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THE WHITE HOUSE

WASHINGTON

February 22, 1995

Remarks of
Patricia S. Fleming
National AIDS Policy Director
to
HIV Infection in Women Conference

GOOD MORNING:

Thank you Rae Lewis-Thornton for that gracious introduction and for sharing your experience and your insights with us all.

I am happy to join you here today at this important conference. It's especially nice to look out over this audience and see so many familiar faces. All of us have spent a large part of our professional lives fighting for the rights and needs of women. We've had some important victories but we still have a long way to go.

When it comes to AIDS, the fight for women is particularly important. Since the beginning of the HIV epidemic, women have been at the center of the storm. Whether we are infected with HIV or affected by the condition of our loved ones, women carry a tremendous burden as our nation and our world deal with this insidious disease. And, of course, women doctors, nurses, and researchers have played a critical role in the national response to AIDS.

Let's be frank. For much of this epidemic, many of our needs were ignored or shoved aside by government leaders who either cared too little or cared not at all. Women were -- and still are -- misdiagnosed or not diagnosed at all. And women were woefully underrepresented in clinical trials of AIDS therapies. The CDC AIDS case definition didn't recognize our symptoms or our illnesses and Social Security didn't pay for our disabilities. And no natural history study was tracking the course of our infections.

These actions and others led many of us to become more active in the fight against AIDS and in the battle to turn around the response to the epidemic. That's why I fought for changes in these policies when I worked on Capitol Hill for Ted Weiss and at the Department of Health and Human Services for Donna Shalala. And I'm still fighting for them now at the White House for President Clinton.

I am pleased to say that we have made some remarkable progress. Working together we have opened the doors that were slammed in our faces. And the remarkable thing is that many of those who were on the other side of those doors are now glad that we pushed so hard because we helped them to do things they'd wanted to do but found it difficult to

accomplish. And the changes we have won have broad implications for women affected by many other diseases.

Don't get me wrong. All of us here recognize that there is a great deal of work that still must be done. But with the right kind of leaders and the right kind of public health experts, I am confident that we will continue our remarkable progress.

Just look at what we have achieved in the last few years. Women's health in general and women and HIV in particular are taken more seriously and are a top priority of the Federal government.

We have seen some very important changes in the area of AIDS research and drug development. NIH now has an affirmative policy requiring the inclusion of women and racial and ethnic minorities in all clinical trials, including those for AIDS. That's an important change, and one we should all be proud of. NIH has created the Office of Research on Women's Health and created women's committees within the AIDS clinical trial group and the Community Programs for Clinical Research on AIDS. And the FDA, in response to the advice of the National Task Force on AIDS Drug Development, has improved its own guidelines on the inclusion of women in clinical trials by pharmaceutical companies.

Almost a decade after the men's natural history study was begun, NIH launched a Women's Interagency HIV Study to identify the nature and rate of HIV disease progression in women. And NIH has established a program of research specific to women with AIDS, including opportunistic infections, malignancies, and neurological manifestations. This year, NIH will devote more than 260 million dollars to AIDS research specific to women.

Two years ago when I attended the International AIDS Conference in Berlin I was convinced that we needed to accelerate our research into female-controlled barrier methods, including a vaginal microbicide that women can use privately. When I returned to Washington, I worked with Secretary Shalala to get the NIH to more than double its commitment to research into what will be a life-saving advance for women. The Office of AIDS Research has identified the development of female-controlled barriers as one of his top priorities and NIH will spend more than 20 million dollars this year on this research. A vaginal microbicide will offer women the ability to control their vulnerability to HIV and other sexually transmitted diseases. I am committed to making sure that NIH has the resources and the leadership it needs to continue this effort. I also look forward to an upcoming meeting of the AIDS Drug Development Task Force where non-scientific obstacles to development of microbicides will be examined.

