Restructuring a ministry of health – an issue of structure and process: a case study from Uganda

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This paper analyzes the recently undertaken restructuring of the Ministry of Health in Uganda, which was carried out because the previous structure did not comply well with the decentralization framework or policy. The Ministry was put under pressure by higher political levels, supported by the donor community, to restructure. The paper describes the principles that were guiding this operation, and assesses whether these principles relate to the final outcome and whether the outcome was actually as expected. This paper also analyses the reasons for the achieved, or not achieved, results and suggests the way forward.

The outcome of the restructuring procedure in terms of change in number of employees was small. The foundation, in terms of a certain structure, has been laid for the Ministry of Health to function in its new role as a coach more than a player, but the work to establish a functioning process is far from complete.

The issue is to make actors at various levels relate to each other, and thereby establish appropriate processes within the existing structure that will help the Ministry develop into a dynamic body. The importance of finding forms for interaction, involving face-to-face relationships between the Ministry and service delivery level, is stressed.

Key words: administrative reform, policy implementation, decentralization, health sector, Uganda

Introduction

During the last decade, a number of government reforms have been undertaken in Uganda, including reorganization and restructuring of the civil service, decentralization, economic recovery programmes, privatization, army demobilization and constitutional reform (Langseth 1996b). The decentralization reforms comprise three components: political, administrative and financial decentralization (Vilладsen 1996). All political and administrative authority has been transferred from the national to the local government authorities (Kisubi 1996). The function of the national government has been reduced to policy formulation, planning, inspection, management of national programmes and projects, security, defence and foreign policy. Line ministries formulate policies and guidelines within their respective sectors, provide technical supervision, set standards and inspect services to ensure appropriate quality; specialized logistical support not available on the district market will also be provided when needed, e.g. vaccines, drugs and medical equipment in the case of the Ministry of Health. Most other activities, including delivery of health services, are now the responsibility of the districts. For the Ministry of Health, the role has changed from the one of a ‘ministry for hospital services’ to a ‘ministry for health policy development’ (World Bank 1994).

As a part of the civil service reform in Uganda, all the national ministries were supposed to be reduced in size to improve efficiency. Most ministries had grown too big since the time of Independence; the efficiency of work had also decreased (Government of Uganda 1990; Langseth 1996a). With the restructuring, the task was to create a civil service with clear organizational mandates and objectives. Some of the guiding principles were transparency, result-orientation, implementation of simple rules and procedures, resource allocation and budgeting based on clearly identified priorities. The civil service was going to be smaller and its employees better paid (Government of Uganda 1993).

For the Ministry of Health, a comprehensive restructuring was carried out in 1995 (Ministry of Health 1995). It is interesting to note that, while one of the main reasons for this exercise was to decrease the size the Ministry, in reality it actually increased. The increase was particularly noticeable among senior and top civil servants, such as directors, commissioners and assistant commissioners. From a former core of 506 professionals at Ministry of Health Headquarters, the restructuring led to an increase of over 40%. The reason for this was mainly a strong bureaucratic pressure from the officers in the Ministry, who had a considerable influence on the process. The issue of new roles for the central government left very few traces in the 1995 organization of the Ministry of Health. One of the most critical issues, the relationship between the national level and the service delivery level, was hardly addressed at all.
After the restructuring exercise in 1995, it became increasingly obvious that the Ministry was still oversized and did not comply well with its new obligations according to the civil service reform. In general, the officials of the Ministry were still working the way they had in the past, i.e. managing vertically organized programmes from the centre down to the local level. This situation can be interpreted as a bureaucratic resistance at the centre against decentralization. This was in great contrast to the change of attitude at service delivery level. Since the districts were becoming increasingly aware of their new powers, interference with the daily activities of a district was simply no longer accepted by the district administrators.

In 1997 it had become necessary to embark on a new restructuring exercise that was to continue until mid-1999. This paper addresses this second restructuring process and its outcome. It aims to describe the principles that were guiding this operation, and to assess whether these principles relate to the final outcome and whether the outcome was actually as expected. This paper also endeavours to analyze the reasons for the achieved, or not achieved, results, and to suggest a way forward.

