/ DPC: AIOS

Document No. _____

WHITE HOUSE STAFFING MEMORANDUM

DATE: 4/7/87 ACTION/CONCURRENCE/COMMENT DUE BY: --

SUBJECT: DOMESTIC POLICY COUNCIL MEETING -- WEDNESDAY, APRIL 8, 1987 -- 2:00 P.M. -- ROOSEVELT ROOM

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☐	☐	GRISCOM	☑	☐
BAKER	☑	☐	HENKEL	☐	☐
DUBERSTEIN	☑	☐	HOBBS	☐	☐
MILLER - OMB	☐	☐	KING	☐	☐
BALL	☑	☐	MASENG	☐	☐
BAUER	☑	☐	MILLER - ADMIN.	☐	☐
CARLUCCI	☐	☐	RISQUE	☐	☐
CRIBB	☑	☐	RYAN	☐	☐
CULVAHOUSE	☑	☐	SPRINKEL	☐	☐
DAWSON	☐P	☑SS	TUTTLE	☐	☐
DONATELLI	☑	☐	CANNON	☑	☐
FITZWATER	☑	☐	_____	☐	☐

REMARKS: Please inform Patsy Faoro (x2800) in the Office of Cabinet Affairs if you will attend.

AGENDA: 1. AIDS

RESPONSE:

Rhett Dawson
Ext. 2702

THE WHITE HOUSE

WASHINGTON

April 7, 1987

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: RALPH C. BLEDSOE
Executive Secretary

SUBJECT: Meeting on April 8, 1987

Attached are an agenda and materials for the Domestic Policy Council meeting scheduled for Wednesday, April 8, 1987 at 2:00 p.m. in the Roosevelt Room. The topic to be discussed is Acquired Immune Deficiency Syndrome (AIDS).

This will be a continuation of the April 1 meeting on AIDS. The following aspects of this issue will be discussed:

o activities of Federal departments and agencies to prevent the spread of AIDS, to be summarized by Bill Roper;

o recommendations pertaining to a communications strategy, also to be presented by Bill Roper, including content for a Presidential speech or radio address on AIDS;

o information about a system for drafting content of a nationwide mailing on AIDS, with review by the DPC, a two-page summary of which is attached; and

o an interim report on AIDS testing, for which a paper is also attached.

Gary Bauer will report on the recommendation for a National Advisory Commission on AIDS. A brief paper is attached.

THE WHITE HOUSE

WASHINGTON

DOMESTIC POLICY COUNCIL

Wednesday, April 8, 1987

2:00 p.m.

Roosevelt Room

AGENDA

1. Acquired Immune Deficiency Syndrome (AIDS) -- William L. Roper
Administrator
Health Care Financing Administration
Department of Health and Human Services

Gary L. Bauer
Assistant to the President for Policy Development
The White House

AIDS NATIONAL PUBLIC INFORMATION CAMPAIGN

DRAFT

PHASE 1: CREATING AN AWARENESS

Feb. 3	Memo: Initial proposal made to OASH for campaign
Feb. 20	Memo: Information and Education Subgroup response to campaign and projection of costs for mailout
Mar. 23-24	Budget review by PHS AIDS Executive Task Force
Apr. 6	Present campaign outline to: o Information and Education Subgroup o PHS AIDS Executive Task Force o Health Policy Subgroup
Apr. 16	Plan technical advisory panel review
Apr. 27	Arrange for pretesting of leaflet(s)
Apr. 27	Working draft of plan and leaflet(s)
May 4	Plan public knowledge and attitudes assessment strategy
May 11	Technical advisory panel review of plan and leaflet(s)
May 18	Review of plan and leaflet drafts by PHS AIDS Executive Task Force INITIAL CLEARANCE BY DPC
May 19	Implement pretesting plan
May 19	Review plan and leaflet with representatives of the following groups: Coalition Health Officer Groups Churches School interests Local government groups, e.g. National Governor's Association, Conference of Mayors, etc.
June 1	Final draft of plan and leaflet submitted for review by PHS Exec. Task Force FINAL CLEARANCE BY DPC
June 8	Solicit support of state and local government officials for designation of "AIDS Month" in October
June 15	Final strategic plan provided to Health Officer Organizations
June 15	Implement printing plan
June 22	Review of plan and leaflet content with representatives of the media to plan releases and coordination of special features to support the programs

June 22	Review of the plan with the Coalition, and selected key groups
June 29	Coordinate the campaign with the professional organizations to focus information efforts, meetings, publications, etc. on AIDS during the campaign period
July 6	Complete procurement of distribution contracts
Aug. 24	Printing completed and received
Aug. 31	Final plan and copies of materials distributed to all key Government officials, Coalition members, and selected others
Sept. 21	Distribution plan implemented
Oct. 5	Major presentations on AIDS by HHS Officials and State and local public health officials which highlight the extent of the crisis, and clarify the importance of the information campaign to everyone
Oct. 12	Major speech by the President
Oct. 19	Leaflets distributed
	Prison programs, hand deliveries in high density areas, special information programs, etc.
	Notices of the AIDS crisis and the current information campaign attached to all pay stubs, social services checks or other information materials, and other key sources of services for the general public
	Workplace programs presented to emphasize the information campaign and to stimulate response by employees, particularly in diffusing concerns regarding discrimination
	Special church services to remember those in the communities who have suffered with AIDS and to support the prevention efforts
	Pauses during the NFL games to emphasize the AIDS crisis

Phase 2: REINFORCING THE MESSAGES

Initiate media campaign to reinforce responses to the messages in the leaflet and related information programs

State and local health information initiatives

Corporate information initiatives and incentives to respond for further information or services

DRAFT

April 6, 1987

BRIEFING MATERIALS ON HIV ANTIBODY TESTING

DEVELOPMENT OF ANTIBODY TESTS FOR HIV (THE AIDS VIRUS)

- The virus believed to be the cause of AIDS was isolated and characterized in 1983 and early 1984.

- Both ELISA and Western blot tests for antibody to this virus were developed rapidly for research purposes.

- These tests showed that a high percentage of people with AIDS and associated conditions also had antibody to the virus.

- In June 1984, five companies were selected by the PHS to develop a commercial antibody test for HIV to screen blood and plasma donated for transfusion and to manufacture blood products.

- Clinical trials of the test kits began in late 1984.

- In March 1985 the first of the HIV antibody tests was licensed. As of March 1987, eight companies had been licensed by FDA to produce HIV antibody test kits

PHS RECOMMENDATIONS FOR TESTING DONATED BLOOD AND PLASMA

- Provisional Public Health Service inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing AIDS were published in the MMWR in January 1985.

- These recommendations:
  - Stated that all donated blood and plasma should be tested for HIV antibody. Units with a positive test should be discarded.
  - Explained the need for repeating reactive screening test results and obtaining a more specific type of positive test (e.g., Western blot) on reactive results before notifying the donor of the test results
  - Established PHS policy regarding the importance of confidentiality of information, of notifying donors that testing would be done, and of notifying those donors with a positive test about this fact.
  - Provided recommendations for people with positive antibody tests about personal practices to avoid transmitting the virus to others

- Screening donated blood and plasma was initiated voluntarily in the United States in late March. By July 1985, virtually all blood and plasma donated or used was tested for HIV antibody.

