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First Do No Harm: Is Government Minding Our Health As it Devolves?

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Executive Summary

Kenya's devolution is now upon us. From March, 2013 counties will come into existence, and begin to run some of their own affairs. Over the next three years, they should be given the money and power to run all of the responsibilities outlined in Kenya's 2010 Constitution.

Although the first big step in the transition to a two-tier system of government is imminent, little is known about exactly what counties will be doing and how much money they will have to provide specific services. This is a matter of serious concern, because counties have core responsibilities in health, housing, energy, agricultural and a number of other areas. In many of these sectors, they share obligations with the national government.

Devolution in other countries has proved challenging when there is a lack of clarity about which level of government is responsible for which services. This is often linked to inadequate funds at different levels of government to deliver services. In light of this, it is imperative that the process of assigning responsibilities to each level of government be transparent, clear and detailed, and that it be easy for citizens to see that each level of government is receiving adequate funding.

In Kenya, the Transition Authority has been given the ultimate responsibility for determining exactly which functions will fall under each level of government. Kenyans are still waiting for the TA to complete its analysis and provide the results of its work to the public for debate. Our analysis is intended to provide an assessment of all available sources of information on Kenya's functional assignment at this time in order to help the public understand and debate these issues while we wait for the Authority to finish its work. In addition, we hope our analysis can help orient public debate about the Authority's outputs when they are finalized.

This Brief focuses on the health sector. We chose health because it is the most important and expensive social sector to be devolved, and it is one where the consequences of failures in service delivery can have a big impact on people's lives. Uncertainty about who is responsible for what in the health sector could potentially result in drug stock-outs, breakdown of morgues and cemeteries, and rubbish accumulating in public spaces and spreading disease.

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Our Brief finds that available sources of information are inadequate and contradictory. There is lack of clarity both about the functions that will be carried out by each level of government, and about the process for determining these. There is also insufficient information available about the costs of delivering key services and how funds will be shared between levels of government.

The information that is available is difficult to understand and the proposed division of functions and funding does not follow any obvious logic. We highlight a few areas of particular concern:

- It is not clear who is going to run provincial hospitals.
- Responsibility for recurrent and development expenditure for the same activities is divided between national and county governments. This is inconsistent with the recommendations of the Taskforce on Devolved Government and may lead to serious coordination problems.
- Some services that clearly require national government to play a role, such as management of the health information system, appear to have been fully devolved in terms of financing in ways that threaten their sustainability.
- Various services, such as nutrition and the National Aids Council Programme, seem to be arbitrarily divided between national and county government in ways that lack adequate explanation and may undermine accountability.

Our broader concern is that the process of transitioning to a new structure of government, and the sharing of responsibilities across the two levels of government, has not been sufficiently transparent or participatory. This is inconsistent with the spirit of the Constitution.

Going forward, we call on Treasury, the Transition Authority and all service ministries to:

1. Release any existing documents explaining their views on the correct division of responsibilities between the two levels of government
2. Release all information related to the cost of delivering services.
3. Provide a narrative explanation of why certain functions and finances have been assigned to certain levels of government, and explain how this is consistent with the Fourth Schedule and the principles proposed by the Taskforce on Devolved Government.
4. Highlight the implications of this proposed division of functions for all major programs that provide services to the public so that citizens know who will be accountable for running these.
5. Organize a series of open public consultations by sector (e.g., health, education, agriculture, etc.) on the sharing of responsibilities between levels of government at which the public is properly informed about the key issues and given an opportunity to provide feedback.
6. Revise the overall distribution of functions and financial flows in accord with substantive feedback received from the public on the appropriate distribution.
7. Provide a detailed timeline for the implementation of Steps 1-6.

We hope that the analysis in this Brief, which looks at budget and policy and planning documents from one sector, provides a guide for how citizens can conduct their own review of the information they receive from government in the sectors they care most about.

1. Introduction

From March, 2013, the dream of devolution in Kenya will become a concrete reality. This we know, but what kind of reality? All that is certain right now is that there will be elected governors and county assembly members on March 4. But what will they be responsible for and how much money will they have to implement these responsibilities?