**Theory and method**

The paper draws mainly on the academic fields of implementation research (Lundquist 1987) and contemporary organization theory (Scott 1987), which both address rationalistic approaches to public sector reforms. Rationalistic approaches view administrative changes as results of deliberate choices between alternative forms of organizational structures, each one serving to support a certain operational system. The reform perspective constitutes a part of a rationalistic and instrumental tradition in implementation research. We will furthermore relate to work by Giddens (1984) on structuration and forms of institution, to analyze the relationship between different levels of the system.

The data have been collected through participatory observation – by actively taking part in meetings related to the restructuring process, by interviews with civil servants inside and outside the Ministry of Health, interviews with donor representatives and by review of documents produced by the consultants, by the Ministry of Health, by other ministries and by donor agencies. Discussions have also been held with a large number of district officials during field trips in all regions of Uganda.

**Results**

The second recent restructuring exercise of the Ministry of Health started in December 1997 with international consultants being hired from one of the most prestigious firms of its kind in Europe. They were hired by the Ministry of Health and funded by the World Bank. Terms of reference were developed within one of the World Bank projects in the Ministry of Health, and the procedure was supported by the Ministry of Public Service and the World Bank.

The first step to be taken by the consultants was to identify the objectives of the Ministry of Health by consulting the current legislation, notably the constitution and the Local Government Act (Ministry of Health 1998a). The next part of the exercise was to identify functional problems inherent in the organization. The problems identified could be described as duplication of responsibility within areas such as setting of standards and regulation on professional issues or pharmaceutical policy, lack of clear responsibility of the different departments in the Ministry, fragmentation of functions into ‘vertical’ technical programmes and problems with departments focusing on specific professions rather than functions.

Based on these objectives, the next step was to identify the expected key outputs of the Ministry of Health. Among these were issues like coordination of the health sector, development of a national health policy, provision of a basic health care package with integrated health services to all citizens, ensuring adequate referral services, ensuring a national human resources development policy, and guiding and promoting research activities.

These key outputs gave the basis to formulate new core tasks of the Ministry; policy-making, planning and mobilization, setting of standards, quality assurance, capacity development and technical support and coordination of services rendered at national level.

There was now a basis for analysis of which functions should remain in the Ministry and which could be transferred to other bodies. An organizational structure for the Ministry was worked out.

The plans to change the structure of the Ministry were met with suspicions and even resistance from the officers concerned (Ministry of Health 1998b). This resistance was particularly strong during the initial phases of the restructuring process. However, since the pressure to restructure actually came from the highest political level in the country – the President – through the Ministry of Public Service – there was an increasing acceptance of the idea that there was need for a change and that this would actually happen. The resistance therefore changed character and gradually came to deal more with the question of how the restructuring was going to take place rather than if it was going to take place at all.

During this ‘how phase’ the discussion came to focus on the actual capacity of the districts to deliver health services. It was generally accepted that the legally founded responsibility to deliver social services was to rest with the district. However, it was argued that since the districts allegedly did not have capacity to deliver the services, the national level should still do so on behalf of the districts as a practical solution during a transitional period of undefined duration. In other words, although the general idea of restructuring was accepted, the practical implications were not.

Gradually the central discussions came to focus more on the structural layout of the departments and divisions of the new ministry and less on their expected interaction with implementation levels. The consultants advocated for the
establishment of broader organizational units like ‘child health’, ‘reproductive health’, etc., while the view held by professionals in the Ministry was that the traditional programmes for immunization, diarrhoeal diseases, nutrition and family planning should instead be maintained to ensure continued support from donors. The main reason given was that these departments were already established and supposedly functioning well.

