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 countermovement 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 the 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 spokesman was underplaying: “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 containing 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 described as “overhead” and would not be accepted by the company’s employees. The medical profession, the insurance companies, and the providers who make profits seem to be too complacent for rational cost controls 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
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Free copies of this book may be obtained by calling (800) 336-3370 or writing Michelle Micheli, Health Plan Administration Division, California PERS, PO Box 720724, Sacramento, CA 94229-0724, USA.

MEETINGS REPORTS


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 evaluation and reporting in health care 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 policy makers and quality management by providers?

Overriding these issues was the assumption that the opportunities afforded by the NHS reforms to refocus the health system on a greater appreciation of the population’s health values should be seized. The speakers raised some of the scientific questions. On the quantification of improvement in health care Kilm McPherson, professor of public health epidemiology, Health Promotion Sciences Unit, suggested a hierarchy of uncertainty which could begin to establish priorities for outcomes studies, and that a lack of information on effectiveness was likely to be a determinant of variable outcome in proportion to their significance. Trish Rudat at Market Opinion Research, 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 may need to be accompanied by appropriate guidelines which conform with best practice. His main concern was, however, to convince the audience of the value of publishing information on comparative performance measures, and to involve the public in a way that would suggest evidence for the efficacy of this approach. Nevertheless this perilous theme was taken up by several speakers and remains a challenge to 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. From different 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, warned that day surgery 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 Elisabeth Alstead from Forest Healthcare NHS Trust.

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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.”

**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 programs 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 slow pace, 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.

**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 0171 408 2119 ext 301; fax 0171 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, 71–73 Clarendon Road, Leeds LS2 9PL (tel 0532 450 034; fax 0532 460 089).

23–25 June

Blackpool: British Association of Medical Managers (BAMM) annual conference. Managing for patients: improving the outcomes. (Members £35, non-members £460 (including accommodation); after 1 May £452, £517 respectively; non-residential rates available.) Further details from Ms Nicola Whittorn, BAMM, Barnes Hospital, Kingstow, 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 0414 91 226546; fax 0414 91 2227090).