

Mapping Progress Toward Australia's National Hepatitis C Strategy Targets

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A joint venture between The University of Melbourne and The Royal Melbourne Hospital



Australia's National Hepatitis C Strategy Targets

- Elimination focus
- No one left behind
- These goals require assessment of disparities in access to treatment
 - Existing variations in access to health care and in HCV burden – may be reflected in treatment
 - Important for assessing equity of access, prioritising regions of greatest burden

Priority outcomes for 2030			
The proportion of people experiencing and reporting hepatitis-C-related stigma and discrimination will be:	Between 2016 and 2030, the number of new transmissions of hepatitis C will be reduced by:	The proportion of all people living with chronic hepatitis C who are diagnosed will be:	The proportion of people living with chronic hepatitis C who are cured of the disease will be:
0%	90%	90%	90%

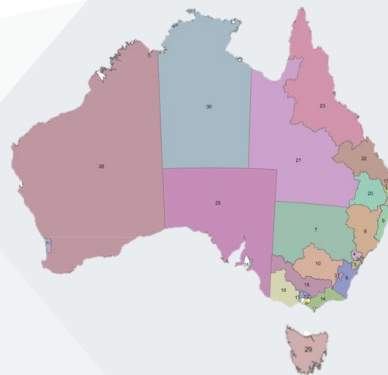
The National Viral Hepatitis Mapping Project

- Commonwealth government funded
- HBV since 2012
- Expanded to include HCV in 2016
- Provide locally relevant, geographically specific estimates of the burden of disease and of access to treatment and care
- Identifying priority areas, progress, gaps and disparities

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Mapping viral hepatitis

- Geographic areas:
 - All based on postcode of residence
 - **Primary Health Networks (PHNs)**: 31 in Australia, population 60,000 – 1.7 million
 - **Statistical Area 3, (SA3s)**: 332 in Australia, population 30,000-130,000
 - All assigned using **postcode of patient residence**



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Data sources – hepatitis C prevalence

Indicator	Estimation method	Source	Geographic basis
Prevalence	Calculated using national prevalence data assigned according to the proportion of notified cases	Published national prevalence data and National Notifiable Diseases Surveillance System data	Where a person who tested positive was living when they were tested

- Based on epidemiology of HCV in Australia, predominately people with history of injecting drug use
- National prevalence data (Kirby Institute¹) distributed according to number of notified cases 2007-2016
- Proportion diagnosed high – likely to generally reflect prevalence

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1. Annual Surveillance Report 2016

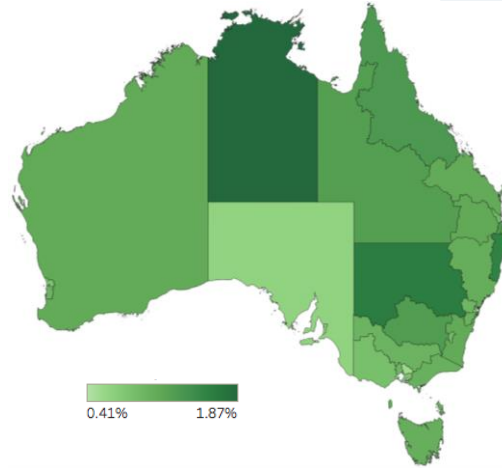
Data sources – treatment

Treatment	Number of scripts dispensed for antiviral medications indicated for CHC	Pharmaceutical Benefits Scheme data	Where a person was living when they were prescribed treatment
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- Medicare records of MBS services and PBS prescribing
- Combined with prevalence data to generate uptake
- HCV treatment in DAA era
- Includes all Medicare-eligible individuals

