



Sexual Health and HIV

An urgent economic and public health challenge

1. Introduction

Over the past six years the UK has experienced dramatic growth in levels of HIV and STIs, and the demand for contraception and abortion services, placing a severe strain on sexual health services, and presenting a major public health challenge. If it is to enable services to meet that challenge, the NHS must establish sexual health and HIV as a national and local priority. This paper spells out the reasons why it is so urgent a problem and what steps should be undertaken to address it.

2. Why should sexual health and HIV be an NHS priority?

Public Health

Increasing diagnoses of sexually transmitted infections (STIs) and record HIV prevalence, make these the fastest growing health conditions in the UK. Current estimates place the number of people living with HIV in the UK at about 50,000, one third of whom do not know their HIV status. Based on current trends, over 90,000 people will be infected with HIV by the end of 2008. There have been significant increases in STI diagnoses in GUM clinics since 1996, with new cases of some major STIs more than doubling during this period. These are summarised in Table 1.

Table 1 – England & Wales HIV & STI diagnoses in GUM, 1996/2002

Condition	Diagnoses'96	Diagnoses'01	Diagnoses'02	Increase 96 /02	Increase 01 /02
HIV	2200	4900	6500	195%	33 %
Gonorrhoea	12140	22992	24958	106 %	9 %
Chlamydia	34136	71957	82206	141 %	14%
Syphilis	122	736	1232	910%	67 %

Source:HPA

The UK's teenage pregnancy rates remain the highest in Western Europe. Young people lack accurate information about contraception and STIs in particular, and they consistently tell researchers that the sex education they receive is too little, too late.

Access to abortion services across the UK varies significantly. In 2002, although 78% of all abortions in England and Wales were funded by the NHS, the percentage of abortions under 10 weeks which were NHS funded varied between PCTs from a low of 9% up to 82%. Some women face difficulties finding a doctor willing to refer them for an abortion in the first place.

There has been a particular worsening of sexual health since the NHS Plan was published in 2000. In a report published in mid 2003, the House of Commons Health Select Committee deemed the situation 'a crisis' and called for urgent government action.

Economic Consequences

Worsening sexual health and growing HIV need are costing the NHS more each year. NHS HIV care costs are increasing by over £50 million a year, with lifetime treatment costing an additional £1 billion a year. Based on figures set out in the DH National Sexual Health and HIV Strategy, lifetime socio economic costs of HIV to the UK are increasing by up to £3 billion per annum.

In 1995, the Office of Health Economics estimated the annual cost of treating STIs to be £700 million. With the growth in STI epidemics since then, it is almost

certain that costs now exceed £1billion.(Source: derived from OHE stats)

According to the Department of Health, the prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already, and yet these crucial services have been de-prioritised. (Source: Health Select Committee Report).

Geographical spread

Poor sexual health is spread right across the UK. 2002 HPA figures showed that approx. 73% of herpes and 76% of chlamydia cases were outside London, being distributed relatively evenly across the country. Some of the highest levels of syphilis are in Manchester and Brighton, whilst the highest levels of drug resistant gonorrhoea are to be found in Yorkshire & Humberside.

London has the highest rates of teenage pregnancy, and PCTs with the worst access to NHS funded abortions under 10 weeks include Newham & Bristol North.

52% of HIV diagnoses in 2003 were in metropolitan centres outside London; this proportion is expected to grow.

Health inequality

In its response to the Health Select Committee Report on Sexual Health, the Government itself acknowledged that 'poor sexual health continues to disproportionately affect those who are often already vulnerable or socially excluded'.

The facts speak for themselves. Chlamydia, gonorrhoea, genital herpes and genital warts are disproportionately diagnosed in the UK's black & minority ethnic communities.

Almost 50% of HIV diagnoses since 2001 have occurred amongst black African communities, with worrying increases now being seen in some London Afro Caribbean communities as well. HIV actively compounds social and economic marginalisation by virtue of the stigma associated with being HIV positive (Source: THT & Crusaid).

Poverty plays a dramatic role in teenage pregnancy levels, with a six-fold difference in teenage conception and birth rates between the poorest areas in England and the most affluent. Access to abortion and contraception services are most problematic for people in disadvantaged communities.

The grave impact of health inequalities on marginalised communities has prompted Professor Sir Ian Kennedy to commit the Healthcare Commission to prioritising the issue.

