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SUMMARY OF

REMARKS ON RMP-CHP RELATIONSHIPS

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We have heard the discussion of Gerry Riso this morning in which he outlined his views concerning the relationships - and problems - of those programs under his administration. He spoke from the vantage point of one who has overall national responsibility for a variety of programs that attempt to create and coordinate community activities in the health arena. He spoke of relating at least five programs in a manner that would accomplish the objectives of improved health care for the American people in the most effective and efficient manner. Conversely, I have tried to base my remarks on experiences at the local level, limited essentially to developments in California and certain neighboring states and to relationships only between two of the programs - namely, Comprehensive Health Planning, including both A and B Agencies, and Regional Medical Programs.

Time does not permit the discussion of all of the relevant points which Gerry Riso raised; therefore, I have chosen only a few to expand upon. First, however, I would like to raise certain aspects about the RMP-CHP relationships that often go unnoticed in any discussion. Essentially, they are developments which occurred during the beginning and early days of the programs that tended to create tensions, suspicions and "myths," some of which still exist today. Like most reactions based upon emotion, they are difficult to overcome with reason.

Those of you who have been associated with the administration of social

programs over the years know that the public's understanding, and even the understanding of some of your colleagues in other programs who should know better, often deviates greatly from the facts as you know them.

Our nation's welfare programs are a good example. Myths permeate the public's understanding of these programs, often to the degree that productive discussion becomes almost impossible. There are some who want to believe the major myths of welfare: namely, that the majority of those on welfare are shirking work, drive cadillacs and enjoy a wide variety of sensual pleasures at the taxpayers' expense. If one or many want to believe a distorted picture of the situation such as this, for one reason or another, then a rational solution to the real problems of welfare or any social endeavor becomes difficult - almost in direct proportion to the degree to which the myth is cherished.

The generator of the myth generally takes one of the more minor but obvious defects in a complex situation, inflates it far out of proportion, and attempts to make it appear as the underlying cause of all problems. Man has always searched for simple answers, but too often has found only the simplistic.

Fortunately, the RMP-CHP relationship generated only one major myth and it should be described as less than major when compared to some of the myths of other social programs. But, it did have a profound effect internally for both RMP and CHP in terms of the staff time spent discussing it. Although at this point it seems to have had little lasting effect other than hours of verbiage, the two programs could have been severely damaged and may be even yet. It is not impossible for the myth to become more real than reality itself.

The myth was of course put forth in the argument that "RMP and CHP

are in vital conflict and are destined for a head-on collision." There were some who found the myth amusing, causing the reply that both would poop out before they saw the whites of each other's eyes. Further, this myth had a rather uneven existence. It varied in intensity with the fluctuations in financial support for the two programs.

About four years ago, I was asked to prepare a talk on this subject for a national meeting at a time when the myth reached one of its several peaks. There seemed to be a deep feeling permeating the local leadership of both programs that there was a potential deep, unavoidable conflict between the programs. Back then, when people complained of the impending disaster, we would ask: "Where have you had problems in your relationships with each other?" Usually, the reply was that it "had not happened yet but it is about to happen - it's bound to happen." When we asked what form this conflict would take, we were told that either both programs would try to do the same thing at the same time, thereby running into and over each other, or one program would stop the other from doing what ought to be done. There was talk to the effect that there was not enough skilled manpower to run one program, let alone two, leading to the specious conclusion that if the two were merged all of the manpower involved in both would automatically become active in the merged program. It was true that if you looked long enough you could find isolated examples of both RMP and CHP trying to do the same thing, but it was the exception rather than the rule. There might be examples of one program denying the other the opportunity to perform some needed function, but as yet advocates of this dire circumstance have been hard pressed to provide examples. Lastly, if we examine closely those programs that have merged, the sum of the people involved

before the merger was far greater than after and the total effort has been less.

What, then, are the underlying causes of the "conflict myth?" Again, this is not a question to which there is a simple answer, but there were several events that led up to the generation of the myth and several that kept it going which we ought to consider. Like most seemingly irrational positions taken by any group or groups of people, at least part of the problem can be traced to fears and resentments on the part of participants in both programs that have never been fully expressed.

First, in the beginning there was a very understandable resentment on the part of some involved in CHP toward RMP because it appeared that RMP would enjoy far better financial support than CHP. Shortly after RMP was passed by Congress, it seemed that we would have sufficient funds to guarantee an early programmatic success.

On the other hand, CHP had a complex and rather low funded situation. As Gerry Riso pointed out this morning, many CHP programs had a difficult time raising the required matching funds at the local level and certainly this was, and still is, a major problem for the B Agencies. The considerable efforts spent by CHP participants in fund raising were efforts that could have been spent more profitably in the health planning process itself. Also, in place of assuring local involvement or a local-federal partnership as it was described, the matching provisions in some cases actually drove people and institutions from the program at the local level and caused both suspicion and resentment. In theory it sounded good, but in practice too often it meant that the funds had to be raised locally from institutions, facilities, agencies and professional groups that later might be subject to

some restrictions as a result of the planning process. It soon became apparent that anything that resulted from the planning process would be subject to question, rightly or wrongly, if its basic decisions involved voluntary contributors to the local matching funds. Justified or not, those who contributed would be accused of buying a decision to their own liking and if the decision went against them, they might never contribute again. This was, and is, so inconsistent with sound public policy that it seems almost unbelievable.

