



Hepatitis B Policy Reflection: The Parity Gap

Why hepatitis B has lagged behind
HIV and hepatitis C, and what
closing the gap by 2030 actually requires.



2030

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The Parity Gap

Hepatitis B against the WHO 2030 elimination targets

In 2016, the World Health Organization set targets for the elimination of viral hepatitis as a public health threat by 2030. The UK committed to these targets, which apply equally to hepatitis B, hepatitis C, and HIV.

Since then, progress across the three viruses has been deeply unequal. Hepatitis C has seen transformative advances in treatment and diagnosis. HIV continues to benefit from decades of sustained investment in infrastructure, surveillance, and community engagement. Hepatitis B, by contrast, has received comparatively little strategic attention and, until recently, no equivalent programme structure. NHS England's viral hepatitis elimination programme now includes hepatitis B, but without the dedicated funding, delivery infrastructure or defined pathway that hepatitis C received.

This document examines why that gap exists, what it means in practice, and what closing it would require before 2030.

Three diseases, one deadline

The 2030 elimination targets apply to hepatitis B, hepatitis C, and HIV equally. Yet the infrastructure, investment, and political attention given to each has been profoundly unequal.

Hepatitis C: Curative treatment (DAAs) available since 2014. NHS England HCV Elimination Programme funded at approximately £1 billion. Diagnosis rate approximately 75%. Treatment coverage high (treat-all since 2015). Significant global funding through Unitaid and pharma partnerships. Moderate public messaging around elimination narrative.

HIV: Lifelong antiretroviral therapy (ART). HIV Action Plan plus sexual health infrastructure. Diagnosis rate approximately 95%. Treatment coverage high (treat-all since 2015). Approximately \$21 billion annually through The Global Fund and PEPFAR. Strong public messaging built over decades of campaigning, including U=U.

Hepatitis B: Lifelong antivirals (limited eligibility). No dedicated national programme. Diagnosis rate approximately 50%. Treatment coverage low (approximately 3% of eligible globally; limited UK data). Minimal dedicated funding. Very limited public messaging and low public awareness.

Sources: UKHSA, NHS England, The Global Fund, World Hepatitis Alliance. Full references at the end of this document.

Why hepatitis C moved and hepatitis B did not

Hepatitis C has benefited from a convergence of factors that hepatitis B has not. The development of direct-acting antivirals (DAAs) made hepatitis C curable in 8 to 12 weeks, with cure rates exceeding 95%. This clinical breakthrough enabled a clear policy objective: find, treat, and cure.

NHS England invested approximately £1 billion in the HCV Elimination Programme, with defined delivery infrastructure, procurement agreements, and measurable targets. The programme created a national framework that linked testing, referral, treatment, and follow-up into a single pathway.

Hepatitis B has no equivalent. There is no cure. Treatment suppresses the virus but does not eliminate it. Hepatitis B now sits within NHS England's viral hepatitis elimination programme, but without hepatitis C's dedicated budget line or a defined pathway from diagnosis to long-term management. The result is a condition managed inconsistently, with no mechanism to track outcomes at population level.

Infrastructure built for HIV, and its absence for hepatitis B

HIV, like hepatitis B, cannot currently be cured. Yet HIV has seen sustained progress toward elimination targets, driven by decades of investment in infrastructure, community mobilisation, and public health messaging.

Globally, HIV receives approximately \$21 billion annually through mechanisms such as The Global Fund and PEPFAR. In England, this funding operates differently: care and treatment are commissioned and delivered by the NHS, while testing, prevention and community support are commissioned locally by local authorities. Not all local authorities are able to sustain this funding as council budgets shrink; Greater Manchester continues to invest in this work, but the picture elsewhere is inconsistent. The HIV Action Plan provides a strategic framework supported by sexual health services, community organisations, and surveillance systems.

The U=U (Undetectable = Untransmittable) campaign transformed public understanding of HIV treatment, reducing stigma and encouraging testing. There is no equivalent message for hepatitis B, despite comparable evidence that effective viral suppression reduces transmission risk.

Hepatitis B lacks a global funding mechanism and a public-facing message that connects treatment to reduced transmission. England now has a national strategic vehicle for hepatitis B, in NHS England's viral hepatitis elimination programme, but it has not yet been matched with the funding and infrastructure that made HIV's progress possible.

The gap in England's own data

England's progress toward the 2030 hepatitis B elimination targets is difficult to measure, in part because the data infrastructure required to do so does not yet exist at the necessary scale.

The estimated diagnosis rate for hepatitis B in England is approximately 43.6%. The WHO target is 90% by 2030. For context, HIV diagnosis in England is estimated at around 95%, and hepatitis C at approximately 75%.

Treatment coverage for hepatitis B is not currently measured at national level. There is no register or reporting mechanism that tracks how many people diagnosed with hepatitis B are receiving antiviral therapy, or how many meet treatment criteria but remain untreated.

