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Prevention

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OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of the Assistant Secretary for Health
Office of Disease Prevention and Health Promotion
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FACSIMILE TRANSMISSION

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DATE: 11-5-93

TO: Kristine Gebbie

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MESSAGE:

FYI -- Here's what was sent to AJPM.

ASSESSING THE ECONOMIC IMPERTATIVE TO AIDS PREVENTION

The United States is now approaching the mid-point of the second decade of the Acquired Immune Deficiency Syndrome (AIDS) epidemic. Since June of 1981, when a tiny cluster of 5 cases was reported in Los Angeles,[1] the epidemic has rapidly spread to take an estimated 33,590 lives in 1992.[2] AIDS now ranks as the leading killer of young men, ages 35 to 44, and as the eighth leading killer for all Americans. More than $7 billion has been allocated for AIDS research by the National Institutes of Health since 1981, and another $6 billion for other AIDS-related activities of the U.S. Public Health Service.[3,4] Nationally between 1985 and 1992 for people with AIDS, the total treatment costs have amounted to an estimated $22 billion.[5] Still, neither cure nor vaccine is at hand.

A strong knowledge base has, however, been developed for the prevention of AIDS. Major risk groups have been identified, the principal modes of transmission have been determined, the human immunodeficiency virus (HIV) has been established as the etiologic agent, and a serologic test to detect HIV infection has been developed. Changes in sexual and drug use behavior could virtually eliminate the spread of HIV. Yet, as witnessed by its movement into new population groups such as non-drug-using women, HIV continues to spread. It is a critical time for prevention.

Compassion compels that we invest--and invest generously--in the treatment, be it palliative or curative, of conditions that inflict pain and suffering on individuals. Because treatment regimens are often costly, and our health care system is designed to facilitate their delivery, the economic and emotional investments in a new intervention can quickly become so substantial that they impede rational discussion about alternate uses for these resources--or about the need to identify yet more resources that take a somewhat different tack. It is often difficult for society to rise above the therapeutic crisis of the moment, take stock of the situation, and draw conscious and studied conclusions about the implications for how resources are being used.

Common sense compels that we also look hard at the consequences of <u>not</u> investing in a particular intervention. This is especially true when it comes to choices about investing in preventive interventions, which by definition may seem less urgent than those focused on treatment. Cost-effectiveness analysis (CEA) and cost-benefit analysis (CBA) can be particularly useful to balancing the analytic perspective in this regard. CEA and CBA can demonstrate the comparative costs and benefits of different interventions and, therefore, provide a basis from which to conclude about the likely health returns for specific investments of health care dollars. To determine the full cost implications of an existing or proposed program, analyses must

address the likely costs saved by the program, the costs incurred in its implementation, and the likelihood of its success.

Guinan et al estimate the gross medical cost-savings for a case of HIV prevented to be from $56,000 to $80,000.[6] Their approach offers a comprehensive and standardized analysis, particularly important for a problem like HIV in which the costs occur over a long period of time (frequently in the range of 10 years) and include various types of health service expenditures. This contribution provides a useful and necessary antecedent to the standardization of CEA or CBA analyses of HIV prevention programs and research; it will be an important tool for policy discussions about intervention strategies. When matched by comparable studies of the costs and outcomes of various preventive interventions--e.g. condom distribution, education, testing and counseling, needle exchange programs, blood supply screening--policy decisions regarding use of these interventions should be well informed.

With $900 billion and 14% of the gross domestic product going to health care,[7] it is a critical time for the nation to ensure that its social resources are invested wisely. We clearly need to recognize the economic consequences of our health investments in order to choose cost-efficient strategies for

program and research funds. Although cost is only one factor to be considered in our national investment for health, it is an important one.

Prevention may appear expensive since the costs are immediate and the savings delayed. It is therefore important to have good, usable documentation of the costs that are averted by these interventions. With a savings in the range reported by Guinan et al for preventing an HIV infection, even a relatively small rate of return for a candidate intervention will make HIV prevention a likely social bargain. For the time being, prevention is our only option.

REFERENCES

1. Centers for Disease Control and Prevention. Pneumocystis Pneumonia--Los Angeles. *Morbidity and Mortality Weekly Report.* 1981; 30:250-252.

2. National Center for Health Statistics. Annual Summary of Births, Marriages, Divorces,and Deaths: United States, 1992 (Provisional Data from the Centers for Disease Control and Prevention/NCHS). *Monthly Vital Statistics Report.* 1993; Vol 41, No. 13.

3. Personal Communication. National Institutes of Health. Division of Financial Management. Budget Formulation and Presentation Branch. November 2, 1993.

4. Personal Communication. Public Health Service. Division of PHS Budget. Budget Branch. November 2, 1993.

5. Personal Communication. Fred Hellinger. Agency for Health Care Policy and Research, Public Health Service. November 4, 1993.

6. Guinan ME, Farnham PG, Holtgrave DR. Estimating the Value of Preventing a Human Immunodeficiency Virus Infection. *American Journal of Preventive Medicine.* 1993; 10(1).

