into account the costs of alternative forms of treatment. My impression is that the second argument carried the day.

The discussions reveal a group of very thoughtful individuals wrestling with the problems of an extraordinary health care system. For example, Lucy Johns, consultant in health care planning and policy in San Francisco, pointed out that health care was a major employer with many people being very happy with the present arrangement. A basic benefit plan would potentially deprive health care staff of income and would not be accepted without a fight. A manager of a state employees association expressed concern that clinical guidelines should not limit the services available to less affluent citizens. He favoured a single tier health care system, and the counterargument was that single tier health care would not be acceptable in the United States and that the aim should be to provide adequate care to all, with any additional care being of only marginal value or even harmful. The buying behaviour of the rich, including that towards health care, is foolish, it was claimed, but a large part of the health care system seems willing to benefit from this foolishness. The role of guidelines in litigation was raised, with one member of the audience suggesting that 20% of health care costs could be ascribed to defensive medicine. If guidelines are to be successful in such an environment they will need some legislative support. A remark from the California State Employees Association's speaker is worth repeating: "Rationing is not the answer until we have some cost controls and business and labour are interested and willing to help do their part in controlling costs."

It is quite bizarre that the United States manages to spend such a vast amount on health care with so little to show for it. It is claimed that \$900 of the sale price of each car produced by General Motors is devoted to the health costs of the company's employees. The medical profession, the insurance companies, and the providers who make profits seem to be too strong a lobby for rational change to take place. Yet it seems to me obscene that the service should be talking about rationing care when so much is spent on care that is of no value. Surely it is the responsibility of all of us to eliminate waste before restricting the availability of care that does have value.

RICHARD BAKER

Director, Eli Lilly National Medical Audit Centre

Free copies of this book may be obtained by calling (916) 326 3387 or from Michelle Mitchell, Health Plan Administration Division, California PERS, PO Box 720724, Sacramento, CA 94229-0724, USA.

MEETINGS REPORTS

Healthy outcomes. Health Service Journal conference, London, November 1992

The healthy outcomes conference was a spirited and invigorating event designed to

challenge the current enthusiasm for health outcomes – as a means of measuring success in health service management, as a method for quality assurance, and as a way of involving consumers more closely in decisions about how much and what health services are available. For an initiative which is profoundly inter-professional, requiring the skills of academics – researchers and economists – public health specialists, managers of health services, and clinicians, the conference did well in attracting a representative audience and an appropriate cross section of speakers, including experience and – it has to be said – energy from the United States.

The event raised the many practical issues surrounding the outcomes movement in the UK. Do we have the information systems to link people's initial symptoms and signs with their eventual health outcome? Do we have the expertise to understand the likely causal relations between health care inputs and health outcomes? Can we predict the outputs per unit of input? Do we understand enough about the influence of confounding variables such as disease severity, co-existing disease, age, income, and social class to make inferences about cause and effect? How will developing information and existing but unused information support priority setting by purchasers and quality management by providers?

Overriding these issues was the assumption that the opportunities afforded by the NHS reforms to refocus the health service toward a greater appreciation of the population's health values should be seized. The speakers raised ways of tackling the scientific questions. On the question of variations in health care Klim McPherson, professor of public health epidemiology, Health Promotion Sciences Unit, suggested a hierarchy of uncertainty which could begin to establish priorities for outcomes studies, arguing that poor consensus or a lack of information on effectiveness was likely to be a determinant of variable outcome in proportion to their significance to the health service. Trevor Sheldon, senior research fellow, Centre for Health Economics, York, gave a cogent account of the problem of confounding variables and bias in considering information on outcomes. He also pointed to the need for central initiatives, such as leadership to overcome the overbearing reliance by the treasury on activity and process measures in formulating the efficiency index for monitoring the NHS, and the need for a national audit on appropriateness.

In considering consumer focus Kai Rudat at Market Opinion Research International described work in progress to reshape patient satisfaction surveys to enhance their objectivity and to include clinical measures. This initiative is clearly to be welcomed as an off the peg approach which may be readily applied to several health care settings. Rabbi Julia Neuberger heralded the beginning of a refreshing and stimulating public debate which would engage those using health services, their families, and their carers in resolving issues of competing demand. Acknowledging the problem of scarce resources, she left us in no doubt who

should answer the question of what works and what doesn't in health care. And with Mr Brendan Devlin declaring that quality of life should be measured routinely as an outcome measure for surgery with effort made to secure greater provision of information to patients it was beginning to look as though the day had been won.

