



House of Commons
Health Committee

New Developments in Sexual Health and HIV/AIDS Policy

Third Report of Session 2004–05

Volume I



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*Report, together with formal minutes, oral and
written evidence*

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. Written evidence is cited by reference to Volume II of this Report, in the form of Memorandum numbers (e.g HA01) or Appendix numbers (e.g Appendix 1).

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Summary

Sexual health

In 2003, we published a report which described a crisis in sexual health. We recommended the introduction of a maximum waiting time of 48 hours for access to sexual health services, a target the Government has just adopted in its recent White Paper on Public Health. However, rates of sexually transmitted infections have continued to rise, and waiting times for sexual health clinics have, if anything, deteriorated further since our 2003 report into Sexual Health. One consultant described the current situation as “a continuing crisis”. We also heard that since our report, funding earmarked for sexual health services has not always reached its targets. Because of this, we have recommended that the Government should closely monitor progress in delivering the 48-hour target, and conduct an audit to ensure that the extra investment promised for sexual health actually reaches the clinics which urgently need to increase their capacity to meet rising demand.

While the introduction of a nationwide screening programme for chlamydia, the most common sexually transmitted infection in young people, is welcome, we are concerned that for such a screening programme to be effective the Government must ensure that men, as well as women are screened for it, and must also ensure that only the most up-to-date screening tests are used. It is unacceptable that nearly half of all NHS laboratories are still using a test which may miss as many as 30% of infections.

As we argued in our previous report, it is essential that GPs are encouraged to address their patients’ sexual health needs. However, our evidence indicates that the new GP contract has failed to provide adequate incentives to GPs to promote sexual health services. We have recommended that the Government review the GP contract with a view to giving higher priority to sexual health, and also that a dedicated sexual health training programme is established for GPs and practice nurses.

Much of our evidence has emphasised the importance of improving sexual health services, but once a young person needs to visit a clinic for a sexual health problem, we have, according to one witness, “missed the boat”. Educating young people about relationships and sexual health is perhaps one of the most powerful tools we have to promote better sexual health. However, a recent OFSTED report reveals that far too often, young people are being taught about sex and relationships by teachers who lack both competence and confidence in this area, and that Personal Social and Health Education is being afforded insufficient priority by schools. We have therefore recommended that by 2007 all PSHE and Sex and Relationships Education (SRE) lessons must be taught by specialist accredited PSHE teachers rather than by unqualified form tutors. We have also reiterated an important recommendation we made in our 2003 report, that PSHE should be established as a statutory and assessed part of the National Curriculum.

Charges for overseas visitors for HIV treatment

Since our report, the Government has introduced changes to the regulations relating to charges for NHS treatment for overseas visitors in an attempt to combat ‘health tourism’. This now means that people who are in the country without proper authority, including illegal immigrants, failed asylum seekers and visa overstayers, will be charged for all NHS treatment. Treatment for certain communicable diseases, including TB and sexually transmitted diseases is exempt on public health grounds. However, treatment for HIV is not exempt. Given the high prevalence of HIV in people born in Africa who are now living in this country, there is concern that this new legislation will have a disproportionate impact on African communities in the UK.

The concept of ‘health tourism’, whereby people from other countries come to the UK solely to access NHS services for free, whether for a single procedure or course of treatment or for management of a longer term chronic problem, is extremely worrying. Large scale health tourism would clearly have the potential to place an unsustainable burden on the NHS, and to divert NHS resources away from those for whom they are intended. In principle, we support the Government’s attempts to tackle this problem wherever it is identified.

We do not in any way underestimate the difficulties of making decisions around the highly sensitive issue of health tourism, and we would not want to suggest that it is an easy area to address. However, we are not convinced that the Government has fully understood the complexity and breadth of the issues involved in charging for HIV treatment, and the potential consequences of getting it wrong.

Although we have received assurances from the Government that abuse of the NHS by ‘health tourists’ does take place, it is difficult to place much weight on these assurances since the Government was unable to supply us with any data, not even a rough estimate, of the numbers of people allegedly ‘abusing’ the NHS, nor of the costs that are associated with this.

By the same token, we were surprised to learn that the Government has introduced significant changes to the rules on eligibility for free NHS treatment without, by its own admission, any idea of the relevant costs or cost-savings that might be associated with these changes. Remarkably, the minister agreed with the evidence we have received suggesting that in many cases it might be more cost-effective for HIV+ patients to receive drug treatment as soon as they were diagnosed, rather than for the NHS to have to bear the costs of treating them once they had become seriously ill.

In our view, however, the most serious adverse consequence of these changes is their potentially disastrous impact on public health. Firstly, if free treatment is not available, people may be deterred from taking an HIV test, and will remain in the community undiagnosed and infectious. Secondly, research evidence suggests that HIV treatment can in fact lower an individual’s infectivity significantly, reducing the potential for onward transmission.

It is a nonsense that the Government is prepared to fund a person’s TB treatment on public

health grounds but not treatment of his HIV infection. Untreated HIV+ people living in this country present a serious public health threat, and we have therefore recommended that all HIV+ people, regardless of their immigration status, receive free treatment to reduce the likelihood of the onward transmission of HIV, of mother-to-child transmission of HIV, and of the onward transmission of TB. In order to achieve this, HIV should simply be reclassified as a Sexually Transmitted Infection, which would make treatment automatically free on public health grounds.

We fully accept that the UK must not become a magnet for HIV+ individuals seeking to emigrate to this country simply to access free healthcare. However, we have seen no evidence that this was the case before these rules were introduced, and in fact some European countries have far less stringent requirements for access to HIV treatment than the UK. Nor have we seen any evidence to indicate that the introduction of these restrictions on free treatment will actively discourage people from entering or remaining in this country illegally, most of whom migrate for economic reasons, or to flee oppressive regimes. Furthermore, people either entering and/or remaining in this country without proper authority are a matter for the Home Office and the Immigration Services, and it is up to these services to enforce immigration regulations robustly and swiftly. While they remain in this country, whether illegally or legally, people with untreated HIV pose a threat to the nation's public health, which is why the Department of Health's primary concern must be providing treatment for them to protect public health.

1 Introduction

“There is a continuing crisis in sexual health and in some respects the situation is worse than it was in 2001.”

Professor George Kinghorn, Consultant in Sexual Health

“There are very good grounds to believe that the charges for overseas visitors are causing, and will continue to cause, harm to public health in the UK. In other words, not only is there no positive gain from introducing charges for HIV treatment and care. Serious harm is going to result.”

National AIDS Trust

1. In June 2003 we published a report into *Sexual Health*, concluding that as rates of sexually transmitted infection and teenage pregnancy soared, services in this unglamorous and underfunded area of the NHS were reaching crisis point.¹ Our initial inquiry into sexual health left a deep impression on the Committee, particularly given the high incidence of sexually transmitted infections (STIs) amongst young people. We were therefore pleased to see a great many of our recommendations adopted by the Government. It also seems that since our inquiry, sexual health has become less of a taboo subject.

2. The Government’s White Paper on Public Health gives prominence to tackling sexual health problems.² However, according to clinicians working in the area of sexual health, the crisis we identified in 2003 is in fact showing no signs of abatement—rates of sexually transmitted infection have continued to climb. Because of this, and perhaps fuelled by increasing public awareness of the risks of STIs, waiting times for GUM services have increased in every part of country; this, in turn, may contribute to further rises in infection levels as people cannot get treated promptly and so continue to infect more partners. In the light of this, we decided to revisit our report’s recommendations and investigate progress to date on implementing them.

3. Since our first report on sexual health was published in 2003, the Government has also consulted on and introduced changes to regulations governing access to free NHS treatment for overseas visitors.³ One of the impacts of these changes has been to deny, for the first time, access to free treatment for people living in this country without proper authority. It was brought to our attention that these changes were likely to have a significant impact on people with HIV, and thus on the nation’s health. We therefore decided to devote a significant proportion of this short inquiry to addressing the specific issue of charges for overseas visitors for HIV/AIDS treatment.

1 Health Committee, Third Report of Session 2002-03, *Sexual Health*, HC69

2 Department of Health, *Choosing Health*, November 2004, Cm 6374

3 Department of Health, *Proposed Amendments to the NHS (Charges to Overseas Visitors) Regulations 1989 – A Consultation*, July 2003; NHS (Charges to Overseas Visitors) Charging (Amendment) Regulations 2004

4. Our advisers on this inquiry were Professor Michael Adler, Royal Free and University College Medical School and Dr Anton Pozniak, Chelsea and Westminster Hospital. We are extremely grateful to Professor Adler and Dr Pozniak for their excellent support during this inquiry which has enabled us to address a great many complex issues in a condensed timeframe.

5. We held two evidence sessions, taking oral evidence from Melanie Johnson MP, Parliamentary Under-Secretary of State for Public Health and officials from the Departments of Health and for Education and Skills; Professor George Kinghorn, Dr William Ford-Young and Dr David Asboe, clinicians with specialist knowledge in this area within primary and secondary care; Anne Weyman of the Family Planning Association; the Health Protection Agency; the National AIDS Trust, the Terrence Higgins Trust, and the African HIV Policy Network; Pam Ward, Co-Chair of the Overseas Visitors Action Support Group, and Peter Nieuwets, HIV Commissioning Manager for West Sussex. We are very grateful to all our witnesses for their evidence.

6. We received over 30 written submissions and these were invaluable to us in our work. Those submitting included GUM consultants, academic institutions, charities, lobbying groups, and Royal Colleges. These memoranda were a very valuable resource for us and we would like to thank those who submitted them.

7. This report begins by examining Government progress to date in implementing the recommendations of our 2003 report into *Sexual Health*, and then considers in detail the separate but linked area of charges for overseas visitors for NHS services with particular regard to HIV/AIDS.

2 Follow up to Sexual Health Report

8. The Government published its *National Strategy for Sexual Health and HIV* in 2001.⁴ The strategy, although it lacked the priority status of a National Service Framework, set out an ambitious framework for sexual health services. Our report into *Sexual Health*, published in June 2003, found that dramatic improvements in sexual health services were needed if the Strategy's aims were to be delivered. We were pleased to note from the evidence we received that many sexual health organisations and clinicians believe that our 2003 report into *Sexual Health* has raised the profile of sexual health and gone some way towards making it a higher priority.⁵ However, in the 18 months since its publication, rates of STIs have continued to rise. According to data provided by the British Association for Sexual Health and HIV (BASHH), since the publication of the *National Strategy for Sexual Health and HIV* in 2001, overall STI diagnoses have risen by 11%.⁶ The numbers of newly diagnosed HIV cases accelerate year on year. It is now estimated that a total of 53,000 people in the UK have HIV. Between 2001–2 and 2002–3 there was a 20% and 19% increase respectively of reported new diagnoses, although part of this upsurge may reflect increased efforts to encourage HIV testing.⁷

4 Department of Health, *National Strategy for Sexual Health and HIV*, 2001

5 For example, HA27, para 2.3, HA04.

6 HA04

7 HA04

STI diagnoses in England 1995–2003

	Number of annual cases			% increase	
	1995	2001	2003	1995–2003	2001–2003
All STI diagnoses	428,575	608,636	674,827	57%	11%
Syphilis	102	717	1,519	1,389%	112%
Chlamydia	29,241	68,256	85,550	193%	25%
Gonorrhoea	9,950	22,418	23,584	137%	5%
Genital warts	51,236	62,551	65,414	28%	5%
Genital herpes	15,021	17,076	17,173	14%	1%

Source: BASHH

9. Demand for sexual health services has also increased. There were over 2 million attendances during 2003 compared to just under 1 million in 1997,⁸ and according to much of our evidence, service access and waiting times have continued to deteriorate. Professor George Kinghorn, a consultant physician in Sheffield, reported that in his clinic, over the period 2001–2003 there was a 73% increase in their annual total caseload and a 30% increase in new patient episodes.⁹ We did not use the word “crisis” lightly when we described the state of sexual health services in 2003. We were therefore deeply concerned to hear Professor Kinghorn describe the current situation to us as “a continuing crisis”.¹⁰

10. The evidence submitted to us in this inquiry raised several points concerning sexual health which need to be addressed. These are:

- The current state of Genito-Urinary Medicine (GUM) services, including access and waiting times, facilities, and the potential impact of the proposed sexual health education campaign;
- Funding for sexual health services;
- Screening for chlamydia;
- Sexual health in primary care, in particular the impact of the new GP contract;
- Sexual health workforce and training requirements;
- Contraception and abortion services;
- Sex and relationships education in schools.

8 HC Deb 13 December 2004, col. 969W, Commons Written Answer

9 HA13, para 3

10 Q40

MedFASH study of sexual health services

11. Prompted by concerns about the challenges facing GUM services and their capacity to respond effectively, the Medical Foundation for AIDS and Sexual Health (MedFASH), which is an independent charity supported by the British Medical Association, was commissioned by the Department of Health to undertake a two-year national review of GUM services. According to MedFASH the review aims to:

- undertake a multidisciplinary assessment of each GUM service in England, highlighting factors both facilitating and obstructing their ability to offer a prompt and high quality service,
- offer recommendations for service improvement and modernisation arising from the assessment, to GUM clinics, Primary Care Trusts and Strategic Health Authorities,
- provide findings and recommendations from the review to the Department of Health.¹¹

12. The first phase of the review was a written questionnaire, sent to all GUM clinics in England in September 2004, about issues to be covered in more depth during review visits. A quantitative analysis of responses from the first 72% of clinics gives the most up-to-date snapshot available of the state of GUM services around the country. The questionnaire provides basic information on issues relating to current GUM service provision including facilities, length appointment per patient, capacity increases and PCT funding. As far as we are aware it is the only available source of such information, and the most accurate and up-to-date information about the state of sexual health services currently available.

13. MedFASH has now submitted its analysis to the Department of Health, which owns the data. MedFASH gave us details of the questionnaire, and told us that it would be happy for the data to be shared with us if the Department agreed. However, the Department has declined to supply it, arguing that it was still “work in progress”.¹² When we pressed the Minister and Department of Health official on this point, we were told they had only recently received the data, and ministers and officials had not yet had time to consider it. The Minister told us that at the time of our evidence session, which was held on Thursday 10 February 2005, she had not yet received the information with advice from officials. Geoff Dessent, Deputy Division Head for Sexual Health at the Department, told us that he had only received the information “a few days” before our evidence session.¹³ However, in the memorandum they sent in December 2004, MedFASH indicated that the data had already been submitted to the Department.¹⁴

14. We are concerned that it took at least seven weeks for the Deputy Head of the Sexual Health Policy Branch at the Department of Health to realise that the Department had been sent key data on sexual health which it had commissioned, and that the responsible Minister had not seen this data in advance of her appearance before the Committee. We are also surprised by the air of secrecy which surrounds this research,

11 HA27, para 16.1

12 Appendix 31

13 Q169; see also the Minister’s letter of 28 February.

14 HA27, para 16.2

and can only surmise from this that it contains findings that would be unwelcome for the Government. If the Government places any value on the scrutiny work of Parliament, and takes seriously its commitment to co-operate with the work of Select Committees, it would seem counterproductive to withhold the most up-to-date information on sexual health services from the Health Committee when it is conducting an inquiry into precisely this subject.

Sexual health services

Access and waiting times

15. One of the key recommendations of our report was the introduction of a 48-hour maximum waiting time target for Genito-Urinary Medicine (GUM) clinics.¹⁵ In its recent White Paper, *Choosing Health*, the Government accepted this as a target for 2008.¹⁶ It will be included in PCTs' Local Delivery Plans from April this year, and will be monitored on a six-monthly basis.¹⁷ However, although the 48 hour target has been broadly welcomed, our evidence suggests that over the next three years sexual health services will face a huge challenge in achieving it from the current position, as problems with waiting times seem to have become even further entrenched since the publication of our report.

16. In its evidence, the BMA cited waits of up to 12 days for urgent cases and eight weeks for general check ups¹⁸, and in its first national audit of GUM waiting times, the Health Protection Agency (HPA) found that, nationally, only 38% people were seen at a GUM clinic within 48 hours of requesting an appointment, and 26% wait more than two weeks to get an appointment.¹⁹

17. The data also revealed significant regional variation in access to services, with the worst access outside London. In the North East region 44% of patients waited more than two weeks to be seen with only 27% seen within 48 hours; in the West Midlands 42% of patients waited more than two weeks to be seen with only 28% seen within 48 hours; in the Yorkshire and Humberside region and the Eastern region 31% and 33% of patients respectively had to wait over two weeks, with only 33% of patients able to access a service within 48 hrs.²⁰

18. The national and regional picture was confirmed at a local level by evidence we received from a GUM consultant about his own service. Despite numerous innovations in service delivery at his Sheffield clinic, Professor George Kinghorn reported "a serious deterioration in GUM access times". Data from May 2004 showed that the numbers of patients who were able to access his clinic within 48 hours of first contact was only 20%. The average time to a routine appointment has now increased to around 3 weeks.²¹

15 *Sexual Health*, para 110

16 *Choosing Health*, para 84, p147

17 Q153, Q172

18 HA33

19 Health Protection Agency, *GUM Waiting Times Audit*, November 2004

20 Health Protection Agency, *GUM Waiting Times Audit*, November 2004

21 HA13, para 6

Professor Kinghorn confirmed in oral evidence that the situation was getting worse, both in terms of the prevalence of STIs, and in terms of access to clinics:

I think there is very definitely a worsening, an increase, in the incidence of sexually transmitted diseases, as evidenced by the cases of gonorrhoea and syphilis that we are seeing. These are new problems. Although some additional resources have gone into clinics, the amount of resource that went in was less than that recommended when we met with you previously. There is a widening gap between the patient demand and our clinic capacity and, sadly, I think that is going to get worse.²²

19. Professor Kinghorn also explained the very real risk that, if patients are not seen promptly by GUM clinics, they will fail to come back, returning to the community with an untreated infection and possibly going on to infect others:

Mr Burns: Do you collect statistics or do you have any evidence that when someone goes to a clinic and they find that they have to wait possibly four, five, six, 10 or 12 days before actually seeing someone then they fail ever to turn up again?

