car tyres. With a sophisticated population like that in Rio de Janeiro television will persuade most viewers to inspect their gardens and help the public health authorities, but this has varying success in the interior. For example, in Roraima state in 1982 10 000 cases of yellow fever occurred in a few months. To make matters worse in terms of control a second species with similar breeding habits has been recorded in Brazil, a known dengue vector *Aedes albopictus*. This species has been recorded in the states of Rio de Janeiro, Espírito Santo, Minas Gerais, Rio Grande do Norte, and São Paulo.

James Porterfield wrote about research into yellow fever in West Africa in the 1989 Christmas issue of the *BMJ*. In 1959 I worked in the laboratory in which Stokes caught fatal yellow fever in Yaba Lagos. The Rockefeller Foundation assault on yellow fever cost the lives of six scientists but led to an understanding of American jungle yellow fever and the development of the 17D vaccine—one of the two most effective vaccines known. Brazil provides millions of doses annually, all made at the Instituto Oswaldo Cruz, Rio de Janeiro. Naturally some failures occur at the end of

the line as in any national programme. Witness me stumbling from a bus at 4 am coming back from the field. In my old clothes and with a beard I am thought to be a hippy estrangeiro. In vain I protest that I am the professor of medicine in Brasília and have been vaccinated. I have no document because I always lose them. The health inspector orders that I receive my seventh dose of yellow fever vaccine (and one lasts 10 years). And the health inspector at Porto Velho airport gives 2-3 doses of vaccine a day on request but opens a 20 dose ampoule that then has to be discarded. It is expensive so why can't we have it in smaller ampoules? Tourist agencies and airport authorities are efficient on vaccine prophylaxis against yellow fever, but some get through.

I'd like to close as I started, with the old port of Salvador. Sometimes, in a time of peace in the old days a big square rig sailing ship would drift in with no one alive on board. The explanation could be several infectious diseases such as malaria, plague, cholera, and typhus but could also be yellow fever. In the nineteenth century nobody paid any attention to *A. aegypti* breeding in the scuppers.

NHS Review

Kenneth Clarke: hatchet man or remoulder?

John Roberts

John Roberts is an American journalist turned internist and epidemiologist. He spent two months with us in the autumn burrowing into the depths of the NHS. We will be publishing a series of articles from him on his impressions, and we begin with an interview with Kenneth Clarke, who at the time of the interview was Secretary of State for Health. He and the Prime Minister have since moved on, but there are no signs that the path on which Mr Clarke set out has changed.

JR: What prompted the government to write the white paper?

KC: We believed that if the health service is to carry on giving free treatment at high clinical standards, reasonably accessible to everybody, we had to improve the way the health service was run—as well as put more resources into it. Also, it is a giant bureaucratic organisation set up on an overcentralised model. It needed modern management and better methods of distributing money. It needed to introduce measures of the effectiveness of health care—some means of judging what we're getting for our money and what we can buy as we put more resources in.

JR: How can one judge effectiveness in something so nebulous as "care"?

KC: No health system in the world measures outcomes. It's not regarded as the subject matter of political debate. We're changing that, of course. Clinical audit obviously is going to be a method of assessing effectiveness. The contract system—whereby people purchase care from providers of care—will get the purchasers to stipulate what they want and to stipulate the quality of what they get—that is, measure performance against what they've asked for.

JR: What's to keep expenses here from going the way of those in the United States?

KC: The BMA had this crazy idea that we were bringing American health care to Britain. I can't see much resemblance between what we're proposing and the

unfortunate state of affairs that exists in the United States. My opponents said we were privatising, going over to American type private health care. We're not. I'm opposed to that.

Consumer demand and the role of the GP

JR: What's to keep hospitals from marketing for certain diseases?

KC: There's no such thing as a "more profitable disease" in the NHS. They won't be allowed to accumulate true profits. They will respond to what health authorities and general practitioner purchasers want to buy. And the fastest growing services I predict are things like geriatric services. If you look at the demography of this country, that's the fastest growing group. High tech surgery won't be profitable.

It is only in an insurance system where it is possible to market particularly high technology, which the

Americans do to an excessive extent. If you have a genuinely patient oriented consumer demand health authorities will wish to purchase in kind. The aim is to reimburse costs, not to encourage profit.

