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https://youtu.be/XR9q77gVqJ8

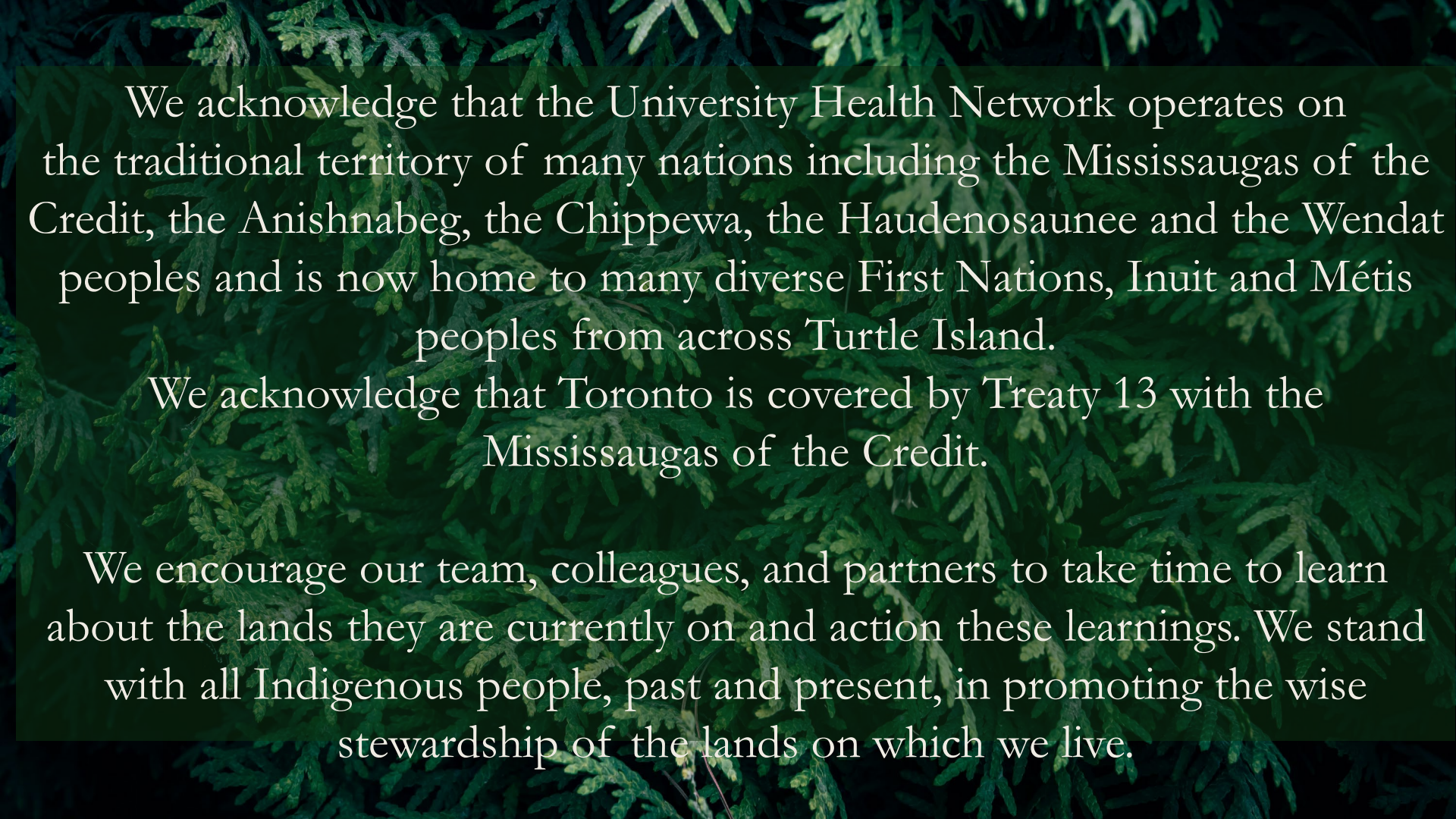
Please scroll down this file to view a copy of the slides from the session.

Bridging Hepatitis C Care Gaps: A Modeling Approach for Achieving WHO Hepatitis C Elimination Targets in Ontario, Canada

Dr. Yeva Sahakyan
Scientific Associate
Health Systems and Policy Research Collaborative Centre, UHN

Dr. Beate Sander
Senior Scientist
Health Systems and Policy Research Collaborative Centre, UHN

Dr. Hong Anh Tu
Health Economist
Health Technology Assessment, Ontario Health



We acknowledge that the University Health Network operates on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples from across Turtle Island.

We acknowledge that Toronto is covered by Treaty 13 with the Mississaugas of the Credit.

We encourage our team, colleagues, and partners to take time to learn about the lands they are currently on and action these learnings. We stand with all Indigenous people, past and present, in promoting the wise stewardship of the lands on which we live.

Disclaimer

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Learning Objectives

- Identify key strategies for scaling up hepatitis C services in Ontario to meet WHO’s hepatitis C elimination goals.
- Discuss the timeline and feasibility of achieving the WHO's hepatitis C elimination goals.
- Assess the cost-effectiveness of presented strategies.
- Describe the use modeling techniques and economic evaluation to assist OHTAC’s funding recommendations in Ontario and guide policy decisions.

UHN Health Systems & Policy Research

SEPTEMBER 2025

Bridging Hepatitis C Care Gaps: A Modeling Approach for Achieving WHO's Targets in Ontario, Canada

Presenters: Yeva Sahakyan, Beate Sander

Chronic Hepatitis C Burden

- Affects **55 million** individuals worldwide
- Lead to life-threatening complications
  - Liver cirrhosis
  - Hepatocellular carcinoma
  - Liver failure and transplantation
- Responsible for **290,000** annual liver-related deaths

World Health Organization. *Hepatitis C Fact Sheet*. https://www.who.int/news-room/fact-sheets/detail/hepatitis-c

UHN Health Systems & Policy Research

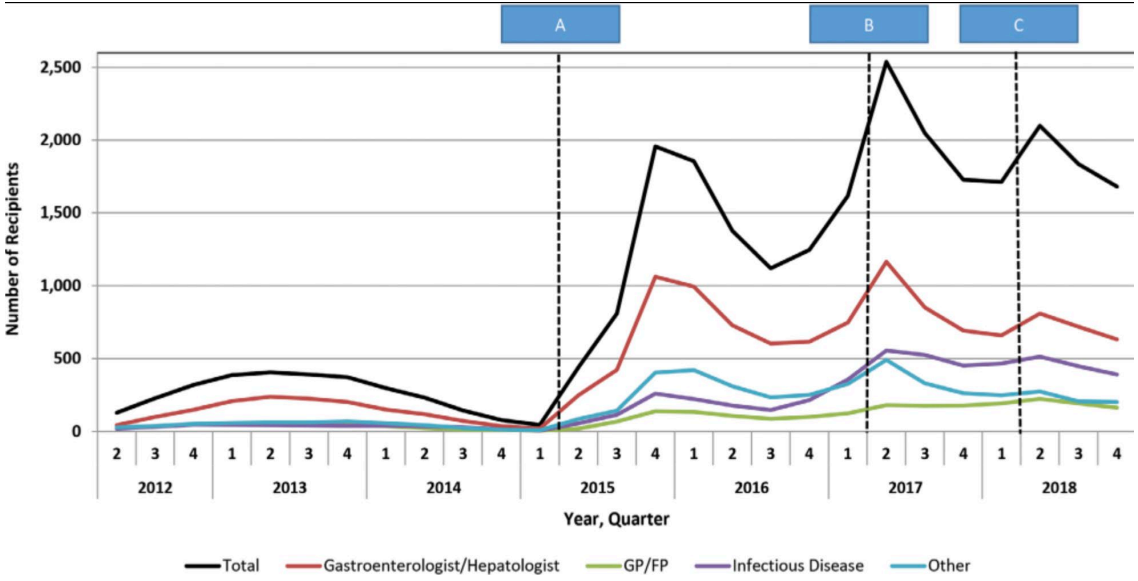
DAA Coverage Policy and Prescribing Trends in Ontario

Direct-acting antivirals

- Cure rates **>95%**
- Favorable safety profiles
- Opportunity to eliminate HCV as a public health concern

Coverage policy in ON

- Q1 2015: initial DAA coverage through prior authorization program
- Q1 2017: expanded listing of all DAAs as limited-use products
- Q2 2018: the introduction of newer DAAs



Tadrous et al (2021). Prescribing trends in direct-acting antivirals for the treatment of hepatitis C in Ontario, Canada

