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REPORT OF THE LEAD REVIEW TEAM
ON THE MID-TERM REVIEW
OF THE
NATIONAL HIV AND HEPATITIS C STRATEGIES.

August 2002

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EXECUTIVE SUMMARY

The reviews of the National HIV/AIDS Strategy 1999-2000 to 2003-2004 and the National Hepatitis C Strategy 1999-2000 to 2003-2004 and the 2002 Strategic Research Review were undertaken to assess the progress of the strategies and to inform the need for and directions for subsequent strategies.

The review process involved a process of scientific review for each of the national research centres, and separate reviews for HIV/AIDS, Hepatitis C and Strategic Research. The role of the Lead Review Team was to provide advice to the Commonwealth Minister for Health and Ageing in order to inform the next phase of Australia's public health response to HIV/AIDS and Hepatitis C, including their relationship to other communicable diseases and broader sexual health issues. In doing so, the Lead Review Team was charged with compiling a final report building on the reports of the individual reviews and drawing on these and the input of the Reference Panel to make recommendations with regard to future priorities and directions.

HIV/AIDS

Australia has maintained an international reputation for the quality and strength of its HIV/AIDS response as guided by its three previous national strategies. The fourth national HIV/AIDS is again serving the people of Australia well in achieving a coordinated and efficient partnership approach to the control of HIV and the care and treatment of People living with HIV/AIDS. For HIV/AIDS, Australia has achieved a coordinated linking of the prevention and treatment parts of the health system and a working partnership with non-government organisations that is a model for other national health priorities.

Australia has achieved and maintained a low incidence of HIV in the face of a global epidemic. Indeed part of the challenge facing Australia is developing an effective response to the growing problem of HIV and its economic consequences in its near neighbours and regional trading partners. The LRT believes that there is a need for a whole-of-government international policy on HIV covering aid strategies and international commitments under UNGASS.

The majority of HIV infection in Australia is still primarily acquired through unprotected male-to-male sex. In terms of general prevention the LRT raises concerns about growing complacency in Australia about the threat of HIV and the real risk for some vulnerable groups that HIV could become rapidly established if the broader control strategies are not maintained. In this context, the LRT also believes it is timely for broader attention to prevention of sexually transmitted infections given the increasing incidence of STIs, the biological synergy with risk of HIV and the small but growing number of heterosexually acquired HIV infections.

The prevalence of HIV/AIDS in Australia will continue to steadily rise because anti-retroviral therapy has markedly increased the life expectancy for people with HIV. The role of the pharmaceutical benefits program in providing widespread subsidised access to retroviral therapy is an under-appreciated component in the current HIV control strategy and from a public health perspective the LRT would be concerned with any changes to the program that reduced that access.

The increase in survivorship of persons living with HIV results in a larger number of potentially infective persons in the community. While the risk of infection from sexual contact maybe substantially less where retroviral therapy achieves very low viral loads it is not negligible in a population sense. Consequently there is a more complicated social environment for which safe sex messages will need to be developed with less visibility of the impact of HIV (ie fewer deaths) and potentially less consciousness of the risks.

HEPATITIS C.

Australia achieved a world first with its National Hepatitis C strategy. In doing so, it has accepted that while the visible burden of disease is not great at this stage in the epidemic, it is necessary to act now to prevent a major burden for future generations. In doing so it has had to recognise that the major cause of the epidemic is intravenous drug use and that socially difficult strategies such as needle and syringe programs are a necessary public health measure. The LRT believes that Australia will continue to need to test and promote approaches to harm reduction and that this will require leadership. In this regard, the LRT is strongly of the view that their needs to be better linking of the National Drugs Strategy and the Hepatitis C strategy. The LRT also believes that in the longer term that the Hepatitis C strategy would be best served by a separate governing committee.

The LRT was made aware of evidence indicating that Hepatitis C was epidemic among intravenous drug users in Australia prior to the first case of AIDS in Australia. Consequently there is a very large and growing pool of people who are positive for Hepatitis C. Consequently given that the strategy has been in effect for only three years, it is not surprising that at this stage there is limited evidence of a change in the tide of Hepatitis C. Control of Hepatitis C will require a concerted effort to reduce the pool of infected people through treatment and expansion of existing harm reduction programs. Evidence presented to the LRT indicates that there is a need to improve access to treatment. In this regard prisons are a major source of new infections and there is a need to address the problems of access to specialist services for Hepatitis C treatment for prisoners.

