KEMRI | Wellcome Trust

IMPROVING PRIORITY SETTING PRACTICES IN KENYA'S HOSPITALS

Recommendations for county decision-makers and hospital managers

KEY MESSAGES

- Hospitals lack explicit processes for setting healthcare priorities; this provides room for the use of inappropriate priority setting criteria such as lobbying and favouritism. Evidence is not used in decision-making.
- Hospitals are severely under-resourced and depend on user fee revenues. This has turned hospitals into revenue-maximisers whereby managers prioritise services that generate revenue through user-fees and overlook services with limited moneymaking potential, including those for young children and disabled people.
- Many key stakeholders including middle level managers, clinicians and community members, are not included in priority setting processes. It is important for hospital managers to institute clearly defined procedures and ensure that priority setting is inclusive.
- Hospital managers are often clinicians with limited training and skills in management and leadership. Many did not choose to become leaders. Educational institutions and county departments of health both have a role to play in strengthening management and leadership capacity, as well as incentivising hospital managers.

Introduction

A fundamental challenge for health system managers and administrators is deciding how and where to spend limited resources. Priority setting is a particular challenge in Kenya's county hospitals, which faced highly constrained budgets and unpredictable funding from the central government at the time of this study. Within hospitals, health services and departments compete for scarce resources.

KEMRI-Wellcome Trust has conducted research to understand how county hospitals in Coastal Kenya set priorities and allocate resources between services. This was an in-depth qualitative study between two hospitals in Kilifi and Mombasa counties. Data was collected in 2012 and 2013.

This brief presents the key findings from the research, showing how hospital managers set priorities and the reasons behind their decisions. Even though the study was conducted pre-devolution, findings remain relevant post-devolution, especially in counties where hospitals still enjoy financial autonomy and as they plan ways to structure hospital financing and priority setting. The brief provides recommendations for county departments of health to improve hospital financing and budgeting, and for hospital managers to improve priority setting and ensure a fair allocation of resources between services.

Key findings

1. Use of inappropriate decision making criteria

Hospitals did not have clearly defined and explicit criteria for setting priorities and allocating resources across departments and/or service areas. This void provided an opportunity for inappropriate criteria to influence decisions such as lobbying and bargaining, noise making and personal relationships. Further, despite the existence of management information systems, hospital managers did not use the information generated by this system, or other types of evidence, to make decisions.

Box 1 ranks the criteria that were used to allocate resources in hospitals, showing that several inappropriate criteria rank highly.

Box 1: Criteria used to allocate resources (in order of importance)

1. Revenue generation
2. Historical budgeting
3. Essential services
4. Making noise
5. Health need
6. Lobbying and bargaining
7. Affordability
8. National priorities
9. Personal relationships
10. Feasibility
11. International priorities

Inappropriate criteria

2. Planning and budgeting processes were inflexible and unresponsive to changing healthcare needs

Decisions about where to spend money were often based on historical allocations with hospitals, departments and service areas receiving similar allocations as in previous quarters. Hospitals had little flexibility to develop individual work plans, which were based on guidelines and templates set by the Ministry of Health. As a result of historical allocations, the budgeting and planning process were not responsive to changing healthcare needs. Further, managers had limited engagement with frontline clinicians and communities to assess their needs, and there were no provisions to make revisions once the budget was set.

3. Priority setting processes were influenced by power dynamics between actors

There were no clear guidelines on the roles and composition of decision-making committees within hospitals; hence, exactly who was involved in priority setting processes such as budgeting and planning activities depended on how structures had evolved within individual hospitals and relationships between senior managers, middle managers and clinicians. A small number of senior managers made decisions and processes were not transparent. Clinicians were often excluded from meetings, and as a result the values of non-clinical managers', e.g. cost, sustainability and raising revenue, dominated in decision-making.

4. Severe underfunding and inappropriately designed funding arrangements turned hospitals into revenue maximisers

Hospitals experienced severe resource scarcity; there were significant gaps between what hospitals needed and the resources available. As a result hospitals accumulated huge unpaid debts as spending needs outweighed the total available funds every year. This resource scarcity, combined with delays and unpredictability of funding led hospitals to over-rely on user fees. This heavy dependence on user fees turned hospitals into revenue-maximisers, whereby resource allocations were based on the potential of departments and service areas to generate money.

