

understandable that Colleges, because of their unique expertise, may undertake some contractual work for governments or other organisations to assist in improvements to healthcare, this must be done with great caution. Colleges should ensure they are not influenced by the provider of the funds; furthermore, it would be extremely unwise to build up a significant College bureaucracy or facilities that are dependent on such external funding.

Equally, Colleges should be extremely reluctant to become fundholders for government-sponsored training programs or to build up organisations dependent on such funding. Political decisions, as has recently happened with the training program for general practitioners, can place a College in a very difficult position. The threat of removal of such funding and the resulting impact on the financial viability of a College could temper criticism of the policies of government or other organisations.

These issues have received considerable attention in North America and Europe. Pellegrino and Relman³ recently argued strongly that a professional organisation such as a Medical College can not become involved in protecting its members' financial welfare or other narrow professional interests: "It would be far better . . . for physicians to promote patients' interests on ethical and medical

grounds as members of medical associations than to seek confrontation as union members. In our view, unions and truly professional associations are simply incompatible." These sentiments obviously have parallels in Australia.

As the eminent ethicist Sullivan⁴ points out, true professionalism depends on the moral contract between the professional and society. It is only when the responsibility to patients and to the public interest is held to be paramount that members of the medical profession can expect society to accept self-regulation of the profession and to listen carefully to proffered opinions and advice. Colleges must continue to promote these principles to their Fellows and trainees, and Colleges and their Fellows must demonstrate to society their commitment to them.

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Hepatitis C: where are we at and where are we going?

We are making progress in our understanding of the hepatitis C virus, but there is still a long way to go

THE IDENTIFICATION of the hepatitis C virus (HCV) in 1989¹ delineated a disease previously masquerading under the title of "non-A, non-B hepatitis". In the ensuing years, hepatitis C has become a national epidemic, with more than 150 000 Australians known to be infected. It is estimated that an additional 11 000 new infections occurred each year during the 1990s.² Escalating rates of HCV infection will have enormous consequences, as 10%–15% of people infected have the potential to progress to end-stage liver disease, with all the implications that has for healthcare services in the years ahead.³

Australia has taken many unique steps in its handling of the hepatitis C epidemic. In 1994 and 1997, the National Health and Medical Research Council published two major reports from working parties comprised of specialists, general practitioners and community representatives.^{4,5} These were seminal in directing approaches to the diagnosis, treatment and management of HCV-infected people and, to a lesser extent, prevention of further spread. Indeed, Australia was the first country to develop a National Strategy for HCV.^{6,7} NSW Health has held successful Hepatitis C Awareness Weeks in 2000 and, more recently, in 2002, which have increased public awareness of many issues relating to HCV. NSW Health has recently released a Treatment and Care Plan for HCV, which, among other

things, emphasises the importance of GPs in the evaluation and management of HCV-infected people.⁸ The possibility of accrediting appropriately trained GPs to prescribe antiviral therapy for HCV is also discussed.

So, where are we going?

The recent report by the Anti-Discrimination Board of NSW on hepatitis-C-related discrimination presents compelling evidence that there is still much to be done if we as a society are to be seen to be dealing caringly and rationally with this disease.⁹ The report highlights the disturbing reality that most discriminatory actions against people infected with HCV are perpetrated in healthcare settings.

The HCV Projections Working Group of the Australian National Council on AIDS, Hepatitis C and Related Diseases, which advises the federal Minister for Health on these diseases, will report later this year on the increasing rate of HCV acquisition, highlighting the imperative of improving our prevention strategies. The rate of infection is increasing, in large part, because an increasing number of young people are choosing to commence injecting drug use. While public messages on safe injecting practices are promoted widely, many young people ignore these messages in their early phase of drug use. The HCV antibody prevalence rate in those injecting for less than three years fell from 22% in

1995 to 13% in 1997,¹⁰ but, despite enormous efforts to increase the availability of clean needles to users, the rate has not dropped any further.

Treatment availability and efficacy also remain problematic. Australia offers, through the “highly specialised drugs” program, combination therapy with alpha interferon and ribavirin, providing a sustained viral response rate of 40% overall (ie, in 40% of treated patients, HCV RNA remains undetectable by polymerase chain reaction) (patients with HCV genotype 2 or 3 can expect a 60%–70% sustained response rate).¹¹ By limiting treatment to patients with fibrosis on liver biopsy, the Pharmaceutical Benefits Advisory Committee led, rather than followed, a trend to downplay the need for treatment of all patients. This has highlighted the need for management strategies for those not eligible for, or choosing not to have, treatment. Many major centres now offer support services and education programs, allowing individuals to defer treatment, awaiting better options in the future.

Progress is being made in providing better services for prison inmates, among whom there is a high prevalence of HCV infection. In the past, access to therapy has been limited, but the appointment of specialists to Corrections Health services and the funding of a health study of the Tasmanian corrections system is changing that. Prevention strategies are harder to implement. Bleach is made available in most prisons, and methadone programs are expanding, but needle/syringe programs are not available.

HCV-infected people from non-English-speaking backgrounds have the added problem of a language barrier. Treatment facilities have become increasingly aware of the need to provide special support for these patients. This is particularly needed if antiviral therapy is to be commenced.

What needs to be done better?

■ Greater attention must be directed to reducing spread within the most at-risk community, namely our population of injecting drug users. This group remains marginalised for reasons that are easy to explicate but difficult to overcome. Debate must continue on optimal ways to reduce the risk of young people contracting HCV infection. Needle/syringe programs, while unpopular with many people in our society, have the potential to reduce the risk and must be supported by those who are in a position to influence policy.

■ We need to increase public awareness of the improved efficacy of treatments. We also need to direct more effort towards improving the evaluation and assessment of patients by GPs before referral to busy liver clinics, so that only those who are eligible for and wanting treatment are referred.

■ The HCV research effort requires further support from major funding bodies, and relevant groups are pursuing this actively. A greater understanding of the virus, the mechanisms of viral clearance and the immunopathogenesis of the disease is required urgently. Research is under way to develop a vaccine.

In summary, we are some of the way there, and making progress, but there is still a long way to go!

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