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Regional Medical Programs, 1965-1966*

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A Nation Starts a Program: Regional Medical Programs, 1965-1966*

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This month [October, 1966] marks the first anniversary of P. L. 89-239, the Heart Disease, Cancer and Stroke Amendments signed by President Johnson on October 6, 1965. The legislation was hailed by some as a landmark in the history of American medicine. It was strongly criticized by others, both for what it said and what it did not say. Even some of those who supported the legislation in principle still maintained a wary curiosity concerning the implementation of such general legislative language. The philosophical hopes and fears of a year ago have been replaced by actual events, real problems, and identifiable progress. It is appropriate at this time to report on the extent to which the Regional Medical Programs legislation has been implemented.

It is estimated that there will be 48 or 49 programs: 45 planning grant applications or declarations of intent have been submitted to date. These programs will actually be defined in large measure through the activity of those people who will make them operative. It is this characteristic of the Regional Medical Programs that makes them a fascinating experiment in federal health policy.

Obviously, experience with the development of these programs is still quite limited, and many of the difficult prob-

lems being encountered in implementing this legislation are influenced by large issues and historical trends which can be seen only incompletely at any one time and from any one place.

While the historian of the future will focus on forces that we can perceive only dimly at present, reflection on the possible impact of the programs brings to mind a view of history presented by Robert Bolt (1) in *A Man For All Seasons*. His theme is that an examination of the trends and forces will illuminate only a portion of any historical event. What is of interest is the way it happened, the way it was lived. " 'Religion' and 'economy' are abstractions which describe the way men live. Because men work we may speak of an economy, not the other way round. Because men worship we may speak of religion, not the other way round."

BACKGROUND

There are a number of long-range factors and trends which constitute a common heritage for the Regional Medical Programs and which set the scene for the passage of the authorizing legislation. The most important of these factors is the impact of science on the nature of medicine and medical practice. The dynamic growth of medical research in this country during the past twenty years and the resulting advances in knowledge form the scientific base which is the beginning point for the program. Following are some of the factors which contributed to the development of the legislation:

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the forty-year discussion on regionalization of medical services; the evolution of the medical schools with the accompanying development of great medical centers; and underlying social factors relevant to health concerns, including the rising expectations of the consumer of health services who is increasingly coming to expect that modern medical science will have the solutions to his health problems.

The legislation was directly influenced by such publications as the Coggeshall Report, *Planning for Medical Progress through Education* (2); the Dryer Report, "Lifetime Learning for Physicians" (3); and the Reports of the Association's Eighth and Tenth Teaching Institutes "Medical Education and Medical Care: Interactions and Prospects" and "Medical Education and Practice: Relationships and Responsibilities in a Changing Society" (4, 5). However, the actual impetus for the introduction of the bill was the publication of the Report of the President's Commission on Heart Disease, Cancer and Stroke (6), which focused on the relationship between science and service in medicine. The mandate of the President's Commission did not include the drafting of legislation; that task was performed under the leadership of Dr. Edward Dempsey, then Special Assistant to the Secretary of the Department of Health, Education, and Welfare for Health and Medical Affairs, and Dr. Dempsey's Assistant, Dr. William Stewart, now Surgeon General. The bill that was sent to the Congress by the Administration contained the elements which have proved to be most important to the development of the program over the past year, including the emphasis on the relationship of academic medicine to medical practice, the creation of workable cooperative arrangements among health resources, and the use of competitive grants rather than formula grants.

Congress did not rubber stamp the

Administration's proposal. Many changes were made in the original bill, primarily as the result of hearings before the House Interstate and Foreign Commerce Committee, chaired by Congressman Oren Harris. By its action, Congress made it clear that this program would be built upon cooperation among existing institutions and that local initiative would play a determining part in the development of the Regional Medical Programs. The law emphasized the role of the required regional advisory group and the intent that this group be broadly representative of all health interests and include practicing physicians and representatives of the interested public.

The House Committee was impressed with the potential contribution that the Regional Medical Programs could make to the more effective utilization of manpower. Therefore, it stressed the role of continuing education and training in accomplishing the purposes of the legislation.

Although the bill as originally written provided authority for new construction, this section was eliminated before the legislation was passed.

Finally, Congress authorized the program for three years and made clear its intent that this initial period be an exploratory phase which would constitute the learning experience on which future extension and modification of the legislation could be based.

