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REPORT FROM THE DIVISION*

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The office I now hold, Director of the Division of Regional Medical Programs, is one to which Dr. Robert Marston lent such great distinction as he guided the Division through its first formative years. Under his leadership, Regional Medical Programs received wide acceptance, and a functioning Program was launched in a remarkably short time. We in the Division of Regional Medical Programs, and you who carry major responsibility for the 54 programs now covering the country, are faced with the difficult task of managing an ever-increasing load of responsibility. We must guard, as Dr. Marston has done, against the emergence of bureaucratic rigidity We must continue to foster, instead, the spirit of innovation and creativity.

Most Regional Medical Programs were faced with the difficulty, at the outset, of judging how best to approach the complex task of achieving voluntary, functional, regionalization. The Division of Regional Medical Programs and its National Advisory Council wisely resisted the temptation to establish a model which could be adopted by those Regions for their planning. The all-too-easy solutions offered by experts in systems analysis organizations were also rejected. Instead, leaders in each of the developing Regions began to cope with the unique relationships peculiar to their own area. Initial planning efforts were directed toward the creation of a climate of cooperation within which regionalization among traditionally independent, autonomous elements of our pluralistic health care system could proceed.

I am no more inclined to prescribe a national pattern or model for the Programs than those who have guided it so well in its beginning years. It is possible now, however, to describe some of the locally derived features that characterize those Programs which are meeting with success in achieving regional objectives. This is information which I believe will prove useful to all Regions, and will assist them to formulate better solutions to their own problems.

I should like to describe the elements that characterize successful Regions:

Success in this, as in every large-scale, practical endeavor, has been unequal and progress has been uneven. And while it is true that no single Region has as yet achieved full regionalization, some are clearly more advanced than others. The success of the more advanced Regions can, I believe, be attributed largely to several significant, common characteristics, specifically, leadership by the program coordinator, organized commitment of the health power structure, sound program concept and design, effective implementation of program, and evaluation of progress.

The first of these critically important attributes is strong, dynamic leadership. Progress in regionalization frequently comes through the leadership of a single individual, the Program Coordinator. This is not to say that leadership must be "singular." Clearly, a larger leadership element than that of the Program Coordinator or of any other single individual is required; but the ability of the Coordinator to mobilize the larger leadership within the Region is often determinative of its success. He exercises personal leadership to secure organized institutional

commitment, as well as individual support, for Regional Medical Programs, support which is essential if the Program is to wield the influence required to bring about significant change. I should like to comment on some of the observed actions of effective Coordinators.

Coordinators secure the confidence of leaders in the medical centers in their Regions, or practicing physicians and hospital administrators, and gain their understanding and support. They establish contacts with key health leaders of the Region to evoke from them a working commitment for Regional Medical Programs. They acquire information of the health characteristics of the Region, its resources, its problems, its politics and its style of getting things accomplished.

The successful Coordinator exhibits his leadership by attracting a competent and respected staff. He develops an organizational framework to perform the functions of administrative planning, implementation and evaluation. His core staff is diversified and includes physicians, nurses, hospital administrators, education and public information specialists, allied health personnel, experts in behavioral sciences, and others. Such professional diversity among the staff contributes to a rounded and balanced program. The Coordinator typically is full time. Undertakings of the magnitude of Regional Medical Programs do not flourish under part-time leadership.

A number of universities and medical centers have assisted in the recruitment of able Program Coordinators (and of other key staff members)

by offering academic and staff appointments. Such appointments facilitate access to the academic and clinical resources of the medical center and to the faculty.

Those institutions which have sponsored Regional Medical Programs are not likely to find individuals with all the capabilities described above. They can, however, select with care individuals who have administrative ability and have had experience in dealing with health care problems both in the medical center and in the community. Having appointed the Coordinator, they have a responsibility for maintaining a continuing relationship with him. He will welcome all the guidance and support he can obtain as he negotiates for the involvement and commitment of the groups described above.

The Division of Regional Medical Programs, too, has a responsibility in this regard. The staff of the Division has discussed ways in which it can provide relevant information to Coordinators as they and their staffs and their Regional Advisory Groups address the task of securing funds through the grant application route.

