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HOSPITAL OBSOLESCENCE: DO NON-CODE COMPLIANT HOSPITALS HAVE TO BE CLOSED?

The pressures of rising health care costs and runaway inflation have focused much attention on increasing health expenditures. With hospital based care taking the largest share of the health care dollar—more than 40 percent—these institutions have been particularly hard hit by the efforts to reduce costs. As a result hospitals are not only unable to expand, but have to fight merely to maintain the level of services they now provide. In many places, particularly in urban areas confronted with fiscal crises on all fronts, the "cost reduction fever" has led to hospital cutbacks without provision for alternate ways of delivering care.

To date, the elimination of hospital beds and cutbacks in staff,supplies and services have been the methods used to reduce operating expenses. In this article we examine an alternative approach to cost reduction, focusing on the relationship between hospital operating cost and the size and design of the hospital structure itself.

Which Hospitals To Close?

Politicians wielding the hospital cutback knife are often seen as tough fiscal managers taking concrete action to save public money. However, their popularity is only possible because the communities most affected by their slashing—the poor, those on public assistance, the medically indigent, racial and other minorities—pack the least political punch. In a time of crisis politics outweighs all else. Unfortunately, planning for an equitable and sensible reorganization of health delivery takes time, and results in less political fanfare than the decision to make a quick cut in community services.

In many cases, decisions to terminate or reduce services are rationalized on the basis of non-compliance with state and federal space and design codes. Since many inner city hospitals were constructed before these codes were established, they often fail to meet the minimum requirements prescribed. This is convenient when a political decision on which hospital to close is being made. Choosing those whose constituencies are least likely to protest effectively becomes merely enforcing an existing regulation.

The Hospital Design Codes

The hospital codes referred to are those which set standards for rooms and other hospital spaces and equipment. They are not fire or life-safety codes. They are function-oriented, for example prescribing minimum floor areas for patient examination and treatment rooms, and requiring that such spaces exist in conjunction with nursing units.

These codes were originally required as a part of the Hospital Survey and Construction (Hill-Burton) Act of 1946. At this time, the Surgeon General was mandated to promulgate "regulations prescribing general policies to be followed in setting up and administering State Plans for Construction of public and other non-profit hospitals." These regulations were subject to the approval of the Federal Hospital Council and of the Administrator. The "General Standards" for hospital construction and equipment first appeared in the Federal Register in February, 1947. All plans for hospital construction submitted to the Surgeon General for approval under the Hill-Burton Act had to comply with the minimum standards as well as state codes.

The original General Standards provided the basis for state hospital codes. Since the individual states received federal funding for Hill-Burton programs for hospital construction, their standards for construction were at least as stringent as those of the federal government.

Over time revisions were made to the original General Standards and by 1974, the original fourteen

page document had increased to seventy-seven pages. By 1979, the minimum requirements had widened their scope further, resulting in the current 106 page document.

At the time of their creation, these codes and standards were intended to enhance patient care and promote patient dignity. As medical equipment became larger and more complex, and post World War II affluence produced"bigger is better" thinking, minimum acceptable sizes of hospital spaces increased. In particular, the required number of square feet per bed grew steadily. In some cases, the increased space surrounding each bed was necessary to accommodate newly developed, crucial medical equipment. Recent technological advances, however, have reduced the size of much of this equipment. Now some of it is even being built into the walls of hospital rooms.

Nevertheless, space standards have not been re-evaluated in the light of new developments and the regulatory effects of the Hill-Burton program remain with us today in the form of federal and state design codes. Although the Hill-Burton program as such no longer exists, and the emphasis in recent legislation has been towards service planning rather than purely facility-based planning, the measures originally adopted to promote high standards in hospital design and construction are now assumed to be instrumental in promoting high standards of service as well.

There has yet to be a thorough study of the relationship between conformance with design standards and the provision of quality patient care, whether measured in appropriate procedures being performed, the outcomes of care or even in patient attitudes. The original General Standards have continued to evolve and are still the accepted measure for new designs submitted for approval.

Enforcing the Codes

Over time, it has become easier to enforce the codes than to try to evaluate their impact on health care. Compliance is easily determined. It simply involves counting rooms, beds and square footage.

Still, when the motivation is sufficient, the design codes can be circumvented, reinterpreted, or ignored. They are only as meaningful as the people using them and the system in which they are used. Many architects and state officials admit, if only privately, that minimum space standards can be skirted if the proper approach is used. On the other hand, selective mandatory compliance can be used as legal support for politically unsavory action.

