- Transport Costs category – subcategories for fuel, spares and maintenance, other transport costs;
- Other Costs category – subcategories for maintenance of equipment, maintenance of buildings, general charges; and
- Capital Costs category– subcategories for medical equipment, nonmedical equipment, transport, buildings.

17. For fiscal discipline, the study proposed the following rules: (a) District managers will have flexibility to reallocate within categories but not between categories. (b) Within subcategories, up to 100 percent allocations could be reallocated to one deserving service. (c) Intra-subcategory reallocations could be allowed up to a ceiling of 40 percent depending on stated urgency for spending to be made in one subcategory over another. (d) Use of standard reporting formats for periodic monitoring. The analysis provided critical information and useful guidelines for the MTEF but by May 1999, it has not been completed and it is not clear to what extent the results will be used to inform the MTEF process, which has been stalled.

18. The Health Status Analysis study, funded by Sida, was commissioned to AMREF with the objectives of conducting a comprehensive assessment of the Kenya’s demographic and health indicators; identifying priority health needs and assist GoK and donors reorient their efforts; and providing recommendations for the establishment of Kenyan capacity for assessing progress in the health sector against a common set of indicators mutually agreed upon by GoK and its donor partners. The study, if done properly, would have provided critical input in moving towards problem identification, evidence-based resource allocation priorities, and development of performance indicators. However, the consultants seem to have misunderstood the scope of work so that the study became just a pastiche of demographic and epidemiologic data that were not useful for policy and programming purposes. In the welter of information provided, it was difficult to pinpoint where the key priorities should be in Kenya’s health sector. It did provide some useful recommendations in reforming the health information system to capture service statistics.

19. At around the same time, the results of the Kenya Demographic and Health Survey³ (DHS) were released in a preliminary report which painted a grim picture of the
mortality and morbidity situation especially with respect to key public health interventions such as HIV/AIDS, sexually transmitted diseases, and maternal and child health. Alarming declines were reported in most coverage indicators especially immunization, no significant inroads were being made on adolescent health, the AIDS epidemic continues to take its toll, and the uptake of contraception has probably slowed, making a dent on one of Kenya’s best performing programs that has been so successful in the past two decades. Like much of the useful information usually generated on Kenya, the DHS findings seem not to have strongly influenced any of the MTEF deliberations. For instance, in light of the stark DHS findings, MoH would have renegotiated for a more robust budget from MoF (say allowances for vaccinators which have dried up).

20. The National Health Accounts (NHA) study was commissioned by USAID to Harvard/Abt Associates to generate sector-wide information on the sources and uses of funds in Kenya’s health sector. Initial difficulties revolving around the institutional locus of the study and the involvement of government staff working on it continued to persist so that much of the work is being done by expatriate staff. The NHA promises to be a critical database to assess system-wide spending and effectiveness, and would therefore be a useful input into the MTEF process and in the long-term, the planned SWAp. A stronger MoH commitment to this activity is needed.

21. This brief review indicates that Kenya (relative to other African countries) was not wanting in available technical information required to initiate an MTEF, though admittedly, the information base remains incomplete. In fact, although most of these analyses were completed, their results were not comprehensively applied to inform the MTEF process.

III. Constraints

22. In the last quarter of 1998 all ministries prepared their PERs as planned which were presented to all permanent secretaries in mid-November. Comments were made on the PERs in November and December, which would have been used in the development of forward budgets in that period, to be revised in February 1999. But by December, it appeared that nothing had changed. By January 1999, most ministries were back preparing their usual budgets in the old traditional mode of incremental budgeting which were unrelated to their “core functions” that they have identified earlier in the PER exercise. MoH staff, however, did indicate that the FY99 budget was “a bit better” than previous years’ efforts in that there was a deliberate effort (a) to minimize the number of projects and to prioritize them based on available counterpart funds, and (b) to control personnel expenditures so that more resources could be devoted to operations and maintenance. The Planning Commission interviewee claimed that “some of the ministerial PER results were already reflected in the forward budget that the ministries submitted to MoF,” but he could not specify the details.

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23. On hindsight, there appear to be three major constraints that stalled the MTEF process and health reforms more generally. There are technical constraints which are well known and solvable, but there are also institutional constraints which do not lend themselves to easy solutions.

24. **Technical Constraints:** MoH continues to lack planning and budgeting parameters needed to underpin the MTEF process:

- No personnel information on established posts and location of staff; available information indicates where staff are paid from, but not where they are physically located. MoH just recently completed a staff headcount at the central office in April; a similar headcount needs to be conducted for all facilities and levels. These and other information should be inputted into a good personnel management information system that shows all the established posts and which are filled or unfilled.
- No staffing norms; the proposed study was stalled under Civil Service Reform II project, which is at the risk of being cancelled.
- No information on state of repair of health facilities.
- No cost data on a standard (well-functioning) health facility, by type of facility, by location that can be used to construct bottom-up budgets.
- No program cost data, except possibly on reproductive health.

25. Constraints were also posed by the different timelines of the supportive analytical work, health sector strategic planning work, and the key MTEF activities. The MoH did formulate the National Health Sector Strategic Plan which is now in preliminary draft form, but this came after the planned first fiscal-year of the MTEF. And the first bunch of analytical results were not available until midway through the first MTEF fiscal year. This problem is not unique to Kenya; other countries in the region also has difficulties properly sequencing the MTEF-supportive activities simply because they are being pushed by different initiatives.

26. **Inadequate Comprehensive Understanding of MTEF Requirements and Implications:** Because of the novelty and complexity of the MTEF exercise, both the MoF and MoH – and the World Bank itself – appear to have underestimated the time and effort needed to carry out the process, its technical and analytical requirements, as well as the political support needed to achieve top-level decisions especially with respect to the overall size of the Kenyan government and the civil service.

27. Within the MoF, the rationale of MTEF is well understood, i.e., “focusing on GoK’s core functions based on available forecast of resources, and enhancing the allocation for operations and maintenance”. However, MoF staff admitted that the technical requirements of this new expenditure planning requires new skills that they are

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4 The MoH recently compiled a directory of all health facilities, which is already a major step in the eradication of “ghost facilities,” a phenomenon that sometimes occurs in certain countries and which can provide a significant drain on budgetary resources.
just learning or will need to learn, e.g., estimating the resource envelop, program costing, integration of the development and the recurrent budgets, and performance monitoring. They indicated strong interest in learning about how other countries are going through their MTEFs, and there might be added value in sharing cross-country experiences.