We are prepared to structure a series of three to four-day seminars in Bethesda for groups of Coordinators to discuss in depth with them the organization of the Division of Regional Medical Programs, its administration, its resources, and its grants review and management procedures. We hope also to use this seminar as a medium through which Coordinators may supplement their knowledge of Regional Medical Program activities throughout the country. This undertaking, which will necessarily be

experimental at the outset, will be carried on under the guidance of Dr. Richard Manegold and his staff, and we shall be prepared to initiate the first of these seminars as soon as we have requests for participation from a group of six to ten Coordinators.

Beyond that we are making plans now to experiment with a "war games" approach to teaching the techniques of long-range planning. Dr. George Miller and his staff at the University of Illinois College of Medicine have agreed to put on a program of this kind as a substitute for one of the irregularly scheduled sessions on medical education, probably in June 1969. We shall make announcement of the course as soon as the details of the program can be formulated and distributed. In the discussion sessions that will be held during this Conference we should welcome any comments or suggestions you may have about either of the above proposals.

Organized Committment of the Health Power Structure: The successful Coordinator recognizes the critical elements in the health power structure and the order of priority in which they must be brought together, actively involved, and committed. The key groups with which he deals include the following:

Medical Centers and Medical Schools - These have provided much of the initial Program impetus. A close relationship between them and the Program must continue because medical centers constitute a reservoir of professional expertise and competence that must be drawn upon for the transmission of new knowledge and techniques. They have considerable potential for serving as a "change agent" and they are a highly specialized resource

for obtaining quality health care. This is not to say that medical schools can or should control the Program. To the contrary, continued exercise of control by this or by any single institution or group will impede and retard the involvement and commitment of other key groups. But without medical center involvement and commitment, there is little chance that the Regional Medical Program can succeed.

Another important group includes practicing physicians - and by extension, State medical societies and their component organizations. It is essential that practitioners be involved in Regional Medical Programs. Not only are they the first point of contact with the health care system, but many significant improvements in the quality of care and in the health status of a population can be achieved only through their direct efforts. But simply "involving" individual physicians is not enough. Organized medicine -- State medical societies and their component organizations -- must participate in the Regional Medical Program decision-making process. In terms of the health power structure, organized medicine represents the collective voice of physicians. We have seen instances where failure to involve these groups in decision-making has created obstacles to program advancement.

A third and equally important group includes hospitals. They represent the major institutional focus for health care in this country. Diagnosis and treatment are increasingly hospital-oriented and hospital-based. Moreover, the hospital represents an important interface with the community

which surrounds it and represents both the providers and consumers of health care. The involvement and commitment of the hospitals, therefore, must be broadly structured to include the administration, medical staff, and trustees.

Fourth, Official and Voluntary Health Agencies - It may be easy to overlook these groups or to wait for them to ask for participation and then to expect from them only a nominal contribution. Such a policy is short-sighted and self-defeating.

- State and local public health agencies play a significant role in the provision of health care. No Region can afford to ignore or proceed without the understanding and backing of city and State health officers, many of whom have the ear of a Governor or a Mayor. Moreover, the statewide and areawide comprehensive health planning agencies, which will play an increasingly important complementary role in structuring the health care system, are by law related to State and local governments -- often through their health departments.
- Voluntary Health Agencies such as heart associations and cancer societies have a real contribution to make. They have built up a community organization which can be a source of education, support, and leverage within the community. This apparatus can be made available to Regional Medical Programs to sponsor training and to assist in other operational projects.