DEVELOPMENT OF HIV ANTIBODY TESTING AND COUNSELING SITES

- In spring 1985, CDC provided money to State and local health departments to develop and promote HIV antibody counseling and testing sites for people at high risk of AIDS.
  - The purpose was to provide a testing site other than the blood banks for people who were at risk of AIDS.
  - During CY 1985, 874 testing sites were established and 79,083 people were tested; 17.3% were positive.
  - Provisional figures for CY 1986 indicate that more than 121,000 people were tested; nearly 19% had a positive test.

RECOMMENDATIONS FOR THE USE OF HIV ANTIBODY TESTING TO PREVENT INFECTION

- In December 1985, PHS published recommendations to assist in preventing perinatal infection with HIV.

- These recommendations stressed that women at risk of AIDS or HIV infection should be offered antibody testing and counseling. The primary intent is
  - To identify women who are not infected and to educate them to prevent infection.
  - To identify women who are infected and to offer services to prevent pregnancy and the risk of AIDS through perinatal infection.

- In March 1986, PHS published additional recommendations or the prevention of sexual and drug abuse-related infection with HIV.

- The recommendations stated that counseling and voluntary serologic testing for HIV antibody should be offered routinely to all persons at increased risk when they present to health-care settings.
    - It was emphasized that interrupting HIV transmission through counseling and testing persons at high risk of infection depended on the ability of health officials to maintain confidentiality and protect records from unauthorized disclosure.

RECOMMENDATIONS FOR EXPANDED HIV ANTIBODY TESTING IN THE UNITED STATES

- On February 24-25, 1987, CDC sponsored a conference on The Role of AIDS Virus Antibody Testing in the Prevention and Control of AIDS.

- Four operating levels of testing for HIV antibody were defined:
    - Voluntary anonymous testing--The person to be tested initiates the request for testing; the testing agency has no specific identifying information.
    - Voluntary confidential testing--The person to be tested initiates the request for testing; test results and information about the person tested are confidential.
    - Routine confidential testing---A health care provider initiates the recommendation for testing; test results and information about the person tested are confidential.

- Mandatory or legislated testing—People would be required to be tested if they were in certain situations or wanted to use specific services; they could only refuse the test by foregoing the service provided.

- The workshop panels strongly supported the increased use of voluntary anonymous, voluntary confidential, and routine confidential HIV antibody testing as an adjunct measure in the prevention and control of AIDS (See Appendix I, Summary of Workshop Reports).

- The workshop panels concluded that mandatory or required testing was neither useful nor required. The reasons given include:
  - Many people would reject medical care or other services if a mandatory test for HIV antibody were required.
  - Mandatory premarital and similar types of screening programs would be required for populations with an extremely low prevalence of HIV infection (e.g., the population of women who are most likely to have HIV infection and to become pregnant are not married and would not be reached by premarital testing).
  - The prevalence of HIV infection in most areas of the country is so low that the costs of mandatory testing and counseling would far outweigh the benefits that might be obtained (See Appendix II, Estimates of Costs of HIV Antibody Testing and Counseling).
  - Resources that could be used for other more effective programs might be diverted to pay for mandatory screening programs.

- CDC discussed the conclusions from the workshop panels with the AIDS working group of the Association of State and Territorial Health Officers (ASTHO) on March 17, 1987.

- Further recommendations and implementation steps are being discussed with the ASTHO working group and other State and local health officials at a meeting scheduled for mid April, of particular concern has been the need for confidentiality or anti-discrimination legislation.

- A summary report from these deliberations will be presented to the PHS by April 30, 1987.

ADDITIONAL RECOMMENDATIONS FOR THE USE OF HIV ANTIBODY TESTS

- In March 1987, PHS recommended that physicians should consider offering HIV antibody testing to some of their patients who were transfused between 1978 and late spring 1985.
    - The decision should be based on the likelihood of infection in a transfusion recipient and the likelihood that that person might transmit the virus to others.
    - Testing is particularly important if the person is sexually active is of childbearing age.

APPENDIX I.

CONFERENCE ON THE ROLE OF AIDS VIRUS ANTIBODY TESTING

IN THE PREVENTION AND CONTROL OF AIDS

February 24-25, 1987

SUMMARY OF WORKSHOP REPORTS

WORKSHOP A

Confidentiality: The Need to Protect Personal Information and Rights

Question: How can HIV antibody test results be used for appropriate medical and public health purposes without their being used for discrimination or social ostracism of a person with HIV infection, AIDS, or associated medical conditions?

Summary Responses:

- "There should be increased support for increased antibody testing" but "antibody testing should be done as an adjunct to counseling. . . . None of this testing should be compulsory or mandatory." (Robert Levine)

- "Within the context of public health practice, . . . it [is] possible to conduct antibody testing with reasonable assurance that confidentiality could be maintained. . . . In the context of medical practice, . . . in doctor's offices or in clinics, and most seriously in in-patient medicine as practiced in the hospital, . . . there [are] much more formidable threats to confidentiality." (Robert Levine)

- "There is a clear and definite need for firm protection of confidentiality of all of the information collected in any program of AIDS control. . . . The Federal government [needs to] firmly support with its own regulations [and] its own guidelines that confidentiality breaches will not be tolerated. . . ." (William Curran)

- ". . . Every effort [should] be made to keep confidential particularly the early stages of infection [and] the early stages of treatment so that there is not an effort made to discriminate against the individual. . . ." (William Curran)

- ". . . The laws of many of the States . . . do not have adequate protection for procedural due process, for substantive due process, or for confidentiality." (William Curran)

- ". . . Antidiscrimination laws . . . will in fact be actually a protection for the development and greater use of AIDS [virus antibody] testing and diagnostic evaluations for people who want to know [if they have been infected]. . . . There should clearly be antidiscrimination laws which make it illegal and punishable to discriminate against individuals who are seropositive in regard to employment, housing, and public access such as hotels, restaurants, and other public facilities. . . ." (William Curran)

- Legal protections and uniform application of them "are related to the trust that needs to be expressed in the authorities that have the responsibility for dealing with this epidemic. In order to encourage that trust, confidentiality must be secure [and] antidiscrimination must be secure." (William Curran)

WORKSHOP B

<u>What is the Role of Antibody Testing in Preventing Sexual and Parenteral Transmission of HIV?</u>

<u>Question</u>: Should persons attending a sexually transmitted disease (STD) clinic have a test for HIV antibody performed? This assumes that appropriate pre- and post-test counseling and education will be provided as part of the procedure.

<u>Summary Response</u>:

- "Persons attending a sexually transmitted disease clinic should have a test for HIV antibody performed." (Beny Primm) (See General Comments below)

<u>Question</u>: Should persons attending a treatment program for drug dependent people as well as their spouses or sexual partners have a test for HIV antibody performed? This assumes that appropriate pre- and post-test counseling and education will be provided as part of the procedure.

<u>Summary Response</u>:

- "Persons attending a treatment program for drug dependent people should have a test for HIV antibody performed, and their sexual partners should also be tested for HIV antibody. . . . Women of childbearing age who are drug dependent should be encouraged . . . to have an antibody test for HI performed. (Beny Primm) (See General Comments below)

Question: Should the sexual partners of people with HIV infection (i.e., people with HIV antibody) be notified about their potential exposure and tested and counseled? This assumes that if an infected person wishes assistance or is unwilling to notify his/her sexual partner(s), health department personnel could assist in this procedure if necessary, following procedures to maintain appropriate confidentiality and anonymity.

