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FIRST CONFERENCE OF COORDINATORS
OF REGIONAL MEDICAL PROGRAMS

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PAPERS, PRESENTATIONS AND DISCUSSION
BY SPEAKERS AND PARTICIPANTS

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THE MEDICAL CENTERS

Delivered By:

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I would like to talk to you briefly about my view of Regional Medical Programs and their possible effects on university medical centers, but before I do that I would like to describe today's university medical center.

Although the university medical center's primary function for a long period of time has been education, we find a number of peculiar things. For example, the teaching hospital operations are dependent primarily on patient fees and our clinical faculty is largely supported by patient fees. Often the number of beds in university medical centers is based on the need for the physician on the staff to earn income rather than the actual educational needs of the students. In addition there has been pressure applied to university medical centers to get into allied health professional education. Although they have been in nursing a long time, they now are being called upon to get involved in many other areas. The pressure that is brought on medical centers comes from a variety of sources, such as legislative groups, private groups involved in the health fields, and the recruitment needs of the medical center itself.

There is a great deal of pressure from accrediting organizations to upgrade quality of programs in the allied health professional fields which in itself is not a bad thing. None of these pressures are accompanied by the money to make these quality educational programs.

We have been able to develop young faculty through the support of NIH and other Federal agencies. We now find that research money is leveling off and not increasing at the rate it has in the past. Anti-inflation measures have been adopted by the Federal Government which make it difficult to create space for these new people we have on our hands. The Congress has recognized some of these problems and recent enabling legislation has been passed which will permit us to improve our educational programs. But, none of this legislation has been completely funded as yet. From the nature of the educational programs in health areas, it will take some time before the recently passed legislation has any effect on the manpower situation which we all recognize is grave.

Finally, Medicare and Medicaid will probably uncover a number of people who have not in the past either sought or received medical attention. We have no way of predicting what this will mean to our service loads.

The important point I am trying to make is that on top of this critical situation in American medical and health education the Regional Medical Programs have been grafted. This is an additional kind of thing that we in some of the schools have been asked to take on. So your obvious question to me is "Why did Kansas apply for and receive and accept a grant?" which we have. I would respond by saying

that I think the impact or the thrust of the Regional Medical Programs will be good for medical education and hopefully for medical care in the community. The reasons I feel this are: The university medical center in most places has consistently in the past been ignorant of the problems of dealing with communities in a free democratic society. Yet we in the medical centers are unaware of the variations in medical practice which occur throughout the country. We are unaware of how health care is delivered in the variety of communities that exist in this broad and varied country. We are not aware of the effects of social and racial problems and different systems of practice on the distribution of medical care. We are unaware of the demands versus the needs of the various communities. We have not been concerned with the distribution or the availability or indeed the quality of medical care as it exists in the community. Many of our people in medical schools feel that if they do a good educational job and then push the student out the front door, they have done as much as they can do. There is a serious question in my mind as to whether this is all that there is to the educational process.

We have clucked piously over what Walsh McDermott has called the plight of the excessively traditional societies as far as health care is concerned and yet in considering our own communities and our nearby areas, we take the attitude of "let them eat cake." There is no question at all in my mind that the kind of care that we give in these medical centers, these university medical centers, is excellent

as far as it goes and for those people who happen to come to the medical center. But the educational setting in which we are educating most of our students is quite foreign to the real facts of life as they exist in communities nearby, and I can point to metropolitan medical centers existing in slums which assume no responsibility or indeed exhibit little interest in the problem, the health problems, of the slums in which they exist.

So possibly, first, Regional Medical Programs will introduce a note of realism into what Ray Pruitt has called our "cloisters" in the university medical centers. The second item I'd like to get into is that the matter of knowing how to provide good medical care or knowing what good medical care in the teaching hospital is and applying it under a variety of circumstances are two quite different things. Some people have referred to the science versus the art of medicine. It seems to me this really begs the question. Admittedly the objective of a college and medical school is to provide a basic education for students and we can define basic as here is what you need to know--now figure out yourself how to use it. But some of the residency programs which are conducted not only in community hospitals but university teaching hospitals in this country are far from basic educational programs.

Unfortunately most of the residency programs meet the needs of the medical center hospital and staff and not the needs of the community. They operate in a kind of splendid isolation.

They do not attempt to provide the physician who is going into a strange environment those tools or that attitude which he needs to deal with a variety of needs and demands which will come from the population of the various communities. This applies not only to our physicians but also to other workers in the health field. I think the nurses are beginning to feel that the concentration in the hospital on nursing education is possibly limiting their view.

The second point is that the Regional Medical Programs will broaden the educational base, hopefully, of the health professions, provided that appropriate feed-back from what goes on in the community occurs back to the medical center.

The third problem area I would like to mention briefly is the question of lack of cooperation and the inability that many places have experienced in the developing of regional arrangements. I think some of this is inevitable in our free enterprise system and I am perfectly willing to admit that in some communities the attitudes of some people are less than we can be proud of. But a very important aspect of this problem of regionalization and cooperative activity is that old saw, lack of communication. But I think it is very true that there is a lack of communication, not only between the community organizations related to health and the medical center but among the community organizations themselves. This rather frantic attempt to run around and do good is probably a good thing. These people, however, do not talk to each other and there is no mechanism whereby they may

talk to each other. Hopefully, Regional Medical Programs will provide communication mechanisms and along with these communication mechanisms one can be sure will go many headaches.

The fourth item is the question of what changes might occur in the medical centers as a result of some of the activities of Regional Medical Programs. And one of the things that concerns many of us who are in the dean's office is what the future of the departmental structure or departmental organization, particularly of the clinical services, of a medical school will be. In the allied health professional areas, there is more of an attempt to establish separate schools of health professional activities, and, when you stop and look at what establishment of separate schools means in terms of university administration, it in effect puts up barriers to communication among the various disciplines which deal with the health field.

Getting a little closer to the medical school itself, the chairmen of the clinical department have been subject to criticism for a variety of reasons. Some of the old time chairmen who felt that teaching at the bedside was a good idea have been criticized for not doing enough research. Some who have done a good deal of research themselves have been criticized for not teaching enough. Still others have been criticized because they allegedly are only making money and not concerning themselves with academic medicine at all.

