Why We Should Be Willing to Pay for Hepatitis C Treatment

Examining the health economics of hepatitis C, this editorial discusses why society should be willing to pay for the current HCV therapies for all patients

November 30, 2015 By Fasiha Kanwal, MD

Hepatitis C virus (HCV), an epidemic impacting up to 3.9 million people in the U.S., could be a rare disease by 2035. How can we so confidently project such an outrageous shift? We can attribute this largely to two factors: updates in HCV screening guidelines and the launch of oral direct-acting antivirals (DAAs) to treat chronic HCV infection. The latter hit the scene in 2014 surrounded by controversy.

With DAAs, the sustained virologic response (SVR) (i.e., efficacy of treatment) has increased to more than 90 percent, treatment duration has decreased to as few as eight weeks and these regimens have no major side effects. For a disease that can kill nearly 20,000 people in one year, this is welcomed news.

However, the high price of DAAs is a barrier, and has drawn criticism from patients and payors. Challenged with a budget needed to treat all HCV patients, Medicaid has restricted these treatments in at least 30 U.S. states to patients with advanced fibrosis stage. With more than a million patients needing HCV treatment in the next 3 to 5 years in the U.S., the high price of DAAs could impact the budget of private payors and government.

On the other hand, several recent studies have shown that these drugs provide a good value for the money. And furthermore, the price of DAAs has decreased since their first availability in 2014. For example, the average discounts on sofosbuvir-based regimens in 2015 have been 46 percent. At such discounts, treatment with DAAs can be cost-saving -- by improving outcomes and decreasing total costs -- when compared with previous therapies. As additional antiviral drugs become available in the near future and competition increases, drug prices may decrease even further.

My colleagues and I recently published an editorial in Clinical Gastroenterology and Hepatology where we put the health economics of HCV into perspective, comparing it with a similar, albeit lesser, evil, HIV (HCV has superseded HIV as a cause of death in the U.S. since 2007). The overall budget needed to treat HCV with these new treatments is not huge and is reasonable when
compared with the cost of HIV treatment. The discounted lifetime cost of treating 1 person with HIV in the U.S. is $315,000 in 2014 U.S. dollars. The corresponding cost of curing HCV with oral DAAs is $58,000 -- which is only 18 percent of the total HIV treatment cost. Note these two unlike words: treating and curing.

We have an opportunity to eliminate hepatitis C by taking appropriate and timely steps. We as a society should be willing to pay for the current HCV therapies -- for all patients -- by providing additional resources and giving the attention to hepatitis C that it deserves now. If we can do this, hepatitis C may be a nonissue by 2035.

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