Hepatitis C in Australia — a role for general practitioners?

The availability of new antiviral agents opens the way for increasing GP involvement in the management of hepatitis C

The new direct-acting antivirals (DAAs) for hepatitis C virus (HCV) infections became available on the Pharmaceutical Benefits Scheme in March 2016. In September 2016, already over 10% of the estimated 230 500 Australians with chronic HCV infection had been treated.[1] While such rapid uptake was unanticipated, it may represent the low-hanging fruit of the HCV epidemic: patients already enlisted in tertiary clinics waiting for treatment. From an epidemiological perspective, the remaining untreated patients may fall under the radar of tertiary-based clinics. If Australia is to capitalise on the opportunities of universal access to DAA therapies, it will require the concerted efforts of general practitioners to improve rates of diagnosis, assessment, treatment and follow-up in the community.

HCV infection is common in people who inject drugs (up to 50%) and prisoners (about 30%).[2] Although the overall rate of HCV diagnosis has declined over the past decade, it has increased in the Aboriginal and Torres Strait Islander population to fourfold the rate in the non-Indigenous population.[2] Many of these at-risk groups face barriers in engaging with tertiary health services, and coordinating their complex care needs, including HCV treatment, will need to be undertaken in the community.

Although preventing new infections (eg, through needle exchange programs and proactive case finding) is important, reducing prevalence by treating people living with HCV infection before they develop progressive liver disease is key to curbing the pending epidemic of liver failure and hepatocellular carcinoma. Until recently, this was problematical because of long treatment duration, disappointing viral clearance rates and limited access. Only a small proportion of patients diagnosed with HCV infection had ever received treatment, and only half of those were cured.[2] The recent listing of DAAs on the Pharmaceutical Benefits Scheme authorises GPs to prescribe DAAs either in consultation with specialists or independently once experienced.[3,4] This is unique and is anticipated to increase access to treatment and improve health outcomes at a population level.

Access to treatment through general practice

GP involvement in delivering HCV treatment is a growing trend, with an increase from 4% to 19% in GP-initiated treatments between March and September 2016.[1] Internationally, trials of different HCV treatment models support the efficacy of community-based treatments, generally targeting at-risk population groups.[5] These models involve HCV clinics in opiate substitution or needle exchange programs, and outreach HCV prison programs.[6] Telehealth is used to up-skill practitioners in underserved areas[7] or facilitate patient–specialist interaction.[8] The Western Australian nurse-led program facilitates access in remote communities, but more involvement of GPs has been suggested.[9] The Queensland Injectors Health Network offers HCV treatment through their bulk-billing GP services to patients with chronic HCV infection, injection drug users or non-users.[10] The Beacon model brings specialists into the general practice clinic, allowing patients to stay in the community and GPs to learn how to manage them more effectively through direct interactions with visiting physicians.[11] This model was developed for complex diabetes care but has been expanded to the management of patients with HCV infection.

Obstacles and opportunities

To reduce the incidence of HCV infection, targeted measures in high risk and vulnerable groups are required, with a multipronged approach using different models. The vast majority of patients living with HCV infection are not actively injecting drugs, and may not have used drugs for decades. They live in the community and may suffer the stigma of HCV, posing a barrier to diagnosis and treatment.[12] Embedding HCV management in general practice can help to identify patients with HCV infection (and also those with undiagnosed cirrhosis), facilitate treatment initiation and improve treatment adherence. Protocols for work-up and treatment monitoring,[13] as well as tools for assessing interactions with other drugs already exist, training courses for GPs are held across the country, and qualitative interviews with Australian GPs reported satisfaction with the initiation training and willingness to engage with HCV management.[14]

Continuity of GP care creates further opportunities to monitor the long term effectiveness and safety of DAAs. More importantly, the whole person approach in general practice is fundamental to managing frequent comorbidities, such as mental health, chronic diseases and concomitant misuse of alcohol or other drugs. DAAs are costly, typically about $60 000–$90 000 per patient; it is therefore imperative that treatment is targeted and monitored well.

Partnerships across primary, secondary and tertiary care draw on the expertise of each partner to meet complex care needs and develop trusting long term relationships. Tackling HCV infection may lead the way for further innovations involving GP–specialist partnerships that bridge the existing divides to improve patient outcomes at an affordable price to society.

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