Bureaucratization and de-Bureaucratization of Social Welfare - Democratic Alternatives to the Bureaucratized Welfare State

Alternative to the Welfare State - Limits and Opportunities from the "Anxious Great Provider" to "Small Functional Units"

Dr.med.Ursula Davatz

http://ganglion.ch

http://schizo.li/

Paper presented at the Gottlieb Duttweiler Institut
CH-Rüschlikon, August 1986

In order to find alternative systems to our bureaucratic Welfare State we have to change our thinking.

Before we can change our thinking, we should examine the basic premise underlying our belief in Social Welfare State. For that reason we shall look at what we consider to be the first development of this premise in prehistoric times and then analyse its later impact on a psychological level.

I. Prehistorical Background of Welfare States

In prehistorical time, at the time of Pristine States about 2000 B.C., bureaucracy had its roots with the rise of the City States under the governing force of the "big men" also called "mummy", meaning great provider. These big men or mummies were hard working, ambitious, public spirited individuals who were pushing their relatives and neighbours to work hard for them producing food by promising to hold a huge feast during which they redistributed food. These big men or mummies thus formed the original nucleus of a ruling class through their power of redistribution of goods, primarily food, in a rising population.

Thus the organization of bureaucracy started gradually. These redistributor chiefs constituted the principal coercive force in social life. Later on they even became kings.
The kings were the agents of bureaucracy, the powerful provider figures “mummies”.

What do these prehistorical bureaucratic organizational forms under the ruling force of these “great providers” have to do with our “Social Welfare State” of today? Although almost 4000 years have past since then, man has in many ways remained the same and so has his thinking about this matter. Our Social Welfare State has taken the role of a “mummy”, a “great provider”, and people’s attitude towards our “Social Welfare State” is probably not much different from the attitude towards a great provider of ancient times. The only difference between an old “mummy” and a “Social Welfare System” is that the latter collects and redistributes money and services instead of food. The health care system distributes health care services and the welfare system distributes social services and money. Along with this redistribution of health care services, social services and money comes an enormous amount of power as in the times of Pristine States, the times of the “mummies”. Although the bureaucratic structures of redistribution of today are regulated by law and not by mere ruling force of the man, a “mummy” or a king, the administrators of these bureaucratic laws are individuals, who often behave like little kings enjoying their power and status tremendously and not caring very much about the functioning of the bureaucratic structures they administer nor the human beings they have to serve.

After this short historical introduction into Social Welfare States we are going to look more closely at some specific characteristics of our Social Welfare States of today. One of the most important characteristic of Social Welfare States is their special selection process for their administrators.

II. Special selection process for administrators of the bureaucracy of our Social Welfare States

What selection process is at work that selects the people to administrate the bureaucratic system of our Social Welfare State? Jobs within the bureaucratic system have always been considered to be very secure jobs, since they are close to the “great provider”, tend

never to be eliminated and offer a pension. For this reason insecure individuals feel especially attracted to these jobs within the bureaucratic system since they are more concerned with security than are average individuals. Thus the selection process tends to select insecure, anxious administrators for our Social Welfare State. This selection process of insecure individuals has profound consequences for the decision-making process within the bureaucratic system. Since these administrators have a rather high anxiety level, their decision-making is heavily influenced by their anxiety. From what we know of decision-making processes in human systems, such as decision-making within families, decisions based on anxiety always promote restrictive regulating measures, don't allow for any progressive change, thereby increasing rigidity of the system and finally promoting pathological functioning. Thus decisions based on anxiety make the system enter a vicious circle, anxious decision-making promotes dysfunction and dysfunction in return promotes anxiety. Such a system looses more and more of its capability to adapt to a changing word since it invests a disproportionate amount of energy in defence mechanism and rigidifying processes which threaten its own survival.

With more complex demands coming from the environment such a system easily runs the risk of going bankrupt and there are plenty of examples of this process in the commercial world. Only government systems cannot go bankrupt since they are fed bottomless through the deficit guarantee. Yet if the main producers of the resources for our Welfare State, namely our free enterprise industry, would not function as well as it does and could not constantly feed our "great provider Welfare State" through taxes, many government systems would have gone bankrupt long ago, and like dinosaurs become extinct.

3

The problem is that the administrators of the Welfare State are generally not being held responsible for the functioning of the economy which produces the money they distribute, nor for the generation of the money they need to keep their system running, therefore they are not forced to realize how dysfunctional their system is nor are they interested to find any way out of this dysfunction.