Characteristically the speakers from the United States were provocative. Ira Raskin described the efforts of the Agency for Health Care Development and Research to establish patient outcomes research teams, a series of multi-disciplinary research projects designed to evaluate health service interventions in areas of high cost, high variation, and high volume medical care. These included benign prostatic hypertrophy, low back pain, myocardial infarction, hip fracture and diabetes, which rely heavily on using information from the extensive Medicare database. Robert Brook from the Santa Monica based Rand Corporation began by claiming that there was no evidence that feedback of information on health status to clinicians would result in a change in behaviour; process information was needed to ensure that doctors conformed with best practice. His main concern was, however, to convince the audience of the value of publishing information on comparative performance to the public, although there is no evidence for the efficacy of this approach. Nevertheless this perilous theme was taken up by several speakers and remains a challenge the *Health Service Journal* may be unable to resist.

ALISON FRATER
Public Health Specialist

Advancing day surgery. North East and North West Thames Regional Health Authorities and NHS Management Executive, London, January

This seminar brought together clinicians, general managers, and chief executives to discuss the key issues of day surgery.

The speakers, from various professional backgrounds, each tackled the main issues from a different standpoint and offered practical advice in achieving a quality service in clinical care, management arrangements, and environment. The overriding concern of them all was that in the drive for efficiency and cost effectiveness emphasis must remain on quality.

The demand for day surgery is growing and it is important to make sure it is well managed. This means considering resources, the impact on the community as well as that on the rest of the hospital. Day surgery is not a short cut; more time is invested in informing patients and there is a higher cost and a higher time factor in communicating with GPs and community nurses. Paul Jarrett, a consultant surgeon, emphasised that day surgery units cannot be seen as a cost cutting exercise if quality is to be maintained, and David Wilkinson, a consultant anaesthetist, underlined the need for swift and accurate information to be received by GPs. The question of medical day care facilities was discussed by Mike Paul and Elspeth Alstead from Forest Healthcare NHS Trust.

Can these two areas of care be incorporated into one unit? Robin Lawson speaking about the "Impact Foundation", considered how to involve voluntary agencies to help to provide proxy "friends and relatives" for those without, so that they might be able to use the day care facilities.

All the speakers agreed that the patient environment was extremely important. For example, maintaining patient dignity and considerate design and planning to ensure that incoming patients do not meet newly postoperative patients was thought to be valuable. Among the other main themes were:

- The need to develop and agree protocols for selection, discharge, postoperative advice, and provision of general information
- The need for standardised patient information to minimise confusion and for that information to be easily readable and frequently updated and improved to take account of changes in practice
- A different psychological approach to inpatients through instilling the concept of "wellness"
- Attention to skill mix, training, and internal rotation to ensure that staff are multiskilled.

The key points of the seminar were neatly summed up by the final speaker, Mr Ross McTaggart, an architect and health facility planner, in his statement that "day surgery is all about quality of clinical care, quality of management, quality of environment."

JANE EVANS
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KATE HATCH
Regional Medical Audit Officer, NWTRHA

COMMENT

Clinical Audit – Getting Started. British Dental Association and Faculty of General Dental Practitioners (UK), 1992. (For the Working Group on Audit in Primary Dental Care.)

This working group on clinical audit in dentistry has wide ranging professional representation, including independent practitioners and dentists in the armed forces. This report *Clinical Audit – Getting Started* is intended as a trigger to develop auditing programmes within primary dental care and sets the scene for audit and quality as an integral part of business management.

A pilot scheme for peer review started in January 1992, funded from post-graduate educational monies, and grants were made available through FHSAs. A few schemes got under way but generally speaking they have been slow to progress.

