HEALTH FOR MANY MORE - A STUDY OF THE ACCOUNTABILITY OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

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This dissertation has been submitted in partial fulfilment of the requirements for award of the Master of Arts in Health Management, Planning and Policy. The examiners cannot, however, be held responsible for the views expressed, nor the factual accuracy of the contents.

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CONTENTS

LIST OF FIGURES

FOREWORD

This dissertation is the result of an interest to understand the theoretical background of organisational structure and management. As a social activist, I was happy and content to work with people at grass roots level to organise and empower them and to participate in their liberative struggles. In every step we took, though challenging, the organised power of the people was the support and strength and their love and affection was heartening. But, when I was invited to take up a management post in the national office of the Catholic Hospital Association of India (CHAI) in Hyderabad, it was altogether different. I realised the need to improve my management skills. I was fortunate to get a chance to do the Health Management course followed by a dissertation on the organisational structure and functioning of the very organisation in which I am working.

My sincere thanks to all those who have helped me to do this course, especially to Fr. John Vattamattom SVD, the Executive Director, and the Board members of CHAI, as well as CEBEMO Holland and MISEREOR Germany for funding my study. I am very grateful to Dr. Thelma Narayan, Dr. Ravi Narayan and Dr. C M Francis for helping me with various resource materials, especially with the information from the "Golden Jubilee Evaluation Study".

My special thanks to Dr. Ann Matthias for guiding me in this dissertation. I really appreciate the interest she showed in this work. I also wish to express my sincere thanks to all the members of the International Division of the Nuffield Institute for

Health as well as to the staff of the Information Resource Centre. I am also grateful to the staff of CHAI for supporting me with necessary information to complete my work. I hope that this study will be another step towards achieving CHAI's goal of "Health for Many More".

INTRODUCTION

The Catholic Hospital Association of India (CHAI), a Non-Governmental Organisation actively involved in promoting health and health care services, is completing 50 years of service in 1993.

On the occasion of its Golden Jubilee, an attempt has been made to evaluate the various activities, programmes and profiles, and its contribution in the field of health and health care in India during the last fifty years. The Evaluation team which has published a "Discussion Document for further study and Action" (Narayan T, 1992) points out various issues which CHAI has to address while planning its future. One such issue was the "accountability of CHAI". The Discussion Document states that the membership of CHAI has raised several questions regarding the accountability of CHAI to its members, to its founders, to the people and to its own goals and vision. Accordingly, the Discussion Document has linked the concept of accountability to:

a management of funds and accounts

b living out its objectives and vision in all its activities and in its internal functioning, quality and effectiveness of service.

Now, the question is how to gauge the accountability of the Catholic Hospital Association of India which is a service providing non-profitable organisation? Studies suggest that organisation audit is possible in those organisations that adopt

and functioning. This audit can be done by measuring the input and output of a system with feedback as the mechanism for achieving a dynamic equilibrium. This approach encourages the management to define what it is trying to achieve, to make the best use of available physical and human resources, to measure the outcome of services and use this information to redefine the original task (Buckley G, 1990). Developing an understanding of the way in which the organisation functions enhances the possibility of implementing changes within it. It is futile to audit specific aspects of practice if change cannot be implemented. In a system approach, specific aspects of organisations, like budgeting and accounting, decision making process, communication systems, leadership styles all these can be audited by using the feedback systems (opus cit).

The feedback from the members of CHAI reveals that the present management profile of CHAI is not relevant to its present size and the services it provides and they expect a better management style for better accountability and improved quality of service (Narayan T, 1992)

1.1 AIM OF THE STUDY

The present study is an attempt to review the internal organisational structure of CHAI based on the scientific theories of organisations and principles of management. It also intends to understand the causes of membership dissatisfaction and to recommend suggestions to improve the quality of its structure to make it more effective and accountable to its members and to its objectives.

management. It also intends to understand the causes of membership dissatisfaction and to recommend suggestions to improve the quality of its structure to make it more effective and accountable to its members and to its objectives.

It is believed that if accountability can be brought into the organisational structure of CHAI, accountability in the management of funds and accounts will naturally follow.

As CHAI is one of the largest Non-Governmental Organisation (NGO) in the field of health and health services in India, its organisation structure is examined from the perspective of a Non-Governmental Organisation.

1.2 METHODOLOGY

Chapter One is a review of the "Discussion Document for further Study and Action" prepared by the "CHAI Golden Jubilee Evaluation Team". Chapter Two examines the theories of organisation to understand the structure and functioning of CHAI. Chapter Three looks at the various contingency factors that have affected the life and the profile of the Catholic Hospital Association of India. Chapter Four analyses the present organisation structure of CHAI. Chapter Five proposes a new structure for CHAI. In the Conclusion, necessary recommendations to effect the proposed changes are suggested.

CHAPTER 1: FEEDBACK ON THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

One of the bold steps the Catholic Hospital Association of India has taken in connection with its Golden Jubilee was to initiate an evaluation of its life and profile during the past half century. This evaluation was entrusted to a team known for its expertise, commitment and vision. They were also helped by an advisory committee who reviewed the progress of the study from time to time. During the course of the evaluation, 62.3% of the membership of CHAI (1,415 institutions) have shared information and given feedback and suggestions on various aspects of CHAI. Another forty people from outside CHAI participated in a Policy Delphi Method to identify trends in the socio-political and economic spheres in India and their impact on the health status of the population in the country.

1.1 FEEDBACK FROM MEMBERSHIP OF CHAI

The Golden Jubilee Evaluation Study Team has gathered feedback on CHAI from its members, Executive Board, representatives of regional units as well as from the staff of CHAI. The feedback on CHAI from its membership was mainly on:

1 The strength of CHAI

2 The weakness of CHAI

3 The expectations of its members from CHAI

4 On the future thrusts of CHAI.

While 62.3% of the members who responded to the questions on the strength of CHAI have made many positive comments regarding CHAI, another 55% of the members have given suggestions towards the future thrusts of CHAI. This study mainly concentrates on the weaknesses of CHAI and on the expectations of its members. Looking at this feedback especially on the "weakness of CHAI" and "expectations of the members from CHAI", reveals the main areas CHAI has to focus on to achieve its objectives.

1.1.1 Feedback on the weaknesses of CHAI

From the feedback, the study team has identified 15 weakness of CHAI:

"1 Poor interaction between CHAI and its members, poor personal contact and communication, and sense of alienation felt by members.

2 Inadequate focus on rural based members and their activities

3 It does not fulfil the needs of its members and does not look into their problems.

4 CHAI programmes are not accessible to many members in terms of cost and their location, especially for the smaller ones.

5 Poor functioning of the regional and State units. The centre does not take much interest in them.

6 Services offered are meagre and inadequate.

7 The administration and functioning is not efficient.

8 CHAI is not practical in its approach.

9 Concentration on bigger hospitals.

10 Discrimination between members in its service.

11 Too much centralisation of power.

12 Charging for "Health Action" to small/poor institutions.

13 Lack of initiative of members in activities of CHAI.

14 Lack of professionalism, It is run as a religious association. Lack of qualified personnel in the medical/health field.

15 It does not stand for its objectives", (Narayan T, 1992).

A closer look at the feedback on the weakness may help to categorise them into the following three main areas:

1 CHAI does not stand for its objectives (15)[1]. Is it because:

a Poor interaction between CHAI and its members (1)

b Inadequate focus on the rural based members and their activities (2)

c It does not fulfil the needs of its members and does not look into their problems (3)

d Charging for "Health Action" to small/poor institutions (12).

Are these issues mentioned above related to the objectives of CHAI at any stage of its history and do they lead to the conclusion that CHAI is not standing for its objectives?

[1] Numbers in brackets correspond to the numbers in the above list on weaknesses

2 CHAI is not practical in its approach (8). Is it because:

a CHAI programmes are not accessible to its members (4)

b Concentration on bigger hospitals (9)

c Discrimination between members (10)

Are these issues related to the diversity of the membership of CHAI? What is the type of CHAI's membership? Why do they feel alienated from their association? These questions may help to look at the direction CHAI has taken in the course of history.

3 Too much centralisation of power (11) Is it due to:

a Poor functioning of regional and state units (5)

b The administration and functioning is not efficient (7)

c Lack of initiatives of members in the activities of CHAI (13)

d Lack of professionalism. It runs as a religious association. Lack of qualified personnel in the medical/health field (14).

This feedback seems to raise questions regarding the structure and profile of CHAI and there seems to be a need for an analysis of these areas.

The feedback on the weakness and CHAI mainly refers to its objectives and its structure and functioning. A reflection on this feedback will help to define the objective and analyse whether its structure and functioning are efficient to achieve its goals and objectives.

1.1.2 Feedback on the expectations of members from CHAI

"1 Better interaction between CHAI and members through visits, more personalised correspondence.

2 Financial assistance.

3 Guidance and support to member institutions, especially smaller ones.

4 Training programmes at the State level, preferably using regional languages.

5 Medical aid (supply of medicines) on a regular basis.

6 CHAI to focus on rural areas.

7 Provision of information to improve health work.

8 Courses/seminars on labour laws, social analysis.

9 Production of health education material in local languages.

10 CHAI should be ready to help members out of their problems.

11 CHAI to arrange for doctors who are efficient and service minded to work in member institutions.

12 Support to/promotion of community health programmes.

13 Promotion of low cost drugless therapy.

14 Strengthening of regional units.

15 Training for community health workers", (Narayan T, 1992).

69% of the members who responded to the questions on their expectations from CHAI categorically say what they expect from their Association. This also helps to re examine whether the services provided by CHAI are relevant to the needs and

expectations of its members. This also points to whether CHAI is upholding the interest of its member or whether the objectives of CHAI need to be redefined to cope with the expectations of CHAI. The feedback on the expectations reveals:

The focus of CHAI:

a CHAI should focus on rural areas (6)[2]

b Promotion of Community Health programme (12)

c Promotion of low cost drugless therapy (13)

d Training of Community Health Workers (15).

The Role of CHAI as Guide and Support

a CHAI should be a guide and support to member institutions, especially to smaller ones (3)

b Better interaction between CHAI and members through visits, more personalised correspondence. (1)

c Training programmes at the State level, preferably using regional languages. (4)

d Courses/seminars on labour laws, social analysis. (8)

e Provision of information to improve health work. (7)

The Role of CHAI as Problem Solver

a CHAI must be ready to help the members out of their problems (10)

b Financial assistance (2)

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2 Numbers in brackets correspond to the numbers in the above list on the expectations of members from CHAI

c Medical Aid (5)

d CHAI to arrange for doctors who are efficient and service minded to work in member institutions (11)

The mode of operation

a Strengthening of Regional units (14)

b Training programmes at state level, preferably using regional languages (4)

c Production of health education materials in local languages (9).

This feedback definitely tells that members of CHAI expect their Association to be a guide and support to them mainly in their programmes and activities and in their problems. Main orientations here seems to be in Community Health in the rural areas which needs support in various ways including the proximity of the Association through regional units.

1.2 FEEDBACK FROM POLICY DELPHI METHOD

The evaluation study team used a Policy Delphi method with a group of forty panellists from various fields of activities and different disciplines to identify trends in the socio-political and economic spheres in India and their impact on health status of the population of the country. In the second round of their feedback, Delphi

panellists have identified several organisational aspects and mechanisms that could be strengthened or introduced by CHAI to enable effective functioning (Narayan T, 1993).

All these factors indicate the need for analysing the organisational structure of CHAI.

1.3 STRATEGIES FOR THE FUTURE

The Discussion Document has also identified twenty key issues for the consideration of the Board, the Executives and the Association in planning future strategies for the coming decade and beyond (Narayan T, 1992) One of the issues identified is the accountability of CHAI. At a closer look at all the other issues identified by the team, it was found that almost fifteen out of twenty issues were very closely related to the issue of the accountability of CHAI to its members, to the objectives and to the Catholic Community in India.

1.4 CONCLUSION

The feedback on CHAI should help the Association to redefine its objectives and restructure its functioning to make the best use of the available human and physical resources. There has been extensive and far reaching changes in the socio-political situations in the country since the origin of CHAI. An organisation started during the colonial period might have changed its objectives and direction to collaborate

CHAPTER 2: THEORY OF ORGANISATIONS

From the survey conducted among the members of the Catholic Hospital Association of India a number of issues and problems the members face in their relations with the association were identified. Most of these issues seem to be related to the management and administration of the organisation. To understand these issues in the correct perspective, one may have to analyse the organisational structure of CHAI and examine how these issues are related to the objectives of CHAI and its organisational functioning. This chapter is an attempt to examine the organisational theories and organisation structures in general. These theories will

> "help one to explain the past which in turn help to understand the present and thus to predict the future which leads to more influence over future events and less disturbance from the unexpected" (Handy c 1985).

