AGC Advisory Group on Contraception

AGC submission to the APPG on Sexual and Reproductive Health's inquiry into access to contraception in England

Introduction

The AGC came together in 2010 with a focus on ensuring that the contraceptive needs of all women in England, whatever their age, are met. Since it was formed, a number of policy developments have shaken the contraception landscape, notably the change in commissioning responsibilities under the Health and Social Care Act 2012 and year-on-year public health budget cuts. We have become particularly concerned about the impact of these decisions on women's access to contraception in England.

To monitor the changes in the contraceptive landscape, the AGC has undertaken an annual Freedom of Information (FOI) audit of all upper and unitary tier local authorities in England. This was largely in response to the £200 million in-year public health budget cuts in 2015 (by 2020/21, it has been estimated that £800 million will have been cut from the total public health budget).[1] This submission therefore outlines the key findings we have identified from our FOI whilst setting out:

- The current challenges in the sexual and reproductive health (SRH) commissioning landscape in England
- The impact these challenges are having on women's access to services
- A series of recommended actions for local and national bodies involved in the planning and delivery of contraceptive services.

Although the AGC campaigns on access to the full range of contraceptive options to support women's choice, members are particularly concerned with the provision of long-acting reversible contraception (LARC). These include: intrauterine devices, intrauterine systems, and sub-dermal implants; and are proven to be the most effective forms of contraception for reducing unplanned pregnancy and the most cost-effective methods in the long-term.[2] Recent years have seen a concerning decline in the number of prescriptions for LARC.[3] As such, this submission will focus predominantly on the challenges facing access to LARC over other methods of contraception.[i]

Commissioning and the contraceptive landscape

There is widespread agreement across Government and its relevant bodies on the clinical efficacy and cost-effectiveness of LARC, and increasing uptake of the most effective forms of contraception is a Government ambition.[4] [5] Indeed, Public Health England (PHE) recently acknowledged the return on investment delivered by contraception in a study that conservatively estimates that every £1 spent on publicly-funded contraception saves £9 in averted direct public sector healthcare and non-healthcare costs. [6]

Yet, despite the recognition of its importance, there are a number of barriers and challenges impeding provision of high-quality contraceptive services in England and – ultimately – impacting on women's access to the full range of contraceptive options. This includes the funding available for contraception; the fragmented commissioning environment that contraception sits within; and a number of growing workforce and training challenges.

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[i] The AGC defines LARC as intra-uterine systems, intra-uterine devices and progestogen-only subdermal implants. The AGC has tended to exclude progestogen-only injectable contraceptives (which are often considered long-acting) because (a) injections rely on timely repeat visits/administration and consequently have a higher failure rate than the other LARC methods, (b) injections are easily administered thus do not require the resources and training that other LARC methods require and (c) injections are outside local authority contracts.

Funding

Public health budgets – out of which LARC is funded – have witnessed substantial cuts since 2015, with the Local Government Association (LGA) warning that SRH services are now at a "tipping point".[7] Since 2015 to the end of the 2017/18 financial year, total SRH budgets have been cut by £81.2 million (12%) and contraceptive budgets have been cut by an estimated £25.9 million (13%).[8] Our FOI found that, locally, this has translated into 66% of councils reducing or planning to reduce their budget for SRH (2016/17 to 2018/19) meaning that 8 million women of reproductive age (15-49) live in an area where the council has reduced their SRH budget since 2016/17.[9]

On contraceptive spending specifically, our FOI found that, worryingly, 84% of councils were unable to provide accurate data on contraceptive spending.[10] Councils indicated to us that they are unable to disaggregate contraception spending from wider SRH budgets. This means that councils do not have visibility of the true impact of budget cuts on local contraceptive spending. Although contraceptive spending data is published by the Ministry of Housing, Communities, and Local Government (MHCLG), for the purposes of reporting this data, many local authorities either estimate contraceptive spending or only report spending on contraception that is delivered separately from sexual health services.

Although data on contraceptive spend is uncertain, there is evidence of cuts having a demonstrable impact on access to LARC. Through our FOI, we found that 49% of councils have reduced the number of sites delivering contraceptive services in at least one year since 2015 with 13% of councils reducing the number of sites over multiple years. This means over 6 million women of reproductive age are living in an area where the council has reduced the number of sites delivering contraceptive services.[11] Concerningly, we also found that the pace of closures is accelerating. While 9% of councils reduced sites in 2015/16, this increased to 21% in 2016/17 and 24% in 2017/18.[12]

Evidence of the link between budget cuts and service closures is noted by the Royal College of General Practitioners (RCGP). The RCGP has reported that payments from councils to GPs to deliver LARC do not always cover the cost of administering and the implication is that GPs are restricting their offering or halting services altogether.[13] This places additional pressure and costs onto other services as women, unable to access LARC from their GP, are referred onto SRH services.