The Regional Advisory Group is the voice of the health power structure. Public Law 89-239 established it as an essential component of a Regional Medical Program and defined its responsibility in the same broad charter-like terms that characterize the other components of Regional Medical Programs. The Guidelines issued by the Division of Regional Medical Programs described the responsibilities of the Regional Advisory Groups in more precise terms. In this discussion of the elements that characterize the more successful Programs, I should like to describe how Regional Advisory Groups are relating to sponsoring organizations and to comment on the specific functions they perform. Some Regional Medical Program sponsors look upon the Regional Advisory Group as a body which the law requires be established but whose function is a nominal one, that of approving operational grant proposals. It may be looked upon as a force which threatens the role of the sponsoring organization. Not infrequently the chairmanship of the Regional Advisory Group is retained by the chief executive officer of the sponsoring organization as a means of controlling this aspect of the Program. The fear may exist (although evidence to support this fear has been notably lacking) that Regional Advisory Groups may exceed the policy-making functions assigned them in the law and in the Guidelines and seek administrative control of the Program. We are pleased to note that many sponsoring organizations clearly recognize that the Regional Advisory Group must become the dominant organization expressing policy on behalf of all cooperating health interests in the Region. One such institution -- the University of Washington -- has identified its role as that of administrative trusteeship, which means that it will exercise the obligations imposed upon it with respect to administrative policies, while at the same time encouraging the

Regional Advisory Group to assume an ever more significant role in guiding and directing the policies to be followed as the Regional Medical Program develops.

It clearly takes time for a Regional Advisory Group to become organizationally mature, to come to grips with important policy problems, and to begin resolving them wisely. Where Regional Advisory Groups are functioning actively, one finds that they have a membership that comprises the leadership of the major health interests and power groups of the Region (i.e. medical centers, practicing physicians, organized medicine, community hospitals, and other groups). Not only are they geographically representative, but they include strong public representatives who have significant regional influence and social and economic "clout". Where they are exercising a real trusteeship, the groups have a significant and substantive voice in setting policy. They determine the overall scope, nature and direction of the Regional Medical Program and establish priorities. They provide a forum for the forces of change as well as for the traditional health power structure.

It is too early to determine whether those Regional Advisory Groups, which are functioning under the chairmanship of the chief executive officer of the sponsoring organization, will in fact become a representative voice of the many elements of the health power structure in the Region. This arrangement at least has the saving grace that its actions are closely coordinated with those of the sponsoring organization.

those who provide care. Categorically oriented, it has a strong technological bent -- the latest advances in heart disease, cancer, and stroke and related diseases, but it is concerned with linking as well as strengthening health resources, a linkage which is the essence of regionalization. A Regional Medical Program requires a wholeness of program that cannot be achieved by an aggregation of loosely related projects; it fosters innovation and change -- not in the relationships between physician and patient, but in the relationships among providers of health service.

Thus, Regional Medical Programs emerges on the American health scene as a voluntary mechanism that depends upon the organizational behavior of health-related institutions -- a "coalition politics" of health, if you will. This is as much a part and parcel of Regional Medical Programs as is the substance of the information related to the latest advances in heart disease, cancer, and stroke.

Against this background which represents the broad national policy establishing Regional Medical Programs, let us look at some of the specific patterns we see emerging.

Many Regions are in the process of developing a "grand design" that will permit them to proceed with specific projects, each of which will fit into the larger pattern. This process is not unlike the one we are using to create the Interstate Highway System for our country.

Initially, some Regions have placed greater emphasis on action, others on planning for action, but the following tactics have been fairly common to all Regions:

> Their planning may best be described as "consensus" planning, that is, once leadership has emerged and organizational involvement has begun, certain immediate needs and problems were so obvious that they could readily be agreed upon. Similarly, there were available certain kinds of ready solutions, such as coronary care units and continuing education programs, which also could be agreed upon as mechanisms for initiating operational activities.

The more advanced and successful Regions have moved from the initial consensus planning to the establishment of long-range planning. This has been expressed by the creation of categorical and other task forces, of special committees at the regional level, at the subregional or community level or even local action groups within the community. The achievement of this kind of layered planning contributes to better understanding at all levels and provides a mechanism for achieving widespread involvement and commitment. Properly done, it requires a great deal of organization and supervision from the core staff. As these planning groups address themselves to specific problems of diagnosis and treatment for heart disease, cancer, stroke, and related diseases, the need for an adequate data base becomes ever more apparent. The data available is often fragmentary or lacking

and Regions are then faced with the decision as to whether they should begin to collect the data they need. It is well recognized that we have as yet no adequate national system to collect the data required for effective management of health care. Scattered and sporadic efforts to collect data will not solve the national problem; not only is the information derived from diverse sources not comparable, but data which is not continuously updated prevents its most effective use -- to tell us how well we are succeeding. Without such a mechanism, the cross-sectional data obtained by local groups have only limited value. Scanty as it is, however, such data as is available must be used by planning groups to make appropriate analyses and to derive as much benefit as possible from it. Regions are reluctant, and properly so, to set up elaborate data collecting mechanisms. We continue to look for the early development of this critically important national health tool.

