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Conference One:

MEDICAL TECHNOLOGY AND THE HEALTH CARE CONSUMER

On June 17, 1978, the Consumer Commission, sponsored by the National Science Foundation, presented the first of a series of four conferences on the subject of Medical Tecnnology and the Health Care Consumer. This issue of *Consumer Health Perspectives* presents excerpts from the papers presented at the general session of that conference and a brief report on each of four workshops held during the afternoon.

The conference papers have been edited down to present the highlights of each speaker's presentation. Unfortunately, space does not permit us to reprint the entire text of each speech here, but in 1979 we expect to publish a complete edition of the Conference papers in book form.

MEDICAL TECHNOLOGY AND THE HEALTH CARE CONSUMER: AN OVERVIEW

by

PETER ROGATZ, M.D., M.P.H.

* * *

The extraordinary decline in disease and death rates over the past two centuries is attributable much more to improvements in environmental sanitation, nutrition and birth control than to medical advances. Typhoid fever, scarlet fever, diarrhea and enteritis—diseases that were major killers in the late 19th century—succumbed to sanitary practices more than to medical treatment. Tuberculosis, whose conquest is sometimes attributed to the development of streptomycin and isoniazid in the mid-20th century, had lost much of its lethal potential long before the introduction of these drugs. We must recognize modern sanitary concepts as being among the great technologic advances of medical history, responsible for massive reductions in the occurrence of communicable diseases and related death rates.

Inoculation against smallpox and immunization against whooping cough, diphtheria and poliomyelitis also represent major triumphs. Although we take such preventive measures for granted, they actually represent outstanding examples of the application of technology in medicine. However, the current interest in medical technology focuses mainly on the diagnosis and treatment.

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We have reached an extraordinary stage in the development of medical practice, and, as a result, we are confronted with questions of unprecedented difficulty. There was a time when a physician unhesitatingly would use every available means to diagnose and treat every patient's illness and to keep every patient alive as long as possible. No patient, no physician and no outside observer questioned the appropriateness of this. Modern technology, however, has greatly complicated our view of the matter.

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We now have diagnostic tools of astonishing complexity so as to prolong life for weeks, months or years. Yet, far from solving problems, in many situations these new capabilities have produced cruel dilemmas for us.

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There is a characteristically American instinct—often described as the "technologic imperative"—which tells us that if something can be done, it must be done. Only recently have we begun to ask ourselves whether the unlimited application of medical technology involves costs greater than we can afford, or at least greater than the benefits that are likely to result.

* * *

Technology has brought about a wide variety of new therapeutic approaches — some dramatically successful and others disappointing; some gratifyingly inexpensive and others incredibly costly. Examples of highly effective yet relatively inexpensive treatment are the use of antibiotics and chemotherapy for the treatment of syphilis and tuberculosis and the use of hormone therapy for endocrine disorders. Dr. Lewis Thomas has made the point that technology of this type, based upon "...a genuine understanding of disease mechanisms...is relatively inexpensive, relatively simple and relatively easy to deliver." By contrast, he refers to certain spectacular technologic approaches which do not strike at the underlying pathology or offer a fundamental cure, as "halfway technology." He cites the examples of organ transplantation; kidney dialysis; treatment of cancer by surgery, irradiation and chemotherapy; and the complex emergency teams and facilities developed to deal with myocardial infarction.

The essential point to be made is that in the absence of a fundamental understanding of the underlying process, the best that medical science can accomplish against most diseases is to develop some type of complex technologic manipulation or gadgetry that modifies the anatomical and physiologic disturbances caused by disease. When fundamental knowledge of the underlying disease process is acquired, we are able to dispense with complex and costly machinery and substitute relatively simple and inexpensive therapy—ideally—effective prevention. One need only contrast the complicated "iron lung" machine used in the 1940s to aid polio victims with the simplicity of today's Salk vaccine to appreciate this point.

* * *

Our presence here today demonstrates the growing importance we attribute to the so-called "technologic imperative"—that seemingly irresistible impulse to acquire and use the newest, most complex, most sophisticated technologic tools with little concern as to whether they have been properly evaluated, with no proof that they are safe or even effective and, in many cases, without regard for their cost.

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It is fair to say that the technologic imperative seems to have a firm grasp upon hospitals throughout the United States...[Even] more intensely in those settings where it is least needed—in urban areas where numerous hospitals exist.

