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MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFA
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATIO

TO : Assistant Secretary for Health
and Scientific Affairs

DATE: 10 AUG 1972

FROM : Administrator

SUBJECT: Role of RMP and Special Health Revenue Sharing

The discussion of RMP in the latest draft papers on special health revenue sharing does not adequately represent my view on the RMP role and function. I believe this caused the tentative but adverse recommendation of the Secretary on RMP contained in the August 7 memorandum from Tom Reutershan.

I hope the attached discussion presenting my views on RMP will help to clarify the matter. I request that you submit the attached to the Secretary at the time you submit our other comments on the revenue sharing proposal.

Vernon E. Wilson, M.D.

Attachment

REGIONAL MEDICAL PROGRAMS: A HEALTH CARE PROVIDER CONSTITUENCY

HEW is, appropriately, a consumer oriented agency, dealing with people and their potentials as well as their problems. In our service oriented functions, the Department emphasizes the potential of consumers to make their own decisions, and the right and responsibility of consumers to make their own choices. In health care, this is reflected in the Department's movement toward investing the right to health care in the individual - not in institutions - through various forms of health insurance and health care benefit packages.

While maintaining the consumer orientation, it is at the same time essential - particularly in the health care arena - that the Department have a locus for dealing with the provider constituency. If we are to impact on the "health care crisis", to improve access to health care, contain costs, improve productivity and quality, then it is the providers that need to be changed so that consumers can, in fact, exercise their choice in a more rational environment. Consumers, exercising their choices on an essentially individual basis, can have little impact on the health care system in their communities. The consumer-oriented CHP agencies can be a collective, consumer voice to deal with community health care systems, through more rational planning of the allocation of resources.

But it cannot be expected that a consumer-oriented CHP alone can be an effective lever in moving providers, individually or collectively, to change, improve, and evolve to more consumer-sensitive institutions. CHPs cannot be given the dictatorial power and authority to bring about these changes, nor can they attract the expert knowledge which could effect change, in the absence of public authority. The aura of the physician, the prestige of the hospital, the science of the medical center, precludes equality of discussion between providers and consumers on the majority of matters pertaining to health care change and improvement.

There must therefore be an arena of equals through which the Department, if it is to develop a successful National Health Strategy, can exert direct as well as indirect leverage on the providers to bring about desired change. The Regional Medical Programs constitute that arena.

Loss of a direct Departmental role in relation to health care providers, either through abolishing RMP altogether or folding it into special health revenue sharing, would mean loss of contact with the most influential constituency that the Department seeks to change. The primary function which RMP serves, and which only RMP serves at this time, is as provider change agent. It does not function as a source of provider support nor, as some have charged, as a "provider revenue sharing" mechanism. It is provider dominated, purposefully, but not to maintain the provider status quo, as has been suggested. RMP has, in part, a categorical emphasis, but that is because providers are specialized.

To bring about change most readily and efficiently, one applies the lever close to the object to be moved, not at a distance from it. Gaining the confidence and cooperation of providers to change in areas of their interest, permits additional more positive movement beyond their immediate specialized concerns. And this is accomplished not just because RMP funds provide a stimulus, but because the providers themselves invest in maintenance of improvements and continuing changes.

While the performance of RMPs has been variable, there is ample evidence that movement is taking place in most parts of the country because of RMP leadership. RMP projects are operated on an essentially seed money basis, so that once activities are off the ground and proven, their support must come from the local area. Evidence suggests that this is, in fact, happening.

When major new national initiatives proposing new directions in health care delivery are announced, it is the provider constituency which must respond, and it is RMP which has the communication with, and the confidence of that constituency to persuade their cooperation. For example, the $8 million allocated nationally to an emergency medical services initiative, was matched with an additional $8 million programmed by the providers through RMPs.

The stimulation of HMOs represents another example of how RMPs, by their provider orientation, were able to further a major Administration policy. Fourteen RMP regions had as a major objective the stimulation of HMO development. In those regions, 33 HMO applications have been funded, or an average of almost 3 HMOs per region. In only one RMP that had HMO development as an objective, were no HMO grants received. On the other hand, 42 RMPs had little HMO activity, and in these regions some 53 HMO grants were funded, or a much lower average per region. In 13 of these regions, where there was little RMP activity related to HMOs, there were no HMO grants.

This example is not meant to suggest that RMP was the only stimulus, or even the prime stimulus, to HMO development. It does suggest, however, that where an RMP takes an initiative and gives it provider sanction, then the climate for change among providers can be improved. It will require, perhaps, increased leadership at the Federal level to assure that all RMPs seek to translate national priorities into local initiatives.

In summary, the Department cannot lose, cannot ignore, the need for a provider constituency in its efforts to improve the delivery of health care. Without that constituency, we cannot hope to effect changes in provider behavior. With CHP serving to identify needs and establish priorities, RMP can be the provider arm of the planning process in suggesting how priorities can be met. Similarly, in relation to an Implementing Agency which operates to allocate funds in accord with the CHP plan, RMP can be the mechanism which assures provider participation in the implementing process. The Regional Medical Programs represent our primary and unique vehicle to communicate with providers and to exert the leverage necessary for change.

HSMHA - 8/10/72