How can diversity and coordination in planning be brought together in integrated fashion? Problems that arise in decentralizing administration are considered here on the basis of experience in a large urban center.

AN EVALUATION OF DECENTRALIZED PUBLIC HEALTH ADMINISTRATION

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DECENTRALIZATION of services has presented public health agencies with challenging, and somewhat controversial, issues over a period of years. The challenge has been how to capture the advantages of efficient decision-making at remote locations while overcoming the problem of coordination with over-all objectives. Restated, it is how to integrate diversity and planning. From the perspective of a study of decentralization in Philadelphia, this paper will analyze some of the problems crucial to decentralized administration.

Definition of Decentralization

Before any intelligent discussion of decentralization can take place, it is necesary to define carefully what is meant by the term. It is not uncommon for an operation covering a wide geographic area to have field offices located at remote locations for the convenience of travel or other considerations. This deconcentration of personnel does not necessarily involve decentralization of administration, as there remains a direct chain of command with the central office with little or no delegation to the field personnel of the power to make important decisions.

Sometimes, comparisons are made erroneously with the relationships between a state government office and a similar office in the local government. As each of these has its own power base in an electorate, the analogy is not germane.

In this discussion, decentralization will refer to the intentional division of authority to make important decisions within a unified agency at a single level of government. In the public health framework, the term has had application to efforts to vest such authority in district offices serving a defined geographical area, but all within the same political jurisdiction.

Health Center Administration

The concept of health centers began to develop in the United States before World War I. The earliest health centers were extensions of the outpatient services of large municipal hospitals.[1] As the concept developed, the center became a base for public health operations, providing clinical services in the center and serving as an office for public health nurses and epidemiologists who worked with the populations living near the center. As time progressed, the advocates of the administration of public health programs through health centers under a system of decentralized administration have been numerous. One such is Hanlon who bases his position in part upon the necessity for the health agency to establish inter-

personal relationships where the people live in their own neighborhoods.[2]

There have been few analytical studies of decentralization in public health agencies. New York City, where the decision to decentralize was initially made in 1915, has been studied extensively. Kaufman's report indicates that original objectives have yet to be obtained.[3] He identifies problems to be tradition, specialization, ease of communications between specialists, lack of political identity of districts, and the blending of the definitions of technical and administrative questions.

Studies by Silver and Lilienfeld led them to take a negative position with respect to the probable success of attempts to decentralize administration.[4] They conclude that such efforts are designed to justify the necessity for a district health officer, and they recommend that the position be abolished altogether. An editorial appearing in the APHA Journal discusses the pros and cons while leaning toward a position favoring decentralization.[5]

In 1963, a questionnaire was circulated by the author to a list of county and city health agencies which had a population of about 500,000 or more. Replies were received from 25 jurisdictions.[6] There was an indication that district offices are established when the population served reaches about 750,000. Above 1,500,000 population, there is an apparent tendency to establish administrative supervision in the district office. Most of the agencies made a distinction between administrative and technical supervision, with technical supervision provided by a central office even when there was administrative supervision provided at the district office. This survey was of a limited scope, and its results are suggestive only.

Decentralization in Federal Agencies

A number of studies of decentralized administration in federal agencies have been conducted. Kaufman, in describing the Forest Service, reviewed the agency's desire to adjust the actions of rangers to the local situation. However, in so doing, the agency was confronted with the problem of maintaining adherence to the general policies and purposes of the organization.[7] Rotation and promotional policies were established to counteract the local pressures to deviate. Truman, in his study of the Chicago field offices of the Department of Agriculture, noted the central office concern with the question of uniformity.[8] Selznick's study of the TVA showed how easy it is for an agency's program to be distorted by accommodation to local influences.[9] In this case, conservation programs of the TVA were imperiled by adjusting the programs to the pressures of farmers in local areas.

Business Experience

Decentralization has occupied considerable interest in business discussion and literature. G. A. Smith, Jr., has written a book analyzing problems of decentralization in business organizations which is based upon 10 to 25 years of contact with the companies with which he gained his experience.[10] Smith cautions against the adoption of decentralization as a goal in itself as though it were a fad. Instead, he recommends the determination of where best to perform given tasks and to make certain decisions. He envisions an organization in which some decisions, particularly fiscal ones, may never be delegated even though there is a great degree of decentralization otherwise. The "proper" set of arrangements will change with time. Thus we see companies decentralizing some activities while centralizing others, and one company will be decentralizing while another is centralizing.

Smith is highly critical of the imprecise language that is used in the discussion of decentralization. He attributes many of the disappointments of person-

nel to this failure. Three misleading implications are:

1. That it will start at a definite time and be completed at a definite time.
2. That all the intended changes in authority are downward delegations.
3. That this program is somehow separate and separable from the routine job of running the company.