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A belated recognition of the costly consequences of the technologic imperative can be seen in the passage of Public Law 93-641 and in development of a more critical approach to reimbursement by many third party payers.

Such constraints, however, are directed primarily at capital formation. There has been relatively little effective control over the use of these costly tools once they have been acquired.

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A significant and disturbing consequence of modern technology has been the occurrence of diseases or abnormal conditions whose cause can be traced to the technology itself. The occurrence of diseases caused by physicians has long been recognized, such disorders being characterized as iatrogenic (doctor-generated).

* * *

With the growing role played by machines at almost every stage of the medical care process, we are seeing an increasing variety of illnesses and disorders that can be traced in whole or in part to the use of the machines themselves—a panoply of what we might call "technogenic" diseases. Many examples come to mind:

- Potential deleterious effects from the use of mammography in screening for breast cancer are the subject of major controversy. Any x-ray exposure produces some risk of causing cancer.
- The mere act of being admitted to a hospital exposes one to the risk of acquiring infection from the Hospital environment. It has been estimated that 5 per cent of all hospital admissions in this country will be complicated by such infections, and that 15,000 patients die annually as a result.
- Laboratory errors may result in unnecessary or even harmful therapeutic actions.

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Some of the most difficult issues raised by the application of technology to medicine do not lend themselves readily to classification as "desirable" or "undesirable" results. They involve complex social, legal, economic, ethical and philosophical values.

- The ability to terminate pregnancy with virtually negligible hazard to the life or physical health of a pregnant woman has, for many years, provoked heated controversy. At issue is not only the biological question of when life begins, but also complex legal questions and exquisitely sensitive religious and moral ones.
- At the opposite end of the life scale, technology has confronted us with questions regarding the prolongation of life beyond the point when an individual (and his/her family) may wish it to be prolonged.
- Does genetic research—recombinant DNA technology—involve the possibility of creating new forms of life that would pose significant hazards for human beings? How great is that risk? The experts disagree. How are we to know whom to believe?

* * *

The growth of technology has been associated with an increasing dependence upon machines...an increasing depersonalization of the medical transactions between patient and physician...and the increasing dominance of the hospital as the locus of medical care...[and] it is in the hospital environment that the patient feels most acutely the impersonal quality of machine-mediated care.

* * *

The advance of technology has raised problems of the most extraordinary complexity for all of us.....it is vital that you not leave the solutions to the professionals alone. I hope that today's conference will stimulate you to consider your own views on how technology has affected fundamental issues of sickness and health — the organization of our health care industry, the objectives of medical care, the functions of our various health professionals and the nature of the transactions between members of those professions and the people whom they serve.

A DEBATE:

A BETTER LIFE THROUGH MEDICAL TECHNOLOGY

PRO:

Medical Technology has made meaningful contributions to improving health, life expectancy, and the quality of life and will do even better in the future.

Dr. Louis R. M. Del Guercio, Professor and Chairman of the New York Medical College Department of Surgery, defended the "pro" position.

The current vogue for the denigration of "halfway technology," that apt phrase coined by Lewis Thomas, is one manifestation of the ecology, youth, healthy life-style axis which longs for a bucolic simple existence free from the tyranny of the machine.

* * *

The modern physician would be paralyzed without access to hemodialysis, pacemakers, respirators, cardiac monitoring, and total parenteral nutrition. This last example, more than any other factor, has significantly reduced death rates from severe trauma and burns. Stanley Dudrick of Houston now has a number of survivors following 90% burns as a result of his sophisticated nutritional support with maintenance of immune competence and energy reserves.

* * *

Technology should not be made the scapegoat for the enormous increases in health care costs (110 billion dollars from 1956 to 1976!). Fifty-five percent of the increase was due to inflation and less than four percent was attributable to increased technology. Population growth, increased utilization, the malpractice turmoil and unionization of the health labor force accounted for the rest of the cost explosion. In 1966 the average hospital wage was $4,000; in 1976 it was $8,650.

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The only way that society can make advanced medical technology available to all who desire it at a reasonable cost is through the application of cost lowering technology itself. Feldstein points out that cost lowering technology is characterized as raising the benefits of inexpensive care proportionately more than the benefits of expensive care. By benefits we mean some combination of increased therapeutic success, reduced diagnostic uncertainty and increased patient comfort. Examples of cost lowering technology include ambulatory surgical centers, medical information systems and effective assessment of preoperative risk.

