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of **REGIONAL
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PREFACE

The Fall 1968 Conference of Coordinators of Regional Medical Programs was called to provide an opportunity for all Program Coordinators to meet for a full discussion of the present and future course of Regional Medical Programs, with special emphasis on administrative problems and on relationships between the Division and the individual Regions.

The contents of this publication reflects the major concerns of Regional Medical Programs at this point in time. The two-day Conference brought these issues to the fore and presented opportunities for discussion of them.

We express our sincere appreciation to Dr. Marc J. Musser, Coordinator of the North Carolina Regional Medical Program and Member of the Steering Committee of Coordinators, for acting as spokesman for his colleagues during the meeting. By voicing their main concerns at the outset of the meeting and later re-stating and summarizing these and others which had emerged during the day and one-half Conference he gave the meeting a framework within which these papers have relevance.

October, 1968

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Director
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"REPORT FROM THE DIVISION"

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The office I now hold, Director of the Division of Regional Medical Programs, is one to which Dr. Robert Marston lent such great distinction as he guided the Division through its first formative years. Under his leadership, Regional Medical Programs received wide acceptance, and a functioning Program was launched in a remarkably short time. We in the Division of Regional Medical Programs, and you who carry major responsibility for the 54 programs now covering the country, are faced with the difficult task of managing an ever-increasing load of responsibility. We must guard, as Dr. Marston has done, against the emergence of bureaucratic rigidity. We must continue to foster, instead, the spirit of innovation and creativity.

Most Regional Medical Programs were faced with the difficulty, at the outset, of judging how best to approach the complex task of achieving voluntary, functional, regionalization. The Division of Regional Medical Programs and its National Advisory Council wisely resisted the temptation to establish a model which could be adopted by those Regions for their planning. The all-too-easy solutions offered by experts in systems analysis organizations were also rejected. Instead, leaders in each of the developing Regions began to cope with the unique relationships peculiar to their own area. Initial planning efforts were directed toward the creation of a climate of cooperation within which regionalization among traditionally independent, autonomous elements of our pluralistic health care system could proceed.

I am no more inclined to prescribe a national pattern or model for the Programs than those who have guided it so well in its beginning years. It is possible now, however, to describe some of the locally derived features that characterize those Programs which are meeting with success in achieving regional objectives. This is information which I believe will prove useful to all Regions, and will assist them to formulate better solutions to their own problems.

I should like to describe the elements that characterize successful Regions:

Success in this, as in every large-scale, practical endeavor, has been unequal and progress has been uneven. And while it is true that no single Region has as yet achieved full regionalization, some are clearly more advanced than others. The success of the more advanced Regions can, I believe, be attributed largely to several significant, common characteristics, specifically, leadership by the program coordinator, organized commitment of the health power structure, sound program concept and design, effective implementation of program, and evaluation of progress.

The first of these critically important attributes is strong, dynamic leadership. Progress in regionalization frequently comes through the leadership of a single individual, the Program Coordinator. This is not to say that leadership must be "singular." Clearly, a larger leadership element than that of the Program Coordinator or of any other single individual is required; but the ability of the Coordinator to mobilize the larger leadership within the Region is often determinative of its success. He exercises personal leadership to secure organized institutional

commitment, as well as individual support, for Regional Medical Programs, support which is essential if the Program is to wield the influence required to bring about significant change. I should like to comment on some of the observed actions of effective Coordinators.

Coordinators secure the confidence of leaders in the medical centers in their Regions, or practicing physicians and hospital administrators, and gain their understanding and support. They establish contacts with key health leaders of the Region to evoke from them a working commitment for Regional Medical Programs. They acquire information of the health characteristics of the Region, its resources, its problems, its politics and its style of getting things accomplished.

The successful Coordinator exhibits his leadership by attracting a competent and respected staff. He develops an organizational framework to perform the functions of administrative planning, implementation and evaluation. His core staff is diversified and includes physicians, nurses, hospital administrators, education and public information specialists, allied health personnel, experts in behavioral sciences, and others. Such professional diversity among the staff contributes to a rounded and balanced program. The Coordinator typically is full time. Undertakings of the magnitude of Regional Medical Programs do not flourish under part-time leadership.

A number of universities and medical centers have assisted in the recruitment of able Program Coordinator (and of other key staff members)

by offering academic and staff appointments. Such appointments facilitate access to the academic and clinical resources of the medical center and to the faculty.

Those institutions which have sponsored Regional Medical Programs are not likely to find individuals with all the capabilities described above. They can, however, select with care individuals who have administrative ability and have had experience in dealing with health care problems both in the medical center and in the community. Having appointed the Coordinator, they have a responsibility for maintaining a continuing relationship with him. He will welcome all the guidance and support he can obtain as he negotiates for the involvement and commitment of the groups described above.

The Division of Regional Medical Programs, too, has a responsibility in this regard. The staff of the Division has discussed ways in which it can provide relevant information to Coordinators as they and their staffs and their Regional Advisory Groups address the task of securing funds through the grant application route.

We are prepared to structure a series of three to four-day seminars in Bethesda for groups of Coordinators to discuss in depth with them the organization of the Division of Regional Medical Programs, its administration, its resources, and its grants review and management procedures. We hope also to use this seminar as a medium through which Coordinators may supplement their knowledge of Regional Medical Program activities throughout the country. This undertaking, which will necessarily be

experimental at the outset, will be carried on under the guidance of Dr. Richard Manegold and his staff, and we shall be prepared to initiate the first of these seminars as soon as we have requests for participation from a group of six to ten Coordinators.

Beyond that we are making plans now to experiment with a "war games" approach to teaching the techniques of long-range planning. Dr. George Miller and his staff at the University of Illinois College of Medicine have agreed to put on a program of this kind as a substitute for one of the irregularly scheduled sessions on medical education, probably in June 1969. We shall make announcement of the course as soon as the details of the program can be formulated and distributed. In the discussion sessions that will be held during this Conference we should welcome any comments or suggestions you may have about either of the above proposals.

Organized Commitment of the Health Power Structure: The successful Coordinator recognizes the critical elements in the health power structure and the order of priority in which they must be brought together, actively involved, and committed. The key groups with which he deals include the following:

Medical Centers and Medical Schools - These have provided much of the initial Program impetus. A close relationship between them and the Program must continue because medical centers constitute a reservoir of professional expertise and competence that must be drawn upon for the transmission of new knowledge and techniques. They have considerable potential for serving as a "change agent" and they are a highly specialized resource

for obtaining quality health care. This is not to say that medical schools can or should control the Program. To the contrary, continued exercise of control by this or by any single institution or group will impede and retard the involvement and commitment of other key groups. But without medical center involvement and commitment, there is little chance that the Regional Medical Program can succeed.

Another important group includes practicing physicians - and by extension, State medical societies and their component organizations. It is essential that practitioners be involved in Regional Medical Programs. Not only are they the first point of contact with the health care system, but many significant improvements in the quality of care and in the health status of a population can be achieved only through their direct efforts. But simply "involving" individual physicians is not enough. Organized medicine -- State medical societies and their component organizations -- must participate in the Regional Medical Program decision-making process. In terms of the health power structure, organized medicine represents the collective voice of physicians. We have seen instances where failure to involve these groups in decision-making has created obstacles to program advancement.

A third and equally important group includes hospitals. They represent the major institutional focus for health care in this country. Diagnosis and treatment are increasingly hospital-oriented and hospital-based. Moreover, the hospital represents an important interface with the community

which surrounds it and represents both the providers and consumers of health care. The involvement and commitment of the hospitals, therefore, must be broadly structured to include the administration, medical staff, and trustees.

Fourth, Official and Voluntary Health Agencies - It may be easy to overlook these groups or to wait for them to ask for participation and then to expect from them only a nominal contribution. Such a policy is short-sighted and self-defeating.

- . State and local public health agencies play a significant role in the provision of health care. No Region can afford to ignore or proceed without the understanding and backing of city and State health officers, many of whom have the ear of a Governor or a Mayor. Moreover, the statewide and areawide comprehensive health planning agencies, which will play an increasingly important complementary role in structuring the health care system, are by law related to state and local governments -- often through their health departments.
- . Voluntary Health Agencies such as heart associations and cancer societies have a real contribution to make. They have built up a community organization which can be a source of education, support, and leverage within the community. This apparatus can be made available to Regional Medical Programs to sponsor training and to assist in other operational projects.

The Regional Advisory Group is the voice of the health power structure. Public Law 89-239 established it as an essential component of a Regional Medical Program and defined its responsibility in the same broad charter-like terms that characterize the other components of Regional Medical Programs. The Guidelines issued by the Division of Regional Medical Programs described the responsibilities of the Regional Advisory Groups in more precise terms. In this discussion of the elements that characterize the more successful Programs, I should like to describe how Regional Advisory Groups are relating to sponsoring organizations and to comment on the specific functions they perform. Some Regional Medical Program sponsors look upon the Regional Advisory Group as a body which the law requires be established but whose function is a nominal one, that of approving operational grant proposals. It may be looked upon as a force which threatens the role of the sponsoring organization. Not infrequently the chairmanship of the Regional Advisory Group is retained by the chief executive officer of the sponsoring organization as a means of controlling this aspect of the Program. The fear may exist (although evidence to support this fear has been notably lacking) that Regional Advisory Groups may exceed the policy-making functions assigned them in the law and in the Guidelines and seek administrative control of the Program. We are pleased to note that many sponsoring organizations clearly recognize that the Regional Advisory Group must become the dominant organization expressing policy on behalf of all cooperating health interests in the Region. One such institution -- the University of Washington -- has identified its role as that of administrative trusteeship, which means that it will exercise the obligations imposed upon it with respect to administrative policies, while at the same time encouraging the

Regional Advisory Group to assume an ever more significant role in guiding and directing the policies to be followed as the Regional Medical Program develops.

It clearly takes time for a Regional Advisory Group to become organizationally mature, to come to grips with important policy problems, and to begin resolving them wisely. Where Regional Advisory Groups are functioning actively, one finds that they have a membership that comprises the leadership of the major health interests and power groups of the Region (i.e. medical centers, practicing physicians, organized medicine, community hospitals, and other groups). Not only are they geographically representative, but they include strong public representatives who have significant regional influence and social and economic "clout". Where they are exercising a real trusteeship, the groups have a significant and substantive voice in setting policy. They determine the overall scope, nature and direction of the Regional Medical Program and establish priorities. They provide a forum for the forces of change as well as for the traditional health power structure.

It is too early to determine whether those Regional Advisory Groups, which are functioning under the chairmanship of the chief executive officer of the sponsoring organization, will in fact become a representative voice of the many elements of the health power structure in the Region. This arrangement at least has the saving grace that its actions are closely coordinated with those of the sponsoring organization.

The most frustrating and perhaps the most destructive arrangement we have observed is one in which the sponsoring organization appoints a Regional Advisory Group as required by law but refuses to identify its role and neglects to take those steps necessary to transform a collection of individuals representing the various health interests into a strong function unit which can indeed infuse into the Regional Medical Program that measure of support which it can obtain in no other way.

Program Concept and Design

The third critical element characteristic of the more advanced Regional Medical Programs is the ability to formulate a sound program concept and design. This too, is a derivative of the function of leadership.

A fundamental prerequisite to the elaboration of a specific strategic concept for the individual Region is a clear understanding of the role Regional Medical Programs are expected to play in establishing a more rational health care system in the United States. This understanding must guide not only the Program Coordinator and those immediately and directly connected with his core staff, it must be conveyed to and shared by the larger health community -- the key groups previously referred to as the health leadership of the Region. These groups and individuals must understand and recognize that a Regional Medical Program is, in the final analysis, concerned with improved health care and health status of individuals, that its focus is on the patient and that, although it is only one of a number of activities and forces with this long-range goal, it has as its direct target, the upgrading of the skills and services of

those who provide care. Categorically oriented, it has a strong technological bent -- the latest advances in heart disease, cancer, and stroke and related diseases, but it is concerned with linking as well as strengthening health resources, a linkage which is the essence of regionalization. A Regional Medical Program requires a wholeness of program that cannot be achieved by an aggregation of loosely related projects; it fosters innovation and change -- not in the relationships between physician and patient, but in the relationships among providers of health service.

Thus, Regional Medical Programs emerges on the American health scene as a voluntary mechanism that depends upon the organizational behavior of health-related institutions -- a "coalition politics" of health, if you will. This is as much a part and parcel of Regional Medical Programs as is the substance of the information related to the latest advances in heart disease, cancer, and stroke.

Against this background which represents the broad national policy establishing Regional Medical Programs, let us look at some of the specific patterns we see emerging.

Many Regions are in the process of developing a "grand design" that will permit them to proceed with specific projects, each of which will fit into the larger pattern. This process is not unlike the one we are using to create the Interstate Highway System for our country.

Initially, some Regions have placed greater emphasis on action, others on planning for action, but the following tactics have been fairly common to all Regions:

Their planning may best be described as "consensus" planning, that is, once leadership has emerged and organizational involvement has begun, certain immediate needs and problems were so obvious that they could readily be agreed upon. Similarly, there were available certain kinds of ready solutions, such as coronary care units and continuing education programs, which also could be agreed upon as mechanisms for initiating operational activities.

The more advanced and successful Regions have moved from the initial consensus planning to the establishment of long-range planning. This has been expressed by the creation of categorical and other task forces, of special committees at the regional level, at the subregional or community level or even local action groups within the community. The achievement of this kind of layered planning contributes to better understanding at all levels and provides a mechanism for achieving widespread involvement and commitment. Properly done, it requires a great deal of organization and supervision from the core staff. As these planning groups address themselves to specific problems of diagnosis and treatment for heart disease, cancer, stroke, and related diseases, the need for an adequate data base becomes ever more apparent. The data available is often fragmentary or lacking

and Regions are then faced with the decision as to whether they should begin to collect the data they need. It is well recognized that we have as yet no adequate national system to collect the data required for effective management of health care. Scattered and sporadic efforts to collect data will not solve the national problem; not only is the information derived from diverse sources not comparable, but data which is not continuously updated prevents its most effective use -- to tell us how well we are succeeding. Without such a mechanism, the cross-sectional data obtained by local groups have only limited value. Scanty as it is, however, such data as is available must be used by planning groups to make appropriate analyses and to derive as much benefit as possible from it. Regions are reluctant, and properly so, to set up elaborate data collecting mechanisms. We continue to look for the early development of this critically important national health tool.

Regions developing their strategic plan may begin with a realistic assessment of the elements peculiar to the Region, including such things as resources, gap areas, regional ecology and traditional attitudes within the Region. We see emerging in certain complex multi-medical center Regions, a geographic or functional division of responsibility with specific areas assigned to each medical center. Division of geography tends to delineate responsibility more clearly; it permits those areas, which for a variety of reasons may be able to move ahead more quickly, to do so -- the pace of all is not determined by that of the slowest element. It is too early to tell whether such division within the Region will, in the long run, advance the program.

Common to all Regions is the phenomenon of subregionalization. In the more successful Regions one sees this in terms of a subregional effort and identity based on referral patterns corresponding roughly to what might be termed "health market areas."

In sum, we see that Regions are:

- . Making cooperative arrangements the guiding principles for action.
- . Encouraging and even suggesting projects and proposals that fit that strategy.
- . Promoting efficiency in terms of regional health manpower and other resources.
- . Fostering interagency relationships and communication.
- . Striving for adequate program balance.

Two examples: We can cite one Region which has adopted as its strategy the establishment of a series of hospital-based centers of excellence for heart disease and for cancer throughout its Region. It hopes subsequently to add facilities for excellence in stroke also.

In another Region the strategy has been described as a series of related thrusts. The first of these thrusts concerns approaches to improving the effectiveness and efficiency of patient care at the local level. The second concerns the development of working partnerships between key hospitals and one of the university medical centers leading to the creation of a "third faculty." The joint appointment of full-time chiefs of service in selected hospitals would be made by agreement between

the hospitals and the medical center. A third thrust is concerned with smaller hospitals which often cannot support the implementation of many of the recent advances in diagnosis and therapy. A proposal has been made to develop selected services on a centralized basis, and alternately to strengthen other specialized services on a decentralized basis.

Effective Implementation of Program - Given leadership, the involvement and commitment of key health groups (including the effective functioning of the Regional Advisory Group), and a carefully thought out regional strategy or design, there remains the problem of formulating operational activities for implementation of the Program. It is in the implementation or action phase where the impact of Regional Medical Programs may best be seen.

The more adequate the implementation, the greater its impact will be in terms of overall Program visibility. Properly achieved, this visibility will encourage local identification with the Program on the part of the medical centers, the hospitals and the physicians in the Region.

Decisions as to what kinds of operational activities to undertake have, in the main, been governed (consciously or unconsciously) by a short-range strategy aimed at demonstrating success and achieving visibility. These general tactics have characterized even the most successful Regions. On the other hand, just as initial consensus planning must be superseded by long-range planning, so the initial tactics and "off the shelf" solutions must be superseded by the development of long-range projects.

The initial operational projects not only provide evidence of regional strategy, but reflect regional cooperative arrangements. They are not just isolated projects aimed simply at expanding and advancing the diagnostic capabilities of individual institutions, physicians, and other health resources. But they illustrate realistically how cooperative arrangements among medical centers, hospitals, and physicians can be implemented.

One sees, for example, as in Louisiana, four hospitals in the same community pooling their resources in cooperation with the State Heart Association and one of the medical centers to establish a single, high quality, coronary care demonstration and training unit. This unit is designed to improve the care of all patients with myocardial infarction in that area. Instances such as this provide the real test of regional cooperative arrangements. When individual institutions are, in effect, required to give something up, or to do things differently than they have in the past, one may judge whether these institutions are truly willing to move from a competitive approach in the solution of health problems to a cooperative one.

In the Washington-Alaska Region, we see the example of a high-energy radiation source planned for one of the Anchorage hospitals. No longer will patients in that vast subregion have to travel to Seattle or elsewhere for such treatment. Planned and approved by both local and Regional Advisory Groups, the radiation unit will be operated as a regional resource.

In a funded operational project of the Georgia Regional Medical Program, the faculty from two medical centers will travel to institutions participating in the development of hospital-based centers of excellence. Consultants will see patients with practicing physicians in those hospitals and will

utilize the consultation mechanism to promote the continuing education of both physicians and allied health professionals.

Similarly, one already sees in the early operational proposals of many successful regions, an indication of concern for and attention to program balance. Needs in stroke and cancer are being addressed as well as those in heart disease, which appear to be more readily identified and dealt with. Areas of prevention and rehabilitation are not being ignored. There is functional balance among research, training, continuing education, and patient care demonstration activities.

Evaluation of Progress

We come finally in our consideration of the characteristics of successful Regions to the subject of evaluation.

Adequate data is, of course, essential to proper evaluation. As noted before, we are badly handicapped by the lack of data concerning the quality of care. We suffer especially from a lack of data concerning the ambulatory care of patients. We know next to nothing about quality of care provided in physicians' offices. We are plagued, too, in evaluating Regional Medical Programs because we are not entirely sure what our "product" is. It may, indeed, be true that in Regional Medical Programs, as some say about television, "the medium is the message."

If we are having difficulty in evaluating our efforts, we are surely not alone in this respect. Nor should we be prevented from moving forward simply because our evaluation techniques are not as clearly defined as we should like them to be. If one considers such as a venerable social institution as education, we find that it has served us well for centuries

even though many observers today believe it has a faulty evaluation system. Success in education has been judged by measuring the amount of retained knowledge. This way of measuring success has influenced teaching and learning techniques for a very long time. Those techniques are being changed as we begin to reach agreement that it is more important to judge the change in behavior of students than to measure the amount of knowledge that can be reproduced on an examination.

But the existence of difficulties and problems in no way minimizes the importance of evaluation for Regional Medical Programs. To the contrary, evaluation is critical to our effort and much more attention must be paid to it in the immediate years ahead.

In almost one-third of the Regions we find neither evaluation staff nor consultants in this field, and only one-half of the Regions have developed an organized approach to evaluation. Some have highly-developed efforts. For example, the North Carolina Regional Medical Program has a Division of Planning and Evaluation, headed by a prominent medical sociologist and a competent staff. It is making a major effort to incorporate evaluation as an integral part of the overall regional effort. The evaluation division of that Region works closely with the executive committee and the Regional Advisory Group and will seek to determine the progress of the Program in meeting its stated objectives. In making this analysis, the effectiveness of each project in changing the status of health care will be ascertained. In addition, it will be the function of the Region's Division of Planning and Evaluation to work closely with each project director to assure the inclusion of evaluation procedures.

A Look at the Future

Let us now turn from what we have been doing, and look to the future of Regional Medical Programs.

To begin with, we might look at the immediate future. Clearly, we are moving from a circumstance in which there has been a surplus of funds (at times an embarrassing surplus) to one in which the reverse will be the case. Based on applications in hand, we can predict that the aggregate demand for grant funds will exceed our appropriations in the fiscal years 1969 and 1970; and beyond that, the amounts which the Review Committee and the National Advisory Council will likely recommend for approval will also exceed the available funds.

This matter was discussed in depth by the National Advisory Council at its meeting in August of this year. The Council has indicated it will continue to judge programs and operational grant applications on the basis of quality. They have rejected the principle of a distributive mode for the allocation of funds based on population or geography. Inevitably, this policy will lead to a backlog of approved but unfunded applications. I know of no better way to bring to the attention of the members of the Congress the requirements for adequate funding, than to present such a record. This is particularly necessary because in the past the Congress has expressed impatience with the slowness with which the Programs have developed, and with the disparity between the amounts of funds authorized and appropriated and the amounts actually spent.

These policies recommended by the National Advisory Council bear directly on the application and approval process at both the national and regional levels. It does not appear possible to provide applicants with an appropriate review within a three-month period. A review of multimillion dollar grant applications requires critical analysis by our own staff, a site visit by a team of consultants and staff members, analysis of the project by the Review Committee and finally, consideration by the National Advisory Council. Applications which are well organized and lend themselves to orderly review will ordinarily be acted upon within four months after application deadline. In general, they will be acted upon in the order received.

Beginning with the next fiscal year, the number of annual review cycles will be reduced from four to three. The deadline dates for submitting applications, tentatively, will be August 1, December 1, and April 1; but you will be given definitive information on this matter.

We are attempting to define the appropriate input of each group to the review process. We shall expect the staff in its review not only to summarize the proposals but to express judgments which can be clearly identified as staff judgments. We are looking critically at the function of the site visit teams in order that the contribution of this important group may become more effective. You may expect that the procedures with respect to site visits will change as we attempt to identify the specific contribution this group can make. We are asking the Review Committee to make an objective scientific and technical evaluation of applications rather than to make value judgments. This latter function

is properly the responsibility of the National Advisory Council.

During the developmental phase of the Program, minimal standards were set by Council as a means of insuring quality and insuring also that every Region would be encouraged to begin the task of regionalization. As we enter a period in which funds exceed requests, Regions will be judged competitively.