The output of the restructuring process (Ministry of Health 1998c) was to a large extent a logical consequence and result of the analysis built on the set objectives and broad key functions expected from the new units. The units were no longer organized vertically by single diseases but rather by areas of disease or even more broadly. However, the old technical, vertical programmes still remain within the new broader units. The overall number of posts (928) was reduced by 69. Out of these, 43 were support staff, mainly cleaners and messengers. The staff budget was reduced by 114.3 million Ugandan shillings per annum1 or 5%. The line of command became thinner at the top, with fewer commissioners (five instead of 11), fewer assistant commissioners, principal medical officers and so on. Although the actual reduction of staff was much less that expected, the plan was still praised from outside the Ministry, especially by donors.

The outcome of the restructuring is the current ministerial body, organized according to its set objectives, but also to a large extent built on compromises with views held by Ministry officials. The number of staff did not decrease substantially. The old technical programmes were largely left untouched, although incorporated into broader units. The paramount question is whether the Ministry now lives up to its mandate, i.e. to develop policies and to facilitate their implementation, rather than implementing policies? If this is not the case, what is the reason? Can such shortcomings be traced?

After the restructuring, the Ministry produced a National Health Policy (Ministry of Health 1999) and several sub-sector policies as was expected in the set objectives. What remains problematic, however, is the actual implementation of the policies. This paper will try to analyze the reason for this.

The planning process for the health sector has been staged by the Health Planning Department of the Ministry, which has gained considerable influence in the process within as well as outside the Ministry, not least in the donor community. Donors and foreign advisers have again supported the process. The instruments developed by the Health Planning Department to put the health policy into action entail a series of steps, mainly developed by technical officers and based on logical framework approaches. The relationship between the Ministry and the districts is largely upheld with the technical functions in the districts, rather than the political or administrative ones.

Civil servants in Uganda describe ministries as ‘wet’ or ‘dry’ (Munene 2000). Wet ministries attract civil servants because they have a continuous supply of resources, including opportunities for field trips. Such a ministry attracts a larger share of the Treasury. It also has more motor vehicles allocated to individual officers. The opposite is true for dry ministries, which may even lack paper for daily activities. Such a ministry is less attractive to civil servants. Similarly, presumptive employees often regard districts as dry. The Ministry of Health is comparatively wet, and hence attractive. This fact attributes more prestige to the Ministry vis-à-vis the districts and affects the way they communicate. This description can also be applied to departments and units within a ministry.

Due to changes in the environment, such as the increased interest by donors for budget support rather than project support, and also due to the actual restructuring, the Health Planning Department gradually increased its influence in the Ministry and got increasingly ‘wetter’, while the opposite was true for most technical programmes.

These continuously vertical, technical programmes have difficulties in defining their roles in relation to the districts, and have also encountered problems in regard to communication with the Health Planning Department in the Ministry. Due to various reasons, technical support visits to the districts have become less frequent. Many officials perceive their roles as producers of guidelines for technical programmes – something that can allegedly be done in the Ministry Headquarters without consulting the district health planners. If these are to be consulted anyway, it can be done by summoning them to Headquarters in Kampala. In addition, many of the finalized technical guidelines are not effectively distributed to the implementers. The general opinion at the national level is that the districts have little to contribute with regard to the planning process at central level, which results in a lack of involvement and subsequent ownership of sub-sector policies by the people responsible for the actual implementation. While the districts often complained about the extensive interference by the central level in the past regarding the operation of technical programmes in the districts, current complaints are rather over the lack of interaction and support supervision.

The first restructuring in 1995 resulted in no change of functions for the national level Ministry of Health vis-à-vis the districts. The national level staff maintained a paternalistic attitude towards the districts. The second restructuring actually resulted initially in a largely non-existent relationship between central and peripheral level, especially between the technical programmes and the districts. This fact seems more disturbing to the districts than to the national level officials.

