Securing Health in Our Urban Future

A Report to the Surgeon General
Public Health Service
by his
Advisory Committee on Urban Health Affairs

U.S. Department of Health, Education, and Welfare
PUBLIC HEALTH SERVICE

Foreword

For nearly all of us in the United States, and for a rapidly increasing proportion of people everywhere, urbanization is a dominant social and cultural force of our time. No matter where we live, the city conditions our lives. Our resources are used to feed and clothe the city and to stoke its fires. Communications emanating from the city shape our philosophy and mores and alter the language we use in talking about them. So pervasive is the influence of the city that we hardly recognize it in our daily lives. We accept it unquestioningly.

Yet urbanization is raising questions which need urgently to be answered. Many of these questions relate to the health of the people who are affected directly or indirectly by the urban environment. What benefits in human well-being result from urbanization? What are the costs in human suffering? What can society do to maximize these benefits and minimize these costs?

Public health leadership in the past achieved considerable success in dealing with those urban health problems which came within the narrow boundaries of its accepted responsibility. Contagion was reduced. Milk and water-borne disease was brought under reasonable control. Certain hazards to the worker and to the consumer were eliminated or controlled.

But variations of these old problems remain to plague us. And there is emerging an overdue acceptance of broader responsibility for health leadership—a responsibility to the public and to every person and family for the promotion of good health and the prevention of illness and injury regardless of its nature or cause. Public health leadership has a clear and continuing responsibility to mobilize effective action for health across the entire range of human activity.

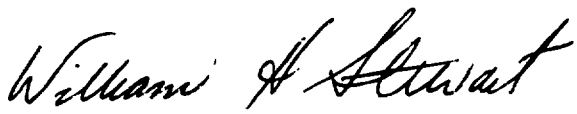
Recognizing this broader mission and the critical importance of urbanization in relation to it, my predecessor, Surgeon General Luther L. Terry, sought the advice of a group of outstanding individuals with wide and varied experience as elected officials, scientists, health administrators and practitioners, and private citizens. This Advisory Committee on Urban Health Affairs presented its report to me in December 1965.

In today's world of tightly interlocking problems, virtually every agency's mission has relevance to health. I believe that this document can profitably be studied and interpreted by officials of governmental and nongovernmental agencies in many fields. For me, as a Federal health administrator, the report highlights the need to evaluate our targets and objectives. We need to understand the effects of all our efforts on urban populations, institutions, activities, and settings. And we need to judge those effects in relation to the national health goals and objectives recommended in the report.

I accept and endorse this report. I am committed in principle to the implementation of its recommendations. I realize this accomplishment will take time, new and regrouped resources, and new ways of thinking about the city and about health. New practices and procedures should be the fruit of this thinking and discussion.

Above all, I commend it to my colleagues, counterparts and successors in agencies whose missions relate to health, as a significant formulation of a kind of field theory in urban health affairs. From the searching questions it asks, the problems it identifies, and the broad principles it proposes should come a continuing development and refinement of national health policy related to the conditions of urban living. If we are to achieve health in our urban future, such continuity of policy is essential. Moreover, the report makes it clear that health policy, to be effective, must develop in the context of the political and administrative processes by which decisions are made in our society.

This report is not intended as the ultimate statement on urban health affairs. It represents a beginning. As the actions it recommends are put into practice, and as these in turn lead to other desirable actions, we can help to make urbanization a strong force for better health.



WILLIAM H. STEWART, M.D.
Surgeon General
Public Health Service.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
WASHINGTON, D.C. 20201

REFER TO:

December 3, 1965

MEMORANDUM OF TRANSMITTAL

To: Surgeon General, Public Health Service
From: Your Advisory Committee on Urban Health Affairs
Subject: Attached report.

On September 19, 1962, Surgeon General Luther L. Terry established this Committee to assist him in formulating "a positive statement of policy defining Public Health Service relationships to health programing in urban areas." Dr. Terry called on us to consult with him about diagnosis and methods of treatment of our society's urban health conditions. Now, with this report, we summarize what, in our opinion, should be prescribed for those conditions.

