The Nature of "Consumer Health" as a Public Health Concept

THEODORE O. CRON

UNDER THE GENEROUS RUBRIC of "public health" have flourished many narrower health interests and disciplines: occupational health, for example, and environmental health, maternal and perinatal health, urban health, and executive health. Each term seems, at first reading, to be appropriate or vivid enough. But with increased use, these terms take on a certain ambiguity. Does "urban health" focus on city health systems or the health of the average city dweller? Does "executive health" provide management with an understanding of health care in the modern corporation, or does it instruct the individual executive in responsible, personal health practices? Rather than obscure meaning, these ambiguities tend to lend interest and permit greater scope to the perceived area of discussion.

A recent addition to this health lexicon is "consumer health." The term identifies health as a marketplace activity or service, the subject of negotiation between buyers and sellers. But there is also ambiguity: consumer health may deal with self-care as well, a person-centered rather than a system-centered view of contemporary health status.

Interest in consumer health—and in consumerism generally—has escalated in American society. The consumer's role in American health care, as purchaser and decision maker, has achieved a respectable prominence. Knowledge about consumer behavior toward health issues is essential to the marketing strategies of health maintenance organizations and independent practice associations, it is integral to government regulatory decisions on foods and drugs, and it can determine the nature and size of the health benefits package in labor contracts.

These are all clear signs that a notion such as consumer health may exist, but they do not tell much of its genesis. An explanation may emerge from an examination of four strong influences within our society:

- the rise in educational levels among our citizens
- the caution society continues to display toward "medical miracles"
- the acceptance of proper health care as a citizen's "right," and
- the understanding (however reluctantly acknowledged) that each person bears the major responsibility for his or her own good health; the community response

Mr. Cron is Coordinator for Consumer Affairs, Public Health Service, Rm. 746 G, Hubert H. Humphrey Bldg., 200 Independence Ave. SW., Washington, D.C. 20201. Tearsheet requests to Mr. Cron.

to environmental hazards, for example, can be viewed as a collective expression of this sense of personal responsibility.

The manner in which these four influences have shaped the consumer's role in health care deserves closer examination.

Effects of Rising Educational Levels

First, the general level of educational attainment in the United States has risen substantially over the past 20 years (*1*). About 85 percent of all young people aged 25–29 have finished high school. Among their parents' generation—persons aged 55 to 64—only 60 percent finished high school. Among blacks the statistics are even more striking: three of every four blacks in their late twenties are high school graduates; only one of every four of their parents are. Nearly 50 percent of all high school graduates go on to college or university studies.

While one may debate the quality of contemporary education, the fact is that more American young people are receiving it at every level. And, in general, American education does keep improving, more or less reflecting the increased breadth of social experience in this country.

The more people know, the less room there is for mystery. And people know quite a bit about health care. Bookstores, magazine racks, libraries, radio and television programs, billboards, and other message carriers deliver a great deal of health information to an educated public that can accept and act on it.

The most striking example of this revolution in popular health care information is the book prepared by the Boston Women's Health Book Collective, "Our Bodies, Ourselves" (*2*). It is accurate, assertive, plain-speaking, and apparently useful. More than 2 million copies have been sold to at least 2 million readers. (That number is for the English language version; the book is also available in 11 other languages.)

Growth of a Health-Aware Public

A second influence behind the rise in consumer health is the greater wariness among the public. The average consumer places considerable faith in the competency of physicians and hospitals, as opinion surveys routinely show, but there is a strong realization that people are fallible: the more the expert may know, the larger is his or her margin for error. Society has been reminded of this in different ways over the years: 20 years ago it

was the thalidomide scare—did drug research really have all the answers? Ten years ago it was the sharp rise in medical malpractice suits and the size of awards to injured consumers made by the courts—do physicians always practice impeccable medicine? Last year it was toxic shock syndrome—does the marketplace function consistently with the cultural (lifestyle) environment?

In 1968 the medical profession was uneasy with the motto of a new consumer health group, the American Patients Association: "The most important member of the health team is an informed patient." Today that motto is part of the conventional wisdom in health care.

Acceptance of Health Care as a Right

Third, there seems to be general acceptance that proper health care should not be an accident of geography or culture or economics; it is a right. It is often compared with the citizen's right to a sound basic education or to protection from crime or fire. Neither the Constitution nor the Congress has said categorically that such a right exists for every citizen. Yet, the presence of Medicare and Medicaid, community health centers, the National Health Service Corps, community mental health centers, nutrition programs for infants and pregnant and lactating women, and other government health programs is a clear signal that society does recognize—however indirectly—the individual's right to good health care.

When rights to service are protected by public servants and services are financed by the public treasury, society requires accountability. This requirement is evident in the tempests that have surrounded the reimbursement programs for Medicare and Medicaid, for example. In fact, it might be possible to say that, to the extent responsibilities are demanded, is the degree to which rights are asserted.

