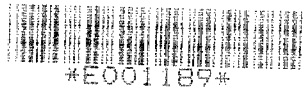
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GOVERNMENT AND MEDICINE

Regional Medical Programs

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IN THE PAST decade or two, the acceleration in medical knowledge has reached such a pace that the total has doubled since 1938 and will probably double again in the next 15 or 20 years. In light of this rapid expansion of what physicians must know if they are to give good medical care to patients, the continuing education of physicians and the allied health professionals has become as necessary as their initial undergraduate teaching and training. More, the sociologic aspects of distributing the benefits of these advances in medical knowledge demand more and more attention.

It is toward these two ends—distribution of care and continuing education—that Public Law 89-239, the Regional Medical Programs for Heart Disease, Cancer and Stroke, is primarily directed. This program, resulting from the deliberations and recommendations of the President's Commission on Heart, Cancer and Stroke (the DeBakey Committee) has been much maligned by practitioners and educators alike, but one can no longer avoid the realization that this great effort is sorely needed, and without such governmental stimulation and help it would probably be several decades off, and even then evolve piecemeal.

In the years immediately after World War II most attention had centered on the mushrooming of the national research effort in medical science. The National Institutes of Health of course played a vital part in this process, with a strong stimulus from Senator Lister Hill and the late Representative John Fogarty. The medical schools, as an important arm of research, very quickly had to come to grips with the realities of a new world of governmental relations.

During much of the same period, those concerned with health services had to consider and deal with federal participation in hospital construction through cost sharing. Finally, at the point where public interest in the problem was brought to the highest pitch, the medicine-and-government relationship was extended, by the passage of Public Law 89-97 (Medicare), to include a measure of payment for services to patients.

We all remember well the keen debate in Congress and the strong feelings generally that were associated with the development of all these programs. This intense interest caused some reexamination of trends in the broad field of health and affected people in government as well as those in medicine.

Public Law 89-239 is a product of that reexamination. It represents a conscious effort to see that the fruits of two decades of medical research be made available to all, with particular concern for those who were the furthest from centers of evolving knowledge. Early in the evolution of the law descriptive terms such as "centers of excellence" raised some alarm in that they seemed to imply a threat of governmental interference with the established patterns of patient-physician relationship and referral. These were later replaced by descriptions placing the emphasis on support for the farthest periphery—for the grassroots. Congress was particularly anxious that those grassroots be reached, be they growing on the concrete pavements of large metropolitan areas or in communities on the edge of a desert, or even in places where grass is supposed to grow. The law addressed itself to the medical establishment, includ-

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ing the Surgeon General and his representatives as well as the university medical centers, the other major medical centers, the professional organizations and the health establishment as a whole. It asked that we turn to account what we now know, and now have, and enhance its effectiveness with cooperative effort, backed by relatively small appropriations of federal money.

New construction, as such, was not a part of this program. Congress felt that such laws as the Hill-Harris legislation discharged the federal responsibility in this area—Regional Medical Programs can only finance a certain amount of renovation in its advanced, or operational, phase.

Similarly, payment for patient services is not a part of this program. Services to patients may only be supported by Regional Medical Programs where they serve a demonstration purpose in pilot projects.

The bulk of support is given first to a planning effort within regions designated as such by the Surgeon General. The planning, on the basis of appropriate data gathering, is to sketch out ways in which existing resources, facilities, manpower and organizations can be brought voluntarily into cooperative arrangements which can make the most advanced of medical capability in heart disease, cancer and stroke available to the patient and the physician of his choice.

