Presented is an analysis of the need for, and the problems involved in, achieving coordination of health services at the local level. These problems arise from the separate authorities that fund and administer the facilities, from the endeavor to provide comprehensive care, and the need to cut across various established but artificial lines among professional and other groups involved in health.

TOWARD THE COORDINATION AND INTEGRATION OF PERSONAL HEALTH SERVICES

Elmer A. Gardner, M.D., F.A.P.H.A., and James N. Snipe, M.P.A.

Introduction

We wish to discuss our efforts to coordinate, and perhaps some day to integrate, two health programs associated with the Temple University Health Sciences Center, both serving areas in North Central Philadelphia. As will be discussed more fully later in this paper, one program is primarily supported by the Office of Economic Opportunity and consists of two Neighborhood Health Centers which are designed to provide comprehensive personal health services for the residents of two communities within North Philadelphia. The other program is supported primarily by the National Institute of Mental Health and the State of Pennsylvania's Office of Mental Health, and consists of a Community Mental Health Center which is designed to provide mental health services for the residents of almost all of the North Central Philadelphia area.

It is our belief that much of the future medical care of this country should be, and probably will be, provided via a service delivery pattern identical with, or closely resembling, the model presented by a health center approach: a decentralized system of generalist care givers providing acute and some chronic care in easily accessible, community-based structures administratively and functionally linked to more specialized and centralized services, somewhat isolated from the population they serve. This model is appropriate for all parts of the population, not just the poor. Therefore, it is necessary that we use these programs now to evolve the most effective and feasible patterns of health care in the future.

Although we wish to describe our efforts toward coordination, there are several issues to be kept in mind during our discussion of the local programs and our recommendations for the future.

1. Given the general recognition of the relationship between physical and psychological health, the very fact that we must make an effort to coordinate is anachronistic.

2. Much of what we have to relate stems from our efforts to cure, at a local level, a health care system that is diseased at a state, regional, and federal level. The problems we face locally reflect the confusion in establishing national health policy, as discussed by Albert Snoke in the September issue of the
COORDINATION OF HEALTH SERVICES

Journal.* Dr. Snoke discusses the erosion of the Public Health Service and the leadership for establishing health policy at a national level. Due to resulting chaos in HEW and the leadership failure of both the universities and national health organizations to prevent this chaos, Community Health and Mental Health Programs are given contradictory mandates and regulations.

3. Even if we resolve the immediate problems in coordinating the various health center programs, we still have ignored a much more serious long-range problem. The development of health center programs represents the initiation of a totally new health care delivery system, one which is currently almost completely isolated from the schools of medicine, nursing, social work, and other presumed sources of manpower for this new system.

4. The mandates for both of our programs emphasize the promotion of health and prevention of illness, speak of comprehensiveness and the total health needs of a designated population, and stress both the social and physical environmental aspects of health. However, in operating these programs, the state and federal governments have ignored these principles and reverted to the traditional modes. They provide budgets and regulations which stress direct care and generally ignore prevention. In the provision of direct care, major administrative obstacles have been created which have been almost ingeniously in blocking comprehensive care.

Thus, much of our energy has been expanded in devising almost Machiavellian tactics to achieve the goals which are explicit or implicit in the federal mandates. We are not proud of these attempts to deliver decent health care within such a chaotic health care system, but if one does choose to survive within this system, we can offer this approach.

Conceptual Framework

Legislation and programs for personal health services, especially those which are designed for metropolitan areas, may be conceptualized in terms of a four-cell matrix, having Service and Clientele on one axis and time, expressed as Current and Future on the other axis. The top left cell, representing Current-Service Programs, is identified as Categorical. The bottom left cell, representing Current-Clientele, is identified as Selected. The two left cells together suggest that current personal health care legislation and programs are predominantly categorical in scope and are designed for a selected few.

The top right cell of the matrix, representing Future-Service is identified as Comprehensive. The bottom right cell, representing Future-Clientele is identified as General. The two right cells together represent our assumption that, in the future, perhaps the ideal model of personal health care programs for metropolitan areas is comprehensive care for the general public. The matrix also suggests the possibility of legislative and program mix in terms of time in that there are categorical health service programs provided for a general public and comprehensive health services provided for a selected few.