Given the clear challenges, it is concerning that the uncertainty surrounding funding is likely to continue. It has been proposed that 75% business rate retention will absorb the public health grant by 2020/21[14] and there is significant uncertainty surrounding how the removal of the public health grant will impact on spending on public health.[15]

Fragmented commissioning

As well as the funding constraints, there are also significant structural challenges – as a result of the fragmentation of commissioning – which are impeding the delivery of high-quality contraceptive care.[16] Since the implementation of the Health and Social Care Act 2012, responsibility for commissioning of contraception has been split across three bodies:

- Local authorities commission contraception delivered in community clinics and some GP practices, including specialist care and LARC
- NHS England commissions basic contraceptive services under the GP contract, including user-dependent methods of contraception
- Clinical Commissioning Groups (CCGs) commission contraception for gynaecological purposes

Fragmented commissioning has translated into fragmented provision of services, with commissioners and providers operating in siloes rather than collaboratively. Fundamentally, this

leads to significant gaps in the care pathway for women accessing contraception, where providers may have restrictions on services, or may no longer be funded to deliver them. The scale of various potential complexities of a woman's contraceptive journey, demonstrating the various and wide-ranging barriers in the care pathway, has been mapped out below (Figure 1). In reality, this can involve women being bounced from service to service and waiting weeks, or even months, to access contraception.

NHS England has recognised this challenge and is considering if there is stronger role for the NHS in commissioning sexual health services to improve joined-up care.[17] The AGC has no position on where responsibility for this commissioning should lie, but regardless of who commissions services, increased collaboration must be prioritised to protect access.