Regions developing their strategic plan may begin with a realistic assessment of the elements peculiar to the Region, including such things as resources, gap areas, regional ecology and traditional attitudes within the Region. We see emerging in certain complex multi-medical center Regions, a geographic or functional division of responsibility with specific areas assigned to each medical center. Division of geography tends to delineate responsibility more clearly; it permits those areas, which for a variety of reasons may be able to move ahead more quickly, to do so -- the pace of all is not determined by that of the slowest element. It is too early to tell whether such division within the Region will, in the long run, advance the program.

Common to all Regions is the phenomenon of subregionalization. In the more successful Regions one sees this in terms of a subregional effort and identity based on referral patterns corresponding roughly to what might be termed "health market areas."

In sum, we see that Regions are:

- Making cooperative arrangements the guiding principles for action.
- Encouraging and even suggesting projects and proposals that fit that strategy.
- Promoting efficiency in terms of regional health manpower and other resources.
- Fostering interagency relationships and communication.
- Striving for adequate program balance.

Two examples: We can cite one Region which has adopted as its strategy the establishment of a series of hospital-based centers of excellence for heart disease and for cancer throughout its Region. It hopes subsequently to add facilities for excellence in stroke also.

In another Region the strategy has been described as a series of related thrusts. The first of these thrusts concerns approaches to improving the effectiveness and efficiency of patient care at the local level. The second concerns the development of working partnerships between key hospitals and one of the university medical centers leading to the creation of a "third faculty." The joint appointment of full-time chiefs of service in selected hospitals would be made by agreement between

the hospitals and the medical center. A third thrust is concerned with smaller hospitals which often cannot support the implementation of many of the recent advances in diagnosis and therapy. A proposal has been made to develop selected services on a centralized basis, and alternately to strengthen other specialized services on a decentralized basis.

Effective Implementation of Program - Given leadership, the involvement and commitment of key health groups (including the effective functioning of the Regional Advisory Group), and a carefully thought out regional strategy or design, there remains the problem of formulating operational activities for implementation of the Program. It is in the implementation or action phase where the impact of Regional Medical Programs may best be seen.

The more adequate the implementation, the greater its impact will be in terms of overall Program visibility. Properly achieved, this visibility will encourage local identification with the Program on the part of the medical centers, the hospitals and the physicians in the Region.

Decisions as to what kinds of operational activities to undertake have, in the main, been governed (consciously or unconsciously) by a short-range strategy aimed at demonstrating success and achieving visibility. These general tactics have characterized even the most successful Regions. On the other hand, just as initial consensus planning must be superseded by long-range planning, so the initial tactics and "off the shelf" solutions must be superseded by the development of long-range projects.

The initial operational projects not only provide evidence of regional strategy, but reflect regional cooperative arrangements. They are not just isolated projects aimed simply at expanding and advancing the diagnostic capabilities of individual institutions, physicians, and other health resources. But they illustrate realistically how cooperative arrangements among medical centers, hospitals, and physicians can be implemented.

One sees, for example, as in Louisiana, four hospitals in the same community pooling their resources in cooperation with the State Heart Association and one of the medical centers to establish a single, high quality, coronary care demonstration and training unit. This unit is designed to improve the care of all patients with myocardial infarction in that area. Instances such as this provide the real test of regional cooperative arrangements. When individual institutions are, in effect, required to give something up, or to do things differently than they have in the past, one may judge whether these institutions are truly willing to move from a competitive approach in the solution of health problems to a cooperative one.

In the Washington-Alaska Region, we see the example of a high-energy radiation source planned for one of the Anchorage hospitals. No longer will patients in that vast subregion have to travel to Seattle or elsewhere for such treatment. Planned and approved by both local and Regional Advisory Groups, the radiation unit will be operated as a regional resource.

