Choosing Health
Response from British Association for Sexual Health and HIV

There is at present a UK crisis in Sexual Health. Sexual behaviour has changed considerably over the last decade, with a median age of first intercourse of 16 years, and –despite increased condom use this has been insufficient to offset the increased number of sexual partners and concurrency which is commonplace. This is manifest in huge increases in STIs and HIV during the past decade. Although some recent progress has been made with reducing teenage conceptions, the rate is still the worst in Europe. It is essential that sexual health is recognized as a key public health issue.

Infectious diseases do not recognize geographical boundaries and are a global issue. The public health challenge of controlling sexually transmitted infections requires continued efforts to change sexual behaviour in parallel with the provision of rapid, easy access to services for prompt and accurate diagnosis, correct treatment and management of partners. There is a societal and individual responsibility. A sustained change of sexual behaviour is difficult to achieve given the mixed messages conveyed through the media. Services have a crucial role to play in reducing onward transmission of infection through rapid access but also through secondary prevention activity but are unable to do so adequately if there is insufficient resource to deal with the demand, as is the case at present.

There needs to be investment as a matter of urgency. To achieve this, there must be prioritization at national and local level best achieved through national guidance for local delivery to ensure that equitable services are provided.

At national level to address this, the Government should:

- Recognise sexual health as a major public health issue and give central political leadership. In comparison to the co-ordinated, resourced and high profile action with the threat of SARS, the Government’s approach to the actual crisis in rapidly rising STI and HIV rates has been dismal, akin to standing by whilst Rome burns.

- Establish an independent Public Health Commissioner to whom a National Sexual Health Director should report. The National Sexual Health Director should ensure that “locally” there are nominated persons who are responsible and accountable for the performance of sexual health services. This would still be in keeping with local devolution but with strong central direction.

- ‘Local’ must be defined and based on a larger population than PCTs. Consideration should be given as to whether Strategic Health Authority nominees such as Directors of Public Health should be responsible for performance managing services, reviewing all the data on HIV and STI prevalence, teenage conception rates and termination of pregnancy statistics within their area. Involvement of Regions via reporting from StHA Directors of Public Health should be considered.

- There must be performance targets within the Performance and Planning Framework against which services can be monitored. Access is imperative and there should be a 48 hours access target for routine appointments at Genito-urinary medicine clinics to ensure that PCTs prioritise sexual health services. For infection control, symptomatic patients should be seen sooner to minimize transmission. This can be addressed through local service initiatives.
• The Modernisation Agency’s work on Accident & Emergency services may have valuable lessons for the development of sexual health services, and could be adapted to provide a useful template.

• New legislation such as the Childrens Bill, Sexual Offences Act and work undertaken within other National Service Frameworks such as Children and Adolescents must take into consideration their impact on teenagers and service deliverers given that confidentiality is the most important aspect of accessing healthcare. **Joined up working** across governmental departments, avoiding reinventing the wheel and producing simple, agreed guidance with input from all key stakeholders would be highly efficient and avoid confusion.

• There should be a health education programme initiated at primary school entry. This should focus on “Healthy Living” and sex education should be addressed as part of this and built on incrementally throughout education, with more focus on relationships and sex education at secondary school. The rationale for this approach is based on the premise that sex is essential to healthy lives, abstinence cannot be the goal and destigmatisation and reduction of embarrassment is more likely to be successful if addressed at a younger age. SRE should be a mandatory part of the core curriculum to ensure that there is equity.

At PCT level, the presence of a performance target should lead to prioritization. However, the following needs to be addressed:

• **Local commissioning arrangements** should ensure there is no perverse incentive for PCTs to disinvest. For example where a neighbouring PCT has a full-time, accessible service, a PCT with a part-time clinic may choose not to deem sexual health a priority leaving the adjacent PCT to provide the service. For a clinic where a number of PCTs contribute to the costs, there has been experience of some of the PCTs being unprepared to prioritise sexual health and bid for resource leaving clinicians and the service for patients unable to move forward

• Open access and non-geographically bound services are essential to promote easy access and **choice for patients**. A range of services should be available. Each locality should ensure that there are a range of services across primary care, community, and specialists’ services which work collaboratively together and are monitored to ensure quality of care irrespective of place of presentation

• Sexual health should be in PCT **local development plans**

• Consideration should be given to amalgamating teenage pregnancy strategy with the sexual health strategy through either closer collaboration of sexual health leads with teenage pregnancy co-ordinators or teenage pregnancy coordinators extending their role with appropriate support to cover other aspects of sexual health and ensuring that commissioners are informed. The rationale for this is that unprotected sex results in transmission of infections as well as unintended pregnancy. The group most likely to be affected are adolescent women and men up to the age of 25. Given that there is a significant overlap in the work to be undertaken together with the lack of expertise in sexual health at PCT level, organizational barriers should be reduced as much as possible.
At service level:

- Trained specialists should share expertise through collaboration with other service providers

- **Networks** with appropriate care pathways for patients must be developed with engagement of specialist and non-specialist services, having respect for their own areas of expertise and standards developed through national professional organizations.

- **Confidentiality** is key to ensure that patients access services. This is very relevant for young people. The present ‘information sharing provisions’ in the Children’s Bill overrides confidentiality if sexual health services are expected to forward details of all under 16’s, or under 18 in care, to a database. As a broad range of people and agencies can have access to these databases, it is not possible for clinicians to reassure young people about who can access these data. From work already undertaken, the younger adolescents, who are often the most vulnerable, will either not present to clinics or lie about their age, both of which are counterproductive.

