Health administration by its very nature is deeply enmeshed in political activity. For a number of reasons this fact has been denied by health professionals, and an antipolitical ideology persists in this field. Current problems and issues in organization demand a reorientation of attitude and ideology in public health administration.

CURRENT ISSUES IN HEALTH ORGANIZATION

Morris Schaefer, D.P.A.

HEALTH administration in the United States has had a long and honorable concern with the organization and reorganization of health agencies to meet changing needs and conditions. Historically, the central aim in reorganization has been the delivery of better health services.

A landmark in the birth of modern public administration, interestingly, was the first major study conducted in 1906 by the New York City Bureau of Municipal Research on the organization and administration of the New York City Department of Health.[1] In the intervening 62 years, public health has seen itself pass through a number of major phases in its continuing concern with organization. Each of these phases has had a particular focus—the establishment of state leadership in public health, the county health department movement, the development of effective hospital administration, the extension of professionalism, the emerging concepts of community health. While the advocates of these foci enunciated goals, values, and ideologies, their extension and development in practice was uneven and spotty. In each instance, the thrust of organizational reform was limited by the pluralism of power and discretion inherent in a federalized system of government and an open society—a condition that current and future movements for organizational reform in health administration must take into account.[2]

The years of this decade have seen health administration confronted with new challenges—increased urgency attached to old problems, new responsibilities and functions, regionalism, comprehensiveness. Moreover, these challenges have presented themselves at an increasingly rapid rate over these seven years. And each of these challenges has raised anew issues of how organization shall be structured so as to respond to continuing changes and yet maintain the stability necessary for effective service.

New administrative demands upon the health professions have led to consequent questions by health administrators on the fields of administrative theory and, perhaps even more relevantly, political theory. How can the questions be framed? And what answers can be expected?

The Past Is Still Present

As health administration faces a new day, it does so with a hangover. Unsolved long-standing problems of organization must affect solutions in the future.

The contemporary health administrator faces a clamor of demands in unfamiliar areas of service, attempts to respond to these demands despite a shortage of personnel and other resources, tries to plan under conditions of uncertainty, and tries to comprehend the swift changes in his environment. The new day is different, if only in the tempo, scope, and number of the demands upon his agency. Official health agencies, only a few months or years removed from the comparatively settled functions and responsibility of "public health," may look nostalgically to the recent past as "the good old days." No longer is the job of organizational analysis limited to designing that agency structure that will maximize effectiveness, or permit increased services or new activities within the same budget. The old need to minimize frictions within the agency—always a neat trick in an enterprise so varied in program, goals, and the relevant scientific disciplines—has suddenly become vastly more complicated in its community-wide dimensions.

We can only speak in relative and general terms, of course, but in "the good old days" relations among governments were fairly orderly. Target populations were limited and usually known. The responsibilities of the health agency were comparatively stable and familiar. Expertness in function was, by and large, achieved. "The public" was usually quiescent, except for an occasional scrap over the budget, and more often than not had to be stirred up over health problems. Relations between the official and nonofficial sectors of the health services industry tended to be polite and comfortably distant, with fairly clear distinctions among roles. What was desirable in a public health system was fairly well known; textbooks were relevant, useful, and changed little between revisions; the American Public Health Association could issue an evaluation schedule to act as a standard for community health services. *Or* so it all seemed.

For not all of the problems of organization were amenable of solution. Indeed, none of them was ever more than partially solved. To be sure, the machine model, generated out of the application of the Scientific Management movement to public administration, provided a basis of order, a distribution of social and functional territories within the agency, and a mechanism appropriate to the key processes of budgetary and personnel administration (which have also changed). But the organization chart that adorned the office wall of the health officer and his key lieutenants only barely concealed the tensions and contradictions of the typical structure. The struggles between agency headquarters and their field units were (and are) classic examples of the effort to find a balance between the expertness of the specialist and the integrative responsibilities of the generalist. The tensions between state and local governments remained (properly, perhaps) a persistent problem. While administrative theory suggested that agencies could be organized according to program (tuberculosis control), process (personnel administration), or clientele (mothers and children)—as well as by area, administrators found their agencies had to use all these bases—and added organizational units based upon particular professional disciplines (nursing, social work), as well. An inevitable augmentation of tensions and struggles for loyalty resulted.

