AN INFORMED DECISION?

Assess whether the patient is making an informed decision. This assessment is based on the patient's answers to questions and level of understanding and mental state. A patient answering yes to "Do you understand everything we've discussed about the HIV test?" is no evidence for informed consent. It is useful to ask patients to highlight the important ideas they most remember from the conversation.[5] In particular, they should mention (or be reminded) of the following: it is not a test for AIDS; the meaning of a positive or negative result; one advantage and one disadvantage of the test.

In some clinics, particularly in the USA, doctors require the patient to sign a consent form. In our HIV testing clinic we feel that verbal consent is sufficient.

SAFER PRACTICES

Discuss reducing the risk for HIV infection. Use the pretest counselling as an opportunity for one to one health education and to promote safer sex and drug injecting practices with patients. Information can be given about where they can obtain free condoms, clean injecting equipment, or hepatitis B vaccination (which may be recommended to some patients).

"Avoid unprotected penetrative intercourse (vaginal or anal). Use condoms, a diaphragm, or cap and preferably spermicidal cream. Use only clean needles if you inject drugs."

TIME TO DECIDE

Some patients need some time to think before having the test. These patients should be given another appointment a few days later, if necessary, or referred to a specialist HIV counsellor if appropriate. There is hardly ever a clinical setting in which an immediate decision for an HIV test is a life or death issue.

Conclusion

The procedure for obtaining consent for an HIV test opens up communication between doctors and their patients and paves the way for comprehensive medical and psychological care and support for those found to be positive.

1 World Health Organisation. *Guidelines for counselling about HIV infection and disease*. Geneva: WHO, 1990.
2 British Medical Association. *HIV infection and AIDS: ethical considerations for the medical profession*. London: BMA, 1988.
3 Laforet E. The fiction of informed consent. *JAMA* 1976;**235**:1579-85.
4 Miller R, Bor R. *AIDS: a guide to clinical counselling*. London: Science Press, 1988.
5 Appelbaum P, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med* 1988;**319**:1635-8.

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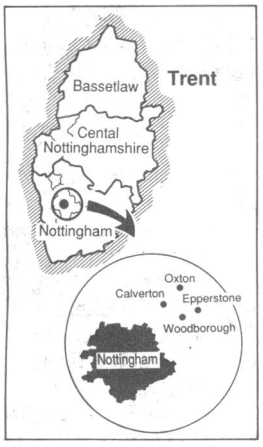
The New NHS: six months on

Budget holding: the first 150 days in Calverton

John Bain



Levinson House, Edinburgh EH8 9DX
John Bain, FRCGP, *professor of general practice*

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Disappointment with progress to date, yet not surprised with the way things are moving—that is the reaction of the Calverton practice as it reflects on the first three months of budget holding.

By holding a budget the partners in Calverton, a practice of five doctors based round three villages outside Nottingham, hoped to influence the behaviour of consultants with the end result being a reduction in waiting times for patients. How successful have they been so far in achieving this aim?

Controlling hospital services

Ground rules for outpatient and inpatient services are not yet established, and the current billing system is extremely cumbersome. The practice had drawn up specifications for minimum waiting times for patients and limits on the number of outpatient attendances, but no overall agreement has yet been reached about these proposals with the local hospitals. Allied to this the method of billing the practice is based on "paper exchanges" as the computer systems in the practice and in the hospital are not compatible.

According to the practice manager, "There are still a lot of bugs in the system," but he is still confident that these can be dealt with. The main frustration for him is that budget holding is up and running without an accountancy package which meets the needs of the practice.

Plans to invite consultants to hold clinics in dermatology and rheumatology in the health centre have been held back. A compromise has been reached whereby a consultant dermatologist will see referred patients at a clinic in a private hospital. In time, this arrangement will be reviewed with the aim of placing the service within the Calverton health centre. In rheumatology a decision is still awaited about where the service for referred patients will be located. Reading between the lines I suspect that consultants may be encountering problems in providing services which satisfy both hospital managers and budget holding practices.

The original intention of the practice was not to go outside traditional providers of hospital care—that is, the NHS—but in the case of orthopaedics there are signs that the private sector will more readily be able to meet the practice's requirements in terms of waiting times and costs. Within the past three months arrangements have already been made for two patients waiting for hip replacements to have their operations performed in a private hospital. Although it is early days, the practice may increasingly have to go outside the NHS to reduce the waiting times for patients requiring surgical procedures.

Apart from laboratory services, there have been few attempts by providers in the private sector to woo the practice. But the practice has no plans at present to move away from NHS laboratory services.

Changes in working habits

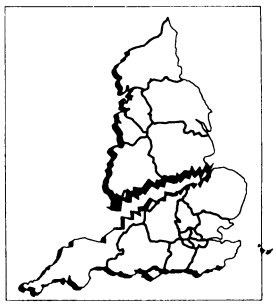
Since the inception of budget holding there has been an estimated 10% reduction in the number of outpatient referrals and laboratory investigations, compared with a similar period in 1990 (April-June). The reasons for these changes have not been fully analysed, and the general practitioners are unwilling to reach any conclusions about trends in referral patterns until a longer period has elapsed. There have been no apparent alterations in drug prescribing behaviour, and plans for a drug formulary have been "put on ice" until there is enough time for the partners to get together and consider new policies on prescribing.

