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SPECIAL ARTICLE

REGIONAL MEDICAL PROGRAMS IN SEARCH OF A MISSION*

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Abstract Created five years ago, the Regional Medical Programs now have established organizations that cover the entire country. Private medicine is involved to a degree unparalleled in any other federal health program. In many cases the Programs have served to bring together elements of the health-care delivery system that have previously been isolated from one another. In other cases they have promoted the extension of recent medical advances out of the medical centers, improving the care given by private practitioners and community hospitals. Yet confusion exists over the mission of the Regional Medical Programs, and the means by which to achieve that mission. Particularly at issue is their role in changing, rather than simply upgrading, the existing health-care delivery system. It remains to be seen whether they are faced with a golden opportunity or an insoluble dilemma.

FIVE years ago, in October, 1965, the Regional Medical Programs (RMP) became law. Also known as the Heart, Cancer, Stroke Amendments, Public Law 89-239 received a mixed greeting from the American “health establishment.” Organized medicine was skeptical or antagonistic; state and local health departments were wary; medical schools and hospital associations were supportive; and the voluntary health agencies were enthusiastic. The President told the American public that the new program would strike at the “killer diseases” – heart disease, cancer and stroke. The public approved.

Today, 55 Programs have been developed, covering almost the entire nation. To some degree, the RMP’s now involve every state medical society, every state health department, every medical school, every school of public health, every state hospital association, every state voluntary health agency and many local agencies. Almost $30,000,000 dollars have been spent on RMP activities.

This appears to be impressive progress for a program that began from scratch five years ago. But the swift development of the 55 Programs, the involvement of private medicine in a federal program, and the large sums spent thus far can be deceptive measures of progress. Crucial questions remain to be answered. In what manner, and with what degree of enthusiasm, and for what reasons are the health providers “involved”? What have the Programs accomplished thus far? What planning has been done to chart future directions, and to ensure future accomplishment? In short, are the RMP viable organizations in pursuit of a mission that justifies their existence?

The answers to these questions depend upon what one expected from RMP to begin with. So it is not surprising, given the differing judgments being rendered today, that the historical development of RMP was rife with differing expectations.

HISTORICAL DEVELOPMENT

The DeBakey Commission

In 1960 the Washington “health lobby,” led by Mrs. Mary Lasker, inserted into the Democratic Party Platform a promise to appoint a committee on heart disease and cancer. President Kennedy appointed the committee shortly after his inauguration. The committee prepared a report calling, not surprisingly, for sharp increases in support for heart disease and cancer research. The report, unfortunately, was presented to the President on the eve of the Bay of Pigs crisis, and did not capture his full attention. After Joseph P. Kennedy’s severe cerebrovascular accident, however, Mrs. Lasker was able to approach the President again about tackling the categories of disease responsible for 70 per cent of the nation’s deaths – heart disease, cancer and, now, “stroke.”

In 1964, after President Kennedy’s assassination, President Johnson – who had suffered from heart disease and who was a long-time friend of Mrs. Lasker – appointed Dr. Michael E. DeBakey to head a full-scale commission evaluating these diseases. The Commission concluded that there were two major problems: basic and clinical research were receiving insufficient federal support; and the fruits of current research knowledge were not being made sufficiently available to the average practitioner and average hospital. The commission proposed to solve both these problems – to augment research and to close the “science-service gap” – by concentrating first on the “killer diseases.”

It appears that the commission argued many hours over the relative emphasis that it should place on “science” versus “service.” It finally proposed spending $2,900,000,000 over a five-year period, $1,700,000,000 (about 60 per cent) of which was to be allocated solely to “science” – basic and clinical research. In addition, a substantial portion of the remaining 40 per cent would also flow into

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research facilities, by supporting their “service” efforts in disseminating research advances. Thus, the commission’s emphasis was primarily on increasing support for research, and only secondarily on “closing the science-service gap.” Private medicine, already anxious over the rapidly increasing power of a federally supported “research establishment,” took note of the commission’s emphasis on research.

The Birth of Public Law 89-239

Some of the key recommendations of the commission were incorporated into the first heart, cancer and stroke bill. The bill proposed creation of a “network” of regional centers for research specifically on the categorical diseases. The bill would have included in the network some existing research centers (e.g., cardiovascular research institutes) and would have built many new centers. President Johnson focused on these proposed centers in his 1965 State of the Union address, causing concern among some medical schools and organized medicine. But the bill proposed more than building new centers. Closely attached to the research centers was to be a group of “diagnostic and treatment stations” — again, some old and some new. Tied into the “centers” and the “stations” would have been the community hospitals, forming a “regional complex.”

