
E0002799

From Nathan Stark
10/8/91

MISSOURI REGIONAL MEDICAL PROGRAM
ANNUAL MEETING OF REGIONAL ADVISORY GROUP
Crown Center Hotel, March 28, 1974

Thank you. Thank you. And now the real Nathan Stark has stood up.

Ladies and gentlemen, it is indeed a privilege and an honor to be here and to have this opportunity to share some thoughts with you on your involvement in programs for better health through comprehensive planning and action.

A few weeks ago, I was speaking in another city. In conversation at the luncheon table I mentioned my scheduled appearance before you today. My table companions, professional health people, were a little less than encouraging. We had been talking about the spate of health legislation we have had in the last few years. Mentioned were the complexities of new programs; how does one implement them in Regional Medical Programs, Comprehensive Health Planning, Medicare, Medicaid, Health Professions Education Assistance, etc, etc? How do we go about mobilizing the needed

men, women, money, physical facilities to achieve these goals for all our people?

I admitted it had taken some temerity for me to accept the invitation and that I had some real misgivings about it. With this in mind, I thought of the story of the seriously sick man who was asked by his minister if he had made his peace with the Lord and renounced the devil? The patient responded: "Considering the fix I'm in, I'm not going to make an enemy of anybody!"

I trust we are not here to celebrate an event marking the end of an era. I hope none of you will be discouraged by the OMB pronouncement in the fiscal 1974 budget wherein the rationale for the discontinuation of the Regional Medical Programs is: ". . . there is little evidence that, on a nationwide basis, the RMP's have materially affected the health care delivery system." If so, we should certainly not have this kind of session in the future. I choose to believe that programs such as you are attending today will have a continuing value and that the subject should be discussed

again and again in the future.

When Doctor DeBakey and his colleagues first gave their report, they hoped it would result in great heart, stroke, and cancer centers spread over the U S A . . . perhaps, because of his origins beginning in Houston, Texas.

The centers were to give citizens access to the finest "new frontiers" in medicine. They would reach out to sub-units. And with this, continuing education of all health professionals and the health care education of the public was to move in and out to the center and then to the sub-units.

As you know, this did not happen. In fact, RMP was essentially banned from direct federal involvement in health care. The decision was made that RMP was to be a "grassroots" program. This grassroot was to be anchored by the medical schools. Thus, the ultimate bill resulted in regional medical programs -- not centers. The only thing from the DeBakey report that one could recognize was the word "regional."

In many respects the RMP enabling act -- Public Law 89-239 -- is quite extraordinary. Its genesis and promotion are intriguing to say the least. The diverse interpretations among various observers of its long-term objectives suggested many misunderstandings and an uncertain but hopefully great future. The zeal and enthusiasm of the men and women -- including numerous medical leaders -- reflect the dramatic appeal that it had for many individuals of good will and high hopes. The vaguely defined authority of the act has seemed to many inadequate to bring about the innovation and organizational changes they seek. The Act's promise was to facilitate the planning, organization, and delivery of health services within a functionally-based regional framework, capable of circumventing state-local political boundaries and orthodox health channels. Additional excitement centered on the possibility that, once launched and successfully demonstrated, the application of regionalism might spread to encompass a number of other problems pressing in on the health field, and might lead eventually to a

Doctor Marston once said, "These programs face the challenge of influencing the quality of health services without exercising federal or state governmental control over current patterns of health activities."

Doctor Charles L. Hudson, a past president of the American Medical Association, pointed out that no one was so naive or so radical as to say that government spending for health should or will stop. He pointed out that the centralization of planning under a system of Social Security, or any other, brought with it the hard fact that one removed from the local community any rights whatsoever, and surrendered to a central voice an opportunity to make decisions which might or might not be beneficial to an individual community. It was with this opinion that he further stated:

"Recently I have paid more attention to a point that I made in my first inaugural address, that to avert the trend toward dependence on government one should help to stimulate local community responsibility for health care. This is a divided responsibility,

consumer-provider, peripheral or central, governmental, or private, but it has the virtue that no lines of opinion or bias need impede the activity. There is something for everyone to do."

Congress, as we are aware, has established Regional Medical Programs and Comprehensive Health Planning Programs, both with Doctor Hudson's thought in mind and both involving regionalization of health services.

What forced us toward the regional concept? Without dwelling too long on this, let me cite just three of perhaps several reasons:

1. The growth of our metropolitan areas and the relationship of the city to the suburb. We can no longer plan solely on the basis of the small community.
2. Costs must be held down by greater attention to organization -- more efficiency.
3. And perhaps, it arises, as Lester Breslau points out, from growing recognition within the health field that

the present complexity and specialization of health care requires exploration of new patterns of organization.