The Constitution and the Transition to Devolved Government Act 2012 provide for a phased transition, over a period of three years, to full county control of all of the functions that have been assigned to them under the Fourth Schedule of the Constitution. The Transition Authority is required to certify the first set of functions that will be transferred by February, 2013. This means that counties will not immediately be responsible for the many services that they are eventually to control.

Although the Constitution divides responsibilities between national and county government in broad terms, this list of responsibilities is not specific enough to determine, by itself, exactly what each level of government should do. This is true both because not everything that government does is listed in the Fourth Schedule, but also because of the complexity of delivering public services.

If the Constitution does not explicitly list a responsibility, this means either:

1. It is considered to be part of a responsibility that is listed (for example, “immunization,” which is not listed, might be considered part of “promotion of primary health care,” which is listed),
or
2. It will be considered a national responsibility.

How do we know which of these two is the correct interpretation? There is no right answer, but the solutions will require public discussion. Clearly, there will be debate over this issue in a number of cases. These debates may even lead to court cases, leaving the ultimate decision with the judiciary. Table 1 below provides a few examples of the challenges in using the Fourth Schedule to determine who is doing what.

Why does all of this matter? First, we need to know who is doing what to make sure that all of the services people need continue to be delivered. We do not want schools or hospitals to close because of disagreements about who is in charge. So we need to clearly list out everything that needs to be done and who is going to do it.

Once we do that, we also need to make sure that we know how much it costs to do all of these things. We need to be certain that each level of government has the money it needs to deliver whatever services it is responsible for. In other words, if counties are to do X, Y and Z, they must receive sufficient funding to pay for those services. And if national government is to remain with U, V and W, the same holds.

If we don't have clear roles and responsibilities and the right sharing of resources, the results can be disastrous. For example, we know that counties are responsible for some health services and national government is responsible for others. Suppose that there is disagreement and lack of clarity about which services each level is responsible for. What if no one is sure who is supposed to provide immunizations? Or who is to run provincial hospitals? The result could be that no one delivers these services and people who become sick are not treated.

Table 1: Examples of Gaps in Fourth Schedule of Constitution

Sector	National Responsibility	County Responsibility	Missing Areas/overlaps	Question
Health	Health policy National referral health facilities	County health services, inc. County health facilities and pharmacies Ambulance Promotion of primary care Licensing/control of food vendors Veterinary services Cemeteries, etc. Refuse removal and disposal	Provincial hospitals Immunizations Drug procurement	Are provincial hospitals to come under county health services or become national? Are immunizations a part of promotion of primary care or an unnamed national responsibility that is not listed? Will drugs be procured centrally or by county?
Energy	Energy policy including electricity and gas reticulation and energy regulation	Electricity and gas reticulation and energy regulation	These seem to overlap	Who will do what exactly at each level of government in the area of regulation? How will national level expenditure on electricity through Equalization Fund be coordinated with county?
Housing	Housing Policy	County planning and development including- Housing	Research into housing materials Civil servant housing	Will counties be responsible for research or civil servant housing? What will happen to National Housing Corporation?

But consider another problem. Suppose that everyone agrees that counties are responsible for immunizations, but no one knows how much these cost to deliver. The counties could end up with the responsibility but without enough money to pay for these, leading to many children not being immunized. This is why we need to split up all of the responsibilities and figure out their cost in order to make sure that the level of government responsible also has the funding it needs. This should be done transparently, so that everyone can see that the resources going to each level of government are appropriate.

There is broad agreement across government that a detailed assessment of each sector must be undertaken, and the specific functions that each level of government will be responsible for must be costed. This work was initially proposed by the Taskforce on Devolved Government in its final report.² It was acknowledged by Treasury in the 2012 Budget Policy Statement released last year. Reference to the need for this exercise can also be found in sector-specific documents, such as the health sector “Position Paper” titled “Implementation of the Constitution in the Health Sector.” Ultimate authority for making these decisions rests with the Transition Authority, as per the Transition to Devolved Government Act.³

Although everyone agrees that this work must be done, there has been a profound lack of clarity about how and whether it is being done. There have been various claims by Treasury, the Transition Authority and different service ministries about what they have already produced. Yet there has been almost no information made available to the public and scant opportunities for public debate about these issues.

