POSITION PAPER: UNIVERSAL ACCESS TO HIV TREATMENT

Removal of co-payments for HIV anti-retroviral medications: reducing HIV morbidity, mortality and new transmissions of HIV with healthcare cost savings

Introduction

As a communicable disease, if HIV is not diagnosed and treated it can be transmitted onwards to others. In short, transmission is associated with high morbidity and mortality translating into significant costs for the health care system and society. Added to this simple equation, there is now irrefutable evidence that early and sustained treatment of HIV not only saves lives, but acts to avert serious illnesses and chronicity associated with late treatment, while also preventing new infections by means of the viral suppression of those being treated[1] [2]. Unfortunately, it is well understood that some people in Australia avoid and delay testing and treatment for HIV due to concerns of not being able to afford treatment. This leads to some people being diagnosed late with advanced HIV infection and sadly permits the otherwise avoidable onward transmission of HIV[3].

Globally, we are historically working towards the virtual elimination of HIV - that being an end to new transmissions of HIV. This goal can realistically be achieved through reaching the United Nations (UN) 90-90-90 HIV treatment targets by 2020:

- 90% of all people living with HIV (PLHIV) will know their HIV status;
- 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and
- 90% of all people receiving antiretroviral therapy will have viral suppression.

As the world works towards the virtual elimination of HIV, investment in universal access to treatment has become a key strategic intervention and principle. It is also a cost effective strategy in the medium and long term due to its impact on HIV transmission and thereby incidence. The provision of universal treatment is both a practical, quintessential public health approach to an infectious disease and one that also fulfils various Australian international human rights commitments. Although at some initial short term cost to the government, the measure is typical of the required investments associated with the last mile of disease elimination programs. As elimination thresholds are approached, additional front loaded investments of resources are required to target the most marginalised and hard to reach populations.

This paper will highlight the strategic policy landscape and political commitments around access to HIV treatment in Australia. New South Wales has already acknowledged the cost benefits of removing co-payments to provide free HIV treatment and done so while enacting a policy that waives co-payments on medication for patients being treated for cancer and chronic diseases such as HIV. The evidence supporting the important public health benefits of removing financial barriers by providing

[1] World Health Organisation, 2015 'Guideline on when to start ART and on PreP for HIV', viewed at http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/

[2] The National Institute of Allergy and Infectious Diseases (NIAID), 2015 'START Trial' http://www.niaid.nih.gov/news/newsreleases/2015/Pages/START.aspx#

[3] NAPWHA, 2013 'Antiretroviral co-payments for people with HIV in Australia', viewed at http://napwha.org.au/sites/default/files/poz%20action%20paper%202_0.pdf

free access to HIV treatment for all PLHIV will be provided. The associated cost projections to remove HIV medication co-payments in Queensland will also be detailed. This paper will advocate that for approximately $2 million per annum, free access to HIV treatment could be provided in the state.

This position paper is the result of collaboration between Queensland Positive People, the HIV Foundation Queensland, the Queensland HIV STI Professorial Chair and the Queensland AIDS Council and seeks to urge the Queensland Government to demonstrate leadership toward ending HIV-related morbidity, mortality and new HIV transmissions by:

- removing co-payments for HIV medications to provide universal access to HIV treatments in Queensland; and
- enacting a Health Service Directive where all PLHIV, regardless of Medicare eligibility, have access to HIV treatment, services and pathology tests with no out-of-pocket expenses to the patient as is currently in place in Queensland for Tuberculosis services[4].

Leadership and the provision of universal access to HIV treatment and care

There is national bi-partisan commitment to virtually eliminate HIV transmission in Australia as demonstrated by the recent 2016 Federal Election Survey carried out by the Australian Federation of AIDS Organisations (AFAO)[5] and the Council of Australian Governments (COAG) Health Council *AIDS 2014 Legacy Statement*[6]. Australian Health Ministers have vowed to take all necessary actions to remove barriers to accessing HIV testing and treatment across legal, regulatory, policy, social, political and economic domains. This aligns with a number of international legal instruments in relation to HIV/AIDS, which emphasise the need for prevention and control of HIV and the affordable, equitable and ease of access to HIV treatment for all[7].

The Kirby Institute estimate in Australia (based on 2014 data) that:

- 88% of PLHIV know their status;
- 73% of people with diagnosed HIV are on treatment; and
- 92% of PLHIV on treatment have viral suppression[8].

