Women and Equalities Committee: Women's Reproductive Health Inquiry
Submission from the Advisory Group on Contraception

Introduction

The Advisory Group on Contraception (AGC) is an expert advisory group of leading clinicians, commissioners, professional organisations, and advocacy groups. Since its formation in 2010, the AGC has been advocating for all women[1] to have ready access to high quality provision of the full range of contraceptive options – in their preferred setting – as part of a robust, and properly funded, approach to reproductive health and prevention.

Poor reproductive health can have a profoundly negative impact on a woman's life, and can often be traced back to services that are not effectively built around women's needs. All women have the right to access high-quality reproductive healthcare across the life course – regardless of their background or location. Yet, too often access to care is hampered by a range of barriers, from fragmented commissioning to postcode lotteries. We are therefore pleased to see the Women and Equalities Committee launch an inquiry into women's reproductive health and welcome the opportunity to help inform the Committee's thinking.

Submission summary

Through its next steps in implementing the Women's Health Strategy for England, it is essential that the Government prioritises holistic and prevention-focused reproductive healthcare across the life-course. Supporting women to achieve and maintain improved reproductive health wherever possible will have a tangible impact on women's everyday life, across the personal and professional spheres. It would also serve to reduce the number of women requiring admission to hospital due to severe and avoidable menstrual and gynaecological symptoms – thus reducing pressure on already overstretched gynaecology services in secondary care.

While the AGC advocates for all women to have open access to, and choice of, the full range of contraceptive methods, this submission focuses largely on long-acting reversible contraceptive (LARC) methods. This is because, under national NICE guidelines, the intra-uterine system (IUS) – a form of LARC – is the recommended first-line treatment for heavy menstrual bleeding (HMB). HMB is one of the most common reasons for gynaecological consultations in both primary and secondary care.[2] LARCs can also form an important component of hormone replacement therapy (HRT) regimes for women going through menopause. However, the role of contraception in supporting gynaecological health is often overlooked, and access to LARC for these purposes subject to significant barriers in many parts of the country. Our submission explores these challenges in further detail, before setting out our recommendations to facilitate universal access to high-quality reproductive healthcare services for all women.

What constitutes healthy periods and reproductive health?

Reproductive health extends across the life-course, from puberty to menopause and beyond. While women's needs and preferences will evolve throughout each stage of the life-course, it is now widely recognised that an optimal approach to reproductive healthcare should focus on prevention and health promotion: Professor Dame Lesley Regan, the Women's Health Ambassador for England, rightly highlights that "the vast majority of times when women consult healthcare professionals, they're not ill, they're simply trying to maintain their health."[3]

For the majority of women, periods will form a central part of their reproductive health experience. Despite the universality of periods, periods remain subject to significant taboo and stigma, and many women suffering from problem or painful periods continue to report feeling unheard and belittled by the healthcare system.[4] While over 25% of women are thought to experience HMB symptoms, most women affected by HMB do not seek medical care.[5]

All women should feel confident that they can consult their healthcare professionals with problem periods, and feel assured that in doing so they will be provided with a range of care options that enable shared and informed decision making. The AGC advocates for a primary care-first approach to reproductive and gynaecological healthcare. This should facilitate prompt and proactive treatment for more common conditions such as HMB, and ensure swift referral pathways are in place for those women requiring more specialist support from secondary care gynaecology services. The Women's Health Hub model – currently being replicated in each Integrated Care System (ICS) in England through the implementation of the Women's Health Strategy – presents a clear opportunity to embed such an approach, supporting women to maintain their reproductive and gynaecological health and easily access care when experiencing unusual symptoms.

Women's Health Hubs must enhance and streamline primary care provision of LARC across both contraceptive and gynaecological indications, taking into account the far-reaching impact of access to reproductive health services. For example, challenges accessing contraception, along with the cost-of-living crisis, have been attributed to unprecedented levels of demand for abortion services. With abortion providers under pressure, more and more women are having to make difficult choices quickly about their reproductive health. This makes flexible abortion access through telemedicine and early medical abortion at home more vital than ever for those women who need it, as part of a system that enables every women to choose the best place to access reproductive healthcare for her own, individual needs.[6] To realise this vision, action will be required to address the current systemic challenges which all too often undermine women's access to high-quality and responsive reproductive healthcare. These challenges are outlined below.

