The England experience: commissioning & prescribing efficiencies

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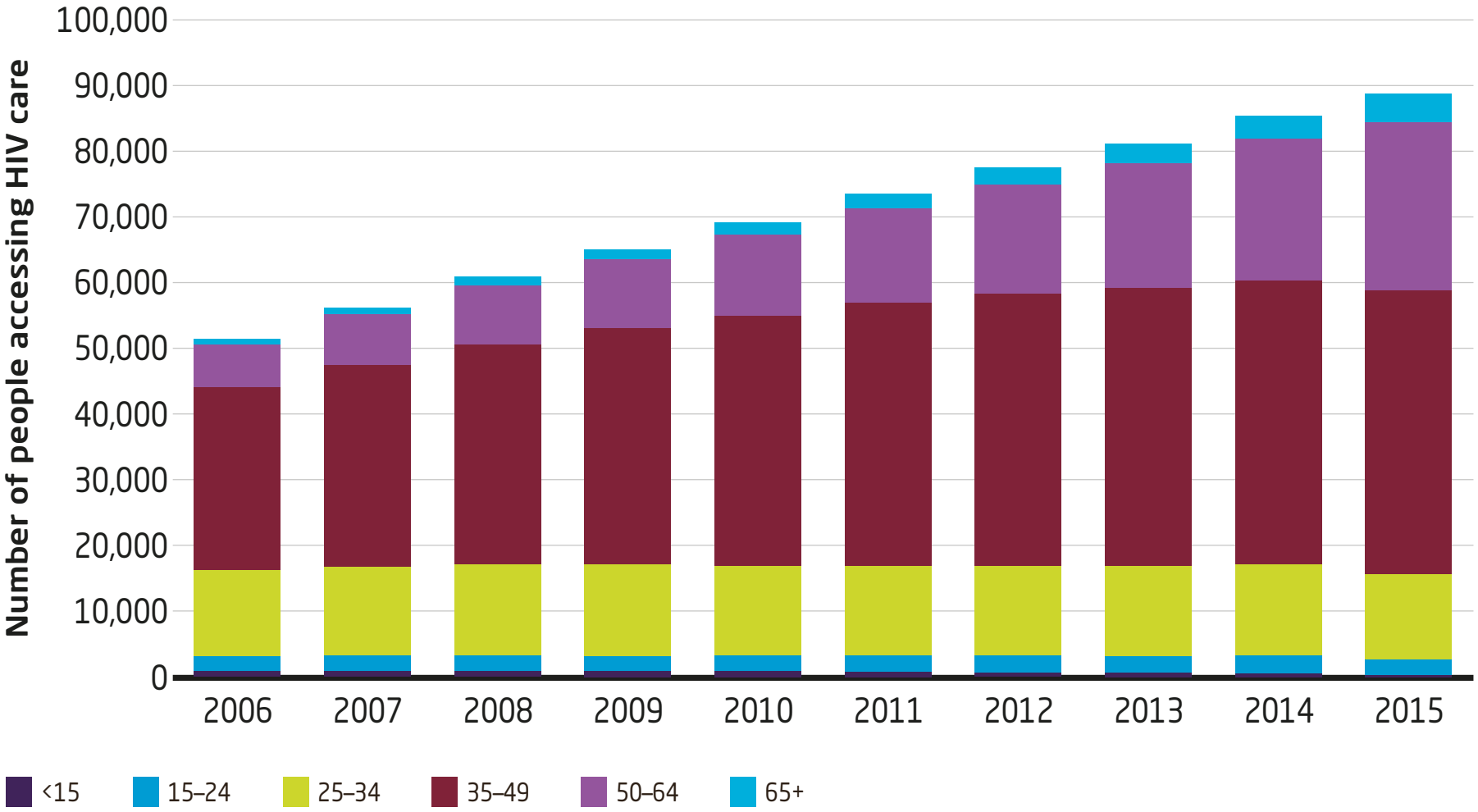
Content

- HIV in the UK/England
- Types of health care funding
- Health care funding & commissioning in England
- Facing up to the challenge
- The future

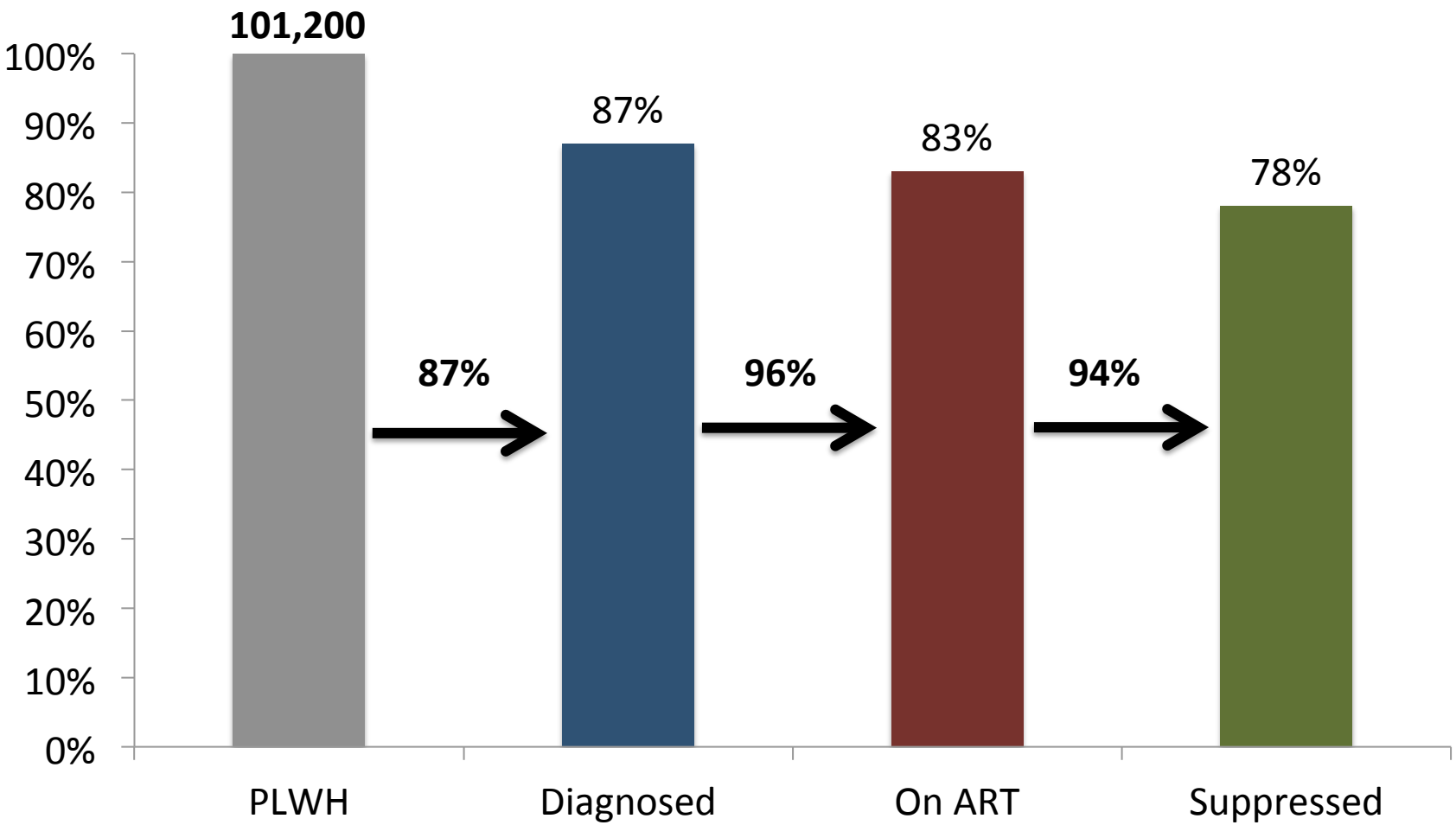
HIV TODAY: UK

Figure 2 Number of people accessing HIV specialist care, United Kingdom, 2006–2015, by age



Source: Kirwan *et al* 2016

UK continuum of HIV care



Kirwan PD, Chau C, Brown AE, Gill ON, Delpech VC and contributors. HIV in the UK - 2016 report. December 2016. Public Health England, London.

