examples of American health management organisations as commissioning agencies are unconvincing, although these organisations have in some cases found ways of effectively managing health care for groups as small as 50 000 people. But the lack of effective gatekeepers in primary care in the United States (except possibly in health maintenance organisations that are based on groups of practitioners providing primary and secondary care) has undermined what "combined" commissioning might achieve.⁶

Many health commissioning agencies are struggling to bring together the different responsibilities and cultures of district health authorities and family health services authorities. To be effective, as Light shows, they will now have to develop workable mechanisms for involving general practice fundholders, even though many managers find that irksome.⁶ Light suggests that, when fundholders are involved, moving from managed competition to managed coordination is possible.⁶ He proposes that the NHS needs to forge a coherent vision and to disentangle the organisational and fiscal contradictions that continue to reduce value for money.

So far, so good. Unfortunately, an entirely separate Department of Health project group also uses the term "joint commissioning." This refers to arrangements between health authorities and local authorities jointly to commission community health and social care. Following a speech by Dr Mawhinney two years ago in which he said that "joint commissioning . . . is a question of sharing responsibilities . . . in pursuit of a common goal of better services for users and carers . . ." the Department of Health issued guidance in March last year.⁷ Together with a paper by Knapp and Wistow,⁸ this set the scene for joint commissioning of community care. Five pilot areas for commissioning services for elderly people were identified and are now operating: Oxfordshire, Hillingdon, Easington, Westminster, and Wiltshire. In each area primary health care teams have been actively involved. Key concerns that have emerged include the definition of locality, how much power should be devolved to local commissioning teams, who should serve as the locality commissioners, the relations between the strategic planning role of health authorities and the operational role of general practitioners, linkages with statutory agencies, and clarification of decision making.⁹

The objectives of the joint commissioning project group are to achieve a seamless service, to help avoid arguments about who is responsible for running services, and to avoid cost shunting. The group also aims to improve cost effectiveness, to ensure that assessment of need is unhindered by organisational boundaries, and to promote innovation. Such objectives could usefully be set for the

locality joint commissioning described by Light. A further twist has been given to this debate by Wandsworth Borough Council's proposal that it should take over the commissioning of health care. Although this has met with a lukewarm response from ministers, it accords with both the present government's agenda for joint commissioning and suggestions from the Labour party for greater local democratic control of health authorities. Joint commissioning may be the route to another far reaching reorganisation.

Good relations between commissioning agencies and fundholders will be essential to achieve the greatest health gain for the population while meeting patients' expectations. As Ham suggests, however, concerns exist about the effort involved in managing budgets and "the ability of enthusiasts in fundholding practices to sustain the workload they have taken on in recent years."

If there is to be genuinely seamless care, particularly for people with chronic disorders, then the further step of involving local authorities' social services departments in commissioning will be essential. Westminster City Council has taken one step in this direction by commissioning community support and rehabilitation services from an NHS trust. The opportunity for seamlessness is available if health commissioning agencies, general practitioners (both fundholding and non-fundholding), and social services departments work closely together. But much organisational development is needed to clarify roles and responsibilities, to simplify and streamline systems, and to ensure that the patients themselves are given a genuine voice in commissioning care.¹⁰

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Returning to work after herniorrhaphy

"Take it easy" is the wrong advice

The annual cost of disability payments after operations for hernias in the groin in the United States is unnecessarily high. This is because patients are being advised to limit their physical activity for six to eight weeks postoperatively to prevent recurrence. Although no scientific backing exists for such advice, this common and costly practice persists.

In Britain when patients return to full activity "within a

few weeks"¹⁻⁴ recurrences are not more common. Troublesome wound soreness is rare seven to 10 days after operation, and immediate return to full activity as soon as the soreness permits has not increased recurrences. Several large studies in the United States, which have included almost a quarter of a million operations, confirm this.⁵⁻⁸

The integrity of a repair of a hernia depends on good surgical technique, strong sutures, strong hernial margins,

and the correct application of prosthetic mesh support. After standard open herniorrhaphy (as described by Bassini, McVay, Condon, and Shouldice, for example) the strength of the wound is 70% of that of intact tissue and strong enough to withstand full physical activity.⁹ Open prosthetic mesh repair, correctly done, can withstand any degree of stress immediately,¹⁰ and postoperative activity need not be restricted at all.

Patients' motivation is the driving factor in the decision to return to work—and that depends on their confidence in their repair. This in turn depends largely on what they have been told by the attending surgeon or physician. Repeated emphasis that what they do physically will not affect the strength of their repair reassures patients that early return to work is safe and justified.

Our own most highly motivated patients (doctors themselves are the best examples) have returned to work in two days or sooner. Desk workers are back at work in less than a week; manual workers average seven to 10 days. Among 3125 patients whom we observed during a 10 year period recurrence rates were low, under 0.2%.¹⁰

In Britain a recent patient information booklet produced by the Royal College of Surgeons of England offers the following advice: "take it easy after operation. . . do no heavy lifting for four weeks" and "resume full activity by eight weeks."¹¹ The American College of Surgeons has recently advised patients that "depending upon your occupation, you can expect a recovery period lasting from one to six weeks."¹² Such caution serves only to engender anxiety and justify the patient's decision to remain off work for a full six weeks, whether necessary or not.

It is contradictory and counterproductive to warn against strenuous activity—a recipe for long disability—and then expect patients to return to work early. Elimination of such iatrogenically induced anxiety can go far to reduce unnecessary time off work—thereby resulting in substantial economic savings.

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Towards a knowledge based health service

Priorities are set for health technology assessment

Few decisions made in health services are made with good evidence.¹ This applies particularly to decisions on how health services are structured and managed but is also true of decisions made every day by doctors and nurses.² The failure stems from those who work in health services being unaware of evidence that is available, from the evidence being disorganised and inaccessible,³ and from the evidence simply not existing. The ambitious mission of the NHS research and development programme is to create a national health service in which decisions are based on evidence,⁴ and the publication last week of the report of standing group on health technology was an important step in that direction.⁵

The failure of research to feed through into practice is currently a hot topic,^{6,7} and the old model of how doctors were supposed to incorporate the latest research into their practice has had only limited success. The model might be summarised thus: doctors are trained at medical school in the latest scientific thinking; their scientific training continues in their postgraduate years; and they pick up on the latest science by reading journals, attending meetings, and talking to colleagues and then incorporate it into their practice. In fact, training at medical school in scientific methods and critical appraisal of research is minimal; many doctors after graduation do no research and those that do often do it badly⁸; most of what is in the journals or heard at meetings is of doubtful standard scientifically and of dubious relevance⁹; and most doctors know little about

how to assess scientific papers critically and know even less about translating what they read into practice. The problems for other health professionals are probably worse.

Another problem—identified by the House of Lords in 1988¹⁰—is that most medical research until now has proceeded with inadequate input from the NHS. The problems that interested the researchers were rarely the problems that confronted the practitioners. "The use of research methods to measure the benefits—or otherwise—of interventions designed to prevent ill health or to diagnose and treat established illness is of central importance to health services and to public health more generally," writes Michael Peckham, director of research and development in the NHS, in the introduction to last week's report. "Yet this activity has languished as the poor relation of medical research. Remarkably, it has taken 45 years for the NHS to set in place mechanisms to assemble a description of health practice methods and to develop plans and methods for the critical assessment of their usefulness."⁵

Health technology assessment is the largest part of the NHS research and development programme, and its scope is broad. "Health technology" covers any method used by health professionals to promote health, treat disease, or organise care, and "assessment" considers effectiveness, costs, outcomes, and acceptability to patients and society. The research and development programme has a standing