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Although physicians and hospital administrators are criticized for jumping on the bandwagon for every technical innovation, in actuality technology transfer in medicine is notoriously slow. Our automated physiologic profile for the assessment of operative risk has taken years of evangelical sweat to catch on, even in university centers.

Rosalyn Yalow, in her 1977 lecture when she received the Nobel Prize in Medicine, supported this view that physicians themselves are the greatest skeptics when it comes to new medical technology. Her magnificent technique of radioimmunoassay took 15 years to reach the market place and now it is used for everything from cancer detection to reducing digitalis toxicity.

* * *

In summary, medical technology is our only hope for the containment of medical costs and improvement in the quality of care. The technological entrepeneur is an endangered species who has provided great benefits in the past with very little return on his investment in time and effort (it's always the big outfits who reap the rewards). The true innovator in the field of medical devices has been overregulated and undersupported, if he disappears from the American scene, health care will suffer and we will either do without or bootleg from abroad.

* * *

CON:

Medical technology has done little to improve health, life expectancy, and the quality of life. Social and economic advances have made more of an impact and will continue to do so in the future.

Michael Stewart, M.D., M.P.H., Chief, Division of General Medicine, College of Physicians and Surgeons, Columbia University, took the "con" position.

Speaking now only for myself, I want to be quite clear that I am not opposed in principle nor on ideologic grounds to the proper application of the most sophisticated technology available. I have recently followed a patient whose brain tumor was diagnosed and successfully treated only after an extraordinarily thorough evaluation including brain scans, CAT scans, multiple biopsies, and extirpative neurosurgery, and I am impressed with the neurosurgical armamentarium. However, I do have some serious reservations as to whether enthusiastic proponents of expensive, equipment-intensive modern medical technology have adequately weighed the relative costs and expected benefits (financial and other) of all the available options, or indeed whether they are really in a position to do so.

So-called "advances" in health and medical care delivery should not be slipped into place without a fair public hearing as to the anticipated costs, expected benefits, the degree of possible risk to patients, and the criteria by which effectiveness and impact are to be evaluated.

Why not, say the pro-technologists? Why should cost be a limiting factor? Isn't health too important an issue to turn over to cost-accountants? When I encounter this line of argument, I usually feel compelled to point out that the

most expensive medical technology is not preventive, and often not even curative; that it is readily available to only a limited number of persons; and that the health budget may grow a bit more, but it will always have finite limits. Resources will always be less than optimal and we will always have to make choices.

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In this broad sense, "medical technology" is virtually equivalent to "the health and medical care system." Therefore, to question the effectiveness of medical technology is the same as asking whether the existing health care system "works." The important questions to be asked are: (1) how good is the evidence that medical technology is actually responsible for reducing morbidity and mortality? and (2) are the results worth the cost? Discussion of these basic questions must be presented in terms of medical technology's "efficacy" (or "effectiveness") on the one hand, versus its "cost-effectiveness," on the other.

The historical record of the past 100 years suggests that a distinction is warranted among the following types of technologies: public health technologies; simple medical care technologies; complex medical care technologies; and non-medical technologies. An example of a public health technology would be the introduction of clean water in the late 19th Century, and more recently, fluoridation of public water sources. A simple medical technology would be tetanus immunization, or the treatment of strep throat with penicillin. A complex medical technology would be open-heart surgery, or coronary by-pass. A non-medical technology reflecting socioeconomic factors would be public television's impact on the nation's children, in terms of its effect on health beliefs and health care utilization.

* * *

There is considerable evidence to suggest (1) that simpler medical technologies are more effective than complex technologies, when measured in overall social terms; and (2) that complex technologies tend to be applied narrowly to selected patient groups. Moreover, complex medical technologies tend to become self-perpetuating. It is important to distinguish between the sometimes competing goals of refining technology with the notion of generalizing its application, and refining technology for the purpose of better serving the limited patient group for whom the application of a specific technology was originally intended or for whom it is most obviously beneficial.

SUMMARY

Pro-technology and anti-technology arguments notwithstanding, the health care consumer who wishes to play an active and constructively critical role in decision-making in the health care field has a responsibility to be well informed regarding the facts of new medical technologies. Even more important is the consumer's obligation to understand the decision-making process regarding the allocation of scarce societal resources for a finite set of social objectives.

