E0021

to last meeting of National association of Regional Medical Programs St Petersburg Fla Sept '76 ?

When I was thinking about what to say to this group today. several ideas came to mind. First, I could have told you about how many and what kind of projects were funded with the $10 million Supplemental Appropriation, what the various final phaseout arrangements were, and how the continuing projects would be administered. Then, too, I could have preached another funeral oration for RMP, but that has been done too many times already, so many in fact, that it is now probably more appropriate to hold a memorial service, and that's about the last thing that you want to listen to at this juncture. So. I'm going to try a new and different approach, and I hope that it will help to capture that essense of the RMP experience and lead to some useful conclusions.

Those of you who have been to Washington lately may have had an opportunity to visit the Smithsonian Institution's new Air and Space Museum which opened on July 1st this year. If you haven't make it a point to get there next time you're in town. It's worth it. When my family and I visited the museum on opening day, I was particularly impressed with one exhibit that sort of grows on you. It's in a hall devoted to space flight and particularly the missions to the moon. The exhibit itself consists of a relatively small, many-sided room with outward sloping walls. The visitor stands on a low step, leans back against the carpet covered wall and watches a slide show projected on three screens near the ceiling. There's a neutral musical background, nothing more.

The pictures are familiar. They are those that we have all seen before, the faces of the astronauts whose names we can no longer remember, the console-filled room, the lift off, the vehicle shining in space, the white suited man floating at the end of a golden cord, the cloud capped earth receding, the desolate moon, the footprint in the sand. At first, how banal. how commonplace it all seemed - like yesterday's ball scores, and then suddenly after a while watching the slides clicking on and off with no captions, no narration, not even the familiar up-and-under music that signals important moments in film and TV. it strikes you - the enormity of the achievement.

So what I will try to do today is to present a sort of verbal slide show to carry you back quickly through the ten years of the RMP program through old, familiar scenes, and to flash before you some verbal pictures that perhaps will bring to you as it has to me some new perspectives and insights. I will begin with the last period of normality just prior to the 1973 phaseout directive, then look at the program in a larger context, and finally try to devine some meaning from the experience.

In January, 1972, the President budget for Fiscal 1973 requested $130.3 million for RMP. Subsequently two separate Appropriation Bills were passed by the Congress in August and October, 1972 respectively and vetoed by the President. Each of these would have provided $165.4 for RMP. To keep HEW programs going until an Appropriation could be enacted, the Congress passed a continuing resolution on October 29, 1972, permitting RMP expenditures at the $150 million level set by the House Until January 29th, 1973 it was expected that the program would continue at least at this level. The 29th, however was a fateful day. On that day the President's Fiscal 1974 budget was released. Smashing all expectations, it recommended zero appropriations for 11 health programs including RMP. The budget gave the following as the reasons for RMP phaseout:

> "Despite Federal expenditures in excess of $500 million for these activities, however there is little evidence that on a nationwide basis the RMPs have materially affected the health care delivery system. Further expenditure of scarce Federal health resources on this program, therefore, cannot be justified on the basis of available evidence."

Immediately after the budget publication announcement of the RMP phaseout was made by telegram. On February 6th, another telegram advised all RMPs with August 31, 1973 end dates that these had been shortened to June 30th. On February 22nd final phaseout applications were requested and on April 4th phaseout awards were issued stipulating that no RMP expenditures were to be made after September 30.

It was not till later that moves were begun in the Congress to reprieve the programs marked for extinction. On May 31st the House passed an extension Bill Authorizing $159 million for RMP. The vote was 372 to 1. On June 5th the Senate passed the House Bill by 94 to 0, and on June 18th the President signed the extension Act providing another year of life for RMP and the other health programs. A telegram on June 28th formally notified the RMPs of the extensions and telegram assured RMPs of viability through September 30, 1973. On July 10th a $6.9 million balance of '73 funds was distributes, but the awards prohibited their expenditure except for purposes to be specified later by HEW. (They never were.)