If decentralized operations inherently present more problems in management than those that are highly centralized, as Smith indicates, then why do we even consider decentralization? It is because complex problems are sometimes solved best by decentralized organization.[11,12] Cordiner has attributed the tremendous growth in sales and profits at the General Electric Company since 1951 to the introduction of a decentralized form of organization.[13]

Philadelphia's Plan

To gain more knowledge of the operations in an organization that functions on a decentralized basis, an intensive study of the Community Health Services of the Philadelphia Department of Public Health was undertaken in 1963.[14] The presumed advantages of decentralization of administration to district health centers was discussed in a 1929 survey[15] and again in a 1949 survey.[16] To some extent it may be said that the decentralization of administration was sought as a goal in itself. While there were district health centers established in the city for a number of years (since 1941), it was not until a new plan of organization was put into effect (in 1958) that the district health director had any real authority over program operations in the district.[17]

According to the new plan, primary responsibility and authority for the execution of field activities was assigned to the district health directors. All personnel working in a health district were made responsible to the district health director. The districts were further charged with responsibility for the initiation of requests for capital and operating budgets, personnel, and material for programs; accountability for expenditures; work assignment and supervision of personnel; development of community relationships; information and recommendation on district health and program needs. Performance evaluation and discipline of personnel was a district responsibility, but the district director was required to consult with the appropriate central program division on such matters. Execution of program was to be in accordance with established professional technics and program standards.

Supporting the districts was the central Professional Direction Group which had primary responsibility for determination of program content and professional method. These central divisions were charged with program planning and development, establishment of technical procedures and program standards, evaluation of program performance and effectiveness, consultation services to districts, and establishment and control of enforcement activity. These central groups were also responsible for the establishment of position classes and their performance standards, recruitment and appointment, resolution of competitive needs for budget and staff, personnel rotation, professional and technical training.

There was no question that there was a greater degree of decentralization of administration after this new plan was introduced. At the time of this study (1963), Philadelphia had been described as having made more real progress in its efforts to decentralize its administration of public health operations than any other large local public health agency in the country.[18] This is not to say that problems had not been experienced. In fact, many district health directors felt that some of their expectations of the new plan had not been fulfilled. Some

program directors were also disappointed but for different reasons.

It was decided to evaluate the operations under this plan for decentralization by studying the communication patterns. Previous writers have shown that communications are frequently the best measure of the actual functioning of an organization.[19-26]

A basic feature of this study was a detailed content analysis of all of the communications of the personnel of the Community Health Services. A mark-sense card was specially designed for this purpose. Elaborate precautions, such as pretesting and pilot studies, preparatory inservice training of a staff, instruction manuals, supervision of the study, internal consistency checks, and post-survey interviews at random, were taken to insure the validity of the data.

A date was selected that covered a period of the year when communications on program needs, plans, and budgets were likely to occur. For about one month (January 7, 1963, to February 5, 1963) environmental health communications were reported, and for about one week (February 6, 1963, to February 15, 1963) all community health services communications were similarly reported. There were over 5,000 communications reported during the environmental phase and almost 10,000 for the other. This was exclusive of many routine communications, such as inspection reports.

Results and Analysis

An obvious finding of this study is that communications are, indeed, a vital factor in the administration of any program and that decentralization of administration presents special problems in communications. Tables 1 and 2 portray the general characteristics of the data from this study. The preponderance of communication with the public is through central office personnel. The bulk of communications between the central office personnel and those in districts was directly between the professionals in each office. This latter might not be viewed so seriously if other analyses (not shown) had not revealed that the communications of district health directors dealt primarily with routine-type matters, such as leave and travel, and that communications concerning program content, budget, and so on, bypassed the district director.

In general, one could say that the communications patterns revealed a role for the district health director that was contrary to the organization plan. This study indicated that the district director was a manager of sorts for the district, relating more to minor routine administrative matters than to program needs and community relations.