Bernard (1983) defines organisations as

> "systems of consciously coordinated activities or forces of two or more persons - to accomplish a common purpose".

Morgan (1990) says that

> "Organisations develop out of a conscious decision on the part of an individual or group to achieve certain goals through the bringing together in a disciplined fashion of human and material resources".

Despite a long history of organisations, research into the structure and functioning of them is of the recent past. Most theories of the organisation originated with industrialisation in the 19th century.

2.1 CLASSICAL OR TRADITIONAL SCHOOL

One of the early theories on organisation comes form the Classical School. It was one of the first systematic attempts to develop a theory on organisations. This theory proposed a formal structure for organisations to improve efficiency. This is associated with F W Taylor (1855-1917). The machine theory, as it is called, or the scientific management of Taylor focused on the advantages of division of labour both among and between managers and workers and also introduced a scientific "work measurement" of daily task and a study of optimal way of doing a task. Within the same broad orientation, writers such as Fayol (1941-1925), L F Wiwick and L Gallick concentrated on formulating a series of management principles concerned with authority, specialisation, span of control and obligations (Collins 1992). All these studies related to organisation and management have been aimed at increasing profit through the improvement of efficiency (Weisboard, M 1978).

The structural approach also relied on the writings of Max Weber (1864-1920) on bureaucracy. Weber presented bureaucracy as a special form of rationality and efficiency. Weber identified the dimensions of bureaucracy which included the clear definition of duties and responsibilities, hierarchical authority, the importance of official rules, impersonality, selection of candidates on merit, etc. For Weber, bureaucracy is the highly efficient system of administration characterised by clarity, reliability, precision, stringent discipline, unity of command, strict subordination, calculability and continuity. Following Weber, Taylor and Fayol presented some fundamental basis to the structural approach to organisational efficiency. They suggest that:

a organisations exist to achieve defined goals

b problems in organisation are caused by faulty structure

c organisations operate best when employees can rely on clear and established rules, when specialisation of work is developed and finally when coordination and control are set out through the exercise of hierarchical authority and impersonal rules.

The structural approach places too much important on organisational structure for efficiency. When structure is well defined it has a significant but limited contribution to organisational effectiveness, Child (1984). It has failed to consider the persons working within the structure. It also lacks environmental variables, interpersonal relations and informal organisations which can also bring efficiency and effectiveness into the organisations.

2.2 HUMAN RELATIONS SCHOOL/BEHAVIOURAL SCHOOL

In reaction to the impersonalised bureaucratic view of organisational management, pioneers of the Human Relations School studied the problems of organisations from the viewpoint of human relations or behaviours of people within the organisations. Pioneers in this area were Mayo, Koethilisbergen and Dickson. Their research has proved that worker performance could be favourably influenced by social factors in the work environment and changes in the attitudes of supervisors (Pugh, 1971). They also showed that people do not pursue financial ends blindly nor can their behaviours be predicted and governed in the way Taylor and others assumed. Mayo and others having studied the role of individuals, informal groups and intergroup relationships within the organisations, developed a number of important concepts:

a people are not only motivated by financial factors but by a variety of social and psychological factors as well,

b an organisation is a social system as well as technical/economic system,

c informal work groups have important roles in determining the attitudes and performances of individuals,

d management requires social skills as well as technical ones,

e traditional "authoritarian" leadership patterns should be modified substantially to consider psychological and social factors,

f participation in work organisation, planning and policy formulation is an important element in organisations.

This means establishing effective communications between the various levels in the hierarchy to ensure a free flow of information.

Following Mayo's pioneering works study of people and their behaviour mainly the motivating factors began to dominate the study. Thus we have Maslow's basic need theory, or self actualising man and McGregor's Theory X and Theory Y, and Herbut's Motivation-Hygiene theories and the expectancy theory of Vroom etc. All have contributed to the understanding of human factors at work yet none of them provides a complete answer. Consideration of the various theories and assumptions on which a manager subscribes will colour his views about the way to manage and the ways to deal with people.

2.3 SYSTEM THEORY/CONTINGENCY APPROACH

Modern researchers on organisation theories have built upon the Classical and Human Relations thoughts, and provide a more comprehensive view of behaviours in organisations. System Theory is one such approach. It sees organisations as complex social systems that interact with their environment and which must respond to numerous interdependent variables such as people, tasks, technology, environment and structure, (Perrow, 1972). While earlier approaches considered their variables in isolation, system theorists study the relationship between several of them. Their writings suggest that there is no one best way of designing organisations but because

of change and volatility the best way dependent (contingent) upon prevailing conditions (Silverman, 1970). Thus the contingency approach has developed out of System's thinking.

The term "contingency approach" was first used by Lawrence and Losch (1969). They examined the operations of a number of firms to assess the effect on the tasks and attitudes of managers in various functions operating with different structures and environments. The first model developed by Levinson (1972) integrated methods of psychology, sociology and system theory in order to discover "points and nodes" of dysfunction of an organisation as a living system in constant change in an active relationship with the environment. According to them, an organisation itself does not have purposes; organisation's purposes come from the people who integrate it. As the organisation becomes more complex in its components, more complex purposes arise.

2.3.1 Integration and coordination

The main emphasis of this approach is on differentiation and integration. An organisation tends to be divided according to the task it performs. These divisions become integrated by specialists who find their own criteria for rewards, control procedures, structure and reporting relations. Integration is defined as the quality of state of collaboration among division to achieve goals and objectives of an organisation.

2.3.2 Method of integration

Integration in an organisation mainly takes place through centralisation or decentralisation.

Centralisation implies that standardisation of common procedures centrally administered.

Decentralisation implies that power is dispersed among its members and its units. Decentralisation can be vertical or horizontal.

Vertical decentralisation when power is vested in the Chief Executive at the strategic apex and he delegates it to the lower levels down in the vertical hierarchy.

Horizontal decentralisation is referred to the extent non-managers control decision making process. The power may remain with the line managers or with people outside the line structure. Here it is assumed that formal power can rest with people who are empowered to elect managers to the strategic apex which is the policy making body. In this case, power goes to everyone by virtue of his membership. Decentralisation is complete when power is vested with people. This is democracy and everyone participates in decision making. Participative and democratic management lead to increased responsibility and accountability (Mintzberg, 1983).

"The structure of the organisation is the sum total of the ways in which its labour is divided into distinct tasks and then its coordination achieved among these tasks" (Mintzberg, 1985).

Lack of a proper design and structure result in low morale and low motivation, delayed decision making, lack of coordination and high cost (Child, 1984).

2.4.1 How to design a structure?

One of the ways of designing an organisation may be based on the specialisation of the organisation. Specialisation is concerned with the division of labour. This means that various tasks and activities needed to meet the objectives of the organisation should be suitably grouped and divided up. This is done through departmentation. People of a department are able to concentrate on a particular task or group of related tasks and develop proficiency, knowledge and expertise. This will increase the efficiency of the organisation. Specialisation can be based on the services or functions; problems or needs of the particular geographical area or by a mixture of both.

Organisations choose structures which will make them efficient to function in particular circumstances with their special objectives. This reinforces the contingency view of the organisation. An effective organisation is the one which has an appropriate structure and a culture. Appropriateness is determined by various

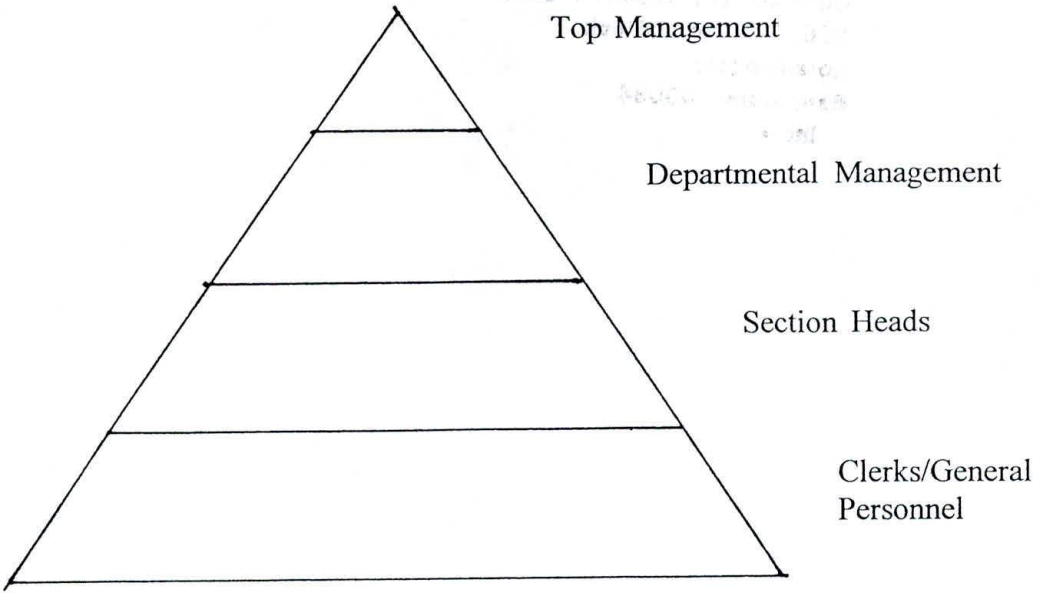

FIGURE 2.1 FLAT STRUCTURE WITH 4 LEVELS
(SOURCE: LOCKETT M & SPEAR R, (1980))

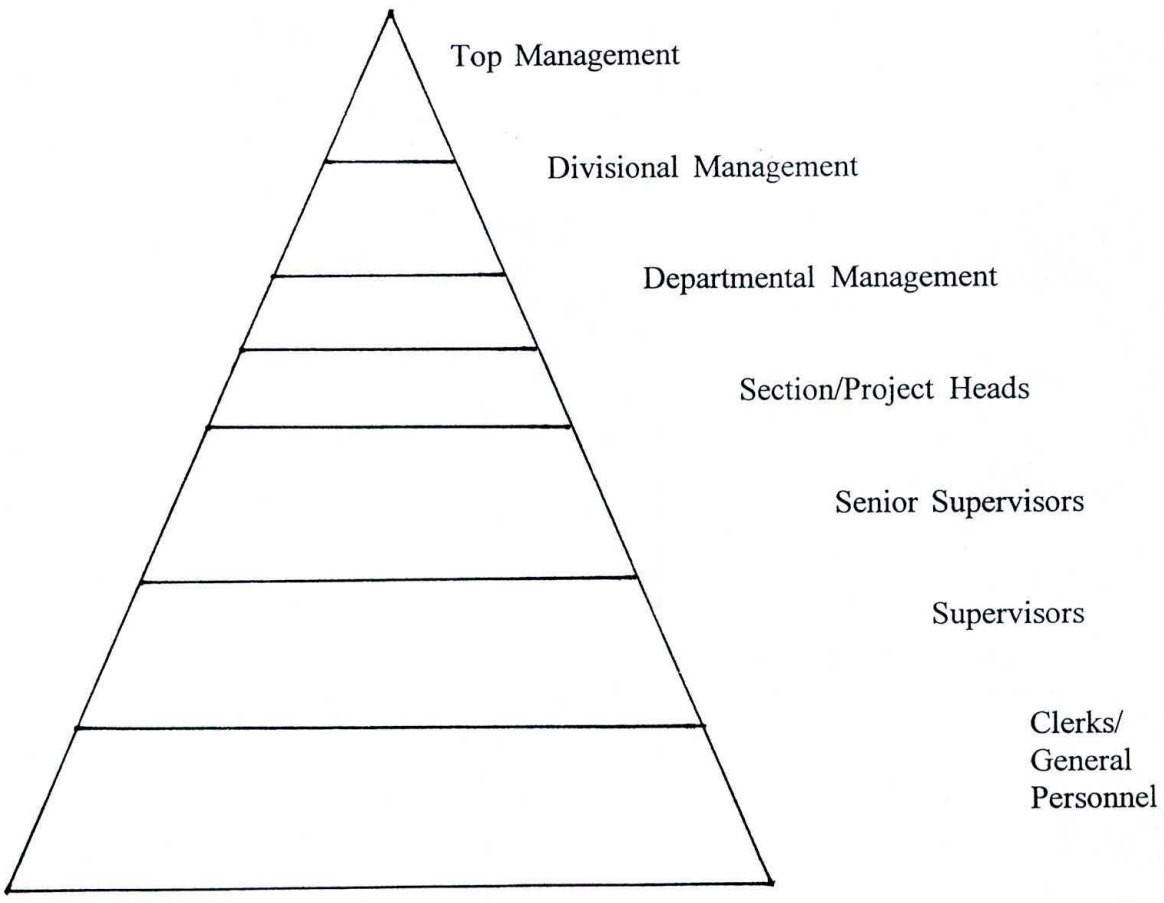

FIGURE 2.2 TALL STRUCTURE WITH 7 LEVELS
(SOURCE: LOCKETT M & SPEAR R, (1980))

Matrix Structure

In the Matrix Structure, project teams each with a designated manager, are combined with a conventional functional structure. Project teams are multi-disciplinary and are formed to achieve a specific goal or task. The project leaders liaise with the functional heads for service and the functional heads provide technical expertise and facilities and give structure to the organisation. The project manager also has a direct or line relationship with his supervisor, usually the Chief Executive. The Matrix form attempts to combine the efficiency and stability of the more conventional departmental and functional form with the flexibility and directness of a project based approach. It is a compromise between the traditional functional organisation and a full scale programme based approach. Some of the Voluntary organisations follow the Matrix structure.