Life expectancy: 2017

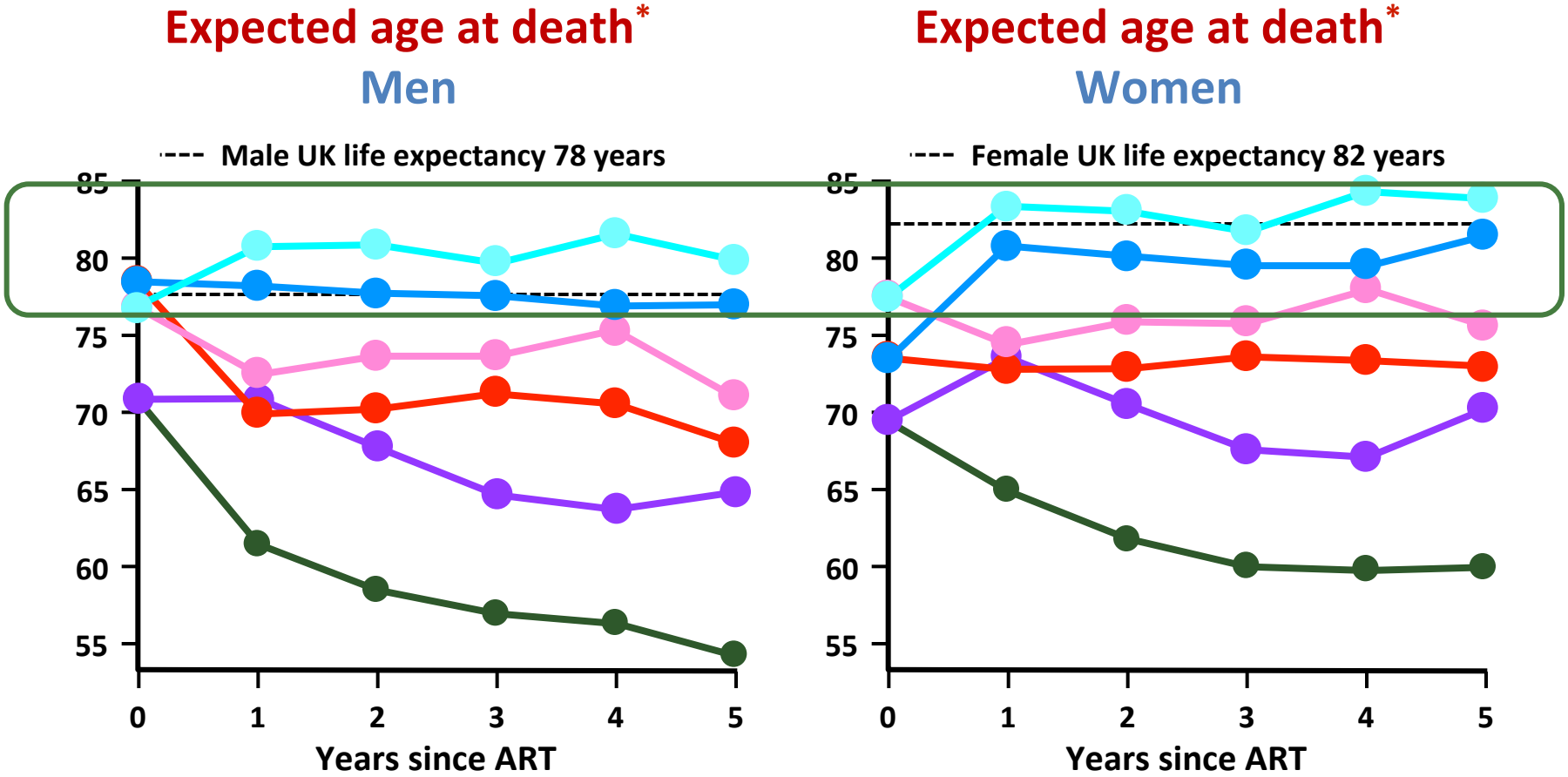
Articles

Survival of HIV-positive patients starting antiretroviral therapy between 1996 and 2013: a collaborative analysis of cohort studies

*The Antiretroviral Therapy Cohort Collaboration**

Lancet HIV. 2017 May 10. pii: S2352-3018(17)30066-8. doi: 10.1016/S2352-3018(17)30066-8.

UK CHIC life expectancy: 2014



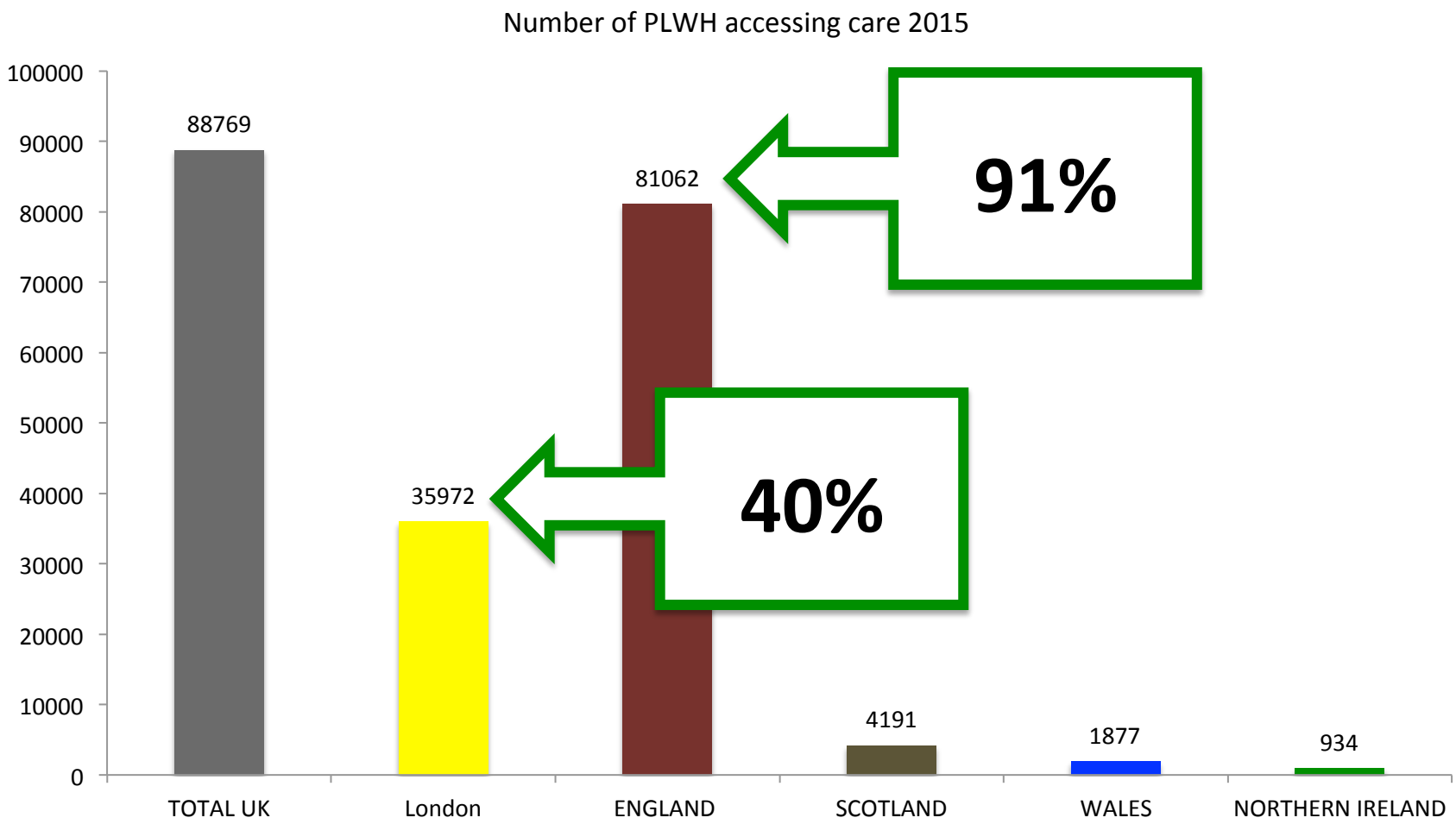
Viral load ≤400 copies/ml — CD4 ≥350 — CD4 200–349 — CD4 <200

