hostel, has piloted the support of staff by a mental health team, offering training and advice as well as treatment interventions for individual clients.[11] Multiagency public protection panels led by police and probation already operate a model of regular review and community surveillance of individuals posing a high risk.[12] Multiagency public protection panels should be recognised as the primary source of community referrals for future mental health assessments under new legislation. But few trusts have so far identified resources to ensure a mental health professional on more than a handful of panels.

Psychiatric interventions cannot influence offending rates at the population level as the problem goes far beyond mental health. But psychiatrists could contribute towards targeted risk reduction in subgroups of individuals identified on the basis of previous criminal behaviour. Future risk management must shift from unrealistic over reliance on mental health legislation towards a new hybrid whereby criminal legislation becomes central. Revision at this stage may be unpalatable. But we risk misplacing ultimate responsibility unto the wrong professionals who will fail.

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1 Department of Health and Home Office. *Reforming the mental health act, part I: the new legal framework, part ii: high risk patients*. London: Stationery Office, 2000.
2 Eastman N. Public health psychiatry or crime prevention? *BMJ* 1999;318:549-51.
3 Mullen P.E. Dangerous people with severe personality disorder. *BMJ* 1999;319:1146-7.
4 Gunn J. A millennium monster is born. *Criminal Behav Mental Health* 2000;10:73-6.
5 Mental Health Law Sub-committee. Response to the government's white paper "reforming the mental health act." London: Royal College of Psychiatrists, 2001.
6 Home Office and Department of Health. *Managing dangerous people with severe personality disorder. Proposals for policy development*. London: Stationery Office, 1999.
7 Department of Health. Effective Care. *Co-ordination in mental health. Modernising the care programme approach*. London: DoH, 2000.
8 Department of Health. *The national service framework for mental health. Modern standards and service models*. London: DoH, 1999.
9 Commission for Health Improvement. Report of a clinical governance review at north Birmingham mental health NHS trust. London: CHI, 2001.
10 Scottish Executive. Report of the committee on serious violent and sexual offenders. Edinburgh: Scottish Executive, 2000.
11 Craissati J, McClurg G. The challenge project: a treatment programme evaluation for perpetrators of child sexual abuse. *Child Abuse Negl* 1997;21:637-48.
12 Maguire M., Kemshall H., Noaks L., Wincup E., Sharpe K. *Risk management of violent and sexual offenders: the work of public protection panels*. London: Home Office, Policing and Reducing Crime Unit, 2001. (Police Research Series. Paper 139.)

Patients choosing their hospital

May not be fair and equitable

In a speech last week, the British secretary of state for health, Alan Milburn, continued his push to extend the right of patients to choose their hospital—and in so doing, cut the time they have to wait.[1] Given Sweden's experience where since 1992 a national guarantee of treatment within a certain period has been in place, and that of Denmark, where a similar guarantee has been in place for the past 10 years, squeezing an individualist notion of choice into a collectivist system of healthcare funding and provision may not prove as difficult as some expect. But it will not be pain free for the NHS or clinicians, or, potentially, for some patients.

As currently conceived patients' choice is being driven by a need to reduce waiting times and hit targets (as it was in Sweden). One of the problems with the NHS has been variations in waiting times, between hospitals as well as between specialists. The pilot schemes on patients' choice set up last year in England have been specifically directed at patients waiting more than six months (a crucial waiting time target for 2005) and are using spare capacity wherever it can be found.[2]

Evidence from these schemes is scant. The national heart surgery choice scheme has only been partly evaluated, and the London patient choice project (initially offering faster treatment to patients from ophthalmology clinics) has not, yet, been subject to any independent evaluation. However, since July last year, of around 5000 patients requiring heart surgery in England who had been waiting longer than six months for treatment, 3700 were deemed to be clinically suitable to be offered the chance of faster treatment. Of these, around 1700 (46%) accepted.[1] And in London, since last October, around two thirds of patients from ophthalmology (mainly requiring cataract operations) accepted.[1] If all goes well with these schemes they will help to even out variations between waiting times.

But the ramifications of patients' choice will extend well beyond such welcome reductions. Not least, specialists will increasingly have to face up to the prospect of losing "their" patients and control over their waiting lists. And as patients move around the system, hospitals need to be reimbursed for the work they do; this April a new payment system based on similar schemes operating around the world will start to roll out, with prices for selected procedures fixed to encourage hospitals to increase output. Poorly performing hospitals will face an incentive to improve—or they will lose income. Some will inevitably face a spiral of financial decline as patients' demands shift. Will ministers be willing to let such hospitals exit this new market? If not, where is the incentive to

BMJ 2003;326:407–8

improve? If they do improve what happens to patients stranded at sink hospitals?

