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

STEPHEN J. ACKERMAN—*chief, Planning and Evaluation, Division of Regional Medical Programs, Public Health Service*

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.

It is important to note in this regard that the term hospital is broadly defined in the act as any health facility in which local capability for improved diagnosis and treatment is involved. It is also clear from section 900(c) and from the makeup of the regional advisory group provided for in section 903 that wide participation of all concerned with health services in the area is contemplated.

The above distinctions are important in view of the attempts in some quarters to take an unrealistically narrow view of the scope of the program established under this law. (Those closely connected with the program invariably refer to it as the regional medical programs, or RMPs, while those outside the program tend to refer to its as the heart, cancer, and stroke program.) The distinctions are the basis for rejecting the view that the program attempts to organize health services along categorical lines, as well as the view that the program would be confined to purely continuing education purposes. Both the regulations and the administrative guidelines for the program have made it clear that unless there is a real regional cooperative arrangement and concert of the major health interests in the area, no individual project for continuing education or for categorical activity, no matter how meritorious, can be supported.

However, it is not words, either written or spoken in the guidelines, speeches, or meeting discussions, but the action that takes place that has real significance. Therefore, let us take a brief look at what has happened in regional medical program activity since the enactment of the law in October 1965.

Some 50 applications have been received for the support of planning efforts for the development of regional medical programs covering 70 percent of the population of the country. The 20 grants that have been awarded have averaged approximately $360,000 each. By the end of fiscal year 1967, it appears certain that total population coverage by way of planning efforts will be achieved.

The major types of activity which have been involved in the planning grants have included (*a*) the development of planning resources, (*b*) the development of a program of studies for accumulation of basic data concerning resources, needs, and wants in the area, (*c*) the development of an environment of cooperation through the establishment of communications, liaison, and interrelationships, and (*d*) the undertaking of some action trials.

Although grants may be made for planning alone, the purpose of the program is action related to accessibility of improved patient care, and awards may be made for operations on a phased basis concurrent with the planning activity. That is, the planning effort is viewed as being continuous throughout the life of the regional program, with operational components being added on a piecemeal basis, rather than as an effort to develop a comprehensive plan which will be followed by a comprehensive operational phase. The first requests for operational projects have already been received by three of the programs which have had planning activities underway for several months.

An index to the participation of the major health resources in the 20 regions for which applications have either been awarded or the 23 in the review process can be gathered from a breakdown of the types of representation on the regional advisory committees. Of the total aggregate membership for the 43 programs, 20 percent are practicing physicians, 20 percent medical center personnel, 12 percent hospital representatives, 13 percent voluntary health officials, 11 percent public officials, 9 percent representatives of other health organizations, and 12 percent public representatives.

Interestingly, in all of the 43 programs, the State health agency is involved, and in 41, it is the State health officer himself. In many others, the departments of welfare and education are involved.

There is much in the experience of the regional medical programs which should prove valuable in the development of the program provided for by P.L. 89–749. And, when it is put into effect, this new program and the regional medical programs must obviously complement one another, if only because the aim of both is the extension of the best health services to all the people.

As to the question of relationship, however, I do not think we can expect greatly simplified or concise answers. As U.S. Ambassador to NATO Harlan Cleveland said at the Associa-

tion for Public Administration meeting in April 1966, "In a complex situation, getting it simple means getting it wrong." Moreover, I commend to you three results of the scientific revolution cited by Dr. Don K. Price in the first chapter of his book "The Scientific Revolution":

> . . . 1) the public and private sectors are coming closer together; 2) the administration of public affairs has been made increasingly complex; and 3) the system of checks and balances in any given system has been upset and is in a process of reorientation.

I see clear and strong evidence of these results in the regional medical programs, and I daresay we will find them in connection with P.L. 89–749.

Areawide Planning Programs

KENNETH Z. BAUM—*chief, Areawide Planning Section, State Plans Branch, Division of Hospital and Medical Facilities, Public Health Service*

Since 1962, when the Public Health Service first made grants available to support areawide planning for hospitals and related health facilities, about $13 million in Federal and private funds have been expended to support planning activities.

Planning programs are now being carried on in about 70 areas, most in metropolitan centers.

Originally, many planning groups concentrated on restraining construction of small facilities, those with unnecessary capacity, and facilities of questionable sponsorship. Over a period of time, however, they have developed a broader and more positive approach.

All groups are now concerned with general hospital planning and many are working on problems of long-term care. Most groups have adopted certain procedures which have become more or less standard in the field. The best known of these techniques are the patient-origin survey and the encouragement of a planning committee at each facility.

Areawide planning programs have not been limited exclusively to facility planning. For example, in manpower some groups have conducted physician and nursing need surveys, developed recruitment and retraining programs, and worked closely with community colleges and schools of nursing to improve and increase the supply of trained personnel.

Areawide planning groups also have been active in the development of health care services. Many councils have been actively stimulating out-of-hospital care programs. They have also produced ambulatory care studies and studies of ambulance service, and in a number of instances have developed centralized patient referral services or directories.

Some other efforts which reflect the broad range of concern of areawide planning groups include activities relating to mental health, disaster planning, zoning, and even parking requirements.

Several planning groups are intimately involved with more than one Federal program. One group is receiving support from the Office of Education for manpower planning, and some agencies have received support for research or demonstration projects under the Hill-Burton and chronic disease programs. One organization is concerned with development of a new medical school, and many others advise on the construction of new beds for teaching hospitals. A number of groups are helping to develop regional medical programs for heart, cancer, stroke, and related diseases, or are represented on the advisory groups of such programs. In addition, several groups are developing specific competencies in mental health planning.

Obviously, with the passage of time the scope of areawide planning has become more and more comprehensive. While development of a broader outlook has taken several years and has certainly been uneven throughout the country, the important fact is that such an outlook exists and that planning which was once concerned primarily with general hospitals now covers, in many instances, the broad spectrum of facilities, manpower, and services.

We can draw an important lesson from this experience. Areawide planning programs have grown in scope not because legislation requires it, not because of regulations or pressure, but because people with operating responsibility for planning programs found that expansion of activity was a necessary and logical course of action.

Here is a program that has outgrown its some-