The goals, needs, and problems of individual health and welfare agencies in the community, and how these may impede interorganizational relationships, form the central focus of this report. Various approaches are suggested by which these barriers may be overcome. Finally, the authors emphasize the need to direct the natural interplay among agencies to meet the health needs of the community.

COMMUNITY INTERORGANIZATIONAL PROBLEMS IN PROVIDING MEDICAL CARE AND SOCIAL SERVICES

Sol Levine, Ph.D.; Paul E. White; and Benjamin D. Paul, Ph.D.

FACILITATING communication among local health and welfare organizations has been a major objective of public health administrators and community organizers. Their writings contain many assertions about the desirability of improving relationships in order to reduce gaps and overlaps of medical services to recipients,[1] but, as yet, little effort has gone into making objective appraisals of the interrelationships that actually exist within any community. Nor have sociologists done much in paving the way for the practitioner. Although sociologists have devoted considerable attention to the study of formal organizations, their chief focus has been on patterns within rather than between organizations. Only recently have they begun to investigate the area of interorganizational relationships.[2]

During the past four years we have been studying relationships among health and welfare agencies in four northeastern communities. Some of our findings appear to have fairly clear implications for the general objective of mobilizing community health and welfare services.

Multiple Sources of Authority and Conflicting Goals

Looking at the health and welfare system in the community, we quickly become aware of an array of diverse organizations, each of which is relatively autonomous and has a separate locus of authority. There are, for example, different levels of official government represented in most large-size American communities. We may find a local health or welfare department, a district or regional health office, a state rehabilitation agency, and a U. S. Veterans Administration clinic. Voluntary agencies within the community also show variation with respect to the locus of their authority. On the one hand are what might be termed the "corporate" health agencies like the National Foundation, American Heart Association, and the American Cancer Society, where authority is delegated from the national or state organization to the local chapter or affiliate. On the other hand, there are "federated" organizations like the Visiting Nurses Association and the Family Service, which delegate authority to the

state and national levels, are less bound by their national associations, and are more oriented toward the problems and conditions of the specific communities in which they operate.[3] There are other instances which could be cited, but these examples will suffice for our purposes. Social scientists have used the term "political pluralism" to refer to the multiple sources of authority which exist within the American scene—a term which has special relevance for the health and welfare agency field.

Given such diverse and multiple sources of authority, it is understandable that maximal interagency cooperation is not always attained. As a result of the pluralistic or divergent sources of authority, and for other reasons as well, health and welfare organizations in the community have varying goals and specific objectives which may conflict with one another, even though all of them share fundamental values, such as the promotion of health and the prevention of disease. Agencies differ in the standards they employ to evaluate their success and the means they use to achieve their objectives. Consider, for example, an official state rehabilitation organization whose objective is to rehabilitate or return to employment persons who have suffered some serious illness. The local community branch of this organization, to justify its existence, has to present a successful experience to its parent organization and to the state legislators, namely, that a given number of persons have been successfully rehabilitated. The goals of the organization cannot be fulfilled, therefore, unless it is selective as to the types of handicapped persons it accepts as clients.

Other community health and welfare agencies, consequently, are often frustrated in their efforts to get the rehabilitation agency to accept their particular clients for rehabilitation. In the judgment of these frustrated agencies the state organization is remiss in fulfilling its purpose. The state agency, on the other hand, is reluctant to commit its limited personnel and resources to the lengthy and time-consuming task of attempting the rehabilitation of what seem to be very poor risks. While the state agency may share the values of the local community with regard to the desirability of rehabilitating the serious cases, and while it wants acceptance and approval from the local community, it is the state parent agency, the state legislators, and governor on whom it relies for its financial support.

United Fund vs. Single Drive

The importance of conflicting goals, especially those which emanate from outside the local health agency system, also is evident in the widespread controversy over fund-raising. As Hamlin has noted, "Of all the controversies currently surrounding voluntary agencies, certainly the most strident has been the debate between advocates of independent and federated fund-raising."[4] It is well known that such corporate agencies as the American Heart Association and the American Cancer Society resist pleas of federated fund-raising advocates and carry out their own fund-raising campaigns. Moreover, these and other corporate agencies often incur the resentment of agency personnel and board members and of community leaders for not spending a greater proportion of their collected funds for local services.