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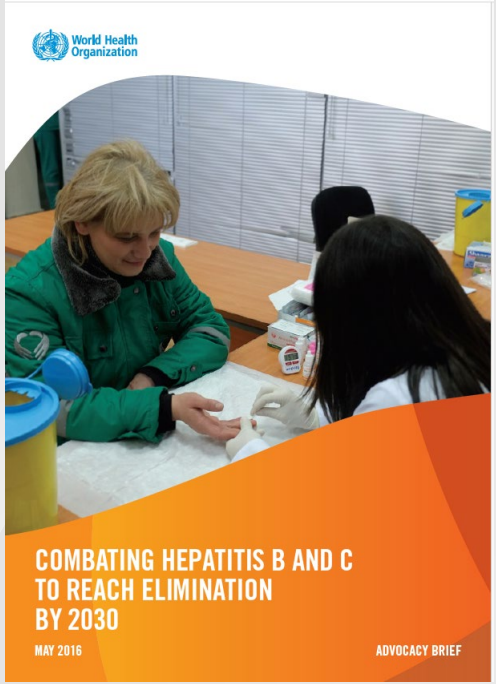
WHO's 2030 HCV global elimination goals

- Reduce new infections by 90%
- Diagnose 90% of people living with hepatitis C
- Initiate treatment for 80% of people living with hepatitis C
- Reduce mortality by 65% compared with 2015 levels



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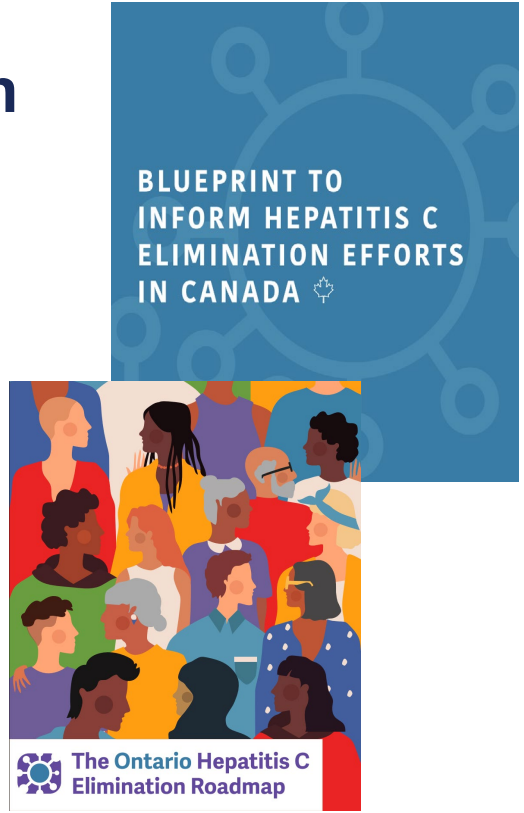
Canada's Commitment to HCV Elimination

- Identify gaps along the HCV care-cascade: diagnosis, linkage to care, treatment, and cure

- Ontario Roadmap calls for intensified testing and treatment scale-up
  - Current screening: risk-based, targeting high-risk groups

- Ontario is lagging in HCV elimination progress



JJ Feld et al (2022) Timing of elimination of hepatitis C virus in Canada's provinces
CATIE. Three Canadian provinces not on track to eliminate hepatitis C by 2030

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Objective

To identify the level of service scale-up and investments needed along the “HCV care-cascade” to achieve the WHO’s HCV elimination targets by 2030 in Ontario, Canada.

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Methods

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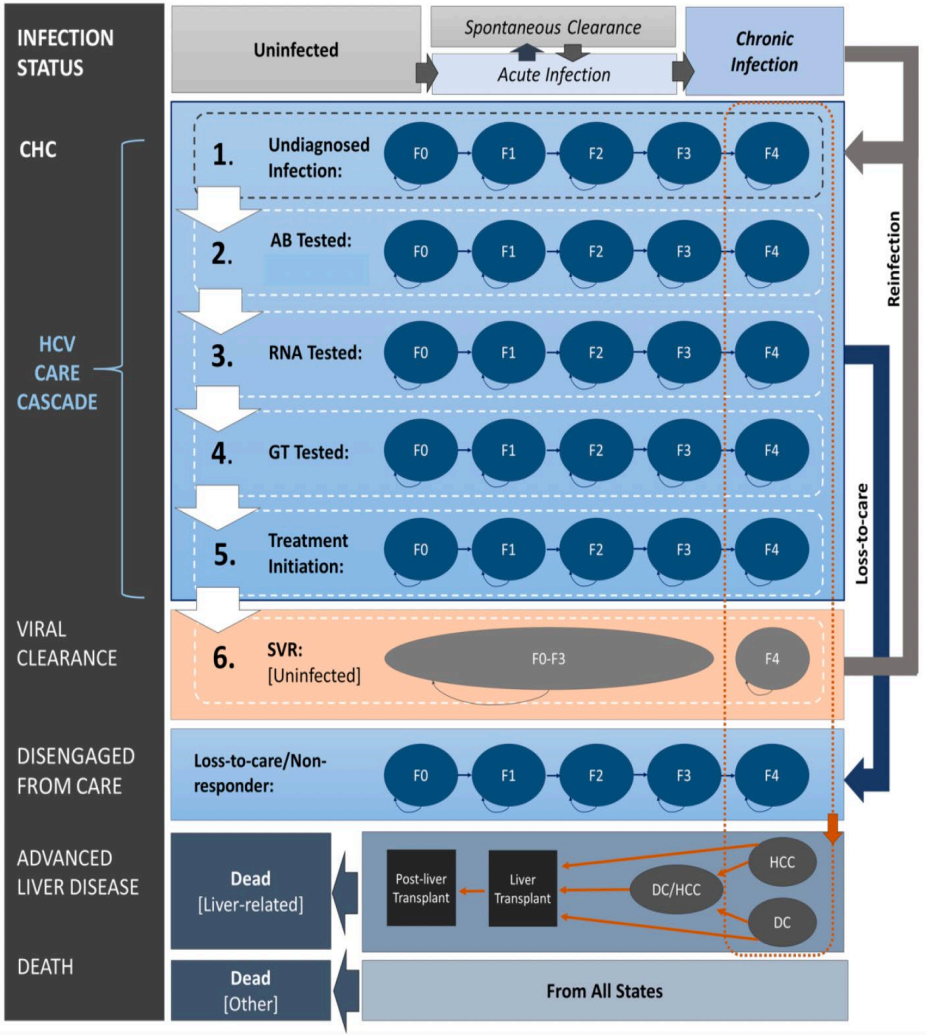
Economic Analysis

Design: Cost-utility analysis using a decision-model
Population: Individuals with HCV in Ontario
Comparators: Scale-up *vs.* Status quo
Outcomes: Mortality, quality-adjusted life years (QALYs), health system costs
Perspective: Ontario health system
Time horizon: 2018-2030 (12 years)
Cost-effectiveness threshold: CA $50,000 per QALY gained

Model Structure

ON population stratified into:



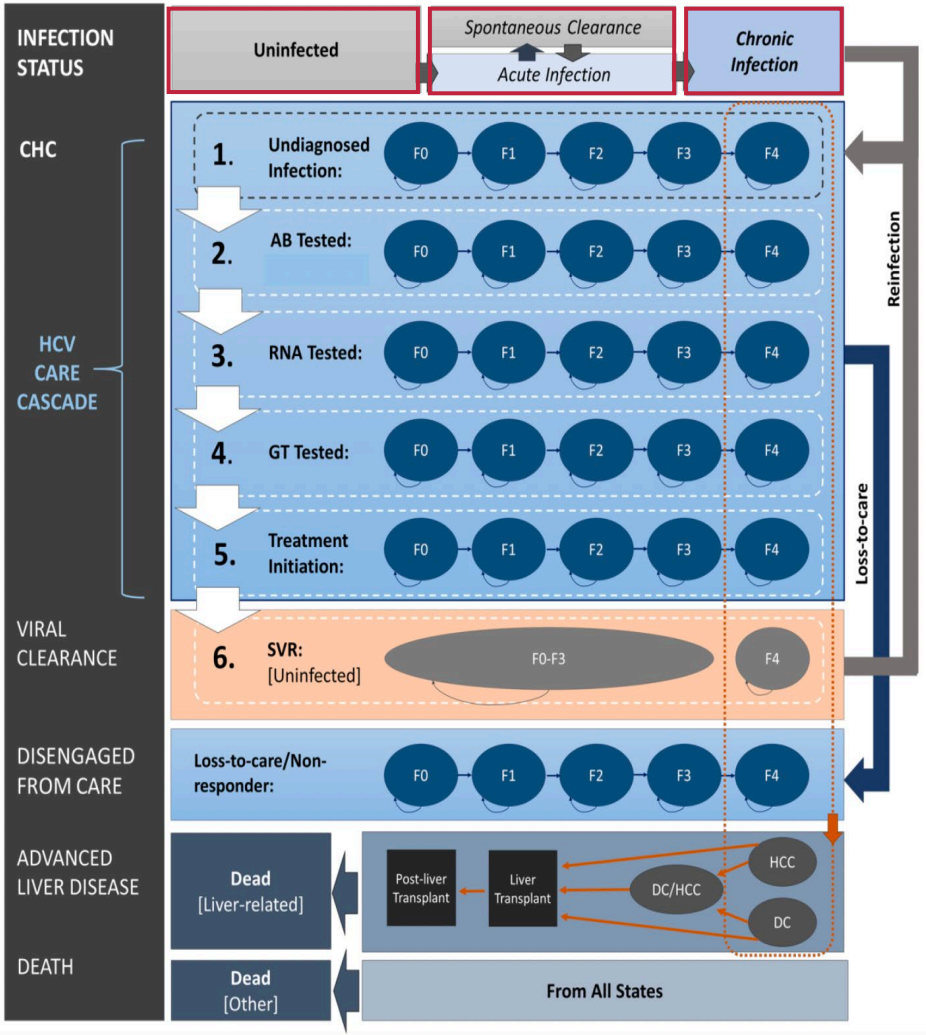
AB: antibody; CHC; chronic hepatitis C; (F1-F4): fibrosis stages;
GT: genotype; ON: Ontario; SVR: sustained viral response

