In 1996, approximately one quarter of the AIDS prevention budget of the CDC was allocated to HIV testing, predominantly for low-risk populations. It was their single biggest HIV prevention expenditure.

Some dozen years later, the CDC is promulgating an even more wide-ranging program: opt-out testing, which does not require risk assessment or counseling, for all health care encounters involving persons aged 13 to 64 years. Ignoring for the moment why a cutoff age of 64 years was suggested, analyses conducted at the Johns Hopkins Bloomberg School of Public Health found that the basis for such a program may be just as misplaced now as was the CDC’s less ambitious program of 1996. Scenario and cost-effectiveness analyses indicate that targeted services would help diagnose 3 times as many infections and prevent 4 times as many infections, all at a fraction of the cost per infection averted. This highlights the important debate between a desire to feature HIV testing without stigma—a “standard medical procedure”—and sound public policy considerations.

Dr David Holtgrave, former head of the CDC’s division of HIV/AIDS prevention, estimated that the health care system would spend $864 million in 1 year to diagnose 56,940 new infections under the opt-out policy, while 188,170 new infections might be discovered for the same amount of money by focusing on drug treatment facilities, prisons, and community health centers in high-risk neighborhoods.

These concerns were echoed by Dr Michael Allerton, HIV operations and policy leader of Kaiser Permanente California. “One of my frustrations with the CDC recommendations is they are based on public health services, not on a private system. . . . Testing everyone may not be cost-effective even if it leads to earlier treatment for those infected,” he said. Dr Timothy Mastro, now deputy director of the CDC’s division of HIV/AIDS prevention, disagreed, arguing that the opt-out approach, with its ability to uncover “missed opportunities,” would complement other targeted federal programs and, thus, could be effective. This is a crucial debate. Annual HIV transmission rates in the United States are 3.5-fold higher among persons with undiagnosed HIV infection than among those who know they are infected.

Dr Anthony Fauci of the NIH, in highlighting the fact that the incidence of HIV infection in the United States has not changed in the past 15 years, recognized that “we have hit the wall with 40,000 new infections in the US each year. We have to push that wall down.” But that may be difficult without a critical change in our thinking about who would benefit the most from our help and how it should be given. In terms of groups at greatest risk for acquiring HIV infection in the United States, the percentage of men who have sex with men (MSM) has risen steadily in incidence from 41% to 49% of new infections from 2001 to 2005. During this period, the incidence of HIV infection among those with other risk factors has remained stable or declined. The dangers are just as real in the resource-poor world, where MSM as a risk group have been largely ignored. For example, Hong Kong health officials recently reported a 4% prevalence of HIV infection among MSM and have forecasted a rise to 30% by 2020 in the absence of a focused prevention program. Equally disturbing are estimates of the fraction of countries’ total HIV prevalence attributable to MSM via bisexual contacts. They ranged from 6.9% in Beijing and 8.3% in Phnom Penh, Cambodia, to 30.3% in Bangkok, Thailand, and 37.5% in Yangon, Burma.

Six years ago, officials from the CDC asked, “Are we headed for a resurgence of the HIV epidemic
among men who have sex with men?" They suggested that we were, “unless we act decisively to reevaluate, refocus, and reinvigorate our prevention efforts.” There has been little evidence of this occurring in the United States or abroad.

Dr Ronald Valdiserri, AIDS expert at the US Department of Veterans Affairs, put the issue into perspective, stating that it would be a “serious mistake to narrow this multifaceted discussion to an artificial dichotomy of opt-out testing versus targeted HIV testing.” He argued that a better question would be, “How can we configure and sustain health care systems that are capable of promoting and incentivizing necessary prevention services such as early HIV diagnosis? . . . [R]eview the timely diagnosis of HIV infection must include operational studies and systems analyses that explicitly evaluate the impact of changes in the design of health care delivery systems (including referral systems) on the receipt of lifesaving services like HIV testing and, when needed, ongoing risk-reduction counseling.”

There are some bright spots in the push for widespread testing among those who are most at risk. There is an increased awareness of the need for testing among this high-risk population. For example, among black Africans in Britain, the rate of HIV testing is relatively high, reflecting their recognition of risk behaviors and potential exposures. A recent review of 26 studies of rapid HIV antibody testing, by which preliminary results can be obtained from blood or oral fluid samples within minutes and with very high sensitivity and specificity, found high rates of client acceptance and receipt of results. But low rates of acceptance of testing in needle-exchange and bathhouse settings suggest that greater efforts are needed to facilitate acceptance among the HIV risk groups needing it the most.

In searching for novel ideas, Drs Copenhaver and Fisher sought comments from 31 HIV prevention experts. Three clusters of strategies for decreasing the persistent rate of new infections in the United States were suggested: improved targeting of existing prevention efforts; large-scale changes to existing prevention programs, including greater involvement of community leaders and schools; and integration of HIV prevention into more aspects of society, particularly as part of routine medical care. How best to effect the last point, if at all, must be resolved.

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