We shall look to the Regions acting in their own self interest to improve the quality of their applications. Evidence that the applicant is moving in the direction of the longer range goals and objectives which it has set for itself in its strategic design will have great weight. Individual project proposals will be reviewed to determine how they relate to the Region's own grand design. Review groups will look for the relationship of individual projects not only to the overall Program concept but to each other. They will expect clear descriptions of what is intended to be accomplished, set forth in specific and, where possible, quantifiable terms, to insure that evaluation of progress and success will be undertaken. (In a program such as this with its emphasis on innovation, both sociological and technological, we must expect some projects to fall short of expectation. What is not tolerable is failure to distinguish between effective endeavors and those that lack effectiveness in improving care. We must learn to make such distinctions and to alter or abandon projects based on these judgments.)

We shall look for evidence that the application has been given a discriminating and qualitative review at the regional level so that only those projects are sent forward which (1) have merit, (2) are capable of

implementation, and (3) are clearly related to the Region's own strategy for regionalization.

We shall look for better information about the role of the Regional Advisory Groups, not only with respect to how they review and evaluate specific proposals but how well they function in setting the overall direction and scope of the total program.

The degree to which many applications have failed to reflect accurately the actual degree of development achieved within the Regions is perhaps best indicated by the experience of site visit teams. Their reports have frequently materially altered or reversed the preliminary impressions obtained from the written applications by staff, Review Committee members, and Council.

Other Issues

I should like now to comment on two major issues relating to Regional Medical Program objectives that have been interpreted as imposing divergent pressures on the regions. They are the problems of the cities and continuing education.

The first issue relates to the matter of how Regional Medical Programs may serve an effective function in improving the care received by the large population groups in our cities and especially that received by our poor and disadvantaged groups living in the ghettos. The complex problems our cities present, pose a national crisis of the gravest order. The health of the poor who live in the cities is of deep concern to Regional Medical Programs. True, we suffer from several constraints

as we attempt to deal with this problem. Facilities are needed, but we have no authority to use funds for construction of facilities. Neither may grant funds be used to pay for the cost of medical services or the cost of hospitalization. Nevertheless, there are major contributions which Regional Medical Programs can make but which can be made only if we understand the nature and mechanisms to be employed in Regional Medical Programs, and understand also the nature of the problems faced by our cities in improving health care for the poor.

The long-established system for the health care of the indigent is now in the process of major change. Over the next seven to ten years more dollars can be expected to be placed at the disposal of the indigent to purchase their care. The process for doing so is only now being structured and we are in that unhappy period of transition when the old system is being allowed to deteriorate and new solutions have not yet become effective. The problem with us today is that many of the poor have neither an adequate indigent type of service nor funds to purchase their own care.

If there is any group which should be in the fore in creating a new system of health care for the urban poor, it is the providers of health care. Regional Medical Programs are functioning organizations specifically designed to link the providers of care together for the purpose of collectively improving services to patients. These Programs can and should contribute significantly in planning general health services for these populations because it is only in this fashion that we can come to grips

specifically with the problems of heart disease, cancer, and stroke. Regional Medical Programs can assist in the improvement of health service activities through projects that supplement elements of both old and new systems aimed specifically at the urban poor. To do this, Regional Medical Programs must enter into cooperative arrangements with the many local and Federal programs already addressing themselves to health problems of the urban poor. But regions must first be able to function as Regional Medical Programs. We recognize that the complexities involved in developing regionalization in urban areas have delayed the development of regions in the very areas where their services may be most needed. This is a matter to which I have already given a great deal of my time and to which I am prepared to devote more of my personal efforts.

The second issue is that of continuing education. From the beginning there has been some degree of controversy about the role and significance of continuing education in Regional Medical Programs. There were some who saw continuing education as the whole program. Others saw very little purpose to be served by supporting the kinds of ineffective continuing education programs which rely mainly on information transfer, which reach relatively small numbers of physicians and which appear not to change the behavior of physicians to any significant degree.

I am convinced that continuing education is the most significant single component of Regional Medical Program activity. What is at issue is not whether we should support and extend continuing education but what kind of continuing education we should encourage. Efforts of Regional

Medical Programs in this field must improve both the knowledge and skill of physicians, nurses, and other providers of health services. They must encompass a variety of innovative techniques which will involve them in an active rather than a passive role. These efforts should result in behavioral changes leading to improved diagnosis and treatment of the patients they serve. Further, our continuing education efforts and activities must be structured in a way that promotes the cooperative linkages upon which the ultimate success of Regional Medical Programs will depend.

Having identified these two issues which would seem to be polarized, as are so many national issues today, on the needs of the cities versus the needs of the rural areas, I should like to reject firmly the notion that we are unaware of the health needs of the rural poor or the importance of including them as beneficiaries of a system of voluntary functional regionalization. Equally, I should like to reject the notion that physicians in the urban areas are not in need of continuing education simply because of their proximity to the centers of learning. In our larger cities many physicians practice independently, without hospital appointments, and are subject to none of the influences which are of major benefit to all physicians who do conduct a substantial part of their practice in an organized hospital setting. We can ignore neither these physicians nor the patients they serve.

In the presentation I have just made, some of the factors leading to the establishment of successful Regional Medical Programs have been described. Special problems such as those encountered in the larger urban areas have also been identified. We have shared with you some of the management problems associated with a very large and complex grant program.

But we are wide of the mark if we regard Regional Medical Programs simply as another Federal program which uses grant funds to implement a specialized objective. The categorical restraints in P.L. 89-239 are clearly recognized. But equally recognizable are the legislative actions which have broadened the program to include additional related diseases and to use the Regional Medical Program mechanism for such activities as clinical trials.

The true significance of the Regional Medical Program effort can be understood only if we recognize that a test is being made, nationwide, to determine whether the quality of health services can be continuously improved by means of voluntary, functional regionalization. We are engaged in resolving an issue of critical significance to the future of the American health care system -- a system which in the aggregate involves the life and welfare of 200 million persons -- a system in which more than \$50 Billion is invested annually.

The best estimates we have of the cost of a fully established regionalization program suggests that we may require \$400 to \$500 Million annually. If these figures are realistic we should be planning the

structuring of a system that will involve every element of the health care process. We are called upon to perform this task at a time when our country is beset with severe economic problems. We are faced with the necessity for establishing our national priorities at a time when there are many urgent problems to be solved, each of which requires large sums of money. Regional Medical Programs are under real pressure, therefore, to present evidence that this Program does indeed have the potential for improving the quality of health care that its advocates have held out.

Ours is a program that has its primary impact on the providers of care rather than on the public directly. We depend, therefore, on those professionally involved in health care to interpret the success of our efforts. They in turn must communicate their understandings of the value of the Program to the Public and to the Public's representatives in the Congress.

We are only now beginning to see the results of our efforts over the past two and one-half years. The limited evidence we have of the validity of the Regional Medical Program process must be used as feed-back into the system to guide our own further planning efforts. It must be used to inform the groups most directly interested in Regional Medical Programs about its effect on health care. It must also extend the base of cooperation upon which Regional Medical Programs ultimately will depend.

"RELATIONSHIP OF THE HEALTH POWER STRUCTURE
TO REGIONAL ACTIVITIES"

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When I accepted this assignment to speak to you on this subject, I did so with some trepidation. To many of my associates in this program the need to acknowledge the existence of "pressure groups," "power blocks," "special interest groups," or whatever you may desire to call them is in itself a deplorable factor. One sometimes gets the feeling that those who do engage in the art of obtaining consensus from various pressure groups for any given goal are indeed practicing some form of Satanism. It is like being the father of Rosemary's baby without ever having known Rosemary. The only solace I take in all of this is to note that when the connotation of evil is applied to any grouping, it is always the other man's organization that is evil. We only belong to good groups to protect ourselves from the advances of those other groups. Anyone who admits seeing some good in the vast majority of the groups, and who tries to mold portions of their efforts together in order to obtain a working consensus on which progress toward a given goal can be made, becomes contaminated with the "other man's evil. Further, to openly admit that you are a member of none -- in effect isolated -- and sitting as if naked atop a beehive, not knowing whether you're about to be seduced by the queen bee or attacked by her suitors... That is why there is some danger, at least to me, in this topic of discussion, and I must add I feel much as Lincoln must have felt as he was being ridden out of a small Southern town on a rail after the Emancipation Proclamation: "If it wasn't for the honor of it all, I'd just as soon walk."

To those of you who would practice the art of obtaining consensus and keep quiet about it, there is little danger. In fact, at times it can be quite rewarding if you can find a way to silently give yourself credit for that which has been accomplished in the names of others. I fear, however, that like all voluntary collective efforts in the social field, observable progress toward a given humane goal is all, and should be all, the reward we should expect. The legislative framework, the Congressional Committee imperatives and the Guidelines offer a unique opportunity to determine on a broad national scale whether or not the components of the health power structure can work together voluntarily for the general good of the public. It may not be virgin territory upon which we are treading but at least it is wild enough to make life interesting.

What are the specific mandates set forth by the law and Congress that we are obligated to observe insofar as the health power structure is concerned? It seems to me that there are at least three main postulations that we must be aware of. The first is the unique wording of the law itself. Section 903 states that grants under this section may be made only if the Advisory Group includes "practicing physicians, hospital administrators, representatives from appropriate medical societies, voluntary health agencies and representatives of other organizations." Secondly, Section 904 which covers operational grants states that they may be made only if "recommended by the Advisory Group" as described in Section 903. This type of language gave virtually unique recognition in the legislation itself to the Regional health power structure. This recognition in effect took the form of the right to veto.

Thirdly, Congress went even further in its subsequent reports on the Program. It used the term "voluntary partnership" when referring to research centers...Practicing physicians and community hospitals indicating a co-equal status. Hearings this year brought out the very deep concern on the part of Congress that components of the health power structure may not be involved uniformly in all Regions to the degree Congress intended. Some sentiment on the part of the national health power group structure tended to support this position although it was pointed out that the problems were sporadic in nature.

At this point in time, Congress seems determined that there be a co-equal involvement of components of the health power structure, not only in the design of the Program but in its operational surveillance as well.

How does one determine what constitutes the health power structure? In this case the law is unusually clear. It identifies medical center officials, hospital administrators, practicing physicians, representatives from "appropriate" medical societies, "appropriate" voluntary health agencies, and other organizations, institutions and agencies concerned with activities in RMP plus informed public members. The statute uses key modifiers, in effect, to identify the power structure that legally must be involved in the decision making processes of the Program.

Unlike the typical legislation which establishes citizens' Advisory Committees, this act specifies that certain specific kinds of representatives must, not may, be included on the Advisory Committee. It certainly

follows that at least Congress looked upon these classifications as the primary power structure involved.

From a practical point of view there may be others, but they are not legally specified. As an example, at least one Governor unofficially proclaimed his State a Region and apparently his remarks carried some weight. At least one State Legislature caused a shotgun marriage between RMP and community health planning and seemingly those involved took note of this act. Whether the marriage has been consummated only the principals can attest.

Although these extra-legal forces are important, time does not permit their discussion here except to mention the fact that eventually we will have to deal with public health power blocks such as those interested in O.E.O. facilities, model cities programs, Medi-Care and Medicaid, crippled children's programs, health planning councils and community health planning among others.

Some interesting conclusions can be drawn from the unique language used by Congress to establish RMP. First, the Program was described as a "partnership" implying an equal role in the decision making process by the partners involved. The only mechanism provided in the Act for exercising this role was the Advisory Group which must advise on and approve the actions of the Region. Later, Congress used the term "oversee."

Secondly, the term "medical center official" was used in place of a "representative of medical centers." An official is one with the authority to commit his organization or institution to a given course of action.

Thirdly, it spoke specifically of "hospital administrators," not representatives of hospitals. This again implied a specific level of authority and function within the hospital world. It further implies that this person or persons would have the authority to speak for others in his category.

Fourthly, the Act specifies both "practicing physicians" and representatives of "appropriate medical societies." The modifier "practicing" would simply differentiate this physician from those who might be in administrative or other capacities. But the modifier "appropriate" would seem to have more specific connotations. From the legislative history we must assume that this was to be a person with the authority to speak for organized medicine in the Region. Even without the benefit of the legislative history, "appropriate" logically would refer to the organization that historically has had the greatest policy impact on medical practice, the most significant legal impact, and geographically covers the area concerned. In the vast majority of the cases, "appropriate" could only mean the state medical society. There are situations where in multi-state Regions more than one state society must be represented and there is at least one instance in which the state society may be described as slightly bifurcated but there can be little doubt as to the general appropriateness of state societies.

Fifthly, the same modifier, "appropriate," is used to describe voluntary health agency representatives, as members of the legal

Advisory Group. Again, the structure, function, and coverage of each voluntary health agency would determine the appropriateness -- that is, whether it should be the statewide organization that is involved, or some other level.

But, from a practical point of view, it would seem that RMP would want to associate itself with the voluntary health agencies at the point in the agency's structure where the major policy decisions are made. This point differs to some extent among the voluntary agencies from state to state. It is evident that to take full advantage of the relationship with the voluntary agency, RMP has to be plugged in at the decision-making point, the point at which new programs are designed, objectives set, data and other information accumulated and stored, financial determinations made and general organizational policy established and executed.

In most cases, this appears to be the state-wide organization. Not to involve the voluntary associations at the policy making point will result in much duplicative effort and the lack of ability to fully utilize all of their existing resources on a coordinated basis. More important, perhaps, is the difficulty in obtaining a definite commitment for support of RMP objectives if this relationship does not exist at the policy making and management level. Agreement on issues without the authority to commit support, funds or resources is as worthless as pursuing the vote of citizens of Washington, D.C. for a Virginia election.

Even though representatives may be chosen from the "appropriate" body -- that is, chosen from the level within organized medicine, the hospital association and the voluntary health agencies where the vital decisions are made and the policy is set -- there is more that must be done if progress is to be made. It amounts to giving the partners a sense of confidence that their role in the Program will not be subverted. This is especially difficult because the relationships that have existed in the past between these partners have been extremely limited and even then, some were viewed with suspicion.

Some times those of us who live with the Programs tend to forget that a massive amount of planning activity has been thrust upon the health leadership. This activity seldom is based on long established, firm relationships; thus, there is bound to be some uncertainty. This uncertainty requires a profuse amount of reassurance and reconciliation to keep the new partnership intact. Let us recognize that this partnership is voluntary, something even less secure than a common law marriage, and until there are abundant children in the form of successful operational projects, it may be hard to keep the faith.

Because of this, I believe it is the Regional Coordinator's role to know intimately the decision making mechanisms of the health power groups primarily involved in his Region. Not only must he understand the mechanics of their decision process, but he has to have a fairly good knowledge of the people involved and what causes them to take

the positions that they do. He has to have some assurances that the representatives of the various power groups have the authority to speak for the decision making apparatus within their own organization. He has to have some assurance that the power group's organizational framework will back up their representative in controversial matters. If the representative's authority is limited, as it is almost certain to be, the Coordinator should know these limits and compensate for them.

The Coordinator is further obligated to back up the representative of the concerned group by personally providing information and assurances to the decision making bodies within the representative's group on matters of controversy. In most cases, this will mean routine appearances before the Executive Councils of the state hospital association, the state medical society, the various voluntary health organizations and medical center groups. It means, above all, that he has to be prepared to negotiate differences in as amicable an environment as passion will allow.

There are other problems within the health power structure that face the more complex Region. Although they may not directly affect each of us, at least to the same degree, they nevertheless may have a very profound effect upon the reaction that Congress has to the Program. To date, Congress has indicated an unusually favorable reaction, but this reaction could reverse itself if these problems are not dealt with properly and soon. In my own self defense, I have not mentioned

California, and I do not intend to, but let me quote from an article written by a man for whom I have the greatest respect, George James, M.D., Dean of Mt. Sinai School of Medicine, New York. It appeared in "New York Medicine", April 1968. I quote without his permission:

"What problems are associated with Regional Medical Programs and how is New York City going about resolving them? New York City has a particularly difficult problem. Those of you who have been associated with the review process of the Heart, Stroke and Cancer Program in Washington have noticed that it is very easy for a state with a single state medical school, a single state health department, and relatively few really vital agencies to organize for a Regional Program. This is true for some of our midwestern states where the entire process is very simple with a single state Governor, a single state legislature, a single state health department, a single state university with most of the doctors in the state being alumni of the state university. All of this makes for a very simple arrangement.

"In New York City we have seven medical schools, we have a large number of additional sophisticated agencies and institutions. This makes for quite a bit of trouble. It creates major problems for intercommunication among groups which have not been notable for their ability to communicate before. Now, in addition to this, New York City has very great needs, and they are very visible needs. If there are any of you who feel incapable of adequately recognizing

these needs, there are at least three dozen agencies in the state that will be very happy to point them out. There is great citizen demand for services."

Dr. James stated the problem of the complex community clearly and briefly. It is not as easy to isolate, understand and describe the decision making process in the areas where the most people are, where the most voters are, where the most Congressmen come from. This poses a far greater problem than most of us realize if you stop to think where the mass of our health problems exist and who votes the dollars in support of the Program.

As Coordinators and as individuals interested in the health of this nation, we face our greatest challenge during the next two years. We are faced with marshalling the health resources of the metropolitan areas which contain our most complex problems in terms of relationships. We have to seek a greater understanding on the part of all the health power structure that this Program, which all of the leadership seems to prefer, may be significantly modified if momentum is not gained in the highly complex urban areas.

At this point in the Program if a speaker raises problems, he ought to have some pat solutions to them. Frankly, I do not, except to say that we should proceed as we have been with more of our energies focused on the urban problems. We should not lose sight of the fact that although there have been problems of relationships,

they have been relatively minor compared to other programs of this magnitude and especially programs as unique in approach as this one.

It does seem to me that in facing these problems the main challenge to the Coordinators over the next few months will be to maintain the integrity of the Program. If the partnership concept is lost -- that is, if it becomes predominately a medical society program or a hospital program or a medical center program in place of a balanced program between the partners -- then its lustre and innovativeness will be lost. We can develop models and pilot projects until we are inundated with the reports involved, but they won't mean a thing unless they are accepted by the total health manpower through their involvement from the ground up. Obviously, there is a price to be paid for involvement, enlarged staffs for the schools, easier access to continued learning for the professional person, and improved service facilities for the institutions. The test will be the amount of dividends that are paid to the people in terms of better health care.

"HEALTH IN THE TROUBLED CITY"

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When the suggested title for this paper was first sent to me it was "The Relationships of Regional Medical Programs to Poverty, Urban Health, and the Urban Crisis." That's a complex title. Subsequently the title was changed to "Health in the Troubled City" -- a simpler title but by no means a simpler problem. The problem is complex and formidable in nature, and we seem to be able to have only marginal impact on it even with maximum effort.

I certainly have no single formula for the problems of urban health care, and I'm sure none of the panel does. I think the best we can do is to elucidate some of the inter-connections of the major aspects of the problem. And even in doing that we must beware not to invoke the kinds of explanations that are longer on charm than they are on truth.

I'm reminded of the answer on a science examination written by a little girl in grade school. In her examination there was a question that said: "On some nights, it is very clear and we can see the moon very clearly, and on other nights it is just as clear and yet we can't see the moon. Why is that?" The girl thought for a long while and then she wrote: "Because of the invisible clouds."

I think the temptation is always before us to invoke such invisible clouds to explain the things we don't really understand, and I will try to avoid that today.

For once, in a discussion such as this, the word "crisis" has been left out -- a word so abused that, in a sense, it is now meaningless. It is hard to call something a crisis when everything is a crisis, when one is living in a crisis. Certainly this applies to what we commonly call the "Urban Crisis."

What is this crisis? It is a crisis in the cities, though not merely of the cities. But it is also a crisis in health, a crisis in response to the people imprisoned in poverty, a crisis in education, a crisis in the choice of national commitments and the ordering of national priorities, and above all a crisis in race --- a fundamental confrontation with the issue of race in American life. We are faced with a continuing major social upheaval that is bubbling, erupting and exploding in every area of our national life, not just health. And while we may focus on health, it is crucial to remember that health merely reflects and illustrates the four central issues in this national upheaval. These central issues, I believe, are race, poverty, migration from rural areas to the cities, and explosive urban growth.

First, and briefly, the question of health and poverty. I won't bore you with all of the details and figures. But the health of the poor in the United States is a national disaster that we have known about for a long time, though we haven't fully faced it. Poor people are sicker, they get less medical care, and they die sooner.

Whether we examine the urban or the rural poor, this is what is happening today -- in the central cities and ghettos of the urban North, in the share-cropper's shacks of the rural South, in the migrant farm workers' hovels that can be found an hour's drive from New York City or Los Angeles, in the poor-white coalfield slag of Appalachia, among the Mexican-Americans of the southwest, and among the Indians on the reservations, to name the most obvious groups. Thirty-five years ago we were told that one-third of our population was ill-housed, ill-fed, and ill-clothed. Today it is estimated that about one-fifth of all the people in this affluent society live in poverty. The apparent improvement from 33% to 20% conceals the growing health gap between the poor and the rest of the population. In 1940, for example, the infant mortality rate of non-whites was 70 percent greater than that for whites. In 1962, 22 years later, it was 90 per cent greater. A few years ago, Dr. George James estimated the annual excess mortality among the poor in New York City alone at 13,000 lives a year. And he added, "It is no exaggeration to state that these deaths are caused by poverty."

Some 50 percent of poor children are incompletely immunized against smallpox and measles; 64 percent have never seen a dentist; 45 percent of mothers delivered in public hospitals have had no prenatal care. For the poor, the risk of dying under age 35 is four times the national average. In Mississippi, the Negro maternal mortality rate is six times the white rate -- and 74 percent of those deaths are due to causes that we commonly classify as preventable.

To forestall any smug northern superiority, let me add that there are a number of northern urban ghetto census tracts in which the infant mortality rate exceeds 100 per 1,000 live births. In these areas, we have reached the level of Biblical plague -- every tenth newborn baby dies. And this says nothing of the quality of life for those who survive.

Second, health and race -- a topic almost but not quite coterminous with the question of poverty. It is hardly startling that the association between race and poor health is even stronger, for here the crushing burden of racial discrimination is superimposed on the effects of economic and social deprivation. There is a phrase in the Book of Common Prayer that is tragically precise in describing our national performance with respect to the health of the Negro population. It reads: "We have left undone those things which we ought to have done; and we have done those things which we ought not to have done; and there is no health in us."

The undeniable fact is: infant or adult, man or woman, northerner or southerner, the Negro is substantially less healthy than the white. He gets less medical care, less adequate medical care, and less assistance in meeting its cost.

The effects of racial discrimination and economic disadvantage begin before birth -- and never stop. Most Negro expectant mothers simply do not get the basic prenatal care that most white expectant mothers take for granted. Fewer Negro mothers have their babies in hospitals than do white mothers. The national Negro infant mortality rate is almost twice the white rate. And women without

prenatal care are about three times as likely to give birth to premature babies than those who do receive proper care. Very small premature infants are ten times more likely to be mentally retarded than full-term children. And some of the infants who do survive the year, particularly in the rural southeast, are likely to be systematically and chronically malnourished. We are just now beginning to explore the contribution of that kind of malnutrition to mental retardation.

