

Department of Health response to the public's comments on The Coalition: Our Programme for Government on Public health.

Thank you to all the people who submitted comments about public health services. The top three issues were about the need for better health prevention, the need for better sexual health services and whether the NHS should charge patients who are treated for lifestyle illnesses.

Preventative health care is better than cure

We will set out our programme for public health in a White Paper later this year. The forthcoming Health Bill will support the creation of a new Public Health Service. This service will integrate and streamline existing health improvement and protection bodies and functions. There will be an increased emphasis on research, analysis and evaluation.

PCT responsibilities for local health improvement will transfer to local authorities, who will employ the Director of Public Health jointly appointed with the Public Health Service. The Department will create a ring-fenced public health budget and, within this, local Directors of Public Health will be responsible for health improvement funds allocated according to relative population health need. The allocation formula for those funds will include a new “health premium” designed to promote action to improve population-wide health and reduce health inequalities.

Improving sexual health services

Improving sexual health, by reducing unintended pregnancies and sexually transmitted infections is very important. Young people need

the right information and advice to make responsible choices. We will be considering how we can tackle these issues.

To help us improve our knowledge of what works, we have commissioned a review about what works in ensuring sexual health. This will examine a number of issues including behaviour change, strengthening links with other public health areas, improving value for money and prevention.

We are examining the links between poor sexual health, risk taking behaviour and alcohol use. We have commissioned a report analysing the data on these issues and are piloting the effectiveness of alcohol brief interventions in different sexual health settings.

On abortion, it is accepted Parliamentary practice that proposals for changes in the law on abortion have come from back bench members and that changes to the law are made on the basis of free votes.

Charging for NHS treatment due to lifestyle illnesses

People's misuse of alcohol and drugs does place significant strain on emergency services, but there are both ethical and practical reasons not to seek payment from patients.

The founding principle of the NHS is that services are free of charge, available to all on the basis of need, not ability to pay. The NHS is funded accordingly, from general taxation (including taxes on alcohol). If charges were to be made when a condition is linked to lifestyle, this would set a precedent that could extend to, for example, sports injuries.

Further, defining and identifying 'culpable' patients would be difficult in legislation, difficult in practice and time-consuming for NHS staff. For example, separating "victims" and "culprits" of intoxicated injury may be difficult.

Lastly, the cost or stigma could deter people from using the NHS, putting their health at risk and potentially increasing long-term NHS costs.

The Government is giving local areas more powers on alcohol licensing to help tackle the crime, disorder and acute harm caused by alcohol.

Background

Preventative health

The response is taken from the Health White Paper “ Equality and Excellence: Liberating the NHS” published on 12 July.

On 7 July the Secretary of State for Health spoke at the UK Faculty of Public Health’s annual conference.

The Government’s plans to create a healthy nation are centred on a whole new approach which focuses on behaviour change; and which goes beyond constraining the supply of illegal drugs, alcohol and tobacco, and begins to understand and influence the drivers of demand.

The framework of empowerment includes:

- A new responsibility deal between Government and business built on shared social responsibility and not state regulation;
- A new ring-fenced public health budget;
- A new ‘Health Premium’ to target public health resources towards the areas with the poorest health;
- Clear outcomes and measures to judge progress alongside NHS and social care outcomes;
- An enhanced role for Public Health Directors so they have the resources and authority to improve the health of their communities; and
- A new Cabinet Sub-Committee on Public Health, chaired by the Health Secretary, to tackle the drivers of demand on the NHS.

A White Paper, to be published later this year, will set out in more detail how a new Public Health Service will work.

The structure and nature of the public health service is still being worked through as will the way the ring fenced budget works. But, in essence by separating out public health resources from health care the concern expressed that health care and other priorities override it is being addressed.

Sexual health

Good sexual health is important for individuals, families, society and the wider public health. The consequences of poor sexual health are serious and can include some cancers, pelvic inflammatory disease, infertility and in the case of late diagnosis of HIV, death. Teenage pregnancy is associated with a range of poor outcomes for the mother and child. Preventing sexually transmitted infections (STIs) and unintended pregnancy is influenced by a number of factors. These include effective health promotion services covering access to condoms and contraceptive choices as well as prompt access and referral to diagnostic and treatment services, including abortion and HIV services. Not all STIs have symptoms so early diagnosis and treatment is essential along with behavioural change to prevent onward transmission. Other risk-taking behaviours (such as alcohol and drug abuse) can also contribute to poor sexual health outcomes.