Meanwhile, the appropriation process had begun in the House which approved an RMP Appropriation of $81,953 million for Fiscal 1973, and at the beginning of Fiscal Year 1974 on July 1, 1973, the President signed a Continuing Resolution in the same amount. During August various spending plans were developed for support of RMPs during the Fiscal 1974 extension period and on August 23rd $41,236 million was approved internally in HEW for RMP grants in Fiscal 1974. On the same date $17.1 million was release to keep RMPs in business through December 31, 1973. An additional $2 million was reserved for continued support of pediatric pulmonary centers. On September 7th each RMP was notified by telegram of its share of the $17.1 million and on September 20th a letter went to all RMPs again extending the program's termination date, this time through June 30, 1974. All of the decisions about Fiscal 1974 funding apparently were made at the Assistant Secretary for Health or higher levels within the Department.

On November 12, 1973, RMPs submitted applications for the remaining Fiscal '74 funds. These were awarded on December 28th for a 6 month period, January thru June 1974. The awards included $24,136 million for RMPs (the full amount allocated by HEW in August minus the $17.1 million already awarded) and $74.444 for pediatric pulmonary centers. The $6.9 million Fiscal '73 balance awarded on July 10th, however, continued to be restricted.

While the application and award process for released Fiscal '74 money had been going on, there were other important developments on the judicial and legislative fronts. On September 21st the National Association of Regional Medical Programs filed suit for release of all appropriated funds. On December 13th Congress actually appropriated $81,953 million, including a 4.5 million arthritis earmark, for Fiscal '74. This was almost twice the level allocated and awarded by HEW, and on February 7, 1974, the Federal District Court for the District of Columbia ordered the release of all impounded Fiscal '73 and '74 RMP funds. The Court Order also prohibited placing restrictions on the expenditure of the released funds.

Action to carry out the Court Order followed quickly. On February 22nd HEW release $89,631 million in previously impounded Fiscal '73 funds. On March 6th a letter rescinding the phaseout per the Court Order was sent to all RMPs. On March 7th the $6.9 million Fiscal '73 balance was released for expenditure and reallocated among the RMPs. Simultaneously all RMP budget periods were extended through June 1975. On March 7th instructions were sent to all RMPs on how to apply for the unimpounded Fiscal '73 and '74 money. Two review cycles were established, one for June and one in August. A quarter of the released funds were reserved for 2nd cycle applications.

On June 13th $84.4 million was awared to 51 RMPs and $4.3 million was awarded for arthritis projects. On August 8th $27.3 million was awarded to 47 RMPs and on October 20th $5 million in contracts for "planning technology" was allocated under Section 910 per a modification of the Court Order. This completed the distribution of the funds released as a result of the lawsuit.

On January 4, 1975, the President signed P.L. 93-641, the National Health Planning and Resources Development Act which replaced the RMP, CHP (Comprehensive Health Planning) and Hill-Burton (Medical Facilities Construction) programs. The new law, however, had special transitional provisions in Section 5 (a) permitting continuation of RMPs until the later of June 30. 1976 or establishment of successor Health Systems Agencies. This set of developments required additonal appropriations for support during the transitional year.

Although a Continuing Resolution passed in March 1975 provided $75 million for RMP transition, accompanying Congressional reports recommended delay in obligating this full amount before the passage of the actual Appropriation. The latter was not enacted until June 12th and contained only $150 million for RMP including a half million earmark for Public Accountability Reporting (PAR). The appropriated funds were awarded on June 27th to support RMPs for a full year through June 30, 1976. The earmarked funds were awarded for a two year evaluative study in accordance with Congressional intent.

As June 1976 approached, final preparations were made for RMP phaseout. The National Association of RMPs met on March 15th in Kansas City and proposed a common July thru September 30th phaseout period for all RMPs. On April 9th RMP and Federal officials met in Boise to develop and agree upon phaseout guidelines which were issued on April 30th. These were followed by meetings for eastern and western RMPs, respectively, to review closeout procedures.

Then, on June 1, 1976, Congress appropriated another $10 million additional to continue "exemplary" RMP projects like those identified in a PAR report issued earlier in April. The RMPs through their own committee structure organized a series of regional meetings and a national meeting to review projects and priorities for applications and submitted total requests for funds within the $10 million available for award. Essentially the funds were awarded on the basis of a formula recommended by the RMPs themselves.