28. The political dimension of MTEF, implicit in most cases, needs to be highlighted especially where it is critical (divestiture, civil service downsizing). MoF staff admitted that they were totally “unprepared” and were not adequately warned of the political implications of the MTEF exercise; in fact, they confessed “regret” at having agreed to certain conditionalities that were outside their “technical” control. At the Ministry of Planning, the single interviewee was not well-versed in MTEF requirements and seemed not to have been informed at all of this new budget imperative.

29. At MoH headquarters, the staff economists were very well versed in MTEF and knew the technical requirements of doing it, as well as the required studies (except initially the chief economist, who was new and was deferring to his deputy). But some senior-level MoH staff were not strongly supportive of the overall thrust of the MTEF and were still arguing for more resources flowing to the health sector (a desire that was expressed all over the draft Health Sector Strategy), instead of focusing on the available resources. MTEF is viewed within the Ministry as a budgetary-cut exercise; most staff were unwilling to hazard opinions on what to do with services to be determined “noncore”, much less on how the GoK will deal with them. The level of understanding of the MTEF at the district and facility levels is much less than that of headquarters staff. Unlike Malawi which launched the MTEF exercise with a national workshop of district health officers, no such MTEF information dissemination exercise seemed to have been conducted in Kenya.

30. MTEF was not well understood in general among health sector donors in Kenya; neither was there strong understanding of the budgetary reform requirements of a SWAp. This contrasts sharply with the case of Uganda and Tanzania where donors were involved in the health MTEF process and were quite knowledgeable about it. The initial enthusiasm and energy among Kenya donors in moving together on the SoI fizzled out in the wake of frequent changes in MoH leadership. The same donor enthusiasm has not been shown with respect to the formulation of the MTEF, even if this is a critical element of the eventual sector-wide approach.

31. Finally, there is as yet no universal agreement on the role of government in health especially in Africa and more so in Kenya. A recurring theme underlying most discussions on health sector restructuring is the Alma Ata goal of “Health for All”5.

5 WHO declared in 1978 that health was “a state of complete physical, mental, and social well-being and not merely the absence of disease,” a premise that somehow buttressed wide government involvement in the provision of health services. In May 1999, the WHO General Assembly marked a significant shift in thinking towards a realistic acceptance of the need to set priorities and to make best use of resources for all within society. “Universal coverage means coverage for all, not coverage of everything,” the new report has been quoted as saying (see British Medical Journal of May 1999). The new WHO stance underscores the need to set priorities on the basis of resources available to each government, and the cost of top priority health interventions – which is the whole premise of the MTEF.
which has been propped by an increasing “culture” of rights, entitlements, mandates\textsuperscript{6}, and health standards, most of which have not been assessed of their monetary implications. Cost-effectiveness is a rather recent notion\textsuperscript{7}; MTEF and its implications of right-sizing is often viewed as World Bank or IMF conditionality. And even where there is a receptive audience that does indeed subscribe to the notion that a government ought to promise only what it can afford, there is nary a country in sub-Saharan Africa that can be cited as a working example where MTEF has worked\textsuperscript{8} and where health services have indeed improved dramatically as a result.

32. **Institutional Constraints:** At the macro level, the separation of independent Kenyan teams doing work all related to the MTEF – civil service reform group, ministerial PER group, finance group, fiscal decentralization working group, and the Health Sector Reform group within the MoH – has been counterproductive. MoF has recognized this problem and is preparing a draft memorandum to merge these groups, or at least force them to coordinate their work. Coordination of these various committees is especially important because many of the reforms need to be synchronized.

33. At the MoH level, frequent changes in the leadership and technical staff weakened the institutional commitment and capacity to proceed with the MTEF and health sector reform more generally. In the past year, the MoH’s top decisionmaking structure has been very fluid, with the permanent secretary being changed twice; the chief economist, thrice\textsuperscript{9}; the undersecretary for finance, twice; and the Director for Medical Services, once. The undersecretary for health financing has been moved to Energy and the position remains vacant. The head of the Health Sector Reform Secretariat (HSRS) was recently replaced.

34. There is no well-defined institutional locus within MoH for MTEF work. Among the four East African countries that we are familiar with, Kenya has the most diffuse planning structure, although it has by far the best technical capacity in planning, financing, and budgeting. In Tanzania, Uganda, and Malawi, everything is vetted through the Planning Directorate or Unit, and the head of planning is an influential figure. This is not the case in Kenya where smaller units have eaten into the purview of the Planning Unit, e.g., the HSRS which is a secretariat but had evolved to become the MoH’s braintrust; the budget section; the Health Care Financing section which handles policies and programs related to user fees and extra-budgetary revenues; and the subunit responsible for donor projects. Poor communication among department heads within the

\textsuperscript{6} For example, the rights of the child, the elderly, and the patient more generally; and the increasing “mainstreaming” of gender issues and of environmental concerns.

\textsuperscript{7} Invoked most widely in the 1993 World Development Report of the World Bank.

\textsuperscript{8} Australia and New Zealand are often cited as notable examples where budget reform has worked. The U.K. may be an example where some health sector reforms and right-sizing has worked.

\textsuperscript{9} The frequent reshuffling of economists in government service affected not only the PER and MTEF work at MoH but in other ministries as well.
Ministry is also a major problem and is an open secret within GoK and the donor community. To ease this problem, the MoH reconstituted the Ministerial Reform Committee in mid-1998 consisting of the PS, the DMS, and all department heads. The Committee was supposed to meet once a month. However, the frequent changes in top-level staff within the Ministry appear to have diluted the efficacy of the Committee until recently.

35. The bifurcation of the top structure within MoH between the PS and the DMS, which is a constitutionally mandated post, can also lead to divided loyalties among staff. If the PS and DMS are on the same “wavelength,” the power division does not get in the way of the Ministry’s work. But in a very fluid situation (as was observed last year) where the PS’ and DMS’ priorities do not concur, and especially if they bring along their own appointees in the department-head levels, loyalties can calcify along individual – rather than institutional – lines, leading to counterproductive staff behavior. The donor community, including the Bank, has not helped the situation as everybody tries to buy performance of MoH staff through various forms of incentives and loyalty. For instance, a particular donor favors the health financing section, another favors the HSRS, while yet another has an eye for STI. This coping arrangement among donors, though successful in the short term, can prove to be counterproductive in the long term, especially under complex arrangements involving MTEF and sector-wide approaches in which the energies of the entire Ministry, rather than subsections of it, are required.