<table>
<thead>
<tr>
<th>Personal Health Service Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Current</td>
</tr>
<tr>
<td>Future</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>Clientele</td>
</tr>
</tbody>
</table>

An analysis of the major health care legislation, enacted or continued by Congress during the 1960s, indicates a continuation of major support in terms of dollars and other resources for categorical health care programs for the selected few. Examples of these types of programs abound. We would classify the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 as a categorical program for the selected few. The act speaks of "comprehensive mental health services," but this phrase seems paradox-

ical to us. From the patient’s point of view, the question might be raised: What is comprehensive about mental health services only? However, the provider might ask: How can mental health services be provided while ignoring the patient’s physical, social, and environmental state of health?

The formula grant programs of federal assistance to combat specific diseases or for specific groups, now combined under the Public Health Service Act by the Comprehensive Health Planning and Public Health Services Amendments of 1966, exemplified categorical service programs for the general public. Although now combined, it may still be argued that these programs should be classified as categorical programs for the selected few because many of these programs fail to effectively reach low-income groups.

The OEO Comprehensive Health Services Program provided for through the Economic Opportunity Act of 1964, as amended, and Section 314 (e) of the Public Health Service Act, entitled “Grants for Comprehensive Health Planning and Public Health Services,” are probably the best examples of comprehensive health service programs for selected groups. The OEO program is restricted to low-income groups, and the 314 (e) program is restricted to populations residing in limited geographic areas. However, we consider these programs as important steps toward comprehensive health services for the general public.

We know of no existing personal health care legislation or programs which are comprehensive in scope and intended for the general public. As previously mentioned, legislative and administrative steps are being taken, albeit haltingly, toward this model. It is the underlying thesis of this paper that much more could and should be done to eliminate the dichotomy which now exists in terms of this nation’s philosophy, policy, and administrative practices pertaining to personal health care services for its citizenry.

It is dichotomous if not paradoxical that this nation should enact in the same piece of legislation a health care program for the aged within an insurance framework, and a health care program for the poor within a welfare framework. What is the rationale for the establishment of Community Mental Health Center facilities and programs to provide so-called comprehensive mental health services, and in the same legislative act provide funds for other facilities and programs for the mentally retarded, funds for other facilities and programs for alcoholics, and funds for still other facilities and programs for narcotic addicts? This type of irrationality suggests that this country’s health care philosophy, policy, and administrative practices are determined by special interest groups and, if continued, will result in greater fragmentation, ineffectiveness, inefficiency, and higher costs of care. With exceeding difficulty some of us in Philadelphia have been attempting to develop a more rational system of personal health care services for a limited population. In effect, we are attempting to develop a miniature model of comprehensive personal health services for a general clientele. The approach, which we shall describe, has been necessitated by the legislative and administrative framework within which we secure our financial support. We do not recommend this approach, except as a short-term method. As will be discussed later, we recommend that steps be taken primarily at the national level with the authorizations which already exist toward the development of a rational approach to the provision of personal health care services.

Attempts to Integrate

Temple University, located in North Philadelphia, which is one of the most
COORDINATION OF HEALTH SERVICES

n economically deprived areas of the city, participates in several federally assisted programs for personal health services through its Health Sciences Center. Its Department of Obstetrics and Gynecology has participated in the Maternal and Infant Care Program since 1965, and through this program serves about 300 mothers and newborns. St. Christopher's Hospital for Children, which is also the Pediatric Department of Temple, received a grant initially in 1965 from the Children's Bureau of the Department of Health, Education, and Welfare to provide comprehensive health services for about 3,000 children and youth. Also, in 1966, the Department of Psychiatry received a Community Mental Health Center grant from the National Institute of Mental Health to provide "comprehensive mental health services" for an estimated 210,000 residents of North Philadelphia. Finally, in 1967, Temple received a grant from the Office of Economic Opportunity to establish two Neighborhood Health Centers and provide comprehensive health services for approximately 11,000 persons in one community known as Hartranft, and 18,000 persons in another community known as West Nicetown-Tioga.

Prior to 1967, each of these programs at Temple followed the national organizational and administrative pattern. Each represented an autonomous entity. The service boundary of each program was unique: each had its own constituency and sponsor. Moreover, each program followed, and still follows, a grant procedure which is unique to its funding agency. Imagine yourself a resident of North Philadelphia wandering through this maze in search of care, or answering the innumerable knocks on your door by people who need you to justify their existence. Imagine the number of people who sit behind desks at the local, regional, state, and federal levels for the purpose of processing the various kinds of paper created by this administrative nightmare.