Nor is all of this merely the effect of the greater concentration of poverty among Negroes. In one carefully detailed study in New York, for example, comparing perinatal mortality among Negroes and whites by social class, the mortality in the Negro population was higher than that in the white population in every socio-economic group -- and, indeed, the mortality in the infants of the Negroes of the highest socio-economic group (teachers, professionals and the like) was greater than that among whites of the lowest socio-economic group.

One actual case may make this more real than any recitation of figures. Consider this report from the Tufts-Delta Health Center in rural Mississippi:

"Miss Jessie Mae and family. A mother and 11 children, ranging in age from 9 months to 16 years, living in a three-room shack off Highway No. 8. She is employed as a day worker rotating between two white families. Her average earnings are \$15.00 weekly.

"I first heard of Miss Jessie Mae from a young man who expressed concern for one of her daughters who frequently had 'blackout

spells' that lasted for hours. To his knowledge the child had never been seen by a physician. Upon arrival, I found seven children playing in the yard. The older girl in the group (age 11) was 'caring' for the baby who was nursing himself on bean soup while resting in a bed made out of a paper box. Although the temperature was 40 degrees, four of the children were without shoes and coats. A five-year-old girl had an open wound on her foot, covered with layers of dry blood and dirt. We were told by a neighbor that she had broken her toe with an axe. When questioned regarding care, she stated that children usually seem to get well fast and that most people didn't bother to take them to the doctor.

'Miss Jessie Mae arrived after I'd been there for about one-half hour and related the following information regarding her situation:

1. She had been burned out nine months ago and now owned one bed, a table, and three chairs. Straw mats were used by the smaller children.
2. The children were out of school for lack of shoes and clothing.
- 3.. She didn't have money to see a physician.
4. She realized that the baby needed better attention, but she had ten others to feed and take care of.
5. She gave the children grits for breakfast, pecan nuts for lunch, and rice, beans and greens for supper. Fatback was to expensive but sometimes she fished and occasionally the boys would

run down a rabbit."

This family I must add is not in southeast Asia. It is in the southeast United States.

But what has this got to do with the urban crisis? Everything, for Mississippi -- and Alabama, Louisiana, Georgia, the Carolinas and other southern states -- are now our back yards. The migration of Negroes from the south to the urban north and west -- toward expected improvement in employment, educational opportunity, and living environment -- reached a net total of 1.5 million persons in the 1940-1950 decade. Another 1.5 million conservatively are estimated to have migrated between 1950 and 1960. This year alone, the number will approximate 150,000. This is the most extensive movement of a single group in American history -- yet there has never been a single, coordinated Federal program focused upon it. At the source of this migration, we fail to equip prospective migrants with reasonable health, functional literacy, or a marketable job skill. At the terminals of the migration -- Chicago, New York, Boston, Detroit, Los Angeles, Washington, and elsewhere -- we fail to do anything effective to ease this enormous transition. As the opportunities for a decent job, a decent education and decent housing in our central-city areas decline, the evidence increases that for many of these people this hopeful migration is self-destructive, destructive of family, destructive of children. It is perhaps symbolic, in a nation built on migration, that this great movement of human beings goes on behind the back of the Statue of Liberty;

she faces the other way. And so, today, we are reaping the whirlwind of four decades of neglect, and all of us who are struggling with the problem of health care for the urban poor are reaping that whirlwind very specifically.

Finally, and briefly, urban growth itself. The demographers tell us that within 30 years most of the population of the United States will be living in four or five huge urban megalopoli. One of them, with more than 50 million residents, will be Bos-Wash -- a continuous urban belt from Boston to Washington. Another, with more than 30 million people, will be Chi-Pitts -- Chicago to Pittsburgh; and a third, with 20 million, will be San-San -- San Francisco to San Diego. The prospects are about as distasteful as the names -- but they are real, and we will have to start to deal with them now, and recognize their magnitude. In health care and in other areas, it is just no use to build a better mousetrap -- when the problem is elephants.


And so, in summary, we have a whole segment of our population -- the poor, the Negro, the rural migrant, the central city-dweller -- sinking into the lower depths, isolated more and more from the mainstream of American life. They are aliens within our own country, with a powerful and despairing conviction that the major institutions of American life do not serve them, are not intended to serve them. And the consequences are apparent in their health.

We ask, how this can be? Look at our magnificent teaching hospitals, our medical centers, our medical schools, our networks of community hospitals, our public health departments and their vast arrangements of clinics, our great array of social service agencies

and voluntary organizations. And the poor, the Negro, the in-migrant --- regardless of ability to pay -- can get medical care of the very highest technical quality! It must be the fault of the poor themselves -- they are apathetic and uncooperative.

This convenient fiction has been called the Mt. Everest fallacy, a name I think is very apt. If we construct a wonderful medical center, complete with a trained staff, the latest equipment, open to rich and poor alike, with a huge outpatient department and all of the necessary diagnostic and therapeutic resources, and then put the whole thing on top of Mt. Everest, and then find that the only regular patients are Tenzing Sherpa and Sir Edmund Hillary, obviously the rest of the world is apathetic and uncooperative!

I am saying that many of our health services for the poor, while they are of high technical quality, are characterized by a series of nearly insuperable barriers to access. For poverty populations these include the barriers of time and distance -- the simple physical remoteness of many health facilities, the inadequacies of public transportation in slum areas, the long hours of travel and waiting time. We have all heard over and over again the story about the Watts area of Los Angeles where it was a two-hour bus trip -- if you could find a bus -- or a ten-dollar cab ride to the Los Angeles County Hospital's outpatient department. If you were sick, the question was whether or not you were "ten dollars sick." Or if you were willing to lose half a day's pay (for, after all, the outpatient department is only open



during working hours, and the jobs available to most poor people are not characterized by sick-leave provisions). Or if there were four children at home, and no one to care for them.

Add to these the barriers of cost and confusing, complex, and contradictory eligibility requirements. Add to these the barriers of discontinuity, irrelevance and impersonality--what Dr. Alonzo Yerby has called "the pervasive stigma of charity." And then, finally, add the barrier of fragmentation of the health care system, the biggest barrier of all and one that must be of overwhelming concern to Regional Medical Programs. "Well-child" care in one place -- but someplace else for the same child when he's sick; adult care somewhere else, ambulatory care at another place, in-hospital care unconnected with all of these, and social work and visiting nurse resources at still other places. One of the reasons for the great rise in the use of the hospital emergency room at night is simply that the so-called 'apathetic' poor are making highly intelligent use of the health-care system: they have discovered that you can get the same piecemeal, episodic, discontinuous, uncoordinated medical care cheaper and faster in the emergency room at night than in the outpatient department in the daytime!

It is within the usual outpatient department, however, that the system really becomes absurd, and let me turn again to Dr. James for a case example that is I think only a little extreme. He states:

"Let me give an actual case history of a man of 76 who lives in a housing project in Queens. He has the following medical problems: cancer of the larynx; he has a tracheotomy, and speaks through the use of his esophagus with special equipment. If he

would go to one of our good teaching hospitals, he would go to the ear, nose, and throat clinic, and the cancer clinic. He has a cataract of his left eye, so he'd go to the eye clinic. He has chronic bronchitis, so he'd go to the chest clinic. He has a hypertrophied prostate, so he'd go to the GU clinic. He has varicose veins, so he'd go to the vascular clinic. He has arteriosclerotic heart disease and an old coronary thrombosis, so he'd be followed in the heart clinic. He has marked constipation, a diverticulosis sigmoid colon, a hiatus hernia, a diaphragmatic hernia, -- and so he'd go to the medical clinic. He also has diabetes mellitus -- so he'd go to the metabolism clinic.

~~'Here's a man of seventy-six who happens to live four miles from the nearest available hospital, and must go to ten different clinics.'~~

Now this may be a wonderfully efficient system for the training of interns and residents in the medical specialties. It may be an efficient way to run a hospital, from the point of view of the hospital. It may be a wonderful system for the diagnosis and treatment of diseased organs -- but the system doesn't work for sick people, and most diseased organs come in that kind of a package. And it doesn't work for sick families, and most people are part of a family. The system has nothing to do with communities, yet most families live in communities -- and family and community are powerful determinants of health and illness from the standpoint of the biological, social and physical environment.

But how did all of this happen? It didn't come into being

because health professionals -- physicians, nurses, social workers, hospital administrators and others -- just didn't care, or haven't tried hard, or aren't concerned and trying hard now. It happened because for the past fifty years we have been experiencing the revolution of scientific medicine: accurate diagnosis, powerful therapy, and a very real ability to save lives. We have made the hospital the center of this revolution, and more and more medical care -- the complex equipment, the multiple diagnostic procedures and the concentration of specialist resources --- has been pulled centripetally into the hospital and medical center. In medical care, the hospital is the hub of the universe and this has had an enormous and important effect on the quality of medical care. But it has left the community, the people, and a whole set of deeper social needs, behind.

And so, on the upper floor of the hospital, we have the very best that American medicine can offer. And down on the street floor -- or in the basement -- we have that great medical soup-kitchen, that cafeteria of clinics, that Siberia of medical care, the old-fashioned outpatient department.

Sir Geoffrey Vickers has defined the history of public health as a series of "successful redefinitions of the unacceptable." If the old outpatient department is unacceptable and innovation is needed, then the Regional Medical Programs need to be very much concerned with a new redefinition of the unacceptable.

One kind of innovation -- and I am not going to dwell on it in any detail at all -- is the Comprehensive Neighborhood Health Center network

funded by the Office of Economic Opportunity. It is a way of putting the existing package together a little bit differently. I am not going to describe it because I know it has been described to all of you many times. But I would like to give you a little bit of the data on results of this reorganizing effort in one community -- the 6,000 people who comprise the population served by the Columbia Point Health Center in Boston.

We are able to have some measurements of impact here because of the OEO's wise provision of research and evaluation money which gave us the unusual opportunity to take baseline measurements before we opened clinical services, before we changed the system, as a reference point for comparison with the measurements at a later period of time. After we had been open for just two years, we found we had managed more than 72,000 patient visits, mostly at a rate of more than 200 patients per day, or three percent of the Columbia Point population every 24 hours for real and evident problems. So much for the so-called apathy of the poor with regard to health care!

We had assumed from the beginning that we would have to turn on a variety of health education programs -- how to use this new source of care, how to utilize it effectively -- to make people concerned about health and health care. We have been too busy since the day the doors opened to ever get around to these programs. Remember -- we see three percent of this community every 24 hours! The rate of ambulatory health care utilization by this community has more than doubled. Before we opened, only 72 percent of the community had identified itself as having any regular source of medical care.

Today that figure is over 90 percent and overwhelmingly represents the health center. Two years ago only 15 percent of the population felt it had a good source of advice about health problems; today the figure is 44 percent. Two years ago, 23 percent of Columbia Point families stated that they had put off needed medical care during the preceding months. The comparable figure is now only 5 percent. Two years ago, 28 percent of the residents had ever had a physical examination for preventive purposes -- that is, when no known illness was present. Today the figure is 55 percent.

Before the health center opened, 70 percent of the Columbia Point population reported that it took from two to five hours to leave home, get medical care, and return home. Fourteen percent said it took from five to nine hours. Today 89 percent of the community reports that the door-to-door time for medical care is one hour or less -- a figure much more consistent with the needs of large families, working mothers, many young children and limited transportation.

And finally, and most strikingly, we have just conducted a study of hospitalizations in a small sample (54 Columbia Point families) for the year before the health center opened and for the two years since. These 54 families (a random selection of those continuously on public assistance, which is typical in this community) consumed 200 hospital days in 1965, the year before the health center opened. The first year we were open, in 1966, these same families required 110 hospitalization days; and in 1967, the second year we were open, a total of 40 days.

In this sample of families, then, the health center has reduced hospitalization by 80 percent in just two years. I didn't believe the figures so we went back and did a much more careful study on a substantially larger sample of families. We also contacted every hospital in the Boston area that was a possible source of hospitalization for any of these people. On the basis of this new data, I have to tell you that the 80 percent figure was wrong. The accurate figure is an 86 percent reduction in hospital days for this community over a two year period.

That's one kind of innovation. But it's not the only kind. I will suggest the bases for considering other innovations. The promise of health action alone is not enough. In the urban crisis, and for the Negro population that is at the center of the urban crisis, it is absolutely clear that the biological, social, economic and political environment of the ghetto is incompatible with healthy life, and no amount of health service as such will alter it. There is just no point in treating rat bites -- and ignoring the rats. This is the reality we must face -- and the reality we have been avoiding as health professionals, preoccupied as we are either with technical medical concerns or with hospital development. To equip a concentration camp with a medical center is not only futile -- it is an expression of the deepest moral cynicism. We cannot simultaneously have health and Harlems, health and slums, health and racial discrimination, health and a second-or third-class education, health and unaided in-migration.

If ill health is not a matter of mere technical medical concern, what then are some of the things that an organization such as the

Regional Medical Programs might do?

I've talked about innovation. It seems to me that Regional Medical Programs, precisely because they are not primarily devoted to the construction of new facilities or the operation of new service programs, but rather to the linking together of the old in new ways, has a particular role to play with regard to innovation, particularly innovation in the organization of care. In taking this path, let me just suggest some ideas to you and to the panel for response.

First of all, I would like to ask, why are we so narrow about our definition of health service? What is a health service? Why do we approach, for example, the problem of lead poisoning by defining only the following things as health services -- screening, case finding, treatment, follow-up remedial care, long-term care for those with neurological damage? We all know that this is a great problem in the slums of our cities; yet we send 98 percent of these children, after treatment, back to the same slums to eat the same lead poisoning paint off the same crumbling plaster walls! Is it not a health service to do something about those walls? No, we say that is not a health service. It doesn't concern the same people who are concerned about diagnosis and treatment.

Why is transportation not a health service? Why is it not included and considered as an integral part of the whole package by Regional Medical Programs and other organizations concerned with health services? We all know that the existing health care system is run by and large for the convenience of the professionals; they are one of the important groups in the system, but not the only one. Yet it is the shortage of health professionals, the need to cater to their

convenience, that forces our outpatient departments to be open only from 8 a.m. to 4 p.m. I often wonder what would happen if, for the same reason, we ran our subway systems only from eight o'clock to four and said that after that it had to be an emergency problem!

What can be added to the planning process? I know there has been talk about the involvement of health professionals as a primary participant in health planning processes, particularly in urban areas. But, I think that the most important thing that can be added to the planning process is the community -- not just the health and related professionals. This is particularly true with urban ghetto communities, and when we talk about urban health problems, we are increasingly talking about ghetto problems.

I am not talking merely about the peculiarly political definitions we have given to community control, community participation, community veto over programs and all of the rest, nor about the resulting political conflicts. I think there is something else, something which is very often left out when we try to identify the parts of a community. That is the community as a set of resources, a set of strengths. We are so trapped by wringing our hands over what we believe to be the unique pathology of ghetto populations that we forget too often to even look for the strengths that are there.

Let me give you just one example. It's from a rural environment, but I am sure there are many urban parallels. Our Mississippi health center has to cover nearly 11,000 people spread across 500 square

miles. That's a lot of territory, with a lot of patients to be brought in to the health center, and returned. Also, health center staff of various kinds must travel those 500 square miles. It became clear to us after struggling with the transportation problem that there just weren't enough wheels in the world to do the job adequately.

The community came to us and said: "Why are you killing yourselves over this transportation problem? Why do you do such stupid things? This territory is travelled one way or another every day. You must take advantage of this existing travel." The upshot was that we are taking a significant portion of our transportation budget and giving it to the 12 health associations we have helped to organize in the area. The health associations, in turn, found local people in old cars to tour the local networks, pick up the patients, bring them to us, wait for them and bring them back.

There was the strength in the community to run this system very effectively, and we are finding the same strength over and over again. There are all kinds of skills and strengths out there in the communities and I think they must be taken into account in our planning for new ways to put things together.

One last item, again in terms of innovation. What contribution can Regional Medical Programs make to change in licensure laws? There is just no point in talking sensibly about new health careers, new responses to the health manpower shortage, unless we are going to do something about the legal restrictions that prevent us from training new people to do what they can do -- systematically taking

away from a physician what can be given to a nurse, from the nurse what can be given to LPNs, and so on down the line.

If there is an encouraging thing to be said about this crisis, this vast set of problems, I think it's the fact that asking health professionals to face them poses nothing really new. It merely asks that we health professionals rediscover the social commitments we made more than a century ago, when we were leaders in the fight for sanitary reform, for an end to slum housing, for the abolition of child labor. Let those who think this is radical listen to the words of John Simon, the first health officer of London, during the first great urban crisis -- the explosion of the cities during the industrial revolution in the 1840s:

"I feel the deepest conviction that no sanitary system can be adequate to the requirements of the time, or can cure those radical evils which invest the under-framework of society, unless the importance be distinctly recognized, and the duty manfully undertaken, of improving the social condition of the poor."

"I would beg any educated person, to consider what are the conditions (of urban life); to learn, by personal inspection, how far these conditions are realized for the masses of our population; and to form for himself a conscientious judgment as to the need for great, if even almost revolutionary, reforms. Let any such person devote an hour to visiting some very poor neighborhood in the metropolis ... let him breathe its air, taste its water, eat its bread. Let him think of human life struggling there for years... Let him, if he have a heart...gravely reflect whether such sickening

evils ought to be the habit of our labouring populations; whether the legislature, which his voice helps to constitute, is doing all that might be done to palliate these wrongs; whether it be not a jarring discord in the civilization we boast, that such things continue in the midst of us, scandalously neglected...

"If there be citizens so destitute that they can afford to live only where they must straightaway die -- renting the twentieth strawheap in some lightless fever-bin, breathing from the cesspool and the sewer; so destitute that they can buy no water -- that milk and bread must be impoverished to meet their means of purchase, that the drugs sold them for sickness must be rubbish or poison: surely no civilized community dare avert itself from the care of this abject orphanage. If such conditions of food or dwelling are absolutely inconsistent with healthy life, what clearer right to public succour than that the subject's means fall short of providing him other conditions than these?"

These are the words of a revolutionary -- a health professional and a revolutionary -- calling for reform, and he and his colleagues led the way in a great social upheaval. It was the sanitary reform movement of the nineteenth century, and it was a first answer to the urban crisis of that era. Today, in the face of another urban crisis, we need analagous social reforms, and we need the participation of health professionals.

If physicians could testify then as to the maximum permissible amount of filth in the municipal water supply, then they can with equal propriety testify now as to the minimum amount of green grass

per growing child, or the minimum standard for accessibility and availability of health care or the effects of racial discrimination on young minds and personalities. Through such institutions as their medical schools they can reach into the slums not merely to give service but to start recruiting, at the third-grade level, the future candidates for professional education -- and that means paying the tax money to support as good an education in the central city as in the suburbs. It is time, once again, to redefine the unacceptable, not as "crime in the streets" or some other euphemism for racial prejudice, but as the social and physical conditions that produced last year's and this year's mass convulsions in our cities. The real crimes in the streets of our cities from the point of view of health professionals, I suggest, are the crimes of slum housing, slum education, slum jobs or no jobs -- and, among other things, the infant mortality rate, the dead babies.

This doesn't ask that the health professions abandon their technical concerns. It does suggest that they add to them a sense of passionate involvement in the social issues that underlie health. Any narrower definition of our proper interest in health, I submit, is an abdication -- one that will leave us once again with "no health among us" and no freedom, either.

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After Dr. Olson called and asked that I discuss with you the management principles that should be operative in the work of cooperative health associations, I started reflecting on what would be most relevant to your situation and responsibilities. The thought occurred that Stan was not really talking about the principles of management. Those of us who teach in graduate schools of business actually don't have much in the way of principles to teach. The great thought today in management is the particular situation in which the manager is operating. We have seen successful management jobs often done by people who were never formally exposed to the principles but who understood the situation in which they were operating. So I have decided that for my presentation I would examine with you very briefly in the short time allowed me, the sorts of obstacles or pitfalls that your particular management situation represents.

The important thing to you and to the mission you have is to develop a staff and to inculcate into that staff awareness of the very difficult administrative situation, the very complex situation, that confronts them as they try to get the job done. You have a number of difficulties that simply are not faced by any other type of organization that I know of in this country. I can say truthfully I do not know of a more difficult management job than yours. And here, I am not talking about you managing your own organization. That I think is relatively easy because you don't

have very much of a snow in itself. The starting of course is difficult because of the low salaries you are able to pay. Finding the type of person that fits into the responsibilities you have is difficult. But, in general, as to managing your own organization, it could be done with your left hand. The real difficulties you have is managing the situation, or what we would call program management rather than enterprise management. This is the most difficult sort of management because it is up to you to get other people that are not in your hierarchy, not even organizationally related, to carry out the purposes, the charge, the mission for which you are responsible.

So it is the unique situation that confronts you that we should examine with the thought that good common sense will handle the rest-- if you can just orient your staff as to the situation in which they are operating. I have listed some eight or ten obstacles, or you might even call them pitfalls, that very seriously affect what it is that you are trying to do.

I have mentioned the first of these already--that is that you are program administrators rather than enterprise or operation administrators. You must put across your assignment through other agencies, through the efforts and contributions of people who do not have line responsibility to your own organization, who are not under a system of inducements that you control, except through such grants as you might influence.

Second, your own staff, and indeed you yourself, are atypical to the situation in which you are working. You are likely to be much more mission oriented than the people with whom you are working, or the people whom you are attempting to convince. That is, you would not be

just a little differently from all of those outside of your immediate organization with whom you are working. This is because if everybody saw things like you do, there would be no need for you. We would already have in operation the arrangements that Regional Medical Programs seeks. But in any movement of this sort, and especially to its pioneers, there must be a high degree of evangelism, a degree almost of fanaticism in support of the goals Regional Medical Programs is trying to accomplish. If you did not, or do not, possess an emotional bias toward these goals you should not have gotten into the movement anyway. I am sure you have seen this as you asked people to join your staff. You have had turn-downs from a lot of very capable people simply because they were not fired-up in behalf of the cause, so to speak. This is a movement that is long past due. Only a few people have fully recognized how needed it is and it is those people who are willing to give up other positions to get the job done. These are capable people who can put the job across for you. But they have been willing to come with you because they were like you-- just a little queer, just a little odd. They believed in something that few others recognized and to that extent you and your people have to be careful that you see the situation through the eyes of the average person engaged in the agencies or activities whose participation you are trying to enlist. You must realize that you can't assign to everyone in a Region the same sort of interest, the same sort of evangelistic effort that you and your staff have. This is a problem in any movement. We forget this

fact and become rough riders, try to roll over the top of people without selling them, without convincing them, without creating an understanding of what it is you are trying to do. We must not start from the position that everyone else is as highly motivated as we are. There is nothing that creates resentment more on the part of the other fellow than to roll over him or to push him, or to pressure him into something he really is not sold on, really does not understand.

