All change at the Department of Health

Mixed reactions

Review by **Helen Barratt**
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In September, Andrew Lansley was replaced as Secretary of State for Health by Jeremy Hunt, the former culture secretary, as part of an extensive government reshuffle. Three of the department's other ministers have also been replaced. The reshuffle saw Liberal Democrat Paul Burstow replaced by Norman Lamb; junior minister Anne Milton by Anna Soubry; and minister Simon Burns replaced by Dr Dan Poulter. Only Lord Howe stayed in post.[1]

Lansley was the architect of controversial reforms to the NHS in England, having been health secretary since the coalition government was formed in 2010. Prior to that he was shadow health secretary for seven years. Hunt will oversee the changes to the health service resulting from the Health and Social Care Act. Many of these come into force in April 2013, including the abolition of NHS primary care trusts and strategic health authorities.[2]

Observers have said the Prime Minister believed Hunt would be better placed than Lansley to present NHS policy to the public in the run-up to the 2015 general election. However, Hunt's appointment prompted mixed reactions from commentators. Some described it as 'disastrous,' whilst others perceived it as a fresh opportunity for discussions about the challenges facing the NHS. Hunt's most prominent previous involvement in the health service was leading a high-profile campaign five years ago to stop the closure of services at Royal Surrey County Hospital. This has sparked concern that he will try to delay planned NHS service changes in his new role.[3]

Increasingly many commentators regard the reform of social care as a priority. The government is being urged to adopt the recommendations of the commission chaired by the economist Andrew Dilnot in 2011.[4] Norman Lamb, the new Minister of State for Care Services has a strong interest in this subject having been the Liberal Democrat party's health spokesman before the 2010 election. The cost of the Dilnot proposals is estimated to be around £1.7 billion. However, in an interview with *The Spectator*, Hunt suggested that he would be seeking 'other versions that might not be quite so expensive.'[5]

Hunt caused controversy ahead of the Conservative Party conference in October. *The Times* reported him as saying that he would favour a change in the law to halve the legal limit on abortions from 24 weeks of pregnancy to 12. Theresa May, the Home Secretary, said she would 'probably' back a change to 20 weeks, and the Prime Minister David Cameron is known similarly to favour a 'modest' reduction. A Downing Street spokesman insisted that Hunt was expressing purely personal views and there were no plans to change the law.[6]

references

1. West D. Jeremy Hunt replaces Andrew Lansley as health secretary. *Health Service Journal* 2012; 4 September
2. Roberts M. Mixed reception of Hunt as new health secretary; *BBC News* 2012; 4 September
3. West D. Concern about service change delay as Hunt replaces Lansley. *Health Service Journal* 2012; 4 September
4. Barratt H. Social care funding. *Triple Helix* 2012; Spring: 5
5. Jeremy Hunt: no promises on the NHS ringfence. *The Spectator Coffee House Blog* 2012; 3 October *http://bit.ly/T1yOzi* (Accessed 10 October 2012)
6. Abortion limit reduction favoured by Jeremy Hunt; *BBC News* 2012; 6 October

Contraceptive jabs and implants for 13 year olds

Neither ethical nor evidence-based

Review by **Peter Saunders**
CMF Chief Executive

School nurses have given implants or jabs to girls aged between 13 and 16 more than 900 times in the past two years.[1] Girls aged 13 have been given contraceptive jabs and implants on more than 20 occasions and a further 7,400 girls aged 15 and under have been given contraceptive injections or implants at family planning clinics.

The implants are effective for up to three years and the injections for up to three months. Under patient confidentiality rules, nurses are prevented from seeking the permission of parents beforehand, or even informing them afterwards, without the pupil's permission.

Sex under 16 is not only illegal, it can also be profoundly damaging – physically, emotionally and spiritually. Children under 16 are judged to be too emotionally immature to drink in a pub, drive, vote or watch certain films, and parental consent is required for any other medical or surgical procedures. Why then is this issue being treated so differently especially when contraceptive implants pose health risks?

Young people who feel that they are secure and protected by contraception will take more risks sexually, a phenomenon known as 'risk compensation'[2] and the claim that this strategy will decrease pregnancy rates *in a given population* is not actually evidence-based. By contrast, there is real evidence that making the morning-after pill more widely available does not reduce unplanned pregnancy rates in a population and may actually increase the incidence of sexually transmitted infections.[3]

Contraceptive implants or jabs also offer no protection against sexual exploitation. If a young teenage girl is in an abusive relationship or has pressure put on her to have sex then she can be very easily manipulated especially if she is emotionally involved with the boy or man who is trying to coerce her. The fact that she is taking contraception may well intensify that pressure and make it harder for her to say no. It is ironic that this story broke around the time of the Jimmy Savile enquiry.

Contraceptive provision alone will never address Britain's epidemic of promiscuity and its consequences. More needs to be done to dissuade young people from having sex and promoting abstinence as a good lifestyle choice. By contrast the government's strategy for sexual health seems to be based on the two false premises that contraceptives are safe and that abstinence is impossible.

There are ethnic and faith communities in the UK – including Christian communities – which have relatively low levels of promiscuity and accordingly very low levels of unplanned pregnancy and sexually transmitted disease, divorce and broken relationships. The government would do better to learn from them and base their strategies on godly wisdom rather than an untested worldly ideology.

references

1. *Telegraph* 2012; 28 October. *http://bit.ly/U8fjR5*
2. *Wikipedia. http://bit.ly/2CWVzD*
3. *Telegraph* 2011; 30 January. *http://bit.ly/eEGwIO*

Where to next with the Millennium Development Goals?

