variation in the percentage of procedures performed on a day case basis; for example, in some DHAs more than 90% of carpal tunnel decompressions were day cases, whereas in some others the position was reversed, with more than 90% done on an inpatient basis.

Britain lags behind many other countries in the use of day case surgery. The Audit Commission's report outlines a number of practical steps to be taken if we are to catch up. These include the provision of self contained, dedicated day case units; better management of the existing units; and changes in attitudes of clinicians and managers.

The report is unequivocal about the benefits of increasing the use of day surgery. However, there is a shortage of research evidence on the extent to which this policy may place an increased burden on GPs and community services, and little is known about the attitudes of patients and their carers to day case surgery. The few studies that have been done are reassuring about the effectiveness of this mode of treatment.

The Commission is attempting to address some of the problems it has identified: it has commissioned the development of a questionnaire which DHAs can use to assess patients' satisfaction, and it has developed a "basket" of procedures suitable for day case surgery, together with a means of standardising for age and case mix to monitor and compare the performance of DHAs. These will be used in local audits of every health authority in England and Wales to encourage the development of local strategies for change.

The true test of this report will be the extent to which it is successful in achieving change in the rate of use of day surgery. It is a model of clarity: well illustrated and jargon free. I hope it will be widely read by surgeons and health service managers.

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What Price Quality? The NHS in Review. Gordon McLachlan. (Pp 298; price not stated.) The Nuffield Provincial Hospitals Trust, 1990. ISBN 0-900574-739.

This Rock Carling monograph of 1900 reflects on quality in the National Health Service and the contributions made by the Nuffield Provincial Hospitals Trust. As Secretary of the Trust for many years, Gordon McLachlan is well placed to observe the protean organisations and politics which shape the NHS. In particular, he uses the immediacy of the White Paper to illustrate more general issues which face a state run health service in a democracy.

The Trust has sought to promote value for money and quality in provincial hospitals (originally reckoned as covering 90% of the population of the United Kingdom) through investment in research and development, and through the publication of results of clinical practice and of health care policy. McLachlan contrasts the independent analytic approach of the Trust with the current mechanisms for

commissioning research and disseminating new technology in health care.

While evidence of the effectiveness and scientific validation are expected of clinical practice, why is health policy (such as on GP budgets, hospital trusts, and service contracts) not also submitted to study and research? How can legislation be passed to endorse NHS reforms when there is a gulf between executive policy and public opinion?

A prime reason, he argues, is that the NHS is funded, managed, and evaluated by the same political national machinery. There is no independent authoritative body "capable of dispensing dispassionate wisdom in the complex field of health care", to evaluate health policy, results of research and quality of health care, and to translate research into practice. He proposes that Britain might adopt the model of the Institute of Medicine of the National Academy of Science in Washington DC in order to separate responsibility for health policy from management responsibility for a government funded service. Similar proposals have come from a Royal Commission, a former chief medical officer, and a former permanent secretary of the DHSS. The idea has merit but who would be the catalyst? McLachlan gives ample details of the Institute of Medicine (and agrees it should really be "Health") but not of who should champion such a cause in Britain.

This book is not light reading but it has a wealth of ideas and evidence, a blend of serious generality and appealing detail worthy of a well-stocked library.

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Setting Priorities in Prevention. K Schaapveld, E W Bergsma, J K S Van Ginneken, H P A Van de Water. (Pp 168; price not stated.) Netherlands Institute for Protective Health Care, Leiden, 1990. ISBN 90-6743-183-4.

With the announcement by the Minister of Health of the Health Targets Initiative in England, the debate on setting priorities in prevention is now a focus of attention. This book is therefore opportune.

Setting priorities in prevention is a report commissioned by the Dutch Ministry of Welfare, Health, and Cultural Affairs and prepared by the Netherlands Institute for Preventive Health Care. The report tries to answer the questions: "What can we realistically expect of prevention? How do we measure any improvements? Is it worth it? And is it possible to establish priorities for a list of prevention programmes?"

At a general level, it goes some way to answering these questions, through giving an overview of all aspects of prevention. As such, it is a valuable and very readable introductory text, but the reader will need to follow up the useful list of references at the end of each chapter to fill in the detail.

It discusses how health, morbidity, and mortality can be assessed by means of health indicators to prepare prevention profiles—which provide pointers for prevention programmes. The use of various indicators

leads to differences in the rank order for different health problems. The preventability of health problems in terms of the health benefits achieved by means of prevention is considered, and some of the models used to calculate these benefits are described. Attention is also given to the cost of prevention, including the use of cost-benefit and cost-effectiveness analyses. Such health gains, however, might be offset. It appears that preventive measures that are successful in themselves in the fight against coronary heart disease and cancer may have other undesirable consequences relating to decompression of morbidity and competing causes of deaths.

A framework for a more rational approach to setting priorities in prevention is suggested, based on the concept of efficiency, with a list of interventions scored against a number of criteria. This process makes decisions explicit in the ranking of priorities for prevention.

In summary, the report provides a good overview of prevention, but perhaps three particular points should be made on its contribution to the debate of setting priorities. Firstly, the list of interventions covered in the report is based on a medical model with respect to promoting healthy lifestyles; interventions involving organisational change (such as no smoking policies, ban on advertising) are mentioned in passing. Secondly, setting priorities does require consideration of the issue of inequalities—even in an overview—and how this fits into the efficiency equation. Thirdly, while the report gives us a framework for ranking priorities, how the public, professionals and politicians are engaged in the decision making process is crucial if priorities are to have meaning and form the basis for health strategies with leadership, commitment, ownership, and resources.

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Costs and Benefits in Health Care and Prevention: An International Approach to Priorities in Medicine. Eds U Laaser, E J Roccella, J B Rosenfeld, H Wenzel. (Pp 160; DM48.00.) Springer-Verlag, Berlin, 1990. ISBN 3-540-52708-7.

Setting priorities for health care is a major policy challenge in all health care systems. The analysis of the costs and benefits of alternative, preventive, and curative procedures is an important technique and the collection of papers in this book is designed, according to the Preamble, to give "a valid and accurate review of the state of the art and problems of cost/benefit considerations in selected chronic diseases . . .". The book was compiled from the proceedings of a conference bringing together economists, epidemiologists, and clinicians from Germany, Israel, and the United States. The problem of international comparisons of cost-benefit studies is one of major themes throughout the book. The 19 chapters are divided into four main sections: discussion of economic concepts; case studies, including five on hypertension; quality of life measurement; and finally some different