The main burden of organising the budget and negotiating contracts falls on the shoulders of the practice development manager. The agreed budget was less than the practice had hoped for and this did cause some initial concern, but it has now been accepted as reasonable for the first year. Handling the changes in practice organisation has caused stress among support staff, and the next step is to appoint a clinic administrator and a fundholding clerk, which will lead to greater efficiency in providing services for patients within the health centre. Many of the staff would welcome a reduction in the level of uncertainty but, according to the practice development manager, "I can't let them know when things will actually settle down."

Side by side with the administration of budget holding is the day to day work within the new contract, which has made demands on everyone in the practice. The extent to which improvements in quality of patient care may have occurred is hard to judge at this stage but the thrust towards defining standards for outpatient and inpatient services is currently the main driving force for change. Overcoming the barriers within the hospital system and the absence of "user friendly" accounting systems are causing difficulties, but everything is new and no one has had any previous experience of negotiating costs of patient care.

It is early days in the process of budget holding with lots of uncertainty still around. The Calverton practice is still committed to what the partners view as an important experiment. The demands on all the staff are considerable, but actually "getting going" has removed some of the original anxieties about how things would work out. A key issue is going to be getting agreements about the specifications for hospital referrals.

The Health of the Nation: responses



Work related disease and injuries

J M Harrington

The consultative document on a strategy for health is described as a new concept for England.[1] It is, and as such should be warmly welcomed. The fact that it is woolly in some places and seriously deficient in others does not detract from its importance as a first step in the right direction. The purpose of the consultation phase is to highlight those deficiencies and sharpen the focus elsewhere. One of the document's deficiencies is the scant attention it gives to occupational health.

Should work related diseases and injuries be a key area?

There are nearly 30 million people of employable age in England and Wales, which, even in these times of high unemployment, means a large number of people at work. Occupational health services of one sort or another are available to about half these people. Most companies employing more than 1000 people have full or part time medical and nursing staff with occupational health qualifications. The under-resourced Health and Safety Executive, through its employment medical advisers, attempts to provide some degree of care for the rest.

This working population faces a variety of workplace hazards. The latest figures (for 1988-9) from the Health and Safety Executive indicate that 514 deaths occurred that year (including 167 in the Piper Alpha disaster), with 150 000 people receiving injuries requiring at least three days off work.[2] Though these figures show a slight fall year on year, they are actually a considerable underestimate of reality. For what they are worth they suggest one new case of work related disease eligible for compensation per 4500 employees. The equivalent statistics from Finland are 10 times worse while in Sweden the annual reported rate is one case per 100 employees. This reflects, without doubt, more effective recording in Scandinavia, not better British work practices.[3]

If the diseases and injuries are extended beyond "work caused" to "work related" what meagre evidence is available suggests that for mortality the work relatedness varies from 12% for cancer to 25% for cardiovascular diseases[4]—equivalent to 1800 premature deaths a year among men of employable age.

Diseases and injuries caused by work are all theoretically preventable. Indeed the ability to prevent rests largely with the employers and government. As the first medical inspector of factories, Sir Thomas Legge (1863-1932), said: "Unless and until the employer has done everything—and everything means a good deal—the workman can do next to nothing to protect himself, although he is naturally willing to do his share."[5] Such a division of responsibility for health and safety at work is enshrined in the Health and Safety at Work Act 1974.

Prevention of ill health is a cornerstone of occupational health practice. The Secretary of State for Health considers that specific areas deserving special attention include maintaining good health, preventing ill health, rehabilitating people to good health, and supporting disabled people. These are the raison d'être for occupational health services. Such services, staffed by qualified practitioners, thus provide the only logical site for preventing work related disease or injury; they also provide a crucial location for general health education and targeted health promotion. The regular opportunities that occupational health services provide for doctors and nurses to influence workplace exposures and alter lifestyles that are hazardous to health could be argued to be unparalleled elsewhere in the health services. Indeed, given that these services are paid for by employers, the secretary of state is missing an opportunity to use a "free" health service.

The problem of responsibility for leading preventive strategies is bedevilled by the two extreme claims "It's up to individuals" and "It's all up to government." The

Occupational health in the strategy document

The green paper recognises that industry and commerce have responsibilities for improving health and that there is scope for investing in the health of the workforce by:

- Promoting healthy living, ensuring that catering services offer healthy food, and providing exercise facilities
- Offering employees the chance to participate in workplace health initiatives

Nevertheless, no specific role for occupational health professionals is identified either separately or in meeting targets in other key areas

Institute of Occupational Health, University of Birmingham, Birmingham B15 2TT
J M Harrington, FRCP, *professor of occupational health*

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