RESEARCH

All aspects of Australian HIV research, social, epidemiological, clinical and virological, has achieved international recognition. The HIV/AIDS strategies have been well served by the investment in the national research centres. However, there is room for review of the priorities in current investment in the centres and potential benefits from moving some aspects of the research into the mainstream competitive research environment.

The LRT was strongly of the view that there was a major need for more research on all aspects of Hepatitis C control, epidemiological, social and clinical. The lack of knowledge of fairly basic aspects of the epidemiology and clinical outcomes is a major issue in the face of potentially very large health care costs in the next 5 years.

Introduction

The Lead Review Team (LRT) was charged with drawing together the reports of the review teams for HIV, Hepatitis C and Research, the subsequent commentary on those reports by the Reference Panel that included the current chair of ANCAHRD and the Department. The Terms of Reference for the Lead Review Team are attached at appendix a.

In its report the Lead Review Team has taken the approach of synthesising the recommendations of the individual reviews to indicate the high level directions that it believes need to be taken. In doing so it has drawn on the international perspective bought to it by two of the Lead Review Team. The Lead Review Team has provided detailed recommendations only where these differ from those of the individual reviews. Unless otherwise specified the Lead Review Team accepts the recommendations of the individual reviews but believes it is the appropriate role of the governing committees charged with developing subsequent strategies to prioritise these specific recommendations.

HIV

Context

The UNAIDS report on HIV/AIDS prepared for the XIV International AIDS Conference in July 2002 clearly articulated the rapidly growing scale and spread of the HIV epidemic in every part of the world.

In particular, major increases in prevalence in near neighbours New Guinea and Indonesia, as well as regional partners Thailand and China, have occurred over the past five years. There is now clear evidence that with committed political leadership, well-resourced prevention programs and widespread access to anti-retroviral treatments, HIV can be controlled and contained (Uganda, Senegal, Brazil). The evidence is equally clear that where these elements are not in place, HIV can spread with remarkable speed (Russia, Ukraine, China).

Australia has benefited dramatically from the long standing strategic approach based on non-partisan political support; partnership between affected communities, government at all levels, and medical, scientific and health care professionals; and the involvement of people living with HIV/AIDS (PLWHA) in all elements of the response.

The annual number of AIDS diagnoses in Australia peaked at 954 cases in 1994 and has dropped to 178 cases in 2001. The decline in AIDS incidence from 1994 was due to a sharp drop in HIV incidence occurring in the mid 1980s and to the effectiveness of combination antiretroviral therapy in delaying progression to AIDS among people whose HIV infection was diagnosed before AIDS diagnosis (NCHECR, 2002).

Access to highly active anti-retroviral therapy (HAART) has seen mortality drop by over 70% since 1997. Australia provides wide access to subsidised retroviral therapy through the pharmaceutical benefits program. It is increasingly recognised that such access to treatment is also an important component in HIV control both through post-

exposure prophylaxis and because treatment probably reduces the potential infectivity of persons living with HIV. In general access to subsidised pharmaceuticals under the Pharmaceutical Benefits Scheme is restricted to Australian nationals and permanent residents and nationals of countries with health care agreements with Australia. This could potentially exclude some groups in Australia such as non-Australian sex workers.

A consequence of the success of HAART is a considerable increase in the number of PLWHA, with major implications for future care demands and HIV prevention programs. An estimated 12,730 people were living with HIV/AIDS in Australia in 2001 (NCHECR, 2002).

Incident cases of HIV in Australia are still primarily amongst gay men, with evidence of recent increases in some States. This trend is consistent with a number of risk indicators, including increased rates of unprotected anal intercourse and increased rates of rectal gonorrhoea. The role of sexually transmissible infections in enhancing both susceptibility to HIV infection as well as HIV infectiousness has lead to their control being recognised as a key strategy for HIV prevention.

