

Dear Committee Members,

I write as an epidemiologist whose work is primarily concerned with hepatitis C infection and its long-term sequelae.

Summary:

Almost a quarter of a million Australians are living with chronic hepatitis C[1]. It is estimated that one third of these individuals have already progressed to moderate or severe liver disease, placing them at increased risk of fatal sequelae in the near future. In spite of this, fewer than 2% of all Australians living with the infection receive treatment each year. The burden of advanced liver disease in Australia will continue to increase until treatment uptake improves substantially. Fortunately, improving access to treatment is both achievable and potentially cost-saving[2]. The current system for managing cervical dysplasia provides a model on which a health system response to chronic viral hepatitis could be based.

Main text:

Due in large part to the high prevalence of chronic viral hepatitis, the incidence of liver cancer in Australia has tripled since the early 1980s[3]. In my home state of Victoria, one third of patients die within a month of diagnosis[4], showing that intervention prior to the development of advanced liver disease is imperative.

In addition to the substantial human cost of advanced liver disease, the long-term consequences of hepatitis C impose a huge cost on the health system – liver transplants in particular can ultimately cost hundreds of thousand dollars per person. Many hepatitis C-associated liver cancers and liver failures are preventable, and preventing them is potentially cost-saving: the Kirby institute have shown that increasing the uptake of traditional therapy to just 5% of those eligible per year from 2014 onwards would result in savings of \$9 million per year over the next three decades[2]. If this is to be achieved, the public health system must improve the mechanisms by which people in need of treatment are identified, referred, and followed up.

Australia's current, excellent system for managing cervical dysplasia provides an instructive model. Each state and territory has a cervical cytology registry, which collects data on pap test screening, and guides clinicians in the appropriate management of their patients[5]. These registries are there to serve every woman of reproductive age in Australia - even those at low risk. The registries ensure that women who are known to be at high risk of cervical cancer receive adequate clinical attention. As a result, the incidence of cervical cancer in Australia has been falling for decades, and it is now much less common than liver cancer[3].

No comparable system exists for people with chronic viral hepatitis, even though they are known to be at high risk of very fatal form of cancer, as well as other

life-threatening complications. Research in a high-prevalence area in western Sydney has shown that GPs often lack basic knowledge about both hepatitis B and C, which compromises their ability to provide appropriate care to their patients. Many GPs surveyed were unaware that hepatitis B and C cause cancer, or that hepatitis C is curable[6]. Given that chronic viral hepatitis affects 1 Australian in every 50, there is a clear need to improve the support available to primary care providers.

The public health community has been calling for government efforts to dramatically increase access to treatment for many years. Although several new agents have been listed on the PBS, and we may hope that more will be added in future, our experience to date clearly shows that simply subsidising drugs is not enough. The fact that so few Australians receive treatment under the current system clearly indicates that the existing mechanisms for referral and follow-up are inadequate. Until we implement a system to ensure that individuals at high risk of developing advanced liver disease receive appropriate care, the burden of hepatitis C in Australia will continue to climb.

It is simply unacceptable for someone in Australia to develop advanced liver disease due to an infection that was identified years or even decades previously, and which the health system failed to manage appropriately. There are of course people who are engaged with care and who have decided not to have treatment for their hepatitis, but this decision should be an informed one. Given the dire level of treatment uptake and the apparently poor knowledge among primary care providers, it appears likely that many Australians with hepatitis C are not aware of their treatment options.

It is imperative that people at high risk of developing advanced liver disease, for example those aged over 40, receive adequate clinical attention. Given that state governments hold identifying information about those who have been diagnosed with hepatitis C, it seems that it should be possible to use these data to conduct some form of follow-up. Linkage to Medicare data, for example, might permit identification of the current GPs of individuals now in middle age, who could be contacted and advised that their patients may be in need of additional attention. This is only one potential strategy, there are of course many others which should be considered.

Although it is important to make all possible efforts to prevent new hepatitis C infections from occurring, there are a quarter of a million Australians already living with the virus. Many older Australians living with hepatitis C are at immanent risk of progression to advanced liver disease. A long overdue, comprehensive response from the health system may spare them the terrible consequences of this infection, but we must act quickly. Governments across Europe are beginning to respond more fully to their own hepatitis C epidemics, and Australia can look to France, Portugal, and Scotland to see what might be achieved with various policies. Australians living with hepatitis C deserve the same quality of care as everybody else, and it is time they received it.

References.

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