HEALTH PERSPECTIVES
A NON-PROFIT TAX EXEMPT ORGANIZATION
VOL. VI, NO. 1 (1979) PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. Pub. 2/79

Conference IV:
THE FUTURE OF MEDICAL TECHNOLOGY

On November 18, 1978, the Consumer Commission, sponsored by the National Science Foundation, presented the last in a series of four conferences on the subject of Medical Technology and the Health Care Consumer. This issue of Consumer Health Perspectives presents excerpts from the papers presented in the morning session and summaries of the afternoon's workshop proceedings.

Unfortunately, space does not permit our reprinting the entire text of each speaker's presentation. However, later this year we expect to publish in book form a complete edition of the papers presented in the Conference series.

THE CASE FOR PUBLIC OWNERSHIP OF MEDICAL TECHNOLOGY

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The Case for Public Ownership of Medical Technology

In her autobiography, one of the earlier New York City Health Commissioners, Dr. Josephine Baker, said: "I remember how I felt when, after we had our baby health stations established and doing well in the Brownsville section of Brooklyn, a petition was forwarded to my desk from the Mayor's office signed by 30-odd Brooklyn doctors protesting bitterly against the Bureau of Child Hygiene because it was ruining medical practice by its results in keeping babies well and demanding that it be abolished in the interests of the medical profession."

Dr. Baker's response to this criticism was: "This is the first genuine compliment I have received since the Bureau was established."

I have used this brief excerpt from Dr. Baker's autobiography to illustrate one aspect of the conflict between the private sector's interests and the public's right to health services.

Now, perhaps more than in Dr. Baker's time, we are seeing how difficult it is to provide for the public when private, vested interests are determining the shape of the health system.

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As the medical arts have evolved into the medical sciences, the provision of health care has become an increasingly technological matter. The hospital plant, the CT scanner, the kidney dialysis machine, the syringe, the vaccine—all are technology. Consequently, questions about the effectiveness of our health system have to do largely with the quality, allocation and costs of medical technology.

The case for public ownership of these technological resources is strong. Not only is it strong morally, it is also eminently practical.

As a society we have said that we believe that no citizen should be barred from receiving health care services. Further, we have said that we believe that the fact of poverty should not disqualify a person from receiving high quality health care. In short, we have proclaimed health care to be a right rather than a privilege. Congress has enacted major legislation which provides health insurance for certain categories of persons. There is Medicare for older citizens, and there is Medicaid for the very poor. By these pieces of legislation we agreed to finance part of the health care bill for certain people. However, these partial financing arrangements have not made reality out of the rhetoric of health care rights. Health services still are not available to all citizens. In actuality, obtaining adequate health care services is still very much a privilege, and obtaining good and comprehensive services is still very often a matter of luck.

Estimates of the proportion of the population who are "medically indigent," that is, not covered by Medicare or Medicaid and unable to afford private insurance, have been put as high as 30 percent, and DHEW reports that about 12 percent of the population has no regular source of primary care, such as a doctor or clinic.

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The problem is, that although the public has taken on some social responsibility in terms of *financing* health care for its citizens; the institutions, the programs, the arrangement of health care resources have been left in private hands. When vested interests continue to vigorously (and successfully) resist any structural changes in the system, it becomes well nigh impossible to fill service gaps, to guarantee quality or to control costs. Organizational chaos, competition among provider and the drive for profits and individual gain remain deterrents to efficiency, to equity and to quality in health care. Not only have financing programs not had any significant impact on these

characteristic weaknesses in the system, they have tended in some cases to reinforce some of the system's worst features.

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Why should the public own health care technology? First because we have already bought it and given it away to the private sector. The whole of the highly technological medical system has been nourished, developed and supported by public resources and public money. Eighty-eight percent of the general hospitals in the United States are either government-operated or tax-exempt private, "voluntary" institutions. These hospitals are either supported directly by tax-levied funds or draw from the tax base by virtue of their tax-exempt status. Mainly through Medicare and Medicaid, the government now pays for more than 50 percent of the operating costs of hospitals, and thus the public underwrites the purchase and maintenance costs of a tremendous amount of acute care technology, as well as the salaries of the interns and residents working in the hospitals. (The public has also made a major commitment to the education of physicians and other health professionals—more than 70 percent of the cost of educating a doctor is a gift from the taxpayer.)

