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ISSUE ALERT: AN HIV EPIDEMIC?

Jeremy Williams
Policy Analyst
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Introduction

A study by the U.S. Department of Health and Human Services (HHS) Centers for Disease Control and Prevention (CDC) released in October 2008 shows that at the end of 2006 (when the most current data were available) there were more than 1.1 million people in the United States living with the human immunodeficiency virus (HIV).[1] This reflects an 11 percent increase—or approximately 112,000 new cases—from the 994,000 total infections reported at the end of 2003. The study states that there were more than 56,000 new HIV infections reported in the United States in 2006 alone. This increase is at least partly attributable to improvements made to antiviral treatments, which can stave off the onset of AIDS and extend the lives of people infected with HIV.[2] These improvements mean that people are living longer with HIV, a positive development from advances in science and medicine; but it also means that the United States has a rapidly growing population of people infected with the HIV virus.

What does this mean for states?

There are several major repercussions resulting from this dynamic that are cause for concern. First, the cost of providing medical services to people living with HIV increases incrementally, as does the burden on the healthcare system as a whole, as the number of people living with HIV increases. With a strained national economy and most states facing imminent budget cuts in upcoming sessions, it becomes difficult to devote the funding necessary to address the needs of a growing HIV-positive population and the communities in which they live. Medicaid, for instance, is the largest source of federal funding for HIV/AIDS care in the country, and HIV/AIDS spending represents approximately 3 percent of the total federal Medicaid budget, or more than $183 billion annually.[3] While Medicaid spending on HIV/AIDS has steadily increased over time, major cuts to the program will drastically diminish the range of services for the HIV/AIDS population, including prevention and treatment programs. This is particularly troubling for most states, since the repercussions of such cuts will most certainly fall on their shoulders. Since HIV is an extremely debilitating disease, individuals often are forced to leave the workforce, thereby causing the loss of income as well as access to employer-based health insurance. Due to low income and lack of health insurance, many people rely on state programs for treatment.

A 2006 study conducted by the CDC, in collaboration with the Emory University Center for AIDS Research and the Andrew Young School of Policy Studies at Georgia State University, concluded that the economic costs of HIV/AIDS extends far beyond direct medical expenses for treating the disease. In fact, the study estimated that if productivity losses, which can be five times that of direct medical costs, are estimated and added to the sum, the total lifetime of cost for Americans newly diagnosed with HIV in 2002 would amount to approximately $36.4 billion. Correspondingly, the study concluded that there is an economic incentive to promoting better medical care for people with HIV, since loss of productivity is minimized. For instance, although antiretroviral therapy (ART) is very costly, it has proven to be very affective extending the lives of people receiving it. On average, patients receiving ART incur direct medical costs of $230,044, but have a projected life expectancy of 24.4 years. On the other hand, patients not receiving these treatments have medical costs of approximately $114,938, but only have a projected life expectancy of 12.4 years. The additional years of productivity for those receiving ART far outweigh the additional costs of the treatment. However, lack of health insurance makes access to ART cost-prohibitive for a great many suffering from the affects of HIV.[4]

Second, because people with HIV are living longer, and because the disease affects a person's ability to fight off infection, people with HIV are at a much higher risk of becom-

