Improving hepatitis C treatment access

Hepatitis Australian position

Access to subsidised antiviral therapy by Australians living with hepatitis C is restricted by:

- limited awareness of treatment options amongst people with hepatitis C and general practitioners
- limited access to specialist services
- limited healthcare infrastructure
- discrimination within health care settings and the general community that can deter access to medical services by people living with hepatitis

The Hepatitis Australian believes that the following actions are necessary to reduce barriers to treatment for people living with hepatitis C:

- **Enhance treatment access points.** Appropriate models of care to enhance accessibility to treatment particularly for those living in rural and remote areas, inmates and people who inject drugs- are needed.
- Expansion of practitioners authorised to prescribe antiviral therapy (s100 prescribers) is needed to enhance treatment access points. S100 prescribers should be expanded to include appropriately trained, non-specialist health practitioners, including general practitioners.
- Regardless of the model of care, access to adequately experienced and resourced allied health professionals should be assured for all undergoing treatment. The centrality of people with hepatitis C in determining models of care is crucial to the development of models that best meet the needs of those living with hepatitis.
- **A treatment awareness campaign targeting general practitioners and other health workers** to increase awareness of treatment options and side effect management.
- Continuation of **treatment awareness campaigns targeting those living with hepatitis C** and including information about options for managing side effects.
- **A general awareness campaign** targeted to reduce discrimination and stigma amongst health practitioners and the general community.

Due to the substantive barriers to treatment, in the short to medium-term, it is likely that the majority of people with hepatitis C will remain untreated. Further, individuals living with hepatitis C may choose not to under go treatment, be advised against treatment or treatment may not result in a sustained viral response. **It is crucial to provide appropriate health maintenance resources and support to those not accessing, or responding to, treatment.**

The Hepatitis Australia is calling for:

- The expansion of s100 prescribers to non-specialist health practitioners to ensure access to treatment providers for people living with hepatitis C.
- Implementation of a national treatment awareness campaign targeting general practitioners and health workers.
- Dedicated resources for a treatment awareness campaign targeting those with hepatitis C.

*For the purposes of this position statement treatment refers to pharmacotherapy aimed at achieving a sustained viral response. The Hepatitis Australia acknowledges that there are other forms of treatment used by people living with hepatitis C.

Background

In 2005, 264,000 people in Australia were estimated to have been exposed to the hepatitis C virus and 194, 270 Australians were estimated to be living with chronic hepatitis C. [1] For those living with hepatitis C, treatment has the potential to enhance quality of life by reducing symptoms, preventing the progression of infection and negating the potential of transmitting the virus. For people living with hepatitis C the alleviation of the emotional impact of living with a stigmatised condition may also be a motivation for undertaking treatment. [2]

The efficacy of treatments for hepatitis C has substantially improved in recent years. Pegylated interferon and ribavirin combination therapy is the current treatment standard. It is estimated to achieve a sustained viral response (or 'cure') in approximately 80% of genotype 2 and 3 and approximately 50% of genotype 1 cases (the primary hepatitis C genotypes in Australia[3]). [4]

Pegylated interferon and ribavirin combination therapy has been listed on the Pharmaceutical Benefits Scheme (PBS) since 2003. The progressive removal of PBS prescribing criterion in recent years has meant a greater proportion of those living with hepatitis C are eligible for subsidised treatment. [5]

Despite improvements in treatment efficacy and the broadening of PBS eligibility criteria, the number of people accessing treatment remains low. In 2005, approximately 2,079 individuals were receiving anti-viral treatment for hepatitis C. This is a very small proportion of these eligible for treatment. To decrease the number of people living with chronic hepatitis C it is estimates that current treatment rates would have to at least triple.[6]