Nevertheless it seems that the awareness of the general population rises that our Social Welfare system is running dysfunctional and that we can't afford any longer to let it run this way.

To illustrate our point of the system run by anxiety and restrictive measures, we will give a little metaphorical example: "if you try to run a car only with brakes (restrictive measures) you can only run it downhill". The same is true for a bureaucratic Social Welfare system that is only governed with restrictive measures, but does not promote any innovations. It can only go downhill. Is this not where we are today?

The dysfunction of our Social Welfare State can be demonstrated very obviously with the example of the Health Care System, which has increased its costs over the last few years overproportional to the increase of the gross national product. And yet health in the general population has not increased in any significant way. This trend seems to continue to go in that direction. All the measures that have been taken to stop this cost increase have been pure lateral movements, shifting costs from one financing system to another. In Switzerland the direction of shifting has been mainly towards the insurance systems and from there to the individual customer of the insurance, in other countries more in the direction of the "great provider" of the government system, but no actual decrease of the health costs has been accomplished. Most of the measures that have been suggested to cut costs have been of restrictive nature. For more detailed information on the dysfunction of our health care system as a main example of our Welfare State we refer to the conference held at GDI on Nov 14th 1985 and the different papers published in the conference report.

4

One of the main psychological reasons why this dysfunctional system can not be broken apart, dissolved or changed into a better functioning system is in our estimation this very deeply rooted premise of the "great provider" that brings the helping person or system a lot of power and the person in need of help a feeling of security even if security is not provided actually. Therefore this bureaucratically institutionalized helping system of the great provider Welfare State can not be given up so easily, even when we can't afford it any more.

Numerous politicians have gained their votes which means their power by promising any kind of social service to the poor and sick through the “great provider” of government and still do so, although they often don’t know where to take the money from to pay for these services.

In the next chapter we will examine what impact this premise of the “great provider”, the Social Welfare State has on the selection process in society in general.

III. Social Welfare as a selective system within the human species

In contrast to the natural selection process of Darwin, which selects the fittest, the Social Welfare State selects the weakest and the sickest. In a Social Welfare State it pays off more to be sick, weak and irresponsible than to be healthy, strong and responsible. The payment system of a typical Social Welfare State fosters dependency and irresponsibility. The strong, be they individuals or business corporations, are punished through the tax system; the weak ones are rewarded through social welfare money or government subsidies due to the unemployment policies. Thus self-help and autonomy of a healthy individual or business corporation tend to be undermined.

Considering this selective mechanism of our Social Welfare State we can imagine what an incapable new generation of mankind we are selecting.

Here we have to come back to our earlier point, namely that the selection of the weakest, or in other words the strategy of protecting the weakest, not only serves those poor individuals but also increases the power of the administrators of this “great provider system” which is for that very reason defended so vigorously even though it is running dysfunctional. Thus the political strategy of protecting and selecting the weakest provides more Darwinian fitness to the administrator of that “great provider system” and is therefore not as human and altruistic as it might look at first hand. This need for power of administrators of Social Welfare Systems, their tendency to increase their own Darwinian fitness shows itself more clearly when one observes their competition for limited government

resources. It is particularly in this instance that Darwinism, meaning clear competitive survival strategies, comes to the surface.

We have argued that the Social Welfare State as a “great provider” of social services runs dysfunctional by selecting insecure administrators using restrictive rules and regulations instead of innovative ones, promoting irresponsible sick behaviour in society and yet it perpetuates itself by allegedly providing for the poor and sick. We will outline some basic ideas for a social system based more on functional lines rather than on emotional ones such as feelings of power or helplesness.

IV. More functional and adaptive alternative systems of our Social Welfare State

1. From the “great provider to “small functional units”

First of all one has to get away from this idea of a “great provider” since all “great provider systems” tend to get dysfunctional even if only due to their size. Instead of these “great provider systems” one should allow more small functional units to develop which are autonomous, regulate themselves, are multidisciplinary and integrate the weak as well as the strong within their small system in a more natural fashion; in short, systems which provide for themselves. Such small functional units allow for a more direct controlling mechanism through direct feedback, are more flexible and more able to adapt to change. Their communication system as well their redistribution system of money is less prone to falter since the pathways are much shorter and there is less hierarchical structure through which energy or money can be wasted. In terms of human behaviour, cooperative survival strategies rather than competitive ones can develop much more easily within such small units. Limited resources become a common good within that small system and therefore a common dilemma. These goods ore services no longer are possessed or administered by one centralized system, the bureaucratic system of the “great provider”. A natural example to illustrate this idea can be given by the experience of fishermen in the North Sea of Europe. As long as all fishermen could fish in the entire Sea, which can be looked at as an anonymous “great provider”, they exploited the Sea ruthlessly. As soon as several communities were assigned a certain territory within the Sea, they

started to fish responsibly and ecologically and they took care of their territory or their functional unit.