This document has been distilled and abstracted from the records of many hours of discussion within the Committee. It is general, especially in its statement of two national health goals. To attain these goals requires the prior achievement of our three national health objectives, through development and modification of specific operating policies, procedures, programs, and administrative mechanisms. All of our recommendations will have to be translated into other language with justifications appropriate for different professional, administrative, and other public audiences. And the implementation of this document will necessitate large efforts in training and in orienting management at every level.

We realize that systematically implementing this report within the near future is a large task, calling for new approaches and new resources. However, even though some of our recommendations are stated in terms of long-range efforts, we wish to emphasize the urgent need for coherently purposeful actions on a broad front now. We feel keenly the need to develop as soon as possible, within the whole health function of our society, a greater sense of responsibility and commitment to the future of all of the people.

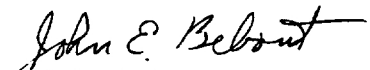
For the performance of these roles as diagnostician, convener of teams of specialists, and leader of a national effort to secure health in America's urban future, the Nation looks to you. In the Public Health Service you have the necessary instrument. In the public you have the resources.

We all have the challenge.

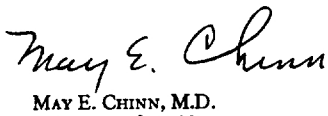
Respectfully submitted,

M. Allen Pond

M. ALLEN POND, *Chairman*

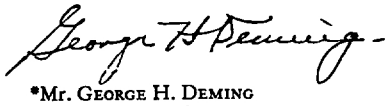


Mr. JOHN E. BEBOUT
Director, Urban Studies Center
State University, N.J.

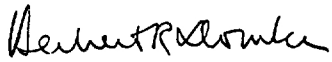


MAY E. CHINN, M.D.
New York, N.Y.

*Mr. EDWARD CONNOR
President Pro Tem
Common Council
Detroit, Mich.



*Mr. GEORGE H. DEMING
Director, Conference on
Metropolitan Area Problems
State University, N.Y.

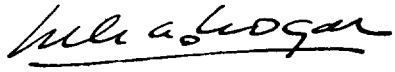


*HERBERT DOMKE, M.D.
Director, Allegheny
County Health Department
Pittsburgh, Pa.

ALFRED L. FRECHETTE, M.D.
Commissioner of Public Health
Commonwealth of Massachusetts

PHILIP M. HAUSER, Ph. D.
Professor of Sociology
University of Chicago

Hon. OTTO KERNER
Governor of Illinois



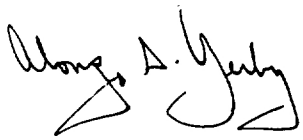
Mr. JOHN A. LOGAN
President, Rose
Polytechnic Institute

Mr. EDWIN G. MICHAELIAN
County Executive
Westchester County, N.Y.

Hon. ARTHUR E. NAFTALIN
Mayor of Minneapolis

RUSSELL A. NELSON, M.D.
President, Johns Hopkins Hospital

*ROBERT C. WOOD, Ph. D.
Professor of Political Science
Massachusetts Institute of Technology



*ALONZO S. YERBY, M.D.
Executive Director,
Medical Care Services
New York City Department of Health

*PAUL N. YLVISAKER, Ph. D.
Director, Public Affairs Program
Ford Foundation

STAFF

*RICHARD A. PRINDLE, M.D., *Chief, Division of Public Health Methods*
*WILLIAM McC. HISCOCK, *Chief, Liaison Services Branch*
JAMES F. KING, Jr., *Public Health Analyst*

*Individual whose title has changed since the period of the Committee's work.

A Report to the Surgeon General By His Advisory Committee on Urban Health Affairs

I. PHILOSOPHY AND PURPOSE

Over a 3-year period, the Surgeon General's Advisory Committee on Urban Health Affairs has reviewed programs and activities of the Public Health Service which affect the health of the people of the United States and urban dwellers in particular. We have looked at the broad picture of programs in personal and community services aimed at: maintaining and improving physical and mental health, pollution control, and environmental engineering for healthful living. In the light of our individual knowledge and interests, we believe this review has given us enough insight into national health problems and into the programs and the thinking of the Service to allow us as a committee to arrive at some conclusions.

