PostScript

CORRESPONDENCE

HIV, HAART and overseas visitors

In March 2004, parliament passed amendments to the overseas visitors legislation, which came into effect from April 2004. According to the Department of Health guidelines, overseas visitors are eligible for free National Health Service (NHS) secondary medical services in certain circumstances.¹ Free NHS treatment may be afforded to overseas visitors if the patient has one of several diseases that require treatment in the interests of public health, such as *Mycobacterium tuberculosis*, or as a result of a referral to a sexually transmitted diseases clinic. In the case of HIV/AIDS, this includes only the initial diagnostic tests and associated counselling.¹ The regulations place a legal obligation on secondary care providers to establish whether a patient is eligible for free NHS hospital treatment, and, if not, a charge must be applied. Patients who have made a formal asylum application are entitled to free care. People who have applied for leave to remain, however, are liable for healthcare charges either until they have been granted leave to remain or until they have been lawfully living in the country for a period of 12 months awaiting a decision on leave to remain, whichever occurs first. Any HIV-positive patient who is not entitled to free care will be charged for highly active antiretroviral treatment (HAART).

We report a case of a newly diagnosed HIV-positive patient in whom antiretroviral treatment for HIV was delayed because she was not eligible for treatment on the NHS and was unable to fund the cost of the treatment herself. The patient, a woman from sub-Saharan Africa, entered the UK on a 6-month visitors visa in early 2004. After recurrent episodes of urinary tract sepsis, she was admitted to hospital and a diagnosis of HIV was made. She was considerably immunosuppressed, with a CD4 count of 64 and a viral load of >500 000 copies/ml. She was treated for cryptococcosis and cryptosporidial diarrhoea and was started on *Pneumocystis jirovecii* (*P. carinii*) prophylaxis. At this stage, in view of her advanced disease, we recommended that antiretroviral treatment be started to prevent further complications. She was informed by the overseas visitors unit that she would be liable for charges for antiretroviral treatment. She was advised at this stage to seek legal advice. However, despite the medical team emphasising the

importance of treating her HIV infection, she declined HAART because she was unable to afford the treatment and was planning to return to her home country.

Having recovered from her earlier complications, the patient's condition deteriorated, requiring admission to the intensive care unit (ICU) for 11 days. She was treated for cytomegalovirus pan colitis and sclerosing cholangitis. After discharge from the ICU, she subsequently started receiving HAART. The patient, having filed for asylum, was now eligible for full NHS treatment. She had a long convalescent period and was finally discharged 3 months after admission. The patient is currently well, with a CD4 count of >200 cells/mm³.

In our clinical opinion, had HAART been started earlier, the patient would have been discharged 19 days after admission, and would not have required admission to the ICU. A cost analysis was undertaken, according to health resources grouping (HRG) codes, for treatment of her medical and ICU care. The cost of admission to ICU was £20 043 and that of the convalescent period was £8,307. The total cost, including the initial admission, the treatment on ICU and the convalescent period, was £32 392. Had she been discharged on HAART at 19 days the cost would have totalled £4042, a saving of £28 350. On the basis of the monthly cost of HAART (£674.13), this represents a possible 3½ years of HAART treatment.

What this case, and in particular, the cost analysis shows is the false economy of withholding HAART from patients who need it clinically, and who are in the country for any length of time. This is particularly relevant to patients who have applied for leave to remain. This process can take several years. Although these people may become eligible for free healthcare once they have been living lawfully in the country for 12 months while awaiting the decision regarding their application, they may be without HAART for up to 1 year, as most will not be in a position to afford the costs. If they are heavily immunosuppressed, HIV-related complications will arise, with resulting hospital admissions, which are considerably more expensive than giving the patient HAART. It may be tempting to view this as an isolated incident; however, recent data from the health protection agency suggest that the major factor contributing to the rapid increase in numbers of diagnoses of HIV in recent years has been a rise in diagnosis of infections acquired through heterosexual

contact in areas of high HIV prevalence, mainly Africa.² This scenario is therefore likely to reoccur.

There are ethical and public health reasons for treating HIV-positive overseas visitors with HAART,^{3,4} but, as yet, there have been few arguments for this stance being of potential cost benefit. The cost effectiveness of HAART is beyond dispute, as shown previously.⁵ As the case above shows, the consequences of delaying treatment may in fact place a greater cost burden on the NHS. For financial reasons alone, we would argue that such people in need of antiretroviral treatment should have access to free health care while they are in the country, until such a time that a decision has been made regarding future residency.

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Reference

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