ashm
Australasian Society for HIV Medicine Inc

Submission to the Review of the National HIV Strategy

Prepared May 2002

Preamble: - The Australasian Society for HIV Medicine, and its priorities

The Australasian Society for HIV Medicine Inc. is Australia's peak non-government organisation representing people who work in the HIV and related conditions sectors. ASHM has a major focus on HIV medicine. However, due to the overlap of its members interests and the co-location of HIV, hepatitis and sexual health responses at a policy and service delivery nature, also works significantly in the hepatitis and sexual health settings. To this end, ASHM is a major provider of continuing medical education and at the request of our customers and stakeholders continuing Medical education programs regularly combine HIV hepatitis and sexual health.

ASHM is a member-based organisation and has over 500 full members and 250 associate members. Unlike other community-based organisations ASHM is not funded to provide policy input. This hampers its capacity to work as effectively as possible in the sector as the Society must fund raise via membership fees and its annual conference to enable it to participate in the sector. **Recurrent funds for core activities and policy development, subject to performance review, should be provided by the Commonwealth.**

Through its education programs and policy development ASHM is well placed to develop National Standards in relation to a range of issues. ASHM can access members from the range of medical and scientific sectors, including social sciences. **This resource should be tapped by Government, in relation to standard setting, rather than duplicating effort and developing Bulletins, Models of Care, Guidelines and Standards outside the ASHM rubric.**

The role of general practice and the education of general practitioners to take on HIV and hepatitis C management is increasing. ASHM is well placed to provide this education and does so in NSW. It will commence providing training in Victoria and is in negotiation with Western Australia for a similar program to commence later this year. This work must be supported and **ASHM should play an appropriate role in any partnership forum such as IGCAHRD**.

ASHM should further develop its role in the region and will need to be supported to do this. **Australia needs to adopt a whole of government approach when responding to HIV in the region.**

The following tables respond to specific issues and terms of reference for the Review of the 4th National HIV Strategy. ASHM would like to further its submission by presenting to the review panel and can do this in both Sydney and Melbourne. We can provide a more detailed response on any specific questions if the panel requires this.

Key issues	
the degree to which HIV/AIDS policy has been integrated with other public health policy and whether a broader sexual health approach is preferable;	ASHM represents medical practitioners, researchers and health care providers from experts in their fields to generalists with an interest in HIV . These observations therefore reflect the differing needs and experiences of health care practitioners with a range of HIV experience and engagement. On the one hand it is essential to maintain specialist expertise in HIV management, but Australia's successful model of general-practice based management of HIV must be maintained and strengthened. The response to this key issue necessarily varies across jurisdictions. In some areas and locations there has been a well coordinated integration, but this by no means universal. In some areas HIV becomes overlooked because it has been bundled with other public health issues. This has been exacerbated by the untying of funding as a result of the PHOFA process, and the inclusion of HCV and related conditions. Without commensurate funding increases and dedicated funding arrangements for this increased remit, HIV funds have been moved into larger budgetary pools. At a service provision level this can mean that previously dedicated HIV funds have been allocated to other communicable disease activities outside HIV, hepatitis and STI areas. The first and second National Strategies made way for the development of a publicly funded Sexual Health Clinic network to provide centres of medical excellence in regard to HIV in areas not served by specialist (usually teaching) hospital HIV units. This decision was made at a time when HIV care was predominantly health monitoring, the management of opportunistic infections or palliative. At that time only a small number of general practitioners were providing care for a great many people living with HIV. It was not done in the current climate of complex antiretroviral therapy, and long-term treatment. The growing complexity of HIV management means the maintenance of general practitioner skills and the formalisation of models of shared care are of growing importance. A broader sexual health approach has some benefits and some dangers. For homosexual men, it makes good epidemiological and clinical sense that HIV care and prevention is seen in a sexual health context. On the other hand, there is some tension providing HCV services in a sexual health context. The expansion of the general practitioner s100 prescribing program has been appropriate and has shifted care for people with HIV to the community where, hopefully management will continue to become normalised. This may also be possible with the expansion of this program to cover HCV. Expansion of this program, and adherence to the agreed National Standards for HIV s100 Accreditation, has been hindered as some states and territories do not

Key issues	
	appear to want to make this investment. ASHM provides this service, but without Commonwealth support to underpin training delivery, uptake remains a function of state/territory preparedness and interest. ASHM strongly believes that a further formalisation of GP education in HIV and HCV is needed to ensure the appropriate use of expensive drugs, and the appropriate health management of people with HIV and HCV. This could be achieved by the development of national standards in care and adoption of National Standards in GP education. ASHM is currently investigating the possibility of providing a diploma level course in HIV care, aimed at GPs, but has thus far not been successful in seeking funds for the development of such a concept.

