The Advisory Group on Contraception
c/o Incisive Health
48 Charlotte Street
London, W1T 2NS

Response to the Department of Health consultation on local authority public health allocations 2015/16: in-year savings

Introduction

We are writing to you as the Advisory Group on Contraception (AGC), an expert advisory group of leading clinicians and advocacy groups who have come together to discuss and make policy recommendations concerning the contraceptive needs of women of all ages.

Comprehensive, open access sexual and reproductive health services play an important part in delivering improved public health outcomes by preventing ill health, improving wellbeing and addressing inequalities. We believe that all women should have ready access to high quality services which offer them information about, and a choice from, the full range of contraceptive options.

Our response makes the case for sustained investment in contraceptive care and then answers the specific questions outlined in the consultation. We hope our arguments will help inform both this round of cuts to public health, and any subsequent discussions in Government about where to look for savings in the future.

The financial impact of the proposed cuts

We are extremely concerned over the proposed £200 million in-year cuts to local government controlled public health budgets[i], and the likely impact this may have on contraceptive care and services around the country. Reducing access to contraception leads to an increase in unintended pregnancy, with consequent and considerable impact on front line services across health, social care and other public services. Cutting funding for contraception is the definition of a false economy. Indeed it would likely result in considerably higher costs than the proposed cuts.

A uniform cut across local authorities means every local authority has to make a 6.2% reduction in spending on public health for the current year. At present, contraceptive care (made up of prescribed and non-prescribed functions such as advice, prevention and promotion) makes up approximately 10% of total public health spend.[ii] The anticipated cut to contraception services, assuming the proportion of spend stays roughly the same, will therefore be approximately £23 million.

This is a false economy. The Department of Health's *Framework for Sexual Health Improvement in England* says that there is an £11 saving for every £1 spent on contraception.[iii] Using this formula, we calculate that the £23 million 'saving' could lead to additional costs to the NHS of £250 million. This is on top of the health, financial and social consequences of unintended pregnancy for women and for their families.

Cutting funding for, and therefore access to, contraceptive care could end up costing the NHS more than it saves local government – a perverse outcome that benefits no one. This supports the case made in the *Five Year Forward View,* that a 'radical upgrade in prevention and public health' is needed to deliver the sustainability of the NHS, the economic prosperity of Britain and the future health of millions of children.[iv]

We urge the Department of Health, Public Health England and NHS England to give more priority to the importance of good contraceptive care in line with a central theme of the *Five Year Forward View*.

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Question 1) Allocations

We do not have a view on this question. We would, however, urge decisions to be made as swiftly as possible to allow as much planning time as possible for local authorities.

Question 2) Minimising possible disruption to services

We do not believe that it is possible to make immediate cuts of this magnitude without having considerable impact across the system. Cuts to contraceptive care will hit three main groups (although these are not exclusive):

1. Local authorities trying to fulfil their statutory responsibilities and the community contraceptive services they commission, including Contraceptive and Sexual Health (CaSH) clinics
2. GPs who will face greater demand to provide contraceptive care without any additional resources and who are already under pressure
3. Women who need access to contraception to help them avoid unplanned and unwanted pregnancies

1. Local authorities

The provision of open access contraceptive and sexual health services is one of just five named functions in the Health and Social Care Act 2012 that local authorities have a statutory responsibility to fulfil. NICE guidance provides clarification – explicitly stating: "*This means local authorities cannot restrict access to people who live in the local area, or who are registered with a local GP, or on other grounds such as age.*"[v]

With budgets being squeezed, services are likely to be restricted. Early evidence suggests that local authorities are already making significant cuts to the contraceptive care they commission both as a result of this cut to public health budgets[vi] and due to tightening finances more generally; in some cases by as much as 50%.[vii] This is an ongoing trend - audits carried out by the AGC in 2012[viii] and 2014[ix] found evidence of commissioners restricting access to contraceptive service, for example by shortening the opening hours of contraceptive care services, limiting access to various contraceptive methods, or cutting training for contraceptive care.[x]

We urge Public Health England and the Department of Health to issue guidance to councils to reiterate their statutory responsibilities in the provision of open access contraceptive services.

This guidance should provide clear signposting to the NICE guidance to local authorities on the provision of contraception and recognition of the financial impact to both local authorities and health services of a rise in unintended pregnancies.

2. Primary care

80% of contraceptive care is provided by general practice.[xi] This includes information about the full range of contraceptive methods and may also include prescription and/or fitting of the contraceptive method chosen.

We are greatly concerned that there will be an unreasonable expectation that GPs will be left to deal with the subsequent unfulfilled need if other community contraceptive services commissioned by local authorities are scaled back as a result of cuts to contraceptive care. Women will then look to their GP service to provide more of their contraceptive care, with limited alternative options.