Selective political use of design codes is clearest when noncompliance is the rationale used to excuse the closing of hospitals that have already been placed on a "hit" list. These are invariably public or small to medium size community hospitals.

In New York City, Mayor Ed Koch's plan to close selected municipal hospitals is a clear example of politically motivated enforcement of design codes. He says he has selected hospitals whose beds are an excess resource and whose physical plants are not in compliance with existing codes, making them unfit places in which to deliver medical care. The plan's bias is so clear that it has been attacked on the local and national levels with charges that implementation would constitute a violation of the civil rights of the city's minority populations. Obviously, neither excess beds nor the quality of care is the real concern. Budget reductrions are primary and poor communities pay the price.

Political selection processes are also evident when it is seen that institutions with design code violations, but strong political connections, are infrequently challenged on compliance. In fact, revamping to meet code minimums has been used by "empire building" voluntary hospitals to rationalize their expansion or renovation, often regardless of whether or not their current space is adequate to provide quality health care. Apparently the need to trim health budgets does not affect these hospitals.

Information Needed For Informed Choice

You may have noticed that the desires, needs, perceptions and ideas of the community served by hospitals slated for closure, and of lay people at large, has not been mentioned. That's because they usually aren't asked. Would they rather have a non-code compliant hospital or no hospital at all? Are the renovations being planned worth the increased cost of care?

If consumers are to make knowledgeable choices about keeping, abandoning or renovating non-code compliant facilities, they must know how compliance will affect hospital operating expenses, its relationship to other measures of quality medical care, and patient attitudes about what constitutes a dignified setting for care. The literature reveals no detailed studies in any of these areas, and what little information is available strongly suggests that further investigation is needed.

The Cost Of Design

Ironically, hospital design is often overlooked as a component in the cost of hospital care. In comparison to the $74 billion spent on hospital based care in 1978, only $5.1 billion went into hospital construction and renovation. Yet, the size and nature of the new or renovated facility determines, to a large extent, its operating costs.

It will come as a surprise to no one that smaller structures are cheaper to heat, cool, etc. and require less staff to operate and maintain. What is a surprise is the extent to which we have passively accepted current hospital design as the given invariable set within which the drama of hospital care is played. Who would think of challenging a hospital architect to defend his design in the light of economic and quality considerations? Who credits the creativity of an innovative hospital layout which enhances the quality of care or permits it to be delivered more economically?

It may also come as no surprise that in Great Britain, a country which spends 57 percent less per capita on health care than the United States—with a longer life expectancy and lower perinatal and maternal mortality rates—construction and design solutions to the problems of rising health care costs have been explored. British architects have made remarkable reductions in hospital departmental gross areas without any evi-

dence of compromising the quality of services and without significant patient objection. Today, the per capita amount spent in Britain on hospital construction is only one quarter that spent in the United States.

One of the ways the British have been able to reduce the size of facilities has been to return to ward and modified ward environments. In the United States, the existence of wards—rooms with more than four beds—constitutes a violation of design codes. In Great Britain they are innovative solutions to a pressing problem.

It seems apparent that a re-evaluation of minimum space standards for facilities, with an eye for reductions in construction and operating costs, would be a worthwhile endeavor. An important part of such a study would focus on the relationship between hospital settings and the quality of care, including the preferences and priorities of the communities and regions served by hospitals.

Design and Dignity

An important element in the original hospital code concerning the maximum allowable number of beds per room, was the desire to assure that patients were treated with dignity. Dignity meant privacy, as much as possible. It was believed that there was considerable psychological discomfort in the forced sharing of the ward environment, and this belief got translated into a legal requirement. Its validity was not researched then, nor has it been since. Moreover, the blind enforcement of this code precludes the intelligent balancing of multiple wants and needs within a limited budget.

The only U.S. study on consumer opinions concerning single versus multi-bedded rooms was undertaken by Lou Harris Associates for Hospital Affiliates International, a hospital management corporation. It was called "Hospital Care in America: A National Opinion Research Survey of Consumers, Government Officials, and Health Care Community Attitudes Towards Health and Hospital Care." As part of the study Harris Associates asked:

> If you went into the hospital in the next year, would you prefer a private room to yourself, or a semi-private room shared with one other patient if the cost to you were the same?