Model Structure

ON population stratified into:

HCV UNINFECTED

- Can become infected with HCV
  - → Spontaneous clearance
  - → Chronic HCV



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ON population stratified into:

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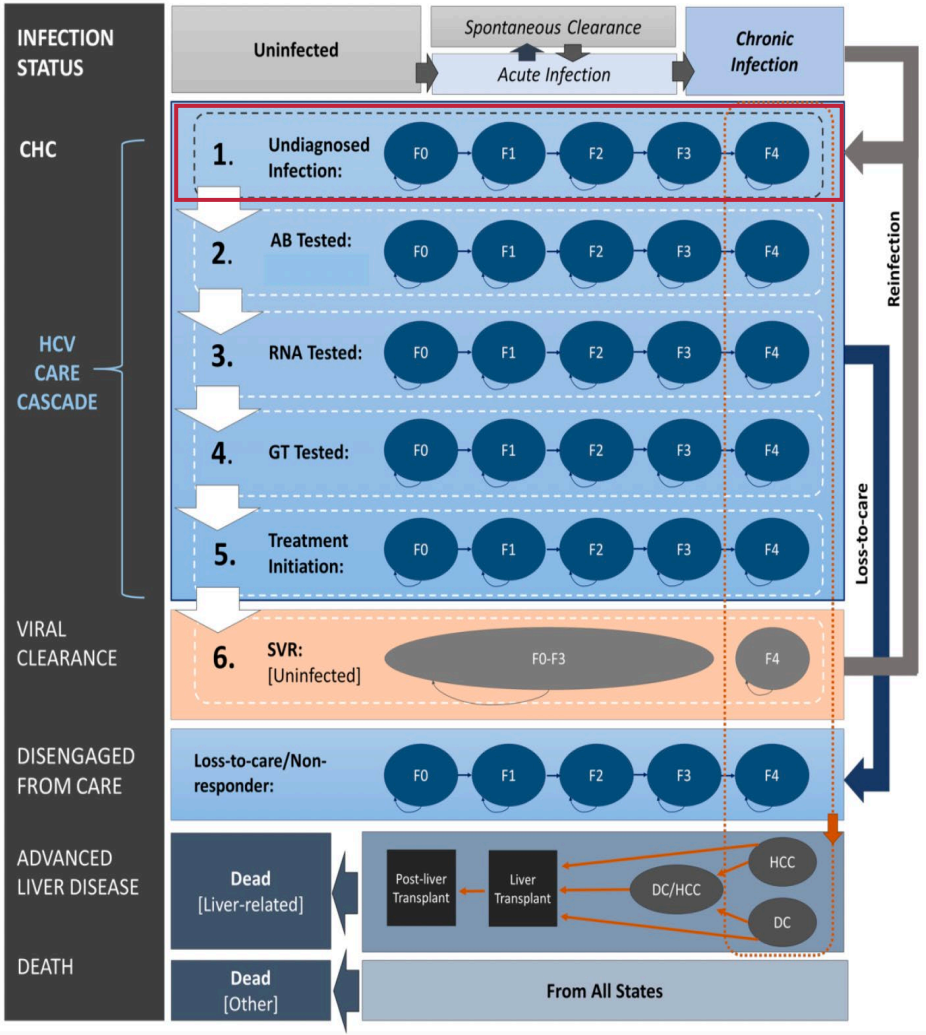
  - → Chronic HCV

HCV INFECTED

- **Undiagnosed CHC**
  - ~33% undiagnosed HCV



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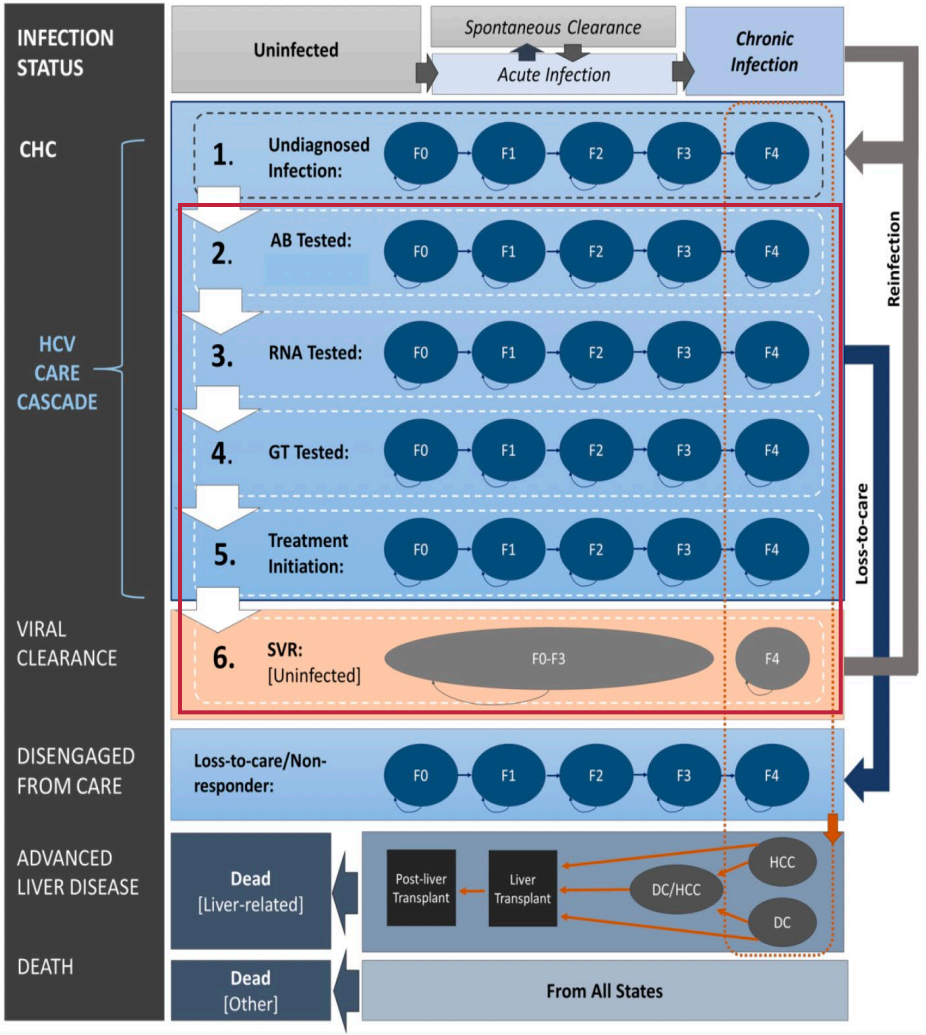
- Can become infected with HCV
  → Spontaneous clearance
  → Chronic HCV

HCV INFECTED

- **Undiagnosed CHC**
  - ~33% undiagnosed HCV
- **Diagnosed CHC (care cascade)**
  - *Tested (AB, RNA, GT)*
  - *Treatment initiated*
  - *SVR (cure)*