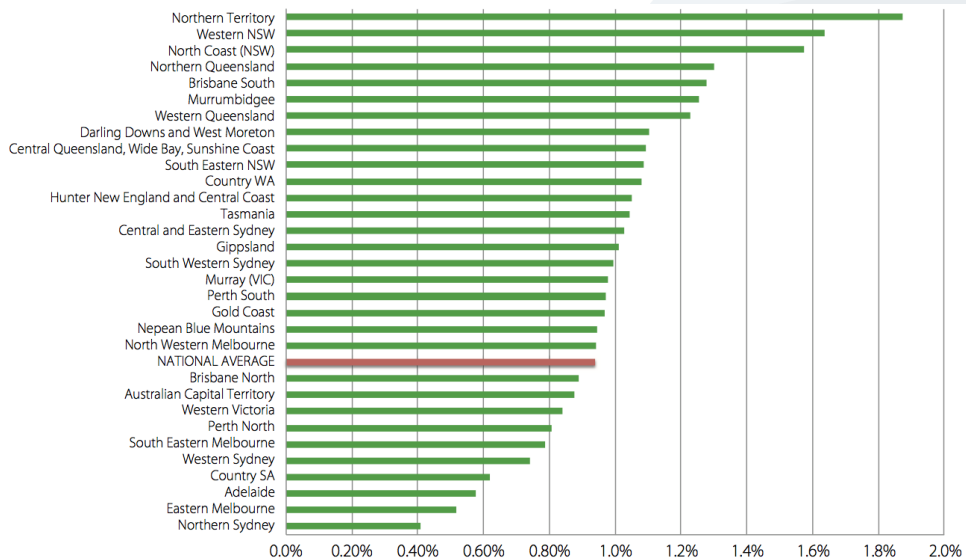
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Hepatitis C prevalence across Australia