Preceding the signing of the legislation, the administrative decision was made that this new responsibility of the Public Health Service would be administered by the National Institutes of Health. This action emphasized the fact that the Regional Medical Programs concept focused on the relationship and interaction between the development of new knowledge and the provision of better medical care. In the period preceding and following the final approval of the legislation, Dr. Stuart Sessoms, Deputy

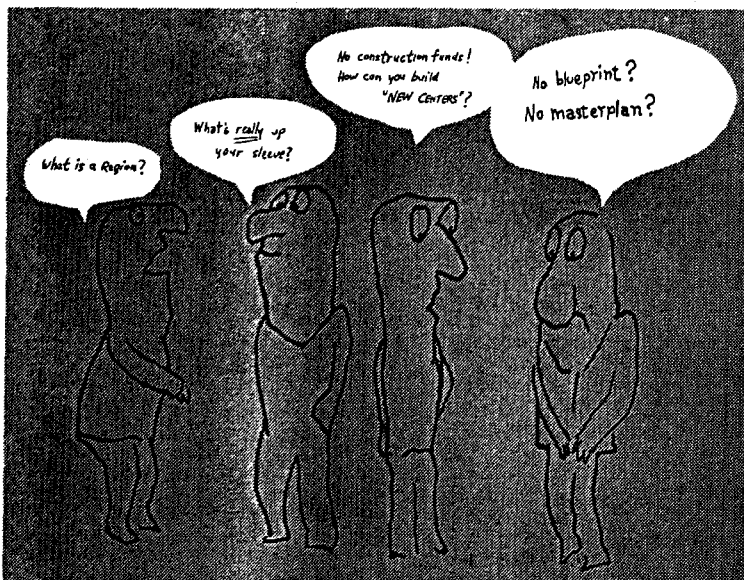


FIGURE 1

Director of NIH, was the focal point for NIH concern with this legislation, assisted by Mr. Karl Yordy. Much of the early implementation which will be described later in this paper occurred under the leadership of Dr. Sessoms, who bore the major responsibilities until February, 1966.

On October 6, 1965 there were no experts on regional medical programs, no master blueprints of how a regional medical program would work. During this period, questions from prospective applicants and other interested parties attempted to probe the flexibility of the legislation in order to determine whether or not there was a specific blueprint for implementation (Figure 1). How do you define a region? How many regions will there be? Who can apply? What will be the responsibilities of the applicant? What is the exact nature and role of the regional advisory group? Tell me in specific terms what a regional medical program will do and how it will function. The answers, or some would say lack of answers, to these questions reflected the

fact that the flexibility of this legislation was deliberate public policy and that this flexibility is central to the concept of a regional medical program.

The legislation clearly prescribed that the program be carried out on a regional rather than a national basis. The law represents a vote of confidence in the willingness of the regions to accept the basic responsibility for devising the programs to accomplish the purposes of the law. The flexibility of the legislative provisions highlights this transference of responsibility to the regional level. A clearly defined national medical program would have led to fewer questions. However, even if workable, it would have meant less opportunity for creativity, fewer opportunities to develop diverse answers appropriate to diverse problems, and less assumption of responsibility at the local level.

After one year of experience, there is considerable evidence justifying this law's almost naïve trust and faith in the ability of formerly divergent medical interests to cooperate on a voluntary