Key issues	
the impact of the growth of the HIV epidemic in the Asia Pacific region and what role Australia might need to play;	The growth of the pandemic in neighbouring regions is a considerable issue for Australia. This issue stresses the breadth of the impact of HIV and will need to be responded to from a whole of government approach. This is already resulting in an increasing demand on services in our far northern areas. ASHM is well placed to play a leading role in providing expertise to the region and as such, along with government and other non-government agencies should be supported in doing this. The response must be coordinated and we strongly recommend that the review consider providing the Society with an International Policy Officer position to assist in the development of this coordinated response. For many years, there has been increasing concern about a burgeoning epidemic in PNG, and more recently, concentrated HIV epidemics have been identified in large population centres in Indonesia. A coordinated response strategy needs to be developed with the Commonwealth, Queensland and Northern Territory Health, ASHM and other key stakeholders such as AUSAID. AUSAID needs to be more centrally involved in any international response to HIV/AIDS, as thus far it has tended not to make use of the HIV partnership, rather relying on a few specialist providers. In this way, the expertise of the sector has barely been used. Likewise it should be noted that Western Australia is a relatively near neighbour to Africa. It has a significant South African migrant community and as such may be called upon to assist in that arena, particularly through collaborations at a tertiary level.

Key issues	
continued resourcing for HIV research, prevention, education and treatment and care;	Australia's success in managing HIV has been a result of broad partnership commitment and appropriate resourcing. While to date we have performed very well, we cannot allow this to lead to complacency. Overseas experience has demonstrated that epidemics with similar characteristics to the Australian epidemic have seen dramatic increases in infection in very short time frames. The HIV epidemic is still evolving. Much of our infrastructure was developed pre-HAART. We need to be reviewing whether our response mechanisms are still relevant. This goes down to the fundamental basis on which resources are allocated. Systems at a state and territory level which rely on an AIDS diagnosis for funds allocation need complete overhaul. Much of the health services planning research which was undertaken in the 1980s has questionable relevance to today's epidemic. This means a sustained research, education and prevention investment is required in parallel to investment in treatment and care. The existence and rapid development of HAART means that continuing medical education is essential. The majority of people living with HIV see a primary care provider for their HIV management, see Table 1. The Commonwealth must support programs such as the ASHM GP education program to ensure that targeted education is provided and so that a competent GP skills base can be developed and sustained in all States and Territories. ASHM would like to discuss these issues in more detail with the panel, particularly adequate funding to allow the promulgation of National Standards for HIV s100 prescribing, and the development of the necessary associated educational materials.

Key issues	
whether the HIV partnership is still effective.	The partnership has served Australia well, but there is need for the streamlining of the advisory and partnership forums. This appears particularly necessary if HIV, HCV, Indigenous Sexual Health and Sexual Health are all to be collocated administratively and learn from each other strategically. These issues are discussed below in more detail and would form part of the panel presentation proposed by ASHM.

Terms of Reference	
Assess the extent to which the current Strategy has been effective: • the Strategy's position in a broader communicable diseases context;	A communicable diseases strategy runs the risk of being so broad that specific issues are overlooked. For this reason ASHM feels strongly that there need to be maintenance of individual strategies for: • HIV • Viral hepatitis We further believe that there has to be concerted consideration of the best way to address indigenous health issues in relation to HIV, HCV and sexual health, and STI management for all Australians. This may result two individual strategies: • Indigenous sexual health, HIV and Hepatitis; and/or • Sexually transmitted infection strategy for all Australians.
• the degree this is implemented;	Implementation varies considerably across jurisdictions.
• the achievement of Strategy objectives listed under the following priority areas • Treatment, care and support; • Research; and • International assistance and cooperation.	**Treatment, care and support** It is essential that health care provider education be supported at a National and State level. It is unrealistic to expect that medical graduates will have sufficient skills in HIV management to allow the effective care of people with HIV. (The majority of undergraduates receive only about 2 hours specified HIV training). As a result, some form of post-graduate training must be provided for those doctors who wish to provide comprehensive care for people with HIV. At a specialist level, this is currently well catered for under infectious disease, immunology and sexual health training. At a GP level this varies markedly across Australia. In NSW, there is a well established system of training and continual medical education, provided by ASHM, and this system is soon to be extended to Victoria. A similar system exists in Queensland, but elsewhere, little GP training is available. To maintain Australia's system of shared GP-specialist care for HIV, ASHM believes that the National Guidelines for GP education need to be implemented and regularly updated to reflect current best practice. ASHM sees itself as being the central player in such a process and would be very interested in joining with other members of the partnership to action this, provided adequate funding is available.