The proportion of heterosexually acquired infections has remained relatively stable and mainly reflected international mobility as most of the primary contact infections occurred outside Australia. In comparison with similar economy countries, the prevalence rate of less than 1% among persons who use drugs intravenously, women who report a history of sex work and prison inmates is exceptionally low. This is probably largely due to the low prevalence generally in the Australian community and the early strong support for harm reduction strategies such as wide spread availability of needle and syringe programs (NSPs). A major threat identified to the review was the evidence of increased sharing of injecting equipment and the closure of local Needle and Syringe Programs (NSP's). International experience shows that if and when HIV infection gains a foothold among vulnerable groups there can be rapid spread of the virus and it is very difficult to regain control.

The return on the investment in needle and syringe programs prevention is extremely good with every $1 spent estimated to have saved upwards of $23 in treatment and care costs and potentially upwards of 24,000 cases of HIV and 800 HIV deaths prevented since 1981. This is likely to be an under-estimate given the most recent higher estimates of life treatment costs of HIV.

The rates of HIV infection in the indigenous community are very similar to the whole population although actual numbers may be higher due to under reporting of indigenous status in surveillance data. Rates of STIs remain substantially higher in the indigenous community then the general population and this is an added concern as indicted above to HIV susceptibility for this community. While male homosexual contact was the most frequently reported route of HIV transmission among Indigenous people, a higher proportion of cases were attributed to heterosexual contact, and injecting drug use (NCHECR, 2002).

Current Strategy

The priorities identified in the fourth strategy remain current and relevant. Specifically these are:

- an enabling environment;
- HIV/AIDS-related health promotion, including disease prevention;
- treatment, care and support;
- research;
- international assistance and cooperation.

Issues identified

Issues identified in the review reports and separately by the LRT include:

General community complacency about HIV as prevention and treatment has reduced the number of deaths and therefore the visibility of the risk;

Perceived disengagement of gay community, both those who have lived through the early phases of the HIV epidemic and younger gay men;

Falling rates of HIV testing, reportedly more so among younger gay men;

Increasing complexity of prevention given the growing number of people living with HIV and the consequent increase the prevalence of the virus, the number of sero-discordant and sero-concordant partners and a growing number of persons living with HIV with very low viral loads;

Increasing complexity of treatment and care issues given the growing number of people living with HIV and the longer term complications of therapy, and the diversity of communities affected;

An increase in the number of late HIV diagnoses particularly from indigenous and CALD population;

The substantial risk of development of rapid epidemics in vulnerable groups such as people who use drugs intravenously and some indigenous communities;

The increase in STI's in the broader community, gay men and in parts of the indigenous community with potential consequences for enhanced risk of HIV transmission;

Lack of clear measures of effectiveness of strategies;

Need for further development and refinement of surveillance approaches;

The importance of general community strategies in protecting vulnerable groups such as persons with mental illness;

Unclear responsibilities for promoting harm reduction strategies;

Continued isolationism from mainstream health agendas;

Lack of clarity over governance roles and responsibilities;

Recognition of potential impact of international mobility in terms of risks within Australia; and

Clarification of Australia's international role in addressing the global epidemic and its devastating socio-economic impact.

The complexity of HIV transmission has been well summarised in the following section of a report prepared for IGCARD:

Patterns of HIV infection are a product of the interaction of a range of factors. Among these factors are:

1. *transmission risks associated with specific sexual activities;*
2. *the rate of sexual mixing between infected and uninfected individuals;*
3. *infectiousness and*
4. *susceptibility.*

Knowledge of the relative weighting of these factors in determining patterns of HIV transmission continues to emerge, but is by no means fully developed. Knowledge of these factors does however explain why rates of HIV infection can fall despite increases in, for instance, risk behaviours.

An historical tendency to over-assume the role of HIV risk practices alone in determining patterns of HIV transmission continues.

Effective HIV prevention activities can include appropriate intervention to reduce the effect of each of these variables, including:

1. *reducing levels of sexual risk through use of condoms; avoidance of high-risk activities; or the adoption of 'risk reduction' strategies, such as 'strategic positioning' and withdrawal;*
2. *reducing the rate of unsafe sexual interaction between infected and uninfected individuals though negotiation of condom use on the basis of serostatus or through seeking out of seroconcordant partners;*
3. *reducing infectiousness through strategies which support individuals' use of treatments, including supporting side effect management and adherence and*
4. *reducing susceptibility through treatment of sexually transmissible infections.* (Mackie and O'Donnell; Sexual Transmission of HIV Among Gay Men: Current Issues. IGCARD 2002)