7. Burner ST, Waldo DR, McKusick DR. National Health Expenditures Projections through 2030. *Health Care Financing Review.* 1992;14:1-15.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

Report on the Prevention of HIV in Correctional Facilities

James O. Mason

James O. Mason, M.D., Dr.P.H.
Assistant Secretary for Health

PUBLIC HEALTH SERVICE
REPORT TO CONGRESS ON THE PREVENTION
OF HIV IN CORRECTIONAL FACILITIES

In its report on the Fiscal Year (FY) 1992 budget for the Department of Health and Human Services, the House Committee on Appropriations stated:

> The issue of health care in the correctional system continues to be an issue of serious concern to the Committee. In a recent report issued by the National Commission on AIDS, the Commission recommended that the "U.S. Public Health Service ... develop guidelines for the prevention and treatment of HIV disease in all Federal, State, and local correctional facilities. Immediate steps should be taken to control the subsidiary epidemics of tuberculosis and sexually transmitted diseases. Particular attention should be given to the specific needs of women and youth within all policies. Consistent with the Commission's findings, the Committee directs the Department to develop a plan for the implementation of programs that address these concerns, as well as the overall health care treatment and prevention needs of the correctional system. The Department should report its findings and recommendations to the Committee before the FY 1993 hearings. (House Report 102-121, page 118).

The following report has been prepared by the Public Health Service (PHS), Department of Health and Human Services (DHHS), in response to this request:

The PHS has made considerable progress in addressing the intent of the Committee's directive. The PHS already publishes HIV prevention, counseling, testing, and treatment guidelines. While these guidelines are not specific to correctional facilities, the Department of Justice (DOJ)/Bureau of Prisons (BOP), has adopted standards of practice, care, and treatment based on these guidelines. The Centers for Disease Control (CDC) considers, and the BOP concurs, that the existing recommendations and guidelines, while not written specifically for correctional facilities, are applicable to prisons and inmates. The BOP has stated to the PHS that, "the difficulty may lie in the implementation and compliance with these guidelines among the state and local prison systems. The state and local prison systems are usually faced with constraints in both human and financial resources."

The DHHS does not possess the authority to implement programs dealing with correctional facilities. The DOJ's BOP has jurisdiction over Federal facilities, and State and local governments are responsible for managing their respective

correctional institutions, including their associated health care facilities. As a consequence, HHS has no authority to require the adoption or implementation of either the guidelines or programs in Federal, State, or local correctional facilities. However, HHS and DOJ have cooperated closely in the past. The BOP Medical Director is an Assistant Surgeon General from the PHS Commissioned Corps; we also have assigned a staff of approximately 380 Commissioned Corps Officers to work with the Federal Bureau of Prisons. In addition, the CDC has assisted the DOJ's National Institute of Justice (NIJ) in preparing periodic updates and recommendations on HIV infection and AIDS in correctional facilities, although the PHS understands that the NIJ does not plan to continue preparing these periodic updates after the release of their most recent report that is to be published in the near future.

In addition, several other related issues are important:

- The BOP has stated that "it recommends pre-release medical health summaries for all HIV-positive inmates. Accordingly, these summaries are provided to the community program managers for use in managing potential care and community resources. Inmates who are released or paroled receive counseling regarding the need for routine evaluation and, if necessary, treatment by a physician. Inmates on parole or released select the appropriate community resources necessary to meet their needs."

- Because of the significant risk of exposure due to airborne transmission of the tubercle bacilli, CDC has recently issued guidelines for health care workers on the control of tuberculosis in correctional facilities. These guidelines specifically address the management of tuberculosis in HIV infected persons.

- Finally, although there have been no reported cases of occupational transmission of HIV to guards and other facility staff working with HIV infected inmates in U.S. correctional facilities, there remains considerable concern by these staff about the risk of occupational exposure. In 1986, the CDC recommended that correctional staff should follow published guidelines for preventing transmission of HIV infection in the workplace.

PHS and DOJ Collaboration

In response to the congressional mandate, PHS is collaborating with the DOJ to establish a PHS Working Group on HIV Prevention and Treatment in Correctional Facilities. This working group will:

- Review current prevention guidelines and legal issues in containing HIV infection in correctional facilities.
- Evaluate prevention programs for prison populations, including HIV, substance abuse, tuberculosis and sexually transmitted diseases.
- Evaluate the pre-release HIV education and coordination of treatment services for parolees.
- Reexamine the PHS role in HIV antibody testing, education and treatment in Federal and State correctional facilities.

The working group will provide technical assistance to the NIJ and the BOP in implementing recommendations from the NIJ Update on the Status of HIV and AIDS in Prisons for 1991. This update will provide a comprehensive review of Federal, State and local correctional facilities.

PHS Programs and Activities Addressing HIV Infection in Correctional Facilities

HIV infection in correctional facilities:

- Through funds provided by the CDC HIV Preventive Health Services Cooperative Agreements and the Tuberculosis Preventive Health Services Cooperative Agreements, States and local jurisdictions have the option to include programs for high-risk populations, including inmates who are incarcerated or who have been recently released.

