Written evidence from Bayer Plc

Summary

Executive summary

- Bayer welcomes the Health Select Committee’s inquiry into sexual health and the public focus on contraception.

- Bayer is one of the largest pharmaceutical companies in the UK, and a leader in women’s health. Our portfolio includes emergency contraception, oral contraceptives and long-acting reversible contraceptives (LARC).

- Investing in contraception is an important component of both sexual health and the wider prevention agenda. Provision is highly cost-effective and critically important to the public.

- However, the recent trends of rising demand for sexual health services and diminishing budgets have resulted in cuts to education about, access to, and training for provision of contraception.

- The fragmented commissioning environment has resulted in obscured lines of responsibility, enabling commissioners to avoid direct accountability. The impact of this fragmented system is that patients struggle to access continuity of appropriate care.

- To increase access and uptake of LARC Bayer makes the following recommendations:
  
  o Public Health England and the Department of Health should launch a national campaign. The campaign should tackle the misperceptions around LARC and ensure women have the information they need to make informed decisions about the most suitable and effective forms of contraception.

  o In parallel with the campaign there should be a Quality and Outcomes Framework incentive for healthcare professionals to counsel women on all contraception options.

  o Local authorities and CCGs should be put under greater national scrutiny, to ensure that they are providing counselling for and access to intrauterine methods, including intrauterine systems/intrauterine devices (IUS/IUD) for contraception and IUS for contraception and therapeutic indications such
as the management of heavy menstrual bleeding (HMB).

- New models of care should be considered as an opportunity to reconfigure IUS/IUD services to improve patient care.
- The Government should address the workforce issues facing the provision of implants, IUS and IUDs by investing in fully-funded fitter training.

This submission outlines the recent trends shaping the sexual health environment, the three overarching challenges to the improved uptake of LARC within this environment and recommended actions to address these challenges for consideration by the Committee.

1. Recent trends

Sexual health services in recent years have been fundamentally shaped by two trends: rising demand and reduced funding.

Visits to sexual health services rose by a third between 2011 and 2015, with some local authorities reporting 6% increases a year. In 2016, the percentage of conceptions leading to abortions across all age groups hit 21.7%, the highest level since 2008.

Figure 1: Percentage of conceptions leading to abortions across all age groups and milestones that may have change LARC prescribing

PERCENTAGE OF CONCEPTIONS LEADING TO ABORTIONS ACROSS ALL AGE GROUPS\(^1\) AND MILESTONES THAT MAY HAVE CHANGED LARC PRESCRIBING

Source: ONS, Conceptions in England and Wales, 2016, (Milestones added by Bayer)
Likewise, while evidence on the use of emergency contraception is difficult to collect, a 2014 European Union study of fifteen EU member states found that the UK had the highest proportion of women who had ever used emergency contraception, with 61% reporting ‘ever use’ compared to an average of around 20% in the countries taking part.3

Simultaneously, public health has suffered significant cuts over recent years. Local authority public health budgets faced a 5% reduction in real terms (excluding inflation) in 2016/17 compared with 2013/144. Sexual health services faced a 30% reduction in budget between 2016/17 and 2017/18.5

As a result of these opposing trends, sexual health services are coming under strain. Specifically, in contraception, there is evidence that open access to contraceptive care and services is being restricted. In their 2017 report, the Advisory Group on Contraception (AGC) found:6

- 32 local authorities closed contraceptive services in 2016/17, a 167% increase on 2015/16
- Half of councils cut spending on contraception in 2016/17
- Over 1/3 of local authorities have reduced, or plan to reduce, the number of sites commissioned to deliver contraceptive services since 2015
- 45% of local authorities have reduced the number of IUS and IUD fitted and removed in general practice, the first port of call for most women accessing contraception

Despite this, cutting funding for contraceptive services is a false economy. Every £1 spent on contraception saves over £11 in averted costs to the NHS.7 Unplanned pregnancies, which currently account for almost half of all pregnancies in England, directly cost the NHS an estimated £240m annually.8