The next pitfall would be that the Programs represent a threat to the status quo. As I said earlier, if your charge was widely accepted, if the regions were already functioning as you feel they should, and just a few refinements were needed, this country would not need the rather elaborate organization of Regional Medical Programs. In that case your program would be proceeding historically, it would have its own traditions, it would have many of its own mores already established. But this isn't the case. You are indeed undertaking something that is a real threat to the status quo. If it is put across in the next couple of decades, if we can after some twenty years of your effort see visible effects of this linkage of our health system, then I think all the efforts, concern, and money that will have been devoted to it will have been much worthwhile.

But to every person now involved or engaged in health activities, Regional Medical Programs do represent a threat to the status quo. Of course, by over-emphasizing your threat to the status quo I could be giving you what I call an excuse for alibi administration. You could go too slow, you could lose the momentum of the Act itself, of the great start it has gotten. But at the same time, as you work with people in the many diverse

agencies and institutions concerned, you will lose them pretty quickly if you out-run them. Also you can frighten them as you proceed. I don't believe people resist change as much as many psychologists say they do, but every person and organization will resist change to some extent and will do so strongly and stubbornly unless it fully understands the implications of that change to its own welfare, to its own existence. The RMP agencies can expect resistance. You are a threat and you might as well recognize it. If you do what you are supposed to do you are a real threat to the established and traditional patterns and practices in carrying out the function of health care.

Next, the forces of inertia are lined up against you. With any movement, with any effort to bring about change, whether people like or don't like what you are endeavoring to do, it is difficult to get them to move off of a dime, so to speak. Just to get individuals and agencies to put out the effort that change requires is in itself a difficult thing to accomplish. Also, the need for stability in society, and the longing people have for the familiar and the routine, fosters inertia. I guess one of the most difficult problems, at least this is what we teach in business administration, is that inertia keeps things from happening much more so than ill will and hostility toward the chance that is being advocated. This is not to say that you do not have hostilities. We will talk about these shortly. You will have them as you restructure, or as you cause to be restructured and reshaped and redesigned the health care delivery system of a nation.

Next, you must introduce people that have long worked around each other to each other. In other words, you must cause the components of

health care to establish new relationships.

period in the health field that there is quite a difference between being familiar with what other people are doing and establishing a relationship between people or agencies that has meaning to what each is trying to accomplish. That is, you must establish close working relationships between groups that hardly speak to one another officially, or agency-wise, or professionally, even though they might know each other's program. Your program involves a whole new chain of relationships. Again, these relationships are hard to establish because it means disrupting other relationships, perhaps turning away from those with whom you have worked closely in order to function in a new alignment. It can also mean the awkwardness of attempting to work with the same groups in a different way.

Next, there is a great diversity of agencies with which you must deal. The health industry, or the health field, is marked in our country by extreme proliferation. This, of course, is no secret to you coming from the health field--and also from the short time you have had to see it from your present vantage point. We are made up of many, many agencies. This partly grew out of the fact that there were so many different facets of the field involved. Not only is there a great diversity of task or assignment, each agency having a small segment of the total health job to do, but also the proliferation of ownership and control. We have a pluralistic system. This means we are highly diversified as between private entrepreneurship, non-profit and public. We are also diversified in relation to the way our various agencies get their funds. Some

providers get them from the client or the consumer, others get them indirectly from third parties, some get them directly from the government, some get them almost entirely from philanthropy. But which ever way you turn in the health field, you find this great proliferation of origin, great proliferation of support, and great proliferation of identity, so to speak. You are charged in your duties of Regional planning to bring together a host of diverse interests and diverse types of agencies, to get them to work together to accomplish a common job. This proliferation does not mark any other activity or field in our society as it does the health field. The health field literally has no counterpart. Education, the only comparable field, is largely public owned, largely public supported and operated. The educational institutions each have a pretty clear cut identification. But, in the health field we have no such clear cut identification of roles. We have many sources of responsibility to which we must respond.

Then, there is a divergency of goals and interests in the health field. There is no use kidding ourselves here, there is no identical set of interests. Everyone sees the same end goal--the better health of people in the Region they are serving. But to be naive and say that there is an identity of goals and interests will only lead you into conflict, or lead you into trouble, because each of the agencies and individuals do indeed have different goals, institutional goals or individual goals. There is a mutuality of interests, of course. But it is a common thought in management, and also in social organizations, that most movements come about rather spontaneously because people sense that they can do better

and achieve their own particular goals better together than they can individually. But my own experience indicates that there is not a sensing, nor a reality, relative to common and identical goals. The planning that you do, the programming that you do, has to bear in mind that you are in some instances asking people and agencies to subordinate. That is a good word, but you probably better not use it out of this room. But to be effective you must secure a subordination of the parts to the whole. This is a sacrifice that few agencies, institutions, and professions are willing to make. In the same connection, I could say, that this divergence of goals and interests means that you have different peer groups, you have different reference groups. Because of the lack of full client payment, except in the actual practice of medicine itself, most all of the institutions that have traditionally supported the doctor and provided the resources and facilities for the doctor have been non-profit, philanthropically supported. Philanthropically supported means that our institutions are very much public relations oriented. They are usually looking over their left shoulder at what will help fund raising, or what will help the rich widow leave them money in her will, or what will help the local industries to come across with checks. If you try to put the pieces of health care together Regionally then you run into the problem of who is trying to impress whom. Their destiny has depended upon public relations much more so than the quality of their effort, or the comprehensiveness of it, or the continuity of it. There are some who claim that the whole health facilities system in this country has been put together by public relations people; that the system has been designed much more by the desire to fill a tin cup than from the desire to fill the greatest need.

You are dealing with a broad spectrum of professionals. If you asked what has been the greatest problem, the newest problem in the past couple of decades presented to management, especially to industrial management, the answer would be the management of professionals. We have seen a great movement towards research and development and the consequent movement of the scientist into industry. When you try to administer the professional you confront numerous variables. His outlook is entirely different, his motivations and aspirations are different, and his reactions are different. He can be described as being very independent. I don't think it any secret that physicians are highly individualistic. Physicians accept a personal responsibility to the individual and are antagonistic to anything that binds them into a situation where they are not in control of the decision-making process relative to the individual patient. But you are dealing not only with doctors but with a whole host of other professionals. All tend toward an individualistic approach. You will be dealing largely with representatives of organized groups both of professions and institutions. They were selected because they have exhibited strong-willed interest and strong leadership. This means you are asking a group of super stars to play on the same team. And super stars are awfully difficult to coordinate. They got to be leaders simply because they were stronger in their opinions, stronger in their motivations and stronger in their efforts than those who failed to become leaders. You are dealing with the strongest people, both professionally, leadership wise, and otherwise, in your Region. To work with these people is a science in itself. It calls for a kid glove technique. It also calls for an

intellectual approach. It is in no way the same as working with individuals who desire to rise in an organizational hierarchy and whose future depends upon your organization. I don't think that you will find many "organization" men in the many diverse groups with which you will be working.

I'm sure I am not telling those of you who have been in your positions for any time anything new. Again I would like to repeat that I am not talking about your own staff. I think every individual who has been chosen for a responsible position on the staff of a Regional Medical Program has already exhibited a high degree of compatibility with organizational goals or he would not have come to the surface sufficiently to have been considered and tapped for such a position with you. This can represent a liability as well as an asset, however. As I stated in an earlier point, you are recruiting and developing a staff that in itself is highly motivated toward its own mission. But having a vision is not enough. You must develop a staff that, while it remains highly motivated to Regional Medical Programs mission, must also realize the difficulties that confront an organization whose responsibility it is to get others to share that motivation, to get other people to involve themselves seriously in the planning function, and then to work hard toward implementing whatever it is that is planned.

Another thing to consider. Your system of inducement is weak, very weak compared to the task that confronts you. Most programs that I know don't ask others to do things unless the program is footing the bill for whatever it is they are asking. Examine other Federal programs and you will find this to be the case. There is a financial quid pro quo that goes along with asking people to put across a particular job. But you

have very little project money compared to your total task. Your movement won't succeed or get very far toward the realignment of our health care delivery system if the only thing done is what you can pay to be done. In other words, even if you had many times the budget you have, you could hardly touch the problem. All you can do with the resources you control is help create the stimulus and help build the momentum. The resources available to you will always be insignificant to the task no matter how generous the Congress might be. You're faced with the fact that you have little more than demonstration money. To a large extent you are asking people to spend their own funds in order to accomplish the purposes for which you are responsible. Because your financial inducements in no way match your responsibilities, you must excel in the art of leadership, the art of administration. Also, you must not only win converts but you must keep them won over the long haul of tedious and slow progress. It is always much easier to get things to fall in line than to get them to stay in line. There is another real handicap you face. You are operating in a glass bowl. Your business is public business and everything you do will be scrutinized not only by the local newspapers but by every health agency and health professions group. Your problem is somewhat akin to that of Mr. Johnson's misfortune in having to fight the VietNam war over television. He is subject to the second guessing of all these arm-chair generals who sit before their television set and see only a fragment of the action and none of the troubled factors that led to the course of action. The visibility of your failures will not extend to your successes, however. They will be obscure. This obscurity of results can cause a dampening of interest on the part of the general public, on the part of Congress, on

the part of the agencies concerned, and indeed on the part of your staff. You aren't going to be able to revolutionize the health care delivery system overnight. You aren't going to be able to rapidly achieve concrete gains. If all the projects that have been funded are highly successful, they will not in themselves make a great dent in the problem you are attacking. There will, of course, be long term results if the projects have meaning. There is no possibility, regardless of the number or quality of projects, of instantly changing a thing so complex, so cumbersome, so ingrained as our health care system. To realign it properly, to give it continuity, comprehensiveness and economy, is an incredibly difficult task. Progress is going to have to come by the inch rather than by the mile. And in many instances things that are done will not prove themselves, or even come to the surface, for several years, or in some cases for many years. Further, the successes will have to be accumulative. Total success will have to be achieved before the worth of individual steps is recognized. In other words it is sort of like climbing a mountain to see the other side--you just can't see anything until you get to the top. The top, I'm afraid, is going to be reached beyond the tenure of some of the directors now involved in making the tortuous climb up the mountainside.

The elusive measure of your efforts can lead to a tendency on your part to do the dramatic, to prove your case, to justify your existence. The temptation will be to choose the sort of projects that show up the most, even though they count the least. To use an old expression, yielding to this temptation can win some skirmishes but lose you the war. In

picking the most dramatic projects, ...

instant success, you can waste your resources and following. Getting mired in the irrelevant can discredit the entire movement and create both diffidence and dissidence toward your later efforts. Along this same line, doing a thing well must not be confused with doing the best thing. We are prone to grab hold of those problems we know we can do most and best about. But these are generally, and especially in the case of Regional Medical Programs, the problems that we needed to worry least about. Another axiom of management is that we work hardest when we see results. It takes a high level of discipline, as well as commitment, to keep in pursuit of a goal in which progress is not well defined, and where you can't go home in the evening sure of how much and how well you did during the day. But by the nature of its mission this is largely the name of the game for Regional Medical Programs.

I close by emphasizing that I'm not trying to say your job isn't do-able. I think it is very do-able. I sincerely believe that over a period of time we are going to see all of the aspirations of Regional Medical Programs accomplished. The program just makes too much sense to believe otherwise. What I have tried to point out is that there are more than ordinary obstacles and that your job calls for the practice of management in its finest sense. You must work through many diverse elements, where the management strings you must pull are held by many different groups and individuals. You can never fully know the true response from those strings.

The problem you have is to develop a staff that is sensitive, as well as dedicated; that they realize they are dealing with real live

jumping people who are also dedicated; that they are dealing with career people; that they are dealing with people who have a great deal of technical, scientific and professional knowledge; with people who belong to other organizations; and with people who have spent a good part of their life getting fixed in the patterns and circumstances of a system that you are charged with realigning and to an extent redefining.

This management task of Regional Medical Programs calls for the art more than the science of management. It calls for a savvy of the situation in which management is being practiced. The best pilot on the Mississippi River can easily run his boat aground on the Amazon. Or, to state it another way, as every effective salesman soon learns: You've got to know the territory.

'THE RESPONSIBILITIES OF MEDICINE
IN ADVANCING OUR HEALTH CARE SYSTEM''

Dwight L. Wilbur, M.D.
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First, I would like to compliment Mr. Brown on having handled a most difficult subject in a superb way. I hope when I'm finished, I will have at least in part done as well in discussing the subject Dr. Olson has asked me to consider-- "The Responsibilities of Medicine in Advancing our Health Care System."

I'm really sorry that I was not here yesterday, but other duties detained me. I notice from your program there was discussion of the Health Power Structure and subsequently a discussion of Issues and Concerns. I also see that this afternoon there will be further discussion of Issues and Concerns.

I also have great issue and concern with the title of "Health Power Structure." If there is such a thing, I suppose I could be said to represent it.

But in making these comments I would like to tell you a little story about Woodrow Wilson. In his early days after he finished his studies in law school, he returned to his old home of Staunton, Virginia, and hung out a shingle to practice law. His first three cases were tried before a judge who was an old family

friend of the Wilsons. Woodrow lost all three cases. He was terribly depressed about this because he knew he had ability; he had the interest and had worked hard. And this was his hometown and he was just getting underway. So, one evening, he went over to visit the judge. He said, "I would like to talk to you man to man and have you tell me what my trouble is." And the old judge said to him, "Well, Woodrow, you have done a superb job in studying these cases. The briefs you have prepared could be used as models in any law school in this country. But your basic problem is that you practice law not the way it is, but the way you think it should be."

This was exemplified in Wilson's subsequent career, particularly in relation to the League of Nations. He was so idealistic that the League had to be only the way he thought it should be. He could not accept the political realities at that time of the nations of the world. My concern now is that those who wish to greatly modify the health care system in this country, and to do it rapidly, may get into the same difficulty that Woodrow Wilson did. They may not lose all the cases, but, in the long run, as with the League of Nations, they are not going to win. And in the meantime, they will needlessly upset an evolving system and do a great deal of harm to many people. I will indicate in my comments why I believe this is so.

The fact that I have been asked to speak on the responsibilities of the profession in advancing a health care system suggests that we do not have a health care system in this country now. I have heard this comment made on a number of occasions. Of course, if you know anything about it, you will know this is not accurate. We do have a health care system in this country. We have top-flight medicine here. There is no system of medicine anywhere in the world that can compare with that in this country. If you don't believe it, all you have to do is note that two generations ago as in my father's time, he and all others who wanted to get ahead in medicine had to go abroad for their advanced training. But this is no longer the case. Now, all the world is coming to this country for medical education, for knowledge of medical research, for information in regard to our health care system. We are the center of medicine in the world.

I don't mean we have a perfect system. I will point out that we have far from a perfect system. There are many improvements that need to be made.

Now, what does this system consist of? Basically, it has to do with a physician-patient relationship, the one-to-one voluntary relationship of one man seeking and one giving relief.

Here it is important to stress a point that is vital but tends to be lost sight of. In our society we are accustomed to hailing mass methods and mechanization as improvements in fields like manufacturing and handling traffic and keeping track of bank checks. Too many people transfer this kind of thinking to human matters, and assume that mass methods and mass handling will also be improvements there.

This overlooking of the human factor is at the root of many of our misfortunes in education. And it can be the root of disaster in our health care.

The human being is at his most vulnerable when he is sick. It is then he needs most the humane attention and understanding of a trusted and knowledgeable expert - of the physician he turns to voluntarily and into whose care he trusts his life and well-being. Since we know that a major part of the health of the individual is based on his psychological equilibrium, it is clear that this sense of trust and well-being is all important in his chances of returning to good health.

The long-discussed patient-physician relationship is the heart of this rule of human well-being. Without it, we may have eliminated "inefficiencies", but we may also have eliminated most of what health care can achieve.

In this country, this relationship occurs primarily in the physician's office. The physician may be a solo practitioner or he may be one of a group. The physician-patient relationship may occur in the setting of the home. But more frequently today it occurs in the setting of the hospital - in the emergency room of the hospital and in the out-patient portion of the hospital. It occurs to some extent in other areas but these are the prime ones, and within this system there is formal or informal referral of patients by one physician to another. During this past year this system provided 1,250,000,000 visits between the physician and the patient in one or the other of these locations I have mentioned.

It is a very large system quantitatively and I believe good qualitatively. In this system the work is carried out by physicians who are either solo practitioners in an informal group, or practicing in a formal group of varying sorts. They have varying capabilities depending on their education, on their motivation and particularly on their participation in continuing medical education.

These visits are carried out in physical structures, primarily physicians' offices and hospitals, as I have indicated. Hospitals are fairly well spread over our country, although not equally spread. They have varying capacities and capabilities and are of varying ages and stages of

obsolescence. They are generally acute general hospitals financed in part through Hill-Burton funds since World War II.

Health care in this hospital system is financed in three ways. The first is voluntary health insurance, which last year paid about one-third of the cost (\$11 billion). Second, at least a third was financed by government - at the federal, state or county level. The remaining financing - less than a third - came from other sources.

This is a good system and the one we have to deal with as we look to the future. Those of us in the profession have to give some consideration to working with it and within it.

This system has some weaknesses and I would like to emphasize them. The first is the variable distribution of health services in this country and their consequent unequal availability. This weakness has to do particularly with variable rural and urban distribution of hospitals and physicians' services. It results in variability of the quality of care the system can render. There are certain barriers to getting into the system, barriers of entry. These barriers have largely to do with 1) ignorance - ignorance of how to get into the system, or that there is a system, or how to find the right physician at the right time in the right place. Other barriers are 2) financial, with which we are all familiar; 3) geographic, which I don't need to discuss

further; and a very important one - 4) social and psychological barriers. This last barrier will exist a thousand years from now because human nature doesn't completely change. There are many people who, because of psychological and social barriers, particularly those related to fear and anxiety, do not want to get into this system, want no part of it, or want a part of it only at certain specified times when pain or some other symptoms drive them to it. A great many people will not use the health care resources when they are brought to them and provided free. Others seek panaceas from quacks or cures from simple nostrums.

Another weakness in our system is obsolescence - obsolescence of some physicians, obsolescence of hospitals or other physical structures. I shall say a bit more on this later.

Another very important weakness is lack of progressive institutional care where patients can "flow" readily, for example, from the intensive care unit after an acute myocardial infarction to the acute general hospital bed and on to continuing care, if necessary, in a bed in extended-care facilities, and then home for home-care services. We have not worked out an adequate system that will provide a progressive "flow" of patients through these various modalities that should be in close physical relationship. Rather, we now confine this care pretty largely to an intensive-care unit at first, subsequently to the acute general hospital bed, and then home.

Another weakness in our system is the lack of proper use of those in the allied health professions and services. This is an area in which there is great ferment at present. I think there is little question that, as time goes by, we shall see great improvement.

The final weakness is in the financing of health care. It is clearly inadequate for many people. It must be improved to, among other things, meet the economic stress of the individual who is sick, or whose family is sick.

Now what are some of the improvements needed? First, improving health manpower. We need more manpower and we need better manpower. In terms of physicians this is very time-consuming and expensive. Five new medical schools were opened in this country in the fall of 1967, five new ones were opened in the fall of 1968, and two new ones will open next year. Twelve new medical schools in three years is a pretty good record considering the cost of establishing a new medical school. Existing medical schools have to some extent, but to a disappointing extent, increased their enrollments. We do need more physicians. We also need a higher-quality product from our medical schools. I think one can say that at present the quality of physicians graduating from our schools is the best that has ever graduated from medical school in any country, but improvement is needed,

particularly to meet the rapid developments in medicine.

We need to improve the existing medical manpower, the manpower now in practice. This basically, I believe, is the most important function of the Regional Medical Programs. I will attempt to convince you of this, or at least present the evidence that has convinced me.

Very little is really understood about continuing medical education. In this respect, let me indicate now the great discussions that are going on in respect to undergraduate medical education, in fact, in respect to all general education in our colleges and universities. There is no agreement as to how best to approach this matter. And similarly there is very little agreement as to how to educate the physician for practice in the future. Yet this is the real key to the success of the Regional Medical Programs, the key to the success of our health care system.

Motivation and communication are the keys to successful continuing education. We need to learn a great deal more about what motivates individuals, and how they can communicate better with one another. These two essential factors must be stimulated and used effectively to further the education of practicing physicians.

We also need to know something we do not as yet know - why are there a substantial number of physicians who never participate in continuing medical education? The answer to

this question is much more important, in my view, than it is to try to increase the number of physicians who take courses and participate in formal programs of continuing medical education. And, as I said a moment ago, the real effectiveness of Regional Medical Programs, to me, is that of continuing medical education. How can one successfully carry out any program of advance in medical care of patients with cardiovascular or heart disease, or cancer or related diseases, unless one can do so through the physician who is going to carry out that responsibility and who has this as his prime responsibility?

We need among other things to improve the capacity of the physician to practice, not only in terms of what he knows, but in terms of the facilities he has available. Let me point out what I think is one thing that Regional Medical Programs have done in a superb way. This is the encouragement to establish coronary care units in many hospitals. Encouragement of these as they are now established, or thought about in an informal way in almost every substantial hospital in this country, is a move as effective and important as anything else that has been done in the last 20 years in the whole area of the continuing medical education of physicians. It not only has saved lives, but equally important, it has made physicians conscious of the need to acquire more

information, more skill, and more capability in the management of patients with acute cardiac arrhythmias, acute myocardial infarction, or other acute manifestations of heart disease. Furthermore, in most such units there are established basic orders: requirements for the care of patients who go into these units. Physicians must learn what these basic orders are and understand the importance and significance of them. Furthermore, some physicians, for the first time, have taken a serious interest in the immediate as well as long-term treatment of cardiac arrhythmias. This is a prime function of the coronary care unit - the prevention and management of cardiac arrhythmias - and I suspect the coronary care units again have done more to inform the profession of the important practical means by which cardiac arrhythmias can be dealt with than has any other single measure. In hospitals where such a unit exists, a standard has been set that has been a very important factor in the education of practicing physicians.

I hope that in some way the same thing could be done in relationship to the individual who has a stroke. Perhaps the establishment of cardiovascular units where neurologists, neurosurgeons, vascular surgeons, internists, and those in general practice could, working together with specially trained nurses and subsequently with physical therapists, speech

therapists, occupational therapists and others, bring to bear on the individual with a cerebral vascular lesion all that medicine has to offer. This could not be done in the small hospital, except in an informal way. But what could be accomplished in the larger hospital, particularly in the teaching hospital, would to a considerable extent gradually filter to the smaller hospital and become another very important method of continuing education.

For the cancer unit, I have less enthusiasm -- except in isolated circumstances. But through tumor boards, tumor conferences, tumor registries, and establishment of centers for chemotherapy, radiation therapy and diagnosis, many similar benefits would bolster continuing medical education.

Another important approach in improving the medical profession's role in the health care system is the further stimulation of peer review. This can best be done through the medical staff of the hospital - by stimulating the adequate function of all those committees that have to do with reviewing the health care of the patients in that institution. Tissue committees, medical record committees, audit committees, abortion committees, evaluation committees and utilization review committees have all served very useful educational functions and have significantly raised the level of medical practice in the hospitals in this country.