We have been impressed by the number and variety of programs within the Public Health Service which relate to urbanization as such and which affect people in the urban milieu. As individuals concerned with the urban community, we have been impressed by the Service's recognition of the significance of urbanization, as demonstrated by the appointment of this Committee to assist the Surgeon General in defining a policy framework for attacking the health problems presented by urbanization.

At the same time, we have found ourselves becoming increasingly distressed about the failure of health programs to make the total impact needed to meet present and foreseeable crises in our urban communities. Major disease problems found throughout this Nation are often increased and made more severe within the urban setting. And, in our opinion, new health problems will emerge from the process of urbanization, requiring new solutions and new programs.

We have been made acutely conscious of the lack of comprehensiveness and integration of health programs. In this regard, we have become very aware of

the health implications of programs outside of the Public Health Service. We believe that this lack may have contributed to illness, disability, and death which might have been prevented. We feel that this situation is the result of a failure of leadership to keep up with rapidly changing social, economic, and physical conditions in urban areas. And we suggest that leadership has fallen behind public readiness for action. What is needed now is a new and stronger impetus to develop appropriate organizational structures, to impress political and civic leaders with health needs, and to introduce health interests into all community programs.

In our opinion, leadership is not enforcement, coercion, or fiat. Nor is it necessarily constituted in authority, power, or control. It is a matter of initiating and maintaining communications; concentrating on problems of people; involving the entire community in participation; creating consensus and commitment to action; and modifying program organization and procedures as needed. Initiative in leadership is not the exclusive prerogative of any one person or agency. It is the responsibility of every element of our society to take the initiative in dealing with the problems it can identify. And every member of our society should participate in community development. Thus leadership is each one doing the best he can for the general health and welfare of the community. Different leadership roles will be determined by differences in knowledge, skill, and resources for dealing with various parts of problems. But there is a leadership role for everyone in national action for healthful human development in our urban future.

We believe that the Surgeon General of the Public Health Service must be the health officer of all the people with an active concern for all health services by whomever provided. *We therefore recommend that the Public Health Service adopt and implement the philosophy that public health is vitally concerned with the health and well-being of the entire population. Public health should be concerned with all aspects of the health of the public, including the problems of medical and psychiatric care, the problems of organization and economics related to hospitalization and health services, the problems relating to total health manpower, the problems of total environmental engineering, and all events which impinge on or otherwise affect human health. This philosophy should stand in sharp contrast to traditional concepts of limited public health practice.*

Historically, public health has been concerned with certain discrete circumscribed areas of the total health picture. These areas have included environmental sanitation, communicable disease control, maternal and child health services, particular laboratory and related services, and special programs for carefully specified "beneficiaries." We think that in the complex and difficult contemporary environment in urban and metropolitan areas, this limited scope is especially inadequate.

We do not intend to convey the impression that we advocate centralized control of all health activities; quite the contrary! Organizations and individuals operating in the private sector of health services must remain free to make their essential contribution to the health of the Nation. We do advocate that public

health authorities at all levels of government be concerned with all health aspects of urban living. In concerted action with other appropriate interests, they should utilize their knowledge and their offices to assure that effective systems of personal and environmental health services, including public and private components, are established and maintained.

In the next section, we recommend two long-range national health goals and three long-range national health objectives.[1] These goals and objectives are interrelated as parts of an ends-means continuum of action toward a national purpose which is difficult to put in a single formula. One brief version of this purpose might read: To provide opportunities for every individual in the United States to develop his maximum potential in achievement and fulfillment. Derived from this would be the national *health* purpose of promoting the best level of physical and mental health attainable for every person at all stages of life, and an environment which contributes positively to healthful individual and family living.

In any case, we believe that the following goals and objectives are conditions *sine qua non* for health. Without an effective *system* of comprehensive personal health services, the maintenance and improvement of the individual's health are impossible. Without effective *engineering* of his total environment, the healthy growth of the individual and the prevention of health problems are impossible. Until there is effective planning and evaluation, such services and engineering will be impossible. Without effective community participation, planning and evaluation will be fruitless. And unless community studies are integrated, the services and engineering will be ineffective.

