

VIRAL HEPATITIS MAPPING PROJECT: HEPATITIS C

Geographic diversity in chronic
hepatitis C prevalence and treatment

NATIONAL REPORT 2024–2025



A joint venture between The University of Melbourne and The Royal Melbourne Hospital

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WHO COLLABORATING CENTRE FOR VIRAL HEPATITIS
THE PETER DOHERTY INSTITUTE FOR INFECTION AND IMMUNITY
ASHM HEALTH



A joint venture between The University of Melbourne and The Royal Melbourne Hospital

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Geographic diversity in chronic hepatitis C prevalence and treatment
National Report 2024–2025

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- Australian Government Department of Health, Disability and Ageing
- The Kirby Institute, University of New South Wales
- Services Australia

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DECLARATION REGARDING THE USE OF PERSON LEVEL INTEGRATED DATA ASSET DATA

The results in this report are based, in part, on data supplied by the Department of Social Services to the Australian Bureau of Statistics (ABS) under the *Social Security (Administration) Act 1999* (Cth), *A New Tax System (Family Assistance) (Administration) Act 1999* (Cth), *Paid Parental Leave Act 2010* (Cth) and the *Student Assistance Act 1973* (Cth). Such data may only be used for the purposes of the *Census and Statistics Act 1905* (Cth) or performance of functions of the ABS as set out in section 6 of the *Australian Bureau of Statistics Act 1975* (Cth) (ABS Act). Any discussion of data limitations or weaknesses is in the context of using the data for statistical purposes, and not related to the ability of the data to support the Department of Social Services' core operational requirements.

Legislative requirements ensure privacy and secrecy of these data are followed. For access to Person Level Integrated Data Asset (PLIDA) data under section 16A of the ABS Act or enabled by section 15 of the *Census and Statistics (Information Release and Access) Determination 2018*, source data are de-identified and so data about specific individuals have not been viewed in conducting this analysis. In accordance with the *Census and Statistics Act 1905*, results have been treated where necessary to ensure that they are not likely to enable identification of a particular person or organisation.

The results are also based, in part, on migration data supplied by the Australian Government Department of Home Affairs to the ABS under the *Australian Border Force Act 2015* (Cth), which requires that such data are only used for the purposes of the Census and Statistics Act or performance of functions of the ABS as set out in section 6 of the ABS Act. Any discussion of data limitations or weaknesses is in the context of using the data for statistical purposes, and not related to the ability of the data to support the Department of Home Affairs' core operational requirements.

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While the Department of Health, Disability and Ageing provides financial support for this project, the material contained in this resource should not be taken to represent the department's views.

ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
CHC	chronic hepatitis C
DAA	direct-acting antiviral
GP	general practitioner
HCV	hepatitis C virus
MBS	Medicare Benefits Schedule
NNDSS	National Notifiable Diseases Surveillance System
NSW	New South Wales
NP	nurse practitioner
NT	Northern Territory
PBS	Pharmaceutical Benefits Scheme
PHN	Primary Health Network
PLIDA	Person Level Integrated Data Asset
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia
WHO	World Health Organization

For a list of data terms and definitions, see [Section B – Data sources and methodology](#).

EXECUTIVE SUMMARY

SECTION A: HEPATITIS C

TREATMENT NUMBERS

- Between March 2016 and May 2025, a total of 112,863 people received hepatitis C treatment through the Pharmaceutical Benefits Scheme (PBS).
- After high initial treatment uptake in 2016, treatment numbers declined until 2022. The monthly average number then increased in 2023 and declined slightly in 2024, before declining more substantially in 2025 (January–May data).
- The decline in monthly average treatment numbers between 2024 and 2025 occurred in all states and territories, and in all but three Primary Health Networks (PHNs).

TREATMENT UPTAKE

- Estimated treatment uptake varied widely by PHN and continued to be generally lower in remote and very remote regions, and higher in regions of higher hepatitis C prevalence. Treatment uptake was estimated to be highest in the **Gippsland, Western Victoria, North Coast** NSW and **Central Queensland, Wide Bay and Sunshine Coast** PHNs.
- The majority (97,150 people, 86.3%) of those treated received only a single course of treatment, while 15,380 people (13.7%) received more than one course of treatment. Re-treatment was more common in Qld (16.5% of people treated) and less common in SA (9.9%) and the NT (9.7%).

TREATMENT PROVIDERS

- General practitioners (GPs) were the prescriber for 34.0% of people who received treatment from 2020 to 2025; non-GP specialists represented 39.0% and nurse practitioners (NPs) 14.7%.
- There was an increase in prescribing by NPs and a decrease in prescribing by non-GP specialists between 2020 and 2025.
- GP prescribing was highest in the **Western Queensland, Darling Downs and West Moreton, Tasmania, Australian Capital Territory** and **Northern Queensland** PHNs.
- NP prescribing was highest in the **Brisbane South, Darling Downs and West Moreton, North Coast** NSW and **Brisbane North** PHNs.
- Due to the high proportion of treatment from 2020 to 2025 that was delivered to residents of correctional facilities,¹ the distribution of prescribers may be influenced by the models of care used in these populations.

TREATMENT BY DEMOGRAPHIC GROUP

- In 2025, the largest group of people treated was those aged 40–49 years (21.6% of the total). The proportion aged under 30 increased from 3.5% to 19.1% between 2016 and 2025.
- Most people treated for chronic hepatitis C (CHC) were male (69.1%) and this proportion increased over time, from 66.2% in 2016 to 72.9% in 2025.
- Aboriginal and/or Torres Strait Islander people represented 14.7% of those treated for hepatitis C, increasing from 7.3% in 2016 to 24.7% in 2024.

HEPATITIS B

- The equivalent reporting on the geographic diversity, prevalence and care and treatment uptake of hepatitis B, as well as liver cancer data, is presented in the [*Viral Hepatitis Mapping Project: Hepatitis B National Report 2024*](#).

MAPPING REPORT AT A GLANCE

The Hepatitis C Mapping Report – overview of concepts, methods and outputs

Data reported:

 <p>Hepatitis C prevalence variation</p> <p>Difference from the national average in the proportion of the total population living with hepatitis C</p> <p>Source: mathematical model estimate of hepatitis C prevalence (generated by the Kirby Institute), adjusted using notifications data according to region of residence</p> <p>Geography available: state/territory, Primary Health Network Time period: 2016 (specified baseline for treatment uptake measurement)</p>	 <p>Hepatitis C treatment trends</p> <p>The number of people who received hepatitis C antiviral treatment</p> <p>Source: Medicare data for hepatitis C antiviral treatment</p> <p>Geography available: state /territory, Primary Health Network Time period: March 2016 – May 2025</p>	 <p>Hepatitis C treatment uptake variation</p> <p>Difference from the national average in the proportion of people who received hepatitis C antiviral treatment</p> <p>Source: Medicare data for hepatitis C antiviral treatment and hepatitis C prevalence</p> <p>Geography available: state /territory, Primary Health Network Time period: Cumulative uptake during March 2016 – May 2025</p>
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Geographic areas used for reporting:



8 states and territories



31 Primary Health Networks
(population 45,000–1.6 million)

Geographic region is based on the residence of the person living with hepatitis C, not the location of the service provider

[Click here to look up a Primary Health Network or remoteness area for an address](#)

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INTRODUCTION

BACKGROUND

The Viral Hepatitis Mapping Project aims to assess geographic variations in the prevalence of hepatitis B and hepatitis C and disparities in access to care to identify priority areas for response. The most recent data regarding hepatitis B prevalence, care and treatment uptake, serology testing for hepatitis B and C, and liver cancer are presented in the [Viral Hepatitis Mapping Project: Hepatitis B National Report 2024](#) (published 2026).

This report presents the most recent available treatment data on hepatitis C up to May 2025 and an assessment of ongoing trends from 2016. The data enable readers to identify hepatitis C treatment uptake variation in local areas and to assess progress in delivering care to those affected. Improving access to care and treatment for hepatitis B and hepatitis C is needed to reduce the burden of attributable liver disease and cancer, the distribution of which is also geographically disparate. This report is informed by the targets set out in the Sixth National Hepatitis C Strategy 2025–2030 (the National Strategy).² At the time of writing, the National Strategy has been drafted and is set for final release. In this report, we are using information about targets that is available at the time of publication.

The authors acknowledge communities and individuals affected by hepatitis C. We thank all people with a living and lived experience of hepatitis C and/or injecting drug use, and acknowledge those who have lost their lives to hepatitis C.

This report highlights a range of disparities that must be addressed to meet Australia's 2030 elimination goals for hepatitis C, focusing on geographic inequities. These often reflect health disparities between Aboriginal and/or Torres Strait Islander peoples and non-Indigenous Australians, which are influenced by historical disadvantage perpetuated by institutional racism and systemic failures. Furthermore, Aboriginal and/or Torres Strait Islander peoples' overrepresentation in the criminal justice system can be inextricably linked to the consequences of colonisation further contributing to poorer health outcomes.

Inequities exist between people who have ever been incarcerated and those who have not. Effective interventions require a focus on prevention and appropriate harm reduction, as well as increased testing and treatment. The criminalisation of drugs exacerbates the risk of hepatitis C transmission by fostering environments where individuals who inject drugs face heightened stigma, barriers to harm-reduction services, and increased likelihood of sharing contaminated needles due to the lack of legal and safe spaces for drug use.

By acknowledging, understanding and addressing systemic issues leading to inequities, comprehensive and equitable approaches to hepatitis C prevention and management in Australia can be supported.

WHAT'S NEW IN THIS REPORT?

This 2024–2025 report contains the following new information:

- Further assessment of trends in treatment for hepatitis C through May 2025.
- First-ever national reporting of hepatitis C treatment numbers and trends among Aboriginal and/or Torres Strait Islander people.
- Updated assessment of prescribing trends according to provider, including GPs and NPs.

HOW TO USE THE DATA

Treatment uptake and prevalence data are presented as ratios relative to the national average, reflecting the uncertainty in estimates and the need for ongoing updates as the understanding of the epidemiology of hepatitis C in Australia continues to evolve. This also reflects the uncertainty in the prevalence of hepatitis C according to geographic area, as estimates of reinfection, re-treatment and correctional facility treatment are not yet available at a granular level. Reporting at the level of Statistical Area 3 (SA3) regions is not available due to this greater uncertainty in geographically specific estimates of uptake. Monthly averages have also been used to account for the partial years available, to allow assessment of trends using the most recent data.

The data presented in this report allow for assessment of the estimated relative uptake of CHC treatment in each region, through assessment of how much higher or lower uptake is compared to the national average. For example, if a given PHN has uptake estimated to be 25% higher than a national average level of 50% uptake, this would represent uptake of 62.5% in that PHN.

These variations are limited by the underlying source data for estimating the number of people living with hepatitis C according to geographic region. For example, estimation of uptake variation is influenced by underlying notifications data, and issues such as disproportionate jurisdictional movement and duplication of notifications may lead to overestimation of prevalence in some regions, particularly in the NT, Tas and the ACT. Adjustment has been applied to account for this based on data regarding movement according to PHN and state/territory;³ however, continued uncertainties remain regarding the true number of people living with hepatitis C in a given area.

For further discussion of these limitations, see the [Prevalence](#) and [Data sources and methodology](#) sections.

This report includes treatment delivered in prisons; however, this cannot reliably be separately categorised. Data collected directly from correctional facilities and identifying uptake in these settings are reported elsewhere.¹

Estimates of treatment uptake variation are intended to be used to identify regions that may be of greater priority for intervention and increased resourcing, and do not intend to suggest that those regions are not providing effective service delivery to those living with hepatitis C.

The report can also be used to assess how treatment numbers have changed over time, enabling evaluation of the impact of specific changes in access to hepatitis C treatment (e.g. the health services impact of COVID-19) or policies and programs aiming to improve uptake.

To explore the data further, visit the [National Viral Hepatitis Mapping Project online portal](#), which provides interactive visualisations of hepatitis C prevalence and treatment Australia-wide. More detailed and geographically granular estimates may be available through direct request via the contact information below.

REPORT STRUCTURE

The Mapping Project is divided into two reports. This report includes:

- [Section A](#): hepatitis C prevalence and treatment
- [Section B](#): data sources and methodology.

The hepatitis B report, with associated data and methodology as well as sections on serology testing for hepatitis B and C and data on liver cancer, will be published separately: [Viral Hepatitis Mapping Project: Hepatitis B National Report 2024](#).

MORE INFORMATION

For further information about the Mapping Project and to access previous reports, please visit the [project website](#). For further information or resources related to hepatitis B, hepatitis C and the Mapping Project, visit www.ashm.org.au/resources/viral-hepatitis-mapping-project and www.doherty.edu.au/viralhepatitis. The Mapping Project is constantly evolving in response to valued feedback and guidance. To provide feedback, or to request further information or specific data, please contact jennifer.maclachlan@mh.org.au.

This report would not be possible without the contributions of the data custodians who provided information, and we gratefully acknowledge their support.

SECTION A: HEPATITIS C

PREVALENCE

Australia's Sixth National Hepatitis C Strategy 2025–2030² sets a target for 85% of the people living with hepatitis C at the start of 2016 (when direct-acting antivirals [DAAs] became available) to have received curative treatment by 2030. Treatment uptake estimates therefore relate to this baseline year, consistent with other reports,⁴ and prevalence data for 2016 are presented to provide context to treatment uptake metrics.

The Kirby Institute estimates that there were 162,590 people living with CHC (viraemic infection) in Australia at the start of 2016, representing 0.66% of the total population.⁴ Since the introduction of DAA treatments and their associated high cure rates, and after accounting for curative treatment, mortality and new infections, the number of people estimated to be living with CHC at the end of 2024 was 62,880.^{4,5} For further information regarding these estimates, see the [hepatitis C annual surveillance report for 2024](#).

