of the Assistance Publique – Hôpitaux de Paris. Her book brings together a summary of the concepts, methods, and experiences of the valuation of hospital medical care from the British and American literature, relating it to the emerging practice of medical audit in France.

It seems that a widespread culture of quality assurance in medicine is even less in evidence in France than in Britain despite the passage in July 1991 of a law obliging hospitals, private and public, to develop programmes to assess and guarantee the quality and efficiency of care. The French National Agency for the Development of Medical Evaluation (ANDEM), established in 1990, had an annual budget of under £9m, compared with the £50m a year allocated for medical audit in Britain since 1989. As well as seeking to stimulate the enthusiasm of care – the audit cycle, the organisation of audit within hospitals, the development of guidelines, the importance and rarity of adequate information systems, the choice and problematic nature of outcome measures. The third describes some important examples of audit in practice. All this is not as dry as it sounds; the book is not an exhaustive textbook of audit but more an invitation to get excited about the challenge of practising better medicine – which acquiring some basic intellectual furniture for thinkers.

A recurring theme in the book is the need to resolve the ambiguity between audit for improving care and audit for limiting costs, and the consequent need for the independence of medical audit agencies from purchasers. We are reminded of the evidence that simple budgetary restriction limits necessary as well as unnecessary uptake of health services – which we are seeing ample evidence of here in Britain this winter.

Potential interest can emerge more from little details than from the main themes. A footnote explains for a French readership the meaning (in the protocol for the Confidential Enquiry into Perioperative Deaths) of the term “warning list.” The lack in France of a source of uncontested medical authority comparable to the British royal colleges presents a problem of one kind, while the serious shortage of nurses, precluding their participation in data collection and audit, presents another. A plea for more importance to be attached to clinical competence and less to research output in determining medical career progress strikes a familiar chord.

This book would, I think, fill a gap in the English audit literature – if it were in English! It was a pleasure to read, and in lieu of the second graphical of the audit cycle it has a beautiful drawing by Andrea del Sarto on the cover. Alexandra Giraud finishes by pointing out that we know so little about what makes a “good doctor” that we are obliged to put the expression in inverted commas. We really need to find out more.

DUNCAN KEELEY
General Practitioner


The NHS reforms have stimulated a minor heightening of the profile of quality in a relatively short period. The separation of purchaser and provider and the internal market have introduced an ingredient of competition (previously missing) that has allowed providers to focus on improving quality as a major selling point to their customers through the application of objectives. The “business” practices has contributed to the growing debate about how to manage quality in the NHS. This has included offering power to customers through a national consumer charter, a plethora of evaluation and audit to extol the virtue of total quality management (TQM) and other quality improvement systems, and the influence of both non-executive directors from outside the NHS and an increasing number of executive directors undertaking MBAs all seeking to change the culture.

There are several set texts on TQM but few considering its applicability to the health service and attempting to link the various elements of the usually uncoordinated hospital quality assurance activities. Ovretveit does not package his book as a “guide to TQM,” though he does refer to TQM briefly as one approach to consider. But what he describes and the way he constructs his argument is, in my opinion, a TQM approach. His book will be essential reading for chief executives and directors committed to improving the quality of service. In most hospitals there are pockets of excellence often influenced by enthusiastic individuals. In very few is this harmonised and meshed into a systematic approach to managing quality, seeking to empower all staff to continually improve the service.

Ovretveit seeks to link the quality programme with business strategy and marketing and concludes that many will be surprised by this approach. He also suggests that client quality, professional quality, and management quality need to be integrated and offers a quality management cycle, with tools to measure each aspect. Such concepts will meet with more enthusiasm from many used the undisciplinary, “professional” internal monitoring. His advice to start slowly and avoid antagonism by seeking ways to demonstrate how staff can benefit from improving quality should be heeded by any chief executive embarking on the major culture change needed. Indeed, the emphasis given to the crucial input of staff should be emphasised by Christina Townsend, NHS training director, in the foreword, where she comments that the quality programme will not succeed if “the necessary attitudes, skills, and working relationships go largely ignored and unacknowledged.”

On accreditation, which is again firmly on the agenda, with the King’s Fund’s organisational audit programme and BS7750, I am not yet convinced of the many other countries have not experienced high quality health care through this process.

The book is easy to read and well structured and its conclusions are backed by interesting practical examples. It is perhaps ironic that the only example of a modern or coordinated quality approach is the Welsh Quality Framework from the United States. What is the progress in the national TQM demonstration sites in Britain? One year on, there should be more progress to report.

