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SUMMARY OF ADL-OSTI REPORT

The ADL contract has been extended for one month (to November 20) without additional funds. This extension was made in order to allow them to (1) more fully and adequately reflect in their final report the extension comments, criticisms, and suggestions received from those selected coordinators, RMPS staff, and others who reviewed their draft report, and (2) prepare a summary of the larger report.

A short staff summary (8-10 pages) of the draft ADL-OSTI report will be available at the time of the Council meeting. Copies of the final report paper and a summary version of it will be sent to Council members as soon as it has been received and reproduced in quantity.

Enclosed are copies of two papers that may be of interest to you.

(1) "Regional Medical Programs: Improving Health Care Through Voluntary Regional Cooperative Programs," by Dr. Donham. This brief paper not only draws upon the contract effect of ADL-OSTI, but in a sense is a highly selective and incomplete summary of that study.

(2) "An Approach to Evaluation for the Regional Medical Program," by Dr. Schon. This paper very nearly mirrors the substantive evaluation chapter found in the draft ADL-OSTI report. It also reflects some of the major themes, such as systems transformation, of that larger report.

Enclosures

REGIONAL MEDICAL PROGRAMS

IMPROVING HEALTH CARE THROUGH VOLUNTARY
REGIONAL COOPERATIVE PROGRAMS

PHILIP DONHAM, D.C.S.

Arthur D. Little, Inc.
Cambridge, Massachusetts

Eastern Regional Conference on Science
and Technology for Public Programs
Boston, Massachusetts
April 2, 1970

Workshop Session I:
Case Reports
Section G: Health Services

REGIONAL MEDICAL PROGRAMS

IMPROVING HEALTH CARE THROUGH VOLUNTARY
REGIONAL COOPERATIVE PROGRAMS

EASTERN REGIONAL CONFERENCE ON SCIENCE AND
TECHNOLOGY FOR PUBLIC PROGRAMS

April 2, 1970

ARTHUR D. LITTLE, INC.

This paper is written for the Eastern Regional Conference on Science and Technology for Public Programs. My assigned subject, "Regional Medical Programs," is heavily weighted with science and technology; and it most certainly is a public program.

Now it would be very satisfying to be in a position to show you how advanced medical technology was expedited throughout the medical system ɜ a result of a public program, but that is not what really happened. When ꞁedical discoveries of great import are made, they become widely known in a very short time. And if they have significant potential for affecting primary care, they spread through the system as if by magic: witness penicillin and the Salk vaccine.

Regional Medical Programs started as a vehicle for accelerating the dissemination of the latest advances in technology to where they could reach the patient. This paper tells why this turned out to be an inappropriate target and what took its place when it did. I rather think that the new target may turn out to have more significance to public officials in the future than the original one would have had.

PHILIP DONHAM

ARTHUR D. LITTLE, INC.

Precis

Regional Medical Programs was .one of several Federal programs that were initiated in the eighty-ninth Congress in 1965 to respond to the growing health problem in the United States. Its contribution was expected to be to unlock the vast storehouse of medical research that had accumulated over a decade or more and make it available to victims of the killer diseases: heart disease, cancer, stroke, and related diseases.

As the Congress finally passed the Law (P.L. 89-239) it conceived of regional voluntary cooperative programs as the most effective vehicle for facilitating the movement of advanced technology through the medical system. When the Regions began to operate, several unexpected conditions slowly emerged:

(1) To the extent that new technology had real applicability to primary health care, it was already very widely known throughout the system.

(2) Obstacles to the application of the latest technology to patients were either economic or institutional for the most part.

(3) When economic, they were usually beyond the anticipated financial resources of RMP to deal with beyond a token level. (And other agencies usually had a more direct responsibility for them, as with renal disease.)

(4) RMP was ideally situated to work on the problem of institutional barriers because of its charter to build on cooperative arrangements among all those participating in or closely related to the medical system.

Regional Medical Programs has found itself able to turn in the direction of facilitating closer relationships and improving communications across institutional barriers without having to abandon the professional orientation it started with.

Regional Medical Programs has thus become a significant practical example of how a public program can learn and evolve as it develops, so that it can be responsive to reality while pursuing its valid social objectives.

As long ago as 1965, the Congress of the United States acted on the emerging awareness that the state of the Nation's health was unacceptably poor even after billions had been spent on medical research. That was the year that the Congress established Medicare and Medicaid to help old people and poor people meet their medical bills.

In the same year, two laws designed to improve the capability of the medical provider system were put on the statute books.   (1) The Regional Medical Programs (P.L. 89-239) dealt with improving health care for victims of heart disease, cancer, stroke, and related diseases through voluntary cooperative arrangements among those directly concerned with medicine.   The other, Comprehensive Health Planning (P.L. 89-749), dealt with state and area-wide planning of health resources to optimize their effective application.

Let us look for a moment at the condition of health in the Nation that led to the concern of those in positions of public responsibility. As told to an audience at Airlie House by Joseph T. English, M.D., administrator, Health Services and Mental Health Administration, on September 28, 1969:

"We are 15th now among the nations of the world in infant mortality."

"We are 22nd among the nations of the world in life expectancy for adult males."

And in another vein he said:

"In 1955 the total public-private expenditures for health care in the United States was about $17.1 billion.   In 1965 it had grown to $37.3 billion.   Today, in 1969, it has grown to better than $60 billion.   A conservative projection of what that total will be in 1975 is that it will approach $100 billion."

In 1965, the relationship of these numbers was not already evident. What was evident was that billions had been spent on health research without a corresponding improvement in health statistics.

President Johnson, in 1964, established a Commission on Heart Disease, Cancer and Stroke, the three leading killers, to investigate what might be done to reduce morbidity and delay mortality from these diseases.   The DeBakey Commission, as it was named after its Chairman, Michael E. DeBakey, M.D., of Baylor University, submitted its report in December, 1964.   The report, which became the basis for an Administration bill recommended a detailed Federal blueprint for action.   It proposed the building of a number of "regional medical complexes" around the United States for research and training and for demonstrations of patient care in the fields of heart disease, cancer,

stroke, and other major diseases.

Implicit in the Report were two beliefs that have since undergone careful scrutiny and, at least in some quarters, strong challenge:

(1) Effort spent directly on the leading killer diseases is the most promising way to improve health statistics quickly, and

(2) Regionally organized medical complexes could force-feed the entire medical system with knowledge that had built up in the great medical research centers.

The administration bill had very hard sledding in the Congress. There was wide resentment in the profession at the suggestion that excellence and the latest medical knowledge were attributes confined largely to research centers. There was also widespread fear that this was a first step toward a Federal medical system directed from Washington.

The Act as passed (P.L. 89-239) turned away from the idea of a detailed Federal blueprint for action. Specifically, the network of "regional medical complexes" was replaced by a concept of "regional cooperative arrangements" among existing health resources. It recognized geographical and societal diversities. It established a system of grants to enable representatives of health resources to exercise initiative in identifying and meeting local needs within the area of categorical diseases. "Other major diseases" became limited to "related diseases." How well local health resources can take the initiative and work together to improve patient care for heart disease, cancer, stroke, and related diseases became a measure of the degree to which the various RMP's would be perceived as meeting the objectives of the Act.

The Act was intended, as was the Administration bill, to provide the means for disseminating to medical institutions and professions the latest advances in medical science for prevention, diagnosis, treatment, and rehabilitation of certain categorical diseases. But the dissemination, instead of being directed from regional centers, was to be implemented through grants which would be used among other things to encourage cooperative arrangements.

RMP AS A VEHICLE FOR DISSEMINATING THE LATEST MEDICAL ADVANCES TO THE PATIENT

By the time the Regional Medical Programs came into being, its objectives had been spelled out in the Law as follows:*

The program was expected to encourage research and training (including continuing education) and related demonstrations of patient care in the

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* Condensed and paraphrased.

fields of heart disease, cancer, stroke, and related diseases.

the program was expected to afford the opportunity to the medical profession and medical institutions of making available to their patients the latest advances in the diagnosis and treatment of these diseases.

The program was expected to improve generally the health manpower and facilities available to the Nation.

RMP, it would seem, was given responsibility to seek out the latest medical advances and find ways to disseminate them for the purpose, so far as possible, of wiping out heart disease, cancer, stroke, and related diseases.

Regions were approved by the Surgeon General and issued planning grants as follows:

1966	34
1967	19
1968	2
	55

With approval of the 55, every part of the United States became included.

While each Region went about organizing and planning in its own way, they all turned almost immediately to the medical schools for access to the latest medical technology that they were expected to help disseminate. The medical schools, by and large, were ready and waiting.

Hopes and expectations ran high in some quarters. There had been considerable publicity given to the truly marvelous medical research being carried out in medical schools and research centers across the country. This brilliant research had resulted in exciting -- even dramatic -- advances in dealing with what had previously been obscure or untreatable diseases.

As the Regional Medical Programs turned to these institutions for the latest advances to be disseminated, the astonishing thing was that virtually no new technology appeared in their grant proposals. Their ideas were almost universally confined to ways of using RMP funds to make already widely known technology more readily available to local physicians and community hospitals; e.g., coronary care units, audio-visual teaching tools, assistance in multi-phasic screening, and a broad spectrum of continuing education programs, from conventional to creatively new. But the expectation that there was a storehouse of unrecognized advances in medical technology, ready to be applied by the medical profession as fast as they could be made aware of them, proved to be a myth.

There could be no quarrel with the kinds of projects that were approved. Clearly they dealt directly with the objective of making what was known more readily available to the patient.

Recognition of the fact that dissemination of new technology must, in the face of reality, drop back from a position of top priority came slowly. It is the nature of things that professionals in medical schools are better positioned to take the time to prepare grant applications than those more immediately tied to patient care. As might be expected, applications from medical schools dominated the scene in the early years of the Program. To some degree this seemed to support the notion that RMP was a tool of the medical schools to disseminate their "superior knowledge," and it concealed from general notice for awhile the fact that little of this knowledge was really an advance in the state of the art. There are still those in medicine who find it difficult to accept the reality that has emerged.

RMP AS A FACILITATOR OF PROCESSES TO IMPROVE PATIENT ACCESS TO HEALTH CARE

As technology transfer dropped from a position of top priority, those concerned with the establishment of policy and program in the Regional Medical Programs began to look at the Law with a new perspective. They recognized that the Law put initiative in the Regions, and with it responsibility to set new priorities.

Public Law 89-239 made it clear that RMP was to focus its energies on making quality care available to the victims of heart disease, cancer, stroke, and related diseases. It placed the profession in the forefront of the Program.*

A very significant emphasis on voluntary cooperative arrangements had been added before RMP became law. While Medical centers and clinical research centers were to play an important role, hospitals, practicing physicians, and other persons and institutions related to medicine, as well as laymen familiar with the need for services, were to be included as active voluntary participants. Regionalization began to take on new meaning.