Finally on July 10, 1976, instructions were issued for reauthorization of balances for support of continuing projects and all necessary arrangements for use of these funds were made in a frenze of paperwork prior to September 30, 1976, the termination date for RMPs. Over $16 million in special project grants will be available for final support of the remaining projects over the next year, with a few continuing beyond that.

Having reviewed recent history, perhaps it will be useful at this point to go back over the whole life span of the RMP program, to put these and other events into a larger context, and to see if any useful conclusions can be drawn.

In this regard, perhaps a review of the whole period will be helpful. Beginning with the passage of P.L. 89-239 in 1966, the RMP program spanned 10 years during which it allocated about 3/4 of a billion dollars. During those years the country focused its attention on many major issues including the "war on poverty", the activest phases of the Civil Rights movement, the Vietnam War, Watergate, the energy crisis, inflation, and the rise of consumerism.

The era encompassed all or part of 3 Presidencies, those of Johnson, Nixon, and Ford. During that time there were 6 Secretaries of Health, Education and Welfare: Gardner, Cohen, Finch, Richardson, Weinberger and Matthews. There were 5 Assistant Secretaries for Health: Lee, Egeberg, Du Val, Edwards and Cooper.

The RMP program successively was in 3 different agencies, NIH, the Health Services and Mental Health Administration (HSMHA), and the Health Resources Administration (HRA). It also was located in 5 different Bureau or Division level units within those agencies. At NIH, the program was administered by the Division of Regional Medical Programs. In HSMHA it retained the Bureau level status as the Regional Medical Programs Service, and within HRA it has been placed successively in the Bureau of Health Services Research, the Bureau of Health Planning and Resources Development.

The RMP program has been under 9 agency Directors (some of whom acted only for very short periods): Shannon, Marston, Lewis (acting), English, Wilson, Sencer (acting), Laur (acting), Buzzell (acting), and Endicott. The program itself has been managed directly by 7 Directors or individuals who effectively were in charge: Marston, Olsen, Margulies, Pahl, Chambliss, Gardell, and Baum.

The program, at different stages, had two essentially different modes of operation, initially project by project technical review at the Federal level, and then roughly since 1970, a form of revenue sharing in which project review responsibility was decentralized directly to the grantees who acted within Federally prescribed standards.

What good did all the money and effort do? What lessons can be learned? What does it all mean? In the brief time available. I'd like to suggest a few answers. Change, once it occurs, is often taken for granted, and those who are involved often fail to experience and recognize the change and evolution that is going on around them. In the last 10 years there have been many institutional changes in health and RMP has contributed sometimes minimally, and sometimes significantly. to a number of these.

What do I mean when I speak of an institutional change in health? Let me illustrate a few examples more related to RMP. When the Courts converted alcoholism from a crime to a disease, that was an institutional change in health. When the birth rate drops and behavioral standards change because of the pill, that is an institutional change in health. When psycho-active drugs and early treatment reduce the population of mental institutions, that is an institutional change in health. But there are other examples closer to home.

A few months ago, for instances, my nine year old daughter spent a day with me at the office during a school holiday I took her to lunch along with some co-workers. We were sitting in the "no smoking" section of the cafeteria when someone at the table took out his pipe and lit it. My daughter pointed to the "no smoking" sign and said, "This is the 'no smoking' section, and anway smoking isn't good for you that is an institutional change in health. Similarly when I was offered a choice of the "smoking" or "no smoking" section of the plane coming here yesterday, that is an institutional change in health. Also, on a personal level, when I go to the supermarket, like many others, I read labels for cholesterol, additive content, and caloric value. The advent and use of nutritional food labels is another institutional change in health.

While ten years ago, coronary and intensive care units were relatively new, they have now become commonplace and are familiar to a large part of lay public through personal experience of that of a relative or friend. The proliferation of these units is also an institutional change in health.

