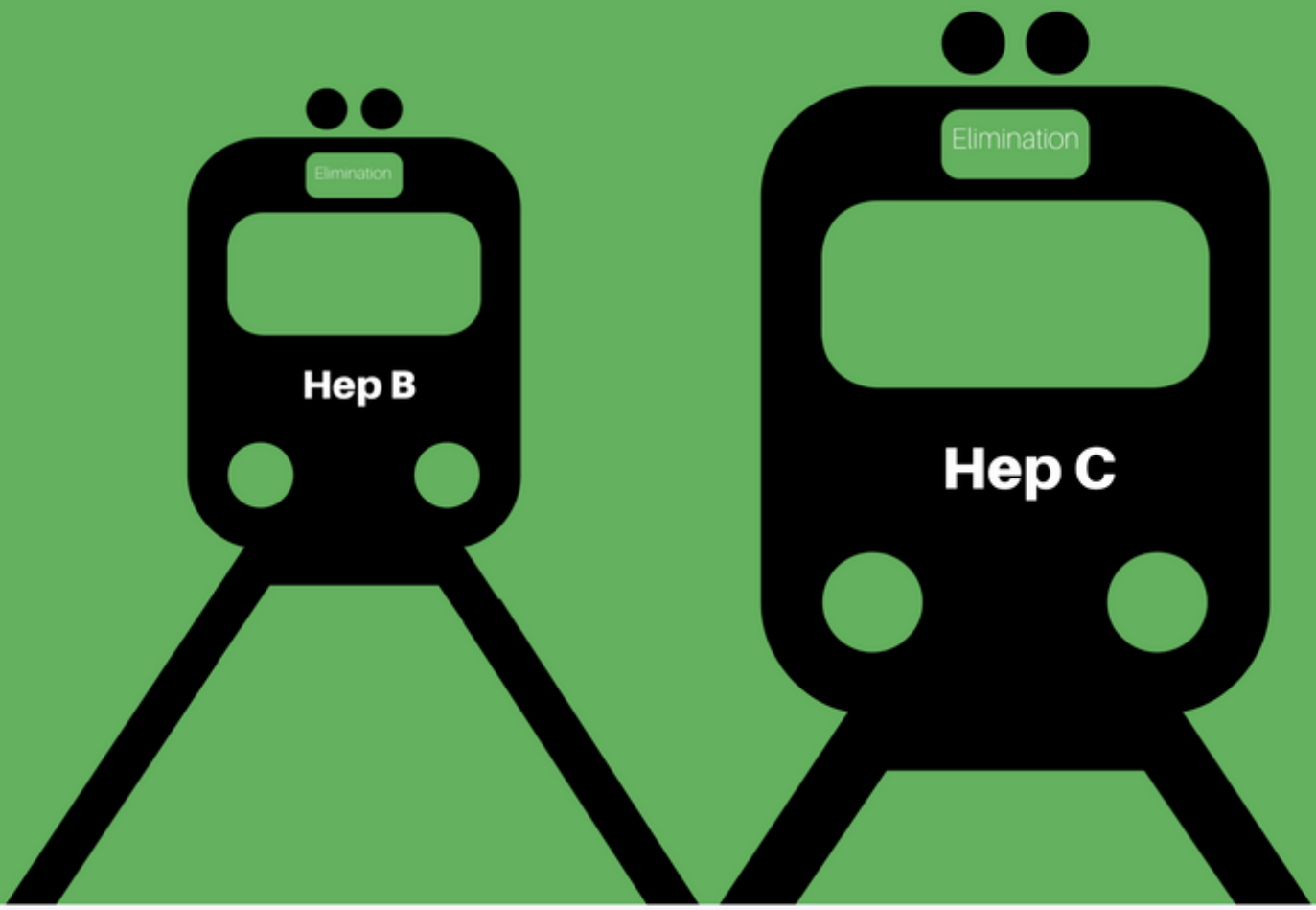
Eliminating Viral Hepatitis in Australia

Destination: Elimination

Arrival Time: 2030

Are we on track in 2017 ?



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This document was prepared by Hepatitis Australia in consultation with a variety of stakeholders working in the areas of hepatitis B and hepatitis C in Australia. This included people involved in primary and tertiary care, social and clinical research, community organisations and advocates.

Hepatitis Australia would like to thank those people for their contribution and continued commitment to responding to viral hepatitis in Australia.

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Destination Elimination – Arrival Time: 2030

The prospect of eliminating viral hepatitis as a public health threat in Australia within the next 13 years is entirely feasible, yet it is by no means certain. The availability of hepatitis C treatments that provide a cure means there is an opportunity to reduce the number of new infections to almost zero, and a vaccination for hepatitis B provides an opening through which to ensure future generations of Australians do not contract the virus.

More advances have been made in the awareness, prevention, diagnosis and treatment of viral hepatitis in the past decade than at any time in history. In 2016, approximately 30,000 Australians accessed new generation hepatitis C treatments that cure around 95 per cent of cases, and nearly 95 per cent of all infants were vaccinated against hepatitis B.