What are women's experiences of being diagnosed with, undergoing procedures and being treated for gynaecological or urogynaecological conditions?

The AGC does not feel best placed to answer this question.

What disparities exist in the treatment and diagnosis of gynaecological or urogynaecological conditions?

Significant disparities exist in the treatment of gynaecological conditions and the standard of reproductive healthcare that women receive. Looking at access to LARC, for example, the latest available data from the Office for Health Improvement & Disparities (OHID) shows that total prescribed LARC (excluding injections) varies significantly across England: in 2021 the London region had a rate of just 30.4 per 1,000 women, while the South West region had a rate of 58.1 per 1,000. Even within higher-performing regions such as the South West, LARC uptake ranges from 20.3 per 1,000 women to 75.1 per 1,000 women. The most deprived parts of England are those most affected by poor LARC access.[7]

The majority of women with HMB can be managed and supported by primary care – making admission to secondary care an often avoidable outcome that is suboptimal for women and costly to the NHS. While waiting for a referral, women may find their symptoms worsening, for example through developing mental health issues or blood-loss related anaemia. NHS data shows that over 25,000 women were admitted to hospital with a primary diagnosis of HMB in 2021/22,[8] with

previous national audits revealing significant variation in the extent of treatment offered to women in primary care between different parts of the country.[9] This suggests that in some areas, opportunities are being missed to provide women with the most appropriate care for menstrual conditions, closer to home.

To improve access to swift and appropriate HMB treatment for all women, regardless of background or location, the Government must support all ICSs to bring more provision of gynaecological LARC out of hospital – ensuring that the postcode lottery is not inadvertently further entrenched by devolution to the system level.

What barriers exist in the treatment and diagnosis of gynaecological or urogynaecological conditions?

Across women's gynaecological and reproductive health, services are too often not designed around women's needs. This can prevent women from receiving the care they need in a timely or streamlined manner and can increase systemwide costs. For example, the postcode lottery in access to LARC as a treatment for HMB is largely shaped by highly fragmented commissioning arrangements. Under the current framework, local authority commissioners are responsible for LARC for contraceptive purposes, and NHS commissioners are responsible for gynaecological LARC commissioning – although, concerningly, anecdotal evidence suggests that some integrated care boards (ICBs) are not aware they are responsible for commissioning LARC for gynaecological purposes. According to a survey conducted by Primary Care Women's Health Forum, around a third of GP practices are only commissioned to fit LARC for contraception, and not for HMB or menopause – despite this requiring the same skills.[10] Of those GP practices who are commissioned to fit gynaecological LARC, only 16% report that the fitting fee is adequate to cover the cost of providing the service.[11]

As a result, women must seek care from secondary or community services, leading to delays in treatment and unnecessary burden on secondary care. This also comes at a cost to the system: LARC fittings in secondary care cost the NHS £221 per procedure under the national tariff[12] – estimated to be 68% more expensive per appointment than carrying out the same procedure in a Women's Health Hub.[13] 23% of HMB spells are estimated to lead to an operation in secondary care,[13] which, in the case of hysterectomy, can cost the NHS as much as £3,000.[12]

Women's health hubs represent a positive step to addressing some of these challenges, and it is welcome that the Department has asked ICBs to establish LARC provision across gynaecological and contraceptive purposes as a core offer of their Women's Health Hubs.[14] The scale of the current fragmentation, however, will mean that ICBs require robust support and guidance to translate this ambition into reality. In addition, women's health hubs should not be seen as a cure-all. It will be some time before women in every part of England are covered by a women's health hub, and in some areas – such as rural regions – this model may be ineffective or unfeasible. Across women's health hubs, barriers such as a lack of trained fitters and inadequate funding will continue to present barriers to care without concerted action across the system to ensure resources are being pooled and managed in the most effective way.

