ORIGINAL

TRANSCRIPT OF PROCEEDINGS

NATIONAL COMMISSION ON

ACQUIRED IMMUNE DEFICIENCY SYNDROME

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PUBLIC HEALTH AND THE HIV EPIDEMIC

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Pages 1 thru 180

Washington, D.C.
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NATIONAL COMMISSION ON AIDS

Public Health and the HIV Epidemic

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C O N T E N T S

AGENDA ITEM: PAGE

1. Prevention:

Allan M. Brandt, Ph.D.
Department of Social Medicine, School of Medicine, University of North Carolina
Chapel Hill 7

Allan Rosenfield, M.D.
Columbia University School of Public Health 12

Ron Rowell, M.P.H.
National Native American AIDS Prevention Center 21

2. The Public Health System and Service Delivery:

Robert G. Harmon, M.D., M.P.H.
Health Resources and Services Administration 46

Steven A. Schroeder, M.D.
The Robert Wood Johnson Foundation 54

Castulo de la Rocha, J.D.
AltaMed Health Services Corporation 60

Jasmin Shirley Moore, M.S.P.H.
Department of Health and Rehabilitative Services, Broward County Public Health Unit
Northwest Health Center 68

Andrew Ziegler, M.H.S.A.
National Association of People with AIDS 79

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CONTENTS: (Continued)

3. The Future of Public Health:

Helen Rodriguez-Trias, M.D.
Consultant in Health Programming 95

Woodrow A. Myers, Jr., M.D., M.B.A.
New York City Health Department 103

Caswell Evans, Jr., D.D.S., M.P.H.
Los Angeles County Health Department
American Public Health Association 111

Kristine M. Gebbie, R.N.
Washington State Department of Health 120

AFTERNOON SESSION: 158

4. Commission Business 159

5. Adjournment 180

P R O C E E D I N G S

CHAIRMAN OSBORN: Before we start with the panel--and I apologize for being a little bit late--I think that I would like to read a brief article from this morning's New York Times so that we are all thinking on the same wavelength. This is a distressing article that we need to be thinking about, the Commission members in particular, during the course of the morning because I think we probably need to do something about it.

The headline says: "Bush Unconvinced More AIDS Money will Curb Epidemic." It is from Reuters.

"President Bush said today"--yesterday--"that although he was saddened by the thousands of deaths from AIDS, he was unconvinced that more Federal money would alter the course of the AIDS epidemic in the United States. Mr. Bush added that the advocates, who shouted down a speech by Health Secretary Louis W. Sullivan at an AIDS conference in June, had harmed their cause: 'I must say some of the excesses of those groups does not help the cause,' the President said. 'I had a lot of mail saying people were quite embarrassed by that.'"

"The advocates have criticized the Government for

devoting too little money to AIDS research. Speaking at a news conference, Mr. Bush said the numbers of AIDS deaths 'breaks my heart when I see it' but he added, 'I wish there were some quick and easy cure. I wish somebody could convince me that if you could only spend a quarter of a billion dollars more, we would have the answer.' The President has requested more than $1.6 billion in Federal spending for AIDS prevention, education and treatment for the fiscal year that begins October 1st."

"Another quote: 'I also think of the fact that when you are wrestling with an enormous medical problem of this nature, it is very difficult to have a snappy answer that will allay the fears of all the people,' Mr. Bush said."

"Congress has not finished writing the new budget, but the House has approved $1.7 billion. By the end of July, 143,286 cases of AIDS had been reported in the United States, and 87,644 of those patients had died, according to the Federal Centers for Disease Control in Atlanta."

End of the story.

So I would suggest that the Commissioners give considerable thought to what we can do to help Mr. Bush recognize that money can help in this epidemic and in fact is

desperately needed. The CARE bill, as you know, is teetering on the edge of being unfunded, after the largest Congressional majority that I am aware of in the recent past in health-related legislation. So as a Commission, I think we should try and figure out how best to respond quickly.

With that as an aside, let me welcome our distinguished panel to start the morning's deliberations. First, I will repeat the advisory from yesterday that says if you stay between four and six inches away from the microphone when you speak--you do need to be somewhat close to it to be heard, but if you get too close, then our sound technician has serious problems balancing things, and we get into screaming and the usual acoustic stuff. So that is a technical comment.

I am very pleased to welcome Dr. Allan Brandt, Dr. Allan Rosenfield, and Mr. Ron Rowell. Thank you very much for being with us.

We like very much to have a chance to interact as a Commission with the people who talk to us, so if you can hit the high spots of your testimony in as succinct a way as you can, these are very good readers, these people, and they do read what you send them, so that sort of doubles the input; if you have other points, you can just refer to your testimony

and go on. Then we would like a chance to talk with you and get more from you.

So thank you.

Allan Brandt, do you want to start?

DR. BRANDT: Thanks very much.

Let me just try to quickly summarize my testimony. I hate reading something that is in front of people. It is a kind of model that isn't very helpful.

CHAIRMAN OSBORN: That's exactly what we had in mind.

DR. BRANDT: I guess I should just say I am a medical historian, and I have been struggling with issues of what history might have to tell us about the epidemic. I haven't really focused on preventive issues, but I am quite concerned because, as we all know, prevention offers in many ways the greatest possibilities for changing the course of the epidemic.

And since the sanitary revolution of the late 19th century, prevention has been a major component of what public health is. Many people often talk about "breaking the chain of infection" but the critical theoretical and public health question was where to intervene in a chain of infection that

went from the most general social conditions to the individual who becomes infected.

So that has really been part of the debate, I think, in the first decade of the epidemic--where might we intervene, how might we go about finding appropriate and effective places to break this chain of infection.

Since the identification of HIV there has been a kind of truism that prevention is our best possibility, but I think in the first decade we haven't gone nearly so far as we might in identifying the possibilities of how to intervene and where to intervene.

Unfortunately I think history often gets used in an inappropriate way in thinking about prevention, and there has been a tendency in the first decade of the epidemic to cite historical public health programs that have often been used for sexually-transmitted diseases as a means of applying them to HIV. I think one thing that history really has to stress is that when we look for analog, we have to look at where they are appropriate, but we also have to ask what is distinctive, what is different, how might these analog fail us if we apply them in a somewhat kneejerk way.

And I want to be sensitive to people who feel they

have programs that will work, but on the other hand the traditional means of identifying contacts, reporting, contract tracing, isolation of cases, the traditional public health tools, are complex in applying to this epidemic and often do not work.

We started out many years ago by having to show that premarital screening, for example, would have no preventive impact on HIV disease. In a sense, now that is well agreed upon, but today we are having a similar debate about tracing of contacts even though there seems to be compelling evidence that given the particular qualities of HIV infection, its particular routes of transmission, the long-term aspects of its infectiousness, that this is as program which while making sense in some common sense way, if you really look at HIV disease it is unlikely to be effective.

So I think part of the story of prevention in HIV disease is thinking about where to go, and if we only look to programs of the past, even though I am a historian, I would say we're going to miss the target in a fundamental way.

Of course, one of the things we have learned in the last two decades, or at least certainly since the Second World War, is that behavior is a fundamental component of

human health. And even though we have been saying that for some time, and we know that diet, nutrition, alcohol and tobacco consumption, sexuality, pose risk, as committed to the public health we have made very little progress in really understanding the nature of those behaviors and techniques for their modification.

The other thing that I think needs to be emphasized is that we can't eliminate risk behaviors. We have talked about this for some time. But we can change risk behaviors in such a way that we could possibly prevent the transmission of HIV, and that should be our principal focus at this moment in the epidemic.

The point that has been hitting home to me is if we could only dramatically expand the use of condoms in the next decade; really set a target, think hard and critically about policies that might dramatically expand condom use; create the kind of cultural revolution around condom use that we were able to create in a somewhat haphazard way around cigarettes in the previous 25 years, we could really begin to have an enormous social impact not only on HIV disease but on many other social problems.

There has been opposition to programs like free

distribution of condoms in our schools. There has been opposition to programs similar to it such as the distribution of sterile needles. I think these are two hallmarks of prevention that we did not get very far on so far and that we really need to begin to think what is the nature of this opposition, and how can we be culturally and politically savvy in responding to the opposition to programs like that, but to really make sure that the disease is not transmitted because teenagers don't have condoms, don't know how to use them, don't think about it, and that the disease is not transmitted because people can't get a sterile needle. I think that has been the criminal neglect of the response to AIDS so far.

Of course, when you raise the issue of prevention, you also begin to talk about individual responsibility. And I don't want to declaim that there is no such thing as individual responsibility. I think in the context of an epidemic, we need to augment individual responsibility. But too often in the history of preventive efforts, as soon as we identify individual behaviors as risk-taking, we also turn it around and say therefore individuals who become infected are responsible for their disease.

So it requires a kind of cultural shift in understanding the nature of behaviors, how they are situated, how they are related to communities and larger social structures, and ultimately, prevention means redefining social communities and networks to make efficacious and safe behaviors a real possibility.

Obviously we need to recognize our strong commitments to those already infected with HIV, but the future of really shifting the course of the epidemic in some positive way means rethinking prevention in a fundamental way that I think the historical record could begin to shape.

Obviously it is a daunting task, but I really hope as much as possible that we won't be daunted by it because it really does offer us certain fundamental possibilities.

Thank you.

CHAIRMAN OSBORN: Thank you very much. That is a wonderfully succinct statement of a theme that you have been developing powerfully over the last several years. We appreciate it.

Dr. Rosenfield?

DR. ROSENFIELD: Thank you.

Let me make a comment on condom use before I start

my presentation. It is interesting that the lead story in the very interesting series of Africa in the New York Times the last three days today talked about the social marketing of condom use in ways in Africa and other parts of the world that is very impressive and that we have not embarked upon in similar fashion in this country--despite the fact that it is an American marketing approach to so-called social marketing.

Many of you have also heard of a man name Meechai [phonetic] in Thailand who has been promoting the use of condoms, first for family planning and now for AIDS, so successfully that in Thailand, the word for condom is "Meechai", to his family's great delight, I suspect.

But in our country we remain unable to make use of the type of promotional activities of Meechai, or of the social marketing scheme.

I appreciate the opportunity to talk, and you asked me to speak today about the role of schools of public health. I would like, as I say in my testimony, to commend the Commission for what I consider an outstanding job in a relatively short period of time. You have not shied away from the most controversial of topics, and you have made your recommendations based on solid scientific information, well-

reviewed, and most of importantly, on American traditions of compassion and respect for the dignity of citizens. Your voice against discrimination and unfounded fear that it exists in our country has been important, and it has been loud and clear.

We all have major responsibility in this country, I think, particularly in relation to the peculiar and unique American problem of access to services and therapy.

Dr. Rogers mentioned to me that he is on his way to help consult in Eastern Europe on their health care, and we discussed his role in helping them understand what is irrelevant about the U.S. health care system and our inability to provide appropriate care to our disadvantaged.

I am afraid, and one of the concerns I think we all have, is that the inequities in health and social services in the past in this country does not paint an optimistic picture of our country's probable response to the issue and challenges of access. This is a challenge to the Commission, as you suggested in reading our President's statement this morning.

I think the field of public health has a uniquely important role to play, particularly at present, when we don't have curative therapy and we don't have a preventive

vaccine, and prevention, as Allan has suggested, plays such an important component of what we have to do.

I think the schools of public health have been important in this arena--schools such as Harvard, Hopkins, Carolina, Berkeley, UCLA, Columbia--and I should add Michigan-

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CHAIRMAN OSBORN: Yes, you should.

[Laughter.]

Dr. ROSENFIELD: --have impressive and broad-based programs, and I have attached to my testimony a report from the Association of Schools of Public Health, published in 1988 on activities of various schools, which clearly have been expanded significantly in the year and a half since that was published, but it does give an idea of the types of activities.

The Association itself has taken a pro-active stance publicly for the various schools, early on supporting the 1982 Waxman AIDS legislation, protesting the Justice Department ruling that employees were not protected from discrimination based on perceptions of their AIDS status, encouraging continuing Federal support for AZT, and endorsing Senator Kennedy's 1988 AIDS bill.

Many faculty and deans have spoken out individually, perhaps best exemplified by the eloquent and moving speeches by the Chair of this Commission, who also happens to be a respected dean of a school of public health.

I think our Association has taken a lead among academic institutions in being willing to speak out as an association in ways that other groupings of academic institutions have not, I believe.

Our schools have a responsibility to engage our faculty and our students in the analysis particularly of current difficult issues about public health traditions of epidemic control, particularly as we respond to the AIDS epidemic.

A contemporary strategy of epidemic control is needed, founded on our scientific understanding of the disease, of behavior and of behavioral change, and particularly on the values of a democratic society in the late 20th century.

The policies that evolved at the turn of the century need not be considered immutable at the present time. Clearly, for the next decade, among the most complex issues whose views are changing and shifting as the management of

the epidemic changes and shifts are those revolving around testing, screening, reporting, partner notification, and selective quarantine, all of which have been discussed in the context of public health and debated, on some occasions, clinicians taking what they might think a public health stance, while public health people have taken what they feel to be a moral stance.

Individual schools and their faculty have attempted to create, and I quote, "scientifically sound and socially responsible AIDS legislation and policies". The faculty at Harvard have been involved in developing model AIDS legislation for the States. The three schools in the UC system in 1986 joined together to oppose, and successfully so, a proposition proposed by Lyndon LaRouche called "Prevent AIDS Now" which could have led to discrimination, quarantine, and mandatory testing.

Behavioral research for which schools of public health have particular expertise with a range of types of people on a school of public health faculty and the range of backgrounds are of critical importance particularly given the very private sexual and drug use practices that are at the face of this epidemic.

I hope the Commission can help us to someday get the NICHD-sponsored research out of its doldrums because we need that research. The opposition is inappropriate, in my opinion, held up by an ideology more concerned with a constrictive, impractical and unrealistic view of morality than with assisting in expanding and improving our prevention efforts.

Studies of the various social, behavioral, psychological and cultural barriers to behavioral change contribute to our understanding of this complex disease, and this is an area where schools of public health have been and must continue to be actively involved. Social scientists at our school have been involved in such studies as following a cohort of gay men from the onset of the epidemic to the present; another looking at reactions, attitudes and practices of health workers first in New York City and now in a national sample of health care workers.

I need not stress the roles in terms of epidemiology and biostatistical assessment, research, modeling and forecasting that are among the core research activities of the field of public health generally and of schools of public health specifically.

Other areas that schools have been involved in include studies on program options, variations in service delivery strategy, looks at risk factors of transmission and infection, and issues revolving around the financing of health care in our country. While we don't really need further evidence of the need for a national health insurance program in our country, the AIDS epidemic tragically demonstrates this even more clearly.

One fiscal issue that I mention in my report that I hope the Commission can help with through its moral stance relates to the pharmaceutical industry and the cost of drugs currently developed. There are no drugs currently available that will be accessible to anyone, in my opinion, in Central Africa or in other parts of the developing world, given the costs both of the drugs and of the blood testing that is required prior to their use.

The Merck Company, through its donation of Ivermectin to developing countries free-of-charge in a campaign to eradicate riverblindness is an example of corporate responsibility and could serve as a model which is not yet seen among those producing anti-AIDS medications.