As the understanding of hepatitis C epidemiology in Australia evolves, the estimated number of people living with chronic infection (hepatitis C RNA positive)⁵ is revised. For this reason, the estimates in this report are presented as ratios relative to the national average to provide an indication of the relative burden of CHC in different geographic areas in the context of changing point estimates (see [How to use the data](#) for further information). Estimates of relative prevalence have also been revised since the 2021–2023 report to take account of the impact of movement after diagnosis (see [Section B: Data sources and methodology](#)).

Additionally, geographically specific estimates are subject to considerable uncertainty, due to the lack of available data regarding new hepatitis C infections (e.g. through reinfection and migration). This means that current prevalence is not presently available by state, territory or PHN; however, this may be possible in the future.

PREVALENCE VARIATION BY STATE AND TERRITORY

In 2016 (the baseline year used for measuring treatment uptake), the prevalence of CHC was estimated to be highest in the NT (69.8% higher than the national average) and lowest in SA (28.7% lower than the national average) (Table A.1). The prevalence of CHC was also estimated to be higher than the national average in Tas (22.4% higher), NSW (11.3% higher) and Qld (8.8% higher); and lower than the national average in WA (6.3% lower), the ACT (7.9% lower) and Vic (15.0% lower) (Table A.1).

Table A.1: Variation in estimated prevalence of CHC in 2016, relative to the national average, by state and territory

State/territory	Estimated CHC prevalence in 2016 relative to national average (% higher or lower)
ACT	-7.9%
NSW	+11.3%
NT	+69.8%
Qld	+8.8%
SA	-28.7%
Tas	+22.4%
Vic	-15.0%
WA	-6.3%

CHC, chronic hepatitis C.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. 2016 is used as the baseline for National Strategy treatment uptake targets.

Totals may not add up due to inclusion of people without a state or territory of residence recorded in source data.

Prevalence may be overestimated or underestimated in a given region due to limitations in notifications as a source for the number living with CHC. For more information, see [How to use the data](#).

Due to the reliance on notifications to estimate hepatitis C virus (HCV) prevalence, estimation of treatment uptake variation is influenced by variation between regions in diagnosis coverage and migration. These estimates are also adjusted to account for movement, which has been estimated using linked national data that records location information among those with a history of hepatitis C service provision.³ Due to this adjustment, estimated variation in CHC prevalence according to state/territory and PHN in the current report is different from data in previous reports. CHC prevalence⁶ and injecting drug use prevalence data do suggest that the variation by state and territory estimated here is consistent with other indicators, for example, being higher than average in the NT. However, there remains uncertainty in the true variation in CHC prevalence by region.

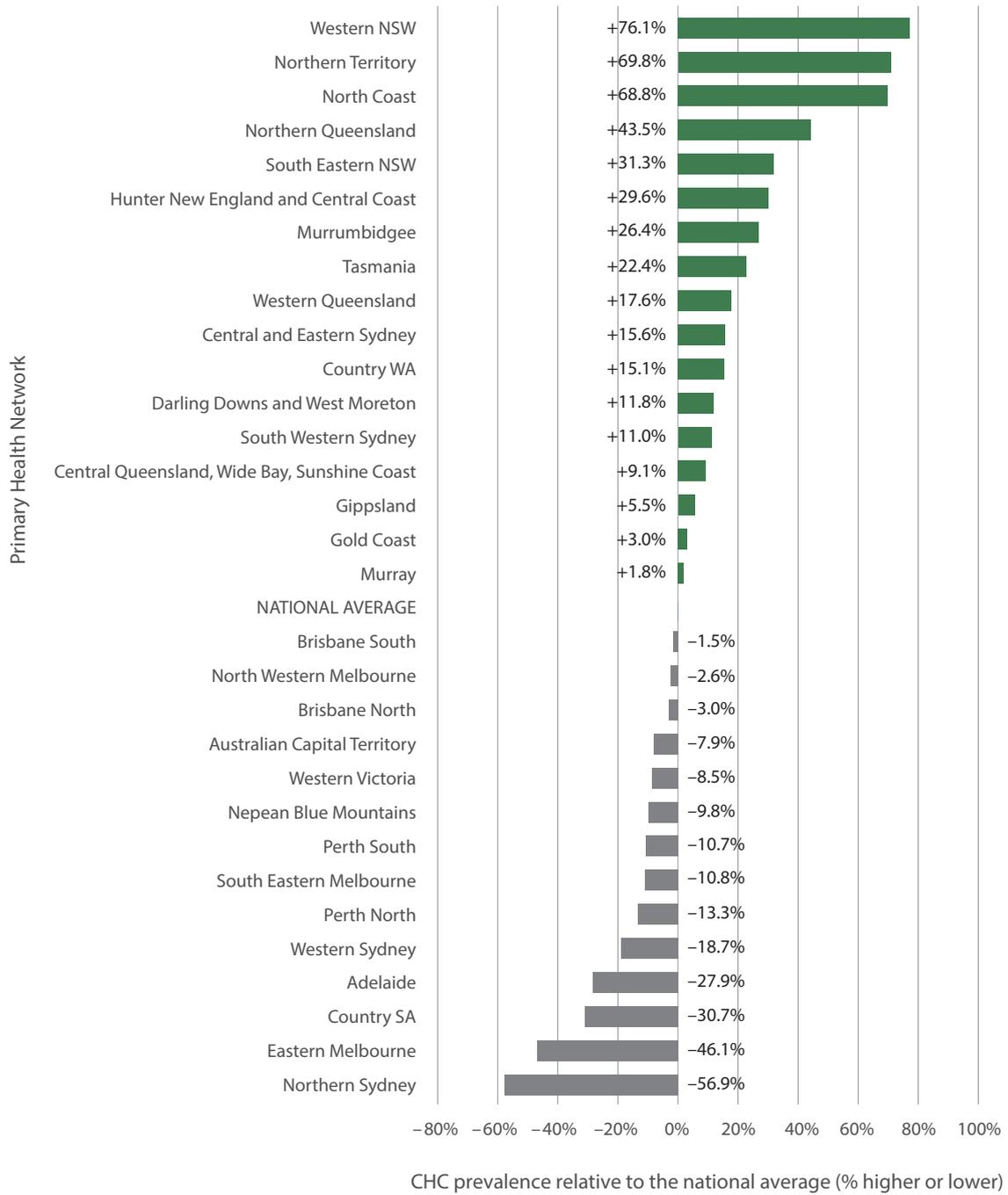
Accurate, systematically collected data on CHC testing and seroprevalence would assist in clarifying these regional variations and allow for verification of treatment uptake estimates. Additionally, linkage of data regarding CHC notifications and treatment would also provide far more information regarding treatment uptake at an individual level.

PREVALENCE VARIATION BY PRIMARY HEALTH NETWORK

The estimated prevalence of CHC also varied considerably by PHN (Figure A.1). Prevalence was estimated to be highest in the **Western NSW** (76.1% higher than the national average), **Northern Territory** (69.8% higher), **North Coast NSW** (68.8% higher) and **Northern Queensland** (43.5% higher) PHNs. Prevalence was generally estimated to be higher in rural and regional PHNs; however, due to urban population concentration, this does not always reflect the greatest absolute numbers of people living with CHC. The relatively greater burden of CHC in non-metropolitan areas presents challenges for access to care and treatment, particularly in regions where hepatitis C treatment services may be limited.⁷

As with the findings by state and territory, estimation of uptake variation by PHN is influenced by underlying notifications data, which may not necessarily reflect underlying prevalence.

Figure A.1: Estimated variation in prevalence of CHC in 2016, compared to the national average, by PHN



CHC, chronic hepatitis C. PHN, Primary Health Network.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. 2016 is used as baseline for the National Strategy treatment uptake targets. ([See data for this figure](#))

Prevalence may be overestimated or underestimated in a given region due to limitations in notifications as a source for the number living with CHC. For more information, see [How to use the data](#).

TREATMENT

TREATMENT NUMBERS AND TRENDS OVER TIME

A total of 112,863 people received DAA treatment for hepatitis C between March 2016 and May 2025.

The monthly average number of people who received treatment has fluctuated over time. There was a consistently decreasing trend from 3,241 per month in 2016 to 432 per month in 2022 (Table A.2, Figure A.2).

However, in 2023 and 2024, the average number receiving treatment per month was higher than in 2022 (455 and 436 per month, respectively). This represented the first increase in treatment numbers since DAA treatment became available. During January–May 2025, the monthly average number receiving treatment declined again to 335 per month.

Table A.2: Monthly average number of people receiving CHC treatment by state/territory, March 2016 – May 2025

State/ territory	Monthly average number of people who received treatment									
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
ACT	63	23	16	11	8	7	5	4	5	5
NSW	1,116	599	422	320	229	166	138	166	160	125
NT	34	17	9	8	5	4	3	3	2	3
Qld	667	360	294	227	179	147	121	126	114	79
SA	204	114	76	51	39	30	20	19	19	10
Tas	73	53	33	18	15	14	9	8	7	5
Vic	857	437	306	221	137	111	84	79	77	63
WA	227	168	126	98	76	69	51	51	50	42
AUSTRALIA	3,241	1,771	1,281	954	688	548	432	455	436	335

CHC, chronic hepatitis C.

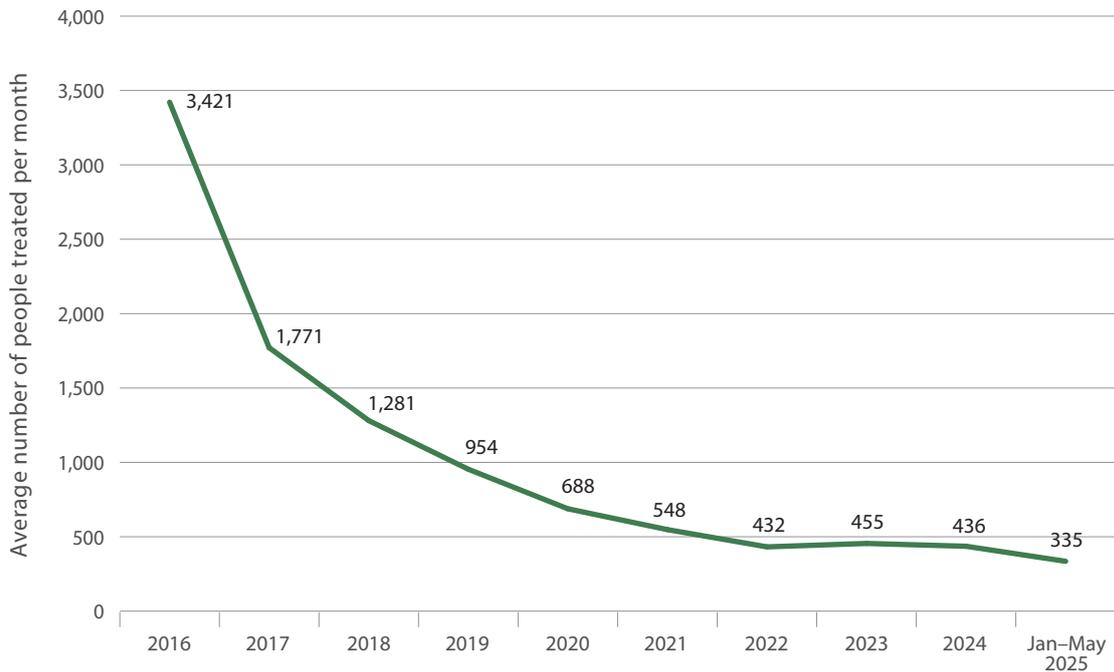
Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare statistics.

For more information regarding the presentation of data in this report, see [How to use the data](#).

These monthly trends varied substantially by state and territory (see [Treatment numbers and trends over time by state and territory](#)).

The data include all PBS prescriptions delivered through both the Section 85 and Section 100 schemes and include those who were treated while residing in correctional facilities. All uptake data reported here count each individual treated once regardless of the total number of courses, and re-treatment data are identified separately later in this report (see [Re-treatment](#)).

Figure A.2: Monthly average number of people receiving CHC treatment in Australia, by year, March 2016 – May 2025



CHC, chronic hepatitis C.

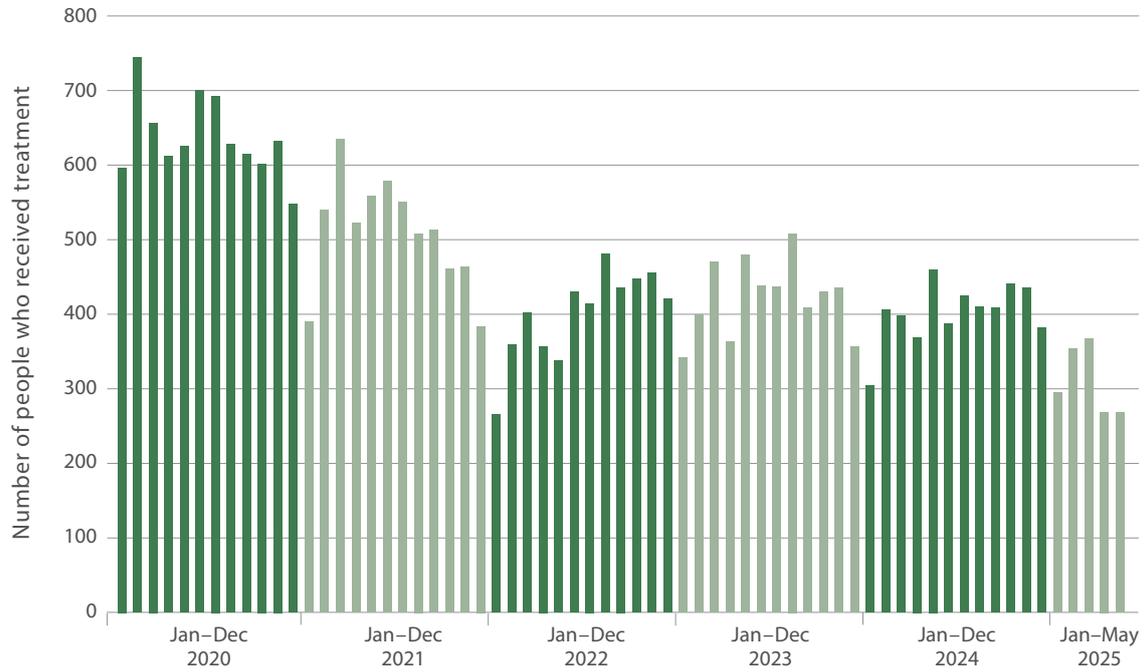
Data source: Treatment data sourced from Medicare statistics. ([See data for this figure](#))

For more information regarding the presentation of data in this report, see [How to use the data](#).