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*Whereas the comprehensive Health Planning Councils under P.L. 89-749 were required to have more than 50% public members, RMP Regional Advisory Groups had to have merely an unspecified proportion of public members. The Regional Advisory Groups were to be themselves constituted in such a way as to bring together all those interested in health in the region. By law, membership of an individual Regional Advisory Group would have to include:

- practicing physicians
- medical center officials
- hospital administrators
- representatives of appropriate medical societies
- voluntary health agencies
- representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried out under the program
- members of the public familiar with the need for the services provided under the program

-4-

If lack of general knowledge of new medical technology was not a prime cause of the poor health statistics of the Country, then "Where is the gap between our obviously superior medical knowledge and the observable level of delivered health care?"

It was at this point that the wisdom of the Congress in insisting on regional cooperative arrangements finally became clear. In the process of trying to get all interested parties to cooperate, the RMP's quickly discovered that the medical system is the victim of its own institutional barriers: mutual town/gown distrust, "guild warfare," defensive referrals, neighboring community hospital rivalries, and other serious interferences in the free flow of the most appropriate care to the patient.

The concept of mutual confrontation of common problems was essentially a new one, only just approaching a level of acceptability under the enormous pressures that had begun to beset everyone connected with medicine. And only RMP, of all the public programs in being, offered a charter to the medical profession to voluntarily address itself to lowering those institutional barriers. Here, then, began to emerge a new sense of mission in the most advanced RMP's.

This new mission led naturally to a need to learn where the system of delivery of health care was failing to reach people. Almost immediately, attention was drawn to the poor, both urban and rural. Whereas the middle income and well-to-do are suffering the effects of the institutional barriers referred to earlier, the poor are really cut off from the mainstream of the medical system even when covered by Medicare and Medicaid.

Dr. English, at the meeting referred earlier in this paper, presented some facts that point up the significance of the desperately bad health condition of the poor:*

"A poor child in this country in 1969 has twice the risk of dying before reaching his first birthday as your child would have, and four times the risk of dying before reaching the age of 35 than your child would have."

"The difference in incidence of chronic disease per 1,000 population... [is] in orthopedic impairments... 32 to 15; in heart conditions of 30 to 12; arthritis and rheumatism of 27 to 8.7... in high blood pressure... of 17.3 to 4.2."

Dr. English also called attention to the disparity in age-adjusted death rates in 1966 per 100,000 population between whites and non-whites. For heart disease, cancer, and stroke his data compared as follows:

	Heart Disease	Cancer	Stroke
Whites	270.5	125.9	67.3
Non-Whites	324.3	152.7	125.5

Poor is defined as under $2,700 annual family income.

Now the significance of these figures for RMP is inescapable. A program whose ultimate objective is, as the Surgeon General said, "...[to] permit the best in modern medical care for heart disease, cancer, stroke and other related diseases to be available to all" cannot ignore them. Indeed, if the medical profession is intent on raising U.S. health statistics to a level equal to the best in the world, they cannot do it without directly confronting the problems of the poor and the non-whites. And the Regional Medical Programs is the only ready vehicle through which all medical professionals can join forces in that confrontation.

Let it be said that the various branches of the medical profession cannot. do the job by themselves. Until other equally severe problems of the poor and underpriviledged -- unemployment, inadequate housing, limited education, and malnutrition -- are dealt with effectively, no amount of the best quality care will bring the health of these people up to the national average.

SPECULATIONS ABOUT RMP

RMP will almost certainly shift its center of gravity toward the outreach of the medical system away from the medical centers. Indeed, this has already begun in most Regions.

As was mentioned earlier, medical schools assumed a position of dominance at first in most RMP's. In a much smaller number of cases regional medical societies took the lead at the start. However, individual Regions were required to engage a broad spectrum of participation both as to occupational background and as to geographical spread.

The interaction of many professional subgroupings and many diverse geographical interests resulted in tensions and conflicts which were destined to bring about change. The required cooperation led to the thrashing out of issues. There was an awakening awareness that interaction among diverse groups, undertaken in a spirit of cooperation, could lead to creative solutions to health problems.

Region after Region discovered that a balancing of interests was more attractive and productive than submission to the dominance of any one group. Reorganizations of boards of trustees, executive committees, and even of Regional Advisory Groups became commonplace after a year or two of experience; and interest in subregionalization began to mushroom around the country.

As new groups of people began to pick up interest, formerly dominant ones moved back to a relatively less active role. All this has resulted in a clarification in each RMP of its program objectives. Within the last year there has been a considerable move in this direction.

RMP will come to believe in and rely more on the quality of local doctors and the capacity of associated medical personnel to take on greater responsibilities.* It came as a surprise to most to discover that excellence is not

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*The shortage of doctors will force this in any event.

imply a quantitative accumulation of technical medical knowledge. First line doctors, it turns out, know some things about patients that the teaching hospital specialists get little exposure to. The "whole man" concept of the local M.D. and some of the paramedical professions has a lot to do with the sense people have of how good their health care is. On the other hand, the repetitive experience of those who specialize in the larger institutions sharpens their skills in diagnosis and treatment of the particular diseases that they have chosen to focus on.

Local doctors usually find themselves treating patients; teaching hospital specialists most often find themselves managing difficult diseases. Both are needed; both call for trained skills. Neither one is by definition more "excellent" than the other. RMP includes them both.

RMP is unlikely to become a powerful force in the economics of medicine. In any foreseeable future, RMP funding is unlikely to exceed 1/2 of one percent of the total expenditures for health care. At best its role will be facilitative and catalytic. The significance of project grants will continue a change that has already begun: it will be just as important that a project contribute to a strategy of building improved medical system relationships as that it be professionally sound.

<p align="center">*   *   *   *   *   *   *</p>

The medical system of the United States is on a collision course. Soon, from one source or another, nearly everyone will have money to pay for adequate health care.

But there is a severe and growing shortage of doctors, nurses, and other auxiliary medical personnel even without the new patients who will come to expect care. Even if we were to double the enrollment of our medical schools and train other medical personnel at a significantly increased rate over what is now being done, in ten years we would no more than hold our own in a position of short resources.

There can be no doubt among thinking men but that public pressures will force some degree of rationalization of our medical system starting in the near future. Since what we are now doing, even if accelerated, will not meet the need, it is clear that new concepts, new relationships, new definitions of professional responsibility will come into being under this public pressure.

If the medical system is to be as radically changed as this suggests, the profession would be well advised to prepare itself to participate in the design of what will take the place of the present system. Medicine is highly technical, and professional participation in the design of the system is imperative if the design is to provide adequate safeguards of quality. A system designed by administrative men or money managers would be likely to exert pressures in favor of the quantitative rather than the qualitative aspects of health care. Incentives would likely be conceived of in these terms, and personal advancement within the system would almost inevitably become responsive to these quantitative measures at the expense of quality. Medicine could easily be the victim of a

kind of Gresham's law, reducing everything to the lowest common denominator.

All elements of the profession should be involved in any systems redesign, if what comes out of it is not to be warped all out of shape by special interests. Consumers, too, must participate in deciding what is needed.. Regional Medical Programs is at the present time the only institutionalized arrangement for bringing all of these elements together. And it does so in a climate of cooperation and voluntarism that will prove invaluable when it comes to destroying old prejudices and building anew.

APPENDIX

In June, 1968, Arthur D. Little, Inc., and the Organization for Social and Technological Innovation (OSTI), both of Cambridge, Massachusetts, commenced a two-year study of the Regional Medical Programs for the Division of Regional Medical Programs (DRMP) of HEW. In essence we were asked what are the Regional Medical Programs as they are developing out there in the country.

We are now about two-thirds of the way through our study. We have spent upwards of 60 man-days in each of three regions and will shortly have done the same in a fourth. In addition, we have spent from two to ten man-days in each of about a dozen more. We have attended several regional group meetings and all national meetings that have been held to discuss RMP matters.

In Bethesda, our study had included many discussions with senior officials in HEW, the National Institutes of Health (under which RMP commenced its existence), the Health Services & Mental Health Administration (under whose jurisdiction it now comes), and the Division of Regional Medical Programs itself (later incorporated into the Regional Medical Program Services under HS&MHA). We have regularly attended meetings of the National Advisory Council and the Review Committee of RMPS as they have established policies, approved procedures, and reviewed program and project applications from the individual RMP's.

We have been studying a fast-moving target. The experiences of building regional programs against a background of growing public concern about health care have brought forth new concepts and new alignments of people, both professional and lay. It has been an exciting time.

An Approach to Evaluation for the

Regional Medical Program

Donald A. Schon

Organization for Social and Technical Innovation

Introduction.

The questions in which we are primarily interested are these:

. What are the criteria, methods, and measures pertinent to evaluation of the activities of the Regional Medical Program?

. How can evaluation be linked most effectively to the planning process?

. What are the appropriate roles for those engaged in evaluation at project, regional, and national levels?

These questions have a deceptively simple ring. They raise, in fact, not only the special problems stemming from the nature, context and history of RMP but several more fundamental questions of theory concerning the evaluation of _any_ activity.

Section 1. Toward a General Theory of Evaluation.

Evaluation is an essential part of intelligent individual and organizational behavior.
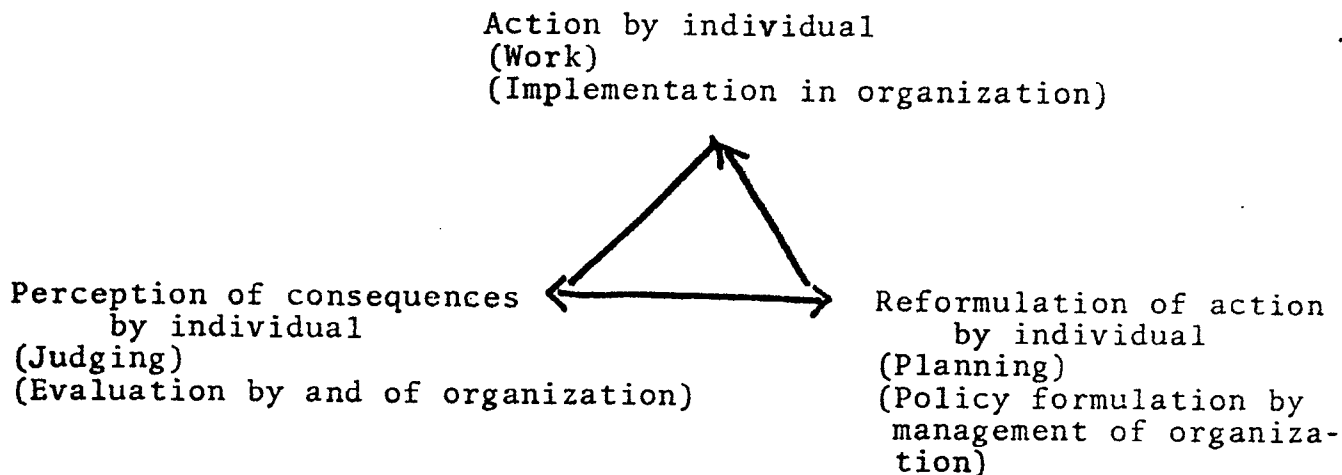
It is the process through which individuals or organizations perceive the consequences of action, assess their meaning for future action, and reformulate plans and policies.