As these financing problems beset CHP early in the history of the two programs, naturally local CHP leaders looked with a jaundiced eye at a closely related program which seemed affluent. It must be added that some local RMP's aggravated this feeling by luring individuals and groups into their fold with promises of support based on the supposed affluency - an act which CHP could not duplicate. RMP began life with better staffing patterns, strong institutional support, less turmoil and what seemed to be a greater degree of security.

Soon, however, the degree of security seemed to lessen for RMP. The first enforced carryover in 1967 made it apparent that RMP was going to have problems in obtaining release of all of its appropriated funds. With this development (although, certainly, this was not the only reason) the tensions over the so called conflict between the two programs began to relax. There were even expressions of sympathy over the fate that had befallen RMP now that we, too, had to wait and scratch for funds. It lessened the apprehensions considerably.

The programs, as they gained experience, then began to settle down and to search for mechanisms upon which to base a relationship where each could coordinate their efforts and keep fully informed about what the other was

doing at the local level. A sound relationship did not develop uniformly throughout the nation, but there were far more examples of productive relationships than problems. Yet, as usual, the latter attracted a disproportional amount of attention. There were still rumblings of conflict, although less than in the beginning, and the purveyors of the "head-on conflict" myth still had problems providing specific examples of where it had happened when pressed to do so.

By this time, nearly three years had passed since Congress had created the programs. Thus, following the recent policies of Congress that these types of programs are legitimatized for only three years' duration, it was time to introduce the extension legislation for another three years. One of the important bills introduced to extend the two programs would have eliminated the categorical approach in RMP and would have made the legal purposes for the two programs identical. Nothing can throw confusion, or perhaps paranoia, into a programmatic situation more than having the legal purposes of two separate programs identical. Admittedly, the several purposes can be administratively divided between separate programs, but it was obvious that this kind of approach would cause renewed apprehension and insecurities to develop again at the local level. It did. Again, the feelings flared up between CHP and RMP in some areas and the issue of conflict reappeared in full bloom.

However, when Congress extended the two programs, it maintained the separate legal purposes of each. It maintained the categorical structure of RMP, but added kidney disease and did broaden the program scope. It mandated cross memberships on the advisory boards of the two programs at the local level. Nevertheless, by this time it had become abundantly clear

that we needed a simplified means of drawing distinctions between the two efforts, especially for the edification of the lay person. The myth of conflict was not going to go away unless we could find a way of describing what each program was doing in terms of the functions they perform, or were supposed to perform if they had the resources, and not in abstract philosophical terms which are capable of many different specific definitions and interpretations. Any such national description of a program in terms of its functions is bound to be interpreted at the local level as a limitation on local autonomy, but it was believed that most reasonable people would accept this as preferable to the seemingly eternal time-consuming conflict myth.

After the extension legislation was passed and signed, we began to hear the programs differentiated in terms more of their composition than philosophy or legal intent, but not as yet in terms of functions. Essentially, RMP began to be described as a provider oriented program which presented to providers, as well as others closely allied to health care, a forum from which discussions could be held and decisions made concerning the means of improving personal health services. CHP was then described as the consumer oriented group which, in effect, represented the overall public in total health planning. Although this distinction began to satisfy some (i.e., by describing vaguely those involved) it did not answer specifically the question of what each was doing. Thus, a void in the understanding of many continued to exist. In a way, this description could have, and may yet, fit the purposes of the conflict myth generators by giving them a chance to assert that provider self-interests are not necessarily in the best interest of the public (consumer); therefore, battle

will come between the two programs as the interests of each are more sharply defined. This is an erroneous argument, but it might have a lot of takers.

It seems to me that our next step has to be an understandable description of the functions of the two programs. Part of this has been accomplished in the guidelines, regulations and other documents of the two programs. Some examples can be gleaned from the objectives statement of various RMP Regions and CHP Agencies but no where, to my knowledge, does such a description exist for either program in a comprehensive, understandable form.

It would be presumptuous of us here today to attempt to outline even vaguely the functions for which CHP might be responsible. Just the thought is overwhelming. If we might consider the early history of CHP, it was difficult to demonstrate specifically the original Congressional legislative intent for CHP because PL 89-749 which created CHP passed the Congress in a rather unusual way. Its final passage came late in the session, with little debate, virtually no committee hearings, and relatively brief discussions by its backers at the time of signing. We did hear such terms as a "mechanism for developing a comprehensive plan for health care in each community," an "umbrella" under which public and private health care efforts could function, and other similar metaphorical descriptions, but much was left to the local imagination as to how to proceed.