Forty seven percent of those surveyed responded "private room" and 47 percent responded "semi-private." In answer to a follow-up question which asked:

> If you had to pay $10 per day more to have the private room to yourself than to have the semi-private room with one other patient, which would you choose?

Twenty eight percent said they would choose a private room under this condition and 68 percent said they would choose a semi-private room.

Unfortunately, this survey did not contain a more comprehensive series of questions about three bed, four bed, and larger rooms. It would also have been interesting if the survey had included trade-off options such as "Would you rather be hospitalized in a room with more than four beds (but less than ten) in your community hospital or in a room with four or less beds in a hospital in another community? Would you be willing to be hospitalized in a room with more than four beds (but less than ten) if keeping rooms with five to ten beds was the only way your community hospital could remain open?" The findings do demonstrate that when money is linked to privacy (as it is in the real world) people respond differently than when room size is considered in a vacuum. If nothing else, further studies of consumer attitudes and priorities is certainly needed.

A recent British study of patient attitudes by the Medical Architecture Research Unit evaluated three different ward environments in the St. Thomas teaching hospital in London. These included a 30 bed Nightingale or open ward with all patients in one large room, a 28 bed ward divided into seven semi-enclosed areas of four beds each, and a 28 bed ward with individual rooms containing from one to six beds. The floor areas per bed in the three environments ranged from 144 square feet in the open ward to 269 square feet in the ward divided into one to six bed sections. Both of these figures are far less than the 419 average square feet per bed found in a Turner Construction study of 20 New York City hospitals.

This study did not substantiate the commonly held beliefs about patients' feelings in the ward environment. Patients did not experience a lack of dignity or privacy, nor were they greatly disturbed by each other. The researchers found that, far from being embarrassed or put off by the ailments of other patients, mutual sympathy and understanding among the patients and for the nurses was high. In fact, the level of satisfaction in the open ward was generally higher than in the other two wards.

The researchers also discovered differences in the behavior and attitudes of the patients and visitors in wards that were subdivided into private and semi-private sections and those in the more open wards. In the ward with individual rooms patients and visitors were found to make fewer allowances for people being ill. The mobile were less sympathetic to the bed bound. They helped each other less. They were less objective about why they were in the hospital, and offered each other less moral support than patients in the open wards or the wards with fewer subsections. In addition, it was found that observation, supervision, and control in the ward with the one to six bed individual rooms required more effort and energy than in either of the other two wards.

To assume a one for one relationship between the findings of this study and American attitudes would be a mistake. But the survey of patients at St. Thomas'sHospital does raise some interesting points concerning patient dignity and the role of the physical environment in its enhancement. The value of this study is its evaluation of the effect of three different physical environments on patient care and morale, and an evaluation of patient satisfaction in each of the three different hospital settings. Such a study in the United States could begin to define acceptable trade-offs in cultural, social, and cost terms.

These issues are immediately important to inner city areas where old hospitals which provide much needed

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CONSUMERS' IMPACT ON THE DIFFUSION OF MEDICAL TECHNOLOGY

by Shelley B. Frost, MPA

According to the Office of Technology Assessment of the United States Congress, the development and diffusion of medical technology takes place in seven steps: the discovery of new knowledge, its translation into a new technology, evaluation of its safety and efficacy, the development and operation of demonstration and control programs, its diffusion into general usage, the education of professionals and lay people concerning the use of the new technology, and its application to the population. In this complicated and fragmented process through which medical technology gets conceived, devised, built, tested and marketed, active health care consumers can play a role only in the fifth step—the diffusion of technology. By the time consumers have some say, the technology has already been developed, evaluated, tested and is generally already in widespread use.

There are three avenues through which consumers can influence the distribution of medical technology. That is, as members of governing and non-governing boards of health institutions and as board members of local health planning agencies, the HSAs.

HSAs where Consumers (are supposed to) Rule

Nowadays, the HSAs are the most often mentioned agencies when discussing the regulation of the distribution of medical technology at the local level. As you may know, HSA governing boards are mandated to be composed of at least 51% consumers. They are to provide effective health planning, promote the development of facilities, services and manpower which meet the needs of the region's population, correct deficiencies and implement their plans. They have review responsibilities over all capital expenditures proposed by health institutions which cost over $100,000 and control over the distribution of certain federal grant monies. In reality, however, the legally given power of the HSAs falls somewhat short of this rather grand sounding mandate. Except through political maneuvering, persuasion and bargaining, HSAs have no authority to make health providers conform with their plans for a regional health system. Except where a state has reduced the minimum, HSAs do not even get to review technological systems which cost under $100,000. When they do review, it is only in response to a provider-initiated request.