What needs to be done

1. Development and continued resourcing of a fifth national HIV strategy that will:

   Have a greater focus on the complex and diverse needs of people living with HIV including mental and social health;

Include a new prevention and education program combining promotion of safe sex to the general community with specific components targeting high risk environments (eg sex on premises venues) and hard to access groups guided by epidemiology and social research data;

Promote regular HIV testing among at risk groups with the specific aim of reducing undiagnosed HIV;

Specific attention to the needs of culturally and linguistically diverse groups;

Incorporate an integrated evaluation framework; and

Incorporate the principles and targets of UNGASS obligations.

2. Support to enable a re-evaluation by community organisations of their constituencies, roles and priorities particularly as it relates to prevention of HIV and STIs and care of those living with HIV/AIDs.

3. Development of a whole-of-government policy on Australia's role and responsibilities with regard to the international epidemic of HIV (see below).

HEPATITIS C

Context

The Hepatitis C epidemic in Australia is similar to that faced by the US, Canada, and UK. Increasing rates are being experienced that reflect the increasing level of injecting drug use (IDU). A specific laboratory test for Hepatitis C has only been available since early 1990. However it is clear that the epidemic was well established among IDUs prior to the HIV epidemic and was probably significantly underway since the late 1960s. In Australia, Hepatitis C is now the most commonly notified communicable disease. It poses a serious threat to population health resulting in increased morbidity and mortality.

The number of notified diagnoses of newly acquired hepatitis C infection continued to increase in 2001, to almost 600 cases, which is still only a small fraction of the estimated 16,000 cases that were estimated to have occurred in Australia in 2001. In 2001, an estimated 210,000 people living in Australia had been exposed to hepatitis C virus. Of these, an estimated 53,000 people had cleared their infection and were not chronically infected, 124,000 people had chronic hepatitis C infection and early liver disease (stage 0/1), 27,000 had chronic hepatitis C infection and moderate liver disease (stage 2/3), and 6,500 were living with hepatitis C related cirrhosis. (NCHECR, 2002). By 2020, it is estimated as many as 500,000 people will be infected with Hepatitis C. (Hepatitis C Virus Project Working Group, ANCAHRD, 2002)

Over 90% of new infections occur in the context of injection drug use. However there is also a concern about cases among established migrants probably acquired through exposure to poor medical practices prior to migration. An unknown proportion of cases is associated with poor tattooing and body piercing practice and the growing popularity of tattooing and body piercing may also contribute to the growing epidemic.

A further complication in controlling the epidemic is that previous infection with one strain of virus does not protect against re-infection with the same or a different strain.

As indicated above, it is estimated that a substantial proportion of cases remain undiagnosed and untreated. At present there is no vaccine to protect against Hepatitis C and is unlikely to be available in the near future. Therapies are improving with "cure" rates approaching 50% in sub groups but are associated with considerable side-effects during treatment. While early data is supportive that "cure" means that the virus is no longer active and that the long-term liver damage is prevented, this remains to be confirmed with longer-term follow-up. The proportion currently obtaining treatment in Australia is estimated to be 7%. Rates of treatment uptake are reportedly higher in some countries such as Italy where it is closer to 20%.

Hepatitis C has major implications for future health care costs unless more effective prevention is achieved. If treatment levels were similar to that of Italy then additional health care costs could be in the order of 0.5-1 billion dollars annually.

The estimation of the future impact of the disease and of the direction of appropriate control programs is severely hampered by the limitations of available epidemiological, social research and clinical research.

Current Strategy

The Australian Hepatitis C strategy was an international first and to be commended. The strategy appropriately focussed on all aspects of harm reduction for recreational drug use and dependency.

There is early evidence that some aspects of the strategy are working. For example, evidence of reductions in incidence among first time IDUs who utilised NSP. As noted above, the return-on-investment from NSP is particularly noteworthy. However there is a very large infected and undiagnosed population which continues to fuel the epidemic. Until this pool is reduced progress will be challenging. More widespread treatment could play an important part of controlling the epidemic by reducing the infective pool.