* * *

Sylvia Law addresses workshop on Patients Rights. At her left are Mary Robinson and Dr. Enoch Gordis.

Marcia Pinkett-Heller and Zita Fearon listening as Dr. Lloyd Novick, New York's Deputy Commissioner of Health, addresses the workshop on evaluating technology.

ROBIN FORBES

Dr. Peter Rogatz (left) chatting with consumer participants at the morning session.

Consumer audience at the morning's general session.

DECISION-MAKING: WHO IS THE EXPERT?

Discussed by
Arthur Levin, M.P.H.
Director of the Center for Medical Consumers and Health Care Information
and
Harold Light, President and Chief Executive Officer
Long Island College Hospital

Mr. Levin:

It has only been in the last several years that consumerism has turned its attention to the area of medical care. I assume that part of the reluctance to apply lessons of consumerism learned in other areas resulted from the belief that medical care was "too complex" and "too technical" for consumers to play an important role in shaping policy.

* * *

Experts are authorities, and authorities are persons whose opinions, it is said, *deserve* our acceptance. There is no question that the layperson, confronted by an ever increasing degree of specialization, may often find it convenient to accept the authority and submit willingly to the decisions made by the expert/specialist. However, I am sure that many of you here today would be able to testify how dangerous to your health such acceptance of authority can be.

* * *

I believe that when consumers saw the experts differing about increasingly risky and invasive technologies, they decided they had to protect their own health by getting involved. The lessons of birth control pills, DES, Thyroid irridation, mammography screening are clear; consumer beware, and be involved.

Experts can release information in whatever way will best substantiate their position. An authority is someone in command, who is in power. The monopoly of information crucial to the decision-making process is the one way that medical/technological professionals seek to retain power over consumers. George Bernard Shaw said, "All professions are conspiracies against the laity."

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That control of information, that unwillingness to share power and grant equal status in decision making to the patient is one of the most often heard complaints of consumers.

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Professionals can monopolize information and gain power by developing jargon which can only be understood by those practicing the same profession. While some experts may claim that these separate languages are scientifically and technically essential, I believe that their major importance is in helping professionals maintain their dominance over laypeople.

* * *

The proper role of professional-specialist is that of advisor to the consumer-generalist. The physician role, for example, should be medical-technical advisor to the layperson. The layperson would use that information as but one part of the decision-making process about health issues. At present, most professional-lay encounters result in the dominance of the professional. The roles of technical authority and technical advisor are quite different. The latter assumes that consumers have ultimate control over the decisions that affect their health. Authority expects submission and acceptance. One of the most important changes that can come about in health care is for consumers and professionals to assume new roles; the locus of power should be with the consumer and not with the professional. The experts can also serve as translators for the consumer.

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Consumers must be sure to understand the particular bias that each professional has. That is, the consumer must always ask what is the self-interest of the expert. Surgeons like to recommend surgery, medical doctors prefer so-called medical solutions.

* * *

If the proper role of the professional is that of technical advisor to the consumer, what should the role of government be? Well, as I have already suggested, one role of government should be guaranteeing that the public have open, complete access to the technological information which may affect their well-being through the decision-making process. Government should also insure that such information is presented in a form which is understandable to laypeople. Government can also try to make sure that all shades of expert opinion are available in public decision-making and that areas of controversy be held up for public scrutiny and not hidden from view.

* * *

Therefore, to answer the question, Decision-Making, Who is the Expert? I would answer that the expert is the consumer-generalist in whom ultimate power should be vested.

The professional-specialist's proper role should be that of advisor and translator. Government should insure that both can perform their respective tasks adequately.

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Mr. Light:

One of the difficulties I had in preparing this presentation stemmed from the fact that the title "Decision Making: Who Is The Expert?" suggests that there is an inherent adversarial relationship between the health care provider and the health care consumer as it relates to the use of medical technology. In point of fact, I do not believe that such a conflict exists. I do believe that the decision making responsibility about the use of such technology—except in the case of life and death emergencies—does rest, and has always rested, with the consumer or his surrogate and that the consumer will, in the future, be even more assertively involved in the decision making process about his own health care.