Although this plan seemed clear structurally, it was not clear functionally. Would the new centers duplicate existing centers? Would the “complexes” be directed by local or federal authorities? Would patient referral patterns or educational programs be superimposed on the structure? Was this an attempt by the federal government to control hospital policies and physician practices? To many, the answers were not clear.

The bill was discussed at length before Congressional committees. Speaking in favor of the bill were the voluntary health agencies, the American Hospital Association, the American Association of Medical Colleges, the American Public Health Association and others. Speaking against it were the American Association of General Practice and the American Medical Association.

The AMA made its views known in another forum, as well. In August, 1965, several AMA leaders met with President Johnson and HEW Secretary Gardner. The AMA told the President that the provisions of the bill were, in the AMA’s words, “jeopardizing AMA’s attempts to work with the Secretary of HEW . . . relating to the medicare law.”

The well-being of Medicare was obviously important to the Administration. Furthermore, HEW was beginning to reconsider the wisdom of emphasizing the creation of new facilities, rather than the improvement of communications between existing facilities. Because of both pressure from the AMA and its own second thoughts, the Administration accepted 20 amendments to the bill. The provisions for regional centers and stations were discarded. In addition, language was added ensuring that the bill would in no way “interfere with the patterns, or the methods of financing, of patient care or professional practice.” The new bill, bereft of the main features of the DeBakey Commission report, quickly became law.

What was the nature of the bill’s metamorphosis, and what could be expected from the new law? First of all, although both the original bill and the enacted law sought to bring the medical centers into closer contact with peripheral hospitals and practitioners, the enacted law placed less emphasis on existing and proposed centers and placed more emphasis on peripheral institutions.

Secondly, the law placed unusual emphasis on voluntary local initiative, rather than mandatory federal direction. The first director of RMP, Dr. Robert Q. Marston, emphasized this point repeatedly, rejecting any federal “socialized blueprint” for a national health-care system.

The most important question asked of the new law related to its potential effect on the “health-care system.” Most people thought that the language of the law, and the history behind the adoption of that language, indicated that RMP would not seek substantial changes in the health-care delivery system; instead, RMP seemed designed to upgrade the existing system. Dr. Roger O. Egeberg and Professor T. R. Harrison, for instance, saw RMP largely as a vehicle for enhancing continuing medical education — one example of upgrading the existing system.

Others, however, still thought that the law represented a mandate for substantial change. Clark and Battistella, for instance, saw RMP as an opportunity to achieve comprehensive regionalization of health care across the nation. Was this a realistic interpretation of the law’s purpose? If so, did the law’s constraints prevent achievement of the law’s purpose? What position would Washington take? What would be the attitudes of those developing RMP at the local level?

STRUCTURE OF RMP

Applicant Organizations

The 55 RMP’s (“regions”) each began by applying to the Division of Regional Medical Programs in Washington for a planning grant. The law established a national advisory council of non-federal reviewers to pass on all grant requests, in the manner of NIH study sections. Thus, “Washington,” but not the federal government, exerted its stewardship. Usually, the RMP grant applicant was a university, sometimes a specially formed nonprofit corporation and sometimes a local medical society. The applicant was permitted to define the boundaries of its region according to any acceptable rationale — such as existing political areas or geographic patient-flow
patterns. Consequently, some regions are whole states, others include several states, others include parts of states, and still others include large metropolitan areas. Some of the regions overlap each other.

Core Staffs

Each region is directed by a core staff, averaging 25 health professionals, whose salaries are paid by federal grants but who are not federal employees. Each core staff is led by a co-ordinator, usually a physician. Staff members include nurses and allied health personnel, health planners, hospital administrators, statisticians and others. The composition of core staffs varies markedly throughout the 55 regions; Washington has never defined an “ideal” core staff.