Our progress extends beyond the research field. Both the Centers for Disease Control and Prevention and the Social Security Administration have changed their AIDS definitions to include conditions found in HIV-infected women. This has made a huge difference for thousands of women who, despite their illness, were unable to gain access to critical benefits

that help them live from day to day. The CDC has transformed our AIDS prevention programs to put community leaders -- including many women -- in charge of deciding what is needed in their area. And CDC has distributed more than 12 million dollars in grants to national and community-based organizations to specifically address the needs of women. At the Justice Department and the EEOC, we are aggressively enforcing the Americans with Disabilities Act, which provides important protection to people with HIV or AIDS.

Each of us in this room today has a right to be proud of these accomplishments. But none of us can rest because the job is not over yet.

Since this epidemic began in 1981, nearly 60,000 American women have been diagnosed with AIDS. Last year alone, 14,000 women were diagnosed with AIDS in the United States. That represents almost one-quarter of all of the cases in women reported so far. And the number of cases in women in the U.S. is rising at a rate of 17 percent a year. In recent months, researchers have confirmed what many of us already suspected -- that women are more susceptible to HIV transmission during heterosexual intercourse than are men.

This finding only strengthens our resolve to empower women to protect themselves with new barrier methods against infection. And we have found that women who are infected with HIV often progress more quickly to full-blown AIDS and die sooner than men. To those of us who are familiar with the barriers to health care that women face, these findings were troubling but not surprising. We are just beginning to examine the risk of HIV transmission for lesbians and other women who have sex with women. This is a population that has been seriously overlooked and needs our attention. A meeting on this subject has been scheduled for this spring.

HIV is also spreading more rapidly than ever among our children, teenagers, and young adults. Of the estimated 40-to-50,000 new HIV infections in this country last year, one in four occurred among people under 20. And one in two occurred among people under 25. AIDS is now the leading cause of death among Americans between 25 and 44. And, since we know that HIV often takes as long as 10 years to progress to an AIDS diagnosis, it is likely many of these people were infected in their teens and twenties.

Our youngest children are also being adversely affected by this epidemic. CDC estimates that 7,000 HIV-infected women gave birth last year. An estimated 1,000 to 2,000 of those children are expected to develop AIDS. Until recently, our ability to prevent such transmission was fairly limited. With no intervention, the chances of perinatal transmission of HIV are anywhere from 20 to 45 percent.

One year ago, as a result of NIH-funded research, scientists in the U.S., Canada, and France achieved a major breakthrough in HIV research. Scientists determined that among women with HIV, the use of AZT during pregnancy, labor, and childbirth reduced the risk of perinatal transmission of HIV by 67 percent. Now, at last, HIV-infected women and their

doctors have some hope of an intervention that may save their babies' lives. Not only is this good news for infants, it is the first indication we have had that a drug intervention can actually block transmission of the AIDS virus.

Despite these encouraging results, there are still many important unanswered questions that our scientists and public health experts must aggressively pursue. We need more information about the short and long-term effects of AZT treatment on both women and children and the effects of AZT treatment on pregnant women in general. These studies are already underway.

There is more that we must do to make sure that all women have the information they need to make the best decisions they can about their own care and the care of their babies. Too many women and men in this country do not know their HIV status. Nearly 45 percent of the men and women who were admitted to hospitals in 1992 with PCP pneumonia did not even know that they were infected with HIV. It is clear that we need a new direction. If a woman knows she is HIV-positive, she can get treatment to prolong her healthy years. And if a pregnant woman knows she is infected she can help herself and protect her baby.

In the past year, the Department of Health and Human Services has taken several steps to translate this science into action for women and children. The FDA has changed the labeling of AZT to allow its use during pregnancy and labor. The CDC has given health care providers guidelines on the best course of treatment. And all agencies have been reaching out to community organizers to find the best way to disseminate this information to all women.