There are a number of services areas which I

attempted to describe--and I won't go into them--as well as collaboration with public institutions, city health departments and others in the implementation of demonstration, research and evaluation projects.

I think we also have a role to play as several schools have in working overseas in developing countries and helping in both epidemiologic assessment and in a variety of prevention, control and education activities.

Finally, the schools play a vital role in education--education of epidemiologists, biostatisticians, public health-oriented behavioral scientists, health policy analysts, health care management experts, maternal and child health specialists, and others. And through short courses such as the type offered through HRSA-supported ETCs, many other categories of personnel receive training on AIDS, including social workers, counselors, nurses and a variety of others involved in the epidemic.

Finally, not related to schools of public health, but a question and recommendation related to terminology used to this disease. I wonder whether the time has come to drop the very what I consider restrictive definition of AIDS and simply talk about symptomatic and asymptomatic HIV disease.

For purposes of characterizing dimensions of the epidemic, for planning purposes and for ongoing monitoring, I think the time has come to officially use this terminology which reflects our current understanding of the disease.

Again, I thank you for the opportunity to speak before the Commission today, and I again congratulate you for an outstanding job.

Thank you.

CHAIRMAN OSBORN: Thanks very much.

Mr. Rowell?

MR. ROWELL: I also appreciate very much the opportunity to speak to the Commission especially in regard to prevention activities and my personal experience and some ideas around prevention with the American Indian and Alaska Native population.

Four years ago, a group of concerned Native, public health, medical, nursing, social work, substance abuse professionals began speaking around the Nation about the risks of HIV in the Native American community because as we saw it, our health status was lower on every indicator than the U.S. population as a whole; we learned that our sexually-transmitted disease rates were on average twice as high as

for the U.S. population as a whole; we knew that over 37 percent of us die before the age of 45, primarily of preventible causes having to do directly or indirectly with substance abuse; we knew that our teen pregnancy rates were one out of four babies born in Indian country. And since that time, we have learned, for example, through seroprevalence studies of HIV that have recently been initiated by the Indian Health Service and the Centers for Disease Control, that out of 13,000 blood samples that were taken predominantly of rural women from prenatal clinics that seropositivity rates were significantly higher for Native American rural women than for other rural women--approximately eight times higher.

To date, we have had 204 AIDS cases reported and verified by Centers for Disease Control. These cases are pretty widely distributed geographically throughout the United States.

The prevention efforts in Indian country is really only about two years old, although we have had AIDS cases since before 1984. There are national, regional, and community-based organizations working in the effort. The national regional efforts are predominantly funded by Centers

for Disease Control, and the community-based organizations are predominantly funded through State departments of health with CDC money; U.S. Conference of Mayors I believe funds a couple of programs now, and CDC of course funds community-based organizations directly of which at least one is an Indian program.

I wanted to say to you that I think that prevention of HIV is really endangered in this country. As I see it from where I sit--and maybe I have a limited view--Congress sees AIDS as care. I recently had the opportunity to go and visit on the Hill where I was shocked by the response of some staff people who said to me that they had never had anyone speak to them about HIV prevention, and they found it very interesting to hear about.

Now, I couldn't believe that they have never heard, had anybody visit them and talk about HIV prevention. They said to me, "We've talked about care, but we have never talked about prevention."

So the question in my mind is where is the voice for prevention in this country.

My program, the National Native American AIDS Prevention Center, is funded by the Centers for Disease

Control. Since we were originally funded in August of 1988, these programs have been on nine-month budget cycles. Since the end of the very first budget period of nine months, we have had our budget slashed after every nine-month sequence, and that has been the experience of most of these programs that were originally funded in the NIAP program in CDC and are now in the Centers for Prevention Services.

The CDC has also decided that nine months equals a year, so what was originally a five-year program was going to have been five periods of nine months. We appear to be going onto a 12-month cycle in this next go-around. We are also going to be fighting to try to add back on those months that we lost in the early period, but there is no guarantee that that will happen, nor of course is there any guarantee that this prevention program in communities of color is going to continue beyond the initial "five-year" period.

Another danger for prevention programs it the recent Hope amendment, which at least for American Indian and Alaskan Native communities is going to be somewhat devastating. As I said, those community-based organizations that have been funded up to now have primarily been funded through State departments of health.

New Mexico, for example, under the Hope amendment has lost 65 percent of its prevention budget; Alaska, 74 percent; Oklahoma, 24 percent; Idaho, 52 percent. We have got to do something about this issue. And let me just say in the context of the Hope amendment that I would like to appeal to you as a Commission to do something about funding formulas for prevention that use AIDS case rates as part of the formula. I do not at all see any justification for that. I can see it in terms of care, I do not see it in terms of prevention if we mean by "prevention" stopping people from becoming infected with HIV in the first place.

There is also, as these gentlemen have referred to, and I was certainly glad to hear it because sometimes I feel that we are very much alone in this battle--there is a very strong philosophical battle over what prevention means. There is a voice within Centers for Disease Control that is very strong, that sees primary prevention, or the centerpiece of a primary prevention program, as counseling, testing and partner notification.

It is clear to me that testing is winning up to now. For example, Indian Health Service and CDC have a memorandum of agreement: The bulk of the money that goes

into Indian prevention through the Indian Health Service goes for counseling and testing. However, I was at a meeting in June in San Francisco of the Indian Health Service AIDS coordinators from around the country where they were basically screaming that they had all gone through this training, they had all set up these counseling and testing programs, but that nothing was happening, and yet they had no money to do primary prevention with. They had never gotten any money, or had gotten so little money that it was basically ineffective to do the kind of prevention education that would be necessary prior to setting up the programs so people knew what they were doing.

The other problem, of course, over prevention is that if you succeed at what you do, nothing dramatic happens. And that is a problem not just in AIDS prevention; it has always been our problem in prevention in this country.

One other small thing that is not very small, actually, is this demand by Congress for evidence that these programs that are being funded for prevention are working. As I said to you, after two years of operation, after working as hard as we can with very few resources to start out with, and less and less every nine months, now Congress all of a

sudden, after two years, wants to see these dramatic outcomes.

Now, that is simply not reasonable. I believe in evaluation, I support evaluation, and I think that if Congress is serious about evaluation it will take the report --I don't know if it is the National Science Foundation or the National Resource Counsel--evaluating AIDS prevention programs, read it, take it seriously, put money into that kind of serious research, and then we'll see what does work. But don't slam us, who are trying to do the front line kind of work, with coming up with all these fancy answers as to what works or not. We are running as fast as we can, and we feel like we're on a treadmill going backward.

What I think will work--and I will try to keep this brief. I want to tell you the story of a film, and if you haven't see it, I highly recommend it to you. It is something that we have seen in Indian country, but I'm not sure it is widely distributed. It is a National Film Board of Canada film called "The Honour of All". It was produced and acted in by the Alkali Lake Band of Shuswap Indians in British Columbia.

This is the story, acted by the tribal members themselves, of how this one rural reservation community went

from being virtually 100 percent alcoholic to 95 percent sober over the period of 10 years. It is in my opinion the most moving film I have never seen, and I have seen it many times. I have never been in a room where people were not audibly sobbing at the end of it.

It is for me the model of prevention because when we set up our National Native American AIDS Prevention Center, in many ways we were thinking of that as the model. It started with one woman who decided that the kind of life that she was living in that reserve was unacceptable; she had an alternative vision; she started bringing other people, slowly--like her husband, her sister-in-law, her brother-in-law--into this tiny group who were working on this new vision. They eventually got a group large enough that it went out and took over the institutions on the reserve that were supporting the ongoing substance abuse--the trading post near the reservation selling alcohol, people bringing in alcohol in vans and selling it on the reservation, the priest in the parish, the tribal council that was alcoholic. They took over those institutions, and they changed the life of that community entirely.

Just one touching thing. They set up a system

where they sent people off the reserve for alcohol treatment. While they were gone, the people on the reserve would get together, and they would fix up and repaint the people's houses, so when they came back there was this whole new place they came back to. That to me has more power in it as a model for doing HIV prevention than all the counseling and testing and partner notification in the world--the kind of patronizing, missionary, top-down approach that is usually taken, at least with American Indians and health care, is worthless. That is why we still, after many, many years of the Indian Health Service, still have the worst health status in the United States.

I think another important issue is helping people to see--

COMMISSIONER ROGERS: Mr. Rowell, let me interject. I'm not sure you heard our little kitchen timer, but you need to wrap up pretty soon so we can ask you some questions.

MR. ROWELL: Fine. What I'll do is leave it there and be open for questions.

Thank you.

CHAIRMAN OSBORN: Well, you have certainly stimulated our thinking, and I think there will be lots of

questions.

Thank you for being willing to entertain them.

Dr. Konigsberg?

COMMISSIONER KONIGSBERG: I have one comment for Mr. Rowell and then a question for Dr. Brandt and Dr. Rosenfield.

Real quickly, Mr. Rowell, I agree with your comments about the Hope legislation. Most of the States in this Union are low-incidence States, which is I think a fallacy, because prevention is not a low-incidence issue--in fact, we probably have better opportunities.

A question for Dr. Brandt. One of the people who testified before us yesterday--I believe it was Dr. Larry Foster, the State epidemiologist from Oregon--I think really made us stop and think about partner notification and the need to really evaluate those programs. Now, some of this has gone on. South Carolina, for example, has done some studies. And I think it is well for all of us in public health to think very carefully about traditional methods and how they are applied not only to HIV but to syphilis.

I guess the only concern that I have would be are we missing opportunities for some of the educational and

prevention activities that you mentioned by finding out who the other folks are that are positive so that we can distribute condoms, discuss safer injection where that can be done, and education. Could you kind of elaborate on that?

DR. BRANDT: Yes. One of the problems is we have confused a kind of preventive ethos with the idea that through a compulsory program we can build a wall around the epidemic.

So for example, I think it is important with people who are known to be HIV-infected that they be encouraged or assisted in notifying people whom they have sexual or drug-sharing relationship with so that those people, too, if they want to, could come and be tested and create a chain of prevention as opposed to a chain of disease.

My concern has been a kind of mentality that if we could only find those cases, trace their contacts, we could bring this thing to an end. It never really worked that effectively for syphilis, even when there were fewer contacts and they tended to be not anonymous.

Now we are in a situation where there are many contacts, they tend to be anonymous. If States mandate these types of contact tracing, reporting, partner notification

programs, what we will do is create a force that takes people away from the institutions that we really need to begin to bring them into.

So my point would be not that we should not be trying to promote education among HIV-infected people that will help them avoid transmitting their infection--and I think that is what most HIV-infected people are really committed to--what we need to do is build institutions that are broadly inclusive, that will bring people to them for the kind of education and preventive behavioral changes that are really required. And to think so narrowly about partner notification as the linchpin is to really mistake what the general goal should be.

COMMISSIONER KONIGSBERG: Thank you.

I have one more question, and this one is for Dr. Rosenfield. The Commission has received the Executive Summary of the IOM Report, "The Future of Public Health", and as I am sure you are aware, this report did discuss at some length about education for public health, referring mainly to schools of public health. It really did not deal with other settings for the training of public health. But I guess I would be interested in your response and maybe elaborating a

little bit on the comment that was made in the report that many observers feel that some schools have become somewhat isolated from public health practice and therefore no longer place a sufficiently high value on the training of professionals to work in health agencies.

One of the things that we heard yesterday from Dr. Bill Roper, from Dr. Magenheim, and I'm sure we'll hear from some of the testifiers today, is the need for leadership and for well-qualified people in public health agencies in terms of building on the infrastructure.

So I would be interested in what activities schools of public health are going about to try to address some of these concerns.

DR. ROSENFIELD: Very briefly, on a formal basis, a forum has been created with some Federal funding, bringing together people from a number of schools of public health and a number of people from the public sector, from health departments around the country, coordinated by Johns Hopkins. That report has just been completed, and we are going to be discussing it at the time of the APHA meeting the end of this month in New York.

There is major interest and efforts on the part of

all the schools in increasing their relevance both in their training programs and in their research and service collaboration in working with the public sector, whether it is the city health department, State health department, county health department, and others involved in the nonprofit and public sectors.

I think this is an effective effort that is being undertaken, and I think it is true that to an extent schools of public health as medical schools sometimes withdraw behind their walls and are not responsive to the public's needs either in education or in program development as they should be.

One comment if I might on your question to Dr. Brandt. It struck me as I was thinking about it at the moment with Dr. Brandt's response that when we talk about mandated reporting, it seems in some ways like mandated parental consent for teenagers that we have been talking about, whether it is for abortion or contraceptive services. Encouraging parental involvement is very important; mandating it is counterproductive. Encouraging reporting, basically, I think is positive; mandating it, I think, is not.

In some ways our society looks more to enforcement

and law and legal issues than it does to education and treatment, as perhaps best exemplified by our attack on drugs in which the bulk of the funds for drug control go to trying to keep the drugs out rather than to education, prevention and treatment. And there is a great link here, as I need not tell this Commission. There is grossly underfunded attention to this area.

CHAIRMAN OSBORN: Harlon?

COMMISSIONER DALTON: My question is for Mr. Rowell, and I do want to say hi to Allan, and I'm sorry that I was getting settled as you were talking, but I swear I took it in.

Mr. Rowell, I wanted to first of all thank you for your written as well as your oral testimony. It is just wonderfully well-organized, sort of a nice combination of detail and the big picture. The statistics in it are chilling, to say the least. So I really did want to thank you for it.

In your oral testimony you did, however, say one thing that worried me a little bit. You indicated that Congress seems to be more focused on care than prevention. You acknowledged that maybe this was just from your perspec-

tive. And I guess that worries me for a couple of reasons. Number one, it seems to pit care against prevention, and as you know perfectly well, that is a mischievous way to conduct public debate.

But I think you yourself also gave reasons for why it might appear that Congress might be seeming to be focused on care. One is that, as you said, State departments of health have taken much of the lead in funding prevention. Secondly, as you point out wonderfully well in your testimony, in a section entitled "Prevention has just begun in communities of color", in some ways prevention has just begun and is already sort of ending; that is to say, Congress' attention seems to be focused on care now for the first time, which is wonderful that it is finally being focused there, but we are just now getting into the prevention game. And I think that is why, from the position of someone concerned about Native Americans, it looks like nobody is any longer talking about prevention because we weren't even being funded or thought about in a particular way when prevention was seemingly the rage. But obviously, it seems to me the ideal is to pay attention to both and to pay attention to them in a way that has particular meaning for different communities. I

just want to commend to everyone the section of your testimony entitled, "Principles to Guide HIV Prevention for Native Americans" which in fact I think quite wonderfully illustrates the ways in which we may need to think about these issues differently when thinking about this population.

MR. ROWELL: Thank you, and let me just say that I am very--usually, at least--very conscious of that pitting of prevention against care, and I certainly wouldn't want to foster that at all.

We also have to become involved in the care side of things, and one of the reasons why I push prevention so much is because I'm afraid that given the current situation, the cost of care, at least through the Indian Health Service-provided care, will destroy the system. And I don't think that is hyperbole.

