HEPATITIS C - PREVENTION AND CONTROL POLICY

The Public Health Association of Australia notes that:

1. Hepatitis C is a blood borne virus that can cause liver inflammation and liver disease. The hepatitis C virus is transmitted when infected blood enters the blood stream of another person. It is rarely transmitted during sex and is not defined as a sexually transmissible infection.

2. The World Health Organisation (WHO) estimated in 2000 that there were approximately 170 million people with chronic infection worldwide with 3 to 4 million persons newly infected each year. In 2005 it was estimated that approximately 264,000 people were infected with hepatitis C virus (HCV) in Australia, with 197,000 of those cases being chronic infections.[1] Of the 197,000 people with chronic hepatitis C infection, around: 154, 000 (58%) were thought to have chronic hepatitis C and stage F0/1 liver disease; 38, 000 with chronic hepatitis C and F2/3 liver disease; and 5, 300 with HCV-related cirrhosis.[2.] The remaining 67, 000 people were thought to have cleared their HCV infection. HCV incidence was estimated to be 9,700 in 2005. [3]

3. Prison populations are at high risk, for example, the overall prevalence of hepatitis C among Australian prisoners is around 35%, rising to 56% among prison entrants reporting current or previous injecting drug use (IDU), compared with an estimate of 1.3% of the general community having been exposed to the hepatitis C virus.[4, & 5.]

4. In 2005, it was estimated that around 218, 000 (82.3%) of people infected with hepatitis C contracted the virus through sharing injecting equipment such as needles, syringes and other equipment used to inject drugs.[6.] Approximately 29, 000 (10.9%) of people with hepatitis C were thought to be from countries of high HCV prevalence who migrated to Australia with HCV antibodies, and around 18, 000 (6.8%) were thought to have been exposed to the virus through receipt of blood transfusions or blood products (prior to 1990 in Australia) or through other exposure routes such as non-sterile tattooing or body piercing or from mother to child (vertical) transmission.[7.]

5. Hepatitis C is not transmitted through social contact. Mosquitoes or other insects do not transmit hepatitis C.[8.] The risk of transmission of hepatitis C through medical or dental procedures in Australia is considered a minimal risk, due to standard infection control procedures and screening of the blood supply since 1990.

Around 25% of all people exposed to the virus will clear the infection in the initial six months post exposure and are not at risk of developing hepatitis C related liver disease. Chronic infection develops in around 75% of all people exposed to the virus. Progression to compensated cirrhosis occurs in 7% of those infected in early adulthood if they remain chronically infected over a twenty year period. Progression rates appear to accelerate with increasing duration of infection. Once cirrhosis is present, the annual rate for developing liver failure is 4%; the annual rate for developing hepatocellular cancer is 2% and annual mortality following cirrhosis is 2%.(op.cit MACASSH,pp.12) Other factors which affect the progression of liver disease include male gender; alcohol use; co-infection with hepatitis B virus and/or HIV; and obesity.[15]

6. Of 100 people who are infected with hepatitis C:
   - about 15 to 35 people will clear the virus completely;[9, & 10.]
   - of the 65 – 85 people who develop chronic hepatitis of variable severity, about 20 to 40 people may never experience any noticeable illness or symptoms;[9 – 12.]
   - after an average duration of around 15 years post initial infection, between 40 and 60 people have developed some level of long-term liver damage (i.e. liver fibrosis);[9 – 12.]
   - after 20 to 40 years or so, between 7 and 16 people have developed cirrhosis (5 – 10% at 20 years and a further 10 – 15% after 40 years); [11, 13, & 14.]
   - between 2 and 5 of these people with cirrhosis have experienced liver failure or developed a form of liver cancer known as hepatocellular carcinoma in a further 5 to 10 years; and[9 - 12.]
   - Duration of infection is the most likely determinant of the risk of cirrhosis and liver cancer.[15] Other factors which affect the progression of liver disease include: age when first infected; male gender; alcohol use; co-infection with hepatitis B virus and/or HIV; and obesity.[15]

7. At present, the approved treatment for hepatitis C is pegylated interferon and ribavirin. Sustained virological response (SVR) to treatment depends largely on the genotype of the virus and whether or not cirrhosis is present. SVR is achieved in between 73-83% of people with genotype 2 or 3 infection and between 41-57% of people with genotype 1 or 4 infection. [ref op.cit MACASSH p.22.] It is now accepted that sustained virological response equates to a cure. Side effects of treatment can be debilitating.