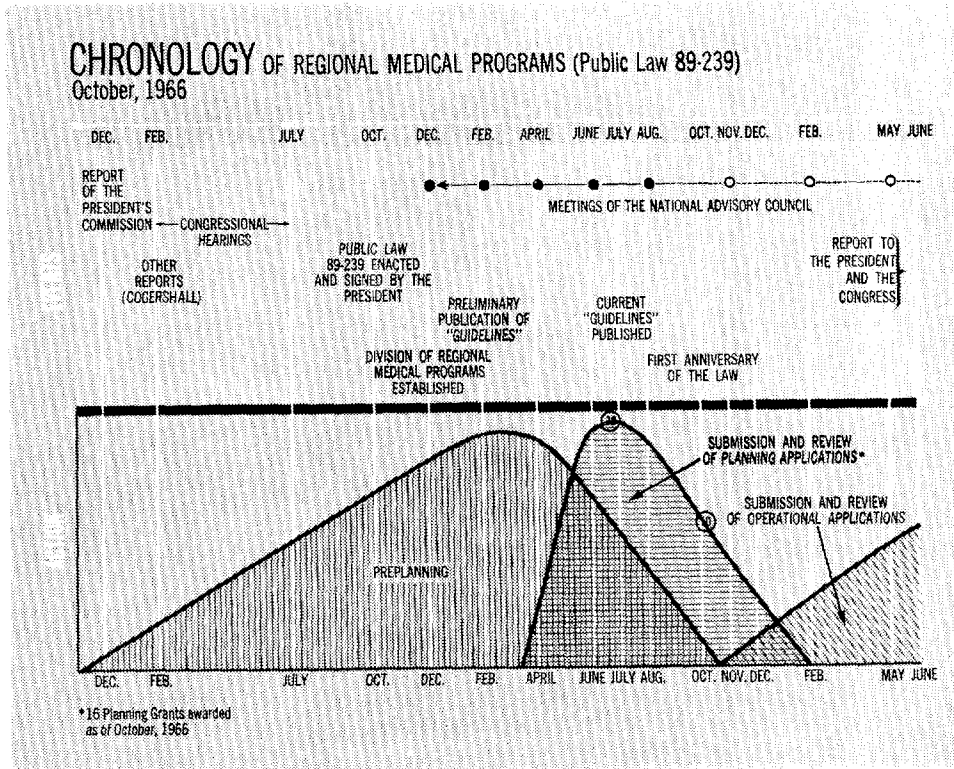


FIGURE 2

basis in accomplishing important health objectives.

DEVELOPMENT

REASSURANCE AND DEFINITION

Experience with the program divides naturally into several phases (Figure 2). The first spans the period from the signing of the legislation in October until about February, 1966. During this time, much of the effort of Dr. Sessoms, the authors, and others was spent in providing reassurance to various medical groups concerning the nature of this program as defined in the law. For some still feared that the program would be a federal medical system which would divert patients to distant medical centers with no concern for the role of the local practicing physician or hospital. Some

of the medical school faculty and administrators feared that their medical centers were being asked to assume the total responsibility in their regions for medical care in the fields of heart disease, cancer, and stroke. Nonaffiliated hospitals feared that they would have no role to play in the program (Figure 3).

However, along with the fears and anxieties, there was a ground swell of interest in the Regional Medical Programs expressed by a very wide variety of health organizations, institutions, and individuals. Meetings were held in regions throughout the country to discuss implementation of the program. The staff at NIH was contacted by literally hundreds of medical organizations and groups expressing interest and support. The Regional Medical Programs appeared as a

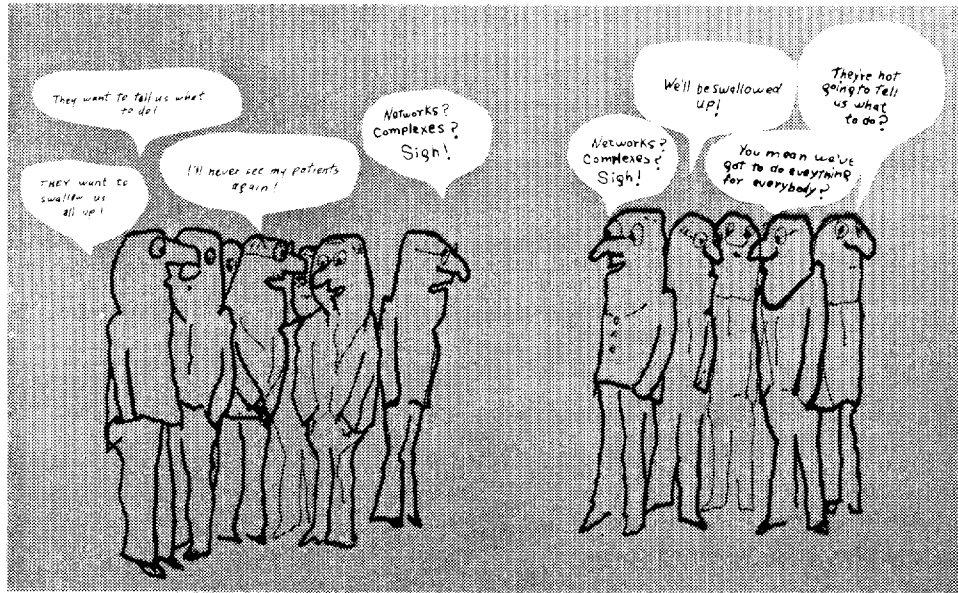


FIGURE 3

topic for discussion in the programs of a number of major medical professional organizations.