Within this framework, evaluation serves three distinct purposes:

- Justification: to defend what's planned or what has been done. We justify in order to assign reward or punishment (as in "grading"), to decide what resources to commit to an activity, or simply to place an activity on a scale of excellence. In any case, justification

concerns itself with identifying what has been done,
or what is proposed, and appraising it against some
standard.

. Control: to monitor an on-going activity in order to
make it conform to standard.

. Learning: to change activity, to do it better.
Learning may be limited to the selection of means
to achieve goals or to conform to standards, or it
may encompass change in the goals and standards them-
selves.

For any program such as RMP, there are always demands for
justification, control and learning. But it is not always
recognized that these several purposes have different implica-
tions for methods and systems of evaluation.

We are accustomed to think about evaluation from the
point of view of a rational manager who supervises the business
of an organization or program. The rational manager takes
as his reference point a systems rationale -- that is, a set
of formal objectives, operations for achieving them, and
methods for appraising the effectiveness of operations in
achieving objectives. In a business firm, the systems rationale
makes reference to profits and return on investment; in the
public housing system, to the provision of standard housing

for persons cut off from access to the market; in the health
care system, to improvement in people's health, in the quality
of care, or in equitable access to care.

According to the rational manager's model of evaluation,
the systems rationale is fixed and given. Justification con-
sists, then, in assessing the impact of past or proposed
activity on established systems objectives. How effective
are these activities in meeting objectives? How efficiently
do they use resources? Control consists in monitoring on-
going activity to make it conform to established standards.
Learning is limited to the selection of means for achieving
objectives.

The evaluation process appropriate to the rational
manager's model depends on the assumption that everybody
in the system is to some extent a rational manager. People's
accountabilities for activities within the system are supposed
to mirror the systems rationale.

Level 1   Top Management

Level 2   Finance

                     Production   Sales

Level 3
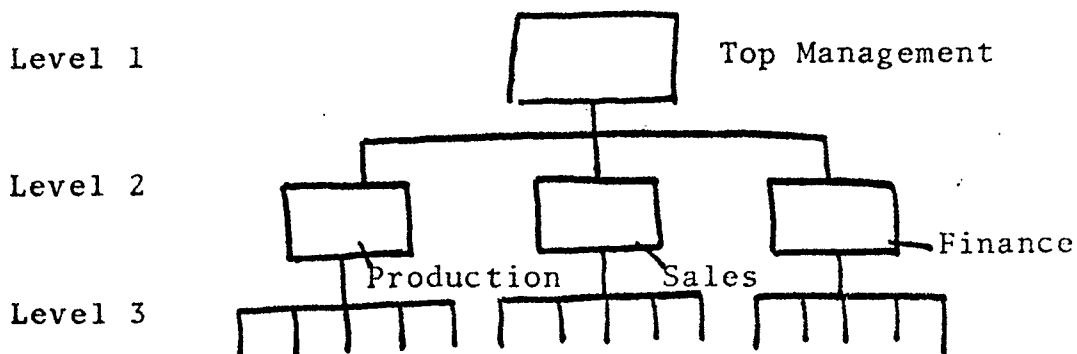
Within the organization or program, as within the systems rationale, activities are organized hierarchically. Each person is accountable for the activities of his component, whose goals are keyed, in turn, to the objectives of the system. The job of evaluation is to compare accountabilities with the actual behavior of individual components within the system. Evaluation tends, then, to become an auditing process in which a third party assesses behavior in terms of the systems rationale, and sends information toward the top of the system. On the basis of this information, decisions flow downward to influence the behavior of the components below. At each successive step of the way, the primary use of information is in justifying and then in controlling the performance of the components the information is intended to characterize.

All variants of the rational manager's model and the evaluation systems that flow from it suffer in practice from an overriding constraint. Characteristically, systems do not behave as they are supposed to. Even the most bounded organized activities result in social systems that do not behave exclusively in terms of the rational purposes assigned to them. As distinct from the rational manager's model, there is always a real system of actors and agencies which interact with one another in the ways they are found to do

and with the interests they are found to have. Their dis-
covered interactions and interests may have little to do with
the interactions and interests imputed to them under the
systems rationale.

The "discovered systems" of organizations and programs
tend to have certain features in common. Regardless of
systems rationale, individuals tend to be interested in:

. their own survival in their positions.

. independence of action.

. local conditions and needs (as opposed to "central's"
  view of them).

. protecting and extending territory.

. maintaining stability.

These interests characterize the informal, homeostatic struc-
ture of organizations and programs. But discovered systems
tend also to be open-ended, associated with emergent objec-
tives and swift changes in goals which correspond to individual
interests in creativity and responsiveness. Often the rational
manager's model constrains creativity, responsiveness and
freedom of action in ways that run directly counter to the
interests of actors and agencies within the system.

Within any on-going program, the rational manager's model
and the discovered system always co-exist. The state of

their relationship critically determines the nature of evaluation.

When the two systems have little overlap and little interaction, evaluation is limited to retrospective justification.

	Performative	Retrospective
The System of the Rational Manager		*
The Discovered System		
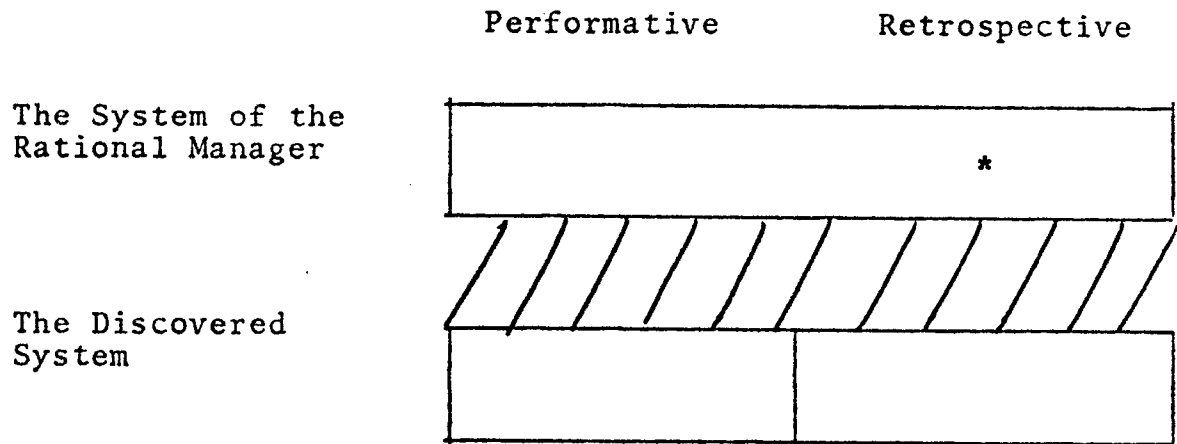
In this condition, the evaluation system produces statements believed neither by the producer nor by the consumer, which are generated ritualistically in response to formal demand. Rational manager's produce justifying statements at regular intervals, expressed in the language of the systems rationale, and resources continue to flow into the system. Evaluation processes have no other output than justification. They are used neither to modify the systems rationale nor to force the real social system to conform to it.

Where there is little overlap, but the rational manager seeks to impose a systems rationale on the discovered system, several things may happen:

(1) The discovered system may respond verbally without other changes in behavior, by offering pro forma retrospective justification long on language but short on substance, a process generally known as "conning." The two systems operate substantially in parallel.

(2) The discovered system may respond to the controls that the rational manager seeks to impose by adapting to the evaluation measures he prescribes but continuing to operate as much as possible as before. Measures of performance are always different from performance itself. For example, in an effort to control expenditures of the vocational rehabilitation system, Congress demanded to know how many "rehabilitations per year" the agency effected for a given investment. "Rehabilitations" were defined as job placements lasting three months or more. As a consequence, the vocational rehabilitation system began to "cream" its clientele for those most likely to graduate to job status leaving out those who were most in need and least able to qualify; to select low-level jobs for graduates so as to facilitate entry; systematically to avoid distinguishing between a "case" and a person, so that a graduate who had achieved job status, lost it and

returned to training, could be counted as another "rehabili-
tation"; and systematically to avoid follow-up of clients
after three months.

(3) The discovered system and the rational manager's
system may fight one another more or less openly until they
reach a compromise. From the point of view of the discovered
system, this is paying a price. Those in the system do some
of what the rational manager wants in order to preserve con-
siderable ability to satisfy the interests of the discovered
system. From the point of view of the rational manager, the
discovered system is merely distorting system objectives in
the direction of its own interests; but he has to put up with
it to get any response at all.

In none of these dissociated cases is there any interest
in producing or using information that runs counter to the
strategy of evaluation as justification. Where the systems
are operating in parallel but without much contact, there is
common interest in avoiding information that threatens dis-
sociation. In the other two cases, there is common interest
in information that supports the systems rationale; since
justification rests on the systems rationale, and resource
allocation rests on justification. The discovered system is
content to generate information that conceals how great the
discrepancy is between the goals of the rational system and
the behavior of the discovered system in order to protect

the resource allocation they need to continue doing more or less what it is they want to do.

However, where the whole activity is conceived as a learning system, then relationships between rational and discovered systems can be fundamentally different from those just sketched. The opportunity for learning is primarily in the discovered system. The discovered system offers the most vital basis for reformulating systems objectives and redesigning systems theory. Discrepancies between the rational manager's system and the discovered system as perceived by its inhabitants become the basis for progressive modification of the system's rationale, of modifying the real interests of individual participants, and of developing relationships between the total activity and its constituencies.

It is critical that an evaluation system aspiring to an important role in intelligent management recognize rather than bury discrepancies between systems rationale and the discovered system. The evaluation system itself must become a vehicle for continuing interaction and continuing mutual influence of the two. Its ability to support intelligent, direct interactions between the rational manager's system and the discovered system becomes a central function and a central criterion of adequacy in an evaluation system oriented to

learning. While these considerations are important at all times, they become essential in a period of development or instability, when new kinds of activity must be devised to meet established objectives more effectively and when program environment changes so as to lead to shifts in objectives, as well.

Learning-Oriented Evaluation in Discovered Systems Hooked to Rational Systems.