Obviously, these goals and objectives entail many kinds of actions. In following sections of this report, we have recommended some immediate ones by the Surgeon General and a first interpretation of the meaning of the goals and objectives in terms of intermediate-range actions.

II. NATIONAL HEALTH GOALS AND OBJECTIVES

We recommend as a long-range national health goal the establishment of comprehensive personal and community health service systems encompassing the entire populations in the urban and metropolitan areas of this country. Such systems should be: (a) focused and integrated in terms of their impact on the individual person; and (b) linked up with other community services having implications for health, including education, welfare, employment, recreation, and corrections. Provisions should be made for the effective delivery of these services and their coordination with other community programs as urban areas develop and urban populations increase.

[1] The distinction we are using is: "goals" refer to ultimate ends desired while "objectives" refer to the broad approaches to be used to attain the goals. "Actions" refer to things to be done to realize the goals and objectives.

We affirm that every person and family should have uninhibited access to highest quality comprehensive personal health services. We believe that personal health services, including private medical care, should constitute basic systems of action to meet health needs which are especially acute in large urban and metropolitan areas. The time has passed when action to provide such services could be carried out by compartmentalized institutions and isolated units. Now it is necessary for the various public and private components providing personal health services to come together to assure effective delivery of all health services needed by each individual.

However, beyond coordination to provide continuity among the elements of comprehensive personal health services, increased access to such services through the operations of other community agencies is needed. Thus persons should enter the comprehensive personal health services system because the police, schoolteachers, social workers, employment agencies, family counselors, and other community services have recognized that such individuals may need medical care, psychiatric care, preventive services, health education, or rehabilitative services.

We recommend as a long-range national health goal the engineering[2] *of the total urban environment—material, social, and cultural—for healthful human development. Health concerns should permeate the development of the total environment as it affects and is affected by concerns for open space, comfort, convenience, employment, production, recreation, education, and aesthetics.*

We believe that water supply and waste disposal facilities, the transportation network, and housing patterns constitute major determinants of the overall patterns of growth and development in urban and metropolitan areas. In our opinion, the potentialities for positive improvement of the healthfulness of the overall physical environment—water, air, and land—are not being realized in these areas. The design and engineering of these determinants must be aimed at meeting the needs of future populations, at cleansing, protecting, and conserving our natural resources, and at introducing health concerns into all community activities. Until such design and engineering are done effectively, we predict the continuation and worsening of: under-utilization of some public facilities and crowding of others; pollution crises; economically depressed areas; urban sprawl; and ugliness.

We affirm that actions to develop the various aspects of the physical environment must give heed to the social and cultural dimensions of the environment and its total impact on the health and well-being of people as whole persons, members of families, and participants in the community. All dimensions of the urban environment are interdependent, and all determinants of its patterns of growth are intertwined. Of paramount importance, then, is the development of community organization which will assure appropriate action to provide, coordinate, and functionally integrate programs and services within and among these basic dimensions. Successful solution of the health and health-related

[2] In many cases, appropriate environmental engineering will be that which conserves, rather than creates, positive attributes of the environment. This is especially true in respect to the material environment. Conservation and protection of natural resources of water, air, and land are essential parts of this goal.

problems of one area of environmental development will require mutually reinforcing solutions to problems in other areas.

We recommend as a long-range national health objective the development of long-range planning and evaluation for the attainment of health goals and objectives set by the politically responsible leadership in each urban area in the light of local needs. These needs should be defined in relation to national criteria by all levels of government working together with a systems approach.

Although we had long been aware of health program and service inadequacies, in some urban communities, only in our work for the Service over the past 3 years have we come to a full realization of their degree and extent. Information presented to us by Service staff demonstrated glaring inadequacies throughout the existing health action systems. These ranged from totally inadequate plans and programs for the disposal of solid wastes, through the inability to define the extent and seriousness of physical, and especially mental, health needs, to the incapacity to provide services to those most in need—the urban poor.

Effective use of the opportunities and resources for the actions needed to solve such problems requires catalytic community leadership and coordinated planning and evaluation in a national health effort. In addition to the need for continuing biomedical research, we believe that there is a pressing need for sustained research to design, test, and evaluate the employment of new organizational systems to provide the necessary health and health-related services. We feel that official health agencies must provide the primary leadership in planning and evaluative research on systems for maintaining and improving the health of the public.