Such broad viewing groups as the Joint Commission on Accreditation of Hospitals, the Council on Medical Education, the AMA and Residency Review Committees for those hospitals in which there are residency programs are important mechanisms at the national level. The appointment of Directors of Medical Education, of full-time staff physicians, and hospital staff consultants who will see patients for other physicians without any economic return are means by which, within the hospital, the level of practice can be greatly elevated and lead to effective continuing medical education.

Another commendable area in which the Regional Medical Programs have been working is bolstering communication between community and smaller hospitals and the larger teaching institution. The achievement of rapid communication, particularly in respect to mechanical devices such as electrocardiographic tracings and monitoring devices of various sorts, unquestionably will be significant - but of less importance in my judgment than some of the other forward steps I have mentioned.

Regional Medical Programs will stimulate planning by the medical profession and others with interest in the health care field. This is best done at the local and regional level involving physicians, hospital leaders, faculties of medical schools, medical staffs of hospitals and those with professional, technical and financial interests and skills in the field of health care.

Perhaps the most effective unit to carry this out is the medical staff of a hospital. I needn't go into this further except to say that an effective planning body of the medical staff in association with other members of the hospital team can do a great deal to raise not only standards of practice, but the caliber of continuing education for the practicing physician. Medical schools and medical centers can do the same by the expansion of clinical facilities, by the expansion of educational facilities, and by aiding the normal flow of patients from physicians to university hospitals and medical centers. When such flows are disrupted, when they are disarrayed by some sort of mechanism - particularly semi-legal or legal ones or by unsophisticated planning bodies - there is apt to be very serious disruption of the normal relationships that lead to the best patient care. In turn, the education of the practicing physician suffers. In this relationship it is important to stimulate a normal flow and not to attempt to divert the normal flow into abnormal channels.

At the level of national medical associations much can be done to improve the health care system. This can be done very effectively by the development of more information on the diagnosis, prevention and treatment of heart disease, cancer and stroke, and to correlate the experience of experts and of large centers. I'm aware, of course, of what has

been done in this respect with the support of Regional Medical Programs through studies being made by the American College of Surgeons, the American Cancer Society, the American Heart Association, and the American Neurological Association.

It is very important not to attempt to establish or impose national standards of treatment. These would be helpful at first, without question. But in the long run they would delay progress and delay it seriously. In this regard there may be no better example than what has happened recently concerning P.K.U. and mental deficiency. For a while it looked as if such testing was going to lead to the prevention of mental deficiency in a significant number of youngsters. Unfortunately, in some forty states, testing for P.K.U. in the urine of new-born infants was frozen into the law. Now these laws will all have to be changed because in the meantime it has been learned that this is not the approach to the problem, that it is not sound, and that mistakes were made, both in positive and negative ways. For example, in the normal infant, it is reported that the limitation of the diet on the basis of a false positive P.K.U. test may produce mental deficiency when it did not exist. So it is very important not to freeze into a standard or regulation, not to freeze into law, those things that are not clearly proven.

But much can be done at the national level in respect

to informing physicians on such important issues as the use of anti-coagulants, anti-arrhythmics, surgical treatment of cerebral-vascular lesions, and the treatment of cancer. In the latter in particular, there is much uncertainty at the present time in regard to many aspects of the surgical, radiological and chemotherapeutic treatment of cancer.

Furthermore, national associations can play a significant role in cooperating with other groups in determining the value of multiphasic screening testing centers and methods of early detection of cancer. But let me issue a word of caution here, too. We really don't know what the benefits are of the multiphasic screening process. It's important, I believe, to let centers, such as that of the Kaiser Hospital Group, determine, among other things, what benefits really flow from the multiphasic screening process. To establish such centers all over the country until we know would be a great mistake.

Let's look at detection of cancer, for example. For a while it looked as if everyone should have his chest X-rayed once each year. We now know that in terms of the early successful treatment of cancer of the lung, such X-ray methods are essentially useless. But for those means that have proved to be useful, such as that of the cervical smear for cancer detection, further education of practicing physicians in its use should be a prime function of Regional Medical Programs. I think all

of you who have contact with practicing physicians.

recognize that most physicians now do a cervical smear as part of the general examination of women.

Let me make a few comments about my views on the role of the Regional Medical Programs in the immediate future. First look at the title. Regional - that's the first word. It is regional, not national. And it is very wisely said, because these are Regional Programs, they are not national programs. These programs should be primarily educational, for the better educated physicians are, the higher the quality of medical care they render - the better the diagnosis and care of the patient with heart disease, cancer, and stroke. Facilities and financing are important, but of prime importance is the widespread availability of high-quality medical care. The key to this is more and better education of practicing physicians.

The function of the Regional Medical Programs, as I see it, is to be a catalyst - to stimulate those things that normally go on to go on faster. And to improve the educational level and understanding of the practicing physician by all available means, as I have already indicated.

How is this to be done? If there is a health power structure, which I deny, the best way to get the cooperation of physicians in this respect, and Mr. Brown hinted at this very well - would

be to stimulate strong support from the profession. This can be done because the profession will strongly support any measure that will improve the health care of the people of this country. But they will do so mainly through cooperation and coordination on a voluntary basis, not by coercion. This means the involvement of physicians at the local level, in professional societies, in hospital staffs, and in other groups where physicians normally relate to one another in the professional activities they pursue.

I think we must maintain on a voluntary basis the unique American combination of multiple, independent focal points of activity and capacity that achieve a commodity that will attain our desired goal. In other words, we need diversity, we need regional involvement, we need cooperation. We need diversity so in the long run we will have the basis on which the practice of medicine can be improved steadily, particularly in relation to heart disease, cancer, stroke and other related diseases as they come into the program.

Many people in our society do not benefit from all that medicine has to offer. One important segment is those in the slums of urban and rural areas. We must make increasing efforts to bring to them the advances in the diagnosis, prevention and treatment of disease.

Let me point out that this is not just a medical problem.

In fact, in many ways it is not a medical problem at all. It's a problem in which adequate housing, good food and jobs have to come first. People must have these things before they want education and health care.

We need above all to avoid radical and rapid departures from our present system until by trial and experiment in certain areas, we can prove that such departures are worthwhile. Those who would totally disrupt our present health care system with the idea that it is all wrong, that it doesn't work, have yet to propose some other type of health care system that is better. The present one, with all its faults, is working and serving nearly two hundred million people.

One doesn't ordinarily consider it wise to undertake a radical new form of treatment for a disease unless the disease is apparently fatal and perhaps in its final stages. Until it is proved that a new method of treatment is helpful and relatively safe, it should not be widely applied. Similarly with respect to our health care system, it's important that we do not use radical procedures, that we avoid them until we have proved in certain test areas that some modification or some other system works better.

We must avoid national standards. We must avoid the impatient administrator with limited or great authority. We must avoid coercion. These do not work in the American system. For evidence of that, just go out to my home area of Berkeley. (Laught

It's important to recognize that much work needs to be done that we cannot, as Mr. Brown said, have instant success. You can't have an instant doctor, you can't have an instant health center or an instant community health center where one doesn't exist. What you, ladies and gentlemen, are working on is a long-time program. You've got to give your successors twenty years hence some problems to challenge them. Don't try to settle them all this morning. If one will follow the route of normal progress, keeping in mind that regional, cooperative, voluntary advancement in the knowledge of the practicing physician is the key to the success of Regional Medical Programs, there is no question that Regional Medical Programs - ten, fifteen, twenty years from now - will succeed. I believe the Program will be a success. But it will be a much greater success if gentle keys are used in opening the doors to what someone has called "the Health Power Structure".

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I particularly welcome this opportunity to meet with you and participate in this program because the birth and growth of the Regional Medical Programs has coincided with my own years at the Department of Health, Education, and Welfare.

Almost more than any other health legislation of the past few years, and there has been a good deal of it, the RMP has carried the promise of creative, original, cooperative adventures in the health field. Although the defined arena has been to improve the care of patients with heart disease, cancer, and stroke, it has been apparent from the beginning that the larger interests of patient care would be served at the same time.

Further, the unusual structure--some might say "unstructured" administration of RMP has in a unique manner challenged the Nation.

I have used the word "unstructured" and I think all of us would agree that it has been this quality which has

made the challenge to you both exciting and at the same time alarming. Exciting because here was a Federal agency which did not attempt to tell you what your region needed or should do, but instead said, "All right, ladies and gentlemen, you have long expressed the need for funds freed from bureaucracy. Here are such funds. Put your regional, cooperating intellects to work and develop the program your region needs."

And, as I have said, this challenge to you also has been alarming. It is much easier to point out the faults in a program when one can criticize someone else's leadership. But when the leadership is not elsewhere, when success or fumble rests in one's own hands, then the "unstructured" nature of the program can certainly alarm.

I think all of us who have participated in the Regional Medical Programs have appreciated the quiet, sustained determination of Dr. Marston and his staff. They firmly held to the goal that the ideas, energy, the very motion, of RMP must come from the people in the regions and not from the central agency. There were times when it seemed that delays at the periphery would jeopardize the program, when it seemed that the too slow trickle of planning

grants and active programs was evidence that the entire program was futile and the periphery sterile.

The final proof of the merit of RMP will take years to be apparent. Perhaps there are no real yardsticks with which to measure the success of such a program. I know that facts and data will be assembled and will be used to justify the future legislative support of RMP. However, as far as I am concerned, we already have the best proof one could want that this program is meeting a real need in medicine. I am referring simply to the quality of the men and women who have put their energies into this new program.

As I look around this room and note familiar names and faces, I think, here is the true expression of endorsement of this program. I know of no other single health legislation that in so brief a time has caused such a remarkable cadre of talent to step forward and declare itself. Knowing that you and many, many others have joined this effort, makes it clear to me that there was a need, a void, in the American medical scene which RMP is filling.

Now, with Dr. Marston leaving RMP and taking on the huge responsibilities of NIH, one would ordinarily feel

insecure in having a change of leadership just as much as RMP is becoming operational. However, any of us who know Dr. Stanley Olson knows very well that here is a very mature, sensitive, calm, competent, compassionate, and committed man. I cannot share anyone's concern over RMP. It has superb leadership, it is demonstrating the vitality in our system, it has strong support from the Administration and Congress. RMP is a success story!

I am well aware that within the staff of RMP there have been concerns over the transfer from NIH to the new Health Services and Mental Health Administration. I can well understand the inherent sense of security in remaining within the tried and true academia of NIH. However, RMP is specifically directed towards improving the health services of the people in certain disease categories. RMP is an active involvement in health services; that is what the Health Services and Mental Health Administration is all about. In fact, I don't in the least expect RMP to disappear into a new bureaucracy. Instead, with the energy, drive, and talent already operating within RMP, one will be very surprised if the very style and cadence of HSMHA is not to a major extent due to the examples set by RMP.

which must occur if your efforts are to succeed is a quality which RMP must extend with missionary skill and zeal. Cooperative arrangements must be worked out in all directions and at all levels. Nationally with the Veterans Administration; with the Department of Defense; with the Bureau of Health Manpower; the new Lister Hill Biomedical Communication Center and the categorical institutes of NIH; with the Office of Economic Opportunity; with the other operating units within the Health Services and Mental Health Administration; with the Medical Services Administration, the Children's Bureau and the Rehabilitation Services Administration in the Social and Rehabilitation Services; and with the Bureau of Health Insurance in the Social Security Administration.

There are many other groups to consider and involve-- professional associations, consumer groups, representatives of State and local government.

At the State and local level we need to develop a network of cooperative arrangements that will assure the kind of change in the system that is needed.

In a recent article "What's Ahead for Medicine"

Dr. Dwight Wilbur noted:

"Now we are in the midst of a third great movement-- a national commitment to health and health care, a phenomenon of the 1960's. The health laws of the 89th Congress-- Medicare, Medicaid, Regional Medical Programs and comprehensive health planning set the pace and clearly indicate the Federal Government's substantial investment in medical affairs. Indeed we are traversing one of those great transitional periods in which the roles of government and the medical profession seem in the balance."

I fully agree with Dr. Wilbur that we are in the third great movement in American medicine in this country. The first was in medical education after the Flexner report, the second in biomedical research after World War II and now in health and health services.

To do the job we need a new alliance for health. We cannot stop by merely allying those already allied. We must work for the active participation of those who have not been effectively represented and those whose needs have been so disastrously neglected.

This will not be an easy task. We have many vested interests in health and health services who believe with a

passion that the only way to meet the need as they see it is to have a special category--be it a voluntary organization or a tax supported program--and maintain it at all cost. The birth of the regional medical program represents, in part, the fusion of such categorical interests. Its ultimate success, however, will depend on the extent to which it forms the backbone for comprehensive health services.

Can a new alliance for health meld the variety of categorical interests so that the needs of all the people, particularly those in greatest need, can be met?

It is here that we can take a cue from the Urban Coalition and its approach to the greatest crisis of our time. At long last groups with a common interest in the cities of this Nation--business, labor, minority groups, and government have joined together in common cause. In years past they went their separate ways ignoring the problems and the opportunities.

The RMP provides American medicine, the consumer, local government, labor, business and minority groups a unique opportunity to develop the new alliance for health that can pull down the barriers to understanding, can

examine and test new ideas and can develop the necessary vitality to overcome the inertia in our health care delivery system.

How can the Regional Medical Programs accomplish what has been beyond our reach in the past? The RMP can do it by providing a new mechanism for cooperative action. It builds on the strengths of the existing system, and it provides for local participation, planning, and action.

It is apparent that the professionals who have been attracted to RMP represent the long sought third force in medicine. The traditional roles have been private practice and academic medicine, organized medicine, and the medical schools, town and gown. To oversimplify it I might describe the interests as those represented in part by the American Medical Association and the Association of American Medical Colleges.

Now an entirely new instrument of expression, the RMP, has given you men and women a cohesiveness, a vehicle, a place to stand. With the talent represented by the cooperative arrangements that are developing, with the muscle supplied by public funds, one can confidently expect you to act as the new third force in American medicine.

One can expect that you will provide the leadership necessary to establish and maintain the new Alliance for Health.

The third force in medicine will include not only teachers, investigators, administrators, and practitioners, but students in the health professions. We have already observed the active participation by students in studies to identify needs, in the planning process and in programs of action designed to meet health needs. They will provide a continuing source of stimulus, energy and enthusiasm to this effort. Their concerns, their compassion and their commitment must be a vital ingredient in all of these efforts.

Another new element is the consumer. They too will bring new insights and perspectives to the third force in medicine. They must have a strong and effective voice in these efforts.

The third force cannot be limited to these elements alone. In each region, the character of the need, the availability of resources, the interest of individuals and groups should determine the character and composition of the third force.

This third force is urgently needed. The need is for coordination, for mediation, for help in defragmenting

the multitude of health programs. In the past four years, 31 major new laws have been enacted that have increased the Department's responsibility in the health field. The total Federal investment in health has grown from \$3 billion in 1960 to nearly \$14 billion in 1969; HEW health investment alone has tripled from \$2.6 billion in fiscal year 1966 to \$9.6 billion in fiscal year 1968.

Although your charge is heart, cancer, stroke, and allied diseases, it is apparent to all that in carrying out this primary mission you will set the pattern for the whole scope of health services. You will deal with the ghettos, the poor, the needy, the uninformed, with physicians at all levels, public health agencies, community hospitals, volunteer health organizations. It is your job to prove that cooperative arrangements are possible. It is your job to find ways to accommodate the antagonistic physician, the recluse medical faculty, the uninformed patient, the demanding legislator. It is your job to seek out new ideas, to be the local arbiters, to get those things done we have all said needed doing, if only there were funds and a mechanism. I believe RMP has provided that mechanism and Congress has shown its commitment by the flow of funds, even in a time of retrenchment.

I believe we have been singularly fortunate having Dr. Marston and now Dr. Olson to provide leadership. I am very pleased that RMP is now firmly based within HSMHA in a central provocative position, and can set the pace for this new health services organization.

Now some of you may quote back to me John Gardner's definition of his former job: "A series of insoluble problems cleverly disguised as a great opportunity" and suggest that is equally a definition of your task.

I just happen to have great enthusiasm for RMP and I would offer you a second quotation, this time from Franklin Roosevelt: "New ideas cannot be administered successfully by men with old ideas, for the first essential of doing a job well is the wish to see the job done at all."

RMP a new idea and it is apparent that it has attracted men who want this new idea to work. I can assure you of my own commitment to this program.

"ISSUES AND CONCERNS OF REGIONAL MEDICAL PROGRAMS"

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Each of the series of meetings we have had here in Washington since January, 1967, has come to be a landmark in the evolution of Regional Medical Programs. Each has concentrated upon the compelling circumstances at a particular point in time-----beginning with the initial stage setting efforts to amplify the altruistic goals which the program was capable of accomplishing, through the subsequent periods of:

The conceptualization of the interrelationship of the planning and operational phases,

The much needed exchange last January between regions of project design and objectives,

And now the constructive sharing between the Division and the Coordinators of the issues and concerns that have emerged as we have been more and more intimately involved with the realities of the situation and have had to concentrate more of our time, energy, and ingenuity upon the mechanics of making the right things happen.

From the standpoint of the record, there can be no more positive evidence of the increasing involvement of the Regions in health affairs and the growing substance of operational activities---- nationwide, than is provided by these landmarks.

Central to the success of this accomplishment has been the splendid cooperative arrangement between the Division and the

Regions. This has been a forthright, mutually supportive, and decisive relationship - that has clearly recognized that we have many more questions than answers, but has kept our goals in major focus and has expedited tremendously our progress toward their accomplishment.

It is indeed remarkable that in such a short period of time we should have reached this point in the promotion and realization of a concept that has been espoused for several decades but seemingly could not be incorporated in the complex and diffuse health system which has grown up more or less like Topsy in our society. Not only did Public Law 89-239 come along at just the right time, but also because of its nature it was able to attract the support of people with the degree of perception and dedication necessary to assure its implementation. The existence of these circumstances has been appreciated increasingly as we have learned that it is much easier to talk and legislate about cooperative enterprise for coordinated planning and the most effective and economic utilization of resources than it is to accomplish all the details necessary to assure their reality and durability. As the issues and concerns increase in number and complexity, the need for the right answers becomes more and more acute.

Several months ago the Division sent a questionnaire to each coordinator asking him to indicate the issues and concerns which in his region seemed to be the most compelling. These have been consolidated and I have been asked to summarize them. By and large, the

issues and concerns reported can be divided into three categories:

(1) those relating to events and activities on the Washington stage, (2) those having to do with interregional relationships, and (3) those relating to interregional activities. Pervading each of these categories, however, is the interrelationship between the regions and the Division.

THE REGIONS AND THE FEDERAL GOVERNMENT

The reorganization of the Public Health Service and the realignment of health programs within HEW has, of course, been a matter of concern to everyone. Probably there is no group of health administrators in the United States more keenly aware of the need for better communications and coordination between these health programs----- particularly as they operate in the field---than the Regional Medical Program Coordinators. No other group relates as intimately to the broad array of health professionals and health interests.

Hopefully, the newly formed Health Services and Mental Health Administration will be able to interrelate Regional Medical Programs, Comprehensive Health Planning, Chronic Disease Control, (Vocation Rehabilitation), Health Services Research, and Mental Health so that their mutually supportive and complementary features can be more effectively utilized in the interests of the public health. A great deal of this has to be worked out at the state or regional level; and some states have made considerable progress in this direction. However, since it appears that everyone takes his cue from what goes on in Washington, it would be immensely helpful if

a prototype cooperative arrangement between these programs within the Administration were more clearly visible so that field representatives would have a stronger motivation to share problems and experiences and work together. Undoubtedly RMP has something to contribute, but the real problem is in getting into the ball game.

There are other federal health interests inside and outside HEW that well might be brought into this cooperative arrangement. Regional Medical Program efforts to contribute to the improvement of the health care of the poor have established contact with the programs of HUD, OEO, Labor, Commerce, just to mention a few. Efforts to generate education and training programs have created a need to know more intimately the sources and nature of support inside RMP. The importance of a mechanism for better coordination of all of these programs becomes more clear when it is recognized that all of them tend to be directed at some point in time and involve the same groups of people-----be they health educators, community or regional health planners, practicing physicians, or allied health professionals. At least in our region more and more of these groups are turning to the RMP for advice as to where to go and what to do, and we are finding this an increasingly difficult challenge.

The increased experience with Regional Medical Program activities and their ramifications has led to several concerns relating to the executive and legislative branches of the government. One of these has to do with the stability and longevity of the Program

and the growing need for some assurance of both. The need springs from the pragmatic realization that the full accomplishment of objectives is a long term affair. Hard won cooperative arrangements and the benefits therefrom can only be secured at this early stage of the game by our integrity and ability to produce. The recognition, confidence, and support we have attained at a regional level can disintegrate in the face of a threatened short life, or increasing evidence of modification of concepts and administrative policies that would deprive regions of their prerogative for determining the nature and modus operandi of their programs.

The greatest asset to acceptance at a local level has been the assurance of local determination, local decision making, and local administration. There are many with whom the coordinators and their staff deal every day who still don't believe this is really true and are continually on the alert for any indication of bureaucratic intervention.

This is especially true of practicing physicians. Their full commitment to the Regional Medical Program is of critical importance, now and for the future. Fortunately, we have been able to obtain a large measure of this because of the sound principles upon which the Program is based. Interestingly enough the intensity of commitment to the Program seems to run parallel to the intensity of feeling about the principles. Recently a key physician in our Program summarized the state of affairs very succinctly, "Regional Medical Programs has been accepted in its original intent, and as such is good. With conceptual changes and if allowed to be infiltrated it

will die aborning. Be assured I will turn 180° for what little that is worth."

Perhaps pertinent to this consideration is the issue raised by one of the coordinators - local planning vs. national planning. Thus far, the bulk of planning at the Division level has been in support of the needs of the Regions, and this has been good. Concern has been expressed, however, that over-enthusiasm or impatience might lead to centrally conceived projects which might appear to compete with local initiative. Unfortunately, the earmarking of certain funds by the Congress last year was interpreted by some as an example of this, and thereby a fair number of ties more strained.

Indeed there is a need for frequent exchanges and joint planning between the regions and the Division in regards to issues, problems, mechanisms, and needs. We also need to share knowledge of what is working and what isn't. As we become more involved in registries and reporting systems, the value of uniformity of basic data becomes obvious, and this emphasizes further the value of cooperative planning. The leadership which the American College of Surgeons is taking in working out with coordinators, the National Cancer Institute, and the Division staff, a concept of cancer registries which might be adopted nation-wide, is a fine example of how some of these things can be accomplished.

Finally, it is important that neither the legislative nor the administrative branches of our government lose sight of the fact that for the first time in the history of our country, the

health professionals and the health interests are joining together to make our health care system more cohesive and more effective, not by legislation or with large sums of money, but by involvement of the right people, communications, good judgment, and a challenge to local initiative.