Professor Kinghorn: Yes, there is a proportion of patients who will not come. This is particularly the case with the young. There is a window of opportunity and it is important that when individuals present they should be seen at that time, otherwise there is a risk that they will not turn up and they will continue to ignore symptoms.

Mr Burns: Do you think it is more likely that they will continue to ignore symptoms rather than that they will try and get help elsewhere, like going to their GP or whatever, or to another clinic, depending on where they live?

Professor Kinghorn: Some will try to go to other settings, but I think many will fail to turn up.²³

20. BASHH provided us with a comparison of regional data for GUM waiting times for clinics set against the number of cases of STIs diagnosed in each region. This appeared to suggest that increasing diagnoses of chlamydia, gonorrhoea and syphilis were associated with increased waiting times. BASHH pointed out that “the argument that increased delay to diagnosis and treatment provides greater opportunity for onward transmission of infection is compelling.”²⁴

Facilities

21. Another major problem highlighted by our previous report was the dire state of GUM facilities, which were frequently located in portacabins.²⁵ Evidence from Professor Kinghorn suggested that this has continued to be a problem, and that it is likely to have an impact on plans to increase the capacity of services:

22 Q2

23 Qq 8-9

24 HA04

25 *Sexual Health*, paras 111-112

Any further expansion of workload is severely impaired by serious space constraints. Our dedicated clinic premises were designed 25 years ago for less than half the current workload. In order to increase patient throughput, we have a very urgent need for additional consulting rooms and appropriate accommodation for personnel. The department was selected as the Strategic Health Authority choice for a share of the designated £15 million capital funding for GUM infrastructure. This funding was inadequate and was eventually allocated only to those services currently in temporary accommodation e.g. portacabins. Whilst this is understandable, this leaves significant accommodation/capacity issues that are pressing in Sheffield and elsewhere, which require a substantial increase in targeted capital allocations.²⁶

Sexual health education campaign

22. In its White Paper, the Government announced a new £50 million sexual health education campaign.²⁷ However, the Medical Foundation for AIDS and Sexual Health (MedFASH) argued that “this is bound to increase the demand for services” and that “this increased demand will put a further strain on capacity”.²⁸ Several memoranda recommended that this should be delayed until more capacity exists within GUM services, so that public expectations can be met.²⁹ Professor Kinghorn reinforced this point in oral evidence:

We are in a bit of a dilemma. I wish to encourage people to take responsibility. I wish to encourage people to take that personal responsibility for their health and for the health of their partners, but, unless capacity increases go hand-in-hand with the education campaign, then there is a risk that services which are under severe pressure would be in a state of collapse. The concern we have at this present time is that new resources for capacity may not become available until 2006–07, which will be after the education campaign has been proposed. That, in our view, would lead to a great dissatisfaction amongst the public because we could not cater for the obvious increase in demand.³⁰

23. We welcome the Government’s adoption of our recommendation of a 48-hour access target for sexual health services. However, the Government should take note of the warnings we have been given by clinicians that this target may not be achieved within the timeframe specified by Government without additional spending, and that inadequate facilities may present a barrier to service expansion.

24. We also welcome the Government’s adoption of our recommendation for a dedicated health education campaign aimed at improving sexual health. However, the Government should not begin the campaign until it is certain that services have the extra capacity they need to meet the extra demand the campaign will generate.

26 HA13, para 9

27 HA01, para 24

28 HA27, para 18.2

29 For example, HA27, HA04 paras 25-26

30 Q7

Funding

25. Clearly, if access times are to be improved in line with the Government's goals, capacity in GUM services must be built up to cope with present and future demand, which requires funding. According to the Department, a total of £300 million has been earmarked for sexual health services over the next three years, which breaks down as follows:

- £130 million capital and revenue funding over three years for GUM services
- £50 million to fund a health education campaign
- £40 million to fund an audit of contraceptive services and to rectify problems
- £80 million to fund the chlamydia screening programme.³¹

26. This extra investment was universally welcomed by our witnesses, but several key questions remain. Firstly, will the extra investment be enough? Secondly, will the funding be delivered quickly enough to enable clinics to cope with the expected increase in demand for services? Thirdly, will the funding be guaranteed to reach clinics, or is the possibility that it may be used by PCTs for other priorities? And, finally, does the funding announced represent new money, in addition to what GUM clinics have already been provided with?

27. £130 million of capital and revenue funding has been promised to GUM clinics by Government over the next three years. However, it is not clear exactly how the £130m funding will be divided between capital and revenue expenditure, and nor is it likely to be enough. Estimates submitted to our previous inquiry into sexual health by Professor Kinghorn in 2002 suggested that an additional revenue commitment of £22m–£30m per annum would be required to fully meet demand for sexual health services, and evidence provided by the Association of Genito-urinary Medicine suggested that around £150m of capital funding would be needed to modernize GUM facilities.³² The funding will also need to reach clinics rapidly if its impact is to be felt in time to meet the Government's access targets for 2007, and it is not clear whether or not this will happen.³³

28. We welcome the extra investment for GUM services of £130 million over three years, but evidence submitted to our previous inquiry into sexual health suggested that the true funding needs of GUM services may be far greater than this. Estimates provided by the Association of Genito-urinary Medicine suggested that around £150m of capital funding alone would be needed to modernize GUM facilities, and on top of this we were given evidence of the need for up to £30 million per year additional revenue funding for GUM services, giving a total of some £240 million. The Government should keep the funding of GUM services under close review and be prepared to increase allocations if this should prove necessary.

29. The welcome for the extra funding has also been tempered by reports that the previous money earmarked for sexual health services has not reached its intended destinations. According to BASHH:

31 HA01, para 24

32 *Sexual Health*, para 91; para 112

33 HA04, para 37

The 2004 DH figure for investment and modernising in GUM services is £26 million; In January 2003, 90% of £5 million allocated direct to GUM clinics was received. £10 million was allocated as recurrent funding in 2003/04 of which £8 million was distributed to PCTs by July 2003. Only 64% of clinics received their full allocation. Of a further £5 million of non-recurrent money given for GUM services in January 2004, approximately 50% of the money reached its intended destination.³⁴

30. BASHH went on to report other examples of Trusts agreeing to carry over the money to 2004/5, but the money then being used for more “pressing priorities”:

A GUM consultant negotiated that £58K was carried over from 2003/4 to 2004/5. Job descriptions were ready, an advertisement placed when she was informed by her immediate manager that this money was no longer available. It was required for an overspend elsewhere. She raised this with the PCT Sexual Health Commissioner, Strategic Health Authority Public Health Lead having failed to influence the Chief Executive. She has been told to keep quiet and stop making a fuss.³⁵

31. Professor Kinghorn described a similar situation:

GUM clinics were notified by the Department of Health of non-recurrent allocations of additional funding beginning in 2003 to promote additional capacity. Only half of the initial £140,000 allocation designated for GUM was received. The remainder was retained by the PCT for other purposes not related to sexual health. This failure to receive the total funding, which was justified by the PCT on the basis that GUM services were not a national or local priority, significantly impaired confidence and our ability to expand service capacity in a timely fashion.³⁶

32. Although this dispute was eventually resolved, it illustrates the problems sexual health faces in not being a national priority. Professor Kinghorn also pointed out that as his clinic is now part of a Foundation Trust, it attracts full tariff funding for overperformance against the baselines agreed in the service level agreement. However, non-Foundation Trust GUM clinics only receive marginal costs for additional workload that do not cover the step costs of delivering more patient service.³⁷

33. According to the Minister, changes to monitoring arrangements will mean that NHS performance in the area of sexual health will in future be subject to far closer scrutiny than has previously been the case. The funding and provision of sexual health services is to be monitored by Strategic Health Authorities through PCTs’ local delivery plans, and clinics’ progress against the 48 hour access target will be monitored on a six-monthly basis. However, if the extra funding for GUM services is still provided to PCTs rather than directly to GUM clinics this may not guarantee that funding reaches its destination.

34. We welcome proposals to improve performance monitoring around sexual health. However, we remain very concerned by reports that previous allocations for GUM

34 HA04, para 17

35 HA04, para 18

36 HA13, para 7

37 HA13, para 8

services, when filtered through PCTs, often did not reach the services for which they were intended, but were siphoned off to fund services identified by PCTs as being of a higher priority. To ensure that this does not happen again, we recommend that, at least for the next three years, the Department supplement its existing performance management of sexual health services by commissioning a specific financial audit to check that funding has reached its intended destination. The audit could be carried out by the Audit Commission or the Healthcare Commission. The results of the audit should be published to identify any funding gaps that may occur.

35. The Department, in its response to this Report, should also supply us with a detailed breakdown of the £300 million funding for sexual health services, specifying whether the funding is entirely new, or is part of the total funding for PCTs already announced, as implied by the Minister.

Screening for chlamydia

36. Chlamydia is now the most common sexually transmitted infection in the UK, with 89,431 new diagnoses last year.³⁸ It is a disease which predominantly affects young people. 68% of diagnoses last year were in people aged under 25.³⁹ Data indicates that approximately 10% of young men and women between 16 and 25 in this country are infected.⁴⁰ Chlamydia can be easily treated once diagnosed, but because it is asymptomatic in 70% of women and 50% of men, it often goes undiagnosed. This is deeply concerning, as, left untreated, it can have serious long term consequences including pelvic inflammatory disease and infertility.

37. During our previous inquiry into *Sexual Health*, we heard that a Government-funded pilot screening project involving 17,000 young women had proved effective, but was facing hold ups in being extended throughout the country. We recommended that the Government extended this screening programme nationwide without delay, and also that the Government explored ways of screening young men.⁴¹ In addition to this, during our previous inquiry we learnt that a sub-optimal test (the enzyme immunoassay or EIA test) which missed 30% of chlamydia infections was still being used by the majority of service providers, despite the availability of a far superior test, the Nucleic Acid Amplification (NAA) test. We therefore recommended that the most effective test be introduced immediately.⁴²

National chlamydia screening programme

38. Rather than a proactive call-and-recall system, where people receive invitations to attend local health services specifically for screening tests at regular intervals, as happens in the national cervical and breast cancer screening programmes, the national chlamydia screening programme is an opportunistic screening programme, where patients are offered

38 Health Protection Agency, *HIV and other STIs in the UK in 2003*, November 2004, para 4.1.2

39 Health Protection Agency, *HIV and other STIs in the UK in 2003*, November 2004, para 4.1.2

40 HA01, para 42

41 *Sexual Health*, paras 123, 125

42 *Sexual Health*, para 129

screening tests for chlamydia, but only if they happen to need to attend health services for another reason. Each individual area determines the different settings where opportunistic chlamydia screening will be made available. Guidance specifies that chlamydia screening should be available within contraception clinics, young peoples' services, gynaecology departments (including early pregnancy assessment units), antenatal services, colposcopy services, termination of pregnancy services and General Practice. Screening may also be offered in a variety of other settings, including GUM clinics, universities, colleges and schools, and military health services.⁴³ Ten opportunistic screening programmes were implemented in 2002, with a further 16 programmes announced in January 2004. The scheme currently covers over 25% of PCTs in England.⁴⁴ The White Paper announced the goal of nationwide coverage for chlamydia screening by 2007.⁴⁵

39. Despite the welcome extension of the screening programme, we have received evidence to suggest that problems still persist within this important area of sexual health. According to several witnesses a key problem with the Government's national screening programme is the limited nature of the population it covers. Firstly, despite the latest research evidence suggesting that it remains beneficial to screen people for chlamydia up to the age of 30, the Government's screening programme does not cover anyone over the age of 25.⁴⁶ Thus it excludes a large group of people in their late twenties still at significant risk from chlamydia infection and its consequences.

40. Secondly, and perhaps even more importantly, it is obvious that even if all women infected with chlamydia are identified through screening, reinfection will continue at the same rates if men who have chlamydia are not also identified and treated. Professor Kinghorn therefore argued that men must be screened as well:

The prevalence in young men under the age of 25 is also about one in ten, or more. It is important that we should be encouraging young men, as well as young women, to be screened.⁴⁷

41. When we put this to the Minister, she agreed on the importance of testing men as well as women, but implied that current efforts to target young men were sufficient:

In the interviews I have done myself in the last few days I have been emphasizing young men as much as young women. Obviously both sexes are infected, otherwise the problem would not be there at all. We need to make sure that both sexes come forward. In fact, we have specific screening programmes running around prisons and also MoD facilities, so there is some specifically targeted largely at the male population, but we want to see both sexes come forward for screening.⁴⁸

43 Department of Health, *National Chlamydia Screening Programme – Programme Overview, Core Requirements, Data Collection*, July 2004, para 5.2.2

44 Department of Health, *National Chlamydia Screening Programme – Programme Overview, Core Requirements, Data Collection*, July 2004

45 *Choosing Health*, para 80, p147

46 Hu D, and Hook, E W, "Screening for Chlamydia in women 15-29 years of age: a cost-effectiveness analysis", *Annals of Internal Medicine* 2004; 141:501-513

47 Q18

48 Q204

42. However, as the White Paper makes clear, women are the major focus of the screening programme:

The 1.2 million women who attend contraception services each year – the vast majority under 25 years old – will be the main focus for offering screening as well as wider health advice.⁴⁹

43. **Both men and women should be screened for chlamydia. We are concerned that current efforts to screen men are insufficient. Furthermore, by introducing the cut-off for the screening programme at 25 year-olds the Government also risks missing a significant proportion of young people who remain vulnerable to chlamydia infection and its consequences. We therefore recommend that the national chlamydia screening programme be extended to men as well as women, and that the target age range be extended from 16–25 year olds to 16–29 year olds, at least initially. If it is subsequently shown that chlamydia screening is beneficial across a wider age range than this, the Government should extend the programme accordingly.**

44. In addition, we note that there are limits to what can be achieved by an opportunistic screening programme, which relies on people seeking out healthcare services for another reason, such as contraception, rather than proactively inviting them to attend for a test. This may pose particular problems in screening young men, as research suggests that young men generally attend health services less frequently than women. We therefore recommend that the Government monitors the rates of chlamydia infection closely to assess the effect of the national screening programme, and that, if rates of chlamydia continue to increase, it considers supplementing the opportunistic screening programme with a proactive call-and-recall system targeting specific high-risk groups.

Availability of appropriate testing technology

45. In its response to our 2003 report into *Sexual Health*, the Government stated that it was “taking action to ensure that nucleic acid amplification (NAA) testing is available in every region” and that it would provide an £8 million “pump priming fund” to enable NHS laboratories to make the changeover.⁵⁰ However, despite the Government’s commitment to using the most effective testing systems to detect chlamydia, and the £8 million they have earmarked for this, BASHH stated in evidence to us that almost half of all GUM clinics still do not have NAA chlamydia testing available for all men and women attending as patients. It estimated that in 2004 45% of laboratories were still using EIA test methodology and 45% of all chlamydia tests were undertaken using EIA, which misses 30% of infections.⁵¹ While the extra funding for the new test announced by the Government in response to our report was welcomed by BASHH, it also pointed out that it will not come into effect until the financial year 2005–06.⁵²

49 *Choosing Health*, para 80, p147

50 Department of Health, *Government Response to Health Select Committee’s Third Report of Session 2002-03 on Sexual Health*, September 2003, pp22-23

51 HA04, para 30

52 HA04, para 30

46. BASHH described the current situation with regard to different types of chlamydia screening as a ‘postcode lottery’.⁵³ NAA testing is being introduced as a priority in those areas which are taking part in the chlamydia screening programme, but this means only 25% of PCT areas so far. There is also inequity within areas that have the NAA testing available. BASHH told us that currently, in areas which have financial support for the chlamydia screening programme, NAA testing would be available for under-25s presenting in community and other screening settings, but that the GUM Department would often still have to use EIAs.⁵⁴ This means that, if a young person is concerned that they might have chlamydia and decides to seek a test, whether or not they are given an effective test will depend not only on the area in which they live, but also on what type of health service they decide to visit.