Regional Advisory Groups

By law, each region must have a regional advisory group whose responsibility it is to stimulate and approve all grant requests, including support for the core staff, before they are sent on to Washington. The law requires that the advisory groups contain a membership that broadly reflects the health providers in the region — practicing physicians, medical-center officials, hospital administrators, medical-society representatives, voluntary-health-agency representatives and others. Most members of advisory groups (46 per cent) are physicians, the next largest group (32 per cent) being high-level health consumers such as lawyers or bankers.1 The advisory groups currently approve about 70 per cent of project proposals presented to them. In some regions the advisory groups are the dominant decision-making body, whereas in others they exercise little influence over the decisions of core staff, the university or the medical society.

An important development in the past two years has been the growth of local “subregional” advisory groups. Stimulated by the need to increase the involvement of those who live in communities away from the center of the region, 27 regions have created 355 such groups. A few of these groups have become the dominant health-planning voice in their communities — for instance, some have used official authority or unofficial influence to help rationalize health-facility expansion plans. If local health “regulatory bodies” are given more official authority, such as through a national health-insurance program, RMP advisory groups could become the nidus around which such bodies could form. As such, these groups have great potential importance.

Operational Projects

After a period in the planning phase, the regions began submitting applications for operational proposals that had developed out of the planning process. No specific types of projects were “pushed” by Washington.

About 60 per cent of RMP funds support various operational projects; the remaining 40 per cent support core-staff planning and organizational functions.11 RMP project staffs currently include over 2000 health professionals.1 Thus far, over 55,000 health professionals, particularly nurses, have received training through RMP projects.1

Questions for the Future

Regionalization

Are the RMP’s a force for developing the planetary regionalization of health care in America? Planetary regionalization models have previously been described, such as the reports by Mountin12,13 and the Lord Dawson Report;14 these models have been summarized by others.15,16 Planetary regionalized health care, to some degree, has been organized in developed nations such as Britain and the Soviet Union, and is being organized in many underdeveloped nations, particularly in Central and South America. The planetary model describes an integrated gradation of personnel and facilities; central specialized capabilities are connected with several levels of progressively more peripheral and more general capabilities. Patients flow, records are exchanged, and consultation and education are provided in both directions.

It is abundantly clear that many Americans do not obtain the health services that they need, and that changes in the organization and delivery of care are necessary. But it is by no means certain that such a planetary model is the answer for America, as Bodenheimer18 has pointed out. Many fear the creation of a group of second-class health professionals and facilities at the periphery, for instance. Whether or not planetary regionalization of care is the answer, it does not appear that the United States is close to such a massive restructuring of its health system. The health providers oppose such a change; it threatens prestige, independence and income. The public, whose concerted action could nevertheless impose such a system, has not even begun to consider the value of regionalizing health care. The accessibility and cost of health care are currently the major public concerns; regionalization, although relevant to these concerns, is not yet a public issue.

In any event, RMP is not now the vehicle for achieving a totally regionalized health system. For one thing, the law does not describe this as a goal. For another thing, most of the leadership in the regions and in Washington do not envision this role for RMP. Also, the development of such a system would require building new facilities, particularly in urban poverty areas, and RMP has limited construction authority. Finally, the funding level for RMP prohibits any such attempt on a national scale.
Partial Regionalization

If RMP cannot achieve a totally regionalized health system, what is its mission? The law states that the mission is the development of “regional co-operative arrangements.” This phase was substituted for language in the original bill shortly before passage of the law. Although the meaning of the phrase was not discussed in Congress, and has never been defined by Washington, a general definition can be attempted: “Regional co-operative arrangements” are voluntary efforts at bringing together isolated elements of the health system. The linkages (“arrangements”) would be formed in a piecemeal, tentative fashion. These separate linkages might one day coalesce into an overall system of greater quality or efficiency. They might serve as models around which such a system could be developed in the future. They might stimulate other linkages among participating institutions. Or they might do nothing more than serve as a device for getting previously antagonistic elements to respect each other. In other words, “regional co-operative arrangements” are a far cry from the legislative creation of planetary regionalization.

At their best, the RMP’s have achieved this kind of “partial regionalization.” Meaningful “arrangements” have been established between groups that had never worked together before. The resources of the centers have been brought out to community hospitals and into poverty communities. A few examples follow:

The Tri-State RMP (Massachusetts, Rhode Island, New Hampshire) has linked the Boston University Medical Center to seven other hospitals in a program providing continuing education, consultation, and referral services, in the care of cancer.

