Written evidence submitted by the National AIDS Trust (NAT) (CSR0064)

Introduction

1. NAT (National AIDS Trust) is the UK’s HIV policy and campaigning charity. We welcome the inquiry from the Health Committee into the impact of the Comprehensive Spending Review (CSR) 2015 on health and social care.

2. We note that this inquiry runs alongside the Committee’s open inquiry into the impact of Health and Social Care Act reforms on public health. NAT also submitted evidence to that inquiry and would stress the relevance of that information to the current inquiry. While presenting different challenges, the financial and structural components of the ongoing reforms to our health and care systems need to be considered alongside one another in assessing the impact of decisions being made.

3. The CSR presented the opportunity for the Government to set out financial backing for structural reform. This has included further support from Government for the plans set out in the Five Year Forward View (FYFV). As we stated in our previous submission to the Health Committee, we feel there is a stark contrast in the Government’s attitude to the NHS and its attitude to public health. This is despite emphasis within the FYFV on the importance of prevention to ensuring the sustainability of the NHS.

4. We welcome the real-terms increase in funding for the NHS, which has allowed NHS England to allocate additional resources to commissioning treatment and care for specialised services including HIV to better reflect current estimates of demand. However, the current cost assumptions for specialised services indicate a risk that this budget will still not be sufficient to meet the need.

5. While the announcements of front-loaded increases in funding to the NHS in the CSR are encouraging, there is a need to address the dichotomy of Government priorities between the NHS and public health budgets. The public health grant was first frozen from 2014/15 to 2015/16, and then in 2015/16 subjected to an unexpected in-year cut of £200 million. The CSR was an opportunity for Government to invest in public health activity in order to support the overall aims for the health and care system. Unfortunately it brought news of further annual cuts of an average of 3.9% over five years. Not only do these cuts seriously limit prevention capability, but they also directly impact on clinical services such as those in sexual health which are directly funded from the public health grant.

6. NAT recommends that the Health Committee questions the Government on the disinvestment in public health. We also recommend that NHS England and the Department of Health put a clear plan is put in place to ensure prevention is effectively addressed within the FYFV, including outlining the potential role for Clinical Commissioning Groups (CCGs) and Clinical Reference Groups (CRGs) in addressing the prevention challenges we face.

The public health ring fence and the future funding of public health

7. There were concerns that the conflicting priorities within financially strained local authorities would mean that should the ring fence be removed from the public health grant there would be further re-directing of funds away from public health. NAT along with others
has therefore welcomed the CSR’s extension of the ring-fence on public health funding to 2018.

8. This extension of the ring-fence does come with a significant caveat in that the CSR introduced Government consideration of increasing the self-sufficiency of local authorities in the funding of public health. The CSR states that ‘the government will consult on options to fully fund local authorities’ public health spending from their retained business rates receipts, as part of the move towards 100% business rate retention’ (para. 1.104 Spending re-view). We await the consultation on the future funding of public health but highlight our concern around implications for the protection of funding for HIV prevention and testing as well as for a wide range of critical NHS clinical services.

9. These are services which many in the public expect to be funded as part of the health budget, whereas in the future services such as sexual health and drug services may become funded based on revenue generation within a local authority. This could have significant implications for equality in health care and will serve to exacerbate public health inequalities.

10. We recommend that the Health Committee carefully examines the suitability of the proposed funding mechanism for public health and clinical services delivered by local authorities.

Fragmentation, accountability and the implications of further cuts

11. The All-Party Parliamentary Group (APPG) on Sexual and Reproductive Health in the UK conducted an inquiry on the accountability and integration in sexual health, reproductive health and HIV in 2015. This followed the significant re-structuring of commissioning responsibilities following the implementation of the Health and Social Care Act 2012.

12. The APPG made a number of recommendations to strengthen lines of accountability within the new system and highlighted barriers to integration which we feel are still very important and have not yet been addressed. These barriers included varied procurement practices resulting in conflicting contractual aims within the same integrated services; unclear commissioning responsibilities; tendering processes affecting the effective functioning of provider networks now in competition with one another; and poor needs assessments and service specifications.1 These issues are compounded by the tightening of resources as short term cost efficiencies are a priority for commissioners.

13. It is important that accountability structures are clear along with guidance on mandated services to ensure a consistent level of quality in this context. Without addressing accountability for the system as a whole, fragmentation of sexual health and HIV services will continue. Such fragmentation challenges coordinated action on, for example, HIV testing in a local area. This has an impact on the efficiency of the system as a whole and ultimately increases the overall cost in public monies.