47. The Government has given a commitment that NAA testing will be available in all areas by 2007, but according to BASHH, the funding allocated to change test methodology will not impact until the financial year 2005/6. This could potentially lead to difficulties in meeting the 2007 target. Professor Kinghorn pointed out that ensuring that NAA testing was technically “available” in all areas may not necessarily mean that all patients have access to NAA testing. He also expressed doubts about the 2007 target:

I hope that it is going to be available by 2007, but I think there may well be difficulties in achieving that date.⁵⁵

48. It is unacceptable that a test is still being used for chlamydia which may miss as many as 30% of infections, when a far more accurate test is available. We are pleased that the Government is to make NAA testing available in all areas, but disappointed that this will not happen until 2007. Some clinicians even doubt that this target can be achieved. The Government will need to monitor this target carefully over the next two years to ensure that NAA testing is, indeed, universally available in all clinical settings by 2007.

Sexual health in primary care and the new GP contract

49. While specialist sexual health services are usually provided in open-access genito-urinary medicine (GUM) clinics attached to hospitals and specialist contraceptive services are often provided in specialist community family planning clinics, the *National Strategy for Sexual Health and HIV* acknowledged the potential for primary care to play a crucial role in the provision of all types of sexual health services, including screening and contraception services.⁵⁶ In our 2003 report, we recommended that the new GP contract recognize this vital role for GPs.⁵⁷ However both the Royal College of General Practitioners and Dr William Ford-Young, a GP with a special interest in sexual health, told us that the new GP contract had provided no incentives at all for GPs to address sexual health or improve the quality of services they provided in this area.

53 HA04, para 29

54 HA04, para 29

55 Q21

56 *National Strategy*, para 4.7

57 *Sexual Health*, para 195

50. Services provided by GPs under the GP contract are currently divided into three categories:

- Essential services, which all GPs must provide – this general category covers the treatment of individuals who are unwell, or have a chronic or terminal condition;
- Additional services, which GPs can opt out of, but which PCTs must allow GPs the opportunity to provide – contraceptive services and cervical screening fall within this category
- Enhanced services, which GPs can provide in agreement with PCTs – fitting of intra-uterine contraceptive devices, and specialized sexual health services fall within this category.

51. There appears to be some confusion over what types of sexual health services should be provided under “Essential Services”. The Family Planning Association (FPA) provided anecdotal evidence that some general practices are declining to offer any sexual health services at all in the belief that they are not covered in essential services.⁵⁸

52. According to Dr Ford-Young, the “holistic nature of sexual health and levels of service provision in National Strategy for Sexual Health” are entirely ignored by the GP contract – instead, different elements of service in the Strategy are segregated and placed in various separate “add-on” elements of the contract or are not included at all.⁵⁹ For example, condom provision is not included within the definition of contraceptive services, which is an additional service, but only within more specialized enhanced sexual health services. Therefore if a GP provides a woman with contraceptive services under the “additional services” heading, they may prescribe her with any form of contraception, but not supply her with free condoms to prevent STIs.

53. A comprehensive framework has been published describing the sexual health services expected under “National Enhanced Service for More Specialised Sexual Health”, but Dr Ford-Young argued that this was “beyond most practices’ skills and capabilities at present” and stated that very few PCTs were currently commissioning such services.⁶⁰

54. Dr Ford-Young also pointed out that the National Chlamydia Screening Programme was not at present supported by the GP contract, despite this being, in his view, the most important element of the *National Strategy for Sexual Health and HIV*, with the potential to be a main driver to improve the sexual health of the nation.⁶¹

55. Under the new GP contract, payments to GPs are also affected by a system of quality points, where quality markers have been put in place to reward the achievement of high standards in certain priority clinical conditions. There are no quality points at all available for sexual health within “Essential Services”. Within “Additional Services” there is currently one quality point available for having a written policy for responding to requests for emergency contraception and one quality point for having a policy for pre-conceptual

58 HA08, para 15

59 Appendix 30

60 Appendix 30

61 Appendix 30

advice, but as Dr Ford-Young pointed out, this is hardly an incentive to encourage practitioners to increase their own or their patient's STI awareness, especially out of a total of 1,050 quality and outcome points available under the contract.⁶²

56. Dr Ford-Young told us he felt that regarding sexual health, there had been “a great missed opportunity in our new GMS contract”. As he went on to explain:

We see a lot of patients through our doors. We provide up to 80 per cent of contraception services in England and, in a way, we are the sleeping giant of sexual health services. Your Committee and we ourselves were optimistic that our new contract would help improve the provision of quality of care for sexual health but, unfortunately, it does not. It appears to have ignored the *National Strategy for Sexual Health and HIV*.⁶³

57. The Minister did not share the view that the GP contract was a missed opportunity to involve GPs in sexual health. She stated that GPs could have a role in sexual health if they wished, but she did not see their contribution as any more important than other potential providers within a “mixed economy”. She emphasised that community pharmacists could be equally important:

There are a lot of different providers who are clearly very keen to provide, and when you say GPs can obviously do this, obviously GPs can, and we hope that they will continue to do so, but we are looking for a mixed economy so that there is a variety of patterns of provision that both meet the individual needs of that particular community, as it were, rural, urban and all the rest of it, but also meet the needs of different sections of the population. For example, community pharmacies may well be one route in a community setting. The GP is one community setting alternative for the provision, but it is by no means now the only alternative.⁶⁴

58. We are disappointed that the Minister does not appear to share the view of many leading authorities in the area of sexual health that primary care services are a huge untapped resource for delivering sexual health services, and crucial to improving the nation's sexual health. Indeed, the Government's own Strategy on Sexual Health and HIV set out a key role for GPs. While we do not want to downplay the potential role of community pharmacies, it is clear they are unable to provide the same level of service as a GP or a specialist sexual health clinic. Moreover, most community pharmacies are not yet in a position to be able to offer sexual health services. By contrast, most of the population is registered with a GP, and GPs currently provide 80% of contraceptive services. Consequently, GPs are uniquely well placed to offer opportunistic screening or health promotion advice in the area of sexual health.

59. We asked the Minister whether sexual health had featured in negotiations over the GP contract, and whether there were plans to review the contract. She informed us that there were no plans to review the GP contract⁶⁵, but Geoff Dessent, the Department of Health

62 Supplementary memorandum from Dr Ford-Young [not printed]

63 Q22

64 Q194

65 Q191

official, told us that in fact there would be a review of the contract, and that the Department would be putting forward the case for including more incentives to promote sexual health services:

Obviously, in terms of the development of the GMS contract, yes, of course we were involved in discussions about that, and made the case for where it might be introduced. I probably should say that there will be at some point a formal review of the GMS contract, and we will be making those same arguments again to see whether there are particular avenues that might be explored that would start to address some of the points that you are raising.⁶⁶

60. The initial negotiations over the GP contract were a wasted opportunity to mobilise GPs to tackle sexual health. We are therefore pleased to hear from the Department of Health official that a formal review of the GMS contract will take place. We recommend that the Government and the BMA review the contract as soon as possible. We further strongly recommend that the Government negotiates for the inclusion of sexual health services within the “Essential Services” or “Additional Services” headings of the contract, with the introduction of quality points to encourage GPs to provide these services.

61. The Minister told us that the purchasing of sexual health services was now entirely in the hands of PCTs: “the PCTs ...have the money and the money follows services, as it were; it follows the patient.”⁶⁷ However, we were told by other witnesses that PCTs were part of the problem. Dr Ford-Young argued that it was possible for GP practices to provide more specialized sexual health services, perhaps for a group of practices. However, PCTs did not see such services as a priority and there was “a reluctance” amongst PCTs to commission them.⁶⁸ This view was supported by the RCGP, which argued that one way to overcome the shortcomings of the contract in the area of sexual health would be for PCTs to commission sexual health services from GPs with Special Interest, with appropriate support staff. However, according to the RCGP, “PCTs are reluctant to commission enhanced work even that which is already outlined in the contract let alone work outside of it.”⁶⁹ Dr Ford-Young went on to suggest that PCTs may lack sufficient expertise to commission sexual health services effectively:

When we lost health authorities and moved to PCTs and we were shifting the balance of power, we actually lost a lot of expertise and competence around commissioning sexual health services, especially some of the more specialised sexual health services like HIV treatment and care. I feel a PCT is too small a body to be commissioning at that level because the more specialist services lie across several PCTs.⁷⁰

62. Dr Ford-Young also recognised that GPs were well placed to undertake chlamydia screening, but explained that as screening is not seen as an essential service, it would need

66 Q195

67 Q192

68 Q24

69 HA31, para 22

70 Q26

to be properly supported and resourced. He argued that anecdotally, in his area, about 50 per cent of practices wanted to be involved in the chlamydia screening but felt the GP contract was getting in the way of being able to find the resources to provide that service.⁷¹ Mr Dessent suggested that when the time comes to renegotiate the GP contract chlamydia screening may be included, as “certainly chlamydia is one of the issues that we particularly recognise as being relevant to this [the GP contract]”.⁷²

63. We are pleased that the Department recognises the advantages of GPs undertaking chlamydia screening. We recommend that the Department makes provision for such screening when it reviews the GP contract.

Sexual Health workforce and training

64. During our previous inquiry, we were informed that there were 90% fewer GUM consultants than the Royal College of Physicians recommended.⁷³ BASHH stated in their latest evidence to us that consultant numbers have risen by only 4% between 2002–2003, and that nearly 16% of consultants are still single-handed (i.e. working in a clinic where they are the only consultant) as opposed to 19% in 2002.⁷⁴ Professor Kinghorn argued that it would be necessary to provide sufficient consultants to deal with an expected increase of GUM patient throughput of between 30–50% before 2008.⁷⁵

65. Professor Kinghorn also argued that it would be essential to provide practical training for dozens of primary care practitioners to provide a similar or greater increase in capacity at community settings. To achieve this, he recommended the establishment of a dedicated sexual health-training budget.⁷⁶

66. Dr Ford-Young told us that there was at present no nationally provided or recognised education and training programme that exists to support and train GPs and Practice Nurses to provide sexual health services in primary care.⁷⁷ He suggested that a useful model might be the training programme for primary care management of substance abuse, which had government funding and backing from the RCGP.⁷⁸ He argued that such a training programme would have the added benefit of helping to make it normal for GPs and their patients to talk about sex and sexual health.⁷⁹

67. In our previous inquiry, serious concerns were raised about shortages of consultants who specialise in sexual health. Our evidence suggests that the situation is little improved since then and that it may be necessary to provide sufficient consultants to deal with an expected increase in GUM patients of between 30–50% before 2008. We recommend that the Government takes account of this in its workforce planning.

71 Q25

72 Q195

73 *Sexual Health*, paras 85-90

74 HA04, para 20

75 HA13, para 13

76 HA13, para 13

77 Q24

78 Q32

79 Q32

68. **It is essential that GPs and practice nurses are properly trained and supported to provide sexual health services. We therefore recommend that the Government develops a sexual health training programme for primary care clinicians, possibly modelled on the successful training programme for the primary care management of substance abuse. This must be funded by a dedicated training budget.**

Contraception and abortion services

69. In our 2003 report, we highlighted contraception and abortion services as a largely neglected area of sexual health services with a particular need for higher priority.⁸⁰ The Family Planning Association (FPA) submitted detailed evidence on contraception and abortion services to this inquiry, arguing that better sexual health choices need to be made available to patients through the integration and joining-up of services, so that, for example, people could access STI screening at a family planning clinic and contraceptive services at a GUM clinic. While they did not believe that it would be necessary to have a combined service in every setting, they argued that GUM and family planning services must be linked together and seen as part of one sexual health service. By the same token, they thought that it should be an urgent priority for PCTs to recognise the links between contraceptive and abortion services and to integrate their approach accordingly.⁸¹

70. According to the FPA, the new system of Payment by Results is a potential barrier to such service integration if services are paid for separate family planning or GUM consultations.⁸² They also argued that services should not be organised on the basis of payment by visit rather than by treatment, as this could have an adverse impact on the choice of contraceptive methods offered to patients. For example it could militate against provision of longer-acting contraceptives which last for a number of years (e.g. IUDs, implants, etc.), and could instead incentivise repeat prescriptions of oral contraceptives at more frequent intervals.⁸³

71. We recommend that the Government takes steps to promote and facilitate better joint working between GUM and family planning services, in order to move towards the integrated model of sexual health services set out in its *National Strategy for Sexual Health and HIV*. This should include addressing any potential difficulties which may arise through new funding and purchasing arrangements.

72. In line with our recommendations, the Public Health White Paper announced that an audit of contraceptive service provision would be carried out in 2005, followed by central investment to meet gaps in local services.⁸⁴ The FPA welcomed this, and argued that it would be vital for general practice contraceptive provision to be included in the audit as

80 *Sexual Health*, para 211

81 HA08, paras 8-9

82 HA08, para 10

83 HA08, para 11

84 *Choosing Health*, para 81, p147

well as family planning clinics.⁸⁵ We were pleased to receive reassurances from the Minister that this would be the case.⁸⁶

73. The FPA also emphasised the need to improve the quality of contraceptive services, and argued that wherever users access contraceptive services, they must have access to all contraceptive methods.⁸⁷ We were told that, admittedly according to anecdotal evidence, not all services currently offer all methods, in particular in general practice where the majority of contraceptive advice is given.⁸⁸ The FPA also argued that the GP contract's lack of quality points for the provision of contraceptive advice "seriously undermines this aspect of the contract, and does not incentivise general practice to provide a comprehensive contraceptive service."⁸⁹

74. We are pleased that the Government has accepted our recommendation to conduct an audit of contraceptive services, with attached funding to rectify any problems, and that this audit will include GP contraceptive provision. We look forward to receiving the results in due course. We recommend that the Department, in its review of the GP contract, consider introducing incentives for GPs to deliver higher quality contraceptive services.

75. According to the Government's *National Strategy for Sexual Health and HIV*, abortion is one of the main elements of a "modern, comprehensive sexual health system".⁹⁰ Prompt access is very important in abortion services, as the procedure becomes more complicated and distressing as a pregnancy proceeds. The *National Strategy for Sexual Health and HIV* introduced a target that from 2005, commissioners should ensure that women have access to abortion within three weeks of the first appointment with the GP or other referring doctor.⁹¹ PCTs are also currently monitored on the percentage of NHS-funded abortions that are performed under 10 weeks in their area. It is evidence to us, the FPA recommended that there should be a target waiting time of 72 hours for abortion, with one week as a minimum standard.⁹²

76. Our 2003 report recommended that the current guideline of three weeks maximum wait for an abortion was too long, and recommended that, to improve this, the Government considered an open access model of service provision, provided in a wider range of settings.⁹³ The FPA expressed disappointment that despite this the recent Public Health White Paper did not include any initiatives on abortion services.⁹⁴ When we asked the Minister why this was, she simply replied that:

85 HA08, para 12

86 Q201

87 Q35

88 HA08, para 13

89 HA08, para 14

90 *National Strategy*, para 4.1

91 *National Strategy*, para 4.33

92 HA08, para 24

93 *Sexual Health*, paras 220-221

94 HA08, para 24

Our White Paper does not mention an awful lot of things actually. We decided to leave many things out of the White Paper. It would have been a huge document had we included everything that technically belongs to public health.⁹⁵

77. We are surprised that although the White Paper devotes an entire section to sexual health, it does not discuss abortion services. They are an important aspect of sexual health services, as the Government’s 2001 Strategy acknowledged. It is crucial that the Government retains the *National Strategy for Sexual Health and HIV*’s target that from 2005 commissioners should ensure that women have access to abortion within three weeks of the first appointment with the GP or other referring doctor. The Healthcare Commission should also retain its PCT performance indicator of the percentage of NHS-funded abortions performed under 10 weeks.

Sex and Relationships Education

78. So far, this report has largely focused on various issues to do with treatment of, and screening for, sexual health problems. However, improving people’s sexual health through prevention rather than cure remains the ultimate challenge for all those working in the area of sexual health, and this is never more the case than with young people. In oral evidence to us, Dr Ford-Young argued that education is a vital part of young people’s sexual health:

As a general practitioner, I have an advantage in that when I see a patient I can provide some education, but that is all too often too late because they may be presenting me with a problem and we have missed the boat. That has to take place in education and not be left to health.⁹⁶

79. The basic biology of sex and relationship education is part of the statutory science element of the National Curriculum. By Key Stage 3 (ages 11 to 14), a child should have learnt about reproduction, and the changes that they will go through at puberty. By Key Stage 4 (ages 14 to 16), a young teenager should have learnt in more detail about the process of conception, and how hormonal methods of contraception such as the pill work to prevent it. The theory of how some sexually transmitted infections are spread should also be referred to as young people learn, as part of the National Curriculum in science, about viruses and how they are transmitted, but this will not necessarily cover all STIs.