The Economic Opportunity Act requires that community action programs, which include the Neighborhood Health Center Program, make maximum utilization of local, state, and other federal resources. It made sense to some of us in 1967 that we attempt to plan and operate our Neighborhood Health Center Program in cooperation with other existing programs, especially those which were operated by other departments of Temple University. Through discussions with staff of St. Christopher's Hospital for Children, it was agreed to operate the OEO-sponsored Neighborhood Health Center Program for the Hartranft area in concert with the Comprehensive Health Services Program for Children and Youth, and to provide comprehensive services to families residing in one common area through one facility. This was accomplished and, although the marriage is tenuous, it may be said that we have functionally and administratively integrated the two programs at the local level.

It should be stressed that the Children and Youth Program, the Neighborhood Health Center Program and, of course, the Community Mental Health Center Program are each authorized to provide mental health services. It was believed essential that the Community Mental Health Center staff participate in the planning of a mental health unit for each of the two Neighborhood Health Centers, and it was hoped that they would ultimately staff and operate the units in cooperation with the Neighborhood Health Center staff. It was believed that this approach would enable us to avoid duplication of effort, and would expedite the development of effective mental health services in the centers through the utilization of existing and experienced professional Community Mental Health staff.

The director of the Community Men-
tal Health Center Program personally participated in the planning of the mental health units for the Neighborhood Health Centers. It is now known that, in order to coordinate and integrate personal health service programs, it is necessary to overcome philosophical differences and administrative and interpersonal barriers. Accomplishing this requires the early and continuing involvement of top-level decision makers.

Temple's Community Mental Health Center Program provides those basic services which are set forth in the Code of Federal Regulations pertaining to grants for construction and staffing of Community Mental Health Centers (42 Fed. Reg. 54, 203 [1964]). The basic elements of a community mental health service plan or program are: inpatient services; outpatient services; partial hospitalization services; emergency services 24 hours per day; consultation and education services; diagnostic services; rehabilitative services; precare and aftercare services; training; and research and evaluation.

It is important to note that the Community Mental Health Center Act authorized funds only for the construction of Community Mental Health Centers and for a portion of the initial cost of professional and technical personnel. Federal personal services assistance is provided only for four years and three months, beginning with the initial grant approval, and only 75 per cent of personal services cost is supported by the federal government during the first 15 months of center operations. This support is reduced to 30 per cent during the last year of the four-year federal assistance period. The act did not provide for financial assistance for acquisition of supplies, equipment, or other material necessary to the operation of a Community Mental Health Center. The authors of the act assumed that the state would provide such assistance and, in Pennsylvania at least, that assumption was not actualized until very recently. The only good that resulted from this shortsightedness is that some of us have eaten quite well, because Temple's Community Mental Health Center staff have given "soul" food luncheons in order to raise money for drugs and other items which their patients needed.

Each of the two Neighborhood Health Centers was designed to serve the residents of a community whose boundaries approximated two census tracts. Only three of the four Neighborhood Health Center census tracts were in the original service area boundaries of Temple's Community Mental Health Center Program. However, the mental health service area boundaries were subsequently changed to include all of the Neighborhood Health Center service areas. It was estimated that 11,000 individuals residing in the Hartranft area of North Central Philadelphia would be served by the Neighborhood Health Center, and that 18,000 individuals residing in the West Nicetown-Tioga area would be served by the center to be located therein. As originally planned, each of the centers would be open Monday through Saturday from 9:00 A.M. to 9:00 P.M.

The original proposal to OEO expressed the agreement that each of the Neighborhood Health Centers would function as an outpatient component of the Community Mental Health Center Program. The purpose of the outpatient program was to identify and treat emotional problems in their early stages, to prevent chronicity and institutionalization, to offer emotional support to chronically mentally ill persons in the community, and to effect social adaptation and readaptation. The plan stated that staff of the Mental Health Program would provide consultation services to family physicians and other health center staff, primarily through the referral process and through periodic case conferences.
The operational plan further stated that the services would be closely integrated with all other health center services and would include case-finding and referrals, casework and counseling, group therapy, home visits for evaluation and care, psychological testing and other diagnostic, therapeutic, and rehabilitative services. In addition to clinical psychiatric services for the mentally and emotionally ill, it was anticipated that special programs for the mentally retarded and juvenile offender would be planned. These programs would include diagnosis and treatment, education, training and, where necessary, referral for custodial and other care.