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Contraceptive care delivered by GPs is commissioned in two ways:

- By NHS England as part of the core GP contract – covering the prescribing and treatment relating to short-acting contraceptive methods, the contraceptive injection and emergency contraception
- By local authorities out of public health budgets – covering the fitting and implanting of intrauterine devices and subdermal implants which are long-acting reversible contraception (LARC) methods

These LARC methods are known to be more reliable and cost effective than other forms of contraception.[xii] If some local authorities stop commissioning GPs to provide these LARCs as a part of their public health cuts, very many women who access their contraceptive care via their GP may not be able to choose these most effective methods.

This is already a problem in some areas and there is considerable variation in primary care in the delivery of good contraceptive care.[xiii] Not every general practice has professionals who are competent to fit any/all LARC methods. This variation in provision is compounded in areas without effective local pathways between services, leaving some women with very limited or no access to LARC methods at all.

There is also inconsistency and a lack of necessary forward planning as to whether local authority commissioners or providers pay for the training of LARC fitting.[xiv] With further restrictions in public health funding for contraceptive care, GP practices may be expected to themselves fund more of this training. However this is challenging, both because of financial pressures and because, if GP practices are no longer being commissioned to fit LARC methods generally, there would be little incentive for them to fund training.

There is likely to be an increase in demand on primary care from women seeking contraceptive care as a result of cuts to local authority contraceptive spend. This will put further strain on primary care at a time when workload pressures and recruitment difficulties are already a problem.

We ask the Department of Health and NHS England to engage with representatives from primary care to help practices anticipate and plan for the likely increase in demand for contraceptive service as a result of any reduction of community provision.

We also ask the Department of Health to clarify who is responsible for funding the training for fitting and removing LARC methods and to communicate this effectively.

The Department of Health and Public Health England need to monitor local provision of contraceptive methods not covered by the GP contract and engage directly with local authority commissioners in areas where women are at risk of not having access to a comprehensive contraceptive service.

3. Women

The impact of restricting access to contraception falls disproportionately on women. Access to barrier methods of contraception is important to help prevent the spread of sexually transmitted infection – which impacts both men and women. However, the consequence of falling pregnant unintentionally, due to unreliable, unsuitable or the complete absence of contraception is an issue that primarily falls on women with life changing results.

As referenced in the consultation, local authorities are bound by law not to negatively impact on protected characteristic groups (i.e. groups pertaining to age; disability; gender reassignment; pregnancy

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and maternity; race; religion or belief; sex; and sexual orientation). It will be important for authorities to consider the equality duty when considering how to make public health cuts.

We believe any guidance to local authorities should remind local authorities of their duties under equalities legislation and consider how cuts to contraceptive services will disproportionately impact on women.

For more information, please contact the AGC secretariat at agc@incisivehealth.com.

The members of the Advisory Group on Contraception are:

- Dr Amanda Britton, GP Principal, Basingstoke; Medical Director North Hampshire Alliance
- Dr Anne Connolly, Clinical Lead for Women's and Sexual Health, NHS Bradford and Airedale
- Genevieve Edwards, UK Communications Director, Marie Stopes International
- Abigail Fitzgibbon, Head of Advocacy and Campaigns, British Pregnancy Advisory Service
- Ann Furedi, Chief Executive, British Pregnancy Advisory Service
- Baroness Gould of Potternewton, Chair of All Party Parliamentary Group on Sexual and Reproductive Health in the UK and Co-Chair of the Sexual Health Forum
- Natika Halil, Chief Executive, Family Planning Association
- Jane Hatfield, Chief Executive, Faculty of Sexual and Reproductive Healthcare
- Jules Hillier, Chief Executive, Brook
- Ruth Lowbury, Chief Executive, MEDFASH (Medical Foundation for HIV & Sexual Health)
- Dr Diana Mansour, Consultant in Community Gynaecology and Reproductive Healthcare, Newcastle upon Tyne NHS Foundation Trust
- Councillor Jonathan McShane, Cabinet Member for Health, Social Care and Culture, London Borough of Hackney and Lead Member for Sexual Health, Local Government Association
- Karen Pitney, Public Health Outcome Manager, Gloucestershire County Council
- Professor Jill Shawe, Specialist sexual and reproductive health research nurse
- Dr Connie Smith, Chair, Healthwatch Camden
- Harry Walker, Policy Manager, Faculty of Sexual and Reproductive Healthcare
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- Dr Chris Wilkinson, Lead Consultant, Margaret Pyke Centre
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Observers to the Advisory Group on Contraception are:

- Dr Kate Guthrie, Medical Expert for Sexual Health and Reproductive Health, Public Health England
- Fiona Campbell, Government and Industry Affairs, Bayer HealthCare
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