costly—simple coagulation tests such as the activated partial thromboplastin time are not sensitive enough for low molecular weight heparins and the more complex antifactor Xa assay is required.1

Several new antithrombotic agents such as hirudin and its derivatives are currently under investigation. Future clinical studies will determine whether they are more effective and safer than low molecular weight heparins and standard heparin.

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Commissioning specialist services

Problems ahead in the regions

The commissioning of highly specialised clinical or support services has never been straightforward. As some such services are of national importance it was sensible for the government to establish a means of addressing the problem. In 1983 the Department of Health set up the Supra Regional Services Advisory Group to consider proposals for clinical services which, to maximise the benefit to patients and yet ensure the maintenance of skill and economic operation, would need to be provided to populations of five million or more. The criteria were set out in a health circular,1 which was subsequently updated.2

Every new bid submitted via the regional health authority to the advisory group is first considered by the relevant college or faculty before any recommendation is made to the secretary of state. The expansion or devolution of centrally funded services also requires constant review—for example, spinal injury units were descheduled last April. About £100m is designated for supraregional services each year, with allocations for individual specialties varying from £500 000 upwards, although three services absorb over half the allocation. The identity of these supraregional services, together with their financial allocations, is open to public comment through the publication of an annual report1 and written answers given in Hansard to parliamentary questions.

With slightly varying definitions of what constitutes a specialty, similar arrangements have been in place for many years in each of the 14 English regional health authorities. These specialties usually serve populations of less than five million but more than would be appropriate in most districts or provider units. Most regions have identified as regional specialties services such as radiotherapy, neonatal intensive care, neuroscience, renal dialysis and transplantation, cardiothoracic surgery, and, more recently, clinical genetics. The principles underlying these services are that they should be in the right place, proliferation should be avoided, and they should handle enough work to ensure the maintenance of skills for patient care, teaching, and research and economics of scale. Regional health authorities have always had to be alert to the possible overprovision of these services to the local communities in which they are located and to the converse problem of inadequate access from other parts of the region.

Proposed changes have been subject to wide consultation with the district health authorities and the professionals, and the decisions have been open to public observation.

Since April 1991 regions have been devolving these services to the district health authorities, and in most cases some form of protection has applied, at least for the first financial year. Donaldson recently described a range of contracting models of the services that might be suitable for different types of contracts.4 But there are signs of trouble ahead, which, if not addressed now, could cause irretrievable harm not just to existing but also to future services.

The consortium model, in which one district health authority purchaser within the host region acts on behalf of others, appears efficient in principle because the regional specialty director has to deal with only one body. The purchaser is assumed to understand the subject clearly and to be able to negotiate on behalf of the wider population. The reality is proving to be very different. Providers are being told that any expansion or other important changes in the services must be negotiated with each purchasing authority separately. Each purchaser, moreover, is demanding evidence of value for money from the current service. Thus the provider, usually the director of the unit, acquires the time consuming burden of satisfying all the parties and begging them to come to his or her way of thinking for the future.

Where the purchasing authorities are acting on their own the provider unit has to negotiate with each one. Even then, however, the situation can be fraught with danger and worry. Purchasing authorities vary enormously in size, knowledge, and desire for change. For example, whereas a large purchasing authority in London may well be able to select from many providers for a particular regional specialty the remaining purchasers in the same region may depend on the large purchaser maintaining a contract with one particular provider to ensure a sufficient volume of service to be effective and competitive. Nor may the other purchasers have any realistic alternative choice of provider for such a service. The specialty reviews, following on from the Tomlinson report, will constantly need to bear in mind the recipients of the services if they are not to allow the views of the powerful purchasers to dominate their decisions. Even worse would be a harmonious

deal between large purchasers and powerful providers. Furthermore, many of the larger purchasing authorities have inherited a higher uptake of these services than the more peripheral purchasers, to the financial disadvantage of the peripheral purchasers if the cash devolved by the regional health authority to the districts has been determined mainly by past patterns of uptake.