Where I live, we have a well equipped emergency medical system that supposedly can respond to a call within 3 minutes. There is now a national effort to establish EMS systems, and that is an institutional change in health. Likewise, kidney dialysis and transplant networks are being established nationally and financing mechanisms have been set up under Social Security. Just as an example of how familiar this is becoming, only recently an Archie Bunker episode on T.V. had to do with signing an organ donor card. When transplantation becomes subject matter for a popular T.V. program, that, too, is an institutional change in health.

Now, I don't want to suggest that RMP has been responsible either wholly or even primarily for all the noted changes or that this brief recitation is an exhaustive list, but RMP certainly was a force, that together many others, helped to raise national consciousness about smoking and diet habits. It equipped myriad coronary care units and trained thousands of professionals to serve in them. It likewise trained many an EMS technician and gave impetus to initiating and improving the nation's EMS systems. It also provided a head start for the kidney program currently institutionalized under Section 299 (i).

In general in our society, it seems to me that what needs to be done usually gets done even though the institutions through which change is accomplished change themselves and evolve over time. Therefore, any given program should be seen as part of a continuum of events rather than an isolated phenomenon. Most programs inherit from their predecessors and hand things on to their successors. The current planning law P.L. 93-641, for instance, can trace its ancestry to non-governmental planning efforts in Rochester and New York City about 40 years ago. These gradually spread to about a dozen other places and in the 50's the Hill-Burton Medical Facilities Construction Program, encourage and financed the proliferation of planning agencies to about 85 areas. The Hill-Burton effort was succeeded by the Comprehensive Health Planning program, and planning now presumably will be institutionalized in a stronger and expanded form under the new Health Resources Planning legislation.

If one looks at RMP activities, these too form a part of a continuum The spread of specialized coronary care units is, at least in part, an outgrowth of prior intensive Hill-Burton efforts to popularize "progressive patient care" a concept in which the complexity of services is scaled to patient needs from "intensive care" to "home care". Intensive care and coronary care units were just starting to catch on at the time RMP came into being and as I have noted, the program played a major role in their institutionalization.

Likewise, there was a specialized kidney effort in the Old Chronic Disease programs. Dialsis and transplant efforts were picked up by RMP after the kidney amendment, and now these two have been permanently institutionalized.

The Diabetes and Arthritis program which also existed under Chronic Diseases effort was phased out in the early 1970's but Arthritis activities were initiated once again through the earmark two years age, and now it appears that the Arthritis effort too, will continue under NIH through new legislation.

HSEAs, emergency efforts and many activities spun-off from RMP to local funding over the years will also continue to operate.

A man in our office has a sign on his desk that says "you can get a helluva lot of work done if you don't care who gets the credit." and that is probably true. Even if the world little notes what RMPs, in concert with other forces, have done, nevertheless the products are there and in many cases the work will continue though in different settings, and under different financing mechanisms.

Now that the program is over, there is no reason for sadness at its parting. It has done its job in relation to the times the resources and the problems at hand. In the future there will be new problems and new issues. Ten years from now current health issues like swine flu, right to die, mal-practice insurance, occupational and automotive safety, national health insurance, etc. will disappear from the headlines because new and accepted institutions will have been

created through evolution of rules, technology and attitudes. In the future as now, when the changes occur, the agents of change, the Governmental programs, the voluntary efforts, the private philanthropy all will be forgotten. Only the results of the work will survive adn really that is all that matters.

In the last years of the program it has been reprieved from extinction 4 times and been buffeted with changing directives. In this time the program has displayed great resiliency largely because it had a dedicated staff and volunteers who believed in what they were doing, because it had positive purposes, because it was decentralized and able to operate largely without Federal interference, and because the RMPs themselves picked up on evaluation and administration when the Federal Government dropped the ball.

The RMP program, looking back, has had a long and useful existence and much of what it has done has been woven into the fabric of American life. That is a record of which all who participated over the years can be justly proud. But, for all those who are here today, and all who worked through the final trying period of uncertainty, confusion and chaos, there is that special pride that belongs to those who know that through it all they have done their jobs, and done them well, and served the public and survived - with honor.