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NURSE CARE AND PARAMEDICAL SCIENCES

ALTERNATIVES TO A BUREAUCRATIC STRUCTURE FOR THE NATIONAL HEALTH SERVICE THE POINT OF VIEW OF A NURSE*

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SUMMARY

Bureaucracy is characterised by rules, specific sphere of competence, hierarchy, specialized training, separation from means of production or administration and the recording in writing. The NHS is not a typical bureaucratic organization, but it has some of its characteristics. The alternative models (democratic, matrix-type structure) do not seem to respond to the need for change. It is suggested that the characteristics of an organization's structure be treated as variables. Partial alternatives are discussed. The relationship between the goals, the users and the workers — workers and users' participation in the planning and control of the NHS. Conflict as a motor for change. Controlling power — representatives of the community and of the workers. The person in the organization — involvement of all workers in management at different levels and the development of persons towards their full capacity. The case is made for the person-centered approach to management.

The title suggests several questions, among which are: what characterises a bureaucratic structure? Is the National Health Service (NHS) structure a bureaucratic structure? Are there any alternatives to a bureaucratic model? Is it possible or desirable to move from a bureaucratic structure to a different one? If so, how to go about it? If not, what partial changes are necessary? Who has the power and authority to introduce those changes? What are the theoretical frameworks and the practicalities of moving from a bureaucratic to a different structure? Do we know in what direction we are moving when changing this type of structure? What risks are involved?

This essay will not give a complete answer to all these questions but rather narrows the discussion to a few key aspects on which change depends. It will relate opinions and facts, research findings and uncertainties.

Max Weber developed a bureaucratic model to analyse and explain complex organizations and considered bureaucracy indispensable in large scale organizations, both in capitalist and socialist societies. But, is it true? Davis and Francis[1], Bennis[2] and others have challenged it.

It seemed bureaucracy brought reliability and stability when compared to a personal patronage type of organization — a way to insure protection against descrimination, corruption, uncertainty. *The bureaucratic machine model* Weber outlined was developed as a reaction against the personal subjugation, nepotism, cruelty, emotional vicissitudes, and subjective judgements which passed for managerial practices in the early days of the Industrial Revolution, man's true hope, it was thought, was his ability to rationalize and calculate — to use his head as well as his hands and heart[2].

Bureaucracy can be considered a model of organization, where norms, communication network, management style, structure, distribution of power and other aspects have certain characteristics. The type of structure found in bureaucratic organizations, a highly rational and hierarchical one, is also called a bureaucratic structure, since it is one of the most important features of a bureaucracy. It seems important, though, to relate it

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to how it works and the functions it performs and not only to look at it in isolation, as if it was a static thing.

Etzioni[3] quotes Weber on the bureaucratic structure:

> *A continuous organization of official functions bound by rules.* Rules save effort by obviating the need for deriving a new solution for every problem and case.
>
> *A specific sphere of competence. This involves a) a sphere of obligation to perform functions which have been marked off as part of a systematic division of labor, b) the provision of the incumbent with the necessary authority to carry out these functions, c) that the necessary means of compulsion are clearly defined and their use is subject to definite conditions.*
>
> *The organization of offices follows the principle of hierarchy, that is, each lower office is under the control and supervision of a higher one.* Compliance cannot be left to chance, it has to be systematically checked and reinforced.
>
> *The rules which regulate the conduct of an office may be technical rules or norms. In both cases, if their application is to be fully rational, specialized training is necessary. It is thus normally true that only a person who has demonstrated an adequate technical training is qualified to be a member of the administrative staff...*
>
> His command of technical skill and knowledge is the basis on which legitimation is granted to him.
>
> *It is a matter of principle that the members of the administrative staff should be completely separated from ownership of the means of production or administration... There exists further more, in principle, complete separation of the property belonging to the organization, which is controlled within the spheres of the office, and the person property of the official.* (keeps the official's bureaucratic status from being infringed by the demands of his non-organizational statutes).
>
> *A complete absence of appropriation of his official positions by the incumbent* is required.
>
> *Administrative acts, decisions, and rules are formulated and recorded in writing...*

Could this be a description of the NHS structure? Rules and regulations do not seem to cover most decisions and many rules are not written and can be interpreted in many different ways. Strauss[4] found that rules governing the actions of various professionals as they perform their tasks, in hospitals, are far from extensive or clearly stated or even clearly binding, which leads to necessary and continual negotiation. He found that not even punishments are spelled out and mostly they can be stretched, negotiated, argued, as well as ignored or applied at convenient moments. The existing *negotiated order* in hospitals and other organizations of the NHS leads us to question the bureaucratic structure of the NHS.

