

# Response to Closure of Brisbane Sexual Health Service and reduction in HIV services by Metro North Hospitals and Health Board

Dr Theo van Lieshout 23 July 2013

On Thursday 11 July 2013 the Metro North Hospitals and Health Board (the Board) announced that the Brisbane Sexual Health and Human Immunodeficiency Virus (HIV) Service (SHHS) located at "Biala" in the Brisbane CBD will to be reduced from 46 full time staff positions to 10 positions. 6 positions are to be transferred away from the service and 30 positions will be abolished. 15 specialist sexual health nurses, three specialist sexual health doctors and 12 allied health and administrative support staff will be axed. These staff numbers are best estimates because documents from Queensland Health are imprecise. The orders of magnitude however are accurate.

The proposed implementation date documented by the Board is 31 July 2013. Another date for closure "after a transitioning process" is said to be 1 October 2013 for the sexual health staff. The staff slated for abolition have not been informed which date their pay cheques from Queensland Health will cease.

Prior to the decision of 11 July, on 28 February 2013, the Board announced a reduction in staff to 9.5 positions without any consultation with staff at the SHHS or the relevant institutions and in direct conflict with accepted medical research and practice. A public outcry ensued and on 28 March 2013 the Board Chair, Dr Paul Alexander, announced that no change was to occur at the service pending an "independent" review of the service by the UK company, Deloitte Touche Tohmatsu Limited. The outcome of the audit is contained in a report released to all staff following the announcement of the abolition of 30 staff positions. The net effect is the closure of the current frontline, "walk-in" sexual health service and the retention of a reduced HIV service. The SHHS provides clinical service delivery to approximately 12,000 patient-visits a year including an HIV positive caseload of around 800 patients. The vast majority of these patients (not clients!) will require alternative avenues of treatment between 31 July 2013 and 1 October 2013. This service currently costs 5.5 million dollars a year to run. The Board's original aim was to reduce the cost of the running the service to 1.5 million dollars a year. By retaining 10 full time staff positions and transferring 6 positions, the cost of the new service will be about 2 million dollars a year. The net "saving" for the Queensland government in the short-term is in the order of \$3.5 million dollars a year. The bulk of the Deloitte's report focuses on how to reduce the HIV patient caseload over a ten month period.

Sexual Health Medicine is a recognized specialty by Queensland Health. Sexual health physicians perform clinical and public health roles to identify, screen, diagnose, investigate, treat and prevent ongoing transmission of sexually transmitted infections (STIs), including those classified as Notifiable Diseases (gonorrhoea, chlamydia, syphilis, chancroid, lymphogranuloma venereum, donovanosis, hepatitis B, Hepatitis C and HIV) and other STIs such as herpes and genital warts. Dermatological genital conditions and transgendered patients are managed. Prevention counselling, condom provision and management of the psychological consequences of STIs are all aspects of a sexual health physician's role. Contributing to public health sexually transmitted disease surveillance is an important aspect of the sexual health physician's role. For example, gonorrhoea treatment presents a major global problem because certain strains of the infection identified in Japan (Strain H041) and France (Strain F89) are resistant to all currently available antibiotics in the community settings. Furthermore gonococcal strains from the South-East Asian region present ongoing challenges because of widespread indiscriminate use of antibiotics in this region. If these strains are not identified early upon arrival in Australia and managed accordingly, they may "escape" into the broader community. This will result in an increased burden on hospitals and poses a major public health problem for the Queensland health system. Australia has a network of over 70 public sexual health clinics, all of which provide an integrated service delivery model which, to date, maintains rates of STIs including HIV in Australia among the lowest in the developed world. By closing the largest sexual health service in a major Metropolitan city in Australia, a breach in the defensive network in the control of STIs and HIV in Australia will be created.

The Board is removing the sexual health service based on Deloitte's report. This report is fundamentally flawed in its recommendations. It is internally inconsistent in its rationale and medically dangerous. Though the report recognises that there are major public health risks for patients with STIs and HIV as a result of reducing the service (page 86), it provides either no strategy or ill-defined strategies to mitigate the risks. As a sexual health physician, it is my view that the financial and public health costs of implementing the mitigating strategies suggested by Deloitte may be greater than the cost of maintaining the current service as it is.