For this paper, we gathered information from available public sources to establish what is known and what can be reasonably guessed from the information government has released up to now. We did this for a single sector: health. We chose the health sector because it is arguably the most important social sector to be devolved (education remains almost entirely a national responsibility) and because health sector devolution is a radical departure from the past. This implies a particular need for sophisticated planning, as well as public communication about change and continuity in the delivery of health services.

Our principal finding is that available sources of information are incomplete and incoherent on the subject of how functions will be shared between national and county governments. There is lack of clarity both about the functions and about the process for determining these. We contend that this lack of clarity poses serious threats to continuity of service delivery and the ability of government to deal with the many challenges in the health sector that government agencies themselves have identified.

Moreover, we do not believe the health sector is unique. Across ministries, there is insufficient information about the implications of devolution for the two levels of government. This is particularly worrying in light of the tight timeline until the first services are devolved.

We identify a number of areas where we believe that more information is needed, and we call on Treasury, the health ministries and the Transition Authority to avail explanations for the questions we raise below. *More generally, across sectors, detailed narrative explanations are required for all major decisions about activities and functions to be devolved and those to be maintained at national level, as well as an explanation of how costs were arrived at for these activities and functions.* Citizen access to this information is protected by Article 35 of the Constitution.

2. What We Did

The motivation for our analysis was the statement by Kenya’s Treasury, in the 2012 Budget Policy Statement, that it began working with all ministries in 2011 to “jointly agree” on which functions within each ministry would be devolved:

² Republic of Kenya, “Final Report of the Taskforce on Devolved Government,” Volume I, 2011.

³ Section 7 of the Act states that the Authority shall facilitate the analysis and phased transfer of functions, establish the resources needed for each function, and develop a framework for the transfer of functions.

Treasury working closely with the line ministries conducted an exercise to assess the budgetary costs of the functions that would be transferred to county governments. This required discussing and agreeing with each line ministry the current functions to be devolved and those that would remain with the national government based on the Fourth Schedule of the Constitution.⁴

The detailed results of this process were said to be contained in the 2012/2013 Budget Estimates, the government's budget proposal tabled in Parliament in April 2012.⁵ These figures in turn formed the basis for the recommendations of the Commission on Revenue Allocation about the total cost of services at both national and county level and how much each level should get (known in Kenya as the “division of revenue”). We decided to start our analysis by looking at these figures.

In order to undertake an exercise like this, one must, as Treasury indicated, start with the Fourth Schedule of the Constitution, which spells out in broad terms the responsibilities of each level of government. So we, too, started with the Constitution.

The division of responsibilities between the two levels of government in health is spelled out in Table 1 in abbreviated form, but we reproduce them here in full.

Table 2: Responsibilities of each level of government in Fourth Schedule of Constitution

National Government will remain in-charge of National Referral Health facilities and health policy formulation.⁶

County Governments will run:

County health services, including, in particular—

- (a) County health facilities and pharmacies;
- (b) ambulance services;
- (c) promotion of primary health care;
- (d) licensing and control of undertakings that sell food to the public;
- (e) veterinary services (excluding regulation of the profession);
- (f) cemeteries, funeral parlours and crematoria; and
- (g) refuse removal, refuse dumps and solid waste disposal.⁷

In addition, counties are responsible for water and sanitation.⁸

Assuming that Treasury then tried to assess the implications of the Fourth Schedule for all of the functions currently carried out by both of Kenya's health ministries—the Ministry of Medical Services and the Ministry of Public Health and Sanitation—we looked at the 2012/2013 Budget Estimates to see what they had done. In effect, all areas that Treasury thought would be devolved are coded “98” in the Budget Estimates, so it is easy to see which costs were to be devolved. We analyze these cost centers in this Brief.

⁴ Ministry of Finance, Budget Policy Statement, April 2012, pp. 28-29.

⁵ At a public function on 24 October 2012 a representative of the Treasury stated that the functional assignment output of this joint exercise could be found in the 2012/2013 Budget Estimates.

⁶ The Constitution of Kenya (2010), Fourth Schedule, Part I, 23 and 28.

⁷ Ibid., Part II, 2.

⁸ Ibid., 11b.

