Planning to alter community health programs is a complex and subtle process. This review of experience in six communities sheds light on several elements in the planning process. Conclusions are presented as a step toward defining the conditions and characteristics of effective planning.

BASIC FACTORS IN PLANNING FOR THE COORDINATION OF HEALTH SERVICES—PART I

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THE COORDINATION of health services for patients with long-term illness appears on surface to be a comparatively simple exercise in logic and common sense; on closer view it involves analysis of: (1) the characteristics of long-term illnesses; (2) the various services which may be required; (3) the necessary or potential relationship between these services; (4) the structures in which services are organized; and (5) the methods of planned social change by which relationships between various services and structures are modified.

Other reports in this series have considered the first four aspects and have clarified the service requirements of most chronic illnesses: Care is needed over relatively long periods during which the needs of patients change; satisfactory treatment or care at any one time depends upon the preceding care already given and the arrangements which can be made for the next stage of care; several types of care or treatment may be needed simultaneously or successively; the varied types of care depend upon several different professions, each of which is differently organized.

This understanding has directed community attention to the means by which various services can be continuously coordinated. Certain forms of interprofessional coordination can be achieved within one agency and have been reported widely—internal administrative reorganization of institutions, medical team work in hospitals, and home medical care programs. However, it has become increasingly clear that coordination of care for the chronically ill depends upon another form of cooperation—that between independent institutions including hospitals, social welfare agencies, and custodial care facilities. The history, control, objectives, standards and programs of these organizations are most varied and determine the policies each is prepared to adopt.

This diversity in institutional or agency policy control has seriously complicated the search for continuous coordination of services, which scientific and professional knowledge demands for adequate and comprehensive care. Informal and casual patterns of cooperation among agencies are no longer sufficient as needs of the chronically ill in-

crease in volume and complexity,* while resources are limited by professional specializations, and shortages in skilled manpower or financial support. A major question has become: "Under what circumstances will health and welfare agencies agree to systematic coordination of their separate programs to assure a workable network of community services?"

As the desirability of cooperation has turned into necessity for coordination, attention has turned to the possibility of planfully designing the patterns of service organization. Six communities were selected for retrospective study of central planning attempts to alter the patterns of institutional service for long-term patients in the direction of cooperation, coordination, or integration†: St. Louis, Toronto, Cincinnati, San Francisco, Philadelphia, and Detroit. In each community studied, a central planning association attempted to bring about a new liaison between a general hospital and a long-term care institution—a home for aged, chronic hospital, or nursing home.

Method of Study

The study sought to identify those central circumstances and planful acts which resulted in a new pattern of association, or which failed to achieve this objective. Through a comparison of successes and failures, it was hoped that certain hypotheses could be framed about the elements essential for effective community organization and planning in this field.

A working definition of success and failure was adopted arbitrarily, since no accepted measure has yet been developed. For the purposes of this study, success in planning was defined as: "Alteration of specified working relationships between two institutions, established as a goal by a community planning organization, adopted by the affected agencies, and operationally effective within ten years of the initial planning." The specified working relationships included major re-division of treatment responsibility, new assignments of personnel, arrangements for transfer of patients, and so on. Failure was defined as the inability to agree on a specific plan, lack of agency acceptance, or termination of the plan within ten years. The test used is failure or success of the planning effort, not of the coordination. Such a definition fails to account for the fact that goals so established may be poor, unattainable, or in violation of accepted standards. Unfortunately, the absence of clear standards for planning made it impossible to use any more rigorous test.