Elevated Role for Self-Care

Fourth, and finally, the accelerated trend toward health promotion and disease prevention has elevated the role of self-care. Physicians are becoming more aware of their role as guides and teachers for their patients, sharing not only the diagnosis of a condition but also indicating the patient's role in helping to gain a successful treatment outcome. The informed consumer is not a passive receptor of data and services but is rather an active participant in the processes of care.

In some instances, after gaining an understanding of a real or potential disease condition, the consumer-patient then assumes the role of physician of last resort and accomplishes the major tasks of health care required for self and family. No Federal program can eliminate obesity, no State official can prevent the transmission of genital herpes, no local ordinance can break a person's smoking habit, no matching grant can guarantee the recovery of an alcoholic. Each individual is the ultimate provider of his or her personal health care.

Self-care is most often discussed in terms of a choice of behavior. But in some instances, no perceived choice is available. The circumstances surrounding the Love Canal and Three-Mile Island threats to personal and family health could not have been foreseen. The toxic wastes and the possible escape of some radiation have affected the health status of families in those two areas —without their exercise of choice. In those instances the exercise of self-care—physical examinations, change of residence, periodic checkups, and so forth—may be post facto. In some instances there is a concurrence of social, political, and personal health decision making; self-care confronts the complexities of both the contemporary marketplace and the natural world. Not a very even match, to be sure.

These four major influences within American society have fostered the notion of consumer health. A benchmark for this view was achieved on September 26, 1979, when the Federal Register published the President's Executive Order No. 12160: "Providing for Enhancement and Coordination of Federal Consumer Programs" (*3*). Governmentwide, the machinery has been turning to provide better service and information to the consumer, who is defined (in paragraph 1–901) as "any individual who uses, purchases, acquires, attempts to purchase or acquire, or is offered or furnished any real or personal property, tangible or intangible goods, services, or credit for personal, family, or household purposes."

People are concerned about much more than a best buy, a 10,000-mile warranty, or bait and switch advertising; they are worried about "intangible services," too. Not only individual medicine, but the practice of medicine, is of concern.

The Executive Order's definition of consumer has proved inclusive enough to be comfortable for all agencies after a year's experience. Within the Public Health Service there is a clearer perception of those "persons, families, and households" who are the end-of-the-line consumers of PHS services, regardless of intermediaries. This clarification of consumer in the broad terms of the Executive Order (plus an awareness of those four major influences already described) has led to the beginning of the institutionalization of the consumer health notion in the Public Health Service. Here are a few examples:

- The Food and Drug Administration routinely mails to consumer health organizations and interested individuals a "plain English" explanation of pending regula-

tions covering food and drug labeling, assessment of the health risks presented by certain products, controversial practices used to market prescription medicines or devices, and related matters of science and medicine in the marketplace.

- The National Institutes of Health have embarked on a widely praised series of consensus development conferences to serve as benchmarks in the evolution of new or re-evaluated medical practices, pharmaceuticals, or surgical procedures. In addition to scientists, physicians, and researchers, the NIH has also invited knowledgeable members of the lay public to participate.
- The Alcohol, Drug Abuse, and Mental Health Administration is nurturing the work of the Community Support Program for the chronically mentally ill, national and local parents' groups to fight drug abuse, support systems for recovered alcoholics and the friends and families of those in the process of recovery, and a range of neighborhood and community groups dedicated to combating mental illness and reducing the stigma that has surrounded such illness.
- The Assistant Secretary for Health and Surgeon General published "Healthy People" (*4*) and a shorter version, "Living Well" (*5*). These reports proposed certain personal health goals and the changes needed in personal behavior and lifestyles among people of all ages to achieve these goals.
- The Health Resources Administration and the Congress have determined that the degree of access for all classes of consumers to health facilities is a major criterion for health planning agencies to use when reviewing applications for a certificate of need. Consumer and citizen groups, who have that data, can help planning agencies make a fair judgment on accessibility.

Business and Industry Actions

While the four influences mentioned previously have considerable social power, there is yet a fifth influence that ought not to be overlooked—the influence of private businesses and industries. They have begun to explore and measure the effects of disease, disability, and death upon the work force and the marketplace.

For example, in 1977 an estimated 44,000 deaths from cancer of the respiratory system occurred among the peak working-age population, those 25 through 64 years. If the working-age people had an overall life expectancy of 70 years, their premature deaths from cancer of the respiratory system robbed them, and the nation, of about 650,000 years of productive life. Similarly, in 1977, among the total number of persons aged 25 through 64 who died of heart disease—some 168,000—there was a loss to them, their families, and the nation of more than 2 million years of life (*6, 7*).

