# Written evidence from Bayer PLC [WRH0041]

## Introduction

Bayer is one of the ten largest pharmaceutical companies in the UK. We provide services that benefit patients and the NHS by enabling better diagnosis, prevention, and treatment across a range of conditions including cardiovascular disease, eye care, cancer, and women's health.

As a global leader in women's health, Bayer believes that access to high-quality reproductive healthcare, at every stage of the life course, is a fundamental right for every woman[1]. Empowering women to decide if – and when – they choose to start a family, to easily access the support they need for gynaecological health conditions, and to live well through the menopause and beyond, is paramount not just for women themselves, but for health systems and societies too.

**Bayer recently published a report on women's reproductive health. Our report 'Informed, Heard, Empowered: Placing women at the heart of reproductive health policy' covers several areas explored by this inquiry.** This includes heavy menstrual bleeding, inequalities, and barriers to access. We encourage the inquiry to refer to this report in its review of evidence and to consider its recommendations.

Through our membership of women's health groups, we have gathered a strong and varied knowledge base, from a national policy-setting level, to engaging clinicians and healthcare practitioners on the ground. Bayer is a member of several women's health groups, including the Advisory Group on Contraception (AGC), Menstrual Health Coalition (MHC), APPG on Sexual and Reproductive Health, and the APPG on Menopause. We encourage the inquiry to refer to the responses of these groups for further evidence.

As an expert in women's health provision, we are well-placed to provide evidence to support this inquiry, based on our experience and discussions with partners. This can include presenting directly to the inquiry or facilitating a meeting between the inquiry and healthcare providers. Contact details are listed at the end of this document.

Our response covers several areas and is split into themes including:

- The role of Long-Acting Reversible Contraception (LARC) in managing Heavy Menstrual Bleeding (HMB)
- Inequalities in access
- Commissioning pathways and setting a minimum, viable fee to sustain LARC
- Disparities specific to the devolved nations
- Workforce challenges
- Education

## What constitutes healthy periods and reproductive health?

[1] Bayer recognises that access to reproductive healthcare is essential to anyone assigned female at birth, no matter how they identify. Bayer therefore supports and advocates for the right to access reproductive healthcare 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 services. We use the word women for simplicity but also in recognition that the majority of those requiring access to reproductive healthcare identify as women.

Reproductive health covers the life-course of a woman, from puberty and early-stage education, to adulthood, through to the menopause. This approach was acknowledged in the landmark Women's Health Strategy for England, published last year[1]. Like many across the sector, Bayer welcomes the Strategy's ambitious vision – however, as the Strategy itself acknowledges, it is not the final step 'on the journey to reset the dial on women's health'[2].

Nevertheless, reproductive health is not just a women's health issue, it is a public health issue, as it affects up to 51% of the population at some point in their lifetime. Considering its scale, not enough action is being taken to address the challenges presented by inadequate commissioning practices and barriers to access.

To support healthy periods and optimal reproductive health as per the Strategy's ambitions, a cross-system approach must be taken, to address fragmented commissioning arrangements, while aligning with national priorities for tackling the backlog and primary care recovery.

**Background on reproductive health and healthy periods**

The impact of Heavy Menstrual Bleeding (HMB) on women's everyday lives can be profound, yet HMB is still rarely spoken about in public. Around one in four women suffer from HMB[3] and approximately a fifth say they have missed work in the previous 6 months due to their condition[4], based on historical research. This does not count the wider impact of HMB, for example on mental health or beyond primary symptoms.

*Bayer recommends that more data is collected on the financial costs across the system – including employment – of women with HMB. This will help areas develop plans to improve access to services.*

**The role of LARC**

Long-Acting Reversible Contraception (LARC) methods are widely accepted to be some of the most effective and cost-effective methods available and include intrauterine system/intrauterine device (IUS/IUD), progesterone-only subdermal implants, and progesterone-only injectable contraceptives[5].

IUS methods are not only effective in preventing unplanned pregnancy but are also the first-line recommended treatment for heavy menstrual bleeding (HMB) in women with no identified pathology or large fibroids or adenomyosis[6].

In addition, LARC's cost-benefit analysis is significant. Government analysis illustrates the significant return on investment that could be harnessed through its improved provision – for every £1 invested in LARC in primary care, there is a saving of up to £48 in healthcare and non-healthcare cost over 10 years[7].

LARC therefore provides an alternative and effective option for women to access treatment for some gynaecological conditions and support reproductive health. LARC commissioning is particularly complex, however:

- Local authority commissioners are responsible for LARC for contraceptive purposes, under Locally Commissioned Service (LCS) contracts.
- NHS commissioners are responsible for gynaecological LARC commissioning, for example to treat HMB, as a locally enhanced service (LES), which local

commissioners can offer to local practices to supplement the nationally agreed GP contract.

The locally-determined nature of LCS and LES contracts means that there can be significant variation in scope and funding between different geographies, and GP practices can decide whether to sign up – based on availability of the trained workforce, or decisions on financial viability[8].