Today, we are taking another very important step. The CDC is releasing draft guidelines designed to help women and their health care professionals make the best decisions they can for the health of women and their children. These draft guidelines recommend that all pregnant women in this country receive counseling on the benefits of knowing their HIV status.

This counseling must be nonjudgmental in nature. Women must not be coerced to be tested or to take AZT. Women must be approached with respect about the benefits of testing and the pros and cons of treatment. And they must make these decisions themselves.

The guidelines recommend that counseling be coupled with voluntary, confidential HIV testing to provide women with the information they need to make informed decisions about their care and the care of their children.

This approach of counseling and voluntary testing of pregnant women has been embraced by the major medical organizations, including the American Academy of Pediatrics and the American College of Obstetrics and Gynecology and is already proving effective in several communities. Copies of these guidelines will be available to you at noon today and we want to hear your comments on this approach. Later today and again tomorrow CDC

officials are here to discuss your concerns and your ideas in sessions on the agenda. And there will be a 45-day comment period that will allow you to provide your advice to the CDC in a more formal way.

These guidelines are not just about protecting babies. They are about offering women the opportunity to empower themselves to make the best decisions about their own health as well as the health of their children. Pregnant women who are HIV-positive need to know the benefits and risks of treatment with AZT for themselves and their children during pregnancy, labor, and childbirth. By helping more women get the information they need about their HIV status, we can help those who need care and prophylaxis. And, by reducing the risk of perinatal transmission, we can save hundreds of lives.

Some have argued for a policy of mandatory counseling and testing of all pregnant women. Let me explain why such a policy would not work. In order for women to understand therapy options presented to them and to be able to adhere to the treatment regimens, we must have the involvement and the cooperation of women, community organizations, and health care providers. We all recognize the benefits of having more women know their HIV status but we must also acknowledge the resistance of many women to testing. Forcing women to be tested for HIV could result in some women staying away from prenatal care. That's of no benefit to women or to their children. If women participate in this decision-making process they then understand why it's important. They develop a vested interest in their care and become a partner with their health care providers in protecting their own health and the health of their babies.

Experience with routine counseling and voluntary testing has produced some very impressive results. In Atlanta, for example, nearly 3,500 women registered for prenatal care at Grady Memorial Hospital and 96 percent of those women chose to be tested after receiving HIV counseling and being offered voluntary testing. At Harlem Hospital in New York, more than 95 percent of pregnant women choose to be tested after being counseled. And during an eight-month period in 1989, of more than 9,000 women who entered Los Angeles County prenatal clinics, 76 percent chose to be tested. And this was before we knew that use of AZT could reduce the risk of perinatal transmission.

But simply publishing treatment recommendations and testing and counseling guidelines is not enough. We know from past experience that we must also make sure that our public health infrastructure will support the policies we adopt. We must and we will be ready to answer some important questions.

How will low-income women without health insurance obtain counseling and testing? How will pregnant women with HIV gain access to AZT treatment? And how will infected women and children gain access to the effective treatments and preventive therapies for AIDS-related conditions?

It is the responsibility of the government to make sure the best research is funded and the results widely disseminated. Washington must work with the states and local communities to assure that the necessary services are available to those who need them. And we must provide training to health care professionals and others to make sure that they communicate this information to women in an appropriate manner. Then we must work with community organizations to find the best way to get all of this information into the hands of women. Each of you has a responsibility to take this information to the grass roots and to bring back the real-world reaction of women living with HIV.

The Public Health Service and other parts of the Department of Health and Human Services have worked hard these last few months to make sure that we can affirmatively answer these questions. Last week, President Clinton released his fiscal year 1996 budget, which contains new resources for this effort. The President's budget includes 724 million dollars for the Ryan White CARE Act, a major source of payment for counseling and testing and for AZT and other AIDS-related drugs as well as primary care. That's a 14 percent increase for that vital program. Last year, the Ryan White Act provided funding for more than 300,000 client visits by people with HIV and AIDS including services under Title IV to more than 2,000 HIV-positive pregnant women. With this new increase in funding, we will be able to expand that number.