While consolidation and integration continued to be ideals in health administration, various public health functions struggled to become autonomous and self-sufficient. At various times and places, either within the agency or by the organization of special governmental districts, tuberculosis control, public hospitals, mental health, and medical

services to the indigent achieved organizational and fiscal identities of their own.

Health needs each generated special units, and the special units found and used constituencies to maintain identity and to present claims. Where political power was insufficient to resist the "encroachments" of administrative and budgetary analysts—and the health officer himself—the intricacy and mystery of the specialty itself frequently served as a defense.

Despite publicized definitions of the boundaries of public health, the frontiers were uneasy. It is difficult to say whether aggressions from the outside, or a sense of irredentism (e.g., school health) within the agency itself, was more powerful in this unease. There were patrols and excursions and skirmishes along the borders in efforts to alter the boundaries that lay between the public health agency and other governmental agencies with health responsibilities, and there was a consistent feeling-out of strength between the official and nonofficial sectors.

In retrospect, it is clear that the fundamental dynamism of health administration could not really be denied or rejected by freezing it into a tidy organization chart. The history tells us, further, that the old and well-propagated myth of the nonpolitical character of public health was a delusion—except, sometimes, in the sense of partisan politics. That the "nonpolitics" myth persisted as long as it did (and does) suggests that many opportunities were lost and many conflicts were generated because health professionals too often lacked the clarity of vision or the stomach for the rough and tumble of program and interagency politics.[3]

To the extent that the myth continues and has spawned an antipolitical ideology, and to the degree that organizational problems have not been solved, health administration faces its new challenges with a burden. Because some of these problems are ultimately insoluble—and because some current problems are extensions and intensifications of those of the past—the hand of the past lies upon the future.

Emerging Issues of Health Organization

But this is not the full limit of the issues in the organization of health services. The social clock has moved, perceptibly and significantly. The shape and the expression of American society has altered. These changes make a difference.

Place of the Local Governmental Unit

The rise of suburbia and development of communications and transportation has made the resources of major metropolitan centers accessible to scattered populations, while technological developments have greatly expanded the effective reach of administrative and service mechanisms. It is not difficult to hypothesize articulated systems of health services—such as medical care services—on a regional basis, with elementary and basic services performed at the locality, and more complex and specialized activities concentrated at the center.

But in most places, there are three barriers to activating these ideas. First, there is the existence of vested interests in practically sovereign local governments. Second, there are the values and emotions that attach to the idea of small government, whose decision-makers are accessible and responsive to relatively small-sized publics. When these values are maintained and are coupled to antipathy toward the metropolis and the prevalent social deterioration there, the development and maintenance of a balanced, rational distribution of responsibilities, tasks and resources become difficult. Experience in the Hill-Burton programs for the construction of inpatient

facilities demonstrates that even financial sanctions may be insufficient to overcome the resistance of smaller communities against becoming dependent upon larger centers for hospital and related services.

The third difficulty is that the regional level of administration is inherently weak. The region has no political or fiscal base of its own. It has no legislature to which it can turn to make its claims for authorization and funding. Its political executive will be the distant chief executive of the state (and his health officer) in an intrastate region; in interstate regional organizations, there is no single political executive to whom the regional administration can turn for support. Thus, regional administration is caught between the demands imposed from above and the resistance that arises from the local level.

Yet the ideology of regionalism in health administration grows stronger, without necessarily addressing itself to the strong tradition of localism. Even more difficult than establishing regional administration over areas lacking effective organized health services is the establishment of regional administration over (or consolidations of) effective units already in existence.

