Why has decentralization of health services had so little appeal? Or are there factors and problems that impede the application of this idea? Is it better to use generalists or specialists in such endeavors? These and other related questions are considered and answers involving an equilibrium concept are offered.

ADMINISTRATIVE CENTRALIZATION VERSUS DECENTRALIZATION AND THE ROLE OF GENERALISTS AND SPECIALISTS

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Introduction

ONE hears much talk these days about decentralized health services. Numerous plans and projects for storefront clinics, satellite health facilities, and local health districts are suggested as a means of bringing needed services to patients with a maximum of availability, comprehensiveness, and use. Such plans are not new, however. As early as 1915, the leadership of the New York City Health Department set about to decentralize its services.[1] By 1920, Hermann Biggs was talking about the desirability of local clinics[2]; A. C. Burnham was reporting the accomplishments of a health center in Alameda County, Calif.,[3] and a local "Social Unit Experiment" in the Mohawk-Brighton District of Cincinnati, Ohio.[4]

Although people have considered decentralization of health services a good idea for many years, minimal progress has actually been made in achieving it. For example, a recent survey of the Philadelphia Health Department, which assertedly had made more progress toward decentralization than any comparable agency in the country, exposed the supposed decentralization as largely illusory.[5]

With the benefit of hindsight it is now possible to see that decentralization is difficult to accomplish. Its advocates have been inclined to believe that once its advantages were pointed out, the appeal of decentralization as a rational pattern for rendering service would make implementation come about quite naturally. In specific application, however, decentralization appears to have lost much of its appeal. Since optimism about decentralization being adopted has not proved justified after these many years, it seems appropriate to explore why.

In this article we try to identify and to explain some of the actual administrative mechanisms that have bearing upon the issue. We attempt to do this, not by analyzing the whole field of health administration, but by examining one important part of that field, the decentralization of health departments and the role of generalists and specialists in

such a framework. We will demonstrate that leaders of these departments who contemplate the decentralization of services do not have clear-cut principles to guide them and are actually confronted with complex issues. In the absence of determining principles, a concept that can exalt tolerance yet keep major health and administrative goals uppermost in the consciousness could be very useful—especially if other health administrators share in this perspective with their leaders.

The Problem

Large health departments serve many people and often encompass extensive geographic areas. They employ generalists and many different kinds of specialists. Such characteristics afford organizational alternatives: (1) Should decisions relating to local neighborhoods (or subcommunities) be made by district offices in such neighborhoods (or subcommunities) or should they be made in the area's central office; and (2) should such decisions be made by the various specialists involved (e.g., venereal disease experts, sanitary engineers, maternal and child health physicians) or by generalists in charge of major divisions? Since both generalists and specialists are found in the field and in the central office, these organizational alternatives become fused into a single complex issue: Should decisions for local purposes be made by a generalist in the field who, in making such decisions, supervises the specialists in the field, or should specialists in the central office make all decisions and supervise their respective specialty counterparts in the field, thereby bypassing both central office and field generalists?

A set of competing values is found in (1) the need to establish decision-making power in field offices where multitudes of varying challenges occur, and the information and understanding relevant to their solution are most readily at hand; and (2) the need to maintain decision-making power in the central office, where major policy directions must be determined and where the ultimate responsibility for actions taken and for over-all coordination reside.

But there is still another dimension involved—the competing roles of generalist versus specialist. Specialization, the division of labor, is the hallmark and fundamental element of modern administration. However, once labor has been divided, the administrator must try to assure coordination to provide an integrated final product. Historically, the specialist has been regarded as the embodiment of division of labor; the generalist, on the other hand, has been regarded as the coordinator or integrator. Traditional views consider the generalist as necessary because coordination is an element of administration, and presumably he can coordinate in situations where the specialist is unable to do so. But increasingly it is asserted that, even when there is conflict, specialists can provide what coordination is needed and that generalists should defer to the specialists.

