

Misplaced advocacy: What does better hepatitis C treatment really mean?

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See also www.cmaj.ca/lookup/doi/10.1503/cmaj.150652 and www.cmaj.ca/lookup/doi/10.1503/cmaj.140290

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In a very short time, hepatitis C virus (HCV) infection has gone from a “silent” chronic infection to a looming threat to our health care system. This shift coincided with the approval of new oral medications that has made HCV infection highly curable. On Dec. 13, 2013, after a long wait for improved treatment, Health Canada approved sofosbuvir, the first direct-acting antiviral treatment, as part of combination therapy for HCV genotypes 2 and 3.¹ On Oct. 15, 2014, ledipasvir–sofosbuvir, a well-tolerated and highly effective oral combination pill for the treatment of genotype 1 infection, was approved for use in Canada.² At the time of release, sofosbuvir was priced at US\$1000 per pill or \$84 000 for a 12-week course of treatment, and the combination drug was priced at \$94 500 for a standard course.³

Although the pricing of the medications was widely criticized as being exorbitant, reported sales of sofosbuvir topped \$10 billion in the first year alone, which makes it one of the most profitable drug launches ever.⁴ It is expected that the costs negotiated by provincial governments will be lower and competition will eventually drive down prices; however, the sheer number of potential “customers” promises to make the HCV drug market a windfall for pharmaceutical companies.

Patients who were previously given reassurance and advised against interferon-based treatments because of their adverse effects are now being urged to get treatment. Pharmaceutical companies with HCV drugs have taken a keen interest in supporting advocacy groups, organizing educational dinners for health care providers, paying for diagnostic testing and having a major presence at national and international conferences. Organizations that once led the charge for access to HIV therapy are now shifting their focus to HCV treatment. Multidisciplinary clinics are being created for HCV management, and there is mounting pressure on governments to allocate a substantial proportion of drug budgets to HCV treatment.

The introduction of effective, well-tolerated oral medications for HCV infection is a major step forward and will help prevent the serious and potentially expensive complications of end-stage liver disease. However, we urgently need a rational approach on how these new drugs are used among patients with serious competing health risks. We must not lose sight of the factors that are driving the HCV epidemic, nor dilute our advocacy efforts for the interventions that could make a real difference to the health of those with HCV infection.

In Canada, an estimated 250 000 people are infected with HCV.⁵ The epidemic can be divided into two waves. The first occurred when people were infected through contaminated blood products during the 1970s and 1980s. The Canadian blood supply has been screened for hepatitis C since 1990, which means that those who were infected with HCV at that time and are still alive have been infected for at least 25 years.

The second wave of HCV infection began in the 1980s among people who inject drugs. For decades, the prevalence of HCV infection in this population has ranged from 50%–90% in major Canadian cities, which has created a saturation of infection among the most vulnerable.^{6,7} The incidence remains exceedingly high among people more recently introduced to injection drug

Competing interests: None declared.

This article was solicited and has not been peer reviewed.

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CMAJ 2015. DOI:10.1503/cmaj.150612

KEY POINTS

- The recent introduction of highly effective oral drug treatments for hepatitis C virus (HCV) infection has directed attention to the health impacts of HCV-related liver disease.
- Although people who inject drugs, both current and past users, should benefit from these improved treatments, they also face a myriad of competing health risks that result in dismal health outcomes that fall outside of HCV infection.
- A rational approach to how these new HCV drugs are used that does not view the treatment of HCV in isolation is urgently required.
- Advocating for access to HCV treatment without addressing the social and structural determinants of how HCV is transmitted will have limited impact on improving the health outcomes of those infected.

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use, and new cases of HCV infection occur almost exclusively among people who inject drugs.⁸ Neglect on the part of government and health care providers toward people who inject drugs has intensified the problem. Aggressive enforcement policies surrounding illicit drug use and a dismissive societal response to people who struggle with addiction have frustrated efforts in controlling the spread of HCV infection through harm-reduction programs.

The current epidemic is deeply rooted in the structural, social and economic determinants of health. The introduction of better treatments for HCV infection will not fix these problems.

Throughout Canada, the outlook remains bleak for homeless people, those who are mentally ill and people who use injection drugs. Hepatitis C virus infection contributes relatively little to the causes of premature death and suffering in these groups, which include drug overdose, violence, suicide, alcoholism, smoking, HIV and injection-related infections.⁹ Many thousands of Canadians spend their adult lives in a relentless cycle of living on the street, in homeless shelters, recovery houses and jails, with just enough social support to keep them from dying but not nearly enough to break the cycle. These are the health and social issues that should capture our attention if we are truly interested in improving the lives of people with HCV infection.

Rates of HCV infection are disproportionately high in the Canadian prison system,¹⁰ a situation exacerbated by our tendency to incarcerate the most disadvantaged people in our society, often for nonviolent drug crimes and the consequences of unmanaged mental health problems. Many inmates acquire HCV infection while in prison because injection drugs are easy to access but clean needles are not.¹¹ Furthermore, little attention is paid to transitioning to life outside prison on release, and many former prisoners end up inadequately housed, unemployed, disconnected from social services and back in an environment where re-infection is likely. In light of this, recent enthusiasm to prioritize drug treatment for people with HCV infection who are incarcerated seems especially misplaced.

The promotion of HCV treatment as a type of transformative medical intervention distracts us from offering real opportunities to improve health and quality of life for the people who need it most. At current prices, the resources to cover a single course of HCV treatment could be

used to provide someone with supportive housing for five years, or to buy a million clean needles, or to fully staff a drug treatment centre for a month. Without these types of interventions, expensive medical treatment will do little to improve the health outcomes of most people currently infected with hepatitis C.

Even if the treatment for HCV infection were free, we cannot afford to neglect the social determinants that are driving dismal health outcomes: discrimination, addiction, mental illness, homelessness, poverty and the criminalization of drug users. As such, our response to the epidemic of HCV infection must continue to focus on prevention and a commitment to addressing these underlying factors. Although it is critical to advocate for equitable access to new treatments, we must not lose sight of the issues that are responsible for the HCV epidemic in the first place and advocate even harder for the social and structural interventions that could make a real difference.

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