When planning begins to incorporate a mutual modification of objectives and activities, evaluation includes much more than mere measurement of the extent to which activities conform to specification. The evaluation system that is oriented to learning has special features:

. The conceptual framework for evaluation has to include a description of the discovered system as well as the rational manager's statement of systems rationale. This includes a description of key actors and agencies, actual relationships and modes of interaction among them, and the several interests of all of them. It must include also a description of the real (if informal) evaluation system as discovered -- the information that actors in the system in fact produce, are interested in producing, and how they use it.

. An analysis of discrepancies and overlaps between the systems rationale and the behavior of the discovered system. This analysis takes account of the differing perspectives of actors in the system.

. Strategies for responding to discrepancies between the discovered system and the rational manager's system. Mere analysis is not enough; learning must be capable of application.

These factors focus on gathering accurate information about the discovered system. The discrepancy between the rational system and the discovered system, or the response of the discovered system to the rational manager's efforts to control it, may mean that the rational manager is simply precluded from learning what's actually happening in the discovered system. But the rational manager may be able to bargain for this information by exchanging information about resources and ongoing administrative changes to which he is privy for accurate information about what's really happening in the social system. Even more powerful, when central rational management gains some freedom to modify systems rationale to take account of real local interests and activities, the basis for withholding or distorting information may disappear. The way may then be clear for central rational

management and local people to bargain effectively and directly over changes in systems rationale, local behavior modification, and information flow. As in all such cases, the bargaining will depend on establishing and maintaining good faith.

Several additional consequences for the evaluation system flow from these considerations:

. Information intended to modify behavior must flow upward to influence systems rationale as well as downward to bring the discovered system into line with pre-existing systems rationale.

. The evaluation information that is gathered should be limited to amounts, complexities, and precisions determined by the capability and willingness of actors within the system to learn from it, as experienced in actual practice. Nobody in the system should be presented with more information than he can handle, nor information laid out in more precision or complexity than he can respond to. Analyses should not present actors with a greater breadth of alternatives than are real for them. As a corollary, the evaluation system needs to be able to detect the changing capability and willingness of actors to use information, and should itself be capable of responsive modification in turn.

. The evaluation process should be structured to accomodate to the different kinds of learning appropriate to different

roles and levels within the system (rational managers, project pushers, evaluators, planners, etc.).

. The learning objective should also determine the content, extensiveness, duration, and accessibility of information in the evaluation system memory. This requirement places high priority on accessibility and retrieval capability on behalf of many different levels within the system in addition to that of the rational manager.

. Since the learning derived from evaluation may be applied to evaluation processes themselves, the conceptual framework for evaluation may itself be expected to change (sometimes rather rapidly); so information needs to be gathered and formulated in ways that make it more or less equally usable in terms of a broad range of systems rationales. Priorities should be given to those bits of information that are likely to retain high relevance across a range of manager's rationale and discovered systems.

Cases in Which There is No Explicit Systems Rationale.

What if the activity to be evaluated is itself recognized as so diverse, diffuse, swiftly changing, and open that no overall systems rationale is credible? This situation may occur with respect to public problems urgently requiring solution but for which there are no clear policy answers,

where national willingness to devote resources to their solution is high, though the credibility of proposed rational solutions may be low. Agencies may be funded to work on such problems, constrained only within every broad limits as to what their work should be like. What are the implications here for evaluation systems?

. Each region or subregion (or other entity) saddled with a whole problem becomes a center of its own problem-solving process. The number and location will depend on the number of centers that turn out to be capable of functioning under their own individually developed systems rationales. In this situation the distance between information and analysis is minimized, and responsibility for designing and conducting the evaluation process is very close to the actors who are accountable for the activities under evaluation.

. In this case central management's evaluation function is changed with respect to that of the regions. Central management may now impose on the localities criteria for the evaluation process, but it is no longer in a position to impose criteria for substantive evaluation of concrete activities. For example, central management can still ask whether regional evaluation processes are differentiated in terms of

justification, control, and learning; but the central evaluator will accord just as high marks to a region displaying one workable form of differentiation as to a region displaying another form. It is only the region that does not explicitly attempt through its own evaluation processes to accomplish justification, control, and learning that is downgraded. Accordingly, the evaluation information flowing to central from the local regions normally reflects the nature of the processes developed for raising and answering evaluative questions in the localities rather than the answers to any specific questions thought up by central management.

. Central also takes on the role of building a network learning system, facilitating information-transfer from locality to locality and encouraging specific local experiments.

Section 2. <u>RMP in the Context of Evaluation Theory</u>.

To place the Regional Medical Program in the evaluation context developed in the previous section, some of RMP's principal characteristics should be recited.

1. There is no single organization corresponding to RMP. RMP is a broad-aimed Federal program concerned with introducing changes of various kinds into a number of more or less inter-connected systems of actors and agencies involved in health care. Within these systems, RMP attempts to play a variety of related roles with respect to other actors and agencies; but for the most part it cannot directly control them. RMP does not, therefore, have to do with a single rational "system," in the sense used earlier, and its boundaries are vague and shifting.

From the point of view of evaluation, this assertion has several implications. RMP's scope and turf do not have sharp boundaries. We cannot go about analyzing RMP as though it were a unitary organization, like the Veterans' Adminis-tration, for example. And while RMP has formulated broad objectives for itself, its fundamental activity in relation to these objectives must be understood for the most part as "influencing" or "facilitating" rather than direct control.

2. There is no single, established systems rationale either for the health care system as a whole or for RMP in

particular. There are various rationales, held at various times and in various contexts by different actors in the system.

3. The larger health care system and the RMP are changeable. They are not in a stable state. The character and functions of these systems are themselves in process of constant change. Within them, the key actors are often unsure of their principal functions or of how best to carry them out, and they tend to shift behavior as they learn and as the system around them changes.

4. Nevertheless, as a Federal program RMP is locked into a structure of controls and demands for justification. At the national level these include regular reviews by the Congress, the Bureau of the Budget, and the Department of HEW. These demands for justification and for controls over the expenditure of funds are, of course, passed on to the regional program level.

The problem of devising approaches to evaluation for RMP is essentially that of meeting what may well be conflicting requirements for learning, on the one hand, and for justification and control, on the other. The vagueness and changeableness of objectives, lack of program control over components to be influenced, and sources of methodological uncertainty all argue for a flexible, process-oriented approach to

evaluation-as-learning; whereas the agents of rational adminis-
trative control tend to press for firm, quantitative measures
of program impact.

Like most broad-gauged Federal programs, the legislation
establishing RMP represented a series of compromises among
the diverse interests of various concerned groups. The
authorizing legislation is, therefore, a kind of mosaic of
objectives, values, and constraints. Among the more impor-
tant elements of the mosaic are these:

- Emphasis on the provision of means to improve the
  treatment of the three "categorical" diseases --
  heart disease, cancer and stroke.

- Emphasis on the transmission of advanced techniques
  and knowledge relating to these diseases.

- Emphasis on the method of continuing education as a
  device for this transmission; and on the major academic
  medical center as the principal source of expertise.

- Emphasis on maintaining or improving the quality of
  medical care.

- Concern with the region as the principal unit of activity;
  concern, that is, that the program be a regional one,
  with regional centers of activity throughout the country;
  concern with recognition of regional diversity of prob-
  lems and resources; and concern with "regionalization"

as a process of knitting together or building regional
resources to realize the purposes of the Act.

. Emphasis on the establishment of voluntary arrangements
among regional institutions as the dominant mode of
program activity.

. Specific warning against "interference in the inter-
face between patient and doctor."

The authorizing legislation made no attempt to rationalize
these elements or to resolve potential conflicts among them.
It was understood by many of the key actors that, as the
program matured, the specific meaning of its legislative
provisions would develop and clarify.

It is not surprising, then, that there have been per-
ceptible shifts over time in the dominant systems rationale
for RMP, even though no element originally considered as
the legislation evolved has altogether ceased to exert some
influence.

Let us be explicit about an evaluation scheme that is
generally accepted as appropriate to one of the simplest and
accordingly most easily rationalized interpretations of RMP.
We refer to the center-periphery regionalization model based
on the diffusion of technology and information that is assumed
to be stored in the great medical centers. In this instance,

it is seen as desirable to judge the program initially, at
both national and regional levels, by its effectiveness in
reducing rates of mortality and morbidity for heart disease,
cancer, stroke, and related diseases. Individual projects
are seen as means to these ends, and fall basically into
the following categories: deployment of new facilities
(for example, coronary care units); establishment of new
linkages between medical centers and peripheral care-providing
centers (for example, exchange of personnel); the development
of new working relationships (for example, changes in referral
patterns); continuing education (for example, training of
physicians and other medical personnel); and information
dissemination (for example, DIAL access).

The major kinds of evaluative questions under this inter-
pretation of the RMP system are these:

1. What are the kinds of baseline data and measures
   of performance by which the impact of diffusion
   projects on mortality and morbidity can be assessed?

2. What is the relative effectiveness and effectiveness
   in relation to cost of the various technologies
   diffused, seen as means of achieving reductions in
   rates of morbidity and mortality?

3. What is the related effectiveness, for particular
   technologies and for particular regional situations,

of the various methods of diffusion?

This question leads, in turn, to questions about
the optimal "regions" for diffusion, the forms of
greatest "diffusion impact" for a given investment
of dollars and other resources, patterns of utiliza-
tion of new facilities and the like.

Other aspects of the activities within the center-periphery
model of RMP -- for example, the management of new institutional
arrangements at the regional level -- must be judged in terms
of their effectiveness in leading to enhancement of the quality
of care through the more effective diffusion of advanced tech-
nology, with the ultimate effect, of course, of reducing
mortality and morbidity from the categorically identified
diseases.

In the minds of many key actors in Washington and in
the regions, the DeBakey model came to dominate the conceptual
climate of the early phases of RMP. But it was not always
or everywhere the dominant view of RMP activity. In the dis-
covered systems of some of the regions, regional co-ordinators
and other key actors took as primary the sorts of changes in
institutional arrangements which, from the point of view of
the DeBakey model, figured only as secondary means to an end.

In this interpretation:

. RMP's central concern may be expressed through cate-
gorical diseases or with the diffusion of advanced medical

technology, but RMP consciously concerns itself with overall improvement in quality of care and equity of access to care.

. But these sorts of improvements require changes in the structure and modes of interactions of care-providing institutions which no single agency controls -- changes that can be generally described as knitting together components of the system that are now fragmented so as to permit more effective and rationalized planning and action.

. These systems changes are necessary conditions for improvement in quality or equity of care. They must precede any significant improvement along these lines.

In the past year, systems transformation[*] has begun to dominate among competing systems rationales for RMP (without, of course, completely displacing other views) at national as well as some regional levels. While it is to some extent a subject for guesswork why this shift has occurred, certain factors suggest themselves.