80. However, these isolated biological facts are the only aspects of sex and relationships education that have a compulsory statutory basis. The biological facts are intended to be supplemented by, and interwoven with, a broader sex and relationships curriculum, which includes the social and emotional aspects of sexual relationships, through a dedicated framework for “Sex and Relationships Education” (SRE), which forms part of the Personal Social and Health Education (PSHE) curriculum. This broader SRE and PSHE curriculum is not statutory.

81. Guidance on SRE was issued by the DfES in 2000.⁹⁷ This guidance specifies that at primary school, children should be taught about puberty and menstruation, and at

95 Q208

96 Q41

97 *Sex and Relationships Education Guidance*, Department for Education and Skills, July 2000

secondary school about contraception, abortion, and STIs including HIV and AIDS, all against a backdrop of education about relationships. However, as this guidance is not statutory, Boards of Governors within individual schools have considerable discretion as to how it is implemented in individual schools. Pupils do not sit examinations or assessments in SRE or PSHE. SRE may be covered within a school's OFSTED inspection, but in practice this may mean no more than checking the school's policy or discussing it with a teacher.

82. Sex and Relationships Education (SRE) formed a key aspect of our previous report into sexual health. Amongst other things we recommended:

- Renewed emphasis on the 'relationships' aspect of sex and relationships education
- Location of SRE within the National Curriculum to ensure it received adequate priority
- Use of specialist teachers to teach SRE
- Young people's health services to be integrated within schools.⁹⁸

83. Anne Weyman of the FPA raised this issue with us, and reported that in her view there had not been very much progress since our previous report:

Although the Department of Education says that it is committed and then there is guidance for schools, it is quite clearly not happening. I think we have to go on making the demands for sex and relationships education to become a broad programme, not the small amount of sex education that is currently compulsory but that we have this within the National Curriculum from an early age.⁹⁹

84. A recent report into PSHE by OFSTED generally endorsed this view, identifying many shortcomings in this area:

- Perhaps the most significant weakness in PSHE relates to assessment. Currently, there is little assessment of pupils' subject knowledge or of their progress
- Some schools do not provide the subject in any form.
- Some schools have included other subjects such as citizenship within their PSHE programmes. Of these schools, too many have failed to ensure that the curriculum and teaching time for PSHE has not been adversely affected by the demands of provision of National Curriculum citizenship.
- The quality of teaching by specialist teachers remains considerably better than that of non-specialist form tutors. Where tutors are teaching PSHE, they are given insufficient training to help them improve their subject knowledge and the teaching skills needed in the subject.
- In many of the schools where PSHE is taught by form tutors the curriculum can be placed under...pressure. Here, the problem is caused by a lack of clarity between their roles and responsibilities as a tutor and that of the PSHE teacher. This lack of clarity

⁹⁸ *Sexual Health*, paras 275, 286, 292, 312

⁹⁹ Q40

between the two roles leads to a reduction in the time for PSHE as tutors give too much time to other activities such as monitoring pupils' progress and target setting.¹⁰⁰

85. We took oral evidence from Julie Bramman, a senior official at the Department for Education and Skills. Ms Bramman agreed about the importance of ensuring that young people receive education about sex and relationships from specialist teachers who are both competent and confident in teaching children about such sensitive subjects:

I think the key points that come out of the Ofsted report are around teacher confidence and teacher competence in actually teaching sex and relationship education within PSHE....We think that that is really what we need to be doing, making it part of a specialist process, which it has not traditionally been, with geography and history, as it is quite clearly a specialist subject, rather than leaving it to form tutors which seems to be the majority of practice at the moment¹⁰¹

86. Ms Bramman also told us that 2,000 teachers were currently training to become accredited in PSHE tuition, either as their main specialism, or as a secondary specialism.¹⁰²

We welcome the acknowledgement by the Department for Education and Skills that Personal Social and Health Education (PSHE) and Sex and Relationships Education (SRE) lessons are far better taught by specialist teachers than by form tutors, and are pleased that increasing numbers of teachers are completing specialist training to becoming accredited PSHE teachers. However, we remain deeply concerned that, by DfES's own admission, in the majority of schools PSHE and SRE lessons are taught by form tutors rather than by specialist teachers. We therefore recommend that the DfES issue specific guidance to schools stipulating that by 2007 all PSHE and SRE lessons must be taught by specialist accredited PSHE teachers rather than by unqualified form tutors. These teachers should build up and maintain links with clinicians working in sexual health, including community nurses and GPs, who can often contribute very usefully to SRE but who should not be used as a substitute for a qualified SRE teacher.

87. Other concerns raised in the OFSTED report related to the fact that PSHE is not assessed, and that it is often afforded insufficient time and priority within the school curriculum. The most extreme example of this was of schools reported by OFSTED to be failing to provide any PSHE at all. Ms Bramman told us that in the case of those schools,

We will clearly have to have very serious conversations with the school about ensuring it has adequate PSHE just as in the same way as if it did not have adequate mathematics or English.¹⁰³

88. However, here Ms Bramman identified a key problem with PSHE, which is that although DfES may take PSHE as seriously as subjects like mathematics or English, many schools simply do not, because unlike mathematics or English it is not a statutory part of the National Curriculum on which pupils, and therefore schools, are assessed. OFSTED's concerns largely reflected the evidence we received about SRE and PSHE in our previous

100 OFSTED, *Personal, Social and Health Education in Secondary Schools*, January 2005, pp1-2

101 Q123

102 Q123

103 Q134

inquiry, and these could be rectified by establishing PSHE, including SRE, as a statutory and assessed part of the national curriculum, as we recommended in our previous report. When we put this to Ms Bramman, however, she replied that DFES had no intention of making PSHE statutory.¹⁰⁴

89. We are disappointed that, despite a report from its own schools inspectorate stating that a major weakness of PSHE is its current lack of assessment, and the fact that it is often afforded insufficient time and priority within the school curriculum, DfES is unwilling to make PSHE and SRE a statutory part of the national curriculum. The costs and consequences of this ill considered decision are considerable. We again recommend the establishment of PSHE and SRE as statutory and assessed parts of the National Curriculum.

3 Charges for Overseas Visitors for HIV/AIDS treatment

HIV statistics

90. The number of newly diagnosed HIV cases is accelerating year on year. There are now an estimated 53,000 cases of HIV in the UK.¹⁰⁵ Latest data indicates that reported diagnoses are increasing by approximately 20% each year.¹⁰⁶ According to the HPA, “this high level of infection is due to sustained levels (and a possible increase) of HIV transmission in men who have sex with men (MSM) and continued migration of HIV-infected heterosexual men and women from sub-Saharan Africa.”¹⁰⁷ There were 6,606 new infections diagnosed in the UK during 2003 of which 58% (3801) of these were amongst heterosexuals. Of new heterosexual infections diagnosed in 2003, 2727 (71%) were acquired in Africa.¹⁰⁸

Background to charges for overseas visitors

The previous situation

91. The concept of charging patients who do not live in the United Kingdom for NHS treatment, while staying here temporarily, is not new. As the Department of Health explained in its memorandum, *The National Health Service (Charges to Overseas Visitors) Regulations 1989*, as amended (“the 1989 Regulations”), placed an obligation on NHS hospital services to establish whether or not each patient is an overseas visitor, and, if so, to make and recover a charge for any hospital treatment provided, unless the patient was covered by one of the specified exemptions from charges. These exemptions included:

- Regulation 4, which specified that where an individual is exempt from charges for NHS hospital treatment then their spouse and children will also be entitled to NHS hospital treatment without charge.
- Regulation 4(a)(i), which exempted from charges any person who had come to the UK for the purpose of “engaging in employment as an employed or self employed person”, meaning that anyone who comes over to this country on a business trip can access free NHS treatment for both themselves and their family.
- Regulation 4(b), which exempted from charges for NHS hospital treatment any person who had spent the previous 12 months in the UK.¹⁰⁹

¹⁰⁵ Health Protection Agency, *Focus on Prevention – HIV and other STIs in the UK in 2003 – an update*, November 2004

¹⁰⁶ Health Protection Agency, *Focus on Prevention – HIV and other STIs in the UK in 2003 – an update*, November 2004

¹⁰⁷ Health Protection Agency, *Focus on Prevention – HIV and other STIs in the UK in 2003 – an update*, November 2004

¹⁰⁸ Health Protection Agency, *Focus on Prevention – HIV and other STIs in the UK in 2003 – an update*, November 2004

¹⁰⁹ Department of Health, *Proposed Amendments to the NHS (Charges to Overseas Visitors) Regulations 1989 – A Consultation*, July 2003

The 12-month residency rule

92. Although the provision to charge overseas visitors for HIV treatment and care has been in place for a number of years, previously the exemption through Regulation 4(b) described above exempted from charges for NHS hospital treatment any person who had spent the previous 12 months in the UK, whether legally or illegally. According to the National AIDS Trust (NAT), this meant that “in practice the fact that anyone could get NHS treatment and care free after twelve months residence meant there was little difficulty in providing free HIV treatment and care for all those living in the UK who needed it.”

93. According to the Department’s memorandum, the 2004 Regulations attempted to tighten up this exemption:

One of the amendments to the 2004 Regulations was to tighten the 12 months residency exemption, which covers those overseas visitors who do not meet any of the other exemption conditions, providing exemption from charges once they have been living in the UK for 12 months. This exemption now specifies that in order to qualify for the exemption the person must have been living in the UK legally for that period. This means that illegal immigrants, failed asylum seekers, visa overstayers and others living here without proper authority cannot now take advantage of free NHS hospital treatment. In order to do so a person must be able to show that they had been living here legally.

94. Although the Department argued that “the 2004 amendment Regulations made no changes to the existing rules on charging overseas visitors for HIV treatment”¹¹⁰, as the NAT pointed out, “the end of the twelve-month rule effectively introduces a charge for a significant number of people”.¹¹¹

In summary, the following groups of people are no longer entitled to free NHS care for HIV/AIDS, where previously they may have been eligible under the 12-month residency rule:

- Illegal immigrants
- Failed asylum seekers
- Visa overstayers
- Others living in the UK ‘without proper authority’

These groups of people can still seek treatment from the NHS, but they will be charged for it.

110 HA01, para 9

111 HA20, para 2.4

Exemptions to this rule

95. There are three instances under which illegal immigrants, failed asylum seekers, visa overstayers and others living in the UK without proper authority will not be charged for NHS treatment. These are:

- If they have a serious communicable disease which is exempt on public health grounds. These include TB and all sexually transmitted infections apart from HIV, for which only the initial diagnostic test and associated counselling is free
- If they seek treatment in an Accident and Emergency Department; treatment, however, ceases to be free if a patient is admitted to an inpatient ward, or referred to an outpatient service.
- If they require compulsory mental health treatment.¹¹²

“Immediately necessary treatment”

96. Where treatment is deemed by a clinician to be immediately necessary, either to save life or to prevent a condition from becoming life-threatening, then Government guidance stipulates that treatment must be given without delay, irrespective of whether the patient is, or may be, chargeable. The Government’s guidance is explicit that, because of the potential risks to both mother and baby, hospital maternity services should always be considered as providing immediately necessary treatment. This could include antenatal HIV treatment for pregnant women where it was considered clinically necessary.¹¹³

97. However, if it is subsequently established that the patient receiving “immediately necessary” treatment is a chargeable overseas visitor, then according to the Department the guidance states that “the patient should be advised of this as soon as is practically possible, and appropriate recovery action should be taken” to charge them for their treatment and recover costs.¹¹⁴

Patients who have begun treatment, whose eligibility status changes

98. The 2004 amendment Regulations also stipulate that where a patient has begun a course of treatment free of charge, that course of treatment remains free until completed, even if their eligibility status changes, for example if an asylum seeker’s application for asylum fails, and they become a failed asylum seeker. However, treatment for a different condition, or starting a new course of treatment for the same condition, becomes chargeable when the status of such a patient changes.¹¹⁵

112 HA01, para 8

113 HA01, para 12

114 HA01, para 12

115 HA01, para 11

Primary care

99. The current legislation on the eligibility of overseas visitors for primary medical services allows GP practices discretion about whether to accept any application to join a practice's NHS list of patients. A person may be accepted onto the list either as a permanent registered patient or as a temporary resident (i.e. where a person is in an area for more than 24 hours but less than 3 months). Where a practice decides not to accept an application, the person can be offered treatment on a private, paying basis. As with hospital services, however, where a healthcare professional believes that treatment is immediately necessary, it must be provided without delay, even if the patient is not registered with the GP practice. It must also be provided free of charge.¹¹⁶

100. The Department of Health has recently conducted a public consultation on proposals to bring rules on the access of overseas visitors to free NHS primary medical services into line with those for secondary care services, effectively meaning that illegal immigrants, failed asylum seekers, visa overstayers, and others living in the UK "without proper authority" will be charged for primary care services. Ministers are currently considering the responses to the consultation with a view to deciding the best way forward.¹¹⁷

"Health tourism"

101. In recent years there has been growing concern about "health tourism", where people enter the UK from abroad to make use of free NHS services. Although no substantive research has been carried out into this issue, according to the Minister of State for Health, John Hutton, it is a serious problem:

There is absolutely no doubt in my mind and I think in the mind of any other person who has dealings on this subject in the NHS that there is a significant amount of abuse going on.¹¹⁸

102. It seems clear that the high levels of HIV infection now seen in this country are attributable, at least in part, to migration from areas of the world where HIV is endemic. However, there is little evidence that HIV sufferers are commonly health tourists. Most reports are isolated to individual cases or "stories" that are difficult to substantiate. A report published by the Centre for Policy Studies devotes a chapter to problems associated with a growing number of HIV+ people coming to live in this country, and gives a case study of a Sudanese woman who migrated to the UK with her family to seek HIV treatment, and who was subsequently granted asylum.¹¹⁹ Under both previous and current regulations, such a person would of course continue to be entitled to free HIV treatment.

103. There are many different issues surrounding migration, health tourism and communicable diseases, all of which are complex and sensitive. Discussion of "health tourism" is often linked to the wider issues of immigration and asylum. Migrationwatch UK argued in their memorandum to the Committee that "the sexual health crisis in the UK

¹¹⁶ HA01, paras 13-14

¹¹⁷ HA01, paras 15-17

¹¹⁸ BBC News Online, *Are Health Tourists Draining the NHS?* 14 May 2004

¹¹⁹ Harriet Sergeant, *No System to Abuse – Immigration and Healthcare in the UK*, Centre for Policy Studies, 2003

is being exacerbated by the unnecessary and avoidable importation of cases of HIV.”¹²⁰ There are also issues relating to whether a person’s health status, including HIV status, should play a part in adjudicating applications to live in the UK. Migrationwatch UK suggested that testing for HIV should be made a compulsory part of an application to the UK, and that if an individual tested positive “refusal would not be automatic but there would have to be strong reasons to grant the visa”.¹²¹ We were informed that 47 other countries, including the USA, Canada, Australia and New Zealand have such testing for applicants.¹²² Although early in 2004 newspaper reports suggested that the Government was considering such a move, no official announcements have been made on this subject.¹²³

104. Dr Barry Evans of the Health Development Agency told us that if free treatment for HIV was available in the UK to all who sought it, it was perhaps possible that, in future, the UK could become a “magnet” for treatment tourists, although he emphasized that there was no evidence that this was occurring at present.¹²⁴ This was also raised by the Minister:

What is clear is that if people think they can come in and, under any circumstances, remain here for free treatment, we would become such a magnet, and that was what we were concerned to deal with. We are a national health service; we are not a global health service.¹²⁵

The Minister also stated in oral evidence to the Committee that “what we are doing is making sure that, when they are here illegally, they are not entitled to remain simply to get free treatment when they are illegal over-stayers.”¹²⁶

105. It is vital that the UK does not become a “magnet” for illegal immigrants coming to the country to seek healthcare, for HIV or indeed for any other condition, and it would clearly be financially disastrous for the NHS to be forced to provide a “global health service”. However, it is very important not to confuse different issues relating to immigration and HIV treatment. The new rules on charging do not prevent people with HIV from entering the country illegally or from remaining here illegally, as the Minister seemed to imply. Nor do they have any impact on the immigration or asylum process. Instead, they simply have the effect of denying free NHS treatment to those who are in the country without proper authority.

106. It is possible that by removing the potential incentive of free treatment, people with HIV may be less inclined to migrate to the UK. However, on the other hand it could also be argued that these people, including failed asylum seekers, illegal immigrants and visa overstayers, remain in this country because of failings in the immigration system, and that the real issue that needs to be addressed is not what benefits such people should or should not be entitled to, but why they are still in the UK at all.

120 HA05, para 7

121 HA05, para 3

122 HA05, para 7

123 BBC News Online, *Immigrants may face HIV tests*, 2 January 2004

124 Q72

125 Q212

126 Q77

What evidence is there of health tourism in relation to HIV?