The study cases were each developed out of the activities of Jewish welfare federations whose structure, settings, and procedures were sufficiently uniform to provide a reasonably comparable group of cases, while also permitting analysis of variations in planning actions. In addition, the selected cases represented the most clean-cut attempts to plan inter-agency coordination or cooperation through a central community organization. Jewish communities were selected with these common characteristics: comparable range of services already organized for the chronically ill; similarity in

* A certain amount of cooperation between agencies evolves through the natural association which grows up between the staffs of two agencies working with the same groups of patients. Eligibility for services, areas of specialization, procedures for admitting or transferring patients are all developed with greater or lesser ease. These forms of cooperation evolve more or less fortuitously, and frequently depend upon the interest or attitude of one or two individuals, or upon the historical relationships which have sprung up between two or more agencies.

† Cooperation is used to mean informal association by two organizations which is not binding upon either party; coordination is used when two agencies formally undertake to relate parts of their programs to each other's needs without reducing the independence of either, although the agreement has the character of a contractual undertaking; integration is used to describe coordination in which the administrative independence in one agency is subsumed to another.

economic conditions; recency of planned effort by a central planning agency (between 1948 and 1956); access to records and key actors in the planning process. Communities differed in: the local history of agency association; relationship between the Jewish community (under study) and the wider surrounding community of many subgroups; geographic location; volume of public and nonsectarian services for the chronically ill; and power of the central planning agency.

The studies were conducted by teams of two or more investigators, usually including a social worker or sociologist experienced in community organization, and a public health physician.* Significant individuals and organizations in each planning effort were identified by several cross-checking methods. Special care was taken to assure that opposing points of view were consulted at every stage of study. Representatives of each agency, some public officials, and some community leaders not associated with any agency were interviewed in each city. A total of 76 persons were interviewed, 35 professional staff and executives of agencies, 41 officers of agency boards. Nineteen agencies and six federations were involved directly in the planning. All relevant records, memoranda, correspondence, and organizational minutes were evaluated and 17 local surveys were reviewed. The resulting analyses of each community experience were reduced to community reports and each was reviewed by all teams of investigators and by professional staffs of the central planning agencies in each community.

The general conclusions which follow are derived from a comparative analysis of the six community records which constitute the basic source of evidence.† The conclusions are not proved with statistical finality by the evidence, but they do explain much of the phenomena encountered in the planning cases and are supported by limited objective data.

The Bases for Social Agency Policy Control

Health and welfare planning has usually appealed to "community responsibility" as the major sanction to induce cooperation among agencies or alteration in their programs. The effectiveness of this appeal has been limited by vagueness of the term "community," and many agencies have responded to the interests of their special constituencies or subcommunities, and not to the demands of any larger loyalty.

In recent years literature dealing with coordination of health and welfare services has referred to "total community responsibility" in order to distinguish between different levels of group loyalty and responsibility. The term "total community" was frequently used by informants in the study, as was the term "total Jewish community," in much the same way as the term is used by nonsectarian welfare councils to describe the over-all and unifying interests of many groups in a geographic area such as a city or county.

The six community studies contributed to clarification of the subject by revealing how limited still is the acceptance of the concept "over-all or total community" when applied to welfare planning. This community, in fact, is made up of many diverse subgroups each concerned primarily with its own history, aims and needs; and only secondarily concerned with a larger unity called "the community." This was found true for Jewish communities and their welfare agencies which are relatively homogeneous when compared with other community welfare complexes. It may be assumed to describe even more accurately the situation confronting general welfare planning.

The community studies also developed evidence that many social agencies must

* A total of eight persons were active in six study teams.

† The detailed community summaries will be available later.

still be viewed as the organized expression of the aims of a specific subgroup rather than of the more loose entity known as a community. In each situation studied, it was found that the voluntary social and health institutions were not "community-wide" in the sense in which the term is usually used—as representing "total" community goals, support, backing, and control. True, voluntary organizations such as hospitals and homes for the aged seek to serve all persons requiring their help and who are members of this total community. Thus the Jewish hospitals included in this study admit patients regardless of religious identity. However, about 50 per cent of all patients are Jewish, and the medical staff is preponderately Jewish. Jewish homes for the aged are willing to accept all the Jewish elderly, but their program reflects the special cultural bias of their controlling trustees (religious and cultural practices are orthodox or liberal, for example). Financial support is reasonably widespread among all Jewish residents of the area but each institution still reflects the aims and aspirations of some subgroup within the larger population. These subgroups seem to exercise dominant control over the policies of the institution associated with them. There are several ways of identifying the subgroups; in some instances they may represent economic or social similarities, rather than ethnic or religious similarities, but the effect is the same when it comes to understanding interagency planning.