Viral load >400 copies/ml — CD4 ≥350 — CD4 200–349 — CD4 <200

* Expected age at death for a person aged 35 years with different durations of antiretroviral therapy according to current CD4 count and viral load suppression

May M et al. AIDS 2014;28:1193–1202

Focus on England



Public Health England figures accessed at https://www.gov.uk/government/statistics/hiv-annual-data-tables 17th July 2017

HEALTH FUNDING

Types of health care funding

- Taxation
- Private health insurance
- Social health insurance
- User charges

https://www.kingsfund.org.uk/publications/how-health-care-is-funded accessed 17th July 2017

Taxation

- **Types:**
  - Direct/indirect, general/hypothecated, central/local regressive/progressive
- **Examples (tax = main funding):**
  - Australia, NZ, Canada, Nordic
- **Pros**
  - Equitable, efficient
  - Strong incentive to control spend
- **Cons**
  - Health costs rise >tax
  - Politicisation of health (?instability)

https://www.kingsfund.org.uk/publications/how-health-care-is-funded accessed 17th July 2017

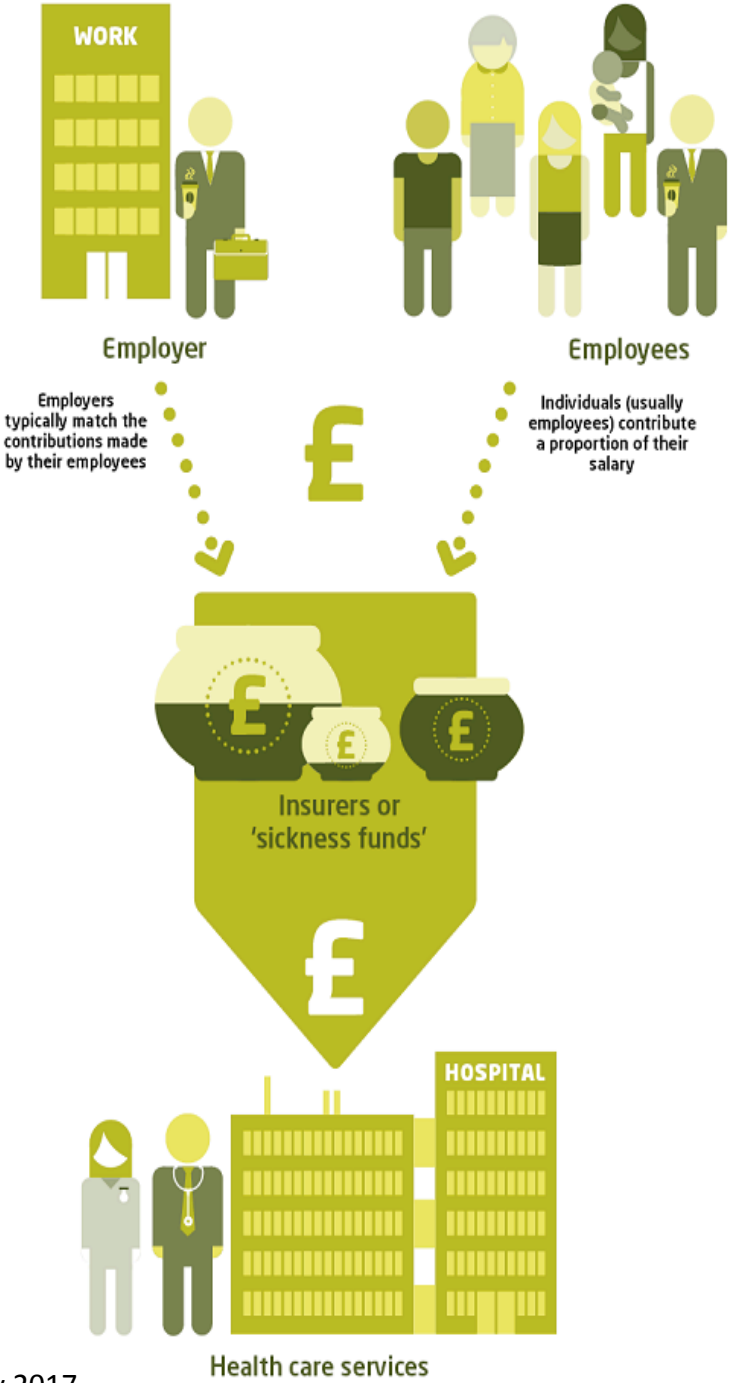
Private Health Insurance (PHI)

- Individuals or employers
- Contribution ≈ risk
- **Pros:**
  - Competition, less state burden
- **Cons:**
  - Inequitable, costly, regulatory requirements, regressive

https://www.kingsfund.org.uk/publications/how-health-care-is-funded accessed 17th July 2017

Social Health Insurance (SHI)

- Employees & employers pay to cover defined service package
- Collected by independent bodies responsible for paying providers
  - **Example**: Germany 14.6% gross income shared with employer + capped co-payments
- **Pros:** equitable (not risk based), efficient, less uncertainty, transparent
- **Cons:** higher taxes, costly if providers ++



https://www.kingsfund.org.uk/publications/how-health-care-is-funded accessed 17th July 2017

User charges as additional funding

- Pay directly for some/all care at point of care or 'medical savings accounts'
- Most European & OECD countries = only a small %
- Developing countries = large part of health care financed e.g. > 70% health expenditure in India
- **Pros**:
  - Extra funding, deters mis-use
- **Cons:**
  - Deters appropriate use, delayed treatment (££), admin £

https://www.kingsfund.org.uk/publications/how-health-care-is-funded accessed 17th July 2017

Kings Fund conclusion

*"Regardless of how health care is funded, all countries face **similar challenges** – namely, how to meet **rising demand** for services and transform care in response to an **ageing population and changing patterns of disease**"*

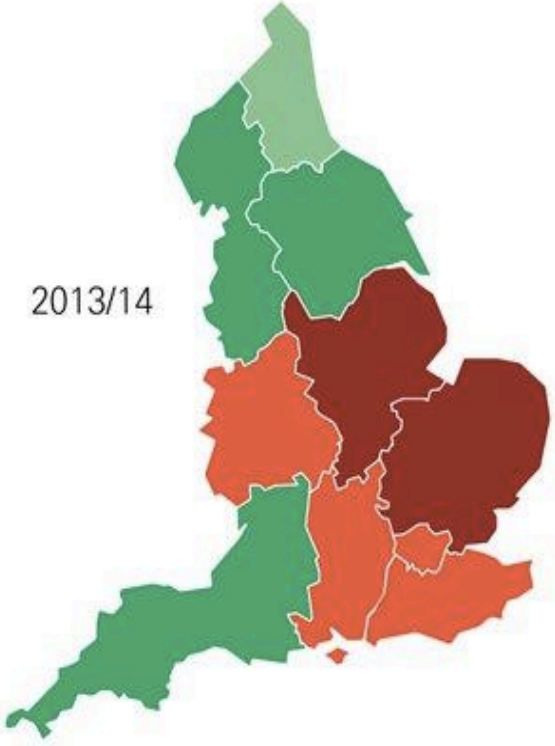
*"This is leading to **increased pressures** on services and **funding challenges** in countries around the world"*