Information obtained from executives of 68 voluntary agencies in four communities indicate that, in comparison with agencies of the federated type, corporate organizations do indeed allocate a smaller proportion of funds for services on the local level (Table 1).

Although the fund-raising issue is an important one and while fundamental values can be invoked to support either position, a more detached view of the problem reveals that underlying much

Table 1—Per cent of Funds Expended Locally by Corporate and Federated Agencies in Four Communities

	Per cent of Funds Expended Locally*			
	0-25	26-50	51-75	76-100
Corporate (N=28)	5	6	10	7
Federated (N=48)	1	0	5	42
Total=76				

* When categories are collapsed, Chi-square value=30.14 and is significant at 0.001 level.

of the clamor and controversy are the varying goals and objectives of the different health agencies. The fulfillment of certain organizational functions (e.g., research) requires concentration of considerable resources on the national level. Organizations specializing in research, therefore, characteristically have a predominantly corporate form of organization whereby authority is delegated from the national to the local. Corporate organizations, requiring greater centralization of resources on the national level, are understandably alert to any activity in the local community which may impede the flow of sufficient funds to the national body. In short, the national single drive agencies view the health picture from a national vantage point and, while their local chapters or affiliates are oriented partly to their respective local communities, the authority of these local chapters or affiliates is relatively limited and circumscribed by priorities established by the national bodies. By contrast, the Community Chests and Councils and the United Funds, comprised of predominantly federated agencies, are more geared to the local community, per se. They want to establish "maximal rationality" in the allocation of resources, and they want the fruits of their fund drives to be delivered on the local scene. In large part, then, the United Fund-single-drive controversy can be seen as a contest between two sources of authority which, in turn, are inextricably linked with the varying objectives and functions of the respective organizations.

Needs and Problems of Organizations

In order to understand why organizations do or do not cooperate with one another it is necessary to focus on the organizations themselves and to consider their respective needs and requirements.* Every organization has some kind of goal or objective toward which it directs its activities: A health department may have as its goal the promotion of health and the prevention of disease; a tuberculosis agency may have as its primary goal the eradication of a specific disease; a child and family service may aim at the development of psychologically and emotionally healthy children and families. In order to achieve these goals an organization must have three main elements or resources. It must have recipients to serve (directly or indirectly); it must have resources in the form of equipment, specialized knowledge, or funds; and it must have the services of personnel to direct these resources to the recipients. Few, if any, organizations have access to enough of these elements to attain their objectives fully. Under realistic conditions elements are scarce, and organizations must select the particular functions, services, or activities which permit them to achieve their ends as fully as possible.

Although an organization limits itself to particular functions because of scarcity, it can seldom carry out even these without, to some extent at least, cooperating and establishing relationships with other agencies in the health and welfare world. The reasons for this are clear. To

* For a more complete statement of our conceptual framework see reference 6.

Table 2—Responses of Health and Welfare Personnel in Two Cities Regarding the Greatest Problems of Their Agencies

Problems	City A (79 Respondents)		City B (68 Respondents)	
	No. of Times Mentioned	Per cent	No. of Times Mentioned	Per cent
Lack of sufficient personnel	22	15.0	14	12.0
Lack of qualified personnel	22	15.0	27	23.1
Lack of money	35	23.8	23	19.6
Lack of facilities	19	12.9	21	17.9
Lack of understanding by other agencies	14	9.5	5	4.3
Lack of understanding by public	23	15.7	20	17.1
Lack of coordination and planning	3	2.0	2	1.7
Lack of use by other agencies	4	2.7	2	1.7
Other	5	3.4	3	2.6
Total responses	147*	100.0	117*	100.0

* Multiple responses were given. Information was obtained from all but one of 34 agencies in City A and all but one of agencies in City B.