HSAs are supposed to be the bottom of a bottom to top health planning process. In theory, the board of the HSA is to be representative of the region's population. Depending on the HSA, this may be accomplished by assigning seats on the board to local groups with an interest in health care, finding individuals who by virtue of their sex, race, etc. can be said to be representative of some portion of the region's population, or through some combination of these two. In any case, the theory is that if you get all these people together they will hash out a health plan which serves the needs of the widest number of people. The theory presumes that each member brings to the board an equal knowledge of health matters, an equal ability to understand and analyze data, and an equal facility in board participation and leadership. Further, there is an assumption that each board member has a similar external support system assisting him in his board duties.

All of these assumptions couldn't be further from the truth. By and large, consumers on HSA boards are not familiar with the complexities of the health care system. Many come to their positions without basic kinds of knowledge, such as what's the difference between prospective and retrospective reimbursement, what is a risk-benefit analysis or the difference between capital and operating expenses. On top of this problem, unlike providers who spend their entire professional life in the health field, consumers hold jobs in other areas. If they are to learn about health, it must be in their spare time. So most consumers don't know too much about health care. Also, most know little about how to effectively participate in a meeting, how to create a positive position, rally people around their ideas, or resolve conflicts. Again, unlike providers who are supported by such powerful and wealthy organizations as the medical, hospital and dental associations, consumers rarely if ever represent organizations of sufficient resources to be of real assistance to them. On top of all these strikes against equal participation, consumers, like the rest of us, have been brought up to defer to their doctor on all issues of health and medicine from the time of their first office visit as a child.

A few years ago, the Consumer Commission on the Accreditation of Health Services did a study in five cities around the country—New York, Birmingham, San Francisco, Los Angeles and Chicago. Commission representatives spoke to consumers on HSA boards asking them of their experiences and what problems, if any, they faced. Overwhelmingly, those questioned were desperate for technical assistance to help them sort through, and understand, the mountains of

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technical material with which they were being inundated, usually at the last moment. These consumers felt alone, hopeless and reported that they usually went along with providers because they simply didn't know what else to do. Almost never did they initiate ideas; they always reacted.

Hospital Boards: Front Line Decision-Making

The problems of consumers on HSA boards are similar to those of consumers who sit on governing and non-governing boards of health facilities. The HSAs notwithstanding, it is at the facility level that most health policy is made. For proposals that require HSA review, it is up to the hospital board to decide if it will go to the planning agency for approval. For decisions that do not require HSA scrutiny, and this includes a myriad of decisions of great importance to the distribution and use of technology and the quality and cost of care, the facility board has the final say. For instance, a board must decide the ratio between how much education, research and service the institution will undertake. This decision will affect the organization and delivery of care. It will have repercussions in the utilization of various research instruments, experimental processes and systems. It may affect the surgery rate or the use of experimental drugs. It will definitely affect patient privacy and the continuity of care.

Traditionally, consumers who sit on hospital boards are older, wealthier and better educated than the community served by a hospital. Board members are usually male and white, regardless of the race and ethnic backrounds of the hospital's patients or the surrounding community. Originally, hospital board members were chosen based on their wealth and standing in the community, not because they represented any part of the community or because they knew anything about health care. They were thought of as good men who would act in behalf of the sick and needy. Their primary job was to raise money for the institution. All decisions about the organization, quantity and quality of care were left to the medical and administrative directors.

Over time the role of hospital boards has changed significantly, although their composition has not. Today, very little hospital funding comes from contributions and philanthropy. Government and other third party payors now pick up over 90 percent of the costs of hospital care in the United States. Increasingly, hospital boards are being held to their legal responsibilities of setting policy, controlling the budget, overseeing the organization and functioning of the medical staff and hiring, monitoring and firing when necessary the chief administrative officer.

Since World War II, medicine has become increasingly the application of technology to people. Hospitals are the center of this technological revolution and hospital boards are making more and more of the decisions about whether or not and when to use medical technology.

The businessmen and professionals who sit on hospital boards are not community representatives. However, they share two very important characteristics with consumers on HSA boards—they are often not knowledgeable about health care, medicine or medical technology and they do not have a support system which can provide them with the technical assistance they need to make informed decisions on medical, technical issues. As HSA consumers usually vote with providers, hospital board members most often let the professionals have their way.

