



The Swiss Hepatitis Strategy as a model for facing future health policy challenges



Raoul Blindenbacher^a, Bettina Maeschli^b, Philip Bruggmann^{b,c,*}

^a Global Health Center, Graduate Institute, Geneva, Switzerland

^b Swiss Hepatitis, c/o Arud, Schützengasse 31, Zurich, Switzerland

^c Arud Centre for Addiction Medicine, Schützengasse 31, Zurich, Switzerland

ARTICLE INFO

Article history:

Received 27 August 2018

Received in revised form 6 May 2019

Accepted 8 May 2019

Keywords:

hepatitis C
elimination
governmental learning spiral
civil society
health policy
strategy
Switzerland
innovation

ABSTRACT

Driven by the increasing evidence of the public health burden of viral hepatitis and the passivity of the health authorities, the Swiss Hepatitis Strategy (SHS) was launched by private initiative with the vision of eliminating viral hepatitis by 2030. The strategy applied the Governmental Learning Spiral method, an approach designed to overcome political barriers and to enhance innovation in the political context. This participative process, where those who develop are also those who implement, enhances a sense of social belonging among the people involved, which leads to the alignment of different viewpoints as well as to the creation of social networks. In consequence, a broader audience becomes involved; this creates feedback loops that lead to the continuous improvement of the strategy process. Within less than five years the SHS has been able to achieve significant goals within the scope of its vision: the implementation of universal access to Hepatitis C therapies has been enforced; increased attention within the general population has been achieved by using progressively more media coverage about therapies, a patient organisation has been founded and the national health authorities have begun to support the strategy financially. The case of the SHS proves, that a carefully designed political learning process is an efficient and innovative tool in the face of today's health policy challenges such as the Hepatitis C epidemic.

© 2019 Elsevier B.V. All rights reserved.

1. Introduction

The global burden of viral hepatitis is significant. Worldwide 300 million suffer from chronic hepatitis B (HBV) or C (HCV). Viral hepatitis causes the death of 1.3 million every year, more than HIV/AIDS, tuberculosis or malaria. The World Health Organisation's (WHO) member assembly including Switzerland adopted the Global Health Sector Strategy for viral hepatitis in 2016. Its goal is the elimination of viral hepatitis by 2030 [1].

Most common transmission routes of viral hepatitis are blood transfusions, sharing drug using paraphernalia, medical and dental procedures and tattoos. HBV can also easily be transmitted from mother to child at birth as well as sexually. While HBV had already been discovered in the 1960's, tests for HCV were only available as late as 1990. Both diseases progress slowly over years and decades, and they usually lead to a certain grade of liver damage with the potential to progress to liver failure and liver cancer. Furthermore,

HCV is a risk factor for diabetes, cardiovascular disease and cancer. Once infected, the virus can affect almost every organ of the body.

In the last decades, the field of viral hepatitis has advanced from discovery of the viruses to today's opportunity to eliminate this epidemic. An infection with HBV can effectively be prevented by vaccination. Since the late 1990's HCV has been curable [2]. In 2014 new, highly effective, well-tolerated and very safe HCV medication took the place of the challenging Interferon-based therapy with many side effects and low to modest cure rates. Today with a few weeks treatment more than 95 percent of the treated patients are cured, without serious side effects [3]. In high-income countries like Switzerland the health burden of HCV is mainly driven by its sequel rather than by transmission rates. Prevention of HCV can be very efficiently achieved by stringent application of sterile equipment during risky procedures [4].

The World Health Organisation (WHO) in its 2014 resolution on viral hepatitis urged member states to develop national plans to fight viral hepatitis [5]. Among one of the first countries to develop and implement a national plan was France [6]. A model is Australia which already has a fifth version of a national hepatitis C plan [7]. Germany integrated viral hepatitis into its HIV and sexually transmitted diseases plan in 2016. [8]. To date, 124 countries have

* Corresponding author at: Arud Centre for Addiction Medicine, Schützengasse 31, CH 8001, Zurich, Switzerland.

E-mail address: p.bruggmann@arud.ch (P. Bruggmann).

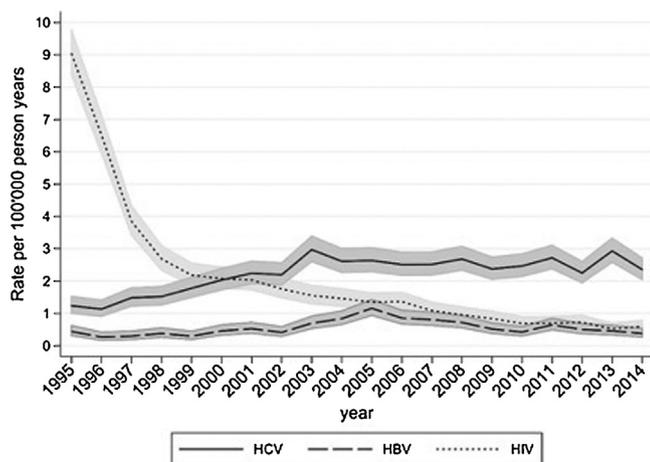


Fig. 1. HIV, HBV and HCV mortality rates in Switzerland.