And I would not want to be seen as saying it is an either/or situation; it is not at all. We need a continuum of effort on this whole problem. But my fear is that Congress, just in terms of the way politics work, Congress sees AIDS as a line item--this is from my point of view, again--and that to them, it is just AIDS, and they don't really care whether it is prevention, care, or what, because

it is an amount of money, and it is for AIDS. And it is up to us then to figure out what to do with that small pot of money.

My fear is simply that prevention is now passe.

CHAIRMAN OSBORN: Don Goldman.

COMMISSIONER GOLDMAN: I have two questions--one for Dr. Brandt and one for Dr. Rosenfield as well.

In listening to the article that June read earlier this morning, I was wondering if you might comment on the ability of the American government and the American people, at least in a health care context, to deal with a long-term struggle as opposed to one in which there is, as some people have suggested, once upon a time and as you well indicated, an issue of a magic bullet in contrast; and whether or not there are any analogies even in other health care delivery arenas that might give us some instruction as to whether or not that is a hope that we can engage this country in that kind of long-term struggle and what kind of techniques might be useful in that process.

DR. BRANDT: I commented on this in a little bit more detail in my written testimony, but I am happy to try to think about it. I think it is a very big problem. I think we are at a moment in the epidemic right now where we have

sort of shifted from thinking of the AIDS crisis to AIDS, which is one of a number of dramatic social problems competing for attention and resources. And we are watching a process of routinization of AIDS, which has had some advantages in a somewhat more dispassionate response and more clinical therapeutic response, but may have great disadvantages in terms of the long-term attention required to address the kind of fundamental issues that we are talking about here this morning.

I think we need to begin to build institutions and mechanisms that will realize that these are the kinds of embedded social problems we will be dealing with for some time and begin to think about doing the fundamental research, answering certain kinds of fundamental questions that will be important in the long run; and that the kind of crisis mentality and the energy of the first decade has faded now, and what I think many of us are seeing in terms of AIDS funding and research and concern is the development of a kind of deep complacency that says so long as those at principal risk of the epidemic seem somewhat socially isolated, we can define this as we have many other social problems.

So I think you are identifying a problem--I keep

thinking about what happened with cigarettes. I have actually been studying the history of the movement against cigarettes, and of course, it wasn't a concerted idea 25 or 30 years ago that by 1990 we would rid the Nation of cigarettes, and we certainly haven't. It remains an enormous public health problem. But we watched over time as the anti-cigarette movement adjusted to see really dramatic behavioral and social change that I think many people wouldn't have anticipated. And I think we need to begin to think about risk behaviors in general, and transforming them in a kind of deep social and cultural way over time.

So I would set as a goal for a decade or two decades hence that adolescents initiating sexual behavior would begin to see the condom as a kind of regular aspect of sexual behavior in a way that is hard to conceive of in our current context, exactly.

And the fact is if we begin to address the fundamental underlying social problems that produce an AIDS epidemic, we'll see more fundamental types of social change. Not only would we be preventing HIV transmission but many other sexually transmitted disease which have phenomenal medical and social morbidities, unintended pregnancy. If we begin to

really deal with drug use in a fundamental way, we not only would begin to prevent HIV transmission but have a more fundamental impact on our cities and our communities.

So I think we need to begin to relate the crisis to the more fundamental social questions at stake in the epidemic. Now, how that happens we have all been struggling with, and none of us are going to pull a rabbit out of a hat. But I think if we begin to think of it in that way, maybe we'll begin to make some progress.

DR. ROSENFIELD: Just a very brief add-on. I think a component of the change that is needed must evolve in the medical profession. We too have focused on a cure and curative medicine almost totally in our history. Prevention is a minor part of medical education. It has evolved as a major part of schools of public health, but it is only beginning to be understood in medical schools.

I think the medical profession needs to take a lead in looking to long-term goals rather than the short-term cure if the person is already sick. And I think the smoking and tobacco history of the last couple of decades is a model of the importance of a long-term perspective that is working, albeit without an effort at the beginning that we are going

to do something over the next 20 years.

Prevention must become a landmark part of our overall health care system, with long-term goals. Our approach to alcohol, our approach to substance abuse more generally, has not focused on prevention and education, and it must if we really want to bring about the type of change that is essential to the future.

COMMISSIONER GOLDMAN: June, do I have time for a quick question for Mr. Rowell?

CHAIRMAN OSBORN: If it is very quick; I want to let Belinda have a chance, and then we need to move on.

COMMISSIONER GOLDMAN: Mr. Rowell, in the data that you submitted, I think a little bit more than 4 percent of the Indian/Native American population with AIDS were people with hemophilia. In that population we do have a preventive, namely in the highly purified and viral attenuating clotting factors that prevent. Of course, those products cost somewhere in the area of between $60,000 and $100,000 per year, and I am wondering what is the situation in the American Indian and the Native American and Alaskan Native populations in terms of the health care system providing those kinds of products to those patients who need it.

MR. ROWELL: That's a good question, and I wish I could answer it. Unfortunately, that is an area that I don't know a whole lot about. My understanding of the Indian Health Service system and the way I think it works--and again, this is opinion--is that that kind of assistance is provided through the contract care program. I have addressed what is expended in the contract care program in the body of my written testimony.

I don't even know how large a problem hemophilia is, frankly, in the Indian community. I know those cases that we have reported have not grown; that is something that now seems to have been taken care of. But frankly, I do not know, and I would be very doubtful that the Indian Health Service provides that kind of support to the majority of Indian hemophiliacs; I really doubt it.

CHAIRMAN OSBORN: Belinda, let me give you the last question in this set.

COMMISSIONER MASON: My question is more of a comment for Mr. Rowell. I want to thank you for reminding us about the power and the necessity of a vision and the strength of the grassroots, because really, all of us who live in the rest of the country know that nothing important

really ever comes down from Washington; rather, it arises up from us, and finally we get their attention, after several years and too many losses and tragedies.

But I would like to have you just elaborate on what you were saying about that a little bit more, and maybe explain to me why we haven't been able to package--the San Francisco Model, yes, but what is it that we are not doing on the Federal level and State level to tell people about how to develop a vision; and is that something you can quantify, and does it take heart, and can you ever teach people heart?

MR. ROWELL: It is not talked about much, as you are probably fairly aware. In all of the conferences that I have attended, for example, since I have gotten really involved in HIV prevention, I have heard mostly from people who do direct education, and most of the talk is around what happens when you simply provide education, and whether people know more at the end of that education than when they started.

I am not quite sure how best to package this other than doing, for example, what we are doing in trying to simply put into words as best we can what we think we are doing as a program, and why we think it works, and again,

that is why I raised "The Honour of All"; I think there is a model out there that hasn't been addressed because it is so limited. We know about it in Indian country to some extent, but other people don't necessarily know about it, and it relates somewhat to the San Francisco Model because it is a grassroots effort.

But that component of deciding that things are unacceptable as they are and having an alternative vision and then working to try to make that become real is the critical part to me.

I don't know if that is an answer to your question or not, but I appreciate your comments.

COMMISSIONER MASON: Thank you.

CHAIRMAN OSBORN: Let me thank the panel very much for some powerful testimony. We really appreciate your giving us the privilege of hearing you.

COMMISSIONER ROGERS: Mr. Rowell, before you leave, could you let us know how we can get that movie?

MR. ROWELL: Yes, I can let you know.

CHAIRMAN OSBORN: Good.

Could I ask the next panel to please come to the table--Dr. Robert Harmon, Dr. Steve Schroeder, Castulo de la

Rocha, Jasmin Shirley Moore, and Andrew Ziegler, please.

And some of you but perhaps not all of you heard me say at the beginning of the morning if you can highlight the central points of your testimony, it gives the Commissioners a chance to interact with you, and we will also have read the more detailed material that you have given to us, and that kind of doubles the benefits. So if we can do that it will give us time to interact, and that is very helpful to us and enriches the whole proceedings.

We will set a little timer here that will "ding" when you are fairly close to the end of the interval of assigned time, and again to help us with that efficiency.

Bob Harmon, we'll ask you to go first.

DR. HARMON: Thank you, Madam Chair.

My name is Dr. Robert Harmon. I am Administrator of the Health Resources and Services Administration in the Public Health Services. I have been in that position since February the 1st.

With me this morning is Dr. Sam Metheny, to my right. Sam is Associate Administrator of HRSA for HIV and AIDS.

I will summarize my remarks. You have been given

my testimony. I will be talking briefly about the U.S. Public Health System as I have experienced it, its response to AIDS, and HRSA's role in that.

My background is that I am a public health physician specializing in preventive medicine, and I also did a residency in internal medicine. I got into public health administration as the health officer in Maricopa County in Phoenix, Arizona in around 1980. There, we got involved in the early days of the surveillance of HIV and AIDS, the early days of counseling and testing. I got especially involved since I was President of the National Association of County Health Officials, where I met Dr. Konigsberg in his role as a local health officer. We have both since wandered off and become State health officers along the way.

But again I was impressed by the fact that county health departments were doing quite a bit with very little resources, were willing to move resources around before Federal and even State funding became available, and were accomplishing a lot with very little, as the Institute of Medicine Report on "The Future of Public Health" pointed out.

In fact, NACHO, the county health officials group, worked closely with the U.S. Conference of Local Health

Officers--Dr. Merv Silverman was the president of that group at the time, and I was NACHO president, and we worked together to get some of the early funding for counseling and testing from the Public Health Service; that has grown considerably since 1985 when that started.

After that time, I went on to the State of Missouri for four years as a State health officer and worked very hard with the Association of State and Territorial Health Officers on their efforts to get better guidelines for counseling and testing and to build public health programs in HIV and AIDS; and beyond counseling and testing, into education, surveillance, legislation, regulation, coalition building, and care coordination.

Throughout this effort I was impressed by how much we need to effect a partnership between Federal, State, and local government health departments and the private sector, community-based organizations, universities, organized medicine, organized nursing, many different associations. It is quite a tall task to bring those groups together, but it is one that many health departments, local, State and the PHS I think have done well

I was also pleased in 1986-88 to serve on the IOM

committee that wrote "The Future of Public Health" report. And as you have probably heard, the committee found that public health is in disarray and that it needs to work much harder on assessment, policy development and assurance, the basic health department functions, and on better partnerships with the private sector.

Since I have come to HRSA in the last eight months or so, I have devoted a lot of my attention to strengthening that public health system--that government health department partnership working with the private sector and others on things like AIDS.

What I'd like to do in the rest of my testimony is focus on HRSA's role. This organization has been around since 1982. It was formed by the merger of the Health Resources Administration and the Health Services Administration, and its role has been to provide resources and services to disadvantaged populations.

Our budget is currently about $1.8 billion, and we have about 2,200 employees. Our AIDS budget is around $112 million. We focus on care and primary care aspects of the system.

The programs in HRSA, the large ones that are

especially pertinent to HIV and AIDS, include community and migrant health centers, of which there are around 550 grantees and over 1,500 sites around the Nation in medically underserved and health manpower shortage areas. These centers take care of many persons with HIV infection and AIDS. That budget is over half a billion dollars.

There is the maternal and child health program, including the block grants. This is over half a billion dollars. They are increasingly involved with HIV-positive persons.

There is the National Health Service Corps, which is going through a rebuilding phase and has 1,500 professionals in the field, and we hope to build that up over the next several years if budget increases can be approved.

And of course we have our HIV programs. There are nine different program areas, and that budget for FY90 is around $112 million.

I would like to direct your attention to the chart at the end of my testimony. I hope you have it in front of you. I would like just to briefly walk through that and bring you up-to-date on where things stand.

We have there four columns. On the left, we have

the nature of the program, starting with education and training centers in our Bureau of Health Professions, this year about $14.5 million, funding 15 university grantees in 14 States, and that does cover the entire Nation, each grantee serving usually several States.

The next area is community and primary health care, through our Bureau of Health Care Delivery and Assistance, which we call BHCDA, at $10.8 million. We anticipate a little over 30 awards not just to community and migrant health centers but also to county health departments, community-based organizations, teaching hospitals and clinics, and other entities. That started with some three pilot projects very successful in community health centers.

Pediatric AIDS, our MCH Bureau, is a little under $15 million, with approximately 18 grantees, including universities, State health departments, and other private entities.

Facilities renovation has been around several years at HRSA; this year, $4.2 million. Up until this fiscal year, we had 33 grantees receiving HRSA funds to renovate facilities to make them more suitable for persons with AIDS.

One of our better-known program is HIV services

grants. We currently have demonstration projects in 15 States as well as D.C. and Puerto Rico, mostly serving adults, but often going to community-based organizations, health departments and other entities.

We have two State formula grants--AIDS-related drugs, just under $30 million, going to all the States and several Territories; and then a newer program, home and community-based services, going to 49 States, D.C. and Puerto Rico.

We have a smaller program in sub-acute care at $1.5 million, that will go up to three awards.

That totals our $112 million.

Also, in concert with other PHS agencies, we have this year a little under $9 million of ADAMHA funds going out in primary care and substance abuse treatment linkage--21 grantees in 15 States, plus D.C. and Puerto Rico--again, to a spectrum of grantees, public and private.

Finally, we have around $7 million going to hemophilia programs. That would be CDC money over to HRSA and our MCH Bureau and on out.

In addition to that, we have a HRSA AIDS Advisory Committee. Ms. Diaz is our vice-chair and Dr. Molly Cloy

[phonetic] is our chair. We are very pleased to have the ongoing advice in the care area in that.

In the future we are dealing with a number of challenging issues, the biggest of which is the new Ryan White CARE law, which has been enacted by Congress and signed by the President. HRSA might be authorized for up to a sixfold increase in HIV funding and some new approaches to how these programs I mentioned would be supported. How much is appropriated remains to be seen; it depends on the budget negotiations ongoing these days.

So we are working closely with CDC on how that might be implemented, and we are looking to advice from our HRSA Advisory Committee and from your Commission on those kinds of matters.

In summary I would say that HIV and AIDS have exposed the best and the worst in our U.S. health system. I think the main lesson we have learned is that we need to enhance our public health, prevention and primary care programs, and also our insurance coverage.

Again, as the IOM report said about the health department system, the wonder is not that so little has been accomplished, but that so much has been done with so little.

Thank you very much.

CHAIRMAN OSBORN: Thanks very much.

Our next witness will be Dr. Steve Schroeder, who I will take the privilege of the Chair to comment that the distinguished tradition of leadership of Robert Wood Johnson Foundation is being continued in his recent appointment.

Welcome, and congratulations.

DR. SCHROEDER: Thank you, Dr. Osborn, thank you, Dr. Rogers and members of the Commission.

I guess I am on here because compared to Dr. Harmon--he is an oldtimer; he has been in his job for eight months; I have been on mine for about two and a half, and before coming to Princeton, I was on the faculty of the University of California San Francisco, where I was personal care physician to a number of patients with AIDS and had an active AIDS teaching program at our institution.

The programs I am about to describe to you that Robert Wood Johnson has sponsored really took place prior to my coming, although I share the organization's pride in them.

It has made over 120 AIDS-related grants since 1985, totalling in excess of $50 million. These grants fall into four major categories. The first is access to comprehen-

sive health and health-related services for people with AIDS and related conditions. Second is targeted prevention for those at greatest risk. Third is policy research, and fourth is public information about the epidemic. I am pleased to tell you that the Foundation-sponsored AIDS Health Quarterly, a Public Television broadcast, recently won two Emmies.

