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Organisational simplification and secondary complexity in health services for adults with learning disabilities

Bob Heyman[a,*], John Swain[b], Maureen Gillman[b]

[a] St Bartholomew School of Nursing and Midwifery, City University, 20 Bartholomew Close, London EC1A 7QN, UK
[b] Faculty of Health, Social Work and Education, University of Northumbria, Coach Lane, Newcastle upon Tyne, NE7 7XA, UK

Abstract

This paper explores the role of complexity and simplification in the delivery of health care for adults with learning disabilities, drawing upon qualitative data obtained in a study carried out in NE England. It is argued that the requirement to manage complex health needs with limited resources causes service providers to simplify, standardise and routinise care. Simplified service models may work well enough for the majority of clients, but can impede recognition of the needs of those whose characteristics are not congruent with an adopted model. The data were analysed in relation to the core category, identified through thematic analysis, of secondary complexity arising from organisational simplification. Organisational simplification generates secondary complexity when operational routines designed to make health complexity manageable cannot accommodate the needs of non-standard service users. Associated themes, namely the social context of services, power and control, communication skills, expertise and service inclusiveness and evaluation are explored in relation to the core category. The concept of secondary complexity resulting from organisational simplification may partly explain seemingly irrational health service provider behaviour.

Keywords: Learning difficulties; Primary health care; Social exclusion; UK

Introduction

This paper is based on data drawn from a qualitative study of primary health care for adults with learning disabilities living in the UK (McKean, Heyman, Gillman, & Swain, 1999). Data were interpreted around the core category, developed during data analysis, of secondary complexity resulting from organisational simplification (see Fig. 1).

The paper will first offer a brief analysis, developed after the core category was identified, of secondary complexity as an unintended consequence of simplifying organisational responses to the underlying complexity of health phenomena. The applicability of this framework in one domain, the provision of health services for adults with learning disabilities, will then be illustrated. Finally, the wider application of the findings to the analysis of health care for people with complex health needs relative to standard provision will be considered in the Discussion.

Complexity and simplification

Health services constantly confront complexity arising from interactions between the myriad of genetic, physical, psycho-social, socio-economic and cultural factors which, magnified by feedback effects, determine physical and mental well-being (Albrecht, Freeman, & Higginbotham, 1998; Griffiths & Byrne, 1998; Walsh, 2000). The number of potential interactions between one or more health needs and other attributes is indefinitely large. To give but one example, adults with dementia manifest more maladaptive behaviours if they have a learning disability (Cooper, 1997a). Each possible combination may have emergent qualities, requiring special expertise for its proper management. Potential

*Corresponding author. Tel.: +44-20-7505-5783; fax: +44-20-7505-5715.
E-mail address: bheyman@city.ac.uk (B. Heyman).

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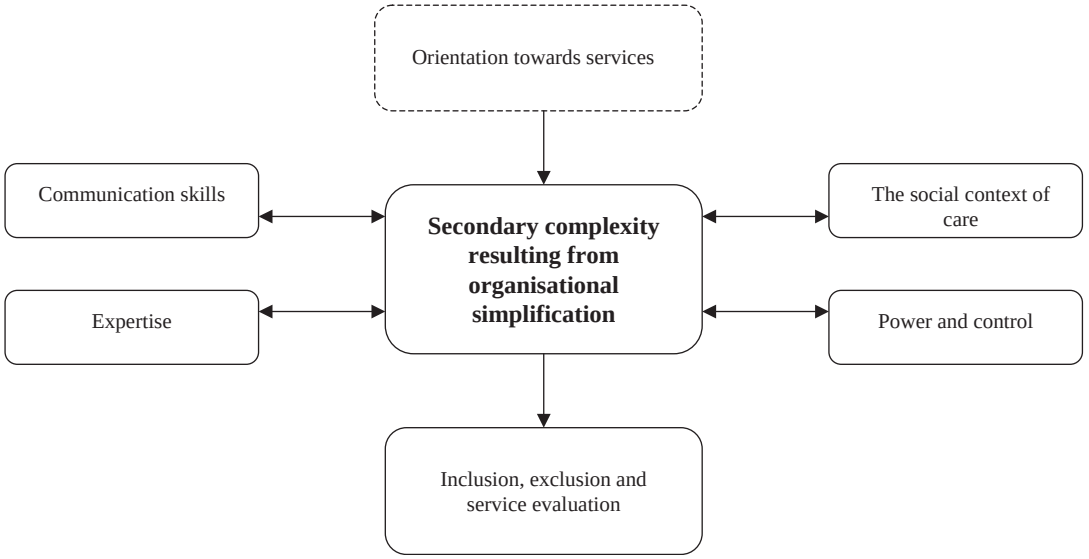

Fig. 1. Emergent themes and relationships to the core category of secondary complexity resulting from organisational simplification.

feedback loops between causal factors, e.g. familial, service and societal responses which exacerbate behavioural problems, make both prediction and management more complex. Although some of these interactions may be organisationally recognised, as in specialist services for sick children, they cannot all be marked out in this way. Moreover, the fragmentation resulting from provision of specialist services diffuses expertise about common factors, and leads to inequalities, particularly for stigmatised social groups (Grieg, 2000).

Large claims have been made about the potential value of the application of the new science of complexity to social phenomena such as health (Byrne, 1998; Albrecht et al., 1998). However, the mathematics of complexity can be applied to such systems only metaphorically (Gell-Mann, 1994, p. 27; Medd, 2002). An alternative, or at least complementary, analytic strategy is to focus on simplification as a response to the inherent complexity of health phenomena. The unknowable complexity of the social world gives rise to simplifying strategies designed to make rational action feasible, including the imposition of ideologies (Luhmann, 1982; Price, 1997), routinisation and exclusion of the anomalous. This approach gives centre stage to the management of uncertainty in organisations (Stacey, Griffin, & Shaw, 2000), with the complexity of health phenomena backgrounded as its source. Social scientists can study these simplifying strategies and their unintended secondary consequences.

Organisationally derived, secondary complexity arises when an organisation attempts to manage primary complexity by standardising and routinising its procedures. In terms of a tailoring metaphor, off-the-peg solutions will work well enough for the majority of service users whose needs and attributes roughly match those implicit in adopted service models. However, simplifying responses to underlying complexity make organisations, and the experts whose knowledge underpins their functioning, systematically blind to circumstances which require bespoke solutions.

This analysis may contribute to the development of health care by differentiating two distinct, although often compounded, sources of exclusion from health services, derived from simplifying routines and heuristics and from stigmatisation. It thereby links the exclusion of the stigmatised to the real difficulties faced by health service managers in their dealings with any complex health problem. Both can be conceptually distinguished from the state of the art which defines the limits of what current services can offer.

The health needs of adults with learning disabilities

The term learning disability, and related terminology, e.g. mental handicap, mental retardation, intellectual disabilities, learning difficulties, encompass diverse types and varying degrees of cognitive disability together with associated health and social needs, including those related to societal responses to disability.

Most people with learning disabilities have always lived in the community, mainly with unpaid family carers. However, community numbers have been increasing in the UK, and elsewhere, as a result of closures of long stay hospitals. This growth presents a major challenge to primary health care (PHC) services,