Medicare ineligible patients living with HIV

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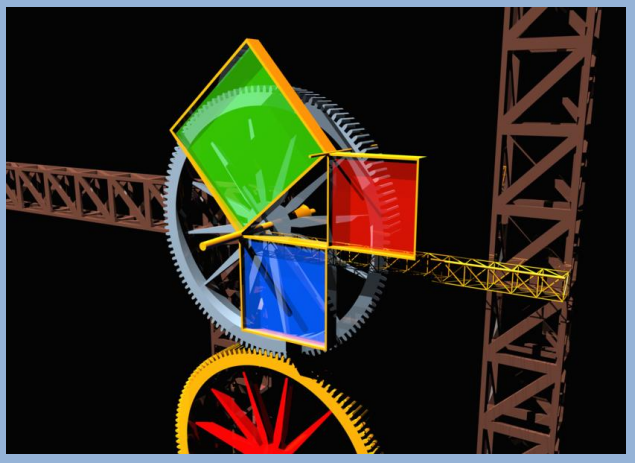


Future Ruins 2015 Victoria Reichelt

Commitment to elimination

- Australia has committed to the control of HIV.
- In 2014: Health Ministers committed to take all necessary actions
  - to remove barriers to accessing HIV testing and treatment
  - across legal, regulatory, policy, social, political and economic domains.
- This included early diagnosis and treatment for PLHIV

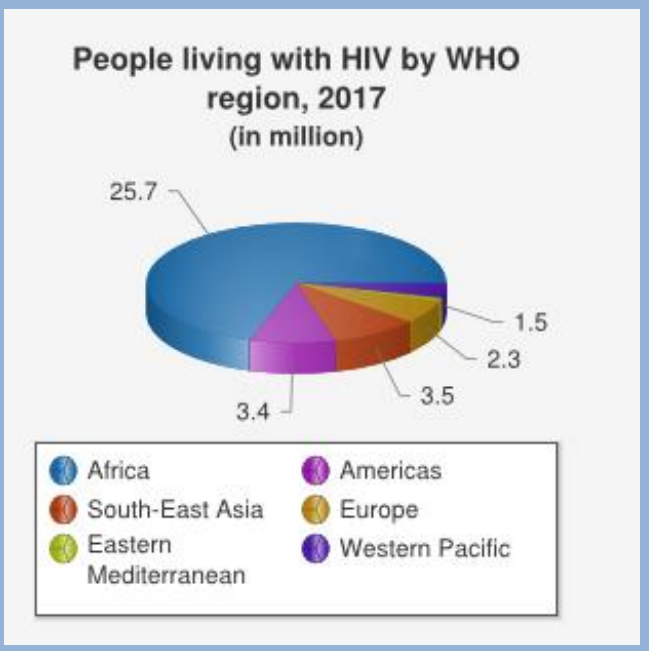
Commitment to elimination

- Treatment as Prevention remains key to the strategy driving toward the elimination of HIV transmission
- Pre and post exposure prophylaxis (PrEP and PEP) for HIV negative people is also part of the wider plan
- Ready access to PrEP was implemented in April this year

Xerox No 1 2016 Guy Maestri

People living with HIV

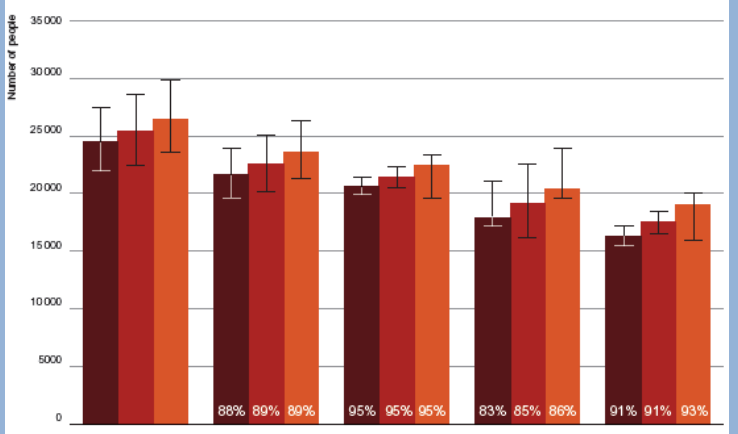
- **In 2017, 36.9 million people were living with HIV worldwide**
  - The highest burden was in Africa (69.6%)
  - The epidemic is still growing in many countries
- **While the total number of people infected rose in 2017, the number of new infections fell**
  - World-wide new cases fell from 3.3m to 2.3m in 2012
  - Largely due to reduced heterosexual transmission
  - Mother to infant infection fell by 38% from 2009 to 2012
- **The number of new HIV cases in MSM is stable**
  - Attributed to a higher incidence of risk taking, receptive anal intercourse, networking and stigma limiting access to care