Increased access to testing, alongside treatment as prevention (TasP) strategies - comprising early and sustained HIV treatment, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) are

[4] Queensland Health, 2015 'Health Service Directive: Tuberculosis Control', viewed at https://www.health.qld.gov.au/directives/docs/hsd/qh-hsd-040.pdf

[5] AFAO, 2016 'Federal Election Survey', viewed at https://www.afao.org.au/media-centre/media-releases/2016/the-2016-federal-election-and-australias-response-to-hiv#.V9s2Hvl95D8

[6] Council of Australian Governments (COAG) Health Council, 2014 'AIDS 2014 Legacy Statement', http://www.health.gov.au/internet/ministers/publishing.nsf/content/6DA3F43553CD3D4DCA257D1B0023553A/$File/LEGACY_SPEECH_2014_A5_WEB.pdf

[7] UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Article 12; United Nations General Assembly. Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS. 8 June 2011; *International Guidelines on HIV/AIDS and Human* Rights (2006), Retrieved from: http://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx;
General comment N° 14 on the right to the highest attainable standard of health, adopted by the Committee on Economic, Social and Cultural Rights on 11 May 2000;

[8] Kirby Institute, UNSW, 2015 ' 2015 Annual Surveillance Report HIV, Hepatitis and STIs', viewed at https://kirby.unsw.edu.au/sites/default/files/hiv/resources/2015%20Annual%20Surveillance%20Report%20of%20HIV,%20viral%20hepatitis,%20STIs.pdf

key elements to achieve the UN HIV 90-90-90 targets[9]. In 2015/2016, Queensland, New South Wales and Victoria State Governments demonstrated global leadership with the funding of the rapid scale up of PrEP to prevent transmission of HIV. This is being implemented alongside a variety of innovative community-based HIV testing services including peer-led models supporting the early detection of HIV, particularly amongst 'hard to reach' people who are not engaging with traditional health services. This provides people with several options or choices as to how they access HIV related services.

Access to early and sustained treatment improves individual health outcomes for PLHIV and prevents the onward transmission of HIV, thereby reducing significant costs to tertiary and primary health services and public health. Economic modelling reviews in Australia have found removing co-payments for HIV treatment is cost saving to governments because of improved retention on HIV treatment, improved individual health outcomes, as well as the realisation of averted HIV transmissions[10].

The Queensland Government has demonstrated leadership in many HIV-related areas with development of the draft Queensland Sexual Health Strategy 2016-2021. The Strategy and the draft Queensland HIV Action Plan (2016-2021) both articulate a commitment to reducing the number of new HIV transmissions through increased uptake of treatment as prevention and treatment by PLHIV, all directed at achieving the UN 90-90-90 targets. The plan articulates the required strategic goals and priority actions including a commitment to, "Continue to examine and advocate for the removal of barriers to HIV treatment access including regulatory rules; treatment guidelines; and costs." While the Queensland Government has rallied behind treatment as prevention strategies, in order for the targets to be truly realised all barriers to treatment uptake must be removed.

It is exactly for such reasons that, on September 2015 New South Wales (NSW) Health announced the policy to waive co-payments on medication for patients being treated for cancer and chronic diseases such as HIV and Hepatitis[11]. Local health districts also have the discretionary authority to waive the patient co-payment for Medicare ineligible PLHIV.

Other Australian jurisdictions, such as Victoria and Western Australia, have also taken crucial additional steps to Queensland to address the financial burden of HIV treatment in order to support the early uptake and ongoing maintenance of HIV treatment. In Victoria, a directive has been put in place to waive all out-of-pocket expenses for HIV treatment and services through the leading sexual health clinic for all PLHIV, regardless of Medicare eligibility. In Western Australia, an operational directive was issued in March 2016 whereby public hospitals must provide free assessment, pathology tests, and for services and pharmacological treatment for notifiable sexually transmissible infections (STIs) including HIV[12].

Internationally, in the United Kingdom (UK), some Canadian provinces and various US states, there is also public health funding for the provision of free access to HIV treatment. In October 2012, the UK removed payments for migrants and non-UK citizens accessing HIV treatment and care.

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[9] United Nations, 2014 'An ambitious treatment target to help end the AIDS epidemic', viewed at http://www.unaids.org/en/resources/documents/2014/90-90-90

[10] Warren E and Rocks K 2013, 'Mind the Gap: An economic analysis of providing free access to ARV therapy for PLHIV in Australia', International Health Economics Conference, Sydney, Australia. Commissioned report (NAPWHA) In press.