A consequence of this is that departments or patients that did not generate money, such as children under 5 who were exempt from fees, were overlooked in allocations. In this instance, government efforts to increase access to health services for young children by abolishing user fees had the opposite effect and incentivised managers to reduce paediatric services. This did not ensure equitable distribution of resources, and perceived unfair choices reduced staff motivation.

Since I am allocated a small budget, I only procure medicines that I can sell. I cannot buy medicines for children under 5 years because they don't pay for services.

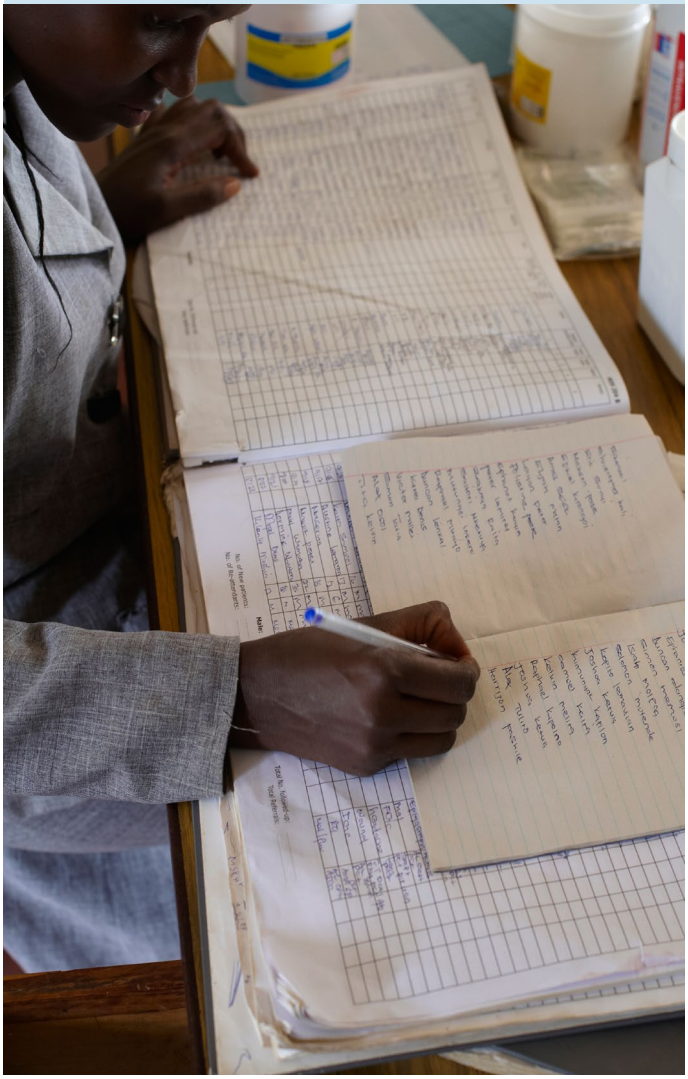
(Senior hospital manager)

5. Hospital managers had limited technical skills and were poorly motivated

Many hospital managers were clinicians who had limited technical management skills in planning and budgeting. There were few incentives for clinicians to take on management positions and they were often forcefully appointed into such roles, resulting in a lack of motivation and commitment to their duties.

Linked to these findings, hospital managers also lacked soft leadership skills, such as the ability to motivate staff, awareness and appreciation of the need to have inclusive decision making processes, the ability to manage relationships and build trust among hospital staff.

> *One day you are a clinician, the next day you are medical superintendent in charge of a big hospital. That is how it happens. You are sent here [the hospital] without any [management] training.*
>
> (Senior hospital manager)



Conclusion and policy recommendations

Inappropriate priority setting criteria, driven by the need to generate funding and weak management capacity, has several consequences. Most significantly, hospital resources are not aligned with healthcare needs and are inequitably distributed across departments: services that have less revenue generating potential, such as those used by young children, elderly and disabled groups are systematically underfunded.

The perceived unfairness of allocations by clinicians and mid-level managers has also led to frustration and reduced motivation, which impacts negatively on the wider functioning of the health system.

Recommendations for county departments of health

Adequate hospital resourcing

Assess the individual resource needs of hospitals, both capital and recurrent, and mobilise adequate, regular flow of funds to enable hospitals to function optimally and reduce their dependence on user fees.

Appropriate design of hospital financing mechanisms

When designing financing mechanisms, policymakers should anticipate the likely effects on the different components of the system, as well as on the full range of actors and stakeholders.

