Evaluation of the Decentralization Process by Employees of a State Health Department

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DECENTRALIZATION, as a principle of organization for public health services, has been the subject of several recent studies. Purdom analyzed the decentralization of Philadelphia's health services in a study of communication between central offices and the neighborhood health centers (*1*). Thomas and Hilleboe contributed a helpful essay which offered a theoretical analysis of decentralization as it relates to generalist and specialist leadership (*2*).

My essay reports on evaluations of this type of organizational design by members of a partially decentralized State health department. Specifically, this is a research report of the attitudes that selected members of the Pennsylvania Department of Health expressed toward the organizational relationships between field offices and the central office at Harrisburg and toward the effectiveness of decentralization in bringing health services closer to the grassroots communities.

Definitions of Terms

Purdom (*1*) defined decentralization as:

> 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.

Thomas and Hilleboe (*2*) described the type of "important decisions" which may be delegated to a district office and those which remain in central offices. They pointed out:

> (*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.

Drucker (*3*) referred to the original meaning of decentralization as:

> The functional delegation of authority and responsibility . . . Functions have to be defined, authority has to be equal to responsibility, and decisions have to be made at the lowest possible rather than at the highest possible level.

These definitions may be frustratingly general, perhaps even vague, but a more precise formulation is undoubtedly not possible. Decentralization is a general operating principle open to different degrees of delegated authority and various patterns of task allocation de-

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pending upon other factors of the specific organization in question. The most rational degree of decentralization may vary according to organizational size, type of product or service, level of professionalism among employees, and other factors.

Decentralization in Pennsylvania

The organizational principle of decentralization was given major impetus in the Pennsylvania Department of Health by the American Public Health Association Survey of 1948 (*4*). In its "Keystone Report" the association recommended:

> Decentralization of the Department of Health services through the establishment of district offices, with full-time, qualified district medical directors to administer all direct state services. The directors should represent the entire department with the responsibility and authority to execute an integrated program specifically oriented to the local problems of each district.

The expressed intention at that time was that this degree of decentralization would set the stage for the creation of a new form of health organization in Pennsylvania, the independent county health department. Such a unit was to provide all ordinary health services except the most technical or those legally reserved to the State.

Costs were to be shared equally between local county tax revenues and State finances, with general supervision by the State health department to assure acceptable standards of performance.

In accord with the Keystone Report recommendation and as a first step toward decentralization, seven health regions were created by executive order of Dr. Russell E. Teague, secretary of health, on January 25, 1954. That same year the late Dr. Carl Kuehn was named director of the bureau of local health services in the central office at Harrisburg. Since that time, the regional field offices have grown in program, staff complement, and scope of public health services. However, the second stage of the decentralization process, the creation of independent county health units, has been enacted in only five of Pennsylvania's 67 counties and in one bi-city health board which is equivalent in independent structure. These include the counties of Allegheny, Bucks, Chester, Erie, and Philadelphia, and the cities of Bethlehem and Allentown. Although this is a small proportion of Pennsylvania's territory, it includes 6,009,608 people or 51 percent of the State's population of 11,637,900 (*5*).

Thus the term decentralization has had two applications for the Pennsylvania Department of Health: (*a*) the creation of regional field offices with a regional administration of health services and environmental protection and (*b*) enabling legislation for independent county health units by citizen referendum (*6*). The first application is classic decentralization by the delegation of specified authority, which formerly was the prerogative of the central office to the field offices. The second application is decentralization of a more profound structural type in that political accountability would be most directly related to the county unit of government with only general supervision by the State.

Organizational Structure

The regional offices of the Pennsylvania Health Department consist of a regional medical director and a potential staff complement of 18 public health specialists and assistants. The two largest regions are subdivided with two district offices. The central office has an executive office, program and staff bureaus and divisions, and a deputy secretary for local health who is a liaison with regions and county health departments.

