Issues in managing patients with chronic hepatitis c in public hospitals

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Abstract

Public hospitals in Belgium are taking care of a disfavoured people such as drug addicts, alcoholics, patients with low income and people referred by refugee centres. Many of these patients are at risk of hepatitis C. The medical and paramedical staff is facing numerous problems in taking care of these patients. Requests of hepatologists from public hospitals are a more effective psycho-social management, an increase of the framing in these hospitals, and a more rapid process of reimbursement of medication for treatment of hepatitis C, allowing to treat the patients according to international standards. (Acta gastroenterol. belg., **2002**, 65, **101-103**).

Introduction

General features

Hepatitis C Virus (HCV) infection is the most common cause of newly diagnosed chronic liver diseases in the developed world. The prevalence of antibody to HCV (anti-HCV) is 3% in the world.

Natural history studies of HCV suggest that progression to cirrhosis occurs in at least 25% of patients with chronic disease, generally after 10-30 years of infection. After the development of cirrhosis, hepatocellular carcinoma occurs in 2% to 5% of these patients each year (1).

The most effective initial therapy for patients with this disorder is the combination of interferon alfa-2b or 2a plus ribavirin given for 24 or 48 weeks. Recently, a new form of interferon (PEG-interferon) with a longer half-life than the natural molecule has shown potential benefits confirmed in a recent study in which 54% of patients treated with the higher dose of peginterferon alfa-2b for 48 weeks achieved sustained virologic response (2). This new medication is currently not covered by Belgian social security.

Epidemiology in Belgium

In general

About 1% of the Belgian population is infected with hepatitis C virus, which corresponds to approximately 100,000 patients (3). Hepatitis C is 8 times more frequent than the infection with the HIV virus and involves significant morbidity and mortality. Over 30% of the patients carrying hepatitis C virus are not aware of being infected. The two high-risk groups are patients transfused before 1991 and drug-addicts.

Specific case of drug addicts

Hepatitis C virus (HCV) infection among intravenous drug users (IVDU) is a major problem of public health.

In previous studies, prevalence of anti-HCV antibodies in IVDU ranged from 55% to 100% worldwide. Incidence ranged from 5% to more than 30% in high-risk people (less than twenty-year-old IVDU, cocaine users or socially disadvantaged people (institutionalisation in prison).

Two majors injection-related risk factors have been emphasised : needle/syringe sharing or borrowing and duration of drug abuse.

The GEMT study (4) assessed the high prevalence of HCV infection among Belgian IVDU (78%). This study found a high prevalence of HCV infection among IVDU who had never shared needles or syringe and highlighted the risk of transmission related to sharing "cotton" (cigarette filter tips used to filter impurities contained in street-heroin). Twenty percent of intravenous drug users are coinfected with HIV and HCV. Only 4% of IVDU with chronic hepatitis C receive treatment.

Management issues specific to public hospital

A. *High-risk population characteristics*

Public hospitals welcome a higher share of disfavoured population, which is mainly composed of :

- Drug-addicts or ex-drug addicts referred by specialised centres

About 30% of treated patients have a history of IVDU in a study performed in Brugmann hospital between 1995-2001 (5).

CHU Brugmann manages drug-addicted patients from the psychiatric unit. CHU Saint-Pierre is especially confronted with drug-addicted patients but also with the particular case of patients coinfected with HCV and HIV virus.

- Patients with a low income who have the advantage of free care in public hospitals
- Alcoholic patients

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In the Brugmann study, about 50% of the patients had a daily alcohol intake > 40 gram for at least 10 years (5) and 14% had the same intake at the time of liver biopsy.

- Patients applying for the refugee status, referred by refugee centres or caritative organisations like the Belgian Red Cross or "Médecins sans Frontières".

Public hospitals are thus confronted with a high-risk population that comes from countries where transfusion still represents a major risk of contamination due to the absence of serological control (Eastern European countries and Africa).

The majority of patients applying for a refugee status do not speak French, English or Dutch. However, the patient's correct understanding of the disease (e.g. natural evolution of hepatitis C), the clinical analysis (e.g. importance of the liver biopsy) and the treatment is a critical success factor to compliance and remission.

Hospitals have hired interpreters but they are hardly available mainly due to the restricted number of interpreters compared to frequent demands and different timetables. As a result, patients often come accompanied by a countryman who assists them with translation, involving repetition, imperfect understanding rendering consultations long and laborious.

B. *Issues relative to social security*

1. Indigent patients, e. g. alcohol and drug addicts

a. Patients with an income between 750 and 1200 and covered by social security : they have to pay part of the medical fees themselves (moderator ticket'). This often renders medical treatment unaffordable. Financial help by a public centre for social welfare (PCSW) is legally impossible in this condition.
b. Indigent patients who are not covered by social security : their medical expenses are paid by PCSW of inscription. Some PCSW, e.g. in Antwerp, pay the complete medical expenses, including the 'moderator ticket'. In this case medical care is free. Other PCSW refuse to pay the 'moderator ticket', although they are legally obliged to do so. In this case medical care for complex diseases like hepatitis C also becomes unaffordable.