Health goals unlikely to be met

Review by **Steve Fouch**
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With only two years left before they are supposed to be met, it looks like a mixed bag of results for the Millennium Development Goals (MDGs). The major goal of halving the number of people living on less than $1.25 per day by 2015 looks well on track – but mainly because of the meteoric rise in living standards in China (and, to lesser extents, in India and Brazil).[1]

MDGs 4, 5 and 6 which focused on health goals (covered in depth in *Triple Helix* in 2006-2007) look far from being met. Even where progress has been made, the current economic climate has reduced the funding to global health programmes.

The focus of the international community is now on what comes next. While the MDGs have had their faults, they have galvanised and focused world attention and resources. But they have also tended to separate issues artificially. For instance, reducing extreme poverty, increasing access to clean water and providing primary education all have significant health benefits. Improving maternal health benefits child health and can have a major impact on HIV and other communicable diseases.[2]

The current buzz is around Universal Health Coverage (UHC) – making effective health services available to all and introducing some kind of local or national universal health insurance. The problem is there are no universally agreed definitions or ways of measuring what constitutes universal health coverage and its outcomes. There is growing research that universal insurance and provision of good quality medical care can have a significant (if modest) impact on the health outcomes for the poorest communities, but only if there is also good government, sound social institutions and a vibrant civil society.[3]

Wherever the world goes next with high level goals, it does seem that the world is slowly realising a principle long expressed in scripture, that our lives are a whole and not a divided set of self-contained areas. Obedience to God goes along with longevity and prosperity;[4] but obedience includes adhering to provisions for social and economic justice,[5] hygiene,[6] dietary practices and care of the land[7]. Health and healing go hand in hand with God expressing his salvation amongst his people. The Bible makes it clear then that good health starts with a right relationship with God, from which all other right and healthy relationships flow.[8]

A set of goals that embody this understanding are unlikely to arise out of the current post-MDG process, but this understanding will continue to inform Christian responses to local and global health needs.

references

1. Sustainable development for health: Rio and beyond. *Lancet*, *http://bit.ly/KglGU5*
2. Positive Gains: Promoting Greater Impact On Health Through HIV And AIDS Programming. *UK Consortium on AIDS & Development policy paper* 2012. *http://bit.ly/RtERaW*
3. Glassman *et al*, A post 2015 development goal for health–should it be universal health coverage? *BMJ Blog* 2012; 25 September. *http://bit.ly/PkOZEK*
4. Deuteronomy 30:16
5. Leviticus 25
6. Leviticus 13:47ff
7. Leviticus 25:11-12, 18-22
8. 1 John 2:1-11

Good news from Massachusetts

A significant defeat for the assisted suicide lobby

Review by **Peter Saunders**
CMF Chief Executive

On the night of the US presidential election on 6 November the state of Massachusetts voted 51% to 49% in a referendum to reject the legalisation of assisted suicide.[1]

The question considered read 'Should a doctor be legally allowed to prescribe medication, at a terminally ill patient's request, to end that patient's life?'[2]

This was a hugely significant result given the medical influence and prominence of Massachusetts itself (the home of Boston and the *New England Medical Journal*) and despite the small margin, it is a huge defeat for the pro-euthanasia movement given that the strongly Democrat state has a reputation for being one of the most liberal in the country.

The measure was defeated after a strong campaign by a diverse coalition called 'No On Question 2' drawn from both sides of the political spectrum and comprised of disability rights organisations, doctors, nurses, community leaders, faith based groups and patient rights' advocates. Alex Schadenberg[3] and Wesley Smith[4] give helpful analyses of how the campaign was won.

The Massachusetts Medical Society issued a statement[5] saying it was opposed to Question 2 and cited insufficient safeguards, the uncertainty of predicting life-spans and the profession's historic opposition to assisted suicide. The Society also reaffirmed its commitment to provide physicians treating terminally ill patients with the ethical, medical, social, and legal education, training, and resources to enable them to contribute to the comfort and dignity of the patient and the patient's family.

They were backed by a group of 15 disability rights organisations.[6] John Kelly, Executive Director of Second Thoughts and former Chair of the Advisory Board to the Boston Disability Commission, argued as follows:

'We already have seen serious cost cutting pressures. We constantly hear about the costs of caring for people in the last year of their lives. We can point to examples in Oregon and Washington, where assisted suicide is legal, of these implicit and explicit cost pressures. Ballot Question 2 legalizes a $100 lethal prescription and that sends a terrible message to people living with serious illness or disability.'

Currently only two US states, Oregon and Washington, have legalised assisted suicide, each on the basis of a referendum. This has led to an annual increase of assisted suicide in each state.[7]

By contrast, whenever a bill has been brought before a US state parliament it has been defeated. This has happened over 120 times in the last 20 years. It is clear that assisted suicide is an issue Christian doctors are not alone in opposing.

references

1. Massachusetts 'death with dignity' initiative. *http://bit.ly/S91X6B*
2. Question 2: Prescribing Medication to End Life. *http://bit.ly/QblUZc*
3. *http://bit.ly/SUHAek*
4. *http://bit.ly/T3y35M*
5. *http://bit.ly/T30XSO*
6. *Life News* 2012; 1 October. *http://bit.ly/PoXdIU*
7. *Christian Medical Comment* 2012; 24 September. *http://bit.ly/TpeYPE*