carry out its functions without relating to other local agencies, an organization must be able to obtain all the necessary elements—clients, labor services, and other resources—directly from the community or from outside it. Approximating this ideal case is the corporate health agency, as we have mentioned, which conducts research on a national level and does not provide direct services locally. In fact, by discouraging its affiliates from providing direct services on the local level, the national is assured that its locals will be less dependent on other local health and wefare agencies, and, hence, less influenced by them.[5] Certain classes of hospitals treating a specific disease and serving an area larger than the local community can also operate fairly well without actively relating to other local agencies. Even in this case, however, other agencies usually control some elements that facilitate carrying out its functions. Most agencies, especially those offering direct services, are unable to obtain all the elements they need from the general community or through their individual efforts. The need for a sufficient number of clients, for example, is often more efficiently met through interaction and exchanges with other organizations than through independent case-finding procedures.

Because ideas of coordination and cooperation are embedded in powerful social values, clear understanding and objective study of interagency relationships are rendered difficult. Who, for example, would admit opposing cooperation when the welfare of a patient might be involved? The cooperative theme which pervades much of American life is even more prescribed for personnel of nonprofit agencies whose raison d'etre is the promotion of human welfare. The foregoing discussion casts a different light upon the question of interagency

coordination and cooperation. Instead of considering "good will" among agencies and the personalities and affability of individual executives, however important these may be, our attention is directed to the organizational factors that affect the flow of specific and measurable elements (i.e., patients, personnel, and nonhuman resources) which are the lifeblood of organizational activity and maintenance. Accordingly, the student of health and welfare agencies must not take at face value generic comments about the desirability of greater coordination and cooperation but must try to ascertain (1) the problems of health and welfare agencies, (2) the specific types of cooperation sought, (3) by whom, and (4) from whom?

It is not surprising that a large proportion of personnel in the health and welfare agencies report shortages of money and personnel as their main problems (Table 2).

Most of the executives and supervisory personnel also indicate that they would expand their services or offer different types of services if they had sufficient resources. While hardly any agency indicates outright that getting recipients constitutes one of its main problems, concern with additional or more selective referrals is evident in discussions with personnel on the need for interagency cooperation.

The Search for Cooperation

A content analysis was made of the responses of all executives and other agency personnel in two cities concerning the cooperation they would like to have with other health and welfare agencies. We were able to classify the types of cooperation sought into the following seven categories:

1. More referrals
2. More or better case information
3. More or better personal services to patients
4. More nonhuman resources (equipment, technical information, etc.)
5. More money
6. More information on agency services
7. More planning and/or coordination.

Although there is considerable difference in the amount of cooperation

Table 3—Responses of Personnel in Health and Welfare Agencies in Two Cities as to Type of Cooperation Sought with Other Organizations

Type of Cooperation Sought	Number of Responses		Ranking of Responses	
	City A	City B	City A	City B
(1) More referrals	55	25	3	3
(2) More or better case information	30	22	5	4
(3) More or better personal services to patients	54	26	4	2
(4) More nonhuman resources (equipment, technical information, etc.)	16	7	6	7
(5) More money	13	8	7	6
(6) More information on agency services	113	16	1	5
(7) More planning and/or coordination	96	46	2	1
Total responses	377	150		

sought in the two communities, the patterns are quite similar when the seven types of cooperation are ranked (Table 3).

In the two communities a large percentage of respondents express their desire to have greater planning and coordination with other agencies. These statements reflect widely different organizational needs and conditions. First, there are those agencies which interact considerably with one another but have not attained complete consensus. For example, whereas a family service agency and a department of welfare may have frequent contact with each other, their relationship may be characterized by considerable attrition. The family service agency may decry the lack of professionalism and the failure of the welfare agency to pay attention to psychological factors. The welfare agency, in turn, may accuse the family service agency of being supercilious and of failing to share case information with other agencies. These differences are not inexorable and in many instances welfare departments and family service agencies have succeeded in achieving effective and harmonious relationships. At any rate, it is evident that these organizations are already involved in a series of cooperative relationships with one another and are seeking more and better means of cooperation.