Despite these achievements and the Australian Government's world-leading commitment to eliminating viral hepatitis as a public health threat by 2030, much more needs to be done.

There are now more people living in Australia with chronic hepatitis B (approximately 230,000) than chronic hepatitis C (approximately 200,000). The national response to hepatitis B is a decade behind that of hepatitis C; and with a cure now available for hepatitis C we run the risk that viral hepatitis will no longer be seen as a pressing issue.

A railway metaphor is worth considering for viral hepatitis, where trains from 'Platform B' and 'Platform C' are bound for 'Destination Elimination'.

The questions in 2017 are:

- have these trains left their platforms
- are they equipped to collect passengers along the journey; and
- can they build up a head-of-steam to avoid delay or derailment?

Departure Delayed at Platform B

Despite a vaccine for hepatitis B being widely available through the National Immunisation Program for infants and funded through State and Territory Health Departments for many adults at high risk of infection, our train from Platform B to Destination Elimination has experienced a delayed departure.

The delay is certainly not due to vaccination rates. Hepatitis B vaccination coverage has sat above 90 per cent for infants and at around 70 per cent for adults at high risk for a number of years but much lower for some migrant and indigenous populations. It is our inability to implement a uniform and widespread diagnosis and treatment program for hepatitis B, mostly across migrant and indigenous populations, which is preventing real progress from being made. More than 6,000 people, largely members of migrant communities, will be diagnosed with hepatitis B in Australia this year alone.

Furthermore, one-in-three people with chronic hepatitis B remain undiagnosed, and approximately two-in-three people with the virus require treatment but most are not receiving it. These figures have improved little since 2013, and that is where the problem lies. Despite best efforts, hepatitis B monitoring and treatment rates remain largely unmoved.

That's not to say that Destination Elimination isn't achievable by 2030; it just means a drastic rethink on the way awareness, prevention, diagnosis and treatment of hepatitis B are approached in Australia and our region – but this is a complex undertaking.

The first National Hepatitis B Strategy was not instigated until 2010 (more than a decade after the first National Hepatitis C Strategy) and no new Federal Government funding was made available until five years later. This funding was earmarked for community-based awareness and health promotion programs, but not for improved clinical services. While awareness and understanding of hepatitis B have marginally increased across the broader population, the funding has been largely inadequate for reaching geographically and culturally diverse communities affected by hepatitis B. Additionally, the issues that surround diagnosis and treatment remain extremely problematic.

Unlike hepatitis C, or even HIV, hepatitis B has not featured heavily in Australian media, nor has it attracted a great deal of community attention. Additionally, many of the culturally and linguistically diverse communities affected harbour misunderstandings of the condition and even prejudice towards those living with it.

Increasing adult vaccination rates in Australia and the region, improving diagnosis and bolstering treatment rates needs to start with the inclusion of the communities most at risk. Building partnerships within these communities will help policy makers understand the barriers to prevention and treatment, and allow for the development of tailored campaigns that educate and link individuals to clinical care.

Viral hepatitis is a leading cause of liver cancer, which is currently ranked as the sixth highest cause of cancer deaths in Australia. Far too often a diagnosis of liver cancer comes at the same time as a diagnosis of hepatitis B. This indicates an enormous opportunity for healthcare professionals to take the front foot on diagnosis and subsequent care.

It is crucial that efforts are made with the Royal Australian College of General Practitioners to prioritise and include screening for hepatitis B as part of any initial consult for a patient identified as being from a high risk group. Education and clinical capacity needs to be enhanced in two areas – identifying risk and providing diagnostic services; and understanding the need for ongoing retention in clinical care and routine disease monitoring. All it takes is a simple, cost effective blood test.

This needs be supplemented by building the capacity of GPs to understand and interpret blood test results; the establishment of clinical pathways that guide GPs to deliver

monitoring and surveillance of patients; and educating GPs on when to refer for antiviral treatment.

To reach Destination Elimination by 2030, there must also be an increase in resourcing for hepatitis B treatment centres. Only once these factors have been addressed will diagnosis and treatment rates increase.

We need to ensure the voices of people with hepatitis B are heard and acted upon by decision makers, and that health service and community workers, specifically those in regular contact with people at high risk of infection, are well versed on not only the clinical aspects of chronic hepatitis B, but cultural nuances and significance of the virus within defined communities. This is extremely important in relation to migrant and indigenous communities.

The Train has Departed Platform C

Since its discovery in 1989, efforts to treat the hepatitis C virus have significantly improved. From that time progress was incremental, that is until the availability of direct acting antiviral (DAA) therapies created a paradigm shift by delivering a higher than 95 per cent cure rate.

When the DAAs were added to the Pharmaceutical Benefits Scheme in March 2016, the initial demand was enormous. It is now estimated that more than 40,000 of the 230,000 people living with hepatitis C at that time have received treatment to date. This take-up was helped by the involvement of non-specialists in the prescribing of hepatitis C treatments. General practitioners and other non-specialists now write at least half of prescriptions for DAAs, with around 80 per cent of treatments dispensed in community pharmacies. The effectiveness of DAAs dictates that treatment form a key strategy for prevention.

