FSRH response to the Department of Health’s consultation ‘Public health grant: proposed target allocation formula for 2016/17’

The Faculty of Sexual and Reproductive Healthcare (FSRH) welcomes the opportunity to respond to the Advisory Committee on Resource Allocation (ACRA)’s proposed target allocation formula for the 2016/17 public health grant.

The Faculty of Sexual and Reproductive Healthcare (FSRH) is a membership body of over 15,000 doctors and nurses delivering sexual and reproductive health (SRH) across the UK in both General Practice and Specialist Contraceptive/SRH Services. The FSRH is a charity whose aims include producing and promoting high standards in SRH, providing national qualifications in SRH and providing learning opportunities for its membership – ultimately to improve care to women and men using SRH services wherever they are provided.

As the representative body of the bulk of SRH healthcare professionals in the UK, this response will specifically consider Question 4 of this consultation. We seek to critically assess the proposed new ‘sexual health services’ formula component in terms of its efficacy, whilst at the same time reiterating our deep concerns about the proposed public health cuts that frame this consultation.

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Summary of Key Considerations:

- The FSRH would like to highlight that the terminology ‘sexual health services’ often refers exclusively to GUM service providers, excluding family planning clinics or contraception provision. Henceforth in this response, for purposes of clarity, the FSRH will refer to ‘sexual health services’ as ‘sexual and reproductive health services’ in order to ensure that the FSRH’s principal concern, the provision of contraception, is understood to be fully encompassed into this concept.
- The FSRH is concerned that the age group 25-34 is omitted from the table of need variables as this age group constitutes the main cohort of patients contacting sexual and reproductive health services for contraceptive reasons.
- Similarly, we believe that there should be more weighting given to older age group variables given their usage of sexual and reproductive health services.
- The FSRH is concerned that the Index of Multiple Deprivation does not fairly account for health inequalities across large, demographically nuanced geographical areas and socio-economically deprived areas that are most at risk of unintended pregnancy.
- The FSRH believes that this component caps access to services at current levels of demand and prevents Local Authorities from addressing unmet need.
- The FSRH is very concerned that the new funding component masks a further public health cut to socio-economically deprived areas.
- The GUMCADv2 and CTAD datasets are flawed in that they only cover level 3 service activity in a GUM setting, failing to take into account level 3 services provided in primary care and family planning clinics.
- We are also concerned that the usage of the GUMCADv2 and CTAD datasets is only representative of GUM services that are funded on tariffs. Generally, these services receive funds in direct correlation to service demand and so are able to bring in additional funding where there is increased service demand. SRH services, on the other hand, are on block contracts that have no mechanism to remunerate additional spending once contracted workload is exceeded.
- The FSRH believes that the binary allocation formula consisting of two differing components will create a problematic disjunction between service demand and access.
**Question 4: Do you agree that the proposed new sexual health services component should be introduced?**

Whilst the FSRH believes that the proposed employment of utilisation datasets theoretically ensures that sexual and reproductive health services fund allocation is calculated in direct relation to service demand, we would want reassurances about the quality and comprehensiveness of these datasets before agreeing to their introduction.

1. **Health Inequalities**

Primarily, the FSRH would like to highlight that Table 4 (p.23) “Need variables in proposed sexual health services” omits the age group 25-34. We believe that if not editorial error, this omission represents a significant cause for concern. The Health and Social Care Information Centre’s (HSCIC) “Sexual and Reproductive Health Services, England: Statistics 2014-2015” report illustrates that the 25-34 age group are the main cohort of women accessing SRH services for contraceptive reasons. It is paramount therefore that service demand for this age group is fairly represented and taken into account by the formula. ¹

Similarly, we are concerned that the 35-44 and all subsequent age groups carry negative weightings as variables. The aforementioned HSCIC report asserts that the percentage of women using Long Acting Methods of Contraception (LARCs) increases with age, 38% of those aged 45 and over use LARC as their main method of contraception.² Therefore these age groups do represent a large proportion of service demand and this should be taken into account in the weightings for older age-group variables.

We support the Royal College of Nursing (RCN) in their response to this consultation which assert that indices such as the Index of Multiple Deprivation (IMD) do not fairly account for inequalities across large geographical areas, in particular rural areas. For example, Local Authorities that span large geographical areas must cater for large and multifaceted health economies whilst at the same time delivering a uniform core service that caters for overall population need. In this sense, the IMD is limited in the extent to which it is able to represent such demographic nuances. The King’s Fund’s recent report *Inequalities in Life Expectancy* (August 2015) corroborates this viewpoint by emphasising the way in which measurement issues become more important in terms of accounting for demographic nuance when health issues are considered on a smaller geographical scale.³ Therefore, the FSRH urge the Department of Health to adopt a more balanced approach to public health spending that takes these factors into account in order to avoid perpetuating health inequalities.

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² Ibid.

Furthermore, as this consultation outlines, the anticipated impact of this new funding mechanism component reduces funding allocation in deprived areas – the areas often in most need of sexual and reproductive healthcare. The recent third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)\textsuperscript{4} demonstrates that there are strong associations between unplanned pregnancy and women from socio-economically deprived backgrounds, as well as women with low educational attainment, depression and potentially harmful health behaviours, which are characteristics typically associated with women pertaining to this demographic. Consequently, the way in which the proposed formula component for sexual and reproductive health services redistributes allocations towards the more affluent areas will only serve to compound health inequalities, going directly against the Department of Health’s stated aims.