The subgroups identified with these social agencies were once quite well defined and well knit organizations—a synagogue, a women's health society, and so on. Each of them was also identified by the unifying characteristics of the members—a common religious emphasis (liberal, conservative, or orthodox Judaism), a common country of origin, similarity in cultural background, or economic and social position. Such groups created all of the social agencies studied. As these groups became more securely established in American society, the number of subgroups and associations expanded greatly. For a time the number of social agencies increased, too, and in major communities there existed for a time parallel family welfare and child care agencies, homes for the aged, and health agencies for each major group. Various pressures soon reduced the total number of social agencies through merger.

This identification of agencies with subgroups in community life is now traced through broad economic, social, and cultural characteristics of the boards rather than through specific club or organization control. In effect, the functioning of these agencies is determined by the aims and aspirations of certain broad social groupings—liberal or orthodox Jews, those who emigrated from Eastern Europe or Central Europe, those who came to this country 100 years ago, as distinct from those who came 25 years ago.

Table 1 identifies certain dominant groupings of trustees among the agencies studied. The table provides tangible support for the widely repeated assertion in all personal interviews that each social agency had to be viewed in light of its functions and the aims of specific groups with which agency policies are identified. Thus, one hospital is "controlled by wealthy families of German origin who emigrated a hundred years ago"; in another city "the hospital is associated with wealthy persons of Eastern European origin"; a home for the aged in one city is identified by the religious emphases of the board (it is orthodox or liberal) whose members are usually less wealthy than are hospital trustees, and are in the middle of a ladder of social prestige.

The recognition of this control is obscured by the continuing integration of all groups into a more standardized form of American life, but the survival of individualizing forces is still clearly traced.

Table 1—Classification of Trustees of 12 Jewish Agencies by Economic and Social Rating* and Religious Preference

City and Agency	Per cent of Trustees in Economic Group AA	Economic Group A	Economic Group B	Social Group AA	Social Group A	Social Group B	Per cent of Trustees with Specified Religious Preferences Liberal	Conservative	Orthodox
Cincinnati									
United Jewish Social Agencies	85	-15-		70	16	14	77	11	11
Jewish Welfare Fund	50	40	10	33	42	25	60	12	15
Jewish Hospital†	100	–	–	75	25	–	100‡	–	–
Home for Jewish Aged†	100	–	–	50	25	25	100	–	–
Orthodox Home for Jewish Aged†	–	50	50	–	50	50	–	25	75
Philadelphia									
Albert Einstein Medical Center**	60	35	5	60	30	10	67§	-33-	
Lucien Moss Home**	29	71	–	43	43	14	67§	-33-	
Toronto									
Mount Sinai Hospital	39	33	28	36	50	14	50	50	–
Home for Jewish Aged	6	7	87	14	26	60	50	25	25
St. Louis									
Jewish Hospital	60	25	15	65	30	5	85	-15-	
Jewish Sanatorium	30	30	40	50	20	30	60	-40-	
Convalescent Home	40	60	–	20	80	–	60	-40-	

* The rating scale is a simple three-step scale. Economic rating: AA—very wealthy, largest philanthropic gifts, large capital reserves; A—wealthy, second line but large contributors, dependent upon current earnings, but with some capital reserves; B—moderate income, substantial philanthropic involvement, dependent upon earnings. Social rating: AA—acknowledged as social leaders, members of most exclusive club, associated with oldest prestige families and their intimate invitation lists; A—prominent socially, not members of inner circle among AA group, including prestige due to recent wealth; B— all others. Ratings were made by local professional staffs.