Second, there are agencies which have little contact with one another but for whom there is a functional need for working together. For example, an osteopathic hospital has many patients who could use the services of the Visiting Nurses Association. Because of the particular status of osteopaths with the medical and nursing profession at the present time, however, there is very little contact between the two organizations. When personnel of an osteopathic organization express the need for more cooperation and coordination with the VNA, they are asking, in fact, that their agency obtain legitimacy from the rest of the health community.

Third, the search for more coordination may reflect a vague notion that some mutual value would accrue from greater contact with another organization. Included here would be organizations struggling for survival which are seeking further justification for their existence and hoping to improve their lot by becoming linked with the activities of other agencies.

In addition, there are organizations which, in stating the need for greater coordination with other agencies, are not only seeking the resources accruing from interagency exchange, but are also expressing their avowed organizational goals. A good example is the community council or planning council, one of whose main explicit objectives is to effect greater interagency coordination. Another case is the health department which is charged with the responsibility for the health of its constituents and which, in the minds of some health officers, should promote the most effective utilization of agency resources within the community.

While only a small percentage of personnel express the desire for money from other organizations, this does not mean that finances are a matter of little concern to health and welfare agencies. As we have seen, the lack of funds and personnel are the two problems most often cited by agency personnel. Rather, it can be inferred that agencies are not random or anarchic in their search for cooperation. What they seek from other organizations is tempered by the realities of the situation. Money is sought in almost all cases only from organizations which normally provide funds to individuals or agencies (e.g., the Welfare Department, the Office of Vocational Rehabilitation, the Cancer Society and the National Foundation).

The functions of an agency determine its need and capacity for interaction.

Nondirect service agencies have less need than do direct service agencies for elements from other local organizations. Of the nine agencies in two communities which are without patients or clients, eight do not express the need for any additional cooperation with the other agencies of the study. The one exception is a United Community Service which expresses a desire for more information about, and for more coordination with, other agencies.

One clear category of agencies seeking all types of additional cooperation with other agencies, particularly referrals, is the local federated voluntary agency which provides direct services. Included in this group are such agencies as the Visiting Nurses Association and the Family Service Agency and the United Cerebral Palsy. These agencies are almost totally dependent upon the local community and the agencies within it for clients and other elements. Although they operate with relatively low budgets, they generally enjoy considerable prestige and have outstanding community leaders on their boards. Yet, despite their modest needs and the support of community leaders, they are not completely assured of their continued existence and, therefore, constantly seek elements from other agencies.

The search for new clients is not always dictated by an immediate need. Additional clients are an important organizational asset in a different sense: They help to demonstrate to board members, the general community, and other legitimizing bodies the value and demand for the services of the agency. In bargaining for support to expand its domain or add specialized personnel to its roster, an agency's case is strengthened if it can point to an impressive waiting list.

These general statements are, of course, dependent upon such factors as the objectives, functions, and needs of the individual agencies. A hearing and speech center, for example, offering needed specialized services which have waiting lists of more than six months, seeks less referrals than are sought from it. Yet, it is intent in obtaining case information and other types of cooperation from the rest of the agency world. Another illustration may be found in a Jewish social service agency which maintains a kind of natural monopoly over a good number of its own clients. The agency appears to be relatively content in the scope of its operations and does not seek much interaction with the rest of the agency system.

In almost all cases, the hospitals of our study tend to seek cooperation less than it is sought from them; and in all cases, other agencies seek referrals from hospitals more than hospitals seek referrals from them. Hospitals, of course, tend to have the highest budgets and caseloads and are generally assured of a large number of patients from physicians. Moreover, they tend to receive more referrals from health and welfare agencies than do other agencies of the health system. In fact, hospitals and other agencies with full caseloads often either discourage the input of too many patients or, depending on their specific functions, develop selective criteria for screening patients. Altogether, they are less desperate for additional elements from other agencies than are other types of organizations.