INTERREGIONAL RELATIONSHIPS

The anticipated need is now materializing to refine concepts and procedures for interregional activities and relationships. This is reflected in an increasing enthusiasm for interregional meetings. Some of these are on-going; more are being planned, and it is likely that many of the questions and issues can and will be resolved among the coordinators. Some will require decisions at a Division level.

There is a growing need for exchange of more detailed planning and operational information between regions, especially adjacent regions. This creates problems of supply and demand. No ideal solution exists at the moment. There is a fair movement between regions of annual reports, operational grant applications, and project proposals, but the very volume of most of these negates their practical utility. A while back, Ed Friedlander conceived the idea of a brief, but complete, profile of each region's program - - something that could be periodically updated to assure currentness. A satisfactory format for this hasn't been worked out thus far, but it still seems a good idea. Also, it has been suggested that broader use could be made of the splendid project summaries Martha Phillips and her staff prepare. These could be incorporated

in the profile of a region; and as of this morning they have been. In each coordinators packet are summaries of his region's projects. Also, these summaries could be regrouped on a disease category or subject basis and made available whenever there is a need to know what is going on nationally.

For example, many regions have concerned themselves with the care of the acute coronary patient. Perhaps there are twenty-five to thirty projects dealing with one aspect or another of this problem. It would be helpful to a planning group to be able to review the essential features of these projects, and also, when such information becomes available, to have some assessment of a project's effectiveness. Presently there is no way to get this information unless one corresponds with every region. And yet it seems to me the availability of this information for bibliographic purposes would contribute materially to improved project design. The Science Information Exchange has provided a service to this type for some years.

Yesterday a group of directors of hypertension projects met to consider the feasibility of a uniform system of data collection and reporting. They also had an opportunity to discuss their plans and share experiences. Perhaps this will become an increasingly attractive mechanism for interregional communications and coordination of activities.

The problem of information exchange will be compounded as regional programs grow and become more complex. If indeed we are preaching the availability of the "latest advances" we need to practice it within the family.

The desirability has been expressed of interregional or, when appropriate, national libraries for support materials, such as audiovisual aids, and the like and also of a multi-regional speakers bureau. In this latter regard, it would be helpful if such a bureau were coordinated with other organizations that provide speakers such as the American Cancer Society and American Heart Association.

Efforts at regionalization have generated planning activities which cross the borders of adjacent Regional Medical Programs. Mostly these reflect the identification of hospital service areas or the firming up of long standing functional relationships between communities. There seems to be no reason why these border adjustments cannot be accomplished between the regions involved. Some difficulties might arise when funds from other than the RMP, such as county or state funds, are required. Experience has indicated that county commissions are extremely careful with their money. Also, there may be some problems with reports and statistics, particularly those compiled on a state basis.

Concern is growing over the coordination between RMPs, especially those serving the same geographical area, interregional programming, and the mechanisms for handling interregional projects. Much of this depends upon core staff interrelationships. The forthcoming guidelines for the implementation of Section 910 of the new RMP law (HR 15758) may clarify this to some extent. However, a number of potential problems can be foreseen. One coordinator has found that the attitudes of public officials or official agencies (part of the power structure) are not always conducive to interregional planning, particularly between states. Also, if interregional projects must compete within a region with other projects which the region has generated independently, and

particularly if tight money causes advisory councils to have more and more rigid criteria for determination of project priorities; they might fare less well than they deserve. Thus, it may be necessary to establish a separate funding mechanism for interregional projects.

The growing need for interregional activities necessitates a serious review of core staff organization and functions. Productive interregional relationships will relate directly to staff input -- and few if any of us have made provisions for this in our present staff organizations. Other unanticipated demands upon core staffs have accentuated the problem. Many of these demands require the availability of skills and knowledge which are not readily available. One possible mechanism suggested for the resolution of this situation is the availability of consultant services between regions and the sharing of staff members with special skills.

We have had an interesting experience in regard to the need for special skills. A year ago we began to make consultative services available to community hospitals in the areas of design, equipping, and operation of Coronary Care Units. This was done in collaboration with the medical schools, the North Carolina Medical Care Commission (Hill-Burton) and the Duke Endowment, which long has acted in an advisory capacity to hospitals. As this service became more popular, it emerged that one of the major needs was for expert architectural and engineering consultation. It turns out that there are no available guidelines for the proper design of these units and for the elimination

of the various hazards which can be of catastrophic consequence. The part-time architect-engineer whom we retained in conjunction with the Medical Care Commission, and who now has acquired a considerable amount of expertise, has been able to properly advise hospital authorities, and in so doing he has saved them well in excess of \$100,000. So important has this service become that we are in the process of employing the architect full time, providing him with further opportunities to expand his knowledge and expertise, and among other duties, to have him prepare the guidelines and standards which are necessary. Chances are these will be of value to other Regions.

An expanded role also is foreseen for the liaison officers of the Division, since they can be immensely helpful in the resolution of many of the problems relating to interregional planning and operations.

INTRAREGIONAL ACTIVITIES

Probably the major concern within regions is the accomplishment of an optimal degrees of cohesiveness among participants in program planning and operations. More and more this has become a core staff responsibility, and yet a willingness to cooperate on the part of participants is essential.

A variety of factors contribute to this problem. One is that the participants have not had much experience working together, and at least at the onset have been inclined to fall back upon their more firmly established patterns of operation when they contemplate the nature of their Regional Medical Program involvement. Thus the medical schools, not accustomed to service responsibility at a community level, have

tended to prefer to conduct educational and demonstration activities within their walls and to try to maintain independent planning staffs. This attitude prevails more strongly at a departmental level than in the Dean's Office. Community hospital boards, administrators, and staffs have found it difficult to think in terms of regional services, even though they have depended for years upon referrals from within their service areas. They also are intensively preoccupied with their own needs and problems. State and County medical societies, curiously, seem to have been excluded from a large number of organized health planning efforts in the past and consequently find it difficult to suddenly be in the mainstream. The universities, community colleges, technical institutes, State Boards of Higher Education, or Divisions of community colleges, though involved in health education have not coordinated their efforts and thus find it difficult to look at the total array of health manpower needs within a region. State health agencies, particularly Boards of Health, first were caught in the confusion of a change in the federal funding from categorical to block grants, and then in trying to decide how they might relate to both Regional Medical Programs and Comprehensive Health Planning.

Slowly but surely, however, these and other groups are becoming more comfortable in this new situation and are beginning to work more effectively together. However, experience is demonstrating that meaningful participation per se requires a sustained investment of time and effort by participants which they are not organized or staffed to provide. Thus there emerges as one coordinator has stated a certain "cost of

togetherness" which hasn't yet been specifically identified in dollars and cents but which the realities of the situation require be recognized.

Crucial to the productivity of these new ties is the availability of a competent and adequate core staff. There must be some mechanism to bring plans or concepts into reality, to manage the countless number of administrative details necessary to assure smooth operation, continuity and evaluation, and to interpret these properly to the Advisory Council.

More and more, the position of the Regional Medical Program becomes that of a way station between the medical schools and medical centers on the one hand and the system of delivery of health service on the other. This interposition is ideal for the purposes of catalyzing stronger and more meaningful ties, and of trying to determine how scientific knowledge and resources can be used more effectively to meet patient care needs. Concern with patient care needs rapidly leads to an identification and understanding of those individuals, organizations, and agencies which in one way or another are involved in ministering to them. Concern with the medical schools, medical centers, and other academic institutions allows for a sharper identification of the resources available and those that must be developed. Only with these two bodies of information can effective and coordinated operational activities be generated.

It is not beyond the realm of possibility that this unique role of the core staff will become one of the major Regional Medical Program contributions to the improvement of our health care system.

Much of all this points up the increasing complexity of core staff functions. As these are more clearly identified, their documentation would be particularly helpful in better acquainting advisory councils, planning groups, participants, and project directors with the mechanics of Regional Medical Program operations.

Money, of course, is and always will be an issue.

One concern has to do with the projected fiscal potential of the Regional Medical Programs. More specifically, this could be expressed by asking what can we expect to be able to support three, five, and ten years from now.

Clearly, the longer range potential will depend upon what the program produces -- how well it attains the objectives of Public Law 89-239 -- with appropriate concern for economics, organization, and administration. The shorter range concerns are more pressing, and yet they have relevance to what might happen in the more distant future. Each Region, in order to mount a visible operational program, has begun cautiously by undertaking limited feasibility studies or pilot projects. In these early stages, visibility, solidification of cooperative arrangements, and a beginning impact upon the improvement of patient care have taken precedence over the amount of money available. Very soon though, the point is reached where tested projects should be expanded, and an increasing number of new project proposals are submitted, reflecting to a large extent the success of efforts to stimulate participation and planning. It becomes important at this stage for those responsible for

decision making to know how close to the belt they must operate, how restricted a priority range they must adopt to stand a reasonable chance of funding. With limited availability of funds, it becomes the tendency to support the winners -- to put one's money on the favorite. However, Public Law 89-239 encourages innovation -- and innovation is the untested, unproved -- very often the long shot. Restricted funding at too early a stage is apt to discourage innovation and thereby seriously limit the program's potential. Certainly there never will or should be unlimited funds, but it must be hoped that sufficient money will be available to enable regions to adequately explore and evaluate new and innovative approaches and to determine how those that are successful can be incorporated into the health care system.

Eventually, it should be possible to free up funds by terminating unsuccessful projects and by devising measures by which good projects can be self supporting. However, as experience increases, project design and relevance to objectives should improve. This could necessitate some very hard choices by Advisory Councils, should limited availability of funds force a choice between continued support of a good project or recommended support of a new one that looks better. Some recourse might be provided by the availability of other than Regional Medical Program funds. To a large extent, this might depend upon how well federal health programs are coordinated from now on.

On a more simple level, a need has emerged for the clarification of a mechanism for a large number of small, short term fiscal

transactions. The original guide-lines indicated that the involvement of community hospitals should be accomplished by a letter of affiliation which would make the hospital a participant. Also, they provided for participant faculty and staff involvement on a part time salary basis, and not as consultants.

Becoming a participant requires conformance with certain Bureau of the Budget regulations, it also makes indirect costs available which in turn eliminates such items as rental charges. This is fine for the long term, permanent type of participation. Thus far, however, most of the transactions with community hospitals have been short term affairs involving small sums of money -- for which the letter of affiliation is not practical. Fortunately, the new guide-lines provide a mechanism to purchase necessary services in a less complicated and more acceptable manner.

In a similar vein, there are some faculty members with long term commitments to the Program who can be employed part time. However, the need is increasing for a simple reimbursement mechanism for occasional or limited services.

Concern has also been expressed over the most practical and realistic manner to deal with equipment that is provided to cooperating hospitals and other institutions. Existing government regulations are directed to a large extent to the established situations where equipment remains under the direct supervision of the grantee. Such will seldom be the case with Regional Medical Program equipment, for it must be

placed in the field where it will do the most good. There is some uncertainty over how this can be accomplished in accord with the existing regulations; particularly in regard to the long term responsibility of the grantee, the availability of a mechanism for the eventual transfer of title or the disposition of the equipment, and the extent to which the transaction should be influenced by the revenue producing potential of the equipment.

And finally we come to the issue of evaluation. Concern with what we get for our tax dollar is long overdue. The extent to which evaluation has been emphasized and required as a component of every Regional Medical Program is realistic and desirable, even if we haven't been able to devise a suitable procedure for every type of activity. It is essential that we have dependable measures of program effectiveness.

However, the impact of Regional Medical Programs cannot and should not be judged on project accomplishments alone. In fact the philosophic, organizational, and administrative impact of Regional Medical Programs upon the improvement of our health care system may far overshadow the impact of a wide array of projects. Core staffs, members of Advisory Councils, and other Program participants are involved increasingly in a wide variety of important considerations and activities not directly concerned with projects.

Already there is a stronger commitment across the country to cooperative effort and regional planning than heretofore existed. Efforts to cope with the health manpower shortages are emerging from the talking and statistical stages and going into production. Physicians

and other health professionals in rapidly increasing numbers are seeking opportunities to acquire new knowledge. More and more this determination to improve our health care system is reflected in the attitudes of organized medicine, the hospital association, professional and voluntary organizations, and other health interests. All this indeed is progress, and rapid progress. It's reasonable, I think, to give the Regional Medical Programs some portion of the credit -- and this should accrue to the evaluation of their over-all effectiveness.

These then are some of the issues and concerns as you reported them a short while ago. By tomorrow we probably will have added some more.

"REVIEW OF ISSUES AND RELATIONSHIPS"

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Regional Medical Program Authorization Bill in Congress

Congressional action on the RMP extension bill is nearly completed, and the major decisions have been made by the Senate-House Conference Committee. We have kept you informed on the progress of this bill through the News, Information, Data publication. In summary, the new Bill extends the legislation two years and authorizes funds, provides that up to one percent of the funds can be used for evaluation, includes areas outside of the fifty States, such as Puerto Rico, the Virgin Islands, etc., changes certain wording regarding participating agencies, increases the membership of the National Advisory Council from twelve to sixteen, permits funding of services to two or more RMPs, permits dentists to refer patients, and permits participation by Federal hospitals.

The differences between the Senate and House versions of the Bill involved the length of the extension and the amount of funds authorized. The Senate version provided a three-year extension at levels of \$65, \$140 and \$200 million. The House version provided a two-year extension at \$50 and \$100 million. The resolution in Conference provides a two-year extension at \$65 million for fiscal 1969 (the Senate version), and \$120 million (a compromise figure) for fiscal 1970.

"The bill as passed by the House authorized a total of \$50 million for the fiscal year ending June 30, 1969, and \$100 million for the fiscal year ending June 30, 1970, for regional medical programs for heart disease, cancer, and stroke, and related diseases. The Senate amendment authorized \$65 million for the fiscal year ending June 30, 1969, \$140 million for the fiscal year ending June 30, 1970, and \$200 million for the fiscal year ending June 30, 1971, for this program.

The Conference substitute authorizes \$65 million in appropriations for the fiscal year ending June 30, 1969, and \$120 million for the fiscal year ending June 30, 1970.

Although the authorization contained in the conference substitute is limited to a 2-year period, the managers on the part of the House wish to emphasize that this program, although a newly established one, has already proved its value, and should be considered as a permanent program, subject, however, to periodic congressional review and legislative oversight. The managers on the part of the House agreed to a 2-year limitation in order to provide an opportunity for the 91st Congress to review the operation of the program."

It is not certain at this time exactly how much money will be available for this fiscal year. Action by the Congress on the appropriation has not been completed. If the amount which is contained in the Senate

appropriation bill is passed, a total of 99 million dollars will be available, including a carryover of 36 million dollars from 1968. There are, however, two factors which can reduce that amount. One would be a lower figure agreed upon in the House-Senate Conference; the other would be a reserve placed on funds by the Administration in order to meet the requirements in the legislation which established the ten percent surtax. In any case, we will keep you informed.

Several important developments should be mentioned in regard to the passage of the RMP extension bill. As Dr. Manegold will discuss with you later this afternoon, it looks as though we are going to be faced with another earmarking of funds this year--a minimum of five million dollars for studies of the effectiveness of Atromid-S in lowering the frequency and severity of myocardial infarctions. The Senate Committee, in our authorization bill report, expressed concern that "enough emphasis is not being placed on clinical research, with particular emphasis on the evaluation of various important therapies which show promise of reducing morbidity and mortality." They go on to point out that the RMP mechanism is ideal in their view for carrying out broad field trials of the efficacy of various drugs, and they refer to the field trials of the Salk vaccine. I'd like to quote you their concluding paragraph on this point:

"The Committee, therefore, in full agreement with the position of the House, urges officials of the regional medical programs to encourage clinical field trials to fulfill the

intent of the Report of the President's Commission on Heart Disease, Cancer and Stroke. The Committee realizes that plans for such programs must develop out of the thinking of State and local regional advisory groups. However, the testimony received indicates that these local groups are eager to conduct such field trials, but they need encouragement and technical assistance from the top administrative officials of the regional medical programs. This encouragement and technical assistance should and must be provided."

Clearly, the Atromid-S earmark and previous earmarks in the Regional Medical Program are symptomatic of things that we can expect in the future. It's important to emphasize that the Congress has given us very clear signals that they expect this kind of program to be carried out under regional medical programs. It's up to us, those of us here in the Division and all of you in the 54 Regional Medical Programs, to figure out how we can carry out these programs so as to strengthen, rather than damage, the regional programs.

Another item that appeared in the Senate Committee Report on our authorization bill was a reference to kidney disease activities under regional medical programs. There was no earmarking of funds, but the Committee did say that they "heard testimony which confirmed that there is sufficient relationship between kidney disease and heart disease to include kidney disease within the scope of regional medical programs as a 'related disease.'" They also went on to say that "Regional Medical

programs offer an appropriate and effective framework for the exploration of the best approach on a regional basis to the great challenges presented by the prevention and treatment of acute kidney disease. The Committee wishes to encourage the use of the regional medical program mechanism for this exploration of how to deal most effectively with the ravages of this disease . . . " Thus, the Committee is telling us that planning for taking care of the kidney disease problem is an appropriate activity in regional medical programs. This does not seem to us, however, to call for change in the previous policy of regional medical programs not to support service programs such as hemodialysis therapy.

Merger of Activities of National Center for Chronic Disease Control and Regional Medical Programs

As part of the recent reorganization, a major portion of the National Center for Chronic Disease Control was moved over to form, with the Division of Regional Medical Programs, a new organization called the Regional Medical Programs Service.

A consideration of the origin and functions of the Chronic Disease Center shows, I think, the logic of this move. Indeed, the principles and concepts which led to the formation of the chronic disease program are quite similar to those that led to the regional medical programs. Both involve an attempt to find ways to foster and promote the application of the latest research advances in the care of persons suffering from chronic diseases like heart disease, cancer and stroke. Indeed, certain program elements of the chronic disease program had their origin as elements of the National Institutes of Health in order to promote

application of research findings.

The Division of Chronic Diseases, as it is now called (and this interestingly reflects a reversion to the name used prior to the last reorganization of the Public Health Service), includes eight categorical programs, most of which are disease categories. These are cancer, chronic respiratory disease, diabetes and arthritis, heart disease and stroke, kidney disease, neurologic and sensory diseases, the nutrition program, and the National Clearinghouse for Smoking and Health. The mission of this Program has been to foster the development of improved methods for the prevention and control of chronic diseases and to promote application of these methods. The developmental effort has been carried out through the contract mechanism, by supporting projects to develop, test and evaluate improved health services related to the categorical diseases. An example or two may serve to clarify this function.

Soon after research developments in hemodialysis for end-stage renal failure made long, continued dialysis therapy feasible, centers were supported throughout the country by the Public Health Service through grants for carrying out dialysis in the hospital. It was immediately apparent that something needed to be done to reduce the cost of this procedure in order to make it available to the large numbers of persons needing such treatment. The Kidney Disease Control Program, therefore, in 1967 initiated a contract program to test the feasibility of home dialysis. Twelve institutions received contracts

to train patients for home dialysis and to gather and supply the necessary experience data on which to evaluate this technique. This Study is currently in progress.

A somewhat different example is the coronary care nurse training program initiated by the Heart Disease and Stroke Control Program. Back in 1965 and 1966, when more and more coronary care units were being established, it was apparent there was a need for training programs to prepare the nurses for their responsibilities. Ten programs were developed under contract to serve as models for the kind of training program that was necessary and to begin to supply at least a small proportion of the need. Some of these programs are phasing into Regional Medical Programs.

The relationship with Regional Medical Programs, I think, is fairly obvious. Both Programs are concerned with fostering the application of new improved techniques for health services. The one, Regional Medical Programs, is concerned primarily with organizational framework and cooperative arrangements whereby this application will take place. The other is concerned with the content of the individual health services. Dr. Olson presently heads a task force which is looking at the way in which these efforts can best be carried out and coordinated in order to achieve the objectives in a way which will be mutually supported.

The two Programs represent a somewhat different approach. In the one case, the ideas and proposals are developed peripherally and reviewed and approved centrally. In the other case, the ideas are

developed at the Federal level, usually with the advice of expert committees, and carried out peripherally through contracts. We must develop ways in which these two efforts can be carried out in order to be mutually supportive. The situation is perhaps somewhat analogous to the matter of Congressionally earmarked funds.

In sum, we feel that this is a very important favorable new development and we will be looking for ways in which the Division of Chronic Disease and the Division of Regional Medical Programs can work together to achieve common goals.

Relationships Between Comprehensive Health Planning and Regional Medical Programs

I am sure you are all concerned and involved in the relationship between Comprehensive Health Planning and Regional Medical Programs. An effort is under way at this time within the Health Services and Mental Health Administration to clarify this relationship. I can't say that all the i's are dotted and all the t's crossed, but a fairly clear, and I think workable, delineation seems to be emerging.

Both programs are concerned with improving health care. Two elements can be identified in this effort--one involves the setting and the resources available for care--the other involves the substance, the quality, of care. It seems clear that planning agencies are primarily concerned with the first of these two elements. Comprehensive Health Planning is the mechanism for determining the needs for health facilities

and health personnel, for finding out how to meet these needs, and setting the appropriate plans in motion. It is quite appropriate that the consumers of health care play a prominent role in this kind of planning.

The second element, the substance of care, or the quality of care, is clearly the area of concern of regional medical programs. The whole thrust of the cooperative arrangements in regional medical programs is to assure that high quality care is available, that mechanisms are set up whereby the latest research findings in health services will be quickly added to the armamentarium of physicians who have the responsibility for primary care of patients. Thus, physicians and other health personnel are the prime constituency of regional medical programs.

Background on Arthur D. Little-OSTI Health Policy Research Contracts with Division of Regional Medical Programs

In early August we advised each of you by letter of a health policy research study relating to Regional Medical Programs being undertaken by Arthur D. Little and the Organization for Social and Technological Innovation. As that letter indicated, the purpose of this Study is to assess the present status of the total program, progress to date, and its actual and potential impact.

The genesis of this Study, and its desirability, dates back nearly a year. A number of us, and particularly those in Planning

and Evaluation who had had a major role in pulling together the required Report on Regional Medical Programs to the President and the Congress, felt it would be desirable to have a group of experienced, perceptive, outside observers look at the program--a multi-disciplinary group that could bring a special set of talents and abilities to the task and that might lead to fresh and perceptive insights of Regional Medical Programs easily overlooked by those of us involved in its day-to-day administration.

As a result, an ad hoc group of key Division staff developed the specifications and screened the 96 firms which expressed interest in doing the work. Eventually, five firms were selected and requested to submit proposals. That submitted by Arthur D. Little, Inc., and the Organization for Social and Technological Innovation, as a sub-contractor, was judged as best by the ad hoc group and a contract was awarded in late June. Both of these organizations are experienced in health matters and have a staff of high caliber.

Four major areas are highlighted for analysis under the Study.

These are:

- (1) Regionalization - A history of past regionalization efforts in relation to the development of Regional Medical Programs and a descriptive report of the organization components and operations of the program with emphasis on cooperative arrangements, regionalized involvement and decision-making.

