Scottish Parliament Health and Sport Committee

Preventative Agenda: Sexual Health and Blood Borne Virus Framework

Response from Professor David Goldberg on behalf of HPS

To what extent do you believe the Scottish Government’s Sexual Health and Blood Borne Virus updated Framework and the approach by Integrated Authorities and NHS boards is preventative?

The Sexual Health and Blood Borne Virus Framework (2015 – 20) is underpinned, at a national level, by a web of national networks and a national (and local) data resource; these are managed by Health Protection Scotland. From the national network perspective, the networks are comprised of representatives from each NHS board, SG and the third sector; administrative and scientific support is provided by Health Protection Scotland. Some of the networks are clinical but two are devoted to primary prevention – the sexual health promotion network and the blood borne virus prevention (injecting drug use related) network. These primary prevention networks cover vital areas, associated with the Framework, from a preventative perspective; the purpose of these national networks is to share best practice, to assess the performance of existing preventative interventions, to make recommendations regarding the improvement of existing interventions or the need for new interventions, and to generally provide preventative leadership. The networks report into the Framework Executive Leads Group which is presided over by the Scottish Government.

From an information perspective, national outcome indicator data (relating to Framework outcomes) are collected by HPS and other organisations. These data reside on a national data portal, now accessible to the general public, which is managed by HPS. A considerable amount of data, held on the portal, relate to outcome indicator 1 (the primary prevention outcome); these data are highly sophisticated and, in terms of quality and comprehensiveness, are among the best in the world.

Accordingly, from the national leadership, advocacy, governance and knowledge perspectives, the Framework works extremely well and the preventative (primary prevention) component is very well represented.

Is the approach adequate or is more action needed?

Because of the excellent arrangements as above, policy/strategy is optimal or near optimal. As far as implementation is concerned, the NHS boards/local authorities would need to provide a view. There is no doubt that financial pressures do make it difficult to maintain and further develop critical preventative measures. The people working in the NHS board Health Protection Units, in particular, are under an enormous amount of pressure. They do a very fine job but, from a Framework perspective, they are thin on the ground in some NHS Boards. My own perception is that, certainly at a local level, the Framework may have served clinical services better, in terms of resources, than prevention services.
Are the services and Sexual Health and Blood Borne Virus updated Framework being measured and evaluated in terms of cost and benefit?

Certainly, in terms of benefit, preventative measures are being evaluated through the collection, collation and analysis of outcome indicator data. Also the Executive Leads Group, chaired by SG, has the job of assessing the benefits of Framework interventions and investments at the macro level. Formal, analytical analyses of costs and benefits are not undertaken; it would be helpful if the Framework could call upon a health economist to undertake such work;

Given the high cost of new medicines, what cost benefit analysis is being done of primary prevention in general and the role of the new medicines as a means of primary prevention?

My point about having a health economist attached to the framework – someone working alongside HPS, the NHS boards and the third sector in particular-- would be of great assistance in this respect. To my knowledge, the idea has not been raised before; if there was a general agreement to pursue this direction, there would be financial implications (albeit relatively minimal ones).

As far as the new medicines as a means of primary prevention are concerned, the relevant infections are HIV and Hepatitis C. For HIV, Scotland has just recently introduced HIV Pre-exposure Prophylaxis for, in the main, high risk MSM. The national HIV PrEP Coordination Group, chaired by myself, is overseeing the evaluation of the impact of this intervention. The SMC approved Truvada for HIV PrEP on the grounds that it was safe and highly cost effective. Since November 2017, generic drugs have become available, reducing the cost of a course of therapy almost tenfold. So a prophylactic agent which was deemed to be highly cost effective is now extremely cost effective. Of course the proof of the pudding is in the eating and Scotland is in a good position to monitor the impact of this intervention.

On the Hepatitis C front, a key question is-- does the treatment of Hepatitis C among active PWID (people who inject drugs) have a population benefit (prevention of onward transmission) as well as an individual one? Modelling work, published in the scientific literature and commissioned by Health Protection Scotland, has demonstrated potential benefit. A study, funded by NIHR and the pharmaceutical industry, is being undertaken in Tayside to evaluate the impact of such an intervention but it will take some years to determine the outcome. If the Hepatitis C therapies were low cost it would make sense to treat all HCV infected active PWID regardless; however, they still cost several thousand pounds and drug treatment budgets are under severe pressure.