2.5 STRUCTURE OF VOLUNTARY ORGANISATIONS

Following contingency theories and the system approach many voluntary and Non-Governmental Organisations have designed their structures taking into consideration the objective of the organisations, the type of function and services they render, the geographical situation, the operational environment, etc. When analysing the structure of voluntary and Non-Governmental Organisations, researchers have identified that some of them have followed a functional structure based on their specialisation of their services while others, following the principle of

decentralisation, have accepted a divisional or Federal structure. Those NGOs that are more project-based have followed Matrix structures in their management (Wilson, 1991).

2.5.1 Functional

Tasks are divided into separate departments or sections based on the functions performed. They are arranged in a hierarchical way that facilitates communication and information flow and submits to managerial level and this to Chief Executive. This is a Functional structure. Functional committees which are coordinating the functions of subcommittees.

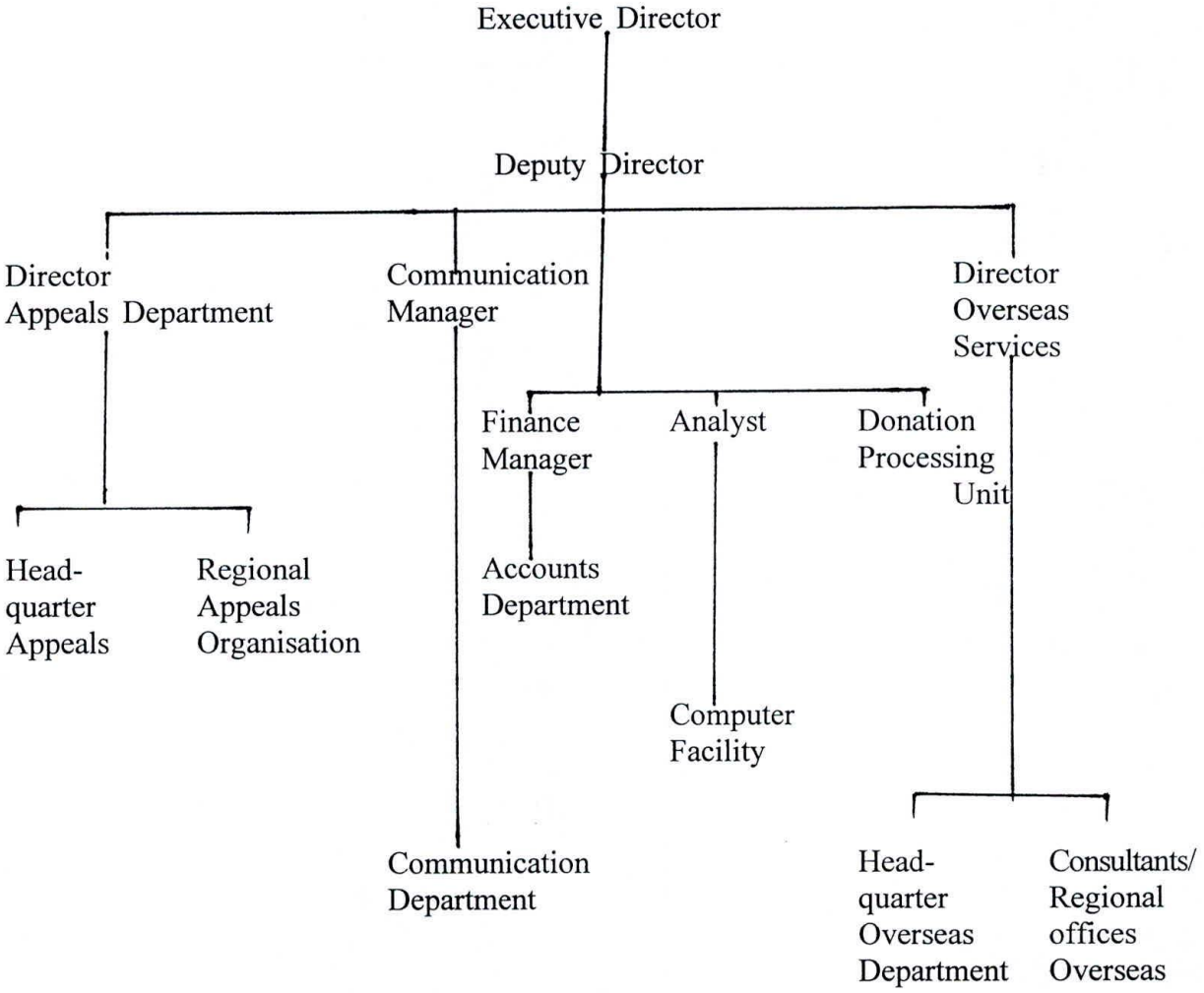

FIGURE 2.3 REF: WILSON (1991) FUNCTIONAL ORGANISATIONAL STRUCTURE OF ROYAL COMMONWEALTH SOCIETY FOR THE BLIND.

2.5.2 Divisional Structure

This structure allows different division of the organisation in different geographical areas or for different types of clients. Each division operates relatively

independently but coordinated and controlled by the head office from where functional services which are lacking in the division are provided, eg Save the Children Fund.

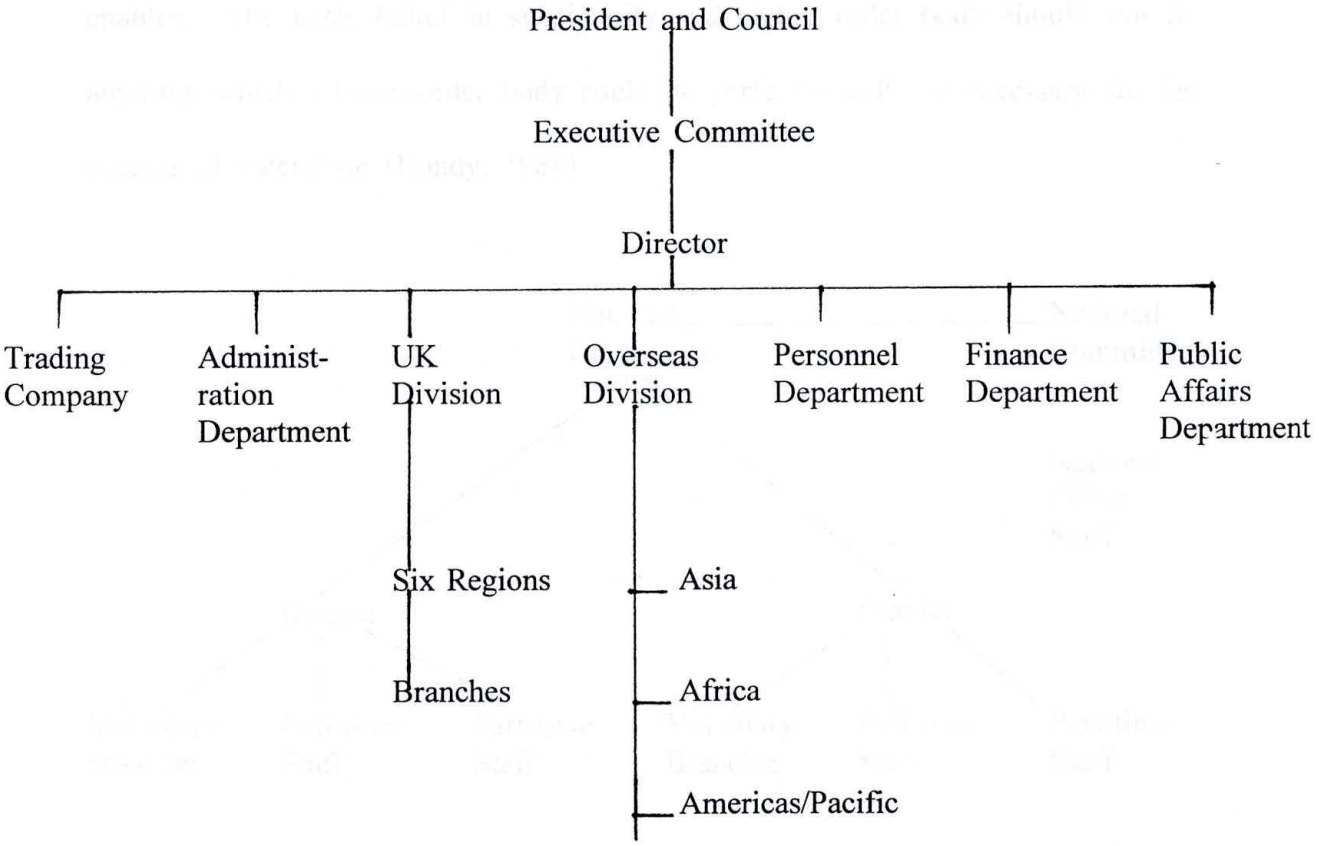

FIGURE 2.4 WILSON (1991): DIVISIONAL ORGANISATIONAL STRUCTURE, SAVE THE CHILDREN FUND

2.5.3 Federal Structure

Each unit is more independent and autonomous in this structure. They are formally part of the same organisation, with the same ideology, vision and objectives. Control and unity are achieved through the same objective and vision. But

Federalism and decentralisation are different. In decentralised structures the control of the centre is extended through delegation to the periphery. In internal structure, the centre does only those tasks which the parts cannot or do not want to do. The centre does not command or direct these parts but it coordinates, facilitates and enables. The basic belief in subsidiarity - a higher order body should not do anything which a lower-order body could do perfectly well - is necessary for the success of federalism (Handy, 1988).

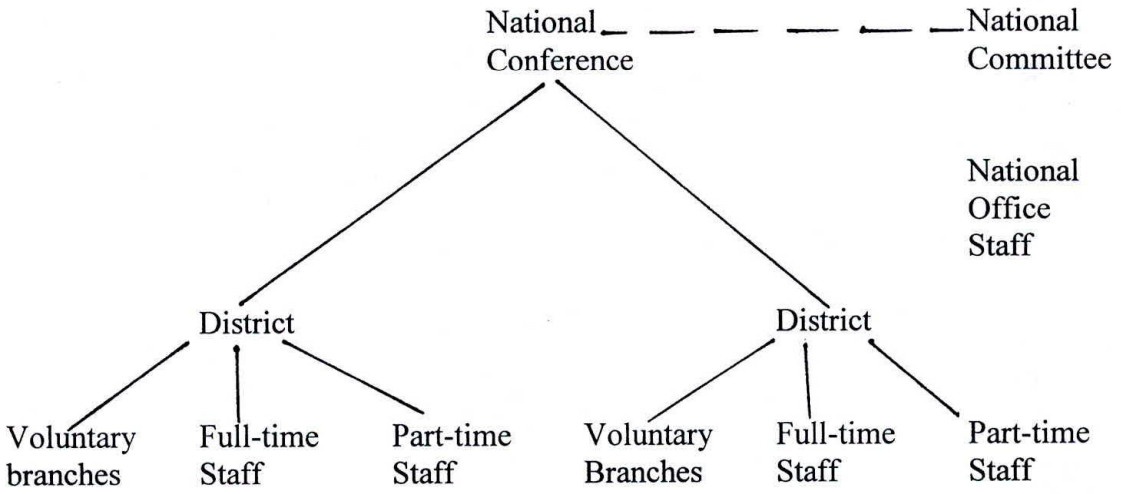

FIGURE 2.5 WILSON (1991), FEDERAL STRUCTURE, WORKERS EDUCATION ASSOCIATION

Federalism is suggested by many as a good model for NGOs as the federal units can reflect their own priorities in their activities but under the umbrella of the central organisation. The centre will be able to influence, encourage and suggest to the units and allow freedom to be different.

easy to channel resources and energies where they are needed most without affecting other branches or divisions. Divisions can be planned according to the geographical area or the need for specialisation. But there can be conflicts when head office tries to interfere with policy control and tries to coordinate the division.