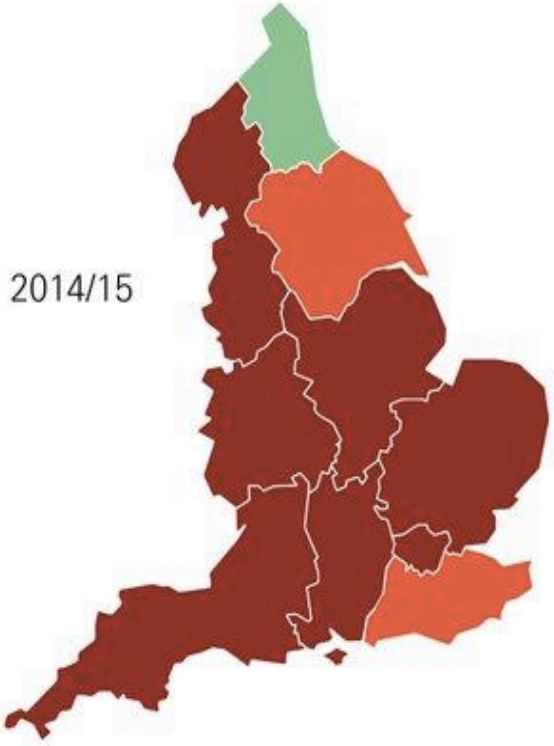
https://www.kingsfund.org.uk/publications/how-health-care-is-funded accessed 17th July 2017

How the NHS is funded

- 98.8% from general taxation and National Insurance
- 1.2% from patient charges
  - Dental fees, prescription charges, bedside TV (!)
  - 90% prescriptions in 2016 **free** due to exemptions
- 10.6% of the population has private health insurance (mainly corporate)
- **Funding is not keeping pace with demand nor inflation**

NHS provider finances: England regions





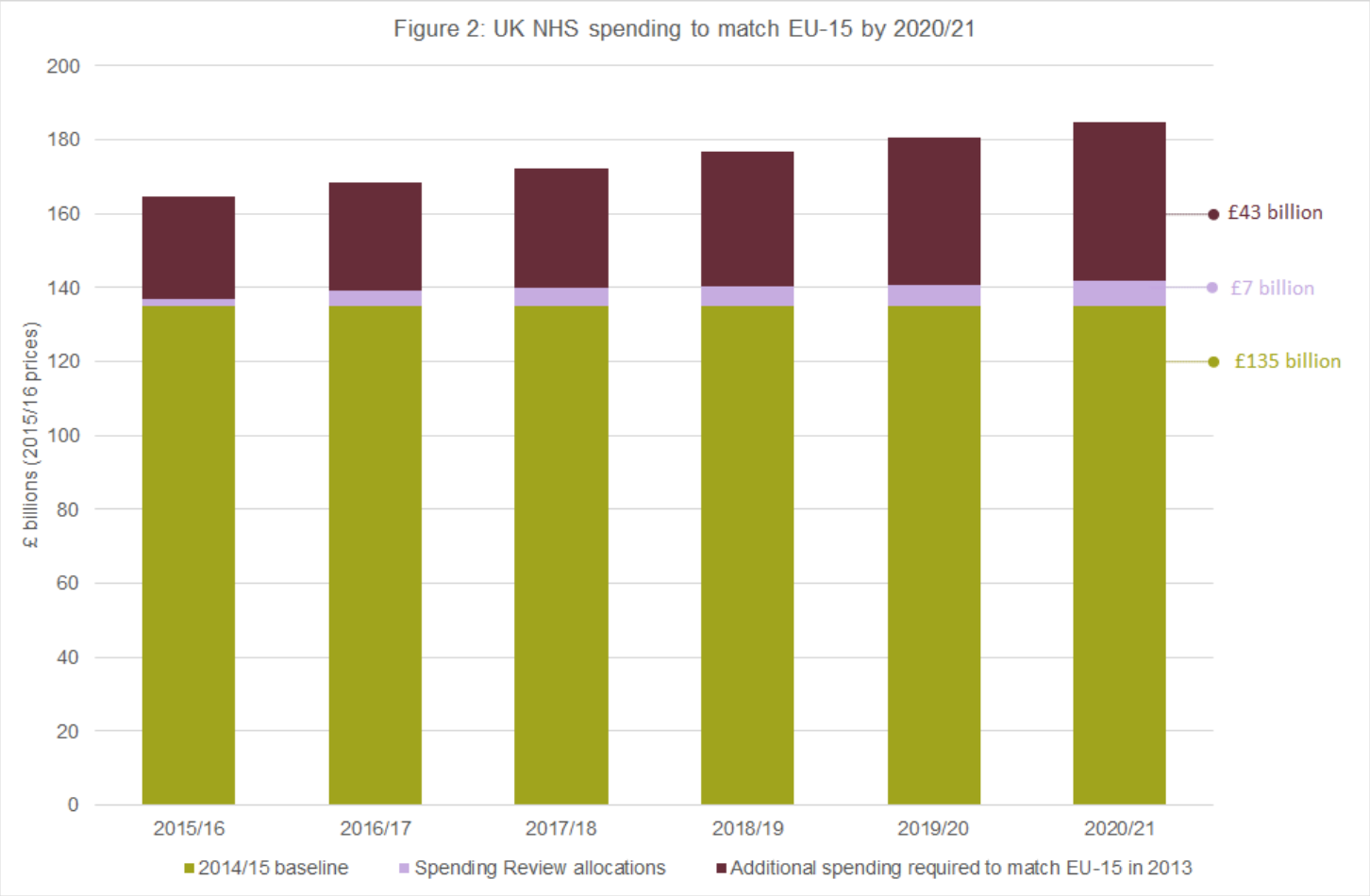
Net surplus: £0 > £30m
Net surplus: +£30m

Net deficit: > -£50m
Net deficit: -£50m > £0
Net surplus: £0 > £30m
Net surplus: +£30m

Net deficit: > -£50m
Net deficit: -£50m > £0
Net surplus: £0 > £30m

http://www.health.org.uk/chart-changing-geography-nhs-deficits accessed 17th July 2017

UK vs EU-14 average



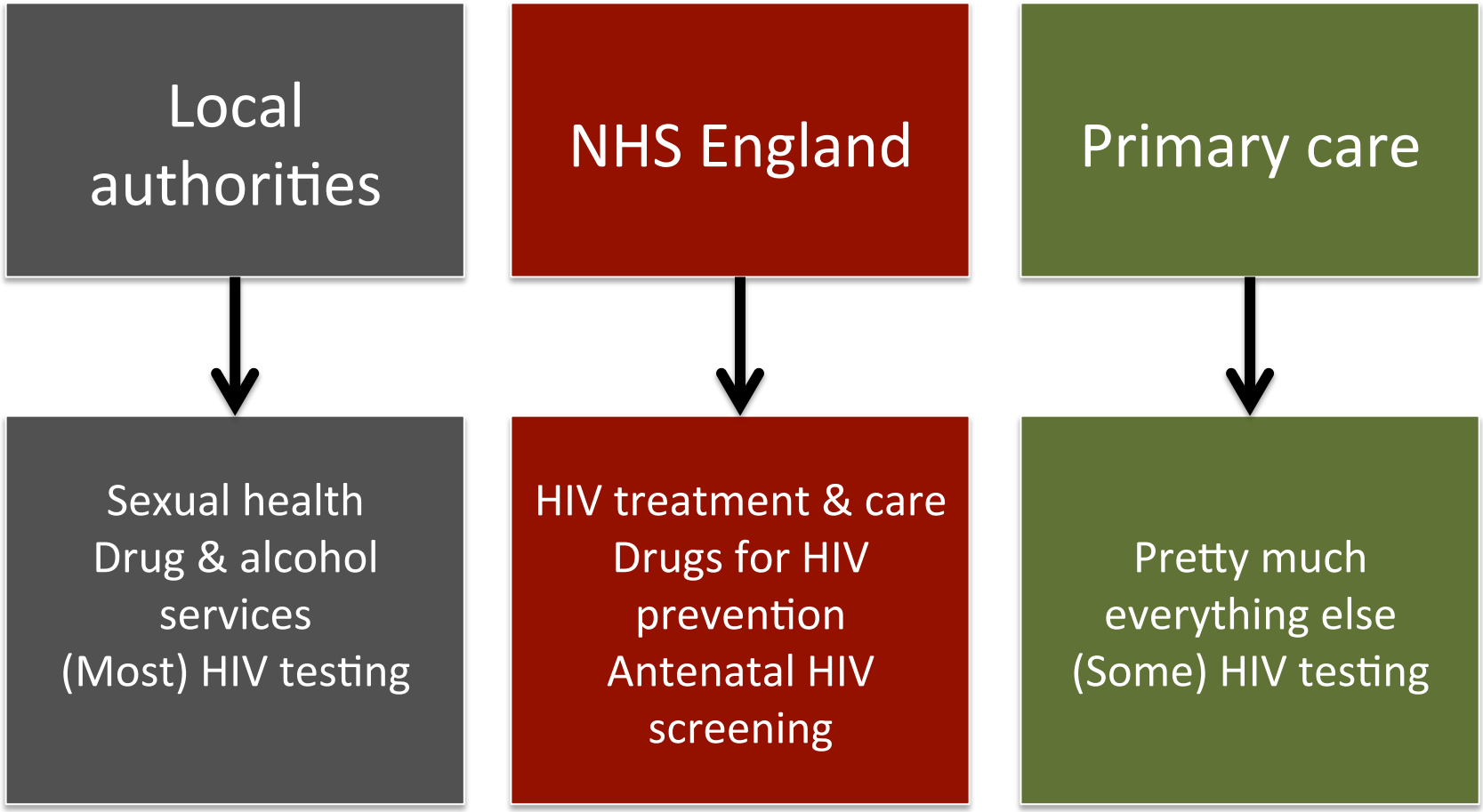
Source: https://www.kingsfund.org.uk/blog/2016/01/how-does-nhs-spending-compare-health-spending-internationally accessed 17th July 2017