The Foundation's largest single initiative in this area is the AIDS Health Services Program. Launched in 1986 this four-year, $17 million national demonstration program provides support to 11 different communities scattered throughout the country to develop case-managed community-based systems of care for persons with AIDS.

The program was designed to find out whether the community-based model that was developed in San Francisco could be exported. The program is now in its final year, and although an independent formal evaluation of the program is still in progress, we can make some tentative observations.

First, and perhaps most important, the model is generalizable, even to communities as hardhit as Newark, Jersey City, and Belle Glade, Florida. This is not to say that each project is successful in meeting everyone's needs. Of course, there are still major gaps in the continuum of

care in most of these communities, and the resources that do exist are stretched very thin.

Case managers, for example, in Newark and Jersey City, or Miami in some instances carry loads in excess of 150 cases per person. Yet these projects are identifying and securing services for large numbers of people who might otherwise have had no real alternatives to costly hospital care.

My second observation is that despite the Medicaid waivers obtained by some of the States, current health care financing policies continue to mitigate against the establishment and maintenance of systems of care that are based in the community. And as our grants are winding down, the projects are all working hard to scrape together sufficient funding, most of it in the form of small, time-limited grants and special appropriations, to keep the infrastructure that they have developed in place.

Some will obviously be more successful than others, but in all cases, they are really going upstream in a health care financing system that was designed to support institutional rather than community-based services.

My final observation from this program is that in

terms of the demands being placed on those communities and their fragile networks of care, as you have been hearing in the testimony here, the worst is still to come. Despite recent reports of a slowdown in the number of new cases, especially among middle class homosexual and bisexual men, the case loads for the 11 AIDS Health Services projects are continuing to rise at what seems a relentless pace. At the same time, the whole character of the epidemic is changing, and new kinds of demands are being placed.

More and more, we see that people coming in for car include women and children and families. Most of these people have limited resources and no insurance, and people with problems of substance abuse and other complicating conditions are increasingly flooding the system, particularly in our larger inner cities.

Increasingly, people are coming in for early intervention and follow-up, although not at the rate that some of our projects had anticipated. And of course people are in need of chronic care, care which in most communities was already in short supply even before the AIDS epidemic.

And we don't mean to imply that these trends are limited to the communities that we sponsor, because clearly,

they are developing all throughout the country. We are getting many solicitations from places where we were even surprised that the AIDS problem had surfaced. So clearly the diffusion of the AIDS problem and trying to cope with it is occurring throughout the fabric of our country.

So, what are the challenges that lie before us?

The first one would be to ensure that the desperately needed relief funds should be given out under the Ryan White Act and allocated where they are most needed, and that is in keeping with the intent of the legislation that they will support a case-managed community-based service infrastructure. Without such support, many of these networks will unravel, leaving the growing number of AIDS and HIV-infected persons in these communities with no alternatives to costly and often inappropriate inpatient hospitalization.

But the Ryan White Act, important as it is, is only a stopgap emergency measure. It does not address the real problem, which is that the health care financing system in this country as it is currently designed and operated is poorly designed to address the health problems it is intended to address. We see this not only in the Foundation's work in AIDS, but in our programs for vulnerable populations such as

high-risk children and youth, the frail and the health-impaired elderly, the homeless, and the chronic mentally ill.

The Ryan White Act can buy us some time. But that time must be used to re-examine our basic health care financing policies, and how those policies can be changed so that the Nation's health care system is more responsive to the health care needs not only of people with AIDS and HIV-linked problems but of all of our citizens with serious health problems.

The other major challenge in the area of AIDS health services is that it is time now to move into a real effort that involves the entire community. The handful of agencies, institutions and individual providers who have been bearing the brunt of the service load until now just aren't going to be able to meet the demands of the 1990s. Mainstream efforts, including private physicians, nursing homes and community hospitals, will have to become engaged and funded.

This will not be easy, particularly in view of the widespread concerns about the risks of infection among both health professionals and the general public.

Right now our Foundation is taking a new look at its current interest areas and its intervention strategies,

and over the next several months we will be coming up with a revision of our current priorities, taking a fresh look at the strategies to help our country deal with problems such as HIV and others.

We will obviously continue to be involved in this problem, and how we do it in terms of how much is in demonstration projects, how much is research, how much is capacity building, policy analysis, or communications, there are active internal discussions going on right now, and we hope to communicate them to you, and obviously, part of the input to our process are the reports and the deliberations that come out of this Commission.

Thank you very much.

CHAIRMAN OSBORN: Thanks very much.

Mr. de la Rocha, welcome.

MR. DE LA ROCHA: Dr. Osborn, members of the Commission, I want to thank you very much for giving me this opportunity to address and to see many of the faces that I had the opportunity to welcome in the East Los Angeles community several months ago.

My name is Castulo de la Rocha, and I am President of AltaMed Health Services Corporation, a Section 330-funded

comprehensive community health center located in the East Los Angeles community.

AltaMed Health Services Corporation is a longstanding member of the National Association of Community Health Centers, and while my presentation this morning reflects my views, I think that my thoughts and my perspectives are shared by the 600-plus community health centers throughout the Nation.

Community health centers offer direct primary health care services to medically-underserved populations and in areas where the epidemic is flourishing and is likely to continue to grow.

The centers were founded primarily on the principle that community health services can best be offered by an organization that is based in the community, providing care for that population. Each community health center is governed by a community board, the majority of whose members are community residents receiving services at the centers themselves.

Strategically, the centers are located in areas where the epidemic is at its worst--in poverty areas, with high unemployment rates, high drug use, gang violence, and

where language is a barrier as is religion, and where sharply defined sex roles prevent early detection and treatment.

AltaMed in its attempt to address the AIDS crisis has added to their service component a county-contracted methadone maintenance and detoxification program, a confidential HIV alternative test site, and an education and consulting group that provides information on HIV and AIDS and drugs to parent groups, educators and the community-at-large.

I may say that this particular program was not easy to develop in our own community. We ran up against a great deal of resistance from our own community and for that matter, the lead charge in opposition to developing drug treatment and maintenance programs in the East Los Angeles community came primarily from the police department. After a number of months, struggling jointly with local communities, elected officials, as well as community representatives, we were finally able to institutionalize and to develop this program in the East L.A. community.

I have been invited here today to speak on a major problem that faces all of us, but rather than a detailed statistical chronicle of AIDS funding in the United States, I think it would be more relevant to this group to discuss

certain key issues and strategies.

But before I involve myself with my presentation, I have spent the last 25 years of my adult life devoted to a movement, a movement that is focusing on developing communities and developing community pride. I think nowadays it is called community "empowerment", or something similar to that--taking pride in what you are, what you represent, being concerned about yourself as a person and as a community and being involved in that community.

I share that with you because I have been in this job for the last 12 years of my life, working in community health centers, and I share that perspective with you because I have worked on the front lines, and the principal problems of our communities need to be addressed.

For the past decade, the United States has been locked in an intense national financial and political debate over the budget. Gone are the days when the War on Poverty, Medicaid, Medicare, and the expansion of Social Security, when nearly every Administration had a mandate to increase spending on social and health programs. In the Sixties and the Seventies, the public sector was seen as the prime mover in meeting health and social needs.

In the Eighties, the United States began to see increasing competition in world markets. In the minds of many, the accelerating costs of public sector programs became a disadvantage in this competition. For geopolitical reasons, a shift in the emphasis to military spending occurred. The result of these changes was the creation of a zero sum game in public health. Public health spending was effectively capped. Money spent on one program was at the cost of another. The message from Washington in the Eighties is and has been that there are no new moneys.

When AIDS emerged in the Eighties, it was into an environment in which claims had already been staked for the public dollar. Funding AIDS not only required that AIDS be shown to be important, but wrested from the grasp of other, already established groups in public health.

Public sector funding decisions are inevitably grounded in interest groups. The most directly interested area, of course, those who are directly affected by the disease.

From the start, the AIDS virus has impacted groups which are characterized as relatively powerless, or definitely part of the power establishment. There have been great

divisions within and between these groups. The groups have very little in common other than the disease itself, precluding a broad-based alliance. They are African Americans, they are Latinos, they are Indians, they are gays, they are drug abusers, they are children, and they are women. They are groups who have had little to say as to determination of public health issues in this country over the years.

All these factors have weakened the case for AIDS funding in the United States. They have not only impacted public funding, but have hampered private sector efforts to combat the disease.

Making matters worse, certain powerful groups in the country have actively opposed AIDS funding. This active opposition has been a thinly-disguised attack against AIDS-affected groups and their lifestyles. Most Americans have remained indifferent.

Funding strategy for AIDS initially took the approach of broadening the victim group. Heterosexual spread was emphasized. Casual spread was publicized. AIDS was characterized as a new plague, with potential to spread devastatingly throughout the population.

These tactics, assisted by bold leadership on the

part of some unlikely individuals and sensationalized by the media, did finally lead to some increased funding.

The strategy, however, brought new problems. First, the funding made available was grossly inadequate to meet the needs of high-risk populations. Second, much of the money was diverted to meet the concerns of low-risk populations. While the disease raged in New York City among New York City addicts, money was sent to smaller rural populations to ease the fears of corn farmers that their sons and daughters might contract AIDS through a weekend indiscretion.

The increased funding also had a mixed impact in our communities. It brought new provider groups into the AIDS funding market. Overnight, groups were formed by people who had no direct interest or history in the disease, solely to tap into the new funding streams. In some cases, some of these organizations have proved to be allies in contributors to the solution; in some cases, they have contributed to the problem.

As the infection has decelerated in the Anglo community, it has accelerated dramatically among blacks and browns. Yet we have the impression that the funding issues have moved off page one. The media no longer has a nightly

AIDS story. AIDS is by many people considered "funded", that is, placed conceptually in a maintenance funding category. This is unacceptable because our needs have not even begun to be met.

COMMISSIONER ROGERS: Mr. de la Rocha, I'm not sure whether you heard our timer go off. You might just tell us what would you like us most to do.

MR. DE LA ROCHA: Thank you.

In conclusion, there are at least two points that I would like to raise. First, we must work to achieve a working consensus on the distribution of AIDS resources. All persons infected with HIV must be treated as equals, certainly in the eyes of God, and certainly in the eyes of the State. We have not seen that to be the case when one views the funding patterns on a national basis.

As we enter the second decade of the epidemic, we must recognize the increasing numbers and proportions of minorities, women and children being infected. Primary health care centers and community health care centers stand prepared and ready to assume a key role in the provision of care. It is unrealistic to assume that these centers will be able and capable--and not because they are not willing to do

it, but capable to--provide care at the level that is presently needed and particularly as we see the necessity to have medical providers involved in intervention; for community health centers to assume that responsibility without additional resources is totally unrealistic.

We are prepared as community health centers to play the vital operating role as an effector mechanism. We have developed the capability through the Seventies and the Eighties, and we are prepared to play a major role as a partner in public health--and not as a junior partner--in a major problem that we face.

I thank you very much.

CHAIRMAN OSBORN: Thank you very much.

Ms. Moore, welcome.

COMMISSIONER ROGERS: Ms. Moore, also as a suggestion, if you can do it, if you are comfortable with it--we have your written testimony, and we will read it with care. Speak from your heart.

MS. MOORE: I will do so.

I'd like to thank you for the opportunity to come before you to provide you with some different perspectives, I think, from my own background in that I am from a traditional

public health department, one who stated with AIDS as a staff epidemiologist tracking the disease. So I can bring you some different perspectives and then let you know how the South with its challenge in AIDS has gone forth to get into other areas within the AIDS arena that we are not accustomed to, such as that care and treatment arena. Many public health departments are not involved, but there is a role that they can play, and as I bring you up to snuff with where we have come from, maybe other areas can do the same and look at their resources and begin to bring on new avenues and new ideas and thinking with the total public health perspective, not only from surveillance prevention activities, education, but through traditional public health department activities as well as complex care and treatment issues, that many of these public health departments will soon be entering into as well.

I say this because we don't have enough resources on the "have not" side, and public health has generally been providing services to those sides, those persons who do not have as much. I say this because Broward County, Ft. Lauderdale, Florida, Hollywood, Pompano Beach area of our particular State has been often referred to as the "Gold

Coast". With all of its affluence, or seeming affluence, we have a population of about 270,000 individuals--in a study that was done in 1980, that has indeed doubled--which are indigent or medically indigent.

Now, that is important because if you put that population group and count it as a county in our State of Florida, it would be the eleventh-largest county of Florida's 67 countries. And because we have the various systems, or the two-tiered systems of health care in our area, the haves versus the have-nots, the privates versus the public sector, our public sector is going to have to take on more of a role because more and more nontraditional persons are moving into the have-not side due to the AIDS epidemic and all the impacts that it has had on persons and their families.

We traditionally do not have medical schools or training programs in our particular area, and that is not unlike any other large metropolitan areas that are connected to or adjacent to a city such as Miami with a medical school and all of those resources.

We traditionally only have two tax-assisted hospital districts that provide the bulk of indigent care--a primary care center that is federally funded, a primary care

center that is county operated, and the health department.

It took us from 1983 to 1985 just to get the heads-to-be of these systems to sit down and discuss the issues and to learn from these issues that AIDS was going to impact them forever and a day, and that unless we came together as one, we would not survive.

It took two years to do that, but it was a public health community that came out front with that leadership; as it has always been in public health, we come forward, when those wish to stand behind.

In our attempts to unify and bring together all of the agencies that need to work with us, we started out as six. I am here today to tell you that we have grown. Remarkably, we have grown to more than 77 agencies in Broward County alone. In Ft. Lauderdale, Florida, the type of county where you never could get anybody to sit down and discuss and put points on the table and prioritize strategies to work together, we did that. It took us two years, but we are there.

We are now looking at our systems to see how indeed we can change the system as a result of the AIDS efforts, of which I have provided for you in the testimony some of the

key points that public health has been very instrumental in. I put one key point in there, which was a table to show our gatekeeper model and how we work together and collaborate our efforts so that all our services, with our mainstream providers of health care, mainstream providers of support services, do interact collaboratively, coordinating all of the services that we will have to have in place for persons.

We as well get together monthly just to sit down and look at our difficulties, where we see our systems collapsing, where we need to entice other people to come onboard with us, those experts in the field--not those agencies necessarily that want to have a piece of the pie, but what you do best, you bring it to the network's table, what you do best, you do it for the network, what you do best, you expand upon that, and we help each other in the process.

I'd like to also let you know that as a result of our coming together in 1983 to 1985, and then in 1985 to 1986, with the first opportunities in the AIDS care arena and services, HRSA and Robert Wood Johnson, we married another county. We married Dade County and Miami. And all of you know about marriages--sometimes they work, sometimes they

don't. But in essence, you do indeed have to work at it.

Now, Dade County is only 25 miles from Broward County. Many of our patients in the early days--we knew all the addresses--would just go on down to Dade County and partake of the services that Jackson Memorial Hospital had to offer. And of course, the bulk of the State dollars also went down to Miami. So Miami realized that it was important for them to marry us because if they married us, then we got our acts together, and we could draw upon one another's strengths and weaknesses--which we did very well.