8. A diagnosis of hepatitis C is often a frightening and alienating experience with people often receiving inadequate or incorrect pre-test information or post-test counselling.[18 – 20.]

9. People with hepatitis C, often report discrimination due to the association of hepatitis C within a social construct of injecting drug use.[21 - 23.]

10. Annual treatment costs for hepatitis C are highly expensive, for instance between 2003 and 2004 the total cost of hepatitis C treatment pharmaceuticals to the Australian Government was approximately $28.1 million and the cost of

all medical, hospital, laboratory and pharmaceutical costs for the same period was estimated to be approximately $78.9 million.[24.] Such costs have significant implications both for individuals affected by hepatitis C and for Australia's health care sector.

By international standards, Australia initially responded well to hepatitis C by enhancing its hepatitis C-related education and prevention, treatment and care, and surveillance infrastructure through developing the initial *National Hepatitis C Strategy 1999-2000 to 2003-2004*. This strategy has since been evaluated and updated to the *National Hepatitis C Strategy 2005 – 2008.* [25.]

PHAA congratulates the RACGP for its work in raising the issue with GPs in Australia through its publication on Hepatitis C.

The Public Health Association of Australia recommends that:

11. An effective national response to hepatitis C includes:
    - strengthening partnerships among stakeholders and involving the affected community;
    - access and equity;
    - harm reduction;
    - health promotion; and
    - research and surveillance.

11. A) The *National Hepatitis C Strategy 2005 – 2008* be adequately resourced to achieve the following objectives:
    - ensure public recognition of chronic viral hepatitis as an urgent public health issue;
    - reduce transmission of hepatitis C infection through targeted and evidence based interventions;
    - raise awareness of hepatitis C transmission risks and improve knowledge and skills for sustaining preventive practices;
    - improve and increase the reach of prevention and education efforts;
    - maximize the health and wellbeing of people with hepatitis C;
    - reduce the personal and social impacts of hepatitis C infection;
    - increase the knowledge and skills of people affected by hepatitis C to help them maintain their health and quality of life;
    - ensure equitable access to health maintenance, care and support services for all people affected by hepatitis C, improve access to treatment and support, and increase treatment uptake among people with hepatitis C;
    - prevent discrimination and reduce the stigma and isolation experienced by people affected by hepatitis C;
    - to continue to monitor and evaluate the success of the strategy, its action plan and its programs;
    - to continue to improve the current hepatitis C surveillance system;
    - encourage clinical organisations such as the RACGP to continue to up-skill their members in the management of people with hepatitis C; and
    - resolve to encourage health care organisations to provide and regularly revise guidelines for the management of people with hepatitis C.

The Public Health Association of Australia resolves to:

12. Advocate for harm reduction measures to be widely available and accessible to groups or communities at risk of exposure to infection, working in collaboration with other NGOs.

13. Collaborate with other NGOs to change the policy focus of drug use and addiction from a law enforcement issue to a health issue, while acknowledging that law enforcement of some drug matters is appropriate.

14. Advocate for national model standards for health care in custodial institutions to be implemented in all jurisdictions in the public interest.

15. Advocate for the establishment of a National Corrections Standards and Monitoring Authority to monitor the treatment of people incarcerated in all Australian jurisdictions.

16. Work with Hepatitis Australia (formerly the Australian Hepatitis Council (AHC)) to assist in the implementation of the *National Hepatitis C Strategy*.

17. Aid in informing the public about the *National Hepatitis C Strategy*, using resources such as *'intouch'*.

18. Work with Hepatitis Australia and the Hepatitis C Partnership to integrate hepatitis C policies with other public health policies, including prison health reform.

19. Maintain hepatitis C as one focus in the Prison Health Conferences.

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