More generally, how can patients' choice be said to be equitable (let alone improving equity, as Alan Milburn claims)? Some patients who, because of their speedier treatment, will enjoy better health for longer. Others who, because of their unwillingness or inability to travel, or because of the choices of the first group, will have to settle for slower or possibly declining services. In one sense this is clearly inequitable. However, that all were offered choice may perhaps resolve such concerns about equity.

Greater inequalities, as Rawls has noted, may be a price worth paying for the benefits flowing from the exercise of choice.[3] Whether it is depends crucially on the reasons why people may not take up on offers of faster treatment with alternative providers—reasons that may be intimately related to the inequitable distribution of other resources across society—income, power, education. We need to know much more about the details of patients accepting and rejecting choices—information that planned evaluation of the London patients choice project will eventually produce. To allow evaluation to follow pilot would be a novel but worthwhile experiment—rather than the usual parade of national policy preceding evidence.

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1 Department of Health. *Milburn sets out expansion plans for NHS choice.* press release (2003/0053) 11 February 2003. http://www.info.doh.gov.uk/doh/IntPress.nsf/page/2003-0053?OpenDocument
2 Department of Health. Proposals for pilot schemes: December 2001. http://www.info.doh.gov.uk/extendingchoice/discussion_dec01.htm (accessed 18 Feb 2003).
3 Rawls J. *A theory of justice.* Cambridge, Massachusetts: Belknap Press of Harvard University Press, 1971.

Fewer new drugs from the pharmaceutical industry

A better understanding of the economic challenges facing research based companies is needed

In 2002 spending on medicines exceeded $400bn (£248bn; €377bn) worldwide. Optimists in the pharmaceutical industry believe that the global market for their products will go on expanding by around 10% a year, with the United States continuing to lead towards higher per capita outlays.[1] Expenditure on research by the pharmaceutical industry is also increasing worldwide. It is now over $45bn a year—twice the sum recorded at the start of the 1990s—and projected to rise to $55bn by 2005-6.[2] Concerns are growing, however, about the productivity of research being funded by the major pharmaceutical companies.

Industry leaders have argued that advances in areas such as genomics will in time identify many new targets for pharmaceuticals to act on.[3] Yet some analysts fear that current programmes will not deliver innovations that are capable of generating the earnings currently coming from high selling medicines close to the end of the lives of their patents. The changed nature of future pharmaceutical products and the marketing support they need may mean that the business model underpinning the mainstream pharmaceutical industry since the 1950s will have to be restructured.

Empirical evidence indicates a crisis in productivity in pharmaceutical research. The number of medicines introduced worldwide that contain new active ingredients dropped from an average of over 60 a year in the late 1980s to 52 in 1991 and only 31 in 2001.[4] The overall number of new active substances undergoing regulatory review is still falling. Perhaps more disturbingly from the perspective of investors in "big pharma," the number of genuinely innovative products launched by the companies responsible for most of the spending on research and development has also declined relative to the number launched by their smaller competitors.

The reasons behind such trends range from tighter regulation to the inherently complex nature of modern research in areas such as oncology, neurology, and virology. For example, unavoidable technical reasons may exist so that tomorrow's new pharmaceuticals will—unlike present blockbusters such as the statins, cyclo-oxygenase-2 inhibitors, and selective serotonin reuptake inhibitors—be products with a relatively high cost for low volumes that unlike "blockbusters" are tailored to the needs of well defined relatively small groups.

Social factors linked to the efforts of research based companies to survive intensified economic competition and reduced protection of brand names could also have affected the productivity of research programmes. Corporate mergers and subsequent processes of reviewing priorities and downsizing have reportedly destabilised research teams. Occasionally, potentially productive lines of inquiry have been abandoned because their projected benefits failed to meet the expectations of incoming accountants rather than the hopes of incumbent medical researchers.

Additional challenges confronting investors in pharmaceutical industry research range from the possible weakening of medicine patents to vulnerabilities associated with an excessive reliance on domestic market revenues in the United States. The latter already represent half the global earnings of the research based industry. They support an even higher proportion of its research and development. One fear that is haunting executives of major companies relates to the political unacceptability of a situation in which high prices limit the ability of Americans to benefit

BMJ 2003;326:408–9