Regional services are not exclusively high in cost and low in volume. Similar problems may be facing other services. Recent publicity has focused on a highly specialised soft tissue tumour pathology service which has until now been funded by a charity, which rightly believes that the service should now be the NHS’s responsibility. This reference service receives about 1100 specimens a year, of which 800 are from several hundred different British hospitals. Its total running cost is over £160 000 a year. Not being a clinical service, it is ineligible for support from the Supra Regional Services Advisory Group.

The Department of Health has, however, just issued guidance on the operation, from 1 April, of notification arrangements for tertiary extracontractual referrals.¹ The guidelines cover referrals of pathological specimens for a second opinion or extra tests where such referrals amount to a significant part of the receiving unit’s workload. In such situations the receiving unit will have, firstly, to ensure that the referring unit is aware that a charge will apply and, secondly, arrange for invoicing and collection of payments. This obviously represents a considerable improvement for such laboratories under threat of closure. Nevertheless, taking into account the time and cost associated with the whole process, one cannot help wondering whether it could not be done more simply given that the refusal of a purchasing authority or general practice fundholder to pay for such a request is inconceivable. In the case of the soft tissue tumour pathology service the charge would amount to about £150, excluding administrative costs. If the referring laboratories ended up paying several such referrals it could decimate their budget for consumables.

Finally, there are high volume and low cost services which are also best organised regionally. The clinical genetics service is a good example, for it is also changing dramatically with the emergence of new technologies for diagnosis and treatment. The introduction of a test such as the antenatal trivalent test for Down’s syndrome presents the director of the service with the bewildering administrative tasks of persuasion and financial unbundling to obtain approval. Perhaps the review of the functions of regions recently announced by the secretary of state¹ will recommend regions being responsible for pump priming or underwriting such developments as an expansion of their role of managing the purchasers.

It was hoped that the contracting process would be non-legalistic, non-adversarial, and based on trust and mutual understanding. Instead it is turning out to be bureaucratic, shrouded in mystery, and potentially damaging. It seems ironic that central control has remained for suparegional services as for so much else in the NHS, yet regions have been encouraged to surrender to regional services.

More evidence may be needed of the difficulties faced by the directors of these services before remedial action is taken. Failing this, one can only imagine the awful possibility of the NHS having to face yet more claims for medical negligence arising from inappropriate care. It must be hoped that common sense will prevail and organisational arrangements will be put in place to ensure that our population is served properly.

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An old problem solved in child care

The goal of a unified, combined child health service should be achieved

The arrangements for child care in the NHS emerged largely by chance and have long been recognised to be illogical. In Britain general practitioners are increasingly involved in child health surveillance, traditionally the responsibility of clinical medical officers and senior clinical medical officers working in child health clinics. These doctors, some of whom work part time, will continue to provide secondary care in the community. A survey in 1992 found 1067 clinical medical officers, two thirds of whom were more than 10 years from retirement, and 643 senior clinical medical officers, half of whom had more than 10 years to serve. The future of these doctors and the service they have been providing has been considered by committee after committee, but the latest set of proposals¹ seems likely to go through—if only because this government seems willing to take difficult decisions if they make economic sense.

The first real attempt to reform the anachronistic tripartite system of child care in Britain was the report in 1976 by Professor Donald Court, which received wide support from the medical profession but achieved little.¹ In 1991 the British Paediatric Association made a further attempt to grasp the nettle and defined the structure and functions of a combined child health service and its relation with the primary health care service for children.¹ This report was welcomed by the secretary of state for health, and the specific problems of the career structure for doctors have now been tackled by a joint working party on medical services for children made up of representatives of the BMA and the Department of Health.¹

The main recommendations refer to the establishment of a consultant led combined child health service within the context of integration with the service provided by general practitioners. Consultant paediatricians (cohurnity child health) would be supported by two levels of career grade posts, probably staff grade and associate specialist. No new appointments would be made to the clinical or senior clinical medical officer grades. The requirements for postgraduate training and continuing medical education in both the hospital and community are defined clearly in the report. The resources currently available for medical staff working in child