* * *

In years gone by—when higher education was not nearly so universal a phenomenon as it is today—the physician was seen not only as a healer and a reliever of pain, but as a cultured and learned man whose knowledge of many things entitled him to make suggestions which, rightly or

wrongly, were often accepted by the patient or his family as decisionsmade for them. The transferential elements in the doctor/patient relationship, plus the factors cited previously, along with a generally prevailing societal respect for authority, often resulted in situations where it appeared as if the patient was not a participant in the decision making process. I do suppose that in many instances, particularly as this relates to the indigent population, decisions were made for the patient without his active participation in the process.

Today, however, we are clearly living in a different era where authority is a much more elusive element and is as often challenged as accepted, where the civil liberties of individuals are much more respected and protected than they were previously and where the medical-legal complications of the modern day practice of medicine all serve to ensure that the patient is a much more active participant in the decision making process related to his own care.

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The courts have also held, in countless cases, for the patient's right to insist that no "heroic measures" be taken in his behalf for the sake of preserving life beyond the point when life would otherwise cease to exist by most laymen's standards. Thus, for example, a patient riddled with cancer may choose to advise his physician that he wants no heroic measure taken in the event that he suffers a cardiac arrest, despite the fact that medical technology, in the form of defibrillation, may exist to resuscitate such an individual. Similarly, the courts have determined that a terminal cancer patient has the absolute right to refuse treatment for the disease itself and may choose, instead, to be administered to only for the sake of being relieved of the pain attendant to such a terminal condition.

* * *

My own sense is clearly that the medical profession, while far from perfect in many respects and even, perhaps, deserving of some of the negative press to which it is now being subjected, has been unfairly maligned in the area of patient's rights and in their respect for those rights. If the profession is guilty of anything in this regard, it is probably in not adequately recognizing the degree to which even the strongest individual is thrust into a dependent state by virtue of his need for hospitalization and his need for the resources provided by a hospital and its professionals.

* * *

WORKSHOP PROCEEDINGS

Left to right are Decision-making workshop panelists David Smith, Bruce Mansdorf, Marshall England and Anthony Mangiaracina.

Workshop I. What Consumers Should Know about *Evaluating Technology.* Moderator Marcia Pinkett-Heller, Director, Consumer Education Program, Columbia University School of Public Health. Panelists: Zita Fearon, Chairperson, Consumer Council to the New York City Health Department and Lloyd Novick, M.D., New York City Deputy Commissioner of Health.

The panelists and moderator in Workshop I not only raised general social, medical and economic issues associated with the increasing technology in health care, they also outlined the specific methodologies most commonly used in judging quality and efficacy of individual practitioners and health facilities.

One of the unforeseen but most interesting issues raised in this Workshop was the question of just what was meant by a "consumer" evaluation. Dr. Novick made a distinction between the concerns of consumers and providers as evaluators, portraying consumers' concerns as primarily subjective (having to do with the "amenities" of care) or involved with those issues pertinent to choosing physicians and facilities with good reputations. He described providers as the objective assessors of health care, *via* outcome analyses, process reviews and the application of structural criteria. He outlined these procedures in detail for the audience.

Consumer participants, along with panelist Fearon, joined the issue by pointing to the difference between consumers as patients and as board members and planners. It was clear that the workshop participants were there in their second role and wished not only to familiarize themselves with the standards used by providers in evaluating technology (and all aspects of the system), but also to develop their own criteria of assessing the merits and necessity for specific technologies. Ms. Fearon saw consumers as having to "evaluate the evaluators," by familiarizing themselves with those questions which must be asked to determine the quality and efficacy of health services, technological and otherwise, and by acting in their official capacities to ensure that all necessary evaluations are performed thoroughly and responsibly. □

Workshop II. *Patients' Rights and Informed Consent in a Technological Era.* Moderator: Mary Robinson, Bronx Borough Coordinator, New York City HSA. Panelists: Sylvia Law, J.D., Associate Professor, NYU Law School and Enoch Gordis, M.D., Associate Professor of Medicine, Mt. Sinai School of Medicine.

This session opened with presentations by the panelists on the subject of informed consent. Professor Law gave a brief history of the doctor's legal obligation to inform patients of the potential risks of medical procedures, noting a

recent shift toward general community standards and away from a strictly professional standard in determining whether a patient has been reasonably informed. Dr. Gordis spoke to the same issues, giving examples from his own practice illustrating a physician's point of view on the complexities of the question of when and how much to inform patients.