The North Carolina Regional Medical Program has linked the intensive-care units in eight small hospitals to each other and to the Bowman Gray School of Medicine. As a result of this linkage, the eight hospitals, which had been relatively isolated from one another, are planning further division of responsibility and labor to the point where they anticipate receiving joint accreditation as a “single” hospital.

The Washington-Alaska RMP has established a program in which 100 physicians from small towns have spent preceptorships with specialists in Seattle, Tacoma and Spokane.

The California RMP has helped establish a new postgraduate medical school in Watts, melding the resources of the University of California, Los Angeles, and University of Southern California medical schools, Los Angeles County and the local Charles Drew Medical Society. The school will provide comprehensive health care and training programs for the surrounding poverty community.

Upgrading vs. Changing the System

With emphasis on “partial regionalization,” there is a danger of confusing ends and means. It is not enough to get people together. The creation of co-operative arrangements is not an end in itself but a means for achieving improved health care; the fruits of co-operative endeavor are more important than the existence of co-operation.

It becomes a very practical problem: When any co-operative endeavor is worthy of support, how does a regional or national advisory board decide where the money goes? Two closely related questions emerge: To what degree must RMP support be limited to projects dealing with the categorical diseases—heart disease, cancer, stroke and kidney disease (included in the new RMP law)? To what degree is RMP a mechanism for changing, rather than upgrading, the system?

For many regions, the categorical diseases have served to delimit and make manageable their area of responsibility. They have restricted their support to co-operative arrangements that extended and improved care in these diseases only, arguing that it is foolish to take on expanded responsibilities without expanded financial support. These regions also argue that the continuing identification of RMP with an attack on these diseases is crucial in “selling” RMP to the people and the Congress; programs to “improve the system” do not have the same appeal.

Other observers, however, argue that improvement of the overall system is precisely what is needed, and that it is ineffective to concentrate efforts, even initially, on individual categories of disease. If one wants only to upgrade the existing system, such as by concentrating on continuing education, a focus on categories of disease is appropriate. But if one wants to experiment with changes in the organization and delivery of health care, the focus is inappropriate. White has been among the most skeptical, arguing that if the United States “succeeds in regionalizing its services along the lines of categorical diseases, it will be the first country in history to do so.”

Should RMP support activities that experiment with changing, instead of simply upgrading, the health delivery system? In the first three years, the regions developed projects that were largely “traditional”: they concentrated on one of the categorical diseases, on inpatient care, on diagnosis and therapy; they used health manpower in traditional ways; and they used traditional educational technics, such as lectures. This all amounted, at best, to upgrading the existing system of health care.

These features still characterize most RMP projects. But a definite shift in the direction of noncate-
gorical projects that seek change is occurring. Multicategorical projects (e.g., library and nutrition), ambulatory care (e.g., home health aid) and preventive care are receiving increasing emphasis. Regions are experimenting with new kinds of allied health personnel and newer educational technics — including the use of computers, television and other technologic advances. More projects are being directed toward urban and rural poverty communities.

Primarily because of initiatives for change in the regions, as well as some federal encouragement, the new RMP law (signed on October 30, 1970) places new emphasis on "primary care," preventive care and care of the poor. The same regions that three years ago were proposing, for instance, to have RMP build a diagnostic center for secondary hypertension at the university medical center are now proposing quite different activities — programs to train physician assistants, programs to recruit and train Spanish-speaking community-health aids in migrant communities, programs to link isolated rural hospitals with distant specialists or computers for instantaneous information and consultation. Most recent planning studies carried out by the regions also seem appropriate to the new directions, dealing with such issues as transportation patterns, health costs and the demography of poverty communities.

Limitations and Failures

Despite these encouraging trends, optimism about RMP's future must be tempered by a realization of RMP's present limitations and past failures. These include the limitations placed on RMP by organized medicine; the inability of the universities to provide a full measure of leadership; confusion in Washington over federal health policy; inadequate planning at the regional level; and funding restrictions.

Despite its original opposition, organized medicine is now, according to its own leadership, more deeply involved with RMP than with any other federal health program. The involvement of organized medicine carries certain conditions, however. These conditions were first outlined by Dwight Wilbur, ex-president of the AMA, who rejected any attempt to use RMP as a vehicle "by which the organization and delivery of health care . . . could be changed in a revolutionary manner." Thus, organized medicine has indicated that it is quietly holding a veto over RMP. Opinions vary over whether it has used or will use that veto. Certainly, it is difficult to distinguish between evolutionary change and revolutionary change. It is difficult to distinguish between activities that "interfere" with traditional practice — the constraint in the law — and activities that merely deviate from traditional practice. In the past two years, organized medicine has not resisted RMP experimentation in such areas as medical manpower. If RMP were to begin experimenting with the financing of medical care, however, many think the story might be different.