Summary Response:

- "Sexual partners of HIV antibody positive persons should be informed of their potential exposure, counseled, and tested. . . . Increased resources [should] be provided for full implementation of contact tracing or partner referral [although] the most cost-effective means of partner referral remain to be determined." (Beny Primm) (See General Comments below)

- Since a disproportionate number of heterosexual cases are in Blacks and Hispanics, "there must be a more concentrated effort on the part of Federal, State, county, and city governments, health-care givers, and others involved to orchestrate the necessity for immediate prevention and education efforts in those communities so severely affected." (Beny Primm)

General Comments:

- ". . . What we . . . were considering is . . . selective routine testing where a test would be offered on a regular basis, certainly to individuals believed to be at risk of having HIV [infection]." (Franklyn Judson)

- The [HIV antibody] test should only be performed with competent counseling. There should be adequate long-term funding adjusted to the need for competent, long-term counseling. Counseling and testing should be accompanied by referral to adequate medical and psychiatric services, [and] that there be adequate social service support provided." It was noted that "counseling and testing [should] not be viewed in isolation but [must be] accompanied by a major increase in resources for AIDS education and [other] prevention efforts." (Beny Primm)

WORKSHOP C

What is the Role of Antibody Testing in Preventing Perinatal Transmission of HIV and as a Diagnostic Tool?

Questions: Should persons seeking family planning services have a test for HIV antibody performed? Should pregnant women have a test for HIV antibody performed as early in pregnancy as possible? These assume that appropriate pre- and post-test counseling and education will be provided as part of the procedure.

Summary Response:

- ". . . HIV antibody testing should be routinely offered in family planning settings and prenatally with a priority to prevent HIV infections prior to conception." ". . . Efforts need to be made . . . to further incorporate counseling for HIV testing" into the services provided by family planning clinics, family practitioners, and obstetricians and gynecologists. "Model pilot programs in both high and low risk areas should be developed at this time. . . ." (Jeffrey Davis)

Question: Should HIV antibody testing, with appropriate counseling and education, be a routine part of a premarital testing program? This assumes that if either partner is positive, both would be notified and counseled before the license is granted.

Summary Response:

- "The provisions of voluntary premarital testing services was felt to be appropriate although clearly of less priority than family planning related or prenatal testing. Individuals could be counseled and tested through their private providers or through alternate site programs." The panelists "were opposed to mandatory premarital HIV testing," particularly given "the cost benefit of such a program in relation to the critical need for the commitment of HIV-related resources for other compelling critical programs." (Jeffrey Davis)

Question: Should every patient admitted to a hospital be tested for HIV antibody as part of the routine diagnostic evaluation? This assumes that appropriate counseling and education will be provided as part of the procedure for people who are antibody positive.

Summary Response:

- ". . . Mandatory testing of patients admitted to the hospital [is] not appropriate at this time. Routine testing of certain admissions may be considered in certain high risk areas." (Jeffrey Davis)

April 4, 1987

* * * D R A F T * * *

APPENDIX II.

ESTIMATES OF COSTS OF HIV ANTIBODY COUNSELING AND TESTING

The rough cost estimates for HIV antibody counseling and testing derived below are based on approximate costs of testing in an existing laboratory that is performing a sufficient number of both enzyme immunoassay (EIA or ELISA) and Western blot tests on a regular basis that it can achieve economies of scale. The costs of the counseling associated with antibody testing are derived from estimates that also assume a dedicated staff able to achieve high efficiency at counseling. This situation and the assumptions that support it provide the lowest estimate of costs for HIV antibody testing and counseling. To the extent that any of the assumptions are altered, the costs will increase, perhaps several fold over those estimated.

Cost estimates to establish laboratory capabilities throughout a State, region, or the nation to support an expanded HIV antibody testing program are much more difficult to derive than are the estimates of costs as part of a small or existing program. The costs to develop a markedly expanded laboratory and counseling program almost certainly will be considerably higher than the costs described below. Expenditures that have not been considered below but that are essential for an expanded program include support for expanded systems of laboratory quality assurance and performance evaluation, for the recruitment and training of laboratory personnel, and for the rapid transfer to the operating level of new technical developments in testing. An additional category of costs that is difficult to estimate are those costs that result from the testing, such as confirmatory testing or medical evaluation of people with ambiguous test results or with false positive test results, liability costs, and other social costs. These costs can be expected to be substantial, and--depending on the program initiated--perhaps could be several times higher than the initial costs of testing and counseling.

BASIC ASSUMPTIONS AND BACKGROUND INFORMATION

1. The enzyme immunoassay (EIA or ELISA) test kits are sold in packs rather than individually. When the purchase cost of a kit is divided by the number of tests per kit that could be performed, the price of a single EIA test would most often range from $1-3. The biggest cost variable is the negotiated contract price; a laboratory performing 20-25 thousand tests annually should be able to obtain the test kits for approximately $1 each.

2. The personnel time to perform a test varies with the kit selected, the equipment (automated versus manual) used, and other factors. A dedicated technician should be able to perform approximately 700 tests per week including all specimen preparation, paperwork and calibration or standardization.
   - o Salaries and benefits for laboratory technicians vary widely. Assume a salary of $25,000 annually. At 700 tests per week and 48 working weeks per year, one technician could perform approximately 33,600 tests annually for an average cost of $0.75 per test. A more realistic figure may be closer to $1.00 per test.

- Overhead costs need to be considered: supervisor's time, equipment purchase or lease, laboratory space and furnishings, utilities, materials, etc. Without any firm basis for the following estimate, assume a cost of $0.50 per test.

3. For the cost estimates that follow, the following figures are used:

o Purchase cost of EIA test	$1.50
o Lab personnel time per test	1.00
o Overhead costs	0.50
o Total cost per EIA test	$3.00

This represents a minimum figure for performing the test in a large laboratory. The cost to obtain the test through a commercial laboratory probably would be multiple times the minimum figure.

4. Cost figures for the Western blot (or fluorescent antibody) test used as a back-up procedure are less well defined since no commercial company has been licensed as of late March 1987 to retail this type of test kit to detect HIV antibody for diagnostic purposes in humans.

The cost of producing or purchasing the reagents for the Western blot test are estimated at $12.00 per test.

5. A dedicated technician should be able to perform 35-40 Western blot tests per day on a schedule of 4 days per week (the Western blot test as performed at CDC requires overnight incubation), for an average of 150 tests per week.
   - Salaries and benefits for laboratory technicians vary widely. Assume a salary of approximately $28,000 annually. At 150 tests per week and a 46-week working year, a technician could perform approximately 7,000 tests annually at an average cost of $4.00 per test.
   - Overhead costs also need to be considered: supervisor's time, equipment purchase or lease, laboratory space and furnishings, utilities, materials, etc. Without any firm basis for the following estimate, assume a cost of $4.00 per test.

