

HIV Policy: The Path Forward

A Joint Statement of the American College of Physicians and
the HIV Medicine Association

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Policy Brief

The American College of Physicians (ACP) and the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America (IDSA) published their fourth statement on AIDS this month. Since the last statement was published in 1994, there have been remarkable advances in HIV medicine. Treatment for HIV disease is now one of the most effective medical interventions available today and yet, in the U.S., 50 percent of people with HIV do not have a reliable source of HIV care and at least 36 percent of people with HIV are diagnosed within a year of an AIDS diagnosis. This policy brief highlights key recommendations for federal policy makers to consider as they reform our health care system and complete the fiscal year 2010 appropriations process. We face important opportunities this year for bringing our public policies in line with our scientific achievements in the HIV field and realizing our country's full potential for combatting the HIV pandemic.

HIV Treatment Advances

More than a decade ago, combination antiretroviral therapy was widely introduced in the United States and Europe, constituting a medical breakthrough that revolutionized HIV treatment in the developed world. The effective suppression of HIV through combination antiretroviral therapy resulted in an 80 percent drop in AIDS-related mortality in the U.S. and dramatic reductions in debilitating opportunistic infections that had been commonly associated with an AIDS diagnosis. Combination antiretroviral therapy is estimated to have saved 3 million years of life.¹ In developing countries, access to combination antiretroviral therapy is still a challenge, and when the drugs are available, most individuals only have access to one drug regimen. Opportunistic infections in HIV-infected patients are common in developing countries, with tuberculosis

leading the way as the number one cause of death for patients with HIV infection in sub-Saharan Africa and much of the developing world.²

Epidemiology

Nearly 1.2 million persons in the U.S. are estimated to be living with the disease today.^{3 4} Of these, 415,000 are estimated to be living with AIDS and 417,000 living with HIV infection. Another 252,000 to 312,000 people are estimated to be living with HIV or AIDS in the U.S. and not know it.⁵ The Centers for Disease Control and Prevention (CDC) estimates that 56,300 new HIV infections occur every year and asserts that this number has remained stable for more than a decade.⁶

An estimated 33 million people worldwide have AIDS. In 2007, 2.7 million persons were newly infected with HIV, and there were 2 million AIDS deaths globally. Sub-Saharan Africa continues to be the region most affected by the AIDS pandemic, accounting for 67 percent of all people living with HIV infection and 75 percent of AIDS deaths in 2007. While women represent 50 percent of people living with HIV globally, they account for nearly 60 percent of infections in sub-Saharan Africa, where transmission is primarily through heterosexual contact. Two million children younger than 15 are estimated to be living with HIV worldwide and 90 percent are in sub-Saharan Africa.

² World Health Organization. Frequently Asked Questions about TB and HIV. Available at: www.who.int/tb/hiv/faq.

³ Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report, Vol. 17. June 2007.

⁴ Glynn M and Rhodes P. Estimated HIV Prevalence in the United States at the end of 2003. Presentation, National HIV Prevention Conference; June 2005.

⁵ Ibid. Glynn.

⁶ Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. *JAMA*. 2008;300(5):520-529.

¹ Walensky R, et al. The survival benefits of AIDS treatment in the United States. *JID*. 2006 Jul 1;194(1):11-9.

Highlights of HIVMA and ACP HIV Policy Recommendations:

1. Federal and state governments should work to support routine HIV testing in sexually active adults, pregnant women and newborns (when appropriate) through (a) coverage and reimbursement by federally supported health care programs and (b) elimination of requirements for a separate informed consent for HIV testing.

In December 2008, ACP and HIVMA released a guidance statement on screening for HIV in health care settings recommending that clinicians adopt routine screening for HIV and encourage patients to be tested. CDC has recommended routine HIV screening in health care settings since 2006. Routine HIV testing should be covered as a preventive service under Medicare and Medicaid. Routine HIV testing also should be supported with adequate federal funding through other federal programs, such as community health centers, the federal bureau of prisons, and the Department of Veterans Affairs. Routine HIV testing should be included in any standard benefits package developed as part of health care reform.

2. Public health officials and others in public leadership should promote evidence-based interventions, including ensuring access to comprehensive sex education for youth, wide availability of condoms and education about their proper use, and broad availability of syringe exchange programs and drug treatment interventions, to minimize the risk of HIV transmission.

Federally funded sexual health education programs in the U.S. and in the developing world should be scientifically based, comprehensive, and culturally and developmentally appropriate. The federal government should shift funding from unproven abstinence-only education programs to support comprehensive programs that provide information on delaying sexual debut in addition to sound scientific information about contraception and condom use.^{1 2 3} The federal government also should fund interventions that have been shown to be effective in reducing HIV transmission in injection drug users, including syringe exchange and drug treatment programs to make them widely available.^{4 5 6}

3. The U.S. government should increase funding for evidence-based HIV prevention activities through CDC to fund community-based programs aimed at populations at high risk and groups with intermittent access to care, and to enhance surveillance activities. There have been no increases in HIV prevention funding for domestic programs in a number of years despite estimates from CDC that the number of new infections occurring annually in the U.S. has remained steady for a decade at 56,300. Increased funding to support a comprehensive strategy to reduce

incidence and prevalence of HIV infection domestically is urgently needed.