Yet, the continued flow of sufficient clients may even pose a serious problem for agencies enjoying an abundance of them at a particular time. Consider, for example, the concern of a large voluntary teaching hospital about the changing function of a municipal hospital. When the voluntary hospital learned that the municipal hospital might modify its program from care of the chronically ill to the care of medically indigent acute cases, it expressed concern that its own supply of ward cases would be depleted, its teaching activities impeded,

and its ability to attract the better internists and residents thereby harmed. This points up the fact that even organizations which normally have a sufficient number of clients still depend upon a continuation of this salutary state. It appears that patients are a familiar and everyday resource that tends to be taken for granted except when there is a serious danger of curtailment.

Most of the relationships among health and welfare agencies, then, center around the flow of elements and, as we will see later, the rights and obligations with respect to these elements. It is necessary to add a practical note here. Interorganizational activity naturally is not confined to obtaining elements but also involves sending them to other organizations. Since no single organization can provide the total spectrum of services required by all patients or clients, an organization, to fulfill the general objective of having care provided to the patient, may have to direct the client to other relevant organizations. In doing so, the sending agency is linking itself with the services of the receiving agency and, to the extent the referral is a successful one, may enjoy the good will of the satisfied client, of the receiving agency, and, consequently, of the community as a whole.

There are times when the referral process has less desirable consequences for the agencies, the patient, or the community as a whole. Agencies which are overloaded, or which for one reason or another are incapable of rendering the services expected of them, may merely be concerned with removing the load or, in less respectable terminology, "getting rid of the client." In such instances, the agency may refer the patient to another organization which is not in a position to accept him. In two communities which we studied, the voluntary hospitals supported the establishment of government-sponsored chronic disease hospitals in the expectation that a hospital for medically indigent, long-term patients would free a number of beds for patients who could pay for services. In one of the communities it was the frequent practice of physicians to arrange for patients to be transferred to the chronic hospital when the patient could no longer pay for medical services. The eager efforts of physicians to transfer patients resulted in persistent conflict between the voluntary hospitals and the welfare department which administered the chronic disease hospital.

Determinants of Organizational Interaction: Function, Access, and Domain Consensus

We have already suggested that the kinds and degrees of interactions that go on among agencies are affected by (1) the functions they carry out which, in turn, determine the elements they need; (2) their access to elements from outside the system of health and welfare agencies or, conversely, their relative dependence upon the local system of other health and welfare agencies. A third factor which affects interaction among local agencies is the degree to which what may be termed domain consensus exists within the system of health and welfare agencies.

As we have indicated, organizational relationships directly or indirectly involve the flow of elements. Within the local health and welfare system, the flow of elements is not centrally coordinated, but rests upon voluntary agreements and understandings. Obviously, there can be little exchange of elements between two organizations which do not know of each other's existence or are completely unaware of each other's functions. Our research findings indicate that agency personnel are often ignorant about the kinds of services provided by other agencies in the system. In a given community where 34 agencies were studied, each agency was asked to comment

about the scope of services provided by all other agencies in the sample, and data were tabulated in the form of a matrix, 34 by 33. More than 50 per cent of the matrix cells were filled in by "don't knows." In another community where 33 agencies were studied, about 40 per cent of the matrix cells were filled in by "don't knows." It is not surprising that, in general, agencies with little familiarity about each other's services do not interact much with each other and, in most cases, not at all.

Also, there can be little exchange of elements between two organizations without at least some implicit agreement or understanding. These exchange agreements are contingent upon the organizations' respective domains. The domain of an organization consists of the specific goals it wishes to pursue and the functions it seeks to undertake in order to achieve these goals. In operational terms, organizational domain in the health and welfare field refers to the claims which an organization stakes out for itself in terms of (1) problem or disease covered, (2) population served, and (3) services rendered. "The goals of an organization constitute in effect the organization's claim to future functions and to the elements requisite to these functions, whereas the present or actual functions carried out by the organization constitute de facto claims to these elements."[6]

When we speak of domain consensus between two agencies we are referring to the degree to which they agree and accept each other's claims with regard to problems or diseases covered, services offered, and population served. Unless organizational domains are clarified, competition may occur between two agencies offering the same services, especially when other agencies have no specific criteria for referring patients to one of these rather than the other. If all the services are operating at capacity or near capacity, competition between the two agencies tends to be less keen; if services are being operated at less than capacity, however, competition and conflict between the two agencies are often in evidence. Vying for patients or clients, contesting the right of another organization to offer particular services to certain classes of patients or clients, and, in fact, sometimes questioning the organization's very right to exist—all these are often the bitter fruits of conflicting domains. If not resolved quickly, these conflicts gain the attention of the rest of the health agency work and of the general community who begin to deplore what they regard as unnecessary duplication of services.

