Can we afford DAA for all?

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ALL living on the same planet but in a different world

HDI: Human Development Index (HDI) value (2011)

VERY HIGH and HIGH-INCOME COUNTRIES
Gross National Income per hab > $10,000/y
Health expenditure: > $3,000/year/hab
>90% of the global pharmaceutical consumption

LOW and MIDDLE-INCOME COUNTRIES
Gross National Income per hab < $950/y
80% of the world’s population
2.5 billion living with less than $2/day
no access to essential medicines
Health expenditure: $2-35/year/hab

HCV epidemic fits with poverty and low access to treatment

**Africa/Asia:** 111 million of HCV infections

**Americas and Europe:** 31.5 million

_Lavanchy, D Clin Microbiol Infect 2011_
High Drug Prices and Pharmaceutical Patents

• **PegIFN-RBV**: €15,000-25,000 /treatment in Europe

  No Generics of PegIFN, very few Biosimilars e.g Egypt, Reiferon (Minapharm)

• **New DAA**: Telaprevir, boceprevir: €20,000-40,000 /treatment

  without taking into account the additional costs


  -20-years **patent protection** to pharmaceutical products

  -Incentives needed for Research and Development?

  ➢ 90% of investments for R&D concern 10% of the richest world’s population

  *Hoen et JAIDS 2011*
“There is no evidence that the implementation of the TRIPS agreements in developing countries will boost research on diseases affecting these countries.”

Health Policy Makers’ responsibility

Viral Hepatitis – Not Even Neglected!

Neglected Diseases
Schistosomiasis

… forgotten by the Global Health Agenda

HIV
Malaria
TB

Onchocerciasis
Cystercercosis
Trypanosomiasis
Leprosy
Dengue
…. 
Viral hepatitis

The Sixty-third World Health Assembly,

Having considered the report on viral hepatitis;¹

Taking into account the fact that some 2000 million people have been infected by hepatitis B virus and that about 350 million people live with a chronic form of the disease;

Considering that hepatitis C is still not preventable by vaccination and around 80% of hepatitis C virus infections become a chronic infection;

2. URGES Member States:

(1) to implement and/or improve epidemiological surveillance systems and to strengthen laboratory capacity, where necessary, in order to generate reliable information for guiding prevention and control measures;

(2) to support or enable an integrated and cost-effective approach to the prevention, control and management of viral hepatitis, considering the linkages with associated coinfection such as HIV through multisectoral collaboration among health and educational institutions, nongovernmental organizations and civil society, including measures that strengthen safety and quality and the regulation of blood products;
Can We afford DAA for All?

1- the legitimacy and the duty
2- the capacity
3- the possibility
Do we have the Legitimacy and Duty? YES

1- Access to Health is a Fundamental Human Right

   Human Universal Declaration, 1946 and WHO constitution, 1948

2- States and Supranational institutions

   ⇒ Moral Obligation based on Social Justice and Equity to ensure health FOR ALL

3- Medical and scientific knowledge= common good accessible for all

4- Access to health is regulated by the current market logic based on Liberalism (TRIPS and Patents) generating unequitable access

5- Social and economic inequities have “to be of the greatest benefit of the least-advantaged members of society”.  

   John RAWLS, Theory of Justice

6- Economy as a Moral science.

Development and justice cannot be based on the despotism of economic liberalism

   Amartya SEN, On Ethics and Economy, Freedom as development
Do we have the Legitimacy and Duty: YES

In a perspective of Global health

1) No HCV vaccine
2) Cost-effective \( \text{Chhatwal et al.} \text{#989, EASL 2012, De Ledinghen EASL 2012} \)
3) Treatment as prevention?

Durier N et al Plos One 2012
Do we have the Capacity? YES

- Efficient drugs (DAA) are on the market
- Even well adapted to the poor settings
  Simplicity/ less side-effects/IFN-free therapy
- Human resources /infrastructures have been generated with the HIV/AIDS epidemic
- HCV treatment is feasible in resource-limited countries with similar outcomes to those reported in rich countries

Metaanalysis, Ford, N Bull WHO, 2012
Do we have the possibility? YES

- **Political calls for action** from the local governements (Appel de Dakar, 2011) the civil society, the Public Health Agencies (WHO, World Hep programme)

  *Easterbrook P, Sem Liver Dis 2012*

- **New innovative technologies**
  Point-of-care tests and dried blood testings (screening, genotype, and even PCR and IL28B under Investigation), non invasive markers of Fibrosis (Fibroscan)

In the name of Democracy, Human rights and Justice.

**MONEY?**

Worldwide military expenditure: $1,531,000,000,000 (2009)
  
  *data from SIPRI, 2011*
“History, as an idiot, mechanically repeats itself”

Paul Morand

The HIV/AIDS experience

1) COST:

• In 2000: ART: $10,000-15,000/patient/year .....today < $100

=> Only 0.1% received ARV in Africa........today almost 40%

2) COMPLEX and POLITICALLY DISREGARDED

• “Many people in Africa have never seen a clock or a watch their entire lives. If you say one pm in the afternoon, they do not know what you are talking about”.

   Andrew Natsios, former USAID director, 2000

• Until 2002, WHO refused to consider ARV as essential medicines
HIV/HCV coinfection

• 4-5 million worldwide
• Mostly living in resource-limited countries

Hoffmann, CJ Lancet Infect Dis 2007

• Waiting for treatment and putting pressure
Washington, AIDS conference 2012
CONCLUSION

Can we afford DAA for all?

Yes, we CAN, and even more, we MUST

1) Global Health
2) Equity and Social Justice
3) High time to implement programs and guidelines on viral hepatitis adapted to the local poor settings
4) With the **combined support of the 4P group**
   - Public Health Community
   - Physicians
   - Scientists
   - Policy makers
   - Pharmaceutical companies
5) Looking at the HIV/AIDS experience
Do not let DAA be a: Discriminating Access to Antivirals
THANK YOU

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