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[*] "RMP as process," "RMP as facilitator," "RMP as opportunistic change agent" were expressions heard as early as 1967 and conveyed the underlying idea behind systems transformation before this rationale became as significant as it now is. Recent legislative proposals convey the idea even more explicitly.

There has been a movement into good currency of certain basic concerns about the national system for providing medical care -- concerns about rising medical costs, about the effective exclusion from the health care system of large numbers of disadvantaged people, about shortages of medical manpower, about the difficulties of negotiating the medical care system even for ordinary middle class people.

The effects of substantial investment in Medicare and Medicaid have begun to convince observers that no amount of investment in payment for care will suffice to introduce necessary changes in the provider system. There is clearly need for some forms of intervention on the provider side as well.

There continue to appear to be overriding objections either to the development of nationalized systems of care or to such decentralized solutions as community-based group practice, on a large scale. Shortages of scarce resources of medical manpower suggest that changes in the system will have to work with existing personnel and, very largely, with existing institutions. This means, to a great extent, attempting to facilitate voluntary re-arrangements of existing institutions.

Of the available program instruments (Neighborhood Health Centers, Comprehensive Health Planning, Community Mental Health

Centers), RMP presents itself as perhaps the most promising
candidate for intervention of this kind. What RMP has been
going, initially en route to the DeBakey model in some regions
or in other regions as a matter of primary though informal
agenda, now is emerging as a more dominant (though not ex-
clusive) rationale for the program as a whole. It must be
added, or course, that by no means all regions regard them-
selves as primarily involved in systems transformation. Some
RMP's still regard themselves as solicitors and screeners
of proposals, and do not yet conceive of themselves as "pro-
grams" in any sense other than as clearinghouses for projects.
And in nearly all regions, there is the residue of the view
of RMP as a conglomerate of projects centering around con-
tinuing education, training, coronary care units, and the
like. At the very least, then, co-ordinators face, as part
of the task of systems transformation, the problem of what
to make of and what to do with the projects initiated under
earlier views of RMP.

Under a systems transformation model for RMP:

. The primary unit for evaluation becomes the program;
and since RMP is conceived as an essentially regional
enterprise, this means the regional program. It will
be necessary to reach both "above" this level to the
national program and "below" it to the project; but the
regional program is primary.

. Every element of RMP takes on a dual aspect. As we
seek to assess projects, regional program and national
program, we must ask both about substantive changes in
the provision of care -- changes in the quality and
configuration of services, changes in access to services,
changes in health -- and about systems transformation.

Seen as systems transformation, RMP functions in two
ways: through the direct efforts of the regional co-
ordinator and those he works with to knit together or
otherwise influence elements of the medical care system
of his region, and through the shaping and selection of
projects which become occasions to effect systems trans-
formation.

. Evaluation must take account of regional diversity.
The starting conditions of the region, the array of
resources, the problems to be attacked, the level of
development, the regional strategy -- there may be as
many of these as there are regions. From the point
of view of evaluation, therefore, the content of re-
gional programs should be expected to be different.
There is no "model" of a regional program to be ap-
plied to all regions, although we should be able to
develop a conceptual framework which will allow assess-
ment of diverse regional models.

The questions of justification demand separate treatment. Given the multiple impacts of RMP activity, justification requires methods for identifying baseline data, ends-in-view, and indicators of change at the several levels of change in health, access to health care, quality of care, configuration of health resources, as well as changes in the institutional arrangements, interactions and attitudes characteristic of the health care system. The issue of justification raises sharply the problem of what it is possible to know about these matters, and at what level of generality it is it is possible to know it.

The remainder of this paper will be taken up with questions (1) and (2), above. We will focus on the view of RMP as systems transformation and will attempt to spell out the bases on which, in spite of regional diversity and open-endedness, judgments about regional performance may be made and learning about systems transformation may be fostered.

Section 3.   The Central-Regional Dialogue.

There is a conceptual framework for systems transformation in RMP from which we can derive criteria and questions useful in undertaking and assessing systems transformation, without violating regional differences and without second-guessing particular regional answers to the substantive questions of medical care.

The essential elements to which attention must be paid are these:

. Starting conditions (What is to be changed?).

. Ends-in-view (Changed to what end?).

. Processes and techniques (How can change be accomplished?).

Broad regional strategies for systems transformation express directions for the process through which the region may be brought to move from its starting conditions (as they are conceived in a particular instance) to particular ends-in-view.   Characteristically, such a process proceeds in stages of:

. Diagnosis (getting started, casing the region).

. Involvement (engaging these individuals and agencies whose interaction is taken to be critical).

. Planning and goal-clarification (discovering feasible processes and choosing and testing specific ends-in-view).

These stages are apt to be cyclical rather than sequential. The passage from diagnosis through implementation leads to a revised picture of starting conditions, and through the cycle again. Because several streams of activity often proceed concurrently, the region may at a given time engage simultaneously in all stages. As the region moves through stages of systems transformation, in its developmental cycle, it may extend the scope and depth of the issues it tackles.

Given this skeletal view of systems transformation, an evaluative process oriented toward learning must take the form of a dialogue--a continuing process of inquiry in which the regional co-ordinator* and RMPs both raise and respond to questions. This is for several reasons. Given the open-endedness of "systems transformation," prospective systems rationales for RMP must be inferred from (rather than imposed on) regional activities. Systems rationales and systems activities must modify one another. The evaluative process must detect discrepancies between systems rationales and discovered systems, and tactics for responding to those discrepancies. Moreover, project and program goals shift over time. That is often a sign of progress; and the evaluative process should help to discover whether it is, and in appropriate cases both reflect and encourage it.

* We will use "regional co-ordinator" as shorthand for those agents involved in formulating and carrying out RMP strategy at the regional level.

In what follows, we list <u>guidelines</u> for the kinds of questions to be raised in such a dialogue; <u>criteria</u> for systems transformation, from which these questions flow; and, in some instances, <u>illustrations</u> of response.

One test of the dialogue is that both co-ordinator and "central" become able, on the basis of it, to form continuing, grounded judgments of regional program performance. A second test is that as a by-product of the dialogue the co-ordinator becomes more proficient at designing and carrying out the process of systems transformation. A third is that the national staff is enabled to formulate progressively more adequate "systems rationales" for RMP.

The dialogue follows what we have identified as the three main elements of systems transformation and, within them, the stages of development.

(1) <u>Starting conditions.</u>

<u>The co-ordinator should be capable of articulating a</u> <u>regional diagnosis which holds water, and which provides</u> <u>the basis for the formulation of directions of systems</u> <u>transformation.</u>

The subject has to be probed to the point that both partici-pants in the dialogue are convinced that:

    . The evaluator understands the spokesman's view of the region and has stated enough of it clearly enough to reassure himself and the spokesman.

. The spokesman has stated whether he believes this par-
ticular array of starting conditions is tough, average,
or a bit simpler to deal with than average (assuming
for the moment the accuracy of what the spokesman has
said).

. All likely emphases have been tried out by the evalua-
tor in an effort to test and understand how the starting
conditions fit together dynamically.

An adequate response constitutes a diagnosis of the regional
health care system. It also furnishes the evaluator with some
beginning hypotheses about how skillful the regional care staff
is in casing the region.

When well explored and laid out in the dialogues, the diag-
nosis includes the data crucial to working out strategies of
systems transformation, both those which define health issues and
health needs and those which define the organizational and poli-
tical character of the health care system.

. What is the character of the principal health problems
of the region? What is their distribution?

. What is the character of the present configuration of
health care facilities and resources? What is the
nature of the health care delivery systems that are
dominant in the region?

. What are the patterns of access to care among the
principal population groups?

The foregoing questions aim at establishing starting conditions
at the level of health, access to care, and configuration of
care-providing resources.

. Who are the key actors and powers within the health
care system of the region? How do they relate to the
power structure and to the politics of the region as
a whole?

. What is the nature of the linkages, the relationships,
the patterns of referral, the tensions and conflicts,
among these key actors?

. What do the central actors perceive as the major issues
of health care for the region--whether these are identi-
fied in disease-specific terms, in terms of access to care,
quality of care, or in terms of costs, manpower, patterns·
of dominance and distribution, or other facets of the
health care system?

This next set of questions aims at an understanding of the
"political" forces that can be used or that must be dealt with
in any strategy for systems transformation.

Out of responses to these questions come regional diag-
noses which provide the material for designing strategies of
systems transformation for the region.

At the point of establishing agreement on starting conditions, the evaluative dialogue has to involve:

- Feed-back to a widening circle.
- Testing the perceptions of those who first describe starting conditions, strategies, or other aspects of RMP and the territory in which it functions.
- Some appraisal (i.e., development of a more or less acceptable description) of the way the local RMP went about data selection and gathering.
- Gradual clarification, through the dialogue itself, of the specifics on which detailed information is needed.

The following are excerpts from regional diagnoses which illustrate something of the variety of starting conditions to be discovered.

- X Region. X is a prosperous, relatively homogenous society. Good medicine is practiced here, and the profession is in relatively good repute with the local political-social establishment. As yet medicine and the other health professions are facing only tentative questions about the "relevance" of where sub-specialization and bigger-better hospitals take us. But something very real is brewing in the state legislature's effort to force a "Family Practice" Department on

the distinguished specialists of the University medical faculty. Additional intimations exist in the reluctance and opposition of the Academy of General Practice to the way the medical faculty had first planned to go about teaching family medicine.

Layer on layer of competent, skilled, devoted people working in hospitals and other health care institutions all over the state, all of which tend to emulate or somehow react or respond to the presence of the internaitonally famous institutions: the Central Clinic, the University, and Rehabilitation Foundation. There is an apparent shortage of manpower willing and able and wanting to perform health care services on the level of ordinary care for ordinary conditions. Town-gown issues are real, but because "gown" somehow includes Central City as well as "The U," and because "everybody" was trained at "The U," the issues take a special form. Centralization of the Clinic and decentralization of the University complicates their association, whenever joint commitments are required or contemplated. Good acute care general hospitals are a dime a dozen, and coming to view one another as competitive whether they are or not. Many are trying to become referral centers both in big specialist consulting staffs and many high technology services.

Generally the establishment, medical and non-medical exhibits a tough-minded, "show me" conservatism, tempered

by a very active consensus and willingness to try out credible ways of improving the situation (e.g., 40% of X-State private physicians have tried out group practice. They and their patients like it well enough to stick with it.)

RMP has to make its way among a number of giants, all zealous defenders of quality medical care, each with its own tradition of constructive innovation, each with its own considerable institutional inertia and sense of independence.

