

Approaches to Managing Health Services Organizations
International Health Section
Group Exercise # 2
SWOT of an Organization in Transition

1. Read the case and background readings prior to class.
2. As a group, prepare in class a **Strength, Weaknesses, Opportunities & Threats (SWOT)** Analysis of a Ministry of Health that is trying to decentralize its services.
3. Consider other models for decentralization for the case, and provide a recommendation on how the Ministry of Health should be decentralized.

Steps in a SWOT Analysis¹

1. **Internal Analysis:** Examine the capabilities of the organization. This can be done by analyzing the organization's **strengths** and **weaknesses**. You may not be able to answer all the questions for this case study, but you should consider the following issues:
 - a. **Management Capabilities:**
 - **Organizational structure:** Does the organizational structure hinder or facilitate a free flow of information? What about client-responsive implementation of activities?
 - **Planning:** Have feasible long- and short-term plans been made, involving staff and community?
 - **Coordination:** How well do different departments of the organization cooperate and coordinate with each other?
 - **Staffing:** Are staff roles clear? Do staff have consistent training and feedback to ensure high performance?
 - **Supervision:** Do all staff meet regularly with a supervisor? Do staff view the supervisor's role as one of guidance, assistance, and support?
 - **Training:** Do you regularly assess training needs of staff?
 - **Management Information System:** Do managers have accurate information on the progress made toward the objectives of the program?
 - b. **Programming Capabilities:**
 - **Capacity:** What is the potential capacity of your program to provide services? Does the current level of activities match this capacity?
 - **Quality:** How can you improve quality of care in your program? What is the level of client satisfaction?
 - c. **Financing Capabilities:**
 - **Self-financing:** What is the current level of self-financing?

¹Adapted from Management Sciences for Health, with permission from: <http://erc.msh.org/quality/ittools/itswot.cfm>

- **Outside funding sources:** What are the current sources of financing? How stable are these sources?
2. **External Analysis:** Look at the main points in the environmental analysis, and identify those points that pose opportunities for the organization, and those that pose threats or obstacles to performance. In practice, you may need to gather additional information, particularly from patients and communities. Decide whether the answers or the data collected reveal external **opportunities** or **threats**.
 3. Enter the information you have collected in into a table as illustrated below:

	POSITIVE	NEGATIVE
INTERNAL	Strengths	Weaknesses
EXTERNAL	Opportunities	Threats

Background Readings:

Atkinson S, Haran D. Back to basics: Does decentralization improve health system performance? Evidence from Ceará in north-east Brazil. Bull WHO 2002; 82: 822-827.

Bossert T. Analyzing the Decentralization of Health Systems in Developing Countries: Decision Space, Innovation and Performance. Soc Sci Med 1998; 46(10): 1513-1527.

Bossert TJ, Beauvais JC. Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space. Health Policy Plan 2002; 17(1): 14-31.

Case Study: Decentralizing a Ministry of Health

You are a Deputy Director of the Policy and Planning Department of the Ministry of Health of a low-income African country, and have been asked by the Director General to visit an important district to provide some information to him about how well new plans for decentralization are working.

Last year the national parliament declared that they were “decentralizing” government over a period of three years, and passed legislation that involves moving responsibility for primary health services, primary schooling, and water and sanitation services to local governments. The bill specifies that primary health care centers are to be financed and managed by district and ward governments, though it is silent on community and district hospitals. District and ward local governments were elected for the first time last year, but were given only token budgets. With next year’s budget, about 5% of central government resources are to be passed on to the district and ward governments to run the services, though it is not clear whether health worker salaries are supposed to be covered by these funds. Currently all public sector health workers are hired and paid through the central government. Union officials have threatened to strike if nurses and doctors are removed from the central government payroll and pension systems, as they fear that local governments do not have the administrative experience or fiscal viability to assure health worker’s incomes. The central government has stated that the next two years are a transition period, and has asked each of country’s 20 district governments to draft a plan for the management of the government services it is to take over.