Collins Street 5pm 1955 John Brack

PLHIV in Australia

Figure 1.4.1 The HIV diagnosis and care cascade, 2014–2016



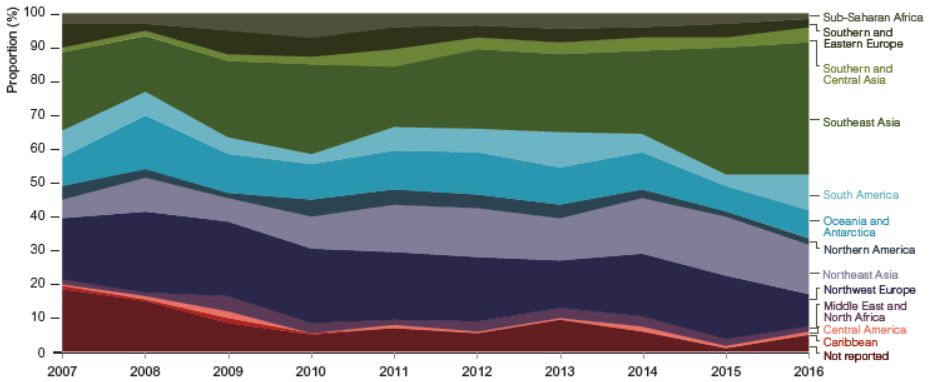
	Living with HIV	Living with HIV and diagnosed	Retained in care	Receiving antiretroviral therapy	Supressed viral load
2014	24 531	21 665	20 582	17 939	16 279
2015	25 404	22 577	21 448	19 189	17 517
2016	26 444	23 648	22 465	20 440	19 013

PLHIV in Australia

Features of the local epidemic

- **HIV disproportionally affects men who have sex with men (MSM) but …**
- **The number of new cases in MSM peaked in 2014 and then fell 29%**
- **The proportion of new cases due to heterosexual transmission has increased**
- **Rates are higher in Indigenous people and migrants than the general population**
  - **Especially migrants from African and Asian countries**
- **The prevalence of HIV among injecting drug users is low (1-3%)**
- **Mother-to-child transmission is rare (≈ 0.2%)**

Figure 1.1.12 Proportion of HIV diagnoses in non-Australian-born men with male-to-male sex as risk exposure, 2007–2016, by region of birth



Case study PAH

- **31 male student from China. MSM.**
- **Active issues**
  - **HIV management**
  - **Medicare ineligible O/S student. No insurance**
- **Background**
  - **HIV EIA reactive 25/08/17. WB confirmed. Established infection**
  - **Probably contracted from concordant Australian partner**
  - **Previously well. Egg allergy**
  - **CD4+ nadir 490 x 10e9 /L (35%).**
  - **HIV zenith = 3, 695 copies/mL - 05/09/17**

Case study PAH

- **Genotype resistance assay**
  - **fully sensitive to agents tested**
  - **subtype CRF 07 - B/C.**
- **HBV immune** (vaccinated). IGRA negative. No OI's
- **HLA B*57:01** excluded
- **ART**
  Commenced Triumeq 27/11/2017. Compassionate access
  Medicare care Card August 2018. PBS Triumeq Sept 2018

Medicare ineligible PLHIV

- **In 2014 a cross sectional survey estimated the number of Medicare-ineligible temporary residents in Australia to be 464 persons (ATRAS study)**
- **In September 2015 approximately 50 Medicare ineligible PLHIV were engaged in care in Queensland.**
- **There were varying arrangements across the Queensland Hospital and Health Services (HHS) for Medicare Ineligible PLHIV attempting to access services and treatment for HIV**

Medicare ineligible PLHIV

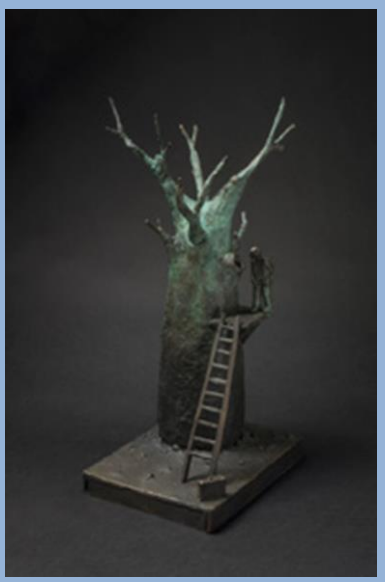
- **We have poor knowledge of how many MIP's are in care at any one time and it's a fluid number.**
- **We also have a 'postcode lottery' for access to care**
  - **Some HHS have mechanisms to provide free access to HIV services and treatment for Medicare ineligible PLHIV**
  - **Others did not provide access to services and treatment unless upfront payments are made.**

Medicare ineligible PLHIV

- **Charge for OPD appointment at PAH**
  - $ 371. 05 per consultation with HCW
  - $ 107. 10 for each pathology request
- Medicare ineligible patients may need three visits in the first year and two visits per year after treatment starts
- PAH has seven MIP's on a compassionate access program
  - One female and six males
  - One from an African country and six from South East Asian countries
  - Three acquired their infections from Australians

Medicare ineligible PLHIV

- Staff from multiple agencies / clinics receive a number of requests for help and support by and on behalf of Medicare ineligible PLHIV
- They spend significant time assisting clients to navigate a complex health system in order to access HIV services and early treatment
- Help exits but it is piecemeal, complex and slower



Seeking Wisdom 2014 Jon Eiseman

Why is this significant?

