

Pricing viral hepatitis as part of universal health coverage



In the past decade, the profile of viral hepatitis has increased on the global health agenda with a greater recognition of the burden of disease, availability of highly effective vaccines (for hepatitis A and B), highly effective treatments (for hepatitis B and C), and greater political efforts to support hepatitis work globally.^{1,2} WHO has set targets to eliminate viral hepatitis as a public health threat by 2030.³

Therefore, it is surprising that the WHO's 2017 estimates of the cost for providing universal healthcare coverage (UHC) through essential health programmes⁴ did not include testing or treatment for viral hepatitis.

In *The Lancet Global Health*, David Tordup and colleagues⁵ from WHO set out to rectify this omission, expanding the previous analysis. They provide the additional cost for the scale-up of testing and treatment for hepatitis in 67 countries and find that, despite being a large sum, it is small relative to the total cost of UHC. Although some of the countries with the heaviest burden are not included (eg, Russia), the combined countries account for 90% and 73% of the global population living with hepatitis B virus (HBV) and hepatitis C virus (HCV), respectively. As a suggestion of the good value of hepatitis interventions, the authors note that a relatively small (1.5%) additional investment in viral hepatitis programmes can yield a relatively large return in health benefits (averting 4.5% premature deaths and providing 9.6% more healthy life-years by 2030).

The costing of ambitious plans for health goals is an important endeavour because it adds a dose of realism, can be sobering, but frequently can be galvanising too.

There are a couple of points to make regarding the approach taken. First, the authors cost out the testing and treating components for hepatitis elimination only. Prevention is assumed to be fully covered, but it would probably be another major cost driver were it to be included. It should also be noted that prevention is the cornerstone of the hepatitis elimination agenda and the targets for incidence reduction might be the most challenging overall. However, with the use of the 2030 horizon in this analysis, the authors report that the cost of treatment is not very much affected by the success of those prevention activities (in the case of HCV), since the benefits of prevention in terms of reducing future

treatment cost will be achieved after 2030, because it takes decades between an infection occurring and the need for treatment.

Second, although the incremental investment is small relative to the total cost of UHC, the total cost of UHC is very high and a comprehensive package is currently not affordable for most low-income and middle-income countries. In the absence of external funds, the challenge for viral hepatitis is establishing its importance relative to other potential health priorities to support national elimination plans. National essential healthcare packages need to make hard choices about which interventions to prioritise. These packages of intervention for national scale-up should be constructed and assessed⁶ in a manner that focuses on the locally realised value of health benefits and health opportunity costs, which are beyond the scope of this Article.

The modelling focuses on the costs of both drugs and diagnostics; reducing these costs will be key in making interventions more affordable. Diagnostics might sometimes be overlooked, but commissions on both viral hepatitis⁷ and tuberculosis⁸ have emphasised their key role in elimination efforts. Even with a modest costs estimate for a viral load (US \$20), diagnostics account for 69% of total costs in the ambitious scenario in the Tordup and colleagues analysis, highlighting that much more needs to be done in ensuring access to essential diagnostics and validating models of simplified care. Moreover, the calculations of Tordup and colleagues do not include any costs for achieving the diagnosis beyond the diagnostics themselves. WHO recommends population screening where prevalence is sufficiently high.⁹ Experience in community-wide screening with HIV and HBV (including trials such as SEARCH,¹⁰ POPART,¹¹ and PROLIFICA)¹² suggests that the additional costs of outreach and public awareness campaigns are an important consideration for delivering the substantial increases in diagnosis required to achieve elimination.

Most key HBV drugs are now off patent, but although new drugs have transformed HCV treatment since 2014, their price remains a barrier to access in many countries. The authors note that 67% of those infected with HCV live in countries eligible for access to generic medications. Prices are dynamic and, in some settings,

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HCV treatment can now be bought for less than \$100 per course. But that leaves many countries, particularly those classified as upper-middle income, struggling to afford HCV treatment despite their designation as essential medicines by WHO. If no price reductions are achieved in middle-income countries, the price of the ambitious scenario would be double (\$118 billion rather than \$59 billion). It remains crucial for countries to explore means to reduce drug prices, if necessary by compulsory licensing.⁶

Tordrup and colleagues correct an important omission from previous UHC costings and the price tag is helpful for advocacy. However, in the absence of a global fund to support viral hepatitis, there is no single customer looking to pay it. It is likely that viral hepatitis will offer an excellent return on investment for national programmes as part of UHC, but only few detailed investment cases are available in the literature to date to support that hypothesis, so more are needed. Affordable elimination plans will need detailed national planning, potentially require innovative financing,⁷ and will benefit from global efforts towards continued reduction in the costs of drug and diagnostics.

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