

## **Response to the Health Select Committee's inquiry into the impact of the Comprehensive Spending Review on health and social care**

### **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. A full list of members of the AGC is available at the end of our submission. We welcome the Health Select Committee's decision to launch an inquiry into the impact of the Comprehensive Spending Review on health and social care.

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 of, the full range of contraceptive options.

Our response covers the following topics:

1. The financial impact of cuts to investment in contraception
2. The consequences of a reduction in funding for contraception
3. The public health funding ring-fence

### **1. The financial impact of cuts to investment in contraception**

Since the reforms of 2012, the majority of contraceptive services fall under the responsibility of local government through their ring-fenced public health budgets. The Spending Review outlined cuts to public health amounting to average annual real term cuts of 3.9 percent, on top of the 6.2 percent in-year cut announced in the 2015 Budget<sup>1</sup>. We are extremely concerned about the cumulative impact that these cuts will have on contraceptive services.

Restricting women's access to contraception leads to an increase in rates of unintended pregnancy, with consequent, and considerable, impact on frontline services across health, social care and other public resources. Good contraceptive services also deliver social, economic, health and personal benefits to individual women and their families, giving them greater control over their lives. Cutting access to contraception directly contradicts 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.<sup>2</sup>

Increased demand for other services (maternity, termination, primary care, emergency care etc.) as a result of a reduction in the use of contraception happens far more quickly than in many other areas of health; this is a major concern at a time of financial pressure across the health service.

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.<sup>3</sup> Therefore cutting funding for contraception is the definition of a false economy.

Indeed last year the AGC demonstrated that the impact of reducing investment in contraceptive care would likely result in considerably higher costs than the proposed cuts. Our calculations show that the 6.2 per cent in-year 'saving' to public health budgets could lead to additional costs to the NHS of £250 million. The Spending Review's further 3.9% annual cut to public health budgets will only heighten this disparity.

***We urge the Committee to recommend to Government that it reverses its cuts to public health budgets over the course of the Spending Review, on the basis that these cuts will cost the NHS more than it will save local government.***

## **2. The consequences of a reduction in funding for contraception**

The increased pressure on contraceptive care is further complicated by the split responsibility for commissioning and delivery of services between health and local government. While local government is responsible for community contraceptive services and the commissioning and prescribing of long-acting reversible contraception (LARC) methods both in community settings and primary care, around 80% of contraceptive care is delivered in primary care<sup>4</sup>. The scale of the cuts that are being actively considered and already in many areas actively implemented by commissioners are likely to impact community and primary care settings in the following ways:

- **Community settings:** The introduction of reduced operating hours or closures of services; they may also introduce tighter restrictions on who can access the service and what contraceptive methods are available to women. This will mean that a woman whose GP practice does not provide a full range of contraceptive methods (for example not having a trained fitter of intra-uterine devices or intra-uterine systems) will have limited alternative options for referral or self-referral and she may not be able to access the method best suited to her. Some vulnerable and younger women, who may not want to talk to their GP about contraception, or who may particularly benefit from a non-user dependent method of contraception, are likely to be disproportionately impacted.
- **GP practices:** Increased demand from women seeking contraceptive care, particularly if community settings that previously provided LARC options are scaled back. PHE data on current GP LARC provision already shows considerable variation (particularly when the shorter term and less effective contraceptive injection is not included)<sup>5</sup> and the delivery of LARC methods in primary care settings may decline further as funding constraints tighten. More women may therefore have to use user-dependent contraceptive methods, such as the pill or condoms, rather than longer-acting reversible methods that are known to be both more reliable and cost-effective. This reduction in services and reduced provision of LARC by GPs will make access more difficult and affect the most compromised and vulnerable. Such as those who are young, or disadvantaged due to social, cultural or language issues, thereby increasing inequality.
- **Cross charging** between local authorities is already inconsistent, with some areas not including access for out-of-area residents in provider contracts and others refusing to pay for care that local women undertake out-of-area. We believe there is a significant threat to open access contraception in the places where providers are only commissioned to deliver services for specified residents.

***We urge the Committee to highlight the need for the Government to better monitor the impact of cuts to services and provision across health and community services.***

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***We urge the Committee to recommend that additional funding be provided to support primary care's provision of contraceptive care and services.***

### **3. The public health ring-fence**

The Spending Review also indicated the likely abolition of the public health ring-fence in 2018, to be replaced by income generated through business rates. We are concerned that removing the ring-fence will lead to funding previously allocated to contraceptive services being absorbed into other areas such as adult social care. Indeed, an investigation undertaken by the *British Medical Journal* in 2014 found that some local authorities are already diverting ring-fenced public health funds to support wider council services.<sup>6</sup>

While we accept that the public health ring-fence was not intended as a permanent measure, we are concerned that its removal will place even greater pressure on local government to cut the provision of contraceptive services for women. Business rates are far from uniform across the country, and it will be essential to introduce a fair funding formula to ensure that areas with lower business rate receipts are not unduly penalised.

***We urge the Committee to recommend to Government that they commit to maintaining the ring-fenced public health grant to local authorities to ensure these vital frontline services can be maintained for the remainder of the Parliament.***

***If the ring-fence is to be removed, the Committee must stress the importance of a robust, fair funding mechanism to ensure every area can deliver their public health functions, including contraceptive services.***

For more information, please contact the AGC secretariat at [agc@incisivehealth.com](mailto: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
- Laura Russell, Senior Policy and Parliamentary Affairs Officer, Family Planning Association
- Dr Connie Smith, Chair, Healthwatch Camden

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- Harry Walker, Policy Manager, Faculty of Sexual and Reproductive Healthcare
- Jason Warriner, Chair of Public Health Forum, Royal College of Nursing
- Dr Chris Wilkinson, Lead Consultant, Margaret Pyke Centre

**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
- Lesley Wylde, Partnership Development Manager, Bayer HealthCare

**References**

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<sup>1</sup> [HM Treasury, Chancellor announces £4½ billion of measures to bring down debt, 4 June 2015](#)

<sup>2</sup> [NHS England, Five Year Forward View, October 2014](#)

<sup>3</sup> [Department of Health, A Framework for Sexual Health Improvement in England, March 2013](#)

<sup>4</sup> [All-Party Parliamentary Pro-Choice and Sexual Health Group, A report into the delivery of sexual health services in general practice, October 2007](#)

<sup>5</sup> [Public Health England, GP prescribed LARC rate/ 1,000 \(including and excluding injection rates\), 2015](#)

<sup>6</sup> [British Medical Journal, Raiding the public health budget, March 2014](#)