2.5.4 Matrix or Project-based Structure

Researchers suggest that matrix structure is the ideal one for the operation of project-based NGOs because it is organised around specific projects rather than a hierarchy or divisionalisation (Wilson, 1991). The Matrix is made of any formal hierarchy on one side and a project leadership on the other side. This is a very flexible and adaptable structure.

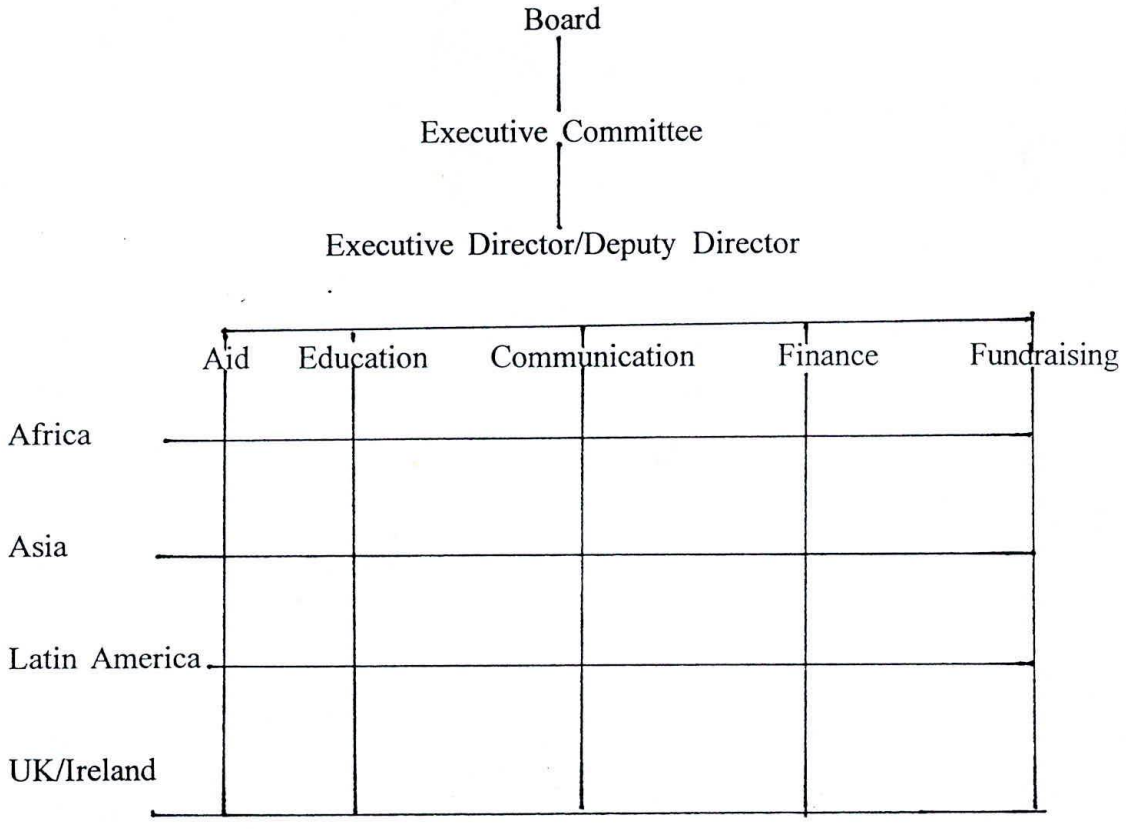

FIGURE 2.6 WILSON (1991): A MATRIX STRUCTURE CHRISTIAN AID

The main problem with regard to this structure is the control and the dual authority. The dual authority creates ambiguity. This can lead to discrimination and preferential treatment especially when there is scarcity of resources.

The project group works as a team with less status differentials and with more internal freedom. The group's objectives are given through the project. This is more motivating and rewarding. Direct supervision is not necessary as the clients

Studies show that many voluntary organisation operate a semi-matrix structure with two lines of authority (Wilson, 1991). Many organisations have a dual structure in which regional offices are accountable to both headquarters and local membership committees (Booke, 1984). The usual trend in NGOs is for Functional structures. Because of the pressure between decentralisation and centralisation many NGOs find it difficult to accept matrix structures.

2.6 CONCLUSION

The effectiveness of an organisation is caused by various factors such as its goals and objectives, the type of work, the environment in which it operates and the communication system that is practised. Because of these contingent factors, organisations are like living organisms under constant change and growth. As organisations grow more complex, more complex purposes arise and efficiency or success is determined by how these various factors are coordinated or integrated. An organisation chooses its structure to effect this integration and make it effective in the particular situations to achieve its special objectives.

CHAPTER 3 THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA AND THE CONTEXTUAL FACTORS

From the discussions on the theories of organisation in the previous chapter, it was concluded that organisations adapt various structures to achieve their goals and objectives. An effective organisation is the one which has an appropriate structure and culture (Handy, 1990). Appropriateness is determined by a variety of factors such as the history, growth and size of the organisation, its operating environment, the goals and objectives for which it exists and the technologies used for coordination and communication (Wilson, 1991), This chapter is an attempt to see how far these contingency factors have contributed to the present structure of the Catholic Hospital Association of India as a Non-Governmental Organisation. The last part of this chapter will try to see the relations between the present structure of CHAI and the feedback from its membership on its functioning.

3.1 CONTEXTUAL FACTORS

3.1.1 Size

The studies on NGOs have shown that many of the Non-Governmental Voluntary Organisation have originated as mutual support groups. People working in the same profession or service come together for support, encouragement or advice. They required minimum organisational structure; at the most they need a secretary or a coordinator to convene the meetings or send out a circular. It seems that these

support groups slowly start to take up certain services for their members. At this stage, some kind of organisational set up begins to take shape. the number of the people joining the group also determines its size. Many of the larger NGOs have started as small support groups. When the number of services increase, the specialisation expands and the requirement for more formal coordination mechanisms and control systems are introduced and thus the formal structure emerges. As the size changes, the culture in the organisation too changes from an informal club culture to more formal role cultures. Communication, systems and procedures become more formalised (Handy, 1988).

3.1.2 Age and History of the Organisation

An organisation's structure is related to where the organisation is in its life-cycle (Kimberly and Miles, 1980, quoted by Wilson, 1991). In the early stages of the organisation it is likely to reflect the preferences of the founder or founders. The organisation is their complete focus and they do most of the jobs and set the climate and culture (Wilson, 1991). During maturity, NGOs need more strategic and management direction and it is now that the structure begins to take shape as functions and tasks, and departments are defined. When new objectives are introduced, that may require new direction, new managing levels, and new skills as growth leads to complex nature (Subramanian, 1988).

3.1.3 Operating Environment

The socio-political and geographic situations also determine how an organisation integrates itself or differentiates. The greater the complexity of the operating environment of the NGO, the greater the need for highly differentiated organisational structures. When a large organisation faces various demands from different types of clientele, it is appropriate to adapt differentiated organisational structures with special subunits to cope with those demands (Handy, 1990).

3.1.4 Goals and Objectives

NGOs may take up additional advocacy or campaigning role and act as a pressure group to campaign and advocate a vision or ideology. At this stage, departments and specialization are no longer sufficient to control the diversity of the problems and an organisation has to decentralise its works through regional units (Handy, 1985). Researchers generally agree that given a strategy of growth, the structural form of the organisation will in due course have to match the strategy it is pressuring (Wilson, 1991). When service providing agencies take up campaigning, problems begin. Service providing and advocacy are two tasks under one umbrella and the organisation has to be decentralised or restructured to meet the challenges.

3.1.5 Technology

Depending on the size and volume of service, geographical differences and the areas of specialisation, technology used to coordinate in an organisation differs. technology is mainly used for communication and information sharing. In small organisations, postal services or telephone facilities may serve the purpose if that is dependable or available. In bigger organisations with larger membership, circulars or newsletters may be used for information sharing. Within the organisation coordination and integration can be achieved through computers and other communicative systems like telephone and intercoms, meetings, interviews, notices, etc.

3.2 CHAI AND THE CONTEXTUAL FACTORS

To understand the present organisation structure and the management style of CHAI, one may have to see how these multiple factors interplay in the various stages of CHAI's growth.

3.2.1 History and size of CHAI

The Catholic Hospital Association was formed by a group of 16 Catholic nuns in 1943. All of them were medical professionals working in different part of the country. They came together as a support group. During the first 15 years, there was no formal structure for CHAI. Over the years, the number of church related

medical and health institutions and consequently the membership of CHAI grew. Now CHAI has a membership of over 2,000 health care institutions including big hospitals, small dispensaries and social service societies (see Appendices 1-3). This diversity of membership is united in their commitment to health care ministry. In 1957 when its first full-time Executive Director took charge, CHAI began to enter into its second phase of growth. Attention focused more to provide services to its members. For the first time, it got a permanent office and new departments were started for membership, projects, publications, employment and later central purchasing service, etc. In most of the voluntary organisations, there is an evolution from mutual support groups to a service providing stage, later taking an advocacy or campaigning role (Handy, 1988).

CHAI entered into this third stage when it accepted community heath as one of the objectives in 1978. A new department of community health was started in 1981 to advocate the vision and philosophy of community health.

3.2.2 Operational Environment of CHAI

When CHAI was started in 1943, the health situation of India was very poor. The medical care of the colonial government was mainly for the settlers and their employees. Those facilities existed mainly in cities or in towns. This selected intervention during the colonial period resulted in the foundation of Western medicine in India. This included training centres for health personnel, basic research in tropical diseases, and a health service system for the country. But simultaneously

it has also caused incalculable damage to the health tradition of India and the indigenous system of medicine. The basic holistic outlook of people on health was eroded and was replaced by the Drug-Disease-Doctor orientation. Colonial exploitation also let to the severe environmental destruction causing many new diseases. According to the National Planning Commission Sub-committee on Health, the distribution of mortality rate among children in 1942 was as follows:

under 1 year	24.3%	
1 - 5 years	18.7%	
5 - 10 years	5.5%	
---	---	
Total 10 years	48.5%	(Mukhopadhyay A, 1992).

The socio-political and economic situation of India was so degraded that half of India's children died before the age of 10. For every 1,000 live births, 20 mothers lost their lives. Malaria counted for 100 million every year, out of which 1 million died. The epidemics and famines took a heavy toll, mainly women and children were the victims. This was the background in which missionaries started health care institutions. During the first half of this century there were 93 Catholic health institutions in India, of which 14 were established before 1900 (Narayan T, 1992).

After the independence in 1947, when the Government of India made a clarion call to the voluntary organisations to participate in the nation building process, the Catholic church in India responded to it by building more hospitals and dispensaries

and more personnel joining the health care ministry. Thus the number of the health related institutions grew and the membership of CHAI. But the membership was very scattered all over the country. In those part of the country where the Christian presence was more, there number of medical institutions also grew. A hospital or dispensary was considered as a basic unit of a Christian Community together with school and the church. The Bhore Committee set up in 1943 by the colonial government and Sokhey Committee established after the Independence set the foundation for the new health policy of India which advocated comprehensive rural health care services through the concept of Primary Health Care. In 1952, the Government of India started the process of establishing PHC's in various parts of the country. The Catholic church supplemented the process by establishing more dispensaries in rural and tribal areas especially where government programmes were lacking. But the approach was predominantly curative and medical.

3.2.3 Goals and objectives of CHAI

The first motto of the association was "Union is strength". During the first 14 years, the main focus of CHAI was on:

1 promotion and upholding of ethical values in medical care,

2 fostering the professional education for health personnel,

3 issues related to the professional management of hospitals.

The emphasis during the 2nd phase was:

1 providing assistance to members to meet their needs for medicines and equipment by developing linkages with various agencies, donors and governments,

2 providing continuous education to its members through journals, seminars and the annual convention (Narayan, T., 1992).

The Synod of Bishops in Rome in 1971 called for

> "Action on behalf of injustice and participation in the transformation of the world" (Vattamattom J, 1984).

In 1972, the Catholic Bishops Conference of India (CBCI) stated that

> "the church should actively involve itself in removing concrete cases of injustices happening in the society in which it exists" (opus cit, 1984).

Following the Alma Ata declaration when the Government of India accepted the goal of "Health for All by 2000 AD", the Catholic Bishops Conference of India exhorted the Catholic community

> "We want our health services to take Primary Health Care to the masses, particularly in the rural areas and urban slums. Catholic hospitals and dispensaries should stress the preventive and promotive aspects of health care" (opus cit, 1984).