- Services must have improved **IT systems** for recording clinical care, auditing outcomes and providing improved data for surveillance purposes across all providers for service planning. It is essential that sexual health services receive funding from the present NHS IT strategy. There are serious concerns that these services may be left behind in NpfIT. There will need to be investment to assure confidentiality, to reassure patients that they cannot be individually identified and that sensitive information will not be shared inappropriately.

**GUM services** have particular issues to address:

- **Access**- In 2001 a report from AGUM revealed that median waiting times to be seen in a clinic was 10 days for men and 12 days for women. The situation has deteriorated with waiting times of 4 –6 weeks in some parts of England, despite changes in practice and modernization to ensure that capacity is increased. Staff working at the front line are working under relentless pressure in many clinics to cope with demand.

- **Manpower** – 25% of consultants are single handed. Genito-urinary medicine physicians need to have time to train and assess competences of other practitioners, particularly in primary care where the majority feel underskilled for taking on more specialist work in sexual health even if they had time and inclination to do so.

- **Estates and facilities** – an estimate done by AGUM survey two years was capital expenditure of £200 million to address clinics in inappropriate sites and increasing space for the workload increase over the last 8 years. The £15 million promised thus far is a start but clearly insufficient

- **Chlamydia screening** – Sub-optimal tests are still in widespread use. There are dual standards for testing in many locations with those attending GU clinics having the ‘substandard’ tests in comparison to those attending other venues for screening. The roll out of the National Screening Programme needs to be hastened and change over to NAATs testing essential, irrespective of screening strategies.

- **Secondary Prevention** through health promotion – GUM clinics have an essential role and have achieved considerable success during the past 80 years. The majority of attenders do not acquire future repeated STIs. This preventative role is now potentially
jeopardized by accelerated throughput and reduced follow up, resulting in scant attention being paid to this important aspect of care.

**Health Promotion**

There should be emphasis on individual choices and rights. In addition to an active healthy living education programme in schools, consideration should be given to:

- Widespread availability of condoms including in primary care
- Influencing the media to at least consider safe sex messages in popular programmes (soaps) and films
- Using role models such as pop stars, footballers etc…to influence young people, encourage people with incurable STIs to reduce the risk of transmission to others
- Use services as appropriate sites for secondary prevention. Specialist services are well placed to provided health promotion but are at present too overwhelmed with patients and with insufficient resource to put more emphasis on this
- There is a role for the National Specialists Society, BASHH, for educating public and professionals and also supporting teachers through appropriate training and support

**Research and Evaluation Programmes**

This requires adequate information systems. There should also be a focus from CHAI on outcomes

- Research is needed into new models of care to provide evidence-based additions to current arrangements and to extend patient choice.
- New initiatives must be evaluated with appropriate outcome measures to ensure that standards are upheld and added value of attendance at services is capitalized upon.

**Health Costs and Resources in relation to GUM services**

There are large direct health care costs related to preventable sexual health disorders. The following has been estimated:

- Costs of unwanted pregnancies – £2.5 billion per year
- Costs of STIs and complications - £1 billion per year (Infertility £250 million ectopics/PID £250 million, HIV care £500 million, STI service costs with 750,000 new cases, tariff £83 and 850,000 follow up, tariff £56 approx £110 million)
- Costs of HIV – for new cases diagnosed just in 2003 alone, at least £1 billion lifetime costs
- New HIV cases per year - £50-90 million in additional annual treatment costs (7000 cases with drug costs of £12,500 per year)
- £0.5-1 million saved by averting one onward transmission of HIV
This excludes the indirect costs related to the disproportionate effect on younger people who contribute to the economy and the societal consequences of breakdown of family and relationships. By contrast the investment required to deal with the increasing workload, deteriorating access, is small in comparison to health gain. Although there is a National Sexual Health and HIV Strategy, there is a lack of credibility about its status, insufficient resource to implement it, and lack of levers at local level to influence policy priorities. The present system of distributing resources to PCTs has failed, with targeted funding in many cases being directed away from sexual health to other health priorities, overspends etc.

To address the problems for GUM services, as recommended by Select Committee on Sexual health, requires investment of £30 million of recurrent money as a matter of urgency i.e. a further £22 million over and above that received in 2003/4 and a fraction of the cost of health care consequences. This will allow Consultants and other health care professionals working within specialist services to fulfill their obligations as part of a network, supporting innovative approaches to self-sampling, rapid testing and screening in sites other than GU services. Genito-urinary medicine can lead a multi-disciplinary approach to screening, prevention and quality control, and can evaluate programmes and new ways of working. Through the present network of clinics and established infrastructure, clinical governance arrangements and case finding/screening can be supported outside of specialist services. With a strong hub there is more opportunity to spread sound practice and address clinical governance, to provide good quality services and to ensure equity in service provision and choice for patients.

Additional funding is needed for the increasing number of newly diagnosed HIV patients which requires resource planning, preferably with flexible funding streams to cope with the dispersal of asylum seekers who may be HIV positive and are moved from one location to another with little notice. PCTs will be required to fund drug treatments but this should not be at the expense of other sexual health services as has often been the case previously.

The British Association for Sexual Health and HIV as a multi-disciplinary, multi-professional organization is well placed to work with NHS, other statutory organizations, other professional bodies and those in the voluntary sector to provide and act as the quality standard for treatment and management of sexually transmitted infections, including providing support to other providers working in non specialist settings.

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