Fig. 1 compares the mortality rates of HIV, HBV and HCV in Switzerland, 1995 – 2014. The graph shows a five times higher mortality rate from HCV than from HIV in 2014.

developed a national plan or are currently developing one [9]. In Switzerland, the health authorities are currently of the opinion that Switzerland does not need to develop such a plan, as most of the WHO targets have already been met [10]. This is in contrast to the assessment of most experts in the field. In a letter to the Federal Office for Public Health (FOPH), dated 16 January 2019 and signed by all the medical associations in the field, the experts demand more action and more resources: “We, the experts on viral hepatitis and patients, are concerned about the current situation. In our opinion, the elimination targets are not achievable due to the existing gaps in care” [11].

In fact, what we are facing is a paradoxical situation in public health. Despite the availability of highly effective prevention and treatment measures, decision makers in the field of health policies are reacting only slowly to this new situation. In consequence an elimination of transmission and sequelae of HCB and HCV is not yet realistic. It appears that the evidence based medical knowhow to combat a major public health threat alone is not enough to evoke the political momentum to act.

Why is a political system only learning from tested and approved experiences at a very slow pace and how can this political blockade be overcome? The purpose of this paper is to describe the Swiss Hepatitis Strategy (SHS), a private initiative launched by the Swiss Experts on Viral Hepatitis (SEVHep), today Swiss Hepatitis, whose goal is to combat and eliminate viral hepatitis in Switzerland [12]. Its underpinning method is the Governmental Learning Spiral[®] (GLSp) an approach designed to overcome political barriers and to enhance innovation and learning in the political context [13].

To strengthen our point we will focus on the discussions around HCV. In the second chapter, this paper describes the barriers that prevent efficient response to the burden of the HCV epidemic in Switzerland. The third chapter elaborates the applied GLSp method of how to overcome these barriers and the fourth chapter illustrates its application as well the results of the strategy process. In a final fifth chapter the SHS will be critically discussed and conclusions will be drawn.

2. Problematic situation

Despite the fact that there has been a cure for HCV for 20 years, mortality rates remains stable, currently at a level which is five times higher than the mortality from HIV, a disease that still cannot be cured [14] (s. Fig. 1). 40'000 people are infected with HCV in

Switzerland and therefore, according to current medical guidelines, in need of treatment [15]. Approximately one third of these people have not been tested and are therefore not aware of their infection. In 2017, 3000 patients with HCV were treated and 1500 were newly diagnosed [16]. The main reason for these considerable gaps in the care cascade is a lack of awareness and education on all levels: general population, health care workers and related organisations as well as public health authorities [17].

The public and political attention on HCV remains far behind that of HIV [18]. Switzerland is considered as a champion in the fight against HIV, since it has already achieved two out of three UNAIDS goals [19]. On a global level, there is a similar picture: the WHO launched its first global hepatitis strategy in 2016 [1]. Despite the adoption of the WHO strategy by the World Health Assembly (WHA), many health ministries in Europe and around the world, including Switzerland, have still been reluctant to launch a national hepatitis strategy and implement an action plan.

It was therefore not surprising that according to the 2012 Euro Hepatitis Index Report (EHIR), which measured prevention effectiveness, screening and treatment instruments, Switzerland was only ranked 12th out of 30 European countries [20]. In the specific area of case finding and screening it was only ranked 17th.

In 2014 a revolution in HCV treatment became a reality with the extent of Direct Acting Antiviral (DAA) therapy development and interferon-free treatments [21]. The downside of these developments is that the cost of HCV treatment is considered unreasonably high, with costs between CHF 60,000 (58'000 USD) and CHF 130'000 (126'000 USD) for a typical person's total cure [22]. Concerned by such high costs, the Swiss Federal Office of Public Health (FOPH) restricted access to these medications only to people with advanced liver disease [23]. This was a measure that physicians and patient organisations alike criticised and refused to accept due to ethical and medical concerns [24]. As a result of these pricing and treatment regulations, viral hepatitis got increasingly high attention in the media and led to fierce debates among health officials, the pharmaceutical industry and the public in general.

On a global level, this lasted until 2014 when the sixty-seventh World Health Assembly (WHA) restated its recognition of viral hepatitis as a global public health problem and the need for governments to take action [5]. It called upon the WHO to develop and implement a comprehensive global strategy to support these efforts and expressed concern at the slow pace of implementation. It urged member states to launch coordinated multi-sectorial national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context. Despite Switzerland having signed the WHO declaration, the FOPH continued to be reluctant to develop a national plan. The FOPH decided repeatedly over the years to focus its measures on fighting HCV among drug users, which made up about half of the HCV population [15,18]. Today we know that despite these efforts HCV care among drug users is insufficient in Switzerland [25] (s. Fig. 2).