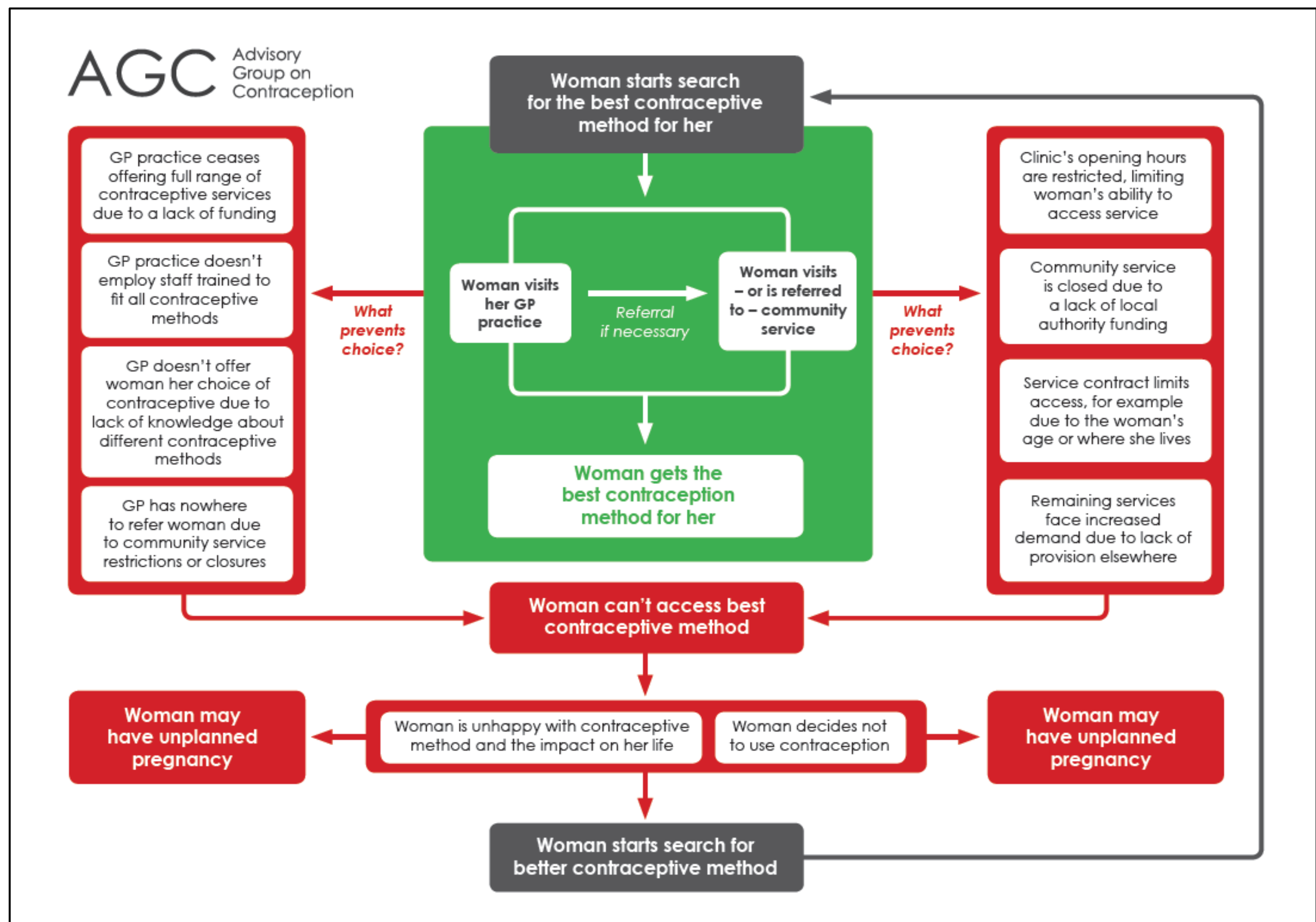

Figure 1: *AGC (2016) Contraceptive care pathway infographic*

Workforce challenges

The challenging access environment has been exacerbated by the loss of training opportunities for, and expertise in, counselling and device fitting/removal for LARC methods. Training is often raised as one of the biggest threats to the sustainability of contraceptive services. The Royal College of Nursing (RCN), RCGP, and Faculty of Sexual and Reproductive Healthcare (FSRH) have all raised concerns about training and maintaining qualifications to fit LARC (IUS/IUD and implants require healthcare professionals to be appropriately trained and certified).[18 19 20] Yet, recently, we have heard from frontline staff that they have been dissuaded from accessing training because they are often expected to self-fund training in their own time.[21] This has led to a situation where healthcare professionals are failing to maintain qualifications or even moving to other specialties that are better funded. This is of great concern as one SRH consultant is able to provide leadership to a population of around 125,000.[22] Every lost SRH consultant therefore places huge burdens on the rest of the workforce. Without the appropriate and qualified workforce, there is less choice for women about

where they can access LARC and variations in whether they are counselled to make an informed decision on their contraception.

The overall picture of funding, commissioning, and workforce is one of an increasingly challenging contraceptive landscape. While a reduction in funding or in the number of services being commissioned may not necessarily reflect the range or capacity of services available, it does highlight the scale of disruption to local services which may impact on service consistency and women's ability to access contraception. AGC members are particularly concerned about the impact of this disruption on health inequalities and vulnerable women's access to contraceptive services.

Implications for women

Uptake of the most effective forms of contraception

The fall in funding is pushing services to the edge and there are real concerns about the sustainability of LARC fitting in the future with some services restricting the availability of contraception. A survey conducted by the RCGP suggests that 27% of GPs currently do not think that women seeking LARC are always able to access it and 29% believe that their LARC service will deteriorate in the next year.[23] Likewise, the FSRH's members' survey revealed that 38% of respondents have experienced reduced availability of SRH services, which has affected women's access and choice.[24]

This has ultimately led to a reduction in LARC uptake. Between 2014 and 2017, prescriptions of LARCs fell by 10% in general practice.[25] This is reflected in the number of contracts local authorities are holding with GPs to provide LARC. Through our FOI we discovered that in 2018/19, 11% of councils have seen the number of contracts held with GP surgeries to fit IUS/IUD and implants reduce.[26]

Right to choose

We have also heard that choice is being eroded. Currently, 62% of women are accessing LARC in general practice, compared with 38% in SRH services (excluding access in hospital settings and abortion services).[27] Yet, PHE has discovered that one-third of women are currently not able to access contraception from their preferred source.[28] Different settings are best for different women, but it is vital that women are able to exercise this choice.

As GP and SRH services are further squeezed and as availability of LARC in these services decreases, the proportion of women accessing contraception from their preferred source will continue to drop, challenging the notion that contraceptive services should be open access and available to all. This increases the chances of women opting not to use contraception, risking unplanned pregnancy. This comes at a time when abortion rates in the England and Wales are increasing, now at their highest level since 2008.[29]

Case studies and examples

We have also heard from healthcare professionals that cuts to contraceptive services are having the greatest impact on the most vulnerable women in society. To demonstrate this, we set out to capture the voices of vulnerable women to uncover the implications of cuts on women's experiences. The women we spoke to were from non-English backgrounds, usually unemployed and, in some cases, from the marginalised Roma community. They therefore may be less likely, or able, to engage with health services and likely to need extra outreach and support.