	Research ASHM has already made submissions to the strategic research review and quinquennial reviews of National HIV centres and collaborating centre. In brief: • ASHM supports the continued funding of the National Centres; • adequate funding for HCV research to be undertaken; and • much closer links between policy and research activities in both HIV and HCV **International assistance and cooperation** ASHM takes its obligations in this area very seriously, but without any resourcing for international involvement this is most difficult. The 2003 ASHM Conference is to be held in Cairns to facilitate involvement of PNG and Timor. Increasingly Australia will be called upon to provide education, training, policy support and care within the region. It is essential that a whole of government approach be adopted in this regard. It is also essential that existing agencies such as ASHM and AFAO are supported to develop strategy and participate fully in this area. A central failure in this arena has been the generally poor level of engagement with AUSAID, despite this organisation's very substantial moves in to HIV-related aid. Formal mechanisms need to be developed to ensure that AUSAID makes use of the HIV expertise built up by the partnership.
The priority health needs of Aboriginal people and Torres Strait Islanders.	A tension in this area has been clearly defining the breadth of the responsibility of IASHC. Should it concern itself with only sexual health or should it have a broader focus? It appears that many indigenous issues are passed to this advisory group, when they should also fall within the remit of the other committees. Based on Australian epidemiology, it also appears awkward in the least to manage HCV from a named sexual health committee. Likewise the positioning of IASHC in OATSIH creates a hiatus from the HCV and HIV sections of the health department, it may be appropriate and timely to develop better linkages between IASHC and the HCV and HIV sections.

Terms of Reference	
Assess the appropriateness, strength and effectiveness of the *partnership* in representing and progressing responses to HIV/AIDS through an analysis of the roles, responsibilities and activities of:	The partnership has served Australia well, but there is perhaps some scope for the streamlining of the advisory and partnership forums. This appears particularly necessary if HIV, HCV, Indigenous Sexual Health and Sexual Health are all to be collocated administratively and learn from each other strategically. These issues are discussed below in more detail.
the Commonwealth Government, State and Territory governments, and local government;	The whole of government response to HIV was promulgated in the early years of the epidemic. At the same time, health was well resourced at a Commonwealth and state level to respond to HIV and particularly to fund new and innovative programs and projects. Rather than supporting the development of a whole of government approach this led to Health being "dumped" with responsibility for issues outside its jurisdiction. As the HIV dollar is decreasing this means that program providers are now being told they will no longer be funded from the Health purse and are being directed to alternative sources of funding where HIV has never been a priority and where no relationships exist. DFAT and AUSAID have a considerable responsibility for supporting science, education and training

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the Australian National Council on AIDS, HIV/AIDS and Related Diseases (ANCAHRD) and the Inter-governmental Committee on AIDS, HIV/AIDS and Related Diseases (IGCAHRD);	**ANCAHRD** has, in taking on HCV, research and Indigenous Sexual Health, created a structure that is cumbersome. ASHM recommends that the structures be simplified and that policy and research activities are more closely linked. A single HIV committee and separate HCV committee should be developed with responsibility for policy and research. These should advise the Minister and be supported by the Public Health Division. If a separate STI strategy is to be developed it could equally be advised by a similar structure. The IASHC chair and chairs of these committees and IGCAHRD could then have an informal liaison and with appropriate exchange of minutes each committee could be kept informed and aware of the work across committees. **IGCAHRD** has been expanded over the years to include non-government representatives. While this was initiated to increase information flow, it is arguable that this has occurred. The process of expansion was also flawed by excluding the medical scientific community from the table – ASHM has only ever accessed IGCARHD on a visiting basis, initiated by ASHM, at ASHM expense, as a way to facilitate communication. One option would be to return IGCAHRD to a truly Governmental Committee, but to hold regular (say 6 monthly) forums where other non-government stakeholders can provide information exchange. An alternative option would be to devote part of each meeting to a broad based forum and part to a government only forum. Which ever option is adopted ASHM must be a stakeholder at this table.