. <u>Y Region</u>. In the region's largest city there is one large medical school and one large community hospital. The region consits of five quite different counties. Three counties made common cause with RMP from the outset. Two are left. In one, a private physician has his own comprehensive health plan; prepaid medical care has been attempted under his auspices; success is believed to be uncertain; critics prophesy failure. The other county is simply cut off and disinterested. It is difficult to get medical or consumer representatives from either county even to meet for reasons that pre-date RMP, but embrace it: several of the major counties are joined in uneasy alliance, with many rivalries, all felt particularly strongly in the smaller cities.

. <u>Z Region</u>. The major hospitals and associated medical schools, are all in the major city and dominate the region.

These are set against the smaller community hospitals, each
of which in turn is trying to be a medical center. Not sur-
prisingly, there is relatively thin patient use of these ex-
pensive facilities in suburban hospitals. Not surprisingly,
too, there are parochial and compartmentalized referral pat-
terns disturbed by conflicts among the several large medical
schools and hospitals. There tend to be economic and social
distinctions drawn between the largest and the other medical
school complexes, though these may be decreasing, and certainly
keep changing. With all, the distribution of physicians to
patients is highly inequitably spread over the region.

- ghetto areas: 1/3000 to 1/5000
- center city: 1/200
- suburban: 1/700 to 1/800
- rural: 1/1000 to 1/2000

The 5 medical centers have limited goals. All are under
great financial pressure, pressure relative to income, to
student load, and pressure to pay attention to the ghettoes.
They are beginning to believe that is where the money is.
In the meantime, the cultural institutions of the major
urban center continue to tend to turn inward, there is very
little that can happen "unless you own it." So the tendency
is rather stronger than average to want to turn RMP and training
dollars to the enhancement of existing institutions and depart-
ments.

crucial substantive issues of health care, issues relating to the political and organizational structure of the health care system, and key actors and initiators of innovation in the health care system.

While the co-ordinator should be capable of arguing for these directions of movement, on the basis of the regional diagnosis, these preliminary views about strategy should remain developmental, in two senses. They should take account of the issues they do not address, and there should be some thought as to the means by which these other issues may come to be addressed. And they should be responsive to changes in the regional diagnosis which come to light in the course of RMP activity.

The basic question is "How have you gone about formulating preliminary strategies for systems transformation?"

. Through what process have you gone?

. What is the substance of the strategy as so far developed?

. Why this far, and no further -- or why so far in this direction?

Often, the best way of getting at these issues in the dialogue is through questions such as these:

. Where are the outstanding strengths and weaknesses among key agencies and actors in the medical care system?

. What are the patterns of alliance and conflict, and
how are these changing?

. For key actors in the system, and for the issues they
regard as critical, what are the ends-in-view both
for changes in the delivery system and for changes
in their own position within the system?

. What are the critical "starting issues," and how might
these be used to move toward systems transformation?

But the specific forms of these questions must come from the
regional diagnoses, and must elicit the ways in which pre-
liminary strategies address themselves, or fail to address
themselves, to the issues raised in these diagnoses.

The following are examples of some of the preliminary
strategies emergent from the fragments of diagnoses listed
above, and questions that the evaluator can or should raise
about these strategies, to push the dialogue a step further:

. <u>X Region.</u>

The primary problem is the isolation of many small com-
munities, especially rural communities from which physicians
are slowly disappearing, and their disinclination to colla-
borate. Corollary to and underlying this is the past success
of medical education in selecting and training physicians to
want to work in sophisticated hospital settings, thus creating

strong impetus for hospitals to compete, even within communities, and to attract physicians by offering ever more highly differentiated and costly services, without careful, credible investigation of community needs and how they are satisfied.

The function of RMP should be (and is) through projects, membership on advisory committees, and core-staff activity to facilitate connections and collaborations among elements of the medical care system, particularly among small communities and particularly among physicians. The connections and collaborations should be multiple and small-scale, so as not to ruffle too many feathers.

So RMP, for example, should serve as broker and supplier of seed money for the merger of hospitals in adjoining rural market towns; should support short-term in-residence programs for GPs at the Clinic; should dot coronary care programs around the State; should promote outreach programs from the Clinic and the University; should use the RAG and its committees to involve all elements of the medical care system and representatives of its consumers, in order to connect small communities with one another and with the centers.

The object is to build larger movements toward collaboration and more ambitious ends-in-view from the success and the fallout from many small-scale efforts, in the process of

learning what is feasible and helping the various interests
and groups involved to assume as constructive leadership roles
as possible.

Some questions:

. Will the small-scale collaborations ever get big enough
   to make an impact on medical care in X Region, and will
   they happen so slowly that one is forgotten before the
   next happens? What is the threshold level of scale
   and pace for facilitation if it is to have a building
   effect?

. Have you taken into account what needs to happen in
   order to get the Clinic and the University really in-
   volved in the medical problems of the smaller communi-
   ties? How much "involvement" do you want and why?
   Can you do that without confronting the "family prac-
   tice" issue, and helping to attain a viable resolution
   to the conflict among the Academy of General Practice,
   the University medical faculty department heads, and
   the legislature? Would sponsoring more activity
   within the allied Health Manpower field force or en-
   courage a more valid solution to the general practice-
   family practice problem -- or just convince the MD's
   that RMP is against doctors?

. How do you propose to respond to the conservative
  stand of many GPs, particularly in southern area,
  who don't see what RMP has in it for them, and who
  feel threatened by or disagree with what they hear?

. What stance will you take toward groups currently
  left out of the strategy -- for example, hospital
  administrators, dentists, mental health practitioners?
  Are there parts of the State in which it would make
  sense to do so?

. Does the current mix of efforts respond, at the level
  required, to the serious problems you have identified --
  i.e., to the problems of rural medicine, isolated
  communities, care for the small but clustered popula-
  tions of minorities, the deficiencies associated with
  the (otherwise desirable) proliferation of specialist
  physicians and the disappearance of family physicians,
  both in the central parts of the large cities and in
  rural areas? If you cannot envisage any adequate res-
  ponse in first-round activities, how do you plan to
  build toward such a response? If manpower shortages
  seem to you the central questions about the response,
  how do you plan to attack the question of manpower over
  time?

Often the formulation of preliminary strategies depends upon the _involvement_ of key actors and agencies.

The co-ordinator should have found ways of including actors and elements of the region's medical care system identified as key in the regional diagnosis; where some of these cannot be included at the outset, the problems about their inclusion should be explicitly confronted and strategies developed for overcoming these problems over time.

"Inclusion" may be indicated by participation in a range of RMP-related activites, including involvement in RMP committees, in project work, or in ventures initiated or supported by RMP. The difference between significant and _pro forma_ inclusion must be resolved by tests that vary from case to case.

What is to be appraised includes:

. Whether there has (or has not) been a real attempt to arrange for specific people to be included in RMP. (Was the labor union representative really invited to RAG meetings? Did he feel invited? Was there anything for him to do?)

. How well the attempt is related to the co-ordinator's sense of starting conditions and his strategy and objectives (which depends on having learned those things first).

. How explicit the co-ordinator can be about who is not
to be included, and under what circumstances those
persons would or should be included.

. How much the co-ordinator and core staff learns about
the process of including people from the experience
of doing it. (If they had it to do over would they
do it another way? Are they increasingly imaginative
and increasingly direct in their approaches to people?)

. The impact on others of the co-ordinator's attempts
at including people (clumsy or skilled, relevant or
irrelevant, useful or useless, well planned and well
understood or otherwise).

A case in point is the following:

. Y Region.

The RMP has taken the position that it is a clearing-
house for projects; it solicits and processes applications
from elements all over the region. RMP is, therefore, a
conglomerate of projects; how can it have a program strategy
for systems transformation or anything else?

But there is the sense of need to involve the two counties
currently disengaged from the program. The preliminary strategy
has impacted on the starting conditions in a way that permits,
encourages, and partly specifies a revision in approach.

One county, medically under the leadership of a strong
physician, has no involvement in the RMP program. And there

are 250,000 people there. The belief in the county is that the big city always wins, and that's where the money is.

In spite of its apparent role as a "clearinghouse for projects," the RMP turns out to be operating on a strategy which says, "Get every major actor and every county active in RMP." Their tactics are based on this strategy.

The major physician in the isolated county is concerned about diagnosis of cancer, and about the 100-mile round trip required to get specialized diagnostic screening in the large city. He is encouraged, therefore, to propose the establishment of a diagnostic center in his county.

Some of the relevant questions, especially appropriate to early involvement phases:

(1) Is the investment worth it? How much does it take to "purchase" involvement? as a percentage of the overall budget? compared to the costs of confronting other urgent health care issues? Are there other excluded or isolated elements of equal importance (geographical areas, professions, voluntary associations, health departments, medical societies, hospitals, or a combination)? What are the potential future consequences (enmity, retribution, etc.) of failing to try to involve somebody now? How does an effort to include Dr. H. relate to the regional diagnosis?

(2) What are the signs that investment has been success-
ful in involving Dr. H. and his county? How do you
distinguish pro forma from significant involvement?
For example, visibility at RMP meetings? Attitudes
of Dr. H. toward the proposals of others? Willing-
ness to permit some "teaching days" in the area?
Other projects coming out of the county? Willing-
ness of Dr. H. and others in the county to lend
voices in support of RMP activities? Willingness
of Dr. H. to share his emergent strategies for de-
velopment of medical care system in his county, or
to participate with others in formulating such
strategies?

(3) <u>Ends-in-View</u>.

. <u>Out of interactions of key actors, ends-in-view should</u>
<u>have been established. These must confront at least</u>
<u>some of the key issues earlier identified as crucial in</u>
<u>the region. On the level of substantive health care,</u>
<u>they must confront at least some of the constant health</u>
<u>problem themes, or emergent issues in health care.</u>

At a zone in time, attention shifts from the problem of
"getting all the key actors active in RMP" to the problem of
formulating the more specific ends-in-view and the strategies
for achieving them which are to emerge from the interaction,
planning, bargaining and negotiating of the key actors.

These ends-in-view are the specific rearrangements sought
in systems transformation. They, too, have many qualities
that are subject to evaluation. The emphasis, again, is first
to discover what attempt has been made to identify these quali-
ties, and to deal with them. Evaluation of specific content
makes sense only after it's clear and more or less agreed what
has been attempted, and the context for attempting it.

The following are examples of appropriate questions:

. Have the issues earlier identified as crucial in the
region found their way into the formulation of ends-
in-view?

This is an illustration of what such a list of issues

might look like:

"--Guidance to get people into the health professions.

--Coordination and involvement of the voluntary agencies.

--The urgent need for dental care in the north.

--The lack of out-patient care centers except for emergency rooms.

--Essentially no preventive medicine is done in the State.

--Too many community hospitals trying to become medical centers.

--There is no weekend and almost no night-time medical coverage now in a major rural county area."

