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AIDS Prevention: Views on the Administration's Proposed Budget for FY 1988

Statement of
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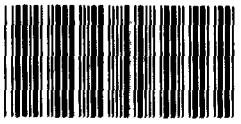
Before the Subcommittee on
Health and the Environment
Committee on Energy and Commerce
House of Representatives



Summary

As of September 1987, over 40,000 AIDS cases had been reported to the Centers for Disease Control (CDC), up from about 300 in 1981. In 1981, the federal budget included $200,000 for the Centers for Disease Control to study AIDS. For fiscal year 1988, the proposed federal Public Health Service budget had increased to more than $790 million, with about one-third ($247 million) for prevention activities.

Since researchers believe a vaccine will probably not be available for general use in the near future, federal, state, and local health department officials and other experts agree that prevention activities, such as education and voluntary counseling and testing, are the most powerful tools available to reduce the potential impact of the AIDS epidemic. GAO obtained the views of over 20 experts from the research and health professional communities, advocacy groups, and state and local health departments in New York, California, Florida, Massachusetts, Illinois, and Washington, D.C., on the adequacy of the funding levels and appropriateness of the funding priorities in the administration's AIDS prevention budget.

Overall, the experts GAO interviewed generally concurred with the priorities reflected in the administration's AIDS prevention budget but suggested that the proposed budget be increased by at least

-- $50 million for methadone treatment to contain the spread of the AIDS virus among intravenous drug users,

-- $65 million for educational campaigns targeted at high-risk groups and the general population, and

-- $250 million for expanded capacity at voluntary testing and counseling centers.

These estimates reflect the views of the experts, not GAO, and were made without regard to competing health priorities or federal budgetary constraints. GAO identified some options that could minimize the need for increased federal funding.

Investing in prevention now could help contain the costs of AIDS. Treating AIDS victims may, according to CDC, cost $8.5 billion in 1991. Including productivity losses associated with deaths of persons in their prime working years, the total social costs of AIDS may reach $64 billion in 1991. A recent estimate of the total costs of treating AIDS predicted that cumulative medical treatment costs might reach $38 billion by 1991. Estimates of lifetime hospital costs ranged from $24,500 to $147,000. Most of the current studies on the costs of AIDS probably understate the total costs of treatment because they exclude the costs of services received outside the hospital, such as drugs, hospice care, and community volunteer support services.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss issues related to federal efforts to limit the spread of Acquired Immunodeficiency Syndrome, commonly known as AIDS. My comments will primarily relate to the report[1] we issued last month on the adequacy of the administration's proposed fiscal year 1988 funding levels for AIDS prevention activities in the U.S. Public Health Service (PHS). I will also discuss the cost of caring for AIDS patients and the possible implications of alternative treatments on those costs.

My comments are based on our review of the literature and the views of over 20 experts from the research and health professional communities, advocacy groups, and state and local health departments in New York, California, Florida, Massachusetts, Illinois, and Washington, D.C. While the experts generally concurred with the prevention priorities as reflected in the budget, they told us that additional funds were needed for education, testing, and counseling services. These views are those of the individuals we contacted and not necessarily those of their affiliated organizations.

Growth in AIDS Cases and Federal Expenditures

As of September 1987, over 40,000 AIDS cases had been reported to the Centers for Disease Control (CDC), up from about 300 in 1981. Most of the cases were clustered in high-incidence areas, such as New York City, San Francisco, Los Angeles, Miami, and Houston. The Public Health Service predicts that there will be a total of 270,000 cases by 1991. While San Francisco and New York currently account for over half the cases, by 1991 eighty percent of the cases are predicted to be in other areas.

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[1]AIDS Prevention: Views on the Administration's Fiscal Year 1988 Budget Proposals. (GAO/HRD-87-126BR, August 12, 1987).

The Public Health Service's budget for AIDS prevention and research has increased from $200,000 in fiscal year 1981 to over $790 million proposed by the administration for fiscal year 1988. Of this budget, about two-thirds ($519 million) would be spent on biomedical research to find a vaccine and cure. The remaining one-third ($247 million) would be used for prevention and education activities--$155 million for education ($55 million targeted at IV drug users) and $92 million for testing and counseling ($15 million targeted at IV drug users). The budget request also includes $24 million for maintaining the safety of the blood supply and other activities.

Experts' Views on the Fiscal Year 1988 Budget

Since development of a vaccine is at least 5 years away and probably longer, federal, state, and local health department officials and experts in the research community agree that education and prevention activities are the most powerful tools available to reduce the potential impact of the AIDS epidemic.

Overall, the experts we interviewed concurred with the priorities reflected in the Administration's AIDS prevention budget for fiscal year 1988--limiting the spread of AIDS among intravenous drug users, targeting education at high-risk groups and at the general population, and expanding voluntary counseling and testing. The experts did not, however, agree with the proposed funding levels and, as I will discuss, suggested that the administration's budget be substantially increased.