In a good number of cases, two organizations may resolve the conflict between them by agreeing to specify the criteria for the referral of patients to them. The agreement may often take the form of the two conflicting agencies handling the patient consecutively. For example, age may be used as a criterion. One conflict in which three rehabilitation agencies were involved was resolved by one agency taking preschool children, another school children, and the third, adults. In another case where preventive services were provided one agency took preschool children and the other children of school age. The relative accessibility of the agencies to each of the respective age groups was a partial basis for these divisions. Consecutive treatment of patients is also possible when patients are allocated on the basis of disease stage. One agency provided physical therapy to bedridden patients; another handled them when they became ambulatory.

Organizational conflict results not only from an organization expanding its domain or intruding on that of another, but also occurs when it is judged as not doing as much as it should. If the general goals of a specific agency are accepted by others, they may encourage it to expand its functions or serve new

population groups. There is some evidence that agency personnel sometimes may even make "incorrect" referrals to other organizations in order to encourage the latter to expand their domains. Over time, however, should an agency not respond to this encouragement, it may be forced to forfeit its claim to a particular part of its domain.

It is important to note that particular organizations may find it more difficult to legitimize themselves to other parts of the health agency system than to such outside systems as the community or the state. An organization can sometimes obtain sufficient support from outside the health system long after other organizations within the system have challenged or rescinded its domain. In one community, a social service agency was pressed by other agencies to go out of existence because it was believed that the services it was offering were being delivered more effectively by another agency. However, the agency in question suddenly became the recipient of a large bequest which assured its continued survival for some time. Instances of this sort sometimes make it difficult for other health agencies to encourage or coerce a particular agency to be more cooperative and "rational" in its relations with other agencies.

While much of our analysis has focused on the "exchange" value inherent in organizational interaction, we should avoid committing a rationalistic fallacy. We should not assume that executive personnel always know their organizational self-interest and are ever acting in its behalf. In fact, overconcern with the immediate acquisition of elements may have long-run negative consequences. In one community, for example, a sheltered workshop, supporting itself from the sale of products, began to exclude the more seriously handicapped in order to maintain a high rate of production. Accordingly, it refused to accept referrals from a number of community agencies and, over time, lost their approval—a factor which resulted in the failure of the sheltered workshop to obtain voluntary grants of funds necessary for its operations. Today, the workshop is barely operating. Yet, it seems likely that had the workshop accepted the more serious cases from other community agencies, they would have lent their support to its continued existence.

It is our impression that, even in terms of organizational survival, a number of agencies have overlooked the usefulness of relating to the rest of the health and welfare system and have been preoccupied with obtaining support from three main sources: (1) the general community; (2) local governing boards; and (3) their parent bodies or policy-making groups outside the community. This orientation often results in exaggerated concern with organizational identity, the publicizing of dramatic instances of organizational achievement, and the devising of glowing statistics to attract community attention and impress board members. The assumption that underlies this orientation is, of course, that it is the best means of insuring continued support. It can be easily understood how this orientation can produce a keen and jealous competitive spirit among individual agencies. While this orientation may be feasible for corporate agencies which are not oriented toward the local community, in the long run it may prove disastrous for many direct service agencies. It appears that the more an agency makes its resources available to other organizations which are carrying out valuable functions, the more that agency will become integrated with and necessary to the rest of the system and receive support from it.