We recommend as a long-range national health objective the development of the widest community participation in planning and evaluation for health. This should be effected by those who, as a result of demonstrated leadership, can obtain consensus and commitment by the public in community action for health.

The individual and community concern for health as a basic human need provides both an opportunity and an obligation to health leaders. We believe that they can provide the motivation for involvement and participation, and the catalytic leadership for commitment, of the person and community in concerted action for health.

We wish to emphasize our concern over the need for health leaders to exert themselves in assuring that health programs, services, and aims are integrated with all the activities in urban and metropolitan communities. This will require that they effectively include the general public in coordinating all phases and types of planning and action for health: with planning and action for transportation, housing, education, employment, and recreation; and with planning of the overall social, economic, and physical development of each urban and metropolitan area. Such coordination should proceed at all levels of public health activities, but it is especially needed in the activities of the Public Health Service Regional Offices. In our opinion, failures to achieve such community participation and program coordination are most likely to result from failures to sustain attempts to communicate.

In this regard, we note with satisfaction the increasing concern with health in the economic opportunity programs. We recognize that these programs cannot be the means of solving all health problems of urban and metropolitan areas. Nor, conversely, can urban health programs alone solve the problems of poverty. But we do feel strongly that failure of official health agencies, at any level of government, to use these vehicles to launch comprehensive programs at the community level would be to ignore a great opportunity for advancing health interests and limit the chances of long-range success of the economic opportunity programs.

We recommend as a long-range national health objective that urban community health studies be integrated—each with other health studies and with other kinds of community studies—so that they are all coordinated in their descriptions of and conclusions about: persons, families, and population groups; and environmental problems in specific geographic areas.

We believe that there is an urgent need for urban and metropolitan areawide studies of health and health-related problems. We affirm that the integration of such studies with each other and with other community studies is needed to provide the baselines for the necessary planning and evaluation of all kinds of programs and projects in terms of their overall impact on people.

In our opinion, urbanization means change and complexity in the total environment of each person and the interdependence of his well-being with that of everyone else in the community. These conditions result from interrelationships which characterize each urban and metropolitan community as an open and unique system developing in a national context. Piecemeal unidimensional studies which ignore this structure of social and economic relations existing among all of the people residing in the community and tying their fortunes to other populations and areas of the country will continue to be self-defeating. And to the extent that such studies are used to justify initiating unilateral action or postponing concerted action, they will, in our opinion, be detrimental to the health of the people.

III. FOR IMMEDIATE ACTION

The broad national health goals and objectives outlined in the previous section will not be achieved overnight. They are conceived as directions for an evolving national health policy. Actions designed to achieve them will not be accomplished quickly. In order to make them possible to undertake, we recommend the following items for immediate priority implementation. Together, they will facilitate the broader intermediate-range actions we recommend in the last section of this document.

If the Surgeon General accepts our recommendations on goals and objectives, we further recommend:

(a) That he recommend these national health goals and objectives to other health and health-related agencies.

(b) That he make strong public statements developed and expanded from the material in this report and from the record of our discussions over the past 3 years.

(c) That he accept as his responsibility the vigorous representation of health interests in urban programs wherever they may be found within the Federal Government.

(d) That he positively search out flexible means of interagency collaboration beyond token liaison, exploring with such agencies as the Advisory Commission on Intergovernmental Relations new techniques and devices that could be used to coordinate the actions of all relevant agencies in respect to health and health-related problems.

(e) That he prepare the Service for increasing interagency collaboration and action, extending to the redefinition of agency missions, in moving more effectively and more rapidly on a variety of fronts to improve our urban communities.

(f) That he attempt to introduce flexibility into the categorical structure of formula grants to the States so that Public Health Service support can be used to meet the changing needs of each particular community according to priorities set by its politically responsible leadership.

(g) That he act to insure the continuation of studies of total Public Health Service impact on particular population groups, institutions, and geographic areas.

(h) That he organize the Public Health Service to improve the integration and continuity of the process of discovery, development, and full application of knowledge related to health. The test of improvement in this process would be how quickly and completely the results of biomedical, behavioral, epidemiological, social, and engineering research in the laboratories and the communities are brought to bear on the health and health-related problems of each individual and our urban society as a whole.