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The major flaws and inconsistencies in the report are:

- on Page 31 the report recognises and acknowledges that STIs are a co-factor in the transmission of HIV. It states "... testing and management of STIs is a key component of both delivery of care to HIV patients and preventing HIV". This is consistent with current medical research about the interrelationship between Sexual Health medicine and HIV medicine. Associate Professor Edwina Wright, the President of the Australasian Society of HIV Medicine (ASHM) released a statement in March 2013 stating that sexual health and HIV medicine cannot be un-coupled. As sexual health specialists, we know that there is a two to five fold increased risk of HIV transmission in patients already infected with an STI (Centres for Disease Control in the USA). The Board accepts the advice of accountants about medical care for HIV patients and ignores the medical opinions of sexual health experts in the field of HIV and sexual health medicine.
- the report recognises that rates of STI and HIV infections will rise where patients cannot access appropriate treatment. The report then recommends disaggregation of the sexual health service from the HIV service despite acknowledging the need for access to appropriate treatment. It states, "the risks and implications of transferring non-complex STIs will need to be determined." In Australia, medically appropriate treatment for targeted at-risk patients is to receive comprehensive, accessible, free and confidential medical management at a dedicated sexual health service. Thus sexual health services cannot be "disaggregated" from HIV care.

A chapter is devoted to identifying key risks to patients associated with removing the sexual health component and reducing the HIV patient caseload from the service:

- clinical risks of transferring patients to other services
- the capability and capacity of other Health Service Districts in Queensland to deal with transferred patients
- the care for socially vulnerable people and overseas visitors
- the capability of GPs to deal with patients infected with STIs especially homosexual men and very young people
- the capacity for GPs with appropriate qualifications to manage HIV
- the problem of co-payments in the primary care sector
- access to HIV pharmaceuticals in the private sector

These risks are not addressed in the final recommendations. It is medically reckless for the Board to accept the recommendation to decouple sexual health services from HIV when a responsible strategy for mitigating these risks has not been investigated and where existing service provision is of a high standard and cost effective nationally and globally.

The report pays scant attention to the national strategies for controlling the transmission of a number of Notifiable diseases such as HIV and including gonorrhoea, syphilis, chlamydia and hepatitis. Queensland along with all states has obligations regarding the screening, control and treatment of Notifiable diseases and the Brisbane clinic forms part of this network. These strategies include the:

- 6th National HIV strategy 2010 - 2013
- 3rd National Hepatitis C strategy 2010 - 2013
- 2nd National Sexually Transmissible Infections Strategy 2010 - 2013
- 1st National Hepatitis B strategy 2010 - 2013

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- 3rd National Aboriginal and Torres Strait Islander (ATSI) Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010 - 2013.

The national strategies target the following groups - homeless populations, mental health patients, Intravenous drug users, commercial sex workers, youth, ATSI people, culturally and linguistically diverse populations, men who have sex with men (MSM) and travellers to and from overseas. The removal of Queensland's largest sexual health service from this robust national treatment and surveillance framework threatens Australia's position as a global leader and model for the treatment of sexually transmitted Notifiable diseases. If the Board's policy to remove sexual health services from this service is implemented, it provides a model for state governments seeking quick and short-term health budget gains to follow suit. It is a *fait accompli* that all sexual health services throughout Queensland clinics will be removed.

Deloitte's report takes unacceptable liberties with accepted medical practices. Rather than examining the target populations, STIs are divided into "complex" and "non-complex". There is no medical basis for this distinction and Deloitte's accountants provide no explanation of the rationale behind the use of these terms. In practice, specialist sexual health nurses are responsible for triaging patients to determine whether a patient is in a target group. Depending on that assessment, the patient is then screened by a team of nurses under Queensland Health protocols and drug therapy protocols for nursing officers qualified in sexual and reproductive health. The nurses provide timely treatment, education and complex clients are collaboratively managed with specialist sexual health physicians. The auditors have provided an arbitrary figure that 70% of STIs are "non-complex" and can be seen by GPs in the private primary care setting thus replacing specialist sexual health nurses. The remaining 30% of "complex" STI patients are proposed to be retained at the service with no consideration of how these patients are identified through the nurse filtering and screening process. The report arrives at a simplistic formula with no medical evidence and ignores the role of highly trained nursing staff.