† Based on ratings for representatives actively participating in joint planning committees, not total board.

‡ A number of persons with liberal religious preferences came from conservative or orthodox families.

** Based on data for one-third of board members. The remaining two-thirds are believed to include a higher proportion of A and AA ratings for the hospital.

§ No data available; estimates based on country of origin of trustees—those of German origin treated as having liberal preferences; those of Eastern European origin as conservative or orthodox.

Although most agencies seek to broaden the base for their support and to bring some representation from many groups into board membership, the central or core control of each agency still lies in the hands of representatives of the originating subgroup. With the progressive breakdown of artificial barriers between groups in American society, it is possible that this characteristic of group control of voluntary agencies may be altered. For the present, the persistence of subgroup loyalties and institutional control must be taken as an essential element in community planning.

This is not to say that the policy decisions of each institution are solely determined by the group characteristics of the board. In fact, most boards seek objective professional and factual guidance for their internal policy making. They are also affected, to some extent, by external standard setting influences, although these are limited by the willing-

ness of agency trustees to adopt them as guides for internal policy decisions. However, when it comes to external planning which may alter the relationships between two agencies, then the essential social character of the boards of trustees becomes of primary importance. These relationships are sometimes determined by considerations of ideology—the perpetration of religious practices in homes for the aged for instance—but where ideology or religious belief does not play a significant role, there remains the fact of group control over a social institution.

This conclusion as to the basis for policy control of social agencies depends not only on the characteristics of 19 boards of trustees, but on the opinions of local welfare leaders and the behavior of these agencies in the six specific planning situations studied. Further study, however, is necessary for a comprehensive understanding about how such organizational control is exercised, modified, or retained. If this interpretation is sustained by further analysis it means that effective planning must take into account not only the logic of professional judgment and professional studies, but also the subtle and often ill-defined influences of cultural survivals, competitive striving for influence, and social interrelationships among groups as well as individuals.

Although the conclusion is based on study of 19 institutions under Jewish auspices in six cities, it is believed that these characteristics may equally be found in agencies sponsored by other sectarian bodies, or in agencies which identify their services as nonsectarian, without necessarily claiming this condition for their policy-making bodies. Further study is necessary to confirm the wide applicability of the analyses.

Factors in Altering Service Patterns

In the six study communities, and in many others, the Jewish welfare federation, as the central planning organization, was confronted by post-war pressures to improve local programs for care of the chronically ill. These pressures took the form of demands to increase hospital and chronic-disease facilities, enlarge medical care teams, incorporate rehabilitation concepts in institutional programs, and upgrade staffs. These steps required more operating funds as well as greater capital investment, with competition by the many separate organizations which were each independently seeking to expand.

In each community, the initial federation response was one of study, to determine whether all of the expansion was necessary, whether it could be planned far more economically, and whether the separate developments of many agencies required any coordination. These exploratory studies generally pointed toward coordination, or greater coordination, between hospitals and long-term care institutions or toward some integration. The suggestions ranged from full merger to loose agreement about the construction of a new rehabilitation facility to be jointly used and controlled.

Six different plans were finally developed representing as many forms of cooperation and degrees of success for the planning effort. The essential facts are briefly summarized as follows:

St. Louis—A complete corporate merger of a general hospital, a chronic disease sanatorium, a rehabilitation center, and a medical social service bureau. In addition, the new medical center and an independent home for the aged evolved a plan for medical care in which the hospital staff assumed responsibility for medical care in the home, while the latter retained administrative, fiscal, and policy autonomy. This represents a complete integration and complete success of the planning objectives.