And now there appears on the scene, for department chairmen who apparently have been torn among these three duties of teaching, research and patient service, a fourth responsibility which Cecil Sheps referred to as community service. How will the chairman respond to this fourth responsibility? Our chairmen for the most part in recent years have been those whom a committee of faculty feels excel in academic medicine. If you explore what this means, it usually means that the man lectures in an erudite fashion about some area in which he is an expert. We are never sure about how to evaluate his teaching ability, and his clinical ability may indeed be very low on the totem pole.

But after all, we can't expect these men to do everything, particularly if they are highly specialized experts in a single field. Possibly the future chairmen of clinical departments may be more managerial types than their predecessors have been. Certainly in industry, there are men who are able to accept multiple responsibilities and delegate authority and power to people under them. Maybe the new chairman of a department will have to take into consideration this fourth responsibility of community service and somehow organize his department so that this can be accomplished and so that he will assume the managerial role.

There is also the possibility that new departments will be developed or new departments will serve a different role in the medical school scene. Departments of Preventive Medicine recently have been

changing their names to Departments of Community Medicine. For most part, they have had some rough times in the pecking order of the normal medical center. They have been looked down upon by their colleagues; they have been considered dilettantes and I myself have accused them of being evangelists rather than productive scientists. But it is entirely possible that some of these new departments will take on a great deal more importance in the operation of the medical centers if Regional Medical Programs indeed does improve communication with the outside community.

And then there is a final possibility which was suggested by some expert in organization. I've forgotten his name but the possibility makes administrators shudder: It is that administration might well occur by task oriented committees of experts in separate fields and they in turn might govern the medical center of the future and that the discipline oriented department could disappear completely.

This look into the crystal ball of the future only gives me the feeling that there will be changes. I detect changes already in the attitude among faculty people across the country. Regional Medical Programs, at least in part, have been responsible for some of this change of attitude. I suspect that the thing that Regional Medical Programs will do is teach us how to live with headaches which occur as a result of trying to deal with communities each as a whole. And there doesn't seem to be much question that in university medical centers as of today, regardless of what happens to RMP in the future, our lives will be changed.

THE PRACTICING PHYSICIANS

Delivered By:

David P. McCallie, M.D.
Representative of
Hamilton County Medical Society
to Tennessee Mid-South
Regional Medical Program

I have two points that I would like to make with you: first, some rambling listenings that I have picked up from positions both in high and low estate since I have become interested in Regional Medical Programs--listenings, which I hope reflect a little bit of what practicing physicians are thinking about Regional Medical Programs; second, thoughts a little more personal--about my own attitude toward the program after having been involved in it for some months.

The first point, and one which I think is perhaps the most important one for you, is simply this: ignorance of Public Law 89-239. I am convinced that the great majority of physicians are still largely ignorant of the intent and the content of the Law.

Only last week I made a presentation to my own large hospital staff about the progress that the Law has made as it effects our area, and I had at least two men tell me after the presentation that that was the first time they had had some understanding of what the purpose of the Law really is...This, in spite of the fact that every doctor has countless periodicals coming across his desk, all of which have had articles of varying degree of completeness regarding Regional Medical Programs. Any physician who has become interested and tried to learn about the programs could easily have done so.

But for reasons which I will leave to you to solve, ignorance of the Law is still very widespread, particularly with regard to the concept of the Programs rather than "complexes" originally publicized. The idea of regional complexes is still prevalent in the minds of many physicians.

A second point I would like to make, and I think this is an obvious one, is that many physicians are concerned that medical schools are going to take over and run the Programs to their own purposes. No matter how good those purposes are, many physicians feel that the Law is in the hands of medical administrators in most areas. I think the statistics bear this out. They feel that it is only natural that, rather than eventually working for the common good of the patient in the periphery, the funds which are made available through this Law will end up being spent for the benefit of the medical schools.

Now, this is not to say that the medical schools do not need money, or cannot spend the money properly. But I think it is extremely important for you coordinators to make it clear in your own communities that the money is being spent in ways that will accomplish the purpose of the Law rather than simply improve the facilities of the medical school.

It is an easy thing to confuse those of us who are distant from medical schools. For instance, in all programs there are going to be large sums spent on continuing medical education. The grantee

is in most cases the university, or the medical school, and the physicians who read about an operational project may not realize that the purpose of the money, spent at the medical school, is actually to improve educational facilities in his own local area. I have already run into this very problem: many look only at the recipient of the funds rather than looking at how the funds are to be spent.

Secondly, I have heard it stated that the Law may become diverted to giving care to patients so that the bulk of the funds will end up being used in paying for patient care. Along the same line, I have heard it stated that the Law will end up being a source of research funds only. This is perhaps another version of the idea that the money will only be spent for the benefit of the medical schools.

Of course, there are going to be physicians concerned about the effect of the Law on their own pattern of medical practice, their own hospital admitting privileges, and their relationships with their patients and their hospitals. I think that this stems from ignorance of the intent of the Law and the progress of the Programs to date. But it is still quite widespread.

Finally, there is fear of the evaluating machinery, as described in Public Law 89-239. Now this, oddly enough, is not something I have heard in my own area but that I heard at the January meeting here in Washington, and which I read in the follow-up materials on it.

I think the physicians may be concerned that this evaluating machinery will apply to their own functions rather than to the function of the Regional Medical Programs. Whether there is widespread concern about this evaluating machinery I am not sure. Perhaps the reason that I have not heard more on this is that the physicians are not aware enough of the details of the Law to realize that there is in the Law provision for evaluation of the Programs.

Let me pass on now to some more personal ramblings or thoughts about how Regional Medical Programs affect the practicing physician, or I would rather put it another way, how the practicing physician may affect Regional Medical Programs. It, I think, must be obvious to all of you that a key, if not the key, to the success of the Regional Medical Program may be the practicing physician. This is so trite as to hardly need to be put into words, but, I think, it must be belabored for the purpose of our point. Unless the physicians who deliver medical care either in the shadow of the medical school or some hundreds of miles from the medical school can be involved in Regional Medical Programs, it seems to me that a major aim of the Law is bound to fail. This is something that I can't emphasize enough because I see in my own area so little awareness of the Law, so little concern about what the Law is hoping to accomplish, that I can't help but feel that unless the practicing physicians can become involved now, in one way or another, the Law may miss its aim.