Thus the teaching of the Catholic church and health policy of India prompted CHAI to accept the concept of community health. In 1983 CBCI again exhorted for an analysis of the society with tools of social sciences and in the light of faith and asked to promote community health on a priority basis (opus cit, 1984).

CHAI entered into its 3rd phase in its life cycle when in 1978 it included community health as one of the main objectives. During the last 15 years, this thrust continued to permeate all aspects of its life.

The Catholic Hospital Association of India adopted for itself the goal of "Health for Many More" (a modification of the Alma Ata goal of "Health for All by 2000 AD"), with a special emphasis and focus on the poor. The concept of community health was understood as

> "a process of enabling people to exercise collectively their responsibilities to maintain their health and to demand health as their right" (Vattamattom, J 1984).

This new vision demanded the paradigm shift in the health care approaches of its members. The community health department was initiated in 1981 to advocate this vision.

3.2.4 Technology and communication

To keep the scattered membership united was the main aim of the Association. So they started an in-house bulletin in 1944 called "Catholic Hospital". In 1957, the bulletin was renamed "Medical Service". In the third phase of its growth, the bulletin was converted into a regular commercial magazine ("Health Action") to promote the vision of community health to a wider public. The members were asked to subscribe to the magazine which many did and many could not. Since "Health Action" was meant for a wider public, it could no more carry the regular information to is members. This caused a break in the flow of communication to its members. This situation continues since 1988.

Within the office, more technological innovations took place - more telephone connections, intercoms, telex, fab, etc were installed, and computer services were made available to all the departments.

3.3 CATHOLIC HOSPITAL ASSOCIATION OF INDIA, A GROWING NGO

The multiple factors that have affected its size, membership, growth, operational environments and the technology have changed the Catholic Hospital Association of India into a third generation NGO.

> "As NGOs grow in sophistication regarding the nature of development and the potential for their own roles, many undertake, increasingly effective strategies involving longer time perspective, broadened definition of the development problems, increased attention to the issue of public policy and a shift from exclusively operational to more catalytic roles", (David Korten, 1987).

In the growth of NGOs, Korten categorises them into three generations:

Generation 1

NGOs of this category are mainly engaged in welfare, charity and relief to the poor.

Generation 2

This includes NGOs that are engaged in the development style projects in areas of preventive health, improved farming, etc. Stress on local self reliance was the main shift.

Generation 3

In this stage, NGOs focus their attention on facilitating sustainable changes on a regional or national basis. In this stage, the NGO will play a more catalytic role than a service delivery role, facilitating services by other organisations by linkages and networking on a sustainable basis, (Korten, D, 1987). A similar view is shared by Sethi (1978) and Meera Chattergee (1988).

If one can accept these arguments, CHAI has to be considered as a third generation NGO with its multiple roles of advocacy, linkages, networking and trying to bring sustainable changes in the field of health. This is clear from the various activities undertaken by the Community Health Department, which included:

Training and orientation,

Research and documentation,

Promotion of rural and urban country health,

Promotion of regional resource teams,

Project planning and evaluation,

Linkages and networks and

Issue based campaigns.

The 50 years of CHAI's growth has shown 3 different stages in its life. The different socio-political environment in which CHAI grew demanded different organisational structures. Depending on the focus an organisation gives during each phase, it develops its own organisational structure and culture.

The phase of expansion or consolidation is a crucial phase for any NGO (Subramanian, A, 1988) and it may face many challenges at this stage. Expansion is the logic of the market and therefore marks the business enterprise. If the organisation does not grow, it is destroyed (ibid).

Changes in services and increase in size means changes in personnel. More specialised personnel has to be recruited and managed. This will mean a more impersonal system of internal administration. The first question is whether the NGO will maintain its proximity and responsiveness to the people it serves. NGOs by nature are closer to the people and more flexible and adaptable. But as they grow in size and as the bureaucratic system develops, it alienates from the people. The organisation turns its focus from the people to its own functioning and management.

Size demands standardisation and therefore administrative bureaucracy is inevitable. This precisely makes it alienated from the community (ibid). At this stage it is

necessary to combine systematisation and standardisation with proximity and responsiveness to the people. A highly developed strategic competence becomes essential at this stage (Korten, D, 1987) to keep the members close to the organisation.

3.3.1 Growth and relationship with members

From the perspective of growth, if one looks at the feedback on CHAI from its member institution it is easy to understand why 45% of the people who responded to the questions on weakness felt that

> "there is poor interaction between CHAI and its members, poor personal contact and communication and a sense of alienation", (Narayan, T, 1992).

The reasons for this are also clear in the feedback. They say that

> "CHAI is not practical in its approach; there is too much centralisation of power", (Narayan, T, 1992).

All other answers to the questions on feedback follow from these basic problems. Again 69% of the members responding to the question of the expectations of the members, expect

"better interaction between CHAI and its members through visits and more personalised correspondence", (Narayan, T, 1992).

It very much shows that they want to remain united to CHAI and expect support in their activities, especially in rural areas.

62% of members answering the questions on the strength of CHAI approved its vision on community health, "Health Action" magazine, its option for poor and many of its actions that support the vision. They strongly feel that

"it is a hand to hold on", (Narayan, T, 1992).

3.5 CONCLUSION

The feedback from the member institutions of CHAI clearly tells that the current structure is not sufficient for the present size and the roles of the organisation. As organisations grow in size and change their roles, the structure and method of functioning are to be revised to avoid problems as well as to facilitate the smooth functioning. The feedback from the field calls for a review of the present structure and the current roles of CHAI.

CHAPTER 4: THE ORGANISATIONAL STRUCTURE OF THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

The situational factors discussed in the previous chapter are only one side of the organisation structure. The other side is the method of integration or coordination that exists within the organisation at various levels. These methods of integration are the design parameters that give shape to an organisation structure. The basic design parameters are centralisation and decentralisation.

> "In designing an organisation structure both situational factors and design parameters should be clustered to create configurations", (Mintzberg, 1983).

The method of integration within organisations indicates the source of power and the flow of communications and information in the organisation. This chapter examines the structure of CHAI to review the source of its power and the type of integration as well as the flow of communication within the various levels of its structure including its membership, diocesan and regional units, its elected executive board and the central office.

Since CHAI is representing the healing ministry of the Catholic church in India, it seems appropriate to review also its relation with the Indian Catholic church, represented by the Catholic Bishops Conference of India (CBCI).

4.1 POLITICAL STRUCTURE

The present structure of CHAI includes a strategic apex which is the Executive Board of the Association and an operational unit in the central office. There are also regional and diocesan units established according to the bye-laws of the CHAI 1961. For a proper understanding of the Association one may have to examine the process of integration that takes place within the Association. As a policy making body, the Executive Board is an important unit of integration.

4.1.1 The executive board

The memorandum of the Association of CHAI (1961) states that

> "the powers and duties of this Association shall be vested in and exercised by an Executive Board".

As a policy making body the:

> "Executive Board shall be responsible for all activities of the Association and its office of all categories", (Memo, 1961).

It is the Executive Board that initiates policies and projects and safeguards the memorandum of Association of the Organisation. The Executive Board consists of nine members elected by the members of the Association during the annual general body meeting of its members.

> "Every constituent member has the right to appoint a delegate to attend and vote at meetings of the Association on its behalf" (Bye-laws 1961, Article III).

The elected members form the Executive Board of CHAI. They are the policy making body and they also guide the central office in the implementation of policies and programmes. Hence election to the board is an important factor in the process of integration in CHAI. The Executive Board functions through board meetings. They also appoint the Executive Director who looks after the regular activities of the Association. The Executive Director is the link between the Executive Board and the operational unit. He is assisted by other offices and staff as necessary.

4.1.2 Drawbacks of the present election system

The members of the Executive Board are elected by the members of the Association during the annual general body which is convened during the annual convention.

"Election of all members to the Executive Board of the Association shall take place at a previously announced meeting held during an annual convention of the Association", (Bye-laws, 1961, Art VIII).

According to the rules of the Association, the quorum for the business meeting is fixed as one half of the members registered at an annual convention. In practice this has many drawbacks:

Elections are annual but conventions biannual

Every alternative year annual conventions are conducted on a large scale with exhibitions and seminars. These exhibitions are on health and health-related technological developments, new equipment for hospitals and other related item like vehicles, computers and office and hospital furniture, etc. These larger scale conventions are conducted in major cities and they attract a good number of participants. Since such conventions are very expensive, they are conducted only on alternative years. When there is no exhibition, the number of the annual general body varies depending on the programme arranged in connection with it. For example, the Bombay convention in 1990 attracted about 600 participants out of 2200 members. In 1991 a meeting of the sister-doctors was arranged in connection with the annual general body meeting and the participants were mostly sister doctors. The total number of participants were only about 100. The survey by the

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COMMUNITY HEALTH CELL
LIBRARY AND DOCUMENTATION UNIT
BANGALORE.

evaluation team has shown that only 32.4% or 132 member institutions have participated in the annual conventions in the past 5 years, that is the annual average is 6.5% (Narayan T, 1992).

Regional imbalances

Conventions are conducted annually in different parts of the country. Participation in the convention depends on the location of the convention in the country and the size of the membership in that particular part of the country. For example, if conventions are conducted in any southern state, it attracts more participants than when it is conducted in northern parts of the country. As travelling long distances is very expensive and time consuming, participation will be restricted form the particular regions.

It seems that the present method of election does nor guarantee a proper representation of the membership of the Association in the Executive Board. In some years, there is over-representation by one region on the Board, while other regions are not at all represented for many years. In 1991/2, out of nine board members three of them were from one state while many other states had no representation at all. This regional imbalance can affect the decision making process. It is also very much against the principle of equity and community participation advocated by the community health vision of CHAI.

A floating electorate

The present electorate is not permanent but almost a floating one. There is no consistent participation in elections. Depending on the theme of the convention and the location, participation by the members varies. This causes not only regional imbalances but also increases the possibility of unequal participation by certain categories of membership, eg doctors, nurses, administrators, social workers. All these factors reduce the responsibility and accountability of the elected Board members as they may not meet the same electorate during the next three years of their tenure. This also reduces the authority of the board members as the source of power which is the membership (General Body) is a floating and unstable one. Conventions are mostly attended by bigger institutions. But the membership pattern of CHAI shows that 70% of the member institutions are smaller institutions. When elections are conducted during conventions, bigger hospitals get representation in the governing board.

Lack of reporting system

The elected board members have no system of reporting back to the electorate regarding the activities of the association. Ultimately there is no flow of information and communication which is necessary for the integration of the Association.

4.1.3 Diocesan and Regional units

When a large organisation faces various demands from different types of clientele, it is appropriate to adapt differentiated organisational structures with sub-units to cope with these demands (Handy, 1990). According to the Bye-laws of CHAI, 1961, regional units are supposed to establish their sub-units in the dioceses. The 2,500 member institutions of CHAI are scattered in the 125 Catholic dioceses of India. Members of each diocese form a diocesan unit. Membership includes hospitals, dispensaries and clinics, and social service societies of the diocese. At present, diocesan units do not exist in many dioceses.

The Bye-laws of CHAI 1961 state the need for establishing regional units to take CHAI policies to local situations. Regional units were planned based on geographical limits mainly depending on the size of the membership in a state or group of states. The purpose of these regional units as envisaged in the Bye-laws are:

1 To bring the Association's acts and policies more effectively to its members.

2 To implement these policies with due regard for local conditions.

3 To study local Government policies and its effects on the general health policy of the Association and share that information with others.

But there were only limited success in decentralising the organisation through regional units. At present there are only 6 regional units. Attempts were made to

form such units ever since the Silver Jubilee of CHAI in 1968 with varying success (Narayan T, 1992). The lack of success in establishing and sustaining regional units may be due to:

1 Regional units were seen only as executors of the policies made at the centre.

2 They had no part in the policy making process of the Association.

3 Most of the regional units were initiated by the central office without initiating a process to establish diocesan units. This meant that the sustainability of these regional units depended on the central office.