In a funded operational project of the Georgia Regional Medical Program, the faculty from two medical centers will travel to institutions participating in the development of hospital-based centers of excellence. Consultants will see patients with practicing physicians in those hospitals and will

utilize the consultation mechanism to promote the continuing education of both physicians and allied health professionals.

Similarly, one already sees in the early operational proposals of many successful Regions, an indication of concern for and attention to program balance. Needs in stroke and cancer are being addressed as well as those in heart disease, which appear to be more readily identified and dealt with. Areas of prevention and rehabilitation are not being ignored. There is functional balance among research, training, continuing education, and patient care demonstration activities.

Evaluation of Progress

We come finally in our consideration of the characteristics of successful Regions to the subject of evaluation.

Adequate data is, of course, essential to proper evaluation. As noted before, we are badly handicapped by the lack of data concerning the quality of care. We suffer especially from a lack of data concerning the ambulatory care of patients. We know next to nothing about quality of care provided in physicians' offices. We are plagued, too, in evaluating Regional Medical Programs because we are not entirely sure what our "product" is. It may, indeed, be true that in Regional Medical Programs, as some say about television, "the medium is the message."

If we are having difficulty in evaluating our efforts, we are surely not alone in this respect. Nor should we be prevented from moving forward simply because our evaluation techniques are not as clearly defined as we should like them to be. If one considers such as a venerable social institution as education, we find that it has served us well for centuries

even though many observers today believe it has a faulty evaluation system. Success in education has been judged by measuring the amount of retained knowledge. This way of measuring success has influenced teaching and learning techniques for a very long time. Those techniques are being changed as we begin to reach agreement that it is more important to judge the change in behavior of students than to measure the amount of knowledge that can be reproduced on an examination.

But the existence of difficulties and problems in no way minimizes the importance of evaluation for Regional Medical Programs. To the contrary, evaluation is critical to our effort and much more attention must be paid to it in the immediate years ahead.

In almost one-third of the Regions we find neither evaluation staff nor consultants in this field, and only one-half of the Regions have developed an organized approach to evaluation. Some have highly-developed efforts. For example, the North Carolina Regional Medical Program has a Division of Planning and Evaluation, headed by a prominent medical sociologist and a competent staff. It is making a major effort to incorporate evaluation as an integral part of the overall regional effort. The evaluation division of that Region works closely with the executive committee and the Regional Advisory Group and will seek to determine the progress of the Program in meeting its stated objectives. In making this analysis, the effectiveness of each project in changing the status of health care will be ascertained. In addition, it will be the function of the Region's Division of Planning and Evaluation to work closely with each project director to assure the inclusion of evaluation procedures.

A Look at the Future

Let us now turn from what we have been doing, and look to the future of Regional Medical Programs.

To begin with, we might look at the immediate future. Clearly, we are moving from a circumstance in which there has been a surplus of funds (at times an embarrassing surplus) to one in which the reverse will be the case. Based on applications in hand, we can predict that the aggregate demand for grant funds will exceed our appropriations in the fiscal years 1969 and 1970; and beyond that, the amounts which the Review Committee and the National Advisory Council will likely recommend for approval will also exceed the available funds.

This matter was discussed in depth by the National Advisory Council at its meeting in August of this year. The Council has indicated it will continue to judge programs and operational grant applications on the basis of quality. They have rejected the principle of a distributive mode for the allocation of funds based on population or geography. Inevitably, this policy will lead to a backlog of approved but unfunded applications. I know of no better way to bring to the attention of the members of the Congress the requirements for adequate funding, than to present such a record. This is particularly necessary because in the past the Congress has expressed impatience with the slowness with which the Programs have developed, and with the disparity between the amounts of funds authorized and appropriated and the amounts actually spent.

These policies recommended by the National Advisory Council bear directly on the application and approval process at both the national and regional levels. It does not appear possible to provide applicants with an appropriate review within a three-month period. A review of multimillion dollar grant applications requires critical analysis by our own staff, a site visit by a team of consultants and staff members, analysis of the project by the Review Committee and finally, consideration by the National Advisory Council. Applications which are well organized and lend themselves to orderly review will ordinarily be acted upon within four months after application deadline. In general, they will be acted upon in the order received.