The Health Resources and Services Administration, which administers the Ryan White program, has also launched a new initiative to enhance and evaluate outreach, counseling, and testing of adolescent and adult women that will help link them to a continuum of care. Three sites in Chicago, New York and St. Louis have already received support and additional sites will be funded soon. In addition, all applicants for Ryan White support will be required to include a plan for women's HIV care.

Another major source of funding for counseling, testing, and treatment is the Medicaid program. Today, an estimated 40 percent of people living with AIDS receive Medicaid benefits. A survey of states by the Health Care Financing Administration shows that all states are providing coverage for HIV counseling and testing in a variety of settings including hospitals, clinics, and doctors' offices. In December, HCFA sent a letter to all State Medicaid directors in the country informing them that States are required to cover the use of AZT for the prevention of perinatal transmission of HIV. We plan to closely follow the progress of States in meeting this requirement.

Together, these steps greatly advance the protection of women and children in the fight against HIV. We have made a good start toward strengthening our government's approach to HIV in women. Working together, you and I can build on this important progress and achieve the kind of sensitive and sensible policies that work.

Thank you.

THE WHITE HOUSE

WASHINGTON

Statement By
Patricia S. Fleming
National AIDS Policy Director
on
President Clinton's Fiscal Year 1996 AIDS Budget

February 6, 1995

GOOD AFTERNOON:

Thank you for joining us today.

Today, I am pleased to present the President's fiscal year 1996 budget for the Federal government's response to the HIV/AIDS epidemic. As you will see, this budget represents a forceful, focused, and dynamic response to an epidemic that has already claimed the lives of nearly a quarter of a million Americans.

Since he took office a little more than two years ago, President Clinton has sharply increased the Federal response to HIV and AIDS while providing the important national leadership and focus that this epidemic demands in the areas of research, prevention, education, and services.

As a result of these investments, more Americans are now receiving the kind of information they need to prevent the transmission of HIV, the virus that causes AIDS. More Americans living with HIV and AIDS are receiving the services they need to stay alive and to enjoy a better quality of life. And more scientists than ever are pursuing our very important goals -- better treatments for people living with AIDS, a vaccine to prevent transmission of HIV, and, ultimately a cure to this insidious disease.

Some have asked why the government is spending so much on AIDS. At a time when all levels of government are reexamining how they do business, this is a legitimate question. I believe the facts show very clearly why we need this kind of commitment.

Just last week, the Centers for Disease Control and Prevention made the startling announcement that AIDS is now the leading cause of death for all Americans between the ages of 25 and 44, what we generally refer to as the prime of life. In 1994 alone, nearly 81,000 new cases of AIDS were reported in the U.S., accounting for nearly one-fifth of the 441,000 cases of AIDS that have been reported in this country since the epidemic began in 1981. In 1994, an average of 220 Americans were diagnosed with AIDS every day. In the last twelve months, more than 40,000 Americans died as a result of their HIV infection, accounting for 16 percent of AIDS-related deaths since the beginning of the epidemic.

In other words, in the United States, an average of 200 people are diagnosed with AIDS every day and more than 100 Americans die of this disease every 24 hours.

HIV is increasingly affecting young Americans, including those who are in their teens. A recent report estimates that of the 40,000 to 50,000 new HIV infections in the United States last year, one in four occurred among people under the age of 20. One-half of new infections were among people under the age of 25. As a result of these troubling trends, it is clear that AIDS will continue to wreak havoc with our next generation of leaders unless we act decisively to stem the tide.