JR: But the United States has a consumer driven system.

KC: But you don't have our family doctor system. I think the biggest strength in the NHS is the general practitioner—the family doctor. And as the family doctor is the sole route into the hospitals and to community services the family doctor is going to make a clinical judgment about how resources should be used. The family doctor is acutely aware of medical demands—from his own patients—for example, in low income groups who are elderly. These people have no clout in the American system but do in ours—through the general practitioner.

JR: Has there been a shift of emphasis from hospital doctors to general practitioners?

KC: Yes. I think our critics have it wrong when they characterise what we're doing as putting all the power into the hands of the hospitals to charge profit on what they do.

JR: Why, then, did the general practitioners fight the new contract?

The biggest strength in the NHS is the general practitioners

KC: It is odd I've had trouble with the general practitioners. I've always been in favour of a contract with family doctors that stipulated what we wanted from them. Now we've put them on performance related pay, which is almost unique for a key sector of public workers. Performance related pay means that we stipulate what standards the doctors should meet to get fees over and above their capitation. They then will strive to provide the services that we pay them for. And that means, I think, a higher level of services for the patients. It also coincides with the general practitioners' average income rising quite sharply. Our eventual hope is that a higher standard of family doctor service will lead to a higher standard of services in the hospitals.

When I use this language of industrial relations it

upsets them greatly, but that's exactly what it is—payment for performance: higher levels of vaccination, higher levels of cervical cytology. We've reached targets in most places—even gone over them. Smear test numbers have risen dramatically. Vaccination numbers have risen dramatically. And so the high targets that I was told would be impossible to achieve only 12 months ago are now being hit by most of our family doctors.

JR: What about doctors in areas with high numbers of people who decide against vaccination or cervical smears, such as women of low risk who have objections to having their genitals examined?

KC: Well, that was a criticism early on, and we will look at that when and if it works out that way. I suspect it was a theory, but won't be a reality. But I will adjust the level of payments if that turns out to be the practice.

Not inflexible

JR: So you are flexible? Some doctors tell me that Kenneth Clarke is inflexible, as demonstrated by how he dictated the general practitioners' contract.

KC: I have quite a reputation with doctors for being extremely and belligerently inflexible. My defence is that I am actually doing something, and that some of the things I am doing are not always with the consent of the community of doctors. The BMA, like the American Medical Association, is accustomed to telling the government what its opinion is and the government doing what it is told. What they actually want is no new general practitioners' contract, no reforms. It is true I've been fairly obviously against that position.

I did negotiate with the general practitioners' leaders, which ended in their being sacked. But I made many concessions: basic practice allowances, even the targets—I lowered the target levels. I originally wanted to go along with the World Health Organisation goals, which meant 90% vaccination and 80% cervical cytology—all or nothing. I conceded to intermediate levels, as well, 60% and 50% respectively. But such concessions were ignored because we still didn't take the whole nasty business away.

JR: How will you deal with possible future targets—for example, mammography or stool occult blood screening if they are shown to be good screening tools?

KC: About two years from now I hope we'll sit down again to see what has been achieved by the new contract. Then we can have a sensible and orderly discussion where we adjust the targets by the light of experience. The snag I faced was that the contract hadn't been touched in 25 years. I hope we won't wait another 25 years for a new contract but adjust it after a couple of years and decide, perhaps, to change some of the targets we'd initially suggested—infuse some fresh priority. That's my ideal.

JR: How do you think the public sees all this?

KC: Public opinion continues to act as if the doctors are still as angry as the BMA said they were 12 months ago. Public opinion will come around as the doctors do. The public now perceives that the profession is wholly hostile. I have to say that pockets of hostility still abound. I still face some very angry meetings, but they are getting better.

Accountability

I have no hostility towards medics. When you get behind all the details of the changes the big change we're making for doctors is that we're making them

more responsible, making them more accountable. They're no longer solely healers of the sick, as they define that role, who look to some administrator to provide them with funds. For the first time, someone is asking them to deliver a particular service, asking that they measure the quality, and checking that quality and agreeing with them that a certain amount of resources should achieve some particular results.