Recommendations for action

Ongoing work to implement the Women's Health Strategy provides a very real opportunity to help every woman in England achieve optimal reproductive and gynaecological outcomes. While the Government has rightly acknowledged that ICSs should have the freedom to design Women's Health Hubs around the specific needs of their local populations, it is imperative that national policymakers

retain sufficient oversight to ensure ICSs are appropriately supported and that transformation is harnessed equitably.

We would encourage the Government to take the following actions:

1. **Take steps to realise the Women's Health Strategy commitment to *"set out our plans for sexual and reproductive health… [include] a focus on increasing access and choice for all women who want contraception, including LARC".*** Since the launch of the Strategy, we are concerned that the Government has rowed back on this commitment, and thus risks limiting the success of women's health hub efforts in offering LARC to manage menstrual and gynaecological conditions in addition to pregnancy prevention.

2. **Disseminate clarification to ICBs on the commissioning framework for LARCs.** Supplementing national guidance already in development on women's health hubs, the Department of Health and Social Care should ensure that all ICBS are aware of their responsibilities with regards to LARC for gynaecological purposes. It should also ask all ICBs to explore collaborative commissioning with their local authority counterparts, streamlining primary care access to LARC across the indications – this should include areas which will not be served by the first generation of women's health hubs, ensuring women in these areas are not left behind.

3. **Ask the newly appointed network of ICS Women's Health Champions to review LARC access in their area.** The Government's decision to ask each ICS to nominate a Women's Health Champion is extremely welcome, and follows advocacy on this issue from the AGC and many other community stakeholders. We believe these Women's Health Champions would be well-placed to lead local reviews of LARC access in their area, which should include compiling information on the availability of gynaecological LARC in primary care. This will ensure every ICS footprint has a baseline understanding of the local situation, and the steps required locally to improve women's access.

We hope to see the Committee further exploring these issues in the course of its inquiry and would be pleased to meet with members to share any additional insight or support.

For further information, please contact AGC@incisivehealth.com.

Advisory Group on Contraception, September 2023

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[1] **The AGC recognises that access to contraception is essential for everyone who can become pregnant, no matter how they identify, and therefore supports and advocates for the right to access contraception for trans, non-binary and intersex people that need it. It is essential that there is an understanding of intersectionality to help minimise inequalities in care and the provision of essential service. We use the word women for simplicity but also in recognition that the majority of those requiring access to contraception identify as women.**

[2] NICE, Heavy menstrual bleeding: assessment and management, last updated March 2018
[3] Women's Health Magazine, What's next for the Women's Health Strategy? We went to Downing Street to find out...., March 2023
[4] Department for Health and Social Care, Women's Health Strategy for England, July 2022
[5] Fraser et al, Prevalence of heavy menstrual bleeding and experiences of affected women in a European patient survey, International Journal of Gynecology & Obstetrics, Volume 128, Issue 3, March 2015, Pages 196-200
[6] MSI Reproductive Choices, Why is the abortion rate rising?, June 2023

[7] Office for Health Improvement and Disparities, Sexual and Reproductive Health Profiles: Total prescribed LARC excluding injections rate / 1,000, last accessed August 2023
[8] NHS Digital, Hospital Episode Statistics (HES), Hospital Admitted Patient Care Activity, 2021-22: Diagnosis, September 2022
[9] Royal College of Obstetricians, Advice for Heavy Menstrual Bleeding (HMB) Services and Commissioners, November 2014, Data on file
[10] Primary Care Women's Health Forum, LARC Fitter Survey Results, June 2020
[11] Primary Care Women's Health Forum, On the brink: The reality of Long-Acting Reversible Contraception (LARC) provision in primary care, June 2023
[12] NHS England, 2020/21 National Tariff Payment System: national prices and prices for blended payments, accessed July 2023
[13] Department of Health and Social Care, Women's health hubs: cost benefit analysis, July 2023
[14] Department for Health and Social Care, Women's health hubs: core specification, July 2023