

THE COST OF TREATING THOSE WHO REMAIN TO BE TREATED: THE CLINICAL EFFECTIVENESS AND COST OF A NURSE AND PEER-LED, MOBILE MODEL OF HEPATITIS C CARE ADJACENT TO THE COMMUNITY CORRECTIONS SETTING.

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Background:

Prison-based hepatitis C models of care treat significant numbers of people in Australia but exclude most people in contact with the criminal justice system; individuals serving their sentence in the community, on community corrections orders. This study evaluated the clinical effectiveness and cost of a mobile, nurse and peer-led model of care, offering hepatitis C virus (HCV) point-of-care testing and treatment initiation, adjacent to the community corrections setting in Melbourne, Australia.

Methods:

Individuals were approached by a peer worker within the vicinity of four community corrections offices and offered point-of-care HCV antibody tests and, if positive, point-of-care HCV RNA tests. Participants testing RNA positive were supported through direct-acting antiviral treatment by the nurse, including telephone reminders and check-ins. We report clinical outcomes and estimate non-drug service-provider perspective costs, including clinic infrastructure, staff wages, and testing costs. The mean cost per individual initiated on treatment and mean cost per cure detected (sustained virological response; SVR) were calculated.

Results:

Between September 2023 and November 2025, 1,221 participants were tested; 427/1221 (35%) were HCV antibody positive, 84/1221 (7%) were HCV RNA positive, 78/84 (93%) were initiated on treatment, and 44 (56%) returned for SVR and achieved cure. The median time between testing RNA positive and initiating treatment was 10 days. The mean number of contact episodes for RNA positive participants to initiate treatment was 11, and separately to support treatment completion was 15. The cost per participant initiating treatment was \$5,382.19 and per cure detected was \$7,613.83. Testing HCV RNA negative participants contributed to 84% of total program costs.

Conclusion:

High treatment initiation rates indicate that a mobile, nurse and peer-led model is effective at providing HCV care to the community corrections population. Service costs reflect a low-threshold, supportive model of care and case-finding in the context of declining community RNA prevalence.

Disclosure of interest statement: This study was funded partially by Gilead Sciences Pty Ltd via an independent medical grant, by a St Vincent's Hospital Inclusive Health Award, the Victorian Department of Health, and by a National Health and Medical Research Council Synergy Grant (GTN 2027497). The C No More study is supported by the Australian HCV Point-of-Care Testing Program. SG is supported by a Research Training Program Scholarship through Monash University. We

gratefully acknowledge the support provided to Burnet by the Victorian Government Operational Infrastructure Support Program.

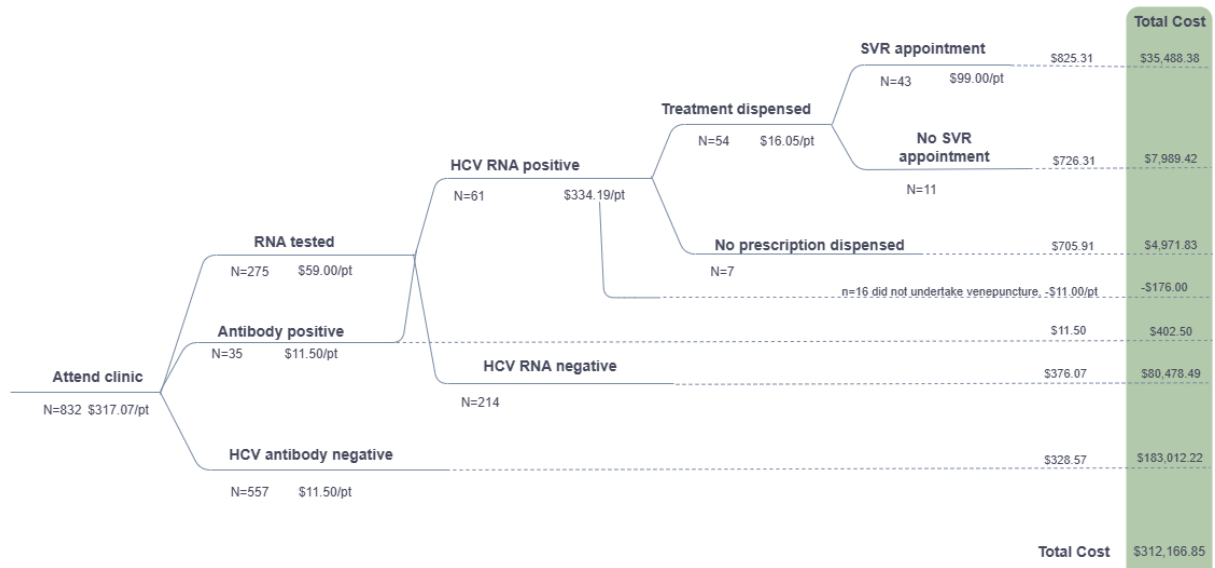


Figure 1. C No More patient pathway costs and total program cost, (n=832)*.

Notes: *A minority (n=35) of individuals received both antibody and RNA testing, as most individuals self-reported HCV antibody positivity and were reflexed to RNA testing. For simplicity, we have added the cost of the 35 antibody tests that preceded HCV RNA testing separately. Similarly, 16 individuals did not undergo venepuncture after testing HCV RNA positive, and we have deducted the cost from the total, but not created a new 'pathway'.