You visit a rural district that has a population of 300,000, where you know there is an influential Chief Medical Officer (CMO) responsible for public health of the district, including primary health care services. Within the district, there is one town (population 100,000) that makes up the largest ward. The rest of the district is divided into 4 wards made up of smaller villages and towns, ranging from a population of a few hundred up to about 20,000 people. The health care infrastructure in your district includes one district hospital of 250 beds in the main town, which is staffed by 20 doctors, 40 nurses, 10 medical technicians, and 150 auxiliary staff. The district hospital is under the authority of a Medical Superintendent who is at the same rank as the CMO, and all hospital staff report to him. However, the CMO has some responsibility for personnel decisions for all nurses in the district (e.g. performance reviews, discipline), including those at the hospital, whereas transfers outside the district and the authority to hire and fire nurses are the responsibility of the central government nursing director. Also under the direct CMO authority are five 50-bed community hospitals (one in each ward), each staffed with 2 doctors (one at each community hospital is the medical officer in charge for the ward), 6 nurses, 2 medical technicians, 10 nurses assistants, and 50 support staff; and 60 primary health care (PHC) units, each staffed by two nurses, along with 5 nursing assistants and a community volunteer in each village (who is paid a small monthly stipend from the Ministry of Health). All staff not part of the district hospital report to the CMO. Besides the CMO, the district health management team (DHMT) includes a deputy CMO, a nursing director, a director public health, a health education officer and 2 junior health education officers, a pharmacy officer, 4 clerks, and 10 other support staff (drivers, cleaners, guards). For monthly DHMT meetings, the CMO calls in the medical officer in charge from each ward, along with one of the nurses from each PHC, who must come to headquarters in any event to pick up their monthly salaries. The district health services package includes a basic set of simple curative care (e.g. malaria treatment, tuberculosis treatment, first aid), reproductive and child health services (e.g. antenatal care, immunizations). The public facilities are intended to provide a smooth referral chain between each level of services, with staff from each level supervising the work of the level beneath it. The PHC units also provide outreach services, largely in the form of visiting maternal child health clinics that reach towns of 1,000 about once every 2 weeks. However, the CMO has difficulty keeping doctors and nursing posts

filled (1/3rd of the physician and nurses posts outside the district hospital are vacant, and he believes that there are actually 30 doctors working at the district hospital, although he has not seen any records that substantiate this). The beds in the community hospitals are usually empty, while private practice in the towns is thriving, in part by the public health workers holding their own clinics. Childhood immunization levels are about 60% (for complete childhood immunizations), and about 15% of women deliver in a health institution, both slightly levels above average for the country.

The local government officials want to build more hospitals, and also complain that the current facilities are rarely open, never seem to have any drugs, and that people are asked to pay for many services despite the fact that most are supposed to be provided free at the point of delivery. At the district hospital, there are long line-ups to see a doctor, and people still have to pay for the medicines and to be seen by doctors.

The CMO, who is a member of the district government's health committee, has strong views about how to run the health services. In your interviews with him, he says:

- “All health staff should be maintained on the payroll of the Ministry of Health with the usual benefits, with the exception of the community health volunteers, whose stipends would be picked up by the ward governments.”
- “All staff, with the exception of doctors at the district hospital, should report to the CMO, although members of the community could be added to the district health management team, and the local government health committee could approve all budgets for the DHMT. Doctors at the district hospital would report to the district hospital medical superintendent, as is currently the situation.”
- “Local governments should provide extra money for drugs and repairs to health facilities.”
- “If funds for salaries of health workers are passed on to local governments, this should be for accounting purposes only, as the payroll, hiring, firing and reporting should be managed by the Ministry of Health.”

You also meet with the district chief executive. He turns out to be an idealist who believes in moving the power of government closer to the people. He has very specific plans, including:

- “All health staff working in the district should be transferred to the responsibility of the district government. All health worker salaries should be transferred to the local government, with the central government maintaining the responsibility for pensions of existing workers. All newly hired staff pensions would be the responsibility of local governments.”
- “The local government should appoint one board of health for the entire district. All staff will report to a chief health administrator, who would be hired by the district board. If circumstances warrant, a separate board would be established for the district hospital. The district hospital and each ward would have its own director, who would report up to the chief health administrator, who in turn would report to the board.”
- “During the transition period, all staff will be transferred in their present capacity, making the CMO the district chief health administrator, and the medical superintendent would become the hospital director. In two years, the district board will decide which staff are to be retained. All those not retained should become the responsibility of the central government.”