107. Despite John Hutton MP's conviction that "there is a significant amount of abuse going on"¹²⁷, no evidence exists to objectively quantify the scale of abuse, either in relation to HIV or more generally. The Department's original consultation provided illustrations of "abuses" that should be stopped, but these only relate to people coming to the UK for a short period to use the NHS, for example during pregnancies to access maternity services, rather than people who are staying in the UK long term "without proper authority".¹²⁸ The consultation document gives no specific examples of people migrating to the UK as "health tourists" to use NHS services for HIV or for any other chronic condition.

108. In fact we received some evidence which strongly refuted claims that HIV-infected individuals are coming to the UK to cynically exploit free access to medical care. Memoranda argued that HIV+ people who were infected outside the UK typically sought access to medical care at a late stage,¹²⁹ when if they had come to the UK with the express purpose of obtaining medical care it would seem logical for them to seek testing and treatment at the earliest possible opportunity. The Terrence Higgins Trust conducted a small piece of research on a population of 60 HIV+ migrants who were recent users of THT services. Approximately 3% (two people in total) had been diagnosed prior to entering the UK. Only 8% were diagnosed with HIV within three months of entry to the UK. In all at least 75% waited more than 9 months after entering the UK before having an HIV test. One third of people in the cases examined did not have a test until more than eighteen months after entry.¹³⁰

109. The survey also collected data on what had motivated the migrants to take an HIV test. By far the most common reason given for testing was the onset of symptomatic HIV, with 58% testing when they became actively unwell. Almost half of these people (27% in all) fell severely ill before diagnosis, as measured by CD4 counts, emergency admission to hospital, or conditions such as TB. 17% were diagnosed antenatally through routine offers of testing to all pregnant women. Another 15% tested only after the death or diagnosis of a partner. Only one person (less than 2% of the sample) was diagnosed as the result of an unprompted visit to a GUM clinic. According to the THT:

This data militates against the argument that people are coming to the UK in order to obtain treatment. Were this the case, one would expect to see a far swifter progression in the overall data from arrival to testing, rather than three quarters of people testing after nine months or more. ...In only one case out of the 60 examined had someone attended at a GUM clinic for sexual health screening without an obvious external trigger, the action most likely by someone who might be already aware of their HIV status and wanting to access services for it.¹³¹

127 BBC News Online, *Are Health Tourists Draining the NHS?* 14 May 2004

128 Department of Health, *Proposed Amendments to the NHS (Charges to Overseas Visitors) Regulations 1989 – A Consultation*, July 2003

129 HA22, para 6 [Dr Jane Anderson]; HA34, paras 3-4 [Health Protection Agency]

130 HA14a

131 HA14a

110. The THT also argued that, although no thorough comparison of requirements to qualify for free healthcare in different countries currently exists, “the UK's nearest neighbour on the European mainland, France, has a much more liberal eligibility requirement than the UK for health services.” The THT added:

In France, since 1997, all health services are available free to anyone who can show that they have been living within French territories or dependencies for the past three months and where someone has a serious health condition for which treatments are not available in their country of origin, they cannot be deported back to there. Therefore, if anyone with HIV was intending to migrate to Europe in seek of HIV services, they would be substantially better off going to France than to the UK.¹³²

111. **It is very important that the UK does not become a magnet for HIV+ individuals seeking to emigrate to this country solely to access free healthcare. However, neither the Department nor any other interested parties have been able to present us with any evidence suggesting that that this is currently the case, or that the introduction of these restrictions on free treatment will actively discourage people from entering or remaining in this country illegally. What little evidence exists in this area in fact seems to suggest that HIV tourism is not taking place. It suggests that HIV+ migrants do not access NHS services until their disease is very advanced, usually many months or even years after their arrival in the UK, which would not be the expected behaviour of a cynical “health tourist” who had come to this country solely to access free services.**

Implementing the charges

Difficulties in interpreting the regulations

112. These regulations already seem to causing considerable difficulties. The first problem is that misinterpretation of the complex rules may lead to people who are actually entitled to treatment not receiving it. While the regulations stipulate that failed asylum seekers are not eligible for treatment, unless it has already been started, Dr Paul Williams, a GP who runs a practice in Stockton-on-Tees which deals exclusively with asylum seekers, pointed out that it is difficult to tell when an asylum claim has “failed”, as some cases may be subject to appeal or to judicial review. He cited anecdotal evidence of mistakes already being made:

NHS staff have already reported people who are not failed asylum seekers being refused NHS treatment. Members of ethnic minorities or people seeking asylum (who are entitled to free NHS care) will be disproportionately affected....the proposals will lead to confusion and prejudice amongst health service staff, undermining other important initiatives to improve social cohesion, redress inequality and facilitate access to health care for disadvantaged groups.¹³³

113. The Terrence Higgins Trust also gave similar examples:

132 HA14a

133 HA24, para 23

There have been several cases known to us of misinterpretation of the new regulations to refuse treatment to those entitled. This included a pregnant woman, refused antenatal checks despite entitlement, who without skilled outreach work would have been lost to both antenatal and HIV services. There have been other cases where the manner of questioning has discouraged people entitled to services from reattending for them.¹³⁴

Who should implement the regulations? The role of doctors, managers, receptionists

114. There has been and still is considerable confusion over who is responsible for implementing the regulations. Elizabeth Ryan of the Department of Health told us that “what would normally happen is that the patient will be told as soon as possible after first contact if they are likely to be chargeable.”¹³⁵ However, she did not specify who was likely to be making this decision, or discussing the matter with the patient. In fact, clinicians are often the first point of contact a patient has, but the BMA argued that the complexity of the entitlement regulations makes it difficult for health professionals to assess precisely who is entitled to free care, and stressed that “it should not be part of their job to do so”.¹³⁶ Several memoranda raised concerns around whether or not it is ethical for doctors to refuse treatment to HIV+ individuals on the basis of their immigration status. The BMA argued that “doctors’ ethical training is based on the notion of an ethical duty to respond to ‘need’”. Its case is based “on humanitarian grounds in that health professionals should not be obliged to refuse care to patients in need because they cannot pay”.¹³⁷ Dr Paul Williams stated that:

Doctors and nurses have an ethical duty to provide care for their patients, based on assessments of medical need and no other criteria. They are not trained, or professionally inclined, to deny treatment to those in need of it. These proposals conflict with ethical codes of conduct governing health professionals, including the GMC’s *Duties of a Doctor*.¹³⁸

Dr David Asboe agreed with this:

Dr Naysmith: You are acting as a kind of gatekeeper in this situation, are you not? You are deciding who has to pay and who has not. Is that a role that you are happy with?

Dr Asboe: Absolutely not. It is very clear that the General Medical Council says in the *Duties of a Doctor*, the very first one, that you must make the primary care of the patient your first concern. You must work with your colleagues to ensure that the

134 HA14, para 2.6.5

135 Q147

136 HA33

137 HA33

138 HA24, para 24

patient's best interests are served and that is in direct conflict with some of these decisions that are needing to be made.¹³⁹

115. The Minister appeared to make a misplaced assumption that when an HIV+ patient was seeing a doctor, that doctor would already know their residency status and thus whether they were entitled to free treatment or not, as “you are not talking about somebody coming in through an A&E clinic here. You are talking about somebody turning up for a booked appointment”.¹⁴⁰ However, a universal characteristic of sexual health and HIV services is that they are open-access, so a person should be able to walk in off the street and have access to a doctor without a referral from elsewhere. Another unique feature of sexual health and HIV services, which the Minister did not take account of, is that they are run on a highly confidential basis. Patients are asked for only a minimum of personal information, and are informed that they do not even have to give their real name or an address if they do not wish to. The information held on patients within sexual health and HIV services is not disclosed to anyone, not even their GP without their consent.

116. The Minister emphasised the importance of the role of overseas patient managers, who have a great deal of expertise about the regulations and their implementation. She argued that:

There is no reason why those who are managing the clinic should not be having a regular dialogue with the overseas visitors managers. If they are not doing so, obviously, they will necessarily be short of understanding and guidance¹⁴¹

117. However, Pam Ward, an overseas patient manager in Surrey, reported considerable difficulty in working with sexual health and HIV services:

The consensus of a lot of overseas managers is that actually to get access into information in GU clinics and sexual health clinics is taboo: we are not allowed in. There is a lot of hostility against overseas managers even to want dialogue with people in GU clinics¹⁴²

118. If the regulations are extended into primary care, the initial assessment of patients eligibility may well end up being carried out by GPs' receptionists, in the absence of professional overseas managers. However Dr Paul Williams also argued that to determine a patient's need for free treatment under the communicable diseases exemption, or to assess whether or not someone has an “immediately necessary or life-threatening” problem, a medical assessment is needed. In Dr Williams' view “reception staff are most likely to be the people turning away patients”, despite the fact that they are unqualified and do not have the skills to make this determination.¹⁴³

119. Dr Asboe argued that although the guidance states that if treatment is deemed to be necessary in order to save life or to prevent a life-threatening illness, then treatment must

139 Q87

140 Q246

141 Q253

142 Q105

143 HA24, para 25

be offered immediately, as discussed above, there is little clarity around this rule, which is likely to lead to clinicians interpreting the rules differently.¹⁴⁴

120. We have received evidence that NHS staff are finding it very hard to implement the new regulations in so far as they affect HIV patients. Because of the highly confidential basis on which they are run, sexual health and HIV services may be reluctant to give overseas patient managers access to their patients, meaning that the difficult job of determining eligibility falls to doctors or receptionists. Receptionists are unqualified to make the clinical decisions that may be necessary to determine whether a person needs free treatment; and doctors, when required to adopt a “gatekeeper” role in determining a patient’s eligibility for free treatment, feel an irreconcilable conflict with their primary duty to care for the patient.

“Immediately necessary treatment”

121. A particular difficulty centres round the provision within the regulations for “immediately necessary” treatment. Guidance issued by the Department stipulates that any “immediately necessary” treatment for a life-threatening problem must be provided regardless of a person’s eligibility for free treatment, and attempts should be made to recoup the costs later. In oral evidence to us, the Minister frequently cited this “easement clause”, which enables clinicians to make decisions about providing “immediately necessary” treatment to patients on the basis of their clinical need.

122. However as far as we can see, from studying the Department of Health’s written evidence as well as others’, this does not, as the Minister seemed to imply, provide clinicians with total freedom to provide treatment free of charge to anyone with HIV, regardless of their eligibility status. As Dr David Asboe pointed out to the Committee, the definition of “immediately necessary” treatment is very vague and may be interpreted very differently by different clinicians:

You may have one clinician in one hospital who takes a criterion of a CD4 count of under 200 – so a patient is very immune compromised, but not at this very point in time having a life-threatening illness – who will make the decision that treatment is warranted under those circumstances and you may have a clinician in a different hospital or on a different day who makes a different assessment.¹⁴⁵

123. We have not seen any evidence to suggest that clinicians feel justified in using the clause of “immediately necessary” treatment for “a life threatening problem” to provide regular, ongoing outpatient HIV treatment to ineligible HIV+ people who are otherwise well. And, even if the clause was interpreted in this way and treatment was begun, as was made clear by Elizabeth Ryan, moves would be made to recoup charges as soon as possible:

What would normally happen is that the patient will be told as soon as possible after first contact if they are likely to be chargeable. In an emergency, if somebody has turned up and they are clearly very ill and treatment needs to start straight away, then that treatment will happen, the treatment will start straight away, so there may

144 Q83

145 Q83

be a day or two before it is possible to ascertain all the circumstances, to establish that they are chargeable, but you will not have somebody going weeks and weeks into treatment and running up a bill of thousands of pounds and then suddenly being told they have got to pay. That will not happen.¹⁴⁶

124. The THT argued that many of those who fall into one of the categories of overseas visitors who are no longer eligible for NHS treatment for their HIV are effectively destitute. According to the THT, NHS staff have told them that “people may be charged but if they can’t pay, we won’t stop treating them”. However, there have already been instances of debts of this kind being handed over to debt collection companies to pursue.¹⁴⁷ Peter Nieuwets, a Commissioning Manager from West Sussex, described disputes over this policy resulting in “an enormous amount of tension within hospitals between administration and medical staff: Treatment or payment? Who has the loudest voice within the hospital?”¹⁴⁸ If patients begin HIV treatment and then stop it, either because it is withdrawn by the Trust, or because they are told they have to pay and cannot afford it, this has the extremely serious consequence that drug-resistant HIV will develop.

125. **During oral evidence the Minister answered almost all of our arguments by repeating that, although HIV treatment is no longer free for people living in this country without proper authority, “there is still provision for easement by individual clinicians under individual circumstances, and at the end of the day, the decisions are the clinician’s”¹⁴⁹. We have not seen any evidence to suggest that the Department intended the clause for “immediately necessary” treatment to allow clinicians to provide free routine HIV care to all HIV+ patients, regardless of eligibility, and nor does our evidence suggest that clinicians and Trusts are interpreting the regulations in this way. If it is the Department’s intention that the regulations be interpreted this way, we recommend that it issues guidance to this effect immediately. However, we do not believe that the Department does intend the regulations to be interpreted in this way. Rather, it seems that regarding HIV, this easement clause provides clinicians with only very limited flexibility to provide treatment for ineligible HIV+ patients once they become severely unwell or their immune system is significantly weakened, rather than enabling them to prevent this deterioration in the first place.**

Financial implications

126. The Government has made no estimates of the number of people likely to be affected by these changes, and was not even able to give the Committee a rough estimate:

Chairman: Has the Government any estimate of the numbers of people who are now no longer eligible for treatment as a result of the change in the 12-month exemption?

Miss Johnson: No, we do not.

146 Q246

147 HA14, para 2.6.6

148 Q82

149 Q213

Chairman: You do not have an estimate of the numbers affected by this change? Have you access to anybody else's estimate as to the numbers affected? Have no voluntary organisations put to you the numbers that are affected? You have no knowledge whatsoever, no guesstimates?

Miss Johnson: No, no. Obviously, people who are being expelled are a matter for the Home Office as well, so that is not an issue for my Department.

Chairman: I appreciate that, but you are in contact with other government departments, obviously, and in conjunction with them, there has been no estimate from them as to the numbers that might be affected?

Miss Johnson: No.¹⁵⁰

127. It is clear from their consultation document that resource implications have been a key motivation for the Government in introducing these reforms:

The current Regulations have some loopholes which the proposals in this consultation document are intended to close. This will help hospital staff, but more important it will ensure that money provided by UK tax payers for the NHS is not diverted to health care for those who are not resident in the UK but have taken advantage of gaps in the current rules.¹⁵¹

128. However, despite this, no cost-benefit analysis of the financial impact of these changes has been carried out, as the Department explained in correspondence with the Committee Clerk:

The Committee...asked about analyses of costs or potential savings arising from the changes to the charging regimes for overseas visitors, particularly in relation to HIV/AIDS services. As regards the hospital charging regime, NHS trusts have never been required to submit statistics on the costs of treating overseas visitors (a proportion of whom will, at any rate, be entitled to receive hospital treatment at no charge), so there is no baseline from which an estimate of savings could start.¹⁵²

129. The Minister confirmed to the Committee that no cost-benefit analysis had been carried out:

John Austin: I understand that, in the correspondence between the Committee and your Department, the Department has made no assessment of the likely cost or cost savings of introducing the changes to charges for overseas visitors. Is that so?

Miss Johnson: I have already explained that there are no figures about the numbers of overseas visitors being treated.¹⁵³

150 Qq 214-215

151 Department of Health, *Proposed Amendments to the NHS (Charges to Overseas Visitors) Regulations 1989 – A Consultation*, July 2003, para 1.3

152 Appendix 31

153 Q219

130. While the Department itself has no data in this area, other estimates have been made, although there appears to be little consensus about the scale of the costs. According to a BBC article from May 2004, figures from CCI Legal Services, a debt collection service, put the cost at anything between £50m and £200m each year, and a leaked report from Newham General Hospital in East London suggested health tourists cost that one trust £1m a year. The article continues:

However, a subsequent study has found that the true figure may be much lower. "Over the last three months, the number of patients identified as ineligible is 17," says Ian O'Connor, its director of finance. "The cost of this treatment over that period is £32,000." With an annual budget of £100m, this figure is practically negligible.¹⁵⁴

131. While it could be argued that any cost savings to the NHS, however large or small, would be of benefit, all policies have practical implementation costs, as Professor Alan Maynard, a leading health economist at York University, argued in the same BBC article:

I think the department itself is creating the headlines...What we need is much better data and evaluation of whether it is worthwhile going to extraordinary lengths to pursue marginal amounts of money. To spend a lot of money pursuing a relatively small amount of money would be unwise and we really have to look very carefully and evaluate this policy much more carefully than has been done to date.