While these findings are interesting and tend to corroborate other studies, the important question is, "Why?" What

Table 1—Proportion of contacts with the public by district and central offices: community health services phase, February 6-15, 1963

Public member or group	Per cent of contacts	
	district	central
Mass media	6	94
Public member		
Individual	38	62
Proprietor	34	66
Consultant	24	76
Attorney or physician	33	67
Political figure	0	100
Public group		
Business and trade	8	92
Civic	36	64
Health and welfare	36	64
Local professional organization	29	71
State, national, and international professional organizations	12	88
Total (N=3,314)	34	66

Table 2—Summary of contacts between central and district offices in per cent: CHS phase, February 6-15, 1963

Central Offices	District Offices																	
				C. N. S.				Dent.		E. H.		Epi.						
	Dir.	A. A.	Clk.	Supt.	Asst. Supt.	P. and T.	Clk.	Dent.	Dent. A.	Supt.	P. and T.	P. and T.	Clk.	P. and T. H.T.	Hlth. Ed.	P. H. Lab	Per cent of total
C. H. S. Dir.	88.9	11.1															0.6
Bldg. Maint.	15.8	63.1	21.1														1.3
D. H. O.	22.3	27.4	44.6			1.7		0.6		1.7	0.6				1.1		11.7
Dent. Hlth.	7.3	5.5				0.9		43.6	42.7								7.4
Env. Hlth.	4.9	1.1	28.3	1.1		0.5				50.0	13.1	0.5			0.5		12.3
Epi.	4.8	1.0	50.9	5.0	5.8	20.7	0.4					8.0	0.8		2.6		33.5
Hlth. Protec.	32.0	7.5	30.2	1.9	5.7	11.3						1.9	3.8	3.8	1.9		3.5
Ment. Hlth.			16.7			83.3											0.4
C. N. S.	3.4		1.7	49.6	14.9	26.3	3.4					0.7					19.9
Hlth. Ed.	30.0	2.0	6.0		2.0										60.0		3.3
P. H. Lab	6.2	6.2	31.4		18.8	6.2				6.2		18.8				6.2	1.1
Stat. and Res.	12.0		77.4	5.3							1.3				4.0		5.0
All	9.6	5.4	31.9	12.0	5.4	13.3	0.8	3.3	3.1	6.4	1.7	3.1	0.5	0.1	3.3	0.1	100.0

can we do about it? At this point, we can only speculate.

In the reorganization of the Community Health Services, it appears that the organizational method was adopted first, rather than matching the organizational arrangements to the over-all objectives. The objectives of this reorganization were clearly stated. There was also a delineation of responsibilities. However, it appears that preplanning stopped short of developing a conceptual model of the contemplated organization to determine who would perform certain functions and where decisions would be made for very specific actions. The end result has been that some of the objectives for which the new plan was formulated have not been attained.

It may be asked whether, in fact, all of the organizational objectives were mutually compatible. Thus the assignment of responsibility for program content to the central divisions may encourage the public to make contact with the central units rather than the district. The selection of personnel for assignments and for advancements by the professional divisions may encourage the field personnel to be more concerned about their relations with the central office than they are about their relations with the district director.

Cordiner's experience at General Electric brings out two points for consideration here.[27] He felt that it was important to managerial decentralization to reduce the strength and power of the central offices. Secondly, organizations should be considered to be dynamic and subject to continued review and change. In the case of the Community Health Services, the central staffs were maintained at approximately the same strength. The field offices were not strengthened. It may be that the established arrangement was just a step on the road to a more complete decentralization, but the plan that was adopted was as far as many of the members of the organization were willing to go at the time.

Proposals for New Approaches

This review is useful only as it may suggest courses for future organizational development. While there may be others, there are three possible approaches which will be discussed.

Improved Communications

Since communications have not received the same attention that has been accorded formal organizational arrangements, it is reasonable to suppose that this would be a profitable area for exploration. It must be borne in mind, however, that the informal communications system is an integral part of the functioning organization. If all communications of the district were required to be channelled through the district health director, there probably would be disregard of the orders or communications would come to a near standstill. The volume of communication is such that it could not all be funnelled through the director's office.

The problem is twofold. One is to involve the district director in those communications which are necessary for him to exercise the responsibilities which have been assigned to him. At the same time, he must be relieved of the administrative communications about routine personnel and fiscal matters. In this latter case, the importance which the higher levels of the department, and even the top city officials, place upon such communications is a controlling factor. This study showed a high proportion of communications related to such matters, and it would be worth investigating to see if public administration requires this emphasis on personnel and fiscal control.

One way to relieve the district director of these chores, assuming that continua-

tion is necessary, would be to strengthen the supportive administrative services in the district. This is not intended to mean merely the provision of the usual administrative assistant, but the placing in the district of a professional administrator who has been trained in public health administration.

This would allow the district director time for his assigned duties. However, in order for him to exert an influence on operations and coordinate related activities, he must be drawn into communications pertaining thereto. The central divisions will have to show restraint in communicating directly with their professional counterparts in the district about matters which fall within the district director's responsibility.

The location of decision regarding program content and emphasis in the central office may encourage contact at that point with the public. Furthermore, the political organization of the city may dictate that the central offices be held accountable for maintaining responsiveness to the community needs. Since Philadelphia has a "strong mayor" type of government, this factor may always impede decentralization, or assignment of responsibilities to district offices.