Ovretveit concludes that quality remains a threatened approach, that responsibility for quality lies first and foremost with management (in my opinion specifically chief executives); and that the importance of a balance between people and processes and between present and future relationships should be recognised.

A chapter is devoted to the cost of poor quality. Improving quality will (eventually) save money. The NHS must be increasingly bold about reducing the cost of quality and challenging the myth that massive resources are needed to improve quality of services.

This book has influenced my thinking considerably, and it will make a significant contribution to the quality debate.

STEPHEN RAMSDEN
Chief Executive


Primary health care teams do not just happen, they need to be created, designed, and sustained, if they are to be effective in delivering quality health care. The assumption, all too often made, that placing various professional and other workers in the same team will result automatically in their working together well is rather like believing that if one throws all the delicate cogs and wheels, the internal mechanisms of a watch, up in the air they will land in perfect alignment and the watch will immediately start ticking. Although much attention has been given to invoking primary care teams to work well together, practical guidance on how to achieve this has been less forthcoming. However, Developing Teamwork in Primary Health Care goes a long way to addressing this problem. It is

In April 1991 a conference was held in California to examine the approach to setting guidelines for services that should be included in a basic package or benefit plan for health care. The basic benefit plan is meant to provide all necessary preventive, diagnostic, and therapeutic interventions and the associated guidelines are required to specify the clinical indication for which specified interventions would be deemed necessary for insurance coverage. The suggested definition for necessary care proposed to the conference was “services that, in the judgment of the panel, have been reasonably well demonstrated to provide significant health benefit.” Health benefit was further defined as being the life expectancy and quality of life improvements expected from the intervention minus any expected negative consequences, including any risk of death or of unpleasant and dangerous side effects. The procedure therefore uses an assessment of expected outcomes by an expert panel to determine whether or not a specific health intervention should be included in a basic health insurance package.

The conference was facilitated by the provision of a model proposal as to how these necessary care guidelines would be developed, and the immediate aim was to give guidance to the California Public Employee’s Retirement System, which currently has a basic benefits program available to 800,000 people in California with an annual premium volume of $1.1 bn.

The published proceedings make a valuable contribution to the debate about guidelines and rationing, not least because of the participants, who include many of the good and the great of American medicine – for example, Robert Brook, David Eddy, Alain Enthoven, Robert Kaplan, and Kathleen Lohr. The format is unusual in that the presentations by the speakers have been reduced to brief summaries whereas the discussion is recorded in some detail. This unusual style does, I think, turn out to be worth while, given the quality of the discussions. For example, we learn from David Hordon that the cost of developing a guideline could be as high as between $250,000 and $500,000. One member of the audience, reporting that the Minnesota state health system was now consuming 12.5% of the gross national product and the figure was still climbing, commented, “Of course we still have 88% to go.” The audience was well aware that the rate of inflation in health care is rising in the United States at twice that of general inflation. An interesting exchange took place over the level of care that should be included within this basic plan and some of the proponents of the scheme (David Hordon) said he would be willing to have his health care governed by 95% of what is covered in the basic plan and so retain the opportunity to pay for extra care outside the plan to cover specific preferences. This made clear some of the difficulties about devising a plan based on necessary care. The delegates struggled with the moral question of whether they are willing to undergo treatment that does not have a widely accepted outcome benefit. There will also be experimental treatments that have not yet come into wide use. These and other situations in which the outcome of specific treatments have not been clearly established present difficult choices to insurers, physicians, and patients.

The conference seems to have continued over several days, and towards the end of the proceedings I found that there were elements of repetition as participants came and went. Some of the later developments could still not be determined, although this may reflect more my own interest in general issues that can be applied to the United Kingdom, rather than specific matters unique to the American health care system.

The concept of the basic benefit plan shares some of the objectives of the Oregon experiment, although in Oregon attempts were made to include the valuation of the public health by way of a state initiative for Medicaid benefits. The Oregon approach was criticised because the priority list of 714 items make little allowance for the fact that for given treatment there are both high benefit and low benefit patients. More detailed guidelines might overcome the blunt instrument of the Oregon list. The conference proceedings provide me with the information to which the development of guidelines is inextricably linked with the movement towards rationing in health care. There is some interesting discussion whether the savings generated by guidelines accrue because inefficient, unnecessary, and wasteful care will be reduced or whether guidelines should be developed that take