Some of the salient features of the formally defined organizational relationships between central and field offices are important to keep in mind as the background for the interpretation of employee attitudes.

1. All but two of the regional programs are administratively decentralized in the sense that regional program personnel are under the "line" authority of the regional medical director who, in turn, is responsible to the bureau of field services and the deputy secretary for local health. Technical consultation and development of general program policy throughout the Commonwealth are the responsibility of the central office division directors. The regional office is responsible for program implementation. This involves adaptation of general statewide policy to the local situation and the assignment of local priorities, according to available resources, to

the numerous programs developed by the various central office divisions.

2. In budget matters, purely administrative items, such as the outlay of money for State cars, are handled through the regions. The budget for health programs is administered through the central office. Regional personnel have a voice in the initiation of the budget for the programs in their regions, but they do not defend their choices at the next highest level of budget review. All categorical program money from the Federal level, such as a grant for tuberculosis control, is administered centrally from Harrisburg.

3. The sanitary engineering program, decentralized in July 1961, was substantially recentralized on April 6, 1966, by an executive order of the late Dr. Charles Wilbar, then secretary of health. Regional sanitary engineers were instructed to report directly to the division of sanitary engineering in the central office in Harrisburg. The drug control program, also decentralized in July 1961, also was recently recentralized.

4. The organizational structure of the current field office was designed for the function of consultation, not as a statewide health service system. At the time the field office structure was designed and enacted, it was expected that the independent county health departments would also be formed. In the words of Kuehn (*5*), "they were designed as a temporary expedient until qualified local authorities could take over." Dr. Teague's executive order in 1954 clearly specified a consultative role for the regions. With the aid of the State health centers in the counties (not to be confused with independent county health departments), the regions have had to take on the responsibility of coordinating State public health services for the majority of Pennsylvania's citizens. The State health centers in the counties are under the administrative supervision of the medical director of the region. The 64 county offices in 1968 had 338 nurses and 168 sanitarians in addition to clerical staff.

Methodology

To assess employees' views on decentralization, an interview schedule was prepared and pretested for use in both the field and central offices. To gain insight from those most concerned with the organizational relationships between central and field offices, a purposive sample of 59 persons consisting of several executive officers, all bureau and division heads, all regional medical directors, and three regional program representatives from each of the six field offices was chosen. This sample yielded 24 interviews from the field office personnel and 35 interviews from the central office personnel. Three persons conducted the interviews, which ranged from 30 minutes to an hour. The interviews were held about 5 months after an executive order was issued to change from seven health regions into six human service regions. The resulting strain on organizational relationships in both central and field offices may have influenced the respondents to be more critical of the organizational structure than they would have been at another time.

Attitudes toward the current, partly decentralized organizational pattern were tapped with the following two questions:

> How would you evaluate the current organizational relationship between the regions and the central office? (The interviewer also was instructed to probe for strengths and weaknesses in program and administrative linkages and in the division of authority.)
>
> Decentralization of health services from Harrisburg to the regions was intended to bring services closer to the grass roots. To what extent has this goal been realized?

Responses to these questions were analyzed for recurring themes and tabulated.

Findings

Responses to the first question which asked employees to evaluate the current organizational relationship between the regions and the central office were coded in terms of a mostly critical response, a rather evenly mixed response, and a mostly positive response. This very general perspective on employee attitudes is reported in table 1.

Almost twice as many in the total sample of employees were critical of the organizational linkage between central and field offices compared to those who gave favorable responses. There was little proportionate difference in the number of central office employees and field office employees whose responses were mostly critical. Proportionately more of the favorable

responses came from employees in the regional offices, although the small number in these cells necessitate caution in considering this finding.

Table 2 indicates the frequency of specific criticisms and favorable responses according to office location. Central office personnel criticized lack of sufficient regional authority in about the same proportion as did the regional personnel. Almost one-third of the sample interviewed expressed the attitude that more authority should be delegated to the regions. This seems to indicate some readiness in the health department to move to a greater degree of decentralization.