We are now combined with the Miami project and termed the South Florida AIDS Network of Broward County and Dade County. The 77 agencies in Broward County have grown to be accepted and work together, coordinating all of our efforts collaboratively with the 25 agencies in Miami. That has been a monumental task that we can now cross county and get the same scope, broad array of services that we have never been able to do in the two-county areas on any other health issues. AIDS brought that together. And it was a public health response as well as a collaborative community response to say we want to take this leadership and we will do it, surmounting all the odds of no funding.

There is a little saying that one of our patients provided to us as we have grown together. The Northwest Health Center, the result of our marriage, is the only outpatient care arena in the Broward County-Ft. Lauderdale area that is comparable to the Jackson Memorial Ambulatory Care Service Center. They helped us to get that together, and they have helped us to survive and know how to be most cost-effective and how to provide the best quality care that one could obtain the Broward County area.

And it is not a clinic of the haves or the have-nots. It is a clinic of everyone. It is a clinic where people are concerned about the quality of care that is delivered.

We have patients now who would never return to the private sector for care again, and they tell us why--because no one took the time to hear all of their concerns, to have them deliberate with the physicians and the care providers and their care plans and to be compliant with all that is done.

The saying that they gave us says: "We the knowing, who have been led by the unknowing, have done so much for so long with so little that we are now qualified to

do almost anything with nothing." And we say that because public health has never had much, and it has always had the crumbs in the pot; it has always had to do with the traditional programs coming down and to expand its horizons. But public health has done one thing. It can bring folks together. Public health can make them deliberate. Public health does look for everyone's concern. And public health does not have to be on guard with who is sitting at the table, for what reasons. Why? Because public health folks are dedicated, they are committed to the effort, and they don't have anything to gain but the rewards of being about looking out for people and the response of public health, looking out for public health, safeguarding public health.

To give you some last points, with our 77 agencies many of the issues we are facing now, we look at ourselves every day and ask how are we going to survive as soon as Robert Wood Johnson and HRSA leave us on September 30th and October 31st, respectively. And I say that because the two gentlemen are here, and it is befitting that we let them know that for four years, we have struggled--

COMMISSIONER ROGERS: Sock it to 'em.

[Laughter.]

MS. MOORE: Thank you.

For four years, we have indeed struggled to keep our response collectively and collaboratively and to bringing about other sources to supplant the efforts that we had. But for four years, we have grown and expanded our services so that more and more of the community are dependent upon them.

One of the reports of the legislature indicated that a system such as that in Dade County, Miami, Ft. Lauderdale, Broward County, Florida, such a system that is so organized as we have come to be with all of our problems and with all of the things that we have to deal with, such a system will then lead itself to one flaw and that is over-dependence of the general community. And I say that because we are not a system of the haves and the have-nots in the AIDS epidemic in Broward County and Miami/Ft. Lauderdale. We are not that kind of a system. Inasmuch as everyone is depending upon us, we are going to be depending on everyone else to keep us afloat.

For four years, we have done some positive things, and I named them off. Not only have we combined the traditional public health problems, concerns, issues, and strateg-

ies, but we have done that in such a sense that our programs were designed to relieve the burden on the hospital systems with traditional primary care or indigent care or whatever kind of care you want to call it--the have-nots care. But we have indeed brought down the lengths of stay from hospitals from 45 days in 1985, before we got started, to 13.8 days in Broward County alone. In Jackson Memorial Hospital, that's down to 12. That has only recently begun to go back up, to about 16 in the Ft. Lauderdale area and about 14-15 in the Miami area. We have decreased the length of stay in those hospitals; we have brought from what used to be 45 days to now the 13 days, and the number of admissions from about 5 to 1.5 or 2.

Our community response on the outside of our hospital systems has been tremendous, and I urge all of you to go back to your respective areas--which I am sure you all have--but to convince other persons as well to go back to the front lines and see how those front lines are working, because they desperately need your help, and we desperately need to convince other persons. Many of these folks have said that the Ryan White bill was going to be a hope. Well, it was a hope for us about a month ago, but when we discovered

that the 16 cities in Title I would not get funding, we wondered how in the hell are we going to survive for the next year and a half to two years before there is any increase in funding, when our State dollars, with the growing demands placed upon the State, how are we going to survive with the State having to pick up the bulk of this care as well and these infrastructures that we started back in 1985-86.

It is bleak. It is very bleak.

For the last part, I'd like to say--

COMMISSIONER ROGERS: Ms. Moore, your buzzer went off, but wherever you end up you will end up ahead, so go ahead--swiftly.

MS. MOORE: Thank you.

Lastly, I'd like to say that public health has always experienced budget shortfalls, but this is a time that we are going to have to stay onboard within the AIDS epidemic with all of the things that we have brought to public health, which are nontraditional for many of the public health departments that are operating throughout this Nation. And since they have taken that leadership role, and there have always been shortfalls in budgets, it is incumbent upon everyone to do in their best power to make sure that public

health is not cut any further, because not only are other traditional programs being impacted, but we have become the leaders in our communities, and they expect the response to stay the same--and just to stay the same, we are going to need to put every dollar back.

I read in the paper some time ago with the Ryan White that the moneys went here and there. Well, I'm going to be looking to trace every, single dollar, and when I find out where they went I'll be coming back before our legislators to say, "This is where the dollars went. Bring it back because we need it."

Thank you.

CHAIRMAN OSBORN: Thank you very much.

Andrew Ziegler, welcome, and we look forward to hearings your thoughts. We also look forward to the interchange, which is why David and I are leaning a little bit on the clock. We would love to spend more time with everybody.

MR. ZIEGLER: Good morning, Dr. Osborn and members of the Commission.

My name is Andrew Ziegler. I am here today as both a public health professional and a person living with HIV disease.

I am currently the coordinator of HIV counseling and testing services for the D.C. Commission of Public Health, and prior to this was the AIDS coordinator for the Public Health Foundation, the research and development arm of ASTHO.

My comments today do not represent the D.C. Commission on Public Health. My remarks are based on my own experiences as both a provider and a consumer of HIV-related services.

I would like to talk with you today about the public health response to the HIV epidemic, and in particular focus my remarks on the need to make good on the contract of comprehensive services, early intervention, and psychosocial support promised to await those who heed the call to get tested.

From my vantage point as both a public health professional and a person living with AIDS, too often it appears that policies are created from an ivory tower without true regard to the reality of the effect these policies may have on people's lives.

First and foremost is the unrealistic cry to test, test, test. I think we should make sure we have services,

medical and psychosocial, available to all people. In many places, people often have to wait weeks and sometimes months for medical and psychosocial follow-up at publicly-funded programs after they find out they are HIV-positive. This to me is criminal and only adds to my skepticism about the programs we are paid to administer. Can we actually deliver on the promise of treatment and care for those who test positive, or is this only an ivory tower concept?

While we want to encourage people to take action and find out their serostatus to get the promised early treatments, this is clearly not a reality for so many people who cannot even access the most basic of health care needs. Again, we are talking about policy for the most privileged, those with the means and capacity to access a very complex system--more ivory tower policy.

I feel I am quite fortunate because I know how to access the system. I know all the "right" people. I know how it operates. I know what my rights are. And I know where to go for assistance, because I am a part of the system professionally. But I can tell you it is still never easy. It is particularly difficult when I have to run all over town to see the ophthalmologist, internist, dermatologist, nutrition-

ist, et cetera, and am not feeling well and trying to hold down a full-time job at the same time.

But what about the people who don't have the ability to access the system due to social, economic or educational barriers? How do they access a hostile system, a system designed to discourage their use and participation?

One recommendation I could offer would be to try to pull together such a fragmented system, to integrate a number of HIV-related services, a sort of one-stop shopping approach to make it easier on all of us who are taxed on a daily basis to try to keep up with this disease.

This point also underscores the need to involve people with HIV disease in policy development and planning. We can provide critical perspective on whether what looks good on paper and from ivory towers will actually work in our lives.

Given all the above, we still need to focus on testing as a personal choice and decision. I fear we are moving away from this personal choice to what is being referred to as "routine" testing.

What seems to be taken for granted by so many policymakers and public health officials is the fact that

this is still a very terrifying test to take. And for many, their infection status is not a priority--it is just yet another problem in a long list of other problems. There are often greater, more immediate issues, such as how to put food on the table, where to sleep that evening, or for many people, where and when to get their next high, et cetera. For so many people, it is a luxury worrying about tomorrow when today is difficult enough.

Another key component to making the personal choice to be tested is the availability and provision of true psychosocial support. There is a great need to help people cope with the pain, anxiety and fear that goes along with HIV disease. I think the area of psychological support has not received the attention it deserves.

It was a rude awakening when I joined an AIDS support group and two people committed suicide within the first five weeks and one other attempted. You can only imagine my surprise when the two individuals' obituaries said they died from "complications associated with AIDS." That seemed to be somewhat of an understatement.

I think my experience points to a fairly common phenomenon which very few people are willing to discuss. And

remember, I am among the fortunate ones, since most existing support groups are geared toward gay men. But what and where are the supports for an addict in early recovery? For an IV drug user's partner who discovers she and her children are infected? For an isolated adolescent, as well as many others?

HIV policy out of ivory towers must include supports for all types of individuals.

Finally and most painfully, let's not overdo the bit about HIV disease being a chronic treatable illness. I can't help getting just a little bit queasy every time I hear someone refer to HIV as if they were discussing diabetes and hypertension. The diagnosis of AIDS is still a death sentence.

We talk of long-term survivors for people surviving several years as if this were a great accomplishment. I don't want my personal great accomplishment in life to be "making it" to my 30th birthday. And when people hear they are HIV-positive, they hear they are going to die. It is offensive to hear people talk about HIV disease in upbeat, optimistic terms, as I stand helplessly by and watch so many people around me, people I love, get sicker and die.

And imagine my tortuous pain as I drink DDI twice a

day--having failed AZT so long ago--hook up to an IV pole every night through a catheter in my chest, and have my blood drawn twice weekly, only to monitor and cheer on my failing blood counts, as public health officials tell me we are moving toward making HIV disease a chronic treatable condition.

We might be moving toward that direction, but we are certainly not there yet, and we are not moving there at the same rate for all affected populations, and we are clearly not moving there fast enough for anybody.

In summary, let's not promote this disease as something that it's not, as a chronic treatable condition, and above all else, let's not promise treatments and services we are not prepared to deliver.

Thank you.

CHAIRMAN OSBORN: Thank you very much.

Eunice?

COMMISSIONER DIAZ: This is partly a comment and a question for Dr. Harmon.

Mr. de la Rocha's paper included a very interesting thought--that this country may consider AIDS funded. And in view of what you said, Dr. Harmon, from HRSA's point of view

is there any long range plan with what we are facing in terms of the total cost of care?

I am concerned that the public is looking at your agency--and I feel part of the HRSA family, being on the advisory--that is, our agency, HRSA, as the provider of AIDS care money, and when that money, because of the different pilot demonstrations that we have within HRSA, dries up, where is the public going to look to next?

Obviously, with what is happening with Ryan White, that may or may not be the total scope of the public's dreams and aspirations of what has to be done in terms of funding AIDS care. What are the long range plans for HRSA for continued funding of AIDS care in this country in view of that comment that he made? I just would like some comment on that.

And could you also just comment a little bit on the success of the CDC/HRSA demonstrations that we have had?

DR. HARMON: First of all, we are doing long range planning at HRSA. We are intending to prepare a year 2000 plan for the whole spectrum of HRSA programs now that the "Healthy People 2000" objectives have come out, and we will be starting that very shortly for all of HRSA's programs.

Regarding HIV and AIDS, we are working closely with the CDC and have a Ryan White Act planning group so that we can get out in front of the activities in this new approach and anticipate the appropriations and so forth.

We will of course be working with NAPO, the National AIDS Program Office, which coordinates the $1.7 billion worth of HIV and AIDS programs throughout the Public Health Service, and we meet about every two weeks with NAPO and the HIV leadership group, with all the Public Health Service agency heads and Dr. Mason, NAPO and so forth, Dr. Allen, to do long range planning, budget, and for other purposes.

We also work closely with HCFA and Dr. Gail Wilensky on the Medicare and Medicaid aspects of HIV, and we will be soon meeting again with Medicaid and the new Medicaid Director, Christine Nye, from Wisconsin, who is just coming onboard as the new Medicaid Bureau Director at HCFA, and there is a lot that needs to be done there.

Finally, the White House Task Force on Uninsured Care, the President directed that Dr. Sullivan convene this group. Dr. Constance Horner, the Undersecretary, is taking a lot of the lead on that, and HRSA is providing input into

that group while we monitor the other commissions, like Pepper and others, Social Security, and their recommendations on uninsured care.

I am pleased that the CDC/HRSA joint projects in community health centers went well, and again we are hoping to make awards to over 30 community health centers soon, around $9 million worth of primary care HIV project funds to expand our primary care activities, which would expand even further if the White Act is fully funded.

CHAIRMAN OSBORN: That's a big "if", isn't it.

Charles Konigsberg, David Rogers, Diane Ahrens, and then Harlon Dalton.

COMMISSIONER KONIGSBERG: I have a question for Dr. Harmon but first just a general note. I never cease to be amazed at the personality factors that go into leadership and mobilizing a community. I am not sure how one quantifies that exactly, but I felt after hearing Jasmin Shirley Moore's testimony that I had to say that. There are things that I think are not taught, but are inherent in individuals.

Dr. Harmon, we heard some testimony yesterday from our good friend, Jim Curran, who has now discovered that there is a link between preventive aspects of AIDS and HIV

and the medical care side. Dr. Curran correctly pointed out that probably most, if not all, infected individuals in this country need to be under medical care, although he phrased that as under the care of a competent physician. I might characterize that a little more broadly, but certainly it starts with the physician.

I know that HRSA doesn't directly affect the medical schools, but in relation to the educational training centers, we have had some questions raised about how effective those are, although we have not had a lot of discussion as a Commission, what you think can be done to expand that concept in terms of bringing more physicians onboard into the mainstream for caring for HIV; the other is the National Health Service Corps, which I applaud the efforts to resurrect the Corps. Do you envision as that develops providing perhaps positions to areas highly impacted by AIDS, but being more flexible than it has been in the past in terms of types and locations of assignments?

DR. HARMON: Well, first of all, on the broad subject of HIV care, we are working with the CDC to link care to its prevention programs. We have recently recruited Dr. Steve Bowen from the CDC to head up HRSA's HIV Services

Division in our Bureau of Health Resources Development. So we are certainly linking that up and will continue to work closely with CDC because those two programs are linked.

Education and Training Centers, we are hoping for a budget increase for these programs, depending on the '91 negotiations, to expand their activities, and certainly, they need to reach out to more primary care physicians because many infectious disease specialists and others are swamped with patient load, and we have to spread this around so that there is better access to care not just among physicians but to midlevel practitioners, social workers, and others.