Beginning with the next fiscal year, the number of annual review cycles will be reduced from four to three. The deadline dates for submitting applications, tentatively, will be August 1, December 1, and April 1; but you will be given definitive information on this matter.

We are attempting to define the appropriate input of each group to the review process. We shall expect the staff in its review not only to summarize the proposals but to express judgments which can be clearly identified as staff judgments. We are looking critically at the function of the site visit teams in order that the contribution of this important group may become more effective. You may expect that the procedures with respect to site visits will change as we attempt to identify the specific contribution this group can make. We are asking the Review Committee to make an objective scientific and technical evaluation of applications rather than to make value judgments. This latter function

is properly the responsibility of the National Advisory Council.

During the developmental phase of the Program, minimal standards were set by Council as a means of insuring quality and insuring also that every Region would be encouraged to begin the task of regionalization. As we enter a period in which funds exceed requests, Regions will be judged competitively.

We shall look to the Regions acting in their own self interest to improve the quality of their applications. Evidence that the applicant is moving in the direction of the longer range goals and objectives which it has set for itself in its strategic design will have great weight. Individual project proposals will be reviewed to determine how they relate to the Region's own grand design. Review groups will look for the relationship of individual projects not only to the overall Program concept but to each other. They will expect clear descriptions of what is intended to be accomplished, set forth in specific and, where possible, quantifiable terms, to insure that evaluation of progress and success will be undertaken. (In a program such as this with its emphasis on innovation, both sociological and technological, we must expect some projects to fall short of expectation. What is not tolerable is failure to distinguish between effective endeavors and those that lack effectiveness in improving care. We must learn to make such distinctions and to alter or abandon projects based on these judgments.)

We shall look for evidence that the application has been given a discriminating and qualitative review at the regional level so that only those projects are sent forward which (1) have merit, (2) are capable of

implementation, and (3) are clearly related to the Region's own strategy for regionalization.

We shall look for better information about the role of the Regional Advisory Groups, not only with respect to how they review and evaluate specific proposals but how well they function in setting the overall direction and scope of the total program.

The degree to which many applications have failed to reflect accurately the actual degree of development achieved within Regions is perhaps best indicated by the experience of site visit teams. Their reports have frequently materially altered or reversed the preliminary impressions obtained from the written applications by staff, Review Committee members, and Council.

Other Issues

I should like now to comment on two major issues relating to Regional Medical Program objectives that have been interpreted as imposing divergent pressures on the regions. They are the problems of the cities and continuing education.

The first issue relates to the matter of how Regional Medical Programs may serve an effective function in improving the care received by the large population groups in our cities and especially that received by our poor and disadvantaged groups living in the ghettos. The complex problems our cities present, pose a national crisis of the gravest order. The health of the poor who live in the cities is of deep concern to Regional Medical Programs. True, we suffer from several constraints

as we attempt to deal with this problem. Facilities are needed, but we have no authority to use funds for construction of facilities. Neither may grant funds be used to pay for the cost of medical services or the cost of hospitalization. Nevertheless, there are major contributions which Regional Medical Programs can make but which can be made only if we understand the nature and mechanisms to be employed in Regional Medical Programs, and understand also the nature of the problems faced by our cities in improving health care for the poor.

The long-established system for the health care of the indigent is now in the process of major change. Over the next seven to ten years more dollars can be expected to be placed at the disposal of the indigent to purchase their care. The process for doing so is only now being structured and we are in that unhappy period of transition when the old system is being allowed to deteriorate and new solutions have not yet become effective. The problem with us today is that many of the poor have neither an adequate indigent type of service nor funds to purchase their own care.

