Testimony
Senate Bill 2320
House Human Services Committee
March 14, 2017 9:00 AM
North Dakota Department of Health

Good morning Chairman Weisz and members of the House Human Services Committee. My name is Lindsey VanderBusch, and I am the HIV, STD, TB, Viral Hepatitis program manager for the North Dakota Department of Health. I am here today to provide testimony in support of Senate Bill 2320.

This bill authorizes a new program in North Dakota that would allow for syringes or needles to be exchanged to aid in the prevention of bloodborne diseases. Pursuant to criteria that will be developed by the North Dakota Department of Health, exchange programs will be established in locations that are deemed at risk, or in locations that have already seen increases in the prevalence of viral hepatitis or HIV. Senate Bill 2320 asserts that state agencies cannot provide state funds for the purchase of syringes or needles under this program. The bill also requires semiannual reporting of the number of individuals served, number of syringes and needles collected and distributed, and any other pertinent information requested by the Department of Health.

Currently there are syringe exchange programs operating in 33 states, and other states are proposing legislation similar to SB 2320 to provide access this year.

Legal (e.g., Oxycontin) and illegal opioids (e.g., heroin) are often injected intravenously. Injection drug use is the primary risk factor for hepatitis C infection in the United States. According to the Centers for Disease Control and Prevention (CDC), syringe exchange programs have been associated with reduced risk for infection with hepatitis C virus.

In 2015, there were 1,063 cases of hepatitis C reported to the North Dakota Department of Health. This was nearly double the reports received in 2011 at 554. Of those, a third were in people aged 30 and younger. Over the past decade, the percentage of hepatitis C case reports in persons under the age of 30 years of age has increased.

Over the past 5 years the number of newly diagnosed cases of HIV in North Dakota have also risen. In 2012, 16 newly diagnosed cases of HIV were reported; this has risen to 46 in 2016. In addition, the increase in the number of

people reporting injection drug use as a risk factor has risen from one in 2012, to six in 2016. We suspect this estimate is low given the sensitive nature of the risk factor.

Multiple sources and studies show that syringe service programs are cost effective due to the significant reduction in transmission of HIV and hepatitis C. A meta-analysis published in the International Journal of Epidemiology in 2014 suggests that needle and syringe exchange programs alone can reduce the risk of HIV infection by 56%. This does not include the number of infections that can be spared by coupling these programs with testing programs that identify new cases early and link and retain those persons to care and eliminate the potential for further transmission.

The lifetime treatment cost of treating an induvial with HIV or hepatitis C is high. Treatment for one individual over a lifetime is estimated to cost $326,500. Newer, highly effective hepatitis C curative therapies can reduce the ongoing harm that chronic hepatitis C may cause. While treatments can cost up to $90,000 for a 12-week course, likely increasing short-term hepatitis C treatment costs, these new therapies decrease the overall lifetime treatment costs from resultant cancer, liver failure and liver transplantation.

Programs designed to prevent these infections in the first place, and subsequently provide services to identify at-risk and infected persons early and link and retain these individuals in care, can greatly reduce the risk of bloodborne infections and the risk for transmission in North Dakota.

This concludes my testimony. I am happy to answer any questions you may have.