VIEWPOINT

Overcome Health Inequities to Eliminate Viral Hepatitis

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Viewpoint

In 2011, the Office of the Assistant Secretary for Health,[1] Department of Health and Human Services, released the first US Viral Hepatitis Action Plan to prevent the silent epidemic of hepatitis B virus (HBV) and hepatitis C virus (HCV) infections and subsequent mortality from liver cancer and liver disease. A year earlier, the National Academy of Medicine had called out viral hepatitis as an "underappreciated health concern for the nation."[2] Building on the academy's recommendations, the plan, developed by representatives from across the Department of Health and Human Services with input from multiple external partners, recommended 55 major strategies and some 150 specific, government-wide actions to prevent new infections and improve early diagnosis and treatment of viral hepatitis. An overarching theme of the plan was health equity by expanding access to prevention and care services for populations with an excessive burden of infection and disease.

When the plan was released, the incidence of HBV and HCV was highest for men who have sex with men and persons who inject drugs, respectively. Most persons living with HCV infection were older, born between 1945 and 1965 (baby boomers). Compared with others, African American individuals were twice as likely to be infected with HCV. And although they represented less than 5% of the US population at the time, half of all persons living with HBV were of Asian Pacific ancestry. Trends in mortality mirrored these disparities.

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Without question, progress has been made on the viral hepatitis front since the plan's release. The development of direct-acting agents, eventually leading to the availability of an all-oral, pangenotypic cure for HCV, is perhaps the most obvious advance. The safety and effectiveness of these new regimens have simplified the delivery of treatment, moving HCV care from the exclusive domain of liver and infectious disease specialists to include primary care clinicians. In 2012 the Centers for Disease Control and Prevention and the US Preventive Services Task Force recommended HCV testing as a preventive service with no co-pay for all baby boomers. In 2020, the recommendation was expanded to recommend HCV testing for all adults. The Centers for Disease Control and Prevention's recent recommendation for onetime universal HBV screening of all adults, coupled with the 2022 recommendation of the Advisory Committee on Immunization Practices for universal HBV vaccination of all adults, can lead to earlier diagnosis and entry into care for those who are chronically infected with HBV and timely vaccination of uninfected susceptible adults.[3] Partnerships have been forged with the commercial sector to supplement information obtained from traditional surveillance systems to better understand trends in viral hepatitis diagnosis and treatment,[4] and organized advocacy in support of viral hepatitis elimination has continued to gain ground since 2011.

However, both new and persistent challenges have marked the US viral hepatitis landscape in the intervening years. Increases in injection drug use linked to the US opioid epidemic fueled outbreaks of blood-borne infections, including HIV, HBV, and HCV. Although expanded access to syringe service programs—a strategy in the 2011 action plan and its subsequent iterations—can prevent the spread of infections and can serve as a bridge into needed clinical services, substance use treatment, and social services, many local jurisdictions continue to oppose their operation. And although many states have lifted Medicaid HCV treatment restrictions, most notably those calling for liver damage before treatment eligibility, other restrictions, especially prior authorization and sobriety requirements, continue to serve as impediments to timely HCV treatment.

During the last decade, the Office of the Assistant Secretary for Health in successive administrations has led efforts to update the national plan to combat viral hepatitis. Still, major disparities in disease burden persist.[5] The incidence of acute HCV infections has more than doubled since 2013, with the highest rates reported among American Indian and Alaska Native persons. Among the reported cases of acute HCV infection containing risk information, 66% report a history of injection drug use. The rate of newly reported chronic HBV cases among Asian and Pacific Islander persons is nearly 12 times the rate among non-Hispanic White persons. Disturbing disparities also characterize the related mortality data. Rates of HBV-associated deaths are almost 9 times higher among Asian and Pacific Islander persons than among non-Hispanic White persons, and HCV-associated death rates among American Indian and Alaska Native persons and non-Hispanic Black persons are 3.2 and 1.8 times higher, respectively, than among non-Hispanic White persons.

When oral treatments can cure HCV, when improved vaccines can prevent HBV, and when disease monitoring and antiviral therapy can reduce HBV-related morbidity and mortality, these disparities are truly jarring and they send an unequivocal message. The na-

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tion must direct more aggressive attention to health inequities. Otherwise, the US will fail to meet its hepatitis elimination goals. Adopting policies that enable access to current approaches to prevention and treatment, although helpful, will not by themselves achieve health equity. The nation must also prioritize populations disproportionately affected by HBV and HCV, locate low-threshold prevention and care services in settings that serve persons with high disease burden, and ensure that the systems in place to treat infected individuals and care for at-risk populations do more than pay lip service to the social factors influencing health outcomes.

Applying the foundational principle of health equity found in the Healthy People 2030 framework[6] to viral hepatitis elimination will require not only improved access to diagnostics, vaccines, and treatments but also an unwavering commitment to work with a broad range of partners, including those who are affected by HBV and HCV. Coalitions at both the national and community level can contribute to health equity by advocating for the revision or removal of laws and policies that restrict access to viral hepatitis services, promoting outreach to underserved populations, and ensuring that hepatitis prevention and treatment services are patient centered and connect to the needed behavioral, drug treatment, and social services.

The recently proposed program to eliminate HCV in the US, included in the administration's fiscal year 2024 budget proposal, is, without doubt, a welcome development.[7] The proposed program's stated focus on persons with poor access to health care who experience social inequities and are likely to be encountered in high-impact settings such as correctional facilities and substance use treatment clinics evidences a clear emphasis on addressing health disparities. But, as noted by others who have worked to engage high-risk populations in HCV care—in this instance, persons who inject drugs—even when low-threshold care is made available, structural variables such as homelessness and lack of social support can pose substantial barriers to engagement and retention in treatment.[8]

Raising concerns about the social, economic, environmental, and structural barriers that can affect hepatitis elimination outcomes does not mean we are dismissive of efforts to expand prevention, treatment, and care for HBV and HCV. Instead, we seek to emphasize the critical importance of addressing those nonclinical factors that can substantially influence an individual's willingness to engage in hepatitis prevention and treatment services.[9] Developing multipartner coalitions and working closely with affected communities will help to resolve viral hepatitis prevention shortfalls and close the current gaps found in HBV and HCV care cascades. The 2011 action plan set the nation on course to improve viral hepatitis outcomes. Now it is time to end the silent epidemic of viral hepatitis by an all-out effort to dismantle health inequities.

ARTICLE INFORMATION

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Additional Information: Dr Valdiserri is the former US Deputy Assistant Secretary for Health for the Department of Health and Human Services. Dr Koh is the former US Assistant Secretary for the Department of Health and Human Services. Dr Ward is the former director of the Division of Viral Hepatitis for the Centers for Disease Control and Prevention. All were involved with the 2011 Viral Hepatitis Action Plan during their service.

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