Surveillance coverage has been growing, but remains partial. Sentinel surveillance for hepatitis B is a voluntary reporting scheme for laboratories, not a mandatory one, and UKHSA has led ongoing work to widen participation. As a result, coverage has increased in recent years, but it currently reaches approximately 45% of the population, with significant regional variation — around 75% in London, but as low as 30% in parts of the South West and other regions. Many laboratories that could join are held back less by willingness than by capability: participation depends on being able to generate the required reports automatically from their existing IT systems, which not all labs can currently do.

Data on ethnicity, country of birth, and community-level prevalence remain incomplete. These gaps are not incidental. They reflect decades of underinvestment in hepatitis B-specific infrastructure and make it difficult to plan.

What closing the gap by 2030 requires

1. Full funding and delivery infrastructure for the existing hepatitis B programme

Hepatitis B now sits within NHS England's viral hepatitis elimination programme, and NHS England, UKHSA and voluntary sector partners are already working to close the gap within the constraints they have. What is missing is not a name but the dedicated funding, delivery mechanisms and accountability structures that hepatitis C received. Resourcing the existing programme to the same standard, rather than building a new one from nothing would give hepatitis B the coordinated framework, progress-tracking and accountability it currently lacks.

2. A national treatment coverage register

There is currently no national system for recording how many people diagnosed with hepatitis B are receiving antiviral therapy, how many meet treatment criteria but remain untreated, or how many have been lost to follow-up. A treatment register would provide the baseline data needed to measure progress and identify gaps in care.

3. Wider participation in sentinel surveillance, backed by lab IT capability

Sentinel surveillance for hepatitis B is a voluntary scheme for laboratories, and UKHSA has already driven real growth in participation. Coverage now stands at approximately 45% of the population nationally, with significant regional variation. Closing the remaining gap will mean continuing to widen voluntary participation and, critically, helping laboratories overcome the IT and reporting-capacity barriers that currently prevent many from generating the required reports automatically — alongside standardising data collection and improving the completeness of ethnicity and demographic data.

4. A hepatitis B equivalent to U=U

The evidence that effective viral suppression in hepatitis B reduces transmission risk is comparable to that which underpins U=U for HIV. A clear, evidence-based public message linking treatment to reduced transmission could reduce stigma, encourage testing, and support engagement with care.

5. Stigma support and outreach infrastructure

Hepatitis B disproportionately affects communities that already face barriers to healthcare access, including migrant communities, people from endemic countries, and those affected by poverty or social exclusion. Outreach, peer support, and culturally appropriate services are essential components of any elimination strategy.

6. Investment that reflects the size of the problem

Hepatitis B affects an estimated 268,767 people in England. The level of investment it receives does not reflect this burden. Closing the gap by 2030 requires funding proportional to the scale of the challenge, directed toward testing, treatment, surveillance, and community engagement.

Summary

Hepatitis C has moved toward elimination because it received a cure, a programme, and a budget. HIV has sustained progress because it received decades of infrastructure, global funding, and a public message that connected treatment to prevention.

Hepatitis B has received none of these at equivalent scale. It has no cure, no dedicated funding for the programme it now sits within, no treatment register, no consistent surveillance, and no public-facing message. The 2030 targets apply equally to all three viruses, but the investment does not.

Closing the gap requires not only clinical advances but also the political will to fund the programme, build the infrastructure, and communicate the message that hepatitis B elimination is both necessary and achievable.

References

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<https://www.gov.uk/government/publications/hepatitis-b-in-england/hepatitis-b-in-england-2025>
2. NHS England, World Hepatitis Day 2025: Building a comprehensive response to viral hepatitis — confirms hepatitis B now sits within NHS England’s viral hepatitis elimination programme via integrated viral hepatitis networks, and that this is not yet matched with hepatitis C-level funding.
<https://www.england.nhs.uk/blog/world-hepatitis-day-2025-building-a-comprehensive-response-to-viral-hepatitis/>
3. NHS England, Ending Hepatitis C in England — the HCV Elimination Programme’s funding, delivery infrastructure and outcomes.
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4. UKHSA, Sentinel surveillance of blood-borne virus (SSBBV) testing — confirms this is a voluntary laboratory reporting scheme led by UKHSA, and the basis for current coverage figures. <https://www.gov.uk/government/collections/sentinel-surveillance-of-blood-borne-virus-ssbbv-testing>
5. WHO, Combating hepatitis B and C to reach elimination by 2030 — the 2030 elimination targets referenced throughout.
<https://www.who.int/publications/i/item/combating-hepatitis-b-and-c-to-reach-elimination-by-2030>
6. World Hepatitis Alliance — cited source for global comparative data in the three-virus table. <https://www.worldhepatitisalliance.org/>