Patients who are eligible for mental health services are also eligible for other Neighborhood Health Center services, and vice versa. The Neighborhood Health Centers were designed to provide medical care; dental service; home health services; physical, occupational, and speech therapy; social services; pharmaceutical services; environmental health services; and auxiliary services, including medical and dental laboratory, x-ray, and limited day care.

It was estimated that, of the total service population for both centers, approximately 3,700 individuals would need some kind of mental health service, and about 500 of this group would require direct psychiatric care. The original mental health unit staffing pattern for each center provided for the equivalent of three mental health assistants, one psychiatric social worker, and one psychiatrist on a full-time basis. It was anticipated that one full-time psychologist would be available for testing, consultation, or special services, and would devote proportionate amounts of time to each center. It was also anticipated that, if necessary, a psychiatric resident would be assigned to each center. Necessary equipment, supplies, and other material were budgeted and requested. OEO approved the proposal and granted more than $143,000 for this component of the program, with the requirement that reimbursement be secured from Community Mental Health Center funds and other third-party payers at a later time.

The Neighborhood Health Center proposal and budget were approved on July 1, 1967. We began renovation of the Hartranft area center in February, 1968, and medical care services were initiated in July, 1968. The OEO requirements pertaining to capital financing changed before we could initiate renovation of the facility for the West Nicetown-Tioga area, and we have been operating out of "temporary" facilities since December, 1968. We hope to complete renovation of the permanent facility before long.

One of the first lessons we learned about coordinating and integrating personal health services was that it will not occur just because top management agrees to do so. The steps that the middle management staff of each of the two programs were required to take, in order to implement the decision, were not taken. There appeared to be a number of reasons for this; for example, each group was busy doing its "own thing" and did not see the relevance of complicating their lives through mutual planning, joint program development, and shared decision-making. Managers and supervisors on each side believed they would lose control if staff were not clearly responsible for one program or the other. There appeared to be a fear of the unknown since one center staff did not know the other, and was not fully aware of the goals and operational patterns of the other program.

At this point, the Community Mental Health Center Program deconcentrated its outpatient services into six teams, each servicing a geographical subdivision of the catchment area. Two of the areas were coterminous with the Neigh-
The members of the primary mental health teams are classified as family health workers, but at the other the leader is a psychiatric social worker. The psychiatrist, who serves as consultant to the team and to other members of the health center staff, assists in diagnosis and participates in the treatment of the more complex cases. The committee has developed several drafts of their recommendations pertaining to operating policies and procedures.

The process has been slow and problems still exist. The team for the center in the Hartranft area cannot begin to function because space is not available. Although space for the Community Mental Health team was provided for in the original layout, this space was occupied by other Neighborhood Health Center staff before the mental health team was designated. We have been attempting to secure OEO approval for the acquisition of additional space, but the request has been enmeshed in broader legal issues. Some of our primary care physicians have difficulty in accepting a procedure which requires that referrals be made to a nonphysician team leader rather than to a psychiatrist. Further, it was originally hoped that one system of patient admission, record-keeping, and reporting could be developed. However, because of a change in administrative procedures recently required by the state, it may be necessary to have a dual administrative system in these areas. Although we have been bent by many of these problems, we are not yet broken.

We would like to report briefly on one other component of our programs that we have coordinated with reasonable success. The Neighborhood Health Center trains and utilizes staff, including those who are classified as family health workers, and the Community Mental Health Programs train and utilize staff classified as mental health assistants. Although these two positions differ in terms of duties and responsibilities, it was agreed that the family nurse and at the other the leader is a psychiatric social worker. The psychiatrist, who serves as consultant to the team and to other members of the health center staff, assists in diagnosis and participates in the treatment of the more complex cases. The committee has developed several drafts of their recommendations pertaining to operating policies and procedures.
health worker needed to learn some aspects of mental disorders and mental health resources in order to do an effective job of casefinding, to relate to patients better and to develop insight with respect to their own feelings about mental illness.

The actual training was conducted by the Community Mental Health Center staff, but the program was planned and continually evaluated by training and supervisory staff of both programs. The first category included not only family health workers, but also two social workers who were also interested. This program has been refined and has now been made part of the core training of all Neighborhood Health Center paraprofessionals. We also hope to initiate mental health seminars for all Neighborhood Health Center professional staff.