Without clear guidance for patients, providers, and commissioners, this variation and complexity risks creating avoidable misunderstanding that ultimately damages women's access to a critical service related to their gynaecological health. It is essential that a sustainable LARC model is implemented based on national guidelines, to reduce variation in access across the country.

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

**Inequalities in access**
There are severe inequalities in the treatment and diagnosis of gynaecological conditions like Heavy Menstrual Bleeding (HMB). This has been exacerbated in recent years owing to changes in the Government pathway for provision of services, the pandemic, and cuts to funding. This includes:

- Fewer than half of the specialist clinics offering a sexual health service in 2015-16 were still doing so in 2021-22.
- Across primary and specialist care, around 500 clinics are yet to reopen following the COVID-19 pandemic.
- 34% of GP practices are only funded to provide LARC for contraceptive purposes, reducing women's access to highly effective treatments for Heavy Menstrual Bleeding (HMB).
- Prescribed LARC rates vary significantly across the country, from below 5 to over 85 per 1,000 women[9].

As outlined above, IUS methods are the first-line recommended treatment for Heavy Menstrual Bleeding (HMB) in women with no identified pathology or large fibroids or adenomyosis. However, commissioning and access to treatment varies significantly. While GP practices and community clinics are well placed to provide IUS for HMB in line with NICE guidance, currently only 6% of women are receiving IUS as a first line of treatment[10].

In the case of HMB, women may be referred to secondary care gynaecology services, even though most women with HMB can be managed in primary care. This makes admission to secondary care an avoidable outcome that is suboptimal for women and costly to the NHS.

There are already disparities and backlogs in access to secondary care in this area. According to the latest NHS data, only 54% of patients referred are seen within the 18-week target. Instead, they could have their needs met more quickly and effectively in primary care[11].

*Bayer recommends that actions to tackle the COVID-19 elective care backlog must be harnessed, alongside collaborative commissioning and integrated working, to enable more women with HMB to access the care and support they need from primary care more easily and quickly.*

*This will help to reduce and streamline referrals to secondary care and ensure more costly, specialised interventions such as hysterectomy are only a last resort, in line with the ambitions of 'Getting It Right First Time'.*

**Introducing a minimum viable fee for LARC to treat gynaecological conditions**
Access to LARC varies significantly, providing a barrier and disparities in the delivery of reproductive healthcare for women.

This includes in the fees for GP practices to provide LARC, with 84% of LARC fitters reporting that the fitting fee paid for gynaecological LARC does not cover the cost of providing the service[12]. The fee underpins LARC provision, as the locally determined nature of LARC contracts and inadequate funding means that practices are finding it difficult to provide LARC to women in their community.

Doing so will improve reproductive health outcomes and address inequities in access to diagnosis and treatment for gynaecological conditions by:

- Narrowing health inequalities: The most deprived communities are most affected by inadequate LARC access, with primary care provision varying significantly across the country[13].
- Cutting waiting lists: HMB is estimated to be the fourth most common reason for referrals to secondary care gynaecology, putting pressure on the system[14]. A fee and viable offer at primary care level will reduce the number of referrals. This may also lead to women and professionals spending their time elsewhere, for example being treated or diagnosed for other conditions – a key part of the holistic Women's Health Hub approach.
- Saving on costs: Hysterectomies can cost the NHS as much as £3,000 per day case and are used as a treatment for Heavy Menstrual Bleeding[15], when activity in primary care can prevent this approach.
- Creating a sustainable future: A suitable fee will allow GP practices to invest in their staff and get them trained up, allowing more women to be treated longer-term.

Effective replication of the Women's Health Hub model will depend on the UK Government taking urgent action to ensure financial viability and appropriate commissioning arrangements for LARC provision in primary care – across contraceptive and gynaecological purposes – tackling the existing and pervasive variation currently in place.

As ICSs mature as statutory organisations and take steps to establish their own Hubs, there is an opportunity to safeguard and make clear how LARC provision can be delivered across England.

*Bayer recommends that the Government takes steps to eradicate this postcode lottery in access to LARC for gynaecological treatment, by introducing a nationally set, minimum fee for the provision of LARC in primary care, ensuring all practitioners who wish to fit across contraceptive and gynaecological purposes are supported to do so sustainably.*

**Commissioning of treatments for gynaecological conditions**
Often gynaecological and reproductive health services are not designed around women's needs. For example, the postcode lottery in access to LARC as a treatment for HMB is largely shaped by highly fragmented commissioning arrangements. This means General Practices are often not funded to provide LARC as a treatment for non-contraceptive purposes, despite it being the right approach in most cases.

To support areas, understand their commissioning arrangements and ways to save costs by moving services to primary care, Bayer's team has taken publicly available data and developed a formula to help teams understand potential cost-savings they could make at a local level if they took a different approach to commissioning.

The 'HMB tool' outlines how many people are eligible for treatment in a particular area, what options are available to treat them efficiently, and how the local health system could make savings if treatment was delivered in a primary care or other setting, as opposed to hospitals or secondary care. We welcome the opportunity to provide further information on the tool to support local areas understand their commissioning arrangements and savings they could make.