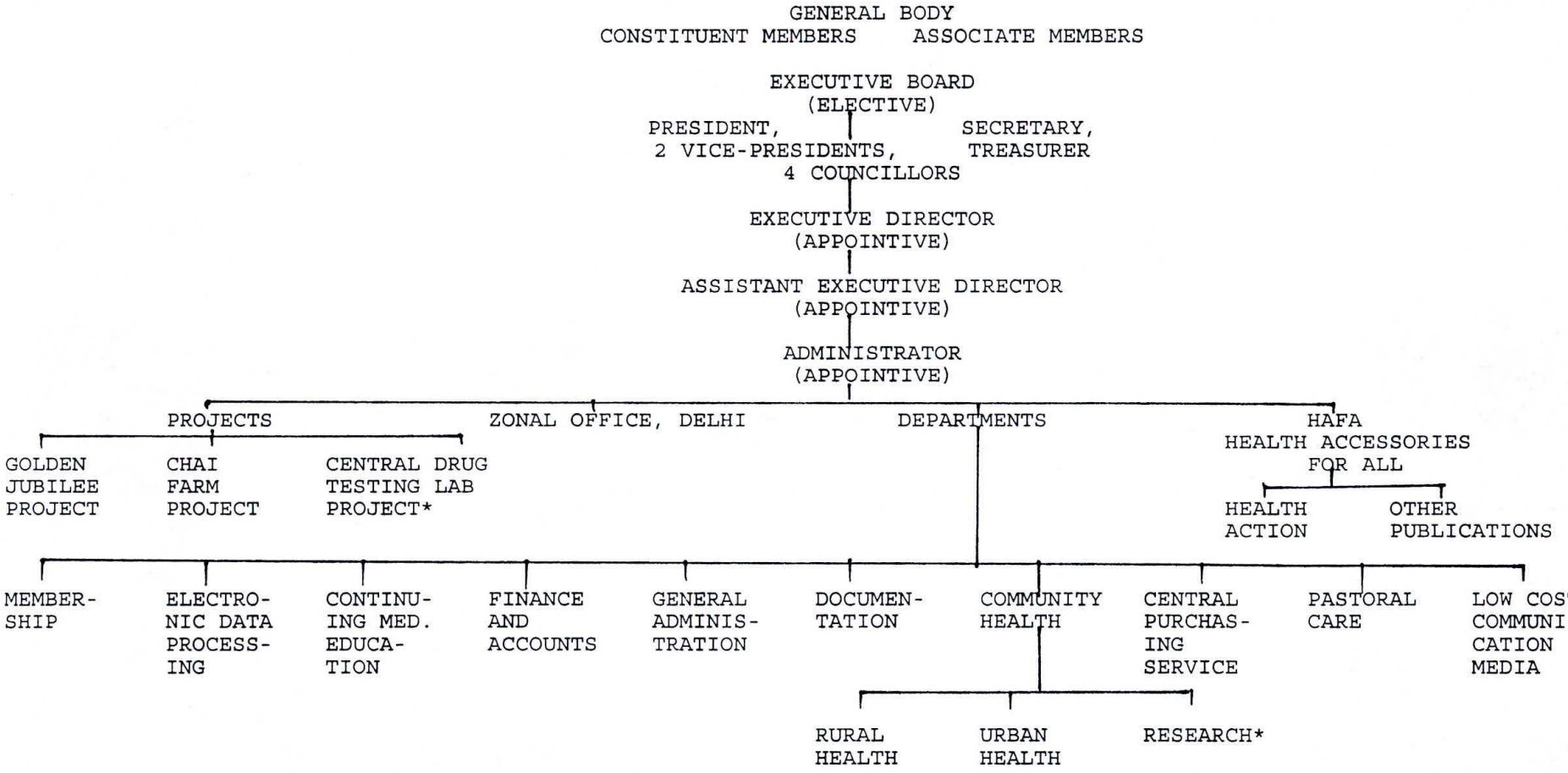
4 The regional units were separate legal bodies registered in each region. The only link with the central office was a letter of approval by the President of CHAI.

5 It seems that the relationship between CHAI and the Catholic Bishops' Conference of India (CBCI) was not strong enough to support the regional and diocesan units.

4.2 THE NATIONAL OFFICE OF CHAI

In Chapter One it was discussed that NGOs following the contingency approach, design their organisation structure taking into consideration the objectives of the organisation, the type of functions and services they render, and other contextual factors affecting the organisation. Looking at the present organisational chart of

ORGANISATIONAL STRUCTURE OF CHAI



*PLANNING STAGE ONLY

FIGURE 4.1 THE CURRENT ORGANISATIONAL CHART OF CATHOLIC HOSPITAL ASSOCIATION OF INDIA (SOURCE: CHAI DOCUMENTATION CENTRE, 1992)

CHAI, one may notice that various tasks of the organisations are differentiated into separate departments or sections on the basis of functions and services. They are arranged in some form of hierarchy with information and communication flowing from various departments to managerial and executive apex. Hence this can be identified as a purely functional structure. Regarding the internal functioning of CHAI the discussion report states that the staff of CHAI have raised questions about lack of clarity regarding goals and objectives, high turnover of staff, levels of confusion regarding roles, inadequate understanding and interrelationship between departments, (Narayan T, 1992). An analysis of the structure reveals the following facts:

Development has been ad hoc

In the course of the 50 years of its history, CHAI from time to time has taken upon itself various tasks and has added one department to another in its structure. As the functions and department increased, middle line managers were also brought in to coordinate these activities of the departments. Hence the present structure has evolved as a result of its growth. Unlike the Royal Commonwealth Society for the Blind, there was no policy decision to follow a particular structure, (Wilson, 1991).

No specification regarding reporting systems

In the structure of CHAI, there is no specification regarding who reports to whom. There are a number of departments and sections under the same management. This

can cause confusion among staff regarding their roles. This also causes confusion among middle-line management regarding control and coordination. Such a situation can cause lack of clarity as to what is expected of people and how their performance is assessed. This can create problems among middle-line management. Studies on the structure of organisations show that the growth in size tends to lead to more specialisation and an increase in the number of levels. This will lead to increased bureaucratization and communication problems and delay in decision making and eventually the morale of the organisation will decrease (Child, 1984).

Ineffective use of senior executives

When there are too many departments, even senior executives may also be forced to supervise and coordinate day to day activities. This may seriously detract them from the time and attention they have to give to long term policy and to dealing with external matters of a strategic nature, (Child, 1984). On the other hand, it can also lead to ineffective supervision.

Problems regarding supervision and coordination

As can be noticed from the organisational chart, some of the departments are service providers while others are mere administrative departments. There are also departments of a specialised functions. Departments dealing with specialised programmes may require less supervision and more internal freedom while purely

administrative departments may need direct supervision and close coordination. These double standards may lead to sharp divisions between the administrative staff and the specialists, (Subramanian, 1988).

Delay to execute collective decisions

The feedback on CHAI shows that there is a time lag between certain collective decision and their implementation. This raises questions regarding the priority of programmes and projects undertaken by CHAI as well as its accountability to the people in whose name funds are received (Narayan T, 1992).

4.3 CATHOLIC HOSPITAL ASSOCIATION OF INDIA AND THE CATHOLIC BISHOPS CONFERENCE OF INDIA

By the very fact that the entire Catholic health care institutions and personnel are united under the umbrella of the Catholic Hospital Association of India, it is also accountable to the church in India represented by the Catholic Bishops Conference of India (CBCI). The byelaws of CHAI (1961) have taken this aspect into consideration and have given considerable importance to the relations between CHAI and CBCI, when it says that

> "The Ecclesiastical Advisor of the Association shall be that member of the hierarchy whom the Catholic Bishops Conference of India shall elect or appoint to guild the policies of the Association" (Art V).

Again in Art VII Sect I, it is said that

> "the Association will esteem as a favour the privilege of the Ecclesiastical Advisor and other special officers and invite them to attend meetings of the Association as deemed appropriate".

The need for a good relation between CHAI and CBCI is very explicit in the byelaws. However, there is no specific mention about how this relation can be established and maintained. For example, how often the Advisor will be invited to attend the Executive Board meeting or his role in the Association's functioning is not mentioned. A proper relation between these two bodies could also be used to promote the accountability of the Catholic Hospital Association of India. CHAI and its members will have more scope in creating awareness among the Catholic community of believers on health issues through parishes as well as through schools and colleges run by the church. This will increase the involvement of community in the activities of CHAI which in turn can improve the 'community capability' in health management (Narayan T, 1992).

4.4 CONCLUSION

A review of the organisational structure of the Catholic Hospital Association of India has shown that both its strategic apex and operational units require changes to make the association more effective to achieve its goals and objectives. To achieve a better democratic participation of its members in the election process,

CHAI has to devise an effective method which will assure meaningful participation by the electorate and guarantee more responsibility and accountability to the elected members. In theory there seems to exist horizontal decentralisation but in practice it does not seem to guarantee the democracy of the decentralisation to its membership.

The operational unit in the central office also has to remedy the drawbacks to overcome or to avoid problems discussed above. Efficiency of the organisation depends on how the process of integration and coordination takes place among various departments. The Association may have to follow new strategies to design a meaningful structure which will guarantee democratic participation of its members in decision making and an adequate flow of information to them from its operational unit. A better relation with the church in India also will promote the accountability of the Association.

CHAPTER 5: A NEW STRUCTURE FOR THE CATHOLIC HOSPITAL ASSOCIATION OF INDIA

Examination of the present structure of CHAI reveals that both its political and organisational units need to be redesigned to make it more effective to achieve its goals and objectives. The result of the survey also shows that the membership of CHAI expects a better management for CHAI that will ensure an improved relationship between them and its central office. This chapter is an attempt to look for an alternative structure to address the present weaknesses.

The strategic apex of CHAI, the Executive Board, should be a democratic and participative decision making body that will ensure increased responsibility and accountability. This may be possible through building up strong regional and diocesan units with vertical and horizontal decentralisation of powers. Studies show that when NGOs take up advocacy and campaign, departments and specialisations are no longer sufficient to control the diversity of the problems, and an organisation has to decentralise its works through regional units (Handy, 1985).

5.1 THE POLITICAL STRUCTURE

The proposal is to make the regional and diocesan units participate in the decision making process through vertical and horizontal decentralisation of powers. 45% of the members who replied to the question on the weaknesses of CHAI stated about

the poor functioning of regional units and another 69% expect that CHAI should strengthen the regional units (Narayan, T, 1992). It seems that those expectations of the members could be satisfied by:

1 Initiating diocesan units in each diocese.

2 Establishing regional units with power to elect representatives to the Executive Board of CHAI.

3 Establishing a Liaison Committee (General Body) of the representatives of the regional units who will elect the office bearers of CHAI.

4 Establishing a better relationship between CHAI and the Catholic Bishops Conference of India.

5.1.1 Diocesan units

The proposal is to initiate diocesan units in each diocese. The members of CHAI within a diocese will form a Diocesan unit. Each diocesan unit can function with a minimum structure. A convenor elected by the members of the unit will be the co-ordinator of the unit and will also act as a link between diocesan unit and regional unit/central office. These diocesan units will try to implement the health policies of the church with the guidelines of CHAI under the leadership of the Bishop of the particular diocese. As the basic units of CHAI, these diocesan units will take the policies and programmes of CHAI to the community around them. This will bring the people and the membership closer to CHAI. This will also allow flow of communication between central office and Regional unit/diocesan units.

5.1.2 Regional units

The proposal is to revitalise the existing regional units and initiate units in those regions where at present there is no unit. All the diocesan units within a state from a regional unit. If a state does not have sufficient diocesan units to form a state unit, a group of states can join together to form a regional unit. Regional units are the link between central office and the diocesan units. Each regional office will have its structure to function which will also include a regional office.

It is proposed that the members of the region in their annual general body elects an Executive Board and the office bearers for the region. The Executive Board consists of the Regional Presidents, two Vice-Presidents, Treasurer and Secretary (all office bearers) and form councillors. The terms of the Executive Board will be three years. But when the new board is set up and internal ballot of the board should be held so that three of the members will stand only for one year, another three only for two years and three for a full three years. Thereafter all members will serve for three years. Each regional unit will try to adapt the policies and programmes of CHAI within the socio-cultural situations of the region. They will also try to collaborate with their respective state governments in the health programmes. One of the Bishops of the Region will be an advisor to the regional unit who will also preside over the annual general body of the Regional Unit. The Annual General Body will conduct election to the Board as well as approving the annual budget and

accounts of the unit. The presidents of the regional units will be responsible to the national unit and will have to work under the guidelines of the central office. Thus each regional unit will be the operational arm of the national unit.

5.1.3 The General Body (Liaison Committee)

The Liaison Committee which will form the annual general body of CHAI will consist of the office bearers of each regional unit, ie the President and vice President, Secretary and Treasurer. There may be also other members coopted by the Executive Board. The President of the CBCI Commission for health will be the ex-officio President of the General Body. This body will elect the office bearers of CHAI and discuss policy guidelines as well as approve accounts and budgets of the Association. The office bearers of CHAI include the National President, two vice Presidents, Secretary and Treasurer and are elected from the Presidents of the Regional Units. The remaining four Presidents of the regional units will be the councillors in the Executive Board.