2. Legal (candidate) refugees

These are assigned to a PCSW, which can claim all medical costs from the state (Ministry of Internal Affairs). Theoretically medical care is completely free. Since November 1, 2001 only one PCSW per refugee can make claims to the state. Problems arise when a patient is assigned to one PCSW but receives medical care in another PCSW. The latter has to make its financial claims through the first PCSW, which results in considerable administrative and financial hassle. As already mentioned, many PCSW refuse to pay the 'moderator ticket'.

3. Illegal refugees

Medical expenses are covered by the state provided a doctor signs a declaration of urgency. According to a Royal Decree of 1996, this includes preventive and curative treatment. This means medical care is possible and free.

In principle there is a safety net whereby treatment of hepatitis C can be provided to everybody. Problems arise :

1. In indigent patients who are covered by social security but who are unable to pay the personal part of the fees ('moderator ticket'). This situation is not remediable in the present legislation.
2. Certain PCSW refuse to perform their obligations. They should be better informed because legal provisions exist allowing them to claim all their expenses from the state.

C. *Issues relative to compliance*

Drug-addicted patients or candidate refugees often lack compliance to the treatment. This is more often the case in the drug-addicts than candidate refugees.

Drug-addicted patients

Centres that have started a substitution treatment and provide psychological support usually refer their patients. These patients have other priorities than solving administrative issues (e.g. solving housing difficulties if they are not sheltered in a specialised centre, meeting legal obligations in relation to their drug-addict past). As a result, they respect their appointment (consultation or technical examination) only when they can pay. If they depend on the PCSW, they must get their indictment, which requires a preceding interview with the social worker. More than 50% of the patients are depending on the PCSW. Imprisonment and social isolation are not infrequent in these patients. For these various reasons, these patients do not present themselves to the appointment or arrive late.

The incentive of the drug-addicted patient may be incomplete.

The drug-addicted patient fears changes in his existence and the constraints resulting from the anti-HCV treatment.

The patient fears the secondary effects of the interferon and the bad reputation of this treatment. Their drug-addicted colleagues complain about the secondary effects and transmit this disrepute. Other drug addicts refuse the treatment because they don't have any incentive to stop drug addiction.

Some patients come to the consultation to get precise information on hepatitis C. They ask precise questions on the natural evolution of the disease, on the necessity of liver biopsy and the efficiency and secondary effects of treatment. Some patients will not return after having received this information.

Liver biopsy can be an impediment to the treatment due to the fear it causes and the cost that it can represent (one-day hospitalisation).

A lack of information exists due to the lack of solidarity between drug-addicts and a false therapeutic inefficiency reputation.

Other patients who started the treatment do not systematically respect consultation frequency.

They will not take their blood tests regularly and can interrupt their treatment episodically, not having had their prescriptions.

Others are going to re-activate an underlying depression and are going to interrupt their treatment or are going to take drugs again.

Candidate refugees

They are generally more compliant. The problem of the language barrier exists, however. A risk of incomplete understanding of the treatment and secondary effects exists.

Some patients can give priority to the recognition of a medical condition rather than treatment itself in view of getting legal authorisation to stay in Belgium for reasons of health.

D. *Lack of medical and paramedical staff*

In our institutions, we suffer from a critical lack of staff.

The number of patients doesn't stop increasing (neither does the number of candidate refugees), which increases the demand for consultation and results in a long delay in obtaining an appointment. The number of patients who do not present themselves at their appointment and then take a new appointment increases this delay.

Consultations are also overloaded by the necessity to see the patients in shorter delays to manage the treatment and the associated side effects.

We meaningfully lack interpreters who are not always easily available.

In the majority of cases, consultations are performed with the respect to the limitations due to language barrier.

The expertise of social workers is often needed (indictment, social security regularisation, contact with the various PCSW, etc…).

The number of physicians and nurses is also insufficient for the workload. The work is assured in conditions of stress and fatigue.

Besides, we feel it is our duty to participate in multicentric studies. We always participate in these studies with the same incentive and the same rigor. It also represents meaningful wage costs since we don't have data nurses as in some academic centres.

Conclusions

Currently, two mainly social problems arise :

In the present legislation, the situation is not remediable for indigent patients who are covered by social security but who are unable to pay the personal part of the medical fees. Moreover, some PCSW refuse to perform their legal obligations.

The development of a multidisciplinary approach notably for drug-addicted patients and the development of treatment networks are necessary. This approach implies collaboration between the hospitals, the patients, the general physicians, the hepatogastroenterologists, the psychiatrists, the centres specialised in addiction, the social workers, the PCSW, the mutual insurance company, and the political authorities.

Requests of hepatologists from public hospitals

1. A more effective psycho-social management

- By the development of specialised centres for drug-addicted or alcoholic patients in collaboration with the hepatologists.
- By the assurance of a better minimum income for the underprivileged patients ;
- By the assurance of a better politic of reinsertion
- By performing a rationale politic of immigration ;
- By the assurance of help in housing.

2. An increase of the framing in the public hospitals

- Social framing ;
- Medical and paramedical framing ;
- Development of efficient and specialised supplementary services (interpreters, jurists, cultural advisers).

3. A more rapid reimbursement of the new treatments such as the combination of peginterferon and ribavirin, now becoming the new standard treatment for chronic hepatitis C.

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