HIV and Ageing Health and Social Care

We now live in era where people diagnosed with HIV, engaged in HIV care and on treatment have a normal life expectancy. The age of those living with HIV in the UK is increasing, with nearly 50% aged 50 or older [1]. Ageing and living with HIV both increase the risk of having multiple comorbidities, increasing the need for health and social care. Data clearly shows that from the age of 50 people living with HIV (PLWH) are significantly more likely to have more comorbidities than age-matched HIV negative peers [2]: one third of PWLH aged >65 will have 3 comorbidities or more, twice as common as those without HIV. In addition, PLWH also face stigmatisation and health inequalities. Ultimately all of these issues intersect causing significant impact on health-related quality of life in PLWH.

Diagnosis and management of age-related comorbidities in PLWH group remain largely opportunistic and below national standards. Our current healthcare design provides at best fragmented care to this growing group due of lack of integrated HIV care, GP service and Geriatrics as well as social and support services. Fragmentation of preventative care puts PLWH at further risk of poor health, frailty and reliance on hospital and social care.

Inconsistent use of existing healthcare frameworks has been shown to impede provision of care and appropriate policy and research. We welcome the recently launched Integrated Care Systems (ICS) which use a model of care built around those with multiple, complex, long-term conditions. ICS aim to improve population health, tackle health inequalities whilst supporting broader social and economic development. HIV, however, has not been specifically included in any ICS plan.

We know that PLWH are well engaged with HIV services. UKHSA data shows that of those diagnosed with HIV, 99% are in care and 99% are on treatment [1]. Patient surveys have shown that PLWH are reluctant to engage with other care as they fear stigma and judgement, often because of previous distressing personal experience, describing stigma and judgement from other providers. Placing trusted HIV specialists at the centre of holistic complex care coordination for PLWH should be a model to explore in ICS planning, reversing care fragmentation, and supporting integrated care delivery involving other services, including primary care.

ICS aim to prevent and reduce cardiovascular disease, diabetes mellitus, mental ill health and bone disease, usually managed in Primary Care. Routine HIV healthcare *could* include the assessment and management of all of these comorbidities as both HIV itself and HIV treatments can impact these conditions. Therefore, formalised health and social care pathways for HIV services to provide more comprehensive preventative care through supported, manageable change within HIV services would

- allow screening for age-related comorbidities,
- significantly reduce burden on GP practices, ED attendances and inpatient services,
- reduce/avoid duplication of screening,
- reduce frailty and lessen the need for inpatient or community based social support.

Although ICS explanations are comprehensive it is as yet unclear what flexibility this new structure will have to allow patients to journey from primary to secondary/tertiary care and

back in the current healthcare system. Formal HIV health and social care pathways could ensure and facilitate the effective movement of patients through care and back into community and could allow, for example, short elective inpatient admissions for focussed investigations.

The 4 ICS categories of Starting well, Living well, Ageing well and Reducing Wait Times all have considerable relevance for PLWH. Use of population level data, however, means that bidding for financial support within these envelopes is unlikely to be successful and people ageing with HIV will be neglected.

Ageing and older people living with HIV, when given a voice, have highlighted they are not a homogenous group and they therefore expect calls to action regarding their health and social care be implemented in ways that are equitable and account for intersectionality [3]. They want and deserve age-friendly and age-affirming information, care, services, and support that considers the impact of HIV status, gender identity, sexual orientation, citizenship, ability, race, ethnicity, and place of residence, among other factors on their health and wellbeing.

In 2023 there is no current or proposed health and social service and/or pathway that provides this for the 100,000 plus people living and ageing with HIV. Therefore, we urge the government to address this as a matter of urgency within this prevention inquiry.

1. https://www.gov.uk/government/statistics/hiv-annual-data-tables. Last accessed 7/2/2023.
2. Age HIV Cohort Study. Schouten J, et al. Clin Infect Dis. 2014;59:1787-1797.
3. https://www.realizecanada.org/wp-content/uploads/GM-for-Print-as-at-Dec-21-2022.pdf. Last accessed 7/2/2023.