Bases of Field Organization

Another dimension of the areal issue centers on the question of (a) whether field units shall be organized according to how health problems and resources are distributed, or (b) whether such units should be organized on a standardized, coterminous administrative basis.

Taking three leading problems for regional administration—water and air pollution and articulated systems of medical care—it is most probable that each will have different distributions of their geographic and economic factors, and that political geography is likely to be irrelevant to all three. Drainage basins differ from the combination of industrial locations, population concentrations and geophysical features that affect air pollution. Medical care programs have to be based upon the distribution of facilities and human resources, as well as how people move and communicate. The "natural" conformation of all three programs is likely to have only accidental relationships to the boundaries of cities, counties, or even states.

A number of approaches to this issue promise to maximize cooperation and coordination among political jurisdictions. Each of them, however, involves either sacrificing existing social values (e.g., by absorbing local programs into new supra-local organizations) or increasing the number of organizational fragments by creating interjurisdictional confederations based on particular problem or resource distributions. In the latter instance, while coordination of the new fragments may be possible, it can be extremely difficult and expensive for a regional organization to do this, and in some instances the geography of the problem may make interregional coordination necessary as a further complication. These difficulties, then, tend to drive program administration to the state level or even higher, to the further detriment of the values of localism.

In some measure these difficulties can be eased by the development of improved information-gathering and exchange systems, employing automated equipment. But such developments will not by themselves obviate the necessity for more sophisticated patterns of management than now exist. And it will require the highest order of epidemiological, planning, and political insights to discern how local interest and initiative can be harmonized with broader views of specific problems and how problems and activities can be better related to each other. The achievement of these objectives and new equilibriums will involve a need for imaginative and highly

capable executive action, as well as a level of competence in information technology that we are only approaching.

The Definition of Integrity

Quite aside from the problems of political geography and program geography, the established boundaries of official health agencies have been brought into question by the related factors of size and status. Already in the larger public health jurisdictions, the sheer size of certain programs not only puts enormous strain on the coordinative abilities of executives, but also generates claims for independence. For example, as official health agencies assume responsibilities and assemble resources for massive programs of water and air pollution abatement or regulating the quality and financing of medical care, program directors find themselves developing relations with and dealing in areas unfamiliar to the executives of the official agency. The rationale for their continued affiliation with the health agency comes into question. They have before them the examples of major programs in mental health, industrial hygiene and school health, organized outside the public health agency, more often than not. Long-standing tensions among the professional groups involved in public health come to the fore and foster aspirations to greater discretion and status through the separation of these programs from the health agency, and the achievement of equal status with that agency.

Looked at objectively, the choice among organization values is cruel. On the one hand, there are opportunities for the program: to escape from having to conform the program to the rules of the agency; to augment the political potentials of the program by giving it greater visibility; to move faster by shortening lines of communications with central control agencies, the legislature, and program constituencies.

On the other hand, the independent organization of these and other programs represents a loss of potentially fruitful melding of research and services addressed to the environment and to the person. Administratively, there will be costs of duplicating supporting services in several agencies, increasing the span of oversight of the chief executive of the governmental jurisdiction, and increasing the competition for personnel and other resources, and still further complicating—perhaps to the point of impossibility—the coordination of services.

The Clientele Approach

The emergence of massive programs oriented to specific clienteles, notably the War on Poverty, raises still another issue for health administrators, among others. Such programs represent a protest against existing fragmentation of responsibilities among agencies and against traditional ways in which agencies do business. When the urgencies of the problems affecting a particular group in the population impresses itself on political leadership, the official health agency is faced with the choice of responding to these strong signals either by liaison or by reorganization. Liaison implies the introduction of "clientele specialists" to coordinate and stimulate contributions from various units within the official agency. It may result in the least disruptive, but it is also likely to be less responsive to political claims. Reorganization, by establishing special units to be concerned with the problems of a particular clientele, will involve costs of duplication and tension. But it will tend to be politically responsive by giving the clientele representation in struggles for allocations, authorizations, and visibility.