A question-and-answer session between audience and panel brought up a number of specific problems on this topic, among them the rights of the patient in cases of "ghost surgery," that is, when surgical residents, unbeknownst to the patient, perform operations in place of the "official" surgeon of record. A discussion ensued on the conflict between the rights of individual patients and the need of a teaching institution to train future surgeons. The related question of whether the less affluent or minorities were more likely to become "training subjects" was also raised in this context.

The discussion over how thoroughly physicians were obliged to inform their patients of the purposes and risks of medical procedures was a heated one, bringing up the issue of paternalism versus self-determination for consumers. Paternalism and increased mechanization of care were also seen by the audience as factors in the struggle by many consumers to get access to their medical charts. □

Workshop III. ***Medical Statistics and the Health Care Consumer or How Not to be Snowed by the Numbers.*** **Moderator: Louis R. Gary, Graduate Department of Urban Planning, Hunter College. Panelists: Geraldine Alpert, Ph.D., Coordinator for Data and Special Studies, NYC HSA and Donna Ganzer Yedvab, M.B.A., Statistical Consultant.**

The presentation by Donna Yedvab familiarized the audience with a few basic statistical concepts, such as the standard ways of expressing statistical "typicalness." Her intent was to show the variety of impressions of the same phenomenon which can be conveyed depending upon the statistical mode employed. The many and varying factors which influence such common indicators of hospital use as "length of stay" or hospital "occupancy rate" were also brought out as examples of the difficulty of relying on unexamined statistics for a single reliable meaning.

The terms "incidence" and "prevalence" of disease were also elucidated, to illustrate problems in interpreting these common statistical expressions of health status. Consumers were told critical questions which must be asked in evaluating the accuracy of surveys whose purpose is to assess need for services.

Geraldine Alpert focused her presentation around two principal questions: "How is data to be used?" and "What are the problems with the data which are available to us?" She began with the *caveat* that data are not "a decision-making apparatus for social choices," but only supplemental tools which we employ to further inform ourselves. She stressed that consumers often have knowledge of the community which has not been reflected in the data, and that their input is therefore invaluable in making health policy.

Ms. Alpert explained the most common and readily available statistical measures of health status—morbidity and mortality statistics—and she sketched out the causes for skepticism when relying on these indicators, among which were unreliable reports of causes of death and the artifacts of increased or decreased reporting. She also outlined the problems of doing accurate population-based planning, given the difficulties of predicting population migrations and changes in medical practice, which, among other factors, will directly affect how many and what kinds of services will be needed in years to come. □

Workshop IV. ***Untangling the Web of Decision-Making—What Role Do (Should) Consumers Play?*** **Moderator: Anthony Mangiaracina, Vice President, W.R. Grace and Company. Panelists: Marshall England, Executive Committee, New York City HSA; David Smith, J.D., Executive Committee, New York HSA; and Bruce Mansdorf, M.P.A., Deputy Director, New York State Health Planning and Development Agency. Judy Wessler, consumer member of the New York City HSA, also joined the panel.**

The presentations and the question-and-answer session in this workshop centered on the possibilities for and drawbacks to effective consumer involvement in health care, especially in the health planning process. Mr. Smith presented a history of consumer involvement in health planning and a brief explanation of the mandated role for consumers in the present legislation (P.L. 93-641). He expressed the view that although the legislation was itself a breakthrough for consumers, only hard work would bring them into a truly influential position.

Mr. Mansdorf spoke to the issue of the relative power of the local HSAs in comparison with the state agency, maintaining that local consumers could not act responsibly as planners without an incentive to contain the total costs of health care in their service area. He mentioned that putting a cap on total regional capital expenditures would be one way of inducing local planning bodies to plan in a fiscally responsible manner.

Panelists Smith and Wessler touched on the relationship (or lack of it) between consumers on the local level and those on the SHCC; and Ms. Wessler expressed the view that SHCC and HSA Executive Committee policy tended to be set by staff rather than members, and that the N.Y. SHCC was unduly influenced by provider interests. There was discussion over the degree to which HSA and DHEW were responsible for educating and informing health consumers. Mr. England and Ms. Wessler proposed that a consumer union or consumer network were indispensable for focusing the impact of consumer interests on the system. □

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