**Recommendations and Conclusion**

We recognize that our attempt at Temple to coordinate and integrate our personal health service programs represents the hard and rocky road. The value of delivering comprehensive personal health services to a general public, even in a limited geographical area, makes any attempt toward this objective worthwhile. As previously mentioned, however, we think there is a more productive and expedient way. We have sought to persuade our funding agencies to facilitate this process, but have met with little success. Although we understand some of the reasons for federal health agency reluctance to coordinate their activities, we consider this reluctance to be a form of passive resistance to the obvious intent of Congress and the President to effect coordination and integration of personal health service programs. We therefore think it necessary for the providers of care, especially those serving metropolitan areas to understand and utilize the available legislative and administrative vehicles that already exist for the purpose of coordinating and integrating personal health services.

It is well known that the Economic Opportunity Act of 1964 (Public Law 88-452), as amended, is the nation's primary legislative instrument for the elimination of "the paradox of poverty in the midst of plenty. . . ." It appears it is less well known that this same act represents a major piece of enabling legislation for coordination and cooperation within and between all agencies and levels of government and is applicable to nonpoverty matters.

For example, the Economic Opportunity Act provides that the "director shall consult with the heads of other federal agencies responsible for programs relating to work and training programs, physical and economic development, housing, education, health, and other community services to encourage the establishment of coterminous or complementary boundaries for planning purposes among those programs and community action programs. . . ." Some progress is being made in this area. Steps are now being taken to define coterminous regional boundaries of the Department of Health, the Department of Housing and Urban Development, and the Office of Economic Opportunity, and to relocate regional offices of these agencies to a common city. This reorganization, if coupled with a true delegation of authority from Washington to the regional offices, especially with respect to the authority to approve grants-in-aid, may facilitate coordination of federal programs and, hopefully, promote greater efficiency and effectiveness.

One danger in this move to decentralize authority is that, unless adequate resources and other supports are provided to regional offices to enable them to acquire knowledge and competent personnel at this level, it will result in just another administrative barrier. It has been the experience of our Community Mental Health Center Program.
that the review process at the state and regional level has produced mostly a bureaucratic maze which has functioned as an obstacle to program achievement rather than as a facilitating entity. For example, to hire an individual for our Community Mental Health Program requires clearance from Temple University authorities, the county government, the state, a representative of the state for our region, the regional office of NIMH, and the Washington office of the National Institute of Mental Health. Most of these agencies have different regulations, different salary requirements, and usually they do not communicate with each other.

The Economic Opportunity Act of 1964 also "established in the Executive Office of the President, the Economic Opportunity Council . . . which (is) composed of the Director (of OEO) and the heads of such Federal departments and agencies, such Presidential Assistants and such other officials of the Federal government as the President may from time to time designate."

It is the "responsibility of the Council to assist the President in:

"1. providing for the coordination of Federal programs and activities related to (the Economic Opportunity Act);"

"2. developing basic policies and setting priorities with respect to such programs and activities;"

"3. resolving differences arising among Federal departments and agencies with respect to such programs and activities;"

"4. initiating and arranging for the carrying out of specific actions or projects designed to achieve the objectives of (the Economic Opportunity Act)."

Unfortunately, we are not aware of any actions which have been taken by this council. In May, 1967, the secretary of Health, Education, and Welfare and the director of OEO issued a statement on joint funding of health services to all heads of the two operating agencies. They stated in their covering memorandum that "one of the most important tasks we have in our continuing efforts to improve access to medical services is the responsibility for efficient and economical management of funds and other resources. This calls upon us to do our utmost in cooperation with other agencies to plan and coordinate and eliminate duplication." Their joint statement expressly indicated that "it is the policy of both the Department of Health, Education, and Welfare, and the Office of Economic Opportunity to encourage the delivery of comprehensive and continuing health services. While there may be multiple and varied sources of support for the provision of health services (they said), efforts should be made to coordinate public funding in such a way that when the services get to the people they are meant to reach, they are as comprehensive and as unfragmented as possible."

This document calls for federal agency assistance to states and local communities to enter into coordinated funding arrangements, provides for reimbursement to OEO Neighborhood Health Center Programs and Head Start Programs from such other federal programs as the Medical Assistance Program, the Medical Care for the Aged Program, and such other federally assisted vendor payment programs. The joint statement also provides for the physical and operational integration of categorical grant program, such as the Maternal and Infant Care Program, the Comprehensive Medical Care Program for Children of School and Preschool Age, Community Mental Health Centers, and so forth. Finally, the joint statement provides for cooperative arrangements between the federal, state, and local agencies whereby Neighborhood Health Centers will receive assistance from the formula grant programs which are now included in the Public Health Service Act.