Another problem that we have talked about is a key word and a byword that we hear constantly: "cooperative arrangements." Cooperative arrangements are outlined very nicely in Guidelines. They are easy to talk about; they are discussed on every hand and are words that are part of almost every presentation. And yet, cooperative arrangements, as they refer to a medical school and to the practicing physician, who may be distant from that medical school, are a difficult thing to come by. I think Dr. Wolf touched on this point very clearly. The history of cooperative enterprise between medical schools and organized medicine is very scanty, and I am aware of very few areas that have organized medicine and medical schools working together for a common good. In many instances the reason is simply that organized medicine does not operate on a regional basis, but rather along lines purely local; one society may have very little to do with another medical society twenty miles away.

Another aspect to the program is the Regional Advisory Group. In many ways this would appear to be to the practicing physician the salvation of the program, because he is well represented here--both as organized medicine and as a member of voluntary health organizations, and as a leader in medical affairs in his community. But, it is obvious to all of you who have had any activities with Regional Advisory Groups that this is, in fact, a fairly cumbersome machinery. It is a fairly difficult thing for Regional Advisory Groups to have practical push as far as the Program itself is concerned.

It is true that they have the approving authority as relates to their Regional Medical Programs. However, the cooperative arrangement of the Regional Advisory Group is a cumbersome machinery, and perhaps it is going to have some difficulty in making itself felt in the community.

So we have practicing physicians, a Regional Advisory Group, and a Regional Medical Program in the hands of the medical schools and the medical administrators. This triad is given the problem of moving medical knowledge from the medical schools out to the physicians and hospitals and paramedical personnel in the community.

I am not sure that this can be made to work--at least as I see it right now...that is, unless you as representatives of Regional Medical Programs can sell programs to the physicians and to the entire medical community. I don't include just physicians, but also the paramedical personnel in the community. Organized medicine in most instances, organized nursing, organized physical therapists are not going to come to you and say, "This sounds wonderful, we are all for it; we have a neatly wrapped up plan which will make Regional Medical Programs go in our area." That may happen, but I don't think it is going to happen in many instances.

You as coordinators, as directors, as manufacturers of Regional Medical Programs, are going to have to go to your areas and sell them on the importance of the work that you are doing; and sell them in a positive way, so that they will see, in effect, that you are

helping them practice or medicine in case they are in a
medical care distant from the medical school, and you have the
know-how and the techniques and the ability to do it with their help.

Now all of this may sound as if I feel physicians are disen-
chanted with Regional Medical Programs, but this is not my point at
all. It's simply that, as far as I can see, so far the practicing
physician is not disenchanted but simply disengaged. And, unless
you can engage him in the program and make him become a part of it,
I feel that it may not work.

It is a good program and it's a good law, and I am sold on it
100 percent. I hope that with help across the country that you can
sell other physicians and make them realize that it is something
that will work well for their particular areas and for their own
efforts.

THE HOSPITALS

Delivered By:

Vane M. Hoge, M.D.
Assistant Director
Washington Service Bureau
American Hospital Association

INTRODUCTION - I very much appreciate the opportunity of attending this meeting and presenting if I can the viewpoint of hospitals as they relate to P.L. 89-239, the so-called Heart, Cancer and Stroke Program.

OBJECTIVES OF THE AMERICAN HOSPITAL ASSOCIATION.

Now a word as to the Association I represent here today. The American Hospital Association is a national non-profit association representing most of the 7,123 hospitals now registered in the United States. Its objective is to raise the level of the quality of hospital care throughout the Country. It does this through an extensive program of educational seminars, educational publications and in many other ways. Over the years the Association has strongly promoted the development of the Blue Cross movement and the Joint Commission on Hospital Accreditation.

LEGISLATION

Another important activity of the Association is in the area of Federal legislation affecting hospitals. Little if any Federal legislation of interest to hospitals is ever introduced without first sounding out the opinion of the Association on the proposal.

FEDERAL AGENCIES

In addition to working with the Congress, the Association works closely with the Federal agencies charged with the administration of programs of special importance to the hospital field. For in this program we have an Advisory Committee chaired by Mr. Ted Bowen, Administrator of the Methodist Hospital in Houston, Texas. This Committee has had several very productive meetings with Dr. Marston and his staff. In these meetings the Committee has tried to bring to the Administration the attitudes of the hospitals and in turn relate to the hospitals the plans of the Program Administrators.

STATE HOSPITAL ASSOCIATIONS

I have mentioned briefly the American Hospital Association as the national organization representing hospitals. In addition, each state has its own association. These associations are independent entities holding membership in the national organization.

OTHER HOSPITAL ORGANIZATIONS

In addition to the national and state organizations, almost every city has its local hospital council which deals with the every day bread and butter problems of its members.

Both the state and local groups are in close and continuing communication with the national organization which in turn keeps them informed of national policy, problems and trends.

AREA WIDE HOSPITAL PLANNING ORGANIZATIONS

Another development in the hospital area of rather recent origin is the area-wide hospital planning councils. There are now about 80 of these planning groups now in existence, most of which are partially supported by Public Health Service grants. Most of these planning groups are non-official in nature. A very few have some quasi-official status. In some areas they represent the industrial power structure of the community. Others have a broader social base. The purpose of all these planning groups is to evaluate and guide the development of hospital and health facilities in their area. With few exceptions, their powers are those of persuasion only. Where the planning group is dominated by the industrial power structure from which the money for new construction must come, their persuasive powers can be quite potent indeed. In most planning groups, however, their persuasive powers are limited.

Perhaps I should have said in the beginning that the American Hospital Association has strongly supported this program in the Congress, and in its administration after it became law. Although, as modern statutes go, it uses very few words, we have always felt that the potential of this legislation for changing the face of hospital and medical practice was almost without limit. For this reason it is only fair to say that the hospitals of the country have not been without some fears and apprehensions as to the ultimate outcome. I personally think that both the hospitals and the Public Health Service are extremely fortunate in having Bob Marston and his able staff as the high priests of this important program.