What does such a functional unit have to consist of; what subsystems have to be represented within that unit? If we take the example of a health care system we would say that such a small functional health care unit would have to consist of the providers of the health care services, i.e. the doctors, the nurses, representatives of the redistributive financing system which is at present times the health insurance company plus representatives of the

Local government so far pays for the deficits made within the health care system. Consumer representatives and representatives of free enterprise should as well be within this small functional health unit. They would form one multidisciplinary interest group. The group would have to work out its rules in a cooperative way without extensive legal regulations and restrictions coming from outside of the system such as from a central government.

This interest group or small functional unit would function like a private health care enterprise that offers health care services at reasonable prizes for the people of the local community. The payment for the services would be made directly by the patient according to their income. This direct payment would promote personal responsibility for one's own health. Rich people would pay a fee, fully covering the cost of services provided, poor people under a certain income would have to pay a small fee, which does not cover the costs of the services. The shortfall of money for the services given to the poor would have to be brought in through special fundraising done by the redistributive financing-system that is at present the health-insurance company.

Another innovative suggestion would be a "health bank" as a financing system that would give loans to people who cannot finance their medical expenses immediately. People would pay these loans as they pay a regular medical insurance today, but only after actual costs have been incurred. With this type of financing system an individual who is not sick would not have to pay any money for any future potential illness in other words, the healthy average income members of the health unit would not have to pay for the poor and sick ones, as it is the case with the present health insurance sys-

tem. The provision of health financing could even be made conditional on adherence to a health maintenance program recommended and monitored by the health unit professionals. Through legal regulation people could even be requested to invest a certain amount of their income into this “health bank” comparable to the third column in the present pension and system in Switzerland.

This private money invested in the “health bank” could then be used al later times to pay for medical services if necessary. The difference of this health bank system would be that the private money always remains on a private account and does not just disappear in a common pool as it does with the present health insurance system. And if an individual would remain healthy to his old age he could use this money on the health bank for other purposes since he wouldn’t loose it as he does with the present health insurance system. The “health bank” would have to be administrated by capable professionals from the world of finance. It also would not be restricted to management of health care money only but could also do other financing business as for example giving loans to doctors who open their private office. In our estimation this type of financing system for health care services would have a positive psychological effect on the health maintenance attitudes of each individual and therefore would promote more responsibility towards one’s own health than the present financing system does. People would bank on their health rather than on their illness.

For the attitude and performance of the medical doctors this type of financing system would also have profound consequences. Before doctors initiate any kind of scientifically interesting expensive medical procedures they would have to think twice if their patient will and can pay for it.

If a patient cannot pay and they would still be interested in the very procedure they would have to do it at their own expenses. This situation would force doctors to behave more responsible in terms of health care costs by making more careful decisions in terms of prescribed medical procedures. For a patient who couldn’t pay, urgent medical procedures would still be performed by a responsible doctor, although payment would have to be organized afterwards. With the present payment system there are no restraints on the doctors performance, especially in hospitals, no matter how costly their per-

formance is, costs will always be picked up by the health-insurance company or the government through deficit guarantee.

The important difference of this small functional health care unit with its different financing system is, that the poor would be treated as the exception and not as the rule.

Therefore the rules and regulations would not be made primarily for them as it is in the present system, but rather for the average citizen. The poor could also not be used to increase the power of those who want to administrate them by organising the “great provider” Welfare State.

In order to let these small functional health care units develop one would have to cut back drastically on centralized legal regulations through government. Only with such a deregulation more adaptive functional units can develop and survive.

A further consequence of such small functional health care units would be the redistribution of health care services in a more decentralized way. We will deal with this issue in the following chapter.

2. Decentralization or distribution of professional skills from large entities such as university hospitals to the periphery of the community

The “great provider” idea also seems to be represented in the huge medical institutions such as the university hospitals which concentrate a lot of professional skills in one central place with the community being left with little or none of the relevant skills. These huge institutions certainly provide a lot of highly skilled health services for a few very sick people, but they also absorb a lot of money for the administration of their system, due to their mere size.

