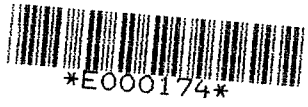
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REVIEW OF ISSUES AND RELATIONSHIPS*

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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.