36. The above problems have been exacerbated by key government restructuring decisions that remained to be resolved. The MoH restructuring has been withheld at Cabinet for close to a year, and MoH staff continue to be wary of their posts. According to MoH staff, the Cabinet has not approved the restructuring because there was a freeze in hiring and the creation of new posts as mandated under GoK’s Policy Framework Paper with IMF/WB. It appears that the MoH structure is not the issue per se but the financial implications of staff upgrading, new staff hiring, and deployment. According to HSRS staff, the Cabinet paper needs to be revised to conform to the Policy Framework Paper, which should have been done by March 31, 1999. According to MoF, the Cabinet deferment is related to the larger issue of the appropriate size of the Kenyan government and the civil service, i.e., the reduction of the number of Ministries from 26 to 17. It is anticipated that a presidential statement on the core functions of GoK will be issued on June 30, 1999.

37. Whatever the proximate and ultimate determinants, it is clear that the MoH environment in the recent past did not elicit optimum performance and productivity from its staff, and the stalled MTEF exercise is just a symptom of a deeper institutional problem. It is extremely difficult to assign tasks and responsibilities, to apply sanctions, and to extract promises of performance, simply because the “Organizational Chart” is quite different from an underlying “Power Chart” that is invisible. It would be too simplistic to say that the lack of a strong political will at the top is the missing critical

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10 According to MoH staff, the restructuring of some technical ministries proceeded as planned, which underscores the issue of why the MoH restructuring did not proceed.
element in pushing for the MTEF; the fact is that the MoH itself has had serious constraints as an institution.

38. GoK counterparts maintain that the World Bank itself has underestimated the technical and partnership requirements of an MTEF. Strained relations with the Bank occasioned by the CAS did not provide a healthy environment within which to operate. MoF and some MoH staff are still smarting from the “strong language” in the CAS, and the CAS itself continues to be “of restricted circulation” in GoK. Thus, there has also been restricted discussion of the MTEF within government circles. There also appears to be incentive problems associated with undertaking what some GoK staff view as “Bank-mandated” MTEF when the Bank itself is under a low-case scenario. In contrast, there has been stronger support for MTEF in Uganda and Tanzania which are not in low-case scenarios, and where the MTEF is perceived more as a multidonor effort, with the Europeans providing quite significant levels of technical assistance.

39. The approach to MTEF work also varies, with macroeconomists often “going for the jugular” and insisting that major macro constraints be dealt with first (e.g., overall size of the government, civil service reform, privatization of key services, governance issues) while sector specialists tend to be “incrementalists,” preferring a gradual approach of technical support, capacity building, and institutional strengthening. Thus, sector specialists tend to focus on the development of a sector strategy, conduct of cost-effectiveness and burden of disease analyses, program costing, financial systems development, and laying out the foundation of government and donor collaboration through a SWAp. Our interview with MoF staff support this incrementalist view, i.e., while macro reforms need to be done, there are reforms within the sector that can be pursued even as the resolution of these macro issues remain pending.

IV. The National Health Sector Strategic Plan

40. The MoH produced the National Health Sector Strategic Plan (henceforth Strategy) the first draft of which was circulated in April 1999. The Strategy contains chapters on the Kenyan health situation; the government’s visions, goals and objectives in the health sector; technical and service interventions; organizational and institutional framework; and financing of health services.

41. In its present form, the Strategy does not logically connect with the MTEF work, which is a glaring omission as the MTEF should be the heart of GoK financing in health. The Strategy paper seems to have been envisioned as a vehicle to list activities to be projectized under a “Health Sector Reform Program” which can then be presented to donors for funding (a mistake made by Tanzania in the initial conceptualization of its SWAp, which is being corrected). This is a serious conceptual misunderstanding of the nature of a sector strategy, which should be for the entire sector (focusing on the core functions of government), and not simply a vehicle for “projectizable” activities. Thus the MTEF should be seen as the budgetary translation of the policies and priorities spelled out in the Strategy.
42. The government’s visions, goals and objectives in the health sector are well described in the Strategy, but there are serious issues about the assumptions, principles, and foci of health interventions that need to be raised, especially as they relate to the MTEF. In summary, these are:

- the underlying assumption about the performance of the Kenyan economy over the medium term;
- the role of the government in the health sector especially under an alternative assumption of less-than-robust economic growth;
- clarity in the economic principles underlying the selection of priority and less-priority health services;
- the role of the private sector and regulatory reforms needed to underpin the proposed thrust of greater privatization;
- the role of donors especially in a future budget support program;
- clarity in the principles on poverty targeting; and
- the thrust on alternative financing which seems unduly focused on informal/agro-based insurance schemes rather than strengthening the existing formal insurance program (NHIF).

43. **Underlying Economic Assumption:** The Strategy is premised on the implicit assumption that the Kenyan economy is likely to grow modestly if not substantially in the future. Based on this assumption, the Strategy focuses almost entirely upon MoH requests to MoF for increasing the health budget, and for aggressive generation of extra-budgetary resources (user fees, formal- and informal-sector prepayment schemes). Following this rather optimistic assumption, the Strategy argues for government “commitment towards expanding the scope of services” in the health sector, which is worrisome especially if the counterfactual proves true (the economy will decline), and if one takes the view that the government is already over-committed in many tasks and functions as exemplified by underfunded health services across the board.

44. It is critical that MoF and MoH leadership and senior staff conduct technical dialogues on the likelihood of economic growth and the robustness of the budget.11 These 5- to 10-year forecasts should be realistic and should be used to inform GoK discussions on the extent and focus of government involvement in the health sector. A less-than-rosy forecast provides GoK with much less choice in its sector involvement, for it means less budgetary resources as well as less expectation of extra-budgetary resources (fees) that can be expected from households. The forecasts should be made as much as possible in real per capita terms to take account of population growth and inflation. Because of the critical nature of these assumptions, it is recommended that the Strategy devote a separate section on them and their implications.