The number of people treated in each month from January 2020 to May 2025 is shown in Figure A.3. The number of people who received treatment in May 2025 (289) was the lowest monthly number since January 2022.

The monthly average decline was most pronounced between 2016 and 2017 (45.4% decline), with smaller reductions during 2018–2022 (20–28% per year; Figure A.2, Table A.3). In 2023, the monthly average increased by 5.3%, followed by declines in 2024 (4.2%) and in January–May 2025 (23.2%). These reduction trends varied widely by region, as discussed in each section below.

Figure A.3: Number of people receiving CHC treatment in Australia, by month, January 2020 – May 2025



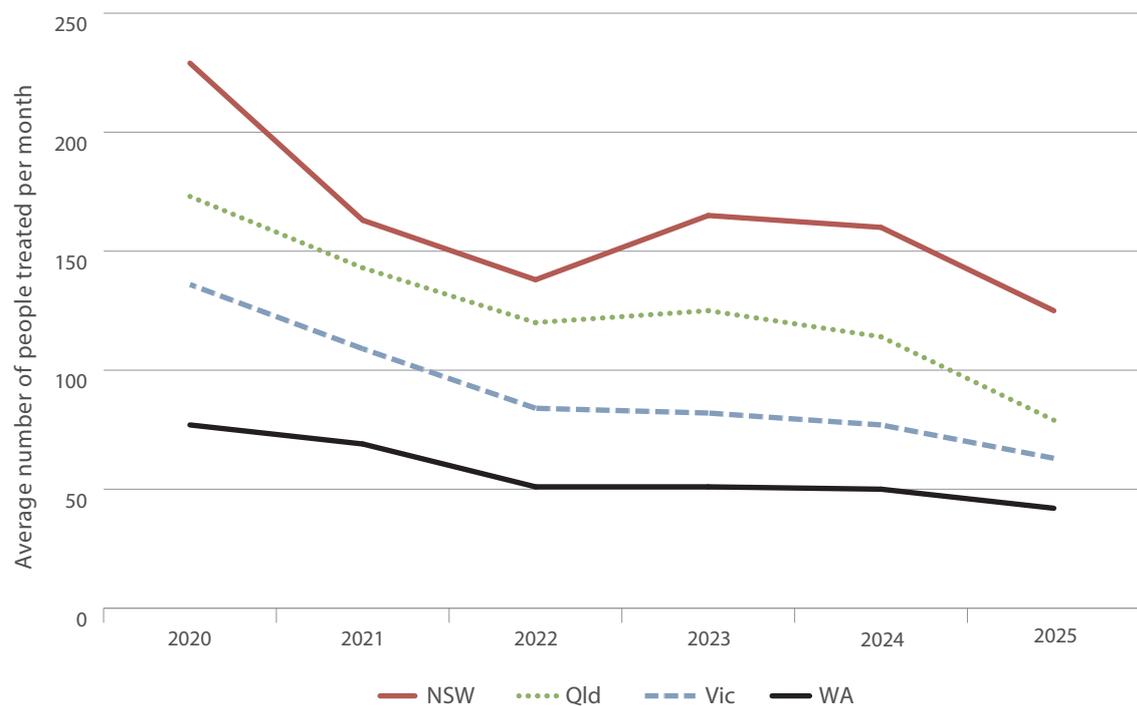
CHC, chronic hepatitis C.

Data source: Treatment data sourced from Medicare statistics. ([See data for this figure](#))

TREATMENT NUMBERS AND TRENDS OVER TIME BY STATE AND TERRITORY

Trends in hepatitis C treatment numbers have varied by state and territory (Figure A.4, Figure A.5). In most jurisdictions, the previously stable annual decline in the number of people receiving treatment was interrupted during 2023–2024, followed by a return to previous declining trends in 2025. Note that trends should be interpreted cautiously for the NT and the ACT, as the monthly average number of people receiving treatment is frequently ≤ 5 per month (Table A.3).

Figure A.4: Monthly average number of people receiving CHC treatment by state/territory, January 2020 – May 2025 (NSW, Qld, Vic, WA)

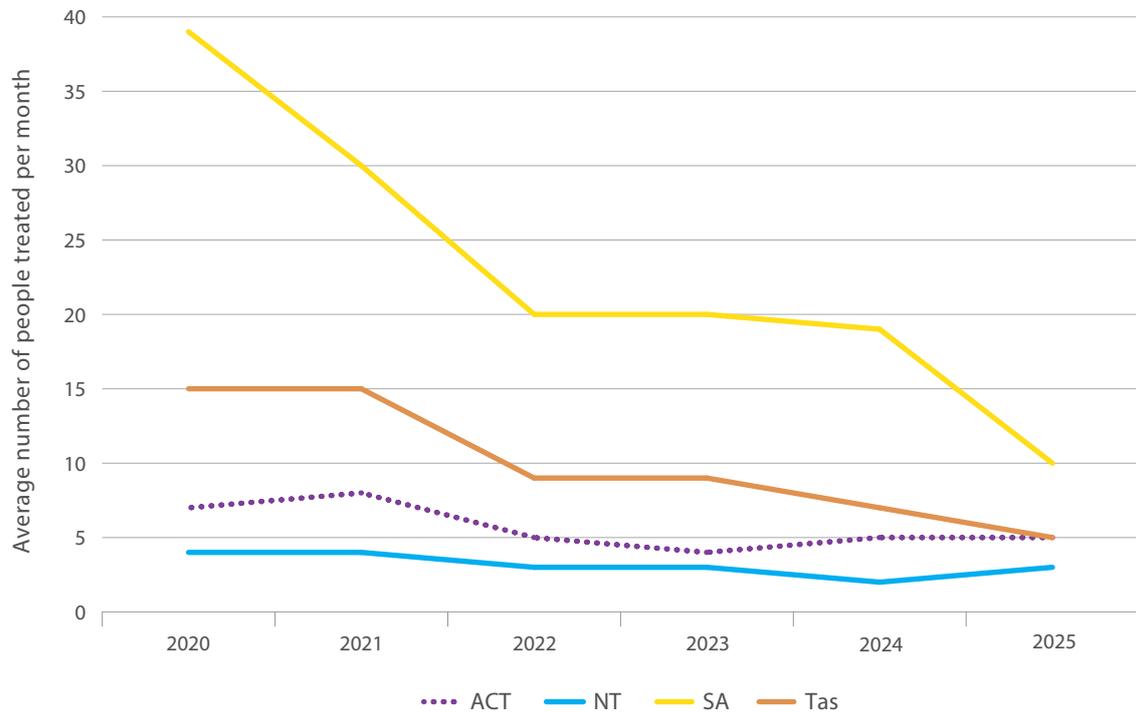


CHC, chronic hepatitis C.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare. (See data for this figure)

For more information regarding the presentation of data in this report, see [How to use the data](#).

Figure A.5: Monthly average number of people receiving CHC treatment by state/territory, January 2020 – May 2025 (ACT, NT, SA, Tas)



CHC, chronic hepatitis C.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare. ([See data for this figure](#))

For more information regarding the presentation of data in this report, see [How to use the data](#).

In NSW and Qld, the number of people receiving treatment increased between 2022 and 2023 (Figure A.4), while in SA, Tas, Vic and WA, the number remained stable (Figure A.4, Figure A.5). Between 2023 and 2024, there were again declines; however, these were substantially smaller than the annual declines from 2016 to 2022 (Table A.2).

During 2025 (data for January–May available), treatment declined again in all states and territories, by a similar magnitude as the trend from 2016 to 2022 (Table A.3).

Table A.3: Proportional change in monthly average number of people receiving CHC treatment, compared to the previous year, by state/territory, March 2016 – May 2025

State/ territory	Change in monthly average by year									Total change
	2016–2017	2017–2018	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024	2024–2025	
ACT	–63.5%	–30.4%	–31.3%	–27.3%	–12.5%	–28.6%^	–20.0%^	+25.0%^	0.0%^	–92.1%
NSW	–46.3%	–29.5%	–24.2%	–28.4%	–27.5%	–16.9%	+20.3%	–3.6%	–21.9%	–88.8%
NT	–50.0%	–47.1%	–11.1%	–37.5%^	–20.0%^	–25.0%^	0.0%^	–33.3%^	+50.0%^	–91.2%
Qld	–46.0%	–18.3%	–22.8%	–21.1%	–17.9%	–17.7%	+4.1%	–9.5%	–30.7%	–88.2%
SA	–44.1%	–33.3%	–32.9%	–23.5%	–23.1%	–33.3%	–5.0%	0.0%	–47.4%	–95.1%
Tas	–27.4%	–37.7%	–45.5%	–16.7%	–6.7%	–35.7%	–11.1%	–12.5%	–28.6%	–93.2%
Vic	–49.0%	–30.0%	–27.8%	–38.0%	–19.0%	–24.3%	–6.0%	–2.5%	–18.2%	–92.6%
WA	–26.0%	–25.0%	–22.2%	–22.4%	–9.2%	–26.1%	0.0%	–2.0%	–16.0%	–81.5%
AUSTRALIA	–45.4%	–27.7%	–25.5%	–27.9%	–20.3%	–21.2%	+5.3%	–4.2%	–23.2%	–89.7%

CHC, chronic hepatitis C.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare.

For more information regarding the presentation of data in this report, see [How to use the data](#).

^ Low monthly average number; interpret change with caution.

Key: Green denotes greatest proportional increase with the colour gradient through to red, which denotes greatest proportional decrease. Grey denotes low monthly average number, which limits interpretation of proportional change.

TREATMENT NUMBERS AND TRENDS OVER TIME BY PRIMARY HEALTH NETWORK

Although the magnitude of changes varied by PHN and year, there was an annual decline in the number of people receiving treatment between 2016 and 2022 in the vast majority of PHNs (Table A.4, Table A.5).

Between 2022 and 2023, this trend shifted, and in 15 of Australia's 31 PHNs there was an increase in the number of people treated, with most located in NSW (8 of the 10 PHNs in the state) and Qld (3 of the 7 PHNs in the state) (Table A.4, Table A.5). In another seven PHNs, the number of people treated remained stable between 2022 and 2023.

Between 2023 and 2024, there were increases in the number of people treated in seven PHNs, and treatment numbers remained stable in another seven (Table A.4, Table A.5).

Monthly average treatment numbers declined during January–May 2025 compared to 2024 in all but three PHNs (Table A.4, Table A.5). In two of the PHNs with a stable or increasing number, two had monthly average numbers <5, and should be interpreted with caution.

Table A.4: Monthly average number of people who received CHC treatment by PHN, March 2016 – May 2025

Primary Health Network	Monthly average number of people who received treatment									
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Adelaide	148	82	55	38	28	22	15	14	14	7
Australian Capital Territory	63	23	16	11	8	7	5	4	5	5
Brisbane North	110	55	52	36	28	22	19	20	19	14
Brisbane South	135	83	69	57	45	37	29	29	24	19
Central and Eastern Sydney	255	104	66	49	33	23	18	22	20	15
Central Queensland, Wide Bay, Sunshine Coast	124	72	60	41	35	24	22	23	26	16
Country SA	56	32	21	13	11	8	5	5	5	3
Country WA	58	41	29	25	19	16	12	13	12	10
Darling Downs and West Moreton	72	45	39	34	26	24	15	18	17	12
Eastern Melbourne	154	64	42	32	22	15	11	11	11	9
Gippsland	55	32	24	16	9	7	6	5	6	3
Gold Coast	94	51	29	21	15	13	13	11	9	5
Hunter New England and Central Coast	200	133	98	73	51	40	30	38	36	27
Murray	91	51	39	29	19	15	11	13	12	9
Murrumbidgee	24	21	17	13	10	6	7	7	9	6
Nepean Blue Mountains	34	26	22	14	11	6	5	7	7	5
North Coast	178	74	45	38	28	19	17	19	16	14
North Western Melbourne	229	117	87	61	39	35	23	23	24	20

Continued next page

	Monthly average number of people who received treatment									
Primary Health Network	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Northern Queensland	127	52	41	35	29	25	22	21	19	12
Northern Sydney	60	25	16	12	7	5	4	4	5	4
Northern Territory	34	17	9	8	5	4	3	3	2	3
Perth North	90	64	45	33	26	25	17	16	17	14
Perth South	79	63	52	40	31	27	21	22	21	17
South Eastern Melbourne	234	111	70	53	33	25	19	16	16	12
South Eastern NSW	103	58	37	29	20	17	13	18	18	14
South Western Sydney	119	64	46	35	26	17	17	19	18	15
Tasmania	73	53	33	18	15	14	9	8	7	5
Western NSW	56	41	33	26	20	17	13	14	14	12
Western Queensland	4	2	2	2	2	2	2	3	2	*
Western Sydney	87	53	43	31	24	15	14	18	17	15
Western Victoria	95	62	44	30	15	15	13	11	7	9
AUSTRALIA	3,241	1,771	1,281	954	688	548	432	455	436	335

CHC, chronic hepatitis C. PHN, Primary Health Network.

Data source: Treatment data sourced from Medicare.

For more information regarding the presentation of data in this report, see [How to use the data](#).

* Suppressed as number of people receiving treatment in this year was ≤ 25 .