On the National Health Service Corps, we are pleased the President and Dr. Sullivan have endorsed a big increase in the Corps budget from $9 million this year for scholarships and loan payback perhaps up to around $63 million, which would greatly increase our field strength by several hundred and get us up to 1,500-2,200 in the next year, and toward our goal of 4,200, so that we no longer have to make those very tough decisions of going to remote rural areas over the needs of urban areas and will have more to go around, and they can go to more highly-impacted HIV areas.

CHAIRMAN OSBORN: Thank you.

David?

COMMISSIONER ROGERS: I'm pleased to hear that.

You mentioned the President's signing of the Ryan White Bill. I hope you go back to him and tell him some of the things you have heard here from people who are desperate for those funds. It seemed to me the height of cynicism for Congress to then not fund it at all. I hope that gets corrected.

We have heard from all over the country the desperate needs, and to pass that bill with an overwhelming vote and then not put any money with it seems to me a betrayal of what many of these dedicated people are doing. And I know what you are doing, and I hope you shout loud about that.

CHAIRMAN OSBORN: Yes--I was going to congratulate you for not giving a primal scream after the reading of this morning's New York Times. I hope, however, that you don't restrain yourself too much.

Diane?

COMMISSIONER AHRENS: As we move along here in our exchange with panels, it appears as more of a conversation than just question and answer, and what I am going to see is

in keeping with that kind of movement. We talk a lot about--and actually, I guess my comments are directed to Dr. Schroeder, and he may wish to respond--we talk a lot about human behavior here, and one of the things I think we neglect sometimes when we are addressing this issue in terms of our own position is how you deal with human behavior.

One of our speakers this morning said so well that the Federal dollars seem to be moving much more in the care area that in the information area. I can't disagree with that. My own experience has been that when money is tight and there is a crisis, you go to the life safety issues, and in this case, that means the care issues, and the prevention really gets set aside or put on the back burner. And as the foundation community looks at this issue now, it seems to me that if anyone is going to begin to pick up on the prevention issue, it will probably have to be that sector.

I heard a question asked this morning as well which really addressed what makes the difference between localities that are doing well and those that are not. I think the thing that makes a difference in leadership--and that is an awfully simple way to put it--but it is really the leadership. And in my 16 years in the job that I now have, if I have

learned one thing, it is that elected officials can find the money to do things if they are really motivated, even in times of real budget crisis.

So when you look at this issue of prevention, and in a very basic way addressing the AIDS epidemic, I think leadership is what makes the difference.

I was wondering whether the foundation community is really looking at this kind of model, this kind of issue, how you get and how you motivate leadership at the local and State levels to devote the resources to getting in there and doing the job to address the issue.

Would you care to comment?

MR. SCHROEDER: Those are very far-reaching comments, and they could be given I think in any health commission, not just one dealing with HIV. And I think one of the interesting things this Commission is going to have to wrestle with is how much--all the criticisms we have heard from the panel, from this panel and the previous one really are much more fundamental than just HIV. They are how this country tries to marshal its resources for illness, whether it is acute, whether it is chronic, whether it is hospital versus prevention. And I think that your voice and the voices

of others will be important in trying to get the right balance.

I certainly share your sense that the Foundation is well-positioned, although it certainly don't have the robust budget that the Federal Government has, but is well-positioned to try to make a difference in areas that perhaps others don't spend as much time on. But I am a little worried when we say there are all these new cases coming, and we're going to have to shift the attention more into care and cure and not worry about the preventive aspects. That has been an ongoing debate for 50 years [inaudible.]

CHAIRMAN OSBORN: We thank all the members of this panel very much, and at this point we'll take a short break.

[Short break.]

ARC

CHAIRMAN OSBORN: The next panel is "The Future of Public Health."

Welcome to you all.

Since I know a couple of you came after my prior admonition, I we always ask people to summarize the highlights and speak from the heart and be even briefer sometimes than in their written testimony.

We all do try to read quite carefully the written

testimony. As you testify, if you could be brief with the knowledge that we will be getting a chance to read it.

We put a little kitchen timer on to help time that. I hope it doesn't interrupt you.

Would you like to start, Ms. Rodriquez-Trias.

DR. RODRIQUEZ-TRIAS: Thank you very much for this chance to share with you some of my experiences as clinician in a primary care setting for many years.

I think, you know, I was told to prepare something on the future of Public Health, and I happen to be a very concrete kind of person and I find it hard to, you know, get rhetorical and so on, when I see something that I have applied and seen actually work, I would like to draw on some of my experiences and training and learning in Puerto Rico and some of the things I have seen in the United States in my 20 years here in primary care in innercity areas, in trying to say that what I have seen as a major problem in terms of the AIDS epidemic, in terms of the Public Health influence, has been the fact that it has very little impact on the health care deliverances, and that that is a schism which I think for those of us who are clinicians but hope that we also have a Public Health approach in what we do in the

clinical setting have found it very, very difficult to live with.

I trained in the clinical school in Puerto Rico and at the time I trained, which was in the late 1950's, there had been a tremendous increased care of the thinking of John B. Grant and some of the other major leaders in Public Health who had developed a regional system, and the School of Public School was very fundamental in the founding of the school of medicine with the belief that when they would train clinicians who would work in the Public Health system, Puerto Rico then had a Public Health system which, free of charge, treated two-thirds of the -- medical services to two-thirds of the population. And the thrust of the regionalization was that there were health centers placed in every municipality, and these health centers united three major services, the preventive services, the social welfare services, and the clinical services consisting of diagnosis, therapeutic, and in some cases rehabilitation, because they had some beds that were long-term care. And although I have to admit that as we train and as we became, you know, more knowledgeable in medical care, we kind of grew a little bit away from admiring the Public Health models, because we felt they weren't real

doctors. Nevertheless, I mean, it became part of us.

You trained in a setting which you knew that if you had somebody who had hepatitis in front of you, you should call the sanitarium and have them find out why, you know, this person had hepatitis and was there, and other cases reported, and could it be because they really had spillage of some of the sewage water, you know, in a public area such as the school. So that is something that, you know, became a way of doing for us.

But just to share one funny experience in terms of the schisms, you know, what it meant to be Public Health versus what it meant to be a clinician. Our dean at that time was a very prominent man in Public Health and joke that went around, which was based on a true incident, somebody collapsed at a meeting and he took the man's pulse and he said, "He's dead." And the man looked up and said, "Not yet, Dr. So-and-so, not yet."

[Laughter]

When we became Public Health people, we would not be good doctors.

What was fundamental, and we were critical of the Public Health system and some of the quality of care provided

in this whole network, was that we didn't know, you know, what was happening in terms of funding and the resources.

The fact was that the resources for this vast array of health services that were being provided to people were one-third of all the resources went to two-thirds of the population.

Furthermore, you had a private system at the same time you had a public system permitted what you might call a number of irregularities in terms of how the public system was used. You might have a doctor who was under a salary in the health center who would still have a private practice on the side, sort of refer the patients either from public to himself and so on. So that there always was some kind of a basis there. But nevertheless, these efforts which had spectacular failures also had spectacular successes. It was an infrastructure there, from beginning to end for people. So that when the funding came in for the maternal/infant care program in 1964, a program-I was privileged to participate in, there was an infrastructure in which you could plug in the newly trained personnel, they could work in the system that had referral patterns that were established, and in the northeast region where this program was instituted, the

infant mortality was lowered by one-third in just a few years. And that was really attributable to this program which had begun to offer better care.

And when I came to New York in 1970, I really missed being able to call sanitaria, I really missed having any kind of outreach capability. I really resented having to call the police to go out and get children on whom we had to establish follow up. I thought that was a terrible travesty.

The local health officer and I became very close friends because we both shared, you know, the stress at a system which was even then beginning to crumble. I mean, there had been TB teams. If you had tuberculosis, you could send a TB team out and you could get other household members to come in for tuberculous testing, and that began to be cut in the early 1970's, so that we had no capability for that.

Throughout the history of the United States, you had that kind of fight over what is the purview of Public Health? What is its mission? What is its domain? And by and large, the separation has been very much institutionalized and a system of medical care has become very separated from the other aspects of health care and from Public Health. And I think to the detriment of the whole Public Health influence

on our thinking and our doing. And it is in this time in history that the AIDS epidemic hits us, at a time when I think the Institute of Medicine report certainly says disarray, but disarray which has its historical roots in this separation.

My experience recently in the AIDS Institute at New York State also taught me, gave me a much clearer vision of how the separation really worked, because at its strongest -- and I consider the New York State Department of Health a very strong department compared to many others around, but at its strongest, it can only wield really integrate power over the health care practices through elaborate regulations, reverse in negativism, to total capital construction. And you can't really begin to put the care modalities out there in a very direct way. It involves a tremendous amount of negotiations.

And I think that is what is happening in the areas of the greatest need for HIV here; it may be an opportunity for the public health system to regain some of that territory in impact on health care, and that is that many institutions are beginning to refuse to take HIV positives. I mean, this is something that is shocking to all of us and very painful

to hear, but it is the truth. I mean there are many private institutions in New York City that shunt over to the public hospitals, to the municipal hospital systems, and try in some way to really close off their services. And there is a research interest, there may be an interest in a particular population, but it is not the whole group of people out there who are HIV positives. And I think this, negative as it is, provides an opportunity to begin to change what the Public Health care system is doing in terms of AIDS care.

I really also envision -- and this is something that had been able to experience, I find a very positive experience -- that the activism and the power participation in health care that has begun to emerge as a result of the AIDS epidemic, that is that people say "Hey, it is my life," I think we have heard a great deal of that here this morning, has created a change in the paradigm. Most affected people are beginning to be a voice, have begun to influence research funding, diagnosis, patient rights, the range of services, therapeutic options, and the nature of the support services.

I think this is something that Public Health people must take into account in developing future way of working with communities. It cannot be any longer from the top down.

It will not work. It simply will not work. And that applies to AIDS, I think it applies also to poverty, and I think it applies also to drug addiction and to many of the other things that I think Public Health establishment has to take leadership in, with an expanded mandate, if we are really to do anything about what's happening to people today. I said I was fortunate in some of the experiences I had had, if I may just mention --

COMMISSIONER ROGERS: The beeper is going off, and so --

DR. RODRIQUEZ-TRIAS: Okay. This will be the last. If I leave you with this, I have done my job.

There is one program that was initiated by some people training HIV positive women to become HIV prevention counselors. That program has already graduated its first class. The only requirement was the women be drug free, and that they had been drug free at least for a year, because some of them are, of course, recurring addicts.

The kind of energy, the kind of knowledge, the kind of legitimacy, the kind of talented creativity, the kind of heart that these women are putting into this program nobody else could bring. And it is that kind of force that I think

we as Public Health workers have an opportunity to become part of if we are open to it, if we really accept an expanded mandate and change paradigm as part of our future.

CHAIRMAN OSBORN: Thank you.

The Commission has seen some of that in action when in New York. Your message falls on fertile soil. Thank you very much.

Dr. Myers.

DR. MYERS: Thank you very much, Chairman Osborn, members of the Commission. I am pleased to be with you today.

If my voice lacks some of its usual luster, it has that, it is because of a cold that I have at the present time, so I apologize in advance.

It's certainly clear that there is no geographic area in this country that has experienced the epidemic in the same way, in a greater way than the greater metropolitan New York City. I've been the areawide Health Commissioner now for some five months. There have been more than 26,000 cases that have been reported. We believe that we are 200,000 New Yorkers, of those cases that have been reported, 500 are men and women and 600 children under 13.

Certainly the burden of care has already overwhelmed

New York City's substantial hospital and social services resources. Planning estimates have indicated that by the end of 1993, New York City will need more than 4,000 new care beds for HIV. The last statistics, by the way, [indicating] have seen show we have now crossed the 2,000 per day census for HIV patients in New York. More than one million patient visits each year will be necessary, initial 3,000 support counsel units, 500 nursing beds, 600 calculated facility beds.

In New York there is a category somewhat less than intermediate called calculated facility bed.

And in the midst, we know thousands of patients have no longer appropriate treatment through early intervention that were available to all but is not.

There are numerous topics I could have covered with you today. Specifically the agenda you have asked me to address, however, is the future of Public Health and how that future affects quality of care, quality care, co-chair admonition trying to talk directly to you, summarize my feelings in this area. There are more specific in the testimony I am about to provide for you. Although --

DR. ROGERS: Get a little closer to the microphone,

please.

DR. MYERS: -- disarray, some aspects of the Public Health system with respect to HIV epidemic in New York City, I would choose to use the word "stressed," more appropriately "severely stressed."

In New York City, we are fortunate that there is an active network of health care organizations, many of whom have been in the vanguard bringing the HIV epidemic to the public's attention. We are also fortunate in many respects because we are sending physical commitment as well.

We have worked through the Office of Management Budget, City Administration, spending fiscal 1990 in New York for HIV remaining issues, so we have estimated that well over $1.1 billion haVe been spent in fiscal 1990 by all sources on the epidemic.

Approximately $50 million of that will have been spent by New York City Department of Health. But as you are aware, an increasing share is going towards the treatment of those already infected; approximately $468 million having been spent by the city's health and hospital corporations for that purpose in the same period of time.

The surveillance, counseling, testing, reporting

activities of the Department of Health continue to escalate, but far less rapidly than the dollars that are now being consumed by care for the city. That's one of the reasons that you all very well know the Mayor of New York City, David Dakins, has taken a leadership role trying to pass the Comprehensive Care Act, and appropriate funding of that bill.

Let me summarize three areas where [indicating] see some of the issues with respect to the future of Public Health and the HIV epidemic. First is the area of prevention. If I had a number of individuals with expertise talk to you about the prevention, we sincerely need to push the issue of how we are talking about what we are talking about, certainly there has to be much increase, very significant increase in both quality and quantity of information provided to our children within our schools and outside of our schools.

I think there are ways to do that, that includes the parents, that help the parents to understand the rationale, and I think both the government and the private sector participate actively.

Some of you who are probably with New York City hospitals are aware that we have a situation now in New York where a boy was identified recently as having the virus, came

forth to tell his story to one of the newspapers. There is a controversy over the last several days of some of the parents in the school about not wanting their children to be in the same classroom as that young boy.

For me, that is like deja vu all over again, given what happened with Brian White four or five years ago.

It is amazing how much we have learned in prevention and it's also amazing how much we haven't learned in that same period of time.

However, I do believe that parents must be involved. I believe that we have got to do more social marketing. You have seen some of the articles about AIDS in Africa in the last few days, the inclusion of social marketing efforts in the population there. We have to do more of that in our country. We have to make condoms more easily available to those who need them.

The way I view this issue, members of the Commission, is plan A for children, including my own, is that I wish they would delay sexual activity, remain abstinate until they are in a stable relationship or marriage. But frequently plan A doesn't work and I think we have to be well prepared in the Public Health to have plan B available; that

means providing condoms to those individuals who choose not to listen to our good advice for plan A.

I think parents have to be involved in that much more than they are today.

I believe that there was some good news we heard from Dr. Harmon with respect to prevention; he is hopeful that the budget for that will increase.

I believe that is absolutely necessary. However, I do also believe that we have to put more emphasis on prevention in the primary care setting with the physician. And I am glad to see there are more physicians becoming available, a quite better means to employ community leaders and workers.

