Like Vietnam, AIDS Will Change America

A Primer on the State of the Epidemic and What We Can Do About It

By Rep. Henry Waxman

Next month, or maybe the one after, the umber of Americans who have been killed AIDS will surpass the number killed in ietnam.

This comparison is not one of pain: Each agedy can be experienced only in its own rms. But the comparison is useful for olicymakers to consider for one reason: ange.

Vietnam changed America, its internaonal image, its domestic politics, its trust the system.

AIDS will also change America. Our blic health system, our research struce, our hospitals, and our insurance proams have been or will be restructured to w the epidemic and to care for the estiated 1.5 million infected Americans who ffer from this deadly disease.

In making these changes, we should derstand the disease itself, not just the adlines and the numbers, but also the terms and the complex questions. Then can begin to make way for some aners.

lep. Henry Waxman (D-Calif) is chairman he subcommittee on health and the envinment of the House Energy and Commerce mmittee.

Number of AIDS Cases Per 100,000 People
(selected states)

California	20.9	New Jersey	30.9
Connecticut	13.5	New York	37.5
Delaware	12.9	South Dakota	1.0
Maryland	13.6	Utah	4.5
Nevada	15.1	Vermont	2.0

Source U.S. Public Health Service

Numbers

Few people have appreciated the numbers involved in this epidemic. One reason is that we have almost always looked at AIDS deaths, not at people living with AIDS or infected with HIV. Another reason is that we simply have difficulty facing up to a crisis until it is actually upon us.

AIDS is thought to be the end stage of an infection with HIV (the Human Immunodeficiency Virus), almost like a stroke is the end stage of high blood pressure. Like high blood pressure, HIV does not always produce serious illness immediately. Some people infected with HIV may be otherwise perfectly healthy for years. Others will get AIDS very quickly. No one knows why.

Most estimates are that about 50,000 Americans have already died of AIDS. About 40,000 are living with AIDS now. It is estimated that 1.5 million Americans are now infected with HIV.

At first, most of the cases in the US seemed to be among gay men. Then cases were recognized among hemophiliacs. Then among intravenous drug users. Then among drug users' sexual partners and their babies.

Case reports are, however, misleading because of the time lag between infection and disease. New cases today represent infections from years ago.

Studies of infection suggest that the disease has slowed almost to stopping among gay men in some major cities. But new infections are accelerating among drug users, their sexual partners, and their babies. There is also real concern that infection is spreading among young people in their teens and twenties who are experimenting with sex and drugs for the first time.

The Disease

AIDS is the collapse of the body's natural abilities to fight disease. The body becomes unable to fight off many illnesses to which it would normally be immune or which it could withstand — diseases like pneumonia or unusual cancers.

HIV seems to cause this collapse by attacking specific blood cells, called T4 cells or CD4 cells. When these cell counts are low, most doctors believe the person may be vulnerable, even if he or she has no other symptoms.

HIV is spread — as every schoolchild should know — by blood, by having sex, and from mother to fetus. As Mrs. Bush has dramatically shown us with AIDS babies and adults alike, it is not spread by being in

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AIDS: Public Hospitals in Some Cities Are Bursting With Patients; No Room for Flu Epidemic in New York

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a room with a person with AIDS, shaking his hand, touching him, or holding him.

Research

AIDS research has moved quickly in some areas, painfully slowly in others. The years of basic research that preceded the epidemic produced a foundation for the emergency work on AIDS, but when the scientific community began to appreciate the magnitude of the epidemic, specific applied research agendas began: cause, diagnosis, vaccines, treatments.

Promising starts have been made in each area, but much remains undone. HIV seems to be the cause, although no one can yet say if other viruses or conditions are also involved in turning an infection into disease.

The antibody test seems to be a good diagnosis of infection, although there are false results. Initial tests may be false positives and must be confirmed by follow-up. Even confirmatory tests may be false negative, however, because it may take from three weeks to six months for the infection to show up.

Vaccines and treatments are now in trial. Vaccines seem to be years away, too scientifically complex to even guess at now. Treatments are only partially successful, producing only temporary health and causing many side effects.

AIDS research has also meant advances in many other areas, accomplishing for infectious diseases and immunology what the space program did for engineering. AIDS projects have produced insights into cancer, MS, hepatitis, and even the common cold.