Table A.5: Proportional change in monthly average number of people who received CHC treatment by PHN, compared to the previous year, March 2016 – May 2025

Primary Health Network	Annual change in monthly average									Total change
	2016–2017	2017–2018	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024	2024–2025	
Adelaide	-44.6%	-32.9%	-30.9%	-26.3%	-21.4%	-31.8%	-6.7%	0.0%	-50.0%	-95.3%
Australian Capital Territory	-63.5%	-30.4%	-31.3%	-27.3%	-12.5%	-28.6%^	-20.0%^	+25.0%^	0.0%^	-92.1%
Brisbane North	-50.0%	-5.5%	-30.8%	-22.2%	-21.4%	-13.6%	+5.3%	-5.0%	-26.3%	-87.3%
Brisbane South	-38.5%	-16.9%	-17.4%	-21.1%	-17.8%	-21.6%	0.0%	-17.2%	-20.8%	-85.9%
Central and Eastern Sydney	-59.2%	-36.5%	-25.8%	-32.7%	-30.3%	-21.7%	+22.2%	-9.1%	-25.0%	-94.1%
Central Queensland, Wide Bay, Sunshine Coast	-41.9%	-16.7%	-31.7%	-14.6%	-31.4%	-8.3%	+4.5%	+13.0%	-38.5%	-87.1%
Country SA	-42.9%	-34.4%	-38.1%	-15.4%	-27.3%	-37.5%	0.0%^	0.0%^	-40.0%^	-94.6%
Country WA	-29.3%	-29.3%	-13.8%	-24.0%	-15.8%	-25.0%	+8.3%	-7.7%	-16.7%	-82.8%
Darling Downs and West Moreton	-37.5%	-13.3%	-12.8%	-23.5%	-7.7%	-37.5%	+20.0%	-5.6%	-29.4%	-83.3%
Eastern Melbourne	-58.4%	-34.4%	-23.8%	-31.3%	-31.8%	-26.7%	0.0%	0.0%	-18.2%	-94.2%
Gippsland	-41.8%	-25.0%	-33.3%	-43.8%	-22.2%	-14.3%	-16.7%	+20.0%	-50.0%^	-94.5%
Gold Coast	-45.7%	-43.1%	-27.6%	-28.6%	-13.3%	0.0%	-15.4%	-18.2%	-44.4%^	-94.7%
Hunter New England and Central Coast	-33.5%	-26.3%	-25.5%	-30.1%	-21.6%	-25.0%	+26.7%	-5.3%	-25.0%	-86.5%
Murray	-44.0%	-23.5%	-25.6%	-34.5%	-21.1%	-26.7%	+18.2%	-7.7%	-25.0%	-90.1%
Murrumbidgee	-12.5%	-19.0%	-23.5%	-23.1%	-40.0%	+16.7%	0.0%	+28.6%	-33.3%	-75.0%
Nepean Blue Mountains	-23.5%	-15.4%	-36.4%	-21.4%	-45.5%	-16.7%	+40.0%	0.0%	-28.6%^	-85.3%
North Coast	-58.4%	-39.2%	-15.6%	-26.3%	-32.1%	-10.5%	+11.8%	-15.8%	-12.5%	-92.1%

Primary Health Network	Annual change in monthly average									Total change
	2016–2017	2017–2018	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023	2023–2024	2024–2025	2016–2025
North Western Melbourne	–48.9%	–25.6%	–29.9%	–36.1%	–10.3%	–34.3%	0.0%	+4.3%	–16.7%	–91.3%
Northern Queensland	–59.1%	–21.2%	–14.6%	–17.1%	–13.8%	–12.0%	–4.5%	–9.5%	–36.8%	–90.6%
Northern Sydney	–58.3%	–36.0%	–25.0%	–41.7%	–28.6%^	–20.0%^	0.0%^	+25.0%^	–20.0%^	–93.3%
Northern Territory	–50.0%	–47.1%	–11.1%	–37.5%^	–20.0%^	–25.0%^	0.0%^	–33.3%^	+50.0%^	–91.2%
Perth North	–28.9%	–29.7%	–26.7%	–21.2%	–3.8%	–32.0%	–5.9%	+6.3%	–17.6%	–84.4%
Perth South	–20.3%	–17.5%	–23.1%	–22.5%	–12.9%	–22.2%	+4.8%	–4.5%	–19.0%	–78.5%
South Eastern Melbourne	–52.6%	–36.9%	–24.3%	–37.7%	–24.2%	–24.0%	–15.8%	0.0%	–25.0%	–94.9%
South Eastern NSW	–43.7%	–36.2%	–21.6%	–31.0%	–15.0%	–23.5%	+38.5%	0.0%	–22.2%	–86.4%
South Western Sydney	–46.2%	–28.1%	–23.9%	–25.7%	–34.6%	0.0%	+11.8%	–5.3%	–16.7%	–87.4%
Tasmania	–27.4%	–37.7%	–45.5%	–16.7%	–6.7%	–35.7%	–11.1%	–12.5%	–28.6%^	–93.2%
Western NSW	–26.8%	–19.5%	–21.2%	–23.1%	–15.0%	–23.5%	+7.7%	0.0%	–14.3%	–78.6%
Western Queensland	–50.0%^	0.0%^	0.0%^	0.0%^	0.0%^	0.0%^	+50.0%^	–33.3%^	*	*
Western Sydney	–39.1%	–18.9%	–27.9%	–22.6%	–37.5%	–6.7%	+28.6%	–5.6%	–11.8%	–82.8%
Western Victoria	–34.7%	–29.0%	–31.8%	–50.0%	0.0%	–13.3%	–15.4%	–36.4%	+28.6%	–90.5%
AUSTRALIA	–45.4%	–27.7%	–25.5%	–27.9%	–20.3%	–21.2%	+5.3%	–4.2%	–23.2%	–89.7%

CHC, chronic hepatitis C. PHN, Primary Health Network.

Data source: Treatment data sourced from Medicare.

For more information regarding the presentation of data in this report, see [How to use the data](#).

* Suppressed as number of people receiving treatment in this year was ≤25.

^ Low monthly average number; interpret change with caution.

Key: Green denotes greatest proportional increase with the colour gradient through to red, which denotes greatest proportional decrease. Grey denotes low monthly average number, which limits interpretation of proportional change.

TREATMENT UPTAKE

It is estimated by the Kirby Institute that 66% of the 162,590 people living with CHC at the start of 2016 had received treatment by the end of 2024⁴ (calculation based on Kirby Institute data and may differ slightly from the ones in this report). In this report, treatment uptake is estimated for each geographic region relative to this national average (% higher or lower), based on the estimated prevalence in 2016 and the number of people who received treatment through the PBS (see [How to use the data](#) and [Prevalence variation by state and territory](#) for further information).

The national estimate of treatment uptake incorporates new infections into the denominator; however, local estimates that account for reinfection are not available. This may have the impact of underestimating or overestimating uptake in a given area if new infections are occurring at a higher or lower rate than average. Further data are required to validate estimates of uptake variation by geographic region.

TREATMENT UPTAKE VARIATION BY STATE AND TERRITORY

Treatment uptake at the end of May 2025 was estimated to be higher than the national average in SA (13.1% higher) and Vic (7.0% higher); similar to the national average in Qld (4.9% higher), WA (3.8% lower) and NSW (4.1% lower); and lower than the national average in the ACT (9.6% lower), Tas (12.3% lower) and the NT (48.6% lower) (Table A.6).

Table A.6: Estimated CHC treatment uptake variation by state/territory, March 2016 – May 2025

State/ territory	Number of people who received treatment	Estimated uptake relative to national average (% higher or lower)
ACT	1,588	-9.6%
NSW	38,197	-4.1%
NT	967	-48.6%
Qld	25,877	+4.9%
SA	6,518	+13.1%
Tas	2,641	-12.3%
Vic	26,305	+7.0%
WA	10,738	-3.8%
AUSTRALIA	112,863	-

CHC, chronic hepatitis C.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare statistics.

Totals may not add up due to inclusion of people without a state or territory of residence recorded in source data.

For more information regarding the presentation of data in this report, see [How to use the data](#).

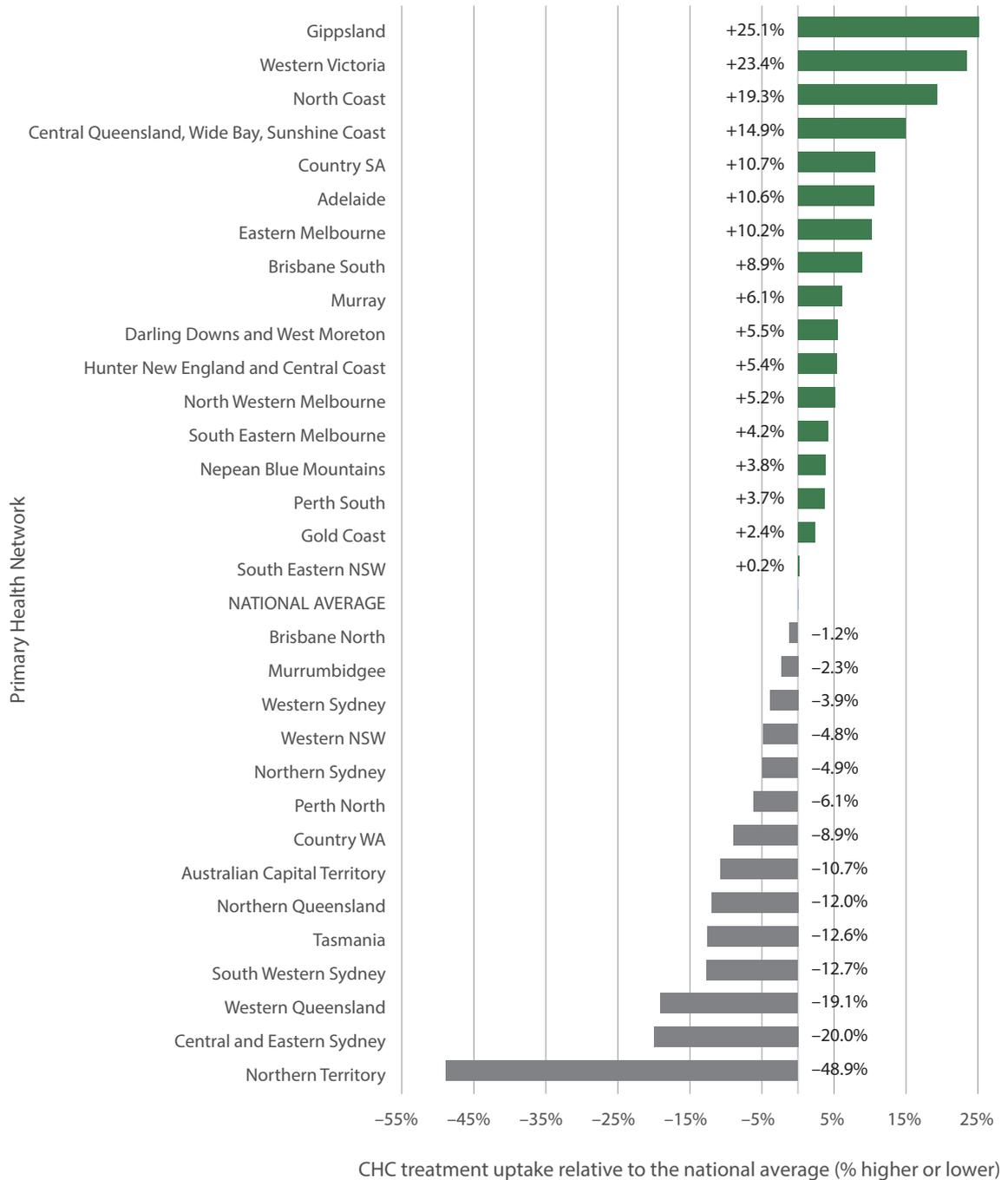
TREATMENT UPTAKE VARIATION BY PRIMARY HEALTH NETWORK

Estimated treatment uptake to May 2025 varied by PHN (Figure A.6), often reflecting state and territory findings. Treatment uptake was estimated to be highest in the **Gippsland** (30.6% higher than the national average), **Western Victoria** (23.0% higher), **North Coast NSW** (22.6% higher) and **Central Queensland, Wide Bay and Sunshine Coast** (19.2% higher) PHNs (Figure A.6; see [How to use the data](#) for further information about uptake measurement).

Treatment uptake was estimated to be lowest in the **Northern Territory** (48.6% lower than the national average) and **Central and Eastern Sydney** (20.4% lower) PHNs (Figure A.6). Treatment uptake variation by PHN is shown in map form in Figures A.7 and A.8.

Estimation of uptake variation by state and territory is influenced by the level of movement and number of duplicate notifications among people diagnosed with hepatitis C. Adjustment has been applied based on observed movement between PHNs among people with hepatitis C;³ however, residual impact may remain, and further data linkage that assesses notified cases is required to further elucidate uptake.