3. Method

In the light of the problematic situation, the development and implementation of a SHS was seen as unknown territory and the viewpoints related to it were numerous and contradictory. Everybody involved in the strategy had a certain scope of relevant knowledge, but as a whole it was too complicated to be overseen by a skilled expert or a single authority. There was widespread concern that the strategy would deteriorate to a stand-alone document with little practical relevance.

Accordingly, the Governmental Learning Spiral (GLSp) was chosen as the underpinning method to design the SHS as a participative process where those who develop are also those who implement

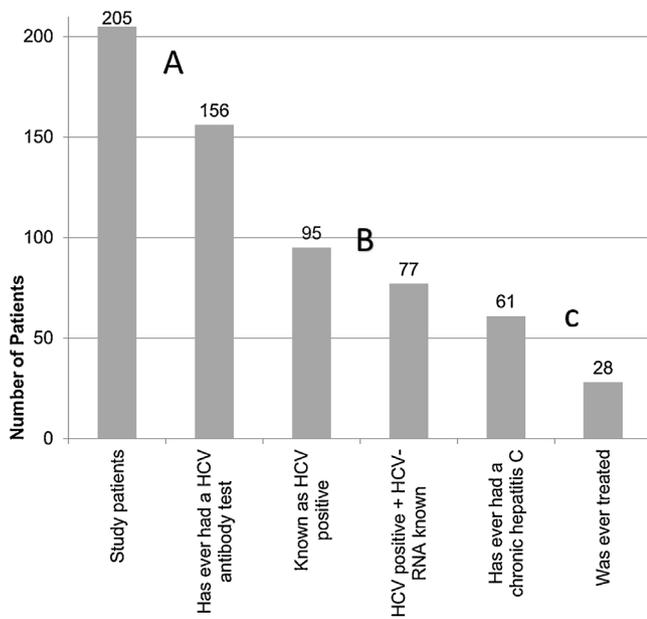


Fig. 2. Cascade of care of patients with substitution therapy in the Swiss canton of Argovia.

Fig. 2 shows the cascade of care of patients in the Swiss canton of Argovia who are receiving substitution therapy, a high risk population for an HCV infection. The gaps are as follows: one quarter never had an HCV screening test (A), almost one fifth never had an HCV-RNA test if they already tested positive for HCV antibodies (B). And over half of the patients never received treatment despite their chronic hepatitis C infection (C).

HCV = hepatitis C virus

A = never had an HCV-antibody screening test: 23,9% (49/205)

B = no HCV-RNA-test, if HCV positive: 18,9% (18/95)

C = never treated, though they had chronic hepatitis C: 54,1% (33/61)

[13]. It is based on the understanding that political knowledge is by nature contextual and short-lived. The goal of such learning is to acquire new alternative courses of action. It is not necessarily about improving human behaviour or human conditions. Instead, it is a form of empowerment by individuals or institutions, leading to an increase in the knowledge base to improve their capacities to deal with politically problematic situations.

An important effect of the GLSp is that it enhances a sense of social belonging among those involved, which leads to the alignment of different viewpoints as well as the creation of social networks. By so doing, a broader audience gets involved, which in turn creates feedback loops that lead to the continuous improvement of the strategy process. It is expected that the actors involved contribute their expertise as unpaid volunteers. Their return on investment is new first-hand insight from the other participants as well as the opportunity to influence the process as a whole. The GLSp is designed and lead by an independent Learning Broker. It consists of a ten-stage template split into three distinct phases [13].

The proceedings start with the “Framing Phase”, where the governance challenge is defined, the existing experiences related, the knowledge frame detected (Conceptualization Stage), the different perspectives to that knowledge and the knowledge holders selected (Triangulation Stage), and participants are invited to take part in the learning process. To make sure that everybody involved gets an equal chance to participate in the process, trust has to be established among the learning actors through detailed information about the proceedings and the communication rules. (Accommodation Stage)

Secondly, the “Reflection Phase” represents the core of the educational process, where the participants review the knowledge frame according to their professional perspectives (Internalisation Stage) and share their newly gained insights with the other actors

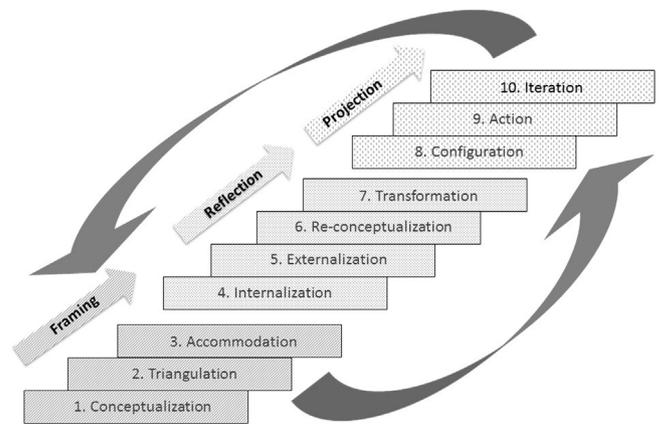


Fig. 3. The Governmental Learning Spiral process.