In substance, the purpose of P.L. 89-239 is to "Make available to patients the latest advances in the diagnosis and treatment of Heart, Cancer, Stroke and Related Diseases." This is to be accomplished through cooperative arrangements among medical schools, research institutions, and hospitals. To relate each of these elements to the others will require infinite patience, knowledge, skill and understanding. Clearly the expressed purpose of this program cannot be achieved without the effective use of each of the three major elements.

Since the program is now in its early developmental stages, it is perhaps understandable that many hospital administrators feel a sense of frustration as to how they can "become involved", as the saying goes. Our constant advice to them has been that they must involve themselves by close cooperation with the program coordinators.

THE HOSPITAL SYSTEM

Let us look now briefly at the vast hospital system of this Country which may ultimately expect to provide better service to its patients through the operations of this program. The 7,123 registered hospitals contain 1,703,000 beds. They admit some 29,000,000 patients annually; they have over 100,000,000 out-patient visitors; they employ nearly 2,000,000 people; they spend \$13 billion annually; and have total assets of over \$24.5 billion.

Our hospitals are run by a wide variety of owners which are: the Federal government; state governments; county and municipal governments; hospital districts; and various combinations. These account for 34.8 percent of the hospitals and 64 percent of the beds. Of the remaining, the great majority are operated by voluntary, non-profit agencies and a smaller number by proprietary owners.

DISTRIBUTION

Due largely to the aid and stimulation of the Hill-Burton program, few areas in the U.S. are now very far removed from a hospital. Many of these hospitals, however, are far removed from educational centers and it is in these areas especially that the benefits of this program should do the greatest good.

PLANNING AGENCIES

In closing I should like to mention one more problem that is bewildering and may turn out to be downright bothersome. That is the rash of planning agencies that seem to have pervaded the health field. I mentioned earlier the 80 odd area-wide hospital planning councils, funded out of Sec. 318 of the P.H.S. Act. The latest is the state-wide planning agency provided under the "Partnership for Health" program under P.L. 89-749. This agency appears to have over-riding powers. Then there are the state Hill-Burton agencies that have been in the planning business for over 20 years. Then there are the mental health planning agencies, and planning is an extremely important part of P.L. 89-239, and I am sure there are a great many more. I foresee problems ahead.

Again, let me say that it has been a pleasure to appear before this group and I want to assure the administrators of this program of the full cooperation of the American Hospital Association and its component agencies.

COMPREHENSIVE PLANNING SHOULD
PRECEDE OPERATIONAL PROJECTS?

Delivered By:

Paul D. Ward
Program Coordinator
California Regional Medical Program
San Francisco, California

I accepted this assignment and title in a rare moment of voluntary cooperation. However, my cooperativeness did not prevent the addition of one minor item to the title of my assigned subject, namely a question mark. Obviously, I do not believe that comprehensive planning in its complete state should precede all operational projects. This, in the long term, would be wasteful both in terms of money and time.

I do believe, however, that it may prove to be what actually occurs in many areas unless we are able to obtain a working consensus in record-breaking time of what this program is designed to do and to determine the proper focal point as well as the functional make-up of a region.

This consensus must occur between the medical schools, at the faculty as well as the Dean level, and the community forces consisting of the practicing physician, local facilities and interested public. Needless to say any such consensus must fit into the boundaries established by Congress and the administration.

In a multi-medical school region, it not only proclaims that each school must "voluntarily cooperate" with the community around it but, in addition, it must also cooperate with other medical schools in the region. This may prove to be too much.

The involvement of medical schools in community activities has to date been largely limited to selected patient care in a special teaching setting plus some continuing education. They seldom have been exposed to the task of bringing community forces together for the purposes of evoking a social program, especially as set forth in this law. Many of the schools, already overburdened with tasks, find the assumption of a completely new and different leadership role a bit difficult to manage.

We are all aware that many medical school deans have enunciated this thesis on innumerable occasions. Perhaps not in these exact terms but certainly the end result was the same.

What, then, are the specific deterrents to planning in its optimal form, i.e., planning with concurrent operational projects. and

HOW DO WE OVERCOME THEM? 11, 1961, 10:00 AM

cannot be overcome then what are the alternatives?

Further, if there is any question in anyone's mind about the value of "process planning" let me hasten to add that you can't live and function in a pragmatic society and at the same time decry the logic of the empirical approach to over-all planning. Anyone who sits in a corner and draws grandiose plans for social programs, with no thought of learning by trial and error, is destined for many sad shocks. The guidelines in fact, mildly and with some reticence, suggest the empirical approach by stating: "...an opportunity is presented to go beyond concept into specific planning and implementation... which represent pragmatic steps..." and again state "...an opportunity to mix creative ideas and specific actions." No one can deny that this is the ideal approach.

But, from the best of all possible worlds, let us turn to the real one. Let us also change the title from "Comprehensive Planning Should Precede Operational Projects" to "Comprehensive Planning May Have to Precede Operational Projects".

One compelling reason that might necessitate the completion of

in a multi-medical center region individual operational grants may not be agreed on until the question of geographical boundaries is decided.

It will be recalled that one of the primary functions of the planning grants is to determine the boundaries of the region. It seems to me obvious that many of the medical schools find themselves in an uncomfortable position when grouped with other schools in a single region and that their anxieties and fears may not subside until the question of boundaries is answered. Most would prefer a separate area unto themselves and fully intend that the planning will so indicate.

Although it is clear that the Surgeon General in the final analysis determines these boundaries, it is presupposed by most of the medical schools that he will accept the recommendations of the planning report. If during the planning period, operational grants are made, they then legally must be tied to the original region thus making geographical boundary changes more difficult, if not impossible.

Some schools view this as a trap into which they do not intend to fall, at least without vociferous protest.

This fear of functioning together is based in part on the lack of a clear understanding of what constitutes a region. The emphasis is still on geography in place of function when most attempt to define and describe a region.

The guidelines state that the program will be built upon existing institutions and manpower resources. They also imply that there will be a co-partner relationship between the medical centers, the practicing physicians, the local facilities and the public in the planning process. In fact, the guidelines ascend to admirable heights when they advance the proposal that the RMP shall be "a synthesizing force" in place of "an abstract conceptualization". In other words, outside ideas are to be brought in, placed in a workable plan form, preferably tested on a pilot basis and then put into operation.

