



Testimony

of

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before the

New York City Council Committee on Health

On

**Evaluating Efforts to Improve Surveillance, Testing, Treatment, Outreach and Education
Relating to Hepatitis B and Hepatitis C**

and

**Int 51-A: Requiring the Department of Health and Mental Hygiene to Issue an Annual
Report Regarding hepatitis B and hepatitis C**

**June 24, 2014
City Council Chambers
New York City**

Good afternoon, Chairman Johnson and members of the Health Committee. My name is Dr. Jay Varma, and I am the Deputy Commissioner for the Division of Disease Control at the New York City Department of Health and Mental Hygiene. I am joined here today by Dr. Fabienne Laraque, director of our viral hepatitis program, and Dr. Jane Zucker, Assistant Commissioner for the Bureau of Immunization at the Health Department. On behalf of Commissioner Bassett, thank you for the opportunity to testify today.

Because this is the first time I have had a chance to testify before this Committee, I will briefly describe the roles played by the Health Department with regard to infectious Disease Control. I oversee all of the infectious disease programs at the Department, which includes separate programs for HIV, sexually transmitted diseases, tuberculosis, vaccine-preventable diseases, and general communicable diseases, as well as our public health laboratory. Our programs for general communicable diseases, vaccine-preventable diseases, HIV, and the public health laboratory all play vital roles in addressing viral hepatitis.

The bill under consideration today, Int. 51-A, is intended to raise awareness about two important causes of illness and death in New York City: hepatitis B and hepatitis C. Though they share a common name, these viruses are distinct. The prevalence of each varies widely across different populations of New Yorkers, and they require different control measures. Therefore, I will talk about each of these diseases separately in my testimony today. The Department appreciates the Council's interest in these areas and the value of data reporting; however, we are concerned that the reporting mandated by this bill would place unnecessary requirements on financially-constrained programs. We are interested in working with the Council to ensure this legislation does not inadvertently pull resources from core programs that identify and treat viral hepatitis in NYC.

Hepatitis C

Let me begin by discussing hepatitis C. Hepatitis C is a virus that is transmitted by contact with infected blood, most often from an unsafe injection. There is no vaccine to prevent infection. Therefore, the primary strategies to control hepatitis C include reducing unsafe injections to prevent new infections, and testing and treating infected people to prevent deaths. We estimate that 146,500 New Yorkers are living with hepatitis C infection. The highest infection rates occur among Hispanics and non-Hispanic blacks, and in the South Bronx and East and Central Harlem. The annual death rate from this disease has increased 46 percent in 15 years in New York City.

Until recently, very little testing and treatment has been performed for hepatitis C, because drugs to treat it were toxic and ineffective. In the past year, new drugs have become available that can cure hepatitis C by taking a few pills every day for only a few months. We estimate that only 50 percent of infected New Yorkers actually know that they are infected, and fewer than 10 percent of infected New Yorkers have ever been treated for hepatitis C. The Health Department works closely with our community partners to educate the public and doctors about testing and treatment. It is essential for more physicians to be trained to treat hepatitis C, and to develop larger-scale public health programs to help navigate patients to appropriate education and treatment services.

Despite large cuts to our disease control programs in the past 10 years, our team is working assiduously on hepatitis C. In 2013, the Department released an action plan to reduce

illness and death from hepatitis C in New York City. Major activities that the Department has taken to implement this action plan include:

- Developing educational content for the public, such as re-design of our hepatitis web pages, production of new print and video materials, and development of an app for patients;
- Developing educational content for healthcare providers and working with providers to improve testing practices and provide training in HCV;
- Continued implementation of the Check Hep C project, which involves education, testing, and linkage to care of patients in high prevalence settings;
- Working to expand services at syringe exchange programs to address increases in injection drug use and hepatitis C infections among young people;
- Building community resources and advocacy through the HCV Task Force; and
- Amending the New York City Health Code to permit more complete monitoring of testing and treatment in New York City.

Hepatitis B

Now let me turn to hepatitis B. Like hepatitis C, hepatitis B can also be transmitted by contact with infected blood. Unlike hepatitis C, however, it can also be easily transmitted by contact with semen or other body fluids. Even more important, a highly effective vaccine to prevent hepatitis B infection has been available in the United States since 1981. The primary strategy to control hepatitis B in New York City, therefore, involves preventing new infections through vaccination.

An estimated 100,000 New Yorkers are currently living with the hepatitis B virus. Chronic infection is most common in Sunset Park in Brooklyn, Flushing in Queens, and Chinatown in Manhattan. Of patients with chronic hepatitis B infection, over 90 percent were born outside the United States, the majority in China.

Routine vaccination of all newborns in New York City began in 1991. Because hepatitis B vaccination is a school immunization requirement, more than 95 percent of all children less than 18 years of age in New York City are fully immunized. The Department also places a high priority on immunizing adults who are at very high risk and on preventing transmission of infection from infected mothers to children. Our sexually transmitted disease clinics offer hepatitis B vaccination to high risk populations. And our vaccine preventable diseases program case manages approximately 1,800 pregnant women with chronic hepatitis B each year, 91 percent of whom were born outside the United States. We work with these mothers and their physicians to ensure that their newborn babies receive both immunoglobulin and vaccination promptly and completely after birth to prevent acquisition of hepatitis B.

A major gap in the health system is that there are limited resources for people already infected with hepatitis B. First, there are no medications that can reliably cure hepatitis B infection. Treatment with a combination of medications can help prevent damage to the liver and prevent liver cancer, which is the most serious complication of infection. The cost of drugs alone exceeds more than \$50,000 per patient per year. Second, as noted above, most infections occur in immigrants from China, many of whom are not eligible for health insurance.

Legislation

The Department shares the Council's concern about hepatitis B and hepatitis C. We are concerned, however, that this legislation imposes a work burden that extends the Department's staff beyond its current resources.

In previous years, we produced a consolidated report about viral hepatitis. We were able to produce that report, because we had a CDC grant specifically for viral hepatitis surveillance. We lost this grant in 2012, which meant that we no longer had funding for seven staff previously dedicated to viral hepatitis. Nevertheless, the Department worked to ensure that the most important and accurate data about this disease is publically available, even if it not in a printed report. The Department's EpiQuery system now includes data about hepatitis B and hepatitis C that can be easily analyzed by anyone through an interactive and user-friendly system.

We are also concerned that some of the data elements requested in Council's proposed legislation cannot be reliably measured, such as acute hepatitis B and hepatitis C infections, liver cancer deaths due to hepatitis B and hepatitis C, adult vaccinations, and the percentage of hepatitis B and hepatitis C cases referred to care or in care. The Department looks forward to working with the Council to improve this legislation, and further broaden awareness about hepatitis B and hepatitis C.

Thank you for the opportunity to testify today. Dr. Laraque, Dr. Zucker, and I are happy to answer any questions.