exactly what it sets out to be, an excellent practical workbook, one of a series of practical guides. Its small size makes it less daunting for hard pressed primary care team members who want to improve their teamwork but find it nearly impossible to create enough protected time to meet and learn together. The text is easy to read, "user friendly," and separated into manageable sections, with clear objectives enabling a sense of achievement at each stage. The aim is that each section could be covered in a one hour team meeting, with short explanations of various aspects of team development to be read before the meeting and small pieces of "homework" to enable individuals to reflect on the team and their role in it before discussion with the whole group. The instructions for the homework and for running the meetings are in the main both clear and precise and would, I believe, enable many teams to run their own meetings without external facilitation. The descriptions of team development theory are skilful summaries from what is clearly a wealth of management experience, indicating the authors' expertise in making such complexities accessible without them becoming meaningless generalities. I particularly liked the explanation of conflict in the section on "Working in a Team," the helpful guidance on time management, and the practical group exercise on the induction and welcome of new team members. The section on team leadership is sensitively covered with a non-threatening but thought provoking team exercise. Sections progress logically through the book focusing on goals, tasks, roles, and procedures rather than getting deeply into values, beliefs, and personality clashes, which, although important, are hard to deal with effectively within most teams and can easily sabotage team-building progress. The authors avoid "doctor bashing," a potential trap when examining reasons for team dysfunction, and neatly display their own knowledge and experience of primary care by using illustrations and insights which teams will immediately identify with.

Organisational development theory is so extensive that individuals working in this sphere necessarily develop preferences for certain management models and beliefs about the "essential" components of successful management and therefore are easily critical of others using different models and theories. Nevertheless, I believe that there are gaps in this book. Although the introduction includes "general hints for conducting exercises," these focus on practical issues such as time and room space. There is no mention of ground rules or agreements about how participants would like the meetings to be – that is, that they are treated with respect, that contributions are valued, and that there are agreements about confidentiality. In my experience such ground rules are very helpful in building group "safety," such that people are able to think clearly and contribute honestly without fearing humiliation or exposure. The authors do state that "the leader will need to ensure that members are in the best possible frame of mind to be open with one another" but without specific guidelines leaders might not have the facilitative skills needed to achieve this.

Teams need to be able to evaluate their progress, celebrate their successes, and review any difficulties. Although there is a section in the book called "Evaluation of Teamwork," it is rather disheartening, with an overemphasis on the difficulties of such evaluation; I would have preferred a greater focus on identifying team achievements and what *can* be done to evaluate teamwork. The final section "The Way Forward" could have been much more detailed, with specific guidance on developing and agreeing action plans, including time schedules, deciding responsibilities (who does what), and review processes so that teams can keep up the momentum of teamwork development.

Despite these few critical observations I highly recommend this constructive book to any primary care teams wishing to develop their teamwork and also to facilitators and others who may be involved in the fascinating task of helping teams to work together well.

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Primary Care Facilitator

Designing a Fair and Reasonable Basic Benefit Plan using Clinical Guidelines. California Public Employees' Retirement System (PERS), Deborah A Lott, ed (pp 115; free). Sacramento, California: California PERS, 1992. ISBN 0-9633681-0-9.

In April 1991 a conference was held in California to debate the approach to setting guidelines for the 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 net 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 Employees' Retirement System, which currently has a health benefits programme 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 Robert Brook 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 United States health system was now consuming 12.2% 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 the basic plan. One of the proponents of the scheme (David Hadorn) 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 of opting for treatment 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 refusing to provide care to patients that could not be absolutely justified in terms of health benefit, but they were unable to reach a satisfactory conclusion. There will always be patients who feel so desperate that 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 sections could have been reduced, 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 valuations of the public, and it was also 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 any 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 have made clear to me that 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

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.

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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.