Health service constraints on HIV care – the research agenda: a UK perspective

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Introduction

- HIV in the UK
- Changes to HIV care in the NHS
- Community involvement research

UK overview

- ~ 100,000 +ve, 25% undiagnosed
- High% on treatment and <50 c/mL
- Good surveillance data on STIs

  National & regional data (hpa.org.uk)
- Public funding for HIV research
- Close links to European and international studies

HIV research

- Good surveillance data on incidence (SOPHID – by age, region, year, ethnicity, risk group, CD4 etc)
- Cohort data on natural history, treatment and safety (UK-CHIC, seroconverters, MHRA, children, pregnancy etc, RITA/STARHS avidity)
- Drug resistance collaboration (HIV DRD)
- European cohort research - COHERE, CASCADE, EUROSIDA, PENTA, DAD etc
- Global – Large, randomised strategy studies: SPARTAC, DART, ARROW, ERNEST, PopART etc

Current examples

- Research less-affected - ASTRA, PROUD (PrEP), CURE (Cherub), HIVDRB; UK in PARTNER, START etc
- Cohort data and reduced monitoring

  - changed use of CD4 and viral load based on data
- Resistance collaboration

  - community-supported (1998), central database, greater numbers: community link = earlier advocacy for access and guidelines
  - understand epidemic dynamics – sub-clades, clusters, virulence
  - reducing risk of first-failure – critical when fewer drug options
  - current TDR from undiagnosed patients with historical mutations
  - stock-outs – 10% from NNRTI-based (Abs 593 CROI 2014)

NHS changes

- Financial pressure on NHS
- Continual restructure & overhaul
- Move to primary care – for cost

  - benefits: ageing cohort, normalising HIV?

  - disadvantages: drug interactions, confidentiality (rural), experience, convenience, cost-based
- Privatising NHS services - loss of HIV expertise: clinical, diagnostic, pharmacy
- HIV prevention & treatment separated

  - makes PrEP difficult to prescribe or study

Flat HIV budgets

- £20 billion savings
  - Nicholson ”challenge” - no inflation uplift, increasing patients
- Commercial ARV tenders by volume
  London saved £10m – challenge to pharma pricing
- Splitting FDCs & generics
  Supported by HIV positive people, 60-85% non-HIV NHS medsare generics, also ”home delivery” to save tax on medicines
- Evidence-based for clinical result
  BUT no shift to older ARVs, EFV 400 mg or boosted-PI mono,
  New-fill still funded

Model for other settings

- **Treatment response and drug safety**

  Essential to collect data on efficacy & safety of ARVs in practice – use of technology advances for collecting quality data

- **Reduce viral failure**

  Early uptake of viral load and resistance tests – but limited availability in other settings – stock-outs and resistance

- **Community engagement**

  Benefits from community involvement and a good profile

- **Improve quality of life**

  Switching options, pipeline and formulation research, cost & access (no premium pricing for new drugs)

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