*Bayer recommends that as part of the Women's Health Hub rollout – and more generally across all sexual and reproductive health service provision – ICBs explore collaborative commissioning with their local authorities. The Government should set guidelines to streamline primary care access to LARC across indications for gynaecology (HMB) and contraception, ensuring women can access services at primary care and reduce burdens on the system.*

*As another route to support joined-up commissioning of services, Bayer recommends the use of the Quality and Outcomes Framework (QOF) or similar provision to incentivise health professionals and providers to prioritise gynaecological conditions and training on women's health.*

**The role of Women's Health Hubs**

Women's Health Hubs represent a positive step in addressing some of the challenges highlighted in accessing gynaecological treatments. It is welcome that the DHSC has asked ICBs to establish LARC provision across gynaecological and contraceptive purposes as a core offer of their Hubs.

However, the scale of the current fragmentation, as highlighted above, 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.

*Bayer recommends that in addition to the guidance on Women's Health Hubs recently published, the DHSC publishes further national guidance to support ICBs understand their responsibilities with regards to commissioning LARC for gynaecological purposes – in addition to for contraception.*

**Barriers and challenges in the devolved nations**

Issues in access and education are prevalent across different regions of the UK, underscoring these disparities.

In Northern Ireland, the Department of Health recently announced that specialist GP clinics set up to tackle hospital waiting lists will have their services cut by 50%[16]. The GP Elective Care Service covers medical procedures including gynaecology.

This change has been recognised by the BMA that will have a negative impact on patients, as they will move to waiting lists. Such a change will result in women waiting longer for services that previously existed, with their symptoms worsening and potentially leading to greater danger for the women and cost to the system.

In Scotland, the Scottish National Blood Transfusion Service confirmed that 175 women in Scotland received a blood transfusion last year due to excessive, frequent and irregular menstruation[17]. Such an impact shows the lack of awareness and education among women in this part of the country, but also the disparity in service delivery.

With women not coming forward, not being able to access a service, or not being supported to manage their condition, the symptoms exacerbate and lead to negative outcomes for the patient and from a cost perspective.

*Bayer recommends the inquiry explores the impact of changes to services in the devolved nations in the UK, to ensure changes in these areas are being scrutinised and the impacts explored.*

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

**Workforce**
The workforce is an essential part of the delivery of treatment and diagnosis of gynaecological conditions. However, owing to a lack of support and clear commissioning guidelines in reproductive health, the workforce is facing limitations, particularly post-pandemic.

A recent survey of healthcare professionals from the Primary Care Women's Health Forum (PCWHF) examined the issues for LARC in primary care and found that[18]:

- 49% thought there had been no change to the LARC training for new clinicians.
- 43% said that they felt training had reduced.
- 25% cannot access training.

This presents a long-term barrier in the delivery of gynaecological healthcare, as professionals are struggling to access learning or those interested are not given the support to learn.

*Bayer recommends that Government puts in place a framework to support ongoing and funded workforce training for LARC, to support provision and access to treatment for gynaecological conditions, including HMB. The committee should explores the role of workforce training on access to treatment as part of its inquiry.*

**Education**
Bayer believes the Government should address the stigma associated with women's intimate health in schools and beyond. Research reveals that:

- Just 40% of pupils rate the quality of relationships and sex education (RSE) as 'good' or 'very good'.
- 56% of pupils reported learning not enough, or nothing, about how to access local sexual health services.
- Only 6% of women learn about intimate health through school or university education[19].

Bayer has already sought to provide information and education to women. Working with Virgo Health, Bayer launched 'Flo', a magazine-style publisher on Facebook. A video was published titled 'The Period Trifle'[20], which communicated the graphic reality of HMB in a palatable, light-hearted way. The video mixed the 'ingredients' of HMB into a mixing bowl of

missed opportunities and coping strategies. The open nature of discussing a taboo topic helped raise its profile and understanding of it.

To support this, last year Bayer launched the award-winning 'The Truth, Undressed' education programme, developed in collaboration with the PSHE Association[21]. It aims to tackle the stigma and confusion around women's intimate health by providing evidence-based digital and social medica content, and school-based lesion plans on vulval anatomy and vaginal health, without metaphors, euphemisms, sexualisation or oversimplification. Since its launch, lesson plans have already been delivered to nearly 150,000 students.

*Bayer recommends that the Government protects and enhances the delivery of the RSE curriculum, embedding vaginal and menstrual health as a core aspect of physical health education. This will ensure that all women are empowered to look after their intimate health as they approach adulthood and beyond, supporting informed and sustainable engagement with health services through the life course. The Committee should explore how the RSE guidance review can deliver enhanced information on sexual and reproductive health as part of its inquiry.*

*While the Government has plans to update the NHS women's health website, more must be done to incorporate wider sources of information and use signpost to existing sources, for example on HMB and use of LARC.*

## Further information

### References


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