Although a step in the right direction, we believe this is an attempt to
achieve coordinated and comprehensive personal health services the hard way. No one federal agency was designated responsible for the implementation of this policy. Our experience has indicated that different federal agencies at the operating level do not communicate with one another. No federal representative has been beating on our doors, suggesting that we coordinate and integrate federally assisted personal health service programs. What little has been accomplished at Temple has been the result of local initiative. Currently, some persons in our institution are resisting for the Mental Health Program the type of consumer participation legislated for in the OEO Health Center Program and this may possibly destroy the Mental Health Program.

Finally, in terms of existing authorizations to coordinate and integrate local health services, on April 22, 1969, the President of the United States issued an Executive Order on administration of jointly funded projects (Exec. Ord. 34 F.R. 6727 [1969]). This order allows the director of the Bureau of the Budget to select one agency to administer projects which are funded by a number of federal agencies. It applies to Neighborhood Health Service Programs funded under the Economic Opportunity Act of 1964, and, by implication, to all other associated programs.

Under the order, the agency that has been designated can waive grant or contract requirements of other individual participating agencies, if those requirements are in conflict with those of the designated agency. The aim of the order is to bring about more efficient management of multiagency projects by designating the grant and contract requirements of one of the participating agencies as the grant and contract requirements of the project. The agency which has been designated will also have charge of financial administration of the project.

It can readily be seen that if this Executive Order is implemented, it will result in simplified grant application procedures, unify reporting requirements, unify patient eligibility requirements, and otherwise facilitate the delivery of comprehensive health care. It appears at this writing that no steps are being taken at the federal level to implement this order. It has been reported to us that it is under study and that a number of legal barriers may exist which may preclude implementation.

We have concluded that the most effective and efficient means of achieving comprehensive personal health services is through the elimination of all federally assisted categorical personal health service programs; thereafter, pooling all personal health service resources under one administrative agency and ultimately translating those resources, with supplementation if necessary, into a federally assisted health assurance program. As practical administrators, we realize that this goal will be achieved only after the passage of many years.

For the immediate term, we recommend that providers of personal health services call upon the appropriate federal officials, principally the secretary of Health, Education, and Welfare and the director of the Office of Economic Opportunity. They should be urged to take immediate and affirmative actions necessary to the effective implementation of the decisions of Congress and the President of the United States as pertain to joint funding and coordination of personal health services.

One final thought has to do with health manpower. Although insufficient in terms of the need, each year of the 1960s has seen increasing federal support for comprehensive personal health service programs and community health centers. These centers are being asked to train and develop new types of health workers and to retrain professionals who have been educated and trained in tra-
dional methods and settings in order for them to be effective in a community-based setting. At the same time, hardly any steps are being taken to change the basic educational system to prepare students of health for group practices, participant decision-making, comprehensive care, and so forth.

Health centers cannot do this job alone. The basic health education system must anticipate new delivery systems and must prepare their students to ultimately participate in that system. The traditional health education institutions must begin to develop a body of knowledge about health practice. We know of no way of doing this, except by applied research, direct involvement in community-based health facilities, by the development of new health curricula, and by the admission of new health careerists such as family health workers, mental health assistants, and other auxiliary manpower.

We do not believe that this will come about, unless adequate federal support and incentives are provided to our health educational institutions. Therefore, we recommend that, as federal dollars are expended for comprehensive personal health service and Community Health Centers, proportionate amounts be made available to those educational institutions that affiliate themselves with Neighborhood Health Centers and that take effective steps toward educating and training manpower that will be equipped to function in such centers.

Those of us who are working directly in urban communities with residents of those communities toward the goals of better health and improved economic status, believe there is still time to develop an effective and yet efficient system of health care in this nation. This can be done with minimal change in our way of doing things. It is urgent that we begin now.

Dr. Gardner is Director, Community Mental Health Center Program, and Mr. Snipe is Assistant Project Director, Comprehensive Health Services Program, Temple University, Philadelphia, Pa. 19140.

This paper was presented before a Joint Session of the Mental Health and Medical Care Sections of the American Public Health Association at the Ninety-Seventh Annual Meeting in Philadelphia, Pa., November 11, 1969.