Note, however, that devolved costs are not the same as devolved functions, because the budget is largely organized by inputs (such as “materials”) and not functions. The Budget Estimates contain no narrative explanation of how or why certain costs were devolved. In the hopes of understanding better the logic of the choices that were made in the Budget Estimates, we consulted additional public documents including the Position Paper on Implementation of the Constitution in the Health Sector, the Health Sector Working Group Report (October 2012) for the 2013/14 budget year, and the draft health bill.⁹

3. What We Found

In this section, we look only at recurrent spending (covering things like wages and supplies). Section 4 looks at the “development” budget, which is where capital investment is concentrated. In separating these, we are following the format of the Kenyan budget itself.

According to the approved Budget Estimates for 2012/13, quite a number of functions fall under code 98. In Tables 3a and 3b, we have listed all of the devolved activities under the Ministry of Medical Services and the Ministry of Public Health and Sanitation. Recall that the budget does not provide a narrative description of these activities, so we have to make an educated guess about what they might be.



Let’s start with Table 3a for the Ministry of Medical Services. What should we make of this list in light of the Fourth Schedule?

1. **It seems logical that District Health Services (and rural health centers and dispensaries, and rural health training and demo centers, under Table 3b: Ministry of Public Health) would correspond, under the new dispensation, to counties.** This is also consistent with the Position Paper. The current health system consists of six levels. The Position Paper suggests that the bottom 4 levels will fall under counties, while Level 5 will be split between national and county government, and Level 6 remains national. All current District and Sub-District hospitals will be reclassified as county referral hospitals, and anything below a district hospital would thus be a county responsibility.
2. **Although district hospitals are devolved as a block, the budget shows that there is one exception. Mama Lucy Kibaki Hospital, which is classified as a district hospital by the Health Facilities master list, is not devolved.** Why should this be? The budget provides no explanation and we found none in other documentation.
3. **The budget classifies all provincial health services as devolved, but provides no justification for this.** Compared to district hospitals, it is much less clear where provincial health services, and particularly provincial hospitals, belong. The World Bank has indicated that

⁹ The draft health bill is legislation that was initially to be passed by Parliament in 2012 to reform the health sector in line with the 2010 Constitution. It was not formally introduced into the Tenth Parliament before it expired.

there is no clarity on this issue in the Constitution or any other legislation.¹⁰ We were also unable to find a clear answer in the other public documents we consulted. However, the Position Paper classifies provincial hospitals as national referral hospitals, meaning that they should not be devolved. There is thus a clear contradiction between the Position Paper and the Budget Estimates. Moreover, the recent County Allocation of Revenue Bill 2012, which determines how much each county will get for the 2013/2014 fiscal year, provides a “special allocation” for “regional referral hospitals.” It is not clear what a regional referral hospital is, but one might assume it was a provincial hospital. However, there are only 9 provincial hospitals, so it is not clear why each county would get funding for this. The regional hospitals might rather refer to county hospitals, but the sum made available for this, Ksh 51 billion, is almost triple what is currently spent on all district hospitals and health centres combined.¹¹ There is no available explanation for this anomaly.

Table 3a: Devolved activities in health sector according to 2012/13 Budget Estimates
(Recurrent expenditure coded “98” by Treasury in the Ministry of Medical Services)

Ministry of Medical Services			
Head Code	Item Code	Description of Devolved Activity	Net Expenditure (Ksh) ¹²
0005”	98	Health Finance Secretariat- Current Grants to Governments Agencies and other levels of Government*	908,512,297
0008”	98	National Aids Control Programme- Specialised Materials and Supplies*	903,000,000
0016”	98	Provincial Health Services	7,745,404,680
0017”	98	District Health Services	15,305,968,018
0038”	98	Radiology Services- Specialised Materials and Supplies*	40,472,307
		Total Devolved	24,903,357,302
		Total for Ministry of Medical Services (Net)	36,086,580,886
		Share of Ministry Expenditure Devolved	69%
*This is the only activity under the area that is devolved. Other activities remain at national level under the area			

¹⁰ The World Bank, “Devolution without disruption: pathways to a successful new Kenya,” November 2012.