Through the past years of tight budgets, there has been intense pressure to whittle away at research and to cut corners and make do. The Congress, however, has consistently looked to scientists from the National Institutes of Health and Centers for Disease Control for advice, and the Congress has appropriated funds for the best research that can be done, not waiting until hundreds of thousands of Americans are sick before acting.

Testing

Much of the public policy debate has focused on HIV testing. Should we test prisoners? Should we test marriage license applicants? Should we test hospital patients or hospital workers? Should we test everyone? As the nation first became aware of the epidemic, people were endorsing testing programs with no goal in sight — just test now and then we'll decide what to do.

Fortunately, more attention is now being given to why someone should consider being tested and why we would want many people to do so. The answers are direct and lead toward a reasonable testing policy.

Testing may be useful for prevention of HIV and AIDS. Most doctors believe that counseling and testing may be the most effective means of getting people to change their sexual lives and their drug habits.

Note: counseling and testing. There are solid studies showing that people who are only tested and not counseled about test results don't change their lives and habits. In fact, they may become reckless (believing they are immune because they have stayed negative) or suicidal (believing they are dying because they test positive).

With counseling, however, people — even drug addicts — do change.

Testing may also be useful for treatment of HIV and AIDS. People who are infected should check their CD4 blood counts. Those with low counts should consider taking preventive drugs — for AIDS for pneumonia, and other common infections.

But both of these uses require patients to cooperate with their doctors. Many people won't agree to be tested unless they are sure that their names won't be released and that they won't lose their jobs or insurance. We need more counseling and testing, but no such program can work until we can help and protect patients.

Health Care

The real crunch begins with the delivery of health care. Public hospitals in a few cities are already straining at the seams with AIDS patients. Many of these patients can't pay, either because they have lost their jobs or because they can't get insurance.

In New York City, hospitals are already operating with more than 90 percent of their beds full every day. If there was a bad bout of flu, there wouldn't be room. New Jersey, Florida, and Texas are beginning to find the same problem — in beds, in emergency rooms, in pediatric services.

All this is with 40,000 living AIDS patients. Next year there will be 60,000 new cases diagnosed. The year after that 70,000 more.

As the epidemic continues, more cities and towns feel it. Just three years ago, Missouri had fewer than three dozen cases; now it has almost a thousand. New York once was half of all US cases; now it is less than a quarter — not because its number of AIDS cases has fallen, but because growth elsewhere is occurring so dramatically.

The bottom line for all of these areas is simply that AIDS health care costs are growing rapidly and must be paid. They will be paid by the federal government (as assistance to states and cities), by the state government (with the feds in the form of Medicaid), by the local government (as public hospital support), by the private sector (as risk pooling in insurance), and by the patient (out of his pocket).

The implications are great for the whole system. If insurance companies are allowed to continue to refuse coverage for people who test positive, then the costs for government will go up. If states limit the availability of Medicaid, then the costs for hospitals will go up. If insurance premiums are made too high for small employers, then the costs for all employees will go up.

Some of the right policy choices are clear. We have created a hospice benefit under Medicaid. We have allowed Medicaid to pay for a range of non-hospital care.

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Most of the choices are hard. We have refused to face the activities of insurance companies and private employers. We haven't acted to deal with the price of drugs that are needed to keep people alive.

All of this is necessary now. If we create testing programs and encourage people to be tested, insurers and employers will want to know the results. As more people get sick, more small businesses are going to face premium hikes. As more treatments become available, more people will need them and have no way to pay.

Moreover, most AIDS patients can get Medicaid only if they are totally disabled and totally impoverished. As research programs develop drugs to slow the development of AIDS, many people are going to find themselves with no way to get these preventives — they will be too sick for insurance, too poor to pay, but not sick enough or poor enough for Medicaid.

This debate cannot be about whether to pay for health care for the sick. We cannot argue whether AIDS patients "deserve" a hospital bed. Rather, we must decide how to reformulate the health financing system to pay for the epidemic.

Like wars, epidemics aren't cheap. No one plans for them, no one wants to pay for them, and no one wants to die in them. AIDS will change the way we think about health.