- CDC is in the process of evaluating applications from community based organizations (CBOs) that responded to Announcement No. 202, "Cooperative Agreements for Minority and Other Community-Based Human Immunodeficiency Virus (HIV) Prevention Projects Program Announcement and Availability of Funds for Fiscal Year 1992," a funding mechanism to address HIV risk reduction and prevention in correctional facilities. In FY 1991, CDC supported a total of 12 such CBOs. Until these reviews are completed, the specific number of CBO's funded for FY 1992 is unknown.

- CDC also supports surveillance cooperative agreements with 20 States to collect HIV surveillance data in 46 United States correctional facilities. Based on this limited sample of facilities, the relatively short time over which the data has been collected, and the turn-over in the prison population, accurate estimates of the total number of men and women incarcerated in correctional facilities who are infected with HIV will be difficult to obtain.

Health care delivery services:

The Health Resources and Services Administration (HRSA) recognizes the need to improve the quality of health care provided to inmates with HIV disease. Under the authority of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, HRSA has developed a special category for applicants who propose models to improve access to and quality of health care for incarcerated persons and recently released inmates by lowering or removing the financial, sociocultural and logistical barriers to this care. These grants are awarded under Title II, Section 2618(a), the Special Projects of National Significance (SPNS) program. With FY 1991 funds, three grants were awarded to test new and innovative models of care. In FY 1992, resources will be utilized to fund at least one additional project. Two of the

four projects are cooperative efforts by State health and corrections departments. The remaining two are community-based providers who work exclusively with recently released inmates and parolees and their caregivers. These projects have developed programs that include specialized case management, access to clinical trials, exceptional release for terminally ill prisoners, peer support, a broad array of support services and training for correctional staff and community based providers.

Clinical trials:

Several AIDS Clinical Trials Units (ACTUs) of the AIDS Clinical Trials Group (ACTG) and the Community Programs for Clinical Research on AIDS (CPCRA) sites are working with departments of corrections and prison systems to enroll HIV-infected inmates in correctional facilities into NIH-sponsored clinical trials.

- The Johns Hopkins ACTG has developed a unique and innovative program that has been enrolling HIV-infected women and men in Maryland into ACTG protocols since May 1991. The protocol establishes a mechanism for follow-up after inmates are released and return to their communities.

- The Richmond, Virginia, CPCRA site has begun enrolling HIV-infected inmates in sponsored protocols.

- The New Orleans CPCRA has been actively identifying specific requirements necessary to enroll HIV-infected inmates of the State Penitentiary.

PHS Working Group on HIV Prevention and Treatment in Correctional Facilities

Tentative List

March 1992

Department of Health & Human Services

Office of the Assistant Secretary for Health:

National AIDS Program Office
Office of Health Planning and Evaluation
Office of Minority Health
Office on Women's Health

Public Health Service Agencies:

Agency for Health Care Policy and Research
Centers for Disease Control
Alcohol, Drug Abuse, and Mental Health Administration
Health Resources and Services Administration
Indian Health Service
National Institutes of Health

Department of Justice

Office of the Deputy Attorney General,
Office of Policy Development
Bureau of Prisons
National Institute of Justice
U.S. Parole Commission

Other Organizations

AIDS Action Council
American Jail Association
American Medical Association
Association of State and Territorial Health Officials
Center for Women Policy Studies
Intergovernmental Health Policy Project, George Washington University
National Coalition of Hispanic Health and Human Service Organizations
National Commission on AIDS
National Commission on Correctional Health Care
National Congress of American Indians
National Council of La Raza
National Governors Association
National Minority AIDS Council
National Wardens Association
State Justice Institute

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

May 13, 1994

NOTE TO: National AIDS Policy Coordinator
Acting Director, National AIDS Policy Office

SUBJECT: Update on Status of Research Compendium

FROM: Research Specialist, Office of National AIDS Policy

The materials for the compendium are still coming in. April 25th was the due date for information from the Departments. May 13 is the due date for all PHS information. Most of the PHS Agencies have already responded. CDC's response is awaiting Dr.Sacher's signature on the transmittal letter and should be here by Monday. FDA was given an extension. DOE (Don Donaldson) was given an extension as well. No one else has asked for additional time. We have not received any information from ACF, HCFA or SSA. I will check on Tuesday, May 17, with OS Executive Secretariat to determine where these documents are in the system.

Some follow-up will be needed to reconcile differences. For example, the State Department claims no programs but NIH lists several collaborative efforts with State.

The following Departments and Agencies have responded: DOD; DOS; DOT; DOL; HHS (PHS - AHCPR, HRSA, NIH, SAMHSA); and NSF.

The original time-line proposes May 13 through June 3 for follow-up and processing information. This time-line is still valid. However, after reviewing the materials already received, we should be able to have a first draft available for review by mid-June. The research cluster will determine format for final product after judging the quality and quantity of all information received.

Johanne G. Messore

cc: Dr. Tran
Mr. Beswick