

attended by hungry patients.¹⁴ At present, however, depot neuroleptics (even though they are no more effective than oral forms¹⁵) remain the best authenticated method of preventing relapse in non-compliant, forgetful or treatment-resistant patients.¹⁶

Will this picture change now that many new antipsychotics (generally referred to as atypical, although all this means is that they lack extrapyramidal side effects, which not all do) are becoming available? The atypical neuroleptics fall roughly into five groups: the later substituted benzamides; the mixed dopamine and serotonin receptor antagonists; the dopamine specific compounds; serotonin receptor antagonists; and sigma receptor antagonists. These new drugs differ from those in current use not only in their actions but also in their method of delivery. At present five of the six neuroleptics most used in Britain are available in depot form. About half the neuroleptics used in patients with schizophrenia are depot formulations.¹⁷

By contrast, few of the new drugs in development will initially be available as depot preparations. The dopamine receptor antagonist raclopride is being developed in depot form, as is the serotonin receptor antagonist sertindole, but generally the manufacturers have shown little enthusiasm for the extra work required to develop depot preparations. This is understandable for clozapine—no one would be keen to give a depot form of a drug known to carry a risk of causing agranulocytosis. No such risk is apparent from existing data on remoxipride, launched in 1991, and risperidone, launched in 1993. Attaching decanoate or ethanoate side chains to the atypical neuroleptics is not proving easy, but this is not the main reason for the lack of depot versions. Depot preparations are believed to be unnecessary—because they are thought to be needed only for drugs with unacceptable side effects.

The true atypical neuroleptics will, by definition, lack extrapyramidal side effects, but do the data support the comfortable assumption that non-compliance is caused principally by side effects? This has scarcely been proved for comparisons of serotonin reuptake inhibitors with tricyclic antidepressants,¹⁸ and the research reviewed earlier in this article has shown the multiple factors relevant to non-compliance with neuroleptic treatment. Might it not be premature to abandon our tried and trusted reliance on depot administration to overcome non-compliance in patients with schizophrenia?

At this stage it seems remarkably naive to assume that patients with chronic schizophrenia will readily swallow the neuroleptics in oral form. Quite possibly the negative symptoms of schizophrenia also influence compliance rates (largely unstudied) perhaps by being confounded with insight.

Insight itself, drug related depression, and other specific and non-specific psychological factors all play their parts in determining compliance. It would be unfortunate if marketing models built on naive assumptions delayed the introduction of new drugs likely to have a major impact on response to treatment. The delivery system most likely to offer the long term benefits of new drugs to patients with recalcitrant chronic schizophrenia is the well tried depot system.

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Public opinion and the NHS

The unaccountable in pursuit of the uninformed

Criticising the current enthusiasm for gauging the public's opinion about the NHS and its services can easily sound undemocratic. Yet why public opinion should matter to the people running the NHS is not immediately clear.

Since 1979 the NHS has been transformed into a series of quangos directed mostly by businessmen with Conservative leanings, usually selected more for their professional position than for their identification with the local community.¹ No body of administrative law has been developed to regulate their activities.² Equipped with a mission statement of effectiveness and efficiency they have been freed from the constraints of formal accountability to those who use the NHS and pay for it through taxes.³

Despite their lack of accountability to the public they serve,

NHS managers are currently being exhorted by their political masters to listen to "local voices." Undoubtedly, the exhortations have spawned a lucrative industry in "communication strategies," the net cost of which has not been estimated. While health authorities and trusts pilot expensive public consultation exercises, sometimes in conjunction with other quangos, there is little evidence of any firm commitment to allow the public to influence purchasing decisions.⁴ The reason for this is obvious: quangos have no reason to be concerned with what the public think about them.

In *Local Voices* the NHS Management Executive tries to provide them with the necessary motivation. It says that involving local people in the purchasing process will enhance the credibility of health authorities, provide them with greater

weight in their negotiations with providers, and facilitate the development of services appropriate to local needs.⁵ These arguments have not been persuasive. In *Listening to Local Voices*, its ninth (unreferenced) research paper, the National Association of Health Authorities and Trusts (NAHAT) seems to continue the precedent set by the management executive in *Local Voices*.⁶ But the document in a combination of ignorance and arrogance reveals what NAHAT really thinks of public consultation.

