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CALIFORNIA COMMITTEE ON
REGIONAL MEDICAL PROGRAM
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Paul D. War
Executive Direct

April 3, 1970

Honorable Jacob K. Javits
United States Senate
Committee on Labor and
Public Welfare
Washington, D.C. 20510

Dear Senator Javits:

Thank you for your letter of March 3rd requesting my comments on S. 3443 entitled "Health Services Improvement Act of 1970." Since the hearing which was held on February 17th and 18th before the Senate Subcommittee on Health which had before it both S. 3443 and S. 3355, a considerable amount of discussion has taken place between the various Coordinators of the 55 Regional Medical Programs and other persons involved in the program in a part-time or voluntary capacity. The comments presented below represent, to the greatest degree possible, a consensus of opinions about certain important aspects of S. 3443. We have made every effort to make our comments in a constructive sense, and it is the intent of this letter to convey the problems with S. 3443 as seen from the point of view of an activist at the community level in the RMP programs.

Based on my experience in public programs over the past decade, I believe it is fair to state there has been a greater involvement of people on a voluntary basis in the Regional Medical Programs than in any other social program of recent vintage. The program thus far has enjoyed unusually strong support from the health related professions, the voluntary associations, the leadership of health facilities, and health-oriented members of the public. For a program of this magnitude and its unique objectives, relatively little adverse reaction has been generated. At this point in time, a strong public base from which to operate has been built in a majority of the regions, but it has been built upon the basis that certain specific objectives exist within the program. Any abrupt change in these objectives will tend to destroy the program's base, and therefor, its effectiveness.

The changes in the purposes of the program, as set forth in Section 900(A) of S. 3443, raises the first problem that we would like to discuss. Although the changes might seem slight, certainly the legislative intent and philosophy that would follow from this change could be major.

Generally, the thrust of the RMP program to date has been to improve the overall quality of care available to the public. The thrust for "improving the quality of care" appears to be changed in Section 900 to "the improved organization and delivery of health services." Section 900(B)(1) speaks of improving the quality of care; however, it combines with this the "distribution and efficiency" of health services. Those actively involved in the program cannot help but interpret the new approach in Section 900, especially when considered with other features of the bill, to represent a very substantial change in the direction of the program. And they further interpret this change in direction as one which may depress their interests in participating in the program.

A fact that seems self-evident at this point is that it would be most difficult, if not impossible, to take a program that is built to a large extent upon volunteers, and whose methods are based on voluntary cooperative arrangements, and then twist its main thrust from having the highly specialized professional help the less specialized health professional improve the quality of care to one where the main thrust is directed towards the re-organization of the delivery of health care. This is, in fact, what S. 3443 seems to be aiming at, even though it never states this specifically. Most of those presently involved will interpret this as a major change in direction. The majority will conclude that the program is no longer of interest to them and will see little reason to participate. If this occurs, four years of planning and development, and several millions of dollars, (to say nothing of the good will and cooperative spirit that has developed between the medical schools and the professions) will have been largely wasted.

We are <u>not</u> arguing that no need exists to re-organize the delivery of health care. What we are saying is that, although a man may be a good chess player, one cannot conclude that he necessarily would be an equally good quarterback. So far as RMP is concerned, S. 3443 represents a new ball game and, for the most part, a new set of players.

It also seems highly unlikely that the delivery of medical care will be re-organized to any great degree through the use of volunteers of any type, or through the use of voluntary cooperative arrangements, especially when the funds available are so out of proportion with the task to be accomplished. Re-organization, if it comes, will be brought about by manipulating the dollars which purchase care, by making it more profitable to provide care

in certain ways, by making it unprofitable to provide it in other ways, and by providing incentives for structural change. Our antiquated licensing laws have to be changed, since in many cases they preclude any substantial reorganization, and far greater resources will have to be devoted to both new and old levels of manpower development.

In this total picture there will always be a need to maintain a uniform level of quality from area to area, from facility to facility, and especially among the various levels of functioning manpower. Maintenance of quality in any system is as important as reorganizing a system to meet changing needs. RMP to date has developed as one of the major factors in upgrading and maintaining a more nearly equal quality of care for the public, regardless of where they might reside, and it is this aspect of the total problem that we feel S. 3443 de-emphasizes. The emphasis seems to be all on the means of "organization and delivery"--not on what is being delivered. Quantity without quality at any price is hardly worth the effort.

Furthermore, Section 900 of the Public Health Service Act currently is devoted to the purposes of RMP. In S. 3443 all of this language is amended out and substituted for it is most of the language in the "Purpose" Section 2.(a) of P.L. 89-749. (Those among us who are of a more suspicious nature suspect that an overzealous CHP partisan wielded a heavy and secret hand in the final, last moment drafting of the bill. Certainly the last changes before introduction reflect an unrealistic appraisal of RMP and most local situations.) Add to this the changing of the phrase "heart disease, cancer, stroke and related diseases" to "diseases and impairments of man" and it becomes virtually impossible to differentiate CHP purposes from RMP purposes.

Two seemingly separate programs with nearly identical purposes may have certain advantages, but this situation also presents several disadvantages. First, CHP and RMP had difficulties in relating to each other as community activities in the early months of program implementation. As time passed and experience was gained, sound working relationships were established where the programs were sufficiently mature. It became apparent that there should be a strong, coordinated relationship between RMP and CHP at the areawide B-agency level. These relationships have developed with a minimum of suspicion and hostility and in most cases are beginning to produce coordinated results. This is due primarily to the fact that those involved have developed a more precise understanding of the purposes and legislative

intent of the two programs. Now we find in S. 3443 the purposes of both programs hopelessly confused, since they seem more identical and less defined. We can only assume that the eventual intent is to merge the programs.