Make no mistake; Australia is a leader in the global response to hepatitis C. The train has well and truly left Platform C, but the hard part of the journey to Destination Elimination has just begun.

Even with a cure available, the elimination of hepatitis C as a public health threat is not guaranteed. In 2017, demand for these medical miracles has fallen sharply. For a number of reasons – ranging from lack of awareness or desire, to marginalisation and stigma – encouraging people with hepatitis C to seek clinical care is problematic and requires novel approaches.

Breaking down the barriers to connecting people living with hepatitis C with clinical care is even more critical for some priority populations, including indigenous Australians; those accessing or seeking treatment via drug treatment programs; and people who are incarcerated or considered long-stay mental health patients. For many of these groups, access to DAAs is not straightforward and at times, beyond their control. As an example, anomalies that exist around prescribing within a hospital setting need to be addressed.

While there is always room for improvement, it must be noted that Australia is getting better at reaching highly marginalised populations in large numbers. An estimated 20 per cent of people who inject drugs have access to the new treatments, and numbers treated through the prison system in some jurisdictions are expanding rapidly. Additionally, Australia has been a world leader in harm reduction for people who inject drugs (resulting in only about one per cent of people who inject drugs having contracted HIV).

Meanwhile, while all eyes have been fixed on a cure, traditional prevention has not been getting the necessary attention. With no vaccine for hepatitis C on the horizon, the cornerstone of prevention continues to be needle and syringe programs (NSPs). Yet, despite these programs saving four healthcare dollars for every dollar spent, clean needles and syringes are not available to everyone when needed. As such, the sharing of injecting equipment continues.

The location, and afterhours access, of NSPs needs to be considered in terms of maintaining anonymity (especially is rural and regional areas) while the role of peer support workers, and those within the injecting drug user community, must be considered as an alternative access point for clean needles and syringes.

Additionally, the value of NSPs as a pathway or point of access through which to better engage with people who inject drugs is under-utilised. NSPs provide an invaluable opportunity to deliver information and support, as well as provide hepatitis C diagnostic testing and treatment pathways, to those using the service and those who may benefit from treatment. More work needs to be done to ensure NSPs are reaching their potential.

Reducing or removing barriers to opioid maintenance therapy (OMT) and utilising them as treatment locations will also provide an opportunity to break the cycle of re-infection risk. OMT provides a regular, consistent and long-acting oral opioid dose that supports treatment goals. However, under the present system – where people pay a daily fee to access OMT – it is cheaper and easier to procure prescription opioids. Ensuring OMT is affordable is an important strategy to help stem prescription opioid as well as heroin addiction.

If the train from Platform C is to reach Destination Elimination by 2030, new tracks need to be laid to address:

- *Awareness* – Increasing awareness of the availability of a cure among the general community, and especially among priority populations. This is equally important for health care professionals, especially specialists across a range of fields. Communicating through Colleges and Societies will equip all medical professionals with an understanding of curative therapies.
- *Safe Spaces* – Empowering more healthcare professionals, including general practitioners, nurses and pharmacists, to confidently test for and diagnose hepatitis C and sensitively discuss the condition and its treatment, as well as taking models of care into the community, directly to those who will benefit most;

- *Acceptance* – Decreasing stigma and discrimination, and allowing those not yet diagnosed or reluctant to seek medical care, to do so with confidence;
- *Access* – Include needle exchange programs in prisons and increase the availability of NSPs in the community, alongside changing laws that prohibit the onward distribution of clean injecting equipment. In addition, increase funding for harm reduction and prevention programs and access to drug and alcohol treatment programs, alongside removing barriers to treatment for those who are incarcerated or considered long-stay mental health patients.

The availability of curative therapies means that hepatitis C can be eliminated as a public health threat by 2030, but only if people living with the virus view the cure as attractive, affordable and accessible and if more is done to reduce the risk of re-exposure to the blood-borne virus.

Destination Elimination – Can it be reached?

Australia's health services are among the best in world, and there is unprecedented political will to make a lasting difference in the viral hepatitis space. Additionally, as a community we are getting better at tackling stigma and rejecting misconceptions. However, to get both trains rolling and build up a head-of-steam to ensure they reach Destination Elimination, there is a need to abandon some past thinking and embrace new ideas.

The priority towards the end of 2017 and beyond is working out how to best roll out awareness, prevention, diagnosis and treatment programs that will maximise inclusion and impact. This will not occur without taking risks and experimenting without fear of failure, nor will it occur unless we celebrate our successes with a consistent and loud voice.

Destination Elimination can be reached in 2030; but only with unwavering political will, broad community support and the inclusion of those living with and at high risk of viral hepatitis in innovative approaches to education and engagement. The task ahead is enormous, but when it is achieved, it will conclude an epic journey.