If your background as a professional man is that you haven't been really accountable to anyone—the work you did was simply well intentioned decisions about what you did, when you did it, and how you did it—it's a devil of a blow to be told you're now going to be held accountable. Suddenly, the work you do in hospital is accountable to general practitioners; the pay you get as a general practitioner will depend on whether you meet these performance targets set by the government. That kind of change would disturb anyone. It affects habits and sense of security. Habits that have been set in the health service for 40 years are hard to shake.

The good and competent doctors have nothing to fear

JR: But why should you as an administrator or politician tell doctors what their standards should be?

KC: I see myself as a representative of the consumer. The public should declare what results it expects from the service. How those results are achieved is a matter for clinical decision, in which I have no competence. It's not my business to start telling doctors how to carry on their practices. I wish to agree with them on what we are looking for and how we are going to be satisfied we are getting it. The good and competent doctors have nothing to fear.

JR: What about the hospital doctors?

KC: I think the hospital doctors at first were less resistant than the general practitioners. The general practitioners now have gone through the first phases of their changes, but the hospital doctors still face their changes. We're not introducing some new breed of supermanager from the world of commerce who's going to order doctors to do this, that, or the other thing. That won't work. We're trying to stop hospital doctors from being so detached from their administrators and to involve them in key management positions—particularly about the uses of resources.

Once we've got clinical units in practice—with clinical directorates—and the hospitals working on a contractual basis the clinical director will then see first hand the level of work his unit can do, what quality it is reasonable to expect to achieve, how he can make use of resources to deliver that quality—resources that he's agreed to take to do it.

It does not mean the doctor is becoming an accountant, but he is becoming responsible for the performance as a whole of his unit, not just carrying out the clinical work and walking away from the rest and moaning because some damned administrator and some bloody politician are failing to provide the resources he thinks he requires.

JR: But shouldn't politicians deal with budgeting and doctors deal with healing?

KC: I don't think it's a very satisfactory arrangement. It leaves the politicians to sit around and take all the kicks when anything goes wrong. Government is a convenient scapegoat. For the average doctor in the hospital who has sought more money his best gambit has been to

raise a fuss and to tell the newspapers how bad his unit is and how the patients stand in line. That way, he might attract more funds from the health authority or the minister. I hope we can pull the politicians away from the bedside—to depoliticise, to have a doctor's unit depend on his success in persuading general practitioners to refer people to his unit because of the quality of what it does.

Different from the United States

JR: But even as you speak of "depoliticising" many rules seem to flow from this office. How can doctors and administrators be free to act under such rule making?

KC: Self governing trusts cannot just make profit. Their prices should reflect their costs. But any surpluses they do manage to acquire are their's to reinvest in their hospital, as they think best.

JR: Then why won't hospitals be able to focus on some areas and reduce others, perhaps opt for profitable procedures, such as orthopaedics, and drop less lucrative ones, such as oncology? That's what many self governing hospitals are doing in America.

KC: I don't see anything wrong with some hospitals focusing on orthopaedics, and other hospitals elsewhere focusing on cancer. If they can sell the idea to general practitioners and their colleagues, fine. But they will not be able to close vital services that a hospital should provide.

Marketing here is different from in the States. In America the hospital is responding to the needs of stockholders. Here, hospitals will respond to the needs of the general practitioners and their patients.

The other great difference is that we do not have direct referrals by patients, and that would happen only over my dead body. I am totally against the American system of self referral. It drums up unnecessary work. Our general practitioners and health authorities live under a cash limited system. Such a system deeply resists the proliferation of unnecessary medical procedures that profits hospitals in the States.

JR: Is it true your ideas came from the States?

KC: From Alain Enthoven, the United States economist, who'd worked in defence before addressing health care. He came over here six to seven years ago and wrote a series of articles for the *Economist* in which he outlined his theory of internal markets.

I liked it because it tried to inject into a state owned system some of the qualities of competition, choice, and measurement of quality that you get in a well run private enterprise. I defend state medicine. But as a Conservative I'd like to see the general standards of management and performance raised to the level of a well run private enterprise. Medicine is more important than baked beans, but most baked bean companies run better than most hospitals.

JR: So why not fully privatise medical care?