45. **Role of Government:** In general, the Strategy’s underlying principles of government role in the health sector are diffuse and sometimes equivocal. These need to

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11 There is a more basic technical problem in that Kenya does not have a reliable in-country economic forecasting model, a capacity that clearly needs to be developed.
be stated in a stronger and unambiguous terms, with rationale and proofs provided. The Strategy hooks its argument on the fact that “government resources are not sufficient to meet the resource requirements of the sector.” This is true, but the more pragmatic and reasonable starting point is, given the available resources, where should the government focus its services? This is the whole point of the MTEF exercise. The Strategy cites the WHO Alma Ata declaration, but there is a need to qualify that “Health for All” (as invoked in Alma Ata) does not provide blanket authority for government to be involved in all health services. The Alma Ata declaration has been overtaken by more recent notions of cost-effectiveness and burden-of-disease. The Strategy does invoke “cost-effectiveness” and “burden-of-disease” as key principles, but these two principles need to be taken in tandem and not separately, and should be used as explicit criteria for investments in the health sector. The application of these principles naturally leads to a GoK reconfiguration of health services based on what should be its “core functions”.

46. The (final) list of priority health interventions and the required analytical and stakeholder consultations to derive it should be laid out clearly and unequivocally. The Strategy definition - “[P]riority health services entail those clinical and public health packages that are considered essential” – is weak and circular. The Strategy has to state the principle for them being considered essential (i.e., high burden of disease and demonstrated cost effectiveness of specific health interventions\(^\text{12}\)), then proceed from these key principles. One principle without the other is not sufficient, i.e., even if a disease is of high burden if the intervention is cost-ineffective, then it shouldn’t be a priority. Similarly, even if the intervention is highly cost effective if the disease burden is low, it shouldn’t be a priority. The Strategy statement on the funding of less priority interventions that “they may not justify the use of government funds” is also weak. Again, the underlying principle should be stated, i.e., that the disease burden is less, or that the ‘publicness’ of these diseases and interventions is much less, and therefore, do not justify full (or possibly even partial) GoK financing, unless overriding poverty considerations apply.

47. **Role of the Private Sector:** The Strategy argues for greater private participation in the health sector but it does not articulate the rationale for such desire, e.g., cost-effectiveness, pluralism that leads to competition and finally to better services, and/or patient choice. Thus, the Strategy pushes for wider nongovernment provision and financing of health services, but does not cite their demonstrated comparative advantage. (Uganda’s health strategy was very specific on this issue, and cites data on NGOs’ cost-effectiveness). The Strategy also argues for the “encumbered provision of services” by the private sector, which runs counter to traditional government’s mandate to regulate health services. There is a need to qualify this strategic objective by putting private sector participation in the context of “national health goals”, however defined.

\(^\text{12}\) It turns out in most instances that cost-effective interventions targeted at diseases with the highest burden in society also are focused on those diseases in which the poor suffer from most. Thus, in general, if the principles of cost-effectiveness and burden of disease are used, the chosen interventions also tend to alleviate poverty.
48. Private financing is especially worrisome in Kenya in light of preliminary results from the National Health Accounts indicating the large and unregulated and possibly uncalled-for over-the-counter purchases of drugs (especially antibiotics), which may have long-term deleterious effects in promoting drug resistance. A second example is the largely unregulated growth of primary care facilities (nursing homes, first level hospitals) that are reportedly abusing the National Hospital Insurance Fund through fraudulent or excessive claiming. There is a need for a strategy statement on the role of government in ensuring that these private expenditures are not misspent, e.g., through better regulation, patient information, continuing education of medical professionals. It is recommended that the Strategy contain a section on the regulation of health services.

49. **Role of Donors:** The discussion of the magnitude and role of donor financing is rather weak. Donor financing is severely underestimated, and there is very little discussion of where they are currently being used. What needs to be laid out in this section are the common principles enunciated in the signed SoI, especially those pertaining to the long-term thrust of moving towards a budget support program and its requirements (especially on budget reform, financial reporting, and performance monitoring). This needs to be connected with the discussions on MTEF, since MTEF is the heart of the SWAp.

50. **Poverty Targeting:** The section on poverty targeting is well conceived but the principles on waiver and exemption need to be more explicitly stated. In addition, the following should be resolved: (a) Means-tested exemption, i.e., the poor and the undernourished - the operationalization of the nutritional status criterion remains an issue to be threshed out. (b) Geographic exemption, i.e., slums and poor areas - the proposed exemption based on non-NHIF coverage is questionable since there are non-NHIF households who can afford to pay. (c) Delegation of the waiving and exempting function to local authorities - this is considered “best practice” in certain settings. Note, however, that local elites may exercise their power unduly and exempt themselves and the least needy, an issue that needs to be evaluated and addressed. (d) There is no mention demographic exemption, which is already in operation in some (probably not all) facilities under Kenya’s Cost Sharing Program, e.g., children under 5, pregnant mothers, persons beyond 65 years of age.

51. **Extra-Budgetary Sources of Financing:** Premised on the assumption that the Kenyan economy will grow at least modestly, the Strategy dwells lengthily on extra-budgetary sources of financing as a potential source of health sector funding. If this premise proves to be too optimistic, the robustness of extra-budgetary funds is in doubt. Aside from this issue, the following also need to be raised. First, the focus in most of the section is on informal/agro-based health insurance schemes. This GoK thrust need to be supported, but caution must be exercised as these schemes are very expensive to sustain (i.e., they involve high administrative costs since there are no existing collection mechanisms and the institution-building requirements can be immense), the risk-sharing

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13 The results of the National Health Accounts exercise should be used in this section and throughout the Strategy paper as it provides the most recent and comprehensive picture of the sources and uses of funds in the health sector.
potential may be limited due to modest contributions, and thus cross-subsidy mechanisms may be slim. It is important that their feasibility be established before any large-scale adoption. A qualified, rather than unqualified, commitment may be called for in the Strategy with respect to these schemes.

52. A more important issue is the expansion and strengthening of formal-sector insurance, especially the National Hospital Insurance Fund (NHIF). The Strategy deals with NHIF peremptorily and does not dwell lengthily on the many issues that need to be resolved in this insurance program, e.g., increasing hospital reimbursements consistent with the Fund’s collections and reserve position; greater monitoring of the claiming of primary-care providers; and improvement in claims processing and payment. The proposal to transform NHIF from an indemnity coverage into a managed care operation is much more technically daunting than what the Strategy suggests, as such transformation has serious implications on consumer and provider patterns of behavior, assignment of primary care providers, information systems requirements, and actuarial and cost analyses to support contract fee negotiations.