As stated in the “Public health grant: Exposition book for proposed formula for 2016-17 target allocations - Technical Guide”, this funding formula does not factor in ‘supply induced demand’ and therefore populations that are not currently accessing services are not considered in the formula, except within the non-mandated elements determined as ‘prevention and promotion’. The FSRH believes that this further compounds inequalities by limiting access to services at the current levels of demand at a time when levels of unintended pregnancy and abortion rates remain relatively high across the UK indicating an evident unmet need for comprehensive and accessible contraception services. This amounts to capping the funding of sexual and reproductive health clinical services and preventing Local Authorities from addressing unmet need- ultimately perpetuating the historical trend of funding GUM services on tariff and sexual and reproductive health services on block contracts and risking that the financial incentivisation of tariffs lead to the prioritisation of GUM care over SRH care.

2. Public Health Budget Cuts

In addition, the way in which this proposed formula component takes funding away from populations most in need of sexual and reproductive health care only adds to our deep concerns about the negative impact of current and forecasted public health budget cuts.

We believe that the recent £200m public health cuts represent a false economy.\textsuperscript{5} These cuts will only serve to increase pressure on NHS services, restrict service provision and have serious ethical and equality ramifications on protected characteristic groups.\textsuperscript{6} In many ways the practical realities of this new funding component seems to mask a further public health cut to socio-economically deprived areas under the guise of a new funding mechanism.

In the same vain, we would like to support the recommendation of the All Party Parliamentary Group on Sexual and Reproductive Health’s 2015 report *Breaking down the*

\textsuperscript{4} Natsal-3 is one of the world’s most comprehensive scientific studies of sexual behaviour in which 15,000 adults aged 16-74 years participated in interviews between September 2010 and August 2011
\textsuperscript{5} See the FSRH’s previous consultation response to the Department of Health’s consultation on the 2015/16 Public Health Allocations: In-year Savings: \url{http://www.fsrh.org/pdfs/FSRHResponseDHLAAllocationsConsultation.pdf}
\textsuperscript{6} Ibid.
Barriers that the public health budget allocation is ringfenced beyond 2016 and that Department of Health provide a thorough oversight to ensure that the sexual and reproductive health services funding calculated by this new formula component is spent on its intended purposes. Worryingly, a report from the BMJ has found that many local authorities divert allocated public health funds to compensate for funding gaps in wider council services. Therefore the FSRH would like to take this opportunity to reiterate the need for an extension of the public health ring fence in order to ensure that allocated funds are spent according to purpose.

3. Disjunction between service demand and access

By its own admission, the GUMCADv2 and CTAD person-based model, recommended by the Resource allocation for local public health report, is flawed. For example, the GUMCADv2 dataset only covers level 3 diagnoses and service activity in GUM clinics only, excluding that which takes place in a primary care or family planning clinic setting. With this in mind, there is room to question if this dataset fairly accounts for SRH service demand in rural areas where there is a greater reliance on enhanced services in primary care rather than specialist services.

Likewise, this model based on existing service users fails to recognise that the very presence of sexual and reproductive health services in an area may lead to higher utilisation. Currently, many local authorities are re-procuring services and moving towards integration. This is likely to lead to an increase in service demand for SRH services that the proposed formula fails to anticipate.

The oversight of ‘supply induced demand’ is further compounded by the fact that GUMCADv2 and CTAD datasets only represent services funded by tariffs. Consequently, allocations for SRH services, traditionally funded on block contracts, will be calculated according to datasets taken from settings where funding generally correlates with service demand. This illustrates a blatant disregard for the eventuality of SRH services needing to cater for increased utilisation with block contract fixed funds.

In terms of practicality, we would question the efficacy of using two different, and in many ways opposing, formula components to calculate allocations for sexual and reproductive health services. In this consultation, ACRA proposes a binary formula: one component that uses utilisation datasets to allocate funds for STI testing, treatment and contraception and another that uses the SMR<75 to calculate allocations for advice, promotion and prevention. ACRA’s own assessment concludes that the SMR<75 is highly correlated with deprivation. Therefore, it can be inferred that deprived populations will receive more funding for advice, promotion and prevention, yet resources will be directed away from these areas in favour of more affluent areas for STI testing, treatment and contraception.

In this sense, these two components are at odds and create a disjunction in deprived areas between information provision and service provision. Deprived areas will have more money

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7 BMJ (2014) “Reading the Public Health Budget” Available at: http://www.bmj.com/content/348/bmj.g2274
to advise and promote preventative sexual and reproductive health care, in turn increasing demand for these services, yet these areas will have fewer resources to implement the services they are advocating in practice. This will undoubtedly create a problematic gap between service access and demand.

**Conclusion**

Whilst the FSRH welcomes the proposed employment of utilisation datasets in terms of how they directly correlate with service demand for sexual health services, we have several concerns regarding the efficacy of this component. We believe that the use of indices such as the Index of Multiple Deprivation (IMD) will only serve to compound health inequalities by diverting funds away from vulnerable, socio-economically deprived groups and overlooking the complex demographic nuances of larger geographic areas. The diversion of funds away from groups most in need of sexual and reproductive health services also adds to our fears about the potentially devastating impact of Public Health budget cuts on aforementioned health inequalities, NHS services and patient access. The addition of this component creates a binary formula that has the potentiality to create a problematic disjunction between service demand and access, ultimately undermining Department of Health’s overarching ethos of ‘open-access’ sexual and reproductive health services.

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