compulsory isolation as a means of punishing people for past (mis)behaviours; rather, it provides for the isolation of people who the court believes may in future put the health of others at risk. Those who are educated and articulate will find it relatively easy to convince the court that in future they will not engage in unsafe practices. People who are less educated or unfamiliar with Swedish customs and the Swedish language or generally less skilled at "playing the system" may be less able to defend themselves successfully in court. To date, most people who have been compulsorily isolated have been drug users, including drug using prostitutes, as well as a few male immigrants; no Swedish homosexual men have been subjected to isolation under the Contagious Diseases Act.⁸

A further bias in the act relates to the legal requirement that doctors report patients who admit to having engaged in risk behaviours. This breach of confidence is anathema to most doctors treating patients with HIV infection, and very few have filed such reports. To protect their patients further, many doctors do not keep full written records of medical consultations so as to avoid having to hand over incriminating material to the county medical officer. Most referrals to the county medical officer come not from doctors but from the police, who keep careful watch over those drug users, prostitutes, and immigrants whom they know to be infected with HIV.

Rights and responsibilities

Sweden's approach to preventing the spread of HIV depends a great deal on the HIV positive person's acknowledgement and the acceptance of a social responsibility to prevent the spread of HIV. Although public information campaigns remind the population as a whole that everyone must take steps to prevent the

spread of HIV, the provisions of the Communicable Diseases Act focus almost completely on the duties of people who are infected with the virus. This approach contrasts starkly with that of Britain, where HIV prevention is seen as much the responsibility of people who are not infected with HIV as of those who are.

One of the frustrations of HIV prevention relates to the difficulty in establishing what works, and what does not.¹⁰ In Sweden there is an apparently unshakeable—but untested—belief that HIV testing is crucial for HIV prevention. Though the emphasis on HIV testing will undoubtedly continue, growing concern about some of the more restrictive provisions of the Communicable Diseases Act has led to the creation of a parliamentary committee to review the act. The committee is expected to report in late 1998, and it is widely expected that it will recommend that this act be reformed.

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Commentary: Promoting testing is no substitute for recognising risk

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Given the continuing transmission of HIV infection in western Europe, preventing new infections and mitigating the effects of infections that have already occurred are major public health priorities. Testing blood donations for HIV has an established role in preventing transmission of the virus. In other areas of primary and secondary prevention, the case for large scale HIV testing is less clear.

With the advent of effective measures to prevent mother to infant transmission, including the use of zidovudine in pregnancy for HIV infected women, there is a strong case for these women to have their infection diagnosed well before they give birth. In England, especially in London, much needs to be done to improve the situation; less than a quarter of HIV infected pregnant women in London in 1996 were aware of their infection.¹ A very high rate of HIV testing of pregnant women may be cost effective in preventing HIV infection of infants, but such a policy would, even if it were performing optimally, prevent

fewer than 30 HIV infections each year in London² (where two thirds of the births to HIV infected women in the United Kingdom take place³)—compared with the many hundreds of infections that arise from unprotected sexual intercourse between men.

In the absence of combination antiretroviral therapy, HIV infection invariably progresses to disease clinically recognisable as likely to be related to HIV, so that eventually almost everyone infected with HIV will have an HIV test. Prompt testing at the onset of illness certainly improves clinical management and short term prognosis, but it is still not known whether early testing of infected people who do not have symptoms improves their survival. Deferred combination antiretroviral therapy may be as beneficial as early treatment.

In Sweden, according to Danziger, there is an assumption that once people infected with HIV become aware of their infection status they will change their behaviour to reduce the risk of transmitting that infection to others. In London, however, a fifth of a

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sample of HIV infected homosexual and bisexual men had presented with another sexually transmitted infection in 1996 when tested for syphilis at genitourinary medicine clinics, despite awareness of their HIV status.¹ This shows that knowledge of infection does not eliminate behaviour associated with continuing risk of HIV transmission.

Despite commonly held beliefs, the evidence is scarce that people infected with HIV are less likely to transmit the virus if they are aware of their infection. Neither is there evidence that an uninfected person who is at risk of being infected will reduce this risk after having an HIV test. Even if test uptake was greatly increased, the maximum risk for onward HIV transmission may be in the period before an HIV test could be expected to be undertaken.

Throughout the 1990s the estimated proportion of homosexual and bisexual men infected with HIV who have had their infection diagnosed has remained around 60%. This suggests both continuing transmission of HIV and a constant proportion of men who choose to delay having an HIV test until clinical illness

makes diagnosis unavoidable. Until early HIV diagnosis is shown to be effective in limiting spread and improving prognosis, most effort should be focused on implementing measures that are aimed at reducing risk behaviours. HIV infection is now established, and in western Europe substantial continuing transmission is restricted to subsectors of society. Doctors and nurses should realise that "normalising" or "mainstreaming" HIV testing is not a substitute for using enquiry about sexual and drug injection behaviours to recognise people at greater risk of acquiring HIV infection, and for undertaking individual health promotion at every opportunity.

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The New NHS: commentaries on the white paper

Encouraging responsibility: different paths to accountability

This week our commentators examine various aspects of accountability. The white paper promises an NHS where accountability emphasises clinical performance (discussed by Nick Black) and is driven by better information for patients and professionals (Jeremy Wyatt), supported by new national institutions (Jos Kleijnen), and ultimately provided by health care workers' own willingness to take responsibility for providing excellent and innovative services (Jonathan Shapiro). Health authorities also take on a new responsibility locally for working with others to create a more healthy society (Siân Griffiths)

Counting and accounting in the new NHS

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The new Labour government came into power in May 1997 intent on abolishing the market in health care, correcting inequities in provision, and improving public input into the planning of services. To what extent does the new white paper achieve these aims? In particular, what are its implications for accountability within the service?

One of the key issues facing the new health team was the linkage of accountability with money. The previous regime had made financial accountability the cornerstone of its reforms; all the leverage for change, whether in the creation of freestanding trusts or the power of fundholding, was invested in tight contractual arrangements. The new government is working from the premise that contracting wrought little positive change but drove only the bureaucracy of accounting and the increase of supply led services and is determined to change the "currency" of the NHS.

In the new white paper accountability seems to follow two separate paths: clinical accountability, and the power of a web-like accountability framework. On the

one hand we read that "policies will build on the professional traditions of standard-setting and self-regulation" (a welcome return to professional values in an age of deepening mistrust of professionalism); on the other, we see that health authorities, NHS regional offices, the Commission for Health Improvement, primary care groups, and even the Secretary of State are all invoked to act "when performance is not up to scratch." In both cases money remains the final common pathway, but as a means rather than as the end.

This balance of mechanisms recurs, and every case suggests that the carrot and the stick are both there, but that the balance between the two is unclear. There may be wide variations in management style and in the way that health authorities in particular discharge their responsibilities for creating health improvement plans and achieving their aims.

Some health authorities will see their "reserve powers" as being genuine last resorts, for use with recalcitrant contractors (individual practitioners, practices, primary care groups, or trusts) when all else has