Patient and public involvement

Because of the stigma associated with poor sexual health and HIV, the people affected are amongst the least visible and least articulate of the UK's patient groups. As such, many of the difficulties experienced with service access and quality are neither reported nor made public. Work should be undertaken by the NHS to avoid compounding this low level of involvement with a lack of focus upon services used by these groups.

Service access and patient choice

At a time at which access has improved to other services such as A&E, primary care, and major specialities, access to GUM services has worsened.

The Health Select Committee noted that six out of eight GUM clinics in North West London have had to close 'walk in' services in the last 18 months and those remaining report being 'inundated'.

Across the UK many GUM services report significant waits of over two weeks for appointments, with some waits as long as eight weeks. Many others report all appointments being fully booked within an hour of them becoming available.

The public health consequences of people with undiagnosed STIs being untreated for a number of weeks, or being put off and not receiving treatment at all, are significant. As such, the service response does not appear to be matching the scale of the challenge, and requires a review of the way services are delivered, and developed. A lack of consultants and adequately trained nursing and support staff, as well as an impending shortage of specialist family planning consultants and senior medical staff is compounding current access problems.

With no option but to wait weeks for an appointment for an easily treatable STI, for many people, patient choice is far from being a reality. Similarly, there remain significant problems in access to contraceptive and abortion services. In many areas, cutbacks in family planning clinics have meant that patients' only real choice for contraceptive services is their GP, many of whom don't advise on or provide access to all methods of contraception. Access to abortion services also varies hugely, and patients may wait anything from one to six weeks for an NHS-funded abortion.

It is very clear that the UK's sexual health and HIV services are in urgent need of development. They are under considerable strain as a consequence of the rapid growth in need, and have received little development or investment focus over the past five years. Such developments should include measures to maximise the impact of the workforce, and look at innovative ways within public and charitable sector services for expanding capacity with minimal resource implications.

It is not only the patient that suffers as a result of lack of access to services. The late presentation of HIV and STIs can

mean generic NHS resources such as A&E and general medicine inpatient services are being used in a manner which would otherwise be unnecessary if earlier diagnosis had been made.

The NHS Response

Despite the best efforts of its staff, the NHS response to the UK's worsening sexual health has been further constrained by the unintended consequences of the NHS Planning and Priorities Framework 2003/06. National per capita spend on HIV prevention is falling, as is per capita expenditure on HIV treatment and care. Service quality and access in the sexual health field is deteriorating, yet quality and access in priority areas of NHS services are improving.

Further, a survey of SHA LDPs undertaken by Brook, fpa, Medfash, NAT & THT showed that HIV and sexual health are only mentioned in about 40% of SHA LDPs, and even in those plans, there appear to be very few specific proposals or development commitments. Neither abortion nor contraception services were mentioned in any SHA LDP, graphically illustrating that these issues are struggling for attention amongst SHAs and PCTs.

3. What might be done?

Poor sexual health is a national public health crisis, which is being compounded by poor access to services, and by low priority amongst NHS planners and funders. This is affecting communities already facing high levels of health inequality and is already causing significant economic implications, with worse to come.

A concerted national and local focus will allow services to develop and reverse the appalling trends outlined in this paper. To this end, the NHS should take immediate steps to prioritise sexual health and HIV through the following actions:

- Establishment of an access standard of a 48 hr wait for GUM services and retention of the existing standard for abortions carried out under 10 weeks. There is also a pressing need for a standard for access to contraceptive services. These should form part of the PCT performance framework being developed by the Healthcare Commission.
- Establishment of sexual health and HIV as an explicit national priority area within the 2005/08 Planning & Priorities Framework, either as a target in its own right, or as an explicit part of a target for improving public health.
- Work by Strategic Health Authorities to assist PCTs to establish sexual health and HIV as explicit local priorities.
- The establishment of a major development programme to improve access, service quality and capacity within sexual health and HIV services.

SHOG (Sexual Health Organisation Group)

Brook
Jan Barlow
Tel: 020 7284
6052

fpa
Anne Weyman
Tel: 020 7837
5432

MEDFASH
Ruth Lowbury
Tel: 020 7383
6315

NAT
Deborah Jack
Tel: 020 7814
6767

**Terrence
Higgins Trust**
Paul Ward
Tel: 020 7816
8603