What we first need to do is to define more precisely the prevalence of genital chlamydial infections in different populations. This does not require the use of new, highly sensitive diagnostic methods. Relatively insensitive, cheap, but nevertheless specific detection procedures can be used if their performance features are known accurately enough. Furthermore, urine samples may facilitate detection of urogenital chlamydial infections in population based prevalence studies.¹¹ Once the overall prevalence has been defined accurately enough to provide a dependable baseline for future reference then more sensitive diagnostic tests can be applied on an individual basis in the context of a well designed and evaluated programme of screening, treatment, and contact tracing. The newer, more sensitive tests are not cheap—these include polymerase or ligase chain reactions.⁸

The alternative to this approach is to give antibiotics to women in perceived high risk groups⁵ without testing for chlamydial infection—an approach recognised generally as poor medicine and carrying the risk of undertreatment and the emergence of organisms resistant to antibiotics.

Vaccination may eventually be feasible,¹² but preliminary results suggest that effective protection will be difficult to achieve. The Swedish experience suggests that vaccination may be indicated only as an adjunct to case finding, diagnosis, and treatment in the highest risk groups.

The targets in the *Health of the Nation* include a reduction in sexually transmitted infections, with gonococcal disease being used as a marker; the aim is to reduce its incidence by 20% by 1995.¹³ This may be achievable with little effort, since the disease is already declining—but a similar decline in the incidence of genital chlamydial infections will surely not be

achieved unless there is adequate financial support for the active programme I have outlined. Steps should be taken now. In the long term they will pay for themselves.

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Arbitration and the internal market

Guidance is needed on using arbitration properly

Arbitration as a means of settling disputes is not commonly used in the NHS. Its greatest use has probably been in general practice to settle partnership disputes. In 1991 the Department of Health issued a consultative paper on the use of arbitration to settle cases of medical negligence,¹ but ministers have so far taken this no further. Now at least one health authority has used arbitration to settle a dispute arising from the workings of the internal market in the NHS.²

As part of their job of managing the market, regional health authorities have played an important part in arbitrating—or, more accurately, mediating—in disputes that arise between purchasers and providers. On p 177 Scott and Stokoe describe how North West Hertfordshire Health Authority opted for arbitration in such a dispute—in this case between a resident and the authority over whether to fund continuing treatment at a non-NHS institution.² The paper raises several important lessons for those who might want to use arbitration.

Arbitration is described by the Chartered Institute of Arbitrators as the only means of resolving a dispute that offers an alternative to litigation because an arbitrator's award is final, binding, and enforceable summarily in the courts.³ Supporters of arbitration claim that it is quicker, more flexible, and consequently cheaper than going to law. The arbitrator, agreed on by both parties, may or may not be an expert in the subject concerned. According to the Department of Health's consultative paper on arbitration for negligence, there would be a panel of three people, of whom two would be

medically qualified (one nominated by each party) while the third, who would chair the panel, would be legally qualified and skilled in medical negligence work. If the arbitrator is not an expert in the subject then the parties can agree that an expert should be available to advise. The procedure is flexible, ranging from the arbitrator considering only written submissions to legal representation, witnesses, and everything just short of litigation. As in the courts, the arbitrator's decision covers not only the issue under dispute but also the parties' liability for costs, including the arbitrator's own costs. An appeal against an arbitrator's decision can be made only on points of law, procedural misconduct, or failure to deal with the issues. Arbitrators' decisions are usually confidential, though they often leak out in practice.

In the case described by Scott and Stokoe the non-NHS provider requested payment as an extracontractual referral on behalf of the patient. When the request was turned down by the health authority the matter was taken up by the patient and her husband. The authors claim that the dispute was over a principle of funding, but the issue is not quite that simple. There are examples of health authorities assuming financial responsibility for continuing a patient's treatment at a private institution—most notably in relation to specialised psychiatric care—but certain requirements usually have to be met. Firstly, the patient should need treatment that could have been provided by the NHS had the patient not opted for private treatment. Secondly, the patient should have run out

of money. And, thirdly, the authority should agree that treatment is best continued in the existing setting. In Scott and Stokoe's case no evidence was submitted that the patient could not afford to continue paying.

The real issue is that the health authority did not regard this form of care as being an appropriate use of NHS funds. Its evidence was simply a report from the Royal College of Physicians. Such a report can be regarded only as general advice, so if it is the only defence there is always the danger of it not being accepted in a particular case. To safeguard against this occurring, the health authority should have tried to seek some supportive evidence. What was the patient's condition? Was the general practitioner's opinion sought? Was there improvement and was it still continuing? Was any second opinion sought? Furthermore, the health authority should have thought through more carefully the question of witnesses. If the authority was not going to have its own expert witness it should surely have insisted that the lay arbitrator had an independent medical adviser to assist him.

As it was, the arbitrator decided on a solution which I am sure would seem rational to any lay person. The arbitrator's imposition of a financial ceiling could be interpreted simply as a way of specifying that the patient received no more intensive treatment than she was currently receiving, thus avoiding abuse by either the patient or the provider.

There will always be cases in which the perception of an individual patient or group of people about what is effective or appropriate differs from the general professional view: there is no better example over the past two decades than the place of confinement during childbirth. There may well also be examples in which purchasers disregard the general professional view, particularly when creating or maintaining a specialised service locally improves access. Often the arguments will be difficult to prove one way or the other.

In evaluating the use of arbitration to resolve these sorts of arguments the first question is whether this dispute could or should have been settled within current NHS procedures. The answer is probably yes. The Hospital Complaints Procedure Act 1985 identifies ways in which complaints, including those concerning clinical judgment, can be addressed.⁴ In this case the views of a local relevant clinician or clinicians could have been obtained if they were not already

available, and should the patient not have accepted those views the clinical complaints procedure could have been activated. Patients also have the services of the Health Services Commissioner to investigate any maladministration. Over and above this there are other possibilities—for example, creating a local appeal mechanism, which could include non-executive members of the authority together with external professional advice.

The second question concerns the way in which the health authority handled the process of arbitration; on the information provided it can be described only as pedestrian. This was not a simple case, and professional clinical advice needed to be available. Because arbitration is final and binding anyone entering into it needs to be quite sure that the whole process will address all the issues properly.

Finally, there is the general question of the place of arbitration within the NHS in relation to contracting. Arbitration is already used to settle disputes between private medical insurance companies and their subscribers. Logically, therefore, it should also be available to the public in relation to contractual decisions made by NHS purchasers once other attempts at resolution have been exhausted. Indeed, one can well imagine circumstances in which the general practitioner might want to exercise such a procedure on behalf of a patient as a result of a purchasing authority declining an extra-contractual referral to either an NHS or a non-NHS hospital. Some guidance on the use of arbitration in such circumstances would probably benefit everyone. There may also be a need for an increase in the numbers of medically qualified arbitrators to deal with clinical issues should the use of arbitration increase.

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