(i) That he act to insure that our considerations of planning permeate the entire Public Health Service.

(j) That he significantly strengthen long-range comprehensive policy planning in the Office of the Surgeon General, seeking new resources to allow assignment of personnel for this purpose to other Federal agencies and to the States and localities.

(k) That he seek new legislation and new appropriations as necessary to achieve the goals and objectives we have recommended.

This Committee does not recommend its own continuance at this time. Rather, it believes that review, study, and appropriate action on the numerous recommendations, advices, and comments which are part of the legacy remaining from its 3 years of work will provide better insight into the Service's further needs. Such insight will then determine whether the Service should establish separate committees to work in the various areas of our concern, or rely on *ad hoc* or consultant groups.[3] In many cases, staff review will suffice. Since we

[3] We suggest that any such *ad hoc* or consultant group include an advisor on interstate and intercounty law, who can advise on ways conflicts in border line laws can be resolved to facilitate the acceptance of new health recommendations.

understand that our deliberations have already had beneficial effects on Service policy in several areas, we suggest that a committee like this be reconstituted at regular intervals in future years, to help the Service examine itself from an external point of view.

IV. A FIRST INTERPRETATION

All of the national health goals and objectives are interrelated, and they are related to public responsibilities on other fronts. We believe that progress toward these goals and objectives will require that official health agencies, and the Public Health Service especially, take the initiative in leadership roles in national attacks on other problems arising from phenomena outlined in the *Message from the President of the United States Relative to the Problems and Future of the Central City and its Suburbs* (Mar. 2, 1965, 89th Cong., 1st sess., H. Doc. 99). Therefore, we urge the Surgeon General to focus the activities and use the resources of the Public Health Service to move toward these goals and objectives in a variety of ways.

As a first interpretation, by the Committee itself, of the implications of the goals and objectives, we recommend the following intermediate-range actions by the Public Health Service.

In order ultimately to achieve the national health goal of establishing comprehensive personal and community health service systems, encompassing the entire populations in the urban and metropolitan areas of this county, focused and integrated in terms of their impact on the individual person, and linked up with other community services having implications for health, *we recommend that the Public Health Service:*

(a) In collaboration with the States, provide leadership and assistance to urban and metropolitan communities in mobilizing available resources toward this end.

(b) Encourage and assist health officials and departments at all levels of government to accept the responsibilities for leadership in providing for all health aspects of such systems.

(c) Encourage and assist health officials at all levels of government in persuading their chief executives to convene regularly all of the departments they administer to evaluate program policies and procedures in terms of requirements for coordination with efforts to establish and maintain complete accessibility of such systems to all persons in need.

(d) Review the specific implications of the operations of other Federal agencies for community action to establish and maintain such systems. The Service should give special attention to needs for continuing liaison, coordination, and collaboration with the Welfare Administration, the Vocational Rehabilitation Administration, the Food and Drug Administration, the Department of Housing and Urban Development, and the Veterans Administration.

(e) In cooperation with other Federal agencies, develop criteria and procedures for the review of applications for award, and plans for expenditure, of Federal funds by State and local governments and private organizations. The purpose of these criteria and procedures should be to package projects, including technical assistance, so as to coordinate the impacts of Federal agency actions on such systems to insure that the services are completely accessible and of the highest quality obtainable.

(f) Welcome and encourage the formation and operation of high-level coordinating mechanisms within the executive branch for the purpose of integrating and focusing Federal agency support of such systems.

In order ultimately to achieve the national health goal of engineering the total urban environment—material, social, and cultural—for healthful human development, *we recommend that the Public Health Service:*

(a) In collaboration with the States, provide leadership and assistance to urban and metropolitan communities in mobilizing available resources for such engineering.

(b) Encourage and assist health officials and departments at all levels of government to accept the responsibilities for leadership in such engineering.

(c) Encourage and assist health officials at all levels of government in persuading their chief executives to convene regularly all of the departments which they administer to evaluate program policies and procedures in terms of health requirements for such engineering.

(d) Review the specific implications of the operations of other Federal agencies for community action in such engineering.