Yet areas are becoming more restrictive on the contraceptive methods available to women and where these services are offered. In particular, access to some of the most effective forms of contraception - long-acting reversible contraception (LARC) is becoming more difficult.9

Public Health England estimates that approximately 60% of women choose to access their contraceptive care via their GP10. However in a 2017 survey by the family planning association they found that11:

- Only around a quarter of women said that a healthcare professional had discussed long-acting reversible contraceptive methods with them such as the implant (24%) and IUD (26%)
- Over a quarter of women (27%) said they felt they didn’t have enough time to discuss all their contraceptive options during their consultation
- A quarter of women have never had a consultation with a healthcare professional to specifically talk about their contraceptive options
2. Long-acting reversible contraception (LARC)

Long-acting reversible contraceptives (LARC) are methods of birth control that provide contraception for an extended period that are non-user dependent. They include injections, copper intrauterine devices (IUDs), intrauterine systems (IUS) and subdermal implants. They are the most effective reversible methods of contraception because they do not depend on user compliance. Their 'typical use' failure rates, at less than 1% per year, are about the same as 'perfect use' failure rates. The typical use failure rate for the oral contraception pill is 9% a year (See Figure 2). A survey of women found that 50% of women missed at least one pill over a 3 month period and another paper suggests that one in four women will miss between 3-6 pills a year. Despite this, short-acting contraceptives are still the most widely used. Unplanned pregnancies and abortions remain high (see Figure 1), suggesting that women are using the least effective methods of contraception and not using them effectively.

In 2016 Public Health England estimated that if 1,000 women switch from oral contraceptive to LARCs, 291 unplanned pregnancies could be avoided over 5 years. This leads to average net saving to the NHS of £29 p.a. per woman moving to LARC (total net savings of £143 over 5 years).

Figure 2: Probability of women as % experiencing pregnancy in first year of use

<table>
<thead>
<tr>
<th>Method</th>
<th>Typical Use use</th>
<th>Perfect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subdermal implant</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>LNG – IUS 52mg</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Female sterilisation</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Cu-IUD</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Injectable*</td>
<td>6</td>
<td>0.2</td>
</tr>
<tr>
<td>Vaginal ring*</td>
<td>9</td>
<td>0.3</td>
</tr>
<tr>
<td>Transdermal patch*</td>
<td>9</td>
<td>0.3</td>
</tr>
<tr>
<td>Oral contraceptives: COC/POP*</td>
<td>9</td>
<td>0.3</td>
</tr>
<tr>
<td>Diaphragm*</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Male condom*</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>No method</td>
<td>85</td>
<td>85</td>
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In 2008, a Quality and Outcomes Framework (QOF) offering financial incentives for GPs giving advice about LARC was introduced. Studies have suggested a 4% increase in LARC prescribing rates during the period the QOF was in place. However, this incentive was scrapped in the 2014/15 pay deal. Between 2014 and 2017 prescriptions for LARC have subsequently fallen by 6%.

3. Barriers to uptake of LARC

Despite LARC being some of the most effective methods of contraception, uptake is still lagging behind other forms of contraception. To improve uptake the healthcare system must overcome three overarching challenges:

The continued prevalence of myths and misperceptions around LARC: There are still a number of misperceptions about LARC that need to be addressed to support improved uptake. For example, 43% of women do not know that the IUS, IUD and implant can be removed at any time by a trained healthcare professional and that their normal fertility will return once removed.

<table>
<thead>
<tr>
<th>Women’s misperceptions about LARC:</th>
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<tbody>
<tr>
<td>- Only 40% of women think the hormonal coil is suitable for women who haven’t given birth</td>
</tr>
<tr>
<td>- Only 25% believe that their fertility will return to what is normal for them</td>
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<tr>
<td>- 35% think coils cause infections</td>
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<tr>
<td>- 37% of women said that they did not know enough about the IUS</td>
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Women getting their contraceptive care via general practice, rather than a community contraceptive clinic, are still far more likely to be prescribed an oral contraceptive than a LARC method, despite the fact that LARC methods are more cost-effective than other user-dependent methods and increasing uptake of LARC methods reduces the number of unplanned pregnancies.

