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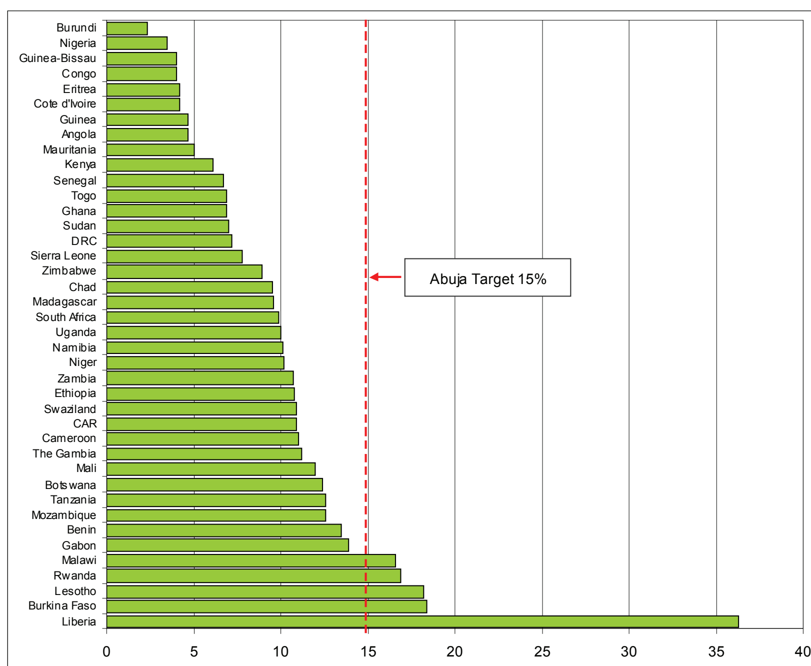
Harmonizing Budget Cycles: Lessons for Health Advocates

Government spending on health remains low in most African countries. In 2001, African heads of state committed to the Abuja target to spend 15 percent or more of government expenditure on health. As of 2005, only five African countries had achieved this target (Figure 1). Why? One obstacle is the misalignment of the national and health budget timelines, which leads to a vicious cycle of under-spending and under-allocation of public funds for health. Kenya's story of misaligned budgets, and the impact on health workers, commodities, and even health managers' enthusiasm for planning, may help other countries to fix an operational hurdle to increasing funding for health.

BACKGROUND

The government of Kenya in 2000 adopted the Medium-Term Expenditure Framework (MTEF) process to better align planning with budgeting and to ensure that the budgets are consistent with policy objectives as stated in the national and sector development plans (Box 1). To firmly establish the MTEF process, the Ministry of Planning and National Development was tasked with building capacity in line ministries and developing guidelines for the MTEF process. The guidelines developed envisaged harmonization of the line ministries' planning process with that of the central government.

FIGURE 1. PROGRESS TOWARD THE ABUJA TARGET: COUNTRIES OF AFRICA, 2005



Policy Brief

HEALTH SYSTEMS 20/20

Box 1. What is a Medium-Term Expenditure Framework?

The MTEF is a multi-year public expenditure planning exercise to set out future budget requirements for existing services, and to assess the resource implications of future policies and programs. The MTEF consists of a top-down estimate of aggregate resources available for public expenditure consistent with macro-economic stability; bottom-up estimates of the cost of carrying out policies, both existing and new; and a framework that reconciles these costs with aggregate resources. The MTEF can:

- Bring together policy-making, planning, and budgeting early in the budgeting cycle
- Encourage cooperation across ministries over a longer horizon
- Enhance stability by letting ministries and districts know what resources are available
- Encourage investment by making taxation, interest rates, and government spending levels more predictable
- Improve transparency by making public a governments' long-term policy goals and fiscal strategy

Sources: http://www.wemos.nl/Documents/whatis%20mtef.pdf, www.idasa.org.za/, http://www.dfid.gov.uk/Documents/publications/med-term-exp-fwks-intro.pdf

The MTEF introduced a bottom-up planning process with participation of districts and other stakeholders to ensure the center finances priorities identified by local communities. The line ministries are required to ensure that the guidelines are adhered to and all documents needed to support the process are produced on time. To this end, the Ministry of Health (MoH) started the Annual Operations Plan (AOP) process to inform the MTEF and to assist in the implementation of the second health sector strategic plan. To date, the MoH has prepared five AOPs.