This figure shows the steps of the Governmental Learning Spiral process, which is an ongoing procedure where knowledge is reviewed, renewed, and transformed into political action. It consists of ten stages, which are bound together by a spin. The process ends with the iteration stage and starts again with the configuration stage.

(Externalisation Stage). By doing so they build up a collective understanding and new knowledge (Re-conceptualisation Stage) that guides the planning of the activities to solve the given problem situation (Transformation Stage).

Thirdly, in the “Projection Phase” this new know-how gets documented and disseminated (Configuration Stage). This puts the participants on the same information level and allows the coordination of their actives in the implementation process. These planning and implementing actions are monitored and evaluated (M&E) regarding their output, outcome and impact (Action Stage). If the results are considered unsatisfactory they have to be reviewed and updated. By doing so they become the new knowledge frame of the next GLSp spin (Iteration Stage).

As shown in Fig. 3, this ongoing procedure where knowledge is reviewed, renewed, and transformed into political action in a real-time and multi-turn process, can be illustrated as a spiral. Each of the ten stages is bound together by a spin, which ends with the iteration stage and starts again with the configuration stage. The template reflects an “ideal type” of process and needs continuously to be adapted to the given problem situation, as in the case of the SHS.

4. Process and results

4.1. Initiation

Driven by the evidence of the HCV epidemic for the health care system and the passivity of the public health authorities, SEVHep initiated a process to develop and implement a Hepatitis Strategy in Switzerland in January 2014 [12]. The recognition of the need to act swiftly was shared by the main medical specialist associations, two patient organisations and the Global Health Center (GHC), which joined the initiative (Conceptualisation Stage) [12,13]. Together they detected more than 30 content perspectives important and distinct enough to be reflected in the SHS. For each of the viewpoints they selected the most knowledgeable experts, uniting health care professionals, patients, politicians, health authorities, health insurance companies, pharmaceutical companies etc, to cover it (Triangulation Stage).

The SHS process was launched with a kick-off meeting where 40 people, representing all selected perspectives, met to set the groundwork of the process (Accommodation Stage). The knowledge frame served the EHIR 2012 [20] and the experiences from

Target Area	Baseline 2016	2020 Targets	2025 Targets	2030 Targets	WHO TARGETS 2030
Impact Targets					
<i>Reduction of...</i>					
incidence (HBV and HCV)	40-50/year	30%	60%	95%	90%
mortality (HBV and HCV)	200/year	20%	50%	95%	65%
viremic cases (HCV)	40'000	30%	60%	95%	
liver transplantations (HBV and HCV)	40-70/year*	30%	60%	95%	
Liver cancer (HBV and HCV)	600/year**	30%	60%	95%	
Service Coverage Targets					
<i>Increase of...</i>					
HBV vaccination coverage	70%	75%	85%	95%	90% (childhood vaccine coverage)
HCV diagnosis rate	24'000	70%	80%	90%	90%

Fig. 4. The Swiss Hepatitis Strategy targets.

Fig. 4 shows the baseline and the elimination targets of the Swiss Hepatitis Strategy for 2020, 2025 and 2030. The Swiss Hepatitis Strategy's targets have been adapted to the matrix of the WHO targets of its global health sector strategy on viral hepatitis 2016–2021. Targets were added that would help to reduce the disease burden in Switzerland. Other WHO targets have been omitted (e.g. injection safety, blood safety), as these have already been reached in Switzerland.

France of the Hepatitis Strategy, France being the leading country of the Euro Hepatitis Index Report index.

In this first event, each participant chose from the given frame the single most important issue (Internalisation Stage) and shared it in the plenary (Externalisation Stage). This exercise allowed the creation of a collective and comprehensive picture of all the aspects required for the SHS. Subsequently, the issues raised were thematically grouped and six specific fields of action were determined: Prevention and Awareness, Surveillance and Screening, Access to Treatment, High Risk Groups, Pricing and Financing, and Politics and Policies.

In a second event, the participants were asked to join one field of action based on their personal expertise. For each of the six constituted working groups one member was chosen to be the liaison person to the other groups and become part of the leadership team responsible for the strategy coordination. Based on all these content and organisational measures the participants developed a common vision of the SHS in a third meeting (Re-conceptualisation Stage).

