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

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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-

what limited initial focus. Here is a program that is still in the process of widening its horizons. Here is a program that has gradually become more comprehensive in terms of people covered, in terms of scope of work, and in terms of interagency cooperation.

I would expect that the comprehensive health planning program embodied in P.L. 89–749 will develop along similar lines, step by step rather than all at once. In the meantime there are many questions that need to be answered, such as: Who is a consumer? Where will we find the people to do the planning and to provide the services? How can priorities be set? How can the best use be made of existing skills and organizations? I suppose these questions will all be answered in time, but we need to start working on the answers now and we need all the help we can get.

Mental Health Services

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We in the mental health field are concerned that the previous experience in mental health planning—both comprehensive mental health planning and community mental health centers planning—will make an active and effective contribution to comprehensive health planning. We are also concerned that the expertise in the social and behavioral sciences which always have been closely associated with the mental health field will also be able to make its maximum contribution to comprehensive health planning.

In terms of our more immediate concerns in mental health, two statements of the Surgeon General are of special interest. First, he noted that the National Institute of Mental Health has deep roots in State and community planning, and later he discussed what experiences provide the "launching pad" for the kind of social action now required. He then cited three innovative experiments that form some base of experience: hospital planning, the new regional medical programs, and the community mental health effort. The third he described as "one of the most exciting and promising developments in health in our time."

It is the activity around one of these launching pads, the community mental health effort, which I shall describe briefly in order to suggest how it has prepared the groundwork for our new and expanded activity in comprehensive health planning.

Comprehensive mental health planning was initiated in 1963 and funded in 1964. Final reports of comprehensive planning were submitted by all the States and territories save one. This planning resulted in a number of particularly noteworthy achievements that have served to set the stage for the community mental health centers planning and can be a substantial asset in the new comprehensive health planning.

1. It mobilized active citizen participation that resulted in a broad public awareness of mental health problems and of the relationships between mental health problems and the broader approaches and problems of public health.
2. It provided an assessment of statewide resources in manpower, facilities, and services for mental health.
3. It identified critical mental health needs and mental health related needs.
4. Through special task forces it provided in-depth evaluations of special health problems, such as alcoholism, narcotics, and services for children.
5. It made general and specific recommendations about what kinds of legislation, organization changes, and financial patterns would improve the delivery and ultimate effectiveness of mental health services.

The comprehensive plan was the first-stage rocket for the later development of additional thrust through the community mental health centers planning. The centers planning also resulted in a number of accomplishments which can be briefly highlighted as foreshadowing the philosophy, procedure, and policy that have now been incorporated in the comprehensive health planning:

1. The centers program in many States provided a context for developing close working relationships between the health department and the mental health department, since the expertise for construction was often in the Hill-Burton agency of the health department, and