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The public has also built many hospitals for the voluntary sector. Since 1946, through the Hill-Burton Act, billions of dollars have been made available by Congress for hospital construction in the private non-profit sector. In return for these public grants, hospitals were required to give a certain small proportion of free care to the indigent. Although a hospital building boom (and a great deal of what may have been unneeded construction) was stimulated by the Hill-Burton program, very few institutions lived up to their free care obligations until legal action on behalf of consumers in the 1970s forced greater hospital compliance with the law.

Much of the technology now used routinely and profitably in the practice of medicine was developed directly as a result of government-sponsored research and/or tax-exempt contributions from the public.

The development and testing of new drugs is an example. Under the supervision of the federal Food and Drug Administration, drug research on human subjects takes place throughout the country in tax-exempt and government institutions. The patent rights designed to insure profits to the developers are then consigned by another agency of government to those in control of production of those pharmaceuticals. The marketing of the drug product becomes a profit-making venture for all who handle the drug's production and distribution. And while the patent rights exist, the generic formula may not be manufactured, distributed or sold without purchasing written permission from the patent holders. What is the public's reward for supporting the development of this treatment technology? According to a Senatorial committee investigating the costs of drugs, the mark-up on some drugs exceeds 1400 percent! This is but one example of the public's lending its resources for the development of technology and then getting its feeding hand bitten.

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Then there is the question of disorganization within our essentially private system and its impact on health and on the national budget. If we take seriously the idea that health care is a right, we must find a way to deliver high quality services, equally available to all people, in an efficient manner.

The present economic chaos in which we are foundering has caused an indefinite delay in promised programs for national health coverage. Recent administrations have engaged in several desperate and sometimes massive attempts to control rising costs in the health sector, but each solution stops short of actually reorganizing the delivery system. Talk of putting a 9 percent "cap" on annual increases in hospital charges resulted in a predictably ineffective voluntary cost control program in the private sector. The National Health Planning and Resources Development Act of 1974, resulting in the creation of an enormous network of regional health planning agencies, was another attempt to deal with economic problems and deficiencies in health services. Again, underlying problems were left untouched.

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The crazy quilt of public and private health institutions, the variety of commercial and non-profit insurance policies, the myriad public programs offering partial and overlapping coverage for certain health services—all are root causes of the expense and inequities in medical care. As a result of the ungainly aggregation of health facilities and practitioners which make up our health "system," individual health institutions are compelled to compete with one another in order to attract attending physicians and patients. In this contest for survival, a tremendous amount of extra technology is purchased and operated, and extra and inappropriate services are performed while other kinds of very basic health services go unprovided.

This kind of wastefulness and duplication is a direct result of the public's open-ended financing of health care services through an unregulated and unorganized private sector. Unfortunately, in the health marketplace, there seem to be no benign economic laws which operate to give the public the services it needs at the best possible price. On the contrary, any and every increase in hospital operating costs and physicians' fees are, in effect, guaranteed by public and private third-party insurance plans. If charges go up, so do taxes and premiums.

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As for the effect of the system's disorganization on quality, it is by now a truism to describe the care received in the system as "fragmented" and "episodic." The absence of needed primary and preventive services is also well known, with the consequence that, in terms of the overall health of our population, we do not compare favorably with the other developed nations of the world.

In terms of technology specifically, there have been many adverse effects on health associated with lack of coordination in the system. The presence of extra technologies is thought to cause an increase in the number of unnecessary procedures and in "iatrogenic" and "technogenic" illnesses. On the other side of the coin, this same disorganization and lack of coordination in the institutional system means that some groups enjoy the advantages of advanced medical technologies while others do not, and that scarce technological resources might be more equitably distributed.

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A regionalized, public system is needed if we seriously expect to deliver comprehensive high quality health services.

Why should the government be involved in overseeing and providing health services? Because government is the only credible organizational framework within which the present chaotic and fragmented system can be unified. In a public system, profit is eliminated as an incentive and the basic motive for the system becomes the meeting of public health goals.