Another possible interpretation of the same data is that some employees wished for more consistent enactment of the degree of decentralization already specified in health department policy. There were instances where both regional and central office personnel expressed satisfaction with their own programs but criticized other health programs and their administrators for a failure to delegate authority.

A higher proportion of central office than field office personnel cited the definition of organizational relations between central and regional offices as a problem. The central office personnel also tended to be proportionately more critical of the separate administrative channels between the central and field offices. This latter criticism was directed toward the policy that administrative matters are to be channeled through the "line" administrative authority of the bureau of field services and the regional medical director, while technical and health program consultation can take place directly between health program personnel in the divisions of the central office and the program representatives in the field offices. As noted earlier, there were exceptions to this general policy in the sanitary engineering and drug control programs.

"General difficulties in communication" was the adverse criticism most frequently cited by the regional personnel. It was the least frequently cited of the four criticisms by central office personnel, possibly because their more specific criticisms, cited earlier, had already subsumed the notion of communication difficulty.

Typical excerpts from the adverse criticisms

Table 1. Employee evaluations of central office-field office relationships, according to office location

Location	Critical		Mixed		Favorable		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Central offices (executive, bureaus, divisions)	16	45.7	14	40.0	5	14.3	35	100
Field offices (regional medical directors and selected program representatives)	10	41.7	5	20.8	9	37.5	24	100
Total sample	26	44.1	19	32.2	14	23.7	59	100

Table 2. Adverse criticisms of relationships between central and field offices, according to office locations

Criticism	Central office (N=35)		Field offices (N=24)		Total sample (N=59)	
	Number	Percent	Number	Percent	Number	Percent
Lack of sufficient regional authority	11	31.4	7	29.2	18	30.5
Poor definition of organizational relationships	19	54.3	1	4.2	20	33.9
Problems arising from separate program and administrative channels	16	45.7	4	16.7	20	33.9
General difficulties in communication	10	28.6	10	41.7	20	33.9

NOTE: Percentages refer to the number of times a response is mentioned in proportion to the number of respondents in a given organizational location; for example, "lack of sufficient regional authority" was mentioned by 11 or 31.4 percent of the 35 central office employees.

Table 3. Most frequently cited responses to adverse criticisms of central office-field office relationships

Criticism	Central office personnel	Field office personnel
Lack of sufficient regional authority.	The mix between central office and regional planning occurs at too high a level. The organizational setup is weak because the central office personnel refuse to delegate authority to the regions; this varies by programs.	In many instances, responsibility is in the regional offices and decision-making power and authority is retained at the central office.
Poor definition of organizational relationships.	Decentralization was crdered but not defined. (The) lines of authority and communication are broken up; more direct communication would help.	There should be a clearer definition of authority concerning responsibility between the regions and the central office. We are on the scene; (we) need to make instant decisions; we should not need to make constant reference to Harrisburg.
Problems arising from separate administrative channels between the central and field offices.	The real weakness is in the division of authority between the regions and the central office. This matter has never been settled. It is particularly acute with Environmental Health. They usually completely bypass the regional medical directors.	There is a lot of weakness (in the organizational linkage). All are responsible to the regional medical director as well as to our program directors in Harrisburg. There is no clearcut authority.
	(The) current division between technical supervision through divisions and administrative (supervision) through the Bureau of Field Services is more hindrance than help.	Under the present decentralization there is a split between program channels and administration channels. This duplicates functions. There is bickering over jurisdictions; no integration of services into one channel.
General communication difficulties.	Everything goes up (in communication) nothing goes down. Central office and field office people do not seem to empathize with each other. (They) tend to have one-sided viewpoints.	Generally, communication is weak. The regional office cannot effectively communicate on needed programs. Our views go through the regional medical director and then to Harrisburg and then we hear nothing. We should at least receive notification that someone read your opinion.

of central office-field office relationships, according to the most frequently cited responses, are shown in table 3.

