

times are all contributing to a situation in which Ireland is getting poorer value for money as patients need costlier treatment, which exacerbates the problem further.

The cross-party parliamentary Committee on the Future of Healthcare released its report in May, 2017, setting out a 10-year plan for the Irish health system.⁷ The report recommends additional spending of €2.8 billion per annum by the end of its 10-year horizon, over and above additional spending arising from an ageing population and medical inflation.

The Irish health system requires extensive structural reform to improve access for public patients at hospital level and private patients at GP level. But equally, the required reforms will not succeed without more investment in the system. It is not a question of either/or, but rather both. In the meantime, expectations for health system performance should be tempered by consideration of historic underfunding.

I declare no competing interests.

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Tackling hepatitis C—Pakistan's road to success

In November, 2017, the annual World Hepatitis Summit in São Paulo, Brazil, assessed WHO's global health sector strategy on viral hepatitis 2016–20, and called for prompt, innovative, and coherent interventions, along with evidence-based research.¹ The viral hepatitis pandemic caused an estimated 1.4 million deaths in 2015, and yet has received inadequate attention from donors and policy makers until recently, as outlined in an Editorial in *The Lancet* (Nov 11, 2017, p 2121).² New data indicate that action has been fragmented and insufficient, with only 82 countries, including Pakistan, adopting strategies to eliminate viral hepatitis by 2030.

Pakistan has the second highest global burden of hepatitis C virus (HCV) infection, with 5% of the population infected (ie, 8 million people).^{3,4} Most of the people who are infected in Pakistan do not know their hepatitis status. Delayed diagnoses result in chronic liver disease, hepatocellular carcinoma, and cirrhosis, further burdening the economically poor country. Risk factors identified for the transmission of HCV in Pakistan are different to those of developed countries. Intravenous drug use was identified as the major risk factor for transmission in developed countries, whereas in Pakistan the reuse of syringes for unnecessary therapeutic purposes was found to be the most important factor.⁵

Understanding the seriousness of the situation, the Government of Pakistan launched its first National Hepatitis Strategic Framework (NHSF) covering the period 2017–21, which closely follows the WHO global health sector strategy on viral hepatitis while accommodating for Pakistan's limited resources and huge burden of disease.⁴ According

to WHO, 95% of people infected with HCV can be cured within 2–3 months with highly effective direct-acting antiviral (DAA) drugs.⁶ Licensed treatments for HCV infection in Pakistan include pegylated and standard interferon, ribavirin, and DAA drugs (eg, sofosbuvir). The government has introduced new DAA drugs that could cure up to 90% of the infected population and made generic sofosbuvir available at US\$15 for 400 mg—the lowest price worldwide.⁴ As a result, the number of people receiving HCV treatment has more than doubled.⁴

Prevention is the key to fighting viral hepatitis. Speakers at the WHO summit agreed that, without improvements in diagnosis and care, dropping the price of medicine will not make a difference. Hence, screening for hepatitis along with preventive interventions must become key pillars of Pakistan's elimination strategy. On the basis of the 2015 WHO guidelines on injection safety,⁷ the NHSF introduced a policy to ensure that syringes used in the health sector are auto-disabled, thus preventing the reuse of syringes and eliminating a major risk factor for HCV in the country. The Government of Pakistan now provides free diagnosis, treatment, and care for patients with HCV, protecting them from considerable health costs.⁷ Furthermore, patients infected with HCV now have free access to new oral medicines. These policies from the Government of Pakistan show that commitment, not finance, is a major barrier to elimination, a subject that was an important part of the WHO summit discussion.¹

Although Pakistan's commitment and bold vision to eliminate HCV infection by 2030 is encouraging, the country has a long way to go. Sustained political commitment is essential for effective implementation of the NHSF. The country should also develop an extensive monitoring and evaluation system for the

NHSF, ensure the safety of all health professionals, and make care easily accessible to even the most marginalised communities. These steps are important to stop the huge numbers of preventable deaths each year and to achieve universal health coverage in Pakistan.

We declare no competing interests.

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Issues with measuring hepatitis prevalence in resource-limited settings

We read with interest the Correspondence from Noemi García-Tardón and colleagues (Sept 23, 2017, p 1485)¹ describing the prevalence of HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV) infections among blood donors in Sierra Leone. Considering there are few data on

viral hepatitis from the region, the authors should be congratulated for their efforts. However, we fear that some of their results and messages might be misleading.

Although the reported proportion of individuals with positive anti-HCV antibodies is high, many serological assays overestimate the prevalence of HCV infection. In a meta-analysis of studies of people living with HIV in Africa,² we found that, in western Africa, the prevalence of HIV-infected people with a positive HCV serology was 6.9%, but that among the study population the prevalence of those with positive HCV RNA testing was 2.1%. As highlighted in the 2016 WHO hepatitis testing guidelines,³ clinical and programmatic recommendations should only be made on the basis of virologically confirmed HCV prevalence estimates. Therefore, more detailed data from western Africa than are available are required to guide implementation of hepatitis care strategies and national action plans.

García-Tardón and colleagues propose that the Ebola virus disease epidemic, which severely affected Sierra Leone, could explain the poor response to viral hepatitis in the country. This statement is questionable, since viral hepatitis care is insufficient throughout western

Africa, independent of other health-related issues. We have shown^{4,5} that the uptake of hepatitis testing in HIV clinics from the International Epidemiology Databases to Evaluate AIDS (IeDEA)⁶ consortium was poor across sub-Saharan Africa, and that physicians had little knowledge of HBV infections. To understand the reason for these gaps in hepatitis care, we did a web-based survey across 35 mainly urban African HIV clinics from 17 countries within IeDEA. Despite widespread availability of HBV and HCV serological tests, only two clinical sites (6%) were found to do routine HCV testing and 13 (37%) did routine HBV testing. Few sites had access to confirmatory viral load assays, with three (9%) sites having HCV RNA testing and 11 (31%) sites having HBV DNA testing (figure). Public health strategies designed to tackle the viral hepatitis epidemics in Africa will only be successful if they are driven by more complete epidemiological data, knowledge of the local barriers to care, and political will.

GW received a grant from the Swiss National Science Foundation. MHK reports grants from the National Institutes of Health. ME reports grants from the National Institutes of Health. The other authors declare no competing interests.

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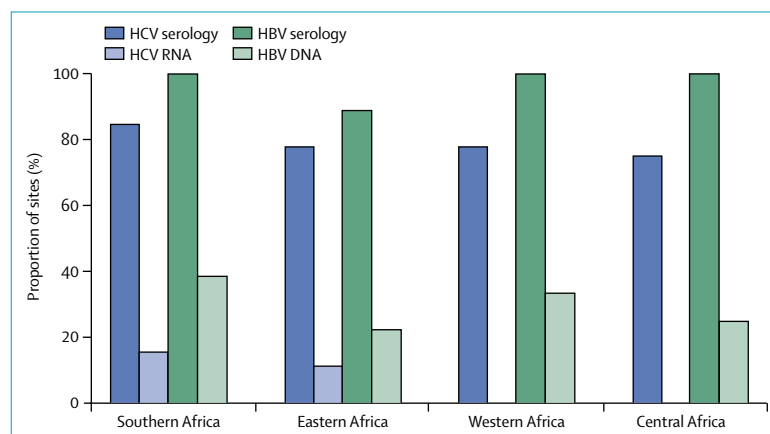


Figure: Availability of HCV and HBV diagnostic tests in 35 HIV clinics across sub-Saharan Africa
Data are from the International Epidemiological Databases to Evaluate AIDS collaboration.⁶ HCV=hepatitis C virus. HBV=hepatitis B virus.