HEALTH COMMISSIONING IN ENGLAND

Health & Social Care Act 2012

- Biggest re-organisation of NHS services since their inception
- It's complicated….

What it means for HIV



HIV commissioning

- Part of specialised services costing >£15bn a year
- There are **6 National Programmes of Care:**
  - **HIV Clinical Reference Group (CRG)** sits within 'Blood & Infection' programme of care along with 5 other CRGs
- **HIV CRG advises NHS England:**
  - On HIV policies e.g. immediate ART policy
  - National policies for new drugs (all since Stribild)

Expectations

- Continual review of services and prescribing to ensure most efficient use of stretched resources
- To do the same/more for less
- To develop & follow cost-based regional guidelines
  - These haven't contradicted BHIVA guidelines yet
- To use generics, where available & suitable, even if that means **more pills**

Example 1: national pressure

- Commissioning levers where meeting certain pre-agreed goals attracts income
- **Examples:**
  - Reduced CD4 monitoring (annual >350, stop >500)
  - Replacement of face-to-face consultations with 'virtual'
  - Increased recruitment to clinical trials
  - Cost-based ART switches:
    - PI/ritonavir to PI/cobicistat FDC
    - Use of generics (including splitting pills)

NHS England ART Switching Project

Current regimen	Switch to	Start Date	Min Proposed %
Atripla	Truvada + gEFV	12/2016	60%
Darunavir 800 + Ritonavir	Rezolsta	07/2016	50%
Atazanavir 300 + Ritonavir	Evotaz	07/2016	60%
Kivexa	gABC/3TC FDC	12/2016	95%
Nevirapine Modified Release 400mg	gNVP MR 400mg	London: 09/2016 Non-London: 05/2017	95%
Dolutegravir	Raltegravir	07/2016	No % switch, but consider switch
Triumeq	Raltegravir + gABC/3TC FDC	On hold until 09/2017	

Personal communication, Janette Harper, Lead Commissioner HIV for NHS England

Forecast savings

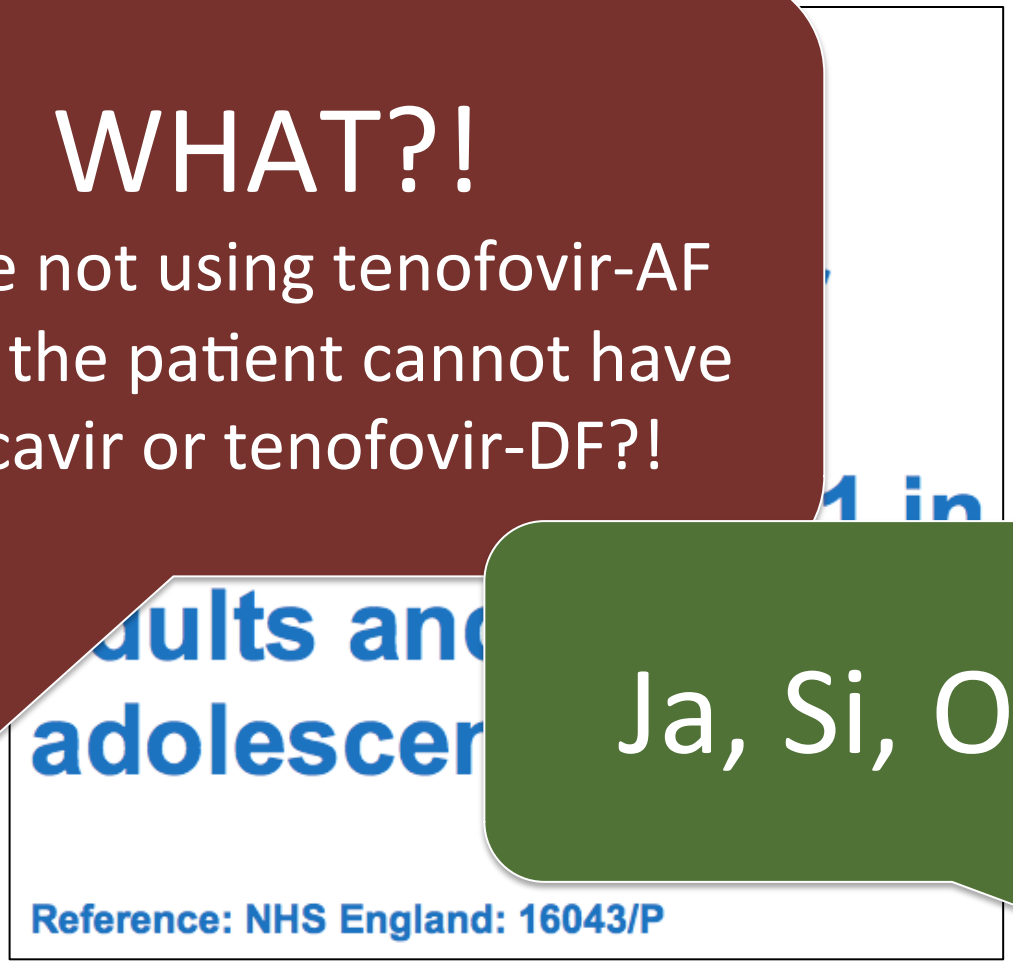
- **Year 1**
  - £10m from switching
- **Year 2**
  - £32m from switching
    - £15m from Kivexa to ABC/3TC FDC alone

Personal communication, Janette Harper, Lead Commissioner HIV for NHS England

Perhaps the most controversial….