The doctor's sphere of competence is quite clear, but the continuous strain and competition mechanisms among the other health workers and the extended role of some of them, are an indication of how ill defined their sphere of competence is. The principle of hierarchy is clearly present in the NHS structure but in hospitals and health centres there are more than one hierarchy, side by side — the administrative and the technical ones.

Legitimation for authority is based on technical skill and knowlegde in most cases in the NHS. To what extent personal problems and *non-organizational status* influences the bureaucratic status is not clear, but it is quite possible that it does. The ultimate justification for a professional act is that it is, to the best of the professional's knowledge, the rigth act. He might consult his colleagues before he acts, but the

decision is of his own. If he errs, he still will be defended by his peers. The ultimate justification of an administrative act, however, is that it is in line with the organization's rules and regulations and that it has been approved —directly or by implication— by a superior rank[5]. It is often so, in the NHS.

The professional organization model has been widely applied to health services, embracing both standard and non-standard events and explaining how organizations, typically large general hospitals, cope with contradictory forms of social relationships while preserving its goals.[5]

It is tempting to see the NHS as a bureaucratic organization but as it has been pointed out above, it is not a typical one. The professional organization model does not account for all the characteristics of the NHS either. We are probably dealing with too complex a situation to apply a single model.

Even if we account for these criticisms, it is still defensable to consider the NHS as a bureaucracy. What is wrong with it? Why this felt need for change? It certainly has its advantages or it would not remain so long as it is. One of them is the defence against anxiety. Health workers use the system to survive the trauma that constant exposure to crisis situations represents. This is very cleary stated by Menzies[6] on her study on the nursing service. Any alternative to a bureaucratic organization has to take this factor into account.

The same mechanism that makes bureaucracy a defense against anxiety turns it into a factor of alienation. The motivation resulting from the need to belong, to be part of, so well described by Maslow, decreases rapidly in a bureaucratic organization and it is recognisable in the NHS. Bennis[2] talks about the bureaucratic mechanism as a social instrument in the service of repression, treating man's ego and social needs as a constant, or non existent or inert. He considers the first assault on bureaucracy was its incapacity to manage the tension between individual and management goals and the second the scientific and technological revolution. He goes on to explain why democracy is inevitable as an alternative against bureaucracy.

The democratic alternative to bureaucracy seems to be too loose a concept to be discussed and too difficult to put into practice as a total model of organizations. The definition of *democracy* depends on the values and preconceptions —seldom articulated explicitly— of those using the word.[7] Several degrees of democratisation have been attempted, one of the most important ones being the management teams. The recent cut of one of the tiers of the hierarchical structure is another important step in the debureaucratisation of the NHS structure. But, do these changes make it a democratic structure?

Another alternative model would be the matrix type structure. The few attempts that have been made in smaller organizations show how difficult it would be to achieve in the NHS. The alternative models do not seem to respond to the need for change of the NHS bureaucratic structure.

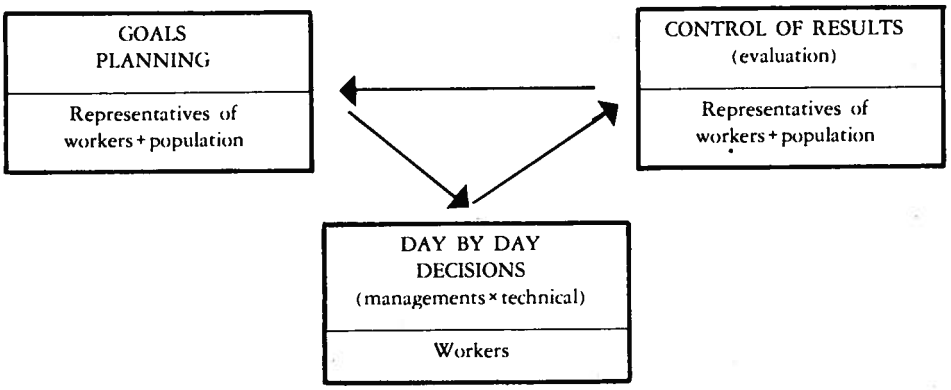
The various characteristics of an organization's structure must be treated as variables which are likely to be influenced by a variety of factors, says Davis and Francis.[1] Let us look at some of them.