(2) Evaluation Indicators for Regional Medical Programs - A description of accomplishments from the point of view of the Regions, a survey of evaluation techniques in use or available, and descriptive statements which suggest the utility of projects in moving toward the goals of the program. An important product of this aspect hopefully will be criteria which give the Division insight into the ways it should be looking at the progress of the Regions and give the Regions insights into evaluating their own programs.

(3) Economics of Regional Medical Programs - The object here is to express the behavior of RMP in economic and financial language to permit the future development of cost and benefit analyses. Projections of future costs and the relationship of the Program to health care costs generally will be identified and described.

(4) The Relationships and Communications Flow Between the Division and the Regions - The consultative and supportive role of the Division will be reviewed along with the regions' perception of this relationship. It is hoped that suggestions will be made leading to a better two-way flow of information and consultation.

Let me emphasize that the purpose of this Study is not to evaluate individual RMPs, but rather to gain a better understanding of the nature of the regionalization process we have set in motion and how to improve it.

In the initial phase of this Study, the ADL-OSTI group visited several regions including Iowa, California, Western Pennsylvania, and Georgia, and have talked with many of the people in the Division and other parts of the Public Health Service including Dr. Shannon, Dr. Marston, Mr. Lewis and Mr. Yordy. They also have been reviewing applications and related materials on hand in the Division in order to gain a better understanding of the Program and its operations preliminary to moving ahead in the substantive areas I briefly outlined.

You may well be contacted in connection with this Study as it proceeds since the contract envisages an in-depth study of several Regions. Selection of these Regions will be made in consultation with the Division and the Regions specifically concerned. Your support and cooperation, needless to say, will be appreciated.

In concluding, let me note that Roland L. Peterson, Acting Associate Director for Planning and Evaluation, is the Project Officer for the Division on this contract, and that Dr. Phillip Donham is the case leader for ADL-OSTI on this Study.

"GRANTS PROGRAM CONCEPTUALIZATION AND STRATEGY"

Richard B. Stephenson, M.D.
Associate Director for Operations
Division of Regional Medical Programs
Health Services and Mental Health Administration

I was asked to speak very briefly to this meeting about the conceptualization and strategy of the grant program presumably because my Office of Operations operates the grant program. The overriding consideration in any such discussion is the fact that P.L. 89-239 is a grant program and the first section of Title IX, which is our Act, begins by stating the purposes of this title are "through grants." Since, as Mr. Ward pointed out to you in his discussion of "the medical power structure," this is in many ways an unusually explicit Act rather than one simply conferring broad granting powers upon an agency and, since much of the conceptualization of the grant program is in fact preempted by the language of the Act, it is probably worth touching once again on these explicit statements in relation to the manner in which they shape the further conceptualization and strategy of the program.

Title IX of the Public Health Service Act begins, as I have indicated, by stating that its purposes are "through grants to encourage and assist, first, in the establishment of regional cooperative arrangements; secondly, that these are to be in the fields of research, training and patient care demonstrations in order to make the latest and the best in the diagnosis and treatment of heart disease, cancer and stroke and related diseases available to all; and finally, by these means, to improve generally the health manpower and facilities available to the Nation." It has been apparent, therefore, that while a strong and strategic categorical thrust has been given to the program, it is a great deal more than a program of projects in heart disease, cancer and stroke, because it is first of all to promote the development of regional cooperative arrangements and thereby

improve generally health care and facilities.

The final statement of this part of the Act that this is to be done without interfering with the pattern of patient care or with methods of payment has, I think, sometimes been misinterpreted; it seems clear from the legislative history of the Act that what Congress was saying here was that this was not an Act designed to interfere with the broad pattern of our voluntary health system, but was rather a challenge to the system and to the profession to develop within this system the kinds of cooperative arrangements which are essential to make it work and to bring about improved patient care. The reference to methods of financing was primarily a reflection of the desire to reemphasize the fact that it was the Medicare Act which was being considered at the same time by the same Congress which dealt with methods of payment and that this Act did not, and was indeed not an Act to, provide patient care at all other than as it related to the purposes of the Act for patient care demonstrations. The medical profession and the providers of health care and education must recognize very clearly the nature of this explicit challenge. It is really a mandate to do something about the quality of medical care, but to do it within the framework of our voluntary system by establishing regional cooperative arrangements - in other words a Regional Medical Program, and do all this through grants.

The reason for reviewing this basic conceptualization is to show that the underlying strategy of our grants program derives from it. The early decisions to establish the Division of Regional Medical Programs within the National Institutes of Health and that this was not to be a formula program but a competitive grant program were both related to the basic mission of this as a program to improve the quality of health care.

This initial decision which, if you will, reflects a preoccupation on quality has been reaffirmed many times since by the National Advisory Council despite some of the pragmatic compromises which are inevitable in getting a program of nationwide scope moving. It follows that such a grant program with these kinds of concerns requires decisions and decision-making processes both at the Regional and National levels. In the Regions these must be made in terms of regional priorities and realities. At the Division of Regional Medical Programs the decision-making must be in terms referable to the National scene, the availability of funds, and in keeping with the mission of the Act.

While the "seven basic steps to Heaven" of "involvement, identification of needs, assessment of resources, " etc., are put forth and discussed in some detail in the Division's newly revised issue of Guidelines, I would like to point out that perhaps even more important and essential is the step that precedes involvement which is the conviction that a commitment to involvement is needed -- the conviction that a Regional Medical Program is in fact a good thing, for until this conviction has occurred in a significant part of what Mr. Ward has called the local medical power structure, there will not be a Regional Medical Program.

My definition of the function of an administrator has always been that he is very simply an expediter, and therefore the administrators in our Grants Office - whether they be Operations Officers, in the Review Branch, or in the Management Branch - exist in order to help the applicant to obtain a grant and use it for carrying forward the purposes of the Act. In order to do this in a competitive grant program we must have a

reviewable document "with the best possible chance of successful review!" Time does not permit detailed discussion but, in brief, what we must have is an application which is (1) succinct, (2) reflects accurately the Region's status and proposals insofar as possible as they exist in fact, and not simply on paper, and (3) that it is cast in a frame of reference which will at least, in summary fashion, permit the reviewers to understand the relationship of the proposed plan or activity to the region's development as a whole.

Since this is still a young program and in relatively early stages of development, and in considerable state of flux, the Division's review process has from the beginning undergone a number of changes to accommodate to this and, as you heard from Dr. Olson this morning, will undergo further changes. Likewise as the Programs have moved from early planning grants through early operational grants to the present state of a rather complete mixture of all these and finally some fairly sophisticated operational Programs, review criteria have also changed and they will continue to change. In the days of early planning, primary considerations were the existence of what seemed to be a viable region with a reasonable basis for undertaking planning. It was clear that many early operational proposals were essentially "off the shelf" but could fit into the plans that the Region was developing and therefore there seemed no justifiable reason for delaying implementation until the whole grand master plan had evolved.

At the present time, the most important consideration in our review and evaluation of operational proposals is the consideration of whether there is in fact the kind of regional cooperative arrangements underway which will lead to a true Regional Medical Program and that, as I said

earlier, these arrangements exist in fact and not simply as wishful thinking on paper. In the future when at some point the availability of funds begin to plateau, not simply in response to the current fiscal crisis but as an inevitable characteristic of any program, there will inevitably be a stronger emphasis on the qualities of imaginativeness and innovation of individual projects.

A final word is in order in relation to the Division's strategy of being expeditors and providing as much help as possible to the Regions. Without in any way making excuses, it seems only fair that the Coordinators should understand that at this particular point of exponential growth and activity of the Programs we are in the midst of as tight a personnel freeze as I have ever encountered in the Federal establishment, so that the Division at the present time in fact has some 20-odd fewer people to do the job today than it had a year ago. Despite this, my staff will all do their best to be as helpful as possible to all of you.

"EARMARKED AND OTHER COMMITTED FUNDS AND PROJECTS"

Richard F. Manegold, M.D.
Associate Director for Program Development and Research
Division of Regional Medical Programs
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In the first session of the 90th Congress, Regional Medical Programs received its first earmarked funds. Presumably this will not be the last. For both the Division and the Regions, special problems were created by these monies. I would like to take this opportunity to describe the genesis of those earmarks, and thereby the genesis of earmarks in general, the philosophy of the Division in managing these funds, and speculate about the future in relationship to designated funds. Earmarked monies offer a challenge as well as a hazard to our program.

As you may recall, there were earmarks for Coronary Care, Community Hypertension Detection and Treatment Program, Community Stroke Detection and Treatment Program, Chronic Pulmonary Disease in Pediatrics, and Emphysema. Each of these programs had their advocates. In the case of emphysema, Congress received testimony from the National Tuberculosis Association. That Association was concerned that insufficient emphasis was being placed on the training of manpower for the growing problems of chronic pulmonary disease. They requested congressional support for this activity. The National Cystic Fibrosis Foundation, facing increasing expenditures of their limited research funds for service programs in chronic pediatric pulmonary disease, urged that Congress develop support for centers for these patients. The American College of Cardiology was responsible for testimony in support of programs for

In each case the proponents pointedly stated that here were methods largely proven for improved care.

The Congressional Record of the Senate on June 23, 1967, will give you insight into the genesis. Dr. Likoff, then President of the American College of Cardiology, stated to Senator Hill: "The matter which moves this testimony is the extent to which talent and competence in the contest against heart disease will be adversely influenced if certain structured allocations are not altered. This Committee is acutely aware, I know, that heart disease is the primary health problem of our time with morbidity and mortality rates far exceeding any other disease. You, Mr. Chairman, have been the author and architect of health programs which have strongly supported research and education in an effort to modify that fact. Over the years, specific Federal resources have created and maintained health agencies such as the National Heart Institute and the National Center for Chronic Disease Control which have stimulated and enlarged the efforts of all of the life sciences involved in diseases of heart and circulatory system." Dr. Likoff continued his testimony and described the present inadequate appropriations for the National Heart Institute and the National Center for Chronic Disease Control. Further in his testimony, he stated: "The American College of Cardiology regrets the failure to provide the Heart Disease Control Program of the National Center for Chronic Disease Control sufficient funds to carry out its full purposes and dedication." Throughout the testimony the discussion related to the benefits to be accrued from the expenditure of the Federal dollar for programs in coronary care. Throughout the testimony, no reference to Regional Medical Programs was made. Testimony for the other categoric programs only related to the National Center for Chronic Disease Control or the

categoric NIH Institutes. Regional Medical Programs was not considered until early in October by Congress.

Included in the Senate action was the allowance of a million dollars for arthritis to initiate a program of pilot arthritis centers and satellite facilities.

Because of the differences between the House of Representatives and the Senate, a joint conference committee was convened in early October 1967. The committee reported as follows: "In general, the conferees are agreed on the desirability of the purposes of the Senate increase, and are also agreed that a large part of the activities for which the increase of over five million dollars was earmarked is so closely related to activities financed under 'Regional Medical Programs' that they would more properly be administered by the National Institutes of Health under that appropriation." With this in mind, the managers on the part of the House agreed to a four and a half million dollar increase for Regional Medical Programs to cover the Senate's categoric directives which incidentally exceeded 5.5 million dollars. Thus the earmarks for the National Center for Chronic Disease Control were shifted to the maximum extent determined to be feasible by the National Institutes of Health.

Dr. Shannon recognized most of these programs could be undertaken by Regional Medical Programs but in a letter to Senator Hill noted: "The scope of the Regional Medical Programs legislation would not allow us to directly support programs designed to increase the availability of techniques for delaying the crippling effects of rheumatoid arthritis."

Regional Medical Programs thus was given the responsibility under appropriation for activities in coronary care, community hypertension,

community stroke, projects in chronic pediatric pulmonary diseases, and emphysema. These programs were laid on, if you will, Regional Medical Programs. To be sure, some of the activities were easily identified in planning and operational stages. Others, such as chronic pulmonary diseases in pediatrics, were essentially new activities.

In considering the methods by which these congressional mandates might be observed, two choices seemed reasonable. Either the Division could fund these under granting authority or seek to expend the funds by contract. The policy decision was made to pursue the grant route. First, had the contract route been taken, Regional Medical Programs would not have appeared different in mechanism from other governmental agencies. The opportunity to demonstrate the effectiveness of Regional Medical Programs to Congressional directives was therefore uniquely offered by pursuing the granting route. In pursuit of the grant route, however, special problems presented themselves, problems with which some of you are acquainted.

Advocates of various of the activities had long been in the habit of a direct contractual relationship with governmental agencies. For several, therefore, the problems of involvement and regionalization as represented by Regional Medical Programs seemed a cumbersome delay and a source of frustration. Secondly, the Division was faced with the problem of responding to a congressional mandate and at the same time protecting the "grassroots" nature of Regional Medical Programs. This we strove to do with fair success, although not complete.

The earmarked monies then represented basically a challenge by which the program could prove itself before Congressional and other critics. In the first go around of the earmarks, the program was able to point to activities consistent with regional planning. In the future, we may not be so fortunate. Nevertheless, earmarks are a reality and have been a method by which specific areas are identified for development. These are usually identified through the activities of special interest groups testifying before Congress. That such special interest groups will not take a continuing and increasing interest in Regional Medical Programs is highly unlikely. The reality is that we will continue to have earmarks, that the Division will pursue this to the extent possible through a granting mechanism rather than contracting; but in those instances where contractual relationships might better protect the integrity of local decision making, this route will be pursued. Further, in considering contractual relationships, the Division would expect that the contractee would be through the regional mechanism and not directly with institutions or individuals.

"RESOURCE FOR DEVELOPMENT OF
CONTINUING EDUCATION PROGRAMS"

Alexander M. Schmidt, M.D.
Chief

Continuing Education and Training Branch
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Since the inception of Regional Medical Programs, statements delineating our goals and the role to be played in meeting these goals by continuing medical education have been refined and clarified. Perhaps the clearest statement of the ultimate purpose of continuing medical education was made at our National Conference this past January: "The principle objective of continuing medical education is to provide for constant improvement in medical care. The problems of medical care and medical education are inseparable, and continuing medical education offers the greatest potential for the rapid and widespread solution of problems and deficiencies in health care."

This potential has been recognized by most regional medical programs, if I judge correctly our conversations and the content of grant requests. Nearly one-half the projects funded have been educational activities. If one includes patient care demonstrations as educational in nature (which I certainly would), then three-fourths of the projects and of the dollars granted are dedicated to education.

These figures document what we have suspected; that in fact as in theory, continuing medical education is a principle means of achieving our program goals.

but to accomplish all that we must, we should aim for the involvement of a major portion of the total health resources of the nation. This means involvement with almost 100 medical schools and their affiliated teaching hospitals, a sizeable portion of the total of 7,000 hospitals, some 288,000 physicians active in practice, 600,000 nurses and large numbers of other health personnel.

Dr. Olson has already spoken of involvement and commitment in his remarks earlier today. The importance of this process of involvement and commitment was emphasized in our report to the President and Congress, in the revised Guidelines recently issued, and especially in recent hearings before Congress held in connection with the extension of our legislation. But this process is a difficult one, and has obviously troubled a great many of us seeking ways of gaining the involvement and commitment to Regional Medical Programs of the significant portion of the nation's total health resources.

I think there is now evidence to suggest that the majority of health professionals now want to be -- and feel they must be -- involved in continuing professional education. Yet, it is clear that the more traditional forms of continuing medical education have not been successful in reaching many more than 10% of practicing physicians, and have had questionable beneficial effect on that small number. One still hears from all sides that physicians have no time to leave their practice, that their needs to learn are not being met, and that they simply are bored by the courses they have attended.

The challenge is obvious: each region must develop an educational program that will meet the learning goals of its many professionals, and that will secure widespread involvement in and commitment to the program.

Some regions are now accepting this challenge. We have been excited by the imaginative approaches being taken by some of our programs and by a few other groups in the country. In studying these, we have tried to identify characteristics of continuing education programs which will not only meet educational needs, but also insure widespread and enthusiastic involvement in our programs. I believe that I can identify four characteristics by which continuing medical education programs can be judged. While these characteristics sound disarmingly simple, they are worthy of our best thought and effort.

First and perhaps most important, the educational program must be based in and integrated with the practice of the professional. Ideally, the educational program should take place where a physician, for example, has most of his problems -- usually his community hospital. His education should not be continuing, but continuous ---- daily ---- an integrated part of the process of seeing patients, gathering and evaluating data, and making decisions. His educational needs must automatically be met by the educational program in such a way that he will perceive the time spent as an integral part of his professional life, and he won't have to "leave his practice." The mechanism for such an educational program is suggested by the second desirable characteristic: the educational need

of the practitioner must be met. The problem of identifying the deficiencies in knowledge and skills and the undesirable attitudes that we all have can be solved only by systematic study of these as they are reflected by our performance. What is needed is some method for looking at the end results of our efforts in practice. If a physician were to have some way of judging the outcome of his performance and were to see that in fact these were deficiencies, he could then ask himself what there is about his performance which yields less than the desired result. It seems that the only rational way to document scientifically and systematically our educational needs is to insure our first characteristic --- that of basing the educational system in the daily practice of medicine. Some of you are now finding new ways to use techniques similar to the utilization review, and finding that these data on how medicine is practiced make obvious what changes must take place to improve patient care.

This suggests the third characteristic: the content and procedures of the educational program must be determined by a systematic inquiry into the Practitioner's knowledge, skills, and attitudes. We need highly specific educational efforts directed toward resolution of an identified need. Evidence now supports the contentions that many physicians don't use knowledge they already have, and that their attitudes must be studied and then changed by appropriate educational experiences. It may well be that our concerns about motivation can be alleviated by such efforts.

Experience suggests that as we begin truly to meet individual needs, and demonstrate to that individual, by means of appropriate evaluation the resulting benefits, we can gain the enthusiastic acceptance, support and involvement of the medical profession in our program.

Such an educational schema could be a threat to our professionalism, if not our profession, which brings me to the last characteristic: the system should be professionally "owned and operated." The importance of this can be seen now in Oregon. What will make their experiment successful is that the members of the Oregon Medical Society themselves decided that all members must engage in continuing medical education. Physicians as members of a trusted profession must be dedicated to assessing the level of practice as a prerequisite to the design of an educational program. I believe that if the first three characteristics are to be present, the fourth must be. Only in a professionally controlled system of continuing medical education can we achieve the necessary others ---- basing the system in the profession, surveying performance in order to analyze need, and meeting this need by problem-oriented teaching programs occurring as part of a practitioner's everyday life.

Such programs are now being developed, and resources are available to assist in building others. Some of you are getting valuable assistance from centers of adult education or offices of research in medical education. The Division staff is eager to be of assistance whenever we can. We will be sending you pertinent information as it becomes available, such as the report of the AMA National Plan for Continuing Medical Education.

I hope that these characteristics might assist you in judging your educational program, its effectiveness, and its promise; and give some insight into how continuing medical education can be a principle means of involving professionals in our program.

"COMMUNICATIONS AND RELATIONSHIPS
WITH AND BETWEEN
THE DIVISION OF REGIONAL MEDICAL PROGRAMS,
THE 54 REGIONAL MEDICAL PROGRAMS,
OTHER ORGANIZATIONS, INSTITUTIONS AND GROUPS"

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Division of Regional Medical Programs

Edward M. Friedlander
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During the past year the Division of Regional Medical Programs has been reorganized to meet the changing needs and demands placed upon it in fulfilling its mission of implementing Public Law 89-239.

One of the areas of activity to which a new emphasis was given in that reorganization was that of developing and maintaining relationships between the Division and national professional and voluntary health organizations and specialty groups. As a result, the Office of Organizational Liaison was established within the Office of the Director. Although not initially given an official role in this new endeavor, the existing Office of Communications and Public Information, also a part of the Office of the Director, has worked with those involved with organizational liaison and contributed to that relationship as an important and integral part of its own total program. Together, these two Offices now are assuming primary responsibility for developing and maintaining relationships and communications with and between the Division, the Regions, other national organizations, institutions and groups.

At the Divisional or national level, these activities are carried on by utilizing a matrix of the professional and institutional groups

who are the providers of health services and are actively involved with the Division of Regional Medical Programs and the Programs themselves, and the public who are the recipients of those services. The first group can be identified as including representatives of the hospitals, medical schools, physicians and their specialty groups, allied health professionals, and all voluntary and public health organizations. The second group comprises all of the people in whose interest the first group operates but subdivided so that the educational or informational effort directed to that complex of publics, is tailored to meet the specific needs of each group. Only by utilizing this matrix can an integrated series of activities be planned and implemented that will effectively achieve goals of understanding, acceptance, support and cooperation among the various professional groups, on the one hand, and among the various publics that they serve on the other.

There must be parallel planning and effort at the regional level so that the activities of the Division cannot only be supportive of those of the Regions, but supplemental to them -- and vice versa. A successful result can only be achieved by a clear understanding of what constitutes effective planning and programming at both levels in organizational liaison and communications and public information.

There is already tangible evidence of the success of the Division in working with such organizations as the American Medical Association, the National Medical Association, the American Hospital Association, the American Cancer Society, the American Heart Association, the American Public Health Association, the American Academy of General Practice, the Colleges of Surgeons, Cardiology and Neurology, and the nursing and allied health professional associations.

The cooperative effort of a number of these organizations is exemplified by the three contract activities aimed at developing criteria for measuring the quality of diagnosis and treatment of patients with heart disease, cancer and stroke as required by Section 907 of the Regional Medical Programs legislation. In each case, one professional or voluntary health organization is accepting the responsibility for coordinating the work of other groups engaged with them in developing such criteria. It is expected that a report of the Committee on Cancer will be available by Spring of 1969, and those on heart disease and stroke shortly thereafter.

The national professional societies have also been encouraged to assume an advisory and consulting role in Regional Medical Programs. Their major contribution to date has been their help in determining what constitutes "the latest advances" or the highest quality of medical care for patients with heart disease, cancer, stroke and related disease which Regional Medical Programs should help physicians and hospitals make available to their patients. Similar efforts at the regional level are also underway and are helping to set the pattern for strengthening these relationships in the Regions.

Another example of joint action between the Division and a major national organization was the American Hospital Association's Invitational Conference on Hospitals and Regional Medical Programs held in June of this year. In addition to the material already distributed in the form of the reprints of July 1, 1968 issue of Hospitals Magazine which help explain this relationship, it can be expected that the proceedings of the meeting expected to go to press shortly will further clarify the issues. Parallel action is already occurring at the local level between the state and metropolitan hospital associations and the Regional Medical Programs in

which they are involved -- or should be.

Education of the providers of health service actively involved in Regional Medical Programs to the philosophy and development of Regional Medical Programs is being carried out through the efforts of both the Division's Office of Organizational Liaison and the Office of Communications and Public Information. This is being done in concert with the organizations already named and others, both in terms of program content at scheduled meetings, and through their own journals and other quasi-professional publications. For example, a full section on epidemiology at the last annual meeting of the American Public Health Association meeting was devoted to Regional Medical Programs. Similarly, the Sixth National Cancer Conference in Denver earlier this month added a day-long workshop-conference on special Regional Medical Programs activities. In addition, such publications as the AMA Journal and News, Bulletin of the American Cancer Society, the American Heart Association, Medical World News, Medical Tribune, Medical Economics, American Journal of Nursing, Hospitals, and Hospital Practice, to name a few, have written and published definitive features on Regional Medical Programs for their own special readership groups which in many instances overlap nationally and locally.

