

Current Problems and consequences

During 2002, current workload the unprecedented demand for GU Medicine services has increased with a corresponding deterioration in patient access times, especially in London and other major conurbations.

- Poor access is now widespread throughout England. The median time to first appointment in 2002 has lengthened to 12 days for men and 14 days for women, compared with 5 and 6 days respectively in 2000 when concern was first expressed. At least 35,000 people are having unacceptable delays for initial assessment and treatment.
- For most GUM clinics, the numbers of women attending exceeds that of men; appointment delays are longer because of their longer examination times.
- Cases of infectious syphilis have spread to other towns and cities from outbreak epicentres, especially in the North of England and London. The numbers of annual cases more than doubled between 1995-2000, and provisional CDSC figures for 2001 show a further doubling of cases compared to 2000.
- Cases are now appearing in women and we fear that congenital infection will reappear in neonates, as happened in similar circumstances in the USA during the 1990s.
- The incidence of gonorrhoea, including antimicrobial resistant infection, is increasing especially in the North West and in Trent. Cases doubled between 1995-99, and further increased by 16% between 2000 and 2001.
- The commonest bacterial STI, chlamydia has increased by a further 9% during 2000-2001. Many clinics are reporting increases in the number and proportion of complicated cases, consistent with deteriorating access.
- The ascending complications of bacterial STIs have a disproportionate adverse effect upon the health of women. In the non-pregnant woman, ectopic pregnancy, tubal damage and infertility commonly ensue. In pregnancy, infections may cause miscarriage, prematurity, and neonatal death. Such complications are associated with delayed treatment and are especially likely in the young, ethnic minorities and other less privileged sections of society. There is a clear association between high STI rates and the local health authority deprivation index.

- The annual numbers of newly diagnosed HIV have accelerated, especially in women where they have more than trebled since 1990 (now representing 40% of the annual total).
- Co-infection with STIs and HIV is regrettably common, facilitates their onward transmission, and often causes treatment difficulties.
- In homosexual men, who have a high prevalence of HIV, alarming increases in STI cases have occurred between 2000 and 2001. New cases of infectious syphilis trebled, of gonorrhoea increased by 50%, of chlamydia and new genital warts each by 72%, and of first episode genital herpes by 44%.
- Co-infection with HIV and tuberculosis, including multiple drug resistant strains, is becoming more common in ethnic minorities. Such cases increase workload substantially, and with the dispersal of asylum seekers often requires less experienced clinicians (who may be single-handed and have little infrastructure) to deal with a significant number of ill patients.
- Many single-handed consultants, especially those covering more than one district, find themselves unable to take leave for either continuing professional development or even annual leave in extreme cases lest their service be left with unsuitable cover arrangements.

Thus, delays in GUM clinic access and inadequate provision of services are exacerbating inequalities in sexual health and jeopardising clinical governance requirements.

Communicable Diseases Strategy

The recently published Chief Medical Officer's Communicable Diseases Strategy ("Getting Ahead of the Curve") has again emphasized sexually transmitted viruses as a priority area.

In our response, we have restated our view that bacterial and viral STIs are inseparable and that the public health control of all STIs including HIV must continue to be a priority. We also have commented about the relevance of STIs and blood borne virus infections to the other infection priority areas of tuberculosis, hospital acquired infection, and antimicrobial resistance.

Sexual health networks

In many locations there is already close working between GUM clinics and other sexual health care providers. However, identifying time for further development of local networks is hampered by having to focus upon meeting workload demands. This will hinder the enhanced collaborative working that is necessary if both the teenage pregnancy and sexual health targets are to be achieved.

Primary care

The Royal College of General Practitioners has made clear that they have neither the time nor the training to take on additional sexual health care provision at present because of the pressures of other priorities. The introduction of the sexual health promotion campaign and of chlamydia screening will inevitably increase patients' demands upon primary care, and their frustrations will increase if specialist providers are unable to cope with additional referrals in a timely fashion. Workload pressures are also inhibiting the contribution of specialists to the education and training of primary care practitioners.

Costs of delay

Delay in treatment of STI promotes their onward transmission, the development of expensive complications, and the spread of HIV.

- Although no comparable data exists for the UK, it is estimated that the costs of treating pelvic inflammatory disease in the USA is at least \$3 billion per annum.
- The average annual cost of managing HIV patients in the UK is £15,000. Thus, for the prevalent caseload of 23,000, the annual treatment costs in 2002-3 can be expected to be in excess of £345 million, and the cumulative lifetime costs of prevalent HIV cases by 2007 to be in excess of £5 billion. However, if the growth in annual numbers of newly diagnosed cases between 2000-2007 continues at 15% rather than 10%, these cumulative lifetime costs will be in excess of £7 billion.
- In the national strategy document, the cost benefit of preventing a single HIV case is quoted as being upwards of £0.5 million.

Solutions

- Strengthening of GUM services must be an urgent priority for the additional funding that has been secured over the next 2 years.

- In our responses to the consultation document, we have asked that there should be restoration of growth in consultant numbers and additional health adviser, nursing, and administrative support.
- Around 70 doctors will complete their specialist training in GU Medicine during 2002-3. These could contribute to the government target of 7500 new consultant posts by 2004 contained in the NHS Plan, and accelerate progress towards the additional 250 consultants required to achieve the Royal College of Physicians recommendation of 1 consultant per 113000 population.
- Unless new posts are created, in line with manpower planning expectations 5 years ago, some of this expensively trained resource could be lost away from front-line patient care in the UK.
- Targeting new posts to currently single-handed consultants whilst ensuring that all posts additionally have some clinical sessions within the nearest inpatient (usually teaching) centre, will ensure that capacity requirements are improved throughout England. It will also promote clinical governance, the development of service networks, contributions to local multidisciplinary planning teams, outreach work and increased support for training in primary care.
- Funding support for continuing professional development of non-consultant grade doctors in GU Medicine, many of whom also work in primary care, and could make further contributions to level 2 service development and promoting linkage of the teenage pregnancy and sexual health strategies.
- We also strongly recommend that there should be incentives for other primary care practitioners to obtain training in sexual health care, such as in the Sexually Transmitted Infections Foundation (STIF courses), to support level 1 service provision.

Implementation of these proposals would require around £14 million in pump priming. We are convinced that improved patient access will be cost-effective and will reduce onward transmission of STIs and HIV, will boost service morale, and increase our capacity to meet the national targets. The cost of the support requested, which would promote increased capacity, help curb the spread and healthcare costs of STIs and HIV, is orders of magnitude less than the inevitable healthcare costs of delay.