In the absence of consensus, the generalist, if he is charged with the coordinating responsibility, often resorts to the use of authority. However, there is impressive empirical evidence that authority stultifies the performance of those upon whom it is imposed, especially if they are people whose work requires imagination and judgment—so often true of specialists.

There are, then, two interacting problems in administration—centralization versus decentralization and specialist versus generalist—each of which accentuates the complexity of the other as the size of the community increases. The larger the community, the greater the need for decentralization. The larger the community, and therefore the health department, the greater amount of spe-

cialization that is likely to occur. The more specialization, the more intricate become the patterns of relationship among generalists and specialists in both the central office and the field offices. A still further complication is frequently found in the presence of an intermediate level—state or city regional offices—with their own complements of generalists and specialists. The number of possible permutations is indeed great. To establish an orderly set of channels of relationships, with so many different places where things can go wrong in such a complex matrix, practically requires legerdemain.

Decentralization

In recent years, many writers on administration have argued for moderating the rigor of central authority. One of the strong themes found pervading organizational theory is the need for expanded decision-making freedom at lower hierarchical echelons. An example of this is given by Blau and Scott:

> "An implicit assumption of bureaucratic theory which we have had repeated occasion to question is that hierarchical authority and discipline are compatible with decisions based on expert judgments made in accordance with professional standards. It seems, on the contrary, that there is a conflict between these two conditions. Rigid discipline stifles professional judgments. Conversely, hierarchical authority is weakened by increasing technological complexity in an organization with its resulting emphasis on technical expertness for all personnel including those on the lowest operating level."[6]

Although this theme of academic opinion concerns organizations generally, decentralization to field offices does receive some specific attention. Blau and Scott distinguish between "interdependent" and "parallel" specialization and offer the local units of the Internal Revenue Service as examples of the latter, where coordination from a central authority tends to be unnecessary. They argue that each local office has a full complement of the various kinds of employees needed to carry out its work, and that efforts to coordinate activities should occur at and from these offices rather than from some remote, more central source.[7]

Not only is the academic world pressing decentralization. It also has become a movement in the field of mental health institutions with numerous enthusiastic advocates among mental health administrators.[8] Within state and local health departments, one also encounters many county and district health officers (the people in charge of the field offices) who feel they cannot do their jobs adequately without decentralization. These health officers protest that administrative castration results when they cannot supervise their own staffs, personnel changes, or make budgetary determinations. They become frustrated when obliged to negotiate with a string of specialists from the central office on minor decisions. Even more distressing are central office decisions made and relayed to field staff without informing the person in charge. Despite justifiable pressures from the field for greater autonomy, it is exceedingly difficult to gain acceptance of decentralization by central office specialists.

Chief among the problems encountered are those involving confidence. Central office administrators are ultimately responsible for the conduct of health departments. Consequently, much of the reluctance to delegate decision-making authority stems from an expectation on the part of these officials that they will be held accountable for field mistakes. This condition is exacerbated by the harsh fact that it is not always possible to staff the district offices with personnel whose competence is commensurate with their responsibilities. Because the well qualified are sometimes loath to accept assignments in which their authority will constantly be in dispute, there is a vicious cycle aspect to this situation. As a result, the chicken-and-egg meta-

phor is relevant: Should decentralization be promoted by delegating authority or by securing leadership at the district level?

Loss of status fears on the part of central office personnel may also impede decentralization. Some health administrators have found that, as operations were shifted to the field, fewer central office personnel remained to be supervised; civil service rules arbitrarily dictated reduction in the rank of central offices. Such status considerations are not entirely groundless.