A Healthier Nation, highlighted the fact that the UK has some of the highest rates of poor sexual health in Europe. It also highlighted the need to address health inequalities. In addition to socio-economic inequalities, sexual health inequalities exist between different ages, sexualities and in some minority ethnic groups. For example, young people (16-24 yrs) are disproportionately affected by sexually transmitted infections (STIs), gay and bisexual men by HIV and STIs. Unlike most other areas of public health there is considerable stigma attached to HIV, STIs and abortion which can impact negatively on health and wellbeing outcomes as well as the offer and uptake of services.

Key facts and statistics

- over 2million attendances at genito-urinary medicine (GUM) services, with 356,329 STI diagnoses (2008),
- 83,000 people living with HIV, of whom 27% are unaware of their infection (2008), 6,900 new diagnoses of HIV in 2009,
- 1,524,339 chlamydia tests in community settings were reported to the National Chlamydia Screening Programme (NCSP) - 6% tested positive (2009/10),
- 2.5m attendances by 1.3m individuals at community sexual and reproductive health services (mainly for contraception 2008/09),

- 3.7m women receiving contraception from general practice and an unknown number attend for STI testing and treatment (2008/09)
- 180,259 abortions (acute and independent sector) in 2009. Since 1992, abortions have steadily increased with the exception of the last two years where there has been a fall,
- around 1.6m supplies (over the counter and prescription) of emergency contraception each year,
- rate of under-18 conceptions has decreased for the last six quarters. The rate for the last full year (2008) was 40.5 per thousand. Despite recent decreases, England still has one of the highest rates in Europe.

Costs to society (including the NHS)

- Annual NHS spend on HIV treatment is around £650 million.
- Abortions in NHS hospitals cost around £82m each year however, this only covers 40% of procedures.
- Spend on GUM services is around £250m each year.
- Spend on contraception is around £173m each year.

Charging for NHS services

Alcohol places significant strain on emergency services – estimated at 35% of total A&E and ambulance costs. A 2003 survey showed that 70% of A&E attendances between midnight on Saturday and 5am on Sunday may be alcohol related.

However, there are significant practical and ethical concerns about the proposal to seek reimbursement:

- Charging individuals for hospital / A&E attendance costs would contradict the principle (reinforced in the NHS Constitution) that patients have a right to receive NHS services **free of charge**. The NHS cannot charge patients, either before or after they access services, without specific legislation to create an exemption (e.g. as is the case for prescriptions).
- In addition, the health harms caused by alcohol misuse present at A&E alongside all the other accidents, poisonings, para-suicides, falls, victims of assault, sporting injuries etc. It is in the nature of A&E departments that they treat acute health harms resulting from a very wide range of human activities, lifestyle choices and misadventure. All of these are paid for via general taxation and National Insurance contributions from the population, without discrimination against any particular type of misadventure (such as misuse of alcohol).
- Supporters of charging would presumably agree that it would be inappropriate to charge someone who is a victim of violence (even if they are drunk themselves), or someone involved in an accident which may, or may not have been caused by the fact that they are drunk. Identifying the 'correct' patients would be challenging and place an additional burden on NHS staff.
- Even if it were possible to do this for alcohol, doing so would create the precedent that people presenting with avoidable conditions linked to their lifestyle should reimburse the NHS. This

would be a fundamental new paradigm with policy implications in a large number of areas including Public Health (Tobacco, Obesity, Exercise, Drugs and Sexual Health as well as alcohol) and diseases such as cancers, CVD and diabetes where lifestyle is a direct or contributory cause.

Alcohol officials are not aware of any plans by Ministers to introduce charging for conditions linked to alcohol or other lifestyle factors.

Coalition Programme commitments on alcohol focus on crime, and include plans to ban selling alcohol below costs, and to overhaul the Licensing Act to give local areas more powers.

Health policy on alcohol (under the new Government) is at fairly early stages. Key components will be cross-government working through HA(PH) committee, external partners including the drinks industry, the Responsibility Deal, and the new Public Health Service. Ministers are keen that the NHS offer early intervention for increasing- and higher- risk drinkers, and treatment for dependent drinkers.

Further information on the PFG website

- [Public comments on Public health](#)
- [Video response from Oliver Letwin and Danny Alexander](#)
- [All government responses to public comments](#)