53. Costing of the Strategy: The costing of the health interventions should be made in the context of the MTEF initiative. In fact, the MTEF should be the costed budget of the Strategy. Ideally and eventually, the MTEF should reflect all resources coming into the public sector (GoK budget, donors whether they appear in the development or recurrent budgets, user fees, NHIF reimbursement to GoK facilities, other community contributions), and should reflect all the activities identified in the Strategy. This then becomes the fundamental basis for a SWAp.

54. Organizational and Institutional Factors: The Strategy has to articulate the role of MoH under emerging challenges posed by decentralization, a growing private health care market, new forms of donor and NGO partnerships with the Ministry, and the persistence of epidemics even as new health conditions are arising due to changes in demographic patterns (e.g., increasing adolescent problems), urbanization (e.g., pollution, crowding, sanitation, lack of water, accidents), and lifestyles (e.g., sedentary life, tobacco, etc.). What is MoH going to look like in the next 5-10 years if it is to carry out its mandate under this new environment? This discussion is missing in the Strategy and need to be developed. The discussion can then lead into the following challenges and issues: (a) Decentralization; (b) Mission/NGO partnerships; (c) Regulation of private for-profit and non-profit providers (missing item); and (d) Relationship with donors (missing items on SWAp and donor financing).

55. Given the above, this section can conclude with the “new role” of the MoH departments, and what needs to be done to strengthen them:

- Planning and Policy Development (including regulation, which is missing);
- Budget Department (especially MTEF work and fiscal decentralization, which is missing);
- Health Financing (work on health insurance, user fees, and donor financing); and
- Information Systems (which becomes very critical under the MTEF and the SWAp).
V. A Way Forward

56. The MTEF exercise needs to be revived and the MoF clearly wants to put it back on track at MoH even as the macro issues remain pending at the Office of the President. MoF staff feel that the health sector is generally well circumscribed to be able to do much of the MTEF work, and that certain pending decisions (especially with respect to human resources) could be dealt with in the preliminary MTEF budget through heuristic or ballpark figures. In our view, the following could be done in the immediate and short term to improve the MTEF.

57. We recommend that the MoH revive the MTEF Task Force, consisting of representatives from Planning, Budget, Finance, Health Financing, Administration/Personnel, and the HSRS (preferably involving a subgroup of staff directly involved in putting together the NHSSP). The Task Force should be the locus of MTEF work within the Ministry, meet with PS on a regular basis, and encouraged to touch-base with, and learn lessons and good practices from, other technical ministries (e.g., Education) whose MTEF appear to be on track (see Box).

The Ministry of Education (MoE) MTEF is an ongoing process and provides a good role model for MoH in its own MTEF work. The following factors appear to have assisted in providing a facilitative environment for the Education MTEF. First, MoE has developed an Education Masterplan that has been discussed and commented on widely within the Ministry and is the basis of the Ministry’s “core activities.” Second, the Teachers’ Service Commission which has the mandate to recruit, assign and deploy teachers, has had the prescience to invest in a good database which generates good staffing and costing data used for planning and modeling costs of operation (e.g., salary increases of teachers). Third, MoE does not have as many projects as MoH; its development budget is not as problematic as MoH’s, which has been plagued by too many projects that it cannot monitor. Fourth, school construction is the purview of the community; MoE involvement is limited to deploying the teachers for the completed school. MoH staff claim their Ministry’s work is far more complicated than this, e.g., health infrastructure is more complex and the cadre of health workers is far more extensive.

58. A clear priority for the government as well as with donors is to finalize the National Health Sector Strategic Plan. The review of the existing draft has to incorporate the comments made by partners. The issue of stakeholder involvement in the development of the plan which was raised by donors can be resolved quickly with MoH conducting the requisite consultations, which need not be comprehensive and expensive,

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14 This position is understandable but it underestimates the gains that can arise from top-level restructuring. Under a nationwide right-sizing, there would presumably be “savings” that can be gained from the eliminated or reduced ministries, and such “savings” can then be applied to the productive or social sectors, including health.

15 There is an MoH MTEF/MPER Committee consisting of all the heads of departments and units (around 15), plus representatives of the Kenya Medical Training Council and the Kenyatta National Hospital. The Committee met for a fifth time on August 6, 1998. The effectiveness of the Committee, however, has been diluted by a number of factors explained in Section III of this report.
but focused and representative. Finally, the content of the sections on Strategy’s technical and service delivery interventions need to be beefed up. In our view, this can be expedited by:

- Having a common working knowledge and vocabulary of the strategic thrusts of the Ministry especially with respect to the MTEF and the SWAp that both MoH and donors want to pursue.

- Writing the departmental sections as “log-frames” of specific departments, with a common outline, a comparable level of ideas and suggestions, a congruence of anticipated outputs, and a standardization of inputs and their nomenclature.

- Seeing all proposed activities in a prism of “core function” of each unit/department, i.e., any activity should relate to or support a “core function”.

- Making sure that department heads understand that their “core functions”, outcomes, and activities should lead to a better budget framework called the MTEF, i.e., the MTEF is nothing but the budgetary translation of the Strategy.

59. Like any major government undertaking, it is important to set and manage realistic expectations within MoH and donor-partners on the nature, requirements, and implications of the MTEF process. MTEF is often viewed as the macroeconomists’ way of “managing by ceilings and ratios.” There are critical technical and consultative activities that need to underpin this process and the eventual ceilings and ratios, and these processes do indeed take an often inordinate amount of time. Determining the “core functions” of government requires the development of a sector strategy which can take anywhere from 2-3 years (Uganda, with 17 versions) to 5 years (Tanzania, with a series of government-donor annual assessments since 1994). Costing the strategy can take anywhere from a few months to 1-2 years; the process gets even more protracted if a thorough cost-effectiveness and burden of disease analyses are conducted. Translating the costing results into budgets, and then into appropriate sector ratios, can involve another year especially if the budget needs to be rewritten and re-coded (as in Malawi, which did not do costing but went ahead and restructured the budget items to reflect priority activities).