[11] NSW Government, 2015 'NSW Government scraps co-payments on s100 drugs', viewed at http://www.health.nsw.gov.au/news/Documents/20150927_00.pdf

[12] Government of Western Australian, 2016 'Operational directive - Guidelines for the provision of treatment of Medicare ineligible patients in WA public hospitals', viewed at http://www.health.wa.gov.au/CircularsNew/attachments/1141.pdf

Early and sustained HIV treatment – evidence of the benefits and barriers

A person's level of income should not determine a person's level of health

Early diagnosis and treatment of HIV are vital for PLHIV fulfilling the highest attainable standard of health. HIV treatment enables PLHIV to achieve an undetectable viral load, which slows down disease progression and restores immune functioning. This directly results in improved health outcomes for the individual and prevents the onward transmission of HIV. The vast majority of PLHIV adhering to treatment live a healthy life across a relatively normal lifespan. Data indicates that in 2015, an individual diagnosed at 20 years of age with HIV receiving early and sustained HIV treatment can live a full and healthy life contributing to society and the economy for at least 5.5 decades[13].

On 27 May 2015, the US National Institute of Health halted the largest study of its kind called START (Strategic Timing of Antiretroviral Treatment) due to overwhelming conclusive evidence that there was a 53% reduction in the risk of developing serious illness or death amongst the people enrolled into the early treatment arm of the study, and a 70% reduction in AIDS defining illnesses in the same cohort, all as compared to those in the delayed treatment arm of the study who waited until their CD4 count fell below 350. The START study offered irrefutable evidence that earlier HIV treatment is superior to delayed initiation of treatment. The START study confirmed that medication is advisable for PLHIV who are ready to consider treatment.

In September 2015, the World Health Organization updated its guidelines to reflect the findings of the START study to recognise that antiretroviral treatment access upon diagnosis saves lives, averts serious illnesses, and prevents new infections[14]. The results of the START study, coupled with international and domestic policy guidance, necessitate the removal of barriers to the commencement of HIV treatment for individuals who wish to be on HIV medication. One of the key barriers and disincentives for treatment is, of course, out-of-pocket payment or co-payment for treatment.

Indeed, financial stress and the cost of patient co-payments for medicines are significant barriers to the uptake, maintenance and adherence of HIV therapy for PLHIV in Queensland and Australia[15]. PLHIV experience higher rates of multi-morbidity and the management of multiple chronic health conditions is associated with higher out-of-pocket health spending. As people struggle to balance the financial burden of health-related costs with other living expenses, decisions about treatment uptake, maintenance and adherence are negatively impacted. PLHIV experiencing financial burden have been associated with a 6-fold higher risk of HIV treatment cessation and disengagement from care[16].

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13 M T May et al 2014, UK Collaborative HIV Cohort (UK CHIC) Study, 'Impact on life expectancy of HIV-1 positive individuals of CD4+ cell count and viral load response to ART, *AIDS Journal*, viewed at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4004637/pdf/aids-28-1193.pdf

14 World Health Organisation, 2015 'Guideline on when to start ART and on PreP for HIV', viewed at http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/

15 J McAllister et al 2012, 'Financial stress associated with reduced treatment adherence in HIV-infected adults in resource-rich settings'', *HIV Medicine*, viewed at http://onlinelibrary.wiley.com/doi/10.1111/j.1468-1293.2012.01034.x/epdf

16 J McAllister et al 2012, 'Financial stress associated with reduced treatment adherence in HIV-infected adults in resource-rich settings', *HIV Medicine*, viewed at http://onlinelibrary.wiley.com/doi/10.1111/j.1468-1293.2012.01034.x/epdf

It is well understood that the existence of financial barriers to HIV testing and treatment act as disincentives for some people to know their status and proactively manage their health. This leads to people being diagnosed late with advanced HIV infection and the transmission of HIV. Australian data indicates PLHIV are vulnerable to other long-term illness in addition to HIV which all have an impact on the health care system. This impact includes higher levels of hospitalisations and increased costs to tertiary health networks and public health[17].

Access to HIV treatment and services for Medicare ineligible PLHIV

Medicare ineligible PLHIV are a particularly vulnerable population and disproportionately experience poorer health outcomes and disease progression rates. The ATRAS study[18] demonstrated the long-term positive effects of Medicare ineligible PLHIV receiving optimal and uninterrupted HIV treatment and services. Access to treatment and care significantly improved not only the health outcomes of individuals but also averted a significant number of new infections. The ATRAS study further demonstrated that the Medicare ineligible PLHIV demographic is a small fluid population as most of this group either become Medicare eligible in due time (median time is 2.5 years) or return back to their home countries.