Secondly, in therapy, I think that we must continue to encourage our completion in the biomedical world to push harder for a vaccine. Certainly we are going to continue to do as much as we can with prevention efforts. We need the help that a vaccine would provide, and we need that quickly. I think that if you look at the numbers, it is hard to tell what number of cases we would have had had we not engaged in the prevention efforts we have thus far, but we must have the adjunct of a specific tool, vaccine.

Finally, I think we are seeing now in the future before us with respect to funding, I believe that we are probably curve funding for HIV, the health care bill which people voted for may be the last major AIDS bill they will choose to work, for funding difficulties associated with that bill are the harbinger of what future AID specific efforts may hold for us.

I think those of us who care about this issue are going to have to find better ways to integrate AIDS funding in funding of other spheres of health care specter.

I believe that that chore would be one for not just those of us in government, but for those of us outside the government as well. It is all of our money.

I believe that we should use the opportunity that we have now with HIV to integrate that disease in with many of the other diseases that infect the same population.

A patient won't come with just one disease, the patient comes with a whole variety of problems. We have to look at the funding of those problems in a more complete way and fight for AIDS, but within the context of funding for other major important Public Health problems.

We have to fund risk reduction efforts outside, so

they are community based. They need to be in the school, at the job site and in shopping centers and other places where people congregate as well.

And so with that, I would again thank you for this brief opportunity to testify.

I can't end without commenting on the remarks by Dr. Rodriquez-Trias; it's certainly on target when she talks about the dichotomy we have had between the Public Health and clinical medicine. I come from clinical medicine, I am proud of that. I have selected people who work in the City Department of Health who come from clinical medicine, and certainly we believe that there should be much more interaction between those who practice and those who are involved in public health. And I believe that that needs to take place both in the medical school level and in the clinical level. I believe the medical schools are not doing the job like they ought to be doing to provide medical students the opportunity to learn about the practice of prevention and the future of Public Health is going to be bright, that has to occur in a much more direct way. I'm sure that there are ways within the setting and other agencies of the Federal Government that can help in moving

that forward.

Certainly Dr. Rodriquez-Trias is right, patients are being shunted from the clinician's office to the public hospital system with HIV, but they are also being shunted for other diseases as well; the phenomenon is not limited to HIV.

Until we address many of the problems this health care system of ours has had for many generations, we are not going to be successful as we want to be for those problems specific to HIV.

Thank you very much.

CHAIRMAN OSBORN: Thank you.

Next, Caswell Evans, of the Los Angeles County Health Department.

Dr. Evans.

DR. EVANS: Thank you, Dr. Osborn.

I am the Assistant Director of Public Services, Director of Public Health Programs for the Los Angeles County Health Services.

I am also here on behalf of the American Public Health Association, the oldest and largest professional health association in the nation.

You have I think as part of your handout some of

the monographs, materials that APHA has produced. I am sure they are not new to you. I want to make sure you have additional copies.

I do appreciate the opportunity to speak to you today.

In my presentation, I will address AIDS and the Institute of Medicine report on the future of Public Health. My comment will be from the prospective of a local health department using examples where appropriate from Los Angeles County.

The Institute of Medicine's report on the future of Public Health cogently describes the state of the Public Health System in this country. While it is a planning document, the report provides a broad framework regarding the Public Health challenges for present and future.

I would like to focus my comments on the overall conclusion that Public Health is in disarray, somewhat echoing Dr. Myers' comments; he stated that's a stressful, strained situation. I would like to suggest the Federal Government is not so much in disarray, rather it is in a period of necessary transition as it adjusts to increasingly complex problems, such as AIDS, drug abuse and chronic

illnesses. And considering these problems and these services, I feel the Public Health has demonstrated effective leadership.

Despite the general validity of the IOM report, it is in fact not perfect. The Future of Public Health Report highlights the many weaknesses of the Public Health System, but it does not in fact point out the strengths and accomplishments of that system.

While our society has yet to demonstrate a consensus as to whether health is a right or a privilege, Public Health agencies in my opinion are the rightful lead agencies to address problems like AIDS, because of their role in protecting the communities' health and the history of being providers as a last resort for the medically indigent, an issue already discussed on this panel.

The Future of Public Health Report also describes the effective -- limit of effective leadership in Public Health. And while Public Health policy is based upon maximizing scientific knowledge and professional judgment, public decision making is often more rigorously and profoundly influenced by crises, hot issues, and interest group concerns, to name but a few.

Public Health has experienced many difficulties in accommodating and participating in the political arena. However, we need to heed the IOM report's recommendation which holds that Public Health leaders and agencies must become better communicators of Public Health concepts and strategies to the community and to our political leaders.

In Los Angeles County, I believe that there are strong signs of Public Health leaders and agencies are becoming more effective in communicating Public Health issues.

In the area of AIDS, our Public Health Department has developed linkages with community organizations, effective groups and service providers, in order to expand public participation in planning and priority setting.

Concurrently, the public has become increasingly knowledgeable and involved in health issues through community organizations. However, we must continue to improve our working relation s with African-American community and with Hispanic community organizations. For our future efforts to succeed will depend largely on our effectiveness in working with these communities.

As a result of our increased community involvement, the public has come to expect Public Health Departments to

become more involved with complex health issues. This increased scope and response of the Public Health could easily be construed as disarray. However, I am convinced that the expanded public involvement is good for Public Health.

The Los Angeles County Department of Public Health Services has the responsibility for the public health and well being of over 8.5 million residents. The County Health operates 42 health centers, 6 comprehensive health centers, and 6 hospitals in addition to the broad array of Public Health services.

The Public Health Program and Services Branch of the department is budgeted at nearly $400 millions. The developing budget, including the hospital system, is more than $2 billion annually. We are really a large complex diverse organization.

Without question, the AIDS epidemic has placed strains on our Public Health System, which has already stretched to provide basic Public Health services, as well as modern prenatal care, emergency and trauma care, sexually transmitted diseases and measle epidemics, alcohol and drug abuse, to name only a few.

Over the past several years, Los Angeles County has significantly increased its AIDS program and services. This increase has happened at the same time, in the opinion of many, as a result of the private sector's general advocation of responsibility to treat the AIDS infected population. The budget for AIDS expenditures has grown from $50 million in 1986-87 to an estimated $60 million in 1989-90. The county cost alone for this figure for 1989-90 was budgeted over $20 million.

The county has developed a continuum of services for AIDS and HIV infection ranging from prevention, early intervention, to case management tertiary care and hospitals. We have gone beyond our mandate as providers of last resort to provide services that have become the community standard of care.

Such is the case for early intervention services provided in our West Hollywood HIV Clinic, and our case management services provided under contracts with community-based agencies. In fact, we've developed a spectrum of services for AIDS that one can emulate for any types of diseases that we see. However, Los Angeles County will not only have to meet the demands in health-related areas, but

also law enforcement, welfare and children's services among others. Thus the AIDS epidemic is superimposed on the already seriously burdened county government and health care physical fitness.

We must continue to have adequate resources to address our many present Public Health problems, while we also advocate for reform of the budgeting process for Public Health Services.

Reforms are needed which will address the funding of Public Health services as an unavoidable fixed cost of society.

When Public Health budgets at all levels of government are subjected to annual appropriations which vary from year to year or in fact are nonexistent, it becomes difficult to adequately plan and implement programs with long-range focus, especially ones that are targeted on multifaceted problems.

The failure to dedicate funding to support the Care Act of 1990 without curtailment of support for other critical services typifies the problem, and simply cannot be tolerated without serious exacerbation of other Public Health problems.

The american Public Health Association has already

expressed strong objection regarding the failure to fund the Care Act of 1990.

In conclusion, many agencies can provide AIDS-related services, but only local health departments have the experience in prevention and in treatment, the legal mandates, and generally the credibility to lead in this fight against AIDS. Yet because of the complexity of this problem, such leadership cannot in fact be achieved by one agency or one health officer acting alone.

Our achievement in Public Health is dependent on our ability to work constructively with other groups, private community organizations, community leaders, and elected officials.

In my estimation, considering the fiscal, organizational and political context in which the Public Health Systems operate today, they have responded well to AIDS.

The Public Health System has been asked to shoulder the responsibility for increasingly complex health issues. However, the products should not lead us to believe that we are in disarray. And these difficult conflicts should not result in a crisis of faith in our Public Health System.

However, in the future, Public Health agencies must become more effective in working with minority community organizations and their leadership, affecting the HIV-IVD interface with effective interventions and services involving the private sector to accept more of the burden that the public sector simply cannot do alone, demonstrating effective leadership in multi-year planning and program development.

We have never lost sight of the Commission's mission with Public Health to the public we serve. Our knowledge of dimensions of the AIDS epidemic in concert with the IOM Report challenge us to prevent complete action to improve our Public Health System. However, we should not allow past successes to result in public or professional complacency. And in fact, it is incumbent upon us to effectively communicate the benefits of the Public Health System.

On behalf of the Los Angeles County and the American Public Health Association, I thank you for your kind attention and the opportunity to testify today.

CHAIRMAN OSBORN: Thank you very much, Dr. Evans.

We will hear from Ms. Gebbie, who presumably is having a nostalgia trip, sitting on the other side.

MS. GEBBIE: Many, many hours, yes.

And I too want to thank the panel for this opportunity for being here, on behalf of the Secretary of Health of the State of Washington.

I have trouble figuring out how to cram into these few minutes some important features, and ones which come from the heart, but perhaps a heart which does not draw at other's heartstrings, the way stories of sick and dying, clamoring at the door for immediate care, can pull. Because we are talking about something that sounds like bureaucracy gone wild when we start talking about Public Health infrastructure and system, and folks don't often like to hear that.

For many, many people in this country, when they do something as simple as walking in to get their child immunized, they have absolutely no knowledge of the immense bureaucratic structure of a Public Health infrastructure which backs that up, thinking that the manufacture of vaccine, the purchase of those vaccines, making them available through either the public or private system. And that is what we are talking about, that system that will bring it all to bear.

We have heard this morning predominantly from

people from the large agency and I think it is important to remind you I come from a state which is smaller than either of the two health departments that we have just heard from, with a population just under 5 million people, and that for many, many there are state health departments that serve less than a million people. For many, many people, their local health agency consists of less than 50 staff, often less than 20 staff. And there is perhaps one nurse who is the confirmation-investigator, HIV counseling and test provider, however you wish to refer to her, hospital discharge planner, and who works on Tuesday afternoons. It is stating a system-wide setup that can provide the organization that holds the system together that I think we are talking about, and I think we fool ourselves if we believe that individual structures of service organized around individual patients can be sustained without a back-up system that holds them together. That back-up system exists in our official federal, state, and local health agencies, but it needs continuing support and help.

It is the diversity of that system that is both its strength and greatest weakness; its strength because it adapts itself to the differences of Federal Government

complexities and state government politics and of local differences, but also which makes it hard to describe it and define it, and which means that at any one time, while one of those departments is doing well, looking vigorous, coordinated, and on top of things, another one is looking like it is about to go down the tube, because it just had 50 percent staff turnover, failure of a local levy, a change in state law that causes a problem, and a fight with the local medical community over how to handle prenatal care. Because all of those things happen and are real.

We shouldn't let the successes fool us into complacency; we oughtn't to let the occasional failures to depress us and cause us to run elsewhere. We need those systems to hold together.

Ii have given you an outline which provides some key points. I am not going to talk to each one of them.

I want to emphasize that we need to look at this epidemic as part of the whole system. You have heard that from several people.

One of my recent encounters, we had a very eloquent meeting to discuss the issue of whether or not there should be universal screening of all pregnant or prepregnant women

for HIV infection as a way of dealing with the potential spread of infection to newly born children. At several points during that two-day meeting, we were brought back to reality, most often by women themselves who suggested that it was a very irrelevant and irrational discussion when in fact it crosses very many women who can't even get in to see a practitioner to confirm the existence of their pregnancy or to get the required prenatal visits before delivering as an emergency through a hospital emergency room.

The same is true if we look at the epidemic of other sexually transmitted diseases, discussions of the spread of sexually transmitted HIV disease while we are watching doubling of syphilis, gonorrhea and many other communicable diseases across the country. And the same intervention that would stop the spread of those diseases will stop the spread of HIV infection, the same risk factors causing them to go up, creating an increase of HIV infection.

We have to see the system as a whole, and I encourage you to do that. I encourage you to keep those basic structural systems in mind and how we keep them under surveillance.

The interdisciplinary features which are such an

important part of Public Health and related practices across this country, the definition of community in all levels, which has to be defined, not just by geographical boundaries, but by individual communities. And by backing that up with both technical resources and funding.

I understand you have heard something about evaluation yesterday and I underscore that as one of the technical resources we all need to recreate evaluation projects. Every city, state, and local health department in this country seems to me a little crazy; on the other hand, funding services and programs need to get down to the local levels as quickly as possible. And that fun ding needs to be a partnership. We don't expect any local government to do it all, but we clearly need everyone involved.

Ii urge you as you do your work and put your reports together, and statements to the world, that you do it in such a way that you acknowledge that structural role of the official health agencies, that you underscore that and you support policies, programs, and funding, which will sustain that infrastructure so that around it, we can build the network of health services by private sources or public sector, the network of community-based organizations, and

outreach organizations that made the successes we have seen possible, and give us hope for a sustained approach to controlling this epidemic through the end of this century and on into the future.

I thank you very much for this opportunity to be here and look forward to discussion.

CHAIRMAN OSBORN: Thanks very much.

All of you, I want to take a second to comment about your hope for a vaccine.

As it happens, I was ruminating that medicine had its most recent set of considerations in this instance, the practicalities surrounding an HIV vaccine candidate quite promising, which at the moment I think it is not and it was quite clear that is many years off. And I find, I would give you the tenth hour at the end of the day, I will spare you that, but I have found repeatedly that the mention of the vaccine in the context of difficult problems as we are facing now in both prevention and care has almost a narcotic effect in terms of dealing with the issues we are going to have for at least a decade before a vaccine, the perfect vaccine were moved into place to help us with any -- I am sure you know that, but I think it is awfully important to get an antidote

for that narcotic very quickly.

Larry.

COMMISSIONER KESSLER: I have several questions. First, I want to make clear the discussions of Dr. Rodriquez-Trias as reality, the clarity which you bring to this panel. I think that is always appreciated.

Dr. Evans, I am also very happy to know, since we have been in Los Angeles in January, things have turned around so dramatically.

You should tell the National Press Corps about that, let them in on the secret.

I think when you talk about leadership, I am wondering, I am going to ask a question, it is not the kind of usual question that we need to ask our guests here, but someone who is responsible for Public Health, who has the kind of leadership in the future, who has responsibility to alert and educate public officials, what have you done with county supervisors in terms of educating them since January about the epidemic in Los Angeles?

DR. EVANS: Well, I must say I am having some difficulty putting your reference to January in context regarding the press corps. I don't think that anything has

been turned around marvelous since January. I think the things are in reasonably good shape under the circumstances in January. Perhaps we come from Los Angeles' experience with a little different perception.

But in response to your question, the Los Angeles County Board of Supervisors has a panel, the County Commission, one august Commissioner Diaz sits on that commission, and I think that that commission in conjunction with the Los Angeles County Public Health Services has spent a great deal of time with the Board of Supervisors and with their staffs educating them on AIDS, laying out recommendations and options for them, and performing the kind of advisory and staff role that we are in fact paid to do.