Like organized medicine, the universities have given limited leadership to RMP, owing to both external and internal pressures. Externally, the prospect of university medical-school leadership has aroused some latent hostilities. In areas with bitter "town-gown" rivalries, organized medicine has sometimes believed that university leadership of RMP was characterized by an attitude of "noblesse oblige." Health departments and state and local governments, too, have been reluctant to concede that a new federally sponsored program with public-health aspects should be co-ordinated by the medical schools.

Internally, the universities have been ambivalent about their role in RMP. Many schools have resisted accepting new responsibilities that would "dilute" their capacities in teaching and research. On the other hand, some medical schools have excessively influenced the regional advisory groups and regional core staffs — many of whom are part-time faculty members. This is the exception, however, and not the rule. Despite frequent charges that the universities dominate RMP, there is evidence that, as the regions grow more mature, university influence is waning. For instance, universities contribute a diminishing number (now only 8 per cent) of the membership of regional advisory groups. Clark hoped that RMP would wed the universities to their surrounding professional and public communities, just as the Flexner Report had wed medical schools with universities. In no area has this yet occurred. At best, RMP has approached fulfilling James's early hope that its efforts would encourage a cautious courtship and invoke new relations between the universities and their communities.

Washington, too, has not provided the leadership expected by many. Over the past five years a spate of new federal health programs — some to organize health services, like RMP, and some to finance health services, like Medicare — have been created. Kissick has discussed the growth of these programs. The federal health budget has risen from $3,500,000,000 in 1965 to over $18,000,000,000 in 1970, the vast majority of this rise going into Medicare and Medicaid. Perhaps because of its preoccupation with these two huge health-financing programs, and with its own frequent reorganizations, the Department of Health, Education, and Welfare has not yet been able to provide clear and coordinated direction to programs directed at the organization and delivery of health care. To be effective, RMP must work closely with at least two of these programs: the National Center for Health Services Research and Development; and Comprehensive Health Planning (CHP). This is only now beginning to happen.

Both RMP and the National Center support health-services research and development; the division of responsibility between the two agencies, however, is not clear, although the two are working
toward such clarification. Some have suggested that the National Center do the research, and RMP the development. The Center would support initial experiments in improving health-services delivery, concentrating on a thorough evaluation. Promising experiments would then be developed more broadly by RMP, using its special influence with those who might be most skeptical — the established health forces.

A more fundamental overlap of responsibilities lies with RMP and CHP. Both agencies are responsible for “health planning.” In some cases, both agencies in a particular community are attempting truly comprehensive health planning — but in isolation of each other’s efforts. In other cases, both agencies are satisfied with only limited data collection. However, in the past two years, there has been progress in co-ordinating the two agencies at the local level. In some cases the two agencies share data-collecting efforts, or have interlocking advisory groups. The new RMP law requires CHP to review RMP proposals. But despite these encouraging signs, the fact remains that in many parts of the country two different federal health agencies with similar missions coexist without relation to each other.

In many cases, RMP has supported fragmented planning and operational efforts. This is not unique to RMP; confusion exists over what constitutes rational health planning. Most of the regions have forsaken planning in its purest terms — an initial assessment of regional health needs and resources, such as described by Marston and Odoroff from which follow the development of goals, objectives, priorities and methodologies. Instead, regional core staffs have found an opportunity that seems appropriate to a general goal. Planning efforts have then been concentrated on determining the idea’s feasibility and worth. Alterations of the region’s priorities have followed, to coincide with the opportunities at hand. This kind of planning has led to meaningful “co-operative arrangements”; however, it has also led to the funding of inappropriate activities cloaked with appropriate rhetoric. “New friendships” have been supported among those who were already old friends. “Co-operative arrangements” have been created solely to obtain the “involvement” of powerful local institutions; these ventures have not often led to the lasting commitment of the involved institutions, beyond the period of funding support.