The professional identity of the field personnel is associated with corresponding central offices. These offices determine the future advancement of this personnel, and advancement may be achieved only through professional lines. These factors present problems of loyalties which can affect the relationships of these professionals with their district director and the central offices. It is unlikely that this situation will change unless there is a major reorganization.

District Manager

A quite different approach would be to presume that the present communication patterns represent a workable solution discovered by ingenious employees. Such an assumption would suggest the modification of the formal organization to conform to the informal arrangements which have evolved.

This study suggests that the role of the district director is one of handling routine minor personnel and fiscal matters related to the operation of the district health center. If this is so, it could explain the discontent which the directors appear to manifest. The training background of the public health physicians who are specified to fill these positions would provide them with expectations which would not be fulfilled by the apparent present role. Even if one disregarded these personal feelings, it would be a waste of scarce technically trained persons to assign them to such a routine managerial role. A person who had been specifically prepared for such a position would be more content with his contribution to the organization and might do a better job.

A change in position classification would require a reexamination of the objectives of the plan to decentralize. It would seem to be even more difficult for a person in such a position to exercise command in the district necessary to the coordination of related activities. It would be difficult for such an individual to provide the symbolic representation of the total public health program to the community. Competition between programs, rather than cooperation, may be fostered.

This proposal would tend to continue the strong central direction by professional divisions which exists. This would coincide with the tendency of other municipal departments to operate under highly centralized arrangements. Some may consider this to be an advantage, as "functional" organizations are reputed to suffer little from "organizational confusion."[28]

While this approach might have features which would commend its consideration under certain conditions, its adoption would require the abandon-

ment of some of the objectives of the present plan. However, the stated objectives appear not to have been obtained. This suggests rethinking. Practical considerations may lead to a favorable response to this proposal, while it might otherwise be rejected if all factors could be controlled.

Strengthen Districts

A still different approach is to assume that the original subsidiary objectives should be retained as necessary to the basic purpose of rendering services to people. These goals do have rational foundations in that they derive from basic values of the American political system.

One may speculate that the assignment of primary responsibility for program content to the central divisions is incompatible with the stated objectives of the plan for decentralizing operations. Perhaps other delegations of responsibility would be more conducive to the attainment of these objectives. Also, experience in business administration suggests that the relative strength of the districts needs to be increased with respect to that of the central offices.

One way of strengthening the districts would be to add sufficient highly trained and competent personnel in the various professional areas so that the districts would become more self-sufficient. It is doubtful if a large enough increase in appropriations could be obtained to finance such an augmentation of district staffs.

Another idea which could accomplish the same result would be to detach some of the high-level professionals from their central offices and assign them responsibilities in the district offices. This would simultaneously weaken the central offices and strengthen district offices. Such a proposal could be expected to be rejected off-hand by the central professionals unless there was an accompanying reorganization which relieved them of current responsibilities which they no longer would be able to fulfill with a reduced staff and which also resulted in their acquiring new responsibilities which would appear to be important, necessary, and attractive.

Under such an arrangement, the function of the central office would be recast to one of research and development, the preparation of longer range plans (i.e., five years or more), consultation, and evaluation. The central office would be relieved of all operating responsibility, including the preparation of annual budgets. These responsibilities would be handled by a chain of command from the director of Community Health Services through the now revised concept of a district director. This line of direction would have to be respected by the city administration and political leadership.

Such an arrangement would still have two problems which require resolution. One is that the personnel department would have to be persuaded that the new duties of the central components were sufficiently important to maintain high enough salaries to attract and retain the highly trained people necessary to the new functions. (It may even be necessary to persuade budget managers that such functions are important to maintain.) There is a tendency for personnel agencies to evaluate jobs for classification and pay on the basis of the number of persons supervised.

If this question could be satisfactorily resolved, the professionals in the district would still look to the central office as the only avenue of advancement. This could be overcome only by opening directory positions in the districts to all public health professionals who possess the necessary administrative abilities. Two channels of promotion would be available thereby—one through technical specialization and the other through generalized management. For district director, the administrative and community relations talents seem to be more important than

medical, nursing, engineering, or other technical training, although professional public health experience seems essential.

This proposal represents such a marked change from present arrangements and prior concepts that it might not be readily accepted in full. Yet it appears to be the type of proposal that would suffer greatly by compromising with other possibilities, for the essential ingredients for its success might be omitted in the bargaining. Thus it would be doomed to failure from the start. However, if it were carefully thought through and if the necessary approvals were obtained, this proposal seems to be the one most likely to produce a progressive and dynamic organization which could be responsive to the local community interests and at the same time be looking ahead to take care of any eventuality which might face the city.

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