This illustrates a need to further develop appropriate relationships between the national Ministry of Health and the districts. The formulation of policies and guidelines has to involve considerable personal interaction as well. There is a lack of openness or contingency in this relationship, which makes a fruitful collaboration between the centre and the periphery difficult. The very reason for the existence of the Ministry lies in the interaction with the implementing level. But this interaction remains problematic, due to a lack of
Discussion

The latest restructuring of the Ministry was effected because the previous structure did not comply well with the decentralization framework or policy. The ministries, agencies of the national government, were not adjusted to the decentralized structure. It was implicitly assumed that the situation could be changed by structural reforms, an assumption, however, that has long been questioned (Scott 1987). Whereas the Ministry had an overall dominating role in the health sector in the past, this situation changed with decentralization. Contrary to the past, the Ministry is not supposed to have any power to sanction, and likewise in principle no control over, funds to the districts. Only the Ministry of Finance has such executive powers. In practice, however, the Ministry of Health has retained considerable influence over the way conditional grants are used at district level, and has developed detailed guidelines in this respect. Since such grants constitute an overwhelming proportion of the funds available to the districts, the Ministry of Health is still in a powerful steering position as regards the planning and priority setting processes in the districts.

The relationship between decision-maker and implementer can be described in terms of steering and control (Lundquist 1987). Steering can either be direct, by commands, or indirect, by policies and guidelines and by financial allocations. Before decentralization, the line ministries were responsible for the direct provision of services and hence largely carried out direct steering of planning and implementation. This changed after decentralization, and the steering carried out by the Ministry of Health is generally indirect, through guidelines and regulations. However, as we have seen, parts of the Ministry, especially the technical programmes, are still often executing direct steering at implementation level – or have given up steering altogether.

Steering can also be viewed from two other aspects: reliability and rationality (Lundquist 1987). Reliability refers to the degree to which the implementer acts in accordance with the steering by the decision-maker. This is where the emphasis of the Ministry traditionally has been. Rationality refers to the degree to which the intended results are actually achieved. Whereas many of the policies and guidelines established by the Ministry are implemented at district level, clear impact in terms of improved health services, and eventually improved health, is limited. Many of the technical programmes had met substantial difficulties in coming to terms with their new roles in the decentralization process.

The immunization coverage rates had, for instance, been consistently declining since the early 1990s, and still are (Uganda Bureau of Statistics 2001). The decline started before the public sector reforms, including decentralization, took place in Uganda, but the difficulties that the national immunization programme had in working with local authorities certainly contributed to the persistently low coverage figures. The maternal mortality rate (MMR) has remained at an equally alarming level (506/100,000) through the last 15 years (Uganda Bureau of Statistics 2001) and no improvement is yet in sight. The efforts made by national technical programmes to strengthen the work of health service providers do not necessarily result in improved service delivery, be it in quantitative or qualitative terms (Health Management Consult 1998).

The steering carried out by the Ministry can therefore largely be seen as reliable but not equally rational. The link between the organization and the actual output still remains an issue. Indirect steering requires emphasis not only on the reliability, i.e. how the procedures are undertaken, but even more on the rationality, i.e. what actually comes out of it.

Concerning the other aspect of the relationship between decision-maker and implementer, the one of control, or retrospective follow-up, the technical control remains the duty of the Ministry of Health. Effective control requires a reliable information system (Rodrigues 2000). Considerable resources have been invested in a comprehensive health management information system, which has had serious difficulties in becoming operational. Even if it finally becomes so fully, there is a focus on the operational aspects rather than the actual output of the services. Consequently, it has been difficult to establish a feedback mechanism whereby important information from the implementation level could be fed into the system and to ensure improved guidance from the centre.

It seems clear that the established bureaucracy, inherited from the British colonial rule, seemed to be capable of resisting reformation even after the latest restructuring. The communication between the centre and periphery is failing. A guiding function means more than just sending out a circular. Giddens (1984) discusses ‘carrying contexts of interaction’ as elements of constructing a system. It seems obvious that in Uganda, circulars and written communication in general may not suffice as carrying contexts. Important processes such as the critical face-to-face relationship, the ‘co-presence’ in space and time, need to be directly and clearly established if the machine is going to work. Anonymous bureaucratic communication without co-presence has very limited ‘carrying context’ in a society like Uganda, a society where modernity and traditionalism exist side by side. But even the modern ‘islands’ of society, often built on expert systems (Giddens 1990), another characteristic of modern society, are still dependent on communication requiring co-presence in its interaction. The critical system integration between the national and local level, which in general terms means reciprocity between actors and collectives at both levels, implies, inter alia, a face-to-face interaction yet to be established.