4.2. Vision and aims

The vision of the SHS is the driving force of all activities related to the initiative. It calls for the elimination of viral hepatitis B and C in Switzerland by 2030 [26]. Based on this vision, three aims were derived: firstly, reducing the socio economic impact of viral hepatitis on the individual, the community and the general population; secondly, reducing transmission of HCV; and thirdly, reducing morbidity and mortality caused by viral hepatitis. The 2030 target values are:

- 1 Impact targets
- 2 New cases of HBV and HCV will be reduced by 95%.
- 3 HBV and HCV-related mortality will be reduced by 95%.
- 4 Viraemic cases of HCV will be reduced by 95%.
- 5 Liver transplants due to viral hepatitis-induced end stage liver disease will be reduced by 95%.
- 6 Liver cancer due to viral hepatitis will be reduced by 95%.
- 7 Service coverage targets
- 8 HBV vaccine coverage at the age of 16 will be increased to 95%.
- 9 HCV diagnoses will be increased by 90%.

Fig. 4: The targets of the Swiss Hepatitis Strategy

Two recent publications based their calculations of the elimination process on the Swiss Hepatitis Strategy's targets. They show that the strategy is working, but that more effort is needed in testing and treatment to reach its elimination goals [27,28].

The proceedings from the first three meetings was carefully reported in a Process Paper or, as it was later referred to, a “living document” (Configuration Stage). The paper was expected to be regularly reviewed and updated, mirroring the course of the process and making it accessible to the public. This allowed third parties such as journalists, sponsors, etc. to follow the SHS process. To date the first version has been renewed three times [12].

4.3. Implementation

The vision and aims were considered as a snapshot and it was expected that they might be readjusted over the course of the SHS. However, at that point in time they were the relevant guidelines for alignment with the forthcoming activities. Based on these goals, the participants planned, coordinated (Transformation Stage), and implemented the forthcoming actions, which were monitored and evaluated afterwards (Action Stage).

To date, almost five years later, seven more learning events have been conducted, on average two per year. Planning and coordination among the working groups was a key part of these meetings as well as adaptation of the forthcoming activities due to new insights and evaluation results (Iteration Stage). Over time the working group members grow together to become a strong network that was open to other individuals concerned about the strategy but not directly involved in its activities. To date, this network embraces more than eighty members. The organisation of yearly public symposia allowed the network, the public and the media to be briefed, with the newest political developments and scientific information. Today the SHS receives endorsement by selected celebrities and thirty institutional partners, among them all the universities in the country, as well as the Conference of Cantonal Health Ministries [12,29].

As mentioned above, the SHS process has been monitored and evaluated so far using six indicators per field of action and defined by each working group. This survey was conducted among the net-

work members and repeated every six months. The compilation of each poll was recorded on a scorecard that gives an overview about the SHS over time. In addition the epidemiological data provided by the FOPH will allow an evaluation of the progress in achieving the targeted values as stated in the aims of the SHS. As currently only data up to 2016 has been published [16,30] this so far has limited meaning and will play a more important role in the evaluation in coming years.

At the beginning of the SHS, the activities were small in scope, short-term, and sometimes poorly coordinated. Despite these shortcomings, the M&E indicators, the media references to the strategy or its representatives, the number of hits on the SHS website, and the outcome of the “Virusbarometer” [31] lend proof to the effectiveness of the overall SHS. However, three years into the process a growing sense emerged that concentrating the resources on a few well-targeted flagship projects could accelerate the SHS. Thereafter four such activities were selected and will be ready for implementation shortly: the first one is on the evaluation of the feasibility and efficacy of different HCV screening approaches in Switzerland, the second develops training tools for general practitioners (GP), the third launches a label for institutions that have reached pre-defined goals, and the fourth develops a follow-up care programme that focuses on patients after successful HCV therapy.

4.4. Structure and financing

The SHS started as an initiative of loosely coupled interest groups led by the chair of SEVHep and the liaison persons. To be both operational and credible, the initiative needed a balanced and predictable budget, consisting of unconditional grants from a broad range of foundations, public institutions and private companies. Besides these generous contributions the SHS almost completely depended on the support of unpaid volunteer work delivered by the working groups.

Overtime, the structure of the SHS evolved to adapt best to the constantly changing process requirements. There was an overall drift from the original informal structure towards a formal one [32]. SEVHep was converted into a fully-fledged association called Swiss Hepatitis in 2017, with a general manager and operational support staff. The liaison persons became Board members and the network members became associates. With this development the working groups were transformed into steering groups whose new task was to ensure that their field of action was considered in the flagship projects. Along with this institutionalisation process the SHS is increasingly becoming recognised as an enduring and trustworthy venture, even though the volunteering work remains a key pillar of the strategy. It is expected that this will be also be reflected in the initiative’s future fundraising efforts.