For the most part, however, fears of losing status and influence in decision-making by the central office personnel are grounded in a misunderstanding of the phenomenon "power." Such a conception is based on the "pile of stones" theory of power (using "power" and "influence" interchangeably) which holds that there is only a finite amount of influence; if field offices have more, then central office must have less. However, as Robert Lynd has made clear, there is no limited amount of power and it is quite possible for both offices to have simultaneously a greater or lesser impact upon decisions affecting their work.[9] A statement by Robert Golembiewski is relevant to this discussion:

> "This (a paradox he is discussing) might seem curious but only if one assumes there is only so much 'power' to be had, so that what superiors gain subordinates must lose. The fact seems to be, on the contrary, that a high-power supervisor can afford to (and usually does) allow his subordinates to exercise greater power also. A low-power supervisor is in such an insecure position that he can seldom bring himself to be so generous. The paradox, then, is that the apparently most straightforward way of adding to one's power is often the most direct way of reducing it."[10]

Thus, decentralization of decision-making is not an "either-or" matter, with all the power tending to reside in only one place. It is, rather, a matter of sharing, and the problem lies in determining what phases of the decision-making process should occur at each level. As Herbert Simon has pointed out, specialization occurs not only horizontally among work processes (e.g., casefinding or rehabilitation in health departments), but also vertically among phases of decision-making, with persons at different levels having different decision-making functions to perform.[11]

Although these views pertain to decentralization, there are other factors that must be considered—factors concerned with specialization. First, it is inescapable that over-all coordination must come from a central source. District health offices might be seen as examples of "parallel" specialization, but some central body must determine the allocation of resources among them. For example, in emergencies who, but central offices, can temporarily transfer field personnel among district offices? Is this not coordination? Second, especially in official agencies, it is the department head alone who must ultimately be held responsible for all decisions made in the department. While he is advised by teachers and practitioners of administration to delegate decision-making authority, he cannot delegate final responsibility for decisions. Thus, from the standpoint of developing thrust to get work done, one principle prevails; but, from the standpoint of coordinating the work and legal accountability, a conflicting principle predominates.

Hardly anyone has advocated abandoning either central coordination or the legal accountability of department heads. Moreover, at each succeeding echelon below the department head, the same conflict of principles is encountered. Thus, administration is conducted in a climate of countervailing principles.

The Specialist

Orthodox administrative thinking about the allocation of responsibilities

among specialists and generalists may be summed up in the terse expression: "The expert should be on tap, not on top." If the generalist is "on top," then he is in the command post. The specialist tends to be assigned a staff, advisory, or consultant function and is denied the responsibility of final decision-making.

It can be noted that the differentiation between these two types is relative. To a mayor or a governor, for example, the head of a department of health is a specialist in public health matters. However, to his subordinates he is definitely a generalist. Observing this relativity from a different dimension, it may also be noted that some generalists are "more general" than others. At one end of a spectrum, a man, as in the British tradition, may be transferred from directing the nation's railroads to directing its telephones on three days' notice—the complete amateur or "expert by assignment." At the other end, a generalist heading a health department may be a physician with several years of experience in a number of health specialties—hardly an amateur in public health. One would not expect him to run the public works department, but one might expect him to administer the health department despite its many professionals.

Almost 20 years ago, Dwight Waldo characterized the epigram "the expert should be on tap, not on top" as nothing more than folk wisdom. However, he was quick to acknowledge that the expression had wisdom, at the same time deploring the absence of any rationale for it.[12] Not much progress has been made since then in understanding why the expert should not be on top. In fact, the "generalist" proposition has been severely challenged. By 1958 James Fesler was saying that although earlier ". . . the generalist 'school' had won out over those arguing that a man must administer something and that a knowledge of that something is a necessary qualification for high administrative rank, new doubts are arising, or old doubts reviving."[13]

In 1960 Thomas wrote: "Are we faced with a clear choice of either generalists or specialists at the bureau chief level? Probably there is no full choice because the dominant forces in our complicated society are on the side of the specialists."[14] The question was definitely up for reconsideration and for good reason. With advancing complexity of organizational undertakings we were finding ourselves more and more dependent upon specialists. As Fesler had put it: "Few would contend that the same army general can bring equal competence to direction of a scientific program, command of an Arctic post, supervision of contract renegotiation, and liaison with Congress."[15] One might add that in the field of health today few would contend the same health department official could bring equal competence to the direction of programs of radiological hazards control, automobile accident prevention, or venereal disease control—all important health department functions.