I have been involved in community health planning for a number of years; I know planning around the nation. I must admit it has not been well done, if at all, nor has it been comprehensive in nature. By congressional action, Regional Medical Programs and Comprehensive Health Planning, it was hoped that it could be done comprehensively and those of us here whether directly related through this field of medical care or as beneficiaries of a health care system, have a major stake and if we take advantage of our privilege and right, a major voice in the quality of planning.

In his report to the President and the Congress on Regional Medical Programs, ~~the~~ a former Surgeon General ~~in 1967~~ set forth at length a number of issues and problems which face the Regional Medical Programs." Some of these surely derive from characteristics of our country's general health make up -- we are essentially voluntary

and private. Today, we measure ourselves as a multi-billion dollar health industry with all the complexities of manpower limitations and rising costs. The law itself spells out other characteristics -- defining a region, the significance of disease categories, use of advisory groups, interpretation and distribution of information concerning advances in diagnosis and treatment, and others.

The Regional Medical Program was established to help narrow a large and disturbing gap which exists between what medical science knows today and the actual care and application that is available to the vast majority of the public. The focus was to be on heart disease, cancer, and stroke.

The problems will be resolved when we know the answers to such questions as these:

How can we cope with the actual logistics of getting the best available health care directly to the greatest number of people, both healthy and diseased?

How can a doctor use his already overtaxed time more efficiently? Can we devise tools -- such as new instruments, new tests or computer programs -- that can help him?

How can the doctor keep current with the burgeoning mass of new and important information that keeps pouring out of medical and other research labs?

What actually can, or should, the profession do to help educate the public about such matters as early detection of disease?

How best can intensive and comprehensive care be administered: in hospitals, clinics, homes?

How best can the busy practitioner avail himself from a distance of the particular skills of the specialist or of the special knowledge available in medical teaching centers? How can better rapport be established between the two?

The most important thing that this legislation should have provided was the opportunity for innovation. Legislation has provided the dollars required to place professional talent on the

development of these programs. To insure that the professional team would not create a static institution revolving about themselves or their programs, the Congress delegated decision-making and hence ultimate power to the regional advisory group. In Missouri, this is a committee -- originally appointed by the Governor -- of members of the medical profession, administrative officials, nurses, and laymen and laywomen, including essentially all of our health and health-related agencies. This committee held the purse strings and decided what programs would meet the law's aims. Then there were twelve -- now with your RAG structure there are sixty, and I think this is good!

In 1942, the President's Commission on the Health needs of the Nation called for a wider range of regional systems of health services. These objectives would have entailed a heavy commitment of medical schools and teaching hospitals in extension services, post-graduate education, and sharing of medical, technical, and administrative resources. The realization of this plan was not

achieved, according to one observer, "because of the traditional reluctance of medical school faculties to project their services beyond the campus, the shortage of medical teachers, and the burgeoning of biomedical research programs." And now we have the Regional Medical Program. The law invited medical schools, research institutions and hospitals to get programs going for patient care. What has been the response? I can't speak for the national program -- only for Missouri.

Let me digress for just a second to relate facts about an individual who shares much of the responsibility for RMP. Few people in this state, yes, this country, have been involved as long or intensively with matters of medical and health affairs as Doctor Vernon Wilson. I first knew Vern as an associate dean at K.U. Then to Columbia . . . the brilliant concept of Hospital Hill. A medical school in Kansas City . . . a new approach to teaching medicine . . . and most important, the development of a model health care delivery system. Before all this was more than a

glint in Verne's eye along came the RMP. Most programs got off to a slow start. Not so with our dynamo . . . he had organized the Council, the bylaws were passed; the application submitted . . . a staff retained . . . and guess who was first to get an organizational grant and then the first operational grant? So, obstetrician Wilson delivered the baby and took it through its first growing pains. Verne has that something called the "touchstone of the professional." When Verne left for Washington, D.C. to head HSMHA, we were already taking bets on whether Washington would change Wilson or would Wilson change Washington. A book recently published--"The Dance Of Legislation"--says of Verne, "Wilson was already somewhat notorious in Washington for like Egeberg he had displayed maverick tendencies within weeks of taking office." The record will probably not be available for some time but my bets are still on Wilson.

In the case of our program, initially large grants were given to the University of Missouri to be used for the purpose previously

stated. MRMP is, therefore, closely associated with the University of Missouri. The interdisciplinary research group included professors of medicine, engineering, and communication who studied intensively the delivery system for health in the region; scientific devices which were needed but lacking, a communication facility which possibly could be adopted for purposes of the program. The research group functions as a medical experiment station drawing together the talents of all university disciplines to contribute to the definition or solution of health care problems.

Lest one get the idea that the MRMP program is university oriented, let me assure you that it utilizes maximum local planning and initiative with regional emphasis upon coordination of efforts and review of quality of endeavors.