6. For the cost estimates that follow, the following figures are used:

o Cost of Western blot materials	$12.00
o Personnel time per test	4.00
o Overhead costs	4.00
o Total cost per Western blot test	$20.00

This represents a minimum figure for performing the test in a large laboratory. The cost to obtain the test through a commercial laboratory probably would be multiple times the minimum figure.

7. Counseling/education time and cost estimates are as follows:
   - The estimated cost of counseling and interviewing is approximately $15.00 per hour, factored as follows: Assume salary costs for counselors average $25,000 annually, salary costs for supervisory & management staff average $32,000 annually, and salary costs for

clerical and support staff average $17,500 annually. Also assume one full-time equivalent (FTE) is 2,080 hours annually, 1 supervisor is needed for every 8 counselors, and 1 clerical/support person is needed for every 12 counselors/supervisors.

- o Pre-test counseling requires 15 minutes, or $3.75.
- o Post-test counseling for a person with a negative test requires 45 minutes, or $11.25.
- o Post-test counseling and interview for a person with a positive test requires 90 minutes, or $22.50. (Realistically, to be most effective, this process may require several hours of counseling over an extended period).
- o Additional time necessary for sex-partner referrals, interviews, counseling and examinations are not included in these estimates.

8. For the purposes of this exercise, the EIA HIV antibody test used for initial screening will be assumed to be 100% sensitive (that is, the test will be positive for all people who are infected and have antibody) and that it is 99.0% specific (that is, the test will be negative for 99 of every 100 people who are not infected).

   With repeat testing of reactive specimens, the specificity increases to approximately 99.5% (range 99.2% to 99.8%), which means that approximately 5 (estimated range, 2-8) people of every 1000 who are not infected will have a repeatedly reactive EIA test.

   The Western blot test for HIV antibody will be assumed for this exercise to have both a sensitivity and specificity of 100%, although in actual laboratory practice these parameters do not differ markedly from those of the EIA screening test.

   The assumptions of sensitivity and specificity used in this model are close to ideal and tend to minimize costs and problems that may result from the false positive and false negative tests that will occur at least occasionally in real-life testing.

OTHER ESTIMATES OF THE COST OF HIV ANTIBODY COUNSELING AND TESTING

The military has a contract with a commercial company to perform EIA and Western blot tests for HIV antibody tests for all recruit applicants. The average costs for antibody testing only are in the range of $4-5 per person, including repeat testing and Western blot testing for the small percentage of people for whom this is indicated.

The United States Conference of Local Health Officers has assessed costs of HIV antibody counseling and testing at several city or county health departments. The total costs for counseling and testing ranged from $22-75, although several health departments estimated costs for people with a positive test at more than $100 each. Pre-test counseling was estimated to cost $7. Costs for testing were:

Western blot test	$25-85
EIA test	4-13

ESTIMATED COST TO TEST A POPULATION OF TEN THOUSAND PEOPLE

Situation 1: A population of 10,000 people at low risk of HIV infection. Assumption: The actual prevalence of HIV infection in the population is 0.1%, or 1 person per 1,000.

Test Results	Total Number	True Positive	False Positive	True Negative	Cost
Pre-Test Counseling	10,000	--	--	--	$37,500
Initial EIA Screen	10,000	10	100	9,890	30,000
Repeat EIA Test x 2	110	10	50	50	660
Western Blot (WB) Test	60	10	0	50	1,200
Post-Test Counseling					
EIA Test Negative	9,990	--	--	--	112,388
WB Test Positive	10	--	--	--	225
Total Cost	10,000	10	--	9,990	$181,973

The dollar cost per infected person detected and counseled is $18,197.

Situation 2: A population of 10,000 people at high risk of HIV infection. Assumption: The actual prevalence of HIV infection in the population is 20%, or 200 people per 1,000.

Test Results	Total Number	True Positive	False Positive	True Negative	Cost
Pre-Test Counseling	10,000	--	--	--	$37,500
Initial EIA Screen	10,000	2,000	80	7,920	30,000
Repeat EIA Test x 2	2,080	2,000	40	40	12,480
Western Blot (WB) Test	2,040	2,000	0	40	40,800
Post-Test Counseling					
WB Test Negative	8,000	--	--	--	90,000
WB Test Positive	2,000	--	--	--	45,000
Total Cost	10,000	2,000	--	8,000	$255,780

The dollar cost per infected person detected and counseled is $128.

DRAFT

THE WHITE HOUSE

WASHINGTON

April 7, 1987

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: GARY L. BAUER
ASSISTANT TO THE PRESIDENT FOR POLICY DEVELOPMENT

SUBJECT: Proposed Presidential Commission on AIDS

Background

AIDS is characterized by a defect in a person's natural immunity to disease. People with AIDS are vulnerable to serious illnesses which would not be a threat to those whose immune systems function normally. AIDS is caused by a virus, usually referred to as HIV (formerly called HTLV-III/LAV), which is transmitted by sexual contact; needle sharing; from mother to child before, during, or after birth; or less commonly through transfusions of blood and blood products.

As of 1987, CDC estimates there were almost 33,000 cases of AIDS reported in the United States since June 1981. The number of Americans infected with the AIDS virus may be as much as 100 times greater than the number with AIDS. It is estimated at 1.5 million, with a doubling time of about 14 months. The actual incidence of the virus in America is unknown.

HHS estimates that during 1991 alone, 145,000 cases of AIDS will require medical attention and 54,000 persons will die, bringing the cumulative number of AIDS deaths in this country to over 179,000.

Discussion

At the Domestic Policy Council meeting on April 1, 1987, a request was made for recommendations on the establishment of a presidential commission on AIDS. The Federal Government has already responded to the epidemic through a variety of ways including scientific, administrative, educational, and budgetary actions.

Public concern increases as news of the epidemic is reported on television, radio and in the print media. Congress is now addressing this issue through a variety of legislative proposals, none of which have received final approval to date. The following options are presented for the Council's consideration and guidance.

Option 1

Wait for the Congress to pass legislation establishing a secretarial commission on AIDS as proposed, for example, by Senator Wilson, et al, in S.613.

-- The Congressional Advisory Panel on AIDS would advise Congress and the President on policies and programs designed to reduce the incidence of AIDS, make recommendations for providing health care for AIDS victims, monitor the progression of AIDS among the general population and specific risk groups, address legal and ethical issues relating to AIDS, among other responsibilities.

The advantages of this option would include allowing the Congress to act and would give HHS, as the lead agency on public health issues, the opportunity to provide a comprehensive report to the Congress and the President.

The disadvantage is that it would take several months for the approval of commission members, and duplicate much of what the Institute of Medicine report has already provided in its report this Spring.

Option 2

Accept the recommendations of the Congress as expressed in a Concurrent Resolution introduced by Senator Dole, et al, asking the President to appoint a commission on AIDS.

-- The resolution asks that a commission establish health priorities, review public and private financing of health care for AIDS victims, coordinate the dissemination of information on AIDS to the public, review laws on infectious diseases as related to immigration, discrimination, and liability. It would also foster and coordinate international efforts to contain the epidemic.

The advantages would include the raising of this issue to the level of a Presidential commission, and would provide an opportunity for a broader review of the AIDS epidemic, its causes, and its international implications.

The disadvantage would be the length of time to establish the commission and the many months required for the completion of a comprehensive report to the President. It could be seen as a way to delay policy decisions on this epidemic.