Figure A.6: CHC treatment uptake variation in Australia by PHN, relative to the national average, March 2016 – May 2025

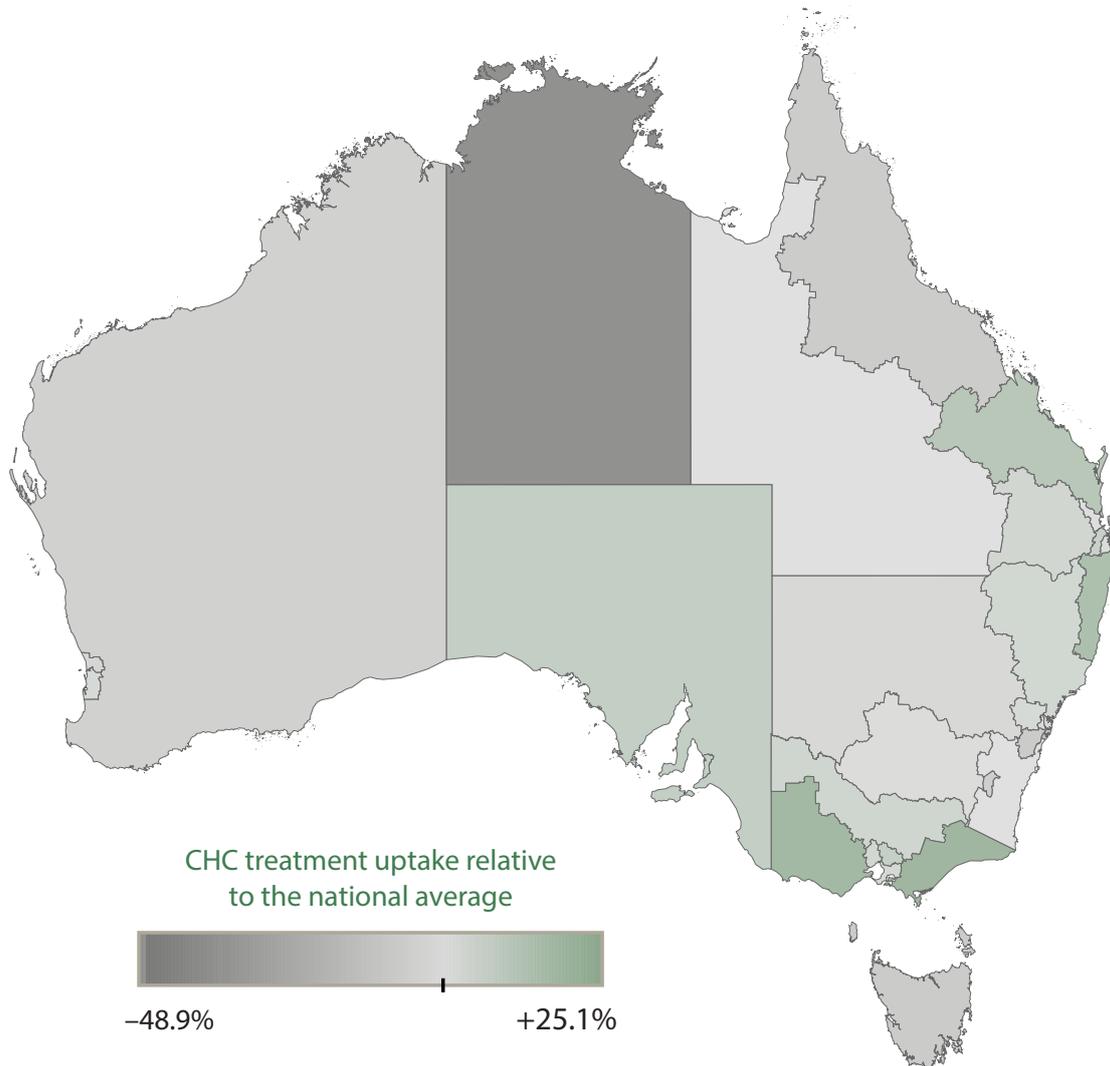


CHC, chronic hepatitis C. PHN, Primary Health Network.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare. ([See data for this figure](#))

Treatment uptake may be underestimated in a given region due to limitations in notifications as a source for the number living with CHC. For more information, see [How to use the data](#).

Figure A.7: Map of CHC treatment uptake in Australia by PHN, relative to the national average, March 2016 – May 2025

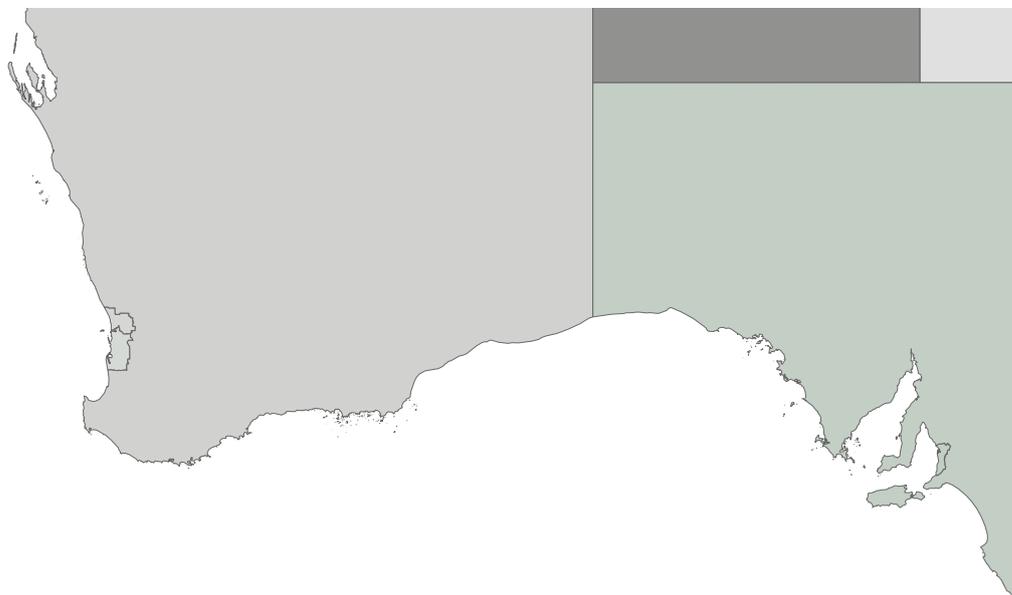
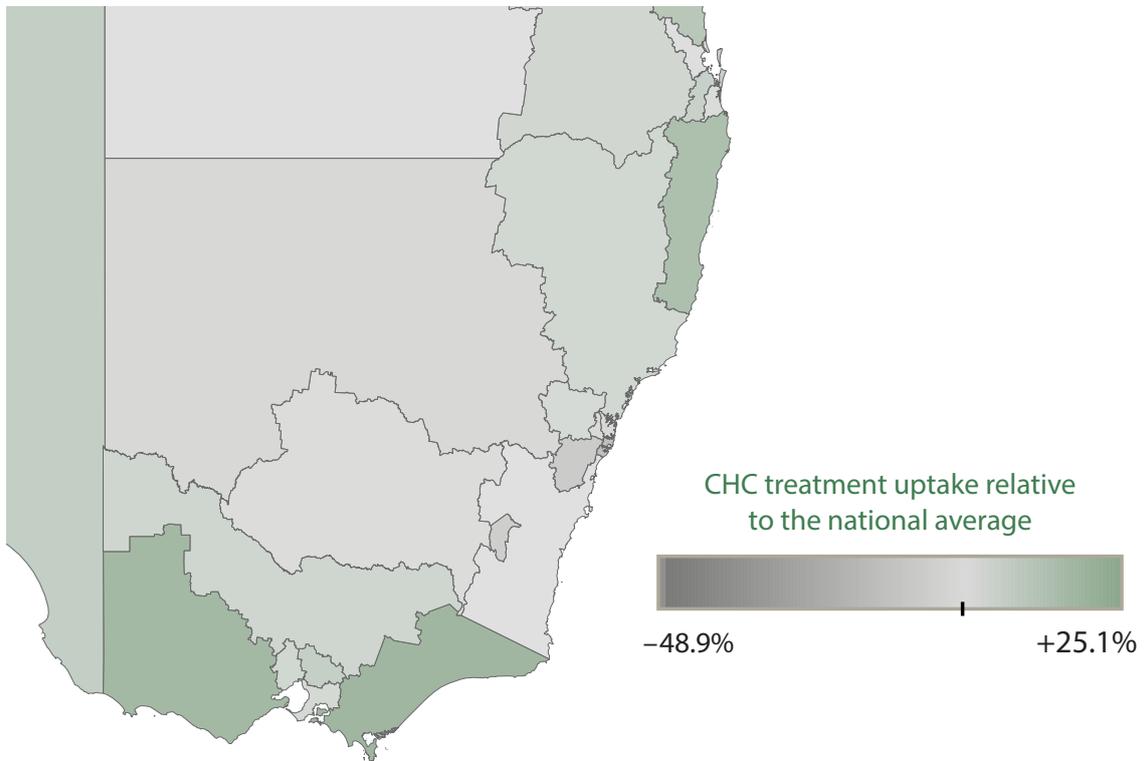


CHC, chronic hepatitis C. PHN, Primary Health Network.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare.

Treatment uptake may be underestimated in a given region due to limitations in notifications as a source for the number living with CHC. For more information, see [How to use the data](#).

Figure A.8: Map of CHC treatment uptake by PHN, relative to the national average, March 2016 – May 2025 (capital city PHNs in ACT, NSW, Qld, SA, Vic and WA)



CHC, chronic hepatitis C. PHN, Primary Health Network.

Data source: CHC prevalence estimates based on published national estimates and notifications distribution. Treatment data sourced from Medicare.

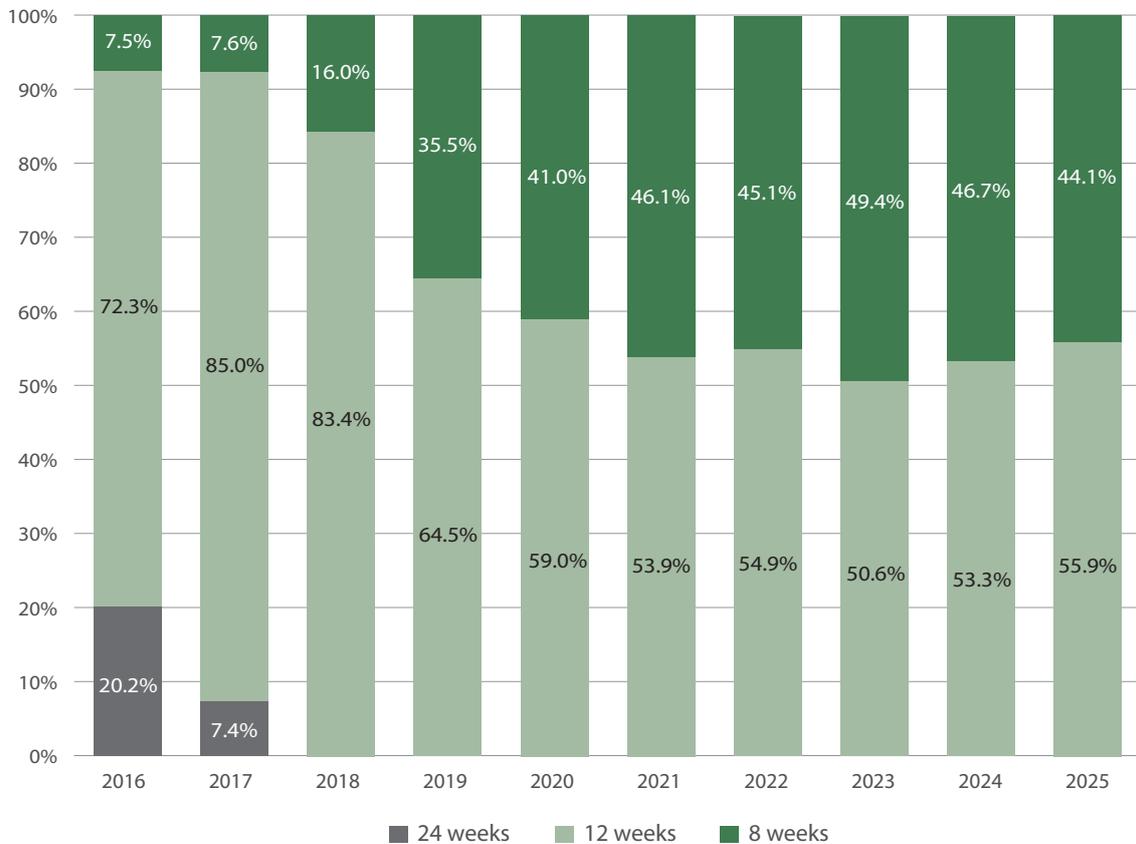
Treatment uptake may be underestimated in a given region due to limitations in notifications as a source for the number living with CHC. For more information, see [How to use the data](#).

TREATMENT DURATION

The distribution of treatment course duration has shifted substantially over time, with an increase in the proportion of eight-week scripts (from 7.5% in 2016 to 44.1% in 2025) and a decrease in the proportion of 12-week scripts (from 72.3% to 55.9%) (Figure A.9).

The proportion of 24-week scripts reduced from 20.2% in 2016 to 7.4% in 2017, and remained ≤1% during 2018–2025. This change reflects the reduced prevalence of cirrhosis among people currently receiving treatment⁸ and the increased availability of newer DAAs with shorter treatment durations for people with cirrhosis.⁹ In all years between 2016 and 2025, 16-week treatment was rare (<1%).

Figure A.9: Proportion of CHC treatment by course duration (8-, 12- and 24-week courses), by year, March 2016 – May 2025



CHC, chronic hepatitis C.

Data source: Treatment data sourced from Medicare statistics. Treatment duration is based on the number of weeks of dispensing indicated in the Medicare item code. ([See data for this figure](#))

All data for 16-week duration treatment and 2019–2024 data for 24-week duration treatment are suppressed due to low numbers; totals reported are calculated excluding these durations in relevant years.