Non-personal interaction requires the system adjusted to a higher abstraction level of communication, which is not yet in place, especially in remote areas of Uganda. The district health systems are still to a large extent a part of the traditional society and require face-to-face interaction. The opposite is true when it comes to the offices of international organizations. This may also, at least partly, explain why many Ministry officials find it easier to communicate with
representatives of international organizations and with the donor community, than with their counterparts in the districts. The global organizations represent modernity, and so does the Ministry. However, the problem is that the Ministry needs to be able to represent modernity and traditionalism simultaneously – and to communicate with all actors within the health service delivery system.

In addition, the academic and professional background generally differs between national Ministry officials and the district health officials. The District Medical Officers (now called District Directors for Health Services) do generally have a postgraduate training in public health, while few officers at Headquarters do. These have more often a purely clinical, usually hospital-based, background and limited experience from the field. Consequently, these two groups apply different conceptual thinking and hence also different frames of reference in their work. The fact that around 80% of the Ministry staff are physicians also adds significantly to the difference in perception of health issues between Ministry and district levels, and this circumstance does not facilitate wider multisectoral approaches to health at the periphery.

The attitude held by Ministry officials is also an expression of power: to stick to the power one already has. For the officials in the Ministry of Health, it symbolizes authority. During the restructuring the Ministry moved from Entebbe to a new premise in Kampala, constructed for US$5.5 million (New Vision 1999). The Ministry now symbolizes to a higher degree the close relationship to the international biomedical and donor community through the move to close proximity of such international institutions. This symbolically devalues the link with the districts, which are supposed to render the service delivery system.

The Ministry of Health was put under pressure by higher political levels, with support from donors, to restructure. It did so rather unwillingly and the changes in terms of numbers were small. Furthermore, the relationship between the Ministry and the service delivery level remains problematic. Whereas the foundation in terms of a certain structure (‘the being’) has been laid for the Ministry of Health to function in its new role as a coach more than a player, the work to establish a functioning process (‘the doing’) is far from complete. A structure is in place that is filled by officials who are largely unaware of how to play their roles or to start crucial processes.

The Ministry of Health is an expert system that easily relates to other expert systems such as international organizations. However, it has encountered difficulties in relating to service delivery levels, an interaction which to a larger extent requires a co-presence, a face-to-face relationship.

The tasks carried out by the Ministry, such as policy development, planning and development of guidelines, are largely done in a top-down manner rather than driven by demand from the districts. The modalities are primarily through defining roles and creating meeting places to start up appropriate processes. The organization can come alive through processes that ultimately establish a process whereby people talk and relate to each other to a large extent through face-to-face interaction, which could then be institutionalized.

An institution needs to interact with the outside world, and the assignment given to the consultants only dealt with some aspects of this interaction, namely the exercise of power and sanctions. However, the main modality for interacting with the relatively autonomous district level has to be with the carrot rather than the stick – through steering rather than control, and processes with this effect need to be developed. Yet, such steering needs to be co-present rather than anonymous and personal interaction is needed.

Whereas interaction is largely based on system integration, which does not require co-presence in more developed contexts, the context in Uganda requires face-to-face relationships for such communication. The issue is to make actors at various levels relate to each other and thereby establish appropriate processes within the existing structure, which will help the Ministry develop into a dynamic body. For this to happen, the forms of interaction between the actors are far more important than the formal structures, which have now been put in place.

Endnotes

1 1500 Ugandan shillings corresponded to 1 US dollar at the time.

References

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