The costs of treating HIV

132. Anti-retroviral drug therapy has revolutionised the treatment of HIV in recent years, but is expensive, costing between £10,000 and £14,000 per patient per year. Once a patient is started on drug therapy, it is likely they will need to take this for the rest of their lives. Life expectancy for HIV+ individuals is also increasing, which also adds to the cost burden. Dr Barry Evans of the Health Protection Agency believed that the high cost of treating HIV was the only reason for its exclusion from the list of communicable diseases exempt from charges on public health grounds:

We would not be here having this debate if with HIV treatment one could treat it for a fortnight and cure it, if it was like syphilis or other sexually transmitted infections which with a course of antibiotics or antiviral treatment you cure the patient. It is a public purse argument.¹⁵⁵

133. However, as discussed above, no data exists on how many people with HIV will now be ineligible for treatment, and hence how much money the changes to charging regulations might actually be expected to save.

154 BBC News Online, Are Health Tourists Draining the NHS? 14 May 2004

155 Q71

The costs of not treating HIV

Treatment in A&E

134. Many memoranda we received pointed out that the cost of *not* treating HIV is also very high, perhaps even higher than the cost of treating it. Without treatment, those with HIV are likely to become seriously ill ever more frequently, accessing treatments through A&E departments on a “revolving door” basis. While those ineligible for free HIV treatment would be charged for any subsequent inpatient treatment if they were admitted to hospital, initial treatment in an A&E department would be free.

“Immediately necessary treatment”

135. As discussed above, there is a provision in the regulations for clinicians to provide “immediately necessary treatment” for a “life-threatening problem”. However, the THT argued that many of those who are no longer eligible for NHS treatment for their HIV are effectively destitute because they have no legal means of employment. If such a patient was admitted to hospital for “immediately necessary treatment” for a “life-threatening problem” and then charged after the event, he or she would be very unlikely to ever be able to pay those charges.¹⁵⁶ The Minister also highlighted this as an issue:

One of the issues is, obviously, that some people do end up receiving charged treatment and are unable to pay, and so trusts do end up sometimes having to write off debts.¹⁵⁷

136. Considering the situation from a purely pragmatic point of view, an NHS Trust could in fact end up losing more money through its obligation to provide “immediately necessary” treatment to an HIV+ person who has developed a life-threatening problem, and who is subsequently unable to meet the charges for this treatment, than if they had provided free ART to that person to prevent them from becoming ill in the first place. As the NAT pointed out, while a year of ART can cost between £10,000 – £14,000, one day in a hospital bed can cost about £500 – thus it would take only a few days a month in a hospital bed to equal, if not exceed the cost of ART for that person.¹⁵⁸

137. The Terrence Higgins Trust argued that where people clearly will not be able to pay, pursuing debts “is not only a waste of time and money but an enormous stress upon the already unwell individuals pursued.”¹⁵⁹ BASHH agreed that “the effort and resource required to bill people for care and treatment, who are unlikely to be able to afford it, is wasteful.”¹⁶⁰ In oral evidence, the THT gave an example of cost escalation and the problems attached to trying to recoup such costs:

For example, there was a long-stay visitor in North London who was rushed to hospital with pneumonia. This is a case that was brought to our attention at

¹⁵⁶ HA14, para 2.6.6

¹⁵⁷ Q247

¹⁵⁸ HA20, para 5.6

¹⁵⁹ HA14, para 2.6.6

¹⁶⁰ HA04, para 10

Terrence Higgins Trust. She was diagnosed as HIV-related and therefore billed after four days for £2,000. Because of that billing, she discharged herself, went home and self-medicated, and after several days collapsed and had to be admitted to intensive care, where her further costs came to £23,000 for that episode alone.¹⁶¹

138. **The Department's consultation on changes to charging rules for overseas visitors suggested that cost-saving was a key reason for reviewing the regulations. We were therefore astonished that, by the Department's own admission, these changes have been introduced without any attempt at a cost-benefit analysis, and without the Department having even a rough idea of the numbers of individuals that are likely to be affected. While generating even small amounts of savings for the NHS might appear to be worthwhile, in the case of HIV treatment we have received powerful evidence that it would in fact be more cost-effective to provide free HIV treatment to all, as, without treatment, HIV+ individuals living in this country without proper authority are likely to place a far greater burden on NHS resources. We recommend that the Department reviews the financial implications of this policy immediately and, furthermore, that it ensures all its future policy decisions are based on evidence and underpinned by robust cost-benefit analyses, as stipulated by Cabinet Office and Treasury guidelines.**¹⁶²

Cost in terms of onward transmission

139. The financial benefit of preventing further transmission of HIV is clear – the Department's own estimates suggest that preventing a single onward transmission of HIV saves between £500,000 and £1million in terms of individual health benefits and treatment costs.¹⁶³ However, as we discuss in greater detail below, introducing charges for HIV treatment may in fact contribute to onward transmission, both because charges may act as a deterrent to testing for people who cannot afford treatment in the event of a positive result, and because untreated individuals are more infectious than those on treatment whose viral load is controlled. **In its cost-benefit analysis of the changes to regulations governing access to free NHS treatment for overseas visitors, the Department must also take into account the potential costs associated with increased onward transmission of HIV.**

Public health implications

140. The British Association for Sexual Health and HIV put the public health position very simply:

HIV positive patients in the UK irrespective of immigration status are of public health concern.¹⁶⁴

161 Q49

162 Cabinet Office Checklist for Policy Makers, <http://www.cabinetoffice.gov.uk/regulation/economic/checklist/costben.asp>; HM Treasury, Green Book, Appraisal and Evaluation in Central Government, <http://greenbook.treasury.gov.uk/index.htm>

163 *National Strategy*, para 1.21

164 HA04

141. According to the NAT, “there are very good grounds to believe that the charges introduced are causing, and will continue to cause, harm to public health in the UK.”¹⁶⁵ The Health Protection Agency, the Government agency charged with providing advice on protection against infectious diseases and other dangers to health, supported this view:

We are concerned that the new and proposed changes may impact on the clinical and public health management of HIV infection in overseas born individuals diagnosed with HIV in the UK¹⁶⁶

142. Several key public health concerns were raised in the evidence submitted to us which are discussed in detail later in this section. The first is the possibility that the lack of treatment will provide a deterrent to testing. The second is the argument that untreated individuals pose a greater transmission risk to the uninfected population than those on treatment; the third is that new regulations may have an adverse effect on antenatal HIV testing and therefore increase rates of mother-to-child transmission of HIV; and finally the potential impact on TB transmission rates.

143. The Department’s memorandum made no mention of the possible public health implications of introducing charges for overseas visitors for HIV/AIDS treatment, and our evidence criticized the Department for not having carried out a public health impact assessment of the charges introduced in hospitals from 1st April 2004, nor of those currently being considered for primary care.¹⁶⁷

144. Although public health concerns relating to HIV were raised by several responses to the Department’s consultation, these were dismissed in the Department’s consultation outcome document:

It was clear that there has been some misunderstanding of our proposals and respondents have raised concerns resulting from this. These included public health issues ... On public health grounds treatment of communicable diseases such as TB is and will remain free of charge to everyone.¹⁶⁸

145. We were surprised to learn that no public health impact analysis of these regulations was carried out prior to their enactment, particularly given the level of the public health threat posed by HIV and the increasing rates now being seen in this country. We are aware that public health arguments were put to the Department during its consultation, but these arguments do not appear to have been answered or taken account of. Given the Department’s responsibility for safeguarding public health this seems short-sighted, and suggests a lack of coherence within policy making within the Department. We recommend that, in addition to cost-benefit analyses, public health impact analyses be carried out in respect of all Department of Health policies.

¹⁶⁵ HA20, para 6.1

¹⁶⁶ HA34, para 1

¹⁶⁷ HA20, paras 5.10 – 5.11

¹⁶⁸ Department of Health, *Proposed Amendments to the National Health Service (Charges to Overseas Visitors) Regulations 1989: A Consultation – Summary of Outcome*, December 2003; <http://www.dh.gov.uk/assetRoot/04/06/83/66/04068366.pdf>

A deterrent to testing

146. A first crucial step in preventing the onward transmission of a communicable disease is to diagnose those already affected, so that they may modify their behaviour accordingly to prevent onward transmission. This is particularly important in infections like HIV which may be asymptomatic for many years. Indeed, a central aim of the Government's *National Strategy for Sexual Health and HIV* is to reduce the number of those with HIV who are undiagnosed.¹⁶⁹ It is estimated that 51% of all undiagnosed HIV infections in the UK are among African communities.¹⁷⁰

147. Research suggests that providing free treatment for HIV may reduce transmission rates within a population by giving people a motivation to seek testing. According to the NAT, research from Taiwan shows that the government policy of providing HIV-positive people with free ART reduced the rate of HIV transmission by 53%.¹⁷¹ However, it is quite possible that for those who will be unable to access free treatment in the event of a positive diagnosis, and who would not be able to afford treatment costs, a primary motivation to seek testing will be lost, as the Terrence Higgins Trust argue is already happening:

People from one of the communities of highest prevalence for HIV in the UK have begun to ask why they should test for HIV if they may not be able to obtain treatment for it. While we believe there is almost always good reason to know one's diagnosis and thus be able to make informed decisions about both health and sexual behaviour, this view is gaining currency amongst migrant communities and is impacting on testing campaigns targeting them.¹⁷²

148. A letter to the *BMJ* from four London-based HIV physicians illustrates the problem very starkly: "Back in the mid eighties before anti-retrovirals were available, many individuals were counselled that there was little point in getting tested if bad news was the most likely outcome. Surely we cannot go back to this era"¹⁷³.

149. The NAT argued that the impact of the new system on the principle of confidentiality might be a further deterrent to testing:

If henceforth at GUM clinics patients cannot receive HIV treatment in an entirely anonymous fashion but have to provide proof of eligibility there are concerns this will deter even from the initial free test those fearful of questions about residence.¹⁷⁴

150. It is also possible that the introduction of charges for HIV treatment for those in the country without proper authority will have a negative impact on testing rates even amongst those who are eligible for treatment. The Terrence Higgins Trust runs the THT Direct national helpline which receives on average around 600 calls a week. According to the THT:

¹⁶⁹ *National Strategy*, para 4.77

¹⁷⁰ HA20, para 4.2

¹⁷¹ HA20, para 6.3

¹⁷² HA14, para 2.6.4

¹⁷³ Nigel O'Farrell, Stephen Ash, Paul Fox, William Lynn, 'Eligibility of Overseas Visitors and of people of uncertain residential status for HIV treatment', *BMJ*, 13 August 2004

¹⁷⁴ HA20, p6.6

Anecdotally, staff and volunteers estimate that enquiries about eligibility for NHS services have gone from around one to two a week (a year ago), to one to two each day (currently), a sevenfold increase. They also state that a substantial number of these calls are from people who are eligible for NHS services, but who are afraid to approach services directly because they do not want the shame of being refused.¹⁷⁵

151. We put these arguments to the Minister, but she did not accept them, stating that she saw “no reason in relation to any of these things why somebody should not come forward early”¹⁷⁶. However, **we are unable to share the Minister’s optimistic view that the introduction of charges will have no impact on the numbers of people coming forward for HIV testing. Although charges have been in place for less than a year, the fact that organisations such as the Terrence Higgins Trust are already reporting a growing reluctance to have HIV tests amongst migrant communities is extremely worrying.**

152. **Coupled with increasing confusion regarding eligibility for HIV treatment even amongst those who are eligible, and fear amongst migrant communities that if, in future, they attend health services they will be questioned about their immigration status, this strongly suggests that the introduction of charges for HIV treatment will increase the number of HIV+ people living in this country who are unaware of their infection, in direct contradiction of the Government’s target to reduce the number of undiagnosed HIV infections. An increase in the numbers of people who are unaware of their HIV+ status will pose a serious and escalating threat to public health.**

HIV diagnosis, treatment and transmission

153. As discussed above, diagnosing HIV is the first step in preventing onward transmission by enabling HIV+ individuals to be informed about various measures they can employ to protect their own health and that of their sexual partners. However, recent research evidence suggests that an HIV diagnosis alone is often not sufficient to stop individuals who are HIV+ engaging in risky behaviour that may potentially pass the virus on to others.¹⁷⁷

154. Because of this, once a person is diagnosed as HIV+, they would normally be referred to a specialist HIV service which they would attend at regular intervals. As well as medical treatment, patients would usually be offered access to a variety of services designed to help them change their behaviour to prevent the onward spread of HIV. According to the Terrence Higgins Trust,

Failure to treat will also mean that people who would otherwise encounter a range of services in a clinical setting will be lost to interventions, such as counselling and group work, designed to support people in maintaining safer sex and preventing behaviour likely to contribute to onward transmission.¹⁷⁸

175 HA14a

176 Q213

177 McGowan et al, “Risk behaviour for transmission of HIV among HIV-seropositive individuals in an urban setting, *Clinical Infections Diseases*, 1 January 2004; 38(1): 122-7

178 HA14, para 2.7.2

155. Recent research suggests that targeted interventions such as regular counselling can reduce unsafe behaviour amongst HIV+ individuals, with the potential of preventing the onward spread of HIV.¹⁷⁹

156. We also heard evidence that another crucial way in which onward transmission can be prevented is by treating patients with anti-retroviral drugs which lower their viral load, and thus their infectivity. If people with HIV are unable to access anti-retroviral treatment and associated services, they will be more infectious than if in treatment. Research evidence indicates that with treatment, transmission rates can be lowered by as much as 60%.¹⁸⁰ Dr Barry Evans of the Health Protection Agency provided a clear and compelling argument for the importance of treatment in preventing onward spread:

On the issue of the onward spread of HIV we have reasonable data now that shows that the spread of HIV is strongly related to viral load. Viral load rises with the progression of the infection. As the CD4 count, the level of immunity drops, the viral load rises, and with high viral load is much more likely to transmit. If people are not diagnosed and they continue to be sexually active, they are more likely to transmit, the higher the viral load. There are other co-factors affecting transmission, including other sexually transmitted infections and so on, but viral load is a powerful indicator of transmission potential, so that if you do not treat individuals and they remain in this country and are sexually active in this country, then the transmission is bound to go up.¹⁸¹

The Public Health Minister, however, did not seem to be aware of the strong correlation between viral load and infectivity, or of the fact that treatment to reduce viral load is likely to reduce infectivity:

Actually, treating somebody with HIV/AIDS, unfortunately, does not reduce their risk to the general population at all. It is only behaviour change that alters that risk.¹⁸²

157. The Minister asked the Chief Medical Officer to write to us to explain the Department's position on this issue after our evidence session. In his letter, the Chief Medical Officer stated that a reduced or undetectable viral load does not, in every case, indicate that a person with HIV is not infectious:

Although many people with undetectable viral load in their blood also have an undetectable viral load in their sexual fluids, this is not always the case. Some people with undetectable viral load in their blood have quite high viral load in their sexual fluids which could be high enough to infect someone...studies conducted in men

179 Metcalf et al, "Relative efficacy of prevention counselling with rapid and standard HIV testing: a randomised, controlled trial", *Sexually Transmitted Diseases*, February 2005; 32(2): 130-8; Sweat et al, "Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania and Trinidad", *Lancet*, 8 July 2000, 356(9224):103-12; Richardson et al, "Effect of brief safer-sex counselling by medical providers to HIV-1 seropositive patients: a multi-clinic assessment", *AIDS* 21 May 2004; 18(8):1179-86

180 Fang et al, "Decreased HIV transmission after a policy of providing free access to highly active antiretroviral therapy in Taiwan", *Journal of Infectious Diseases*, 1 September 2004; 190(5) 879-85; Porco et al, "Decline in HIV infectivity following the introduction of highly active antiretroviral therapy", *AIDS*, 2 January 2004; 18(1): 81-8

181 Q69

182 Q216

have found that having an untreated sexually transmitted infection, particularly gonorrhoea, increases the chance that viral load will be detectable in semen.¹⁸³

The Chief Medical Officer also emphasised the importance of continued condom use for HIV+ patients, not only to prevent further transmission, but also to avoid the transmission of other STIs and drug-resistant HIV.

158. We agree with the Chief Medical Officer that HIV treatment cannot guarantee that an individual will not be infectious, and that the presence of other untreated STIs can make a person with HIV more infectious. For this reason, we strongly support his emphasis on the importance of condom use for HIV+ patients, even if they are being treated. However, his letter did not dispute our central argument that, although it cannot cure HIV infection, treatment can reduce a person's infectivity and can therefore lower transmission rates. In fact, his letter would seem to support this view, as it states that "an undetectable HIV viral-load is the goal of anti-HIV treatment" and that "many people with undetectable viral load in their blood also have an undetectable viral load in their sexual fluids".

159. The Minister argued that there was a crucial difference between the public health impact of treating other communicable diseases and that of treating HIV, which was that while treatment for other communicable diseases is curative and reduces the risk of onward transmission to zero, treatment for HIV/AIDS is not curative, and does not entirely eliminate the risk of onward transmission:

Miss Johnson: There obviously is a difference. The free bit of it is around the public health risk, and the public health risk if somebody has another sexually transmitted infection is that actually, if we treat them, that risk goes down to zero.¹⁸⁴

Dr Taylor: Although as soon as you begin to decrease the viral load, you begin to decrease the infectivity. Our attention has been drawn to...