In December the Division of Regional Medical Programs was established and its National Advisory Council held its first meeting.

REGULATIONS, GUIDELINES, AND OUTLINES

The second phase of the program extended from February until April. Special groups of consultants with expertise in such relevant fields as continuing education, community health planning, and hospital administration were called together to advise the Division on the implementation of the program. Regulations were drafted and proposed. Preliminary guidelines for applications and the application forms themselves were developed and widely distributed. Another meeting of the National Advisory Council was held and a process for the review of applications was developed, consisting of a preliminary review by staff and by a group of *ad hoc* consultants prior to the review by the National Advisory

Council as required by the law. Members of the Council and the *ad hoc* consultants became increasingly articulate in interpreting and defining the program in speeches, in their own professional organizations, and in the development of individual regional plans.

RECEIPT AND REVIEW OF APPLICATIONS

The period from April through June constituted the third program phase. During this time, the emphasis changed from reassurance, definition, and preparation to the receipt of applications for planning grants and the review of those applications (Figure 4). No deadlines for the receipt of applications were publicized. Instead, it was the Division's stated intention to hold frequent review meetings so that applications could be considered without undue delay and without the development of a crash program. Therefore, the National Advisory Council met to consider applications in April, June, and August, preceded each time by a meeting of an *ad hoc* initial review

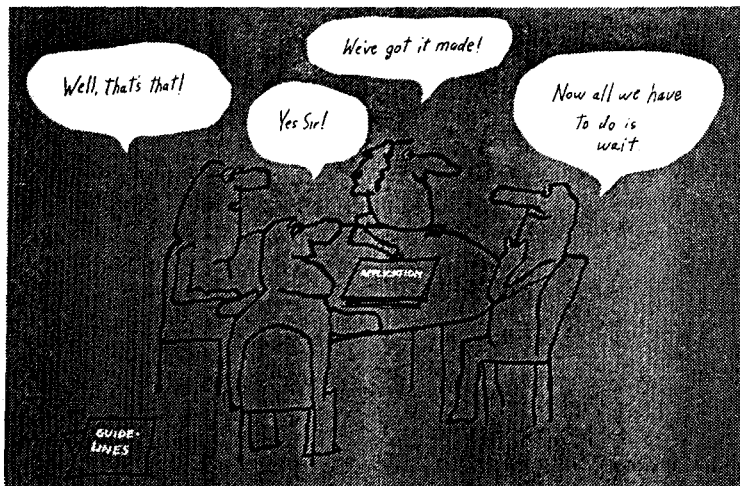


FIGURE 4

group representing a variety of backgrounds in health affairs. These groups were able to consider applications with varying approaches to the planning of a regional medical program and reach a consensus on the merits of the proposals in terms of the purposes of the law. During this phase, 39 planning-grant applications were received—overwhelming evidence of the willingness of regional groups throughout the country to accept responsibility for the development of a planning program.

In reviewing the first applications, the Division was able to identify certain areas of emphasis and problems, which were then reflected in the organization of the Division's staff and development of Division policies. Examples are the consideration given to continuing education as a major function of the Regional Medical Programs and the proposed large-scale use of systems analysis techniques in the planning of specific regional medical programs. As a result, the guidelines document (7) issued by the Division on July 1 was based not only on the intent of the Congress and the judgment of the National Advisory Council and other advisors but also on experience

in the actual review of planning-grant applications.

NEGOTIATIONS AND ANTICIPATION

During the final phase of the first year of the program, lasting from June until October, concern was with (a) continued review of applications for planning grants; (b) a rapid buildup of activities in continuing education; (c) preparation for the required Report to Congress in June, 1967; and (d) anticipation of applications for operational grants.