In 2018 a study found that 73% of women said that they would consider a LARC if they had substantial information about it from their healthcare provider. The healthcare professionals questioned estimated that 38% of women would be interest in LARC.

*OC = oral contraceptive, COC = combined oral contraceptive, POP = progestogen only pill

Source: Trussel J. Contraception 83 (2011) 397-404
A survey of GPs by the Family Planning Association in 2016 found that:

- Only 2% of healthcare professionals offered a full range of methods during a consultation
- More than 50% said there is not enough time in a consultation to talk about all contraception options
- 20% do not offer IUD or IUS to women as an option
- 23% do not offer subdermal implant to women as an option

This is likely to reflect:

- GP appointment times being under pressure leaving GPs with little time to effectively counsel women about their contraception options and address misperceptions about LARC methods.
- No QOF incentives for GPs to counsel women on the full range of LARC options available to women.
- Persistent misperceptions held by GPs, including misidentification of major risks (e.g. ectopic pregnancy) associated with IUS and commonly held incorrect views about eligible of candidates, such as the view women with a history of pelvic inflammatory disease are ineligible.
- GPs tend to underestimate the number of women who will fail to take an oral contraceptive pill

**Fragmented commissioning:** The 2012 Health and Social Care Act significantly changed the landscape for sexual and reproductive health services. In April 2013, contraception commissioning for all methods of contraception from contraception and sexual health services and IUS/IUD services provided by GP services was shifted from NHS Primary Care Trusts to local government public health teams. General contraception excluding IUS and IUD remained part of the GP contract. GPs providing IUS services for therapeutic purposes are commissioned by the CCG.

These changes have resulted in greater fragmentation of responsibility for provision of contraceptive methods across health and local government, making it a difficult environment for women to access reproductive health services.

This fragmentation is further exacerbated in cases where contraceptive methods are indicated for non-contraceptive purposes. A notable example of this is heavy menstrual bleeding (HMB), wherein the first-line treatment recommended by NICE is an IUS. However, given the complex commissioning environment and workforce capacity challenges within primary care (see below), women are often referred directly to hospital rather than treated effectively, and cost-effectively, by their GP.

Some CCGs do not commission IUS for HMB at all, presumably believing this to be the responsibility of local authorities who are mandated to commission LARC which
will likely include IUS/IUD services. However, providers will not get reimbursed for fitting an IUS for HMB from their local authority, whose sole focus is LARC for contraceptive purposes.

A Public Health England report in 2017 highlighted concerns that as cuts to Local Authority budgets hit community reproductive and sexual health services there is not sufficient capacity in Primary Care to ensure access to all methods of contraception.  

**Workforce skills shortages:** The split commissioning environment and increasing demand on financially-constrained services have also led to a lack of accountability and capacity for ensuring availability and training for an appropriately-skilled workforce.

In March 2014, the Royal College of General Practitioners (RCGP) raised concerns that moving provision of sexual health services away from trained primary care providers might result in many primary care practitioners being unable to maintain their skills and a reduction in training opportunities for future clinicians. This concern is practically relevant for the provision of IUS and IUD, as fitting and removal are highly skilled procedures.

A 2015 audit by Bayer demonstrated that there is confusion over who should be funding training in contraceptive care moving forward. When local authorities were asked if they have formal arrangements in place to fund the training of healthcare professionals to fit IUS / IUD for 2014/15, 56% said they did not have funding arrangements in place, and 10% of those who did have funding in place planned to cut this for 2015/16.

### 4. Action to improve LARC uptake and sexual health services

To address these aforementioned challenges, we have identified four key recommended actions for national leaders to take forward:

**Challenge: The continued prevalence of myths and misperceptions around LARC**

Evidence suggests that knowledge is an important driver of LARC consideration, with women who are knowledgeable about contraception or informed on side effects, fertility and convenience are more likely to consider LARC.