Terms of Reference	
research, medical, scientific and health care professionals;	The role of these sectors must be reassessed in the response to HIV, particularly since the development of HAART. There is some tension about the status of ASHM. It is a dedicated community organisation, which came into being only as a result of the medical and scientific community responding to HIV, and needs to be funded appropriately as an NGO. ASHM has from within its membership, and through its links to others in the professions, the capacity to provide education, training, and policy development. It is particularly well placed to take on the writing of national standards and models of care. It is also well placed to promote research interests in the area of HIV and to act as an advocate for the sector. The Commonwealth should be resourcing the development of standards for this workforce and the education of this workforce.
the Non-Government Organisation and community sectors.	ASHM is a non-government organisation, representing health care providers and needs to be recognised as such.
Examine the transferability of approaches, partnerships, principles and services in HIV/AIDS to other chronic diseases.	The models developed in HIV can serve the HCV and STI sectors well. The principles of partnership, involvement of affected and medical and scientific communities would be transferable to other chronic illnesses.

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Examine the impact of HIV/AIDS in the Asia-Pacific region, analysing the role Australia might play in providing assistance, and identifying which bodies might most appropriately implement Australia's role.	Australia must act to implement the UNGASS and Asia Pacific Health Ministers Declarations. A whole of government approach is required to do this and a number of partners in Australia including ASHM and AFAO should be appropriately resourced to work in these areas. DFAT, AusAid, AG and Health must work cooperatively to achieve these ends. These organisations should also be involved in policy development and recognise their responsibilities in regard to HIV. The role of overseas serving military as a potential risk group for HIV must not be allowed to go unnoticed. There needs to be appropriate education provided to defence personnell and training to defence health services. This is of particular importance when troops are working in high incidence areas.
Links to the National Hepatitis C Strategy	There is a close link between these strategies, but the hepatitis C strategy needs to be appropriately resourced to enable an appropriate response to be developed. The advisory structure described above will allow for the appropriate development of the Hepatitis C strategy. This development should draw from experiences of the HIV strategy development process.
Identify shifting priorities, gaps and barriers.	We have seen in other countries that the epidemic can explode with little warning. One of the major causes of this has been through the spread of HIV in the drug injecting population. Australia needs to maintain and further develop its commitment to harm minimisation, particularly via the needle and syringe program. This will require Commonwealth leadership and commitment at a state and territory level. General practitioners are a primary source of information management and treatment Their centrality needs to be reflected in an appropriate investment in their on-going education and strategies to attract new practitioners to the area. Support of and participation in the Asia-Pacific region must be seen as a priority for all levels of government and all of the partnership.

Table 1

Sources of information about treatments and living with HIV (percentage of those who get prescribed drugs through a GP)

	Information about TREATMENTS	**Information about HIV MANAGEMENT**	**Information about LIVING WITH HIV**
HIV GP/S100 prescriber	91.5%	77.0%	40.7%
HIV magazine/ newspaper	49.0%	45.0%	44.7%
Publications from HIV/AIDS groups	42.6%	42.4%	43.7%
Articles in gay press	42.1%	34.8%	38.1%
HIV positive friends	31.8%	36.3%	44.0%
HIV specialist at outpatient clinic	25.7%	20.5%	9.6%
Internet	25.0%	21.0%	18.7%
Treatments officer	17.3%	11.4%	8.6%
Pharmacist	16.5%	7.2%	3.8%
Other HIV/AIDS organisation staff	15.9%	15.1%	17.4%
Partner/ lover	15.3%	14.8%	22.9%
Publications from other sources	11.3%	9.4%	8.5%
Alternative therapist	11.1%	14.4%	13.3%
Dentist	10.7%	12.4%	9.3%
Other GP	10.5%	9.0%	5.6%
Dietician	7.6%	12.6%	14.3%
Sexual health service	7.2%	6.6%	6.4%
Other friends	7.2%	5.4%	15.9%
Public Health Nurse	6.9%	6.0%	6.1%
Peer Support Officer	6.8%	7.8%	10.7%
Family	5.8%	5.3%	11.2%
HIV specialist at inpatient clinic	5.4%	2.6%	1.2%
Liver Specialist	4.7%	2.8%	.9%
Other Nurse	4.2%	4.0%	3.3%
Positive heterosexuals group	4.2%	4.2%	4.3%
Positive women's organisation	2.8%	3.0%	2.8%
Hep C Support Group/Organisation	2.8%	.7%	2.3%
Other doctor	2.1%	3.0%	3.0%
Injecting drug users' organisation	1.2%	1.3%	1.7%
Haemophilia Foundation	.7%	1.5%	2.0%
Family Planning Association	.6%	.4%	1.5%
Sex worker organisation	.6%	.7%	1.1%

Source ARCSHS Futures III report - 2002