4. All people living with HIV/AIDS in the U.S. should have access to HIV care provided by or in consultation with those skilled in providing care for HIV/AIDS. Physicians, hospitals and other health professionals are obligated to provide state-of-the-art and humane care to patients with HIV infection or to arrange for referral to an HIV expert. Adequate resources should be dedicated to addressing the unique psychosocial needs of newly identified patients in the health care setting. Funding for HIV care should be sufficient to maintain a competent workforce. The federal government should evaluate the adequacy and capacity of the HIV clinical workforce. Since the early days of the AIDS epidemic, studies have demonstrated improved patient health outcomes, and the delivery of more cost-effective care by clinicians with experience treating HIV disease.^{7 8} As the first generation of HIV clinicians retires, we face a serious shortage of qualified HIV clinicians in the U.S. In a 2008 survey of Ryan White funded clinics, 69 percent of clinics reported difficulty recruiting HIV clinicians. They identified the top two challenges to recruitment as lack of HIV clinicians and reimbursement issues.⁹ Given the federal investment in HIV care and treatment and the move to make HIV testing routine in health care settings,¹⁰ we call on the federal government to evaluate the adequacy and capacity of the U.S. HIV clinical workforce and to address the HIV medical workforce shortage in the context of health care reform.

5. The U.S. government should work with states to ensure access to care to all patients with HIV/AIDS in the U.S. by establishing a program that would provide comprehensive medical care and prescription drugs to all low-income persons with HIV infection, as recommended by the Institute of Medicine (IOM). At a minimum, Congress should increase funding for programs under the Ryan White HIV/AIDS program and enact legislation that would allow state Medicaid programs to expand eligibility to low-income persons with HIV infection before they progress to AIDS. We urge policy makers to end the disparities in access to HIV care in the U.S. through health care reform.

6. The U.S. government should continue to support a comprehensive portfolio of research into the causes, prevention and treatment of HIV infection and AIDS, including research aimed at identifying a vaccine; prevention technologies including barrier methods to prevent HIV acquisition; the development of improved antiretroviral therapies; and therapeutic and prophylactic regimens for opportunistic infections and malignancies that affect persons with HIV infection. Further research evaluating the behavioral and cultural aspects of prevention and

treatment of HIV in the U.S. and the associated co-morbidities should also be well represented in the research agenda.

7. The U.S. government should continue to devote substantial resources to respond to the global pandemic with a particular focus on developing countries. Resources should be devoted to evidence-based prevention interventions such as risk-reduction programs for sexual transmission, condom distribution, syringe and needle exchange, drug treatment programs and programs to prevent perinatal transmission; antiretroviral treatment and comprehensive medical care and support services for infants, children and adults; and programs to provide care and services to HIV-related orphans. The U.S. government should also remain a major contributor to the Global Fund to fight HIV, Tuberculosis, and Malaria. U.S. scientists, physicians, and other experts should continue to assist and be supported in the assistance of developing countries to address the operational, scientific and training issues surrounding implementation of new programs. We urge the U.S. government to continue its robust commitment to global health by funding the reauthorized program at the levels recommended in the *United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act* and maintain and enhance the U.S. financial support to the Global Fund for HIV, tuberculosis and malaria.

8. Visitors with HIV should be able to enter the U.S., and otherwise qualified immigrants with HIV should be able to obtain permanent residency status or citizenship. We urge the Secretary of Health and Human Services to move expeditiously to remove HIV disease from the list of communicable diseases of public health significance to end this long-standing discriminatory practice against visitors and immigrants with HIV.

Read the Full Recommendations

This issue brief is a summary of *HIV Policy: The Way Forward*, published in the May 15, 2009 issue of *Clinical Infectious Diseases*. The full paper is available online at www.journals.uchicago.edu/toc/cid/current.

ACP/HIVMA Guidance Statement on Routine Screening for HIV

ACP and HIVMA recommend that clinicians routinely screen for HIV and encourage their patients to be tested. The ACP and HIVMA guidance statement on screening for HIV in health care settings is online at www.annals.org.

For More Information

To share your comments on this issue brief or on the full position paper, please contact Andrea Weddle with HIVMA at (703) 299-0915 or aweddle@idsociety.org or Renee Zerehi with ACP at (202) 261-4555 or rzerehi@mail.acponline.org.

ACP is the nation's largest medical specialty organization representing 126,000 internal medicine physicians (internists) and medical students.

HIVMA represents more than 3,600 clinicians and researchers committed to HIV medicine who work on the frontline in communities across the U.S.

¹ Section 510(b) of Title V of the Social Security Act, P.L. 104-193.

² US Department of Health and Human Services, Administration for Children and Families. Community-based Abstinence Education. Available at: <http://www.acf.hhs.gov/programs/fysb/content/abstinence/index.htm>.

³ Adolescent Family Life Act. 42 U.S. C. 300Z.

⁴ Office of the Surgeon General. Evidence-based findings on the efficacy of syringe exchange programs: an analysis from the Assistant Secretary for Health and the Surgeon General of the scientific research completed since April 1998. Washington, DC. 2000.

⁵ Holtgrave DR et al. Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States. *J Acquir Immune Defic Syndr Hum Retrovirol* 1998;18Suppl 1:S133-8.

⁶ National Institute on Drug Abuse. Principles of HIV Prevention in Drug-Using Populations: A Research-Based Guide. NIH Publication No. 02-4733. March 2002.

⁷ Kithata et al. Physicians' experience with the acquired immunodeficiency syndrome as a factor in patients' survival. *N Engl J Med*. 1996; 334(11):701-706.

⁸ Brosgart C, et al. Community patterns of care for HIV disease: experience makes a difference. *Proceedings of Int Conf AIDS* 1998; 12:1143-44.

⁹ Lubinski, C. HIV Medical Workforce Overview and Preliminary Results from the HIVMA Ryan White Part C Survey. Presented at the HRSA/HIV/AIDS Bureau HIV/AIDS Workforce Meeting. Rockville, MD. Sept 2008.

¹⁰ Centers for Disease Control and Prevention. *MMWR*, Vol. 55, No. RR14, 2006.