5.1.4 Executive Board of CHAI

The Presidents of the nine regional units will form the Executive Board of CHAI, and office bearers of CHAI are elected from them. They will be the ultimate policy making body responsible for the over all affairs of the Association. They will appoint the Executive Director and any other officers needed to assist the Executive

Director to manage the day-to-day affairs of the organisation. The term of the office bearers of CHAI will be three years but care should be taken to keep the continuity in the Board. Elections to the board may be conducted in such a way that each year three out of nine will retire and three new people will come in. When the new board is set up an internal ballot of the new board will be held so that three of the members will stand for only one year, three for two years and three for the full three years. Thereafter all members will serve for three years.

5.1.5 Executive Director

He will be the overall manager of the central office and link between central office and the General Body and Executive Board. He will present the annual reports to the Annual General Body and periodical report to the Executive Board. The Executive Director will represent the Association in all forums and bodies in connection with the work of the Association.

5.2 NATIONAL OFFICE OF CHAI

Studies on organisations structure show that there is no best way of designing an organisation, mainly because of the contextual variables that influence each organisation differently. But most of the proponents of the contingency approach think that certain important factors such as division of labour, coordination, span of control and information systems are key to the process of integration. In proposing

a new design for CHAI's National Office, attempts have been made to consider these elements of management to overcome the weaknesses of the present structure discussed in the previous chapter.

In the new structure it is proposed that the National Office of CHAI in Hydrabad should consist of various departments as shown in the organisational chart. Executive Director of CHAI is the overall coordinating person and manager of the office. He is assisted by an Assistant Executive Director and other middle line managers which include the Administrator, Divisional Manager and the Head of the Community Health Department. They coordinate various departments under them. Middle line managers are coordinated by the Assistant Executive Director who in turn reports to the Executive Director. The Administrator looks after those departments that are more of an administrative nature. The Divisional Manager coordinates the regional units, zonal office and other special projects. Head of the Community Health department co-ordinates all programmes of the department. All these sections work together to achieve the goal of CHAI and improve the quality of service.

ORGANISATION STRUCTURE OF CHAI

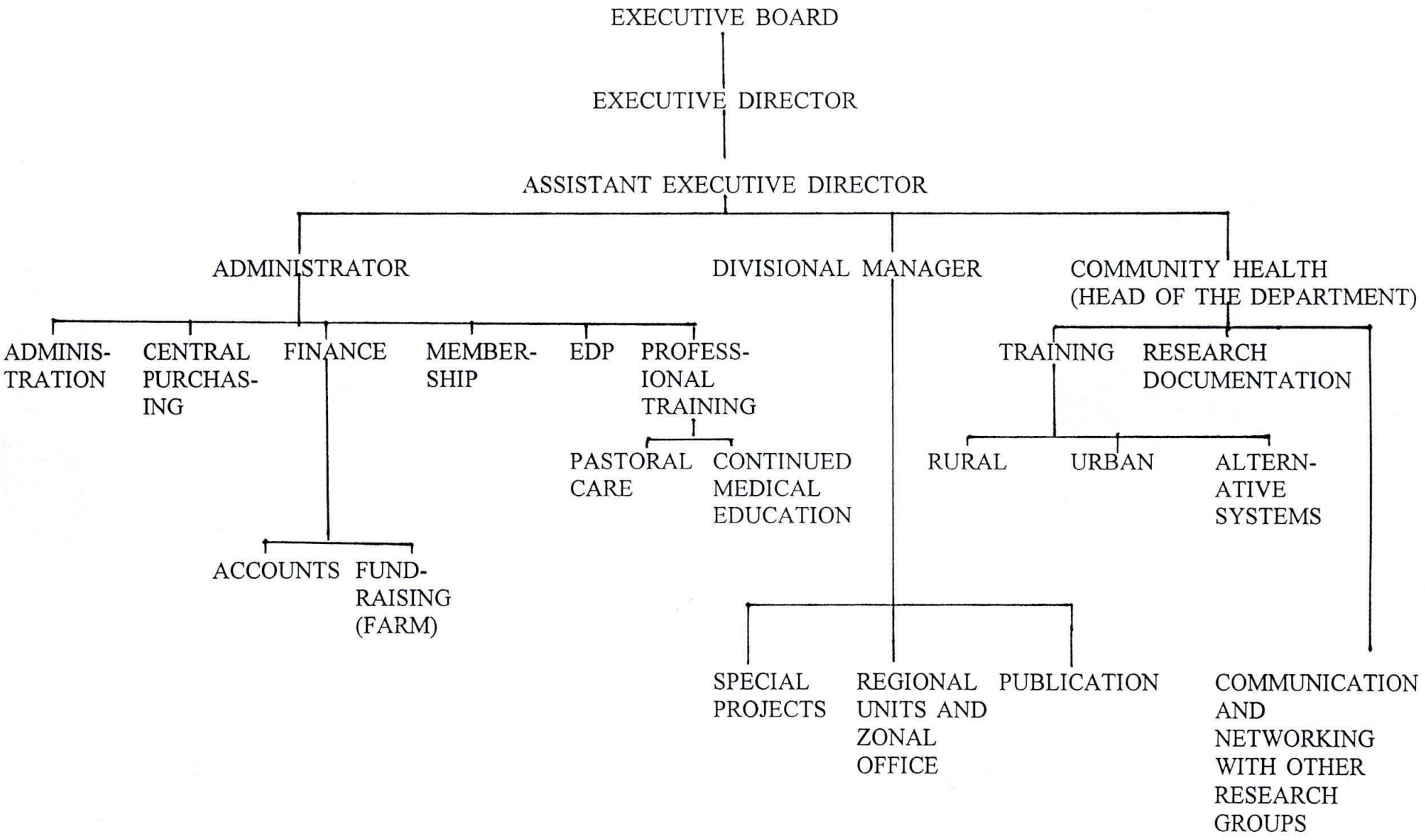


FIGURE 5.1 THE PROPOSED ORGANISATIONAL STRUCTURE OF CHAI

The new design takes care of the following points:

Division of work

Departments are divided based on the type of services the organisation is rendering to its members. Some of the works in the central office of CHAI are merely administrative while other departments are more functional and specialised in nature. This will help each department to become specialised in their particular field of activity.

Reporting

Information is one of the important means of control in an organisation. It is important that each person in the organisation knows to whom he or she has to report. This will help communication and flow of information which facilitates decision making. This also takes care of the principle of unity of command which recommend one person, one boss. Hence all the administrative departments report to the administrator who reports to the Assistant Director and the Assistant Director to the Executive Director. There will be 6 people reporting to the Administrator who will coordinate the departments

Coordination

The type of work determines the type of coordination. While certain departments may need direct supervision, others need only mutual adjustment, standardisation of process, outputs or skills. Combining all these under the same management can result in management problems and inter-group conflicts within the organisation

(Handy, 1988). Head of the Community Health Department and the divisional manager reports to the Assistant Executive Director who coordinates those departments and reports to the Executive Director.

Span of Control

If the span of control is too wide, the supervisor may spend more time in supervising and coordinating and may not get sufficient time for decision making, training and support. Depending on the type of work, the span of control can be wide or small. Hence all the administrative departments in the new structure are managed by the administrator. This also allows more time for senior executives to look into more specialised and strategic areas of the organisation.

Culture

Depending on the nature of the work, culture of a group within the department or section varies, ie, the type of work determines the type of culture in a section. For example, the publication division which has to bring out a magazine every month on a stipulated date may develop a task culture while a community health department involved in training, may develop a personal or team culture. Combining different cultures in the same organisation also can result in intergroup conflicts and management problems.

> "Many of the ills of organisations stem from imposing an inappropriate structure on a particular culture to thrive in an inappropriate climate" (Handy, 1984).

The above consideration leads to another proposal for a divisional approach for certain type of work. Specialised divisions like publications could be a separate division with more independence. The survey shows that 95.5% of the members felt that the "Health Action" Magazine is relevant to their work and 92.7% members receive them regularly. When there is a strong clientele to judge the quality of the product and when the output is standardised, direct supervision will only increase bureaucracy and delay in the work. Hence publications can be a separate division. It can be even attached to a regional unit of CHAI which may also vitalise that regional unit. They will be controlled by the policy of the organisation and the allotted budget.

5.3 BENEFITS AND CONSTRAINTS OF THE NEW STRUCTURE

Benefits

The new structure proposed for CHAI has the following benefits:

1 The policies, programmes and vision of the Catholic Hospital Association of India can reach down to the grass root level through the decentralised system.

2 More active participation of the members in the decision making process of CHAI is envisaged.

3 Regional imbalances are taken care of.

4 More involvement and better relation with the Catholic Bishops Conference of India.

5 Better flow of communication between CHAI, CBCI and the members of CHAI.

6 Operational unit is sufficiently decentralised so that senior executives get more time for strategic matters of the organisation.

7 New division of work allows more scope for specialisation and better service to the members.

8 This will bring CHAI closer to its members.

9 Better relations and more democratic participation in decision making generates better accountability in the organisation.

Constraints

The proposed structure also has certain constraints which have to be considered:

1 Decentralisation and divisionalisation are costly and CHAI will have to look for new sources of funding.

2 This also requires more personnel to manage regional units from the voluntary sector.

3 As the diocesan directors of social work are also members of CHAI, there is a possibility of their dominance in the election over majority of the health personnel who are women.

5.4 CONCLUSION

An attempt has been made in this chapter to propose a new structure for the Catholic Hospital Association of India that might improve the process of integration between various level of the Association. Decentralisations proposed in the election and the decision making process is supposed to improve the participation of its members in the activities of CHAI as well as to facilitate a better flow of communication between the central office and various levels of the Association. The proposed structure also aims at a better relation between CHAI and the Bishops Conference of India. The operational structure proposed above might remedy certain drawbacks of the present system discussed in the previous chapter and make it more effective to work towards the objectives of CHAI. Finally this new structure is supposed to bring more accountability to various units and CHAI as a whole.

CONCLUSION

The Catholic Hospital Association of India was established fifty years ago as a mutual support group for the health personnel of the Catholic church scattered in the Indian subcontinent. During the last fifty years, it grew into one of the largest health and health care services at a national level. During the last couple of decades the concept of health and health care approaches have undergone drastic changes all over the world. These phenomena have also influenced an evolution in the vision and objectives of CHAI. From a mere support group for medical personnel it has become a staunch proponent of community health vision and ideology.

Following the Alma Ata declaration when the Government of India accepted the goal of "Health for All by 2000 AD", CHAI welcomed this concept and adopted it for itself as "Health for Many More" (Narayan R, 1988). This meant a paradigm shift in the health care models of over 2,000 member institutions of CHAI. During the course of the last 15 years, the membership of CHAI has generally come to grips with the new vision and community health and has undertaken various programmes and projects to promote the same.

The growth in size as well as the evolution in its vision and objectives has also brought with it many problems in the Association. The feedback of the evaluation study sowed that CHAI has to give urgent attention to certain areas of its life and activities to address some of the issues identified by the evaluation team.

The analysis of the issue of the "Accountability of CHAI" has shown that there is a dichotomy between its vision and its structure. The community health vision of CHAI is based on the principle of decentralisation, community participation and equity while these basic ideas were accepted in its vision, these were not absorbed into its structure specially in its decision making process. This dichotomy has caused dissatisfaction and alienation of its members from the organisation.

Having looked into these issues from a theoretical point of view, it has been found that CHAI follows a contingency approach in its organisation's structure and functioning. In a systems approach, it is possible to overcome these issues by redesigning the present structure and improving the functioning of various systems within the structure. One of the suggestions is to decentralise the decision-making process, that the strategic apex which is the Governing Board of CHAI that it may have more democratic participation.

This will also improve the flow of communication within the various levels of the organisation that will bring the members of CHAI closer to each other and to the organisation itself. Following are some of the suggestions to improve the functioning of the organisation and the quality of its services:

1 Establish Regional and Diocesan units

2 Delink election and convention

3 Make necessary amendments in the bye-laws to allow

a Regional units to elect their representatives to the Governing Board of CHAI and to the Liaison Committee

b The presidents of Regional units to form the Governing board of CHAI

c Regional units to elect their representatives to form a Liaison Committee which will replace the Annual General body of CHAI

d The Liaison Committee to elect the office bearers of CHAI

e The Governing Board to coopt experts from various fields to the Liaison Committee which will also act as a think-tank for CHAI

f The Chairman of CBCI Commission for Health to be the ex-officio President of the Liaison Committee.

4 The Liaison Committee will discuss and advise on policies and programmes and will have the power to approve the budgets and accounts of the Association.

5 The Governing Board of CHAI should be the policy making body which will have the power to initiate and monitor policies and programmes.