However, after almost a decade, the MoH still initiates its bottom-up planning process too late in the year to ensure that the AOP informs and influences government allocations to health. This brief describes the current misalignment of the national and MOH cycles and its impact on public health funding and spending for critical inputs such as human resources and commodities; it then presents several practical improvements that are pushing the cycles into alignment.

GOVERNMENT OF KENYA PLANNING PROCESS – HOW IT SHOULD WORK

The Kenyan fiscal year (FY), which follows the standards of the East African Community, starts on July 1 and ends on June 30 of the subsequent calendar year. The national planning process for the FY starts when the Ministry of Finance (MoF) issues MTEF guidelines in September (see Table 1). Based on the guidelines, line ministries are required to start the planning process for the following FY's AOP, which when finalized (in April) will include input from the districts and participation of stakeholders in the sector.[1] As this is happening, the MoF begins to draft the Budget Outlook paper (BOPA), which sets the sector[2] ceilings in line with the country's Vision 2030.

The line ministries must submit their plans, Public Expenditure Tracking Surveys (PETS), and Public Expenditure Reviews (PERs) to the MoF in October so that these analyses inform the preparation of the final BOPA. After finalizing the BOPA, the MoF submits it to the Cabinet for approval. The approved BOPA is circulated to ministries in October/November.

The BOPA is the first important "window" for line ministries to influence how much funding will be allocated to their sector and consequently how much funding will be allocated to their ministry. Because sector ceilings in the approved BOPA are not subject to change, it is important that ministers are well briefed on resource needs well ahead of the Cabinet meeting to enable them to influence the sector ceilings.

In December, each sector working group (SWG) submits its initial sector report to the Treasury/ Ministry of Planning and National Development. Each SWG also arranges to start the resource bidding process (in line with the BOPA ceilings) among its

[1] *See Table 1 and next section for timeline of the MoH planning process.*
[2] *Current MTEF is stratified into 10 sector working groups. Health is part of the human resource development sector, along with education and other social sectors.*

TABLE 1: NATIONAL AND MINISTRY OF HEALTH PLANNING AND BUDGETING: TIMELINES MISALIGNED

Month	National Timeline	MoH Timeline	Lost Opportunities
July (FY begins)	MoF issues circular on management of funds	Issuance of Authority to Incur Expenditures (AIE) to implementing agencies	—
Aug/Sept	MoF issues MTEF guidelines for line ministries to begin planning MoF launches SWGs	—	—
Sept-Oct	MoF prepares the BOPA to set sector ceilings	MoH begins preparation of its AOP by conducting internal and external reviews of health system performance during the previous FY	—
Oct	MoF receives plans, PER, and PETS from line ministries. MoF submits BOPA to Cabinet Cabinet approves the BOPA, which sets sector ceilings	MoH submits plans, PER, and PETS to the MoF without input from districts due to lack of time	MoH's AOP not ready for this first "window" to influence the MoF as it sets the ceiling for the human resource development sector (health, education, and related social sector ministries)
Dec	Treasury and Ministry of Planning and National Development receive initial sector reports from the 10 SWGs	MoH participates in the human resource development SWG public hearings and resource bidding process – again without input from districts	MoH's AOP not ready for second window to influence the SWG bidding process to set ceiling for health
Jan	SWGs publish final sector reports. Treasury prepares BSP, which sets line ministry ceilings	MoH fails to initiate the staff replacement plan to fill staff vacancies and to initiate commodities procurement for coming FY, leading to late deliveries and payments, which MoF sees as under-spending	MoH AOP not ready for third window, the BSP. Also, ceiling for next FY will be adjusted downward to reflect under-spending in current FY
Feb	Cabinet approves the Budget Strategy Paper (BSP) and sends it to Parliament, which locks in the line ministry ceilings	MoH begins bottom-up district planning process with the District Health Stakeholder Forum to inform the AOP	District stakeholders' effort to plan and budget are too late to influence the two windows (in Oct and Dec) that determine the MoH budget ceiling set in Feb
Mar	Treasury issues circular to finalize MTEF estimates, Program-Based Budget (PBB), and line ministries' itemized budgets	District planning process continues	—
Apr	MoF finalizes the MTEF and PBB	MoH finalizes its AOP (including resource gaps) and MoH itemized budget	Final AOP not shared with districts, losing opportunity to mobilize funds from the Constituency Development Fund
May	Cabinet approves ministries' itemized budgets or printed estimates	Districts required to devolve (give back) unused funds to the Constituency Development Fund	—
June	Cabinet submits to Parliament ministries' itemized budgets or printed estimates	MoH hosts the Health Review Summit where the AOP is approved	AOP finalized too late to advocate when the two windows are open (in Oct and Dec)
July (new FY begins)	Parliament approves the MTEF, PBB, and ministries' itemized budgets and grants authority to spend	MoH initiates procurement of commodities and replacement of staff	Both processes take 5-8 months to spend funds, risking commodity stock-outs, unfilled vacancies, and under-spending (see Jan)