In considering the applications, the review groups found that a straight "yes" or "no" answer was seldom sufficient to communicate the intent of their actions. Therefore, the National Advisory Council requested that the Division staff discuss with each applicant the action that was taken and the reasons for that action. It was felt that this interchange and discussion between the applicant group and the staff of the Division would contribute to a better understanding on both sides of the nature of the proposal. On many applications the National Advisory Council required that additional information be obtained from the applicant before the application could be

recommended for approval and a grant awarded. When the additional information requested would not affect the basic soundness of the proposal, the Council recommended approval, conditional upon receipt by the Division of clarifying information. If the information to be provided was more substantial, the Council deferred action on the application until it could consider the additional information supplied by the applicant. On other applications the Council did not feel that it could recommend approval of the application until substantial revisions had been made in the proposal. In recommending revisions, the Council emphasized the fact that it expected to see the revised application at its next review meeting and that in negotiating these revisions, the staff of the Division would not require that applications conform to a standard pattern. The Council wanted these applications to retain their unique characteristics; but it felt a strong sense of responsibility that the award of federal grant funds could only be recommended after satisfactory evidence had been presented that the proposal, whatever its proposed approach, could reasonably be expected to result in a plan for a regional medical program that accomplished the objectives of the legislation.

This phase of the program saw the appointment of a blue ribbon *ad hoc* committee, which has now had 2 meetings to focus on the Surgeon General's Report to the President and Congress, due June 30, 1967. Also during this phase, initial plans were made for a national meeting to be held January 16-17, 1967 in response to a number of requests for such a meeting and also because of the need to get grass-roots opinion for the Report to Congress.

At this time, a change in the types of questions which medical groups asked staff representatives became apparent, primarily because increasingly large proportions of audiences had actively partici-

pated in the development of applications. Actually, many have now given in their regions the same type of talks staff members were giving a few short months ago.

PLANNING-GRANT APPLICATIONS

One of the most productive sources of information at this relatively early stage of the program has been the grant applications themselves. They provide preliminary insights into the types of activities to be carried out on behalf of the Regional Medical Programs as well as a rough gauge of the extent to which "regional cooperative arrangements" among medical schools, research institutions, hospitals, and other health agencies and institutions have developed to date.

Forty-three applications have been recommended for approval or are currently under consideration. They cover regions which contain about 80 per cent of the nation's population. Certain of the major metropolitan centers account for most of the remainder of the population. As might have been expected, multi-medical-center urban areas have had particularly difficult problems in developing the cooperative arrangements essential to the Regional Medical Programs. However, pending applications and discussions with groups in New York, Philadelphia, Chicago, and Boston, for instance, have led to the conviction that effective ways will be found of bringing together the many health interests that exist in these urban areas.

The applications which have been received indicate that the initial planning of the Regional Medical Programs will generally include 4 major types of activities: (a) organization and staffing; (b) studies to collect and analyze data on resources, problems, and needs; (c) development of ways to strengthen communications and relationships among the health institutions and agencies of the region;

and (d) preparation of proposals for operational projects.

The approaches to the organization and staffing of the programs vary widely.

In a majority of cases (26), the formal applicant—the institution acting as the “programming headquarters” or “agent” for the region—has been a medical school; this situation is particularly likely when there is only one medical school in the region and that institution is part of a state university system. There have been 4 applications from medical societies, 2 from existing private nonprofit agencies, and one from a state agency. In 10 of the 43 regions new corporations have been established to be the applicant. It has been suggested that these new organizations may be of considerable significance for the development of more effective cooperation among major health resources.

In addition to the applicants themselves, well over 400 other cooperating agencies or institutions are represented in the applications, with hospitals, both affiliated and nonaffiliated, constituting the largest group. Among the other key participants are medical societies and state or municipal health agencies.

It is clear from the applications that utilization of existing health personnel is planned; experienced senior health administrators and educators are being sought and found to fill major positions. It is also evident that many of the grantees will be looking to other disciplines and to other university faculties for assistance. For example, there have been a number of proposals for the participation of such individuals as sociologists, economists, and communication specialists. In addition, applicants will seek advice and assistance in areas such as computer technology and operations research on a contractual basis, either from universities or from private firms.

The surveys which are most commonly mentioned in the applications are concerned with the collection of data on

health manpower, facilities, and specialized capabilities. Most of the applications include proposed studies of the distribution of and needs for medical and nursing manpower. They also give high priority to problems associated with the shortages of laboratory and other allied health personnel.

Most of the applications include plans for continuing education activities for allied health personnel as well as for physicians, dentists, and nurses.

The strengthening of communications and relationships among the existing and potential participants in the Regional Medical Programs through a variety of devices is planned.

In view of the critical importance of cooperative arrangements in the programs, the following delineation of the membership of the regional advisory groups may provide an initial measure of how effective the programs are likely to be in engendering these arrangements:

1. Practicing physicians and medical center officials *each* make up about 20 per cent of these advisory groups.

2. Hospital administrators, representatives of the voluntary health agencies, other health professionals, and public health officials *each* account for about 13 per cent of the total.