¹¹ The County Allocation of Revenue Bill, 2012. See Section 5. Level 5 facilities that are not provincial might also be considered “regional,” but there are only a handful of these, not one in every county either.

¹² The expenditures are “net” because they include fees generated by the Ministry itself, known as Appropriations in Aid. Think of it this way: if the Ministry spends Ksh 10, but raises Ksh 2 itself from its own fees, the net expenditure by Treasury on the Ministry is only 8 (while the gross expenditure is 10).

4. **The mystery deepens when we look at the National Aids Council Programme (NACP).** NACP is to remain a national responsibility, except the budget shows that one particular activity will be devolved: “specialised materials and supplies.” As it happens, this particular item makes up the bulk of the resources under the NACP. It is hard to know what the intention is here, but this example makes it very clear why the Treasury’s Code 98 in the Budget Estimates cannot be considered a “functional assignment.” The budget books are not really organized by functions, and so when a particular item like “specialised materials” is devolved, it does not tell us what function this is supporting. This is rather the devolution of inputs. And with no narrative, it is an open question why this facet of NACP is being devolved while others are not.
5. **The same question must be asked of radiology services, where again, only materials and supplies are devolved (and again, this is the vast majority of the resources for the area).** What is the logic behind devolving only this activity or input?

Let’s now look at Table 3b, Ministry of Public Health and Sanitation.

6. **Both Environmental Health Services and Nutrition might be thought to fall under “promotion of primary health care,” which is a county responsibility. It is natural then that they would be devolved. However, it is not clear that the entire block of services under each of these categories should be devolved.** For example, it would seem equally logical that the policy functions in both of these areas would continue to be a national responsibility. Unless these policy responsibilities are free, it is hard to see why some share of the costs under these areas does not remain at the national level. Furthermore, the health bill states that both levels of government “shall ensure...measures for managing environmental risk factors.”¹³ Yet the budget shows these as fully devolved areas.
7. **A similar question can be asked about both Health Informative Systems and Health Education: should not the national level retain some control, and therefore costs, for these areas?** Presumably, Health Information Systems have to be managed at national level, not left to each county to manage entirely on its own. And Health Education presumably is based on national curricula or some set of national standards and should not be fully devolved. In fact, the draft health bill states that it is a national responsibility to “continue the development and expansion countrywide of a National Health Management Information System.” Similarly, the bill asserts that national government will “develop, in co-operation with other sectors, standards of training and institutions providing education to meet the needs of service delivery.”¹⁴
8. **Another mystery is the location of immunization under Code 98.** Immunization is an area that is not covered by the Fourth Schedule. Recall that any area not explicitly mentioned in the Fourth Schedule is either a national responsibility, or it must be shown to fall under one of the broad categories that have been devolved. One could again argue that immunization falls under the “promotion of primary health care” (a county responsibility), but this is at odds with the government’s own stated views in its Position Paper. There, immunization is considered to be a national responsibility. The logic seems to be that it is not related to primary health care promotion, but rather falls under a set of “public goods” national government should provide. As the Position Paper says, “Most public health programs have a major public good element....coordination of their delivery should be handled by the National Government, as it would not be practical for a County....Examples of such programs are immunization services, emergency/disaster management, Polio control, and TB control.”¹⁵

¹³ The Health Bill 2012 (Draft), Section 2.

¹⁴ The Health Bill (Draft), Section 16. See also Section 96.

¹⁵ We take no position on this issue, but it is not clear that just because a particular activity has a “public good” element to it, that there is any *constitutional* basis for assigning it to the national level.

Table 3b: Devolved activities in health sector according to 2012/13 Budget Estimates
(Recurrent expenditure coded “98” by Treasury in the Ministry of Public Health and Sanitation)