In September 2015, there were approximately 50 Medicare ineligible PLHIV engaged in care in Queensland. There are varying arrangements across the decentralised Queensland Hospital and Health Services (HHS) for Medicare Ineligible PLHIV in accessing HIV services and treatment-effectively resulting in a 'postcode lottery' for patient access. While some HHS's have mechanisms in place to provide free access to HIV services and treatment, others refuse to provide access to services and treatment unless upfront payments are made. Staff from multiple agencies and clinics receive a number of requests for help and support by and on behalf of Medicare ineligible PLHIV and spend significant time supporting clients to navigate the complex health system to access HIV services and early treatment.

It is imperative that Queensland find sustainable solutions to support access to HIV services and the early uptake and maintenance of HIV treatment for all PLHIV, including those groups that are particularly vulnerable. It is our position that measures towards universal access to HIV treatment would not only provide greater health equity, but is the practical way to reach the Queensland's goal of 90% of all people with diagnosed HIV infection receiving sustained antiretroviral therapy."

Cost projections for removal of co-payments for HIV medications

The HIV Foundation Queensland funded the preparation of cost projections for the removal of all co-payments on HIV medications to provide universal access to treatment in Queensland (Refer to Appendix A). Costings have also been prepared on the introduction of a single HIV ARV patient co-payment for PLHIV resident in Queensland – regardless of the number of HIV medications prescribed.

In summary, the following options are detailed in Appendix A:

[17] NAPWHA, 2013 'Antiretroviral co-payments for people with HIV in Australia', viewed at http://napwha.org.au/sites/default/files/poz%20action%20paper%202_0.pdf

[18] UNSW 2013, 'The Australia HIV Observational Database Temporary Residents Access Study One year Follow Up Report', viewed at https://kirby.unsw.edu.au/sites/default/files/hiv/attachment/ATRAS%20Report.pdf
UNSW 2015, 'The Australia HIV Observational Database Temporary Residents Access Study Final Report', viewed at https://kirby.unsw.edu.au/sites/default/files/hiv/attachment/ATRAS%20REPORT_2015_March2015_FINALv1.1.pdf

Option 1: (preferred)

Removal of Co-payments on all HIV ARV medications to provide universal access to HIV treatment

Based on initial estimates, the cost to the QLD Government of removing co-payments - regardless of the number of HIV medications prescribed – would be:

- **$2,013,103** assuming a **90%** uptake of HIV antiretroviral (ARV) treatment.
- **$1,789,425** if **80%** uptake of HIV ARV treatment
- **$1,565,747** if **70%** uptake of HIV ARV treatment.

Option 2:

Single ARV Patient Co-Payment for all Medicare eligible Queenslanders diagnosed with HIV

Based on initial estimates, the cost to the QLD Government of introducing a single patient co-payment - regardless of the number of HIV medications prescribed – would be:

- **$996,192** assuming a **90%** uptake of HIV antiretroviral (ARV) treatment.
- **$885,504** if **80%** uptake of HIV ARV treatment
- **$774,816** if **70%** uptake of HIV ARV treatment.

Summary and recommendations

The virtual elimination of HIV and the realization of the UN 90-90-90 targets can only be achieved with by investment in human rights driven and evidence based responses to **HIV prevention, testing, treatment and care.** It is essential that treatment, free of out-of-pocket expenses to the patient is guaranteed to all PLHIV in Queensland.

The Queensland Government has made bold commitments to scaling up and investing in highly active HIV prevention in line with similar commitments in NSW and Victoria. However, the Victorian and NSW governments have demonstrated further commitments to the full realisation of the second and third tenets of 90-90-90."

Investment in universal access to treatment is cost effective in the medium and long term due to treatment as prevention's impact in averting HIV transmission and thereby lowering HIV incidence. To provide universal access to HIV treatment fulfills international human rights commitments and is a quintessential public health approach to an infectious disease. Further, it is typical of the required investments associated with the last mile of disease elimination programs. As elimination thresholds are approached, the front loading of investment and resources are required as the most marginalised and hard to reach populations increasingly become the targets.

This paper urges the Queensland Government to continue its commitment to the required leadership in Australia and internationally to end HIV-related morbidity and mortality and new HIV transmissions by:

- removing the co-payments for HIV medications to provide universal access to HIV treatments.
- enacting a Health Service Directive where all PLHIV have access to HIV treatment, services and pathology tests with no out-of-pocket expenses to the patient as is currently in place in Queensland for Tuberculosis services.