Long-Acting Treatments in the Asia-Pacific

Are health systems ready?

Health systems in the Asia-Pacific have long been under pressure. And as we march toward UN SDG #3 for Universal Health Coverage (UHC), especially in light of the modern pandemic, budgets are more constrained than ever. The increasingly short-term thinking, though, is having a direct impact on access to medical innovation. So, what is the outlook for an acceptable return on investment in healthcare going forward?

In other industries, the concept is: "built to last". Investing in those technologies, products, services that will remain efficacious and durable over a reasonable amortisation period.

In our seminal report published in March 2020 looking at more sustainable financing for health systems in the Asia-Pacific, we call for greater consideration of concepts such as social impact bonds and risk pool consolidation; however, these mechanisms could only ever be realised with a "built to last" mentality.

At present, healthcare remains too reactionary and volatile rather than interceptive. In this article, we cover our experience with handling Long-Acting Treatments (LATs), particularly of the injectable variety. These treatments can last weeks or months at a time, freeing people from daily regimens of pills (and lack of adherence therein).

Such a concept is not only more in line with a "built to last" ROI, but moreover jives well with broader health system transformation efforts such as community-based care models, preventative intervention, and the role of individual accountability in our well-being.

We focus on two types of LATs – for infectious and for chronic disease.

Infectious disease: an unforgiving reminder

The modern pandemic is a wake-up call – while much focus over the recent years has been around the rise of chronic/lifestyle related disease, we cannot overlook the impact of continued viral infections. Nearly 30,000 people die every day from infectious disease, with proven interventions costing as little as $1 per head in many cases. And practically all of the deaths (97%) come from developing countries.

HIV/AIDS, a virus of the body's immune system, remains a top 10 killer among lower- and middle-income regions. 85% of the deaths occur between the ages of 15 - 59, literally wiping out an entire future generation. Progress has certainly been made, especially with the intentional awareness campaigns conducted over the prior decades. Of the 38 million people living with HIV today, 67% have had access to antiretroviral therapy. That being said, there are still an estimated 7+ million people who remain undiagnosed despite the 90-90-90 ambition by 2020.

Fortunately, not only are awareness of the virus and access to interventions being scaled up, the therapies are evolving too. Standard of care is a regimen of regular oral medication, often combination drugs compounded into the same pill. While non-invasive for the patients, medication adherence remains a major barrier to bending the curve of HIV prevalence and transmission.

Viiv Healthcare, the HIV company owned by GSK with Pfizer and Shionogi as shareholders, made waves in March 2020 with the approval of CABENUVA, a once-monthly, complete long-acting regimen for the treatment of HIV-1 infection in adults. Approved by Health Canada, the treatment reduces dosing days from 365 to 12 per year.

The kit, containing two injectable medicines, was co-developed with Janssen. In a patient sentiment study about the revolutionary therapy option, 9 out of 10 prefer CABENUVA to taking daily oral pills. Such ecosystem collaboration as well as a patient-centric approach is welcomed for next-gen healthcare.

In supporting similar LATs for the infectious disease space, KPMG learnt the following:

1. User experience of medication (by both doctors and patients) is critical to LAT success
2. A level of detail, by market, about existing care delivery models for injectables is required
3. Related to the above, resourcing and infrastructure constraints must be carefully considered
4. Beyond the LAT itself, support services and tools (e.g. patient education, sharps containment) are helpful, especially with consideration of cultural nuances related to such therapy switching
5. Ultimately building market-specific hypotheses about injectable care delivery, and validating those hypotheses by speaking directly to the stakeholders, is a winning strategy

Chronic disease: the new reality

Leading up to the modern pandemic, most of the health system rhetoric centered around the rise of Non-Communicable Diseases (NCDs). And with good reason – while the 20th century saw average life expectancy nearly double, we are now dealing with a new set of consequences in the form of a more chronically-ill, co-morbid society. Thus the ongoing management of such disease states, sometimes for decades, is the new reality.