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Model Structure

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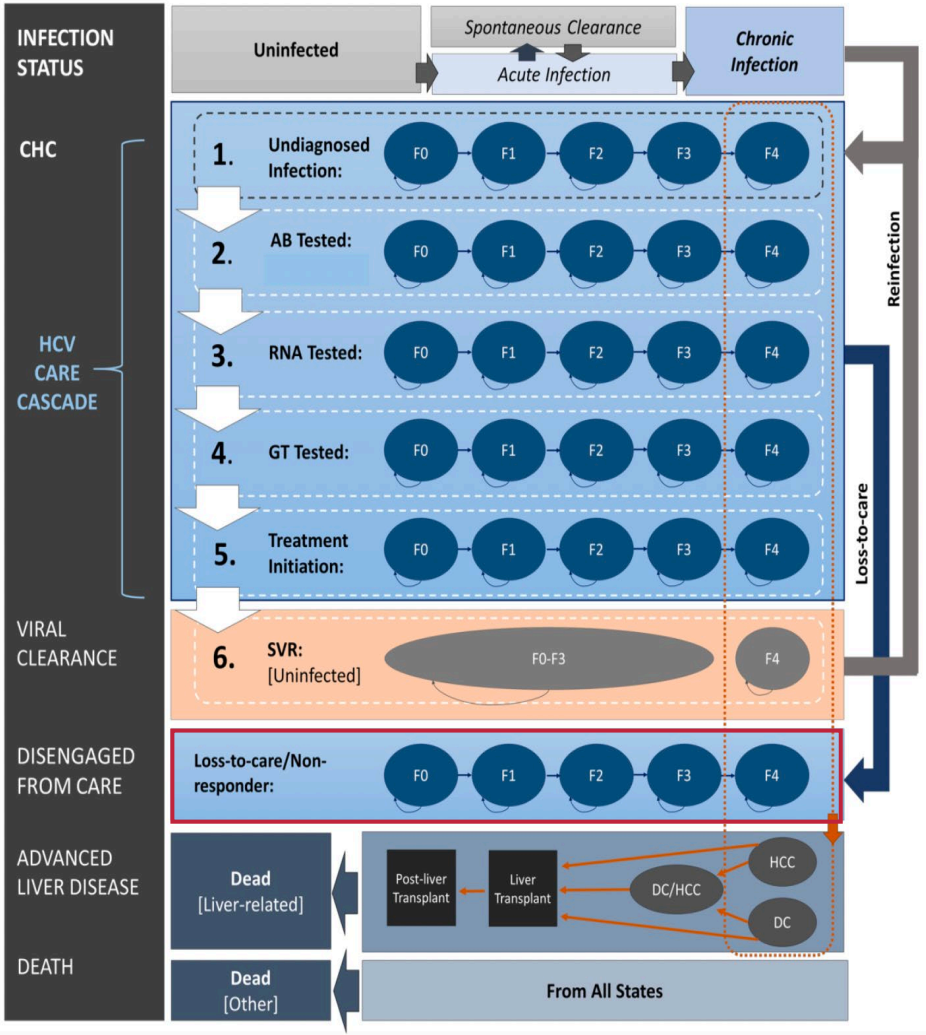
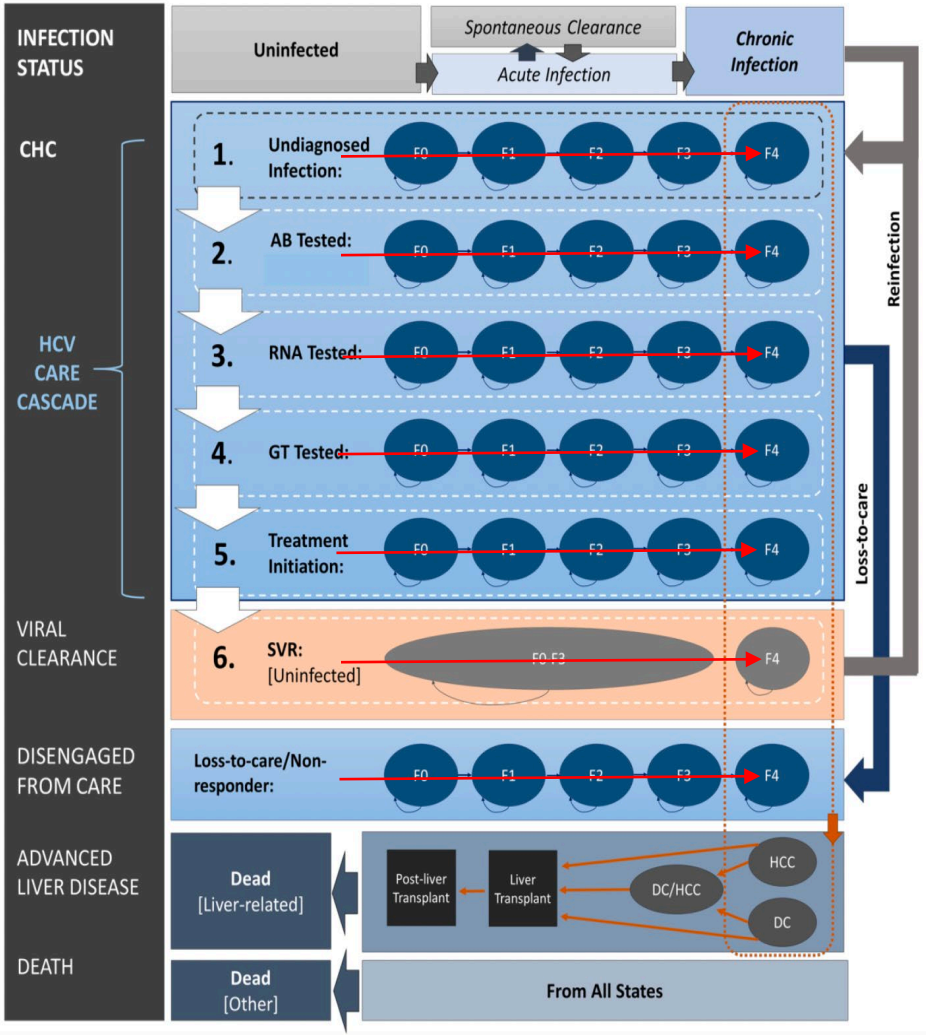
  - *Tested (AB, RNA, GT)*
  - *Treatment initiated*
  - *SVR (cure)*
- **Loss-to-care**



AB: antibody; CHC; chronic hepatitis C; (F1-F4): fibrosis stages; GT: genotype; ON: Ontario; SVR: sustained viral response

CHC Natural History

- **Fibrosis [F0-F4 (cirrhosis)]**



AB: antibody; ADL: advanced liver disease CHC; chronic hepatitis C; (F1-F4): fibrosis stages; GT: genotype; ON: Ontario; SVR: sustained viral response

CHC Natural History

- **Fibrosis [F0-F4 (cirrhosis)]**

Individuals with cirrhosis can progress to advanced liver disease (**ALD**)

- **Decompensated cirrhosis**
- **Hepatocellular carcinoma**
- **Liver transplantation**

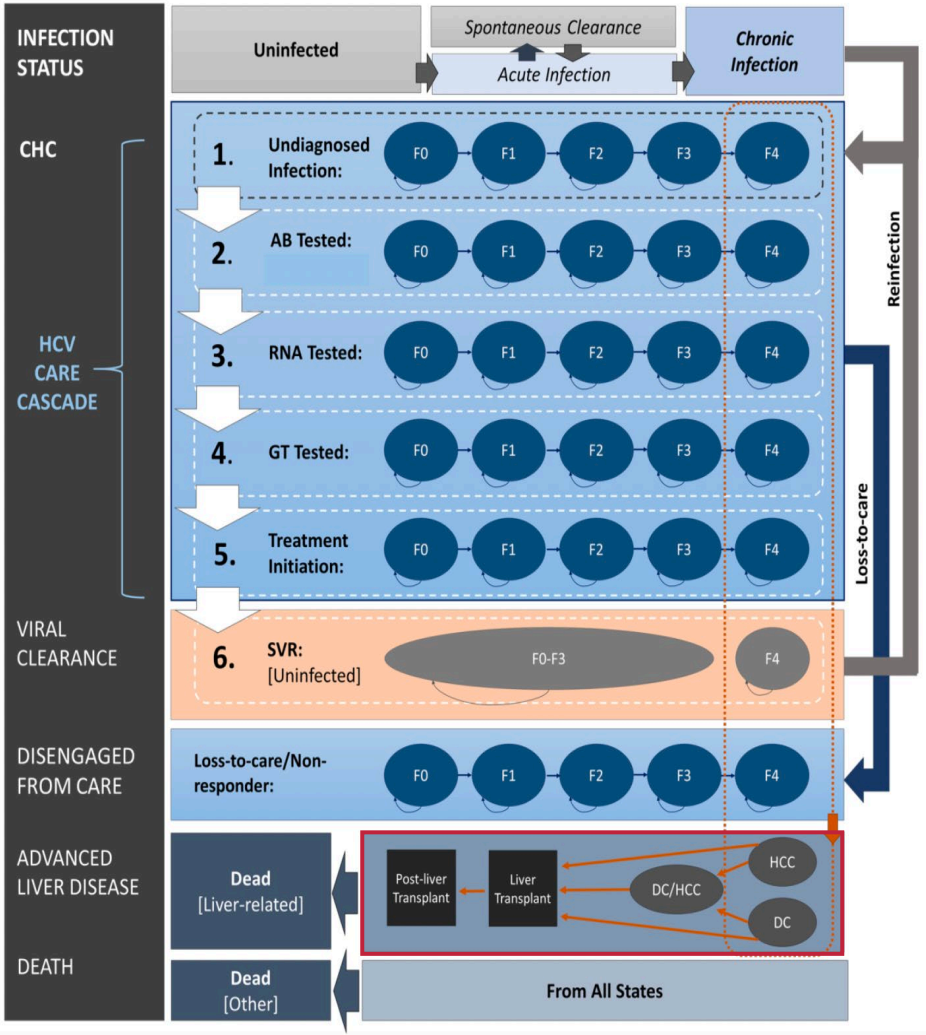
Only individuals with ALD are at risk of