Beyond its human toll, AIDS is also having a severe impact on our economy. People with AIDS account for a sharply increasing percentage of entitlement program spending by the Federal government. In the coming fiscal year, we estimate that the Federal share of Medicaid costs for people with AIDS will be 1.8 billion dollars, an increase of 10 percent over fiscal 1995. States will bear a similar increase in their share of this program. Medicare will spend approximately 690 million dollars in fiscal 1996, an increase of 15 percent over fiscal 1995. The Federal Employees Health Benefits program expects to spend 235 million dollars on AIDS care for federal workers and their families, an increase of more than 9 percent.

Perhaps the most troubling evidence of the economic impact of AIDS is in the Social Security program. In fiscal 1996, Social Security will spend 1.2 billion dollars on disability and other benefits for people living with HIV and AIDS. That's a 19 percent increase over fiscal 1995. In fact, over the last two years, we have seen Social Security costs related to AIDS rise by an astonishing 30 percent.

President Clinton's fiscal 1996 budget reflects this Administration's continuing commitment to fight the battle against AIDS on every front -- research, prevention, and services. This budget focuses on some very important goals. First, it seeks to reduce the number of new HIV infections in this country. Second, scientists will continue to examine the AIDS virus and its impact on the human body so that we can lessen that effect and eventually find a vaccine and a cure. And, third, we will work to ensure that people living with HIV and AIDS have access to the kind of high-quality cost-effective services that they need to live longer and live better.

There have been some very promising advances in AIDS-related research in the last year. Scientists funded by the National Institutes of Health have discovered that the use of AZT during pregnancy and childbirth can reduce the risk of HIV transmission from mother to child by 67 percent. This is the first time in the history of this epidemic that we've been able to find a way to actually block transmission of the AIDS virus. Scientists at last week's retroviral meeting in Washington were very encouraged by the early results of tests of protease inhibitors, a new class of AIDS drugs that help the body repair its immune system.

We must continue our investment in AIDS research. President Clinton's budget includes 1.4 billion dollars for AIDS research at the National Institutes of Health, a five percent increase over fiscal 1995. This will allow us to increase our commitment to basic research into how the AIDS virus works. It will also allow us to continue the vigorous research into new AIDS drugs and vaccines and to conduct clinical trials of these agents. The NIH budget also will continue our efforts into prevention, including the development of a microbicide for women.

Until we are able to find a vaccine or a cure for HIV, education and prevention programs are our only hope to slow the spread of this epidemic. Community-based prevention programs have helped to slow the rate of infection in segments of the population. Among gay men, such education has resulted in a declining percentage of new AIDS cases being reported among gay and bisexual men. In 1994, these men accounted for fewer than half of new cases. That's a sharp contrast to only a few years ago.

President Clinton's fiscal 1996 budget includes 624.7 million dollars for AIDS education and prevention programs at the CDC, a 6 percent increase from fiscal 1995. Of this total, 327 million dollars will be spent on national outreach and education, technical assistance, and research. The remaining 298 million dollars will be awarded through a new Performance Partnership Grant with the states that I will describe shortly.

With more than a million Americans living with HIV, it is essential that we provide the medical and social services necessary for them to continue to live independent lives and retain their health for as long as possible. The President has made a major commitment to guaranteeing that all Americans living with HIV have access to these needed services. The Ryan White CARE Act provided funding for more than 300,000 client visits in 1994. In fiscal 1996, the President proposes an additional 91 million dollar increase, bringing the three-year increase to 108 percent.

The 724 million dollars requested for the Ryan White Act will allow us to increase the number of Americans living with HIV who receive care. It will permit all of the 42 metropolitan communities currently receiving Ryan White formula grants to receive at least as much as they did in fiscal 1995 and it will provide enough money to assist ten to fourteen new cities. It will also permit us to increase assistance to states, recognizing the growing impact of AIDS in smaller cities and rural communities. And it provides funding for primary care services and care for women and children with HIV.

In addition to medical and social services, people living with HIV and AIDS frequently need assistance with their housing costs. Early in this epidemic, we saw an increase in the number of people with AIDS who were forced to live on the street because they could no longer afford their rent payments. The Housing Opportunities for People with AIDS program, or HOPWA, has helped thousands of people find or keep their housing. The President proposes to continue this program and provide another 186 million dollars in fiscal 1996. Since the President took office, funding for this program has increased by 46 percent.