The closures of community sexual health services coupled with increasing pressure on GP’s time and the removal of the LARC QOF, means that it is almost impossible to overcome or address misperceptions, especially within short appointment slots. Furthermore, unlike other prevention products (for example, smoking quitting aides), manufacturers are extremely limited by regulations regarding the promotion of medicines in what they can do to address these misperceptions. The combined effect of this is that women are not being provided with the information they need to make informed decisions.
**Recommendation:** Public Health England and the Department of Health should launch a national campaign. The campaign should tackle the misperceptions around LARC and ensure women have the information they need to make informed decisions about the most suitable and effective forms of contraception.

GPs should be incentivised to ensure that women are counselled on the full range of contraception options including the most effective forms of LARC.

**Challenge: Fragmented commissioning**

Current provision of LARC is becoming too piecemeal and fragmented. As a consequence:

- It often is too challenging for women to navigate the system to the right care
- Where commissioners do not work together strategically the individual services can become unsustainable
- There is a lack of proper accountability when access to services is reduced

**Recommendation:** Local authorities and CCGs should be put under greater national scrutiny to ensure that they are providing access to IUS/IUD fitting services for contraception and therapeutic indications as appropriate to meet the population’s needs.

The establishment of Sustainability and Transformation Partnerships (STPs) and a greater focus on place-based approaches also introduce an exciting opportunity to innovate in the delivery of health and care services at a local level.

Bayer Women’s Health team has been working with Public Health England to understand how consistent, collaborative care can be provided around the needs of women within a women’s health hub. The hub is an integrated IUS/IUD fitting service funded by pooling budgets to provide services on a larger scale, providing high-quality fitting for women regardless of their indication and the skills within their local GP surgery. Using this model, IUS/IUD fitting services could be commissioned for all indications, making them accessible and efficient whilst driving up women’s outcomes and experiences of care.

**Recommendation:** New models of care should be considered as an opportunity to reconfigure IUS/IUD services, establish new relationships, and improve patient care.

**Challenge: Workforce skills shortages**

While training in LARC is costly and time consuming, competencies must be maintained.
Funding for training to fit LARC methods has been subsidised by pharmaceutical companies for many years. More recently healthcare professionals have become more and more reliant on this goodwill as funding has become more restricted and clarity on accountability for who is responsible for funding training has been lost. This situation is unsustainable and should not be relied upon.

**Recommendation:** Greater emphasis must be placed on workforce planning and clear responsibility and accountability established with regards to the provision of training for the fitting of LARC.

**The Government should address the workforce issues facing the provision of LARC by investing in fully-funded fitter training.** They must ensure that an appropriate number of healthcare professionals are trained to fit, and make sure the funding needed to train these professionals is provided. This is crucial to ensure accountability of services and to ensure that women are given the best possible care now and in the future.

5. **Conclusion**

The RCGP has long warned that mounting pressure on both public health and primary care budgets, combined with fragmented commissioning, is damaging the ability of GPs to provide the full range of contraception and in particular LARC.29

The Advisory Group on Contraception’s 2017 report found that since 2015/16, “45% of local authorities have reduced the number of intrauterine systems (IUS) and devices (IUD) fitted and removed in general practice, and 29% have reduced the number fitted and removed in community services.”30 In 2017/18, 13% of local authorities reduced the number of contracts with general practice to fit IUS/IUD.31

While local authorities are required to commission “open access services for contraception” under the Department of Health’s guidance and national legislation,32 there is very little detail on what this means, leading to different areas interpreting ‘open access’ in different ways.

Investing in contraception is an important component of the prevention agenda. Provision is highly cost-effective and critically important to the public. Yet falling budgets have meant cuts to education about, access to and training for contraception. This situation is exacerbated by the fragmented commissioning environment, which obscures accountability for access to high quality services and creates a system that is hard for women to navigate their way around to access the most appropriate service for their needs.

It is essential that action is taken now to ensure women are counselled on and have access to the most effective forms of contraception and high quality services.

*September 2018*