- **Liver-related mortality**

SVR:

Individuals who achieved SVR (cure) at stages:

- F0-F3 were assumed **to stop** disease progression
- F4 (cirrhosis) or ALD were assumed **to have reduced** progression



AB: antibody; ADL: advanced liver disease CHC; chronic hepatitis C; (F1-F4): fibrosis stages; GT: genotype; ON: Ontario; SVR: sustained viral response

Model Parameters

INFECTED (CHC prevalence in ON)

- **Undiagnosed CHC**

- **Diagnosed CHC (care cascade)**

AB: antibody; ADL: advanced liver disease CHC; chronic hepatitis C; (F1-F4): fibrosis stages; GT: genotype; ON: Ontario; SVR: sustained viral response

Model Parameters

INFECTED (CHC prevalence in ON)

- **Undiagnosed CHC**

By age and fibrosis level [F0-F4]

- ~33% undiagnosed HCV
- Based on annual incidence of ALD events using back-calculation

- **Diagnosed CHC (care cascade)**

Received: 18 September 2023 | Revised: 20 December 2023 | Accepted: 8 February 2024
DOI: 10.1111/liv.15875

ORIGINAL ARTICLE

Liver INTERNATIONAL WILEY

Impact of new direct-acting antiviral therapy on the prevalence and undiagnosed proportion of chronic hepatitis C infection

Farinaz Forouzannia[1] | Abdullah Hamadeh[1] | Ana Maria Passos-Castilho[2] | Aysegul Erman[3] | Amanda Yu[4] | Zeny Feng[5] | Naveed Z. Janjua[4,6,7] | Beate Sander[3,8,9,10] | Christina Greenaway[2] | William W. L. Wong[1,3,8,9]

AB: antibody; ADL: advanced liver disease CHC; chronic hepatitis C; (F1-F4): fibrosis stages; GT: genotype; ON: Ontario; SVR: sustained viral response

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Model Parameters

INFECTED (CHC prevalence in ON)

- **Undiagnosed CHC**

By age and fibrosis level [F0-F4]

- ~33% undiagnosed HCV
- Based on annual incidence of ADL events using back-calculation

- **Diagnosed CHC (care cascade)**

By age and fibrosis level [F0-F4]

Based on HCV care cascade 2018 (ICES data)

- *Tested (AB, RNA, GT)*
- *Treatment initiated*
- *SVR (cure)*
- *Loss-to-care*

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Received: 2 April 2023 | Accepted: 14 June 2023
DOI: 10.1097/HC9.0000000000000222

ORIGINAL ARTI C LE

AASLD

OPEN

Engagement with the HCV care cascade among high-risk groups: A population-based study

Aysegul Erman[1,2] | Karl Everett[2] | William W.L. Wong[1,2,3] | Farinaz Forouzannia[3] | Christina Greenaway[4] | Naveed Janjua[5] | Jeffrey C. Kwong[2,6] | Beate Sander[1,2,7]

AB: antibody; ADL: advanced liver disease CHC; chronic hepatitis C; (F1-F4): fibrosis stages; GT: genotype; ON: Ontario; SVR: sustained viral response

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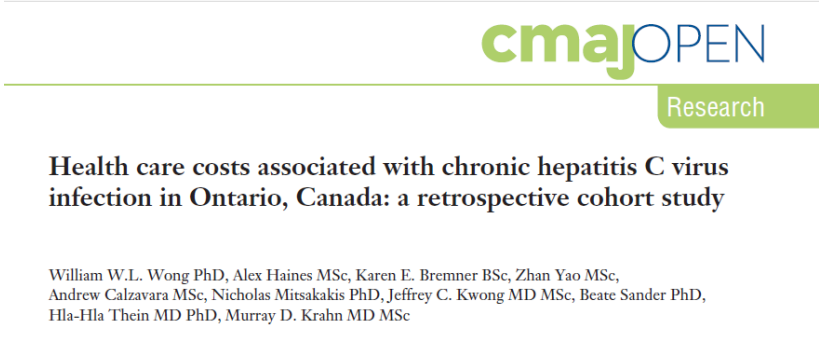
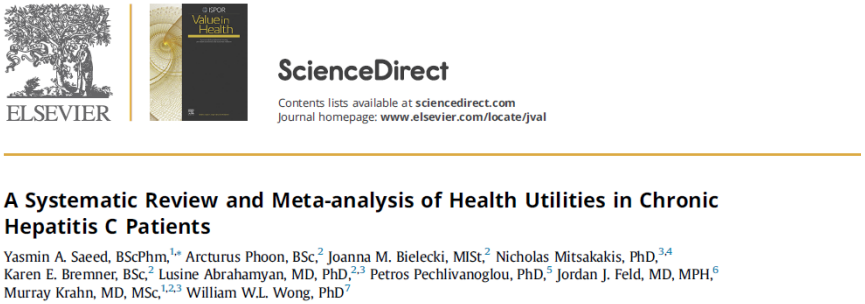
Model Parameters: Costs and Utilities


cmajOPEN
Research

Health care costs associated with chronic hepatitis C virus infection in Ontario, Canada: a retrospective cohort study

William W.L. Wong PhD, Alex Haines MSc, Karen E. Bremner BSc, Zhan Yao MSc, Andrew Calzavara MSc, Nicholas Mitsakakis PhD, Jeffrey C. Kwong MD MSc, Beate Sander PhD, Hla-Hla Thein MD PhD, Murray D. Krahn MD MSc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Journal homepage: www.elsevier.com/locate/jval

A Systematic Review and Meta-analysis of Health Utilities in Chronic Hepatitis C Patients

Yasmin A. Saeed, BScPhm,[1,*] Arcturus Phoon, BSc,[2] Joanna M. Bielecki, MISt,[2] Nicholas Mitsakakis, PhD,[3,4] Karen E. Bremner, BSc,[2] Lusine Abrahamyan, MD, PhD,[2,3] Petros Pechlivanoglou, PhD,[5] Jordan J. Feld, MD, MPH,[6] Murray Krahn, MD, MSc,[1,2,3] William W.L. Wong, PhD[7]

ICES Health Administrative Data

- Stratified by
  - Disease severity (fibrosis, ADL, end-of-life) level
- Cost categories

  inpatient, outpatient, medication, physician services, ED, home care, long-term care other

Systematic review and meta-analysis

- Stratified by
  - Age, sex,
  - Disease severity (fibrosis, ADL) level
- EQ-5D-5L instrument

ADL: advanced liver disease

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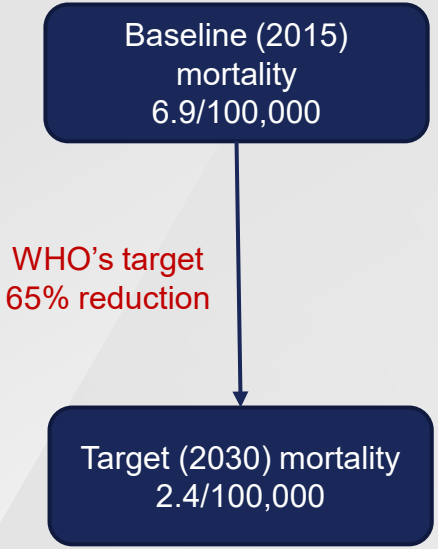
Strategies

1. **Status quo:** two-step diagnosis
   - Annual AB testing: 4.0% - 12.7%, depending on birth cohort (Wong et al 2023)
   - 88% of AB(+) receive RNA test (Erman et al 2023)
   - 53% of RNA(+) receive treatment (Erman et al 2023)
2. **Improving linkage to care**
3. **Reaching the undiagnosed population**



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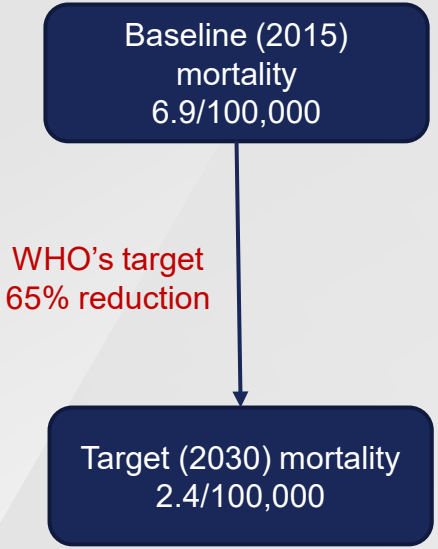
Strategies

Improving linkage to care: reflex testing

1. Increase in RNA testing 88% → up to 98%
2. Increase treatment uptake 53% → up to 98%

Incremental increases to see if target could be met by 2030

- Count liver-related deaths in 2030 and compare with # of deaths in 2015



If unmet:

Reaching the undiagnosed population: screening

- Two-fold increase in AB testing

Increase the f/u: if not by 2030 then when?