The most recent critic of the traditional determination that the generalist should be on top is Robert Presthus.[16] To study the matter, he went to Great Britain which is, if not the source of the generalist concept, at least the place where it has been most widely and thoroughly adopted. Presthus persuasively argues that members of the British higher civil service, comprised traditionally of men educated in the classics or history at either Oxford or Cambridge, are not qualified to handle many economic, scientific, and other technical questions of the day. He maintains that the generalist concept has held sway in Britain as long as it has because it is essentially based on social class structure rather than on something related to the effectiveness of organization:

". . . The vital point is that the class system itself became the major basis for legiti-

mating personal authority. In effect, authority in every context tended to be validated on class ground rather than on ground of personal achievement or expertise. As Rupert Wilkinson has shown, moral certitude, social poise, a compelling style of speech, disdain for scientists, and a certain magical air of authority—these have been the currency of British leadership, rather than technical skill in a given discipline. Since these qualities were the prerogative of members of the upper-middle and upper class, they were in effect validated on a class basis. Perhaps inevitably, their utility diminished in a world of increasing scientific and economic complexity."

Noting that there is a certain romanticism about the generalist—part of the heritage of the period "when knighthood was in flower"—Presthus maintains convincingly that the generalist tradition represents a failure of British administration to develop from the traditional (patrimonial) stage to the legal-rational (bureaucratic) stage, as described by Max Weber.[17]

In the United States, however, the problem has not been one of too much generalism but rather the opposite, a predominance of specialism. Thus, Presthus is aware that his critique has limited applicability in this country and acknowledges the prevailing specialism in the American higher federal civil service. (He does not examine the situation at the state and local levels.) Without the kind of class structure still tending to exist in Britain, the concept of the generalist has never become even a shadow here of what it has been there.

The Generalist

Some American academicians have attempted to promote the widespread use of generalists but their efforts, for the most part, have been abortive. Moreover, the kind of generalism sponsored has been different than its English counterpart. Since the early decades of our republic, the American most closely resembling an amateur-gentleman generalist has been the person appointed to political office as a reward for financial contributions or service to the party. Parallel with the progressive reforms in civil service that began to take shape in 1883, the amateur-generalist increasingly has fallen into disfavor. As a matter of fact, the continuing reforms have been largely made possible by the introduction of technologists into government service and the incorporation of their professional and technical standards in merit examinations.

Corresponding attempts to develop bodies of generalists have encountered trouble because of the failure to develop a body of principles that could be designated as the content of a discipline in "administration"[18] upon which candidates for civil service office could be examined. In the city manager movement, an area where the attempts have had some success, generalism is a far cry from the British variety. City managers are trained in the management of cities, not in the classics and history. Thus, it is the scientist, the professional, the technologist, who has the highest prestige in the American value system —not the "well-rounded" man from a prominent family. Even where attempts have been made to advance generalism, the concept has been, and remains, one involving a generalist with special talents.

Particularly in the field of health in America generalism does not hold a position of high repute. This has created problems. The difficulty is that the function of integrating many different kinds of activities to achieve program goals (which can be accomplished only through collective effort) and of focusing responsibility for the achievement of these goals, is more a generalist than a specialist function. Propensities of specialists to see matters from their own unique perspective and not a general one, have been noted over and over. For example, Don K. Price has said: "These specialists are not, in general,

the men who judge their accomplishments by the absence of criticism and by administrative convenience. They are far more likely to fall into the opposite error of believing that the public interest is the same as their professional specialty."[19]

Moreover, the presence of a host of autonomous professionals greatly complicates the matter of determining whom to hold accountable for performance. Writing in 1956, Herbert Kaufman put the problem this way: "Political scientists of the . . . future, looking back, may well conclude that it is not easy to bridge the gap between a generation seeking to encourage the growth of professional bureaucracy and a generation in turmoil over how to control it."[20]

