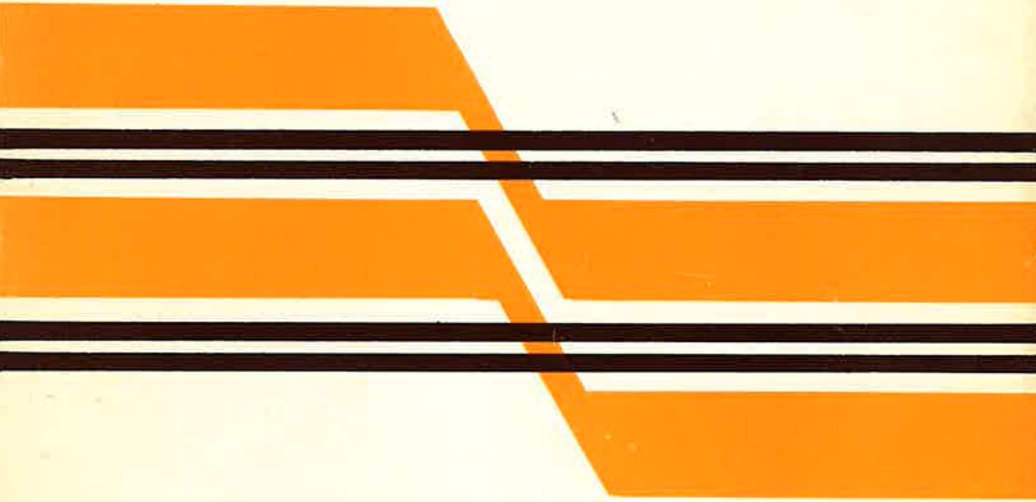
Medical Technology, Health Care and the Consumer



Allen D. Spiegel
Donald Rubin
Shelley Frost

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Interrelationships between medical technology and its applications, the health care system and consumers are critically evaluated in this book for a variety of viewpoints. There is an analysis of the impact of technology on the health care system, with emphasis on the burgeoning role of consumers in technology decision making. The book begins with an extensive primer of the basic concepts and issues concerning medical technology, and details the mechanisms for technology's entrance into the health care system. The rest of the book presents a general orientation to medical technology, the impact of technology on sickness and death, the economic aspects of technology, and the future role of medical technology.

A detailed historical perspective of medical technology is given along with a critical discussion of the advantages of technology on health care. The impact of technology in the treatment of heart disease, cancer and stroke—the three major killers in America—is assessed. Several papers propose innovations in policy and decision making which would increase the role of the consumer in order to promote more responsive health care.

About the Authors:

Allen D. Spiegel, Ph.D., is an Associate Professor of Preventive Medicine and Community Health for the State University of New York, Downstate Medical Center, College of Medicine. In public health since 1951, Dr. Spiegel's experiences include a wide range of activities in medical and health care services, comprehensive health planning, public health education, and health and medical communications. Formerly, Dr. Spiegel was with the New York City Health Department, the Medical Foundation, Inc. of Boston, was a U.S. Public Health Service Special Research Fellow at Brandeis University, and a consultant on numerous health and welfare projects. He has authored and co-authored more than one hundred articles, reports and pamphlets on health care and edited and contributed to a number of books on community and mental health, including a leading reference work, *Perspectives in Community Mental Health.* He is also co-author of *Medicaid: Lessons for National Health Insurance; Basic Health Planning Methods* and *Curing and Caring;* and editor of *The Medicaid Experience.*

Donald Rubin is president and co-founder of the Consumer Commission on the Accreditation of Health Services. He has co-authored more than fifty Consumer Commission reports on issues of health policy and has written several articles on health, welfare insurance and automation for other journals. Mr. Rubin has administered and consulted to labor-management health and welfare funds and served as Administrative Director of the Medical Department for the Health Insurance Plan of Greater New York. He is also president of Donald Rubin, Inc., a firm providing consulting services. Mr. Rubin co-chaired the project advisory committee to the National Science Foundation grant which sponsored the conference series from which the papers in this volume are taken.

Shelley Frost, Project Director of the NSF funded conference series on the impact of science and technology on health and medical care out of which this volume grew, has served as Research Director and Associate Editor for the Consumer Commission on the Accreditation of Health Services for the past five years. She is senior author of the recently published manual, *A Consumer's Guide to Evaluating Medical Technology.* Ms. Frost earned her Master's degree from New York University in 1977 at which time she had more than ten years experience working in the health-related computer sciences.

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MEDICAL TECHNOLOGY, HEALTH CARE AND THE CONSUMER

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PREFACE

Health care consumers now serve on governing boards of local, state, and national health planning agencies as required by legislation. In this capacity, consumers are regularly making health policy decisions. Many of these decisions are related directly to the introduction of sophisticated medical technologies into the health care delivery system. Despite the fact that consumers may not be knowledgeable about health care issues and services, they are involved equally with the expert in decision making. In fact, federal health planning legislation calls specifically for consumers who are not involved with the health care industry to be in the majority on the governing boards of health planning agencies. This situation creates a problem in providing adequate, understandable information to those consumers thrust into unaccustomed policy-making roles.