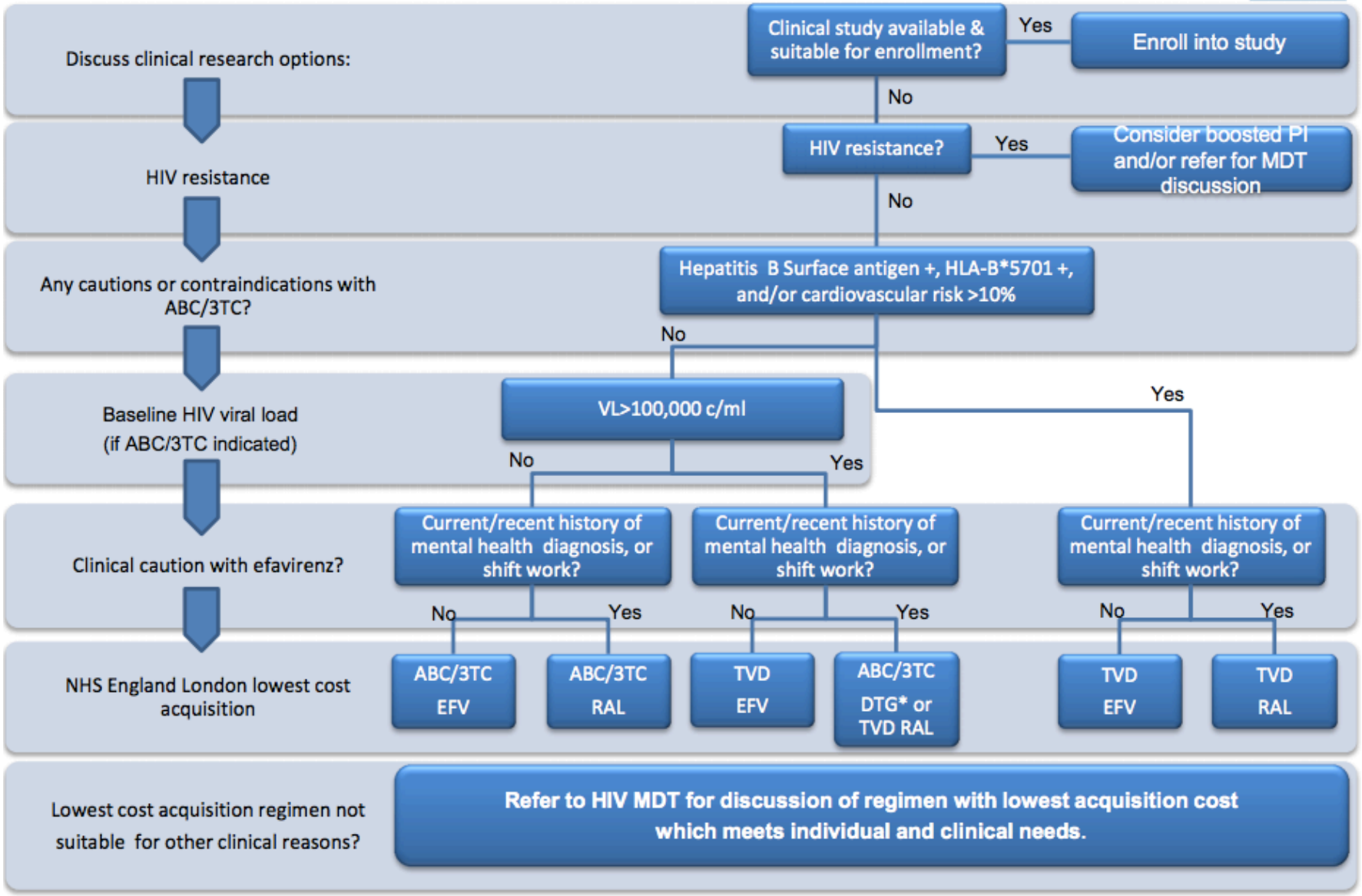
WHAT?!

You're not using tenofovir-AF unless the patient cannot have abacavir or tenofovir-DF?!



Ja, Si, Oui!

Example 2: London 1st line ARV policy



London policy on generics

Prescribing of generic ARVs

NHS England

Generic agents are widely used across the NHS in all disease areas; the use of generics in HIV could result in significant financial savings to the NHS.

- Where there are contracts for generic ARVs, patients should be switched from the branded equivalent at the earliest opportunity, taking into account the need for discussing and agreeing the switch with patients prior to it, providing appropriate information, and avoiding drug wastage.

- The use of generic NRTI fixed dose combination (FDC) will be used in preference to single tablet regimens (STRs).

Example 3: local pressure

- Negotiations with HIV commissioners & local Trust
- **Examples:**
  - **Reduced pathology costs**
    - Pooled STI screening
    - Creatinine vs whole renal profile
    - Hepatitis C antigen vs RNA
  - **VAT savings on drugs**
    - Home delivery
    - Community pharmacy
    - Outsourced (privatised) pharmacy

Use of generics

- **The market & potential savings will vary**
  - Existing providers
  - Regulatory climate
  - Typical cost difference
- **In England**
  - Broadly no generics until patent expiry
  - Generic use promoted
  - Generics typically at least 70% cheaper than branded

Current generics use

- **'Automatic'**
  - Kivexa to generic abacavir/lamivudine
  - Efavirenz, nevirapine-SR, nevirapine-MR, lamivudine

- **Offered/encouraged**
  - Atripla to Truvada + generic efavirenz
  - Suitability for abacavir/lamivudine if on different backbone

Are we doing the right thing?

BENEFICENCE

NON-MALEFICENCE

JUSTICE

AUTONOMY

Are we doing the right thing?

Are we doing the right thing?

Generics

- **Bioequivalent**
- Several studies support bioequivalence including 'random check' studies[1]
- Excipients may vary
  - Lactose of content nevirapine preparations
  - Monitoring is CRUCIAL
- Cohort evidence to support switch[2]

1. Sapsirisavat V et al. PLoS One. 2016; 11(6): e0157039. 2. Engsig FN et al. J Acquir Immune Defic Syndr. 2014 Aug 1;66(4):407-13.

“But STRs are better!”

PLOS | ONE A Peer-Reviewed, Open Access Journal

PLoS One. 2016; 11(1): e0147821.
Published online 2016 Jan 25. doi: 10.1371/journal.pone.0147821

PMCID: PMC4725959

Cost-Effectiveness of Single- Versus Generic Multiple-Tablet Regimens for Treatment of HIV-1 Infection in the United States

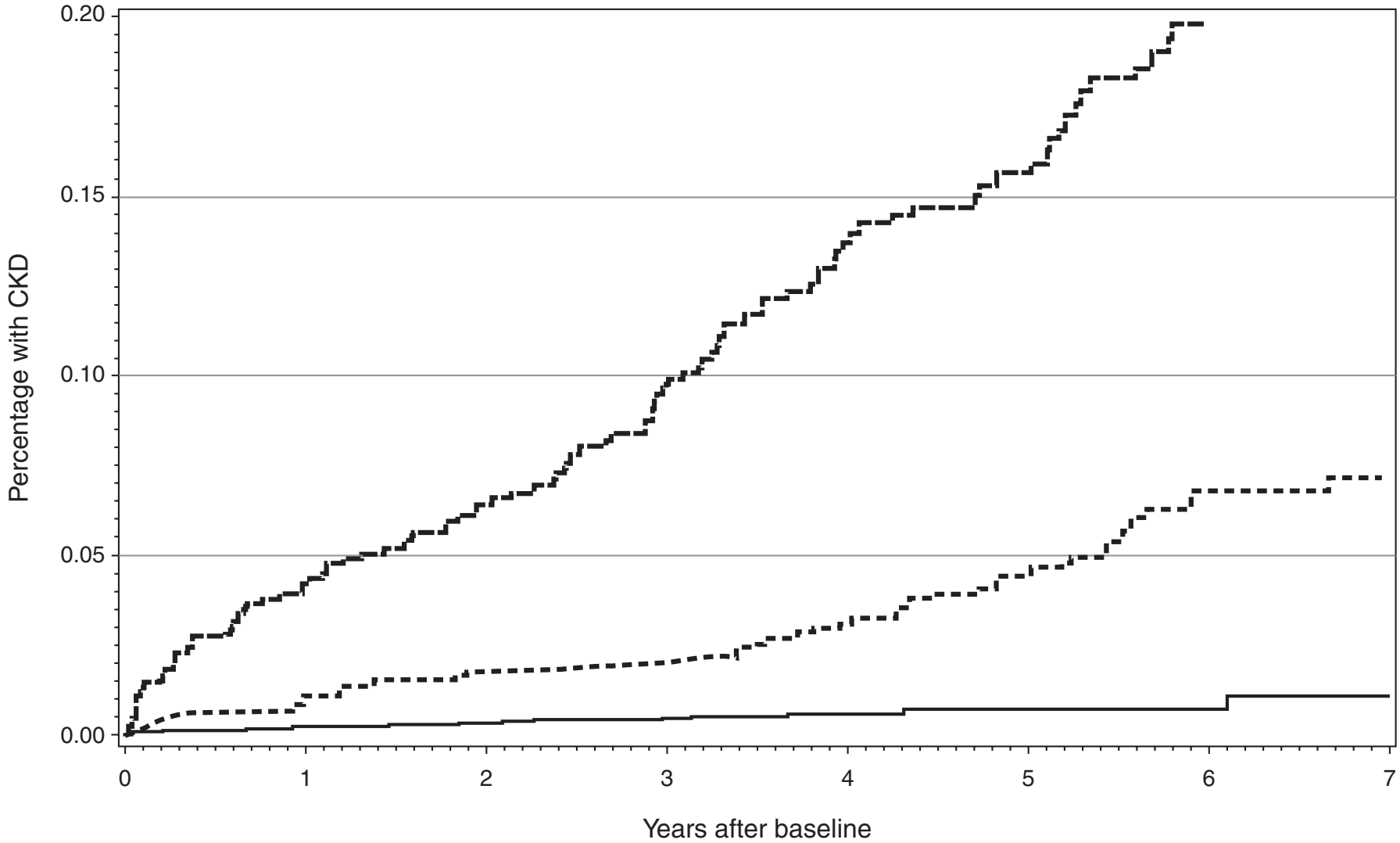
Donna E. Sweet,[1] Frederick L. Altice,[2] Calvin J. Cohen,[3,¤] and Björn Vandewalle[4,*]