Is the RMP engaging some of these issues through the deliberations and interactions stimulated among elements of the health care system? "Engaging" means, here, facilitating the formulation of ends-in-view and strategies adapted to them.

. Certain general criteria cut across regions and across possible activities within regions. Questions about "relevance" of particular activities apply not only to the match between ends-in-view and judgments about issues, but to the need for some attention to these criteria.

--Costs of care, particularly for hospitalization, extended care, and costs as experienced by lower- and lower-middle income persons as well as others.

--Quality of care, and the distribution of quality of
care across the region.

--Access to care, and equity of access to care, across
socio-economic strata, minority-and-majority-groups,
and geographic subregions.

. Have the processes making for inclusion , discussed
earlier, extended beyond formal membership in RMP
activities, to formulation of ends-in-view and strategies
for achieving them?

. How are priorities formulated?* Are priority issues
being confronted explicitly at all? By whom? Do pri-
ority considerations enter explicitly into the delibera-
tions and interactions of elements of the medical care
system, or are they handled by the coordinator or core
staff alone, or ostensibly or really left to Washington?
If there are conflicts among elements judged to be cru-
cial to the region -- for example, conflicts between
major hospitals and medical schools, between town and
gown, between professional providers and representatives
of users -- are these conflicts allowed and encouraged
to enter into the formulation of priorities? Does the
coordinator intend to attempt to build clusters of these

*This may be the first time that themes of RMP activity become
explicit and that questions of priorities become real issues
(often first stimulated by conflicts over ownership of limited
funds).

elements into working groups, through explicit confrontation of these questions? If he is not doing this, is it a matter of deliberate intent? Is he working -- temporarily, or as a matter of continuing strategy -- on a model of compartmentalization, in which conflicts over priorities and ends-in-view are not allowed to come up, except within limited subsets of elements? Is he "sub-regionalizing" in this sense? If so, does it make sense to do so?

Is conflict of ends-in-view being handled as a matter of "dividing up the pie" among competing actors, or is there also an attempt to relate such judgements to shared judgements about the urgency of health issues, or about the usefulness of issues as ways into systems transformation in the region?

. Major themes of RMP activity should be developed and stated. These should be not merely a reflection of what is common to ongoing activities, but a source of guidance for the generation of new activities. Questions of priorities among ends-in-view should have been confronted, through a process in which key actors in the region work on their conflicting interests not only on the level of ownership of RMP resources but on the level of substantive health issues and strategies.

. How appropriate, acceptable and feasible are the strategies being developed for achieving the ends-in-view adopted? For example,

-- an outreach center, as a way of involving a major hospital and medical school in the problems of an adjacent ghetto? Who will make it work? Who wants it?

-- a joint coronary care project as a way of encouraging collaboration and rationalization of planning among a set of community hospitals? What will make it transcend its original focus?

Questions about such strategies will focus on a number of dimensions:

-- Adequacy of scale of the "solution" to the "problem."

-- Feasibility of the methods proposed.

-- Appropriateness of the strategy to objectives on multiple levels of the activity (e.g., substantive health impact, as well as systems transformation ends-in-view; clarification of ends-in-view as well as involvement).

-- Appropriateness of the strategy to the constraints and problems perceived to be underlying the issue. One of the questions to arise at this point is the question of "teeth." Is the issue one that will yield best, or at all, to voluntary involvement on the part of the key actors concerned? Or does it require some forms of sanction and compulsion? This is a question of ideology,

strategy and legislative mandate for RMP, as well as of propriety: possibly some other agency is more appropriate.

Where the focus is on learning, attention will go not only to questions of this kind but to questions about the ways in which the development of strategies is handled:

-- Is there evidence of the active consideration of alternative ways of achieving the same ends-in-view?

-- Does the deliberation over strategies carry with it consideration of effectiveness of the strategy in relation to the costs of carrying it out, and consideration of the cost/effectiveness characteristics of alternative strategies?

-- Are there timetables for accomplishment? How realistic are they?

-- Has there been consideration of ways of determining over time how effective strategies are in achieving ends-in-view? Tests for their achievement?

Where the focus is successfully placed on learning, the impact of such questions will not be to "grade the strategies at this zone in time where emphasis is on the development of specific ends-in-view, but to influence their development positively, by "accelerating" and "enriching."

(4) <u>Implementation</u>.

<u>The process of implementation should be characterized by
involvement of implementers in selection of ends-in-view
and strategies for achieving them; and by a relationship
of co-ordinator or core staff to implementers which permits
continuing mutual modification of strategy and end-in-view
and of implementing activity</u>.

The implementation of strategies toward ends-in-view may
take the form of core staff activity, of the conduct of speci-
fic RMP projects, or of the activities of committees or <u>ad hoc</u>
groups, under the aegis of RMP. The end-in-view and the strate-
gy may be specific enough to lend themselves to only one of these
kinds of activity, and to a well-defined unit of implementation,
or they may lend themselves to a widespread cluster of activities.

For example,

End-in-view	Implementation
To foster collaboration and rationalization of planning among 13 community hospitals.	A coronary care project jointly granted to the 13 hospitals, requiring the use of common facilities.
To encourage multi-level collaboration between two hospitals in adjacent rural communities.	Brokerage functions by core staff, RMP support of one hospital staff member charged with working out details of the merger.

To increase the "power base" of the medical community "on the other side of the	A series of projects, funded in that area, linked to major medical institutions. Broker- age activities. Use of RMP committees to establish rela- tionships crossing the moun- tains.

Some of the relevant questions are these:

. Are initiators and leaders of the activity aware of the ends-in-view, and the processes leading up to their formulation, on the basis of which the activity actually came to be undertaken by RMP?

. What are the patterns of access to resources required for implementation? Is there a basis for judgments to be made, on a continuing basis, as to the adequacy of resources to the task?

. Is attention given to the possibility of shifting defi- nitions of ends-in-view as more of the reality of the discovered system comes to light? Is the project or activity leader locked into a potentially stultifying view of what constitutes "success"?

. What constitutes progress? Are there operational tests of performance, short of more nearly final judgments of impact, which can help to guide performance in the course of the activity?

. What is the relation of the regional co-ordinator and his staff to the activity? If it is not their activity, do they have, in relation to it, a continuing monitoring, learning-evaluative contact which allows mutual

modification of the ends-in-view and the strategies by which the attempt at implementation is being made?

. How compartmentalized is the activity? Is it connected to analogous activities in the region, or to activities which are parts of the same program strategy, so that both learning and concerted action may occur, where appropriate?

. What is the relationship of these processes of implementation to the overall strategies of systems change held by the coordinator and/or his collaborators? Has the coordinator attempted to be explicit about these? Is there an effort to relate them to particular strategies for achieving particular ends-in-view? For example, to connect a particular activity as a feature of a "master plan"; to identify a particular negotiation as part of an overall strategy which seeks to involve key actors in a process of negotiation over their interests and conflicts in relation to the system of medical care. Is the coordinator able to use the experience of particular activities to learn from or to influence his overall strategies of systems change?

There is one side of the question of impact which should be treated separately here, because it involves the impact of the process of implementation, which can reflect back both on

the formulation of particular ends-in-view and on the region's capabilities for carrying out further systems transformation activities. This is the process through which the definition of accepted ends-in-view may shift.

. The connections established and reinforced in a particular activity may lay the groundwork for new forms of collaboration, e.g., the joint planning of a coronary care unit which leads to joint planning of a range of common facilities; the diagnostic screening project in a county previously cut off from the medical system of the region, which leads to a series of boundary-crossings. Are these things happening? Are there attempts to make them happen?

. Learning from an implementation process can lead to changes which facilitate new processes, e.g., the cumbersomeness of a process of review and monitoring can lead to simplifications which make it easier and more attractive for others to enter the orbit of RMP activity.

. Processes of implementation can display or enable development of "role models" which influence the character of new activities undertaken, e.g., the impact of Jim Musser as broker-facilitator on other key actors in the North Carolina region, or of Paul Ward in California, e.g., the influence of the few emerging medical care corporations in California on similar, varying approaches to medical corporations.

Questions about impact f implementation, then, need also
to be addressed to the impact of the process of implementation
itself.

At this point, RMPS criteria for systems transformation in
the region take the form of meta-criteria for the evaluation
processes carried out in the region.

- Without specifying evaluative criteria to be used in
  assessing the impact of implementation on any of the
  levels of change, RMPS should require that such criteria
  be developed and that they be appropriate to the ends-
  in-view and strategies adopted.

- These criteria should not be limited to programmatic
  criteria (e.g., how many nurses trained? how many calls
  received?) but should attempt to assess change at one or
  more of the several levels of change in substantive health
  care.

- In each instance, consideration should have been given to
  the choice of level at which change is assessed, aiming
  at health outcomes, then at access to delivered care, and
  so on. There should have been review of the definitions,
  test-methods, and measures appropriate to the end-in-view
  and strategy involved.

- With respect to the process of evaluation, the evaluative
  framework should have been developed collaboratively
  between the regional center and the implementing agency.

There should be an openness to modification, through the process of evaluation, both of the implementing activity and of the original choice of end-in-view and strategy. This openness should be evidenced in the demonstrated capacity of evaluative activity to influence the planning of the implementing process, and in the evolution of the concept of end-in-view and strategy during the course of implementation; and the frequency and pattern of contact between core staff and implementing agency should be such as to make that kind of mutual influence feasible.

. The evaluative processes adopted by co-ordinator and core staff should be conducive to learning across sub-regional boundaries, so that those engaged in analogous activities (continuing education for GP's, for example) can learn from one another's experience, and those whose activities are elements of a larger strategy can interact in the light of that strategy.

(5) The Developmental Cycle.

Regional programs develop iteratively, if at all. Cycle succeeds cycle, each growing out of, but resembling, its predecessor. A regional program, seen as systems transformation moves through its cycle: casing the region, planning, and implementing. Then through another cycle widening and deepening its rings of activity. The evaluative questions of any one phase continue to be relevant; only, new sets of questions are also relevant to established activities, and to other sets of activities. The process of bringing new elements into RMP, for example, continues even as the ends-in-view emerging from earlier processes of inclusion begin to be carried out.

The most relevant new questions help uncover the directions of change in the scope and purchase of the whole program as it moves through successive interactions of the process. These questions are of several kinds:

. Is the process increasing its scope?

-- Is it increasing in the overall volume of activity, as measured by actors involved, dollars mobilized, number of separate activities undertaken?

-- Is there a widening range of parties involved in interaction and negotiation? Is the level of aggregation of the parties increasing? For example, is the interaction beginning to involve clusters of community hospitals rather than individual community hospitals?

Is the level of aggregation also decreasing? For ex-
ample, are individual physicians as well as medical
society representatives coming to be actively involved
in a way that extends the scope of the program?