Toronto—A plan to independently re-build both a hospital and a home for the aged, the latter to add a large unit for care of the chronically ill. Plans to integrate medical and nursing care between the hospital and the chronic disease unit were successfully carried out. In effect, one medical staff serves two institutions, but the fiscal policy

and nonprofessional administrations remain independent of each other. There is also a high degree of cooperation between the home for the aged and the hospital. A successful planning effort.

Philadelphia—Two simultaneous planning efforts were carried out since efforts to combine both in one scheme were not possible. A nursing home, once administered by a general hospital, was legally separated from the hospital and launched upon an independent career, but medical, nursing and other professional services (except for social services) continued to be provided by the hospital. In time, the separate nursing home was to become a modern rehabilitation service. Concurrently, a home for the aged independently developed its own medical program. Plans to integrate its medical service with that of the hospital failed. A partially successful planning.

Cincinnati—The construction of a new and independent chronic disease center for active nursing and rehabilitation. This was loosely associated with the adjoining general hospital but medical care was not fully integrated as planned originally. The new institution depended upon close cooperation by the hospital and two homes for the aged, but only limited cooperation resulted for several years. Attempts to merge two homes for the aged to improve infirmary care failed. An incomplete planning attempt. Later a plan for medical cooperation between the hospital and one of the homes for the aged was developed. The results are not yet known.

San Francisco—A plan to erect a rehabilitation hospital independent of but associated with a general hospital. The unit was built, but association between the hospitals was never completed. Relationships between these two and a home for the aged were not developed until the failure of the original plan, and the final closing down of the rehabilitation unit. Before the plan finally failed, the rehabilitation hospital and a nursing home were merged and patients of both lodged in one building. An unsuccessful planning effort.

Detroit—A federation committee met over a period of several years to coordinate medical and health programs of the Sinai Hospital and Home for Aged. Several plans were projected ranging from a "cooperative medical program between home and hospital" to a "hospital administered program of medical service at the home including research, teaching, and direct service to residents." No agreement was reached over several years' time.

Analysis of the history of these efforts suggests that six factors account for the differences in achievement. Each attempt to isolate the critical factors in social change encounters the same difficulty—the great variety of uncontrolled and uncontrollable factors which may place a decisive role in any change in real life. A few central factors can rarely be isolated with absolute certainty, but it is possible to identify certain complexes of action which, taken as a whole, are associated with one outcome rather than another in community planning. The factors found to be associated with successful efforts to integrate or coordinate the work of several agencies are:

1. Simultaneous crisis in the functioning of agencies to be coordinated or integrated.
2. Substantial informal and social interaction between the trustees of the agencies involved.
3. A planning structure significantly committed to the goal of interagency cooperation.
4. Individual leadership of high status capable of bridging antagonistic agency boards of trustees; and possessing negotiating skill capable of modifying agency autonomy without destroying it.
5. Conduct of expert studies.
6. Discriminating use of incentives.

Two of the factors are in the nature of preconditions for successful planning: the existence of simultaneous crisis affecting the agencies; and substantial trustee interaction. The term "precondition" is used to denote that circumstance which, if present, significantly improves the likelihood of success for a welfare planning effort; and the lack of which increases the risk of failure. The other four factors can be viewed as tools for use in current planning.

Simultaneous Crisis in Agency Operations

In the most successful cases the agencies were simultaneously disturbed by some of the basic social and economic forces listed below. In the least successful cases, one of the agencies was untouched, or had already taken independent successful steps to adjust. The patterns of agency

operation had already been disrupted or unhinged by such external social and economic forces as: consequences of the war, with its long delay in civilian building; the accumulating effect of long-time demographic trends; an aging population; emergence of chronic illness as a major health problem; and the unpredicted increase in total population. In every instance, the agencies involved in the planning had been impelled to plan for their own expansion, or for some basic alteration in their program—changes which necessarily affected the relation each had with other community agencies. These shifts were further encouraged by new financial factors (increasing medical costs, Social Security payments to the elderly, public assistance payments for medical care, and the growth of prepaid hospital insurance); new concepts of medical care (rehabilitation, medical specialization, and team work, and wide use of the hospital as the center for major medical activities); and new social concepts (service to the well elderly in their own homes rather than in institutions where possible, and service to substantially disabled elderly people in institutions for long-term care).