Other adverse criticisms which occurred with lower frequency but which may have relevance to the problem were (*a*) failure to enact the degree of decentralization that was planned, (*b*) too many bureaucratic regulations, (*c*) failure to provide for an organizational link between the program directors in the divisions and the regional medical director, (*d*) failure of the public to accept regionalization, (*e*) failure to initiate more independent county health departments, and (*f*) political interference. Favorable responses are shown in table 4.

Table 4. Favorable evaluations of central office-field office relationships, according to office location

Location	Current organizational links between central offices and field offices are good	
	Number	Percent
Central offices (N=35)	9	25.7
Field offices (N=24)	11	45.8
Total sample (N=59)	20	33.9

Proportionately more field office personnel responded favorably to current central office-regional office relationships than did central office personnel. This appears to be consistent with the data in table 2, except for communication. There was also a general tendency for the adverse criticisms to be specific and for the favorable reactions to be expressed more generally.

Some favorable responses to "good organizational links between central and field offices" were as follows:

Central office personnel: I can't see any great weaknesses in current organizational relationships between central office and regions; we maintain good, close

working relationships with our people in the field. The field staff inspects; the central office sets standards and policy; this works effectively.

Regional office personnel: Organization links in terms of programs and division of authority are basically good.

Table 5 shows responses to the interview question on how well the goal of services closer to the grassroots communities has been realized with the initiation of decentralization. The largest single response category for the total sample was that the goal of services closer to the grassroots has been well realized. Proportionately more of the field office personnel expressed this opinion. About one-third of the total sample stated that the goal of services closer to the grassroots had been only partially realized, and the proportion did not vary measurably for central and regional office personnel. Their reasons for a qualified answer most often related to a perception of too little authority for the regions or the failure to have created more independent county health departments. Some typical responses to this question are shown in table 6.

The brief excerpts from the interview responses illustrate a rather wide variety of attitudes toward the current organizational

Table 5. Responses to question on how well goal of services closer to the grassroots communities has been realized with decentralization, according to office location

Response	Central office		Field offices		Total sample	
	Number	Percent	Number	Percent	Number	Percent
Well realized	12	34.3	11	45.8	23	39.0
Partially realized	12	34.3	8	33.3	20	33.9
Not realized at all	5	14.3	1	4.2	6	10.2
Not enough information to judge	6	17.1	4	16.7	10	16.9
Total	35	100.0	24	100.0	59	100.0

Table 6. Typical responses to question whether goal of services closer to the grassroots has been realized with decentralization

Question	Central office personnel	Field office personnel
Goal of services closer to the grassroots has been well realized.	Very well realized—we can be in touch with our regional counterparts in a matter of minutes. We now have much better coverage in terms of service. Fairly well realized; recently regions have been allowed to issue water discharge permits; enforcement work has been delegated almost exclusively to the regions.	This has been definitely realized. Program representatives in the region can tailor their schedules to fit particular communities. It has been realized in our program very much; we are more readily available; we know the needs of the people here.
Goal of services closer to the grassroots has been partially realized.	To some degree, but the public has not accepted regionalization as much as the department has; the public tends to look to Harrisburg. Proved rather successful but grassroots services cannot be complete unless we have county health departments.	Local services are closer to the people with independent health units. In some areas, in some programs regionalization has been a real boon. It benefits both communities and the health department. In some programs where control is retained by the central office it has not been realized.
Goal of services closer to the grassroots has not been realized at all.	Decentralization has not done much to develop community feeling of responsibility. Some regional personnel see themselves as subunits of a large bureaucracy, not as a community resource; they still relate too much to the State; lack of effective liaison.	Decentralization has never occurred. Programs are still directed from Harrisburg as much as ever. Services are no closer than they were over 20 years ago.

structure. Part of the variation in attitudes may be attributed to differences among the many and varied health activities in a State health department. For example, some differences may be related to the nature of the programs, some to individual styles of administration at several organizational levels, and others relate to the kinds of publics to be served.