Issues Identified

Limitations of the available Hep C specific epidemiological, social and behavioural and clinical research;

Inadequate attention within the National Drug Strategy to broader health issues for IDU particularly control of Hepatitis C;

Recognition of specific role of prisons in driving the epidemic and of the special needs in delivering health care to such populations;

Inadequate surveillance information on rates and characteristics of new infections

Inadequate information on risks associated with sources other than IDU, specifically for body piercing and tattooing;

Greater need for specific championing of Hep C as a major public health issue in its own right;

Inadequate response of health care professionals to recognising the broader benefits of testing for and treating Hep C;

Limitations of available treatments;

Difficulty of access to existing health care arrangements particularly in regional areas and a need for more innovative and responsive models of care;

Increasing community resistance to maintenance and expansion of relevant harm reduction strategies such as NSP;

Drug treatment services not responsive to broader health care needs and particularly public health benefits of treating Hep C.

What needs to be done

1. Clear identification and championing of Hepatitis C as an urgent national public health problem by medical and public health community.

2. Better identification and documentation of burden of illness, health care costs and future likely costs to PBS.

3. Better understanding of the barriers to effective treatment.

4. Better approaches to prevention including in relation to body piercing and tattooing in order to protect current low prevalence populations.

5. Implementation of a program to enhance maintenance and expansion of harm reduction strategies including specific attention to the concerns and needs of local communities in the proximity of NSPs.

6. Development of specific programs for prevention and treatment in prisons.

7. Greater engagement of IGCD and drug dependency services in controlling Hepatitis C.

RESEARCH

All aspects of Australian HIV research, social, epidemiological, clinical and virological, has achieved international recognition.

Hepatitis C research is lagging quantitatively and qualitatively in all areas compared to HIV, although there are some examples of high quality endeavours. This is probably similar to other comparable countries and as with HIV there is an opportunity for Australia to show leadership.

The Strategic Review of Health and Medical Research (1999) has guided recent developments in Government policy with regard to health research investment. Some key issues articulated by the review are:

- the recognition of the different needs of priority driven research and investigator driven research;
- a strong emphasis on contestability for investigator driven research funding;
- support for development of critical masses of researchers through networking and aggregation; and
- the need to support longer term research initiatives.

In responding to that review, the Government has indicated its commitment to contestability and made this a requirement of the large increase in health research funding. The National Health and Medical Research Council (NHMRC) in responding has introduced new initiatives such as an increase in the number of large 5 year program grants, industry-linkage grants, public health capacity building grants and the recently announced joint Wellcome Trust-NHRMC program grants in tropical disease research. These principles and opportunities need to be considered in any future decisions on Hepatitis C and HIV specific funding.

Current Situation

The specific funding of the National Centres in HIV epidemiology, social, behavioural, viral and clinical research has provided a solid research capacity as confirmed by the individual program reviews. It has enabled the development of internationally competitive research groups.

Issues identified

The Lead Review Team identified the following broader issues with regard to research for Hepatitis C and HIV:

- Role of Population Health Division in funding research;
- Concerns in community about priority setting for research;

Perceived lack of response to regional research needs and specific populations;

Tensions in research agenda between strategic research (research questions arising from and directly informing the directions of policy and practice) and investigator driven research normally funded through competitive mechanisms;

Perceived lack of responsiveness of NHMRC and ARC to strategic research needs particularly in social health and to community priorities;

Concern that without specific purpose funding there will not be the necessary research effort, that the effort will become to diffuse and that expertise will be lost overseas;

Perceptions in the broader medical and social research community that the quality of HIV research funded by the specific funding to the national centres is not of the highest quality that could be achieved through open competition;

Vital role of surveillance and monitoring with specific research needs around new methods of surveillance; and

Tighter funding environment for strategic research.

At this stage in their development the Lead Review Team does not believe the ongoing success of the national centres is endangered by a close examination of the alignment of their current resourcing with the strategic research needs.

The Lead Review Team is clear that the Population Health Division as with other sections of the Commonwealth Department of Health and Ageing has a requirement for strategic research to inform policy decisions and program setting. The Lead Review Team is also clear that monitoring and surveillance of HIV, Hepatitis C and STIs and the associated risk behaviours are core public health functions. The Commonwealth funding for these activities is an essential part of the national public health surveillance efforts. The Lead Review Team does not believe that the Population Health Division has a principle role in funding investigator driven research except where it is aligned with their strategic research needs. The NHMRC and ARC more appropriately handle this type of research.