Because of the stated intent of the program to improve care by increasing the effectiveness of present systems, attention was directed to early detection of disease, methodology for systems to provide maximum economy and effectiveness, and initially a

small number of models of delivery systems, planning for service to a specific population of people with emphasis on delivery of care as close to the patient's home as is consistent with economy and quality. With this in mind, we initially funded three programs in community hospitals, Springfield, Smithville, and Kansas City.

One of the satisfying results of an effective RMP effort, we believed, was to be in the improvement of the environment of more hospitals for learning and the improvement of the capacity of more hospitals for the application of new and more effective methods of treatment. One can readily see why the public comes into the picture. I referred to lay members of the public on the top council of the regional advisory group. But every member of the public has a stake in the law. It is not only that we are all likely to be patients, one day, at the mercy of these great diseases, but we can all do a great deal to make this law effective.

Remember also that the public is increasingly able to evaluate quality health care -- and increasingly vocal in their

demands for it. Their criteria for evaluation are becoming more reliable in that they equate quality with the availability of qualified personnel and accredited facilities. And they are finding increasing ability to pay for what they want, either through congressional action or voluntary prepayment.

A couple of years ago Dr. Wilson asked me to ~~send~~ join an extraordinary consultant committee of HSMHA with four able health professionals. I guess he thought I must know something about the health field because I was then head of operations and in charge of Hallmark's "Get Well Cards." At the time he told me we could have used sympathy cards as well.

So, now let me leave Missouri and put on my national glasses for a few minutes . . . the Regional Medical Program -- as much as I would like to think of it as having a permanent abode -- was shifted from one agency to another -- from NIH to HSMHA and now HRA Health Resources Administration. The directorship changed far too rapidly . . . Marston, Olson, Schmitt, Margulies . . . Herb Paul . . .

all men of stature . . . all personally known to me as dedicated individuals who have shifted to other areas of work.

What is the role of Regional Medical Programs today? RMP can be a major link between the federal government and the providers of personal health services. It can, thus, serve as a professionally oriented vehicle for upgrading the health care system, and provide technical expertise necessary to develop workable plans and determine the feasibility of programs.

RMP also provides a link from the federal government to the medical and other health professional schools. It can tap this important source of knowledge for programs of broad social significance and service in a way that conventional grant programs to the universities and other schools cannot do.

RMP can be viewed as the agency that monitors and helps maintain the quality of health care. To do this, RMP sponsors continuing education programs for health professionals, promotes education of the public, and conducts research upon and demonstrates

new and better methods of patient care.

RMP's are an unusual expression of decentralization of policy and decision-making responsibility. They are responsive exclusively to locally determined need. They are non-bureaucratic in that staff function is limited to facilitation of the policy making and the implementation responsibilities of a consortium of voluntary, local expertise.

In simplest terms, the RMP functions as a developmental agency; the catalyst of the provider response to the need identified by comprehensive health planning.

Let me list a few problems and issues concerning RMP. Despite the discouraging outlook for RMP coming from the present administration, it can be reversed by a change of strategies. The most consistent shortcoming of the national program appears to be its lack of a clearcut strategy. Although each RMP has its own parochial goals and programs, and these vary greatly from region to region, RMP has not been an effective vehicle for expressing

regional goals and priorities for the delivery of health services. The basic common denominator of the RMP programs is their methodology: cooperative arrangements and conversations between various provider groups. The effectiveness of RMP varies greatly. A few regions have outstanding programs; a majority have satisfactory ones; and a few are clearly unsatisfactory. In general, the development of satisfactory programs has been slower in the large metropolitan areas than elsewhere. It is not clear whether or not RMP is a categorical program. Since various parts of the law support the position that it is both a categorical and a non-categorical program, the law itself is confusing. — it must be clarified.

If the RMP law is not a perfect mechanism for creating a unifying instrument, it is the closest approximation on the current scene. And while the results of its implementation are not altogether orderly and uniform, they are, in sum, encouraging. I won't now repeat what you have already heard in your morning seminars about those accomplishments but merely emphasize their importance.

The fragmented medical service, the rising costs of care, the shortages, the impersonalized and disjointed system, and the educational imperfections are the fabric of our health care crisis. These are real challenges, unmet. Perhaps, a new strategy using the RMP process can help to overcome.

And now I conclude with a portion of the Code for Physicians written several hundred years ago:

"If physicians more learned than I, wish to counsel me, inspire me with confidence in and obedience toward the recognition of them, for the study of science is great . . . grant me the strength and opportunity always to correct what I have acquired, always to extend its domain; . . . man . . . today can discover his errors of yesterday, and tomorrow he may obtain new light on what he thinks himself sure of today." (Maimonides)

I thank you.

Nathan Stark