KC: Turning health into an ordinary private enterprise is costly, as America has demonstrated. You don't have any real consumer resistance to spending more, and you certainly don't have any real informed consumer choice. When I buy a car I might know what kind of car I'd like, but I also know how much I can afford, and I adjust my expectations accordingly. In health care, I know of no patient-consumer who does that. If you or someone in your family is ill you will not accept constraints in price—unless you're forced to. You try to buy the most expensive thing offered. But you have no means of judging it. The more expensive, the

better. That's how America came to spend 12% of gross domestic product to produce a medical system that is no better than anyone else's. It even has some rather serious deficiencies.

If we were to introduce a true market—even insurance based—we would produce very well paid doctors and a very expensive system, but I doubt we'd produce any more quality.

General practitioners and health authorities are much more informed customers of services than any patient, whether here or in the States.

JR: What's your vision for 10 or 20 years from now?

KC: That we've retained the principle of universal access to the highest possible quality care. How high we can get depends on politicians, doctors, administrators, and others in the service. I don't imagine the system I introduced will be permanent. Nothing is, of course. I do believe that nobody will go back on things like clinical audit, measurement of quality, better resource management. These are tools to discovering better ways of doing things.

Understanding Benefits

Introduction to the social security system

Simon Ennals

Because it is widely believed that the government changed the whole social security system in April 1988, replacing legal entitlements with official discretion, many people assume that any previous knowledge they may have had of the benefits system is now obsolete. In fact, the major changes that occurred in 1988 were not that sweeping. Certainly there is now more discretion, but the main structure of the social security system remains fundamentally unchanged. The changes were mainly concentrated in one part of the system: the means tested benefits—but since so many people depend on means tested benefits the changes in this area have tended to overshadow other more stable areas of the system. This article outlines the main features of the current system.

The structure of the system is still largely that set up after the second world war, following the Beveridge Report. The aim was to establish a system of social insurance that would be paid into by the working population and would then provide benefits as of right during times when the breadwinner could not earn a living, without resort to the hated means test. The centrepiece of social security is still the contributory benefits, such as retirement pensions and invalidity benefit, paid, without any means test, on the basis of National Insurance contributions.

Although most needs were intended to be met by the contributory benefits, it was accepted from the start that some needs, such as family support, were best met without a contribution test or a means test. Child benefit (and its predecessor family allowance) have always been paid as non-contributory benefits without reference to means. The range of needs to be met by non-contributory benefits was considerably expanded in the next 40 years, especially during the 1970s, when benefits were introduced for the long term sick,¹ and severely disabled.

Moreover, it was also accepted that there would need to be a residual means tested sector to provide a safety net for those who, for whatever reason, slipped through the net of National Insurance. In the late 1940s this national assistance was expected to have to provide for only a few thousand people at most. That, of course, was the major flawed assumption which has led to the chaos surrounding present day social security. In 1989 the successor to national assistance—income support—was claimed by almost four and a half million households. Housing benefit and family credit—the other main means tested benefits—were being claimed by 5 350 000 and 285 000 respectively.

So why have means tested benefits grown from a residual safety net to being relied on by millions of

Benefits checklist for patients

<i>Patient group</i>	<i>Contributory benefits</i>	<i>Non-contributory benefits</i>	<i>Means tested benefit</i>
Elderly	Retirement pension	Over 80 retirement pension Attendance allowance	Income support, housing benefit, community charge benefit
Disabled and long term sick	Invalidity benefit	Severe disability allowance, attendance allowance, mobility allowance, industrial injury benefit	Income support, housing benefit, community charge benefit
Short term sick	Sickness benefit	Statutory sick pay	Income support, housing benefit, community charge benefit
Families in low paid work		Child benefit, one parent benefit	Family credit, housing benefit, community charge benefit
Pregnant women/nursing mothers	Maternity allowance, sickness benefit	Statutory maternity pay	Income support, housing benefit, community charge benefit, social fund
Unemployed	Unemployment benefit, sickness benefit		Income support, housing benefit, community charge benefit
Widows	Widow's pension, widowed mother's allowance, widow's payment		Income support, housing benefit, community charge benefit
Some people will fall into more than one group.			

Essential Rights,
94 Chaworth Road,
Nottingham NG2 7AD
Simon Ennals
Written in association with the
Child Poverty Action Group
This is the 2nd of 10 articles

Br Med J 1990;301:1386-8