The Lead Review Team agrees with the Research Review Team that there is an ongoing need to maintain the capacity of the National Centre in HIV Epidemiology and Clinical Research. The work funded by the Population Health Division is clearly either core public health business or strategic research.

The Lead Review Team agrees with the Research Review Team that there is an ongoing need to maintain the capacity of the National Centres in social science research in HIV, Hepatitis C and STIs. There remain concerns about the perception that the currently funded centres have not adequately addressed needs in some regions and some populations nor have they adequately met their intended role of fostering capacity outside of the centres. This will need to be rapidly addressed by the Centres.

If the Lead Review Team's view on the priorities in the Population Health Division research funding is accepted then the Department needs to review its funding commitment to the National Centre for HIV Virology to ensure it is consistent with its core business of surveillance and monitoring or its strategic research needs.

The Lead Review Team also believes there is a strong case for additional investment in research in all aspects of Hepatitis C. In addition to reviewing the distribution of the current funds, consideration should be given to this forming a core component of National Drug Strategy research investment. An appropriate mechanism would be a jointly funded NHMRC program grant in Hepatitis C research.

The Lead Review Team believes there should be no constraints on the National centres applying for competitive NHMRC and the Australian Research Council (ARC) research funds for HIV and Hepatitis C research other then where the work is identified as part of their contractual monitoring, surveillance and strategic research obligations.

What needs to be done

1. The contracts between the Commonwealth Department and the National Centres be reviewed to specify as clearly as possible the elements of funding for surveillance and monitoring and strategic research.

2. A yearly round table of stakeholders be convened by PHD to identify and set priorities for strategic research questions.

3. An assessment be undertaken of the HIV social research centres in two years to ensure that the concerns around the reach of their research programs are addressed.

4. Negotiations be commenced to identify funding for and process to establish a research program for Hepatitis C.

LEADERSHIP and GOVERNANCE

The Lead Review Team acknowledged the importance of the ANCAHRD in providing high profile leadership relevant to HIV and Hep C under the third and fourth strategies. It has:

provided a single point of reference that has been particularly important for overlap issues such as supporting the need for harm reduction strategies and discrimination;

enabled coordination of efforts;

established a level of community and political profile;

provided an arms length vehicle for endorsement of specific campaigns,

fostered the development of the Indigenous Australian's Sexual Health Strategy; and

actively sought to engage with States and Territories and regional stakeholder communities.

The Lead Review Team recognises concerns that any change to governance arrangements not loose those benefits.

However there were simultaneously held concerns about the:

lack of clarity on the executive versus advisory role of ANCAHRD;

deflection of government responsibility for leadership;

perceived lack of responsiveness to interest group concerns;

degree to which synergies between HIV and Hep C can be achieved;

structural barriers to better articulation of Hep C issues with the NDS; and

lack of clear remit to address broader issue of STI's in the community.

There was a strongly expressed view that the Commonwealth needed to re-establish its leadership role more directly and through parliamentary liaison processes. International experience confirms the importance of the political leadership in containing epidemics.

Other issues in leadership already covered include the need to re-invigorate Non Government Organisations, clinicians and States and Territories roles in leadership.

The Lead Review Team considered the following options for governance arrangements:

1. Continuation of the current ANCAHRD.

2. The model proposed by the Hepatitis C and HIV reviews of four separate committees (Hepatitis C, HIV, Indigenous Sexual Health and Legal Working Party) with and with out a coordinating committee made up of chairs and deputy chairs of those principle committees.

3. A model proposed by the chair of ANCAHRD, which expanded the role of ANCAHRD.

4. A model limited to two separate principle committees, Hepatitis C and HIV, with joint working parties on overlap issues including harm reduction, legal issues and indigenous health.

5. A model based on the National Health Priorities framework with Hepatitis C and HIV-STIs as separate priorities.

6. Model 5 but with a small overarching coordinating committee with well defined roles limited to promoting overlap issues.

In weighing up the options, the Lead Review Team was influenced by:

The need to lift the profile of Hepatitis C and STIs as major national health problems;

The need to better recognise the complex care and treatment needs of people with HIV or Hepatitis C which overlaps with the issues with other chronic diseases;

The benefits of consistency in approaches with other national health problems including recognition that these require a whole-of-Department response rather then Population Health Division alone;

The need to signal that these will remain national health problems for the foreseeable future; and

The undesirability of multiple committees with overlapping responsibilities.