Ministry of Public Health and Sanitation			
Head Code	Item Code	Function	Net Expenditure
0005”	98	Environmental Health Services	
0006”	98	Communicable Disease Control	155,698,197
0007”	98	Port Health Control	152,552,194
0008”	98	Nutrition	385,126,165
0009”	98	Family Planning Maternal and Child Health	56,422,083
0010”	98	Health Education	79,383,368
0011”	98	National Public Health Laboratory Services	274,970,472
0015”	98	Health Informative Systems	65,970,725
0017”	98	Kenya Expanded Program Immunization	295,310,029
0018”	98	Food Control Administrative Services	320,910,108
0021”	98	National Leprosy and Tuberculosis Control	228,135,508
0022”	98	Vector Borne Disease Control	47,138,125
0023”	98	Communicable Disease Control and Management	56,400,672
0024”	98	Special Global Fund	98,399,683
0026”	98	Special Global Fund-Malaria Control	76,875,070
0028”	98	Provincial Administration and Planning	577,953,757
0029”	98	Rural Health Centers and Dispensaries	7,498,638,093
0030”	98	Rural Health Training and Demonstration Centers	83,351,434
		Total Devolved	12,701,329,429
		Total Ministry of Public Health (Net)	14,615,502,409
		Share of Ministry Expenditure Devolved	87%

9. **In general, it is not clear why certain areas are remaining at national level while others are devolved.** The Position Paper puts TB and immunization both in the category of “public goods” that should be at national level, but both are devolved according to the budget (Table 3b). Nutrition is currently divided between the two ministries. The activities covered by Ministry of Medical Services are to remain national, while those covered Ministry of Public Health (Table 3b) are to be devolved. Why? Aids control might also be thought of as a “public good,” but the bulk of the budget is devolved, as we saw (Table 3a).
10. **Total recurrent spending for the two ministries was nearly Ksh 51 billion in the 2012/13 estimates, of which 74 percent (about Ksh 38 billion) was labeled as devolved.** Since finance is meant to follow functions, and we know that the Transition Authority has not devolved all functions to all counties from March, it is in turn unlikely that such a large share of resources will be given to counties in the first year of devolution.¹⁶ It would seem that this is an issue that should be discussed in some budget documents, such as the Budget Estimates themselves, or perhaps this year’s Health Sector Working Group Report. Yet devolution merits only a single paragraph in that nearly 60-page report, and that paragraph has no particular insights into this matter.¹⁷

Summarizing the trends above, it is not clear that there is any consistent rationale for the choices that have been made about which activities remain at national level and which are devolved. Even in the event that such consistent rationales exist, there has been no transparency about them. And we have no information about how or when these functions and funds will be devolved to counties over the course of the next several years of the transition.

4. What We Found: Development Spending

Kenya’s budget for development spending has always been confusing, because development spending includes capital projects, as one might expect, but also funds for recurrent expenditure, like wages, particularly when these are funded by donors. (See Table 4b, first row for an example of recurrent spending in the development budget.) Putting this aside, when we look at the development budget for 2012/13, we immediately see again that the information in the budget cannot be used to understand the assignment of functions to different levels of government.

Let’s start by looking at the development budget for the Ministry of Medical Services in Table 4a. At first glance, it seems fairly consistent with the recurrent budget: most of the devolved development spending is for Provincial Health Services and District Health Services, which are both set to be devolved in the recurrent budget (Table 3a). But there are a number of inconsistencies.

1. **First, while National Quality Control Laboratories is devolved under the development budget, it is not devolved under the recurrent budget.** Once again, we have a strange scenario where only “Specialised Materials and Supplies” is devolved under a larger block of activities that remain at national level without explanation.
2. **While Table 4a shows that a large share of development spending for District Health Services is devolved (about Ksh 2 billion), nearly Ksh 900 million in development spending is not devolved.** Most of the spending that remains with national government is in the same categories of spending as that which is devolved: construction and refurbishment of

¹⁶ On 17 January 2013, the Transition Authority published a notification in the newspapers indicating the “Initial Functions for Transfer.” This clarified that in the first phase of devolution, the county health facilities, pharmacies and ambulances would be transferred only to Nairobi, Kisumu, Mombasa, Nakuru and Uasin Gishu. All counties would receive cemeteries and related services, and refuse removal and related services. However, no explanation was provided for why this set of functions was the first to be transferred, or how this fits with the broader process of functional assignment.