A particularly strong statement against the generalist has come from Victor Thompson who spells out the thesis of his book as follows:

> "There is a growing gap between the right to decide, which is authority, and the power to do, which is specialized ability. This gap is growing because technological change, with resulting increase in specialization, occurs at a faster rate than the change in cultural definitions of hierarchical roles. This situation produces tensions and strains the willingness to cooperate. Much bureaucratic behavior can be understood as a reaction to these tensions. In short, the most symptomatic characteristic of modern bureaucracy is the growing imbalance between ability and authority."[21]

Thompson then goes on to say that ". . . we suspect that the advantages of specialization always outweigh the associated costs of hierarchical coordination."[22] To the vital question of how integration is to come about, he replies that the specialists will integrate themselves as they come to realize the increasing interdependence they have upon each other.[23]

Presthus appears to be adopting Thompson's reasoning, and he elaborates somewhat: "The professional is less likely to take an ideological view of policy issues because his training will push him toward a 'law of the situation' approach, with perhaps less emphasis upon prestige and hierarchical components of the issue. This scientific, experimental approach to problems should also make him somewhat more amenable to change."[24]

The "law of the situation" refers to a process described by Mary Parker Follett,[25] in which contenders examine all of the relevant facts and arrive at a conclusion that satisfies fully—not as a compromise—what each side wants. Its unreliability as an administrative technic has been exposed repeatedly. Sidney Verba puts the matter briefly:

> "While it is true that such 'best-for-all-concerned' solutions exist in some situations, politics would hardly be as complex and frustrating as it is—both for the scholar and the practical politician—if all conflicts could be so easily resolved. This approach to decision-making ignores the myriad complex social situations in which the goal of some members of the system may not be the same as that of the others, and the best solution for some participants will not be the best for the others."[26]

Some acrobatic logic, which requires one to face opposite directions at the same time, has gone into the argument that specialism should prevail in the line of command. For example, Admiral H. G. Rickover has one set of precepts he would apply to scientist-engineer experts and quite another to experts in education. When speaking of his nuclear submarine project, he observes that the work calls for an impersonal and scientific attitude. He adds:

> "This means on the part of non-technical administrators, who are set above the technical people doing the actual work, that they must forget their organizational "status" when it comes to dealing with technical problems. Because here they are inferior in knowledge to the experts who are organizationally their subordinates."[27]

Rickover goes on to say that the country does not benefit fully from the qualifications of his engineering group be-

cause much of their time is "frittered away" reporting to "non-expert" administrators. One wonders how he can reconcile this with what he has said two pages earlier in the same book about educators:

> "The Value of Outsider's Judgment—All this, I know has no value whatsoever in the eyes of educational officialdom. Like most bureaucracies, this huge organization would like to escape lay criticism and tries to do so by constantly using the stereotyped argument that only 'professionals' or 'inside' critics can judge the performance of other professionals. . . ."[28]

Perhaps it is simply a matter of whose ox is being gored.

For a last example of the limitations of specialism, consider the findings of a recently concluded study of the New York State Interdepartmental Health Council—a body of department heads, specialists in each other's eyes, and coordinates in authority—constituted in part to bring coordination to the area of human resources. The study concluded that, lacking provisions for central coordination from the governor's office, the council has produced little coordination during the course of its 20-year history, except in situations where there has been a clear mutual interest of the member agencies—and these invariably involved only minor or peripheral matters.[29] No "law of the situation" was discovered operating. In fact, it might be said that the study results confirmed "Hilleboe's iron law": "Coordinates cannot coordinate each other." In the real world of administration, the exercise of authority often becomes the only way to get things done.