On balance, the Lead Review Team favours a governance model that better encapsulates a whole-of-health response with separate strategies for Hepatitis C (and other viral hepatides) and HIV-STIs.

Each strategy should have a governing committee appointed by the Minister. Membership should include:

a specialist clinician,
general practice,
allied health,
at least 2 consumers and a representative of the indigenous community,
a public health expert,
as well as expertise in health promotion, research and evaluation.

The advantages of this approach are seen to be:

Separate but equal governance arrangements for Hepatitis C and HIV;

Specific recognition of broader issues of STIs and its commonalities with HIV;

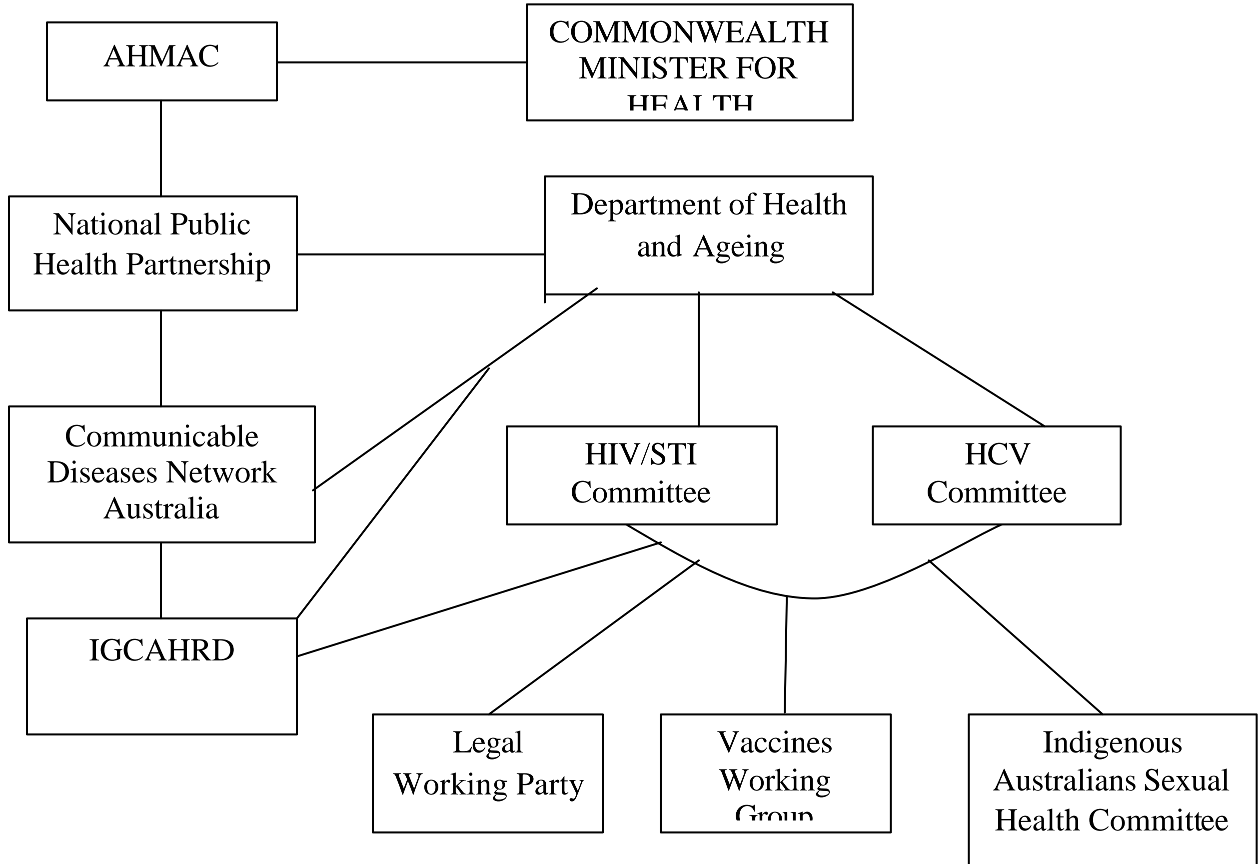
Consistency with other whole of Department approaches such as the National Health Priority Areas;

Better recognition of the complex care and treatment needs;

Better recognition of the full cost implications; and

Maintains the advantages of an appropriate arms length arrangement for endorsement of specific campaigns and programs.