The effect of these changes on some agencies and social institutions was to prepare them for new patterns of association with other groups. This potential receptivity to new ways of functioning may be a vital element distinguishing successful from unsuccessful planning. It can only be proposed for further testing since all the agencies here studied were subject to similar external pressures for change. It nevertheless seems reasonable to suggest that planning efforts are most likely to succeed when the involved agencies already face some organizational crisis and need to change their operations.

Simultaneity in crisis in the involved agencies seems central to this analysis. Community planning frequently is initiated because one agency is in some difficulty, and a solution is sought through the cooperation of another organization. Such cooperation may sometimes be forthcoming for logical reasons, but more often it results only if both parties to the cooperation stand to benefit, a circumstance most likely to arise when both are actively in need of assistance and change. In the six cases, the least successful attempts were those in which one of the institutions was relatively untouched and the other was seriously affected by the forces mentioned. The most successful efforts involved agencies simultaneously affected.

Mention has been made only of external social or economic changes of a more or less uncontrolled character. It is necessary to consider whether crises can be induced in the work of these social agencies, so that "readiness for change" can be consciously prepared for.

All social agencies are more or less dependent upon external sources of income and crises in the life of an agency can undoubtedly be induced by significant alteration in this income. However, central planning bodies in social welfare are seldom capable of controlling major income sources of the voluntary health agencies. As Table 2 indicates, the central planning agency provided only a small percentage of the incomes of the institutions in three of the four cities. It is doubtful if complete withdrawal of these funds would cripple any agency.

These voluntary agencies serving the sick and handicapped have benefited from the widening financial base of support for health and welfare in the United States. Payments by voluntary insurance organizations and reimbursements by public welfare agencies rather than fees paid by patients now constitute the major sources of income. This development has served not only to strengthen community services, but to make agencies less dependent upon central planning as it is now organized.

More significant, certain factors militate against the withholding of funds by

Table 2—Jewish Welfare Fund Support of Hospitals and Homes in Four Cities—1947*

City	Allocations to Homes and Hospitals	Federation Funds Raised in 1947		Home and Hospital Combined Income	
		Total	Per cent Represented by Allocations to Homes and Hospitals	Total	Per cent Represented by Allocations from Federations
Cincinnati	$151,578	$1,545,205	9.8	$1,683,863†	9.0
Philadelphia	669,833‡	8,239,208	8.1	3,100,953**	21.6
St. Louis	144,572‡	2,732,355	5.3	1,269,760	11.4
Toronto	4,920‡	922,009	0.5	426,475	1.2

* Totals include community chest funds distributed through a federation for homes for the aged, hospitals, family and vocational services; 1947 chosen as the beginning year of planning processes studied.
† Exclusive of Jewish Convalescent Home.
‡ Funds provided primarily by the community chest and distributed through federations.
** Exclusive of Willow Crest Convalescent Home.
SOURCE: Statistical Unit, Council of Jewish Federations and Welfare Funds, New York.

central agencies. The welfare federations are voluntary associations in which authority is widely dispersed among members. Antagonistic acts against one agency member can easily be countered by withdrawal from the association, without necessarily destroying the seceder. In other words, the central financial bodies are limited in their freedom of action.

While it is true that contributors usually dominate the policy-making mechanisms of many planning agencies, they do not constitute a monolithic or unified body of interest, but rather reflect a great variety of welfare interests, which need to be reconciled if the planning mechanism is to function smoothly. This circumstance creates a measure of uneasy stability in community welfare planning, which is maintained through delicate negotiation. A determined effort to impose a course of action upon one constituent member usually leads to upsetting a hard won stability. Exceptions can be found, when the object of such effort is weak, has little independent support, and is largely dependent for financial support upon a single external source of funds.