This kind of after-the-fact planning may have been the only kind that RMP could realistically have done. The pressure was on the director of RMP in Washington and the regions to spend money to demonstrate “progress” to Congress. To have designed grand strategies, heedless of realistic opportunities for action, would have been self-defeating. Nevertheless, the pressure to “get moving” and “gain visibility” has indisputably placed qualitative limitations on RMP’s planning and operational activities.

There are also quantitative funding limitations. RMP will spend approximately $80,000,000 on grants this year; this is about 0.1 per cent of the national expenditures in health. The new Administration budget calls for a 10 per cent funding reduction in the next two years. Thus, RMP activities can have appreciable impact only if, by setting impressive examples, they influence the expenditure of other federal (e.g., Medicare) or private third-party funds. McNerney in the Medicaid Task Force report, discusses this crucially important concept. Slowly, many RMPs are coming to appreciate the value of this “broker” role — organizing new programs that other funding sources will sustain.

**Final Comments**

Despite its limitations and failures, RMP may have arrived at a particularly propitious time in American history. Several current trends bode well for RMP’s future. Across the nation, halting steps are being taken to regionalize health-care delivery; several states (e.g., New York and California) have passed hospital franchising laws, health facilities are merging into single management units, and community hospitals are seeking linkages with medical centers. Another important trend is the increasing importance being attached to continuing medical education, a primary function of RMP; this trend stems from a growing concern with the quality of medical care, and growing interest in physician re-censure. Finally, RMP is in step with an increasing governmental belief in decentralizing authority to local agencies: The Nixon Administration is emphasizing a “New Federalism”; recent amendments to the Medicare law encourage the development of local “professional standards review organizations” and “health maintenance organizations”; several of the proposals for national health insurance would create local health regulatory bodies. Thus, although it is too early to know whether RMP will have a role in creating or sustaining these organizations, the potential is great.

Nevertheless, serious questions remain about RMP’s past record and probable future accomplishments. RMP appears to be at a crossroads. Will it continue to be a program to upgrade the existing system of health care, particularly for heart disease, cancer, stroke and kidney disease? Or will it move farther in the direction of experimenting with broad, noncategorical changes in the organization and delivery of care? If it chooses the latter course, will it win the understanding and support of its dubious constituents — the “health establishment”? Whichever direction the regions choose, particularly if they choose to experiment with change, it will be a hard task. In the first place, RMP has relatively little money. Brown states that “there is a financial quid pro quo that goes right along with
asking people to serve society,” and points out that RMP is not able to offer much, particularly to the private practitioner, whose involvement is so essential. Secondly, RMP has no authority. The regions are expected to encourage the involvement of people who are not in the same hierarchy. They are expected to “catalyze” co-operation; but when the elements of the reaction are incompatible, RMP, like any catalyst, cannot be effective.

Great expectations have been held for the RMP’s. Farber\textsuperscript{6} claimed that RMP would become “the most important program in the field of medicine in the history of our country that is applied directly to the care of the patient.” Mayer is quoted\textsuperscript{5} as predicting that RMP would have greater impact on medicine than the development of the clinical clerkship, the Flexner Report, the evolution of the full-time medical faculty, or the growth of federal support for research.

These predictions have not come true. Perhaps someday they will. But it appears that RMP’s, in their current form, cannot realistically meet these expectations. At their worst, they are aggravating the fragmentation and isolation of elements in the health system. At their best, they are helping to slowly pave the way for major improvements. They are developing regional groups of sophisticated health providers and consumers who may become key figures in the organization and improvement of the health system at the local level. They are experimenting with change. They are creating a climate of co-operation; they are acting as the Dolly Levi of medicine, a matchmaker to bring together people and institutions who have previously ignored or scorned each other. This role, even when it is played well, is never heroic. It may be essential. Or it may not be nearly enough. The complexity and urgency of the problems facing society, in health and in all areas of social organization, may require society to place more controls upon itself. Voluntarism and pluralism, traditional American virtues, may not be sufficient to meet the challenges to America’s future. The RMP’s are betting that they will be. RMP offers an opportunity for those of us providing health services to help define our own future, through the encouragement of voluntarism and the co-ordination of pluralism. Is the opportunity worth pursuing? Are the RMP’s already relics of the past, or are they vehicles to carry us into the future? Were the RMP’s rendered impotent at their birth, or is their noncoercive nature precisely what is needed to rally and unite health providers in a spirit of sacrifice and change? The answers lie with us.

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