JOINT RESPONSE TO PUBLIC HEALTH CONSULTATION – ‘CHOOSING HEALTH?’

Introduction

This response is submitted by the key voluntary organisations with a national remit for sexual health and HIV – Brook, fpa, Medical Foundation for AIDS and Sexual Health (MedFASH), National AIDS Trust (NAT) and Terrence Higgins Trust (THT).

The definition of sexual health includes issues of contraception, pregnancy choices, including abortion, sexually transmitted infections, sexual wellbeing, as well as HIV.

This submission complements the individual and more specific points and recommendations made in each organisation’s consultation response. It presents a shared vision of what is required to address the current crisis in sexual health and a unanimous conviction that sexual health must be a priority in any effective public health strategy for the NHS.

Prioritising sexual health

Public health should be a priority within the NHS, and sexual health and HIV should be a priority within public health policy and service delivery. Inadequate resources have been invested to deal effectively with rapidly rising STI infection rates and record HIV prevalence, which are now the fastest growing health conditions in the UK.

The UK’s teenage pregnancy rate remains the highest in Western Europe. Contraception services are being consistently deprioritised, while access to abortion services across the UK varies significantly.

Diagnoses of sexually transmitted infections are increasing rapidly, with new cases of some STIs more than doubling since 1996. Current estimates state that about 50,000 people are living with HIV in the UK, a third of whom do not know their status.

These rising infection rates result in increasing morbidity, declining mental health and well-being, in the case of chlamydia rising infertility, and in the case of HIV long-term illness and mortality. Unlike many other public health concerns, STIs and HIV are
communicable diseases and a failure to diagnose and treat them promptly not only harms the individual concerned but others to whom the infection might then be transmitted. Delays in diagnosis and treatment result in continuing high levels of infectivity. An individual diagnosed late is also less amenable to treatment.

The forthcoming Public Health White Paper should unequivocally place sexual health and HIV at the forefront of the Government’s public health activity. The Health Select Committee identified the sexual health crisis as in part a result of ‘a lack of political pressure and leadership over many years’. The current public health consultation provides the Government with an opportunity to reverse past failures.

Despite increasing infection rates, sexual health is not currently included in the NHS Priorities and Planning Framework as a priority area. There is an inevitable knock-on effect on local services.

A recent survey of SHA local delivery plans revealed that none of them mentioned abortion or contraception services, and that HIV and sexual health were mentioned in only 40 per cent of them (10 out of 28), even then with few specific proposals and development commitments.

**Key Recommendations:**

- **That the forthcoming Public Health White Paper should make sexual health and HIV a key public health priority.**

- **That sexual health be included as a priority area in the NHS Priorities and Planning Framework for 2005-08, with specific standards and targets.**

- **That SHAs assist PCTs to establish sexual health and HIV as explicit local priorities and ensure incorporation in performance management systems.**

**Health inequalities**

Poor sexual health disproportionately affects those who are vulnerable, marginalised or socially and economically excluded. High levels of deprivation are associated with less consistent use of contraception. The age of first intercourse also increases with educational attainment. There is a sixfold difference in teenage conception and birth rates between the poorest and most affluent areas of the UK.
Chlamydia, gonorrhoea and genital herpes are disproportionately diagnosed in the UK’s black and minority ethnic communities. Almost 50% of HIV diagnoses since 2001 have occurred amongst black African communities, with worrying increases now also being seen in London’s Afro-Caribbean communities also.

**Key Recommendation: That plans to improve the sexual health of the population should be cross-departmental, include assessments of those wider factors which are determining health inequalities, and address issues such as income inequality and the expectations of young people.**

**Access to services**

Access to sexual health services is declining at the same time that infection rates and demand for services are increasing. Patient choice is far from being a reality.

Sexual health services need to be as accessible as possible to all sections of society. They should therefore be planned so as to be accessible, for example, to young people, to those who work during the day, to those who have difficulty travelling considerable distances, and to people from different cultures and communities.