Whatever the explanation, in five out of six cases central fund allocations did not play a major part in planning, except for new capital construction. In the sixth case, the size of allocations was sufficient to give the federation added influence, but this was effective only with one agency and not with the others (Table 2).

These strictures may not always be operative in all places. Certainly wherever an agency is predominately dependent upon financial support from one corporate source, which has freedom of action over disposition of those funds, then that source may be in a position to induce a change in program according to plan. Lacking this power, the limited funds from such sources can still be used to affect the course of planning, if not to control it. These possibilities will be considered under "Tools for Integration."

Informal Trustee Interaction

The unfreezing of past patterns through crisis only sets the stage for succeeding events. Different communities and different agencies respond differently to similar social forces. What then determines the direction of changes

which each finally takes? If coordination or integration is the planning goal, then substantial trustee interaction emerges as a second precondition. Successful cases were identified in communities in which the trustees of involved agencies already had developed a network of informal social and economic associations with each other. A lesser degree of informal interaction was found in cases where planning effort failed or was incomplete.

The significant aspect of this interaction is its unofficial and informal character. Agencies, as distinguished from individuals in small groups, interact through formal exchange between official representatives; exchange of services; and contacts between professional staffs. While each of these is important, the informal contacts among trustees require special attention—their social and religious contacts, business associations, leisure time use patterns (the country club games and dinner lists)—for these appear to be more persuasive in the lives of people and in the planning of welfare programs in these six cases, than are the formal associations and committees which receive first attention.*

The significance of this fact can be summarized for each community, since each of them had formal and representative planning committees of similar make-up, but leading to widely differing results. Table 1 has indicated how the agencies' trustees were divided along economic, social, and religious lines. In St. Louis, with maximum integration achieved through merger, the merging agencies were dominated by trustees predominately liberal as to religious preference and German in background. While each board included members with other religious and ethnic backgrounds, the central coloration of each agency's policies was determined by a core group with these common characteristics. Many trustees of the merged agencies belonged to the same country club and were even associated in the same businesses. Many levels of wealth and prestige were represented, but each agency contained a significant group of key policy makers with similar cultural, financial, and social interests. On the other hand, the home for aged, which resisted merger, was controlled by a board dominantly orthodox in religion and Eastern European in origin. Agreement by the home to coordinate its medical services with the hospital was facilitated, and perhaps made feasible, by the fact that several of its leaders had achieved social and financial prominence and were beginning to move in similar circles on a basis of equality with other leaders. A few from this group already served on the boards of agencies controlled by the other elements, although not in any controlling position. Thus the sharp isolation of these two groups from each other in the welfare field was beginning to break down in the social arena well before this planning had been initiated.

In Philadelphia, maximum interaction was found between the boards of the hospital and the Lucien Moss Home, each being dominantly liberal in religion and German in origin. While differing in financial and social position, a few key leaders on the home board moved in the same social and financial circles as did the majority of hospital trustees. The Home for Aged presented a different picture. Its board was made up of financially prominent persons in

* It sometimes happens that the informal patterns of trustees association and the formal agency and planning structures coincide. This provides the optimum environment for integration of programs. Unfortunately it also leads to narrowness and restrictive planning; for by definition, subgroups not in the social pattern of association are excluded from the community planning. As a result, most community planning groups have evolved planning structures which include diverse subgroups with the consequence that much of the informal interaction for planning takes place outside of the formal planning machinery.

a different social position, more heavily weighted by those of Eastern European origin and more orthodox than liberal in religious interest. The Lucien Moss was well coordinated with the hospital; the home for aged only peripherally.

In Toronto, the informal relationships between the two boards of trustees was less complete. Each shared a common European background, by and large, and a similar measure of financial influence. However, each group moved in different social circles, and the sources of financial influence were quite different. This suggests a limited basis for cooperation between two comparable trustee groups, but not enough for full merger, as in St. Louis. In fact, the Toronto agencies achieved a level of coordination between those in St. Louis and Cincinnati.