TREATMENT PROVIDERS AND TRENDS OVER TIME

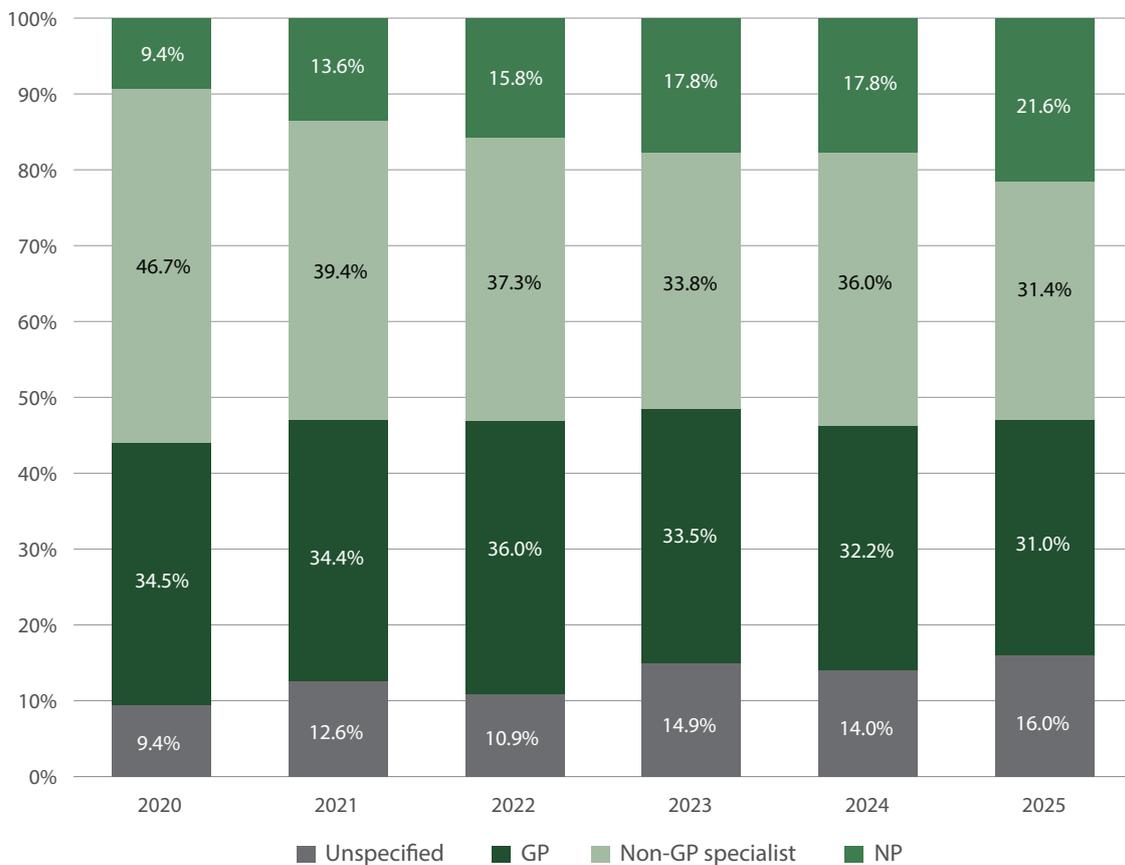
Complete data regarding prescriber specialty for CHC treatment was available for the period January 2020 – May 2025. The data reported rely on the registered specialty of the prescriber as recorded by Medicare, which accurately classifies NPs.¹⁰

From January 2020 to May 2025, the prescriber for 39.0% of people treated was a non-GP specialist, most commonly one specialising in gastroenterology/hepatology (64.6% of those prescribed by a non-GP specialist) or an infectious diseases physician (21.9%). A GP was the prescriber for 34.0% of people who received treatment from January 2020 to May 2025, while an NP was the prescriber for 14.7%. A further 11.1% of people treated had a provider without a classifiable specialty. This included non-vocationally registered doctors (most commonly GPs who were registered prior to the implementation of GP specialty codes), Rural Other Medical Practitioners and interns.

Between 2020 and 2025, prescribing by non-GP specialists decreased as a proportion of total treatment, from 46.7% in 2020 to 31.4% in 2025 (Figure A.10). The proportion prescribed by NPs more than doubled (from 9.4% to 21.6%) while the proportion prescribed by GPs declined slightly (from 34.5% to 31.0%) (Figure A.10).

People treated by NPs were younger than the national average, with 76.8% aged under 50 years, compared to 62.2% of the overall treated population and 55.3% of those prescribed by non-GP specialists.

Figure A.10: Proportion of CHC treatment by prescriber specialty, by year, January 2020 – May 2025



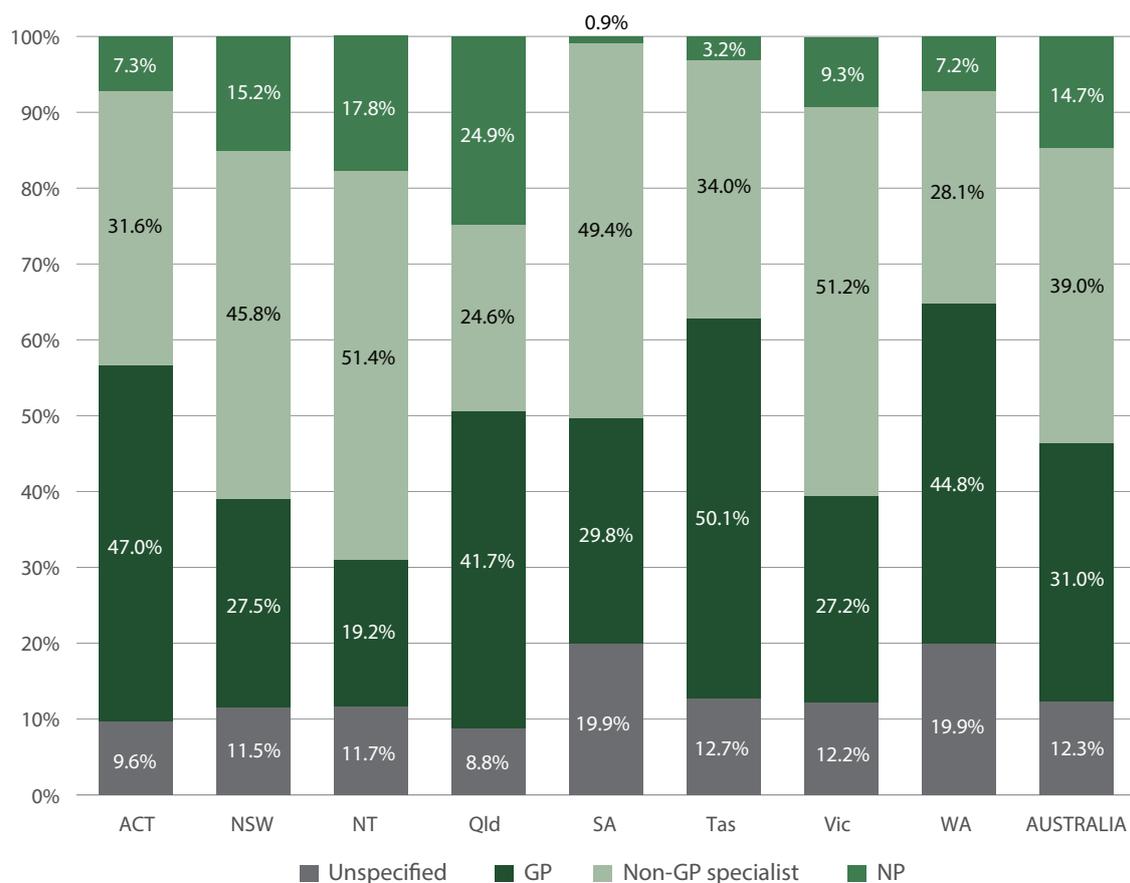
CHC, chronic hepatitis C. GP, general practitioner. NP, nurse practitioner.

Data source: Treatment data sourced from Medicare statistics using registered provider specialty. Unspecified providers include non-vocationally registered doctors, Rural Other Medical Practitioners and interns. ([See data for this figure](#))

TREATMENT PROVIDERS AND TRENDS OVER TIME BY STATE AND TERRITORY

GP prescribing made up the greatest proportion of CHC treatment in Tas (50.1% of treatment), the ACT (47.0%) and WA (44.8%; Figure A.11). NP prescribing was most common in Qld (24.9% of treatment) and the NT (17.8%).

Figure A.11: Proportion of CHC treatment by prescriber specialty, by state and territory, January 2020 – May 2025



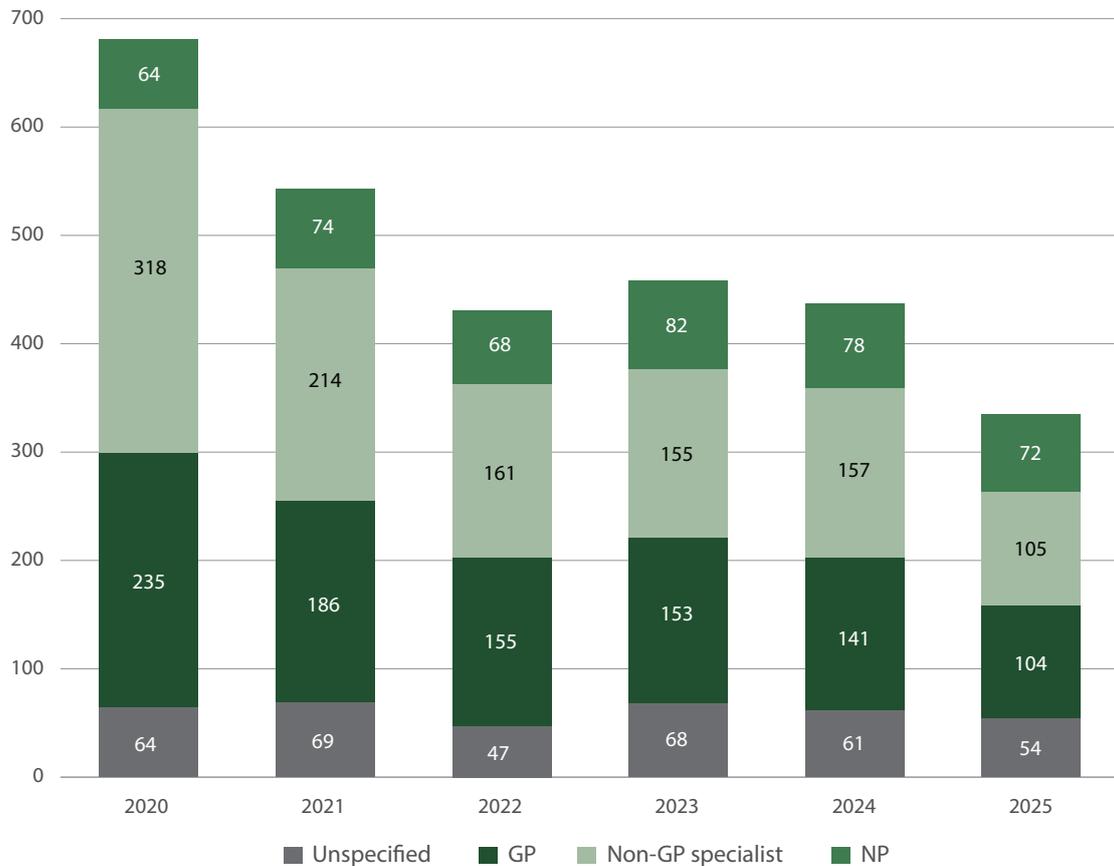
CHC, chronic hepatitis C. GP, general practitioner. NP, nurse practitioner.

Data source: Treatment data sourced from Medicare statistics using registered provider specialty. Unspecified providers include non-vocationally registered doctors, Rural Other Medical Practitioners and interns. ([See data for this figure](#))

The decline in non-GP specialist prescribing and increase in NP prescribing occurred in all states and territories between 2020 and 2025. In NSW, where this change was the most substantial, the number of people prescribed treatment by an NP increased by 51%, while GP prescribing remained stable.

The monthly average number of people treated by provider is shown in Figure A.12, demonstrating that the increase in CHC treatment from 2022 to 2023 occurred predominantly among those prescribed by NPs, while the number prescribed by GPs and non-GP specialists remained stable or declined.

Figure A.12: Monthly average number of people receiving CHC treatment, by year and provider, January 2020 – May 2025



CHC, chronic hepatitis C. GP, general practitioner. NP, nurse practitioner.

Data source: Treatment data sourced from Medicare statistics using registered provider speciality. Unspecified providers include non-vocationally registered doctors, Rural Other Medical Practitioners and interns. ([See data for this figure](#))

TREATMENT PROVIDERS AND TRENDS OVER TIME BY PRIMARY HEALTH NETWORK

In 18 PHNs, non-GP specialists were the most common prescriber of CHC treatment, while GPs were the most common in the remaining 13 PHNs (Table A.7).

PHNs with the highest proportion of GP prescribing were most commonly those with predominantly rural and remote populations, including **Western Queensland** (55.1% of treatment was by a GP), **Darling Downs and West Moreton** (50.2%), **Tasmania** (50.1%), **Australian Capital Territory** (47.7%) and **Northern Queensland** (47.1%).

The PHNs where NP prescribing was highest were **Brisbane South** (30.5%), **Darling Downs and West Moreton** (30.2%), **North Coast NSW** (28.9%) and **Brisbane North** (27.9%).

Due to the high proportion of treatment from 2020 to 2025 that was delivered to residents of correctional facilities,¹ the distribution of prescribers may be influenced by the models of care used in these populations.

Table A.7: Proportion of people treated for CHC by prescriber specialty (most common prescriber indicated in bold), by PHN, January 2020 – May 2025

Primary Health Network	Non-GP specialist	GP	NP	Unspecified
Adelaide	49.7%	28.2%	0.7%	21.4%
Australian Capital Territory	35.0%	47.7%	7.6%	9.6%
Brisbane North	23.4%	39.6%	27.9%	9.1%
Brisbane South	23.6%	37.0%	30.5%	8.9%
Central and Eastern Sydney	47.6%	22.8%	13.6%	16.0%
Central Queensland, Wide Bay, Sunshine Coast	29.2%	40.8%	24.6%	5.4%
Country SA	48.6%	33.9%	1.4%	16.1%
Country WA	25.5%	44.9%	5.9%	23.8%
Darling Downs and West Moreton	11.2%	50.2%	30.2%	8.3%
Eastern Melbourne	63.3%	21.9%	6.8%	8.0%
Gippsland	53.7%	27.2%	11.9%	7.2%
Gold Coast	28.6%	35.0%	23.4%	13.0%
Hunter New England and Central Coast	37.5%	29.6%	24.0%	8.9%
Murray	47.5%	27.6%	16.9%	8.0%
Murrumbidgee	37.2%	45.1%	8.5%	9.3%
Nepean Blue Mountains	44.7%	28.3%	6.2%	20.8%
North Coast	34.2%	31.9%	28.9%	5.0%
North Western Melbourne	48.3%	27.0%	9.5%	15.2%
Northern Queensland	32.3%	47.1%	12.1%	8.4%
Northern Sydney	57.1%	23.7%	9.7%	9.4%
Northern Territory	51.4%	19.2%	17.8%	11.7%
Perth North	28.4%	43.3%	8.5%	19.8%
Perth South	29.4%	45.8%	7.0%	17.8%
South Eastern Melbourne	51.4%	29.3%	7.3%	12.0%
South Eastern NSW	47.4%	32.9%	7.3%	12.4%
South Western Sydney	55.6%	23.2%	7.0%	14.2%
Tasmania	34.0%	50.1%	3.2%	12.7%
Western NSW	45.4%	22.0%	19.0%	13.6%
Western Queensland	23.5%	55.1%	15.3%	6.1%
Western Sydney	62.6%	20.2%	6.3%	10.9%
Western Victoria	46.9%	30.9%	5.9%	16.3%
AUSTRALIA	39.0%	34.0%	14.7%	21.4%

CHC, chronic hepatitis C. GP, general practitioner. NP, nurse practitioner. PHN, Primary Health Network.

