

Austerity and sustainable sexual and reproductive health care

English sexual and reproductive health (SRH) services are commissioned by local authority councils from their public health budget. Their allocations are predicted to shrink by up to 50% by 2017.¹

To show that SRH care is good value for money it has to generate net earnings or net savings for those commissioning services. Clinical commissioning groups (CCGs) and NHS (National Health Service) trusts gain little from preventing uncomplicated pregnancies because they generate a net income from these pregnancies. SRH commissioners do not fund maternity care, abortion services, paediatric care or services for children and as a result do not benefit from any savings created from prevention initiatives. In order to have sustainable services we need to work with those who will have a net savings as a result of our care. New funding could come from two sources: (1) NHS or mental health trusts and (2) social services.

Most SRH services in England are now also integrated with hospital-based genitourinary medicine services and some struggle to find recognition for their role. Community SRH (cSRH) needs to deliver a service that no one else can deliver *and* generate savings for funders. The key to this is *community*. A community is a social unit defined by shared values, norms, needs, customs, habits, behaviour and beliefs including health beliefs. A patient's SRH is strongly influenced by these factors and understanding the cultural needs or the 'community needs' of our patients is essential for the provision of high-quality care. Providing culturally appropriate care is a prerequisite for access to care under a human rights framework. The ecological niche for SRH is defined by four criteria:

- 1 It requires more medical expertise than primary care can provide.
- 2 It requires more cultural competency than hospital-based services can offer.
- 3 The biomedical content or the patient group needs are complex enough to warrant specialist services.
- 4 Health gains or societal gains have to be high enough to convince commissioning to invest in cSRH.

The ecological niche for cSRH services is anything but narrow. Maternity care providers have a financial interest in contraception for patients with multiple or complex medical conditions such as morbid obesity, chronic infections, cardiac disease, severe mental illness or learning disability as pregnancies in these women would create net losses.² Yet there are many communities meeting all four criteria mentioned above which are currently not receiving nearly as much attention as they should.

The most obvious are women who have or had their children taken into care. Many of them have had too many traumatic experiences to trust people in authority and one size will definitely not fit all. We know that women with severe drugs and alcohol problems do not use conventional SRH services because of "a range of practical, social and emotional barriers".³ The same is likely to be true for the 1 in 220 people in England with a learning disability and the 1 in 400 who use secondary care mental health services. Meeting their SRH needs is not only likely to be cost saving but it is also their human right.

In England on 31 March 2015, 69 540 children were in care costing £36 524/year per child and £2.49 billion for child care alone in 2013/2014.⁴ These children came from well-defined groups: many have siblings who have been taken into care and most of their parents had drug or alcohol addiction, serious mental health problems or were victims of domestic violence. The Framework for Sexual Health Improvement in England supports a focus on this population group: "Care pathways should be in place for those women who need support from mental health, domestic or sexual violence, drugs and/or alcohol services".⁵

With better SRH care for these patients everyone benefits: patients benefit because their pregnancies are planned, they receive appropriate pre-conception care and they are also spared the risks and distress of an unplanned pregnancy; NHS and mental health trusts benefit because pregnancies that generate net losses are prevented; SRH departments benefit because their highly trained staff will enjoy providing complex care; and maternity services benefit as their case mix becomes more profitable.

A service that saves money by providing contraception to people at the margins of society must have the highest ethical standards and must from the very outset be driven and protected by a human rights-based approach. To reach these patients we have to leave our comfort zone and also deliver care to people with chaotic lives in new clinical or non-clinical environments. We need to make new efforts to fill a genuine ecological and market niche for complex patients with complex social or medical needs. To achieve meaningful impact we need joined up commissioning involving sexual health commissioning, mental health commissioning (CCGs), social services and other local commissioning areas, and national government departments in the case of asylum seekers.

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