While CHP A Agencies and B Agencies were struggling with their goals, purposes and patterns of organization in order to accomplish the planning they were charged to do, several RMP Regions were able to move ahead into their operational phase. Several projects in the categorical fields of heart, cancer and stroke were well underway in several Regions before CHP Agencies were functioning. Ideally, I suppose, it would have been

preferable if each community could have had a master plan for health to which RMP could have related its activities, but this was not the case and master plans for health, five years later, still seem distant.

Although the health field has, with rare exceptions, successfully avoided planning up to now, it seems evident that any field that has grown to the magnitude and importance of health care will succumb eventually. If we speak of functions for CHP, there is no less of a need today than when PL 89-749 was enacted for an overall plan development in the fields of health facilities, manpower development, personal health services and health factors in the environment. To be sure, some planning on a piecemeal basis is being done in all of the areas, but it is uncoordinated and often not compatible or in the best interest of the public. CHP should be the master plan developer in these areas: it should provide the "umbrella" under which all related planning efforts are assembled at the community level in order that the individual efforts can be made compatible and the voids filled. There are those who will argue that this is what CHP Agencies are doing now. Perhaps some are. But those I have seen, although they make a valiant effort, have neither the resources, authority or sanctions to bring this result about in a meaningful way.

As I see it, the functions of RMP in planning and operations relate to a relatively small portion of CHP's overall planning responsibility. We relate to a portion of the health manpower development planning and we relate to a portion of the personal health services planning. There will be arguments that we relate also to health facility planning and environmental planning, but our concerns here must be described as minor. We are not concerned with all of health manpower development either, since we have

done little in the mental health field, although Area Health Education Centers may broaden this interest. There are several personal health service areas in which we have not functioned, but it has been an area of major concern. In terms of CHP functions, at least as we know them today, we have sought to establish close working relationships with the CHP health manpower and personal health services committees, even to the extent of providing staff assistance, in order that CHP can become fully informed of our activities. Review and comment by CHP after our planning is done is too late and too costly; the input has to be on a more regularized basis, especially if overall plans begin to emerge.

Turning specifically to RMP, how can we describe the functions of our Program in terms understandable to other health efforts, those involved in CHP and the lay public? I have taken five areas that essentially emerged from the discussion held between the Secretary of HEW, certain Coordinators and HEW officials. These descriptions would have to be expanded on in greater detail than we have time for today, but essentially they are as follows:

1. <u>Regionalization of Services</u>

This seems so obvious that it need not be explained since we have all been involved in the creation of coronary care systems, cancer and stroke care systems that required arrangements between facilities and manpower. But there is an added element. Since in most cases there is no master plan for health services, and since in many cases the duplication of high cost services without regard to their location has resulted in a low utilization of these services, which in turn has increased the cost to each patient, we are obligated to consider the potential cost and utilization factor when

providing any assistance, such as training or consultation, toward the creation of the service. Logically, CHP in its planning process should determine where services are needed but, in the absence of a plan, reasonable efforts should be made with CHP to provide a means of assuring high utilization where consistent with sound practice in order to avoid further unnecessary inflation.

2. Area Health Education Centers

RMP has been assigned the function of establishing the proposed centers. Again, the actual need for manpower should eventually be determined by a central agency that has the resources and capabilities to make reasonably accurate predictions about not only today's needs, but the needs of the future when current students will graduate. This illustrates again the need for an overall manpower plan with input from a number of sources. Our immediate function, however, is to collect our current efforts in manpower development, including continuing education, into a series of consortiums, expand the efforts where necessary, and to work with CHP on the development of a system for determining needs. In California we are attempting to develop a joint program with the A Agency and the State Department of Public Health to have a single agency determining needs.

3. Kidney Disease

Perhaps we are stretching a point to separate this function from the other categorical disease services that should be regionalized with concern for cost and utilization. But it is somewhat unique, at least in California, in that the Medicaid (MediCal) program is a major third-party payer and the State has a major interest in and control over dialysis treatment center

approval. Also, it was originally planned to create a national network which thereby involved further considerations apart from the usual regionalization process.

4. HMO Involvement

Our functions in regard to HMO development are less than clear at this point. HEW leadership seems to have indicated that RMPs should act as consultants in certain areas of HMO development, both to the developers and to the agencies that purchase care. It has been suggested that we might define what constitutes health maintenance and to evaluate the quality of services. At this point, it does not seem feasible for RMPs generally to be the primary developers of HMOs.

5. Organization and Delivery of Care

Some RMP Regions have used their developmental component funds to organize units to provide care in areas where no care existed. Some have also used these funds to develop new levels or classifications of manpower. The ability to blend the new units of care into the existing system and to find a licensing slot for the new manpower calls for an involvement far beyond RMP. Thus, again it would be helpful if there was a master plan for health in the communities where these efforts are being made in order that there might be broad agreement on the goals to be achieved.

The above description of functions is by no means all-inclusive or complete. It is only a rough outline, but it has been helpful in explaining to others what we are trying to do. It tends to minimize the resurgence of the conflict myth. Hopefully, CHP will acquire the resources, the mandate and the legal authority in the not-too-distant future to develop the type

of community plan for health that is needed. RMP can then be guided in its functional role as the manpower and service developer.