The goals of the NHS are not always clear. Health in itself is difficult to define and the size of the service makes it doubtful that the interpretations the health workers make of the goals, will coincide.

The relationship between the goals (translated regularly into objectives, plans and programmes with its financial and timing characteristics), the users and the workers is an essential one. Weber paid little attention to the question of who makes the rules and to the process by which they are made.[8] The process includes different types of decisions. Who feels the health problems, who's problem is it?, who pays for the service, who said it should be a national health service? The community did, both the population at large and each community corresponding to regional or local authorities. But is the community really exercising the corresponding power? If not in the

planning and allocation of the resources is it exercising the power to control (evaluate) the services produced (the product)?

A possible model of the right to exercise power is presented below.



The rationale for this model is the right of the workers and the users to participate in the planning and controlling of the NHS. The day by day decisions would have to rest mainly with the workers though the technical decisions should be validated with the individual client. The demand for health services is mainly by individuals whose level of health make them dependent on the health workers which makes it utopic to consider their participation at the same level as the workers.

The Royal Commission[9] on the NHS points out that community health councils have made an important contribution towards ensuring that local public opinion is represented, but it was felt additional resources were needed to fulfil this task more effectively. Informal patient committees were seen as a constructive way of bringing patients views to bear on the provision of neighbourhood primary care services. Regarding the workers, right to exercice power, it was thought that pay negotiating bodies are too dependent on government and in all cases staff interests needed to be consulted and that the health departments should ensure that the machinery for this was adequate.

The differences between the *possible model* presented above and the Royal Commission's comments are quite apparent. Different political ideologies are certainly one of the reasons for the discrepancy.

Conflicting ideologies of practice and different objectives among the health workers, at different levels of the hierarchy, including management, can be an incentive for change. It is often the disconfort, the pain that goes with conflict, that acts as a motor for change. It is in this sense that Fletcher[10] talks about the *end of management*. He analyses the conflict between the workers who have managerial responsibilities at present and the other workers. Unionization and politicization would help those workers feel part of the health workers group and acquire a new way of dealing with problems. Some degree of rotation of health workers through managerial functions might help all to feel the difficulties and might be an incentive for motivation and creativity.

After having mentioned some of the factors that will influence various characteristics of an organization like the NHS, our attention will concentrate on the areas —controlling power and the person in the organization— where partial alternatives to bureaucracy can be found.

The question of controlling power is, naturally, ideologically biased. The planning and controlling should be directly linked, since the results of controlling will influence future planning and the planning should include decisions about ways of controlling. Planning and controlling are done at different levels — at least 3 — national, regional and local. The process of negotiation used in planned economies would probably help to define better these levels and to allow for greater satisfaction in decision making. Different kinds of decisions are taken at these three levels. The representation of the community (utilisers of the NHS) and the health workers will then have to be different at each level. The difficulties of getting representatives are discussed in depth by Klein[7] but the possibility still remains of organizing 3 bodies of representatives of the community and workers for the different levels. Political parties representatives and elected local government representatives are possible solutions not mentioned by Klein.[7] The proportion of representatives of workers and utilizers of the Service is a question for debate, but the workers' representatives (Union's representatives in proportion to the number of associates in each union) should account for about 25%, since they are also utilizers of the service and part of the community at large. The fact that there might be conflicting views between workers and community representatives seems a useful fact, specially if they can be clarified at the planning and controlling stages. The need for strikes might be greatly reduced. For these planning and controlling committees to be effective they have to have real bargaining power in the structure. The profecy made by Godber[11] that *Community Health Councils must be made to work if public confidence is to be maintened... If they are mishandled and antagonized they will certainly become pressure groups for those with real or imagined grievances against the Health Service and constant irritants to the management* did not come true. Do Community Health Councils have the power to bargain? *For instance, there is no point in establishing a patient's committee for a group practice of GPs if nothing happens when they take decisions.*[12] It would seem there is no point in establishing a committee at such a basic level where direct confrontation would not really take place between patients and their own doctors. The same applies in relation to finance. *Those held responsible for expenditure were often not in position to control it*, recognizes the Royal Commission.[9]

In China, the decentralization of health services requires that each local health unit support many of its own activities... In addition to monetary contributions, brigade members are encouraged to support health care by actively participating in the health scheme. Reports indicate that in some villages all inhabitants spend time collecting herbs for medicinal purposes and making their own medicines. They also build their own facilities.[12] What would the equivalent type of participation be in a developed society like Britain? Probably more than the present relationship with the voluntary organizations.