¹⁷ Republic of Kenya, “Health Sector Working Group Report,” October 2012.

buildings, and purchase of specialized plant, equipment and machinery. Why should the same activities be split between the two levels of government, particularly if District Health Services are to be fully devolved? No obvious rationale is provided for this by the budget. Some of these funds might be from foreign grants that are not supposed to be shared with county governments, but it is impossible to know. This potentially creates a scenario where there is lack of clarity about who is responsible for capital investment in the health sector. This violates one of the principles of the Taskforce report, which is that recurrent and capital spending should be “aligned,” meaning that both types of spending are carried out by a single level of government in each specific sector.

Table 4a: Devolved development expenditure for Ministry of Medical Services in 2012/13 Budget

Ministry of Medical Services Development Expenditure 2012/13			
Head Code	Item Code	Activity	Net Expenditure (Ksh)
0009	98	National Quality Control Laboratories-Specialized Materials and Supplied	200,000,000
0016		Provincial Health Services	
	98	Construction of Building	120,000,000
	98	Purchase of Specialised Plant, Equipment and Machinery	95,300,000
0017		District Health Services	
	98	Other Operating Expenses	9,000,000
	98	Construction of Building	686,768,947
	98	Refurbishment of Buildings	307,566,261
	98	Purchase of Specialised Plant, Equipment and Machinery	750,000,000
	98	Rehabilitation and Renovation of Plant, Machinery and Equipment	250,000,000

The development budget for the Ministry of Public Health and Sanitation also presents some inconsistencies. Consider Table 4b. We have not included all budget lines that are devolved here, but just the major ones, as there are quite a number of activities with very small budgets.

3. **As before, we see a number of cases where “Specialised Materials and Supplies” are devolved.** In this case, these do sometimes correspond to devolved activities, such as immunization. However, taking the case of immunization, while the entire recurrent budget is devolved, the national government retains approximately Ksh 828 million in development spending for the immunization programme. This is to be used primarily for construction, but also for “Specialised Material.” There is no obvious rationale for this, if the programme is fully devolved.
4. **The Health Sector Service Fund (HSSF) is not devolved.** A couple of years ago, Kenya introduced a direct grant to health facilities known as HSSF to ensure that they actually got the money they were entitled to (a lot of money was being lost in the process of transferring it). According to the HSSF Frequently Asked Questions (FAQ), this grant is only to support facilities that are Level 3 or lower; these would all be facilities devolved to the county level.¹⁸ Yet the Fund, amounting to approximately Ksh 1 billion, remains a national activity under

¹⁸ HSSF FAQ available online. See <http://www.publichealth.go.ke/health-sector-services-fund-hssf/faqs-on-hssf>, accessed 28 January 2013.

“Rural Health Centres.” Why should this be so? If these facilities are run by counties, then shouldn’t the counties control the Fund?

Table 4b: Selected devolved development expenditure for Ministry of Public Health in 2012/13 Development Budget

Ministry of Public Health and Sanitation			
Head Code	Item Code	Activity	Net Expenditure (Ksh)
0001”	98	Headquarters and Administrative Services- Basic Wages-Temporary Employees	4,109,316,022
0008”	98	Nutrition- Specialised Materials and Supplies	2,160,970
0009”		Family Planning Maternal and Child Health-	
	98	Specialised Materials and Supplies	522,750,000
0017”	98	Kenya Expanded Programme Immunization- Specialised Materials and Supplies	5,600,365,820
0029”	98	Rural Health Centres and Dispensaries- Specialised Materials and Supplies	2,813,140,900

5. Implications

The lack of clarity in the available documentation is a matter of concern. Here’s why:

1. **If there is confusion about which level of government is in charge of what, services are likely to suffer after March, 2013.** A common problem in devolved systems around the world is that the different levels of government blame one another for service gaps, claiming that their hands are tied and that failures to deliver services are the responsibility of the other level of government. In the health sector, this can have disastrous consequences. What will happen to provincial hospitals if it is not clear who is supposed to run them? How will citizens access drugs if neither level of government is clearly in charge of buying them?
2. **The lack of clarity also means that the two levels of government may not have sufficient funds to run the services they are responsible for.** The Commission on Revenue Allocation has used the costing in the budget books to determine how much money should go to counties and how much should stay at national level. If the actual division of responsibilities differs from what is in the budget books, that costing will be incorrect. Imagine if this happens across all sectors, not only health. Either counties or national government could find themselves without enough money to deliver services. This could potentially result in drug stock-outs, lack of ambulances to transport sick patients, breakdown of morgues and cemeteries, and rubbish accumulating in public spaces and spreading disease.
3. **Finally, lack of clarity means lack of accountability.** Citizens need to know where to turn to demand better services and who to hold to account when it is time to vote politicians into office. Without clear lines of accountability, the link between citizen demand and official response will be broken, making it difficult to maintain or improve the quality of health services. This problem can affect all services under the new Constitution, but may be a

particular problem where responsibility for service delivery is substantially shared by both levels of government.