Miss Johnson: Yes, but it is not like having another sexually transmitted infection where a course of antibiotics will remove the infection from the body. Let us just be clear. There is quite a difference here... I nonetheless maintain the very firm understanding, which is that there is a zero risk for some things after treatment and there is not a zero risk with HIV/AIDS.¹⁸⁵

160. The Minister's argument appears to us to be fundamentally flawed on two counts. The first is that, there are several other communicable diseases which are exempt from charging, including, for example, TB and herpes, where treatment does not reduce the risk of onward transmission to zero. Even if treated, the genital herpes virus can be shed through the skin and infect others, even if there is no outward sign of infection present. After treatment for TB the risk of relapse is between 2–5%, and the disease can recur and be passed on to others. Shingles is another example of a communicable disease which, even when treated, can recur and be passed on to people without immunity as chickenpox. Secondly, the Minister's focus on reducing transmission rates to zero is misplaced: it is worthwhile reducing a risk even if it cannot be eliminated.

183 Appendix 29

184 Q216

185 Q228, q258

161. The evidence refutes the Minister’s stance that anti-retroviral treatment does not reduce HIV infectivity and therefore has no impact on public health. On the contrary, the scientific literature to date suggests that HIV infectivity is directly linked to viral load, and therefore that treatment which reduces the viral load of HIV+ individuals will potentially reduce onward transmission of HIV. Indeed, the Health Protection Agency, the Government’s own public health advisory body, stated unequivocally to us that “if you do not treat individuals and they remain in this country and are sexually active in this country, then the transmission is bound to go up.”¹⁸⁶

162. While we accept that, in giving evidence to us, the Public Health Minister was not supported by a Department of Health official with medical expertise, we are surprised that she appeared so unbriefed on basic aspects of public health prevention. Firstly, many treatments do not reduce the risk of onward transmission to zero. This is the case for genital herpes and for TB, both of which are exempt from treatment charges on public health grounds. Secondly, it is worthwhile reducing the risk of onward transmission of a disease, even if it cannot be eliminated.

Mother-to-child transmission

163. Many memoranda have raised the issue of HIV+ women who are pregnant.¹⁸⁷ By adopting a range of measures, including delivery by caesarean section, use of the drug AZT during pregnancy and childbirth, and avoidance of breastfeeding, rates of mother-to-child transmission can be reduced from between 25–23% in an untreated population to below 1%. Because there are such effective measures available, HIV testing is now routinely recommended for all women using antenatal services in this country.

164. Unfortunately, there seems to be considerable confusion over whether or not HIV+ women who are not eligible for free NHS care can be treated to prevent them passing on the infection to their babies. According to the Department, where treatment is deemed by a clinician to be “immediately necessary, either to save life or to prevent a condition from becoming life-threatening, then that treatment must be given without delay, irrespective of whether the patient is, or may be, chargeable”. The Department also states that its guidance on the application of charges is “explicit that, because of the potential risks to both mother and baby, hospital maternity services should always be considered as immediately necessary treatment. This could include HIV treatment where it was considered clinically necessary.”¹⁸⁸

165. However, several memoranda have reported examples where pregnant women have not been able to access HIV treatment¹⁸⁹, and the NAT points out that if women are refused free access to ante-natal services at the outset, their HIV infection may never be picked up:

We know of at least one pregnant woman who has been refused free temporary HIV treatment to prevent HIV transmission to her unborn child, and we understand

186 Q69

187 HA22, para 12; HA20, para 6.10; HA33; HA29

188 HA01 para 12

189 HA20, para 6.10; HA14, para 2.6.2

there may well be others. More generally, in relation to women who may or may not be HIV positive, we have heard of another woman who fled when asked to pay charges for ante-natal screening, and of two other cases where it appears ante-natal care is either not going to be commenced or is going to be suspended because of inability to pay bills. Many more of such cases are never noted or reported by clinicians since they do not get to hear of them. The individuals are refused at an early stage by the overseas manager in the hospital.¹⁹⁰

166. We welcome the Department’s statement that hospital maternity services should always be considered immediately necessary treatment, including, where necessary, HIV treatment. However, evidence presented to us suggests that considerable confusion exists over eligibility for maternity services. If the charging regulations are extended to encompass GP services, this situation is likely to worsen, as primary care is a key access point for ante-natal services. We recommend that the Department immediately issue further guidance to the NHS stating that antenatal and maternity services, including HIV treatment to prevent mother-to-child transmission, must be made available to all women, regardless of their immigration status or ability to fund the treatment.

TB infection rates

167. TB cases have increased by nearly 20% in England and Wales over the last two years, with London now a “TB hotspot”, accounting for 3,000 cases a year, nearly half of all UK cases.¹⁹¹ The Chief Medical Officer has recently published the TB Action Plan to address this.¹⁹²

168. Co-infection with HIV and TB is a relatively common combination for African people in the UK. TB is exempt from any charges under the regulations. However, in order to ensure TB treatment is effective, the underlying HIV must also be treated. The THT reported that individuals coinfecting with TB and HIV have been told that, while TB treatment is free, the HIV treatment necessary to ensure that their TB treatment is effective will be charged for:

This has resulted in at least two cases known to us where patients have left hospital before the end of their TB treatment, risking the development of multi-drug resistant tuberculosis (which is transmissible) and returning to the community still able to transmit TB, as well as HIV.¹⁹³

This point was reinforced by the Health Protection Agency:

Underlying HIV infection is an important consideration in the management and treatment of tuberculosis (TB) and failure to address this can lead to inadequate

190 HA20, para 6.11

191 HA20, para 6.14

192 Department of Health, *Stopping TB in England*, October 2004

193 HA14, para 2.6.1

treatment of TB, running the risk of reactivation, the potential for developing drug resistant TB and ongoing potential for transmission.¹⁹⁴

169. Those who are TB/HIV co-infected are more likely to develop the active form of TB and pass it on to others, and a person with active TB will typically infect between 10 and 15 people a year.¹⁹⁵ If, as described above, a person is able to transmit multi-drug resistant TB, this is much harder to treat and poses an even more serious threat to public health.

170. Thus the failure to treat HIV, as well as increasing HIV transmission to others, may result in an increase in TB infections, which will occur amongst HIV-negative people as well as HIV-positive people. According to the NAT, a recent study has shown that HIV infection dramatically increases incidence of TB, with a direct increase in those who are HIV infected but also a doubling of TB incidence in those remaining HIV negative amongst the group studied.¹⁹⁶

171. We are extremely alarmed by the prospect of people co-infected with HIV and TB being managed ineffectively. If their underlying HIV is not treated because of cost, they may then default from care and as a consequence transmit TB to as many as 15 people a year. It is a nonsense that the Government is prepared to fund a person's TB treatment on public health grounds but not treatment of his HIV infection.

Primary care

172. Many of the memoranda we received argued that the proposed extension of the new charging regime to primary care will be extremely harmful to the fight against HIV in the UK, suggesting that this will close another vital channel through which people can access HIV testing.¹⁹⁷ The NAT argued that this also undermined attempts to treat other serious or emergency conditions free of charge, as without some health assessment available in primary care, other conditions which require urgent treatment might well be missed. These conditions might include communicable diseases such as TB, for which free treatment would be available on public health grounds.¹⁹⁸ Dr Paul Williams, a General Practitioner who works in a practice in Stockton-on-Tees that exclusively serves asylum seekers, states simply that "access to all types of health care begins in primary care".¹⁹⁹ At the same time, many people ineligible for free NHS care except in A&E Departments may present at A&E with relatively minor conditions, overburdening the A&E service and increasing waiting times and pressure on resources in A&E.

173. The NAT were amongst many to argue that a free primary care health assessment should continue to be available to all, regardless of eligibility status.²⁰⁰

194 HA34, para 5

195 Department of Health, *Stopping TB in England*, October 2004

196 Sonnenberg et al, "HIV and pulmonary tuberculosis: the impact goes beyond those infected with HIV" *AIDS* 2004 Vol 18 No.4

197 HA20, para 7.1; HA24, para 13

198 HA20, para 7.3

199 HA24, para 13

200 HA20, para 7.4

174. Primary care can be a vital access point for all types of services. This includes services which the Government stipulates must continue to be provided free to all people, regardless of their eligibility status, such as HIV testing, treatment for communicable diseases such as TB, antenatal and maternity services, and “immediately necessary” treatment for emergency problems. Refusing patients free access to GP services could, arguably, be seen to undermine all these exemptions that the Government has made within the charging regime by denying patients access to a first, basic health assessment. We therefore recommend that all people, regardless of their eligibility status, are given access to a free primary care health assessment.

Conclusion

175. We are deeply concerned that neither the Department nor the Public Health Minister appear to have considered or understood the public health implications of refusing HIV treatment to people who, although not legally resident, continue to live in this country. Firstly, it seems that this policy is already deterring people in high-prevalence migrant communities from accessing HIV testing. Equally importantly, by denying people free HIV treatment, a vital opportunity is being missed to reduce by perhaps as much as 60% their likelihood of transmitting HIV within the wider resident population. We dispute the Minister’s view that HIV treatment benefits only the person receiving it, and her view that for a public health intervention to be worthwhile it must reduce the risk of onward transmission to zero – TB and genital herpes are just two examples of communicable diseases for which treatment is currently free where a significant risk of recurrence and onward transmission remains despite a course of treatment. We also have serious concerns about the impact of this policy on mother-to-child transmission of HIV, and of the onward transmission of TB, including drug-resistant strains.

176. During our evidence session, the Minister mentioned the “easement clause” the Government has introduced, which enables clinicians to provide treatment deemed to be “immediately necessary” regardless of a person’s eligibility status. In a subsequent letter she also further emphasised the clause which states that where a person has begun a course of free NHS treatment, that treatment will continue to be free until the course of treatment has been completed. According to the Minister, “for HIV in many cases this will mean treatment will continue free of charge for a very long time”. While we appreciate these attempts on the Government’s part to reduce the impact of the regulations on those who have life-threatening problems or who have already begun treatment, we feel that they do not adequately address the problems that we have identified in respect of HIV.

177. We agree with the Minister that it is appropriate to provide a national health service, not a global one. However, a crucial part of the Government’s responsibility to provide a national health service is to protect the health of the population. Untreated HIV+ people living in this country present a serious public health threat, and we therefore recommend that all HIV+ people, regardless of their immigration status, receive free treatment to reduce the likelihood of the onward transmission of HIV, of mother-to-child transmission of HIV, and of the onward transmission of TB. We believe that to achieve this, HIV should be reclassified as a Sexually Transmitted

Infection, which would make treatment automatically free on public health grounds. If, subsequently, there is evidence that as a result of this decision the UK is becoming a magnet for HIV+ people around the world seeking access to free treatment, which from the evidence we have heard we do not anticipate, the policy can be reviewed.

Conclusions and recommendations

1. We are concerned that it took at least seven weeks for the Deputy Head of the Sexual Health Policy Branch at the Department of Health to realise that the Department had been sent key data on sexual health which it had commissioned, and that the responsible Minister had not seen this data in advance of her appearance before the Committee. We are also surprised by the air of secrecy which surrounds this research, and can only surmise from this that it contains findings that would be unwelcome for the Government. If the Government places any value on the scrutiny work of Parliament, and takes seriously its commitment to co-operate with the work of Select Committees, it would seem counterproductive to withhold the most up-to-date information on sexual health services from the Health Committee when it is conducting an inquiry into precisely this subject. (Paragraph 14)
2. We welcome the Government's adoption of our recommendation of a 48-hour access target for sexual health services. However, the Government should take note of the warnings we have been given by clinicians that this target may not be achieved within the timeframe specified by Government without additional spending, and that inadequate facilities may present a barrier to service expansion. (Paragraph 23)
3. We also welcome the Government's adoption of our recommendation for a dedicated health education campaign aimed at improving sexual health. However, the Government should not begin the campaign until it is certain that services have the extra capacity they need to meet the extra demand the campaign will generate. (Paragraph 24)
4. We welcome the extra investment for GUM services of £130 million over three years, but evidence submitted to our previous inquiry into sexual health suggested that the true funding needs of GUM services may be far greater than this. Estimates provided by the Association of Genito-urinary Medicine suggested that around £150m of capital funding alone would be needed to modernize GUM facilities, and on top of this we were given evidence of the need for up to £30 million per year additional revenue funding for GUM services, giving a total of some £240 million. The Government should keep the funding of GUM services under close review and be prepared to increase allocations if this should prove necessary. (Paragraph 28)
5. We welcome proposals to improve performance monitoring around sexual health. However, we remain very concerned by reports that previous allocations for GUM services, when filtered through PCTs, often did not reach the services for which they were intended, but were siphoned off to fund services identified by PCTs as being of a higher priority. To ensure that this does not happen again, we recommend that, at least for the next three years, the Department supplement its existing performance management of sexual health services by commissioning a specific financial audit to check that funding has reached its intended destination. The audit could be carried out by the Audit Commission or the Healthcare Commission. The results of the audit should be published to identify any funding gaps that may occur. (Paragraph 34)

6. The Department, in its response to this Report, should also supply us with a detailed breakdown of the £300 million funding for sexual health services, specifying whether the funding is entirely new, or is part of the total funding for PCTs already announced, as implied by the Minister. (Paragraph 35)
7. Both men and women should be screened for chlamydia. We are concerned that current efforts to screen men are insufficient. Furthermore, by introducing the cut-off for the screening programme at 25 year-olds the Government also risks missing a significant proportion of young people who remain vulnerable to chlamydia infection and its consequences. We therefore recommend that the national chlamydia screening programme be extended to men as well as women, and that the target age range be extended from 16 – 25 year olds to 16 – 29 year olds, at least initially. If it is subsequently shown that chlamydia screening is beneficial across a wider age range than this, the Government should extend the programme accordingly. (Paragraph 43)
8. In addition, we note that there are limits to what can be achieved by an opportunistic screening programme, which relies on people seeking out healthcare services for another reason, such as contraception, rather than proactively inviting them to attend for a test. This may pose particular problems in screening young men, as research suggests that young men generally attend health services less frequently than women. We therefore recommend that the Government monitors the rates of chlamydia infection closely to assess the effect of the national screening programme, and that, if rates of chlamydia continue to increase, it considers supplementing the opportunistic screening programme with a proactive call-and-recall system targeting specific high-risk groups. (Paragraph 44)
9. It is unacceptable that a test is still being used for chlamydia which may miss as many as 30% of infections, when a far more accurate test is available. We are pleased that the Government is to make NAA testing available in all areas, but disappointed that this will not happen until 2007. Some clinicians even doubt that this target can be achieved. The Government will need to monitor this target carefully over the next two years to ensure that NAA testing is, indeed, universally available in all clinical settings by 2007. (Paragraph 48)
10. We are disappointed that the Minister does not appear to share the view of many leading authorities in the area of sexual health that primary care services are a huge untapped resource for delivering sexual health services, and crucial to improving the nation's sexual health. Indeed, the Government's own Strategy on Sexual Health and HIV set out a key role for GPs. While we do not want to downplay the potential role of community pharmacies, it is clear they are unable to provide the same level of service as a GP or a specialist sexual health clinic. Moreover, most community pharmacies are not yet in a position to be able to offer sexual health services. By contrast, most of the population is registered with a GP, and GPs currently provide 80% of contraceptive services. Consequently, GPs are uniquely well placed to offer opportunistic screening or health promotion advice in the area of sexual health. (Paragraph 58)

11. The initial negotiations over the GP contract were a wasted opportunity to mobilise GPs to tackle sexual health. We are therefore pleased to hear from the Department of Health official that a formal review of the GMS contract will take place. We recommend that the Government and the BMA review the contract as soon as possible. We further strongly recommend that the Government negotiates for the inclusion of sexual health services within the “Essential Services” or “Additional Services” headings of the contract, with the introduction of quality points to encourage GPs to provide these services. (Paragraph 60)
12. We are pleased that the Department recognises the advantages of GPs undertaking chlamydia screening. We recommend that the Department makes provision for such screening when it reviews the GP contract. (Paragraph 63)
13. In our previous inquiry, serious concerns were raised about shortages of consultants who specialise in sexual health. Our evidence suggests that the situation is little improved since then and that it may be necessary to provide sufficient consultants to deal with an expected increase in GUM patients of between 30–50% before 2008. We recommend that the Government takes account of this in its workforce planning. (Paragraph 67)
14. It is essential that GPs and practice nurses are properly trained and supported to provide sexual health services. We therefore recommend that the Government develops a sexual health training programme for primary care clinicians, possibly modelled on the successful training programme for the primary care management of substance abuse. This must be funded by a dedicated training budget. (Paragraph 68)
15. We recommend that the Government takes steps to promote and facilitate better joint working between GUM and family planning services, in order to move towards the integrated model of sexual health services set out in its *National Strategy for Sexual Health and HIV*. This should include addressing any potential difficulties which may arise through new funding and purchasing arrangements. (Paragraph 71)
16. We are pleased that the Government has accepted our recommendation to conduct an audit of contraceptive services, with attached funding to rectify any problems, and that this audit will include GP contraceptive provision. We look forward to receiving the results in due course. We recommend that the Department, in its review of the GP contract, consider introducing incentives for GPs to deliver higher quality contraceptive services. (Paragraph 74)
17. We are surprised that although the White Paper devotes an entire section to sexual health, it does not discuss abortion services. They are an important aspect of sexual health services, as the Government’s 2001 Strategy acknowledged. It is crucial that the Government retains the *National Strategy for Sexual Health and HIV*’s target that from 2005 commissioners should ensure that women have access to abortion within three weeks of the first appointment with the GP or other referring doctor. The Healthcare Commission should also retain its PCT performance indicator of the percentage of NHS-funded abortions performed under 10 weeks. (Paragraph 77)

