grants, and we can begin to develop the information systems which will be vital in evaluating the effectiveness of funded activities.

We have a tremendous task to do in our new partnership. To do it well, we must not only strengthen patterns of collaboration between established health resources in each community, but we must extend and include in this creative partnership practicing physicians, academic medicine, general government, Federal, State, and local agencies with health and related missions, and above all, the people we serve.

Most important, we must accept the consideration that this new partnership, if successful, will introduce on the American scene a constant feeling of dissatisfaction on the part of the whole health field and the public with the state of health in this country.

Role of Regional Offices

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Regional health directors are acutely aware of the responsibilities placed on regional offices by the Surgeon General for the implementation of P.L. 89–749. We are engaged in discussions of the reorganization of the regional office functions necessary to discharge the new responsibilities effectively and efficiently. Our discussions, and the decisions to be made by the Surgeon General and his Office of Comprehensive Health Planning and Development, concern:

1. The establishment, composition, and functions of Regional Office Review and Advisory Committees to advise the regional health director on grants to be made under section 314 (a), (b), (c), (d), and (e) of the act.

2. The use of Public Health Service employees in regional offices, States, and metropolitan areas as comprehensive health planning officers. Their roles include three primary areas: (*a*) assuring that all facilities and resources of the Public Health Service—perhaps ultimately all the Federal civilian health facilities and resources—make significant contributions to the comprehensive health plan of the State and area; (*b*) assisting with the formulation of State health plans to which the Service, within the national policy, rules, and regulations, can be responsive; and (*c*) serving as an effective communication channel between the State and the Surgeon General, identifying the health problems of national significance which must be assessed by the Surgeon General with respect to the need for additional legislation or appropriations or both.

3. The number and kind of representatives of Public Health Service bureaus and their programs that will be located in the regional offices as resource managers—managers of all Service resources that must be brought to bear on comprehensive health planning and program implementation, both State and areawide.

4. Identification of the roles of all the headquarters bureaus in support of regional implementation of section 314 of the act. The Surgeon General has mentioned the special responsibilities of the Bureau of Health Services in assisting regional health directors in the operating phase of the new program. Of equal importance is the Bureau of Disease Prevention and Environmental Control, which contains much of the Service's competence to judge the technical validity of project grant proposals for public health. The same can be said about the National Institute of Mental Health with regard to the many-faceted mental health programs of the country. The National Institutes of Health's regional medical programs have much to contribute to comprehensive health planning, and regional health directors will look to the new Bureau of Health Manpower for support in planning for health manpower.

With regard to formula grants, I can do no better than repeat a part of Deputy Surgeon General Leo J. Gehrig's testimony on Senate bill 3008, which was enacted into P.L. 89–749:

> S. 3008 embodies, therefore, a fundamental revision of the Federal health grant structure. Federal grant funds would be made available to States and through them to local communities, on a non-categorical basis for the provision of comprehensive public health services. States and communities would be able to use these funds to provide services which are focused on individuals and on families in their communities rather than on separate disease conditions. Through this flexible grant structure comprehensive public health services will be developed, expanded, and supported to maintain physical and mental health; to detect, pre-

vent, control, or reduce the impact of diseases, injuries, and disabilities; to maintain a healthful environment; and generally, to make available to all persons within the State a continuum of public health services based on the most up-to-date scientific knowledge and techniques.

The project-grant approach, which allows (*a*) the development of a concentrated direct effort for the control of a particular disease peculiar to a geographic area, (*b*) new and untried methods in disease control, and (*c*) the exploration of new methods in the delivery of health services, is well known.

What is new is that States are encouraged through Federal support to make their own comprehensive health plans, and, if a comprehensive health plan exists, both formula and project grants must be spent "in accordance with such plans." However, if the project is for developmental and training grants for new and improved methods, the law does not require that it be in accordance with the State's comprehensive health plan.

Perhaps not many plans will have been developed pursuant to section 314 (a) by fiscal year 1968, but it is the intent of the new legislation that both formula and project grants must be used to provide services in accordance with the State's comprehensive health planning decisions.

Drafts of policy guidelines, terms and conditions, and regulations are being developed by a Public Health Service committee, chaired by Dr. Paul Q. Peterson, deputy director of the Bureau of Health Services. As this committee completes its recommendations, they will go to the Office of Comprehensive Health Planning and Development to be reviewed by another Service-wide group, the Comprehensive Health Planning and Development Board. The legislation requires the Surgeon General to consult with the State health agencies affected by rules and regulations and, insofar as possible, to obtain agreement before rules and regulations regarding section 314 (a) and (d) are issued.

In summary, I think that the Public Health Service and State health and mental health authorities have never before been faced with such challenging opportunities to better the health of the nation's citizens. As a regional health director, I can state that the regional offices are ready, willing, and, with the support of all the Public Health Service bureaus, able to work toward the strengthening of the Federal-State partnership.

Regional Medical Programs

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In examining the nature, implications, and ramifications of any law, whether P.L. 89-749 or, as in the case of this discussion, P.L. 89-239, the Heart Disease, Cancer, and Stroke Amendments of 1965 which created the regional medical programs, my recommendation is the same. Rather than retreating to Salvador Dali's maxim that "a real happening is when no one knows what is happening," I recommend first seeking the meaning in the words of the act itself, the substance of the provisions.

Therefore, let us take a look at the purposes of P.L. 89-239 as set forth in section 900. The fundamental purpose of the act is set forth in the second paragraph: "(b) To afford to the medical profession and the medical institutions of the nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases. . . ."

The fundamental process for achieving this purpose is stated in section 900 (a), but it must be broken down into its elemental parts for complete understanding. The first dominant phrase is: "(a) Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals. . . ."

This phrase is then modified by two phrases dealing with the functional activities which are appropriate parts of the regional cooperative arrangements, and the categorical emphasis of these activities: ". . . for research and training (including continuing education) . . . for related demonstrations of patient care . . . in the fields of heart disease, cancer, stroke, and related diseases. . . ."

As indicated, the dominant functional mechanism—the sine qua non—is the establishment of the regional cooperative arrangement among the major health resources in a given region.