In a National Health Service, all institutions and health resources would be publicly owned. Each geographical area would have a coordinated system of workable units in which health professionals would provide the full range of health services.

In such a system, the facilities provided to each region would include: a number of health centers for primary and preventive mental and physical health services; general hospitals for acute care; a university medical center serving as the site for superspecialty care and tertiary level hospitalization; long-term hospitals and home care services.

The advantages of this kind of system are many. First, the public's resources can be effectively and evenly distributed among all groups in the population. Second, people can enter the system at the appropriate level of care (whether primary, acute, specialty or long-term) and be assured of continuous, coordinated treatment. Third, since one complete set of services would be planned for each region, superfluous costs associated with competition and unnecessary duplication are minimized. Fourth, a regionalized, public system obviates the need to administer a number of separately funded, narrowly focused programs covering certain categories of consumers (the elderly, the poor, mothers and infants, etc.).

The purchase and distribution of medical technology through a single public system would mean that all people would have access to whatever medical technology is part of the medical arsenal of the day. Public need would be the determinant of what public money would buy; competition among hospitals would no longer drain the public's resources.

A unitary system would also assure a more reasonable distribution of technology both among the facilities within a given service area and from region to region across the country.

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Finally, it should simply be said that since the public has already paid in great part for the development of technological medicine, the least it can do for itself is to decide how it might best enjoy its technological advantages and protect itself from technological dangers and abuses.

CONSUMER ACTION FOR HEALTH IN THE FUTURE: An Illinois Perspective

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If the conclusions of a panel of federal government experts on the products of the Chicago Health System Agency's planning efforts are any indication, the standards being used have less to do with the ability of the agency to do the planning job, than with political considerations—a problem not unique, we are told, to our part of the country....

"The [Chicago HSA] plan ignored virtually every component of the health care delivery system except facilities operated by the Chicago Board of Health—like the HSA, a politically dominated agency answerable to City Hall. The plan made no mention of either private doctors' offices, or varied programs offered by the Cook County Health and Hospitals Governing Commission, which has been politically independent of organization Democrats since 1969." The Governing Commission, it might be noted, operates Cook County Hospital, the City's only public hospital and the largest provider of medical services to Chicago's sick poor....

"The plan ignored factors affecting exposure to injury and disease of employees in the workplace. The agency made only a 'limited' attempt to explore how Chicagoans use the health system, habits whose analysis is seen by federal health planners as the key to the careful mapping of change." The six-page internal HEW report went on to conclude that the Chicago HSA had spent $1.5 million in federal funds to draw up a health plan for the City that was found to be unacceptable.

The report of the federal review panel was voluntarily released by HEW to the [Chicago] *Sun Times* under the Freedom of Information Act after a federal investigation was begun into the reasons behind HEW's approval of permanent designation status for the Chicago HSA as a planning agency. The Chicago HSA contract was awarded by HEW despite the unanimous opinion of its own panel of experts that the Agency's Health System Plan should be rejected, and despite vigorous objections of Chicago consumer health activists who had previously been critical at every level of the health planning review process.

In rural Champaign County, Illinois, the local HSA is now on a one-year probationary status because of its lack of accountability to consumer interests. It was only after a prolonged two-year battle led by consumer activists, that legitimate consumer representatives were able to replace provider sponsored members on the local board.

In Chicago, HSA board members and staff are virtually all political appointees. The HSA, according to the previously mentioned *Sun Times* report even went so far as to return $100,000 to the federal government in order to avoid setting up sub-area advisory councils in the City's neighborhoods. Sources inside the HSA were quoted as saying "the program was scrapped when City Hall officials complained that public participation would mean effective consumer control of the agency." An HEW insider reportedly stated the highest ranking HEW official in Washington had ordered full designation after City Hall pressure was brought to bear in Washington.

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The largest (planning) gains have been made in Illinois Insurance Department hearings reviewing the operations of Blue Cross/Blue Shield of Chicago, the state's largest health care insurer. Illinois consumer activists have been able to address health issues through these actions that are completely out of the jurisdiction of health planning agencies.