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Analysis

“Reverse” cost-effectiveness

- Estimating the maximum cost the program could incur while remaining cost-effective at a $50,000 threshold

- Stratified analysis by birth cohorts

Results

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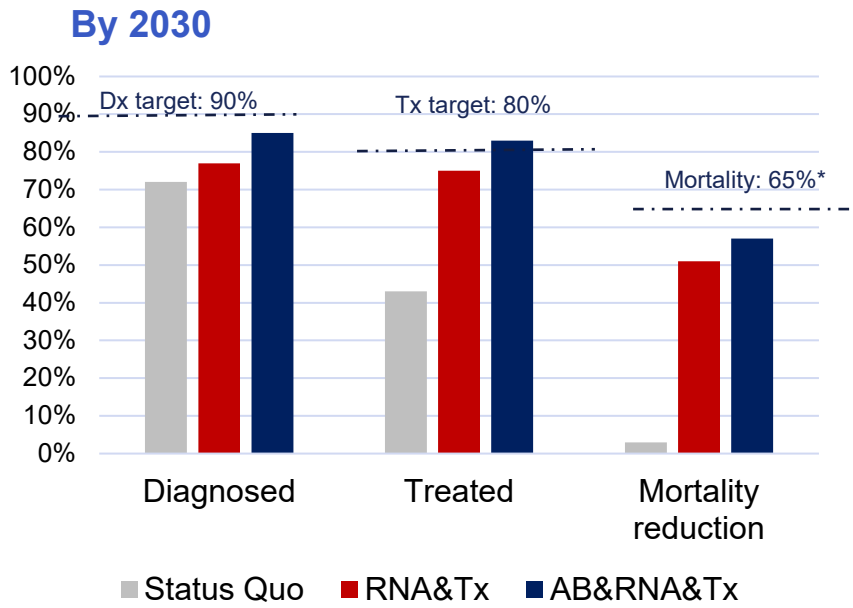
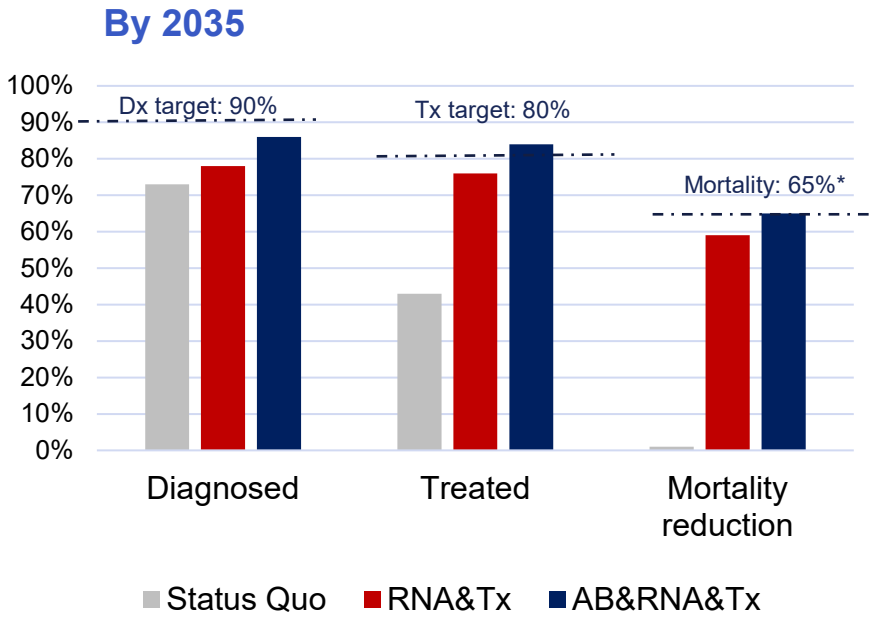
Do The Strategies Meet WHO's Targets?





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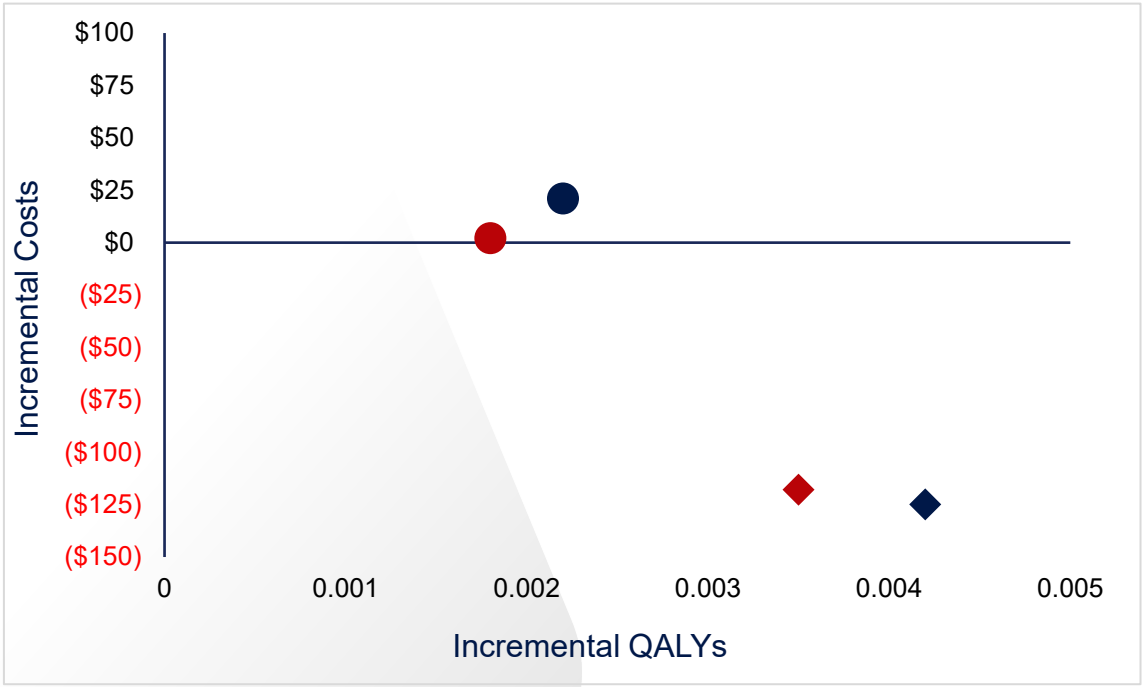
Are the Strategies Cost-Effective?



To remain cost-effective at $50K/QALY, the annual program implementation cost **per 100,000 people** may reach

Year 2030	**Cost**
RNA&Tx	**$852K**
AB&RNA&Tx	**Not CE***
Year 2035	
RNA&Tx,	**$2.1M**
AB&RNA&Tx	**$280K****

*compared to the RNA&Tx strategy
** in addition to RNA&Tx implementation costs, the program may incur an additional $280K

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Are the Strategies Cost-Effective?

To remain cost-effective at $50K/QALY, the annual program implementation cost **per 100,000 people** may reach

	Year 2030	Year 2035
<1945 birth cohort:		
RNA&Tx:	$702K	$1.5M
RNA&Tx&AB	**Not CE***	**Not CE***
1945–1965 birth cohort:		
RNA&Tx:	$2.1M	$3.8M
RNA&Tx&AB	$123K	$335K*
>1965: birth cohort:		
RNA&Tx:	$450K	$1.1M
RNA&Tx&AB	**Not CE***	$288K

*compared to the RNA&Tx strategy
** in addition to the RNA&Tx program implementation costs, the AB testing program may incur an additional $123K

Limitations

Modelling assumptions

- Static cohort – did not account for immigration patterns
- One-time screening only – no repeated testing for high-risk populations
- No evaluation of existing HCV prevention measures (harm reduction services)

Policy Implications

Bridging Research and Policy: Advancing HCV Elimination in Ontario

Challenge

- WHO's 2030 targets are unlikely to be met under current infrastructure
- Extending the timeline to 2035 is more realistic

Strategic Focus

- Streamline care through **reflex RNA testing** and point-of-care diagnosis and treatment
- Tailored outreach and expanded screening to reach undiagnosed populations

Policy

- Modeling supports strategic resource allocation
- Informs evidence-based decisions for Ontario's HCV strategy

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Thank you!