This implies a situation diametrically opposed to the usual NIH grant. Instead of an institution accepting a grant and developing a result internally, it must now use its grant to draw the public and the

community actively into its planning. This is a new role for the majority of our institutions and one that is not fully understood or accepted. Furthermore, involving the outside community forces in planning is difficult enough let alone entering into operational projects which gives any degree of responsibility to those outside of the walls of the institution.

There are other beliefs held by those within the institutions that make operational projects difficult. You still find faculty members who believe that difficult medical procedures should not be performed outside of the University medical centers, now or in the future. This belief defies a major purpose of the regional medical programs, that is, the distribution of the available medical knowledge and ability as equally as possible throughout the region so that everyone can obtain high quality care.

There is the argument that you should not "beef up the operations of your competitors", even though that competitor is a highly sophisticated hospital already experienced in some of the necessary work. There is a

prevalent, although sometimes unexpressed, fear of all operational projects that are not totally centered in the University medical center.

The argument that no difficult procedures should be performed outside of the medical center leads to the obvious conclusion by those performing medical services in the community that the medical center in fact lacks confidence in its own former students. There is much talk about the pirating of patients, the lack of follow-up reports on referred patients and the competition of the school with its own alumni. All of these side issues tend to cloud the main issue: that is of "capitalizing on the rapid advances of scientific medicine" for the benefit of the patient.

There can be no doubt that for many medical schools RMP is an excruciating experience. The historical position of the schools in providing education and training, research and just the right mix of patient care to subserve those functions may not be universally adaptable to the major objectives of this program. Needless to say,

innumerable difficulties faced by the medical schools have been pointed out before. They have been described most eloquently by medical educators; Deans themselves have asserted strongly that the schools must reach out to the community for more than human cargo carriers bearing interesting diseases for teaching and research. But it is significant that this exhortation still must be made. So far as regional medical programs are concerned, if the focal point is to be the school, then the program coordinator in each medical center has to be a man blessed with the ability to draw the school into the community and community functions, and at the same time draw the community into the school. He has to provide a bridge over the issues and positions that have separated the two worlds in the past.

Perhaps this all leads to the conclusion that the school per se should not be the focal point of the regional program. It is conceivable that a region made up functionally of co-equal partners could have a focal point set apart from anyone of the partners. If this were the case, decisions independent of the many historical side issues could be made

in creating the cooperative arrangements necessary for the purpose of the law. It would permit the consideration and choosing of operational projects on the basis of their functional merit with much less emphasis on area or geography. The region, as a whole, could purchase services necessary to the cooperative arrangements where ever they might exist.

This shift in focal point challanges the concept that each school is sovereign in its own area, but this challange may be essential to the efficacy of the regional concept. If there is general understanding that the region exists as a sum of all the resources and further, its leadership serves as the impartial catalyst for causing the optimal organization "to assist our medical institutions and professions in capitalizing on the rapid advances of scientific medicine", then we will have overcome the first obstacle in a long road.

Then, finally, we will be in a position to test an application for an operational project during the planning period by asking the key question: will this project help define the shape of a region functionally? Will it help give substance to the organizational matrix out of which, realistically, a true regional structure can be built? Or, will the proposal merely continue the isolated role of a single center? These,

it seems to me, are the questions which, in the end, will relate operational projects to the comprehensive planning needed for a regional structure.

OPERATIONAL PROJECTS ARE A MEANS
FOR ACCOMPLISHING
ANOTHER KIND OF PLANNING

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in this presentation we are not concerned with an academic discussion of planning versus action. We are concerned with realistically assessing the way in which Planning Activities and Operational Projects can mesh into a continuous process that will attain in each region the objective of RMP. We understand that objective to be: the development and maintenance of plans, that can be readily implemented in each region, and that will attain economically a high level of health care for the consumers who are at risk for heart disease, stroke and cancer. This objective is to be attained through early application of appropriate knowledge, from whatever discipline, using existing patterns and systems of health care delivery. The attainment of this objective is to be measured by the extent to which the level of health of the ultimate consumer is modified.

From this we may deduce that the planning objectives of a given RMP should be:

1. To describe and assign priorities to desirable operational projects that will provide needed data for consumer health program planning.
2. To describe and assign priorities to viable programs in heart disease, stroke and cancer, that are designed to deliver to the consumer the kind of health care that will elevate his level of health.

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three kinds of knowledge are necessary:

- A. What is known but not yet applied to the delivery of health care.
- B. A good working knowledge of current systems of delivery of health care.
- C. Characteristics of the consumer that affect his acceptance and use of health care.

(It is assumed that basic knowledge is available of heart disease, stroke and cancer in relation to diagnosis, treatment and rehabilitation.)

In any given region at any given time, some knowledge in these three areas will be present so that in most, if not all cases, there should be sufficient information for the development and initiation of useful operational projects.

The following types of operational projects will advance regional planning and may warrant almost immediate funding:

- A. Evaluation tools and methodology development and perfection. These may be cost benefit analysis or measurement of effects on the consumer.
- B. Obtainment of basic health data about the consumer population from hospitals, physicians, and by household surveys.
- C. Improving a health delivery system in an area served by D.O.s and M.D.s.

- D. Application of systems analysis techniques to health care delivery systems, utilizing economists and industrial engineers.
- E. Applications of the computer to the delivery of health care:
 - 1. Fact bank.
 - 2. X-ray diagnosis by computer.
 - 3. Screening by multiphasic testing.
 - 4. Automated patient histories.
- F. Application of journalistic and psychological techniques to the consumer motivation.
- G. Economical delivery of comprehensive heart disease, stroke, and cancer care through a community health center program (e.g., the Smithville project of the Missouri Regional Medical Program).
- H. Application of modern technology to increasing the mobility of the consumer and producer of health care services.
- I. Application of technologies to increase the amount, quality and effective utilization of health manpower.

In summary: Operational projects should be designed to feed back into the planning process the critical data needed to perfect viable health care programs that will elevate the health level of consumers at risk to heart disease, stroke and cancer.

into one continuous process.