The *person in the organization* area refers to decisions by planning and controlling committees, to the managerial decisions and to the technical decisions in the daily contact with clients. The most typical type of conflict is expressed by Heller[12] *the shape of the NHS has been determined by the conflict between the two major decision-making goups within it, the medical profession and the management/administration. The interests of these two groups are quite different. The medical profession wants to keep in control and resents and resists attempts to introduce the rational management of its affairs that would be required by the managers to create an* efficient *system.* But the same type of conflict is perpetuated through the NHS.

Argyris[11] theorizing about the impact of the formal organization upon the individual, comments *...organizations adapt an initial strategy where they are willing to pay wages and provide adequate seniority if mature adults will, for eight hours a day, behave in a less than mature manner.* The problems evolve around self-development, individual and group growth and learning. Different values will correspond to different assumptions. One of the possibilities is management development as described by Reilly.[15] *Management development provides a different kind of learning opportunity.*

To me, development means legitimizing individual differences, providing opportunities for the person to actualize his own potential, and encouraging managers to be more different than they are alike along certain dimensions. It can be argued that management should be exercised by all those involved in the decisions, which means that all workers will be involved in management at different levels. Management teams at present, only exist at certain levels, but the smaller units, like health centres and hospital wards, where important decisions about life and death are made, are open to the indirect fighting among the health workers with consequences in the case of clients. It might be useful for the health team to work as such, meaning to work through their differences in direct and open dialogue.

Carl Rogers[16] gives evidence that an organization which focuses on persons and their potencial can function as effectively as a conventional hierarchical outfit and concludes *I believe the problems of a person-centered organization are fully as complex and difficult as those of a hierarchical organization. They are, however, quite different in kind, and with far more personal growth involved in their resolution... its efficency is human, its leadership is multi-faceted, and one of its most important* products *is the development of persons towards their full capacity.*

The comments and suggestions made above can only be taken as a basis for discussion. Different and sometimes opposing values, goals and norms make it difficult to *know* what partial alternatives exist to certain characteristics of a bureaucratic NHS.

Nevertheless, if trusting relationships are developed in small units, giving the opportunity for dialogue, people will discover their strength and creativity and start influencing the structure of the service, which in any case should not remain static.

The person centered approach can be learned and developed, but it involves personal growth, therefore it is a slow process and sometimes a frightening one. As in all authoritarian approaches, the end justifies the means, in the person-centered approach, the *process* is all important, and the changes are only partially predictable[16].

All this is directly linked with change — both the changes of natural development of people, organizations and societies and planned change. Planned change will be more effective if the forces in the reality are identified, the restraining forces reduced and the person-centered approach is valued and put into use.[17] Strategies for change have been studied and tried out but it is important, in all situations to assess if the *climate for change* is right. If it is, person-centered approach managers, at all levels, can introduce change by favouring the dialogue and by trusting people. Rogers[16] contrasts various elements of *common sense* with the evidence that contradicts it. Here are two examples:

> It is fuzzy-minded and weak not to take control over persons.
>
> But it is found that when power is left with persons, and when we are real with them, understanding of them, caring towards them, constructive behaviour changes occur and they exhibit more strength and power and responsibility.
>
> It is obvious that in any organization there has to be one boss. Any other idea is preposterous.
>
> But it has been substantiated that leaders who trust organization members, who share and diffuse power, and who maintain open personal communication have better morale, have more productive organizations, and facilitate the development of new leaders.

When thinking about alternatives to the bureaucratic structure of the NHS, let us first ask ourselves — to what end? to improve things or people?

RESUMO

A burocracia caracteriza-se por regulamentos, esfera de competência específica, hierarquia, formação especializada, separação dos meios de produção ou de administração e por registos escritos. O Serviço Nacional de Saúde não é uma organização burocrática pura, mas tem algumas das suas características. Os modelos alternativos (democrático, estrutura matricial) parecem não responder às necessidades de mudança. Sugere-se que as características da estrutura duma organização sejam tratadas como variáveis. Alternativas parciais são discutidas. Relação entre finalidades, utilizadores e trabalhadores — participação dos trabalhadores e utilizadores no planeamento e controlo do Serviço Nacional de Saúde. O conflito como motor de mudança. Poder controlador — representantes da comunidade e dos trabalhadores. A pessoa na organização — envolvimento de todos os trabalhadores na gestão aos diferentes níveis e o desenvolvimento das pessoas no sentido da sua capacidade total. É feita a defesa da modalidade de gestão centrada na pessoa.

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