The report, funded by the Department of Health, has been circulated to every dental practitioner and will be followed early in 1993 with a "workbook" which

will describe the clinical audit process in more detail. At the same time courses for training "audit leaders" will be initiated at three sites in the country. These will be used as a framework to expand the scheme so that a network of dentists trained in teaching the clinical audit process is established and locally available. This method and the cascade principle will facilitate, it is hoped, the expansion, coverage, and adoption of audit as a concept within general dental practice.

Selling "audit" will not be easy in the current climate in dentistry. As a starter this document is well produced, readable, and persuasive. It might have been helpful to have described how the ideas expressed in the pamphlet would fit into the overall plan for selling "audit" as part of the total quality management process.

Most dentists will be aware of the need to add "value" to the care they provide, particularly if they are moving from NHS to independent practice. Many dentists were encouraged by the development of better materials and improving technology and have therefore wished to improve the quality of the service they provide, but increasingly over the past 10 years they have become frustrated by the fee scale, especially for high tech work, and other financial pressures. This initiative may be seen by dentists as implying a lack of quality to date and thereby acknowledging an awareness of diminishing standards and increasing pressure. More, it reflects the dilemma of government to satisfy the increasing demands for "quality" and "high tech" dental care from both the professional and the public without increasing funds. A system to encourage audit is very relevant to dental practice, but it will need to be introduced tactfully and sensitively.

F J RHODES
Consultant in Dental Public Health
ANN BINDER
General Dental Practitioner

Quality, Standards, Organisational and Clinical Audit for Hospice and Palliative Care Services (Occasional paper No 2). Higginson I. National Council for Hospice and Specialist Palliative Care Services, 1992.

Audit is sometimes thought inappropriate to palliative care, where quality of life is paramount but so difficult to measure. This concise paper clearly sets out the arguments for using multidisciplinary audit as a tool to measure care outcomes, evaluate alternatives among policy options, and avoid devoting scarce professional skills and time to unhelpful activity. Audit measures need to be developed specifically for palliative care in order to be sensitive to the needs of individuals. Irene Higginson assesses the available techniques for auditing care for practicality and validity in this context, with the emphasis on measures of outcome and process (when this can be shown to be linked to outcome) rather than structure, as this is the most relevant aspect of care for patient and family. Many of these audit methods could be used to evaluate the care of dying patients in settings other

than specialist palliative care units, such as care of the elderly wards and in the community. There is a useful and very up to date review of current methods in palliative care and a helpful bibliography. This paper should be read by not only those working in palliative care but also commissioners and providers of care, who need to be assured that dying patients are being well cared for by specialists and non-specialists alike.

ANNE NAYSMITH
Consultant in Palliative Medicine

DIARY

27 April

London: Royal Society of Medicine. RSM Forum on Quality in Health Care. "Is money wasted on audit?" (£20 RSM members and fellows, £30 non-members). Full details from Nicole Aaron, Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE (tel 071 408 2119 ext 301; fax 071 355 3197).

22–24 June

Leeds: Nuffield Institute for Health Services Studies. Coming to grips with quality assurance. A workshop for those with professional and managerial responsibility for, or interest in, quality assurance, whether as purchasers or providers. (£440 excluding accommodation.) Further details from Sally Sugden, Nuffield Institute for Health Services Studies, 71–75 Clarendon Road, Leeds LS2 9PL (tel 0532 459034; fax 0532 460899).

23–25 June

Blackpool: British Association of Medical Managers (BAMM) annual conference. Managing for patients: improving the outcomes. (Members £395, non-members £460 (including accommodation); after 1 May £452, £517 respectively; non-residential rates available.) Further details from Ms Nicola Whitworth, BAMM, Barnes Hospital, Kingsway, Cheadle, Cheshire SK8 2NT (tel 061 491 4229; fax 061 491 4254).

2 September

Newcastle upon Tyne: Newcastle Quality Centre, University of Newcastle. Special health services day – Quality and its Applications in Health Care, keynote speaker Professor Richard Grol; part of First Newcastle International Conference on Quality and its Applications (1–3 September). (£150 (£125 before 1 August), including coffee, lunch, and photocopy of health services papers.) Further information from Mrs Val Adams, Newcastle Quality Conference, Centre for Continuing Education, The University of Newcastle upon Tyne, Newcastle upon Tyne NE1 7RU, United Kingdom (tel 044 91 226546; fax 044 91 2227090).