-- Is there an increase in the number of health issues
engaged? Is there an increase in the coverage of the
region represented by those issues and by the ends-in-
view and activities generated? Within each phase, the
map of the issues confronted and their location in the
region should reveal changes of the following kind:

Regional Location

Issues

X						X			
		X							

Phase 1

Regional Location

Issues

X	X								X
X	X								
		X	X				X		
X	X	X						X	

Phase 2

. Is the process increasing in depth and intensity?

-- Is there an increase over time in the perceived importance, urgency, and ambition of the issues engaged and the ends-in-view formulated?

-- Is there an increase in the connectedness and "clout" brought to bear on the issues engaged?

-- Is the level of aggregation of the parties decreasing? Are individual physicians as well as medical society representatives coming to be involved in a way that deepens the program?

We can provide an example of the development of ends-in-view and strategies in a regional program as it begins to go through a succession of cycles:

The K region:

Dr. P., the coordinator, came from a program of continuing education in the one large medical school, a program of continuing education for GPs which, by his own present view, was not too successful. He began by seeing the creation of RMP as an opportunity to expand his own educational program, and obtained a planning grant to create K-RMP. He visited local medical societies over the region and with them set up a program around tumor registry, coronary care units, and continuing education. Boundaries of the region were set up by the expression of interest of the parties approached who attended the meeting.

As the program has begun to expand, its emphasis has shifted away from the categorical approach. The RAG, which began with 30 physicians, has begun to change composition to include lay--men. In view of the relative weakness of other institutions, including the State Health Department, KRMP has moved toward a controlling position for health planning for the State.

Concentration at the beginning has been on work with individual physicians and community hospitals, with an emphasis on education, viewed as the easiest and least threatening way in. At the same time, core staff became involved in project -writing for individual hospitals, KRMP has now withdrawn from CCU programs, except for continuing education. However, a similar effort based on the earlier experience (establishing facilities, loaning equipment to communities who could not afford to buy it) is now being carried out for respiratory programs.

Dr. P. now realizes that in his region, which is poor in physicians and clear in its referral patterns and which has one medical school and not much institutional rivalry, the provision of continuing education to physicians and others is not enough. What is needed is the provision of a system of care and appropriate facilities within which the fruits of education can be realized.

Here, since the structure of the program as a whole is built around the coordinator, the development of ends-in-view becomes very much the development of his own views of the issues that need to be confronted and the ends-in-view adopted.

. Is the process characterized by an evolution of issues, ends-in-view and strategies, which reflects learning?

The regional diagnosis of the coordinator, the issues he takes to be important, the ends-in-view and strategies to which he is committed -- in short, his own systems rationale -- may shift in response to new perceptions of the discovered system of the region, as regional activities bring that system into focus.

This learning may take the form of an explosion of "rational" plans for the building of the health care system, by contact with the political interests and powers of the real-world actors in the system. It may take the form of a shift in priorities about health issues, as previously "hidden issues" -- for example, the depth of inadequacy of health care in ghettos -- come to the surface. It may take the form of perceiving the extent to which the needs of physicians and community hospitals in "have not" areas are inadequately served by diffusion of the technologies and research findings generated at the major medical center.

In each instance, the discrepancies between systems rationale and discovered system, at the regional level, may lead to the reformulation of regional diagnosis as well as of ends-in-view and the strategies corresponding to them.

It is not reasonable to set uniform standards for the periods of time within which regions should have reached certain levels of maturity in their developmental cycles, just as it is not reasonable to apply uniform standards across regions to the time periods within which the various stages of development should be completed. On both levels, the time intervals will vary with regional conditions. The key factors here are not so much the size of the region as its complexity, its internal connectedness or disconnectedness, the number of conflicting or disconnected elements within it, and the seriousness of their conflicts or isolation from one another.

Elements that affect the speed of motion include:

-- simplicity of the politics of the medical care system. Few elements to be connected; few conflicts to be resolved.

-- relative weakness of other elements of the system, permitting RMP to function from the beginning in dominant or unusually significant health planning role.

-- relatively high degree of connectedness among elements of the medical care system.

It may be possible to establish a typology of RMP regions in terms of their potential for movement, similarities in strategy, and characteristic types of activities chosen to carry out the RMP program. There are, for example, many instances of efforts to stimulate collaboration among community hospitals

through their joint involvement in some program of approach to categorical disease; to establish outreach arms of major medical centers; to reach isolated subregions through programs using paraprofessionals, continuing education, and the secondary support of specialists. Regions and subregions differ as to the constraints they put in the way of these kinds of activity, but they, too, can be grouped in terms of the seriousness of those constraints.

The purpose of such a typology would not be so much to permit judgements of the effectiveness of one region against another as to provide guidelines both for RMPS and for regional coordinators as to the rates of movement it is reasonable to expect in a given region and for a given kind of activity.

Judgements about a region's progress in systems transformation may be made on the basis of its ability to meet criteria within any given stage of development; its rate of movement from stage to stage, given the constraints under which it is operating; and the level of scope, depth and learning evidenced by its overall cycle of development.

In point of fact, most of the RMP regions are still primarily involved in the problems of inclusion of key elements of the medical care system in RMP activity and on the formulation of preliminary directions of movement and strategies. In spite of the number of operational projects, most regions are only beginning the work of fitting projects into strategies for achieving

specific ends-in-view. Most are only now at the stage where the formulation of themes of RMP activity and the confrontation of questions of priority among ends-in-view become feasible tasks.

Conditions for the Central-Regional Dialogue.

Having sketched out a national-regional dialogue aimed at fostering learning in relation to systems transformation, there remain questions about the particular vehicles through which such a dialogue may be brought to reality and the conditions under which it can be effective.

. The two parties to the dialogue must begin with some commitment to and understanding of the goals and methods of this kind of evaluative process. The requirements here relate both to the theory of the evaluative process and the role of the dialogue within it, and to the particular skills and techniques involved in carrying it out.

. Although we have used simple words like "central" or "RMPS" and "co-ordinator," the parties to the dialogues will be complex. On the regional side, the dialogue will be carried on by groups of varying kinds, depending on the makeup of those involved in carrying initiative at the regional level. In one region, it may be a "strong man co-ordinator," his key assistants, and from time to time others that he may wish to bring along in order to involve or educate them. In another region, it may be the team the co-ordinator has been trying to assemble out of core staff, certain RAG members, and certain key actors in the medical care system of the region.

. On the side of the national staff, there is a key re-
quirement for continuity of involvement in the dialogue with
region over long periods of time -- ideally, over the life of
the region's development under RMP. The requirement for
continuity becomes particularly critical, given the diversity
and open-endedness of regional approaches to systems trans-
formation; it is only out of intimate knowledge of the content
of earlier stages of development that central can be effective
in dialogue with the region.

But, given the realities of life in both central and
regional bureaucracies, continuity of this kind is to be
achieved not through one man but through small groups whose
members overlap in the course of time.

From central's point of view, the small group permits
the inclusion of the varieties of competence required to carry
out effective dialogue with the region -- competence to ques-
tion and respond on issues of substantive medical care and on
issues of systems transformation, and skills in the evaluative
process of the dialogue itself.

There will be no need to distinguish the central-regional
dialogue from funding decisions, and, concurrently, to move
away from the usual mode of central-regional contact, in which
the region displays its wares for central and central and the
region then engage in a game of attack and defense. For the

central-regional relation to be solely or primarily in this mode prohibits learning, in the senses outlined above, and makes it difficult or impossible for central even to gain information about regional activities.

On the other hand, the dialogue requires that the RMPS staff be capable of being tough with the region, raising issues hard enough to be heard and challenging the region in the light of findings and commitments which emerge from the dialogue over time.

In order to make these things feasible, there is first a need to model the roles involved and to set the tone for such a dialogue, and concurrently to set apart and formally distinguish the funding-justification process from the central-regional dialogue. The dialogue will surely feed into RMPS judgments about regional funding, but should be formally and operationally separate from the funding process.

Will such a distinction be feasible, given the tendency of the region to view central as monolithic and the region's knowledge that funding decisions will be made by central? This problem is comparable to the problem of the regional evaluator in establishing his "helping" role, in spite of the fact that his findings will be influential for decisions on project funding; indeed, the problem is central to any process of good management in which the manager seeks both to

facilitate learning and to exercise control. The feasibility
of the effort will depend ultimately on the good faith that
central and the region are able to establish with one another,
and on the extent to which the dialogue is found to facilitate
learning.

The dialogue requires a certain frequency of contact
between central and regional groups. Given the rate of move-
ment in most regions, once-a-year is not often enough. Within
the interval of a year, too much happens, and too many decisions
are made which lock the region into patterns of activity. Fre-
quency of contact should be determined by the time required
for the co-ordinator to take significant steps, or for the
regional situation to shift in significant ways that mark
important milestones in the stages of systems transformation.
Intervals are likely to vary over the course of the region's
cycle of development. For example, contacts might be established
around key events such as the first formulation of regional
diagnosis, the establishment of themes of RMP activities and
the first effort at establishing priorities for specific ends-
in-view, or the first phase of experience in implementing a
specific strategy. Within the range of frequency indicated
by "oftener than once a year," there should be provision for
flexibility increases if a representative of central and the
regional co-ordinator can maintain contact during intervals

between meetings of central and regional groups.

The central-regional dialogue offers another perspective on the role and conduct of regional site visits, and on the proposed process of anniversary review.

The central-regional dialogue could become the main function of the site visit. The site visit team would then become central's party to the dialogue. Such a concept would answer to some of the problems currently reflected in regional and central reactions to the conduct of site visits -- for example, the pattern of regional display and of attack-and-defense which make it difficult or impossible to find out what is really happening in the region; lack of continuity in the site-visit team; lack of feed-back to the region; inability of the site-visit team to respond to the region by clarifying or modifying central's "signals." There are also significant potentials of the site-visit as a vehicle which the central-regional dialogue may help to tap: the opportunity for on-site contact with regional actors and agencies, and the presence in the region of persons regarded as peers by many of those undertaking regional activities.

There is the further issue of the manpower requirements RMPS would experience if it took seriously the conduct of central-regional dialogues with all of its regions. The site-visit team concept, in which outsiders are mobilized along

central personnel, would provide a crucial extension of central staff. But the concept would also require intensive efforts at internal training and team-building for the site-visit teams.

With respect to Anniversary Review, that event would have a very different significance if it were to function as the yearly culmination of central-regional dialogue, rather than as an isolated contact which will tend to be seen, whatever the intent, as a funding-justification process. The site-visit team would then come to play a critical role in the anniversary review process, and the results of earlier phases of the central-regional dialogue would then provide the basis for the inquiry conducted and the judgments made in the course of anniversary review.