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The result of consumer intervention in the hearings has been a complete denial of rate increase requests and a long series of orders to the "Blues" to institute programs and policies that would benefit their subscribers. The "Blues" have been ordered to renegotiate their 28-year-old contracts with Illinois hospitals, and to include in the new contracts provisions requiring them to provide a mechanism that would prospectively assess the reasonableness of a hospital's financial requirements and its rate structure. The insurance director, using a new consumer-sponsored law, would be able to monitor the "Blues' " activities in this area and would be able to contain rates of reimbursement not only to hospitals but also to other participating health care providers.

A total of sixteen orders have been imposed on the "Blues" specifying programs that would expand subscriber rights; develop stringent standards for utilization review; require plans to be drawn up to reduce excess hospital capacity; expand extended are and coordinated home

care services, preadmission testing, outpatient surgery, second opinion surgery, provider education services and would help implement state-mandated generic drug programs. Non-hospital providers were also affected as they were ordered to negotiate new contracts which must include hold-harmless agreements that protect subscribers from being charged for hospital and physician services the "Blues" refused to pay.

In short, because of the insurance department legal interventions, consumers have made inroads in areas that health planners don't get into in their wildest dreams. The consumer strategy here has been relatively simple. The Chicago "Blues" were selected as a target because they account for almost 50 percent of the revenue of 300 hospitals in the state, 20 percent of which is federal Medicare money. The "Blues" are chartered under their own unique not-for-profit insurance law, which made it possible for consumers to oppose them in a one-on-one confrontation in the hearings. The economic leverage this one insurer holds over medical providers in the state, however, was the most significant factor influencing consumers in their decision to mount a legal offensive in the hearings.

THE REALITY OF HEALTH CARE DECISION-MAKING

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President, Consumer Coalition for Health

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Political decisions should be made through a public process. Why was the allocation of billions for CT scanners made privately? At the time the CT Scanner boom started in the early to middle 1970s, there was little in the way of a legal structure which imposed public planning or control. Certificate of need laws were either non-existent or weak, doctors' offices were not covered in any case, and planning agencies were provider-dominated. Despite changes introduced by the National Health Planning and Resources Development Act, the situation remains basically the same today.

It is interesting to inquire as to what the doctors and hospital administrators knew about CT Scanners when the decisions to invest billions were made. They knew that in certain special cases, remarkable diagnostic results could be achieved. They did not know, and probably still do not know, because the research is at best preliminary, the extent to which these diagnostic improvements effect health outcomes. For example, identification by a CT Scanner of an otherwise undetectable brain tumor does not affect outcome if the tumor cannot be treated. Nor do physicians consider alternative health uses of the funds which are to be used to purchase Scanners. They are not trained to do so, nor does the practice of medicine generally develop a public health perspective in the physician. The physician has a private health perspective, which focuses on crisis intervention and a relatively small group of individual patients for whom the physician feels personally responsible. In these circumstances, the decision to use a new instrument of technology is an easy one, if a payment mechanism is available. When faced with a sick human being for whom no diagnosis or treatment seems effective, utilization of a new technique for that individual seems to make sense, regardless of whether the outcome will be affected in only one case in 50, 500 or 5,000....

Hospital administrators are hardly in a better position to make social decisions. They are responsible to their individual institutions. Their decisions are made with little or no regard for general health needs of the public, particularly those needs unrelated to hospital care. The careers of hospital administrators, particularly in the dominant voluntary sector, are best advanced by expanded modernization and construction programs. A new wing is a permanent tribute to the skill of the administrator.

Since doctors admit patients, hospitals cater to doctors; if doctors want a Scanner, the hospital will provide one. Otherwise, a "competing" hospital will, or a group of doctors will buy one of its own. Once installed, the Scanner miraculously tends to be used enough to pay for itself, no matter how many are already in operation in the area.

As the demand for public control of scientific policy decisionmaking has increased, a new phenomenon has arisen—regulation by experts. Rather than resulting in true public accountability and control, however, a process develops in which lip service in institutional form is given to a public process, but the staff of the new regulatory agencies exercise the actual power.