These numbers are estimates, but they do indicate the size of the problem. Some industry estimates of the dollar costs of these premature deaths are equally staggering; nonfatal heart attacks cost industry the equivalent of 4 percent of the gross national product in loss of output, something in excess of $19 billion per year in the decade of the 1960s and closer to $40 billion in the current decade. The American Heart Association concluded several years ago that the cost of replacing heart disease victims in private industry was $700 million, a fiscal burden industry cannot easily carry (*8*).

In the current climate of concern about revitalizing American industry and raising productivity levels among American workers, additional cost burdens cannot be tolerated, particularly health cost burdens, which tend to linger and even multiply. The Ford Motor Company discovered that heart attacks struck down only 1.5 percent of its headquarters employees—but accounted for 29 percent of its total headquarters' health costs (*9*). Since 1972 Ford has established smoking cessation programs, improved the nutrition levels in its cafeterias, instituted a range of physical fitness opportunities and, in other ways, has begun to reduce the impact of cardiovascular disease upon people and budgets at Dearborn.

Marvin Kristein, chief of the division of health economics of the American Heart Foundation, estimates that "the average one-pack-plus per day smoker may, over his or her lifetime, be costing his or her employer about $624 per year (January 1980 dollars)" (*10*). Included in this estimate are excess annual insurance costs for disability and life ($20–$30), fire ($10), and health ($204). The higher rate of absenteeism among smokers also translates into an additional $80 annual cost to employers per employee who smokes.

Kristein offers a similar analysis of the alcohol abuser, who burdens society each year with $3,585 in lost production because of illness, premature death, highway accidents, homicide, fire damage, and family violence. An estimated 9 million adult Americans abuse alcohol.

Such statistics motivate the country's major businesses and industries to set up effective inhouse physical fitness—health promotion—disease prevention programs. More than 300 companies—most of them among the Fortune 500—have full-time physical fitness directors on their staffs; oil companies like Mobil, Texaco, Exxon, and Phillips Petroleum; financial institutions like Merrill Lynch, Chase Manhattan, and Metropolitan Life; and manufacturers like Kimberly-Clark, Gillette, Boeing, and Rockwell International.

The people who operate these programs are members of the American Association of Fitness Directors in Business and Industry (AAFDBI), a professional orga-

nization affiliated with the President's Council on Physical Fitness and Sports. AAFDBI's chief concerns, as reflected in the program of its sixth annual conference held in September 1980, include cardiac rehabilitation, stress management, smoking cessation, drugs and alcohol abuse, nutrition and weight control, and "general wellness."

Another organization, only 5 years old yet deeply involved in health matters, is the Washington Business Group on Health. Willis Goldbeck, its executive director, notes that only 186 American companies (from which the WBGH membership of 160 is drawn) provide health benefits for better than 50 million workers, retired workers, and their families.

What impels such companies as Bethelehem Steel, Nabisco, RCA, International Harvester, and AT&T to focus on health services at the worksite? Goldbeck said, "Many companies reason that bad employee health habits increase corporate costs and that the employers have the right to attempt to change employee lifestyles which affect these costs" (*11*).

Over the past 5 years, he said, "a great many companies have begun offering programs for smoking cessation, hypertension control, fitness, stress management, nutrition education, and obesity control. Here, too, there is evidence that due to reduced hospital and medical care utilization, health insurance premium cost increases are slowing."

Goldbeck added that a number of companies are also offering voluntary, after-hours help to their employees. "Counseling for alcoholism, substance abuse, psychiatric disorders, and family, financial, and legal problems are offered with followup referrals into community agencies." The companies report some reductions in use of hospitals and medical and surgical services as well as improved employee productivity.

Managers of the employees' programs have been able to move from the relatively routine tasks of installing exercise rooms and making space available for SmokEnders' meetings to the more complex tasks of providing marital counseling and prenatal care for pregnant employees. The level of sophistication parallels the level reached by the population in general.

This fifth influence on the development of the consumer health concept cannot be underestimated, since most Americans are salaried or hourly wage employees. In addition, both business and labor recognize the need —in their own self-interests—to promote and maintain the health of the American work force.

Conclusion

It can be said that consumers' consciousness was first raised in recent years when the Food and Drug Administration prevented thalidomide from being marketed in the United States. The Kefauver-Harris Drug Amendments quickly followed, requiring more stringent proof of efficacy and safety and manufacturing standards for new drug approvals. Since 1962, however, the consumer health issues have become far more complex, demanding greater attention from an informed, aware public.

And the public is responding. Consumers are indeed lengthening their attention span for health issues, absorbing and processing highly technical and equivocal data, and routinely making judgments that protect and enhance personal and family health. Consumer health has already had—and will continue to have—a profound impact upon the development of public health policy at all levels of government and in all sectors of society. It is an impact, however, that is positive, constructive, and contemporary.

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