4.5. Outcomes

After almost five years of operation the SHS has delivered numerous tangible outcomes on the different levels of action:

- With the ongoing campaigns of the SHS, among them the very effective observation of the annual World Hepatitis Day, HCV achieved progressively more media coverage and attention in the general population [31]. Whereas up to 2014 viral hepatitis had rarely been a topic in the leading media in Switzerland, all of a sudden more than 150 articles and broadcasts have covered the topic since then. Although media attention was driven by the pricing issue, the strategy has repeatedly succeeded in making hepatitis C an issue beyond price discussion and in making patient portraits possible, for example [33]. Most of the articles were initiated through press releases and SHS media contacts [34]. In 2017 over 100'000 visits were registered on the SHS website. In 2015 a

national study showed a significant increase of test acceptance and readiness to test in Switzerland [31]. This trend was also reflected in the first M&E surveys, which showed a significant rise in the level of information about HCV prevention among high-risk groups. Thanks to public attention and the political contacts of the network members, the SHS received higher recognition at the political level, which was reflected in several national and cantonal parliamentary initiatives.

- Due to very high prices of the new HCV medication, the FOPH limited its access to patients with advanced liver damage only [23]. The SHS initiated two round table discussions with the officials who were responsible to set out the medical and ethical concerns of such restrictions. In parallel the SHS built up a safe and legal pathway for patients affected by these restrictions to access generic medication from India. Patients affected by the limitation could legally import HCV generics via an Australian buyers’ club. In cooperation with one of the big Swiss health insurance companies, coverage of the costs of these generics was achieved [35]. This temporary measure generated considerable pressure on the supplier, which eventually led to a significant reduction of the drug prices and the lifting of the FOPH limitation.
- From the beginning the FOPH showed reluctance to support the SHS officially, even though its staff participated regularly at its meetings. After a review on epidemiological data of viral hepatitis in Switzerland [15] the FOPH decided in 2017 to unofficially support the SHS with a financial contribution. From then on, the results of the situation analysis served as a baseline upon which the impacts of the SHS activities were measured. At the request of the SHS the FOPH announced it would publish annual reports on the hepatitis data of the mandatory notification system, starting in 2018.
- One of the key results and assurances for the success of the SHS was the commitment of the working groups and the network members. Their readiness to work for free for the common cause over a time period of almost five years is extraordinary. Whereas the number of participants in comparable projects is on the decline, it kept slowly growing over time. One of the initiative’s important achievements was the foundation of a new national patient organisation, the Swiss Hepatitis C Association (SHCV). Thanks to this broad alliance of network members and organisations it was possible to implement national medical guidelines and specific guidelines for HCV care among People Who Use Drugs (PWUD) [36]. Last but not least the HCVree trial, which aims to provide HCV treatment to all HIV/HCV positive men who have sex with men (MSM) in Switzerland, is building an important step towards the micro-elimination of HCV among HIV positive MSM [37]. The study is being conducted by a group consisting of several members of the network.
- Four so-called flagship projects emerged from the strategy. These aim to close the gaps in treatment and care and thus reach the elimination goals. The most advanced is the HepCare project (see www.hepcare.ch). It focuses on motivating and empowering general practitioners in order to conduct hepatitis C therapies themselves with the aid of a specialist. A strong focus is on the practitioners who care for patients in opioid substitution therapies. As mentioned in chapter 2, there are significant gaps in the care cascade of PWUD, which should be closed. HepCare will be an important activity in achieving this goal.

5. Discussion

Knowledge about a health threat and its medical response is a necessary, but by far not a sufficient condition for political change. Particular measures are required to enhance political action; it does not just happen by itself, as demonstrated in the case of HCV in

Switzerland. The GLSp proved, against all the odds, to be an efficient tool to transform into practice existing experiences about combating HCV. Its application allowed the SHS to become a catalyst that helped to accelerate and guide a much-needed development in the field of testing, treating and curing HCV. Just five years into its practice, there is much hope that the vision to eliminate HCV by 2030 will be achieved.

Crucial to the success of the SHS was the spirit among the actors involved and the fact that a private initiative could develop and implement a national strategy with little support from the public health authorities. This was only possible thanks to a willingness and appreciation of those involved to collaborate across fields of expertise. Keeping this heterogeneous group together and focused on the common cause brought rapid and visible results. In such a process, actions have to materialise quickly even though their aptness may not be clear for everybody at all times. To lessen the risk of wrong-doing, these activities have to be evaluated and monitored to assure that they deliver the results that contribute towards the SHS vision.

An important feature of the SHS was that the same actors were in charge of the development and implementation of the strategy. This guaranteed the practicability of the plans and goals and kept the participants' commitment high. The downside of this was possible self-restraint, not allowing thinking outside the box. However, the strategic and operational overlap proved to be effective and innovative in itself: the fast track of repeating GLSp spins of developing, implementing, evaluating, reviewing and redesigning new activities made the SHS responsive to the given needs of the process. Not "what" was done but "how" it was done became the real innovation.

