ample of recent controversial proposals of this type. Seatbelt and motorcycle-helmet laws exemplify the balancing act between health benefits and individual rights: these laws have financial costs for enforcement and the purchase of helmets and perceived societal costs in loss of personal freedom, but they prevent traffic injuries and deaths and reduce societal costs, including health care costs and lost productivity. Such measures may be best enacted at the local or state level, where government’s proper role can be debated; deliberations will be fairer if there are no major vested financial interests, as is generally the case with helmet laws.

Beyond the societal costs in health care and lost productivity, actions to protect health are supported by the recognition that although many people express remorse over past behavior, we tend to assign limited weight to future events or conditions—a pattern behavioral economists call “hyperbolic discounting.” Action by democratically elected leaders may therefore be needed to protect public health over the long term.

Opponents of specific public health actions may believe that the health burden is low, the intervention is too costly or is likely to be ineffective, and that therefore the expected benefits don’t warrant the costs. The costs cited may include financial costs to government, industry, and the economy and to individuals who might not benefit personally. There may also be philosophical objections, such as perceived loss of personal autonomy or the belief that these actions will undermine self-reliance or individual choice. Some opponents fear a slippery slope toward “sabotaging our rights on all fronts.”

The potential benefits of public health action include economic, health care, and productivity gains, as well as the intrinsic benefit of longer, healthier lives. The dissemination of accurate information on costs and benefits may be the best way to reduce opposition and implement effective public health actions. When government fails to protect and improve people’s health, society suffers. Opponents of public health action often fail to acknowledge the degree to which individual actions are influenced by marketing, promotion, and other external factors. They also may underestimate the health costs of inaction and overestimate the financial or other costs of action. For-profit corporations have a fiduciary responsibility to increase return on investment; some (e.g., tobacco companies) have incentives to oppose actions that may harm their business, even if these actions would promote overall economic development and benefit other businesses. And in some cases, current judicial philosophies may limit possibilities for public health action in the United States.

Government has a responsibility to implement effective public health measures that increase the information available to the public and decision makers, protect people from harm, promote health, and create environments that support healthy behaviors. The health, financial, and productivity gains from public health actions benefit individuals and society as a whole.

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Hepatitis C in the United States
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C are for hepatitis C is evolving rapidly, with increasingly effective and better-tolerated antiviral therapies being evaluated and approved for use. It’s clear, however, that not everyone who would qualify for therapy has been tested and identified, referred for appropriate care, and offered or given the best therapy available. Furthermore, currently used antiviral drugs — pegylated...
interferon and ribavirin “base” plus either telaprevir or boceprevir — can cost more than $70,000 for a full course of therapy. It is expected that the new oral antiviral agents will be just as expensive, at least in the short term. All these factors affect personal, medical, public health, and national policy decisions. One fundamental problem in making such decisions is that it’s difficult to estimate the number of people with chronic hepatitis C virus (HCV) infection in the United States who have been identified and have received appropriate care.

Over the past 4 years, members of the Division of Viral Hepatitis at the Centers for Disease Control and Prevention (CDC) have executed and analyzed two large studies of hepatitis C in the United States. Researchers conducting the Chronic Hepatitis Cohort Study (CHeCS) are currently examining reasons why about 1.6 million adults in the United States — received follow-up hepatitis C care. In the NHANES, 77% of respondents indicated that they had seen a clinician after their first HCV test result; these included 71 of 82 persons who knew they were infected before they were tested in the NHANES (87%) and 59 of 85 persons who discovered their infection because of their participation (69%). From these data it seems reasonable to deduce that 63 to 77% of people who have tested positive for HCV antibodies — 32 to 38% of all persons who have tested positive for HCV — 32 to 38% of all persons who have tested positive for HCV — would be expected to receive follow-up care. Among those receiving care, such as the 8810 who were initially examined in the CHeCS, 5540 (63%) had had at least one HCV RNA measurement between 2001 and 2010. Of the HCV-
Hepatitis C Virus (HCV)–Infected Persons in the United States and Estimated Rates of Detection, Referral to Care, and Treatment.

Percentages in parentheses are percentages of the total estimated HCV-infected population (3.2 million persons).

In the NHANES, 22 of the 170 HCV-infected persons who answered follow-up surveys (13%) said they had received treatment for HCV infection. It is more difficult to determine whether treatment has been successful, but in the CHeCS the most recent test results indicated that HCV RNA was “undetectable” in 21% of patients, and 80% of patients with such results had documentation of having received antiviral therapy — that is, about 17% of the total CHeCS cohort, or about 5 to 6% of all HCV-infected people.

One limitation of both the CHeCS and the NHANES results is that because estimates are unavoidably based on progressively smaller numbers of patients, they have wide confidence intervals. Both studies were biased toward following (in the CHeCS) or recruiting for interview (in the NHANES) persons who were more likely to have health insurance and to be receiving health care; thus, the resulting estimates may actually be high. Still, these data and estimates derive from two large U.S. studies using different methods and sampling sources, one a managed-care population (CHeCS) with the largest cohort of HCV-infected patients in the United States and the other the noninstitutionalized civilian U.S. population (NHANES). Despite the different methods and unavoidable selection biases, the results appear to be consistent and credible.

This big picture suggests that there are many points of intervention — or opportunities — to improve the identification and care of patients with HCV and to mitigate the increase in hospitalizations and deaths resulting from HCV infection. For example, the CDC recently recommended a one-time test for everyone born between 1945 and 1965 to help identify the many infected people who would not be targeted for testing as the result of established risk-based testing strategies. Clearly, there is also a need to do a better job of getting HCV-infected persons who know their HCV status into care, evaluated, and, as appropriate, treated. It is past time to address more vigorously what Assistant Secretary for Health Howard Koh has called the silent epidemic of viral hepatitis.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

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