Operational projects can and should be initiated in any given region at the earliest moment.

Because each RMP must generate its own planning data through operational projects, each project must be designed to provide useful data economically, and the RMP staff must be of high calibre, with considerable experience in research and in planning. And lastly, there should be a national feed-back system whereby data useful in more than one region are delivered to the DRMP with a minimum loss of time.

RELATIONSHIPS BETWEEN
COMPREHENSIVE STATE HEALTH PLANNING
AND REGIONAL MEDICAL PROGRAMS

Delivered By:

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The title that I was originally given was "Comprehensive State Health Planning -- A Boon or A Threat to Regional Medical Programs." What an assignment -- a boon or a threat! As a speaker and a potential recipient of the benefits of both programs I found the prospect of entering into this forum a threat, indeed.

At the conclusion of these remarks you may decide that my position resembles that of the ideologically agile politician who once was accused of taking a firm stand on both sides of a question. Despite this risk, I want to stipulate at the outset that I consider myself a partisan of neither program.

First, because I do not profess to have a sufficient grasp of all the intricate relationships between them, and secondly, the uncertainties surrounding both programs are too great for anyone to declare at this stage that one is preferable to the other, or that one is incompatible with the other. I certainly think that the previous three speakers demonstrated that point. Furthermore, I feel a deep commitment to the objectives of both the Regional Medical Programs and the Comprehensive Health Planning Program.

In my view, the objectives of both programs are virtually indistinguishable. A passage from a talk by Mr. Yordy, at a recent hospital conference, is striking evidence of this fact. "These are times of change and crisis for American medicine. There are problems of availability of sufficient manpower to meet increasing needs and demands. Severe economic pressures are being

exerted on the entire field of health -- pressures which are felt particularly strongly by the hospitals. There are difficult problems in providing good care for those receiving the poorest care of all -- the poor, the minorities, the isolated, both in rural areas of the country and the heart of the cities. There is an urgency with respect to how we shall organize to best use the many new technologies that promise great potential benefits if they are wisely and effectively used." I have heard the problems to which the Comprehensive Health Planning Program addresses itself described in almost identical terms.

It would be a grave misfortune, if disagreement over the means of fulfilling these needs were to hinder their accomplishment. This is not to say that noble aims automatically exempt the means from critical scrutiny, the attitude expressed by Louis XV when he declared, "My intentions are good; therefore, all who oppose me are scoundrels."

For the sake of brevity, I will refer occasionally to the Regional Medical Program as RMP, and the Comprehensive Health Planning Program as 749. Comparative analysis of these two programs have been made a number of times. One of the most definitive, I think, is a document on the complementary relationships that has been prepared by the Surgeon General's Office, which I suspect that you have received. It carefully delineates the basic differences in mission and function of distinguishing the two programs while at the same time recognizing the aspects of each that are likely to lead to overlap and duplication. Since so much of this material dealing with the definition and boundaries is familiar to you or readily available, it seems unnecessary to present another detailed review of the respective provisions of the two programs. Moreover, I am frankly less

interested in trying to offer reassurances that the respective turfs are immune to claim jumping, than I am in considering the possible benefits and liabilities that may proceed from overlap, duplication, and even conceivably from confusion and conflict.

Let's frankly acknowledge that there are not only similarities in the objectives of the two programs, but that there may be possible areas of overlap and duplication in means and operational activities. However, under certain conditions overlap and duplication are justified.

In research activities, the usual justifications are based on three factors: First, the degree of uncertainty that exists as to the successful outcome of the research; second, the extent to which the alternative outcomes or means may be qualitatively different from each other; and third, the magnitude of the expected payoff or benefits. It seems quite evident that the Regional Medical Program and the Comprehensive Health Planning Program fulfill all of these criteria. There is great uncertainty as to the outcome; the payoff certainly promises to be huge if they are successful. The most decisive factor, it seems to me, is that of uncertainty. The greater the degree of uncertainty, the greater the justification for overlap and duplication. In the case of the Regional Medical Program and the 749 Program, the uncertainty lies in whether or not we can make them work, and whether or not they will indeed improve the quality and the availability of health care services.

The recognition of needs, however, and the establishment of lofty goals and even the construction of facilities for their accomplishment and the formulation of plans and development programs do not by themselves carry any guarantee that the goals will be met or the programs put into effect.

Take the following statement, outlining health needs and objectives, for example. "At the present time," it states, "many persons do not receive medical services which are adequate either in quality or quantity and the costs of the services are inadequately distributed. These conditions are largely unnecessary. The United States has the economic resources, organizing ability, and technical experience to solve these problems. There is a lag between scientific advance and application."

The source from which I am quoting also contains recommendations for medical complexes, moving doctors' offices closer to hospitals, joining the facilities of several hospitals with research institutions and educational institutions, the establishment of affiliated branches and stations, progressive patient care programs, the manpower development program and the establishment of planning bodies in counties, areas, and states to coordinate and evaluate medical services and public health services. They sound identical to the current recommendations associated with the Regional Medical Programs and 749, and urge changes that some still consider progressive and even daring. Their origin dates back many years, all the way back to 1932 when the Committee on the Costs of Medical Care issued its report, an event which at the time was considered no less significant than the Report of the President's

Commission on Heart Disease, Cancer and Stroke. Yet, most of the recommendations I have cited have never been put into effect. The study was headed by Dr. Ray Lyman Wilbur, who among his numerous other distinctions was a former president of the American Medical Association. It was subsidized and backed by the Rockefeller Foundation, the Russell Sage Foundation, the Milbank Foundation and other powerful and influential foundations. It received the wholehearted endorsement of President Hoover. The needs, it recognized, were real. The recommendations it made were sound. The means for accomplishing these recommendations were fully outlined in the Report. But more than 25 volumes, containing the studies and recommendations of the Wilbur Committee have been gathering dust on obscure library shelves for nearly 35 years.