6. Recommendations

The process of devolution requires a rigorous and open approach to functional assignment. The Transition Authority is the body that is ultimately responsible for leading the process of functional assignment. While the Transition Authority is in the process of finalizing its approach to functional assignment, little information has been made available to the public about its process or timeline, nor have there been adequate opportunities to provide input. TA has held some stakeholder meetings, but these have been done by word of mouth and without following basic principles of public participation, such as advance notice, non-discrimination in who can participate, provision of information with narrative explanations, clarity about desired inputs, and so on.¹⁹ The process has also been delayed. This is not only the Authority's fault; service ministries have not necessarily been timely in their own analyses and support to the Authority.

Whatever the Transition Authority produces should build on the work that Treasury and the service ministries have already done: the work that is contained in the kinds of documents we have analyzed here. We have shown that these documents are confusing and inconsistent, so we must hope that the Transition Authority will help to resolve some of the inconsistencies in its recommendations.

Our analysis has highlighted gaps in what has been done so far. Below, we make suggestions for the process going forward. We are optimistic about the outputs of the Transition Authority's work, but note that these outputs should be assessed against broader principles of transparency, participation, constitutionalism and common sense. The public should fully interrogate any functional assignment that lacks comprehensiveness or full narrative explanations.

Going forward, we call on Treasury, the Transition Authority and all service ministries to:

1. Release any existing documents explaining their views on the correct division of responsibilities between the two levels of government.
2. Release all information related to the cost of delivering services.
3. Provide a narrative explanation of why certain functions have been assigned to certain levels of government. This should explain how the division of finances reflects the distribution of responsibilities and is consistent with the Fourth Schedule and the principles put forth by the Task Force on Devolved Government. These principles include: subsidiarity (services should be provided at the lowest level that is feasible), alignment of recurrent and capital spending within a single level of government, a preference for policy formulation to remain at national level and implementation at local level, and a preference for certain functions that are inherently national, such as defense or macroeconomic policy, to remain at that level, while social services should generally be devolved.²⁰ It is also important to consider the efficiency and effectiveness of spending at different levels of government.
4. Highlight the implications of this proposed division of functions for all major programs that provide services to the public so that citizens know who will be accountable for running these.
5. Organize a series of open public consultations by sector (e.g., health, education, agriculture, etc.) on the sharing of responsibilities between levels of government at which the public is properly informed about the key issues and given an opportunity to provide feedback.

¹⁹ For more on these principles, see "Public participation under Kenya's new Public Financial Management Law and beyond," 13 August 2012. <http://internationalbudget.org/wp-content/uploads/Joint-Brief-on-Participation-in-Kenyas-New-PFM-Law.pdf>

²⁰ See "Final Report of the Taskforce on Devolved Government," Chapter 6.

6. Revise the overall distribution of functions and financial flows in accord with substantive feedback received from the public on the appropriate distribution.
7. Provide a detailed timeline for the implementation of Steps 1-6.

We hope that the analysis in this Brief, which looks at budget documents and policy and planning documents from one sector, provides a guide for how citizens can conduct their own review of the information they receive from government in the sectors they care most about.

7. Conclusion

Devolution is literally on our doorsteps. Figuring out exactly which level of government is doing what is critical for a successful devolution process, and it is work that must be done immediately. It is also vital to ensure that finance follows functions and that each level of government is adequately resourced to provide its services. The relevant institutions should give a clear timetable of activities to make it easy for citizens to follow and take part in any discussions that require public participation. The procedure as set out in the Constitution and related legislation must be followed. If this is done well, everyone wins. If it is done poorly, the most vulnerable Kenyans will feel the disruption in services the most. The time is now.