Toward Public Funding of Hepatitis C Screening: Process on How OHTAC Makes Funding Recommendation

September 23, 2025

PUBLIC HEALTH ONTARIO ROUND

HONG ANH TU

Ontario Health

Disclosure

- Salaried employee of Ontario Health*, a publicly funded government agency
- No conflict of interest

* https://www.ontariohealth.ca/

Outline

- Overview of health technology assessment (HTA)
- Ontario Health's current HTA process and methods
  - Hepatitis C Screening

Overview of Health Technology Assessment (HTA)

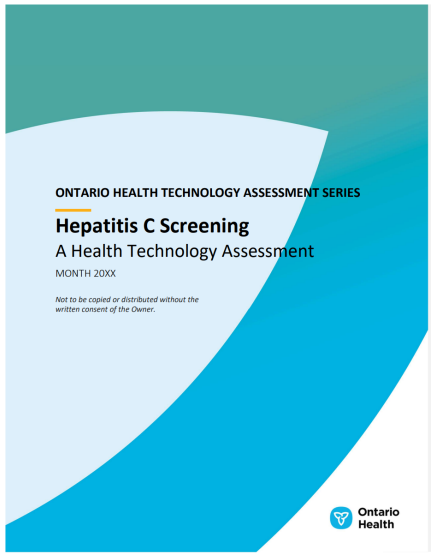
What is HTA?

- A multidisciplinary process
- Uses explicit methods to determine the value of a health technology at different points in its lifecycle
- Purpose is to inform decision-making in-order-to promote an equitable, efficient, and high-quality health system*

Ontario Health

*O'Rourke B, Oortwijn W, Schuller T, International Joint Task Group. The new definition of health technology assessment: a milestone in international collaboration. Int J Technol Assess Health Care 2020;36(3):187–90

HTA Program at Ontario Health

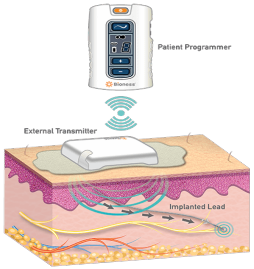


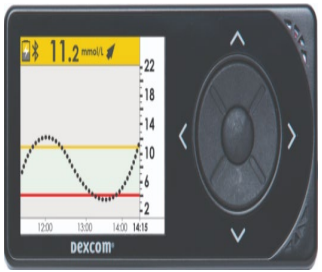
- To inform the Ontario Ministry of Health about which health care services and technologies to fund publicly based on Ontario Health's recommendations

Ontario Health

What Types of Technologies Do We Assess?

Medical Devices





Peripheral nerve stimulation

Continuous blood glucose monitoring

Lab Tests

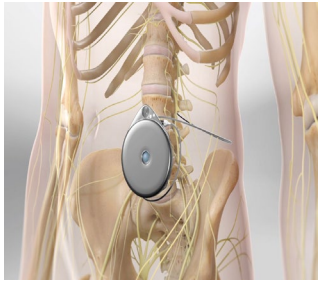
Hepatitis C screening

Models of Care

Internet-delivered cognitive behavioral therapy

Remote cardiac monitoring

Procedures



Intrathecal drug delivery

Ontario Health

OH-HTA Program Team

Clinical Epidemiology

Health Economics

Patient Partnering

Information Specialist

Policy and Program Planning

Operations

Leadership

Ontario Health

HTA End-to-End Process

Topic Prioritization Guide
www.hqontario.ca/Portals/0/documents/evidence/reports/hta-topic-prioritization-guide-en.pdf

Methods and Process Guide
www.hqontario.ca/Portals/0/documents/evidence/reports/hta-methods-and-process-guide-en.pdf

Hepatitis C Screening

Context

- Policy Issue
  - To conduct an HTA to help inform a recommendation for HCV screening as part of the MOH's plan to achieve the elimination of HCV as a public health threat in Ontario by the year 2030
    - **A risk-based approach** to HCV screening is currently used in Ontario
    - Expanding the HCV screening approach to **all adults** or to **people born between 1945 and 1975** in addition to risk-based screening

Expertise Consulted

Ministry of Health and Ministry's Hepatitis C Working Group

- Including members of the Ontario Ministry of Health, Public Health Ontario, the Office of Chief Medical Officer of Health, Health Programs and Delivery Division, Provincial Programs Branch, and the Research, Analysis and Evaluation Branch (RAEB)

Hepatitis C experts

- 2 clinicians and 2 nurse practitioners

Primary care provider

- 1 primary care provider

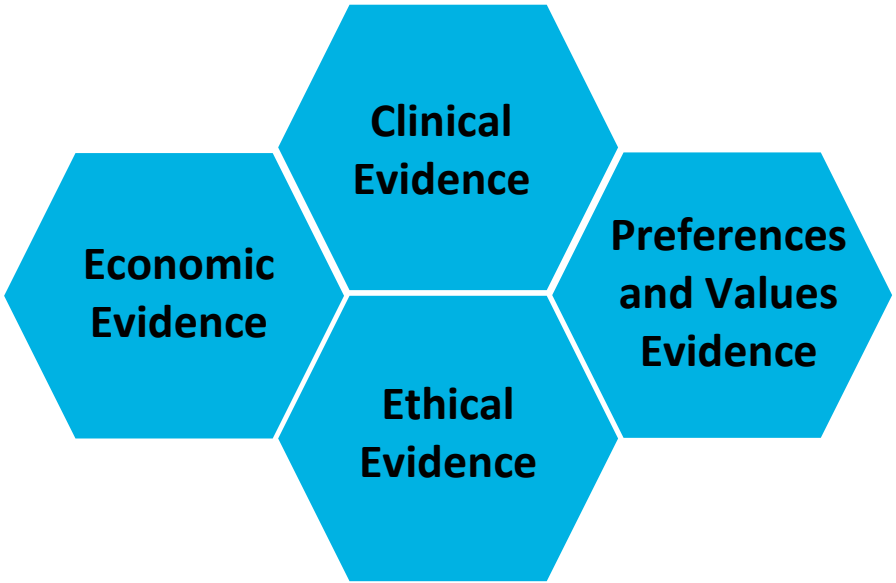
Ontario Health

- Ontario Health personnel

Health economic experts

- 2 health economists

What Evidence Did We Consider?



Ontario Health

Primary Economic Evaluation

- From the perspective of the Ontario Ministry of Health, what is the cost-effectiveness of **1-time hepatitis C virus (HCV) screening plus risk-based HCV screening** compared with **risk-based HCV screening alone** for:
  1) all adults
  2) individuals born between 1945 and 1975 (1945–1975 birth cohort)

Ontario Health

Abbreviations: HCV: hepatitis C virus

Adaption to the Sahakyan et al. Model- Methods

Methods	Sahakyan et al	Ontario Health's model
Design	Cost-utility analysis using a decision-model	Cost-utility analysis using a decision-model
Population	Individuals with HCV in Ontario	Individuals ≥ 18 years in Ontario Individuals born between 1945–1975 in Ontario
Comparators	Scale-up *vs.* Status quo	Scale-up *vs.* Status quo
Outcomes	QALYs, health system costs	QALYs, health system costs (updated costs of antibody, RNA tests)
Perspectives	Ontario health system	Ontario Ministry of Health
Time horizon	2018-2030 (12 years)	Lifetime
Cost-effectiveness thresholds	$50,000 per QALY gained	$50,000/QALYs, $100,000/QALYs

Reference Case Analysis: All Adults; Results Per Person

1

Strategy	Average total costs, $	Incremental cost, $[a,b,]	Average total QALYs	Incremental QALY[c,d]	ICER[b]	Life years [e]
Risk-based HCV screening alone	289,702		22.8245			36.9537
HCV screening for all adults*	289,646	−55.30	22.8253	0.0008	Dominant[c]	36.9547

Abbreviations: ICER, incremental cost-effectiveness ratio; QALYs, quality adjusted life years, HCV: hepatitis C virus

[a]Negative costs indicate savings; [b]Results may appear inexact due to rounding

[c]Less costly and more effective; [e]Life years were not discounted

*Plus risk-based screening

Ontario Health

Reference Case Analysis: All Adults (Number of Cases per 100,000 People)

1

	Cascade of Care Outcomes (Cumulative cases per 100,000 people)			
Strategies	**DC**	**HCC**	**Liver transplants**	**Liver-related deaths**
Risk-based screening alone	229	151	4.0	325.3
HCV screening of all adults*	224	148	3.8	319.3

HCV screening of all adults **reduced** numbers of DC, HCC, liver transplants, and liver-related deaths

Ontario Health

DC, decompensated cirrhosis; HCC, hepatocellular carcinoma; HCV, hepatitis C virus
*Plus risk-based screening

Reference Case Results: 1945–1975 Birth Cohort; Results Per Person

Strategy	Average total costs, $	Incremental cost, $[a,b,c]	Average total QALYs	Incremental QALY[b]	ICER[b]	Life years[e]
Risk-based HCV screening	308,996.75		16.6774			24.7684
HCV screening of the 1945–1975 birth cohort*	308,980.37	−15.38	16.6777	0.0003	Dominant[c]	24.7688