This book is one outcome of a project which attempted to address the issue of medical technology and the consumer. The project was created and sponsored by the Consumer Commission on the Accreditation of Health Services, Inc. and supported primarily by the Science for Citizens program of the

National Science Foundation (Grant No. OSS-7720845). Project objectives included the following:

- To provide accurate and reliable information about technological and scientific advances in health care to consumers involved in decisions about those advances and their relation to the health care delivery system.
- To inform consumers about the issues related to quality care assessment and to cost/benefit evaluations regarding the increased use of medical technology and the impact of such use on medical and hospital delivery systems.
- To stimulate the receptiveness of health care providers to consumer participation by increasing the substantive knowledge of consumers presently involved in the health care decision-making processes.
- To develop a manual that could be used by consumer decision makers in evaluating medical technology.

To achieve these objectives, four all-day conferences were scheduled during the latter part of 1978. Each conference format called for a morning session in which speakers made presentations to the audience and responded to questions. Afternoon sessions included workshops at which participants and presenters were able to engage in an exchange of ideas and information. Each conference had a different theme as noted below:

June 17, 1978—Medical Technology and the Health Care Consumer

September 16, 1978—The Impact of Medical Technology on Sickness and Death

October 21, 1978—The Economics of Medical Technology

November 18, 1978—The Future of Medical Technology

Intensive effort was devoted to presenting a balanced point of view about the health care system and its problems relative to consumers. Staff members and the Project Advisory Committee (identified in the lists on pp. 23–29) sought to bring together health economists, public health specialists, private practice health care providers, health lawyers, medical scientists, and third-party payers with consumer advocates and community people involved in health policy-making activities. Information exchange and consciousness raising were important features of the conference series. Both consumers and providers were asked to consider the social, economic, and ethical issues bearing upon the use of medical technology in the health care system and the legislative health planning mandates to develop a rational comprehensive system.

Since the mid-1960s, there was a significant expansion in the concept of community participation in health care policy making. Experts no longer exclusively determine the allocation of health resources; consumers play a vital role in those determinations. However, issues relating to health care decisions have become more and more complex over the years creating difficulties for experts and consumers alike. Today, any scientist or consumer who wishes to make informed decisions faces an intellectual challenge in understanding the implications of adopting complex medical technologies.

Response to the conference series was enthusiastic, testifying to the need and desire to exchange views and to clarify the social and scientific problems raised by medical technology. Mailings and conference announcements drew hundreds of registrants from the ranks of consumers as well as providers. Consumers came from community health centers, voluntary health organizations, trade unions, consumer health groups, hospital advisory boards, and from the local and state health planning agencies of New York and surrounding areas. Health care providers, including private physicians, scientists, health planners, hospital administrators, economists, and third-party insurance administrators also attended in large numbers. Speakers and panel members were nationally recognized in their fields and locally prominent. Many organizations were helpful in developing the program content and in making conference arrangements. Verbal and written evaluations overwhelmingly endorsed the series and expressed the hope that similar conferences would take place in the future.

Addresses presented at the morning sessions of the four conferences are reproduced in this book. In addition, brief summaries of the 16 afternoon workshops are included so that the reader may share the flavor of those participatory sessions as well. In the workshops, techniques such as role playing, simulation, panel minipresentations, and the hard-nosed question and answer method were used to stimulate participation and to motivate thinking.

As an additional outcome of this project, the Consumer Commission on the Accreditation of Health Services, Inc. has written a manual[1] for consumers serving on health care decision-making bodies. This manual will assist consumers who must systematically examine and gather information about medical technology so that they can make informed decisions.

Since 1972, the Consumer Commission on the Accreditation of Health Services, Inc. has been involved in research and information services for consumers in New York City and elsewhere. This conference series was a natural outgrowth of the Consumer Commission's activities in assisting consumers to better understand and assess health care issues.

It is hoped that through the publication of this book, people will begin to think about the issues raised by advances in medical technology. With this information, consumers will be able to take an ever more responsible role in deciding how and for whom the health care system should be operated.

ADS

DR

SBF

June 1979

REFERENCE

1. Frost, S. B., Fearon, Z. & Hyman, H. H. *A consumer's guide to evaluating medical technology.* New York: Consumer Commission on the Accreditation of Health Services Inc., 1979.

Chapter 18

WORKSHOP SUMMARIES

WORKSHOP 1: MAKING THE WORKPLACE SAFE FOR WORKERS AND THE COMMUNITY

Panelists: Michael McCann, Ph.D.
President, Center for Occupational Hazards
New York, N.Y.