The experts made their funding suggestions without regard to competing health priorities or federal budgetary constraints. Although GAO did not develop its own funding recommendations, we offer comments that may reduce the need for federal cost increases suggested by the experts.

Limiting the Spread of AIDS in Intravenous Drug Users

The experts cited the sharing of contaminated hypodermic needles by intravenous drug users as a dangerous and alarming problem because it represents the primary means of spreading the AIDS virus among the heterosexual population. Nationwide, 60 percent of heterosexual cases and 73 percent of cases in newborns were transmitted as a result of intravenous drug use.

Methadone treatment can, the experts believe, reduce the spread of AIDS by reducing the number of addicts who inject heroin. Public health officials in New York suggested an additional $50 to $150 million to expand methadone treatment in New York City, where about one-third of the nation's IV drug users live. Officials in Boston and San Francisco also indicated that they need additional federal funds to expand methadone treatment, but did not cite a dollar amount.

Many social, political, and financial barriers preclude expansion of drug treatment programs and other means aimed at intravenous drug users. For example, communities often resist expansion of methadone clinics in their neighborhoods. While drug treatment may be the preferred option, rapid expansion over the next few years will be expensive. In the interim, less costly but also controversial methods of reducing the spread of AIDS that do not involve changing drug users' basic behavior, such as teaching drug users how to disinfect needles, can be implemented.

Educating the Public About AIDS

The experts told us that AIDS education for high-risk groups and the general population should be pursued with a sense of urgency and a level of funding that is appropriate for a life-or-death situation. Moreover, to limit the spread of AIDS infection, education must start or be expanded immediately in all geographic

areas, including those where there are as yet few cases. In particular, because the virus can be spread through unprotected heterosexual intercourse, the experts believe that clear and direct messages about safer sexual practices, such as using condoms, can help prevent the spread of AIDS in the general public.

According to the experts we contacted, the administration's budget request of $155 million does not provide sufficient funding for education of the general public and targeted groups. Experts from the Institute of Medicine's (IOM) Committee on a National Strategy for AIDS estimated that at least $100 million--in contrast to the $29 million in the budget request--is needed to launch a massive public education campaign on how AIDS is spread. They suggested that the Centers for Disease Control use paid commercial advertising in prime viewing hours instead of relying on public service announcements, which are generally not aired during prime viewing hours. American Medical Association (AMA) experts suggested increasing funding for AIDS education by 3 to 5 times over the fiscal year 1987 spending level--$65 to $215 million more than the fiscal year 1988 budget request.

Many experts expect the federal government to underwrite a major portion of funding for educational AIDS efforts. We believe, however, that private sector organizations, such as insurance companies, have strong financial incentives to become involved in AIDS educational efforts because they will also have large outlays in the next few years if the AIDS epidemic goes unchecked. Also, the costs of the mass media campaign envisioned by the Institute of Medicine may be reduced if television and radio stations were encouraged to broadcast public service announcements during prime viewing hours as an alternative to paid advertising. Other relatively inexpensive measures, such as posting notices on public transportation, would provide a constant reminder of the threat of AIDS.

Providing Testing and Counseling Services

The experts expressed concern that individuals requesting testing and counseling typically had to wait several weeks to be tested. Citing unacceptable waiting periods at test sites in Chicago, for instance, the AMA recommended that testing capacity be increased by 3 to 5 times.

The populations at high risk of contracting AIDS, such as homosexual/bisexual men, IV drug users, and their sexual partners, number nearly 10 million persons, according to recent CDC estimates. At an average cost of $45 per person, potential resources needed if these individuals request testing would approach $450 million. Assuming the states match the Administration's budget of about $90 million, about $250 million more in total funding would be needed to meet this demand.

Experts we contacted at CDC and IOM were unable to predict, however, the potential demand for testing from either high-risk individuals or the general public. Additional costs also would be incurred for heterosexuals who perceived themselves to be at risk for whatever reason; persons who received multiple blood transfusions in high-incidence areas before 1985; and prostitutes. Moreover, intensive educational campaigns may increase demand for testing in relatively low-risk populations. Precise budgetary needs are, therefore, difficult to estimate.

The Total Costs of Treating AIDS

Investing in prevention now can help contain the future direct medical costs of treating AIDS. A study prepared for the Centers for Disease Control projected that treating AIDS may cost $8.5 billion in 1991 (or 1.4 percent of total personal health expenditures, up from 0.2 percent in 1985). Including the indirect costs of losses in productivity associated with premature death,

these researchers predicted the total social costs of AIDS may reach $64 billion by 1991.[2] A more recent estimate of the total costs of treating AIDS predicted that cumulative medical treatment costs might reach $38 billion by 1991.[3] This study based its projections on recent research indicating that the future caseload may be greater than the Public Health Service originally predicted.