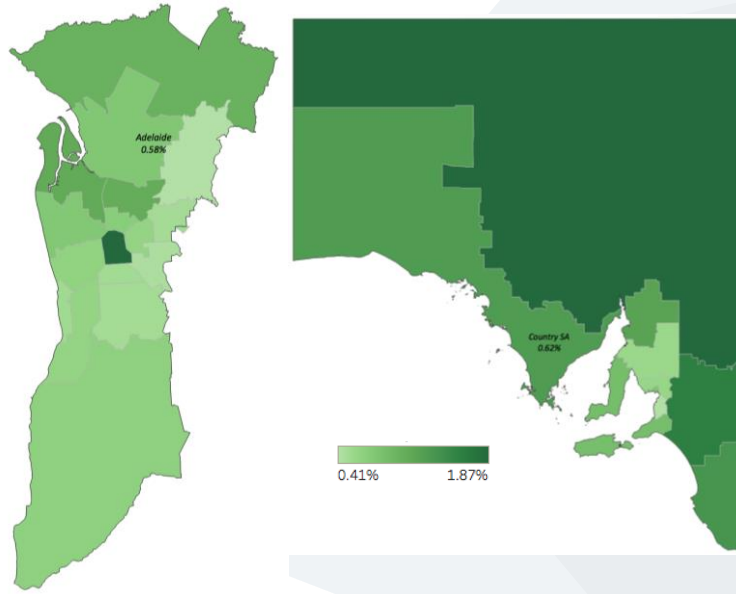


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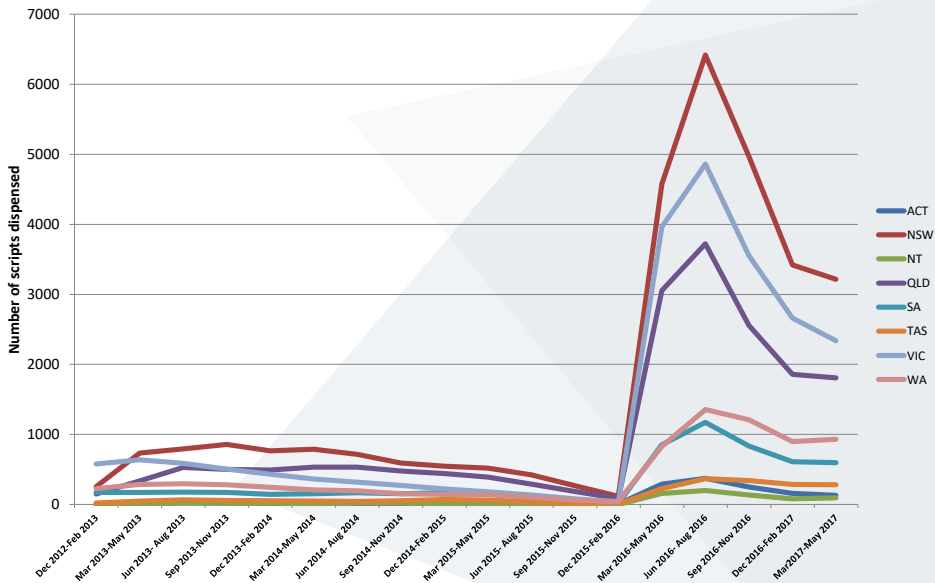
Estimated prevalence of hepatitis C according to PHN, 2016



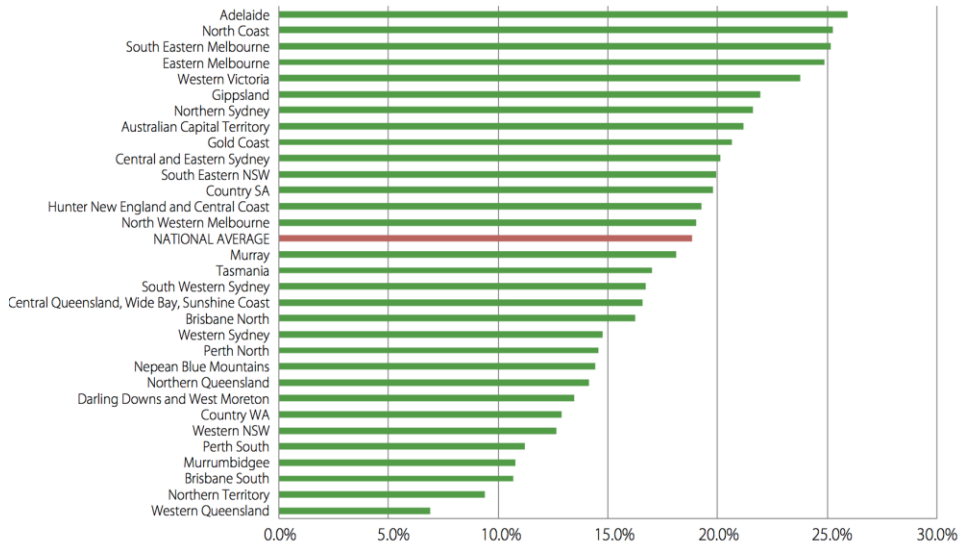
Hepatitis C prevalence in South Australia