As I mentioned, the increase in funding for the Ryan White CARE Act has helped thousands of Americans live with HIV. It also has helped an increasing number of cities cope with the impact of this epidemic.

Title I of the Act, which provides direct assistance to cities severely affected by AIDS, will receive 407 million dollars in fiscal 1996, an increase of 14 percent over fiscal 1995. Title I will receive more than half of the total budget for the Ryan White CARE Act.

We are proposing a 23.7 million dollar increase in funding for Title II, which provides assistance to the states. As a result, Title II will receive 221.9 million dollars, or 31 percent of the total.

Title IIIB, which provides money to local clinics for early intervention services, will receive 63 million dollars, an increase of 16.1 percent.

Finally, Title IV, which provides assistance to women and children with HIV, will get 32 million dollars, an increase of 23 percent.

Let me finish up by discussing our proposal to consolidate certain programs at the CDC. As you know, this Administration has been committed to improving the way that the Federal government serves the people of this country and to strengthening the relationship between Federal, State, and local governments.

In the area of AIDS, we have already strengthened our ties with state and local governments and community-based organizations through a partnership on education and prevention. The proposal to consolidate certain HIV prevention activities with similar programs in the areas of tuberculosis control and prevention of sexually transmitted diseases will further that cooperation. The consolidation will allow us to unify programs serving similar or overlapping populations and give local communities greater flexibility to provide "one-stop shopping" for needed services. Most importantly, the new proposal retains the new community planning effort and eventually will expand that approach to TB and STDs.

In conclusion, let me say that this is a remarkable budget. In an era of zero-growth budgeting, the national commitment to fighting HIV and AIDS remains very strong. Thank you.

THE WHITE HOUSE

WASHINGTON

Statement By
Patricia S. Fleming
National AIDS Policy Director
on
President Clinton's Fiscal Year 1996 AIDS Budget

February 6, 1995

GOOD AFTERNOON:

Thank you for joining us.

Today, I am pleased to present the President's fiscal year 1996 budget for HIV/AIDS. As you will see, this budget represents a forceful, focused, and dynamic response to an epidemic that has already claimed the lives of nearly a quarter of a million Americans.

Since he took office a little more than two years ago, President Clinton has sharply increased the Federal response to HIV/AIDS while providing the important national leadership and focus that this epidemic demands.

As a result, more Americans are receiving the kind of information they need to prevent the transmission of HIV. More Americans with AIDS are receiving the services they need to stay alive and enjoy a better quality of life. And more scientists than ever are pursuing better treatments for people living with HIV/AIDS, a vaccine to prevent transmission of HIV, and, ultimately a cure for this insidious disease.

Some have asked why the Federal government is spending so much on AIDS. This is a legitimate question. Recent trends show very clearly why we need this commitment.

Last week, CDC made the startling announcement that AIDS is now the leading cause of death for all Americans between the ages of 25 and 44, what we generally refer to as the prime of life. In 1994, nearly 81,000 new cases of AIDS were reported in the U.S. This accounts for nearly one-fifth of all the cases of AIDS that have been reported in this country since 1981. In the last twelve months, more than 40,000 Americans died of AIDS, accounting for 16 percent of AIDS-related deaths since the beginning of the epidemic. In other words, in the United States, an average of 200 people are diagnosed with AIDS every day and more than 100 Americans die of this disease every twenty-four hours. HIV is increasingly affecting young Americans, including those who are in their teens.

A recent report estimates that of the 40,000 to 50,000 new HIV infections in the U.S. last year, one in four occurred among people under the age of 20. And one-half of all new infections were among people under the age of 25. As a result of these troubling trends, it is

clear that AIDS will continue to wreak havoc with our next generation of leaders unless we act decisively to stem the tide.