Discussion

The meaning of decentralization. The term, decentralization, emerged from the interview data as a word with different meanings to different people. For some, it is equivalent to having regional service areas and field offices. But for conceptual clarity, there is no necessary connection between regionalization and decentralization. Regionalization simply refers to "arranging the field organization on the basis of geographic regions" (*7*). Conceivably, health services and environmental protection could be handled on the basis of common regions with minimal local authority, with comparatively great local authority or with a mixture of authority structures, with variations according to the most rational operation of specific programs.

Regionalization is a geographic fact and is not necessarily associated with a particular authority structure. Neither is there a necessary association between the principle of decentralization as defined here and the organizational design of separate technical and administrative channels between central and regional offices. When these channels are separate, there is the advantage of administrative coordination of diverse skills at the local level and a division of labor in which the program specialists in the central office can give full time to consultation in their professional specialties.

When these channels are combined and centralized, as in the drug control and sanitary engineering programs mentioned earlier, there is a loss of day-to-day administrative coordination on the local level. This loss is presumably offset by a gain of administrative clarity through the elimination of dual supervision. However, the issue of whether coordination of day-to-day activities should come from field offices or central office is a separate issue from that of decentralization as a functional delegation of authority to individual specialists.

No matter where coordination of day-to-day activities is located, the most urgent decentralization issue for the individual program specialist in the field is whether he has authority to make important decisions in his speciality. For example, early in 1968 the sanitary engineering program and the air pollution program in the Pennsylvania Health Department delegated more authority to the regions to make decisions about waste discharge permits and acceptable air pollution controls. Routine matters are now handled in the regions with only the more technically difficult or controversial matters referred to the central office. This practice illustrates functional delegation of authority even though coordination of activities remains centralized. It appears from the interviews in this study that the program representatives in the field are more concerned about sufficient authority to make decisions in their specialties than they are about the issue of central office versus field supervision and coordination.

By contrast, the regional medical directors are understandably more concerned with the issue of local coordination of the work of the regional program representatives. They feel their understanding of local conditions makes them more knowledgeable about the priorities of needs in their respective regions. Administrative control over the day-to-day activities of the field staff is an important component of their formal organizational role.

Whatever the rational solution of these issues, there is a gain in conceptual clarity which results from separating the issue of the authority of program specialists to make important decisions and the issue of field office versus central office coordination of work.

Another issue that emerges from analysis of the interview responses is whether decentralization should be regarded as a unitary organizational principle, that is, applying to all programs, or as a functional decision on a case-by-case or program-by-program basis. There is a communication advantage to the simplicity of a single policy statement which affects all regional office-central office relationships. Some respondents' position was that decentralization should be regarded as an ideal

principle for all health department activities and the failure to organize a given activity in this way as an indication of poor organizational design.

Recent organizational theorists, however, urge a pragmatic, case-by-case approach to the decision to centralize or decentralize. Purdom (*1*) and Sherman (*8*) take this position in the context of governmental organization. Sloan (*9*) and Smith (*10*) advocate this approach for business administration. Sloan (*9a*) advocates that central management assume responsibility for the determination of which decisions can be made best by central offices and which by the divisions (in our situation, the regional field offices). Smith (*10a*) phrased the basic problem as follows:

> Those responsible for allocating powers and responsibilities must think not merely in terms of business functions but also of the many small activities into which these functions subdivide. They must decide at what level in the company *each activity* will be not only performed, but also coordinated and controlled. [emphasis supplied]

Health department employees' evaluations. Evaluations of the current partially decentralized organizational structure of the Pennsylvania Department of Health were obtained by interviewing central office bureau and division directors, field office regional medical directors, and a selection of regional health program representatives. The two most frequent criticisms by central office personnel, in order of frequency, were poor definition of relationships in the organizational links between field offices and central office and problems arising from separate administrative and health program (technical) channels between central and field offices.