Viviane D. Lima, Editor

Using tenofovir-DF over tenofovir-AF unless clinically indicated

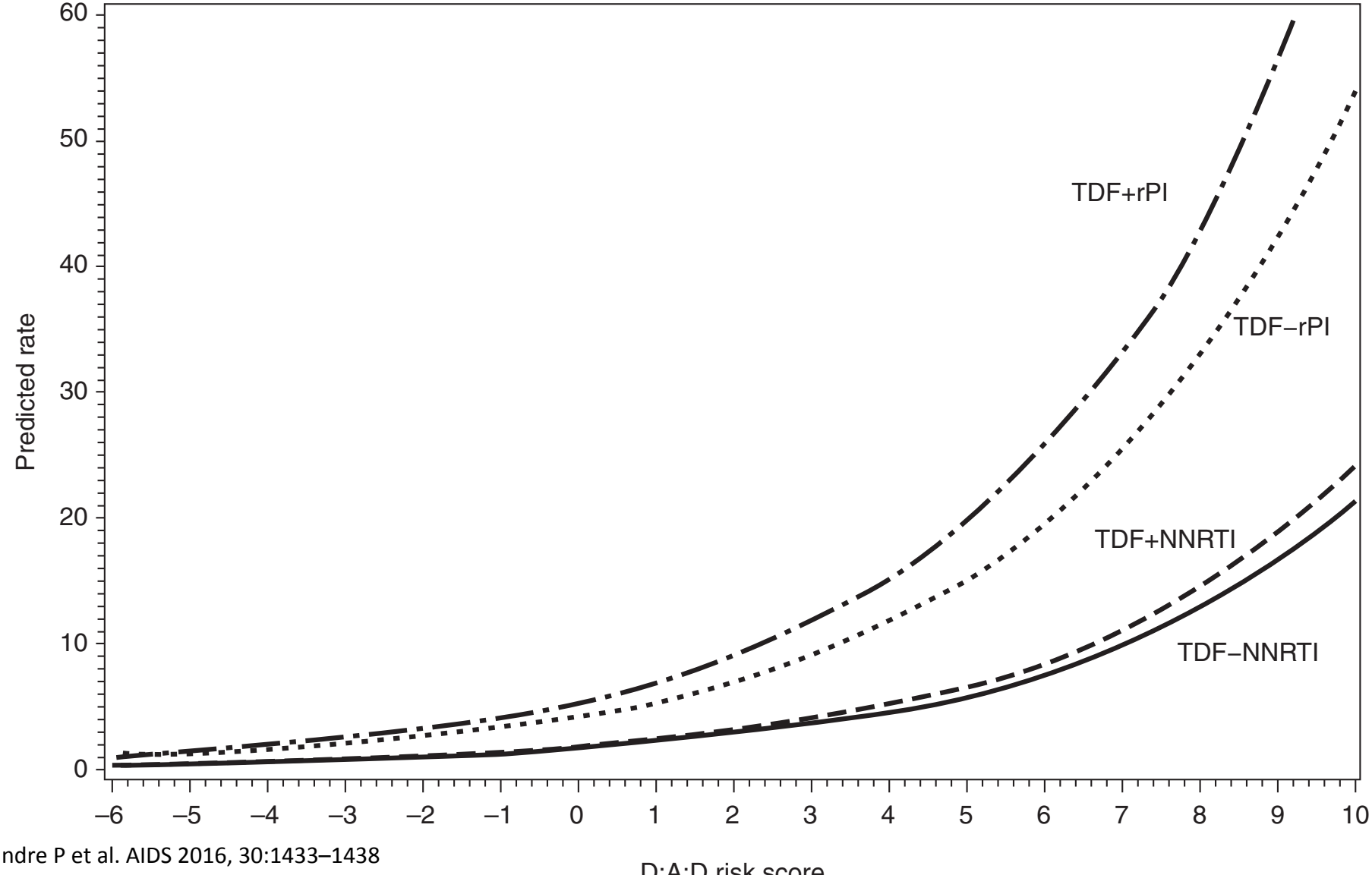
- Much debated (and criticised)
- **Data supporting TAF safety:**
  - Surrogate markers vs clinical end-points
  - Validity of DEXA end-points in a largely young(ish) male population?
  - Lack of cardiovascular surrogate marker/cohort data
- **Main arguments for using TDF:**
  - Safe for many
  - Regular monitoring
  - Imminent generics savings

Dat'AIDS group:
risk of CKD by D.A.D score



Flandre P et al. AIDS 2016, 30:1433–1438

Dat'AIDS group:
risk of CKD by D.A.D score & ART regimen



Flandre P et al. AIDS 2016, 30:1433–1438

Author conclusions

"tenofovir alafenamide comes with promises of less renal toxicity than tenofovir…..in patients with low risk of CKD, tenofovir remains safe for the kidney"

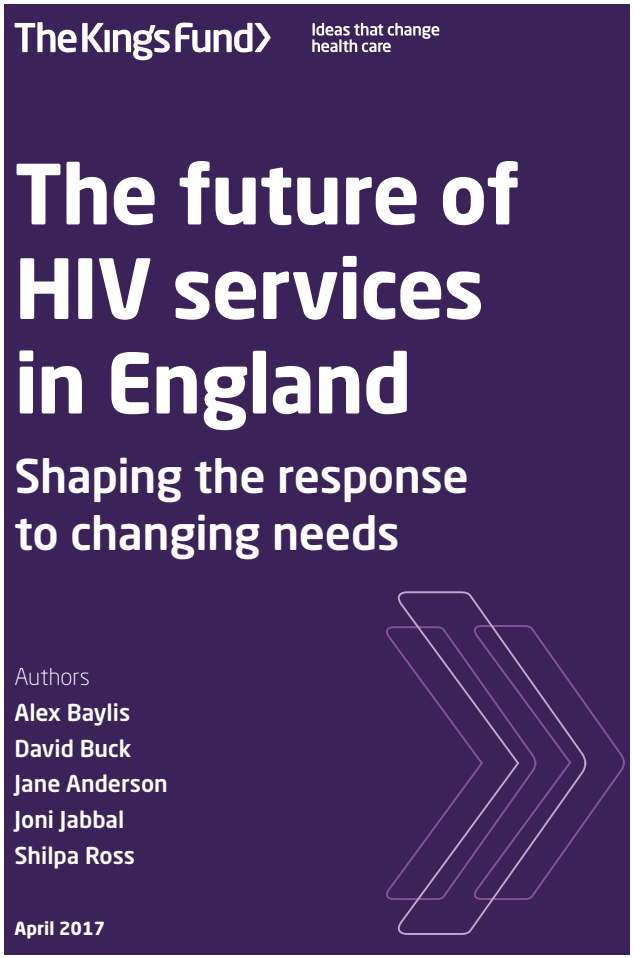
"in low-risk patients tenofovir-including regimens may be safely prescribed, with an economic benefit due to soon available….generic formulations"