This trend is becoming most evident in the health planning field. A great deal of publicity is given the Health Systems Agencies, and to their "broadly representative" consumer majorities. But the reality is that the greater power is retained by the State Health Planning and Development Agencies, state agencies staffed by professional planners with no citizen involvement. The greatest power now possessed by planning agencies is the certificate of need and this power lies in the state agency. In effect, institutions need a license to make capital expenditures; the power to grant or deny a certificate of need, properly utilized, can have substantial impact on allocation of resources. HSAs play only an advisory role in the certificate of need process. HSAs do adopt the Health Systems Plan, but there is no legal requirement that the state agency adhere to the Plan in certificate of need decisions. At the HSA level, traditional provider dominance still prevails in many areas. In others, it has often been replaced by the domination of the professional planners. These professionals are often well-meaning; they believe they have the knowledge and the ability to make the best judgments. The members of the public, consumer and providers alike, serving on the boards and committees are viewed by the planners as chess pieces to be moved about to provide support for the planners' decisions. Planners have a virtual monopoly on information and training, particularly vis-a-vis consumers. And consumers are acting as volunteers, with limited time to devote.

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It is not an easy task for the public to exercise control in areas of technical complexity and professional mystification. Individual citizen participants face a long and often lonely uphill effort. What is needed is a well developed community organization lending support and demanding that professionals play their proper role as advisers....

All of the materials incorporated in this issue were developed with the financial support of the National Science Foundation Grant No. OSS7720845. However, any opinions, findings, conclusions or recommendations expressed herein are those of the authors and do not necessarily reflect those of the Foundation.

PUBLIC HEALTH IN THE UNITED STATES: The Next 100 Years*

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During the next 100 years, sanitation of the environment will cease to be a stepchild of public health and become, as it was until recent years, a major activity of health departments. Health departments will be radically reorganized. There will be a Department of Health at the Federal level, responsible for basic national policies and standards for all public health programs, including those concerned with environmental health. Health departments at the State and local levels will be responsible for carrying out national policies and maintaining national standards; their jurisdiction will include all environmental health programs, such as air and water pollution, sewage disposal, milk and food sanitation, radiation, occupational disease and injuries, automotive and other accidents, and drugs, food additives, and other chemicals.

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The past 100 years have seen the virtual completion of the first epidemiologic revolution—the conquest of the infectious diseases. Even though the control of a number of these diseases, such as influenza, the common cold, and the venereal diseases, remains elusive, there is every reason to believe that improved scientific tools and control methods will be developed to cope with them.

The second epidemiologic revolution—the control of noninfectious diseases—has already begun. Whether this revolution will also be virtually completed within 100 years is difficult to say. On the other hand, there is no doubt that major declines in the most significant noninfectious diseases will be achieved. From 50 to 75 percent of the morbidity and mortality from such leading causes of death as coronary heart disease, cancer, cerebrovascular disease, chronic obstructive lung disease, and cirrhosis of the liver will be prevented.

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Health education in the next 100 years will be well financed and conducted on a large scale. It will also be highly sophisticated, using all the techniques developed by our modern media. But it will not stop there. For example, health education will no longer be a hit or miss program in the schools, but will become an important aspect of the curriculum, taught by sufficient numbers of well-trained, full-time personnel.

Even more important, health education will assume its rightful place in the curriculum of schools of the health professions because all health workers—physicians, dentists, nurses, social workers, nutritionists, psychologists, and so forth—regardless of their position in the health care system, will be expected to spend a certain amount of their working time in health education.

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After a distressing period of experimentation with private and governmental health insurance—in which bureaucracy will increase as a result of vain attempts to contain costs, and inequities in health service will continue—the United States will establish a National Health Service.

This National Health Service will have three major components: research, disease prevention, and personal health services (health care). The research component will be comprised of the National Institutes of Health, including new Institutes that will have been set up in different parts of the country. Disease prevention will include all programs for the prevention and control of infectious and noninfectious diseases and trauma. In accordance with the policy of recognizing the primacy of prevention, this component will receive a great deal of budgetary and organizational emphasis.

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Services will be comprehensive, including mental, dental, and long-term care. There will be no payments by patients for any of the services. These will be provided in community health centers and hospitals staffed by salaried physicians and other salaried health workers. Furthermore, the National Health Service will make possible the establishment of a national network of medical institutions. The dream of regionalization, so remarkably well conceived by Dr. Joseph W. Mountin and his colleagues in the Public Health Service in the 1940's, will now be realized. In accordance with patients' needs, they will be referred from small hospitals to larger and more specialized institutions, and eventually if necessary to university medical centers.