Nationwide Policy Needed: Probability Grim

It seems obvious that an organized, need-oriented policy concerning medical technology should be developed on a nationwide basis. It should be concerned with all phases of technology development from conception to application and the decision-makers should include consumers at every level. The problem is that it is unlikely that such a system will be implemented in the foreseeable future.

Policy-Making: A Social Not a Technical Job

Nevertheless, there is something that can be done right now which has the potential to create widespread change. Today decisions about medical technology are, by and large, left to the experts. Not malevolently, but naturally, the financial and professional self-interest of these scientists and technicians has dictated an ever expanding concentration of resources into technology development and use. Self-interested experts are not the appropriate people to whom policy making responsiblities should be delegated. Representatives, however selected, of the general public should rightfully be making value judgments for society. Experts should advise and explain, but it is up to people to make the final decisions on what their priorities are within their budget limitations.

Consumers Can Ask Questions

To reach this goal is a long road to travel. Yet, starting may not be so difficult. Consumers must begin to treat the experts as a technical resource to their decision-making. They must begin to ask, and require understandable answers, to simple, pointed questions about the technologies they are considering. Those looking for public money or sanction should be required to present their case fully, addressing themselves to the six basic categories into which the evaluation of medical technology falls. These categories are need, safety, efficacy, cost, regional impact and relationship to health plans.

. . . About Need

Those of you who do not sit on HSA or facility boards will probably be surprised to learn that projects are presented for review without answers to such basic questions as: What is the medical problem addressed

by the technology? Will it prevent, diagnose or treat the problem and how many people can expect to benefit from it? If it's a diagnostic technology, is there treatment available for the conditions which are identified? If a treatment technology, will its use result in partial or complete recovery? Does it stabilize or rehabilitate the patient? Likewise, proposals will infrequently mention whether or not there is some other method currently in use which also addresses the medical problem and what, if any, are the advantages of the technology being proposed.

If the preceding questions were answered to the fullest extent possible, board members would have some concrete information on which to base their decisions concerning the need for the technology being proposed.

. . . About Safety

Similar simple questions can be asked about safety, efficacy, cost, regional impact and relationship to health plans. In the area of safety, anyone making a decision about a technology would want to know what the probability is that someone using it might be harmed and how severe this harm might be. You would also want to know how the proposed technology compares in terms of risks and benefits to others which address the same medical problem. Are there established standards for the safe use of the technology and will the setting proposed meet these standards?

. . . About Effectiveness

At the local level, it is probably more useful to ask questions about a technology's effectiveness than its efficacy. Effectiveness refers to how well something works under normal or usual circumstances, while its efficacy is an indicator of how well it does what it's supposed to do under ideal conditions. In this area every proposal for medical technology should simply state what it is supposed to do, what result is supposed to come from its application, what are the optimal conditions for its use and under what circumstances will it be used by the proposer. How is the technology's effectiveness measured and what is the evidence that it performs well. Proponents should present the data which shows that using the technology makes a difference to patients with the identified medical problem.

. . . On Cost

Cost, of course, is one of today's most crucial topics. Yet decisions continue to be made by facility and planning boards without the simplest data on the real cost of technology. For instance, expensive, complex technology often requires special staff and environment and maintenance by experts. These costs, as well as the purchase or lease price of the technology should be presented. Again, in order to make an intelligent decision, the cost of the proposed technology must be compared to that of current methods which address the same medical problem. Two other issues of cost frequently overlooked are whether or not the technology will pay for itself during its life span and what affect its introduction will have on the facility's reimbursement rate.

. . . Regional Impact

Regional impact is the fifth category in which information must be gathered. HSAs are supposed to be planning for the optimal distribution of health resources within their region. It is therefore incumbent upon HSA board members to take the regional point of view whenever medical technology comes up for review. Indeed, if HSAs more actively reviewed projects from the point of view of regional balances, facility boards which are too often parochial in their outlook, might be forced to also evaluate their own and their medical boards' requests in the light of the community's need. In this way, HSAs can foster a broader view while curbing institutional imperatives which conflict with regional goals. First, a board member should ask whether there is an adequate, alternate way of providing the needed technological service without adding a new program or piece of equipment. Perhaps the service already exists elsewhere in the region and there is sufficient capacity to handle an increased patient load. Perhaps the medical problem does not usually require emergency care and therefore patients could even be transported out of the region for service. If it has been decided to acquire the technology, it is extremely important to ask about and to evaluate the proponent's plans to establish a region wide system, through which the benefits of the technology will be made accessible to all those who need and can benefit from it. Looking ahead to the possible affects the technology may have on the characteristics of the region's population and on the demands for other health services is also crucial for health planners on the regional and institutional levels.