Key to all this…

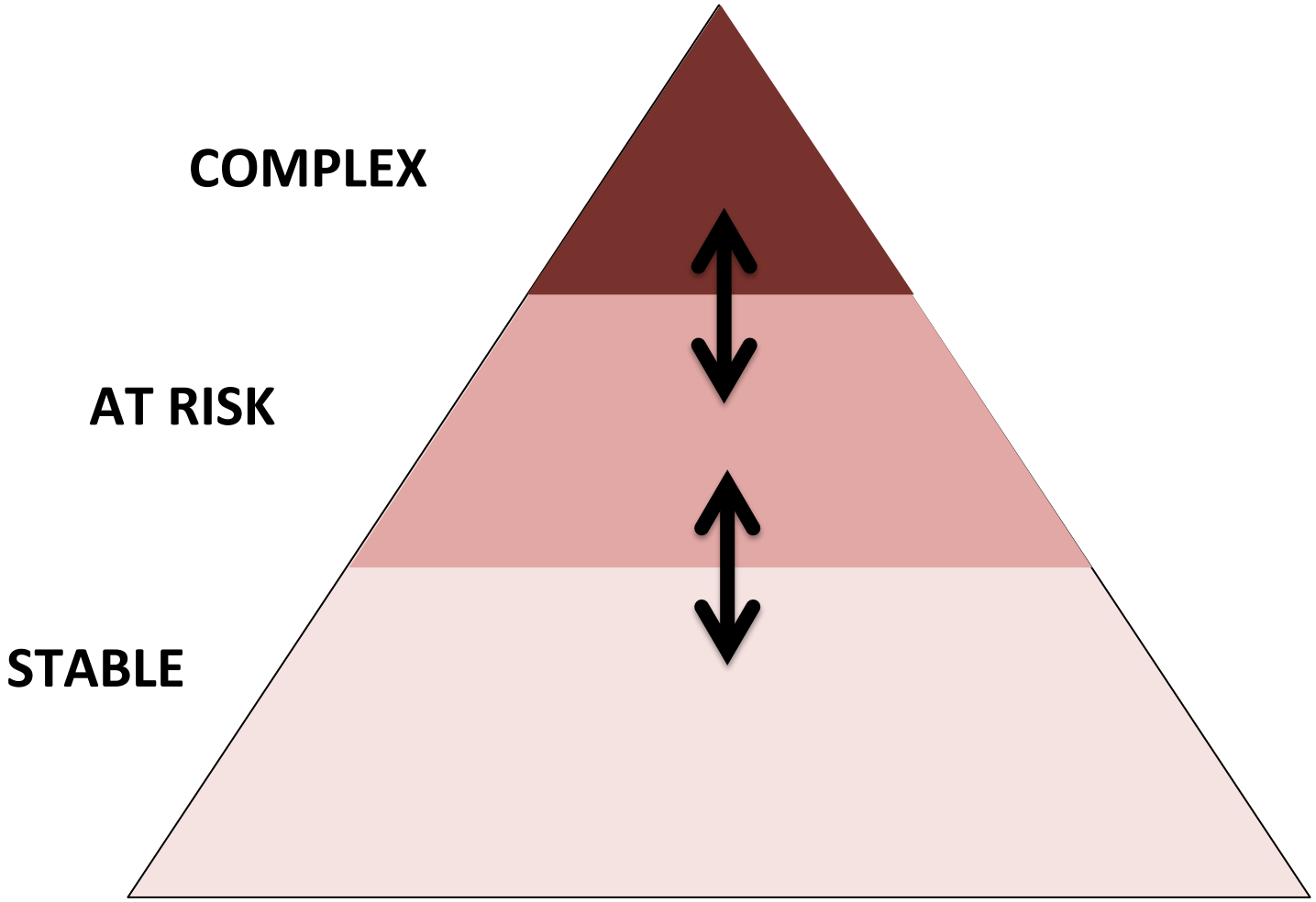
- **PATIENT ENGAGEMENT**
- Patient representatives at every level of decision making
- Key role of peer support
- Patient information, developed with patients
- Preservation of **choice**

THE FUTURE

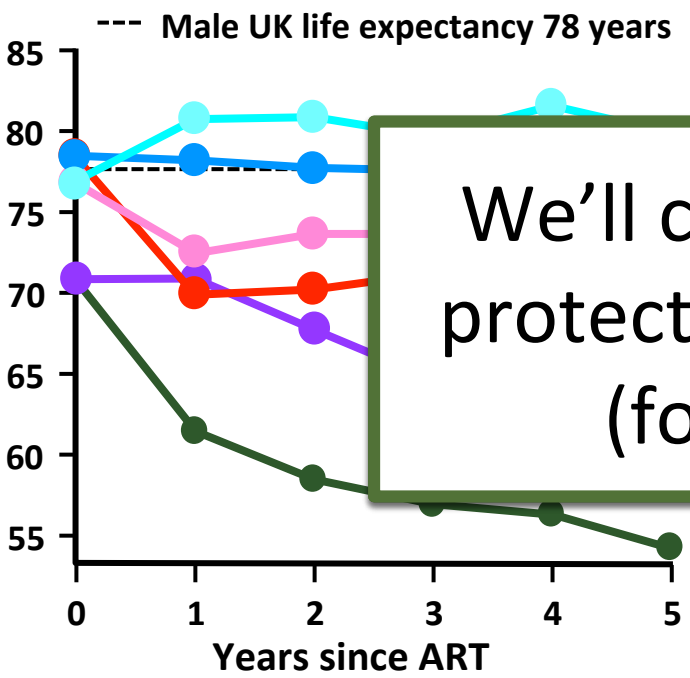
King's fund report



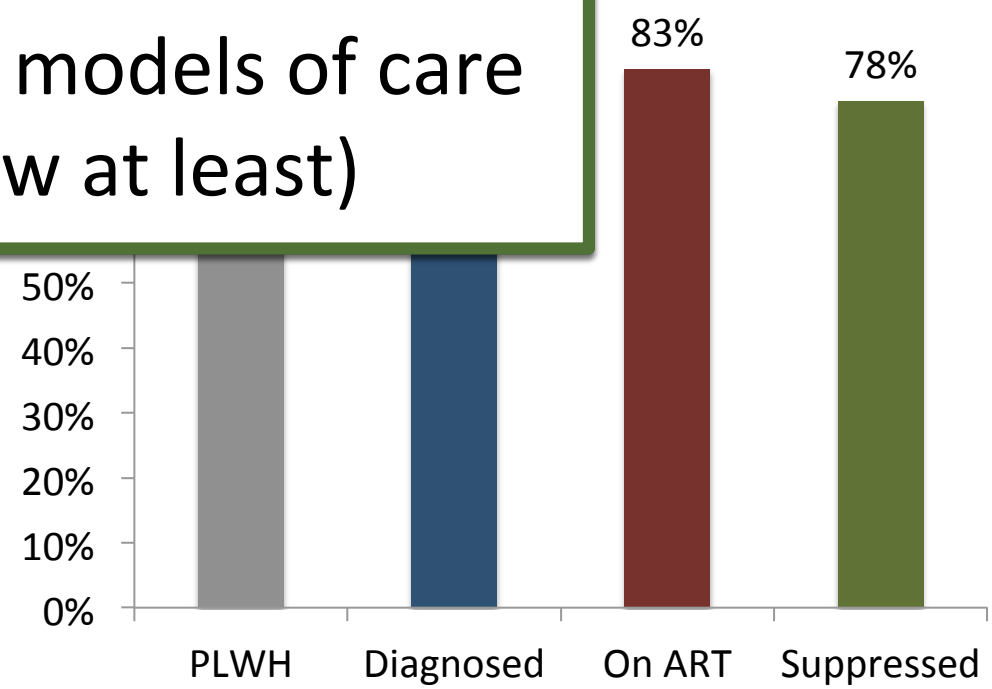
The care pyramid



Conclusion



We'll continue to work to protect our models of care (for now at least)



Thank you!

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