The Sectoral Boundary

Recent federal legislation has involved health agencies deeply with problems of medical care that until recently were

matters of interest but not responsibility. The issue before official health agencies is: Where is the new boundary of the official sector vis-à-vis the private and voluntary sectors to be set? Realistically, the answer to that question will evolve over some years. So long as it remains an active question, a strong element of uncertainty must continue to exist in the organizational planning and actions of official agencies.

The Title 18 and 19 Amendments to the Social Security Act, the regional programs for heart, cancer, and stroke, and the legislation for comprehensive health planning (P.L. 89-749) all involve official health agencies more intimately with the private and voluntary sectors. In certain states and large municipalities, additional legislation intensifies involvement in such areas as medical audit, approval of construction for inpatient facilities, financing of those facilities, and major programs of medical research.

In some instances, the legislation is partly a hunting license and partly a promissory note. Beyond certain core authorizations, the interests concerned are left to negotiate and otherwise develop the extent and character of their respective participation. Uncertainty in structuring and managing organizational results. Not only do the boundaries, which define the scope of the agency, remain ambiguous, but the agency may need to reorganize itself more than once within a relatively short span of years, in order to attain and maintain a structure of authority and communications that will respond to a changing situation.

Place of the Planners

Under the impetus of P.L. 89-749 and various governmental efforts in Programming—Planning—Budgeting Systems (PPBS), a quiet revolution has begun to take place in the planning of health programs and activities. Earlier —and not notably well developed— planning efforts by official public health agencies were mainly concerned with mounting effective programs of limited scope. By contrast, contemporary planning efforts are to be directed toward policy formulation, to use highly sophisticated statistical information and planning technics, to emphasize values of coordination and holism, and to become involved with the private and voluntary sectors in varying ways.

These expectations are substantial enough to require the development of specialists in health planning prepared in a more rigorous and professionalized basis than heretofore: indeed educational efforts to develop such specialists are already under way. The emergence of such health planning specialists will challenge the assumptions that previously governed the organization of the planning process. These assumptions were (1) that planning was but one aspect of managerial or executive activity, (2) that the training in planning contained in the typical public or business administration curriculum provided adequate expertness to the health agency, and (3) that through a minimum of training and progressive experience, health officers and other executive personnel without professional administrative training could contribute the necessary guidance and direction to planning efforts.

Beside this stands the conception of planning as a major social process and institution, equal (if not superior) to budgeting in guiding the outcomes and direction of governmental and quasi-public agents. In this view, planning is coordinate with health, education, public works, and other public functions. Central planning agencies legitimately would make claims upon planners in health agencies as their counterparts[4] and supporters.

While such an ideology may have an intense and shocking impact upon health

agency organization, it appears likely that to view planning as being simply another of the functions of managers will not be a socially or politically viable position in the years to come. The finding of a middle ground—and obtaining acceptance for it among the parties concerned—is becoming an urgent problem for health leaders. Nor will this be the last "new" specialization to emerge.

Conclusions

It appears that—beyond the continuing problems from the past—health agencies are faced with problems of organization centering upon levels of governmental authority, programmatic versus community bases of organization, the needs of special clienteles, the divisiveness of disciplines, the relationship of governmental efforts to voluntary and private efforts, and the impact of new processes and specializations. What is striking about these problems is that they are not so much administrative in character as they are political. They have to do with the structuring of authority and power.

Search for a Theory of Organization

If this be so, health executives cannot go about finding resolutions of these issues by simple reference to the body of administrative theory. It is not that administrative theory is useless—indeed, it has provided the framework for the preceding analysis of organizational issues. But it cannot be expected to provide formulas and clear solutions, mainly because the nature of the emerging issues go beyond the issues with which conventional administrative theory has been concerned.