60. Work should continue on the DfID-supported budget analysis, especially those related to the standard costing of services provided by typical facilities by each level of care and the formulation of resource allocation criteria for districts. Results of these two analytical exercises can be used to inform the larger context of costing of GoK’s core functions, activities and services in the health sector, as laid out in the Strategy. The issue of human resources and MoH structure, which remains pending with the Cabinet, can be dealt with heuristically by using existing and assumed salary levels and positions which can then be presented to MoF in the form of various scenarios, for the Treasury’s approval. All these costing activities, if properly conducted and applied, can result in a dramatically better recurrent budget.
61. There is a need to develop a medium-term resource envelop (3-5 years) that takes account of financial flows in the health sector that are within the manageable interest of the GoK. These include the health budget, extra-budgetary expenditures including fee revenues and hospital reimbursements from the NHIF and other insurers, and donor resources. The MoH group that worked on the NHA is a natural locus of responsibility for bringing together all the information needed to formulate the sector’s resource envelop:

- **GoK budget** – There is a need to conduct forecasting exercises, using macroeconomic trends and other useful information, on the likely level of budgetary resources flowing into the health sector. This effort could be supported by IDA under any of its existing macroeconomics initiatives. The MTEF exercise requires that MoF provide technical ministries with a solid and reliable budget constraint that they can use “to contract” with their constituent facilities and agencies.

- **User fees** – MoH’s Health Financing Department regularly collects information from districts and facilities on the magnitude and uses of these revenues. While actual revenues are important, it is also critical to know the resource-generation potential of this program, and how much of the collections are leaked through various forms. A revenue targeting exercise will prove useful in this regard and should be conducted on an annual basis. The results of such an exercise can be used to improve collection efficiency and to inform MoH of what services or commodities at the peripheral levels can be financed under this program (thereby eliminating the potential of “double funding” from the budget and from fee revenues).

- **Health insurance reimbursements** – NHIF reimbursements to member patients and participating hospitals continue to be far less than what existing Fund collections and reserves tend to indicate. The MTEF process needs to take account of this still largely unrealized source of hospital financing. This is critical in view of the National Health Strategy’s focus on the financing of core health services, implying that more expensive secondary and tertiary care will be increasingly dealt with under health insurance or prepayment arrangements. As an initial step, MoH should examine the magnitude of current reimbursements received by government facilities and work towards increasing such reimbursements consistent with the Fund’s financial position and reserve requirements.

- **Donors** – Donor resources flowing to Kenya continue to be a “black box” with little information officially being collected on the magnitude, recipients, and uses of these flows. An inventory of donor flows could be done that collects information on existing and planned or indicative commitments and disbursements by year over the next 3-5 years, the recipients of these flows (MoH, districts, nongovernmental organizations, others), their service foci, and whether the expenditures would be recurrent costs or capital investments.
Tanzania, Uganda, and Malawi now have preliminary data on these flows, which they are continuing to refine in support of the SWAp or of the MTEF process.

62. In respect to the resource envelop, we suggest that next year’s Public Expenditure Review change its focus from a retrospective examination of previous year’s health expenditures to a prospective “Public Expenditure Preview” that examines possibilities of MoH expenditures under alternative assumptions of budget resources, user-fee revenues and hospital reimbursements, donor commitments, as well as other available financing, based on information generated from the above activities.

63. The MTEF exercise could be vastly facilitated with the resumption of the stalled administrative project-by-project review of the MoH development budget which should culminate in an inventory and status assessment of MOH projects. The series of tasks entail (a) identifying which projects have been cancelled, postponed, or rescheduled, and providing a revised date of completion as well as estimates of financing requirements both for donors and GoK counterpart funding; (b) sorting out the development expenditures and extracting the real capital expenditures (investments) from those that are really recurrent-cost in nature; (c) adopting a consistent set of budget codes for the recurrent and development budgets; (d) conducting appropriate analyses on the “true recurrent” and “true capital” expenditures; and (e) providing necessary recommendations for project assessment and criteria for selection, e.g., it may be useful to have recurrent-cost assessments for new projects presented for GoK consideration. This exercise has to be as comprehensive as possible, especially in the listing of foreign-funded projects.

64. As part of the “cleaning up” of the recurrent and development budgets, MoH has to consider developing budget ratios consistent with the policy thrusts and “core functions” specified in the Strategy. At minimum, the completed MoH MTEF exercise should provide the following ratios over a three-year period starting FY00/01: (a) percent of the GoK recurrent budget devoted to the health sector; (b) percent of the recurrent health budget devoted to operations and maintenance expenditures; (c) percent of the recurrent health budget devoted to primary and basic secondary health services; and (d) percent of the recurrent health budget devoted to health services delivered at the district level and below.

65. The MTEF will also necessitate the formulation of new budget codes and formats consistent with the configuration of better-defined cost centers. The new simplified budget groupings proposed under the Budget Analysis study, Phase II appear reasonable and can be proposed to MoF. However, these new budget codes should be proposed in tandem with a clearer MoH notion of a “cost center,” i.e., the smallest segment of activity or responsibility unit for which costs are accumulated and whose head is accountable for the quantity and quality of services provided relative to the (operational) costs incurred by the unit. At present, the concept of an MoH cost center is loosely defined, e.g., there are Ministry staff paid from one unit or area but who may be working in another location, making it difficult to relate service outputs to expenditures.
Closely related to the above issue is the need to focus on sector-wide and cost-center specific performance measurement and monitoring.\(^{16}\) This long-term goal must start now for it is needed both under MTEF and the SWAp. The existing Kenyan health and management information system is not up to speed with the requirements of an MTEF, much less with the old requirements of the MoH\(^ {17}\). Pursuing an MTEF is basically akin to business re-engineering applied to the government sector’s core functions. Thus, there ought to be greater and more focused investment in the information system that supports such re-engineering, and its focus on performance monitoring. Malawi is undertaking an Integrated Financial Management Information System or IFMIS at MoF to support the MTEF work there; in tandem with this activity, MoHP’s redefined its cost centers and adopted new budget codes. Tanzania has also embarked on an Integrated Financial Management and Accounting System or IFMAS which allows tracking of payments against specific programs and activities and is envisaged to evolve into a relational database system that permits analysis of proportional spending according to source of funds. These efforts are at an early stage, but there is an increasing recognition of the need to capture fiscal as well as physical performance data, ideally in a relational way, so that the performance of various levels and facilities can be compared with each other and that appropriate incentives or sanctions can be provided to those accountable for delivering performance.