member ministries and, in collaboration with the MoF, organizes public hearings, which are attended by interested sector stakeholders: government ministries and agencies, civil society groups, donors, and the public. The stakeholder inputs from these forums are used to finalize the sector reports, which are published by January. Following completion of the sector reports, Treasury prepares the Budget Strategy Paper (BSP),[3] which sets the budget ceiling for each line ministry. In February, Treasury submits the BSP to the Cabinet for approval. The BSP along with budget policy statement are then forwarded to Parliament. The BSP, because it sets line-ministry budget ceilings, is the second important "window" for line ministries to influence how much funding will be allocated to their ministry.

In March, Treasury issues a circular for the finalization of the MTEF and Program-Based Budget (PBB) (Box 2). By April, line ministries must finalize and submit their itemized budgets and PBBs to the MoF. The MoF reviews and finalizes these two documents by May and submits the budget estimates to the Cabinet for approval. Upon approval by the Cabinet, the ministerial itemized budget and PBB are published, and finally, by mid-June, ministerial itemized budgets or printed estimates are presented to Parliament as per the Constitution. Parliament approves expenditures by a Vote on Account (which serves until the appropriation bill is passed in September/October), thereby kicking off the new FY on July 1.

Box 2. What are the Program-Based Budget, Annual Operations Plan, and Itemized Budget?

Kenya's PBB is a monitoring and evaluation tool that defines specific program outputs, outcomes, and key performance indicators for all line ministries that can be assessed and measured. The AOP is the MoH's annual operational plan, defining the ministry's objectives, targets, and resource requirements. The itemized budget is a detailed budget broken down into line items based on chart of accounts.

MINISTRY OF HEALTH PLANNING PROCESS – LOST OPPORTUNITIES

The MoH planning process starts in September with an extensive internal and external review (see Table 1, above); the external review includes input from stakeholders and consultants. These reviews look at the broad performance of the health sector in the past FY and identify key issues and priorities for consideration in the AOP for the following FY. The findings of the review process along with the MoH plans, PER, and PETS are presented to the MoF and other stakeholders at the national level, but due to time constraints, the findings are not widely disseminated to the districts. The MoH is not well positioned to influence the BOPA, which the MoF and Cabinet finalize by the end of November, effectively locking in the resource allocation to the human resource development sector.

The MoH begins the formal bottom-up district planning process in February through the District Health Stakeholders Forum. The MoH and district health officials finalize the AOP, including identified resources gaps, in April and the AOP is approved in a Health Review Summit in June. Unfortunately, this timing means the AOP is completed too late to influence the second "window" in December, when the human resource development SWG is conducting the resource bidding process with its ministry members. In addition, the AOPs are not presented to districts for alignment with resources available for the next FY. For example, the districts are not able to take full advantage of the Constituency Development Fund, which is given to constituents for development investments such as rehabilitation or construction of new health facilities, or purchase of new medical equipment. This poses challenges because implementing entities have to adjust their budgets and targets during the implementation process. For example, a district will be forced to spend less for nurses than they proposed

[3] *BSP contains the line ministries ceilings.*

in their AOP because that AOP was not done in time to inform the budget allocation to the MoH.

The failure to align the AOP and MTEF calendars and use the AOP in the resource bidding process has contributed to under-funding of the health sector. The persistent under-funding of AOPs is creating "planning process fatigue," especially in the districts, where AOP preparation consumes appreciable staff time without producing the requested resources. As a result, stakeholders are agitating for harmonization of the AOP and MTEF processes.