There are, of course, other factors which impede greater coordination and effective mobilization of resources within the health agency community. These may be listed briefly. Lack of cooperation between two agencies in the health

world is often a reflection of different views of the world held by professionals and nonprofessionals. For example, in the communities we studied we found instances of conflict between strong social work agencies whose personnel have graduate training in social work and welfare departments whose staff workers are called social workers, many of whom have no training in this specialty, graduate or otherwise. Lack of cooperation also may be a reflection of the same kind of professionals being subject to diverse authority systems. In some communities, trained nurses may be employed by the health department, the Visiting Nurses Association, and the school department. Professionally, these nurses might be in considerable agreement in their approach to the patient and his problems, but the respective organizations for which they work may have divergent policies regarding ways of handling the patient and of referring him to other agencies. Finally, the same general class of professionals may have differing outlooks and goals, such as those of public health nurses and of other registered nurses. The public health nurse is more concerned with health education, whereas the registered nurses emphasize direct treatment.

Practical Implications

Our findings suggest various approaches which may be used by health leaders and community organizers to achieve greater interagency cooperation.

1. Realize the limitations in solving certain problems on the local level and, where relevant, turn to the state or even national levels to effect change—As we have seen, local affiliates of corporate health and welfare agencies, as well as branches of official state organizations, must fulfill minimal obligations to their parent bodies to remain in existence. Whatever the merits of these organizations, there is a limit to which changes in their policy can be effected by pressure on the local level. While there may be little point in investing time and energy locally in criticizing their organizational goals, some headway may be made by working on the state or national levels where basic organizational policies are formulated.

2. Improve the knowledge organizations have regarding one another—The goals, functions, problems, and restrictions under which organizations operate should be made explicit. We have found that an agency is sometimes taken aback when its overtures for cooperation with another agency are not met with immediate favorable response. The reason for this often lies in the failure of the initiating agency to appreciate the problems and goals of the organization it is approaching. Obviously, there is little likelihood of obtaining cooperation when only one organization will benefit. Yet, many organizations seek to enter into exchanges with other organizations and bemoan the lack of cooperation from others when only their own goals can be furthered by the proposed activity. A clearer knowledge of the problems and goals of the other organization would appear to be a first step in developing cooperation between two organizations which is based on mutual benefit.

The usual listings of agencies and their functions which exist in communities provide little guidance in this respect, either for other agencies or for the recipients of services. These lists appear to be developed more for public relations purposes than for guides to intelligent utilization by other organizations or clients. As a result, clients are sent to inappropriate agencies and others who should be referred are not referred. It would help if the caseload and capacity of each organization were known to all. So often an organization is listed in most impressive terms with a yearly caseload of ten people and a capacity not much beyond ten. If the

list of agencies contained some information about the agencies main problems (e.g., getting volunteers, transportation, and so on) and about the resources they possess which might be made available to other organizations, it would provide a useful guide for others in the health system.

3. Recognize and analyze domain differences and related tensions between organizations and develop mechanisms for the solution of these differences—In our study of domain consensus, we learned that conflicts were often resolved when agencies agreed on criteria by which others could distinguish their respective functions. Such delineation of function can result in greater efficiency in the health and welfare system by permitting greater professional specialization and by facilitating the referral of patients and the flow of information.

4. Educate the boards and community leaders to recognize the interdependence of the health and welfare agency system—One of the major tasks for the agency professional staff is the reorientation of board members to the fact that direct service organizations (1) can no longer survive solely by depending on large individual private sources in the community, and (2) that agency continuity can best be assured by contributing to the rest of the health and welfare system. Once the boards adopt this view, professional staffs will be freer to redefine their roles and objectives to include greater cooperation with other agencies.

5. Means and mechanisms must be developed whereby professional personnel are provided appropriate rewards or incentives—Because the average health worker has internalized broad professional norms, he tends to act to safeguard the welfare of his clients and, when necessary, to refer them to other appropriate agencies. However, unless the health worker's positive behavior toward clients and other agencies is valued or approved by the individual agency by which he is employed, there is a limit to the degree to which his professional norms can sustain him. In short, it is not sufficient to plead with professionals to modify their behavior; incentives must be introduced within each organization to foster desired courses of action (i.e., cooperating with other agencies).