6 It should ensure sufficient representation to women in the decision making bodies as they form the backbone of the health care ministry in India.

7 The operational unit in the central office of CHAI needs to be redesigned to allow better coordination and to avoid role conflicts.

8 As far as possible middle-line managers should be people with professional training in Human Resource Management.

9 Every new staff member should be carefully initiated into the goals and objectives of the organisation.

10 The Association should regularly publish a newsletter to inform its members regarding the various activities of CHAI and its membership.

The policy making body of CHAI is requested to take notice of these recommendations and to act upon them to make the Association more accountable to its members, to its objectives and vision as well as to improve the quality of its services.

BIBLIOGRAPHY

ALLAN, J, (1989), Personal Management Skills. Kogan Page Ltd, London.

BATSLEER, J (ed), (1991), Issues in voluntary and non-profit management. Addison-Wesley publishing company, UK.

BIDDLE & EVENDEN, (1993), Human Aspects of Management. Institute of Personnel Management, London.

BROOKE, M Z, (1984), Centralisation and Autonomy: a study in Organisational behaviour. Holt, Reinhart and Wilson, London.

BUTLER, R J & WILSON, D C, (1990), Managing Voluntary and Non Profit Organisations: Strategy and Structure. Routledge: London.

CAMPBELL, P, (1987), Four major influences of the management of NGOs, NGO Management, No. 6, July - September, pp 19-20. Geneva.

CATHOLIC BISHOPS CONFERENCE OF INDIA, (1992), Health Policy of the Church in India. CBCI - Commission for Health Care Apostolate.

CATHOLIC HOSPITAL ASSOCIATION OF INDIA, (1961), Memorandum and Bye-Laws of the Catholic Hospital Association of India. CHAI - New Delhi.

CHAI - CHD TEAM, (1986), Health and Power to People - Theory and Practice of Community Health. CHAI, New Delhi.

CHANDLER, A D, (1963), Strategy and Structure: Clusters in the History of the American Industrial Enterprise. MIT Press, Cambridge, Mass., USA.

CHATTERJEE, M, (1988), Implementing Health Policy. Centre for Policy Research, New Delhi.

CHILD, J, (1984), Organisations - A guide to problems and practice. Harper and Row Ltd, London.

COLLINS, C (1992), Handout on 'Hospital Organisations', Nuffield Institute for Health.

GOVERNMENT OF INDIA, Collaboration with Non-Governmental Organisations in implementing the national strategy for Health for All.

HANDY, C B, (1985), Understanding Organisations. Penguin Books, Middlesex.

HANDY, C, (1987), Organisations in search of a theory, NGO Management, No. 7, Oct - Dec, pp 20-21. Geneva.

HANDY, C B, (1988), Understanding Voluntary Organisations. Penguin Books, Middlesex.

HARRISON, R, (1972), How to describe your Organisation, Harvard Business Review, Sep - Oct.

HOEKENDIYK, L, (1990), Cultural roots of Voluntary action in different countries, proceedings of the 1990 conference of the Association of Voluntary Action Scholars. Centre for Voluntary Organisations, London School of Economics.

KORTEN, D, (1987), Third Generation NGO Strategies, NGO Management, No. 7, Oct - Dec, pp 18-19. Geneva.

LOCKETT, M & SPEAR, R, (1980), Organisations as systems. Open University Educational Enterprises Ltd.

MARINKER, M (ed), (1990), Medical Audit and General Practice, The MSD Foundation, British Medical Journal, London.

MINTZBERG, H, (1983), Designing Effective Organisations. Prentice Hall International Inc, London.

MUKHOPADHYAY, A (ed), (1992), State of India's Health. Voluntary Health Association of India, New Delhi.

Narayan, R, (1989), Community Health in India, Health Action, Vol. 2, No. 7, July. HAFA Publications, Secunderabad.

NARAYAN, T, (1992), Seeking the signs of the times. Community Health Cell, Bangalore.

PAPAL DOCUMENT, (1978), The New Orientation of Health Services with Respect to Primary Health Care Work. The Pontifical Council COR UNUM, Vatican City.

PERROW, C, (1979), Complex Organisations. Scott, Foresman and Company, USA.

PRIYA, (1988), Management of Voluntary Organisations: Leadership and change, NGO Management, No. 8, Jan - March, p 14. Geneva.

PRIYA, (1991), Voluntary Development Organisations in India. Society for Participatory Research on Asia, New Delhi.

PUGH, D S, (1971), Organisation Theory. Penguin Books, Middlesex.

REED, M & HUGHES, M (eds), (1992), Rethinking Organisations - New Directions in organisation theory and analysis. SAGE Publications Ltd, London, New Delhi.

SAMUEL, P & ARUNO, I, (1991), Non-Governmental Organisations and World Bank. The International Bank for Reconstruction and Development, World Bank, Washington DC.

SANGBEN, M, (1988), Third Sector Management, NGO Management, No. 8, Jan - March, p 16. Geneva.

SETHI, H, (1978), Alternative Development Strategies: A look at some micro experiments, Economic and Political Weekly, pp 1307-1316.

SILVERMAN, D, (1970), The Theory of Organisations. Heinemann Educational Books Ltd, London.

SUBRAMANIAN, A, (1988), Indian NGO and Management: Voluntary Health Organisations, NGO Management, No. 8, Jan - March, p 15. Geneva.

VATTAMATTOM, J, (1984), Community Health and the Healing Ministry of the Church. Catholic Hospital Association of India, New Delhi.

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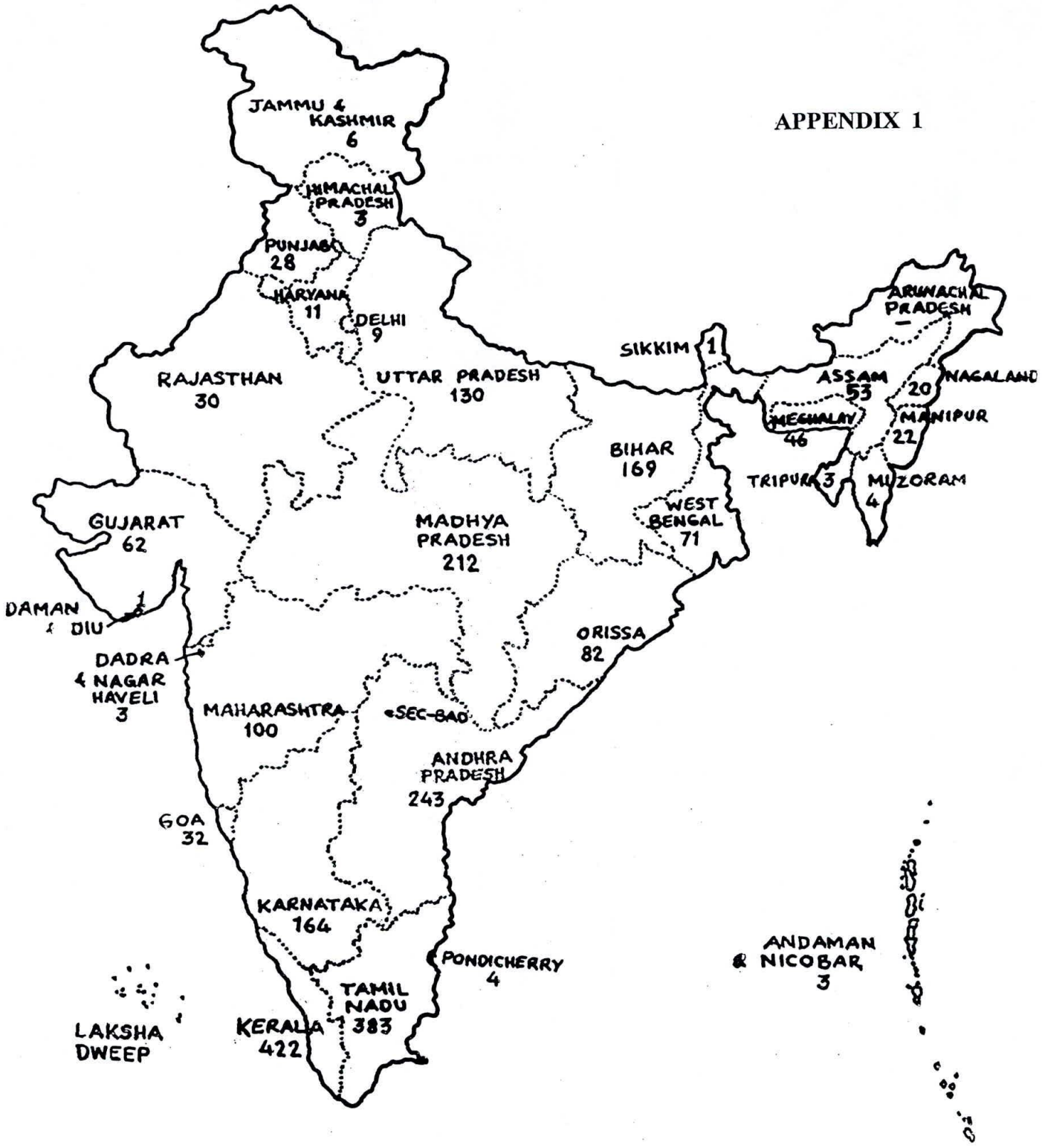
APPENDIX 1



CATHOLIC HOSPITAL ASSOCIATION OF INDIA
STATE-WISE DISTRIBUTION OF MEMBER INSTITUTIONS
(Source: CHAI Documentation Centre)

APPENDIX 2 STATE-UNION TERRITORY WISE DISTRIBUTION OF CHAI MEMBERS
(Source: CHAI Documentation Centre)

STATES/UNION TERRITORIES	HOSPITAL/ HEALTH CENTRES	DIOCESAN SOCIAL SERVICE SOCIETIES	ASSOC-IATES	TOTAL
STATES				
1 ANDHRA PRADESH	225	8	10	**243**
2 ARUNACHAL PRADESH	-	-	-	-
3 ASSAM	50	3	-	**53**
4 BIHAR	165	4	-	**160**
5 GOA	30	-	2	**32**
6 GUJARAT	58	1	3	**62**
7 HARYANA	11	-	-	**11**
8 HIMACHAL PRADESH	3	-	-	**3**
9 JAMMU-KASHMIR	5	1	-	**6**
10 KARNATAKA	157	6	1	**164**
11 KERALA	398	18	6	**422**
12 MADHYA PRADESH	205	4	3	**212**
13 MAHARASHTRA	96	1	3	**100**
14 MANIPUR	21	1	-	**22**
15 MEGHALAYA	46	-	-	**46**
16 MIZORAM	4	-	-	**4**
17 NAGALAND	20	-	-	**20**
18 ORISSA	82	-	-	**82**
19 PUNJAB	28	-	-	**28**
20 RAJASTHAN	30	-	-	**30**
21 SIKKIM	1	-	-	**1**
22 TAMIL NADU	365	13	5	**383**
23 TRIPURA	3	-	-	**3**
24 UTTAR PRADESH	123	7	-	**130**
25 WEST BENGAL	65	6	-	**71**
UNION TERRITORIES				
1 ANDAMAN/NICOBAR	3	-	-	**3**
2 NAGAR HAVELI	3	-	-	**3**
3 DELHI	8	-	1	**9**
4 DAMAN & DIU	1	-	-	**1**
5 PONDICHERRY	2	1	1	**4**
TOTAL	**2,208**	**74**	**35**	**2,317**

APPENDIX 3 **BED-WISE ANALYSIS OF MEMBER INSTITUTIONS**

(Source: CHAI Documentation Centre)

CATEGORY	NUMBER OF INSTITUTIONS
HEALTH CENTRES AND DISPENSARIES (0 TO 6 BEDS)	1,533
HOSPITALS WITH 7 TO 10 BEDS	149
HOSPITALS WITH 11 TO 25 BEDS	219
HOSPITALS WITH 26 TO 50 BEDS	141
HOSPITALS WITH 51 TO 75 BEDS	32
HOSPITALS WITH 76 TO 100 BEDS	31
HOSPITALS WITH 101 TO 150 BEDS	21
HOSPITALS WITH 151 TO 200 BEDS	17
HOSPITALS WITH 201 TO 250 BEDS	12
HOSPITALS WITH 251 TO 300 BEDS	4
HOSPITALS WITH 301 TO 350 BEDS	1
HOSPITALS WITH 351 TO 400 BEDS	1
HOSPITALS WITH 401 AND ABOVE BEDS	7
LEPROSY INSTITUTIONS	40
ASSOICATE MEMBERS	35
SOCIAL SERVICE SOCIETIES	74
TOTAL	**2,317**