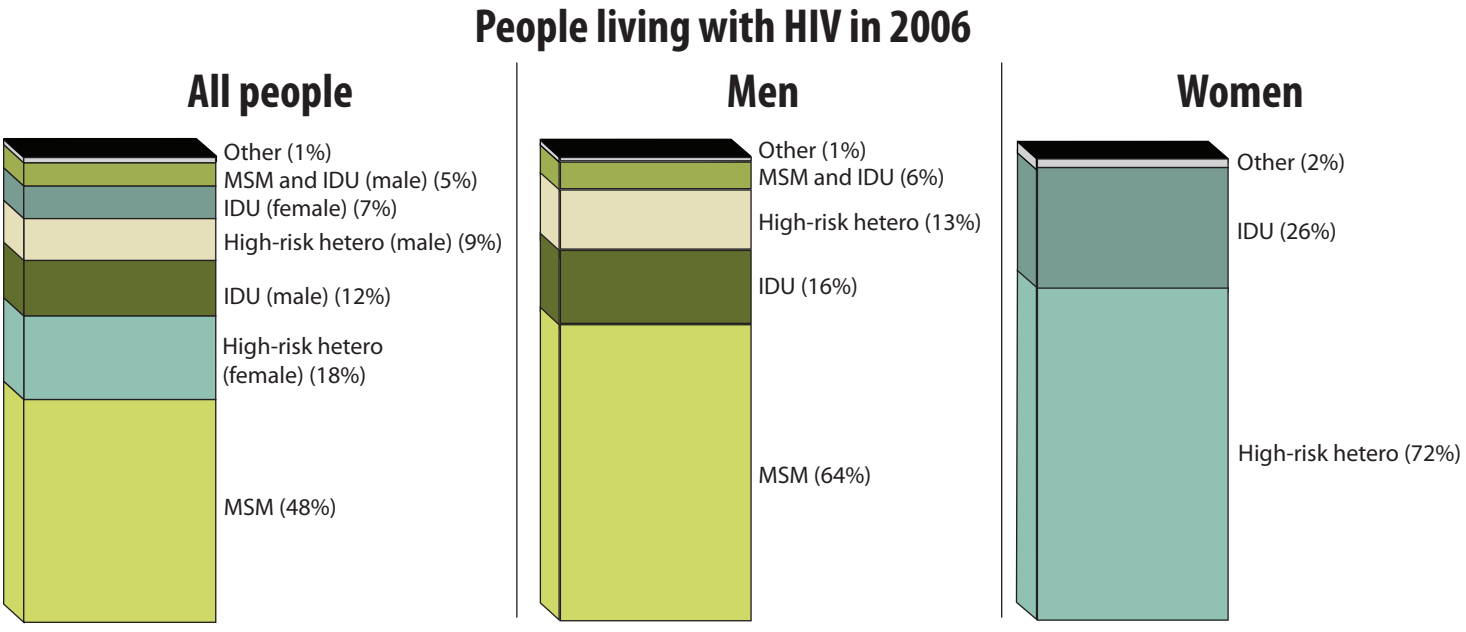
ing victims of other illnesses such as serious infections or cancer. Some studies indicate that persons living with HIV are as much as 10 times more likely to develop certain types of cancer. Consequently, a greater number of people with HIV will require advanced medical treatment for serious illnesses in the coming years.

Third, and perhaps most significantly, more people living with HIV means increased risk of transmission. Effective testing is imperative for this reason, since the majority of new infections are transmitted by individuals who are unaware they are infected. The CDC report indicated that, overall, approximately one out of five people living with HIV in 2006 was not aware of the infection. This percentage has actually improved since 2003, when the number of unaware individuals hovered around one in four. However, although the percentage of those unaware of their HIV infection may have decreased, the sheer number of unaware individuals—estimated to be as many as 232,000 people currently living in the United States—continues to steadily increase. This is of particular concern since an increase in persons who are unaware that they carry the disease inevitably means an increase in the likelihood that they will spread HIV to others. Of the 1.1 million people in the United States currently living with HIV, it is estimated that the three-quarters of infected persons who are aware of their infection contribute to less than half of all new infections, leaving the 25 percent that are unaware of their infection responsible for at least 54 percent of new infections.

Which demographics does this most impact?

The CDC study indicated that the most heavily affected groups were African Americans, Hispanics or Latinos, and gay and bisexual men (of all races). The report stated that the population of young black men saw the highest increase of incidences in 2006. Of all people living with HIV in 2006, 46 percent were black; 35 percent were white; 18 percent were Hispanic or Latino; 1 percent were Asian or Pacific Islander; and less than 1 percent were American Indian or Alaskan Native. Although blacks account for only 12 percent of the U.S. population, the report pointed out, they represented almost one-half of all people living with HIV. In fact, the HIV prevalence rate for blacks (1,715 per 100,000 population) was almost eight times that of whites and, in 2002, HIV/AIDS was the leading cause of death for black women ages 25 to 34. A similar disproportionality exists for Hispanics and Latinos. Although they account for only 15 percent of the population, Hispanics and Latinos make up 18 percent of all people living with HIV, and the overall prevalence rate among this group was nearly three times that of whites in 2006. Also, this group, perhaps more than any other, experience longer wait times at emergency rooms and are more likely to be denied services due to language barriers or lack of health insurance. There also is evidence of the risk of inadequate medical service due to a lack of cultural understanding on the part of the provider.