This brief review focused on the budget preparation stage of the MTEF process and did not dwell lengthily on aspects related to budget execution, monitoring and evaluation.\(^ {18}\) Secondly, the review focused on the macro requirements of MTEF and did not cover the fiscal aspects of health service decentralization.\(^ {19}\)

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\(^{16}\) In an interesting observation, Jeffrey Fine (1999) notes that “performance auditing” in Africa is “now largely conducted under the rubric of public expenditure reviews” mostly funded by donors and “largely carried out by externally based professionals” resulting in “little ongoing feedback into the [domestic] decisionmaking process… Another serious drawback has been failure to disseminate findings in a user-friendly format to the general public.” We support Mr. Fine’s implicit argument for institutionalizing performance measurement and auditing, beyond the usual auditing of government funds.

\(^{17}\) The Health Management Information System (HMIS) is in a very poor state and the Ministry’s HMIS Unit need to be dramatically strengthened. Service statistics are not reliably collected nor disseminated. In addition, financial data are unintegrated (extra-budgetary revenues from fees and hospital reimbursements are collected and reported separately from budgetary expenditures, and reporting of both are very uneven across facilities). Personnel data are incomplete. Data on assets (status of health infrastructure) are nearly nonexistent.

\(^{18}\) In brief, this would require (a) capacity to monitor actual MoF allocations and releases, MoH disbursements, and expenditures at the facility or cost-center level during – not after – budget execution; (b) ability to identify any pressure points on aggregate disbursements as well as facility-level “wrangling”, and to inform affected facilities or contractors; and (c) ability to reconcile actual expenditures with budget estimates in a timely (within the budget year) and public (transparent) manner.

\(^{19}\) MTEF in Kenya has been associated, whether rightly or wrongly, with “right-sizing” the government. On the other hand, decentralization may, in fact, lead to a larger government service, as many central-level functions (procurement, financial management, etc.) are often replicated at provincial or district levels. These are complex issues beyond the scope of this brief review paper.
VI. Lessons from Other African Countries

The MTEF exercise in Kenya can learn from similar experiences in the region. The intention of this brief review is to impart good practices and to learn from the mistakes that neighboring countries made. A review of these experiences yield the following key points:

- MTEF is as much a political process than a strategic, technical and financial one. Strong political will can sometimes compensate for relatively weaker technical capacity.

- MTEF needs to be underpinned by good quality technical work. However, it is difficult to line up all the necessary technical inputs before the launching of the MTEF exercise, and what may happen is that MTEF may become a “learning-by-doing” exercise, which is not unproductive in itself for as long as MoF and the line ministries do not lose sight of the ultimate objectives of the budgetary reform.

- MTEF should also be underpinned by a solid sector strategy which has the support of all partners. Discussions on a SWAp and its attendant elements can provide the impetus for this budgetary reform process, and the goal of a budgetary support program can indeed be an important incentive for the government.

- The technical requirements and sector implications of an MTEF are complex, difficult, and far ranging and need to be explained as comprehensively as possible to the host government and donor partners. The timelines of MTEF are frequently underestimated, and expectations for implementation and results have not been managed well, leading to frustrations of all involved. The costs of budget reform have been particularly de-emphasized.

- Governments and donors are often confused by the co-existence of initiatives (“health sector reform”, “sector-wide approach”, “MTEF”) which may use different terminologies but which often have very (if not exactly) similar objectives. For instance, a health specialist’s “essential package” is synonymous to the macroeconomist’s “core function”. One donor’s “policy-based lending” may be another donor’s “nonproject assistance”. A well-developed SWAp financing and expenditure plan is, by definition, the MTEF. There is certainly a need for more education of all players on the similarities, and differences if any, of these initiatives.

- The MTEF and SWAp processes, at least in the four African countries reviewed, appear to have involved the Planning Commissions much less than they should be. There was not enough time to examine this issue, but since much of the development budget (read: donor projects) is still in the purview of the Planning
Commission, there is clearly a need for greater synergy. But these commissions appear to have even less institutional capacity than the technical ministries.

69. **Uganda:** The government re-introduced the MTEF with three-year ceilings covering each sector and vote in FY98 and the ceilings were published as part of the draft estimates in June 1998. The MTEF projections are becoming a key planning tool and have given line ministries the basis to discuss realistic medium-term sector plans.

- In health, the MTEF projections formed an essential foundation for the government’s preliminary discussions with donors on the minimum essential health package in December 1998, and the broader Health Sector Investment Plan in April 1999. The MTEF projections were aided by the NHA work that produced estimates of the resource envelop (government + donor flows) for the health sector.

- Devolved districts are starting to develop their own budget plans and framework using as input the likely level of available resources from the central government. The exercises are far from complete because the district authorities have to do a thorough inventory of all the resources coming from various sources (including donors) but there is a clear desire to go in this direction.

- Although there continues to be disagreements on the specific elements on the essential package of health services, the government is committed in moving in this direction, defining its core functions around them, and providing specific MTEF budgetary ratios so that funding for such essential services are protected.

- It is not clear to what extent the approved restructuring of the MoH aided in the development of the MTEF but the transition to a new structure certainly did not impede the MTEF process and did not seem to have any visible negative effects on staff morale (in contrast to the case in Kenya where it does). Strong and uninterrupted MoF and MoH leadership in Uganda, even under relatively weaker institutional capacity than Kenya’s, certainly yielded good results.

- There is an increasing common understanding of a sector-wide approach among partners including the centrality of the MTEF and the government budget in moving towards a SWAp. As a demonstration of such understanding, the government is devoting considerable attention to the costing of the investment plan for the health sector.

70. Ranged against these positive developments, there continues to be major challenges to the Uganda MTEF process:

- The health strategy was formulated quite contentiously over a period of two years within the MoH as well as with donors. Sticking points have to do with the long list of the essential package of health services (which has since been
cut into a “core” package) as well as specific interventions that some partners were in doubt of supporting, e.g., nutrition rehabilitation, mental health, and some aspects of maternal health. Refinement of the package is expected to continue as part of the government-donor dialogue.

- The existing costing of the Health Sector Investment Plan remains problematic for a number of technical reasons (facility-based rather than program- or service-based costing, time horizon that is too short to be realistic, top-down costing approach that ignores key implementation-capacity issues, missing items on facility rehabilitation). Further refinement of the costing exercise need to be done so that it can be translated into financing and implementation plans that donors and the government can agree on.