These studies probably understate the total costs of treatment because they exclude the costs of services received outside the hospital, such as drugs, institutional or home-based long-term care, hospice care, ambulatory physician and ancillary services, and community support services. In fact, despite widespread concern about the financial repercussions of AIDS on the health care system, data on the costs for medical care of persons with AIDS are surprisingly scarce. Furthermore, no estimates are available of the costs associated with AIDS-related complex--AIDS-virus infections that do not meet the CDC definition of AIDS.

Other factors, however, may raise or lower total costs. First, the distribution of cases of AIDS and AIDS-related complex by diagnosis may change over time. For example, according to CDC, the proportion of AIDS patients with certain cancers, such as Kaposi's sarcoma, may decrease while severe lung infections, such as pneumocystis carinii pneumonia, may increase. Since the latter is more expensive to treat, direct personal medical costs would be expected to rise. Other changes in case-mix may also raise or lower total treatment costs.

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[2]Scitovsky, Anne and Dorothy Rice. "Estimates of the Direct and Indirect Costs of Acquired Immunodeficiency Syndrome In The United States, 1985, 1986, and 1991," Public Health Reports, Vol. 102, No. 1, Jan.-Feb. 1987, pp. 5-16.

[3]Pascal, Anthony. The Costs of Treating AIDS Under Medicaid, 1986-1991. Rand Corporation, Santa Monica, Calif. May 1987.

Second, numerous drugs are being tested and are under development. Drugs like AZT (azidothymidine) affect treatment costs in two ways--by raising pharmaceutical costs and by changing the clinical course of the disease. Patients on this drug may live longer but require different health care services, which may in turn raise or lower costs. Moreover, drugs like AZT may improve the quality of life and decrease productivity losses if AIDS patients can continue to work longer than would have been possible without the drug. Obviously, development of a cure or vaccine will change the cost situation.

Costs Per Case of Treating AIDS

A review of cost studies done between 1985 and 1987 shows that the costs per case of treating AIDS vary significantly.[4] Meaningful cost comparisons are difficult, however, because the studies varied in their definitions of AIDS, the types of costs included, the time periods analyzed, and the geographic areas. The studies were conducted using data from New York, California, Florida, Massachusetts, Maryland, Minnesota, Alabama, and New Mexico.

Estimates of lifetime hospital costs ranged from $24,500 to $147,000. The variation is due largely to differences in lengths of hospital stays for AIDS treatment, for which there is no standard medical model. There is also some evidence suggesting that AIDS patients are now less likely to be admitted to intensive care units than they were when less was known about the disease.

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[4]Sisk, Jane. "The Costs of AIDS: A Review of the Estimates." Health Affairs, Vol. 6, No. 2, Summer 1987, pp. 5-21.

According to two recent articles in the Journal of the American Medical Association,[5] the use of inpatient hospital treatment for AIDS appears to have decreased over time. As a result, lifetime treatment costs for AIDS patients seem to have fallen. Specifically, days in the hospital from diagnosis to death fell from 168 for the first 10,000 cases[6] to 35 days (based on San Francisco data) and to 62 days (based on Massachusetts data) in 1984 and 1985.

The average length of stay is also shorter in areas where alternatives to hospitalization exist, such as outpatient diagnosis and therapy and home- and community-based services. In San Francisco, the mean length of hospital stay for all AIDS diagnoses was 11.7 days in 1984. Voluntary organizations in San Francisco provide support services to AIDS patients that allow them to leave the hospital sooner or avoid hospitalization completely. Providers in Florida also have been able to cut hospital costs by setting up outpatient treatment services for AIDS patients.

While it may be possible to increase home-based services in other communities where the caseloads are comprised of mostly homosexual men, it is more problematic in areas where intravenous drug users account for a greater percent of cases. For example, the average length of stay for AIDS patients in New York City was 50 days in 1984. This may reflect, in addition to differences in severity of

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[5]Scitovsky, Anne, Mary Cline, and Philip Lee. "Medical Care Cost of Patients With AIDS in San Francisco," Journal of The American Medical Association, Vol. 256, No. 22, Dec. 12, 1986, pp. 3103-3106, and George Seage, et al, "Medical Care Costs of AIDS in Massachusetts," Journal of The American Medical Association, Vol. 256, No. 22, Dec. 12, 1986, pp. 3107-3109.

[6]Hardy, Ann et al. "The Economic Impact of the First 10,000 Cases of Acquired Immunodeficiency Syndrome in the United States." Journal of The American Medical Association, Vol. 255, No. 2, 1986, pp. 209-215.

illness, a lack of outpatient or home-based care for AIDS patients in New York City, of whom 30 percent are intravenous drug users.

In summary, although it is difficult to predict how the costs of treating AIDS may change over time, there is evidence that the costs per case can be minimized by delivering care outside the hospital setting. This appears to be occurring in several areas of the country.

This concludes my statement. I will be happy to answer any questions you may have.