Regarding transmission likelihood, nearly one-half of all people living with HIV in 2006 were men who have sex with men (MSM). Among all men living with HIV, MSM accounted for 64 percent of all infections, by far the largest group. Individuals who contracted the virus through high-risk heterosexual contact accounted for more than one-fourth of all people infected with HIV. This percentage



NOTE: MSM=Men who have sex with men; IDU=Injection drug users
Source: Centers for Disease Control and Prevention, *Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2006*

was much higher in women; 72 percent of all women with HIV were infected through high-risk heterosexual contact, whereas only 13 percent of all HIV-positive men were infected through high-risk heterosexual behavior. Injection drug use (IDU) accounted for almost one-fifth of all people living with HIV in 2006. Sixteen percent of all men and 26 percent of all women with HIV contracted the virus through IDU.

What does this mean for the South?

The South presents a unique case in addressing the rise of HIV infections since an almost 26 percent increase in HIV/AIDS cases has been reported since 1996, the greatest increase of any region. Texas experienced the largest increase of any state during this time, at 66 percent. According to the *Southern States Manifesto: Update 2008*, published by the Southern AIDS Coalition, a public-private nonprofit program based in Birmingham, Alabama, there was a more than 10 percent rise in AIDS-related deaths in the South from 2001 to 2006. The report pointed out that although the South contains only 36 percent of the nation's population, approximately one-half of all AIDS deaths in 2005 were in the South, and more than one-half of all Americans living with HIV, and 40 percent of all Americans living with AIDS, reside in the region. The report also found that nine of the top 15 states with the highest HIV diagnosis rates were in the South, and more than 40 percent of all new infections occurred in the region. Also, of the 20 metropolitan areas with the highest rates of AIDS cases in 2006, 16 were in the South.[5]

The infection and transmission factors that exist for the particular groups discussed are exacerbated in the South. Much like the rest of the country, HIV disproportionately affects blacks, Hispanics or Latinos, and MSM in the South. More than one-half of blacks living with AIDS, and 58 percent of new AIDS cases reported in 2006 among blacks, are found in the South. Over the past 15 years, the greatest increases of HIV for Hispanics or Latinos have been in rural areas of the South.

This disproportionate impact of HIV in the South is attributable to a variety of factors, according to the report. For instance, in recent years, the increase of HIV prevalence has not been met with increased federal funding for the region. There are other factors that pose problems for the region as well. Screening and treatment for HIV/AIDS is particularly problematic for rural areas, which are common throughout the South, since living in these areas complicates accessibility to appropriate medical services. Healthcare systems as a whole are underfunded in the South. In the region, it is not uncommon for individuals to experience a stigma associated with being HIV-positive, regardless of how they contracted the disease.

The South also has a higher rate of poverty and unemployment than the rest of the country, and greater poverty entails greater levels of homelessness. The National AIDS Housing Coalition (NAHC), an organization that studies the relationship between housing stability and HIV treatment and prevention, reports that homeless people or people living in unstable housing conditions are two to six times more likely than individuals with stable housing to share needles or engage in risky sexual behavior. Moreover, the NAHC reports that, over time, persons with improved housing status reduced their level of involvement in risky behaviors by one-half.[6]

Perhaps most significantly, the South has the highest rates of uninsured and underinsured residents in the country. This means that a greater number of people living without access to basic medical care live in the region. These individuals tend to have limited access to advanced treatments such as ART, drastically reducing their life expectancy and, in turn, the years of productivity that they would otherwise contribute to the workforce and the economy as a whole.

There are other, far-reaching factors to consider when assessing the full impact of HIV/AIDS on the South. A study at the University of Alabama estimated that approximately 20,000 residents have been directly affected by the death or illness of a parent due to AIDS, including 7,000 children in the state that have been orphaned by AIDS since 1982, with the state's poorest counties being the most heavily affected. The study points out that funding typically is directed toward people with HIV/AIDS, and not necessarily their family members.