- We know that around 5, 000 of the 26, 000 PLHIV in Australia were not on treatment in 2016 (14%).
- In addition there are roughly 500 Medicare ineligible temporary residents with HIV. Some are on treatment
- If we reach the WHO goal of 90% local PLHIV on treatment by 2020 the proportion of Medicare ineligible patients not on treatment will be higher
  - This represents a potential public health problem

Treatment

- Suppressing HIV improves the activity of the immune system and quality of life, lowers the risk of both AIDS-related and non-AIDS-related illness and prolongs life
- Failure to control viral activity also increases the risk of heart attacks, strokes, kidney disease, liver disease, brain and nerve complications and some cancers
- The latest treatments are more effective, convenient and better tolerated than older medicines
- Early treatment avoids complications and therefore costs
  - "Temprano" study

Prevention

- *Tools to prevent HIV transmission in Australia include*
  - Promotion of safer sex practices, including the use of condoms
  - Use clean needles by injectors
  - Medical strategies – usually drug based prevention (PrEP)
- *Other prevention strategies promoted in Australia include*
  - Regular HIV testing in at risk people*
  - Immediate HIV treatment to reduce HIV viral load
  - HIV post-exposure prophylaxis

* Australian guidelines recommend that all sexually active MSM are tested for HIV every 12 months. Those at high risk should retest up to 4x a year.

Treatment as prevention

- Anti-retroviral drugs reduce HIV load to unmeasurable levels
  - The so called an "undetectable" viral load
- Trials show that if HIV viral load stays undetectable there is almost no risk of passing HIV on through intercourse (U = U)

Rodger A et al. *Risk of HIV transmission through condom-less sex in gay couples with suppressive ART: the PARTNER2 study expanded results in gay men.* 22nd International AIDS Conference, Amsterdam, abstract WEAX0104LB, 2018.

- Newly infected patients are the most infectious to others and the least likely to know their diagnosis
  - Delayed treatment leaves the virus detectable for longer and the new sufferer untreated during the most infectious stage of the illness
- Temporary visa holders are the least likely to know their status

Treatment as prevention

- **Treatment access for Medicare ineligible patients**
  - **Private insurance**
  - **Personal importation** www.tga.au\personal-importation-scheme
  - **Generic drugs**
    - Pharmacy or online www.aids-drugs-online.com etc
  - **Clinical trials**
  - **Compassionate access schemes**
  - **Emergency treatment fund**
    - Up to three months plus two clinical visits

PEP

- ***Post-exposure prophylaxis (PEP)***
  - A preventative treatment given within 72 hours of sexual contact with an infected person or person of unknown status
- **Available in all hospital emergency rooms and SH clinics**
- **A doctor calculates the risk of catching HIV in each case and prescribes a course of tablets for at risk people**
  - Course is 28 days long
  - Drugs available to Medicare ineligible patients at no cost
  - Can be charged for an ED visit

PrEP

- ***Pre- exposure prophylaxis***
- A preventative treatment given to people who are known to be HIV negative but remain at increased risk of HIV infection
- In Australia, sexually active gay and bisexual men, transgender people and heterosexual people with an HIV positive partner who does not have an undetectable viral load are population groups that are at higher risk.
- From April 1st 2018 any doctor or general practitioner (GP) can prescribe PrEP through the PBS to a resident who holds a current Medicare card.

PrEP

- **People at high risk who do not have a Medicare card can buy and import PrEP from overseas (ttps://www.afao.org.au/wp - content/uploads/2016/12/PrEPAccess-Options-2017.pdf).**
- **The cost of personal importation per month is about the same as a general PBS co-payment (approx. $40 per month)**
- **Many MIP's are students or temporary workers**
- **Most start on Medicare or leave the country in less than 2 years**

Options

- Consider restructuring the model in QLD
- Use central register to tag MC ineligible patients
- Provide a fixed sum to each HHS to cover OPD and drug costs for 12 -24 months
  - Cap the entitlement for each HHS district
- The benefit may out-way the cost of acute complications and early transmission to locals
  - Average undiscounted lifetime cost of providing ART after infection 641, 800 to 1, 069,702 (ATRAS 2014)

Still Life c. 1995 Gwyn Hanson Piggott