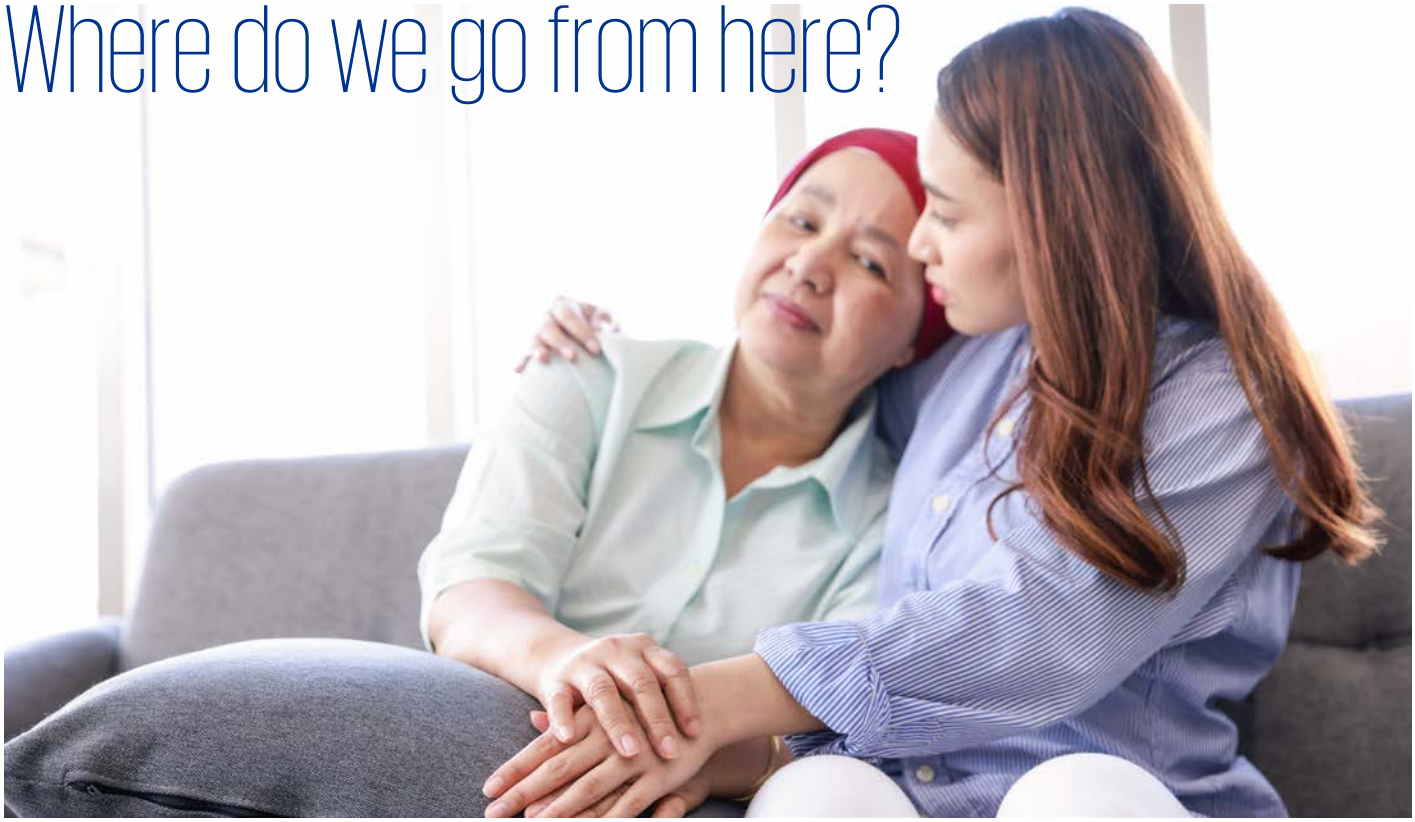
NCDs can be both physical and mental conditions, the latter category representing one of the single largest disability burdens yet receiving disproportionately less attention. In this article we look at Neuroscience as a field ripe for novel therapeutic interventions. People suffering from mental health conditions are typically slower to reach out for help, see variability in a symptoms-based diagnosis, and are provided with a wide range of interventions from oral medications through to, at the extreme end, shock therapy. Patient adherence and remission are key challenges.

Schizophrenia is particularly worthy of attention. Affecting 20 million people worldwide, 90% of whom live in low- and middle-income countries, the large majority do not receive proper care. People suffering from Schizophrenia are up to three times more likely to have a shorter lifespan than the average population. In 2015, Janssen made news with its upgrade of the INVEGA portfolio. Originally an oral medication, Janssen now offers the only monotherapy for Schizophrenia. The medication can be administered as a once-monthly injection for four months, after which the LAT is only required to be administered once per quarter. For those with Schizophrenia and their families/caregivers, such regimen relief can be life changing.

In supporting similar LATs for the chronic disease space, KPMG learnt the following:

1. Explore the current patient pathways, and look for the inefficiencies; for example with Schizophrenia, average Length Of Stay (LOS) in institutional settings exceeds 300 days and the 3-month readmission rates are very high at 25%
2. Then, consider how such pathways need to evolve in order to be line with broader health reform – community-based models, making space for other demanding diseases (e.g. Dementia), workforce allocations, etc
3. Focus on a realistic eligible patient cohort % for the LAT, and reduce the switching cost for care facilities by tapping on existing financing schemes such as ward stratifications, integrated care, LOS and readmissions reductions, and the push for same-day bed rates
4. Concurrently, work collaboratively across the industry to advocate for policy change around the LAT, including such mechanisms as LAT administration fees and tax benefits to support care providers with the switchover

Where do we go from here?



Despite the scientific progress of LATs for both infectious and chronic disease, and with more such innovations expected to be landing, we are not sure if health systems in the Asia-Pacific are ready to harness the potential. In addition to evidence-based health outcomes that can be achieved through LATs, the model of people spending more time at home and in their communities, versus in institutional settings, should be enticing from a social and economic perspective. Near-term priorities, though, are continuing to usurp a "built-to-last" mindset, with more rhetoric than reality as it pertains to evolving the preventative system design.

We recommend three actions for Asia-Pacific country leaders on their journeys ahead:

1. Incorporate LATs into the next policy planning cycles as a core mindset shift, and ensure the broader population and medical practitioner communities are receiving proper education on the topic.
2. Continue the rigour of evaluating novel medical technologies through the likes of the HTA mechanism, while ensuring that the full spectrum of LAT benefits are being understood in terms of patient adherence and accountability, as well as the shift toward outcomes-based reward schemes.
3. Match the financing of LATs by making more efficient use of health system resources; in other words, existing innovation budgets for topics like LOS, readmissions, integrated care can be achieved through use of LATs.

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