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There will be increasingly democratic control of health services. All health departments and institutions will be responsible to boards or councils representing all sections of the population. This situation will be in sharp contrast to the present one, in which relatively small sections of the population dominate the boards of hospitals, health departments, and voluntary health agencies.

Perhaps even more important, the public will be drawn into the work of health departments on a scale far greater than in the past. This involvement will be particularly common in programs for the prevention of infectious and noninfectious diseases and trauma, but will also be common in health care.

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Poverty and its too constant partner, discrimination, are responsible for a great deal of unnecessary disease. They are also at the root of much of the violence that threatens all classes of the population in our cities. Just as cholera in the 19th century moved out of the hovels of the poor to reach into the homes of the well-to-do, so violence today moves out of the slums and the ghettos to make entire cities unsafe.

From a public health viewpoint, therefore, and from every other point of view, it will become necessary for society to bring an end to unemployment, poverty, and discrimination, and to assure satisfactory pensions for the retired instead of the current crazy quilt of inadequate programs. That these changes will be accomplished in the next 100 years, there can be no doubt. As with all significant social changes, however, we must be concerned that they be consummated with as little travail as is humanly possible.

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*The complete text of Dr. Terris' presentation (abridged here) was published in *Public Health Reports*, Nov.-Dec., 1978, Vol. 93, No. 6.

WORKSHOP PROCEEDINGS

Workshop I. ***Making the Workplace Safe for Workers and the Community.*** **Panelists: Michael McCann, Ph.D., President, Center for Occupational Hazards, New York City; Henry Velez, M.D., Environmental Sciences Laboratory, Mt. Sinai Hospital; Deborah Nagin, M.P.H., Program Planner for Occupational Health, New York City HSA; William H. White, Assistant Director, Borough of Brooklyn, New York City HSA.**

A discussion of occupational health as a major health and political issue for an industrial society opened this workshop. With HEW's own regulatory and monitoring agencies reporting 20% of cancers linked to occupational hazards and other reports suggesting 390,000 new cases of occupational disease a year, there is little doubt that numerous workers are affected. The deleterious effects on individual health may not be apparent for some time, but the effect on the community—as with PBB in Michigan—can be immediate.

Occupational illness is growing. Several factors inhibit the control of its growth. The government's research and regulatory agencies—NIOSH and OSHA—are understaffed; the regulation process itself is slow to respond and rectify abuse. The inflationary impact of controls on industry means that the business community will not voluntarily respond to statutory requirements. And, the lack of trained monitoring personnel at the workplace and small numbers of workers at individual workplaces lessens the chance for effective hazard detection by the workers themselves.

The second half of the workshop was concerned with the relationship between the health care system and occupational illness. Although occupational illness is by no means a "new" issue, it remains outside the mainstream of health care concerns. Proper screening and surveillance require organized, standardized record keeping. Doctors have little training in recognizing occupational illness and rarely take an occupational history of patients. Detection and treatment for occupational illness can require expensive, special equipment. Finally, the injured worker may not have health coverage adequate to cover the expenses of intensive screening or treatment.

Another consideration for the worker is disclosure of a work-related illness to the company doctor. An injured worker could be transferred to a lower paying position, away from a hazard rather than the company eliminating that hazard..Worker involvement in the monitoring and control of the workplace to assure that toxic substances are eliminated is one positive strategy. However, knowledge of hazards is limited; there is no right-to-know legislation for [chemical] labeling standards and other toxic hazards.