3. “Public” members, including lawyers, industrialists, labor leaders, and housewives, account for the remaining 8 per cent.

4. The state governors have been involved, in one way or another, in about one-half of the cases.

5. The state health officer or a member of the state board of health from the staff of related health departments is a member of the regional advisory group in almost every case.

6. Staff members of area-wide hospital planning agencies are members of about one-half of the groups. In all other cases a representative of the appropriate hospital association is named.

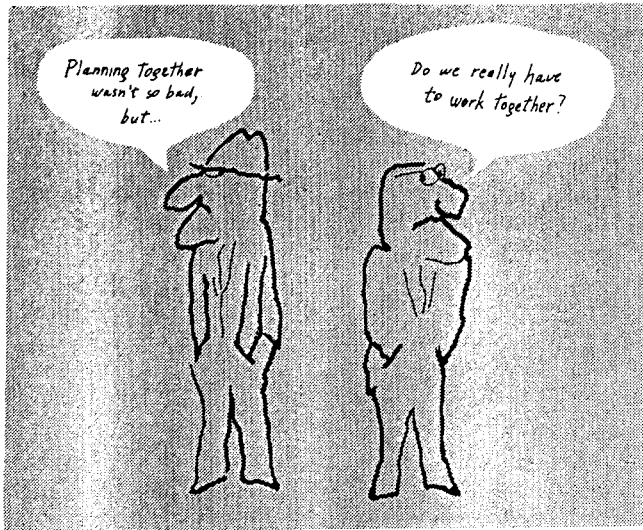


FIGURE 5

7. The groups have representation from heart associations and cancer societies.

OPERATIONAL GRANTS

The purpose of the planning grants is to develop operational programs (Figure 5). While continued planning is a crucial part of the programs, it is anticipated that only a few new planning grants will be submitted and that increasingly the focus will be on the need for supplemental support for planning and for the initiation of operational components. A number of applications for operational grants have been submitted or are in preparation.

The Division has been deeply involved in the development and clarification of the review and approval processes which will be required for these applications. As a result of this study, it has become apparent that this process must establish 3 new types of relationships:

1. There must be a continuing and specific relationship between the Division staff, the review committee (now appointed on a permanent basis), the National Advisory Council, and the grantees. The frequent meetings of both the review committees and the National Advisory Council as well as the extensive staff

negotiations with applicants represent beginnings in the development of these relationships. The creation of a branch for consultation and assistance under the direction of Dr. Margaret Sloan resulted from a recognition of this need. Further, applicants are being advised to make free use of supplemental applications so that their programs can more easily be developed by incremental steps.

2. It is necessary to develop flexible but specific involvement of other federal and nonfederal sources of support, including their review and approval processes. It is recognized that just as the program calls for an integrating and synthesizing activity on the regional level, the Division has a synthesizing and integrating responsibility to the grantees. In some instances it is clear that specific procedures must await the opportunity to work with concrete examples.

3. The review and approval process developed on the national level must be related to the review and approval mechanisms which exist in the various regions. Basic to the goal of establishing the decision-making mechanisms on the local level is the assumption that different priorities exist in different parts of

the country. However, neither the National Advisory Council nor the Public Health Service can delegate its fundamental responsibility and accountability for the wise expenditure of federal funds.

The mechanisms of the review process can be simply described. The regular process will be a familiar one: grants will be received and reviewed by the initial review committee; additional information will be gained by site visits, which in many instances will be conducted by members of both the committee and the Council; and then there will be a recommendation by the Council and the final action involving administrative decisions by the Public Health Service. In addition to this regular process the staff will custom-tailor the review process to meet the particular needs of individual grants. In many instances this will mean obtaining additional information on scientific merit or other aspects from the existing expertise in other institutes or bureaus of the Public Health Service or other agencies in the government to insure that acceptable standards are maintained; and it will also involve exploring the potentialities for support.