Sexual health services also need to be integrated, dealing with all aspects of sexual and reproductive health. It should be possible to access STI services via a family planning clinic and contraceptive services via a GUM clinic, whether provided on site or via integrated care pathways within a sexual health service network.

The actual situation, however, is one of worsening access to GUM services, with waiting times increasing. In 2002 median waiting times for GUM services were 12 days for men and 14 days for women, with some patients having to wait up to 6 weeks. The situation appears to have got considerably worse in 2003.

The physical state of many GUM clinics remains very poor. It is estimated that 20 per cent of clinics are located in portakabins with £152-248 million required to update all premises. The impact of such poor accommodation on stigma, accessibility and uptake of testing and treatment services cannot be underestimated. Access is further compromised by the lack of consultants and adequately trained nursing and support staff in GUM.

In contraceptive services, there is an impending shortage of specialist family planning consultants and senior medical staff. In
some areas where there have been cutbacks in family planning clinics, patients’ only real choice for contraceptive services is their GP, many of whom do not advise on or provide access to the full range of methods of contraception. There is similar wide variation in access to abortion services, both in terms of waiting times and in terms of the proportion of abortions which are funded by the NHS.

Increasing access must mean increasing choice. This means not only improving waiting times, infrastructure and opening hours of GUM clinics, and improving waiting times and access to abortion services, but also extending the role of primary care and GPs. Training is necessary, and further development of the GMS contract, for GPs, nurses and primary care workers to offer the full range of contraceptive services, and to address sexual health and HIV prevention. There should also be the development of community walk-in centres, with evening and weekend opening.

A framework of performance measures and financial incentives are needed to enhance service delivery at local level.

**Key Recommendations:**

That there be a 48 hour access standard for GUM services, along with a similar standard for contraception services, and a target waiting time of 72 hours for abortion with one week as a minimum standard. These should form part of the PCT performance framework being developed by the Healthcare Commission.

That there be a major training and development programme to improve access, service quality and capacity within sexual health and HIV services.

**Economic costs and effective resourcing**

There are serious costs to the UK economy from climbing infection rates. It is estimated that the annual cost of treating STIs now exceeds £1 billion. HIV care costs are increasing by over £50 million a year, with lifetime treatment costing an additional £1 billion a year. Lifetime socio-economic costs of HIV to the UK are increasing by up to £3 billion per annum.

Delayed diagnosis can also often increase the later costs of treatment and care.

Adequate resourcing of sexual health services and HIV prevention is therefore immensely cost-effective. NHS contraception services
according to the Department of Health save the NHS over £2.5 billion a year, yet they have been deprioritised. It has also been calculated that NHS spending for HIV prevention has decreased over the last five years by about £10 million a year. A significant proportion of funds allocated by the DH to address the crisis in GUM services did not reach GUM clinics as funds were diverted by PCTs or acute trusts to meet other priorities.

Significant investments are needed in HIV and STI prevention to reverse recent decreases in funding.

**Key Recommendation: That the Government act to provide increased funds for sexual health services, ensuring such resources reach the intended beneficiaries.**

**Sex and relationships education**

Sex and relationships education (SRE) is an essential intervention to prepare young people before they become sexually active in order to prevent unsafe patterns of sexual behaviour. Currently, it is mandatory for National Curriculum Science to cover the biological elements of the reproductive process. However, comprehensive SRE is not a statutory component of the National Curriculum. The result is significant variation in the provision of SRE in schools. SRE should both impart knowledge and develop skills; be bold in approach; focus on relationships, not just biological issues, including subjects such as homosexuality; and be designed with links to clinical services. Provision also needs to be made for those who attend school irregularly or are excluded.

Such SRE education needs to be in a wider national context of a much more open and positive attitude to sex and sexuality.

**Key Recommendation: That sex and relationships education become a statutory part of the curriculum within the PSHE framework.**

25 June 2004