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PROBLEMS AND ROLE OF RMP IN LARGE COMPLEX METROPOLITAN AREAS

BACKGROUND

Fourteen of the fifty-five Regional Medical Programs involve more than one medical school and encompass complex metropolitan areas with populations of more than a million persons. Although there is a wide variation in the character and stage of development of these Programs (e.g., California and Metropolitan New York; Illinois and Bi-State) it is generally true that as a group they have lagged behind in the organization of the core program, initiation of operational projects, and level of funding. This gap has even greater significance when viewed against the size and specific needs of the population which these programs serve. At the request of Council, staff prepared for the May 1969 meeting an issue paper "Problems and Role of RMP in Large Complex Metropolitan Areas." This paper considered the question in relation to three problem categories:

Regional Characteristics These programs operate in a complex environment. The cities contain large concentrations of poor persons who receive inadequate care while rising medical costs sap the available resources. There are multiple sophisticated health resources in these Regions, but with often uncoordinated and overlapping responsibilities. In addition, high public investment makes health emerge as a major political issue.

Improvement of Health Care There is a demand for both qualitative and quanitative improvement in the health care system with differing priorities for action than in rural areas. The problems of the health care of the poor often serve as an indicator of the weakness of the system as it affects the more affluent population. As these Programs develop, the nature and limitations of the categorical approach must be examined along with the concept of regionalization to determine how it can most effectively be implemented in the cities. The role of the medical school may be quite different here than in the other areas.

RMP Organization These complexities have resulted in special organizational problems for these Regions related to: leadership; staffing; commitment by medical schools to RMP; lack of broad community involvement; "turf" problems; difficulties in bringing multiple participating parties together.

The Council briefly considered the issue paper presented and indicated its general agreement with the situation and problems as outlined by staff. There was no consensus as to what appropriate policy or other action might be taken, however. Thus Council asked for further delineation of a specific policy action which it might review and adopt.

The following statement accordingly is presented for Council consideration. It primarily consists of suggested approaches which would make these Regions more directly responsive to their local situation and which would encourage them to address the major health problems they confront. While many of the approaches are applicable to all Regions, they are particularly critical for large, complex urban Regions, constituting necessary if not sufficient conditions for program progress. This statement does not meet questions of the specific technical or program goals which these Regions should seek. Rather it recognizes that the role and program of each Region may vary considerably according to local circumstances.

The statement also leaves unanswered the question as to the extent to which these Regions realistically can hope to be relevant and responsive to the major health problems of urban areas within the context of RMP, given current funding constraints.

RECOMMENDED STATEMENT

The National Advisory Council on Regional Medical Programs recognizes the special complexity of the health care problems facing those Regional Medical Programs which encompass large metropolitan areas. Although there is often a relative abundance of health resources in these areas, including hospitals, manpower and medical schools, the health care system is so constituted as to result in large segments of the population having only limited access to care. In response a multiplicity of public and private health agencies have emerged with sometimes conflicting roles and overlapping services. Regional Medical Programs seek to promote the development of formal linkages or cooperative arrangements between health institutions and professionals concerned with heart disease, stroke and related diseases; linkages to facilitate the transfer of knowledge and the referral of patients among the more sophisticated medical institutions and those with lesser capabilities; linkages with specialized community facilities and agencies to assist in prevention of disease and bringing services to persons who otherwise would not recognize the need or be able to take advantage of them.

The Council reaffirms a basic position that the development of patterns of regionalization will require a unique approach in each area taking cognizance of specific local problems and capabilities. There is no one model which is applicable for all programs. However, it is felt that there are certain organizational approaches which large, complex urban Regions should consider as they plan their future activities. Each should:

1. Become well acquainted with other urban health programs which receive Federal assistance, such as OEO neighborhood health centers, Model Cities programs and comprehensive neighborhood service programs; and should seek to develop projects and activities which would compliment and supplement health services provided by them.

2. Strive to develop close working relationships with the areawide comprehensive health planning agencies operating

within their area. The possibilities for joint support of staff and joint planning should be explored.

3. As appropriate, actively seek to develop projects aimed at physicians who do not have hospital staff affiliations. Efforts also might be directed at hospitals, including the many proprietary institutions, which have no medical center affiliation or teaching program.

4. Review the membership of its Regional Advisory Group and planning and other committees to ensure that there is appropriate representation of physicians and other health professionals who have an understanding of and concern for delivering care to an urban population, including the poor. In addition efforts should be made to expand participation in the program by community and consumer representatives, particularly those representing the disadvantaged.

5. Encourage projects which involve outreach into the community especially on the part of medical schools and teaching hospitals. The development of meaningful outreach mechanism by these institutions is becoming increasingly important.

6. Obtain, if no already available, staff qualified to work on problems of organization and delivery of care.

In conclusion, the Council would encourage the Director of RMPS to take into account in setting funding priorities, the extent to which the proposals of large complex Metropolitan Regions reflect activities which provide for wider distribution and better utilization of existing health care services, especially as these relate to disadvantaged and high risk populations.