Much in the same way, the journals of the Medical Associations of North Carolina, Georgia, Utah and the Northwest (Oregon, Washington and Idaho), to name a few, have been most constructive in detailing the Regional Medical Program activities in their Regions to their own readers. So too have the state and regional publications of the Cancer Society, Heart Association and voluntary and public organizations which have given special regional emphasis to the material issued by their national offices in the interest of the Programs in their areas.

A combination and extension of this kind of activity at both the national and regional level must be encouraged. Only in this way can there be an understanding of Regional Medical Program issues in both national and regional terms.

There still remains much to be done in terms of inter-Regional exchange of information. Unfortunately, too little has been done to meet the demands for various informational elements that have already been identified. There is, however, some promise and progress in this area. In response to Dr. Musser's suggestion, we are pleased to announce that the Directory of Regional Medical Programs will incorporate some of this type of information in its forthcoming issue. Included will be a listing of all approved projects in the 23 operational Programs funded to date. Coordinators and Directors of these Programs will find summaries of their projects for review and approval in their folders. Also, the selected bibliography Dr. Musser asked for is in press.

For the past 18 months, the Division of Regional Medical Programs has assumed the presumptuous role of providing a wide range of informational materials, including its News, Information and Data publications, to any and all who asked for them, either on a one-time basis or regularly as they became available. The concept of the Regions developing their own materials for their own audiences now requires a re-evaluation of this policy. The Division's mailing list is now in its final stages of being regionalized. The question now arises of how best each Program can further maintain and develop that list to include all of the people with whom that Program must communicate, and then assume responsibility for doing so as part of a total informational program for that Region.

Regional Medical Programs, unlike any other Federal program, not only has put roots down into the 54 separate Regions, but each Program is indeed a special kind of autonomous entity. Each is separate in many ways not only from the Division of Regional Medical Programs, but from the other 53 Programs as well. As such, each Program must develop its own relationships and systems of communications and information among the various groups within its own Region to meet its own needs and demands. But each Program is still a part of a national effort being funded with Federal dollars and operating under Federal law. Therefore, all Programs have an obligation not only to keep their own Regional audiences properly informed and aware of their activities and progress, but also those who represent those constituencies in the Congress.

These facts add up to the unique factor of Regional Medical Programs that makes them different. Separately, each develops activities which are in the best interest of those who live in their Region. Together, they do the same for the entire country and, as such, have the potential for providing a collectively significant influence on the kind of support that is needed to insure the success of all of the Programs.

"Grant me the strength and intelligence to change those things I can; the patience to bear those things I cannot change; and the wisdom to know the difference." As this quote applies to Regional Medical Programs, we quote the Frenchman who said "Vive la difference!"

"ISSUES AND CONCERNS IN RETROSPECT"

Marc J. Musser, M.D.*
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North Carolina Regional Medical Program
Durham, North Carolina

I will now attempt to highlight for you the "Issues and Concerns" as they appeared to have emerged last evening during the six dinner sessions.

First, I would like to express the appreciation of the Coordinators to those members of the Division Staff who served so ably during last night's dinner sessions as recorders and secretaries. Without their help we certainly would not have been able to have had any kind of a meaningful activity this afternoon.

The discussions last night fell into three general areas: Opinions, Issues and Questions. I would like to explore each of these categories with you. Concerning opinion, there seems to be a consensus that there should not again be a large general meeting such as this Conference for the time being unless some special purpose should arise. Instead, smaller, targeted meetings, as suggested by Dr. Olson, were favored. In such meetings the various disciplines of the core staff could meet to discuss their own problems as related to those of other Regions and also as related to the activities of the Division of Regional Medical Programs. It would also appear that Coordinators would like some kind of a business meeting at least once a year but prefer that there should be limited

* General Discussion begins after Dr. Musser's initial summary of topics and issues brought up in the Dinner Discussion Sessions the previous night.

attendance and adequate time for full discussions. These might even be accomplished on an inter-regional basis with appropriate members of the Division staff attending.

Incidentally, the Division had hoped to provide more time for discussion at this meeting. It had to compromise this desire, however, in the interest of the material that needed to be shared - or at least it felt it needed to be shared - with the Coordinators.

There was also strong opinion last night that the entire communications and informational efforts of the program should be improved and expanded, Division to Program, Programs to Programs, and groups of Programs to groups of Programs. However, no specifics were advanced as to just how "bigger and better" communications should be achieved.

I would like to note here that the Division is very much aware that as the Programs become more sophisticated, so must be the case with the development and dissemination of information. Mr. Friedlander talked yesterday afternoon of the re-evaluation presently going on in the Division to meet these increasing needs at both the national and regional level. Some of these plans should be ready for discussion shortly. This would seem to be an ideal occasion for "targeted" meetings.

It would also appear that, while the need to educate and more deeply involve members of Regional Advisory Groups is desired, this could best be accomplished if the Advisory Group members and the Coordinators participated jointly.

In the area of improved relationship between Division and Program, one novel suggestion was made. Why not permit Programs to make site

visits to the Division? Certainly such visits would enable the Programs to gain more familiarity with the problems, philosophies and procedures of the Division. This suggestion might also reflect the concerns of Regions over the lack of feedback to them following site visits or staff visits from the Division. There is a strong desire to know the bases upon which judgments were made and also to obtain as much constructive criticism as possible.

These were the opinions. Now, I would like to summarize the several issues that seem to be paramount and then take them up individually with the panel.

Certainly the most widely discussed subject -- the most pressing issue -- was the relationship of P.L. 89-749 to P.L. 89-239. This is getting to be a very tired horse, it seems to me. There appears to be a widespread anticipation that some high and unimpeachable authority will provide the answer as to how these two programs can and will live and work together forever hereafter. Chances are this will not happen in the near future. It must be noted, however, that in some Regions reasonably adequate working relationships have been established without the benefit of an oracle.

There was also a great deal of discussion concerning the issue of the urban poor -- just what Regional Medical Programs could or should do to bring about more and better care for these people. There seemed to be the feeling among some that the Division was attempting to tell us

yesterday -- without really saying it -- that there has been either a policy change or a higher priority assigned to projects in this area. In this connection some wondered how such a national priority might relate to regional priorities.

Planning, evaluation, priorities, involvement, and continuing education each came in for their share of discussion. It would appear that those Programs having difficulty in these areas would greatly appreciate assistance from both the Division and from the more advanced Programs. This cry for help, I believe, is a part of our earlier remarks concerning the need for more sophisticated communication procedures.

Another issue -- and I am not sure it is as much an issue as it is a sensitivity -- is concern over the way in which Regional Medical Programs need to be developed to assure long range goals and at the same time generate short term activities that demonstrate viability.

As Dr. Wilbur and Mr. Brown pointed out, change must be accomplished slowly in so complex a health system as ours. Yet, at the same time, the public is impatient for quick solutions to long-standing problems. This, indeed, is our dilemma.

The last issue that seemed to come through clearly was what I choose to call the "coordination of the concepts and strategies" of the Regions and of the Division in the development of initial operational and subsequent proposals. At this early stage it is probably true to say that neither the Division nor the Regions have been able to crystallize fully their concepts and "grand strategies" and thus progress toward

these ends will be made more rapidly with a free exchange of ideas, good faith and open minds.

So that the Panel might respond to some of these issues, let me ask Dr. Olson if he would like to make any comment concerning the relationships of P.L. 89-749 and P.L. 89-239.

GENERAL DISCUSSION

DR. STANLEY W. OLSON, Director, Division of Regional Medical Programs: I suspect that the trouble with trying to get the position of the relationship between 239 and 749 straight is that while you can see 239 in your own Region and in other Regions and get some fairly tangible evidence of what it is doing, you can't do the same with P.L. 89-749. The development of the 749 program is not nearly so advanced. When we try to give a theoretical description of what it ought to be, one looks to see what basis of reality there is against which to test his conceptual idea. It is so diffused and so varied from state to state that we are tempted to say, "They are trying to tell us in different words what the law says, what it means as a Federal conceptual strategy." Well, that's all right. But when we come right down to it we can't find anything that conforms to our individual notions of 749. And since we are realists, this doesn't help us any.

Mr. Peterson, who is in Planning and Evaluation, did a very nice analysis of 749 for me based on available information. I thought, as I read this analysis, that one would be hard pressed to formulate it into a describable program.

I would suggest to you that it is only just now becoming possible to do this with Regional Medical Programs -- and we have been at it for two and a half years in a fairly intensive way. I think we are terribly fortunate in being able to recruit the kind of talent assembled here in this room. This, to my mind, is why Regional Medical Programs has moved ahead more rapidly than the other program. This is not to say in anyway that the other program is of less importance. Rather, it is to say that 749 is trying to collect a different element within the community to do somewhat different things with the health care structure and that it may be some time before a recognizable pattern will emerge in that area as it has in 239.

I don't know that we can clarify this any more. But, perhaps we can clarify what Coordinators ought to do in the absence of a more definable 749 pattern. Clearly, I think Coordinators must keep fully abreast of what is going on in the development of Comprehensive Health Planning in their area. They may wish to do as Paul Ward has done -- offer to provide specific help. Mr. Ward has trained 749 personnel in his office in order to give them the benefit of what information and organizational activities have been pulled together by 239. Clearly this, or any other form of cooperation, is well within the purview both of 239 and 749. More than this, I think it is entirely appropriate. I would advise that Coordinators send the person in charge of 749 in their Region copies of applications including budget, so they will have full information about what is going on in the 239 program. Also, in a cooperative venture such as this, there

is nothing wrong with Regional Medical Programs assuming leadership if no such leadership is presently apparent. The only caution I would urge is that Coordinators assume this leadership in a kind of a trusteeship capacity and at such time as the leadership of 749 does emerge, when the staffs become organized, that 749 be allowed to occupy the ground that is rightfully theirs. Do not dispute that ground with them. Clearly 749 and 239 have complementary roles and it would be dangerous to confuse those respective roles.

Dr. Baumgartner suggested last night that the two groups sit down together and stop worrying about what their roles were. They should simply decide what each group, including other participating groups, can do best and then let them go ahead and do it. Only in the doing of what each program must do, will the role of each emerge.

Clarification is bound to emerge. But I'm not at all sure that it will emerge at the rate Coordinators would like it to. Perhaps this will be a test of some of the challenges Mr. Brown pointed out this morning -- a test to prove the Coordinators ability to deal with complex problems and complex groups that they don't manage, don't feel comfortable with. I think this is as much as I can contribute -- unless there are some specific questions.

DR. MUSSER: We might move on. I don't think we'll clarify this issue any further.

Another issue raised last night was whether, indeed, the Division was trying to convey a message to us that there was now a different

emphasis upon the importance of Regional Medical Programs involvement with the health care of the urban poor. And, if this were indeed true, how could this emphasis at the national level be reconciled with some of our own regional priorities.

DR. RICHARD F. MANEGOLD, Associate Director for Program Development and Research, Division of Regional Medical Programs: There are no new signals. There is, however, an emphasis of old signals. You will remember that the News, Information, Data reported last September on the concerns of the National Advisory Council. These concerns related to the relative visibility of Regional Medical Programs. In January, Mr. Irving Lewis, then of the Bureau of the Budget, emphasized the importance of the urban health problem. Thus, there have been two major statements -- one from the National Advisory Council and one from the Bureau of the Budget in regard to this problem. Dr. Marston and others have made numerous references to this area throughout the year.

The new Guidelines, in describing the Regions, state that they must be relevant to the complete population coverage. Nevertheless, one recognizes that Regional Medical Programs require time for their development, that regional priorities vary, and that the protection of the Regions' integrity is crucial.

Clearly there are difficulties in developing programs for the poor. The health status of ghetto populations is too well known to this group to require recitation. You are equally aware of the difficulties of

developing cooperative arrangements in areas where provider systems are thin. Therefore, special innovative approaches will be required. Solution to the urban problem will come from those with the imagination for innovation.

The signal means emphasis. We are only re-emphasizing a problem. If the signal means "'cool it baby' and put it all in the ghetto," then the signal is being badly misinterpreted.

DR. MUSSER: Any more questions about this one?

DR. RICHARD H. LYONS, Program Coordinator, Central New York Regional Medical Program: I have a question in reference to Regional Medical Programs involvement with the health problems of the urban poor. How do we do this? Do we operate through a grant request --through planning grant requests? What kind of mechanism do we have without putting in a new planning grant request to get around your auditors?

DR. OLSON: I don't believe there is anything the auditors would take exception to if you use your planning funds to do planning for your entire Region. I don't know of any aspect of planning which is restricted. Is there any question on this? You may not have as much money as you would like to identify needs. But I hope no one believes they must have a special planning grant to plan for the poor. This is not consistent with any experience I have had. I hope we are clear on this point.

VOICE FROM THE FLOOR: Dr. Olson, how does this question of Regional Medical Programs assisting the urban poor relate to your earlier discussion of 749? It would seem to me that 749 would be the more logical approach to the solution of the urban poor problems. How should Regional Medical Programs concern itself with the health problems of the ghetto?

DR. OLSON: Planning funds are awarded to the Regions to help them to carry on those things they believe are relevant to their mission. If some Regions say they do not need to concern themselves with the health problems of the ghetto, and have some data and information to support such a position, I don't believe they will be challenged. Remember, Regional Medical Programs has a non-directive type of approach.

I think what Dr. Manegold is suggesting is that if the Regions studiously ignore the ghetto the Division may raise the question: Why aren't you interested in the ghetto? But that doesn't mean there is any special directive to move in the direction of the ghetto. I think this is a matter that is generally understood.

...As far as I'm concerned planning is a continual process which we will be involved with as long as we're involved with Regional Medical Programs. When projects with respect to the ghetto are proposed you must take a look at some of the constraints that are imposed upon Regional Medical Programs in terms of neither being able to provide services, nor being able to construct facilities. This is where we begin to talk with

the 749 program, talk about their ability to accomplish these facets of a total program. The 749 program can indeed support the more active financial phases of bringing health care to the ghetto. The activities of 239 must be complementary to those of 749 in this area. Specifically, Regional Medical Programs is concerned with the quality of care that will be provided in terms of heart disease, cancer and stroke. Clearly, the Office of Economic Opportunity will be a third mechanism for the solution of ghetto health problems. Granted, this is a complex approach, but any approach by the nature of the problem will be complex.

DR. JOHN BUCHNESS, Public Health Service Regional Office, Denver: I would like to go back to Dr. Manegold's earlier statement and say that in my opinion there has definitely been a change in signals. I speak from the viewpoint of the Department's Regional Offices. The signal is very clear. It is fundamentally important that all of us understand the urgency of the urban poor problem, and the extent to which this urgency must be woven into a total program -- Comprehensive Health Planning, Regional Medical Programs, Model Cities, OEO Clinics, --- and so forth. If we're going to sit around and wait for years and years of planning to see what we should do, then I think we are regressing rather than progressing. There must not be competition between programs, but concerted action to get things done.

DR. J. GORDON BARROW, Program Coordinator, Georgia Regional Medical Program: I think we are being told that we must pay more attention to the problems of the urban poor. I also believe this goes against the

grain of the most popular facet of Regional Medical Programs -- that its activities are non-directive. I would suggest that assistance to the urban poor is a "directed" activity. Notwithstanding the fact that I sincerely believe there is much urgency in this area of the urban poor I do believe this urgency should be stressed to Coordinators in a private way and not by news releases that go to so many people in the Region. I say this because I find growing resistance to this approach in my area. My people have been given the impression that they are being pressured by Secretary Cohen. And, as most of you know, he is not a popular fellow in my part of the country. I think that concern for the urban poor, or in my area, the rural poor, must come originally from the area itself and not from Washington. I would suggest that it would be a whole lot more diplomatic, and a whole lot more effective if the Federal government's concern in certain areas would be transmitted quietly and not broadcast throughout the entire Region.

VOICE FROM THE FLOOR: We talked yesterday at some length about earmarked funds. I would like to ask either Dr. Olson or Dr. Manegold whether they believe that the great importance of the ghetto problem might in the future entail the earmarking of funds for application in this area.

DR. OLSON: Other national priorities have been set besides the ghetto area. But funds have not been earmarked for these other national priorities. I would hope that none would be so marked for the ghetto,

because earmarking is inconsistent with the mechanisms whereby funds are allocated to Regional Medical Programs.

...I would also like to speak in reply to Dr. Buchness' belief that there has been a change in the signals. To my knowledge there has been no directive to Regional Medical Programs as to what they must do in respect to poverty problems. The fact is that the poverty problem exists and Regions may wish to use some of their funds to study the problem. This is certainly an appropriate use for planning funds. But, as the law specifies -- operational projects must be approved by the local Advisory Group. These Groups must set their own priorities, and must determine how to distribute awarded funds among approved projects.

There is no message going out to Coordinators from the Division that they must shift their funds into the urban poverty areas. Nonetheless, having said this, I would remind you that the urgent problem of the urban poor remains. Major needs must be resolved, and if the opportunity exists for Regions to solve these needs in their way, they should do it. Ignored needs will not go away. This, I think is the only special signal that the Division is trying to make."

DR. DEAN W. ROBERTS, Greater Delaware Valley: The problem in Philadelphia is not so much in not wanting to deal with the ghetto problem, as it is how does one effectively relate Regional Medical Programs to the problem. In Philadelphia, as in most large cities, there are numerous agencies

that are trying to do something about this problem. Unfortunately, there is relatively little relationship between these agencies. Also, many of these agencies believe they have a direct mandate to deal with the ghetto problem. The relationship of Regional Medical Programs seems to be relatively peripheral. I do not see any particular niche where Regional Medical Programs might make a particularly significant contribution. It would seem to me that if there is any one thing the ghetto does not need, it would be a special emphasis on categorical diseases such as heart, cancer and stroke.

I believe that the contribution Regional Medical Programs can make to the ghetto health problem will be the effect of its planning on other agencies, its influence in getting them to work together. I believe a direct approach on the part of Regional Medical Programs to the varied problems of the ghetto would be similar to walking into a cul-de-sac.

DR. MUSSER: I don't believe it possible to identify a niche for Regional Medical Program involvement in the ghetto that would be nationally applicable. No Region has exactly the same resources available as another. Whatever contribution the Regions make in this area must have some relationship to the resources they have at hand. Again it is a question of local initiative, local innovation.

DR. BARRY DECKER, Program Coordinator, Northeast Ohio Regional Medical Program: I would like to speak to the question raised by my colleague in Philadelphia. I believe that planning toward operational funding for

programs in the ghetto is only one phase and may turn out to be the least important from the standpoint of Regional Medical Programs. It seems to me that Regional Medical Programs is the mechanism whereby one gears a community to set up cooperative arrangements for an attack on the ghetto health problems. In this sense, we in Cleveland are using the Regional Medical Programs mechanisms without the need for additional funds to approach some of these inner-city problems. Quite specifically we are working out cooperative arrangements with the Cuyahoga County Medical Society. One of their current activities, which we have stimulated, is an effort to convince the physicians of this county that their functioning in inner-city areas is quite important. This type of motivation is necessary if we are to realistically approach the problems of the inner-city. I believe that this can be a real Regional Medical Programs contribution. Regional Medical Programs with its large body of expertise is helping to establish a new OEO center in our area without requesting additional funds. The point I'm trying to make is that Regional Medical Programs contributions to ghetto health problems need not be tied to money. When it is not tied to money, it is not tied to the limitations of the law.

DR. MUSSER: I would like now to get a little dialogue going concerning the issue I earlier identified as a situation wherein neither the Division nor the Regions have been able to crystallize fully their concepts and "grand strategies" concerning the development of initial operational and subsequent proposals. From time to time we see at the regional level a

desire for the Division to make very clear just what kind of material should be contained in a grant application. Also at the divisional level, from time to time there is a feeling that the regional people should have better documented their application in terms of concept and strategy.

There has been some sparring on this matter between the Division and the Regions. This has been reflected in the expressed desire of some Regions that there be Division feedback to them after site visits. The Regions feel they would get a much better idea as to whether they were on the right track if the Division would give them constructive criticism.

I do believe, though, that we're better informed on this matter than we were two years ago. Certain concepts have emerged at the Divisional level. This is particularly true in regard to the necessity of establishing some kind of continuity, some kind of a story of regional activity as the Regions begin to send in requests for additional operational projects. I wonder, Dr. Stephenson, if you would talk about this. I believe it quite important.

DR. RICHARD B. STEPHENSON, Associate Director for Operations, Division of Regional Medical Programs: The business of casting new applications into some frame of reference does make sense to the Division. And to the Review Committee and Council. I believe it a matter of just plain common sense. It has been clearly expressed a number of times by both the Review Committee and the Advisory Council that supplemental applications, or indeed even initial operational proposals, must be related in

some meaningful way to what has gone on before during the planning stages. At the Divisional level it must be clearly understood what the Regions subsequently hope to accomplish. The Division must have this frame of reference if it is to make a meaningful judgment as to the merits of the proposal.

A simple solution to this would be if the Division staff could prepare a detailed summarization of the status of each Region for the use of the Review Committee and Advisory Council. But there are two objections to this. First, the Division could never accomplish such a task in as meaningful a way as the Region could. The other barrier is that as of today the Division is shorthanded -- some 25 fewer people than it had a year ago. We are in the middle of the tightest personnel freeze ever experienced in the Federal government.

DR. OLSON: The big question which the Review Committee, the Advisory Council, and the site visitors are always interested in is: Has the groundwork really been laid? Have regional cooperative arrangements really begun? Is there in fact a basis for a viable Regional Medical Program. This is far more important than the content of the individual projects in the application package.

I would like to change the subject at this point. Many of you are anxious to catch your planes and I think we have now come to the time where the Conference program should be terminated.

I would like to express my deep appreciation to Dr. Musser for having been your spokesman this afternoon in setting forth the Concerns and

Issues that have been expressed during this Conference. In the past few minutes I have been trying to compare what has gone on these past two days with what went on at the Conference in June of 1967 -- just 16 months ago. This organization has come a long way during that time. Nonetheless, I suspect many of you are leaving with the feeling that far too few answers were provided by this Conference. Many of you came to Washington with a whole bag full of problems, thinking that you would find someone here who would have an answer for each of them. Now, here it is two days later, you have to catch your plane, and most of your problems remain unanswered. Well, that's the way it is, you know. You are not going to get all the answers out of Washington. The challenge is for you to develop an organization that can provide the answers to your own problems.

I would, however, like to say that some of the problems you brought with you to Washington concern the management policies of this Division. You do deserve specific answers to these questions and I will see that you get them.

On behalf of all the staff I would like to express my sincere appreciation for your participation at this Conference.