Beyond its human toll, AIDS is also having a severe impact on our economy. People with AIDS account for a sharply increasing percentage of entitlement program spending by the Federal government. In the coming fiscal year, we estimate that the Federal share of Medicaid costs for people with AIDS will be 1.8 billion dollars, an increase of 10 percent over FY95. States will bear a similar increase in their share of this program. Medicare will spend approximately 690 million dollars in FY96, an increase of 15 percent over FY95. The Federal Employees Health Benefits program will spend 235 million dollars on AIDS care for workers and their families, an increase of more than 9 percent in 1996.

Perhaps the clearest evidence of the economic impact of AIDS is in the Social Security program. In FY96, we will spend 1.2 billion dollars on Social Security disability and SSI benefits for people with HIV and AIDS. That's a 19 percent increase over FY95. In fact, over the last two years, we have seen Social Security costs related to AIDS rise by an astonishing 30 percent.

The President's Budget

President Clinton's 1996 budget reflects this Administration's continuing commitment to fight the battle against AIDS on every front -- research, prevention, and services. This budget focuses on some very important goals. First, it seeks to reduce the number of new HIV infections in this country. Second, scientists will continue to examine the AIDS virus and its effect on the human body so that we can lessen that effect and eventually find a vaccine and a cure. And, third, we will work to ensure that people living with HIV and AIDS have access to the kind of high-quality cost-effective services that they need to live longer and live better.

Research, Prevention, & Services

We must continue our investment in AIDS research. President Clinton's budget includes 1.6 billion dollars for AIDS research, a 4.5 percent increase over FY95. This will allow us to increase our commitment to basic research and to continue clinical research into new AIDS drugs and vaccines. The NIH budget also will continue efforts into prevention, including the development of a microbicide for women.

Until we are able to find a vaccine or a cure for HIV, prevention programs are our only hope to slow the spread of this epidemic. Community-based prevention programs have helped to better protect some segments of the population. Such education has resulted in a declining percentage of new AIDS cases among gay and bisexual men. In 1994, these men accounted for fewer than half of all new cases. That's a sharp contrast to only a few years ago.

President Clinton's FY96 budget includes 527 million dollars for AIDS prevention efforts. At the CDC, the President provides 327 million dollars for national outreach and education, technical assistance, and research. Another 298 million dollars will be awarded through a Performance Partnership Grant that I will describe shortly.

The President has made a major commitment to guaranteeing that all Americans living with HIV have access to these needed services. The Ryan White CARE Act provided funding for more than 300,000 client visits in 1994. In FY96, the President proposes 724 million for Ryan White, an increase of 91 million dollars. Combined with the President's previous two budgets, this brings the overall increase in Ryan White funding to 108 percent during the Clinton Administration. All together, the commitment at the Public Health Service totals 2.9 billion dollars, an increase of 7 percent.

In addition to medical and social services, people living with HIV and AIDS frequently need assistance with their housing costs. The Housing Opportunities for People with AIDS program, or HOPWA, has helped thousands of people find or keep their housing. The President proposes to continue this program and provide another 186 million dollars in FY96. Since the President took office, funding for this program has increased by 46 percent.

Combined with other programs at the Veterans Administration, the Department of Defense, and the U.S. Agency for International Development, total discretionary government spending in response to the AIDS epidemic is $3.7 billion, or an increase of 5.1 percent in FY96.

Ryan White CARE Act

As I mentioned, the increase in funding for Ryan White has helped thousands of Americans live with HIV. It has also helped an increasing number of cities cope with the impact of this epidemic.

Title I of the Act, which provides direct assistance to cities severely affected by AIDS, will receive 407 million dollars in FY96, an increase of 14 percent over FY95. As a result, Title I will receive more than half of the total Ryan White budget.

