EDITORIAL INTRODUCTION

Four years after the National Center for Health Care Technology (NCHCT) was abolished (Perry, 1982), the United States Congress has enacted legislation establishing an entity in the private sector authorized to assume, in part, similar functions.

In realization of the fact that many technologies were diffusing into health care in the absence of adequate information about their benefits, clinical risks, and cost-effectiveness, the Congress established NCHCT in 1978 with the mandate to undertake and support by grants and contracts comprehensive assessments of health care technologies, both new and existing, to ensure that their safety, efficacy, cost effectiveness, social, ethical, and economic impacts are more completely explored (Public Law 95-623).

Although the NCHCT has disappeared, interest in medical technology assessment has increased and there are now at least 45 organizations in the US that engage in some form of evaluation. Particularly noteworthy is the Clinical Efficacy Assessment Project of the American College of Physicians, the Diagnostic and Therapeutic Technology Assessment (DATTA) program of the American Medical Association, the Office of Health Technology Assessment (OHTA) and the Office of Medical Applications of Research in the Executive Branch of the government, and the Congressional Office of Technology Assessment (OTA). The newly established Prospective Payment Assessment Commission, an advisory body to the government on the Prospective Payment System has the authority to engage in or sponsor assessments but its program in this area has not yet been fully implemented.

While these activities should be applauded and encouraged, there are a number of deficiencies in medical technology assessment from a national perspective:

1. The efforts in technology assessment are fragmented and with little coordination. Most are quite modest, poorly funded, ad hoc, and with a few exceptions limited to safety and efficacy. Cost and cost-effectiveness are usually not considered.
2. Each organization in the private sector engaged in technology assessment has its own agenda, understandably choosing topics to reflect the interests of its constituents. In the government, the priorities of OHTA are driven by the needs of Medicare and OTA's priorities are set by the Congress. None of the groups either in the public or private sectors deliberately addresses the national implications of major new technologies—their potential benefits or hazards and their economic and resource costs for the nation.
3. There is no single organization that provides a repository for information on medical technologies or on the results of assessments.

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4. Finally, while the United States spends more than $10 billion on health research and development (U.S. Department of Health and Human Services, 1984), comparatively little is spent on technology assessment. If the budgets of the most prominent technology assessment programs are added to related activities in industry (clinical trials not included), it appears that less than $30 million is spent for this purpose, a tiny amount compared to the national health expenditures of nearly $400 billion. The recently renamed National Center for Health Services Research and Health Care Technology Assessment, the only agency in the federal government with a mandate to sponsor and support assessment research, spent less than $4.5 million in fiscal year 1984 on medical technology assessment.

In recognition of these serious deficiencies in the overall medical technology assessment capability in the U.S., at least five legislative proposals to remedy the situation were introduced in the Congress last year. One of these was enacted and subsequently signed by the President (S771, Congressional Record, 1984). This law changed the name of the National Center for Health Services Research to the National Center for Health Services Research and Medical Technology Assessment ("Center"), strengthens and broadens its mandate in technology assessment, and provides a legislative basis for the program of the existing Office of Health Technology Assessment. This is the office which was created to continue those activities of the abolished NCHCT related to Medicare coverage. In making recommendations on coverage, the Center is mandated to consider not only safety, efficacy, and effectiveness but, "as appropriate, the cost-effectiveness and appropriate uses of the technology." A National Advisory Council on Medical Technology Assessment is established with a composition similar to the council that served the NCHCT. The renamed Center is authorized to fund research related to technology assessment including diffusion, methodology, and studies of specific technologies. Therefore, to a certain extent, NCHCT may be said to have been reincarnated.

Of particular interest is the Center's authority to provide grant support to the National Academy of Sciences (NAS) for the establishment of a council on health care technology. This provision serves to implement the proposal of the Institute of Medicine (IOM) of the NAS which was issued in 1983 urging that a private/public entity or "consortium" be established for assessing medical technology.

The Council on Health Care Technology is to be composed of individuals broadly representative of health professionals, providers, and insurers as well as consumers, employers, and manufacturers of products used in health care. The goal of the Council is to foster technology assessments and to identify obsolete or "inappropriately used health care technologies." Unfortunately, the relationship of this Council to the National Advisory Council is not delineated in the law.

Under this new law, the government is authorized to award the NAS no more than $500 thousand for planning and establishing the Council (presumably under the IOM), provided the NAS can raise one-third of the cost from the private sector. For operational purposes, any federal grant obtained by the Council must be matched by twice the amount by the IOM. Privately, IOM staff are optimistic about being able to garner sufficient private sector contributions from health in-

surers, industry, and others to establish the Council. However, whether sufficient long-term fundings can be obtained to discharge its mandated functions is uncertain.

At the time of this writing, a small technical problem in the language of P.L. 98-551 is delaying its implementation, apparently only temporarily. Beyond that, the relationship between the new entity and both the IOM and the Academy will have to be defined. Having the Council under the umbrella of the Academy will represent a departure for the latter since in general both the Academy as well as the IOM have preferred to take on relatively short-term tasks and have avoided long-term commitments. However, the IOM proposal cited above envisioned a developmental period of five years and thereafter the new entity "might" become independent.

Whether the new entity at NAS or the existing Center in the government can rectify the deficiencies in medical technology assessment remains to be seen, but the need seems clear because of several considerations. The nation's commitment to heavy support of biomedical research and development ensures that medical advances and technological innovations will continue. The demand for medical services and the application of new technologies will intensify as the proportion of the American population in the elderly group increases. In order to provide quality care and to employ the products of the research enterprise efficiently and cost-effectively under constraints of cost-containment, the nation's technology assessment capability must be strengthened. The new developments cited above once more provide the opportunity to create a rational framework for medical technology assessment in the United States. It is to be hoped that this time the opportunity will not be lost.

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