14. NAT recommends that the accountability structures for public health and for clinical services which reside across a number of commissioning streams are re-visited and strengthened.

1 The full report from the inquiry can be found here: http://www.fpa.org.uk/all-party-group-uk/accountability-inquiry-standards-sexual-and-reproductive-health
15. Taking these issues into account, the further financial strains brought on by the public health settlement in the CSR will have a further negative impact on the overall delivery of sexual and reproductive health services, as well as the services funded by the NHS which interlink with them. These include HIV treatment and care and contraceptive services through the GP contract.

16. **NAT recommends that the Health Committee ask the Government to address the implications of public health cuts on clinical sexual and reproductive health services to avoid a significant reduction in their quality and the wider negative implications this would have.**

17. NAT has raised questions as to whether it is right for sexual health commissioning to be outside the NHS in the long-term. At the very least these issues underline the importance of a clear mandate in ensuring sexual health clinic services are available in every local authority.

**Public Health England (PHE)**

18. NAT has previously raised concerns about the adequacy of funding for PHE to fulfil its functions effectively. For example, within the HIV and sexual health team, thinning staff teams have inevitably slowed important tender processes. The Spending Review notes the importance of PHE in supporting local authorities in their public health function, and so this must be recognised with an appropriate level of funding.

19. In the context of HIV we are particularly concerned about the future of the National HIV Prevention Programme. While some aspects have gone out to tender, there is no clear statement regarding the overall funding settlement for the programme post April 2016. The funding for this programme has decreased since 2013 putting important national activity at risk.

20. **NAT recommends that the Department of Health is questioned on the level of investment in the activities of Public Health England as part of a commitment to enhancing public health, reducing public health inequalities and reducing the long-term strain on the NHS.**

**Spend on HIV prevention and non-clinical support services**

21. NAT has undertaken a survey of all local authorities in England with a high prevalence of HIV (>2 per 1,000 residents). High prevalence local authorities account for about two-thirds of people living with diagnosed HIV and of new HIV diagnoses annually. We asked for information both on the services commissioned and the amount spent on primary HIV prevention and HIV testing services outside the sexual health clinic (as recommended by NICE).2 Extrapolating across all local authorities at the same rate of expenditure we estimate at most £15m was spent in 2014/15 on primary HIV prevention and out-of-GU HIV testing. This contrasts with £55m allocated for HIV prevention at the local level in 2001/02.

22. For every £55 spent on HIV treatment in England, local authorities collectively spend just £1 on HIV prevention. There is no correlation between the amount spent on HIV prevention/testing by local authorities and their HIV prevalence.

23. The decline in HIV prevention funding was a clear trend prior to 2013 and there was a slight increase in spending between 2013/14 and 2014/15 by local authorities which we don’t

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expect to be repeated for 2015/16 given the in-year cuts to the public health grant. We must also stress how inadequate investment is whether looked at historically or in relation to current need. Every HIV transmission averted saves between £280,000 and £360,000 in lifetime treatment costs. Late diagnosis of HIV also increases longer term health and social care costs for the individual.

24. A growing number of local authorities are announcing that they are decommissioning most or all community-based HIV support services. This has been an ongoing trend precipitated by the dissolution of the AIDS Support Grant and unclear lines of responsibility for funding these services which span treatment, prevention and social care and support. The £200 million cut to public health within the current year has been a strong influence on the most recent cuts which have seen many areas left without support services – these are still important aspects of the care pathway for people living with HIV and have an important role in secondary prevention.

25. The further cuts to the public health budget set out in the CSR will have a further detrimental impact on these specific HIV-related issues, demonstrating the importance of the recommendations made above.

Health equality

26. Finally, we would like to reiterate a point made in our previous submission, that poor sexual health is not evenly distributed across society. Public health cuts, including those most recently announced in the CSR, will have a disproportionate impact on sexual and reproductive health expenditure, including essential clinical testing and treatment services. This will in turn disproportionately impact on health in areas of high deprivation, on men who have sex with men, on women, on young people, and on BME communities.

27. **We do not believe that cutting the public health budget is compatible with the Treasury, Department of Health and local authorities meeting their respective Health Inequalities Duty and Public Sector Equality Duty.** We would urge the Health Committee to ask the Government whether an appropriate impact assessment took place before decisions about public health cuts were made.

25 January 2016