What, then, is the role of the HSA in enforcing and monitoring environmental and occupational issues? A panelist suggested that HSAs could initiate health goals through the project review process; that is, establish occupational criteria for health care institutions. Presently, project review criteria do not include concerns of health care workers. The economic and political factors involved require labor-management participation, often difficult to achieve. Through the project review process, an HSA could include institutional compliance with environmental and occupational safety and health standards. □

Workshop II. ***Our Aging Population: Does Medical Technology Hold Any Hope?*** **Moderator: Nelly Peissachowitz, National Citizens Committee on Nursing Home Reform. Panelists: William Wolarsky, M.D., F.A.C.P., M.S.P.H., Medical Director, Daughters of Jacob Geriatric Center; Ron Brooke, Health Care Consultant, Brookdale Center on Aging, Hunter College; Clyde Behney, M.B.A., Senior Analyst, Health Programs, Office of Technology Assessment, U.S. Congress.**

Nelly Peissachowitz opened the workshop by describing the situation of the aged in the U.S. as indicated by national economic and social characteristics. Although the elderly represent only 10% of the total population, they are 25% of the impoverished. As people age, they *become* poor. The fragmentation of health services and the absence of preventive provisions within Medicare programs only heighten the sense of alienation and loss felt by the elderly person. Medicare and Medicaid have in some ways actually promoted the further deterioration of health services for the elderly—deductibles and "mills" contribute to the inaccessibility of decent services. And, those 5% in nursing homes have no opportunity to choose or affect the quality of conditions where they are placed; they are often at the mercy of social service professionals who must find suitable bedspace, often far from the elderly person's community. One solution, said Ms. Peissachowitz, is to stress human concerns in medical and nursing education.

Dr. Wolarsky continued with the theme of medical education. There is no need to create yet another subspeciality of geriatrics;but internists, who usually treat the elderly, must begin the actual study of the aging process. Caring, rather than medical care, is needed. Dr. Wolarsky outlined possible alternatives to institutionalization: the Lombardi Bill, "nursing care without walls" paid for by the State; home health care; meals on wheels; day hospitals for the rehabilitation of stroke and fracture victims; and clinics functioning within day-care centers, with the emphasis on preventive screening. The last option, he felt, is unlikely to come about.

Ron Brooke gave a brief history of medical specialization and technology, suggesting that the "organ-oriented" pattern of medicine has not changed in 4000 years. Medical care, he emphasized, has never been shown to affect life expectancy—public health measures, however, have had a more profound affect. Our priorities then are inappropriate. We spend more on medical care than we do on benefits that would improve living standards. Mr. Brooke mentioned two important ways to improve health services to the elderly:

encourage the exercise of enabling legislation (Subchapter C of the State Hospital Code) for hospitals to provide day care services for rehabilitation, socialization and nutrition; and place nursing homes into service areas where HSA's and the community will become a "community of interest" to monitor care and advocate for patients.

Focusing on federal activities on behalf of the elderly, Mr. Behney remarked that most research funds are channeled into traditional areas like medicine rather than human services. The NIMH, for instance, admits that disorders associated with the aging process are ignored. A plethora of federal agencies contributes to the fragmentation of both services and benefits available to the elderly. Because the elderly are not a political force, their demands are not heard. Also, the Congressional Committee on Aging has no legislative power. □

Workshop III: *Third Party Payers: How Do (Should) They Impact on the Future of Technology*? Moderator: Ben Riskin, Administrator (retired), ERM Health Center. Panelists: Eugene Sibery, Vice President, Blue Cross/Blue Shield of Greater New York; Bruce Mansdorf, M.P.A., Deputy Director, New York State Health Planning and Development Agency; Donald Rubin, President, Consumer Commission on the Accreditation of Health Services, Inc.

Questioning the need for third party payers, Moderator Riskin was of the opinion that the geographical redistribution of medical personnel and guaranteed health services for every citizen are the more critical issues.

Mr. Sibery traced the "technological revolution" of the last 78 years, concluding that federal, corporate and private funds continue to finance research that will bring additional wonders. The result is that health care goals and needs cannot keep up with advances in diagnosis and treatment. New procedures—expensive and needlessly applied—combined with the proliferation of specialized manpower have contributed to uncontrollable costs. The "Blues" of Greater N.Y. believe that availability and allocation of resources are controlling factors governing the use and total cost of health services. In 1970, they adopted a planning and reimbursement policy to eliminate surplus beds, the duplication of services and to strengthen ambulatory care services. At the same time, they applied prospective reimbursement methods in concert with the hospital cost control law. Consumers must play their part, too. Improved health education could also help to curtail unnecessary utilization.