Lack of awareness about treatment

Lack of awareness of treatment options has been identified as a key barrier to people with hepatitis C accessing treatment. In a study of approximately 400 Australian women undertaken in 2000, the primary reasons offered by those who had not undergone treatment for not accessing treatment included: never having heard of treatment (27%); believing they were not eligible for treatment (16%); and, deciding against treatment due to associated side-effects (17%).[7] Similarly, in a study of 312 Australian men undertaken in 2002, the primary reasons offered for not undertaking treatment included that they had never heard of treatment (42%).[8]

Awareness and knowledge have been associated with low treatment rates amongst people who inject drugs. In 2004 hepatitis C antibody prevalence among injecting drug users attending needle and syringe programs nationally was 60%. However only 5% of survey respondents reported ever receiving interferon-based treatment for hepatitis C. [9] A study of 100 people who inject drugs and who are living with hepatitis C found that knowledge relating to treatment was poor. Whilst 85% had heard of treatment, only half were aware that current injecting drug use was not an exclusion criterion for treatment. Less than half (43%) had discussed treatment with their health care worker. [10]

Limited knowledge about hepatitis C treatment and referral recommendations amongst general practitioners can limit access to treatment providers for those living with hepatitis. The review of the National Hepatitis C Strategy 1999/2000 to 2003/04 found that general practitioners are often ill-equipped to offer appropriate information, support or referrals to people with hepatitis C. [11] A study undertaken by McNally et al. addresses barriers to treatment access, including from the perspectives of GPs and specialist physicians. McNally et al highlighted the limited guidance for GPs and the differing available recommendations on when to refer a patient to a specialist. [12]

Accessibility of medical services

Limited access to medical services is a barrier to treatment for some living with hepatitis C, particularly those in rural and remote areas and in custodial settings. At present, antiviral treatment can only be administered by a liver specialist affiliated with a specialist hospital unit. Treatment is not available through GPs (outside of pilot environments), although they may be involved in patient 'workup' prior to commencing treatment or in shared care arrangements. Accessing services in specialised clinics for those in rural and remote areas may often require significant travel, expense and inconvenience and may not be feasible. Further, anecdotal evidence highlights the lack of health care support available in some rural areas for managing treatment and side effects. For those in custodial settings there may be no, or extremely limited, access to treatment services.

Limited health care infrastructure

It is highly unlikely that the current healthcare infrastructure will be able to provide the full range of treatment services to those who qualify for treatment. Anecdotal evidence suggest that currently, extensive hospital waiting lists in some States have meant that people with hepatitis C may wait up to two years from the time of referral for assessment at a gastroenterology unit. Whilst hepatology nurses and allied health professionals have been shown to be central to enhancing treatment outcomes[13], significant deficiencies in access to these ancillary care structures have been noted. [14]

The implementation of alternative care models and the expansion of those who are authorized to prescribe antiviral therapy (s100 prescribers) are likely to reduce the demand on specialist providers and enable greater treatment access. A number of alternative models of care have been trialed in Australia, including the accreditation of general practitioners as community prescribers and the use of remote clinics and visiting specialists. The potential for the greater role in treatment management for nurse practitioners and appropriately trained staff in sexual health or drug and alcohol services has also been raised. [15] A pilot of community prescribers in drug and alcohol services is expected to commence in the near future. A greater diversity in models of care and enhanced treatment access points may also increase access by those who may prefer to access treatment through a health worker they are acquainted or comfortable with.

Discrimination as a barrier to treatment

Discrimination experienced within health services, or fear of discrimination by health service workers, can also discourage people from utilising medial services and thereby reduce access to treatment and health maintenance support. [16] Anecdotal evidence continues to situate discrimination from health workers as a barrier to assessment of treatment options.

Research shows that people who inject drugs are less likely to receive referral to a liver specialist and are less likely to receive treatment after referral.[17] Similarly, a study of people who inject drugs, the majority of who were in treatment for drug dependency, found that whilst 73% reported seeing a health care professional for monitoring of hepatitis, less than half had discussed treatment for hepatitis C with a health care professional. [18]

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