Social Lag as a Factor

The assertion that an existing social lag has kept specialists in positions of subordinate status belies the facts. In the New York City Department of Health the specialized bureau chief in central office in the past has had the prestige.[30] Public interest becomes aroused about such matters as Asian flu epidemics, narcotics control, and antismoking campaigns, and the central office specialists are the people interviewed by newspaper reporters. Given the present temper of public values, borough or district health officers (generalists) had little opportunity for such public recognition. The bulk of their work was comprised of administrative duties which did not arouse public interest; they were associated with the glamour of public service only in applying decisions made by others.

A study of the Philadelphia Department of Health done by Paul Purdom is a case in point. He reported that he found "a preponderance" of communication between that department and members of the public involves the central office rather than the field offices. Dr. Purdom also noted that "the bulk of communications between the central office personnel and those in districts was directly between the professionals in each office." What communication the district health officers were involved in primarily dealt with such routine matters as leave and travel, and not budget and program content.[31]

Thus, while part of the problem may be social lag, this social lag is really the lack of recognition of the importance of administration in an era when its significance has surpassed that of technical knowledge. Dr. George James has noted this problem clearly:

> "I am told that administration is considered not quite respectable in some circles. Often blamed and rarely praised, many think of it as a just barely necessary evil—perhaps one we could do away with entirely if we were really clever. But today the patient and his doctor need help from a very large number of scattered specialists and consultants and complicated facilities and resources. One patient with one illness may use the services of municipal, state, and private laboratories. There may be a need for an open-heart surgery team, a rehabilitation team. There are thousands of resources the patient may need.

Even knowing where they are is a problem for a doctor, let alone the question of exactly what they have to offer. Administering a total health program, including all these, plus the federal establishment, plus all the public health facilities the patient never sees, is the real challenge of the future. The excitement in medicine in the next few years will be in administration and organization."[32]

Recently, this value condition has been recognized more subtly in a number of quarters. In the delivery of health services, for example, there is a call for a different kind of balance between the development of new health knowledge and the utilization of existing knowledge. The Trustees and Council of the New York Academy of Medicine have said:

"In the United States today a serious gap exists between the state of health of significant numbers of people and that state of health which would be attainable if the best present-day medical knowledge were more universally available and more fully utilized by the people of this country."[33]

Social lag is, however, only one of the problems besetting the proposition that the generalist should be on top. The general applicability of the concept—which rests upon the assumption that coordination and accountability are necessary, even at the possible cost of some thrust, and that stalemate is to be avoided—is also questioned.

Other things being equal, coordination and accountability can be achieved more effectively if decision-making authority is vested in one man rather than distributed among several, even though all may assist in formulating the solution to a given problem. One draws this conclusion about coordination because (1) no two people operate from the same set of values or perceptions of reality; and (2) communication involving several persons is complex. Therefore, chances for stalemate to occur are greatest when final decision-making authority rests with more than one man. As to accountability, it clear that holding one man responsible, who in turn holds others responsible to him, is more expeditious than attempting to determine, after the fact, which of a number of persons should be called to account.

One person may have internal conflicts that interfere in decision-making. However, the intrapsychic mechanisms in a healthy person appear to be more effective at mediating conflicts that arise within the individual than are social mechanisms in mediating conflicts among individuals.

Advantages of the Generalist

By examining both aspects of the question, we conclude that generalist decision-making has many advantages over that of specialists at the several levels of administrative organization. The crux of the difference between the two types has to do with the range of programs or specialities of which the person is aware and to which he attaches comparative values. The generalist promotes a broader range of endeavors than the specialist. Therefore, lodging decision-making authority with the former should result in more consideration of interdependencies and relative values of different administrative purposes and activities. Coordination is at the core of administration and it is here that the generalist plays the key role.

Attempts are made to assure that persons expected to perform as generalists are appropriately prepared to carry out their tasks by giving them diversified education and varied experience. There is a further attempt to insure broad interests by the assignment of relatively comprehensive responsibility. This is inherent in the nature of hierarchical organizational structure which puts generalists over specialists.