The nature of these cooperative relationships is not specified. Each region seeks its own route. In California, we have been doing just that with a state-wide program that should have cohesiveness, cooperation and coordination. Here we have formed the California Committee on Regional Medical Programs. This Committee is made up of representatives from the medical schools, the schools of public health, the California Medical Association, the California Hospital Association, the Heart Association, the California Division of the American Cancer Society, and the State Department of Public Health. Eight representatives best identified as consumers' representatives serve as advisory members to the CCRMP. The 19 CCRMP members with the eight public members constitute the Regional Advisory Committee whose purpose is to solve questions of overlap of interest or area, to see that no areas are left out, to pass on the validity of the various programs suggested, to encourage programs in general, to act as a cohesive force in what might be considered a federation of purveyors and consumers. Within this structure, preliminary geographic delineation of eight realms of influence, each containing a medical school, has been suggested. These will be further worked out. Grants have been requested, coordinators of the programs have been appointed and efforts are being made to involve hospital staffs in the programs which as a matter of course emphasize a new and presumably strengthened venture in the old field of continuing medical education. Also high on the priority lists in most regions are demonstrations and training projects in advanced techniques—for example in the setting up of coronary care units. Most regions, ours included, are taking a hard look at such problems as storage and retrieval of medical reference material, extension and strengthening of medical library networks, and transportation factors where they may affect delivery of vital services for heart disease, cancer and stroke.

Activities of the CCRMP

Among the funds allocated from the first supplementary grant awarded last spring were modest sums to the California Medical Association and the California Hospital Association. But modest through they were in finances, the two projects helped conspicuously in putting the base structure of the Regional Medical Program on a firm footing.

The CMA is refining a survey questionnaire to seek information from a representative sample of practicing California physicians on continuing education. Such questions as "What courses of postgraduate instruction do you take" and "What would you like to see offered that is not available" are at the heart of these surveys. This activity by the CMA was preceded by and now is concurrent with strong and continuing support given by the Association to the concept of regional medical programs. The CMA Council has endorsed the formation in each component county society of a regional medical program committee whose function is to help each local community obtain professional guidance in the development of its program. Several county societies have created these RMP committees, and they are actively at work.

The California Hospital Association project was also intended to stimulate interest throughout the community of 600 or more hospitals in the state. Informational meetings have been held by the CHA in widely scattered communities, and among those attending from the hospital family

have been hospital administrators, chiefs of medical staff, directors of medical education and chairmen of boards of trustees. A medical school representative and a staff member of the California Committee on Regional Medical Programs have shared speaking duties at these meetings with CHA representatives.

The bulk of the Committee's activities has been centered, so far, in the medical schools of the state. Recruiting for top level staff has, for the most part, proceeded slowly. Nevertheless, each area has generated a large and variegated volume of response, interest and desire to become involved in regional medical programs—even among the far reaches of the medical school's geographic planning effort.

At the same time, the CCRMP established a Committee of Staff Consultants, composed largely of area coordinators and deputies to the members of the full CCRMP. The Staff Consultants in turn created four subcommittees to guide activities vital to each of the areas.

A Subcommittee on Communications has helped make the nature of RMP better known throughout the health community in California. It was aided in this by brochure material distributed by the California Medical Association. Further informational material is being prepared.

A Program Development Subcommittee has given counsel to the CCRMP on the problems involved in setting up RMP where it does not now exist.

An Evaluation Subcommittee has taken on the planning for one of the most crucial jobs in the program, finding answers to questions such as: What have been the consequences of RMP? What will physicians retain from continuing medical education? Will such programs reach new areas? What in the long run will be the effects—if any are measurable—on mortality and morbidity?

Finally, a Data Needs Subcommittee has grappled with the acquisition of hard facts needed to prepare the way for operational projects. Each area has data needs. These are coordinated by the subcommittee. Overlaps and duplications are avoided, where possible. Gaps in the data picture are filled. And five planning studies which go beyond the basic data on population, mortality and transportation have been launched.

One study is constructing an inventory of teaching facilities for manpower in the allied health fields. This is basic to training programs which may become operational. Another will survey patient geographic origins, based on hospital discharge forms, throughout the state. A third will interview a sample of physicians to obtain their views on referral patterns in heart disease, cancer and stroke. A fourth will make a new approach to review and analysis of morbidity data, based on county medical society review mechanisms. And, last, a look is being taken at the problem of registries and the possibilities of follow-up inherent in them for the categorical fields other than cancer.

All of this activity is pointing toward operational projects in the near future. The operational program, with the continued cooperation of all components of the health professions, points toward a new kind of regional relationship between medicine and government.

This short description of the Regional Medical Programs in California ends on an upbeat since the programs are still in the making, still in the shaping.