Option 3

Establish a Presidential commission by administrative action.

-- This action would include setting up a small commission to review research done to date and identify future areas of research that would be needed, investigate the long-term impact on the health care system and our national security, and recommend ways to protect those Americans who do not yet have the disease.

The advantage of establishing a Presidential commission by administrative action would include the ability to act immediately, set a date certain for a report to be issued (possibly 90 days to 6 months) and would narrow the focus to those actions which could be implemented within the next year.

The disadvantage would be that it could put the President in a position of taking action beyond what is currently being recommended by the Public Health Service professionals.

Option 4

Take no action on establishing a commission at this time.

The advantage would be to rely on Congress to take whatever action they believe is appropriate, and support the continuation of Public Health Service activities to contain the epidemic.

The disadvantage is that it would appear to be a lack of leadership on the part of the President, particularly in the light of the upcoming Economic Summit in Italy, where AIDS will be on the agenda.

Recommendation

The Office of Policy Development recommends Option 3, the establishment of a Presidential commission by administrative action. If the Council agrees with this action, OPD will convene a small working group to develop a charter and work with Presidential Personnel to identify candidates to serve on the commission. We would report to the Domestic Policy Council by May 1, 1987, with our recommendations.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator
Washington, D.C. 20201

March 30, 1987

MEMORANDUM FOR THE DOMESTIC POLICY COUNCIL

FROM: THE WORKING GROUP ON HEALTH POLICY

SUBJECT: AIDS Issues

The Council will meet on April 1, 1987, again to discuss the effort against the acquired immune deficiency syndrome (AIDS), and to consider what further should be done by the federal government.

Background

The Domestic Policy Council first dealt with the issue of AIDS on September 11, 1985. Secretary Heckler made a presentation and the Working Group on Health Policy recommended that:

- Federal agencies and state and local governments be urged to take necessary actions to lessen the risks of the spread of AIDS, and
- For the general welfare of society, AIDS be dealt with as a major public health problem.

On December 19, 1985, the Council met with the President on AIDS. He approved continuation of research and information dissemination efforts.

In his February 1986 Message to the Congress on the State of the Union, the President requested a report by the Surgeon General on AIDS.

The Council met on October 1, 1986, and agreed to forward the Surgeon General's report to the President.

On January 13, and January 21, 1987, the Council discussed education policies regarding AIDS, which the President subsequently approved on February 11, 1987.

The Working Group has met several times recently to consider what information to report, what additional steps to recommend, and on what items to request further guidance from the Council. This paper focuses on four federal government roles with respect to AIDS: scientific, information, administrative and leadership.

Scientific Efforts

The Public Health Service (PHS) has led a rapidly expanding scientific research effort directed against AIDS. Tab 1 includes information on several of the medical and public health issues which the Working Group has discussed.

Since the first reported cases of AIDS in 1981, this federal government effort has included:

- o Characterization of the disease AIDS, and its eipdemic nature, through epidemiological studies;
- o Discovery of the virus that causes AIDS;
- o Development of a blood test for AIDS virus antibody;
- o Development of AIDS treatment agents (including AZT, which has now been licensed by the FDA); and
- o Preliminary work on an AIDS vaccine.

The Working Group recommends that scientific efforts focus on AIDS treatment and vaccine development and on further virus research and blood test development.

Information Dissemination

As the scientific efforts have yielded data, the federal government has conveyed information on AIDS to influence public policy and individual behavior.

This effort has included:

- o Consensus recommendations by the Public Health Service on AIDS prevention;
- o Recommendations for blood bank testing, leading to protection of the blood supply;
- o Publication of the Surgeon General's Report on AIDS, as directed by the President;

- o The President's approval of an AIDS education strategy for the Administration; and

- o Publication of the AIDS Information/Education Plan by the Public Health Service, after interagency discussion.

The Working Group recommends that further information efforts should include implementing the AIDS Information/Education Plan, with continued interagency coordination, in keeping with the President's guidelines on AIDS education.

In addition, the Working Group has discussed the merits of a mailing on AIDS to every household in America. The PHS estimates that such a mailing would cost $10-20 million, and could be done as early as this fall, including appropriate clearance of the text. The benefits of a mailing would include the direct information conveyed plus, indirectly, the attention brought by the coverage of the mailing by the news media.

The government of the United Kingdom has done such a mailing to its citizens. Tab 2 includes the UK brochure.

Finally, the Working Group has discussed the many issues involved in possible further recommendations on AIDS virus antibody testing. As explained in the PHS memorandum at Tab 1, the PHS is currently considering the matters discussed at a February 1987 meeting which the CDC held on this subject.

Public health authorities at the state and local level are generally free to set policy on these and other issues, but these authorities usually rely on the Public Health Service recommendations.

The Council may wish to devote a future meeting to a discussion of the issues of AIDS virus antibody testing, confidentiality, and related issues. The PHS will be ready with its recommendations later this spring.

The issues might include the following:

- o Should recommendations for wider testing be for voluntary testing only, or should there be some use of mandatory testing?

- o Whether mandatory or voluntary, should testing be "routine" in some settings, such as drug abuse clinics, sexually transmitted disease clinics, prenatal clinics, before marriage licenses, etc?

- o Given the lethal nature of AIDS, what are the appropriate roles for tracing and informing contacts of persons who test positive?

- o What is the appropriate role for testing for life or health insurance, employment, etc.?

Administrative Actions

The Public Health Service has undertaken a large number of activities, including basic and clinical research, public information, development of a blood testing system, evaluation of the safety and efficacy of AIDS therapies and vaccines, and overall coordination. Including payments under Medicare and Medicaid, over $900 million will be directed by the Department of Health and Human Services for AIDS in FY 1988.

Various other federal agencies have also taken a number of administrative actions on AIDS, including:

- o The Department of Defense has begun testing recruits and active duty personnel;

- o The Veterans Administration has focused its health care resources to establish AIDS treatment units for eligible veterans;

- o The Health Care Financing Administration has worked with the states to target Medicaid on AIDS needs;

- o The State Department and the Peace Corps are testing some employees for overseas deployment; and

- o The Office of Personnel Management is pursuing AIDS education and prevention for federal workers.

The Working Group recommends that further AIDS administrative efforts should include continuing these activities, plus preparing for the federal role in future AIDS treatment needs. The PHS memorandum at Tab 1 describes some of the planning underway for the likely demands of AIDS on the health care system.

The Working Group has also discussed, but would like Council guidance on the merits of the establishment of an AIDS Policy Board at the Cabinet level, and the appointment of a National AIDS Advisory Commission. The Public Health Service has recommended these steps, as explained at Tab 3.

The proposed AIDS Policy Board would be chaired by the Secretary of Health and Human Services and would include other cabinet members. It would set policy, develop strategies and guide implementation.

The PHS seeks this AIDS Policy Board as a means for structuring input and focusing the activities of the proposed National AIDS Advisory Commission. Further, the PHS notes the parallel to the recently established Drug Policy Board.

Other members of the Working Group have said they would prefer not to separate AIDS policy matters from the DPC process.

Also included in the PHS memorandum at Tab 3, is a proposal for appointment of a National AIDS Advisory Commission. Several bills, offered by members of both houses of Congress and of both parties, would mandate such an Advisory Commission. The idea of administratively establishing the Advisory Commission could be considered along with or separate from the consideration of an AIDS Policy Board.