Thus, there is a soundness to the generalist concept but, as noted earlier, there are serious questions as to how universally it can be applied. The con-

cept requires frequent use of the qualification "other things being equal" and usually other things are not equal. If the one man authorized to make decisions has inferior intellectual equipment, better coordination might be achieved by requiring him to share authority with others.

Because American traditions have tended to exalt the specialist, there has been a corresponding tendency for the most able people to seek specialty careers rather than administrative-generalist careers. As a result, we have developed higher quality specialists than generalists.

Recognition that there are important differences between specialists and generalists does not mean that the conflicts must paralyze us in stalemate. There often is merit in de-emphasizing the differences. The intensity of the conflict has been mitigated by the partial specialization of generalists—an accommodation to practical imperatives. Taking the opposite tack—developing competent generalists out of specialists—has great potential for bringing the generalist and specialist into appropriate balance. To be profitable this transition should be made without the loss of all the skills of the specialist. The process should be one of adding on new skills rather than substituting some for those already possessed, thus making the person a generalist with a specialty. This should be done before productive years have passed. (Actually many successful generalists started out their professional careers as specialists.) Providing more opportunities for generalists and specialists to meet on common ground would be of reciprocal benefit.

Education can help. Continuing education is one means; overhauling the curricula of professional schools is another. Columbia University and other leading law schools, whose graduates often rise to the highest kinds of posts in the nation, have already abandoned the narrow vocational education pattern. In the health professions, Johns Hopkins and Western Reserve Medical Schools have moved in this direction[34] and Dr. Lowell Coggeshall's report is a harbinger of further development.[35]

Administration related to the generalist-specialist dimension, then, as well as that related to the centralization-decentralization dimension, is conducted in an atmosphere of conflicting principles. There is the dilemma of competing values—specialist freedom and output on one hand versus the need for coordination and accountability on the other. However, there are still other factors contributing to the confusion: (1) One cannot assume that present-day generalists are better administrators than specialists; (2) there is a culturally rooted inclination to elevate specialists at the expense of generalists—a tendency not in keeping with the nature of today's tasks of planning and problem-solving in the health field; (3) although the difficulties may be expected to continue in complex organizations through the foreseeable future, there is unrealized potential for achieving an acceptable balance of generalists and specialists.

Organizing for Decentralization of a Health Department

One major challenge in achieving decentralization of a large health department is to provide administrators in charge of field operations who are competent; the more competent, the more likelihood of success. In the event that the knowledge and judgment of such personnel are found wanting, substantial effort may be required to build up competency. Civil service traditions, budgetary limitations, and the somewhat low esteem of administrative office may be expected to constitute serious barriers to this undertaking. And, as noted earlier, capable men may be unwilling to assume posts offering little discretion. So

it is essential to assure that such personnel, existing and newly recruited, are given every opportunity to exercise their talents.

It would seem that the decentralization of a health department could be greatly facilitated by an organizational structure and allocation of responsibilities that clearly specify decentralization as a primary policy. This would require the post of a generalist at the central office to outrank specialists there, thus bespeaking the emphasis put upon generalism; also authorization for the incumbent to make overriding determinations, if necessary, in decisions involving specialists.

As an ideal model, structure should clearly designate a generalist for each geographic field district as the official to whom all other personnel in the local office are responsible, and from whom they receive their assignments and instructions. General policy statements should emphasize the desirability of decentralizing decision-making from the generalist in the central office to those in the field. For example, initiation of program changes and budget estimates should be the responsibility of the field office administrators, subject only to broad policy guidance at the outset, and review before final approval from the central office. Moreover, with minor exceptions, all communications from the central office to the field should go through a central office generalist for endorsement before transmittal. A clearinghouse function is necessary to avoid duplication, inconsistencies, and conflicts in scheduling.