If there is any group which should be in the fore in creating a new system of health care for the urban poor, it is the providers of health care. Regional Medical Programs are functioning organizations specifically designed to link the providers of care together for the purpose of collectively improving services to patients. These Programs can and should contribute significantly in planning general health services for these populations because it is only in this fashion that we can come to grips

specifically with the problems of heart disease, cancer, and stroke. Regional Medical Programs can assist in the improvement of health service activities through projects that supplement elements of both old and new systems aimed specifically at the urban poor. To do this, Regional Medical Programs must enter into cooperative arrangements with the many local and Federal programs already addressing themselves to health problems of the urban poor. But regions must first be able to function as Regional Medical Programs. We recognize that the complexities involved in developing regionalization in urban areas have delayed the development of regions in the very areas where their services may be most needed. This is a matter to which I have already given a great deal of my time and to which I am prepared to devote more of my personal efforts.

The second issue is that of continuing education. From the beginning there has been some degree of controversy about the role and significance of continuing education in Regional Medical Programs. There were some who saw continuing education as the whole program. Others saw very little purpose to be served by supporting the kinds of ineffective continuing education programs which rely mainly on information transfer, which reach relatively small numbers of physicians and which appear not to change the behavior of physicians to any significant degree.

I am convinced that continuing education is the most significant single component of Regional Medical Program activity. What is at issue is not whether we should support and extend continuing education but what kind of continuing education we should encourage. Efforts of Regional

Medical Programs in this field must improve both the knowledge and skill of physicians, nurses, and other providers of health services. They must encompass a variety of innovative techniques which will involve them in an active rather than a passive role. These efforts should result in behavioral changes leading to improved diagnosis and treatment of the patients they serve. Further, our continuing education efforts and activities must be structured in a way that promotes the cooperative linkages upon which the ultimate success of Regional Medical Programs will depend.

Having identified these two issues which would seem to be polarized, as are so many national issues today, on the needs of the cities versus the needs of the rural areas, I should like to reject firmly the notion that we are unaware of the health needs of the rural poor or the importance of including them as beneficiaries of a system of voluntary functional regionalization. Equally, I should like to reject the notion that physicians in the urban areas are not in need of continuing education simply because of their proximity to the centers of learning. In our larger cities many physicians practice independently, without hospital appointments, and are subject to none of the influences which are of major benefit to all physicians who do conduct a substantial part of their practice in an organized hospital setting. We can ignore neither these physicians nor the patients they serve.

In the presentation I have just made,some of the factors leading to the establishment of successful Regional Medical Programs have been described. Special problems such as those encountered in the larger urban areas have also been identified. We have shared with you some of the management problems associated with a very large and complex grant program.

But we are wide of the mark if we regard Regional Medical Programs simply as another Federal program which uses grant funds to implement a specialized objective. The categorical restraints in P.L. 89-239 are clearly recognized. But equally recognizable are the legislative actions which have broadened the program to include additional related diseases and to use the Regional Medical Program mechanism for such activities as clinical trials.

The true significance of the Regional Medical Program effort can be understood only if we recognize that a test is being made, nationwide, to determine whether the quality of health services can be continuously improved by means of voluntary, functional regionalization. We are engaged in resolving an issue of critical significance to the future of the American health care system -- a system which in the aggregate involves the life and welfare of 200 million persons -- a system in which more than $50 Billion is invested annually.

The best estimates we have of the cost of a fully established regionalization program suggests that we may require $400 to $500 Million annually. If these figures are realistic we should be planning the

structuring of a system that will involve every element of the health care process. We are called upon to perform this task at a time when our country is beset with severe economic problems. We are faced with the necessity for establishing our national priorities at a time when there are many urgent problems to be solved, each of which requires large sums of money. Regional Medical Programs are under real pressure, therefore, to present evidence that this Program does indeed have the potential for improving the quality of health care that its advocates have held out.

Ours is a program that has its primary impact on the providers of care rather than on the public directly. We depend, therefore, on those professionally involved in health care to interpret the success of our efforts. They in turn must communicate their understandings of the value of the Program to the Public and to the Public's representatives in the Congress.

We are only now beginning to see the results of our efforts over the past two and one-half years. The limited evidence we have of the validity of the Regional Medical Program process must be used as feed-back into the system to guide our own further planning efforts. It must be used to inform the groups most directly interested in Regional Medical Programs about its effect on health care. It must also extend the base of cooperation upon which Regional Medical Programs ultimately will depend.