The two most influential and most complete bodies of administrative theory seem to be inadequate to the task that faces health leaders. Both Scientific Management theory (also called traditional or O & M), and the human relations variant are probably inapposite to the most crucial of these issues because each uses an equilibrium model, seeking to define a pattern of organization that will operate with a minimum of friction and conflict.[5]

A third body of organization theory —behavioralism—to date has produced only fragmentary findings and may be generically incapable of developing a general body of theory. The fourth body —general systems theory—is as yet insufficiently developed, particularly with respect to nonphysical processes.[6]

This deficiency is more than an academic matter, for the theory that health executives absorb and observe tends to govern their expectations, ideals, and behavior. And theories that assume clear boundaries, stable goals, settled relationships, and lasting divisions of responsibility and function will not be responsive to the needs of community health at the present time. Such theories cannot adequately orient executives for innovation, bargaining, modifying, planning under conditions of uncertainty. They cannot raise the administrator beyond the level of coping with conflict—to dealing in it.

Certain elements of administrative theory may be applicable and useful, but they will not be completely relevant unless they are joined to certain elements of political theory appropriate to the character of the problem. Consensus-building, constitutionalizing, bargaining, coalition-formation, compromise and trade-offs may sound strange in the lexicon of community health administration—but they are the keys to the future.

Yet, because these terms and concepts may not only be strange but even abhorrent, the first step of attitude reorientation may be the most difficult to take. So long as the myth of the nonpolitical character of public health prevails, too many health leaders will be frightened off by the label of politics. If this be-

havior persists, we may be signaling our incapacity to appreciate the character of the problems we face, and our inability to select the analytical and predictive instruments appropriate to those problems.

REFERENCES

1. Morstein, Marx F. Elements of Public Administration (2nd ed.). Englewood Cliffs, N. J.: Prentice Hall, 1959, p. 24.
2. National Commission on Community Health Services. Task Force on Organization of Community Health Services. Health Administration and Organization in the Decade Ahead. Washington, D. C.: Public Affairs Press, 1967, pp. 9, 13, 17–21. Chapter V.
3. Schaefer, Morris. Area and Function in the Administration of Public Health in New York State. Chapter VII. (Unpublished doctoral dissertation at Syracuse University, mimeo, 1962.)
4. Hilleboe, H. E., and Schaefer, M. Papers and Bibliography on Community Health Planning. Albany, N. Y.: Graduate School of Public Affairs, State University of New York, 1967. Part One, "The Middle Way in Health Planning."
5. Krupp, Sherman. Patterns of Organizational Analysis. New York: Holt, Rinehart, and Winston, 1960. Chapters 6 and 9.
6. Schaefer, M., and Hilleboe, H. E. The Health Manpower Crisis: Cause or Symptom. A.J.P.H. 57:6–14 (Jan.), 1967.

Dr. Schaefer is Professor and Head, Department of Public Health Administration, University of North Carolina School of Public Health, Chapel Hill, N. C. 27514.

This paper was presented before a Special Session on Current Issues in Reorganization to Deliver Better Health Services at the Ninety-Fifth Annual Meeting of the American Public Health Association in Miami Beach, Fla., October 23, 1967.

Respiratory Disease Fellowships

The American Thoracic Society, medical section of the National Tuberculosis and Respiratory Disease Association, offers fellowships for training in the field of respiratory diseases. Physicians entering the second or third year of residency in internal medicine, pediatrics, or thoracic surgery, or other specialty; holders of doctoral degrees interested in advanced work in this field; and graduate students with a B.A. or M.A. who are to work on a research project in this field for an advanced degree other than an M.D., may apply for training fellowships.

Edward Livingston Trudeau Fellowships may be granted physicians who have completed their formal training in respiratory diseases and are assured of a teaching or research appointment during the fellowship year.

Applications must be submitted by November 1, 1968. Further information from Director of Medical Education, American Thoracic Society, 1740 Broadway, New York, N. Y. 10019