WHY MISALIGNED BUDGET CYCLES MATTER

Missed funding opportunities

Misaligned budgets undermine the effectiveness of advocacy for increased overall health resources in the MTEF process because information on resources needs required for advocacy is produced months after the resource envelope for the sectors and line ministries have been set in the BOPA and BSP. The health sector resource needs do not reach Parliament in time for Members of Parliament to influence resource allocation. For example, the MoH misses the opportunity to capture more Constituency Development Fund financing to upgrade the health infrastructure.

In addition, misaligned budgets lead to inefficient resource use within the health budget due to inadequate attention to long-term planning as health sector staff are busy preparing the AOP. This problem is especially serious in the case of funds earmarked for human resources and commodities, which constitute more than 60 percent of total MoH funds.

Delayed payments and commodity stock-outs

The delay in preparing annual procurement plans, and starting the procurement process after line ministries ceilings have been set, has contributed to late delivery of critical health commodities. Orders for drugs and supplies arrive as late as May or June, just when the accounts for the fiscal year are being closed.[4] Consequently, the unpaid bills for these late deliveries are rolled over to become the first charge in the next FY's allocations, reducing the resources available for that year's commodities (Box 3). As a result, the sector is forced to buy fewer medical commodities and trigger shortages in the supply chain. It is estimated that 10-15 percent of medical supplies are not paid for within the FY and are carried as pending bills.

http://images.google.com/images?hl=EN

The lack of harmonized budget cycles results in stock-outs of pharmaceuticals and other supplies, as these empty pharmacy shelves show.

Box 3. Vicious Cycle of Delays and Under-spending

Waiting to begin procurement orders until funds are actually available means that payment for procurements happens late in the FY, when resources are limited. The MoH ends up using next year's resources to cover this year's procurement costs

[4] *Funds not spent within a FY lapses and are not reallocated to the line ministry.*

Unfilled vacancies for health workers

Similar inefficiencies are found in human resource management. The public health sector employs over 35,000 clinicians and administrative staff, with 4 percent of its workforce retiring each year. The absence of a human resource replacement plan leads to staff vacancies, and payroll expenditures during the first half of the FY are less than the budget allocation. Because the mid-year revisions are based on the first six months' expenditures, the MoH receives less for staff emolument, thereby constraining its ability to fill the vacancies. Consequently, there are fewer health workers, which compromises service delivery. This is worse still because the personnel line item is non-fungible and any unspent funds cannot be reallocated to other line items. This problem could be resolved if the MoH were to anticipate vacancies and start the replacement process once allocations for personnel have been set in the BSP.

Health funds "left on the table"

The delays and under-spending cited in the two cases above reduce the MoH's ability to advocate for additional resources from the government. The MoF has very good information on MoH expenditures and cites the MoH's under-spending and inability to absorb[5] more resources as the reasons for not increasing its funding for a FY, and even reducing an allocation mid-year. Development partners also have cited low absorption capacity as a factor for not allocating more funds to the health sector.

CALLS FOR REALIGNMENT

For health planning to be harmonized with MTEF-based national planning, the MoH should start the bottom-up district planning process in Feburary, so the MoH can produce a draft AOP by September/October; this would allow it to influence the sector ceilings set by the MoF in October, the SWG resource bidding process in December, and the Treasury's setting of line ministry ceilings in January.

Over the past three years, health sector stakeholders have debated how to revitalize the health sector through a Sector Wide Approach (SWAp), which would require improved coordination under a single, common planning framework. Such a framework will require government planning procedures that enhance efficiency and accountability.

As part of this process, stakeholders have agreed to harmonize the health sector planning process with that of the central government. A schematic representation of the harmonized process has been developed (see Table 2) and steps taken toward its implementation (see below). The government and its partners are developing a Joint Financing Agreement, which is also lending momentum to the realignment effort.

http://images.google.com/images?hl=EN

A harmonized budget cycle will allow for timely procurement of pharmaceuticals and other medical supplies.