The proposed new governance structure is as follows:



These committees particularly Hepatitis C would be well served by chairs who can champion with the independence, acumen and commitment shown by the current chair of ANCAHRD.

Harm reduction remains a cornerstone of the National Drug Strategy and is broadly accepted across Government. The Lead Review Team is concerned that there is a lack of clarity for responsibility for monitoring, development and promotion of communicable disease prevention components such as needle and syringe programs. This should be a specific term of reference for one of the committees. Alternatively a case could be made for a high level committee with this specific mandate. If such a committee were deemed essential then its authority should be limited to this area and not broader executive authority over the individual strategy committees. Its membership should include representation from the ANCD. A clear signal of the Commonwealth's commitment to leadership in this area would be chairmanship by the Chief Medical Officer.

The current Indigenous Australians' Sexual Health Committee and the Legal Working Party should continue as working parties of the Hepatitis C and STI-HIV Committees either jointly or separately.

The LRT also considered the issue of the accountability and reporting arrangements for Commonwealth funded programs. There were strong views particularly from the community sector that there was a need for greater accountability. Overall the LRT felt that the issue was more about how the overall level of response to both HIV/AIDS and Hepatitis C could be monitored rather then specific accountabilities. The LRT supports the approach suggested by the HIV/AIDS review team of a regular survey of activity separate from the reporting requirements of specific inter-government agreements.

INTERNATIONAL ENGAGEMENT

The human social and health consequences of the global HIV epidemic are well established particularly in Africa and parts of South-East Asia. The economic (and population) impacts of the epidemic are now raising international security concerns because of its potential to political destabilise regions including South-East Asia.

Australia has maintained a special relationship with its nearest neighbour, New Guinea, and New Guinea remains the largest recipient of Australian aid funds. Both because of this and because of its proximity, the rapid growth of the HIV epidemic in New Guinea must be a specific concern.

Australia has taken an important leadership role in pressing for an international response to HIV and had a major role in the development of the UNGASS agreement and is a signatory to it.

The size and impact of the global HIV epidemic is such that the Lead Review Team believes there is a need for whole-of-government international policy on Australia's role in tackling this problem. This policy would specify:

- How and who will coordinate Australia's reporting obligations under the UNGASS agreement;
- Arrangements for the coordination of Australia's response;
- Aid funding priorities;
- Development and maintenance of human resource base to support international efforts;
- Development of a system to ensure better integration of Australia's research and project capacity into international efforts particularly with regards to vaccine and microbicide development and trialing;
- Development of a position on funding of and access to affordable HIV therapy in developing countries;

Development of inter-country agreements within the region on treatment and prevention programs for STIs.

The development of this policy should be a joint responsibility of the Departments of Health and Aging, Department of Foreign Affairs and Commerce and AusAid possibly under the chairmanship of the Chief Health Officer.

CONCLUDING REMARKS

In conclusion the LRT believes that Australia has been well served by it past and current HIV/AIDS, Hepatitis C and Research Strategies. The LRT in making its recommendations has strived to ensure that any suggested changes would not loose the strengths of previous strategies. However, the epidemiological, social and clinical context for both HIV/AIDS and Hepatitis C is changing and this needs to be taken into account, as is the broader social and political environment. Health systems responses for many health problems have been influenced by the success of the response to HIV/AIDS. Over the period of the HIV epidemic there have been enormous changes in the way health care more broadly is provided. Our HIV/AIDS and Hepatitis C strategies need regular review to remain current and at the forfront of such changes.

The LRT would like to specifically acknowledge the work of the individual research and strategy review teams whose reports form the basis of this report. The LRT found very few examples of issues that the individual reviews had not already addressed and with regard to recommendations any differences are primarily of focus, pragmatism or opinion.

The LRT also thanks the Reference Panel who provided frank and sometimes challenging feedback that was absolutely essential.

The LRT would also like to acknowledge the excellent support provided by Departmental staff that has made the task substantially easier and enjoyable.