Deborah Nagin, M.P.H.
Occupational Health Program Planner, NYC Health Systems Agency

William H. White
Assistant Director (Brooklyn), NYC Health Systems Agency

Henry Velez, M.D.
Environmental Sciences Laboratory
Mt. Sinai Hospital
New York, N.Y.

A discussion of occupational health as a major health and political issue for an industrial society opened this workshop. HEW's own regulatory and monitoring agencies report 20 percent of cancers linked to occupational hazards. Other reports suggest 390,000 new cases of occupational disease a year. There is little doubt that numerous workers are affected. 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—National Institute of Occupational Safety and Health (NIOSH) and Occupational Safety and Health Administration (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. A lack of trained monitoring personnel and small numbers of workers at individual workplaces lessen the chance for effective hazard detection by the workers themselves.

Next, 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 and 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 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 by establishing occupational criteria for health care institutions. Presently, project review criteria do not include concerns of health care workers. Economic and political factors involved require labor-management participation which is often difficult to achieve.

HSA could include institutional compliance with environmental and occupational safety and health standards in the project review process.

WORKSHOP 2: OUR AGING POPULATION: DOES MEDICAL TECHNOLOGY HOLD ANY HOPE?

Moderator: Nelly Peissachowitz
National Citizens Committee on Nursing Home Reform
New York, N.Y.

Panelists: Clyde Behney, M.B.A.
Senior Analyst, Health Programs
Office of Technology Assessment, U.S. Congress
Washington, D.C.

Ron Brooke
Health Care Consultant
Brookdale Center on Aging, Hunter College
New York, N.Y.

William Wolarsky, M.D.
Medical Director
Daughters of Jacob Geriatric Center
Bronx, N.Y.

Nelly Peissachowitz opened the workshop by describing the situation of the aged in the United States as indicated by national economic and social characteristics. Although the elderly represent only 10 percent of the total population, they are 25 percent of the impoverised. 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. Five percent of the aged in nursing homes have no opportunity to choose or affect the quality of the conditions where they are placed. Often, they are at the mercy of social service professionals who must find suitable bed space, at times 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. Internists, who usually treat the elderly, must begin the actual study of the aging process. Patient care, rather than medical care, is needed. Dr. Wolarsky outlined possible alternatives to institutionalization: the Lombardi bill in New York to provide "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 4,000 years. Medical care, he emphasized, has never been shown to affect life expectancy. However, public health measures have had a more profound affect. Our priorities 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 HSAs 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 such as medicine rather than human services. For instance, the National Institute of Mental Health 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 3: THIRD-PARTY PAYERS: HOW DO (SHOULD) THEY IMPACT ON THE FUTURE OF MEDICAL TECHNOLOGY?

Moderator: Ben Riskin
Administrator (retired); ERM Health Center
New York, N.Y.

Panelists: Eugene Sibery,
Vice President

Blue Cross/Blue Shield of Greater New York;
New York, N.Y.

Bruce Mansdorf, M.P.A.
Deputy Director
New York State Health Planning and Development Agency
Albany, N.Y.

Donald Rubin,
President
Consumer Commission on the Accreditation of Health Services, Inc.
New York, N.Y.

Moderator Riskin questioned the need for third-party payers. He was of the opinion that the geographic redistribution of medical personnel and guaranteed health services for every citizen are the more critical issues.

Mr. Sibery traced the technologic revolution of the last 78 years, concluding that federal, corporate, and private funds continue to finance research that will bring additional wonders. Health care goals and needs cannot keep up with advances in diagnosis and treatment. New procedures, sometimes expensive and needlessly applied, combined with the proliferation of specialized manpower have contributed to uncontrollable costs. The "Blues" of Greater New York 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 Certificate-of-Need (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. Third-party reimbursement mechanisms 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 according to Don Rubin. Insured consumers are unaware of service charges. Hospitals take the insurers blank check and add up the units of service. A fee-for-service system mitigates 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, a refusal to pay providers for unnecessary work, and a "hold harmless" clause so that families of patients are not sued if the provider delivers treatment that is rejected by the carrier. Third-party payers should be "watchdogs" 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 4: REGIONALIZATION: CONCEPTS, MYTHS, AND REALITY

Moderator: Gail Gordon, M.P.H.
Committee for a National Health Service
New York, N.Y.

Panelists: Allan Goldstein, M.D.
New York City Health Systems Agency
New York, N.Y.

Frank Grad, LL.B.
Professor of Law
Columbia University Law School
New York, N.Y.

Marvin Lieberman, Ph.D.
Executive Secretary, Committee on
Medicine and Society
New York Academy of Medicine
New York, N.Y.

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 areawide planning but neglects local, autonomous control. CON, as the "cutting edge" of planning, is blunted by the mix of local, regional, and federal definitions of regionalization.

Dr. Goldstein basically concurred with the view 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 for the audience following the panel presentations. In answer to a query about consumer power within an HSA and regionalization, Dr. Grad responded that at the local level consumers may confront provider interests, at the national level consumers must face each other. 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. Professor 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. 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.

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