Since its inception in early 2014, the SHS has experienced different structural periods. Each had its own strengths and weaknesses, which had to be carefully balanced against the given process requirements. Initially the activities of the strategy were individually driven and there was little coordination. Accordingly the organisational structures had to be very flexible; the downside was that they were rather unstable and unpredictable. Over time the SHS was institutionalised and by doing so, formalised. The advantage of this measure was that the organisational structures became more reliable and predictable but conversely slowed down the decision-making process and increased its complexity.

6. Conclusions

The case of the SHS proves that a carefully designed political learning process is an efficient and innovative tool for today's health policy challenges such as the HCV epidemic. It can also be used as a model for other countries which face similar obstacles. Despite the fact that more and more countries are developing official national strategies, implementation remains difficult. With the GLSp method, we can overcome these obstacles, as its main focus is not only on producing a document, but is also action-oriented.

However, it is important to be aware that the impact of the GLSp template is such that it is on the one hand a generic method to address any health policy challenge; on the other hand it does not go unnoticed and always has to be adapted to the given context. In less than five years the SHS has been able to achieve one of its key goals by enforcing the implementation of universal access to HCV therapies. Based on the Center for Disease Analysis (CDA) Foundation Report, Switzerland is now considered to be on track to eliminate HCV [38].

Declarations of interest

RB und BM: none. PB has served as a consultant and speaker and received project grants from Abbvie, Gilead and Merck pharmaceutical companies.

Acknowledgement

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

- [1] WHO. Global health sector strategy on viral hepatitis 2016–2021. Geneva: World Health Organization; 2016. Contract No.: WHO/HIV/2016.06.
- [2] Burstow NJ, Mohamed Z, Gomaa AI, Sonderup MW, Cook NA, Waked I, et al. Hepatitis C treatment: where are we now? *Int J Gen Med* 2017;10:39–52.
- [3] Falade-Nwulia O, Suarez-Cuervo C, Nelson DR, Fried MW, Segal JB, Sulkowski MS. Oral direct-acting agent therapy for hepatitis C virus infection: a systematic review. *Ann Intern Med* 2017;166(9):637–48.
- [4] Ansaldo F, Orsi A, Sticchi L, Bruzzzone B, Icardi G. Hepatitis C virus in the new era: perspectives in epidemiology, prevention, diagnostics and predictors of response to therapy. *World J Gastroenterol* 2014;20(29):9633–52.
- [5] WHO. New York67th World Health Assembly Resolution on Hepatitis (WHA67.6)2014 67th World Health Assembly Resolution on Hepatitis (WHA67.6) 2014;.
- [6] Plans de lutte contre les hépatites virales B et C en France; 2017. Available from: <http://invs.santepubliquefrance.fr/Dossiers-thematiques/Maladies-infectieuses/Hepatitis-virales/Hepatitis-virales-Generalites/Plans-de-lutte-contre-les-hepatites-virales-B-et-C-en-France>.
- [7] Australian Government DoH. Fifth National Hepatitis C Strategy 2018–2022. Canberra: Australian Government, Department of Health; 2018.
- [8] GfMo Health, Berlin Integrated strategy for HIV, hepatitis B and C and other sexually transmitted infections; 2016.
- [9] Global hepatitis response gains ground – more action needed to achieve universal health coverage targets; 2019 [press release].
- [10] Heim B. In: Department H, editor. Résolution de l'OMS tendant à l'élimination de l'hépatite C. Etat des lieux. Bern: Federal Council of Switzerland; 2018.
- [11] Letter to the FOPH, unpublished. [Unpublished Letter]. In press Division transmissible Diseases: "Mehr Anstrengungen sind nötig; 16. Januar 2019, signed by Swiss Hepatitis, Swiss Association for the Study of the Liver SASL, Swiss Society for Infectious Diseases SSI, Swiss Society for Gastroenterology, Swiss Hepatitis C Association, Swiss Positive Council; 2019.
- [12] Swiss Hepatitis Strategy 2014–2030. Process Paper; 2016.
- [13] Blindenbacher R, Nashat B. The Black Box of Governmental Learning: the learning spiral - a concept to organize learning in governments. *World Bank*; 2010.
- [14] Keiser O, Giudici F, Mullhaupt B, Junker C, Dufour JF, Moradpour D, et al. Trends in hepatitis C-related mortality in Switzerland. *J Viral Hepat* 2018;25(2):152–60.
- [15] Keiser O, Bertisch B, Zahnd C. Situationsanalyse Hepatitis B und C in der Schweiz. Bern: Institut für Sozial und Präventivmedizin der Universität Bern; 2017.
- [16] Richard JL, Schaetti C, Basler S, Mausezahl M. The epidemiology of hepatitis C in Switzerland: trends in notifications, 1988–2015. *Swiss Med Wkly* 2018;148:w14619.
- [17] Bruggmann P. Die Hepatitis-C-Epidemiologie in der Schweiz und die Rolle der Grundversorgung. *Praxis (Bern 1994)* 2016;105(15):885–9.
- [18] Bachmann C, Bachmann R, Cattacin S. Risikoverwaltung: Lernen aus der eidgenössischen Politik im Umgang mit Gesundheitsrisiken: HIV/Aids, Hepatitis C und BSE im Vergleich. Basel: Helbing & Lichtenhahn; 2002, 131 p.
- [19] Kohler P, Schmidt AJ, Cavassini M, Furrer H, Calmy A, Battegay M, et al. The HIV care cascade in Switzerland: reaching the UNAIDS/WHO targets for patients diagnosed with HIV. *AIDS* 2015;29(18):2509–15.
- [20] Cebolla B, Björnberg A. Euro Hepatitis Index 2012 Report; 2012.
- [21] Afdhal NH, Zeuzem S, Schooley RT, Thomas DL, Ward JW, Litwin AH, et al. The new paradigm of hepatitis C therapy: integration of oral therapies into best practices. *J Viral Hepat* 2013;20(11):745–60.
- [22] Sanger-Katz M. \$1,000 hepatitis pill shows why fixing health costs is so hard. *New York Times*; 2014.
- [23] Flubacher R. Ein Geschäft fast ohne Konkurrenz. *Tagesanzeiger*; 2015.
- [24] Brotschi M. Ärzte kritisieren strenge Medikamentenpraxis. *Tages Anzeiger*; 2016.
- [25] Bregenzler A, Conen A, Knuchel J, Friedl A, Eigenmann F, Naf M, et al. Management of hepatitis C in decentralised versus centralised drug substitution programmes and minimally invasive point-of-care tests to close gaps in the HCV cascade. *Swiss Med Wkly* 2017;147:w14544.
- [26] Network SHS. Swiss Hepatitis Strategy 2014–2030: It's time to act now. *Swiss Hepatitis: Process Paper - A Living Document*. Zurich; 2019.
- [27] Mullhaupt B, Bruggmann P, Bihl F, Blach S, Lavanchy D, Razavi H, et al. Progress toward implementing the Swiss Hepatitis Strategy: Is HCV elimination possible by 2030? *PLoS One* 2018;13(12):e0209374.

