MAPPING PROGRESS TOWARDS AUSTRALIA'S NATIONAL HEPATITIS C STRATEGY TARGETS

MacLachlan JH[1,2], Thomas LA[1,3], Katelin Hayes K[3], Towell V[3], Allard N[1,2,4], Cowie BC[1,2,5]

[1] WHO Collaborating Centre for Viral Hepatitis, The Doherty Institute, [2] Department of Medicine, University of Melbourne, [3]Centre for Health Policy, Melbourne School of Population and Global Health, [4]Australasian Society for HIV, Viral Hepatitis, and Sexual Health Medicine, [5]cohealth, [6]Victorian Infectious Diseases Service, Royal Melbourne Hospital

Introduction
Australia has one of the most broad-reaching hepatitis C treatment access programs in the world, and initial uptake of treatments has been rapid. However considerable progress is still needed to achieve elimination targets and ensure the opportunity for treatment reaches all people who are eligible. We assessed variations in treatment uptake according to geographic area, to identify priority areas for improving access and expanding successful initiatives.

Methods
Chronic hepatitis C (CHC) prevalence according to Primary Health Network (PHN) and Statistical Area 3 (SA3) was generated by applying national estimates weighted by the distribution of hepatitis C notifications to the National Notifiable Disease Surveillance System. Data for all PBS-subsidised treatments were obtained from Medicare, including provider information and patient demographic data. Other sources including specialist workforce data and social health indicators were also incorporated.

Results
Prevalence of CHC varied substantially according to PHN, being highest in Northern Territory (1.87%), Western NSW (1.64%), and North Coast NSW (1.57%) PHNs, and lowest in Northern Sydney (0.41%), Eastern Melbourne (0.52%), and Adelaide (0.58%) PHNs. Average treatment uptake in Australia during the first year of DAA availability was 19%, however this varied according to PHN from 25.9% to 6.9%. There was larger variation within PHNs according to the constituent SA3s in each area. Many factors influenced treatment uptake, however uptake was generally lower in areas of higher prevalence, those with lower concentration of specialist physicians, and those with a higher burden of preventable adverse health outcomes and lower engagement with health care services.

Conclusions
Wide disparities exist in both burden of CHC and access to care within Australia. Identifying areas of greatest need can guide the delivery of programmatic responses in order to continue Australia's concerted efforts to eliminate CHC as a public health threat.

Disclosure of Interest Statement
No authors have any relevant conflicts of interest to declare.