Through collaboration with community groups working with vulnerable women we have heard:

- Some doctors are not considering women's personal preferences. For example, one woman told us that she wanted to use the contraceptive pill but had been told by the doctor that there were too many side effects and she now has to rely on condoms and the morning after pill

- Services are becoming inaccessible. For example, one woman told us she wanted to use a coil but that only two places near her provided it. Another informed us that she previously received the injection, but has stopped accessing it, and contraception altogether, as it is too far to get to the clinic

- Long waiting lists are making it difficult to secure appointments. For instance, one woman told us that she is having issues with her coil but is unable to secure an appointment with a healthcare professional to discuss her options, while another wanted to start using a coil but could not get it as there are "long waiting times"

- Some women in complex situations felt under pressure from their partners or families not to use any contraception and so were afraid of talking to their family doctor. To overcome this challenge, some were able to access contraception and advice through a local children's centre, but this suggests that there is a need for local authorities to ensure that alternative options to GPs are available for vulnerable groups

Similarly, we have found that 61% of councils in the quartile with the highest social deprivation cut or froze their SRH budgets between 2016/17 and 2017/18 and of these 89% are planning to freeze or cut budgets in the next financial year. [30] This is corroborated by the British Medical Association (BMA) who also suggest that cuts to services are having the greatest impact in areas already experiencing worse health outcomes. This has led to significant variation in the quality and availability of services in England.[31]

Through our FOI we have also discovered that in some areas current practice is abandoning the idea that contraceptive services should be open to all, regardless of age or place of residence, and these findings are supported by the All-Party Parliamentary Group on Sexual and Reproductive Health.[32] For example, some areas only provide services to residents of their local authority, while other areas have put in place age restrictions on accessing schemes offering emergency contraception.[33] In fact, in 2016 we found that approximately 3.9 million women of reproductive age were living in an area with some form of restriction on access to contraception.[34]

Recommended actions

There is no single panacea to address the impact that year-on-year public health cuts and fragmentation has had on women's access to high-quality contraceptive services. However, the AGC is recommending five key actions to the Government, local authorities, and the NHS, to safeguard comprehensive and inclusive contraceptive services for the future:

1. **Funding** – The Government should announce an immediate **reversal of cuts to public health** budgets since 2015 at the Spending Review and ensure public health services are put on sustainable footing for the future

2. **National oversight** – DHSC should introduce a **women's health strategy,** overseen and implemented by the Women's Health Taskforce, to ensure all women have access to high quality and well-staffed SRH services, offering all methods of contraception

3. **Strengthened mandate** – DHSC should **strengthen the mandate for the provision of contraceptive services in line with national standards and guidelines** to ensure there is adequate service provision at a local level for all women to access the full range of contraception

4. **Local collaboration** – Regardless of who is responsible for commissioning contraception, increased collaboration is required between commissioners and providers of services to ensure that all women can access the full range of contraception in a clear and streamlined pathway

5. **Workforce** – Health Education England (HEE) should facilitate the **implementation of the recommendations** of its recent report *Improving the delivery of sexual health services*

It is vital that women's access to the full range of contraception is protected. Over the past three years we have witnessed a decline in contraceptive spending, the number of services offering contraception, and in the workforce. All of this has resulted in less choice and worse care for women. Services are at a tipping point and if action is not taken to reverse this trend the potential implications could be disastrous.

The Advisory Group on Contraception

The AGC is an expert group of leading clinicians and advocacy groups, working together to highlight the impact of policy reforms on women's access to contraception. The group came together in November 2010 with the aim of ensuring that the contraceptive needs of all women in England are met, regardless of age or location.

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Please be advised that some AGC members are responding to this inquiry separately through their various organisations. This submission is intended as a broad consensus of AGC members and does not necessarily reflect the views and opinions of individual members.

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[2] D Shoupe (2016) LARC methods: entering a new age of contraception and reproductive health, *Contraception and Reproductive Medicine.*
[3] PHE (2018) What does the data tell us?
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[6] PHE (2018) Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England.
[7] LGA (2017) Sexual health services at tipping point warn councils.
[8] MHCLG (2018) Local authority revenue expenditure and financing England: 2017 to 2018 individual local authority data – outturn.
[9] AGC (2018) At tipping point.
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[13] RCGP (2017) Time to Act.
[14] LGA (2018) Business Rates Retention.
[15] FSRH (2018) SRH sector join forces and call on SoS Jeremy Hunt to strengthen local authorities' SRH mandate.
[16] PHE (2017) Sexual Health, Reproductive Health and HIV: A Review of Commissioning.
[17] NHS England (2019) NHS Long Term Plan.
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[23] RCGP (2017) Time to Act.
[24] FSRH (2018) FSRH Consultation Response: Health and Social Care Committee (HSC) inquiry into sexual health.
[25] PHE (2018) Rate of GP and Sexual and Reproductive Health Services prescribed long acting reversible contraception (LARC) excluding injections.
[26] AGC (2018) At tipping point.
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[32] APPG on Sexual and Reproductive Health (2015) Breaking down the barriers.
[33] AGC (2017) Cuts, Closures and Contraception.
[34] AGC (2016) Private lives, Public health.