In view of the likely congressional action requiring an AIDS Advisory Commission, the Working Group seeks your guidance on this matter. If a Commission were to be appointed, it could be a Presidential or a Secretarial Commission.

Leadership

The federal government has made AIDS a high priority and has focused government and public attention on AIDS.

Because of the growing magnitude of the problem of AIDS, and the obviously growing public concern, further leadership activities may be warranted, including involvement of the President.

The Working Group has discussed the merits of the President speaking to the nation on AIDS, to communicate the need for public education and individual responsibility. We believe the appropriate type and length for such a speech would be a Saturday radio address. Another occasion for a White House spokesman on AIDS is the upcoming International Conference on AIDS, which will be in Washington, D.C., June 1-5, 1987.

We seek your guidance on an appropriate communications strategy for the President on AIDS.

A Summary of Recommendations and Items for Further Discussion

The Working Group recommends that:

- Scientific efforts for AIDS treatments, vaccines and tests should be continued;
- The AIDS education plan should be implemented, with interagency coordination, in keeping with the President's guidelines on this subject;
- Administrative efforts against AIDS should be pursued, including the assessment of AIDS demands on the health care system; and
- Federal leadership should continue to make AIDS a top priority.

The Working Group suggests that the Council consider giving guidance on:

- An AIDS educational mailing to every household in America;
- The establishment of an AIDS Policy Board;
- The appointment of a National AIDS Advisory Commission; and
- An appropriate AIDS communications strategy for the President on AIDS.

The Working Group also suggests that, at a subsequent meeting, after the PHS presents its recommendations, the Council consider giving guidance on the many issues involved in possible further recommendations on AIDS virus antibody testing.

MAR 20 1987

Assistant Secretary for Health

Improving AIDS Policy Oversight

The Under Secretary
Through: COS _____
ES _____

The AIDS issue is growing rapidly in terms of both national and international importance. The number of AIDS cases has reached 30,000 and as many as 1.5 million Americans are estimated to be infected with the virus. We are requesting over $900 million in the Fiscal Year 1988 DHHS budget for this disease. If the activities of other Federal Agencies (DOD, the VA, and DOL) are added to this, the total Federal request is over $1 billion.

As the dimensions of this disease have increased, significant medical, social, economic, and ethical issues have arisen. The National Academy of Sciences, the Congress, and others have recommended that the growing problem demands a broader form of oversight that goes beyond the Department, and I would agree.

Accordingly, I am proposing a new integrated management structure (Tab A). It features a National AIDS Policy Board (Tab B). Chaired by Secretary Bowen, the Policy Board would have as members, cabinet level Federal officials. It would address the complex policy decisions that cut across Federal agencies. It would set policy, develop strategies, and guide implementation. Actual implementation of the policy will take place within the appropriate departments and agencies. Within this Department, a National AIDS Program Office will be responsible for implementation. We are currently exploring the structure and staffing requirements for such an office.

In addition to the Policy Board, I recommend the establishment of a National AIDS Advisory Commission similar to that proposed in the various bills before Congress. The Commission (Tab C) would be composed of non-Federal members with

expertise in AIDS or in problem solving and would address the broad societal issues related to AIDS. Issues for consideration would be identified by the Policy Board.

I believe that it is critical to establish the Policy Board before legislation creating a Commission is passed. The Board can provide the Commission with direction and limit its tendency to become a vehicle for interest groups to lobby for increased but uncoordinated funding.

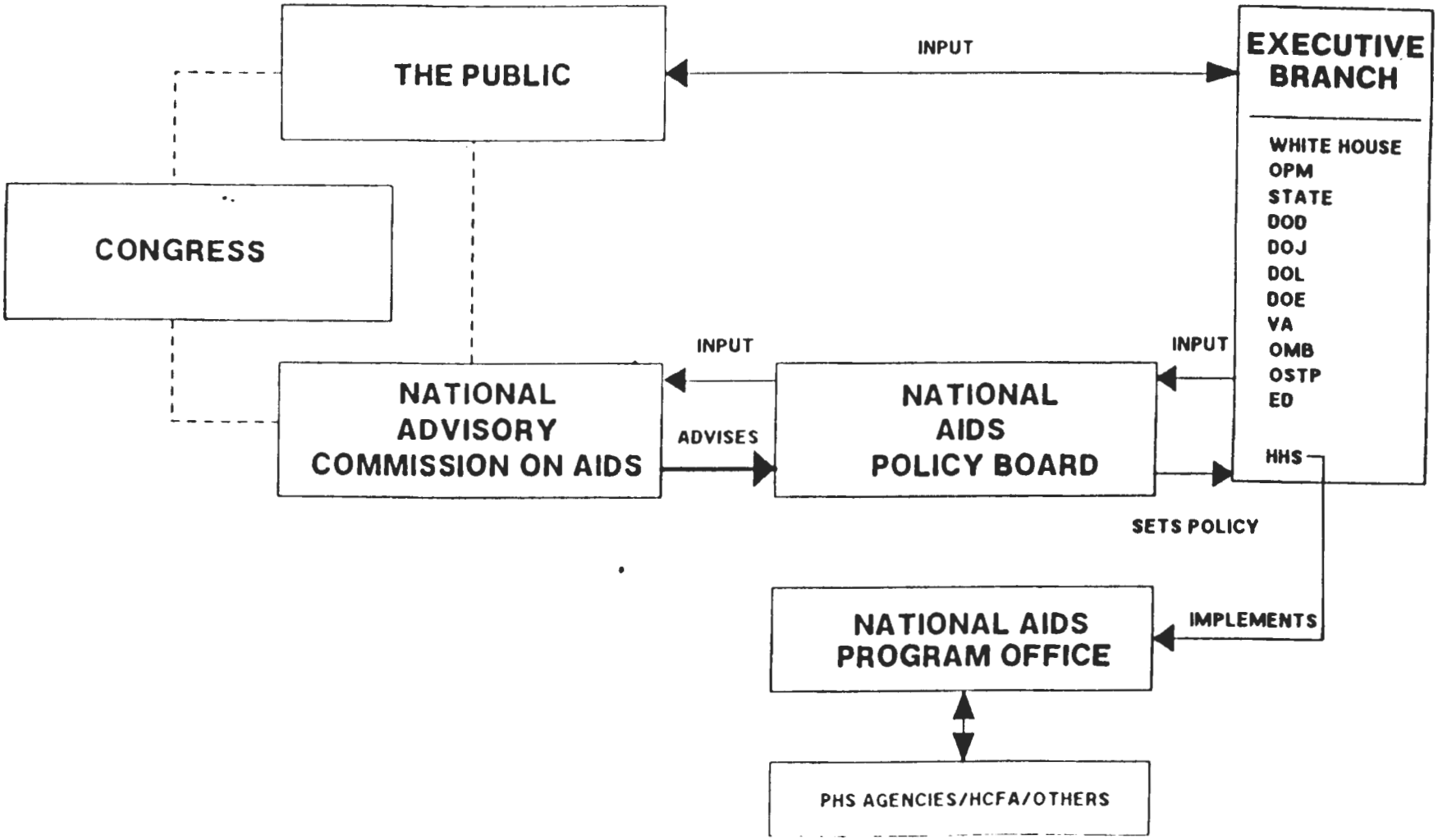
I would like to see this management structure put in place and would welcome the chance to discuss it with you.