The public's contribution is described as mainly "negative," citing as its example opposition to the closure of services. The failure to bring about changes in services is partially attributed to an "innately conservative public," which tends to resist changes in strategy and provision. Meanwhile campaigning groups are dismissed as "having distorted the range of public views." At the same time as diminishing the importance of pressure groups and Community Health Councils on the grounds that they are unrepresentative, NAHAT remains unperturbed by the composition of the health authority boards. From NAHAT's perspective, communication provides quangos with a means of disciplining a recalcitrant and ungrateful public, rather than a means of opening up the debate on the acceptability to the public of shrinking budgets and the effects of the internal market.

The trouble is the lack of incentives to rethink their approach; no sanctions are imposed on quangos who fail to consult and listen. The Audit Commission, for example, insists that the job of purchasers is to achieve "health gain" and cites the targets set out in the *Health of the Nation* as measures of success.⁷ But when it comes to communicating with patients—which it calls a core activity of district health authorities—the champion of performance indicators fails to spell out concrete ways of measuring achievement.

The lack of a good reason why purchasers should communicate with the public is evident in the recent priority setting exercises. A common feature of these attempts at public consultation is the failure to make a clear distinction between improving the planning of services and needs assessment, and using public opinion in a process that might result in the denial of health care to some groups. Whereas public consultation on service delivery is being used to legitimise contracts between purchasers and providers, "rationing" and so called priority setting exercises masquerade as research into community "health care" values. This is dishonest when the same exercises are sold to the public as public consultation on developments of purported benefit to the respondents or local community.

The priority setting exercises also show how a lack of respect for the public and its opinions can influence methodological considerations and interpretation of data. Firstly, it can discourage attempts to ensure that sample populations are representative. A study in City and Hackney surveyed over 600 respondents' views (community groups and a random sample of the public), but the extent to which they represent the 196 000 people living in the borough, which is famous for the diversity and heterogeneity of its residents, is unclear.⁸

Secondly, the questionnaires used may not be capable of reflecting the knowledge or values of respondents.^{9,10} The recent health enquiry and reinvestment options (HERO) exercise developed by the health authority in West Glamorgan in conjunction with the Audit Commission is almost unsurpassable in the complexity and technical language of its questions and approach. In this exercise, the public were asked to decide on the appropriate level of funding for services such as pinnoplasty, dentoskeletal problems, or a comprehensive cardiothoracic service, without prior information as to cost or the effect their decisions will have on those services or on their community. In a similar vein, Bowling *et al* asked

respondents to rank a combination of 16 service interventions and care groups in order of priority.⁸ The multidimensional nature of the questions, however, means that the investigators cannot identify the preferences underlying the response to each question. For example, it is unclear whether the public's ranking of special care and pain relief for people who are dying (for example, hospice care) above long stay care (for example, hospital and nursing homes for elderly people) is due to down ranking of the care for elderly or long stay patients or preference for terminal care.

In contrast to these efforts stands a recent priority setting exercise carried out in east Surrey that provided respondents with information about local health needs and outcomes.¹¹ Respondents were encouraged to comment on the process, and they made quite clear their concerns about funding and cuts to services. Undoubtedly, public opinion is not formed or expressed in a political vacuum.¹² For example, public awareness of threats to services increases the level of reported dissatisfaction with those running the NHS.¹³

Thirdly, the policy implications of these studies seem to elude even the researchers, which leaves little scope for acting on public opinion. What are they to make of Hackney respondents' ranking of specialties—terminal care above cosmetic surgery; or of procedures—hip replacements before family planning; or of the relations between specialties and procedures—services for people with mental illness ranked much lower than heart and liver transplants? Bowling *et al* concludes that respondents valued perceived lifesaving technologies and the "saving of life with quality rather than the preservation of life at all costs." Is this interpretation justified? Even if it is, no one can conclude that a low score means that people are prepared to forego certain procedures or that a particular service or treatment should be withdrawn.

Much has been made of how such studies have raised local district health authorities' awareness of people's attachment to local services. The significance of this is hard to judge if one considers the failure of "local voices" to influence decision makers despite active and vociferous campaigns. The danger is that these exercises claiming to gauge the public's opinion may be invested with a false legitimacy by the world of quangos. If used as part of the current process of reducing access to and comprehensiveness of health services this will further undermine the central tenets of the NHS—equity, comprehensiveness, and services free at the point of delivery.

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