The two most frequently mentioned criticisms by field office personnel, in order of frequency, were general difficulties in communication and lack of sufficient regional authority. The latter criticism was also mentioned in about the same proportion by central office personnel.

About one-third of all employees interviewed gave generally favorable responses to the current organizational relations between central and regional offices. Regional personnel tended to be proportionately more favorable in their responses than did central office employees.

More than 72 percent of the total sample indicated that with the current degree of decentralization, the goal of better service to the grassroots communities had been either well realized or at least partially realized.

The data cited support the conclusion that the principle of decentralized administration of health services in the regions had strong support among health department employees. The degree to which the general principle of decentralization is to be applied in policy, budget, and planning is an issue on which attitudes differ.

Conclusion

An important motivation for undertaking research into organizational structure is to obtain some insight into how the efforts of many diverse health professionals can work most efficiently to deliver health services and enforce the laws that protect our environment. In drawing conclusions from the present research effort, however, it is well to remember that many variables affect organizational performance. Adequacy of financial resources, the state of scientific health research and knowledge, and citizen support of public health goals are all important to the success of public health efforts in addition to the present consideration of centralized versus decentralized design.

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Tearsheet Requests

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Michigan's Sea Grant Program

A massive effort to produce a model, designed to let Great Lake resource planners and decision makers determine the long-range consequences of their actions beforehand, has begun in the Grand Traverse Bay area of northwestern lower Michigan. The results will be a model that describes the bay area today and predicts how the bay could change if, for example, industry doubled there during the next 10 years.

The effort is part of the University of Michigan's Sea Grant Program which seeks to integrate education, research, and public service in the interest of Great Lake resources. Begun last year, the Sea Grant Program will focus its work in the Grand Traverse Bay area during the next 4 years.

This year's research is funded with a $719,400 grant from the National Science Foundation's Sea Grant Institutional Support Program and $360,000 in matching funds from the university. Last year's grant was $380,100 and was matched with more than $191,000 from the university.

Acting director of the program is John M. Armstrong, assistant professor of civil engineering and water resources. He said the 4-year study at Grand Traverse Bay will treat the bay as a miniature version of Lake Michigan. Researchers will study the area's physical, chemical, biological, and socioeconomic factors. About 22 faculty members and 25 students from several University of Michigan schools and departments will be involved in the work. The research is also coordinated with other institutions and several State agencies.

While these researchers are collecting data, others will use it to develop eight "specific process submodels." The submodels will deal with the area's water budget, meteorology, water circulation, shoreline changes, biological production, geochemical cycles, institutional interactions, and regional economics.

Professor Armstrong said Grand Traverse Bay was chosen as the location for the pilot study because it has several characteristics in common with the upper Great Lakes. The bay is physically similar to Lake Michigan. Both the lake and bay are long and deep. Both are fed primarily by inland water sources and show similar waterflow patterns. Each has a developing urban center at its inland extremity—Chicago on Lake Michigan and Traverse City on Grand Traverse Bay.

Pollution studies in the bay will be particularly interesting, Professor Armstrong said. The bay is divided into east and west arms by a long peninsula. The west arm has Traverse City at its end and is much more populated and industrialized than the agriculturally dominated eastern arm.

Much of the data will be collected with the Sea Grant Program's newly acquired research boat, Sea Grant I, whose homeport will be Traverse City.

Professor Armstrong emphasized that the model being developed by the researchers will not make absolute, right-or-wrong decisions for anyone. It is designed to help planners and decision makers evaluate several possible actions facing them by predicting the effects each action would have. The objective is to foresee what implications current and projected trends hold for the environments of the future, to point out these implications as clearly as possible, and to assist in the formulation of programs that are responsive to predicted needs.