6. Establish some formal mechanism by which specific professionals would be charged with the main responsibility of studying and assessing community needs and of stimulating and coordinating the activities of various health agencies—Who would this person (or persons) be? It should be someone who views the community as a patient and is intent on developing maximal rationality among the system of health and welfare agencies; someone steeped in community organization and the sociology of organization and familiar with the scope of each of the health and welfare professions; someone able whenever necessary to reach outside the community to achieve more effective coordination. It should be someone capable of dealing with official and voluntary organizations and various kinds of hospitals.

Contrary to the beliefs of many public health people, the health officer is not often recommended as the person most suitable for this role. In two communities the head of the Community Council or United Community Service is cited more frequently by agency personnel. Even when the question is posed in terms of coordinating only health agencies, the health officer does not receive an impressively large percentage of mentions. On the other hand, the Community Council is mentioned most when the question is restricted to welfare agencies. This would indicate that having the health department accepted as the principal coordinator of health and/or welfare agencies is not shared by the rest of the health and welfare

agency personnel. It also suggests that most agencies are not as yet prepared to invest in a single person or agency the responsibility of coordinating their work with one another. Another point of interest in this respect is that there is even less acceptance of the welfare department as the potential coordinator of welfare activities. This may be due in part to the fact that many of the welfare department's personnel are without graduate training.

Our findings indicate that the choice of a coordinator and the delineation of his role is still problematic; yet, we trust that our other recommendations provide bases for an approach to solution of the problem.

Conclusion

In this paper we have discussed the goals, needs, and problems of individual agencies and how these may impede interorganizational relationships. At the same time, we have pointed up that agencies, in fact, cooperate with one another considerably and actively seek cooperation in order to acquire necessary resources. In short, there is a patterned interplay among health and welfare agencies which stems largely from their respective functions. However, since these functions have arisen in a laissez-faire manner with each agency independently attempting to meet its specific objectives, various barriers to greater interorganizational cooperation have developed. We have suggested various approaches by which these barriers may be overcome. But increased cooperation among agencies does not automatically guarantee that the health needs of the community are being met. An even more important objective challenges the skills and ingenuity of health leaders and community organizers: how to direct the natural interplay among agencies so that their functions are congruent not only with one another but also with the needs of myriads of recipients?

REFERENCES

1. Haldeman, J., and Flook, E. The Development of Community Health Services. A.J.P.H. 49:10–21 (Jan.), 1959.
2. Etzioni, A. Organizations and Society: Three Dimensions of Recent Studies. Paper presented to the Annual Meeting of the Eastern Sociological Society (Apr. 11-12), 1959, New York, N. Y.
3. Sills, D. L. The Volunteers: Means and Ends in a National Organization. Glencoe, Ill.: Free Press, 1957.
4. Hamlin, R. H. Voluntary Health and Welfare Agencies in the United States. New York, N. Y.: The Schoolmasters' Press, 1961.
5. Briggs, J. L., and Levine, S. Control Over Local Affiliates by National Health Organizations. Paper presented at Meetings of American Sociological Association, St. Louis, Mo., 1961.
6. Levine, S., and White, P. E. Exchange as a Conceptual Framework for the Study of Interorganizational Relationships. Admin. Sc. Quart. 5:583–597 (Mar.), 1961.

Dr. Levine is associate professor of social psychology, Department of Public Health Practice, Harvard University School of Public Health, Boston, Mass.; Mr. White is assistant professor of social anthropology, Department of Maternal and Child Health, Johns Hopkins University School of Hygiene and Public Health, Baltimore, Md.; and Dr. Paul is professor of anthropology, Department of Anthropology, Stanford University, Palo Alto, Calif.

This paper was presented before a Joint Session of the Dental Health, Medical Care, and Public Health Education Sections of the American Public Health Association at the Ninetieth Annual Meeting in Miami Beach, Fla., October 17, 1962.

The project was sponsored by the Social Science Program at the Harvard School of Public Health and supported by Grant 8676-2 from the National Institutes of Health. Dr. Paul was the director of the program and co-investigator; Dr. Levine was principal investigator; and Mr. White was assistant project director.