[5] *The 2009 PER showed the public sector's recurrent budget performance in terms of budget versus actual expenditure averaged almost 94 percent, while that of the development vote averaged 52 percent. (The "development vote" finances capital projects and budgets all donor funds, both capital or operating.)*

TABLE 2: NATIONAL AND MINISTRY OF HEALTH PLANNING AND BUDGETING: TIMELINES ALIGNED

Month	National Timeline	MoH Timeline
July (FY begins)	MoF issues circular on management of funds MoF issues MTEF guidelines for line ministries to begin planning	Issuance of AIEs to implementing agencies
Sept-Oct	MoF prepares the BOPA to set sector ceilings	MoH finalizes the AOP for FY+1*; and hosts the Health Review Summit, where the AOP is approved
Oct	MoF receives plans, PER, and PETS from line ministries, incorporates information into the BOPA, and submits the BOPA to the Cabinet Cabinet approves the BOPA, which sets sector ceilings	MoH submits PER, PETS, and AOP for FY+1, reflecting input from districts, to the MoF
Dec	Treasury and the Ministry of Planning and National Development receive initial sector reports from 10 SWGs	MoH participates in the human resource development SWG public hearings and resource bidding process with AOP reflecting input from districts
Jan	SWGs publish final sector reports Treasury prepares BSP, which sets line ministry ceilings	
Feb	Cabinet approves the BSP and sends the BSP to Parliament, which locks in the line ministry ceilings	MoH begins in FY0** bottom-up district planning process for FY+1 with the District Health Stakeholder Forum to prepare the AOP
Mar	Treasury issues circular to finalize MTEF estimates, PBB, and line ministries' itemized budgets	MoH initiates in FY0 procurement of commodities and staff replacement for FY+1 based on BSP projections
Apr	MoF finalizes the MTEF and PBB	
May	Cabinet approves ministries' itemized budgets or printed estimates	Districts align in FY0 their plans with the ministries itemized budget for FY+1
June	MoF submits to Parliament ministries' itemized budgets	
July (new FY begins)	Parliament approves the ministries' itemized budgets and grants authority to spend on Vote on Account	MoH positioned to spend its budget quickly and efficiently on staff and commodities Districts embark on implementation of their plans

** FY+1 refers to next financial year*
*** FY0 refers to current financial year*

PROGRESS ON REALIGNMENT

While formal realignment is being worked out, the MoH and its development partners have begun to prepare a "shadow budget" that includes programmed on- and off-budget resources for the health sector. The estimation of off-budget resources looks at when these resources will lapse, thereby enabling the MoH to plan for their phase-out or their sustainable takeover by the MoH, the latter of which calls for MoH advocacy for additional funds through the government budgeting process. The shadow budget has become a critical input to the MTEF process in terms of guiding resource allocations to priority areas, identifying under-funded interventions, and mobilizing additional resources for the health sector. Efforts are being made to institutionalize the process of preparing the shadow budget at least once a year. This process is supplemented by National Health Accounts (NHA) institutionalization, which aims to harmonize data collection tools on health expenditures. Once the harmonized tools have been adopted by stakeholders, it will be easier to regularly prepare shadow budgets and PERs.

Several other practical steps have been taken to make the planning process more meaningful and ameliorate problems that result from the misaligned budget cycles:

- Recognizing that the districts are losing faith in the planning process and are simply recycling old plans, the MoH has adopted a resource-constrained planning process based on ceilings set in the MTEF. It is hoped that through this process, districts whose capacity is limited will prepare a single plan based on their resource envelope, thereby eliminating the need for revision and give them more time to focus on implementation and service delivery.
- On personnel, the MoH has analyzed the Integrated Personnel and Payroll Database (IPPD) and established that approximately 1,000 health workers retire every year. The MoH has sought authority to replace retired workers, a positive move to ensure funds allocated in the MTEF are fully utilized. However, this process needs to be synchronized with monthly retirement data to ensure that there is no delay in replacement once a person retires.
- Recently, as part of streamlining the Kenya Medical Supplies Agency, the MoH is considering the institutionalization of the medium-term procurement plan and introducing a biannual procurement plan linked to the MTEF in order to increase absorption of funds earmarked for medical supplies and minimize commodity shortages.

CONCLUSION

The misalignment of MoH and central government planning cycles reduces the MoH's ability to advocate for additional funds for the health sector, because information required for advocacy is not provided in time. Under-spending in critical areas such as personnel and commodities, further puts the MoH capacity to absorb more resources in doubt. The issue of alignment of the two cycles continues to be under discussion. There is now an agreement under the Code of Conduct that the "annual health planning process will follow the government of Kenya timelines." Efforts are being made to align the two cycles to increase absorption capacity and reduce planning fatigue in the districts.

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