- Extra-budgetary sources of funds (chiefly user fees) continue to be severely underestimated owing to the absence of a national health financing policy that makes fee programs virtually “underground” operations.

- Last year’s health PER was weak, and it appears that the MTEF process has proceeded way beyond the PER work. Problems on data quality and scarcity and lack of a strong focus of these health PER exercises make them less influential than they could be.

- The devolution of health services to district authorities will continue to challenge central authorities’ (MoF, MoH, Ministry of Local Government) ability to influence the peripheries’ decisions on the funding of priority health services as stipulated in the health strategy and investment plan. The central government has developed quite a sophisticated set of fiscal instruments (conditional grants, unconditional grants, delegated funds, and equalization grants, in addition to district authorities’ constitutional mandate to generate local revenues) which require intensive monitoring to ensure that they are used for the purposes they were intended.

71. **Tanzania:** The MTEF was launched in FY99 although activities supportive of the health MTEF have been going on for most of the 1990s. The Health Sector Reform (HSR) Program has been recast into a three-year Program of Work and a one-year Plan of Action that both the government and donors will fund, some through parallel financing and others through joint financing that is expected to start modestly in FY00. Tanzania’s development of its sector strategy, the attempt to convert elements of the strategy into a SWAp operation, and finally to mainstream these activities into the budget – these exemplify a “learning-by-doing approach” to health sector reform whose history was marked by a number of missteps but which is expected to lead eventually to a budget support program. In our view, the missteps leading to a protracted process were the following:

- The HSR Program was envisioned by the government as a set of “projectizable” activities that it can present to donors for funding, i.e., the HSR
was seen as another discrete project. The costed activities did not have any relation to the budget, and in fact key budgetary items (either recurrent or capital) were missing in the original financing plan, an omission that is being corrected.

- The series of joint government and donor missions that assessed the HSR Program between 1995 and 1998 were too focused on specific reform strategies and activities rather than on the overall financing of the sector and the approach to be taken to achieve such financing and budgetary reallocation. Thus the strategies and activities were constantly refined while the overall sector financing was largely ignored, and the financing modality for donor involvement was not given much attention until early 1998 when the SWAp idea was introduced and both government and donors tried to have a common understanding of its requirements.

- The highly diffuse and disaggregated nature of donor financing, as well as the multiplicity of budgetary flows within government itself, made it extremely difficult to get a good grasp of the overall financing of the sector, and how it can be improved.

- Initiatives that the donors wanted to pursue (e.g., joint district financing) could not be expedited as the policy framework on local government reform and civil service reform were still being worked out. Coordination and harmonization of HSR with these two reform areas required a herculean effort.

72. Despite these difficulties, the HSR process is moving forward due to a visible government leadership and political commitment in the process, a sustained and relatively well-coordinated donor involvement in the reform dialogue, and a strong sense of Tanzanian ownership of the reform agenda. These factors appear to have overcome the relatively weak institutional capacity within MoH.

73. The key action that need to be done is how to mainstream the HSR activities and costing into the regular government budget. Specific HSR activities have been assigned to relevant MoH departments and work is ongoing so that a unified budget, inclusive of those to be funded by donors in the HSR program, is produced. It is expected that next year’s MTEF ratios will be amended to take account of these factors. Meanwhile, analytical work funded by various donors to further strengthen the MTEF continues, including: a study on performance output indicators in the health sector; a study to project recurrent cost requirements in the health sector; and a study on the financial tracking of health sector expenditures.

74. **Malawi:** In response to the extremely tight budget situation, in FY95 Malawi’s Ministry of Health and Population (MoHP) became one of the four ministries to do an MTEF for the purpose of keeping health services in line with available budget resources. Despite initial difficulties, positive elements have been incorporated to rationalize the MOHP’s public expenditure management, but these were often difficult to achieve in practice:
- Development of sector objectives – In the second year of MTEF, MOHP conducted a log-frame exercise, developed sector objectives, and initiated the move away from incremental budgeting towards a more programmatic approach. On the basis of current program portfolio, however, it appears that the log-frame exercise was used to justify cramming all the existing programs within the framework, rather than used as a device to prioritize.

- New budget accounting system and classification – The old budget system reflected accounting inputs. In FY96, a new budget system was put in place that lumped similar institutions and functions together based on the concept of a “program”; the definition of cost centers also clarified financial responsibility. The new system is viewed to be more transparent and has a greater focus on performance.

- Cash budgeting – In theory, the introduction of cash-budgeting and lump-sum releases under MTEF should have encouraged ministries to prioritize their spending. However, it appears that cash budgeting may unduly create adverse incentives to spend quickly. It can also engender aggressive lobbying by program managers and hospital directors who can subvert “reformed” allocations based on strategic considerations.

- Stoppage of virement – MoF has stopped ministries from using a line item to fund expenditures in another line item which has been exhausted. In theory, the prohibition of virement is intended to instill fiscal discipline but in practice, the policy can be rendered ineffectual by the delay of releases to specific programs or budget items; virement may also reduce a program manager’s ability to meet emergencies and contingencies.

75. After three years of continuous MTEF work in Malawi, the budget system continues to show the following weaknesses:

- It is still unable to make a clear distinction between public and private goods. The log-frame exercise attempted to thresh out this issue but it did not suffice. The problem was that there was no national health strategy, approved by all stakeholders, that clearly specified the government’s core functions, as supported by analyses. The MoHP is currently finalizing the health sector strategy which, when concurred to by donors and other stakeholders, should provide a stronger basis for defining the government’s core functions in health.

- The costing of priority (core) programs remains incomplete, and the timepath to achieve the targets have not been defined.

- The development and recurrent budgeting exercises remain bifurcated (coordinated by different government agencies), and frequently inconsistent. Donor-funded expenditures remain reckoned within the development budget, even tough much of these expenditures are recurrent in nature.
• “Buy-in” at the political level could be made far stronger than it is now. The health sector continues to suffer from political constraints especially with respect to capital investments which are often accepted from donors with little regard for their recurrent-cost implications.
References


List of Persons Met

From the Ministry of Finance: Mr. Daniel M. Amanja, Senior Economist, Budgetary Supply Department; Mr. G. N. Gicheru, Director of Budget; Mr. Dunstan Maina, Deputy World Bank Desk Officer; Ms. Phyllis N. Makau, Economist;

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20 This is a list of persons met; they do not necessarily share the views and opinions expressed in this document.