Conclusion

The growing number of people living with HIV in the United States warrants increases and improvements in HIV testing and treatment, as well as prevention programs that would curtail this epidemic. Early detection is a primary tool to combating the spread of the disease, and targeting populations that are most in danger of infection is the most practical avenue for doing so. While testing is relatively inexpensive (a single test can cost as little as $8.00), testing policies vary from state to state and can stimulate controversy. Confidentiality and the availability of proper counseling for individuals undergoing testing is of the utmost importance. Simultaneously, maximizing the opportunity to test all at-risk persons is imperative as well, and should be the cornerstone of any HIV public health policy. For instance, the Forum for Collaborative HIV Research, a public-private partnership based out of The George Washington University School of Public Health and Health Services, estimates that only about 5 percent of patients with symptoms of a serious ailment entering emergency rooms are routinely tested for HIV. The practices that lead to these inefficiencies warrant examination. Also, the inequities in the federal HIV funding portfolio need correction in order that proper attention be given to populations that are adversely affected by this epidemic. In particular, the severity of the situation in the South cannot be ignored nor treated with the same planning and programming that exists for other regions. With adequate funding and a comprehensive approach to screening, treatment and prevention, states and regions can continue to move in the direction of limiting the spread of HIV and providing care for those who continue to live with the disease.

HIV/AIDS IN SLC STATES

State	HIV (not AIDS)		AIDS		Total		% Change
	2001	2006	2001	2006	2001	2006	
Alabama	5,311	5,486	3,427	3,755	8,738	9,241	5.8%
Arkansas	2,127	2,298	1,781	2,145	3,908	4,443	13.7%
Florida	38,308	35,723	38,742	45,663	61,787	82,386	33.3%
Georgia	N/A	N/A	11,269	17,383	11,269	17,383	54.3%
Kentucky	N/A	N/A	1,873	2,602	1,873	2,602	38.0%
Louisiana	7,364	7,462	5,851	8,074	13,215	15,536	17.6%
Maryland	N/A	N/A	11,288	14,581	11,288	14,581	29.2%
Mississippi	4,265	4,232	2,341	3,168	6,606	7,400	12.0%
Missouri	4,432	5,033	4,548	5,486	8,980	10,519	17.1%
North Carolina	9,910	11,760	5,402	8,463	15,312	20,223	32.1%
Oklahoma	2,364	2,208	1,685	2,194	4,049	4,402	8.7%
South Carolina	6,744	6,394	5,172	7,058	11,916	13,452	12.9%
Tennessee	6,095	6,631	5,021	6,414	11,116	13,045	17.4%
Texas	10,646	25,003	24,936	34,063	35,582	59,066	66.0%
Virginia	8,043	9,978	6,443	8,447	14,486	18,425	27.2%
West Virginia	577	665	538	754	1,115	1,419	27.3%

Source: U.S. Centers for Disease Control and Prevention, HIV/AIDS Surveilance Report, Vol. 13, No. 2; and HIV/AIDS Surveilance Report, Vol. 18.

Endnotes

[1] Although "HIV" is commonly used to refer to those individuals who are HIV positive but have not developed AIDS, the statistics cited in this article refer to all people who have tested positive for the HIV virus, regardless of whether they have developed AIDS or not.

[2] The CDC considers a person to have AIDS if the level of white blood cells drops below 200 per cubic millimeter of blood as a result of a severely compromised immune system due to HIV infection.

[3] The Henry J. Kaiser Family Foundation, "HIV/AIDS Policy Fact Sheet: Medicaid and HIV/AIDS," October 2006.

[4] Angela Hutchinson, Paul Farnham, Hazel Dean, Donatus Ekwueme, Carlos Del Rio, Laurie Kamimoto, Scott Kellerman, "The Economic Burden of HIV in the United States in the Era of Highly Active Antiretroviral Therapy: Evidence of Continuing Racial and Ethnic Differences," *The Journal of Acquired Immune Deficiency Syndromes*, September 2006.

[5] Southern AIDS Coalition, *Southern States Manifesto: Update 2008*, July 2008.

[6] National AIDS Housing Coalition, *AIDS and Behavior: Volume 11, Supplement 2*, November 2007.

THE SOUTHERN OFFICE OF THE COUNCIL OF STATE GOVERNMENTS
PO Box 98129 | Atlanta, Georgia 30359
ph: 404/633-1866 | fx: 404/633-4896 | *www.slcatlanta.org*