Fixing a Hole in the HIV Safety Net

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(See the HIV/AIDS Major Article by Doshi et al on pages 117–25.)

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The fifth track on The Beatles' iconic 1967 album *Sgt. Pepper’s Lonely Hearts Club Band* is a song entitled “Fixing a Hole.” In a 1968 interview, Paul McCartney indicated that the song referenced “a hole in the road where rain gets in, a good old analogy—the hole in your make-up which lets the rain in and stops your mind from going where it will” [1]. For >2 decades, the Ryan White Care Act has been the safety net that provided access to care for more than half a million human immunodeficiency virus (HIV)-infected persons who would have had substandard or no care for their infection. The program has been remarkably successful, achieving outcomes that are similar to most every other country in the industrialized world. Yet, the program has some shortcomings resulting in holes in the safety net it provides.

In this issue of *Clinical Infectious Diseases*, Doshi and colleagues at the HIV/AIDS Bureau of the US Health Resources and Services Administration (HRSA) provide evidence of the Ryan White HIV/AIDS Program’s (RWHAP) remarkable successes in service delivery while also noting its gaps and limitations. Using data collected directly from Ryan White–funded providers, the HRSA staff demonstrate that the majority of beneficiaries are doing quite well. Among the 317 458 HIV-infected clients who were seen at least once for medical care, >82% were retained in care and 73% achieved virologic suppression. These numbers far surpass the national estimates for retention in care (40%) and virologic suppression (19%) in the so-called HIV treatment cascade [2]. Moreover, for those who are retained in care, >77% obtained virologic suppression. These numbers are comparable to those in Western Europe, where 95% of diagnosed patients are retained in care and 79% of those have virologic suppression [3].

Yet, the Doshi et al study identified some key gaps in coverage by the RWHAP. In particular, younger patients and those who represent racial minorities failed to achieve the same level of benefit from the program as others. For example, those individuals who were aged >55 had virologic suppression rates of 81.5%–86.6%, whereas those patients between the ages of 19 and 24 years achieved only 49.2% success rates. Similarly, compared with white patients (79% virologic suppression), black, multiracial, Native American, and Hispanic clients achieved 67.1%, 72.8%, 74.5%, and 76% suppression rates, respectively. Although these rates of success indicate a deficiency in the program, they also represent an opportunity to improve the outcomes for these populations through targeted interventions.

The findings by Doshi and colleagues should be celebrated for several reasons. First, the data indicate the tremendous success of the RWHAP, which is a tribute to both HRSA and the many clinics and providers who make up the RWHAP.

Second, the simple existence of such comprehensive data creates an opportunity for ongoing assessment and implementation of targeted interventions, as noted above. Third, in our highly pressurized political environment where government is demonized and government workers are scorned as ineffective bureaucrats, this study is a “tip of the hat” to the women and men at HRSA who make a difference to so many people living with HIV/AIDS in the United States.

Finally, the findings of this study underscore the impact access to care can have for so many uninsured and underinsured individuals in the United States. Although the Affordable Care Act has reduced the numbers of uninsured in the United States from 18% to 13.4% [4], the 40 million Americans who remain uninsured have no safety net to catch them as they free-fall through our dysfunctional healthcare system. For HIV/AIDS patients in the United States, the RWHAP provides that safety net. But what about the others?
All of the uninsured in the United States with diabetes, heart conditions, and cancer are left to fend for themselves against a chaotic healthcare system that creates tremendous financial barriers. These barriers result in, at best, inefficient access to care or, at worst, no access to care at all until it is too late. A modern example is hepatitis C virus (HCV). As with HIV, most patients with HCV are uninsured or underinsured [5]. With the recent release of HCV therapies that result in cure rates of >95%, a substantial number of these patients cannot access the new drugs owing to the expense of the treatments and the lack of coverage. To gain access to these curative therapies, their providers and staff have to file multiple forms requesting either prior authorization or compassionate use. This requires substantial time and effort by the provider team that is totally uncompensated.

For most of the other patients with diseases in the United States that do not have a Ryan White program, their “safety net” boils down to the goodwill of their providers. I have frequently said that “the safety net that catches folks as they fall through the cracks of our disease care. delivery system is made up solely of the fabric of healthcare workers who give a damn” [6].

This begs the question: What does the Ryan White program look like in other countries in the developed world? The sad answer for Americans is, there are no Ryan White programs for HIV patients in other industrialized countries. Why? Because they don’t need one. Their health systems provide universal care to all of their citizens, resulting in health outcomes that dwarf those in the United States for most every disease in every age group [7]. And these better outcomes are achieved at roughly one-half the costs expended in the United States.

Through their study, Doshi et al have identified some holes in the safety net provided by the RWHAP. By using the data derived from their analysis, over the next several years they will attempt to fix the holes, much like Paul McCartney suggested in his song almost 50 years ago. For the rest of the US healthcare system, however, there is an enormous chasm in the safety net rather than holes. I wonder what Sir Paul would propose to fix this? Perhaps we could start by looking at the National Health Service in his home country.

Notes

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References