Surely, the fate of the Wilbur Committee study is an ominous and dramatic reminder of the uncertain future of any program attempting to achieve, change and reform in the realm of medical services. All the basic objectives of nearly 35 years ago remain unchanged. The uncertainty of achieving them is still great, though perhaps not quite as great as it was then. Faced with such uncertainty, can anyone predict at this time that either the Regional Medical Programs or 749 will be more successful in achieving its common goals. If not, is there any basis for making a determination that one is preferable to, or incompatible with, the other. We are attempting to forecast the future of what may be said to be "a riddle wrapped in a mystery inside an enigma," to borrow the phrase Winston Churchill used to describe the Soviet Union.

To be sure, essential differences have been pointed out in the basic features of these two programs. RMP is said to be focused primarily on the categories of heart disease, stroke, cancer; 749 is said to be non-categorical, extending over the entire range of health services. RMP is said to be regional in scope. 749 is said to be confined to individual states.

The clearest distinction, however, is the respective structures of power bases on which the programs rest. The central locus of the Regional Medical Program is the medical profession and its related educational institutions and health care institutions. The central focus of Comprehensive Health Care Planning is a social and political structure and is dependent upon the agencies of state government.

It could be asked whether these are intrinsic differences, or whether they are artifacts related to the origins of the programs. If duplication and overlap result from these artifacts rather than the essential nature of the essential missions or objectives, we should candidly examine the differences and ask ourselves whether they are real, and whether they have any functional utility in fulfilling a common objective. We might even be so daring as to ask, do we have duplication because the legislative mandate compels duplication, or do we have it because of a conscious, calculated and considered attempt to create useful redundancy? Despite the sincere attempts to reconcile the two programs by delineating the differences, there are obvious efforts where the means employed will impinge upon one another.

Now, let us examine briefly some of the differences imputed to the two programs. I emphasize that this is a first, and admittedly, superficial analysis, since we hope to spend the next few months carefully examining

some of these issues in much more detail. A number of differences between these programs seem to me to be more apparent than real. Let's first examine this power-base question. I believe it is pointless to assume that the political base of one program and the professional base of the other preclude mutual participation in action.

De Tocqueville spoke of attitudes that survive as illusions, even after they had been abandoned by all but a small minority. Yet he says, the empty phantom of public opinion is strong enough to chill innovators and keep them silent, and at a respectful distance.

The belief that politics can be kept out of medicine, and that medicine can remain aloof from politics, is clearly an opinion that survived as only an empty phantom. Government is deeply involved in medicine, and the only question is how fully medicine will participate in and influence the course of actions and decisions of government programs related to medicine. I believe that the American Medical Association is beginning to express regret that it did not take a more effective part in shaping the Medicare Program.

Dr. Charles Odegaard, one of your Ad Hoc Advisory Committee members, at a recent meeting, turned a neat phrase when he said, "The Regional Medical Programs will be vulnerable to the insights of state planning bodies." Conversely, there is little doubt that state planning bodies will be vulnerable to the insights of Regional Medical Programs. First, by virtue of the prestige and leadership of those of you engaged in these programs, and secondly because the leaders of the Regional Medical Programs will undoubtedly serve

on advisory councils of the state planning agencies. Dan Zwick, of the Public Health Service, has noted that the same key individuals will almost certainly become associated with both programs. This will be due to some extent to the limited number of health leaders at the local level, and certainly to the shortage of health planners and other staff. There are simply not enough people to go around twice. Granting that agreement on ultimate goals already exists, and assuming that agreement on proximate goals of the state and regional levels can and will be reached, it seems apparent that the outcome of the two programs will be decided by the quality and effectiveness of the alternative means designed to achieve implementation. Exaggerating the differences, or even artificially creating the differences, could affect the quality of the plans that are developed and certainly could adversely affect their implementation.

Another point of difference that has been emphasized is the categorical character of the Regional Medical Program. This is accepted, I believe, as a fundamental distinction. Nevertheless, the experience in planning and assessment of resources obtained in the initial phases of the Regional Medical Programs are bound to produce insights applicable to Comprehensive Health Planning. We certainly have seen this in Minnesota. I find, for example, that one of the background papers prepared for the January Conference made the following comments with regard to categorization. "These activities are generally generic by nature, and consequently have not significantly involved problems of categorical definition. In most cases in order to plan

effectively for heart disease, cancer and stroke it has been found necessary to consider at the same time the entire spectrum of research available for personal health services." Decategorization has been stressed as a salient characteristic of Public Law 89-749, the Comprehensive Planning Law. To be sure, the categorical restrictions imposed by the Federal Government have been considerably relaxed, and as such the "Partnership for Health Program" has been regarded as an important first step toward creative federalism, and right now it is being embraced by governments all over the country as evidence of good faith on the part of the Federal Government. It might be pointed out in passing, however, that in the very process of creating decategorized formula grants for Public Health in the states, Public Law 89-749 states categorically, I might add, that at least 15 per cent of a state's allotment must be made available to the state's mental health authority. However, decategorization at the Federal level does not mean that categories as such will be abolished. Rather, categories will be established by planning groups with a direct knowledge of prevailing local conditions -- a very positive step indeed.

The commitment to specific problems such as heart disease, cancer and stroke will undoubtedly be in keeping with their rank as the nation's foremost medical problems. If anything, the delegation of planning responsibility to the states will bring the decision-making process closer to the Regional Programs, thereby offering opportunity for more direct influence over related health problems.

It might be said that the 749 Program will provide ongoing facilities for planning. I have heard this argument used in the development of planning techniques and personnel, while the planning functions of Regional Medical

Programs are considered as an initial, pre-occupational phase of the program. However, it seems improbable that any one can arbitrarily cut off, and on a given date declare here is where we stop planning and start operating.

The complex and dynamic operations of Regional Programs will naturally require continuous planning, evaluation, revision of goals and processes.

The regional scope of the Regional Medical Program and the statewide scope of 749 has also been cited as a basic distinction between the two programs. It might be argued that the regional character of the Regional Program is contradicted by the fact that 31 of the 44 programs follow state boundaries. As a result, there is no doubt that the primary locus of many of the educational institutions and other organizations, around which the Regional Medical Program has been built, are directed at activities within a state. At the same time, the Comprehensive Health Planning Bill uses state agencies as a chief instrumentality. It doesn't follow that comprehensive planning can be done if it is strictly circumscribed by state boundaries. Air pollution sheds, patient-flow characteristics, super-cities, and all kinds of other geographic, social and economic boundaries must enter into any sort of comprehensive health planning arrangement.