Cincinnati and San Francisco illustrate the relation between limited coordination or integration of service and limited trustee interaction. Each community federation attempted vigorously to reach agreement about a community plan. Cincinnati tried to have two homes for the aged merge and rebuild so they could, together, take care of persons requiring nursing service, while the hospital would build for the active rehabilitation cases. In both communities the boards of each agency represented distinct patterns of religious, social, financial, and cultural backgrounds. Informal exchange was limited. In Cincinnati it was commonly reported that "if you worked for one institution you did not work for the other." In San Francisco the differences were so sharp that a nursing home board was not represented in the formal planning committee for several years, and then only after the original plan had begun to flounder. In neither case was the programing of existing agencies directly modified by planned attempts at coordination or integration. Instead, planning efforts were directed into the path of creating new agencies to fill new needs. In one case the new agency failed, due to lack of full cooperation; in the other it received limited cooperation so that for years it teetered on the edge of failure.

In sum, these case studies illustrate the important role which informal trustee association plays in any effort to integrate or coordinate agency services through formal planning procedures. Success is more likely to crown the planning attempt if the agencies' boards are already on friendly and intimate terms. If they are not, coordination is still possible but it necessarily takes less comprehensive forms, and must safeguard the separate identities of the groups from which the trustees are drawn.

This interaction among trustees serves an additional and more general purpose: it exposes agency leadership to standards of action other than their own, and this may facilitate adoption of broader guides for internal policy selection. If the term "general community" is to have significance in planning, it must project certain goals which various agencies and individuals can adopt for the guidance of their separate acts. The interaction referred to above neither creates nor imposes such standards automatically but it provides one communication system through which such standards are developed and adopted.

These preconditions for successful integration do not destroy the prospects for rational planning. They only set some of the conditions which need to be reckoned with. Given a readiness in agencies to change somehow, due to social forces, and an intimate friendliness among the policy makers of each agency, there still remains the choice of direction for change, the specific form that any plan should take. It is in this limited but vital area that formal social and health planning can make its greatest contribution.

The study of the six cases reveals that

there are four tools by which communities can consciously begin to shape the patterns of their local services, given the favorable preconditions. Each of these will be discussed briefly.

There is nothing fixed or routine about these elements in planning. Not all elements are necessary at all times; other factors play a significant part in community action; the full use of these tools does not guarantee a successful outcome. Nevertheless, these elements appear to play a central part in community efforts to integrate agency services. It becomes, therefore, essential to understand the ebb and flow of relationship between these elements, in order to better understand how much influences the rest.

(The second and concluding section of this paper will appear in the March issue of the Journal.)

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This is the fifteenth of a series of reports on findings from the Study of Coordination of Health Services for Patients with Long-Term Illness which is conducted under the auspices of the Council of Jewish Federations and Welfare Funds, Inc., and supported by a grant from the U. S. Public Health Service.

Helps Train Youth in Air Sampling

To bring newer aspects of air pollution problems to the attention of high school science students and teachers, the California State Department of Public Health has now revised its "Experiments for the Science Classroom" (orginally published in 1958). The dozen experiments in this teachers' manual will interest schools in other states experiencing photochemical air pollution. Most of the experiments use actual procedures in air sampling, and they vary in difficulty. Representative titles of experiments are: "How Dirty Is the Atmospheric Dust?"; "How Is the Smog Index Determined in Your Community?"; "What Is the Relation Between Suspended Colloidal Particles and Cloud, Fog, or Smog Formation?"

Available to institutional administrative personnel, when requested on official letterhead, within the limits of the supply. It is not for sale. Address Bureau of Air Sanitation, CSDPH, 2151 Berkeley Way, Berkeley 4, Calif.