Data source: Treatment data sourced from Medicare statistics using registered provider specialty. Unspecified providers include non-vocationally registered doctors, Rural Other Medical Practitioners and interns.

RE-TREATMENT

Of those treated for CHC from March 2016 to May 2025, the majority (97,150 people, 86.3%) received only a single course of treatment, while 15,380 people (13.7%) received more than one course of treatment.

The proportion of people who received more than one course of treatment varied according to state and territory, and was highest in Qld, where 16.5% of people treated received more than one course. The proportion was similar to the national average of 13.7% in WA (13.7%), NSW (13.6%), the ACT (12.9%), Vic (12.1%) and Tas (11.5%), and lower than the national average in the NT (9.7%) and SA (9.9%).

Re-treatment was more common among males, among whom 15.7% of those ever treated were re-treated, compared to females, among whom 9.2% of those treated were re-treated. Re-treatment was most common among those aged 20–29 at the time of their first script (31.4%).

It has been estimated that reinfection represented 56% of re-treatment instances from 2016 to 2022, while treatment failure represented 44%.¹ These demographic characteristics observed, including variation by state and territory, likely reflect variation in the populations who are more likely to be exposed to hepatitis C reinfection or experience treatment failure, due to factors such as the prevalence of injecting drug use and social factors that may impact the ability to continue treatment.

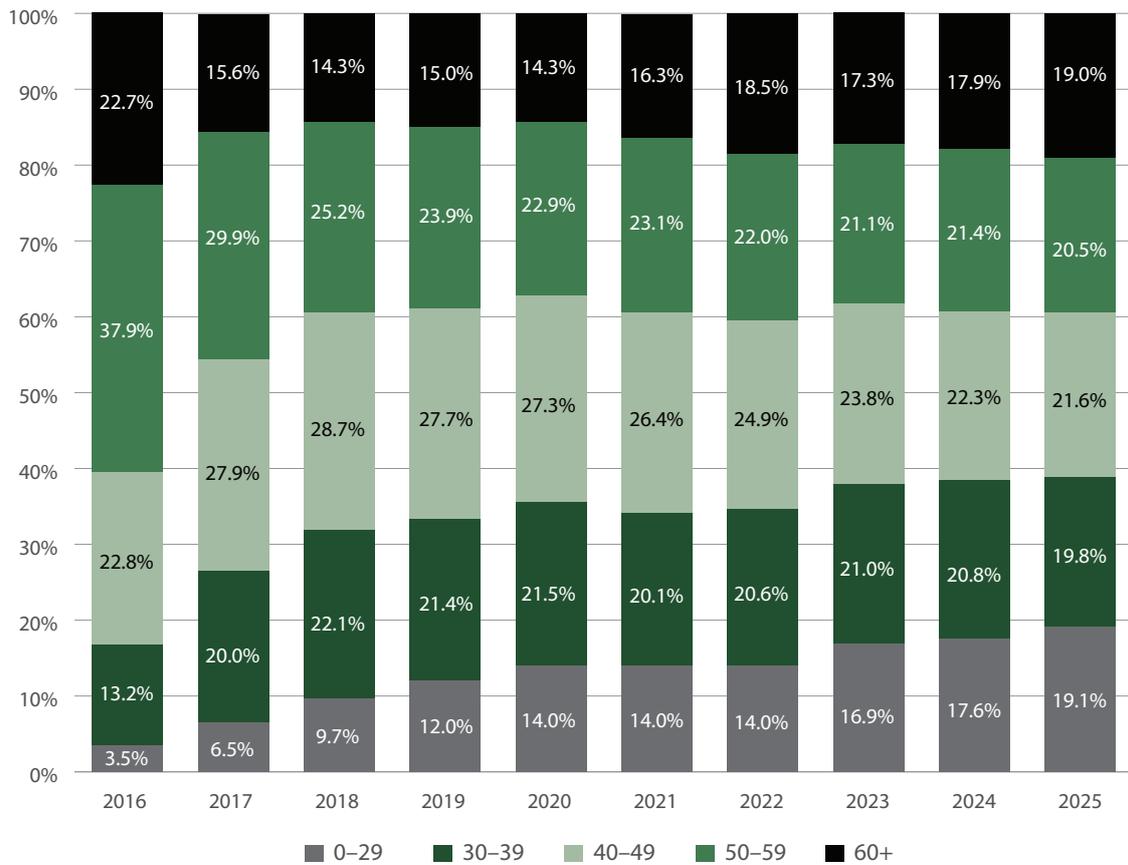
TREATMENT TRENDS BY AGE AND SEX

The age distribution of people treated for CHC shifted over time, with a reduction in the proportion aged over 50 and an increase in younger age groups. In 2016, people aged 50–59 were the most common group treated, making up 37.9% of the total (Figure A.13); however, by 2025, people treated were most commonly aged 40–49 (21.6% of the total). The proportion aged under 30 has increased from 3.5% to 19.1% between 2016 and 2025.

This shift in the predominant age groups receiving treatment likely reflects the initial uptake being concentrated in people who were older and who had more severe liver disease. Now that many of those older people have been treated, a higher proportion of treatment is prescribed to younger people, whose risk of adverse outcomes is less immediate.

Most people treated for CHC between March 2016 and May 2025 were male (69.1%), which reflects the epidemiology of CHC in Australia;⁴ this was also consistent across age groups. The male proportion has increased over time, from 66.2% in 2016 to 72.9% in 2025.

Figure A.13: Proportion of CHC treatment by age group, by year, March 2016 – May 2025



CHC, chronic hepatitis C.

Data source: Treatment data sourced from Medicare statistics. ([See data for this figure](#))

Age group based on age at the time of the first dispensed script for that person.

TREATMENT TRENDS BY ABORIGINAL AND/OR TORRES STRAIT ISLANDER STATUS

From 2016 to 2024, 15,891 Aboriginal and/or Torres Strait Islander people received CHC treatment, representing 14.3% of the total (Table A.8). This proportion increased from 7.7% in 2016 to 24.2% in 2024 (Figure A.14).

This proportion increased in all states and territories with sufficient numbers for reporting (Figure A.14). The proportion of people receiving treatment who were Aboriginal and/or Torres Strait Islander in 2024 was highest in WA (19.4%) and lowest in Vic (6.5%) (Table A.8). These trends reflect variations between states and territories in both treatment access and the populations affected by hepatitis C.

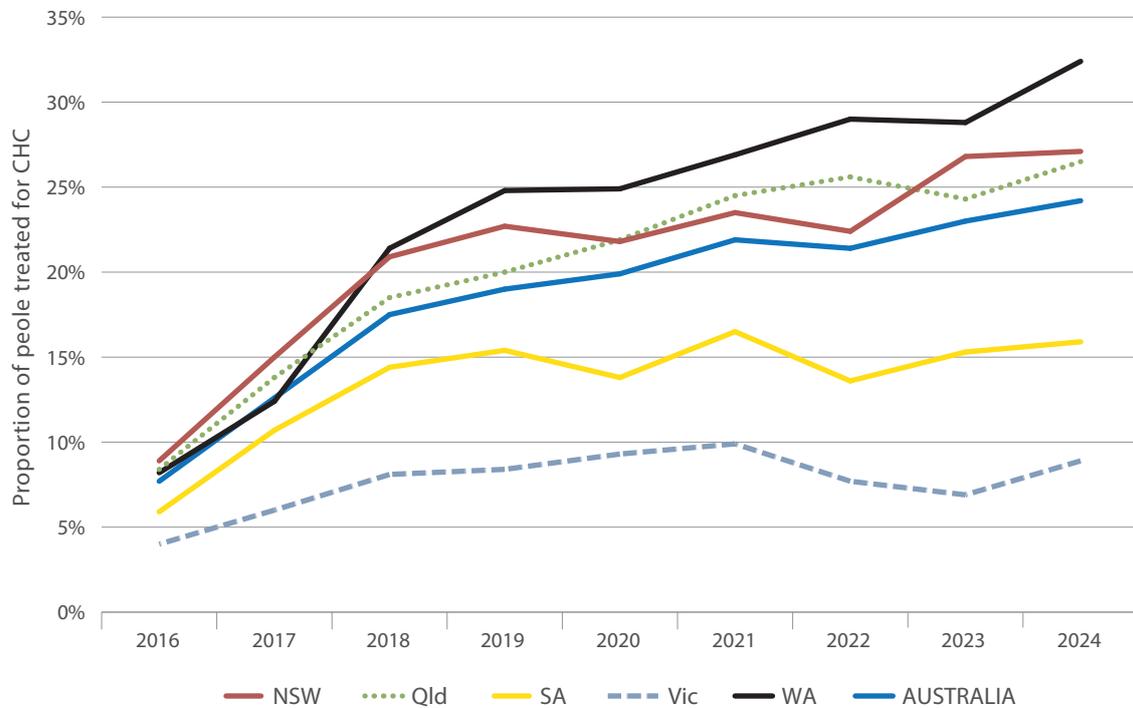
Table A.8: CHC treatment by state and territory and Indigenous status, March 2016 – December 2024

State/territory	Total number of people who received treatment, 2016–2024	Number of Aboriginal and/or Torres Strait Islander people who received treatment, 2016–2024	Proportion Aboriginal and/or Torres Strait Islander people
ACT	1,533	181	11.8%
NSW	37,609	6,495	17.3%
NT	935	169	18.1%
Qld	24,769	4,248	17.2%
SA	6,264	701	11.2%
Tas	2,580	368	14.3%
Vic	26,235	1,696	6.5%
WA	10,494	2,033	19.4%
AUSTRALIA	110,855	15,891	14.3%

CHC, chronic hepatitis C. PLIDA, Person Level Integrated Data Asset.

Data source: Treatment data sourced from Medicare statistics, linked to demographic information derived from the Census and other sources in the PLIDA environment.

Figure A.14: Proportion of people receiving treatment who were Aboriginal and/or Torres Strait Islander people, March 2016 – December 2024



CHC, chronic hepatitis C. PLIDA, Person Level Integrated Data Asset.

Data source: Treatment data sourced from Medicare statistics, linked to demographic information derived from the Census and other sources in the PLIDA environment. ([See data for this figure](#))

Data not reported by year for Tas, the NT and the ACT due to number of people receiving treatment being <10 in at least one year.

SECTION B: DATA SOURCES AND METHODOLOGY

If you have questions regarding methodology, data sources, or findings of the Mapping Report, or would like to provide feedback, please contact jennifer.maclachlan@mh.org.au. For an overview of the concepts, methods and outputs used in the report, see [Mapping report at a glance](#).

Table B.1: Hepatitis C: summary of data sources

Indicator	Method of estimation	Source	Basis of geographic data
CHC prevalence relative to the national average, start of 2016	Calculated by applying national prevalence data proportionally to geographic areas according to the distribution of notified cases and history of movement among those with a history of hepatitis C services, and deriving the prevalence ratio relative to the national average	Published modelled national prevalence data and NNDSS data (for the period 2007–2016) Area of residence history from hepatitis C nucleic acid testing and treatment data via the MBS and PBS	Postcode of residence when the person tested positive for hepatitis C
CHC treatment	Number of individuals prescribed DAA medications indicated for hepatitis C during the period March 2016 – May 2025	PBS data	Region of residence when a person was first dispensed DAA treatment

CHC, chronic hepatitis C. DAA, direct-acting antiviral. MBS, Medicare Benefits Schedule. NNDSS, National Notifiable Diseases Surveillance System. PBS, Pharmaceutical Benefits Scheme.

Table B.2: Common data terms

Term	Definition
PHN	Geographic area derived as part of the national health reform agenda; populations range between 50,000 and 2 million residents. There are 31 PHNs in Australia.
Remoteness area	Geographic area defined by the ABS based on measures of relative access to services; categories are major cities, inner regional, outer regional, remote and very remote.
Prevalence	The proportion of the total population living with a health condition. For example, if CHC prevalence is 1%, this means 1% of people in a given population have CHC.

ABS, Australian Bureau of Statistics. CHC, chronic hepatitis C. PHN, Primary Health Network.

DETAILED STATISTICAL METHODOLOGY

HEPATITIS C PREVALENCE

Data sources

The data sources used are:

- published estimates of national prevalence
- notifications from the National Notifiable Diseases Surveillance System (NNDSS).

Details

Estimates of the number of people living with CHC and the population prevalence are derived by applying published national prevalence estimates⁴ to each geographic area proportionally, according to the distribution of diagnosed cases reported to the NNDSS. The estimated number of people living with CHC is used as a denominator to estimate relative treatment uptake; however, raw data are not reported due to ongoing uncertainties in these estimates according to geographic region. Estimates of prevalence relative to the national averages are presented as ratios to provide an indication of the relative burden of CHC according to area.