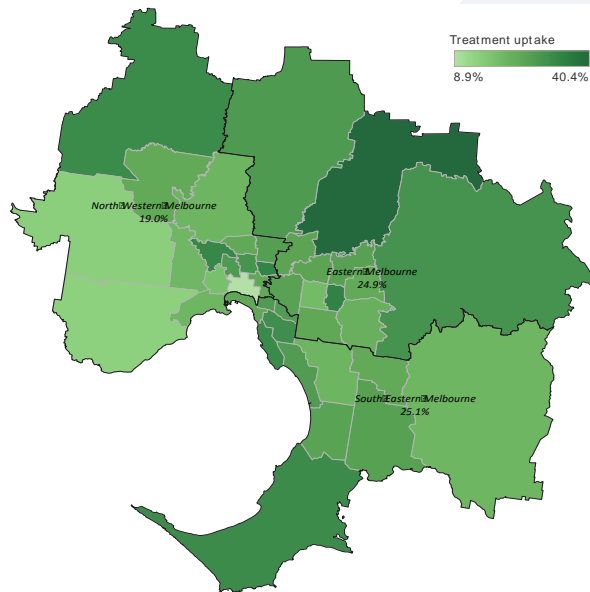
Hepatitis C treatment over time



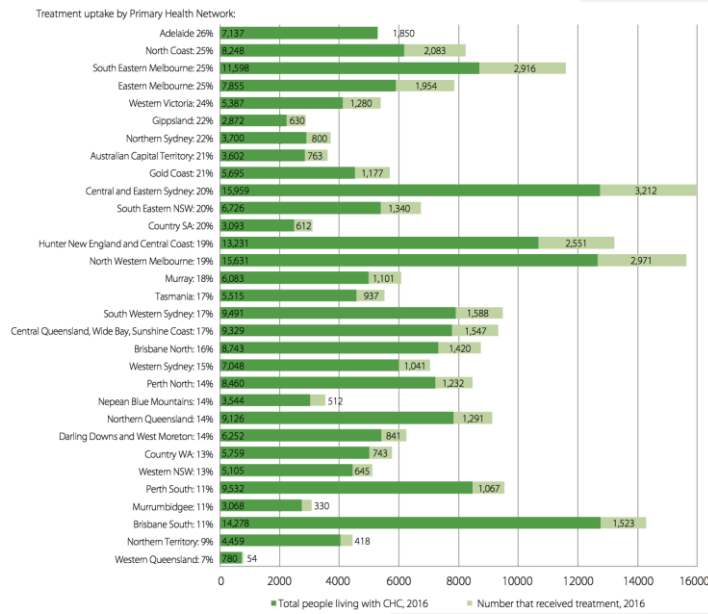
Estimated hepatitis C treatment uptake by PHN, 2016-2017



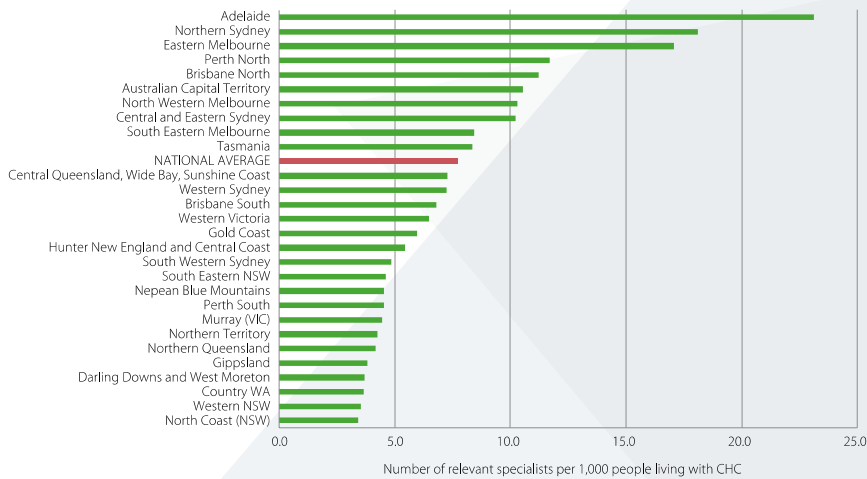
Melbourne: Estimated hepatitis C treatment uptake according to PHN and SA3, 2016-2017



Treatment relative to population size, by PHN, 2016-2017



Health service access: specialists per 1,000 people living with HCV



Limitations and next steps

- Data specificity for key priority populations: incarcerated persons, Aboriginal and Torres Strait Islander populations
- Information about outcomes (HCC)
- Notifications data limitations
- Feedback from stakeholders and local experts

Summary

- Prevalence of and treatment uptake for hepatitis C vary widely
 - Rural and regional areas over-represented
 - Predictors of treatment uptake include geographic factors, socioeconomic, and health service factors
- Data assist in identifying priorities for improvement and increased focus – advocate for action

Acknowledgements

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Our Research Advisory Group

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