If merger of the two programs is the end being sought, complete merger at this time might be more desirable, since it would prevent the kind of tensions that will develop between those active at the community level in the programs over the next two years. With this kind of vague language, there is apt to be many struggles for position, consuming much of the energies and resources of both programs, and leaving the public totally confused in the process. Although the Secretary might be able to write regulations defining the roles of the two programs, the time and energies wasted, and the frictions created in the meantime, would be a pathetic waste unnecessarily perpetrated.

The most significant loss to the total effort, if merger based on CHP purposes is the end result, would be the medical schools and the highly specialized providers. The majority of the medical schools have never looked upon CHP and its purposes as relating directly to them. As the name implies, they view CHP as a "community-oriented" program. RMP, on the other hand, provides the bridge between the medical school and the community. RMP, and its original purposes, drew the schools and their teaching centers into the community; and in this sense, the two programs complemented each other in a very constructive way. Historically, the medical schools have never become deeply involved in a state-oriented health effort, as an A-agency relationship would require, and I cannot help but believe that an RMP type bridge is essential to their continued involvement.

The additional fact that RMP projects must be submitted to both the A-agency and B-agency "for review and comment" prior to their submission for funding places the RMP program in a vulnerable position. Since it is possible for 10 percent of the appropriation to be transferred from RMP to CHP, it is not unreasonable to assume that some A-agencies might give preference to CHP programs in order not to have 10 percent of their appropriation transferred from their funds to RMP funds, or, conversely, there might even be a tendency to delay proposals in order to have funds available from the other programs transferred to CHP. I am not suggesting that anyone would do this deliberately; however, subconsciously it would always be a factor that would create suspicions. It could not help but create serious tensions between the personnel of the two programs,

and any delay on the part of the A-agency would sooner or later be interpreted as a deliberate delay for the purposes of protecting their own economic position.

The fact that the Bill creates a single advisory council for all four programs represents another problem. From the point of view of sound public administration, it is an unbelievably bad way to construct any program. Any single council that tries to advise on four programs and work with four administrators of those programs is bound to be overly subscribed and, as a result, torn between the programs and the administrators concerned. Each administrator would have a tendency to lobby the council if important decisions are to be made between the programs in order to obtain equal treatment for his program. When competition of this kind develops between the administrators, there is a tendency to spend a far greater amount of time in lobbying the individual council members than in doing the constructive things necessary to administering the program. There certainly will be conflicts of interests involved, and it would seem that such a council would spend far more time arguing over the special interests involved than in giving worthwhile advice on conducting the programs.

The fact that the Bill provides for experiments in certain areas of the United States in the combining of the programs is perhaps the paramount indication of its actual intent. In addition to this, the only "new money" in the proposal is the $10 million that would be provided for these experiments. This could be described as incentive money, or it could be described as "bribery". In order to obtain any new monies, which incidentally would be earmarked for very specific purposes, the region would have to agree to something for which it might not be ready to accept and certainly might have to do things not in accordance with the original intent of the law; namely that the community or region should have some voice in its destiny.

Also, the project approval mechanism set forth in S. 3443 causes major concern. Those involved in RMP certainly have no objections to an advisory council which would assist the Secretary in developing a national health policy. Great concern is expressed, however, over the elimination of the National Advisory Council of RMP. This Council has consisted of imminent people in the health field with a great many different points of view. These views have been reflected in policy decisions and program leadership at the national level,

and the synthesis that has taken place has provided a high caliber atmosphere in which policy and program direction could be decided. To eliminate this group from overseeing and providing direction for the program would be a great loss. Although it does not state specifically in the Bill that the decision on the projects would be referred to the regional HEW offices, many believe that this is what is in store. Those active in the program cannot help but conclude that it would be difficult to obtain the same kind of input in the decisions on projects in this manner as has been obtained from the present council.

In all honesty, it must be stated that the vast majority of the coordinators and lay people with whom this has been discussed prefer the wording of S. 3355 (Yarborough).

To S. 3355, they would like to see added an extension of CHP as set forth in the present Rogers Bill (H.R. 15895). To this could be amended the language for extension of Health Services R&D as stated in S. 3443. Additional language then could be added expanding Health Statistics and relating it more directly to the CHP extension.

Certainly language indicating an emphasis upon "the improved organization and delivery of health services" would not be objected to if the present language in Section 900 relating to RMP was retained. We would prefer that the categories be broadened by using the wording in S. 3355, since this provides greater encouragement to voluntary associations for participation in the program and it limits the confusion with CHP.

The opinion on the insertion of the term "construction" is divided, but there is need for indication, if it is retained, that this does not apply to the creation of large centers and facilities.

We believe that the CHP relationship should be at the B-agency level and the function should be to coordinate the planning efforts of RMP, OEO, Childrens Bureau, Model Cities, and other local health planning efforts from the inception of the concept to the final planning efforts.

Most of those involved would prefer retention of the non-interference clause because it hasn't created that much of a problem, and they would prefer the inclusion of primary care as stated in S. 3355.

Most approve joint funding as stated in S. 3443, with some indication that the intent here is to permit the program with the most resources involved to be the overall manager.

Nothing in the above should be construed to indicate that those active in RMP do not endorse the continuation of CHP. In fact, we support the continuation of this program wholeheartedly. Our only hope is that the continuation of the two programs can be accomplished in a realistic manner.

We would be happy to discuss some of these points in further detail with you if you wish.

Sincerely,

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PDW:lms

cc: Roger O. Egeberg, M.D.
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