Mr. Mansdorf addressed the role of government in efficacy testing, the CON process, the appropriate use and affordability of equipment. The CON program should be controlling the acquisition of new technologies but "loopholes" —such as private acquisition by physicians—make regional assessment difficult. The third party reimbursement mechanism has actually stimulated the expansion of services and technology without regard to cost effectiveness. An alternative to cost control through reimbursement would be to establish an annual statewide capital expenditure limit; a finite limit on available funds would balance the acquisition of new technology with other demands on health resources. Such a proposal is before New York State lawmakers this year.

Third party payments operate on the blank check theory said Don Rubin. Insured consumers are unaware of service charges. The hospital takes the insurers blank check and adds up the units of service. The fee-for-service system militates against cost containments; unwarranted and useless services are subsidized. In short, third party payers contribute directly to inefficiency and waste. A total utilization review program by the third party payer is in order. This program should include adequate record keeping—a profile of tissue committee results and mortality figures related to specific treatments—mandatory second opinions and a refusal to pay providers for unnecessary work, a "hold harmless" clause so that families of patients are not sued if the provider delivers treatment that is rejected by the carrier. The third party payer, then, should be a "watchdog" over the quality of services as well as the use of them.

Panel-audience discussion following the presentations touched on whether or not hospitals served community needs and the extent of the impact of third party payers on standards of service. □

Workshop IV. *Regionalization: Concepts, Myths and Reality.* Moderator: Gail Gordon, M.P.H., Committee for a National Health Service. Panelists: Frank Grad, LL.B., Professor of Law, Columbia University Law School; Marvin Lieberman, Ph.D., Executive Secretary, Committee on Medicine and Society, New York Academy of Medicine; Allan Goldstein, M.D., New York City HSA.

Moderator Gail Gordon defined regionalization as shared services or group purchasing. Her challenge to the panel: Can regionalization be implemented in our present system or is total reform necessary?

Professor Grad addressed the relationship between the CON process—as the key to planning strategy—and regionalization. The reactive nature of the CON process and the unclear definition of "need" make the goal of redistribution of services problematic. Professor Grad emphasized that the planning law encompasses area wide planning but neglects local, autonomous control. The CON as the "cutting edge" of planning is blunted by the mix of local, regional and federal definitions of regionalization.

Dr. Goldstein basically concurred that the lack of standard designations, such as definitions of primary, secondary and tertiary levels of care, demands that planners work from hard data to confront each issue on its own merits. He presented three possible planning strategies for regionalization: the geographic division of services; a division of service categories; or the designation of the three levels of care. While the standardization of regional terms, for example, may help planners decide "what" to do, it will not necessarily tell them "how" to do it.

"Is regionalization possible under our system?" asked Dr. Lieberman. He cited the British approach to regionalization and concluded that it could not be applied within our present economic structure. He cautioned against tripping over definitions of regionalization. The ultimate goal of improved access may not be reached through regionalization. He noted that the price of regionalization to the British was domination by a medical elite. Our approach to health planning, he said, both reflects and promotes the

pluralism of our society. He balanced the British regionalized system with its elite domination against a less than ideal regionalization responsive to consumers.

Several provocative questions came from the audience following the panel presentations. In answer to a query about consumer power within an HSA and regionalization, Prof. Grad responded that at the local level consumers may confront provider interests, at the national level consumers must face each other. And again, a question surfaced about regionalization and a national health service. Dr. Goldstein replied that HSA was committed to the idea of regionalization without a national health service. Prof. Grad agreed that regionalization must proceed although a national health insurance will appear eventually.

A question about the dominance of the HSA staff and providers in decision-making brought two responses. Dr. Goldstein said he was weary of complaints about staff-provider dominance. The HSA records show geographic solidarity rather than consumer-provider splits. Dr. Lieberman thought a weakness was inadequate consumer leadership; perhaps paid consumer advocates would be one solution. □

THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC.

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PUBLISHED BY CONSUMER COMMISSION ON
THE ACCREDITATION OF HEALTH SERVICES INC.
377 PARK AVE. SO., NEW YORK, N.Y. 10016
TELEPHONE: 689-8959