and many may groan at the thought of yet another institution. But reliable measurement is essential for improvement. Otherwise, we can never know whether changes are making things better or worse. It might be that this body could be absorbed into the new Commission for Healthcare Audit and Inspection (CHAI), particularly as its chairman, Ian Kennedy, says that he wants to replace the "men in bowler hats" of the old CHI with "a mirror" that can be held up for trusts and government to assess their performance. It will be essential, however, that the data can be believed by the public and professions. Any sense of the data being spun will be disastrous. Leatherman and Sutherland say that the body must be credible, independent, dispassionate, "deeply" competent, stable, and long-standing, and "serving in the interest of the public." These criteria may be hard to achieve for a health service that is one of the most politicised in the world. One product of QuIC might be an annual report on the state of quality.

Another recommendation is to engage the public and patients. Angela Coulter, director of Picker Institute Europe (which specialises in measuring patients' experiences and using their feedback to improve the quality of health care), contributed a chapter to the review and concluded that a critical stocktaking of achievements to date (in the strategy to put patients at the centre of the NHS) reveals a collection of disconnected initiatives rather than a coherent joined up strategy.[4] Leatherman and Sutherland present many proposals on how to engage the public and patients but had much greater difficulty with knowing how to implement their recommendation to engage the professions. A fundamental problem with the quality initiative is that it isn't owned by the professions. Many clinicians are involved in many improvement projects, but the initiative belongs to the government and those directly in its thrall. Yet real improvements can be delivered only with the full participation of clinicians and their institutions. There must be a role here for the royal colleges and specialist associations, but few have risen comprehensively to the challenge.

The final conclusion of Leatherman and Sutherland is that the quality initiative is moving in the right direction and that incremental refinements are needed not a complete redesign. Nobody in the service could stomach a complete change in direction, but producing reliable evidence on the quality of the NHS and fully engaging the public, patients, and the professions are major challenges. I am not confident that a state of quality and grace will be achieved in the NHS in another five years. Further muddling through seems more likely.

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Lessons for the NHS from Kaiser Permanente

Ownership and integration are the key

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Kaiser Permanente is a healthcare organisation providing managed care to 8.2 million Americans. It is widely admired for doing this in a cost effective way that is valued by both its members and its clinicians and has been closely studied over the past few years as researchers have tried to understand how it works and why it is so successful. Last year a paper by Feachem et al in the *BMJ*, which compared Kaiser and the NHS, provoked a sharp debate by implying that Kaiser achieved better outcomes for similar inputs.[1] Now a study by Ham et al, reported in this week's *BMJ*, this time looking at lengths of stay in hospital (p 1257),[2] has produced similar conclusions. It is time to summarise the key lessons that can be learnt from Kaiser Permanente and to consider their relevance for the NHS.

Kaiser Permanente is essentially a closed system that offers little distinction between primary and secondary care and has well established pathways of care for many diseases. Undoubtedly the hospital based aspects of Kaiser are highly efficient. With lengths of stay well below half of those for many comparable conditions in the United Kingdom, Kaiser has put together an apparently seamless system that meets the needs of the patient from well before admission until well after discharge. Moreover, its system has fewer hospital admissions per head of population than does the NHS[2] and seems to function with management costs at least as efficient as those of the NHS (B Trudell, Kaiser Permanente, personal communication).

The two words that summarise the attributes of the Kaiser system are ownership and integration. Despite its many weaknesses, the pluralistic US healthcare system offers clinicians and the public great choice of healthcare providers. Not only is there a choice between managed care organisations and the more straightforward (if more expensive) healthcare insurers, within managed care there is also a distinction between relatively egalitarian organisations such as Kaiser and more aggressively cost conscious providers.

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People who subscribe to Kaiser Permanente do so knowing that the system aims explicitly to provide an equitable service to all its members. Many of those who visit Kaiser from the United Kingdom report that it feels highly value driven and is perhaps less materially oriented that some of its competitors. Patients who choose Kaiser Permanente are buying into this notion of egalitarianism and generally accept that their choices may be more constrained than those for subscribers to other managed care organisations. The notion of patient "buy in" (perhaps comparable to the traditional UK view of "our" NHS) permits the system to offer less inherent choice, and this must contribute to Kaiser's financial efficiency.

As for members, so for doctors: unlike other managed care organisations, Kaiser employs its doctors, who work in large, self governed, multispecialty groups and provide their services exclusively for Kaiser. Once again, the doctors are aware of the values that underpin the organisation, and those who join do so with a commitment that distinguishes them from clinicians in other organisations. Many doctors outside Kaiser actively disparage those who sacrifice a proportion of their material ambition to satisfy a philosophical urge.

The fact that clinicians and members have signed up to the Kaiser philosophy means that the entire service can be set up with a single set of values. Thus, the traditional distinctions between primary and secondary care, between generalists and specialists, perhaps even between doctors and nurses, may all be considered as largely obsolete. Services can be planned in a seamless way that can ignore the traditional tribal rivalries, and it is this secondary theme of integration that allows Kaiser to apply planned clinical pathways to such good effect. Unlike the NHS, structures within Kaiser create far fewer obstacles to patient care.

How relevant is all this for the NHS? If the key determinant of success is ownership it may be that the UK government's current concern to promote choice for patients will allow both public and clinicians to opt into our own service in a way that has not been possible before. However, creating a real sense of opt in implies the possibility of opt out—a concept at odds with the NHS's principle of universality.

The irony is that there already exists an enormous sense of ownership among both public and NHS workers. Where the system seems to have failed is in harnessing and increasing this commitment. Instead, increasing centralisation, micromanagement, and a general sense of disempowerment are causing us all to lose our sense of collective ownership. The challenge is to recreate the sense of pride and identity in the NHS: once priorities of service delivery take precedence over tribal and organisational issues, then the systems of working so effective in Kaiser Permanente that are driven by the culture of the organisation may be applied to the NHS.

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Should we be screening for and treating amblyopia?

Evidence shows some benefit

In 1981 the award of the Nobel prize for medicine for the discovery of the pathophysiology of amblyopia marked a turning point in the management of children with this condition.[1] Recognition that early visual experience is essential for the development of the visual brain has fundamentally changed the way we manage disorders that interfere with image formation in the eye during early life. For example, very early screening, detection, and intervention for sight threatening congenital cataract[2] has practically eliminated this condition as a cause of long term visual impairment in the developed world.

People looking after children with amblyopia often see improvement of vision after patching of the good eye and no improvement (or even deterioration) in children whose patching is not carried out as recommended,[3] but the lack of controlled trials led to the recommendation that a randomised controlled trial should be carried out in which the control group would not be treated.[4] The trial reported by Clarke et al in this week's *BMJ* (p 1251)[5] is a response to this challenge and affirms that treatment of unilateral amblyopia is effective in improving poor vision, but not in improving vision in children with a starting visual acuity of 6/9 or 6/12 vision. A visual acuity of 6/9 can fall within the age norms for the logMAR crowded test used in this study,[6] so it is possible that not all children with this level of vision were amblyopic and that the small changes observed represented normal visual maturation. The lack of a statistically significant loss of vision in the no treatment group undermines the argument that children with 6/9 or 6/12 vision in the affected eye need to be identified and treated to prevent their vision from deteriorating.

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The optimal time for visual screening has also been the subject of debate. Preschool screening in the community has been advocated to ensure timely treatment, but high default rates hamper the efficacy of detection and screening for amblyopia.[7] The current finding that treatment efficacy is not diminished if treatment is

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