In my experience with the Governor's Commission on Health and Rehabilitation, in Minnesota, which was one of the early attempts at engaging in comprehensive planning, we found it possible to consider the question of medical manpower without extending the scope of planning over a four-state region.

On the other hand, in serving on the executive committee of the Regional Medical Program in Minnesota, I have noticed that we have had to consider patient movements which occur far outside of our state's boundaries which the Regional Medical Program is based on. Duplication will, no doubt, occur as these programs progress and develop. This may be justified by the high degree of uncertainty of the outcome we face. However, there are obvious dangers inherent in overlap and duplication that can't go unrecognized.

Like any public speaker I've got to quote from "Alice in Wonderland".

"I wish you wouldn't squeeze so," said the Dormouse in Wonderland,

"I can hardly breathe."

"I can't help it," replied Alice, mildly "I am growing." You've no right to grow here," said the Dormouse.

"Don't talk nonsense," said Alice, "You know you're growing too."

"Yes, but I grow at a reasonable pace," said the Dormouse, "and not in that ridiculous fashion."

Duplication and overlap may have an undesirable effect when disputes arise over respective rates of growth or shapes of growth in the two programs. When two programs agree to regulate their growth rate in a mutually acceptable fashion, they make themselves subject to artificial restrictions.

Henry Kissinger in an editorial in Daedalus entitled "The Lonely Bureaucrat", hits this one right on the head, stating: "Creativity must make so many concessions that it may exhaust itself in doctrinal adaptations...the method of arriving at decisions can be achieved at a high price. Decision-making

can grow so complex that the process of producing a program may overshadow the purpose of the effort. Serving the machine becomes a more absorbing occupation than defending its purpose."

Further, there is the very practical question as to whether the sources of Federal funds will be made available to projects that apparently overlap and duplicate even if such overlap and duplication has some scientific utility in terms of redundancy for reaching an uncertain end.

However, I think, the greatest danger of duplication may be the attempt to deny that overlap and duplications do exist. The fiction that we are trying to perpetuate may harden into a fact which we find it difficult to live with. Displaying a sincere desire to reconcile the two programs, and to demonstrate their compatibility, spokesmen for both programs have stressed the distinctions between them and the manner in which they may be expected to complement and augment each other. Many others though have openly voiced the fear that the two programs are on a collision course and destined for inevitable conflict. Frankly, I don't find this possibility as disturbing as the possible consequences of straining too hard to avoid the collision and in erecting too many safeguards against the possibility of conflict. The danger lies in the fact that this tendency can threaten the single most valuable essential feature of both these programs, namely, their flexibility, permissiveness, and the shifting of responsibility for decision-making into the communities.

Paradoxically, the very freedom that has been accorded to us has produced, in many of us, I think, a kind of a sense of insecurity which may prompt us to seek reassuring refuge in rigid guidelines and strict definitions. Permissiveness has made us weary of what we are going to do, and who is

going to do it. And permissiveness may make us yearn for more rigorous enforcement of categories. The laborious and time-consuming effort that has been expended in drawing the boundaries between the two programs is perhaps evidence of this tendency. The only means of finally allaying the doubts and uncertainties created by permissiveness is to establish rigid lines of demarcation and pacts of mutual agreement that will have the effect of stifling innovation, imposing limits on permissiveness and flexibility that will harden the program into fixed rigid patterns.

Karl W. Deutsch, a distinguished student of social change, has said that a concept could be developed for measuring possible outcomes of conflict. According to Deutsch, one must first consider the probable extent of incompatibility between the respective programs for the future, and secondly the probable cost of avoiding collision between them, wholly or in part.

Evaluation of Regional Medical Programs might be based on the extent of change that would be affected in one or both of the programs if the conflict with 749 were joined, measured against the changes that would be required in one or both of these programs if the conflict were to be avoided. Avoid the conflict by building boundaries and what is the result? It may be worth asking ourselves whether avoiding conflict by the suppression of flexibility might not be costlier than the risk of the possible conflict. I might say that I feel we have already reached the point in health manpower where the cost of avoiding collision between specialties, professions, and subprofessions is more costly and risky than the conflict itself.

The impelling force between 239 and 749 was the determination to transcend the barriers and fill the gaps that the artificial demarcations that we all live with have created. It seems to me it would defeat the avowed purpose of both programs and perpetuate the same deficiencies, if we distort these broad and permissive programs to fit the existing structure.

I am not suggesting that we blindly pursue any course of action that seems attractive at any given moment without attempting to coordinate our efforts. For example, the justification for redundancy no longer exists in the absence of agreement on objectives. It seems to me that the entire planning process out there in the regions and in the states has got to set itself up in such a way that there is no fundamental disagreement on the objectives of the two programs. How this is done, I don't know, but there certainly are a number of things that should be considered.

This might be handled by creating a single National Advisory Council for Health at the Federal level, thereby effecting a coalition between advisory councils and the states, or using the same staff or parts of the same staff in the states to do the work. One of the provisions of the Comprehensive Health Planning Act stands in the way of putting these proposals into effect. These provisions require that 50 per cent of the staff members of the Comprehensive Health Planning Agency must be on the staff of some state agency. Luckily enough, the wording of the regulations also says that the Surgeon General can suspend this regulation.

It must be recognized that the resources available for these and other health programs are limited and that priorities must be set in accord with some mixture of very complicated factors and even some of the principals of the cost effectiveness that we have been hearing so much about.

Now one of the challenges of these two programs is to make full use of the capabilities of some of the modern concepts and techniques of planning. We should be no less willing to accept these adjuncts to medical care than we have been to accept the sophisticated technology in advanced diagnostic and therapeutic institutions that have revolutionized medical care. And certainly the field of planning, particularly as characterized by organizations like the Rand Corporation, has undergone a complete revolution. And certainly one of the things that has characterized this revolution is the candor with which issues like we are talking about here today are faced. This has been a superficial analysis of a complex issue, and I am sure that you can think of many other factors that can make these two programs go or not go. But there is no question that they are intimately related, and can be made to work together. If the lesson of the Wilbur Commission may be considered instructive, our work is cut out for us.