Many of the medical professionals which are concentrated in these medical centers would be much more effective if they could disperse their services in the community. If we take the nurses for example certainly there would be many people in the community who could make use of services offered by nurses, but the nurses services are in general only accepted and paid for when provided in a hospital under the official orders of a doctor. Health insurance pays

for nurses who work in a hospital without any problem. It also pays for community nurses who are officially employed by local government, but does not pay for a private community nurse.

10

And yet there is no reason why a responsible nurse should only do a good job when she works in a hospital or is officially employed by the bureaucratic Welfare System but not if she works on her own in the community. There are still a lot of needs for health care services in the community that could be provided by self-employed nurses. Yet since the financing system for this kind of service does not exist, the regulations of the health insurance companies do not allow payment for these nurses, it is almost impossible to develop this type of decentralized health care system under present circumstances. The existing rules and regulations keep the Health Care System centralized in big medical institutions no matter how dysfunctional those institutions might be and how much money they might waste.

For this very reason we would emphasize once again that a lot of existing bureaucratic structures and regulations would have to be abolished in order to allow for a decentralization of socio-medical services. Once the services of community nurses would be distributed more evenly through the community we would expect them to have a catalyzing effect on public health since they would be easily available to people at an early stage of problems or illness. For that reason they also would have a preventive effect. These services would be far less expensive than the service of medical specialists in a big hospital at a late stage of the course of illness. The few community nurses we have now employed by local authorities are only a slight beginning in the trend in that direction.

If medical services are being more decentralized away from the huge hospitals medical education of course has to be decentralized as well. With this topic we will deal in our last chapter.

V. Alternative education for medical professionals

Part of the problem of our health care system is the education of our medical professionals in these centralized medical care systems. These centralized medical educational systems neglect the socio-medical aspect of illness meaning the relationship-factors in any kind of illness represented by the attitude and behaviour of the people surrounding the patient and therefore cannot really train community nurses or community doctors very adequately. They can only train professionals for their own system, which again has the consequence that most of these trained professionals remain within their system or move into another comparable centralized medical system. It is understandable that these highly qualified professionals who could go to the periphery of the community stick to the centralized system since this is the place where they feel at home and therefore secure. Thus the centralization of the health care system perpetuates itself through the medical training system. If this suggested decentralization of medical professional services should be promoted, more decentralized training of the medical professionals also has to take place. It would have to be offered for the doctors as well as the nurses.

Since the above mentioned socio-medical concept of illness is getting increased recognition it would be only beneficial to include it into the regular training of doctors and nurses. Of course this goal would be much easier to reach if some training would take place within the community rather than in a hospital. Medical professionals trained in a decentralized medical service system working with a socio-medical model of illness would most likely be able to reduce some of the health care costs, since they also would be better equipped to make effective preventive interventions than the doctors of todays training system, which is mainly based on pathology and dysfunction but teaches little about relationships.

Summary

The conceptual shortcomings of our present bureaucratic social welfare and health care systems lie in the basic underlying premise of a powerful “great provider”. This premise fosters huge and growing bureaucratic systems, which run dysfunctional and yet perpetuate themselves despite their dysfunction. Our suggestion for alter-

native health care structures is based on the idea of small functional units, which operate like small health service enterprises combining a medical and a financial service. The service would operate with less governmental regulations and more according to the rules of free enterprise.

Instead to the traditional medical insurance system, that makes every individual pay for any potential illness in the future through a regular insurance fee, we suggest an innovative financing system that works like a “health bank” which lends loans to people at the moment they really need them in order to pay expensive medical bills. The individual consumer would have to carry the responsibility for both, the health maintenance and health care costs rather than the “great bureaucratic provider”. The medical services as well as the training of medical professionals would have to be more decentralized. A socio-medical concept of illness would be used. This type of concept would lend itself better to preventive interventions than the pure medical model. Along with this suggested financing system the decentralized medical services and training of the professionals and an effective prevention we definitely hope to decrease the health care costs.

Bibliography

- Harris, Marvin:
  “Cannibals and Kings, the Origin of Cultures”, Vintage Books Edition, 1978
- Diamond, Stanley/Narr, Wolf-Dieter/Hofmann, Rolf:
  “Bürokratie als Schicksal“,
  Leviathan Zeitschrift für Sozialwissenschaft, Sonderheft 6, 1985
- GDI: „Kostenexplosion im Gesundheitswesen - Auswege aus der Resignation“, GDI Schriften 44, 1985