Increase hospital autonomy

Hospitals should be given greater autonomy to manage their operations and make budgeting and planning decisions that are responsive to population needs

Strengthen leadership and management of hospitals

Invest in strengthening leadership and management capacity in hospitals, for example by implementing in-service training programmes on core leadership and management skills

Improve hospital manager motivation

Managers' motivation could be improved by implementing an incentive system for staff that take on management roles. This could include financial incentives such as responsibility allowances or higher salary grades. Non-financial incentives could include relieving staff of their technical responsibilities and capacity building through training. Further, managers should also be selected based on their interest and willingness to become managers.

Institutionalise the use of evidence in decision making

Sensitise managers about the importance of basing decisions on evidence. Make it a requirement that priority setting and resource allocation decisions or requests should be justified or supported by evidence.

Recommendations for hospital managers

Systematic and explicit priority setting procedures

Ensure that the priority setting process has clearly defined procedures, roles and responsibilities for different actors, and explicit decision-making criteria that are responsive to hospital needs and health systems goals.

Strengthen inclusivity and stakeholder engagement

Hospital decision-making structures should be designed so that all actors (senior and middle level managers, front line staff, community) are represented. This will improve the legitimacy and responsiveness of priority setting processes. Further, ensuring that decision-making meetings include relevant stakeholders, and structuring meetings to allow all participants a chance to share their views, will improve the inclusivity and sense of fairness in priority setting.

Improve transparency of priority setting practices

Provide information about hospital decisions and their rationales to all relevant actors. This information should be easily accessible and appropriately communicated.

Revision and appeals mechanism

Implement mechanisms that allow for budgets to be amended in light of any new information. This will ensure that hospital priority-setting processes are responsive to changing needs

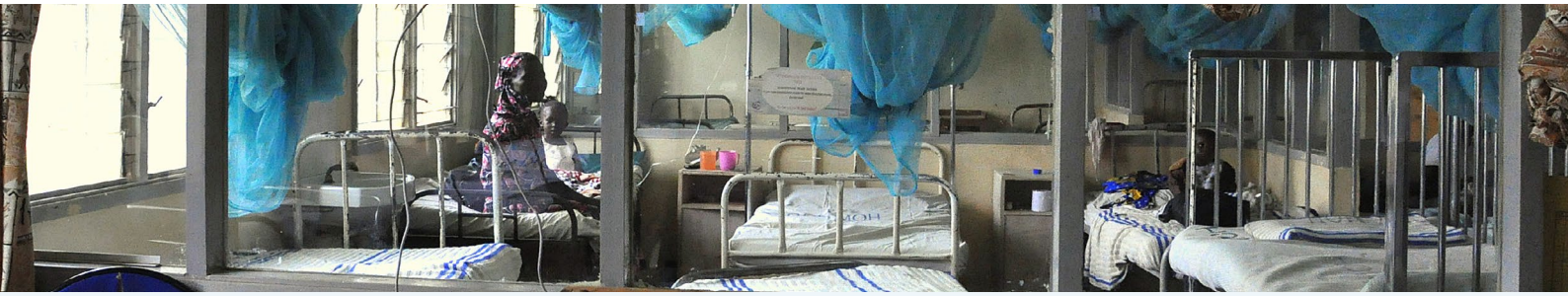
Stakeholder engagement

Incorporate participatory community engagement mechanisms. Hospitals could align this with county initiatives to involve the public in planning and budgeting; however, the selection of community representatives must be seen to be transparent and fair.

Recommendations for educational institutions

Pre-service training in leadership and management

Institutions that train health workers should review their curricula to include training on leadership and management. This would help improve the capacity and preparedness of health workers for leadership roles, and also contribute to shaping the identity of health workers so that they consider themselves to be managers as well as clinicians.



About the research

Related publications

Barasa E, Molyneux S, English M, Cleary S **Hospitals as Complex Adaptive Systems: A Case Study of Priority Setting at the Hospital Level in Kenya** *Submitted.*

Barasa E, Cleary S, English M, Molyneux S **The influence of power and actor relations on priority setting and resource allocation practices at the hospital level in Kenya: A case study** *Submitted.*

Barasa E, Cleary S, Molyneux, English M **Setting healthcare priorities: A description and evaluation of the budgeting and planning process in county hospitals in Kenya** *Submitted.*

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