All positive diagnoses of hepatitis C (defined as a positive HCV [hepatitis C virus] antibody or positive HCV nucleic acid test result) are legally required to be reported to jurisdictional departments of health by the diagnosing laboratory, and are collated and published by the NNDSS. Notifications are de-duplicated by jurisdictions, and the aim is to record only one positive diagnosis per individual per state or territory. However, duplicates may exist if individuals have been diagnosed in multiple jurisdictions. Duplication across jurisdictions is approximated using movement among those who have ever had a hepatitis C nucleic acid test or treatment script, based on address data collected in various datasets available in PLIDA. The number of people notified in each state/territory and each PHN is adjusted for relative movement away from that state/territory or PHN,³ and prevalence reduced accordingly. However, these measures remain subject to uncertainty, and linkage of notifications data with the Census and with Medicare data at the national level would greatly enhance the accuracy of geographic measures of treatment uptake.

Use of notifications data was approved by the Australian Government Department of Health, Disability and Ageing and the Communicable Diseases Network Australia. Due to the inclusion of antibody-positive cases as notifications, the data used are likely to have included a proportion of people who had previously been infected but did not have active infection at the time of testing. However, the denominator data used, and therefore the prevalence data generated, only include people living with chronic infection.

Data were provided according to postcode and are assigned to each PHN using the concordances published by the ABS¹¹ and the Department of Health, Disability and Ageing.¹² Cases in which the postcode is unknown but the jurisdiction is provided are distributed proportionally to each PHN across each jurisdiction. All estimates are based on diagnosed cases that occurred during the period 2007 to 2016, but sensitivity analyses were conducted to assess the effect of different years of source data (the periods 1997–2016 and 2016 only), and the 10-year period was then selected as the most representative (see *Viral Hepatitis Mapping Project National Report 2016*, Section 3: Data sources and methodology for further detail).

Correctional facility adjustments

The number of hepatitis C notifications is disproportionately concentrated in some geographic regions due to the presence of correctional facilities, which often have high rates of both CHC prevalence and screening, leading to a higher number of infections detected each year. Data facilitating assessment of the effect of correctional facilities on the overall number of notifications in

each area and through the collection of a correctional facility status variable were readily available from jurisdictional departments of health in Vic and Qld. Data were requested to provide the proportion of hepatitis C notifications from correctional facilities in each region. Prevalence calculations for hepatitis C were adjusted when the data indicated that more than 50% of notifications originated from a correctional facility, so that notifications by correctional facilities were excluded from the data for that region and redistributed across the rest of the state or territory.

Adjustments were applied to selected regions in NSW, the NT, SA, Tas and WA and were identified using Census data that indicated the presence of correctional facilities¹³ and outliers in hepatitis C notification rates.

HEPATITIS C TREATMENT

Data source

The data source used is PBS records.

Details

These sources include all services provided through Australia's national subsidised health care system, Medicare. Data were provided regarding the period 1 March 2016 to 30 May 2025. Hepatitis C treatment uptake is measured cumulatively as the total proportion of people ever treated, of those living with hepatitis C at the start of 2016. Each individual is only counted once.

Data exclude those who do not have a state or territory of residence reported (representing less than 10 individuals in a given year).

Regions of residence reflect where a person was living at the time of prescription dispensing or service provision (not the location of the service provider, such as a pharmacy or laboratory). All time periods are based on the date of supply/date of service, which represents the date the patient was supplied with their medication by a pharmacy (for treatment) or the date a test was performed (for testing).

These data do not include services that were not provided by Medicare, such as those paid for out of pocket or subsidised by state/territory government services (including services provided to hospital inpatients). The data also do not include pharmaceutical company compassionate-access programs or clinical trials, but access to hepatitis C treatment through these channels will mostly have been limited to the period before the listing of DAAs on the PBS in March 2016, which is not assessed in this report. Medicare Benefits Schedule (MBS) and PBS data also do not include those who are ineligible for Medicare; for example, due to their visa status.

Treatment definitions

Treatment data for CHC represent the number of individuals prescribed any DAA drug listed on the PBS⁹ for the treatment of CHC. These drugs and drug combinations include daclatasvir +/- sofosbuvir; glecaprevir + pibrentasvir; grazoprevir + elbasvir +/- ribavirin; sofosbuvir +/- ledipasvir; sofosbuvir + ribavirin; paritaprevir + ritonavir + ombitasvir + dasabuvir +/- ribavirin; and sofosbuvir + velpatasvir. Individuals treated multiple times are only counted once in overall figures, to effectively measure overall uptake as a proportion of the number of people living with CHC. Re-treatment is estimated separately, using the assumption that either a different drug combination commenced at any time after the estimated completion of the initial course, or that a treatment course of the same drug combination more than one month after the estimated completion of the initial course represented a re-treatment course.

Treatment uptake was derived by dividing the number of people receiving treatment by the total estimated population living with CHC in each geographic area (see [Prevalence](#) for details).

Ascertainment of age and sex in Medicare

Age is ascertained as age at the time of the most recent demographic record available. Sex is provided as only male, female or missing.

Treatment uptake by Aboriginal and/or Torres Strait Islander status

Aboriginal and/or Torres Strait Islander status is ascertained from combined data across the PLIDA linked dataset, which provides Medicare data linked to other Australian Government datasets including the ABS Census, migration records, and social services and taxation databases. People are categorised as Aboriginal and/or Torres Strait Islander if they have ever been recorded as such in source data, and this may overestimate uptake.

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DATA TABLES TO ACCOMPANY FIGURES

Figure A.1: Estimated variation in prevalence of CHC in 2016, compared to the national average, by PHN

Primary Health Network	CHC prevalence relative to the national average (% higher or lower)
Western NSW	+76.1%
Northern Territory	+69.8%
North Coast	+68.8%
Northern Queensland	+43.5%
South Eastern NSW	+31.3%
Hunter New England and Central Coast	+29.6%
Murrumbidgee	+26.4%
Tasmania	+22.4%
Western Queensland	+17.6%
Central and Eastern Sydney	+15.6%
Country WA	+15.1%
Darling Downs and West Moreton	+11.8%
South Western Sydney	+11.0%
Central Queensland, Wide Bay, Sunshine Coast	+9.1%
Gippsland	+5.5%
Gold Coast	+3.0%
Murray	+1.8%
Gippsland	+3.7%
Murray	+3.5%
NATIONAL AVERAGE	—
Brisbane South	-1.5%
North Western Melbourne	-2.6%
Brisbane North	-3.0%
Australian Capital Territory	-7.9%
Western Victoria	-8.5%
Nepean Blue Mountains	-9.8%
Perth South	-10.7%
South Eastern Melbourne	-10.8%
Perth North	-13.3%
Western Sydney	-18.7%
Adelaide	-27.9%
Country SA	-30.7%
Eastern Melbourne	-46.1%
Northern Sydney	-56.9%

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Figure A.2: Monthly average number of people receiving CHC treatment in Australia, by year, March 2016 – May 2025

Year	Average per month
2016	3,421
2017	1,771
2018	1,281
2019	954
2020	688
2021	548
2022	432
2023	455
2024	436
Jan–May 2025	335

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Figure A.3: Number of people receiving CHC treatment in Australia, by month, January 2020 – May 2025

Month-Year	Number of people treated
Jan-20	643
Feb-20	802
Mar-20	708
Apr-20	660
May-20	674
Jun-20	755
Jul-20	747
Aug-20	677
Sep-20	663
Oct-20	649
Nov-20	682
Dec-20	590
Jan-21	420
Feb-21	582
Mar-21	684
Apr-21	563
May-21	602
Jun-21	624
Jul-21	593
Aug-21	548
Sep-21	553

Month-Year	Number of people treated
Oct-21	497
Nov-21	500
Dec-21	414
Jan-22	286
Feb-22	387
Mar-22	433
Apr-22	385
May-22	364
Jun-22	464
Jul-22	447
Aug-22	518
Sep-22	470
Oct-22	482
Nov-22	491
Dec-22	453
Jan-23	368
Feb-23	430
Mar-23	507
Apr-23	391
May-23	517
Jun-23	472

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Month-Year	Number of people treated
Jul-23	471
Aug-23	548
Sep-23	440
Oct-23	464
Nov-23	469
Dec-23	384
Jan-24	328
Feb-24	438
Mar-24	429
Apr-24	398
May-24	496
Jun-24	418

Month-Year	Number of people treated
Jul-24	458
Aug-24	442
Sep-24	441
Oct-24	475
Nov-24	469
Dec-24	412
Jan-25	318
Feb-25	382
Mar-25	396
Apr-25	290
May-25	289

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Figure A.4: Monthly average number of people receiving CHC treatment by state/territory, January 2020 – May 2025 (NSW, Qld, Vic, WA)

State/territory	2020	2021	2022	2023	2024	2025
NSW	229	163	138	165	160	125
Qld	173	143	120	125	114	79
Vic	136	109	84	82	77	63
WA	77	69	51	51	50	42

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Figure A.5: Monthly average number of people receiving CHC treatment by state/territory, January 2020 – May 2025 (ACT, NT, SA, Tas)

State/territory	2020	2021	2022	2023	2024	2025
ACT	7	8	5	4	5	5
NT	4	4	3	3	2	3
SA	39	30	20	20	19	10
Tas	15	15	9	9	7	5

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Figure A.6: CHC treatment uptake variation in Australia by PHN, relative to the national average, March 2016 – May 2025

Primary Health Network	CHC treatment uptake relative to the national average (% higher or lower)
Gippsland	25.1%
Western Victoria	23.4%
North Coast	19.3%
Central Queensland, Wide Bay, Sunshine Coast	14.9%
Country SA	10.7%
Adelaide	10.6%
Eastern Melbourne	10.2%
Brisbane South	8.9%
Murray	6.1%
Darling Downs and West Moreton	5.5%
Hunter New England and Central Coast	5.4%
North Western Melbourne	5.2%
South Eastern Melbourne	4.2%
Nepean Blue Mountains	3.8%
Perth South	3.7%
Gold Coast	2.4%
South Eastern NSW	0.2%
NATIONAL AVERAGE	-
Brisbane North	-1.2%
Murrumbidgee	-2.3%
Western Sydney	-3.9%
Western NSW	-4.8%
Northern Sydney	-4.9%
Perth North	-6.1%
Country WA	-8.9%
Australian Capital Territory	-10.7%
Northern Queensland	-12.0%
Tasmania	-12.6%
South Western Sydney	-12.7%
Western Queensland	-19.1%
Central and Eastern Sydney	-20.0%
Northern Territory	-48.9%

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Figure A.9: Proportion of CHC treatment by course duration (8-, 12- and 24-week courses), by year, March 2016 – May 2025

Year	8 Weeks	12 Weeks	24 Weeks
2016	7.5%	72.3%	20.2%
2017	7.6%	85.0%	7.4%
2018	16.0%	83.4%	-
2019	35.5%	64.5%	-
2020	41.0%	59.0%	-
2021	46.1%	53.9%	-
2022	45.1%	54.9%	-
2023	49.4%	50.6%	-
2024	46.7%	53.3%	-
2025	44.1%	55.9%	-

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Figure A.10: Proportion of CHC treatment by prescriber specialty, by year, January 2020 – May 2025

Year	Unspecified	GP	Non-GP specialist	NP
2020	9.4%	34.5%	46.7%	9.4%
2021	12.6%	34.4%	39.4%	13.6%
2022	10.9%	36.0%	37.3%	15.8%
2023	14.9%	33.5%	33.8%	17.8%
2024	14.0%	32.2%	36.0%	17.8%
2025	16.0%	31.0%	31.4%	21.6%

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Figure A.11: Proportion of CHC treatment by prescriber specialty, by state and territory, January 2020 – May 2025

State/territory	Unspecified	GP	Non-GP specialist	NP
ACT	9.6%	47.0%	36.1%	7.3%
NSW	11.5%	27.5%	45.8%	15.2%
NT	11.7%	19.2%	51.4%	17.8%
Qld	8.8%	41.7%	24.6%	24.9%
SA	19.9%	29.8%	49.4%	0.9%
Tas	12.7%	50.1%	34.0%	3.2%
Vic	12.2%	27.2%	51.2%	9.3%
WA	19.9%	44.8%	28.1%	7.2%
AUSTRALIA	12.3%	34.0%	39.0%	14.7%

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Figure A.12: Monthly average number of people receiving CHC treatment, by year and provider, January 2020 – May 2025

Year	Unspecified	GP	Non-GP specialist	NP
2020	64	235	318	64
2021	69	186	214	74
2022	47	155	161	68
2023	68	153	155	82
2024	61	141	157	78
2025	54	104	105	72

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Figure A.13: Proportion of CHC treatment by age group, by year, March 2016 – May 2025

Year	0–29	30–39	40–49	50–59	60+
2016	3.5%	13.2%	22.8%	37.9%	22.7%
2017	6.5%	20.0%	27.9%	29.9%	15.6%
2018	9.7%	22.1%	28.7%	25.2%	14.3%
2019	12.0%	21.4%	27.7%	23.9%	15.0%
2020	14.0%	21.5%	27.3%	22.9%	14.3%
2021	14.0%	20.1%	26.4%	23.1%	16.3%
2022	14.0%	20.6%	24.9%	22.0%	18.5%
2023	16.9%	21.0%	23.8%	21.1%	17.3%
2024	17.6%	20.8%	22.3%	21.4%	17.9%
2025	19.1%	19.8%	21.6%	20.5%	19.0%

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Figure A.14: Proportion of people receiving treatment who were Aboriginal and/or Torres Strait Islander people, March 2016 – December 2024

Year	NSW	Qld	SA	Vic	WA	AUSTRALIA
2016	8.9%	8.4%	5.9%	4.0%	8.2%	7.7%
2017	15.0%	13.8%	10.7%	6.0%	12.4%	12.6%
2018	20.9%	18.5%	14.4%	8.1%	21.4%	17.5%
2019	22.7%	20.0%	15.4%	8.4%	24.8%	19.0%
2020	21.8%	21.9%	13.8%	9.3%	24.9%	19.9%
2021	23.5%	24.5%	16.5%	9.9%	26.9%	21.9%
2022	22.4%	25.6%	13.6%	7.7%	29.0%	21.4%
2023	26.8%	24.3%	15.3%	6.9%	28.8%	23.0%
2024	27.1%	26.5%	15.9%	8.9%	32.4%	24.2%

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