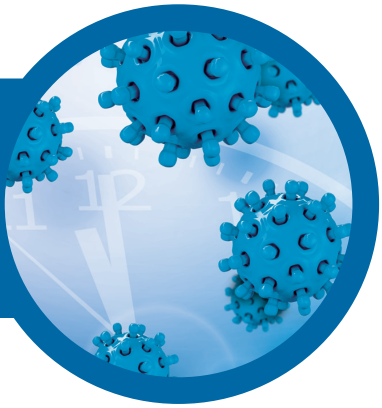
The Economist Intelligence Unit

A living document: Australia's national hepatitis C strategy



As nations across the globe struggle to address the growing threat posed by the Hepatitis C virus (HCV), experts lament the lack of co-ordinated strategies for confronting the illness. Australia is one of a handful of countries to have adopted a national strategy, yet its experience shows that even the most comprehensive and integrated policies face challenges in implementation and require constant adaptation.

HCV is one of the most commonly reported notifiable diseases in Australia, with an estimated total of 173,500 people believed to have chronic HCV as of 2012, accounting for just over 10,100 cases a year, according to a report by the Kirby Institute at the University of New South Wales.[1]

The Australian government is currently in the process of developing its fourth three-year national strategy on HCV, which will span the 2014-17 period (the first strategy was launched in 1999). The government's 2010-13 strategy paper acknowledges the importance of close collaboration with community groups, including those serving marginalised populations, healthcare providers and patient organisations.

"Australia has clearly benefited from having all the relevant groups at the table: clinicians, researchers, policymakers and—critically—the voice of the affected communities," says Helen Tyrell, CEO of Hepatitis Australia, a non-governmental, not-for-profit organisation. "A true partnership recognises the unique value of each of these groups in the development and execution of national strategies."

An ambitious goal for public health policy

The main goals of the national HCV strategy include: reducing transmission, which underscores the commitment to prevention strategies using harm-reduction initiatives; reducing morbidity and mortality, in part through increased access to clinical care for those with chronic HCV; and minimising the personal and social impact of the virus, which involves addressing stigma and discrimination on access to prevention education, care and treatment.

Ms Tyrell notes that the absence of specific targets in previous national strategies is a key deficit that the government is trying to address in the strategy currently under development.

The country's national testing policy is based on best-practice standards, but the third national strategy (2010-13) highlights that insufficient implementation has created poor diagnostic practices, including insufficient counselling before and after testing, and insufficient referral to clinical and

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[1] *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual Surveillance Report 2013*, The Kirby Institute, University of New South Wales, Australia.

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support services. Jack Wallace, a research fellow with the Hepatitis Social Research Programme at La Trobe University in Melbourne, says that while a framework for testing and policy exists, it is unclear how many general practitioners are aware of it. Screening is also inadequate, with an estimated 50,000 undiagnosed patients living in Australia.

Reaching out to marginalised groups

Marginalised populations, including people who inject drugs (PWIDs), prisoners and those from culturally and linguistically diverse (CALD) backgrounds—such as aboriginal groups—have the highest prevalence of the virus and are thus key outreach targets for the national HCV strategy.

For PWIDs, who are identified by the strategy as the largest group at risk from the virus, the government supports needle and syringe programmes (NSPs) to provide access to clean injecting equipment and fulfil the objective of reducing transmission rates. It cites previous research, which found that PWIDs are more likely to engage with other infected users in peer education programmes. The government estimates that NSPs prevented 32,000 HIV and 97,000 HCV infections among PWIDs between 2000 and 2009, saving the country’s health system a total of AUS$1.28bn (about US$1.2bn at current exchange rates).

Those in custodial settings are considered to be at high risk of exposure to the virus because of the widespread use of non-sterile injecting equipment, as well as tattooing and piercing practices. A 2007 study put the share of prisoners testing positive for HCV antibodies at 35%—40 times higher than in the general population.[2]

Yet the government itself has noted that efforts to reduce the high rates of infection among prisoners remain hampered by restrictions on implementing the full range of harm-reduction interventions, particularly NSPs, and by the fact that individual states and territories have their own systems for police, courts and prisons, making it difficult to co-ordinate research and policy development.

It is a problem that has frequently undermined elements of Australia’s HCV strategy, according to Mr Wallace, who adds that getting state governments to implement programmes developed by the federal government has been a challenge. Overcoming legal barriers to evidence-based prevention strategies across states and regions and conducting a feasibility study into providing prison-based NSPs are among the priority areas for future plans.

Addressing stigma

Among CALD groups, aboriginals and Torres Strait Islanders are the main focus of the national HCV strategy. They have high rates of intravenous drug use and are over-represented in both adult and juvenile prisons, accounting for just under one-quarter of those in custodial settings. Although they make up only 2.4% of the country’s population, they constitute 8.3% of those infected with HCV.[3]

Alleviating discrimination and isolation is one of the biggest challenges in giving marginalised groups access to diagnosis and treatment. Disclosure of HCV status is frequently an obstacle to accessing support because it is perceived as contributing to social isolation and “often requires

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[2] *Third National Hepatitis C Strategy,* page 17.

[3] Ibid, page 4.

people to disclose participation in criminalised behaviours such as injecting drugs," the HCV strategy acknowledges. The Deadly Liver Mob, a peer education and outreach programme funded by the government, uses the aboriginal tradition of oral storytelling to spread the message about HCV.

Mr Wallace points out that while most people from groups likely to have been infected with HCV have been tested, diagnosed and are aware of their infection status, the majority have never received treatment from special liver services. "Specialist treatment services are located in specialist hospitals," he adds, noting that most of these are either far from patient populations or more challenging for them to access owing to social isolation. In addition, the government itself notes that limited capacity at treatment services remains a serious obstacle, with only 3,500 people treated per year out of some 6,000 needing treatment to avoid progressing to advanced liver disease.

Ms Tyrell notes that developing clearly defined targets that are signed off by Australia's federal health minister and eight state and territory health ministers will make it more likely that the next national strategy will succeed. Backing up measurable targets with the funds and manpower to fulfil them is another key precondition, adds Mr Wallace. "The development of strategies is absolutely fantastic, but unless you put resources for implementing them in place, they don't go very far," he says.

Although it differs in many respects from other countries in Asia-Pacific, Australia's experience holds lessons for other countries in the region as they shape their own HCV policies, and it is likely to play an important leadership role in sharing best practices for the development and implementation of national strategies.