We are proposing a 23.7 million dollar increase in funding for Title II, which provides assistance to the states. As a result, Title II will receive about 222 million dollars, or 31 percent of the total.

Title IIIB, which provides money to local clinics for early intervention services, will receive 63 million dollars, an increase of 16 percent.

And, finally, Title IV, which funds research and direct assistance to women and children with HIV, will get 32 million dollars, an increase of 23 percent.

CDC Consolidation

Let me conclude by discussing our proposal to consolidate certain programs at CDC. This Administration is committed to improving the way the Federal government serves the people of this country and to strengthening the relationship between Federal, State, and local governments.

In the area of AIDS, we have already strengthened our ties with state and local governments and community-based organizations through a prevention partnership. The proposal to consolidate certain HIV prevention activities with similar programs in the areas of tuberculosis control and prevention of sexually transmitted diseases will further that cooperation. Most importantly, the new proposal retains the community planning effort and eventually will expand that approach to TB and STDs.

Conclusion

This is a remarkable budget. In an era of zero-growth budgeting, the President's commitment to fighting HIV and AIDS is very strong.

I'd be happy to answer any questions you might have.

Thank you.

AIDS Spending
Public Health Service

(in thousands)

Program	FY94	FY95	FY96 Proposed	+/- 95 $	+/- %
FDA	$72,399	$72,745	$74,200	+$1,455	+2%
HRSA	$607,796	$661,185	$751,685	+$90,500	+14%
Ryan White CARE	*($579,365)*	*($632,965)*	*($723,465)*	*(+$90,500)*	*+14%*
Title I	*($325,500)*	*($356,500)*	*($407,000)*	*(+$50,500)*	*+14%*
Title II	*($183,897)*	*($198,147)*	*($221,897)*	*(+$23,750)*	*+12%*
Title IIIB	*($47,968)*	*($52,318)*	*($62,568)*	*(+$10,250)*	*+20%*
Title IV	*($22,000)*	*($26,000)*	*($32,000)*	*(+$6,000)*	*+23%*
Other HRSA AIDS	*($28,431)*	*($28,220)*	*($28,220)*	*(0)*	*0%*
IHS	$3,556	$3,637	$3,933	+$296	+8%
CDC	$543,253	$589,962	$624,718	+$34,756	+6%
NIH	$1,297,115	$1,335,421	$1,407,824	+$72,403	+5%
SAMHSA	$28,111	$24,825	$24,755	-$70	0%
AHCPR	$10,624	$10,585	$11,079	+$494	+5%
OASH	$5,263	$4,083	$4,083	$0	0%
Total, PHS	**$2,568,117**	**$2,702,443**	**$2,902,277**	**+$199,834**	**+7%**

AIDS Spending
Other Departments & Agencies

(in thousands)

Department/Agency	FY94	FY95	FY96 Proposed	+/-$	+/-%
AID	$115,000	$121,000	$121,000	0	0%
Defense	$129,000	$127,000	$98,000	-$29,000	-23%
HUD/HOPWA	$156,000	$186,000	$186,000	0	0%
Justice/Prisons	$6,000	$7,000	$8,000	+$1,000	+12.5%
Labor	$1,000	$1,000	$1,000	0	0%
State	$1,000	$1,000	$1,000	0	0%
Veterans	$312,000	$329,000	$345,000	+$16,000	+5%

AIDS Spending
Entitlement Spending

(in thousands)

Program	FY94	FY95	FY96	+/-$	+/-%
Medicaid (Federal Share)	$1,490,000	$1,640,000	$1,800,000	+$160,000	+10%
Medicare	$500,000	$600,000	$690,000	+$90,000	+15%
Social Security (SSI)	$240,000	$300,000	$370,000	+$70,000	+23%
Social Security (DI)	$600,000	$705,000	$830,000	+$125,000	+18%
Total	**$2,830,000**	**$3,245,000**	**$3,690,000**	**+$445,000**	**+14%**