Abbreviations: ICER, incremental cost-effectiveness ratio; QALYs, quality adjusted life years, HCV: hepatitis C virus

[a]Negative costs indicate savings; [b]Results may appear inexact due to rounding

[c]Less costly and more effective; [e]Life years were not discounted

*Plus risk-based screening

Ontario Health

Reference Case Results: 1945–1975 Birth Cohort (Number of Cases per 100,000 People)

	Cascade of Care Outcomes (Cumulative cases per 100,000 people)			
Strategies	**DC**	**HCC**	**Liver transplants**	**Liver-related deaths**
HCV risk-based screening alone	227	147	4.0595	308
HCV screening of the 1945–1975 birth cohort*	224	145	3.9814	305

HCV screening of 1945-1975 birth cohort **reduced** numbers of DC, HCC, liver transplants, and liver-related deaths

DC, decompensated cirrhosis; HCC, hepatocellular carcinoma; HCV, hepatitis C virus
*Plus risk-based screening

Budget Impact Analysis

1 2

- What is the potential 5-year budget impact for the Ontario Ministry of Health of publicly funding **1-time hepatitis C virus (HCV) screening plus risk-based HCV screening** compared with **risk-based HCV screening alone** for:
  1) all adults
  2) individuals born between 1945 and 1975 (1945–1975 birth cohort)

Ontario Health

Reference Case: All Adults

1

Strategies	Budget impact, $ million[a]					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HCV risk-based screening	**5,543**	**5,994**	**6,359**	**6,713**	**7,057**	**31,666**
Cost of antibody testing	2.62	2.61	2.60	2.59	2.57	12.99
Cost of RNA testing	0.09	0.10	0.10	0.10	0.10	0.49
Cost of DAAs	48.39	84.66	87.67	88.39	88.45	397.55
Cost of treating CHC complications	5,492	5,907	6,268	6,622	6,966	31,255
HCV screening of all adults*	**5,565**	**6,025**	**6,383**	**6,733**	**7,071**	**31,777**
Cost of antibody testing	3.93	3.91	3.89	3.87	3.85	19.46
Cost of RNA testing	0.14	0.14	0.14	0.14	0.13	0.69
Cost of DAAs	69.25	115.86	115.42	113.04	110.40	523.97
Cost of treating CHC complications	5,492	5,905	6,264	6,616	6,957	31,232
Budget Impact[b,c]	**22**	**31**	**25**	**19**	**14**	**111**
Cost of antibody testing ↑	1.31	1.30	1.29	1.29	1.28	6.47
Cost of RNA testing ↑	0.05	0.04	0.04	0.04	0.03	0.2
Cost of DAAs ↑	21	31	28	25	22	126
Cost of treating CHC complications ↓	-0.15	-1.89	-4.31	-6.76	-9.22	-22

Ontario Health

[a] In 2025 Canadian dollars. [b] Results may appear inexact due to rounding. [c] Negative costs indicate savings.

*Plus risk-based screening

CHC: chronic hepatitis C; DAAs: direct-acting antivirals; RNA: ribonucleic acid

When Will HCV Screening of All Adults Be Cost Savings?

Ontario Health

Abbreviations: BIA: budget impact analysis; HCV: hepatitis C virus

Reference Case: 1945–1975 Birth Cohort

2

Strategies	Budget impact, $ million[a]					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HCV risk-based screening	**2,425**	**2,648**	**2,845**	**3,053**	**3,277**	**14,248**
Cost of antibody testing	0.59	0.58	0.58	0.57	0.56	2.88
Cost of RNA testing	0.04	0.04	0.03	0.03	0.03	0.16
Cost of DAAs	22	36	34	32	29	153
Cost of treating CHC complications	2,402	2,611	2,810	3,021	3,248	14,093
HCV screening of 1945–1975 birth cohort*	**2,434**	**2,659**	**2,852**	**3,058**	**3,279**	**14,282**
Cost of antibody testing	0.88	0.87	0.86	0.85	0.84	4.30
Cost of RNA testing	0.06	0.05	0.04	0.04	0.03	0.22
Cost of DAAs	31	48	43	38	33	193
Cost of treating CHC complications	2,402	2,610	2,808	3,019	3,245	14,085
Budget Impact[b,c]	**9**	**11**	**7**	**4**	**1**	**32**
Cost of antibody testing ↑	0.29	0.29	0.28	0.28	0.28	1.42
Cost of RNA testing ↑	0.02	0.02	0.01	0.01	0.01	0.06
Cost of DAAs ↑	8.85	11.85	8.88	6.38	4.33	40.30
Cost of treating CHC complications ↓	−0.06	−0.75	−1.62	−2.42	−3.16	−8.01

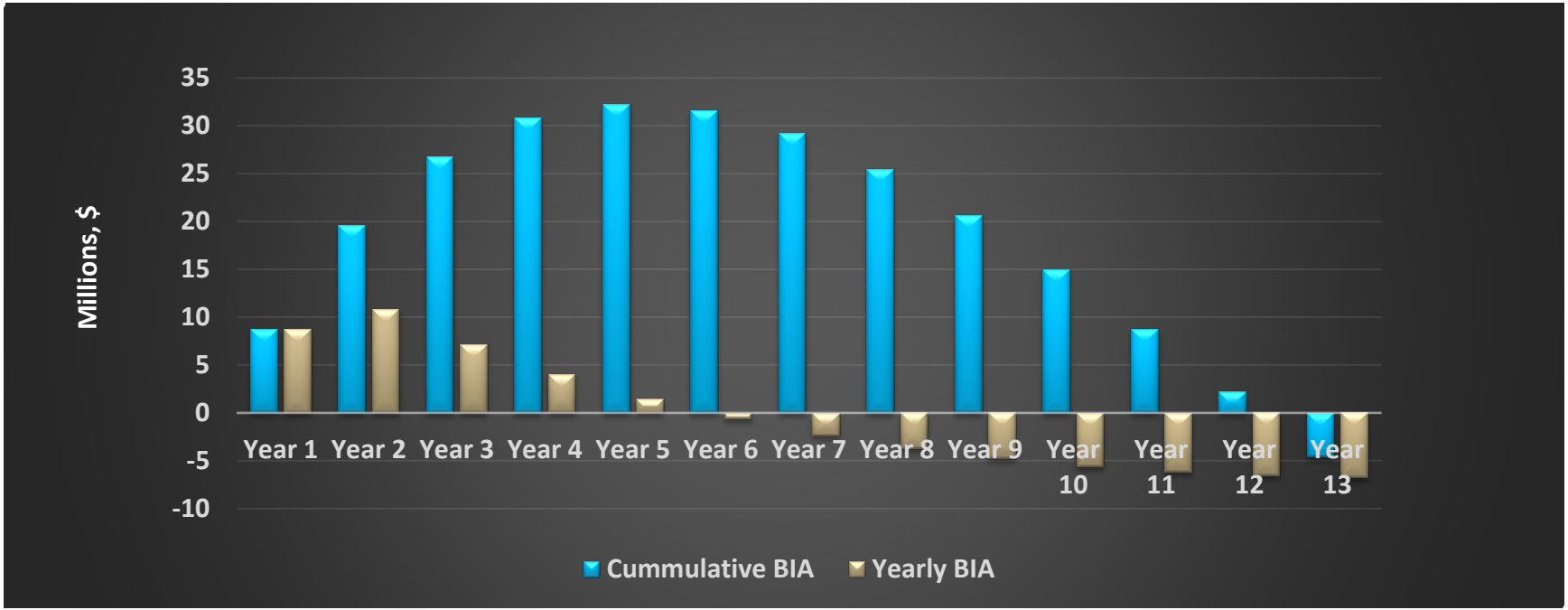
Ontario Health

[a] In 2025 Canadian dollars. [b] Results may appear inexact due to rounding. [c] Negative costs indicate savings.

*Plus risk-based screening

CHC: chronic hepatitis C; DAAs: direct-acting antivirals; RNA: ribonucleic acid

When Will HCV Screening of 1945–1975 Birth Cohort Be Cost-Savings?



Ontario Health

BIA: budget impact analysis; HCV: hepatitis C virus

Funding Recommendation

Will be available at public posting

Key Messages

Key Messages

Model-based recommendations

- Streamline care
  - **Reflex RNA testing**
  - **Point-of-care** diagnosis
- Modeling supports strategic source allocation

OH analysis

- Screening all adults, or the 1945–1975 birth cohort, plus risk-based screening is a dominant strategy (less costly and more effective than risk-based screening alone)

5-year Budget Impact

- Public funding of HCV screening for all adults **~ $111M**
- Public funding of HCV screening for the 1945–1975 birth cohort **~ $32M**

Thank you