/s/ Robert E. Windom

Robert E. Windom, M.D.

3 Attachments
Tab A: Diagram
Tab B: National AIDS Policy Board Specifications
Tab C: National Advisory Commission on AIDS Specifications

AIDS FLOW CHART



NATIONAL AIDS POLICY BOARD

Purpose

The purpose of this advisory board is to assist the President, Federal agencies, and the Secretary of the Department of Health and Human Services in guiding and coordinating the Administration's efforts against AIDS.

The high level board will address the major policy issues regarding AIDS that cut across the purviews of Federal agencies and make recommendations on these complex decisions.

The board will also assure coordination on major AIDS program and policy initiatives in the various departments and agencies of the Federal Government. Initiatives requiring such coordination may include:

- Educational activities, such as the introduction of AIDS education into schools as part of an AIDS prevention strategy;
- Medical service delivery issues that affect veterans, the military, as well as civilians;
- Legal issues, such as those involving employability of AIDS patients;
- Ethical issues, such as whether to expand screening/testing and to what groups; and
- International issues, such as whether to add AIDS to the list of diseases that would preclude aliens from entering the United States.

Structure

The Board would be a Secretarial level advisory body chaired by the Secretary of Health and Human Services.

Relevant issues would be brought to the Board by the Chair, members, the National Advisory Commission on AIDS, or the Assistant Secretary for Health, who chairs the PHS Executive Task Force on AIDS and the AIDS Federal Coordinating Committee.

Membership

The Board membership will include representatives from the President's staff, the Vice President's, and the Secretary or Director of the following departments and agencies:

- Department of Health and Human Services;
- Department of Defense;
- Department of Justice;
- Department of Labor;
- The State Department;
- Department of Education;
- The Veterans Administration;
- The Science Advisor to the President (OSTP);
- The National Science Foundation;
- The Office of Management and Budget;
- The Office of Personnel Management; and
- The Federal Communications Commission.

Staff

Staff to the Board will be provided by the National AIDS Program Office within the Department of Health and Human Services.

SPECIFICATIONS FOR A NATIONAL ADVISORY COMMISSION ON AIDS

Purpose

- The purpose of the body is to advise the President, the Congress and the National AIDS Policy Board on how well society (including both public and private entities) is conducting the efforts against AIDS.

- The advisory body would be primarily concerned with broad areas of societal concern, philosophy, and policy issues which may include:

  - monitoring policies and programs designed to reduce the incidence of AIDS;

  - reviewing the efforts of State and local health agencies to combat AIDS;

  - considering legal and ethical issues surrounding AIDS;

  - investigating potential civil rights violations of persons having AIDS;

  - exploring the problems encountered by individuals having AIDS; i.e., employment, housing, insurance, medical care, and confidentiality;

  - reviewing issues of the quality of and access to health care services;

  - encouraging private organizations, including businesses, and print and broadcast media, to participate in activities to expand Federal efforts on education and information;

  - identifying public and private financial resources available to prevent and treat AIDS, and

  - encouraging national consensus building on controversial issues (e.g., AIDS education in elementary and secondary schools).

- The National AIDS Policy Board would identify specific aspects/issues for consideration by the Commission.

Structure

- The Commission would be a "blue ribbon" advisory body reporting to the National AIDS Policy Board.
- The Commission would be a chartered group. It would be established with a two-year renewable charter.
- The Commission would meet quarterly, and could be called into additional sessions, if needed.

Membership

- The Commission would have as members 15 "blue ribbon" experts. As a criterion, expertise in problem solving would be as important as expertise in various aspects of AIDS. The President in consultation with the Congress and the Secretary, DHHS, would select the members and the chairperson.
- Members might be drawn from the following broad categories (n.b. there are more categories than members thus many of the members would need to be able to represent more than one of these categories) including:
  - a Governor or State health official;
  - a State legislator;
  - a local health official or mayor;
  - an international representative;
  - a former ASH;
  - current or former members of Congress;
  - an AIDS center official;
  - a hospice administrator or social services administrator;
  - a representative of the gay community;
  - an American Medical Association official;
  - an American Hospital Association official;
  - a "distinguished" lawyer or former jurist;

- a college president;
- a school educator;
- a civil rights or human rights expert;
- an ethicist;
- a religious leader;
- a representative of the insurance industry;
- a representative of the pharmaceutical industry;
- a clinician/researcher;
- a blood bank official;
- a public "personality";
- a media expert;
- a member of the IOM panel that issued the recent report on AIDS; and
- a union/labor representative.

- o As directed by the National AIDS Policy Board, the Commission could hold several regional meetings, which would be well advertised and open to the public. The purpose of these meetings would be to facilitate discussion of different problems/issues encountered in the various geographical regions.

Staff

- o Staff for the Commission would be provided by the National AIDS Program Office within HHS.

Budget

- o A financial operating plan would need to be developed, but the annual cost could be expected to be approximately $1 million. Funds would come from the existing DHHS AIDS budget.

Report

- o An annual report to the Secretary, DHHS, the President and the Congress on the Commission's deliberations would be required.

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date MAR 19 1987

From Assistant Secretary for Health

Subject Responses to AIDS Policy Questions for DPC Health Policy Working Group

To DPC Health Policy Working Group

1. **In what ways does the public health effort to control AIDS differ from the effort directed against other infectious diseases, and especially against other sexually-transmitted diseases (STDs), and why?**

   - The scientific and public health response to AIDS and infections with human immunodeficiency virus (HIV), the virus that causes AIDS, has been greater than that for any sexually transmitted infection in the past thirty years. During Fiscal Year 1987, $416 million dollars in Federal funds are budgeted for research and prevention and control. In addition, several States and major cities have dedicated substantial funds for AIDS prevention.

   - Unlike most STDs, the AIDS virus can be transmitted efficiently by parenteral means, through blood transfusion or needlesharing by drug users. Major public health efforts have been directed toward high risk donor deferral and antibody testing of donated blood and plasma.

   - The Public Health Service has published 14 sets of consensus recommendations for prevention of AIDS, beginning in March, 1983.

   - Since no vaccine or curative therapy is available, prevention of AIDS must come through behavior change achieved through health education and counselling to influence knowledge, beliefs, and attitudes.

   - Contact tracing and partner referral have in the past been restricted to selected STDs, primarily syphilis and some subgroups of patients with gonorrhea, for which specific therapies are available, and infected individuals can transmit the infection to sexual partners for a limited period. These activities have not been previously undertaken for sexually transmitted viral infections such as genital herpes or hepatitis B, for which no curative therapy exists, and an infected individual may remain infectious for life. Due to the severity of AIDS, antibody testing and counselling are routinely recommended for persons at risk for AIDS virus infection. Referral of all sexual and needlesharing partners has been explicity recommended for all persons infected with the AIDS virus.

   - Fifty percent of AIDS cases in women, 65 percent in heterosexual men and 75 percent in infants are directly or indirectly related to infection in IV drug abusers. Never before has control of an STD been so closely linked to control of intravenous use of heroin and cocaine.