18. We welcome the acknowledgement by the Department for Education and Skills that Personal Social and Health Education (PSHE) and Sex and Relationships Education (SRE) lessons are far better taught by specialist teachers than by form tutors, and are pleased that increasing numbers of teachers are completing specialist training to becoming accredited PSHE teachers. However, we remain deeply concerned that, by DfES's own admission, in the majority of schools PSHE and SRE lessons are taught by form tutors rather than by specialist teachers. We therefore recommend that the DfES issue specific guidance to schools stipulating that by 2007 all PSHE and SRE lessons must be taught by specialist accredited PSHE teachers rather than by unqualified form tutors. These teachers should build up and maintain links with clinicians working in sexual health, including community nurses and GPs, who can often contribute very usefully to SRE but who should not be used as a substitute for a qualified SRE teacher. (Paragraph 86)
19. We are disappointed that, despite a report from its own schools inspectorate stating that a major weakness of PSHE is its current lack of assessment, and the fact that it is often afforded insufficient time and priority within the school curriculum, DfES is unwilling to make PSHE and SRE a statutory part of the National Curriculum. The costs and consequences of this ill considered decision are considerable. We again recommend the establishment of PSHE and SRE as statutory and assessed parts of the National Curriculum. (Paragraph 89)
20. It is very important that the UK does not become a magnet for HIV+ individuals seeking to emigrate to this country solely to access free healthcare. However, neither the Department nor any other interested parties have been able to present us with any evidence suggesting that that this is currently the case, or that the introduction of these restrictions on free treatment will actively discourage people from entering or remaining in this country illegally. What little evidence exists in this area in fact seems to suggest that HIV tourism is not taking place. It suggests that HIV+ migrants do not access NHS services until their disease is very advanced, usually many months or even years after their arrival in the UK, which would not be the expected behaviour of a cynical "health tourist" who had come to this country solely to access free services. (Paragraph 111)
21. We have received evidence that NHS staff are finding it very hard to implement the new regulations in so far as they affect HIV patients. Because of the highly confidential basis on which they are run, sexual health and HIV services may be reluctant to give overseas patient managers access to their patients, meaning that the difficult job of determining eligibility falls to doctors or receptionists. Receptionists are unqualified to make the clinical decisions that may be necessary to determine whether a person needs free treatment; and doctors, when required to adopt a "gatekeeper" role in determining a patient's eligibility for free treatment, feel an irreconcilable conflict with their primary duty to care for the patient. (Paragraph 120)
22. During oral evidence the Minister answered almost all of our arguments by repeating that, although HIV treatment is no longer free for people living in this country without proper authority, "there is still provision for easement by individual clinicians under individual circumstances, and at the end of the day, the decisions are

the clinician's". We have not seen any evidence to suggest that the Department intended the clause for "immediately necessary" treatment to allow clinicians to provide free routine HIV care to all HIV+ patients, regardless of eligibility, and nor does our evidence suggest that clinicians and Trusts are interpreting the regulations in this way. If it is the Department's intention that the regulations be interpreted this way, we recommend that it issues guidance to this effect immediately. However, we do not believe that the Department does intend the regulations to be interpreted in this way. Rather, it seems that regarding HIV, this easement clause provides clinicians with only very limited flexibility to provide treatment for ineligible HIV+ patients once they become severely unwell or their immune system is significantly weakened, rather than enabling them to prevent this deterioration in the first place (Paragraph 125)

23. The Department's consultation on changes to charging rules for overseas visitors suggested that cost-saving was a key reason for reviewing the regulations. We were therefore astonished that, by the Department's own admission, these changes have been introduced without any attempt at a cost-benefit analysis, and without the Department having even a rough idea of the numbers of individuals that are likely to be affected. While generating even small amounts of savings for the NHS might appear to be worthwhile, in the case of HIV treatment we have received powerful evidence that it would in fact be more cost-effective to provide free HIV treatment to all, as, without treatment, HIV+ individuals living in this country without proper authority are likely to place a far greater burden on NHS resources. We recommend that the Department reviews the financial implications of this policy immediately and, furthermore, that it ensures all its future policy decisions are based on evidence and underpinned by robust cost-benefit analyses, as stipulated by Cabinet Office and Treasury guidelines. (Paragraph 138)
24. In its cost-benefit analysis of the changes to regulations governing access to free NHS treatment for overseas visitors, the Department must also take into account the potential costs associated with increased onward transmission of HIV. (Paragraph 139)
25. We were surprised to learn that no public health impact analysis of these regulations was carried out prior to their enactment, particularly given the level of the public health threat posed by HIV and the increasing rates now being seen in this country. We are aware that public health arguments were put to the Department during its consultation, but these arguments do not appear to have been answered or taken account of. Given the Department's responsibility for safeguarding public health this seems short-sighted, and suggests a lack of coherence within policy making within the Department. We recommend that, in addition to cost-benefit analyses, public health impact analyses be carried out in respect of all Department of Health policies. (Paragraph 145)
26. We are unable to share the Minister's optimistic view that the introduction of charges will have no impact on the numbers of people coming forward for HIV testing. Although charges have been in place for less than a year, the fact that organisations such as the Terrence Higgins Trust are already reporting a growing

reluctance to have HIV tests amongst migrant communities is extremely worrying. (Paragraph 151)

27. Coupled with increasing confusion regarding eligibility for HIV treatment even amongst those who are eligible, and fear amongst migrant communities that if, in future, they attend health services they will be questioned about their immigration status, this strongly suggests that the introduction of charges for HIV treatment will increase the number of HIV+ people living in this country who are unaware of their infection, in direct contradiction of the Government's target to reduce the number of undiagnosed HIV infections. An increase in the numbers of people who are unaware of their HIV+ status will pose a serious and escalating threat to public health. (Paragraph 152)
28. The evidence refutes the Minister's stance that anti-retroviral treatment does not reduce HIV infectivity and therefore has no impact on public health. On the contrary, the scientific literature to date suggests that HIV infectivity is directly linked to viral load, and therefore that treatment which reduces the viral load of HIV+ individuals will potentially reduce onward transmission of HIV. Indeed, the Health Protection Agency, the Government's own public health advisory body, stated unequivocally to us that "if you do not treat individuals and they remain in this country and are sexually active in this country, then the transmission is bound to go up." (Paragraph 161)
29. While we accept that, in giving evidence to us, the Public Health Minister was not supported by a Department of Health official with medical expertise, we are surprised that she appeared so unbriefed on basic aspects of public health prevention. Firstly, many treatments do not reduce the risk of onward transmission to zero. This is the case for genital herpes and for TB, both of which are exempt from treatment charges on public health grounds. Secondly, it is worthwhile reducing the risk of onward transmission of a disease, even if it cannot be eliminated. (Paragraph 162)
30. We welcome the Department's statement that hospital maternity services should always be considered immediately necessary treatment, including, where necessary, HIV treatment. However, evidence presented to us suggests that considerable confusion exists over eligibility for maternity services. If the charging regulations are extended to encompass GP services, this situation is likely to worsen, as primary care is a key access point for ante-natal services. We recommend that the Department immediately issue further guidance to the NHS stating that antenatal and maternity services, including HIV treatment to prevent mother-to-child transmission, must be made available to all women, regardless of their immigration status or ability to fund the treatment. (Paragraph 166)
31. We are extremely alarmed by the prospect of people co-infected with HIV and TB being managed ineffectively. If their underlying HIV is not treated because of cost, they may then default from care and as a consequence transmit TB to as many as 15 people a year. It is a nonsense that the Government is prepared to fund a person's TB treatment on public health grounds but not treatment of his HIV infection. (Paragraph 171)

32. Primary care can be a vital access point for all types of services. This includes services which the Government stipulates must continue to be provided free to all people, regardless of their eligibility status, such as HIV testing, treatment for communicable diseases such as TB, antenatal and maternity services, and “immediately necessary” treatment for emergency problems. Refusing patients free access to GP services could, arguably, be seen to undermine all these exemptions that the Government has made within the charging regime by denying patients access to a first, basic health assessment. We therefore recommend that all people, regardless of their eligibility status, are given access to a free primary care health assessment. (Paragraph 174)
33. We are deeply concerned that neither the Department nor the Public Health Minister appear to have considered or understood the public health implications of refusing HIV treatment to people who, although not legally resident, continue to live in this country. Firstly, it seems that this policy is already deterring people in high-prevalence migrant communities from accessing HIV testing. Equally importantly, by denying people free HIV treatment, a vital opportunity is being missed to reduce by perhaps as much as 60% their likelihood of transmitting HIV within the wider resident population. We dispute the Minister’s view that HIV treatment benefits only the person receiving it, and her view that for a public health intervention to be worthwhile it must reduce the risk of onward transmission to zero – TB and genital herpes are just two examples of communicable diseases for which treatment is currently free where a significant risk of recurrence and onward transmission remains despite a course of treatment. We also have serious concerns about the impact of this policy on mother-to-child transmission of HIV, and of the onward transmission of TB, including drug-resistant strains. (Paragraph 175)
34. During our evidence session, the Minister mentioned the “easement clause” the Government has introduced, which enables clinicians to provide treatment deemed to be “immediately necessary” regardless of a person’s eligibility status. In a subsequent letter she also further emphasised the clause which states that where a person has begun a course of free NHS treatment, that treatment will continue to be free until the course of treatment has been completed. According to the Minister, “for HIV in many cases this will mean treatment will continue free of charge for a very long time”. While we appreciate these attempts on the Government’s part to reduce the impact of the regulations on those who have life-threatening problems or who have already begun treatment, we feel that they do not adequately address the problems that we have identified in respect of HIV. (Paragraph 176)
35. We agree with the Minister that it is appropriate to provide a national health service, not a global one. However, a crucial part of the Government’s responsibility to provide a national health service is to protect the health of the population. Untreated HIV+ people living in this country present a serious public health threat, and we therefore recommend that all HIV+ people, regardless of their immigration status, receive free treatment to reduce the likelihood of the onward transmission of HIV, of mother-to-child transmission of HIV, and of the onward transmission of TB. We believe that to achieve this, HIV should be reclassified as a Sexually Transmitted Infection, which would make treatment automatically free on public health grounds. If, subsequently, there is evidence that as a result of this decision the UK is becoming a magnet for HIV+ people around the world seeking access to free treatment, which

from the evidence we have heard we do not anticipate, the policy can be reviewed.
(Paragraph 177)

Formal minutes

Tuesday 8 March 2005

Members present:

Mr David Hinchliffe, in the Chair

John Austin

Dr Doug Naysmith

Mr Keith Bradley

Dr Richard Taylor

The Committee deliberated.

Draft Report, proposed by the Chairman, New Developments in HIV/ AIDS and Sexual Health Policy, brought up and read.

Paragraphs 1 to 177 read and agreed to.

Resolved, That the Report be the Third Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the provisions of Standing Order No. 116 (Select Committees (reports)) be applied to the Report.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

A Memorandum was ordered to be reported to the House.

[Adjourned till Thursday 10 March at 9.45am.]

Witnesses

Thursday 27 January 2005

Professor George Kinghorn, Consultant in Genito-urinary Medicine and Clinical Director for Communicable Diseases, Sheffield Teaching Hospitals NHS Foundation Trust, **Ms Anne Weyman**, Chief Executive, fpa, and **Dr William Ford-Young**, general practitioner. Ev 6

Ms Lisa Power, Head of Policy, Terrence Higgins Trust, **Dr Max Sesay**, Chief Executive Officer, African HIV Policy Network, and **Mrs Deborah Jack**, Chief Executive, National AIDS Trust. Ev 29

Dr David Asboe, Consultant in Genito-urinary Medicine, Chelsea and Westminster Hospital, **Dr Barry Evans**, Health Protection Agency, **Ms Pam Ward**, Co-Chair, Overseas Visitors Action Support Group, and **Mr Peter Nieuwets**, Chairman, English HIV and Sexual Health Commissioning Group.. Ev 37

Thursday 10 February 2005

Ms Julie Bramman, Head of Curriculum, Specialism and Collaboration, Department for Education and Skills. Ev 45

Miss Melanie Johnson, a Member of the House, Parliamentary Under-Secretary of State for Public Health, **Ms Elizabeth Ryan**, Section Head, Injury Costs Recovery and Charging for Overseas Visitors, and **Mr Geoff Dessent**, Deputy Division Head, Sexual Health and Substance Misuse, Department of Health. Ev 56

List of written evidence

1	Professor George Kinghorn, Genito-Urinary Services in Sheffield (HA 13)	Ev 1
2	fpa (Family Planning Association) (HA 8, 8A)	Ev 2, 13
3	Terrence Higgins Trust (HA 14, 14A)	Ev 14, 32
4	African HIV Policy Network (HA 28)	Ev 17
5	National AIDS Trust (HA 20)	Ev 24
6	Health Protection Agency (HA 35)	Ev 34
7	Department of Health (SH 1, 1A)	Ev 48, 71
8	Medical Foundation for the Care of Victims of Torture (HA 02)	Ev 73
9	Children and Young People HIV Network (HA 03)	Ev 74
10	British Association for Sexual Health and HIV (HA 04)	Ev 76
11	Migrationwatch UK (HA 05)	Ev 82
12	Lesley Lockhart (HA 06)	Ev 83
13	Durex (HA 07)	Ev 83
14	Barnardo's (HA 09)	Ev 86
15	Faculty of Family Planning & Reproductive Healthcare (HA 10)	Ev 88
16	Brook (HA 11)	Ev 90
17	Positively Women (HA 12)	Ev 91
18	Family Education Trust (HA 16)	Ev 93
19	Dr Anatole Menon-Johansson (HA 17)	Ev 94
20	Dr Colm O'Mahony (HA 18)	Ev 97
21	Royal College of Nursing (HA 19)	Ev 97
22	Joint Council for the Welfare of Immigrants (HA 21)	Ev 100
23	Dr Jane Anderson (HA 22)	Ev 101
24	Providers Association for AIDS Care and Treatment (HA 23)	Ev 102
25	Dr Paul Williams (HA 24)	Ev 103
26	Royal College of Paediatrics and Child Health (HA 25)	Ev 107
27	Association of Directors of Social Services (HA 26)	Ev 109
28	Medical Foundation for AIDS and Sexual Health (HA 27)	Ev 110
29	National Study of HIV in Pregnancy and Childhood (HA 29)	Ev 115
30	Dr Mayura Nathan (HA 30)	Ev 116
31	Royal College of General Practitioners (HA 31)	Ev 117
32	Medecins du Monde UK (HA 32)	Ev 120
33	British Medical Association (HA 33)	Ev 126
34	Linda Grant (HA 35, 35A)	Ev 130
35	Nigel O'Farrell (HA 36)	Ev 133
36	Department of Health (HA 1B)	Ev 133
37	William Ford-Young (HA 37)	Ev 134
38	Department of Health (HA 1C)	Ev 135

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074) hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

Loud Mouth (HA 15)

William Ford Young (HA 37A)

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2004–05

First Report	The Work of the Health Committee	HC 284
Second Report	The Prevention of Venous Thromboembolism in Hospitalised Patients	HC 99

Session 2003–04

First Report	The Work of the Health Committee	HC 95
Second Report	Elder Abuse	HC 111 (Cm 6270)
Third Report	Obesity	HC 23 (Cm 6438)
Fourth Report	Palliative Care	HC 454 (Cm 6327)
Fifth Report	GP Out-of-Hours Services	HC 697 (Cm 6352)
Sixth Report	The Provision of Allergy Services	HC 696 (Cm 6433)

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395 (Cm 5876)
Third Report	Sexual Health	HC 69 (Cm 5959)
Fourth Report	Provision of Maternity Services	HC 464 (Cm 6140)
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571 (Cm 5896)
Sixth Report	The Victoria Climbié Inquiry Report	HC 570 (Cm 5992)
Seventh Report	Patient and Public Involvement in the NHS	HC 697 (Cm 6005)
Eight Report	Inequalities in Access to Maternity Services	HC 696 (Cm 6140)
Ninth Report	Choice in Maternity Services	HC 796 (Cm 6140)

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308 (Cm 5567)
Second Report	National Institute for Clinical Excellence	HC 515 (Cm 5611)
Third Report	Delayed Discharges	HC 617 (Cm 5645)