- [28] Rusch U, Robbins S, Razavi H, Vernazza P, Blach S, Bruggmann P, et al. Micro-elimination of chronic hepatitis C in Switzerland: modelling the Swiss Hepatitis Strategy goals in eastern, western and northern regions. *Swiss Med Wkly* 2019;149:w14694.
- [29] Hepatitis-Strategie [Internet]. 2018. Available from: https://www.hepatitis-schweiz.ch/files/Dokumente/PDF/DC_Hepatitis_20180118_d.pdf.
- [30] Richard JL, Schaetti C, Basler S, Masserey Spicher V. Reduction of acute hepatitis B through vaccination of adolescents with no decrease in chronic hepatitis B due to immigration in a low endemicity country. *Swiss Med Wkly* 2017;147:w14409.
- [31] Golder L, Mousson M, Tschöpe S, Hagemann M, Schwab J. Neue Themenlage, anhaltend hohe Impfskepsis. Gesundheitspersonal kein Vorbild punkto Impfschutz, Hepatitis-C-Sensibilisierung wirksam. Berne: GfS: Schlussbericht zum Virusbarometer 2015; 2015.
- [32] Blindenbacher R. The task dilemma in human service organizations and its impact on efficacy - A possible solution developed out of the theory of society of Jürgen Habermas. *Eur J Soc Work* 1999;2(2):131–8.
- [33] Ricklin F, Hepatitis C. Die Hälfte der Infizierten Weiss von nichts, Schweiz am Wochenende. *Schweiz am Wochenende*; 2016.
- [34] Medienhighlights; 2016 [Internet]. 2016. Available from: https://www.hepatitis-schweiz.ch/files/Dokumente/Medien/161205_Medienhighlights_2016_neu.pdf.
- [35] Blindenbacher R. Guten Ideen zum Durchbruch verhelfen. Die «gouvernementale Lernspirale» ist ein Lösungsansatz für komplexe politische Probleme. *Neue Zürcher Zeitung*; 2017, 25.07.2017.
- [36] Federal Office of Public Health S. Hepatitis C bei Drogenkonsumierenden. Bern: Richtlinien mit settingsspezifischen Factsheets; 2019.
- [37] Braun DL, Hampel B, Kouyos R, Nguyen H, Shah C, Flepp M, et al. High cure rates with grazoprevir-elbasvir with or without ribavirin guided by genotypic resistance testing among human immunodeficiency Virus/Hepatitis C virus-coinfected men who have sex with men. *Clin Infect Dis* 2018.
- [38] EASL ILC [Internet]. 2018. Available from: Press Release: CDA Foundation Reports that only six European countries currently on track to eliminate hepatitis C by 2030; 2018 <http://cdafound.org/only-six-european-countries-currently-on-track-to-eliminate-hepatitis-c-by-2030/>.