The new role for GPs in the management of STIs that is envisioned by the Board is not supported by the College of GPs and the Minister for Health in Queensland has been notified of this in writing by the College. A recent review by the Department of Public Health in Western Australia revealed that only eight per cent of GPs took a comprehensive sexual history from symptomatic cases, 53 per cent routinely tested for blood-borne STIs and only 29 per cent recorded a discussion of partner notification in the medical records.<sup>1</sup> Many of the most vulnerable populations (such as men who have sex with men, sex workers, new migrants) are often reluctant to disclose sensitive information to their GP or are unable to access GP services. This is likely to be even more relevant in the new era where increasing testing of the population for HIV infection is currently being promoted as an important component of the national HIV strategy. A recent study from Denmark revealed that half of the late presenters with HIV had consulted a GP three to 12 months prior to their HIV diagnosis. HIV antibody testing had not been performed, although complaints consistent with possible underlying immune deficiency had been reported.<sup>2</sup>

Chapter 4 of the report (page 75-89) concludes (page 86) that "There is a public health risk if patients (both HIV and non-HIV) fail to access care and treatment because of resistance to accessing services that do not provide

- Anonymity and confidentiality
- Open access (walk-in)
- No charge/co-payment
- Specialist services
- Acceptance of socially marginalised populations.

While there are many advantages to delivering HIV services in primary care, GPs need flexible models of training and accreditation, support in strengthening relationships with other health and medical professionals, and assistance in achieving service accessibility. These processes take time to put in place and require detailed consideration of how to support the GP workforce (including funding) with training so that appropriate care can be made available in the broadest range of geographical<sup>3</sup> and service settings. This is critical if systems of HIV care delivery are to be realistic, cost-effective, meet consumer needs<sup>3</sup> and deliver national public health outcomes.

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Finally the report clearly states that the implications are that "the rates of HIV and STIs will increase due to clients not accessing appropriate HIV and STI testing and treatment ". It provides no responsible mitigation strategy relating to these risks . Possible strategies offered involve a major reorientation of the health sector in Queensland which require many years to develop and potentially involve costs which are far greater than the cost of maintaining the current service.

On 30<sup>th</sup> May 2012, the Minister for Health, The Honourable Lawrence Springborg released a statement expressing the Queensland Government's determination to reverse increased HIV diagnoses rates in Queensland. In the context of the recommendations of Deloitte's report and the ensuing decision by the Board to remove the Brisbane sexual health service, the weight of medical evidence predicts that there will be increased HIV infections in Queensland along with an increased number of infections in other sexually transmitted notifiable diseases.

The decision of the Board needs to be reversed. In the interests of public health, the Minister for Health must intervene and override the Board Chairman if the Board fails to recognize the dangers of this reckless public health policy and reverses it before 31 July 2013.

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- 1 Bangor-Jones, R D. Sexual health in general practice: do practitioners comply with the sexually transmitted infections guidelines for management of suspected chlamydial infections? *Int J STD AIDS*. 22(9):523-4, 2011 Sep.
  - 2 Leutscher PD. Laursen T. Andersen B. Ostergaard L. Laursen A. Larsen CS. HIV late presenters in Denmark: need for increased diagnostic awareness among general practitioners. *Dan Med Bull*. 58(4):A4253, 2011 April.
  - 3 Newman CE. de Wit JB. Kippax SC. Reynolds RH. Canavan PG. Kidd MR. The role of the general practitioner in the Australian approach to HIV care: interviews with 'key informants' from government, non-government and professional organisations. *Sex Trans Infect*. 88(2):132-5, 2012 March.