. . . And Consistency with the Health System's Plan

How the placement of the proposed technology in a particular institution relates to the regional goals set forth in the health systems plan is the final area for consideration. Projects which are approved should promote high priority regional goals and be evaluated within the context of a balanced regional distribution of complex technologies.

The questions presented above were developed by the Consumer Commission under a grant from the National Science Foundation. They are basic to intelligent decision-making for consumers and all others concerned with the financing and distribution of medical technology. The list is not an exhaustive one, but if used, can create a move toward more critical evaluation and informed decisions. These questions are contained in a 48 page manual recently published by the Consumer Commission entitled *A Consumer's Guide to Evaluating Medical Technology.*

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Hospital Obsolescence . . . Continued from page 3

health services are being stamped obsolete based on non-compliance with design standards.

What We Have Found

The growing use of design code violations as the reason for closing hospitals in poor neighborhoods has prompted us to this examination. We have found:

- unequal enforcement of the codes favoring the expansionistic aims of politically powerful institutions
- unfounded assumptions about consumer attitudes which disregard the need to balance priorities
- no real studies on the relationship between code compliance and the quality and cost of care.

Recommendations

As a result, we recommend the following course of action:

1. A moratorium on hospital closures for non-life safety design code violations should be imposed until research results from an investigation into questions of cost, quality and patient attitudes related to ward environments are available.
2. A study of American hospitals should be conducted to determine the relationships between physical environments and patients' and providers' perceptions of privacy, dignity, and environmental quality.
3. A space use observation study of American hospitals should be undertaken to determine:
   - the extent to which the space required by the codes is used and for what purposes
   - who uses the space
   - the quantity and location of over and underused hospital space
   - the cost of underusing hospital space.
4. A study of hospital operational costs should be conducted to determine if a consistent relationship exists between square feet per bed and staff costs.
5. There should also be a study of hospital procedures and the amount of space necessary to adequately perform them, so that ways of better utilizing existing hospital space can be developed.

In Conclusion

Changes in design codes could lead to significant savings in hospital construction and operations and keep open institutions otherwise scheduled for closure, but they will not cure the other ills of the American health care system. The innovative changes undertaken in the British health care system were possible not just because of the intangible cultural differences between the British and American people, but also because of the more concrete difference between the health delivery systems. Britain operates a National Health Service and America continues to deliver care within a private, fragmented, fee-for-service system. The ability to plan on a system wide level, the integration of the planning and implementation functions, and the removal of profit from the major part of their health care system allows the British to institute cost savings design innovations while still maintaining checks and balances that guarantee equitable and decent health care.

The discriminatory use of space and design codes in the closure of facilities, the lack of studies on the relationship of hospital settings to the quality of care, and the failure to consult consumers about their feelings about fitting settings for care are all reasons to continue research and investigation in this area. At present, only one model for acceptable hospital design exists. As an alternative to hospital closures, other models must be considered.

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And Need Independent Staff to Help with the Answers

In addition to asking questions and requiring answers, consumers must have expert technical staff, independent of those who advise providers, to conduct research, gather and interpret data and develop consumer-oriented policies and proposals. One of the major findings of the previously mentioned Consumer Commission's study of HSA board members was the extent to which consumers felt their frustration and helplessness to be the result of their inablity to get their hands on the information they needed and have it analyzed in a fashion they could understand, in sufficient time for them to develop an informed position. In this consumers are very different from provider board members. Providers are usually representatives of well organized organizations with active constituencies and well articulated points of view. Provider organizations have access to most source data and staff whose job it is to analyze proposals and develop programs in the light of the organization's goals. Ironically, while consumers have none of this technical and political support, they finance the efforts of provider associations through reimbursement allowances and tax write-offs.

Independent technical staff will assist consumers to intelligently analyze proposals about technologies and technological systems and to develop their own goals and priorities for technology development and distribution.

The combination of asking specific questions with the capability of understanding the answers, will be a giant step down the road to the real involvement of non-technical people in health decision-making.

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