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Opening Statement of
Chairman Tom A. Coburn, M.D.
Chairman
Subcommittee on Federal Financial Management, Government Information, and International Security

"Ensuring Early Diagnosis and Access to Treatment for HIV/AIDS: Can Federal Resources Be More Effectively Targeted?"

Good afternoon.

Today's hearing examines domestic efforts to promote early diagnosis of HIV infection and ensure access to AIDS treatment.

It has been nearly 25 years since the first cases of what would become known as AIDS were recognized. As a physician during much of this period, I experienced the heartbreak of watching as some of my patients, including mothers and children, succumbed to this mysterious and incurable illness in the early days of the epidemic when effective treatments had not yet been developed. Even today with the availability of revolutionary antiretroviral treatments that have transformed a disease that was a death sentence into a manageable disease for many, it is still heartbreaking to deliver an HIV diagnosis to a patient and agonize with each one to determine how they can afford these life saving, yet extremely expensive, medications.

As a physician, I believe it is essential that if we are to end this epidemic, we must make every effort to promote early diagnosis and ensure access to treatment for those who are infected. We must also empower both those who are infected and those who are not infected to prevent HIV from taking another life.

This may require rethinking and re-evaluating past and present policies and reconsidering ideas that have long been abandoned or even demonized.

It is no secret that I have had my differences with some within the AIDS community, federal health agencies and even with the drug companies that produce the miraculous AIDS drugs that many now take for granted regarding how we could best address this disease. But we must not let our differences of opinions allow us to make enemies of those with different viewpoints when we all hold the same common goal, ending AIDS, and the same common enemy, HIV.

So many of the medical advances that my patients and those affected by HIV around the world benefit from today are the result of activists who forced the government to act on this epidemic when so many preferred to look away because they disapproved of the behaviors that were associated with this disease.

Unfortunately, so much of how we all have reacted to the AIDS epidemic has been based upon fear. Lack of knowledge led to fear. Fear led to discrimination and stigma. Discrimination and stigma led to fear. And fears became the basis of our response to HIV/AIDS. The results have been tragic.

Consider that the U.S. federal government spends more than $20 billion on HIV/AIDS prevention, care and research annually, yet:

- More than one million Americans are now living with HIV/AIDS;
- Up to 59 percent of these Americans are not in regular care.
- More than 40,000 Americans become newly infected with HIV every year and this number has remained unchanged for over a decade;
- More than a quarter of those who are infected do not know it.
- Hundreds of patients are on waiting lists for AIDS drugs; and
- More than a half a million Americans have already died from this disease;
- As many as 45 percent of persons testing positive for HIV received their first positive test result less than a year before AIDS was diagnosed. With an average of 10 years between HIV infection and an AIDS diagnosis, this suggests that people are living with HIV for many years before they are aware of their infection and may be unknowingly spreading the virus to others.

To address these shortcomings, fear must be replaced with hope. We have the knowledge, the resources and the commitment to provide hope to every American who is living with HIV/AIDS. But to do so we must update our policies to ensure that all of those living with HIV have access to the hope that treatment can provide.

This means we must also remove barriers to testing. Fear-based policies continue to serve as deterrents to testing and diagnosis and deny the benefits of those miraculous AIDS drugs that the early activists fought so hard to make available to thousands of Americans today, often until it is far too late to prevent the inevitable.

One example of the hope that can result from eliminating barriers to testing is the great success that has resulted from the "Baby AIDS" laws in New York and Connecticut that require every newborn to be tested for HIV-antibodies and treatment provided to affected mothers and infants.

New York passed a law requiring HIV testing of all newborns in 1996. According to data we received just this week, the results of this law have been dramatic. **[chart #2]** The proportion of all pregnant women being aware of their HIV status at delivery has increased from 64 percent in 1997 to 95 percent in 2004. The number of HIV infected infants in New York dropped from more than 500 a year in the early 1990s to 8 in 2003. Furthermore more mothers and impacted infants are receiving treatment.

Connecticut passed a similar law in 1999 requiring that newborns be tested for HIV antibodies if their mothers' HIV status was unknown. Prior to the law, only 28 percent of pregnant women were documented as being tested for HIV. Prenatal testing rates for other diseases were over 90 percent which demonstrates how the unusual

counseling regulations for HIV testing discouraged testing. After the law was enacted this number of pregnant women being tested for HIV jumped to 90 percent. In the year that the law was passed, 70 HIV-exposed newborns where born with five infants infected with the virus. Since that time, over 300 HIV-exposed infants have been born with only five infants becoming infected with HIV. The last baby infected with HIV to be recorded in the state was in 2001 meaning Connecticut's law has essentially eliminated baby AIDS.

The success of these laws are rare victories in our battle against HIV/AIDS.

The Government Accountability Office (GAO) today releases its second report this year that examines some of the issues involved with providing access to treatment and early intervention.

The report reminds us of facts that we already know, such as "most new HIV infections originate from HIV-infected persons not yet aware of their infection. This emphasizes the need to identify HIV-infected persons and link them with appropriate services as soon as possible."

It raises other issues of concern, such as "ADAPs with waiting lists may not represent all eligible individuals who are not being served."

And it points to opportunities where policy makers can do a better job to maximize the impact of the tens of billions of dollars that we are directing every year towards HIV/AIDS efforts.

Coincidentally, GAO's reports come at a time when Congress is faced with reauthorizing the Ryan White CARE Act, which is the largest HIV/AIDS-specific federal care program. While the program's authorization expired six months ago, efforts are currently being made to renew the program and I know of at least one bill that has been introduced in both the House of Representatives and Senate that would do so taking into account many of GAO's findings as well as the issues I have outlined and others we will explore today.

I look forward to hearing from our witnesses today who include: Dr. Marcia Crosse, Director of the Government Accountability Office's Public Health and Military Health Care Issues; Dr. Deborah Hopson, Associate Administrator of the Health Resources and Services Administration's HIV/AIDS bureau; Dr. Kevin Fenton, Director of the National Center for HIV, STD, and TB Prevention (NCHSTP) at the Centers for Disease Control and Prevention; Ms. Beth Scalco, Director, HIV/AIDS Program, Louisiana Office of Public Health, and Michael Weinstein, President of AIDS Healthcare Foundation (AHF), the nation's largest provider of HIV/AIDS medical care.