The development of a decision-making process in each region is a prerogative of that region, and much time and effort have already been devoted to this area by the Division and by applicants throughout the nation. Some factors relevant to evolving effective processes seem to be either easily identifiable or particularly pertinent: (a) The initiation of the first steps in the operational program along with continued planning should represent movements toward the fuller development of the regional program. (b) On the one hand there will be a need to determine the appropriate balance between dependence on retrospective data, opinions, and the experiences of others, and on the other hand there will be the need to initiate activities which will themselves provide the basis for future decisions. The

law anticipates the use of research and experiments, and the initiation of activities which, when evaluated, can be modified as indicated. (c) Criteria for specific projects must be developed. The scope and flexibility of this legislation is such that there is no difficulty in listing great numbers of meritorious and needed projects which could be supported. Suggested criteria for setting priorities are as follows:

1. The degree to which the project would assist in the wise utilization of manpower. As one applicant noted, the regional group is not interested in tying up resources with fine projects for which the necessary manpower is not readily available.

2. The degree to which proposed projects involve multiple institutions and types of institutions and, therefore, would lead to more effective development of cooperative arrangements, particularly in the initial steps.

3. The degree to which the proposed project relates science to service.

4. The degree to which the project will contribute to continuing education and training for physicians and other health personnel.

5. The degree to which latent talent or unique regional resources might be utilized more effectively.

6. The degree to which the proposed project represents a critical area which, if supported, will beneficially affect a larger program. A regional medical program offers the opportunity to bridge gaps and to support new and innovative approaches which of themselves may be only a small portion of much more extensive activities.

Finally, of course, the fact that this is a broadly categorical program in the area of heart disease, cancer, and stroke must be taken into consideration.

The Division has been convinced that as the programs proceed into the operational phase, grantees will be well ad-

vised to select those activities which they can see clearly, rather than depending on the development of some master plan in vague and unexplored areas. Therefore, it is anticipated that many will choose those initial steps which will contribute to further refinement of the basic decision-making processes which they have established.

As those who are involved in the program move along this not uncomplicated path, it is worth remembering the way a dean once described the problem of the vice president for health affairs in bringing together groups with nonidentical goals. After speaking to the value of such activities, he raised a word of caution in the following way:

What do they do? In short they try to hitch mules and cows to the same plow and then drive the rig. What do they try to do? They try to assemble the team, work together, combine assets, etc. To continue to enlarge upon our metaphor of hitching two thousand-pound beasts together without recognizing that the objective of one is to pull and the other to be milked could end with one going unmilked and the other sitting down. Both have highly and equally commendable objectives, but working together as a team neutralizes the effectiveness of each.

The goal of the Regional Medical Programs, like that of the vice president for health affairs, is to make the activities of its members more effective in their pursuit of their own goals.

CONCLUSION

The success of the Regional Medical Programs requires that medical schools as well as all other participants share authority as well as responsibility. Gardner (8) made the following statement in his monograph, *Self-renewal: The Individual and the Innovative Society*:

Every great creative performance since the initial one has been in some measure a bringing of order out of chaos. It brings about a new relatedness, connects things

that did not previously seem connected, sketches a more embracing framework, moves toward larger, more inclusive understanding.

The beneficial changes which have been effected by the program twenty years from now will depend upon the extent to which it has stimulated creative performances which have contributed to constant improvement in the quality of medical service in the nation.

REFERENCES

1. BOLT, R. *A Man for All Seasons*. London: Heinemann, 1961.
2. COGGESHALL, L. T. *Planning for Medical Progress Through Education*. Evanston, Illinois: Association of American Medical Colleges, April, 1965.
3. DRYER, B. V. Lifetime Learning for Physicians: Principles, Practices and Proposals. *J. Med. Educ.*, 37: June, Part 2, 1962.
4. SHEPS, C. G., WOLF, G. A., JR., and JACOBSEN, C. (Eds.). "Medical Education and Medical Care: Interactions and Prospects." Report of the Eighth Teaching Institute of the Association of American Medical Colleges. *J. Med. Educ.*, 36: December, Part 2, 1961.
5. WOLF, G. W., JR., and DARLEY, W. "Medical Education and Practice: Relationships and Responsibilities in a Changing Society." Report of the Tenth Teaching Institute of the Association of American Medical Colleges. *J. Med. Educ.*, 40: January, Part 2, 1965.
6. President's Commission on Heart Disease, Cancer and Stroke. Report to the President. *A National Program to Conquer Heart Disease, Cancer and Stroke*. (Volume I.) Washington, D.C.: U.S. Government Printing Office, 1964.
7. *Guidelines—Regional Medical Programs*. U.S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, Division of Regional Medical Programs, July, 1966.
8. GARDNER, J. W. *Self-Renewal: The Individual and the Innovative Society*. New York: Harper & Row, 1965, P. 39.