2. & 3. **What further steps should be taken with regard to testing for AIDS antibody positivity? What action should the Federal government, or other levels of government, take, using public health or other powers, to control the spread of AIDS?**

- In February, 1987, CDC held a conference of health officials from across the U.S. to discuss public health, medical and public policy issues about broader implementation of antibody testing for HIV. Broad agreement was reached on the need for wider testing for infection in programs for persons at risk for acquiring sexually transmitted diseases, drug dependent people, as well as their spouses and sexual partners, and sexual partners of people with HIV infection, provided it was voluntary and accompanied by adequate counseling and safeguards to keep results confidential. No formal recommendations were adopted at the meeting, but CDC will submit recommendations to the Assistant Secretary for Health by early April.

4. **What is the medical evidence about modes of transmission?**

- HIV infections can be transmitted through three primary routes: sexual contact with an infected person, parenteral exposure to infected blood or blood products, and perinatal transmission from an infected mother to her child. Sexual transmission of HIV can occur during heterosexual or homosexual contact. Among heterosexuals, current evidence indicates that transmission can occur from women to men, and from men to women. HIV has been transmitted from infected donors to recipients of blood and clotting factor concentrates. Studies of intravenous drug users have suggested that HIV transmission occurs through the transfer of small amounts of blood during the sharing of needles. Perinatal transmission is thought to occur during pregnancy, at the time of birth, and possibly, shortly after birth.

- Ninety-seven percent of all patients with AIDS in the U.S. are known to belong to groups at risk for HIV infection through one of these routes of transmission. The proportion of all AIDS patients without recognized risk factors has not significantly increased over time.

- Four reports have documented seroconversion for HIV antibody in health care personnel through parenteral exposures to blood from infected persons. To assess the risk of HIV transmission through parenteral or mucous membrane exposures in health care settings, at least 5 studies have been conducted to determine the prevalence of HIV antibodies in over 1,000 health care workers with such exposures from HIV-infected patients (1-5; CDC, unpublished data).

- In developing countries, medical injections with contaminated needles are assumed to play a role in HIV transmission, but this has been difficult to quantitate (6).

- Both laboratory and epidemiologic data indicate that HIV transmission through oral secretions, if it occurs at all, is very unlikely.

- o To evaluate the risk of HIV transmission through casual contact, at least 10 studies in the United States have evaluated the risk of HIV infection in over 450 household or boarding school contacts of persons infected with HIV (7-9). Household members have had a variety of interactions with these infected persons, in some cases helping the infected person to bathe, dress or eat; household members have also shared toys (with infected children), household items (such as eating and drinking utensils) and facilities (such as the kitchen, bath and toilet). None of these studies has found serologic or virologic evidence of HIV transmission within households other than among sexual partners, children born of infected mothers, or household members who themselves had risk factors for AIDS.

- o Epidemiologic data uniformly indicate that HIV is not transmitted to persons by arthropods.

5. **What actions should be taken now to prepare for future AIDS treatment demands on the health care system?**

   - o The Intragovernmental Task Force on AIDS Health Care Delivery was created at my request in November 1986. Dr. David Sundwall, Administrator, HRSA, is serving as Chairperson. The responsibility of the Task Force is to look at how health is being delivered to AIDS patients with particular emphasis on the quality of care; access; financing, integration of Federal, State and local roles; and the family. A report will be submitted to me in June regarding the findings and recommendations.

   - o HRSA and the Robert Wood Johnson Foundation have funded some community demonstration projects to look at innovative ways of providing care for AIDS patients, reducing time in hospitals and emphasizing care in outpatient and community settings to provide more effective, compassionate care at reduced costs.

   - o HCFA has also been involved in this area through its Medicaid and Medicare reimbursement program. Dr. Roper presented data on Medicaid and Medicare reimbursement costs during his testimony at Congressman Waxman's hearing on the cost of AZT.

6. **What steps should the President be advised to take with regard to AIDS?**

   - o He could discuss the importance of the AIDS problem to this administration and promote the safety of blood donations during one of his Saturday radio programs;

   - o He could give the keynote address at the Third International Conference on AIDS, on June 1, 1987, Washington, D.C. (The Secretary will be giving the closing remarks on June 5);

   - o He could issue an executive order to the Cabinet calling for increased AIDS prevention efforts;

- He could participate in some PSA's promoting the AIDS information/education effort;

- He could provide leadership in the campaign to mail out AIDS leaflets to all U.S. households.

Robert E. Windom, M.D.

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WHAT CAN'T YOU CATCH THE VIRUS FROM ? 8

The Government's clear medical advice is that you cannot get the AIDS virus from normal social contact with someone who is infected.

You cannot get it from shaking hands. Nor is there any record of anyone becoming infected through kissing.

There is no danger in sharing cups or cutlery. Nor can you catch it from public baths or toilets.

In hospitals, standard disinfection precautions protect patients, visitors and staff.

Giving blood is safe. All the equipment is only used once.

And all the blood used in this country for blood transfusion is rigorously checked.

HOW SAFE IS IT ABROAD ? 9

The AIDS virus exists throughout the world. In certain areas a large number of both men and women have it.

So it is even more important that you follow the advice in this leaflet if you're going abroad.

Otherwise if you do have sex with someone who is not your usual partner, not only might you become infected, but you may also infect your partner when you return home.

Again, in some countries blood transfusions are not checked for the AIDS virus. In those places where the virus is widespread do not, if you can possibly avoid it, have blood from a local donor.

Also, in certain developing countries, medical equipment may not be properly sterilised. If you can, avoid any treatment involving injections and surgical procedures.

If you have any worries about this, discuss them with your family doctor.

DO YOU NEED MORE INFORMATION ? 10

The true picture about AIDS is that, at the moment, relatively few have the virus in this country. Those most at risk now are men who have anal sex with other men. Drug misusers who share equipment. Anyone with many sexual partners. And sexual partners of any of these people.

But the virus *is* spreading. And as it does, so the risk of having sex with someone who is infected increases.

Ultimately, defence against the disease depends on all of us taking responsibility for our own actions.

More detailed information is available from:
Your own doctor.
Clinics for sexually transmitted diseases. (Look in the phone book under Venereal or Sexually Transmitted Diseases or your nearest main hospital.)
Healthline Telephone Service 01-981 2717, 01-980 7222, 0345-581151. (If you're phoning from outside London, use the 0345 number and you'll be charged at local rates.)
Terrence Higgins Trust 01-833 2971.
Welsh AIDS Campaign 0222-464121.
Scottish AIDS Monitor 031-558 1167.
London Lesbian and Gay Switchboard 01-837 7324.
SCODA (Standing Conference on Drug Abuse) 01-430 2341.

For a copy of the more detailed booklet AIDS: What Everybody Needs to Know, write to Dept. A, PO Box 100, Milton Keynes, MK1 1TX. (In Scotland write for The AIDS Problem: What Everybody Needs to Know, to the Scottish Health Education Group, Woodburn House, Canaan Lane, Edinburgh EH10 4SG.)

If you're travelling abroad, read leaflet SA35, Protect Your Health Abroad, available from travel agents.

DON'T AID AIDS

AIDS

DON'T DIE OF IGNORANCE

GOVERNMENT INFORMATION 1987