(e) In cooperation with other Federal agencies, develop criteria and procedures for the review of applications for award, and plans for expenditures, of Federal funds by State and local governments and by private organizations. The purpose of these criteria and procedures should be to package projects, including technical assistance, so as to coordinate the impacts of Federal agency actions on efforts at such engineering. The Service should give special attention to the needs for review of all construction project applications by State, regional, and local planning agencies.

(f) Provide leadership and assistance to urban and metropolitan communities in developing total waste management systems which will solve the major part of the problems of cleansing, protecting, and conserving our water, air, and land resources.

In order to achieve the national health objective of long-range planning and evaluation for the attainment of urban health goals and objectives set by the politically responsible leadership in each local area in the light of local needs defined, in relation to national criteria, by all levels of government working together with a systems approach, *we recommend that the Pubic Health Service:*

(a) Develop national schedules of quality criteria for: (1) the various components of comprehensive personal and community health services; and (2) the material, social, and cultural conditions of the environment. These criteria

should be defined in terms of the best knowledge of the effects of such services and conditions on health.

(b) Develop health problem profiles as aids to decision-making by politically responsible public administrators at all levels of government. These should be complete communitywide analyses of particular categorical problems, such as the "tuberculosis problem," the "child health supervision problem," or the "air pollution problem." These profiles should relate estimated action costs in terms of time, manpower, and money to health status changes, health condition changes, or other health outcomes.

(c) Develop Servicewide descriptions of all Service activities impinging on all population groups and institutions in every geographic area in the country as an aid to administrators at all levels of government.

(d) Seek increased manpower and financial resources to support the health planning and evaluation activities of State and local governments.

(e) Work with other Federal agencies, the States, and local communities to coordinate or integrate existing interstate, State, and local regional mechanisms, special districts, and single-function governments to simplify planning and evaluating coordinated urban areawide action for health.

(f) Support the development of new urban and metropolitan areawide and regional intelligence and planning mechanisms of a multifunctional nature to strengthen the ability of the State and local governments, and especially their chief executives, to take concerted action toward the solution of urban health and health-related problems.

In order to achieve the national health objective of developing the widest community participation in planning and evaluation for health, *we recommend that the Public Health Service:*

(a) Seek more manpower and financial resources for support of: (1) community development activities in general; (2) involvement of public and private agencies in community action; (3) design and implementation of health programs as integral parts of action programs for community development; and (4) introduction of health concerns into all phases of community planning.

(b) Work with other Federal agencies, the States, and local communities to coordinate or integrate interstate, State, and local regional mechanisms, special districts, and single-function governments in order to increase the ease with which the public can participate effectively in planning and evaluation of coordinated urban areawide action for health.

(c) Support the development of new urban and metropolitan areawide and regional mechanisms of a multifunctional nature which will increase community participation in planning and evaluation by State and local governments of action toward the solution of urban health and health-related problems.

(d) Provide leadership and assistance to health programs developing as significant components of community action programs of the Office of Economic Opportunity.

In order to achieve the national health objective of integrating urban community health studies with each other and with other kinds of urban community

studies so that they all are coordinated in their descriptions of and conclusions about: persons, families, and population groups; and environmental problems in specific geographic areas, *we recommend that the Public Health Service:*

(a) In cooperation with other Federal agencies, encourage and assist the integration of health problem profiles with other urban community studies through its support to States and localities and to the private sector.

(b) Develop coordinated longitudinal health base studies, i.e., areawide samples of standardized case studies, including personal histories. These studies would describe the development over time of the physical and mental health problems of persons considered as wholes. The studies would provide a basis for evaluating the directions of overall urban community development. They would also permit analysis of the health of people and communities at particular times despite on-going environmental changes and the great mobility of the population. They would thereby contribute to the development of the health problem profiles.

(c) Facilitate the conduct of such health base studies and the coordination of the health problem profiles by developing a comprehensive national system of linked vital and health records. This is now feasible with the computer, which would permit the centralization of such records while protecting the confidentiality of the information contained in them. Centralized medical records for each individual person would lead to improvements in the quality of patient care since the records would be available to the physician whenever and wherever he might treat the patient.

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