To continue in this rather ideal vein, the functions of the central office specialists should be identified as (1) keeping the departmental staff informed of technical developments in their respective fields; (2) developing new technology whenever possible; and (3) making their specialized knowledge available (by consultation, not direction) through the designated channels, for use by counterpart field specialists. They should also plan and conduct evaluations and postaudits of field performance. In emergencies there could be direct communication between central and field specialists, but only with the concurrent knowledge and endorsement of the generalists involved. Specialists from all echelons might meet on technical matters from time to time, but the agenda of such conferences should be worked out with generalists in the central office. The results of such conferences should (1) become available to all who are interested; (2) not deprive the field generalist of decision-making.

By the establishment of appropriate organizational structure and specifications for procedures and communication channels, it should be possible to apprise all employees of a health department, specialists and generalists alike, of a conscious purpose of strengthening the generalist function and decentralizing the majority of decisions to the field. This could help to counteract the prevailing American propensity to favor specialists unduly.

But following such an approach, by itself, probably will not insure the venture's success. Differences of opinion are bound to arise and authority will continue to be challenged. Frequently, it will not be easy to determine whether specialist opinion is being unjustifiably rejected by generalists. No one has yet found a way to distinguish between technical and administrative aspects in all situations. Power struggles between specialists and generalists may be expected.

Such struggles may be made less crippling, however, by intensified efforts to bring about an administrative understanding between the two types. Developing a body of specialists who are more than that, who also have some knowledge and skills in organization and management, is one course to take. How-

ever, the frequent exposure of specialists and generalists to one another in training courses, in problem-solving sessions, and in social and professional gatherings, is likely to be more immediately effective. Regular meetings, where members of each group meet and discuss their work with each other, can be especially useful. If social processes are given an opportunity to operate in the health department, they can do a great deal to overcome parochial viewpoints, to promote communication, and to crystallize mutuality of purpose.

The Dual Problem Reconsidered

Even if such approaches as those outlined above are vigorously and persistently pursued, administrative problems will still endure. Administration cannot totally rely upon principles, for, as stated many times in the literature, they are often logically inconsistent. ("Look before you leap" . . . "He who hesitates is lost.")[36]

For both specialists and generalists demands for spontaneity and freedom are at odds with demands for accountability and coordination,[37] while precepts elevating authority for field administrators run counter to zealously guarded prerogatives of central office specialists. Successful leadership therefore requires a sense of when to emhpasize one set of ideas and when another. With skill, an able administrator may have incompatible sets operating simultaneously and derive utility from each, although it may be necessary to keep one or the other in a latent rather than a manifest state from time to time.

It is a responsibility of health leaders, of course, to stress the mission of the department. To the extent they succeed in keeping all eyes on departmental goals, they are able to enhance the possibilities of their achievement. If departmental goals are achieved, then logical inconsistency relating to narrower goals, such as neat distinctions between workers' functions and responsibilities, become less important. Although all of us have a longing for the security that precise job descriptions afford, uncertainty and ambiguity are the omnipresent facts of life. As T. V. Smith has succinctly observed: "Only impetuosity cannot abide ambiguity."[38]

Increasing interdependence in our society makes collective action for most kinds of achievement necessary today. Pressures develop whereby workers are found to reassess the benefits they derive from the immediate, the limited, and the security-offering goals, as compared with the value for them of mutual confidence that enlarges the compass for concerted effort. R. W. Revans has spoken favorably of "a period of cultural preparation" during which employees in a hospital may learn "that operational success demands an organic approach, rather than dependence upon energetic competition, however good for the reputation of individuals among its leading members."[39]

Such reassessment of value judgments is actually a part of the evolution of the worker's philosophy in relation to organization and, in our contemporary society of huge and complex organizations, to life. The development of an appropriate equilibrium of centralization versus decentralization and the role of specialist and generalist functions in health departments constitutes a thoroughgoing integration of many activities. This concept follows an approach that sees the department organically, as a whole, with the many parts important only as they contribute to the whole. Basically, the beliefs and values of the administrative personnel are more important than the existing principles of administration.

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This paper was presented at a Seminar on Public Health Practice at Columbia University School of Public Health and Administrative Medicine on April 5, 1967, and submitted for publication in October, 1967.