The Los Angeles County Board of Supervisors, like any board of supervisors, are elected officials and they make the final decisions in the county, and they establish county policy.

Our role is to advise. We've done that dutifully and responsibly. And I think in terms of the department's time,I believe I have addressed that, you might address what the Los Angeles County Commission on AIDS has done with your colleague.

COMMISSIONER KESSLER: What I am referring to, I think, is when we were there, quite clearly we heard that it was generally strong resistance from several of the commissioners to preventive efforts to launching care systems that could serve the credible numbers of people in Los Angeles who are without adequate care. And I guess I am frustrated, because what Ii heard in your address was a lot of rhetoric about planning, coordination, collaboration, and I am wondering do we need to wait another ten years before some of those programs that really work get to the drawing board and actually have a written -- the urgency I think, particularly in Los Angeles and York, in terms of leadership, I think requires perhaps a split between those elected officials and those in charge of Public Health who publicly say you folks, elected officers, are not doing your job. I know you are paid, you are hired by elected officials, but there comes a time somewhere where the issue of leadership we should have with AIDS around.

Do you ever think it is conceivable that you would go to Los Angeles Times and say that you have got a bunch of people who don't understand what AIDS are about in Los Angeles and not doing their job? Would you take that public

profile and speak clearly about the crisis?

I am not talking about public relations, but the crisis epidemic proportions that exists in Los Angeles.

DR. EVANS: When you refer to the letter, I refer to as factual and straightforward report to you.

Now, perhaps this is a discussion that we may wish to continue in some other format. I certainly am not here to enter into this kind of discussion or be placed in this kind of position. But since I am in this kind of position, I will indicate to you once again that as far as the Los Angeles County Public Health Services is concerned and as far as my personal work is concerned, I can only assure you that the description of AIDS in Los Angeles County has been more than adequately depicted, and I think that the board in the range of financial reality for the county has in fact acted reasonably.

You talk about rhetoric. You asked about specifics. I mentioned in my report to you as well as was presented to you on your visit in January the HIV Clinic in West Hollywood, and I believe that when that report was given to you in January, it was said then that we consider that to be a salient accomplishment in the county, providing an early

intervention of service before early intervention, in fact got coined as a popular phrase or packaged in some other funding package. We were in the forefront in terms of conceptualizing that early dimension system, in fact it was working and we had it in place.

Now, I point that out to you as being straightforward and fact finding, and not rhetorical.

COMMISSIONER KESSLER: I guess my question was, I had a similar question of Dr. Myers, when the other 49 clinics that the County of Los Angeles needs, needs to meet the need that exists today, not that is going to exist five years from now.

DR. MYERS: Well, when it becomes available, we in fact will implement those clinics.

COMMISSIONER KESSLER: Dr. Myers, I am going to follow on the same trail here. Recently you heard about the May or of New York making a pledge and there didn't seem to be much asked about it, to hire 5,000 extra police officers at an incredible level of funding; recruit, train and sustain those 5,000 police officers.

Did you go in the next day and ask for the equivalent amount of money for 5,000 care bed treatment

slots?

I mean, if we can figure out how to hire 5,000 cops pretty quickly because we conceive the crime emergency has worsened, isn't there another emergency going around in New York called AIDS that ought to get comparable attention?

DR. MYERS: First of all, no, I did not do that. Nor would I do that. And I must say to you I resent the implication in your question that those of us who served the public in these kinds of positions, in order to do our jobs, must somehow publicly confront elected officials, who hired us, or must take on an adversarial role with them, or must somehow provide information to the press that, from the tone of your question, you believe has not been provided, or perhaps is being in your opinion provided inaccurately. I don't believe that is the case.

Certainly there has been no mayor in the city who speaks with any more deference than Dakens, nor has there been a mayor of any city that has been more aggressive in the short period of time he has been in office, on the subject.

He has carefully spoken to all of his commissioners and carefully discussed this issue with the public in New York City, has testified frequently in Washington and Albany

on this issue, and on the type of severe crisis that New York City has experiencing, found money to increase the budget of the Department of Public Health for this epidemic, as he reduced the budget of other areas. So any implication that you have made that this mayor is not fully committed to this epidemic, or thousands of us in this kind of public responsibility are somehow deceiving the public or being less than fully forthright, is resented.

COMMISSIONER KESSLER: I appreciate that. That is not exactly what I am saying.

What I am trying to get is how you set priorities.

It seems to me that when there is a will, there is a way.

When a tourist is killed in New York, it is a tragedy and it is a tragedy. It shouldn't happen in any city. But if it triggers the kind of response that said we have got to hire 5,000 more cops, I wonder how many people it takes to die of AIDS in New York City to get a comparable response?

Over -- I am thinking outloud my frustration of the last two days on this panel, but so be it -- what we have been hearing is that we have to sort of work with our public

officials. What I am afraid I am hearing is we've got to do what the pollsters, campaign funders, campaign managers and so on, ask us to do, rather than protect public health.

If that's the case, then I think we have to take health commissioners at the state and city level and make them elected officials, rather than appointed officials, because then we could elect people who at least might do something in three or four years' term without being apologetic all the time.

I used, for example, yesterday the metaphor of jobs. You know, at times of a sense we are doing a remake of that movie, having a police chief saying "Let's not talk about the sharks in the water, it's bad for tourism, bad public relations thing."

It's like when you say the system is stressed in New York, that sounds like a public relations slogan. I say it is in disarray from what we have seen there, from what we know about it.

But I guess I am annoyed and concerned about the rhetoric and the level of the terms of devising these days sugar coating of the epidemic.

DR. RODRIQUEZ-TRIAS: I know, you know, we share

the concern for the reality that the national conception of AIDS problems, or the national conception of personal safety, or whatever it is called, is very dramatic, and that is true in New York even more so, where you will get the constituency from the lily-white sectors of Queens very concerned about the young men from Promo who was killed on the subway, but you do not hear that concern at all, even when the people are dying from AIDS, coming in. We have to be aware that it just doesn't have the same political clout.

I am not in any way, you know, apologizing for anything, because I came here as an individual and I am fortunate I don't have to represent a very complex and terrible situation, you know, in confronting one.

I think we have to be very professional as we want the people to be compassionate about other crises, such as drug addicts. I think we have to be very compassionate in the difficulty of the task that we carried out, because it is only in that climate of compassion that we are going to be able to really work together.

I just wanted to register my somewhat distress at the tone of, you know, the latter part of the discussion.

CHAIRMAN OSBORN: Thank you.

Yes.

MS. GEBBIE: I think this latter exchange gets to the heart of what distinguishes Public Health and Public Health practice from the private practice of medicine, nursing, and any of the disciplines we represent, and should not go unremarked. And that is that official Public Health is the intersection of the sciences of medicine, nursing, public health, environmental health and so on, and political will.

We operate statutes and structures that are political animals, and we operate at the will of a political structure. Electing us rather than appointing us will not make that go away. In fact, it makes it even more stark. And the fact is the elected officials across this land at all levels of government have gotten no enlargement input on this, and only marginal sources to come through with decisions that would put health and public health in higher priority than road building, police action, education, and all of those other structures that are at the heart of the public and political will.

Each of u s makes our own decisions about how we provide facts to those decision makers, how we provide facts to their constituency. We use news letters, we use press

releases, we use conversations and we use appearances in front of you, we use whatever we can find. We meet behind closed doors and open doors. But at the end, it is in fact the political will of the people as they vote on those ballot measures and personal choices that effect the relative priority of this epidemic.

And there is no real need for us to point fingers at each other if we were to make it happen. It is not within this health role we will make it happen; it is out in the bigger role.

CHAIRMAN OSBORN: Thank you.

We have several commissioners still wanting to participate,a nd I want them to, but again I am going to have to suggest we be brief. We have substantial Commission business to do after what is going to be a very brief luncheon break.

Belinda.

COMMISSIONER MASON: I will try to be as brief as possible. It's hard for me to do so, but I will try .

I have got a lot of questions for you. I want you to tell me candidly, as I would speak candidly to you about anything you would ask me to, about what extent your

leadership of Public Health is influenced or exacerbated by politics? Ms. Gebbie referred to that to some degree. I want you to tell me how much the politics ties your hands? How much it leads you along the path?

I also want to know what your position is on the contract pricing, what you propose to do along those lines?

Similarly, I would like to hear your position on changing efforts, things you may have said before?

You have to understand I am in Kentucky. I don't read as much as I should. And I have my own kind of concerns.

And, you know, these efforts will change. If we are talking about HIV prevention efficacy, so I would like to have some answers from you, please. Know it is in the spirit of freely exchanging that I am not trying to beat you to death or anything.

DR. MYERS: First of all, you asked a question regarding politics and Public Health and what I do.

Politics is an everyday part of what I do and every other county commissioner.

What we have to do is take what we know about science, what we know about public health, and try to change that into effective public action. We do that in the context

of city council or state legislature, or mayor, governor, who appoint us, whom we work for. And if we are successful, we move forward. If we are unsuccessful, we stay where we are or we move backwards.

I think that with respect to this epidemic, there has been forward motion, albeit not as much as I would like to, or you and other members of the Commission would like either. But nonetheless, that is the system of democracy we live in in this country.

We are bound to follow the rules of that system and try our best to positively affect the system as we spend our time with it.

You have asked me about the issues surrounding the department, major activities of the New York State Department of Health, as it has been for years, and we will be expanding that in the Health Department.

Certainly we believe that there is a role for the Health Department to play in helping individuals understand what the risks are.

Does that mean we need to do it in a forceful way? No.

Does that mean we need mandatory reporting or to

make sure that that job is accomplished? No.

Does that mean that we are insensitive to individuals and to their concerns about privacy? No.

Does that mean we violate confidentiality? No.

However, we do believe it is one of our roles to assist individuals to know, we do believe the physician has to play a major role in that as well we have encouraged physicians in New York City to do that. However, in those situations where there is not a physician to work with that patient, we believe the Health Department should move in.

We are actively looking for strategies to deploy.

Certainly there are a number of experimental programs under way throughout the world, including the United States, on the efficacy of such programs. That efficacy in my opinion has not been documented. There are some subjects which show either approach to what we term as "safe for rejection," reduced rate of service furnished for an individual HIV.

We are continuing to follow that research and will be -- I will personally be reviewing each and every document that I receive, and I conceivably can get to help my understanding of that research, but certainly given the

current state that we have to make very difficult decisions about our fund, not to put our efforts in that aspect of that approach.

We believe that individuals who are using drugs ought to stop. I think if they can't stop on their won, we have to provide help in doing that. I think that ought to be our primary message, which it is.

We certainly follow the steps that have been outlined eloquently by Dr. Rogers and Dr. Desalay in their report they have issued on the subject that the drug addict ought to stop.

The second one, I believe if you must take drugs or continue to take drugs, you ought not to object, you ought to follow our advice one or two.

The third approach of share report.

And the last is to try to teach him to inject safely.

That is the approach that we take with our educational efforts in New York City Department of Health for the foreseeable future. We have drawn the line of funding actual leads to purchase and exchange.

We don't believe that that is appropriate to take if

we ask the question as follow up whether or not there are political considerations in making those kinds of decisions, there are always political considerations in making public decisions, as there will always be. And we who are at this interface between Public Health and politics have to be involved in that process, we have to do the best job we can under the circumstances that we operate under; otherwise there is no purpose for us to be there and we can't be successful.

So I hope that adequately summarizes three very tough questions.

COMMISSIONER MASON: Just very quickly, I think I heard some sign of value judgment for use of cessation, cessation of drugs isn't the answer. You know, isn't answering the highest moral concern the preservation of life regardless of what it takes to do it?

DR. MYERS: I hope it didn't come out as moral judgment. I think it is very clearly medical judgment, injection of illegal drugs is bad for you in a variety of ways. There's n o argument that it is also bad for you socially, and certainly bad for you legally. And so I very strongly believe one ought not to use illegal drugs.

COMMISSIONER MASON: Thank you.

CHAIRMAN OSBORN: Okay, we have a whole list of commissioners. We are way over time, and I remind you we have substantial other work to do after lunch.

That having been said, I'll move on.

Charlie.

COMMISSIONER KONIGSBERG: I'll be brief.

I am not sure whether to comment on substantive or comment on the interchange, or to prob ably obey David Rogers' unsaid but probably communicated thoughts not to react. Kristine Gebbie probably said it much better than I did.

I think I would say as a state health official that there needs to be a dose of reality throughout the political system.

I guess my plea would be do let health officials that select, but select wisely. That is not always done.

I think we can probably leave it at that except to say my own experience has been -- and I'm sure the panelists' experience too -- that when we fall back on our science of public health, we are usually on pretty high ground for elected officials, who rarely challenge. When we move into

the art of public health -- public health like medicine is both art as well as a science -- we then start treading on other people's turf sometimes, and we are not always listened to initially, perhaps in the long run.

I would also remind this Commission that there is another commission report out, the National Commission on Infant Mortality, which I read recently, which has beautifully documents, and describes another national disgrace and tragedy which is why we are nineteenth in infant mortality. So we have a more fundamental problem here than just AIDS.

Now, let me get to a bit of substance or common interest for the record. First, I agree with Dr. Evans, Public Health is going through a necessary transition. Some of us have been working through that transition for a couple of decades or more, wondering where it is all going to end I suppose.

One of the transitions has to do with what Dr. Rodriquez-Trias brought out, that is that blending of clinical care and Public Health, which I thought she described better than anyone I have heard in a long time.

One of the things that concerns me about the IOM Report, I think it really missed the point about where Public

Health relates to clinical care. And I think that if we reflect back on Jasmin Shirley Moore's testimony, one day she may be able to make that transition. Although it was perhaps scarier to do than she might have told us, it is because we were already in the business of delivering primary care. We had established ourselves and it is important that when Public Health does these things, that they adhere to the same qualities, so we don't have poor quality second class, second tier care, as occurs in many areas. We have got a long way to go.

CHAIRMAN OSBORN: Donald Goldman.

COMMISSIONER GOLDMAN: Thank you.

I just would like to make a few points of things that have been said to me in the past and then I would ask any of you if you wish to comment on them.

It has been suggested that reality, one of the most important strengths of the Public Health System is its own credibility. The Public Health System that is credible in the community can't be effective with limitations.

Yet the Public Health System, at least in connection with the HIV infection, goes through the prescreening systems that have been developed without assuring -- and I use that

term I guess in the way the IOM Report does -- assuring access to care, then it diminishes its own credibility and ultimately its credibility is what makes it work.

So when talking about prevention, if people were short of access, a majority of persons for HIV infection would probably seek HIV testing to get into that system of care if it were available, and wouldn't spend so much time and energy debating those kinds of testing issues and things of that nature.

The same thing may be true in terms I know we haven't covered here, but in terms of some of the other issues involving drug testing, that at least in many people's minds some of the rationale and issues involved getting involved in research projects as a ticket to get access, not available anywhere else.

I was wondering if anybody could comment on that and what the implications are for the Public Health System in terms of loss of credibility down the road of urging testing, urging people to get involved in a system, and not at the same time providing any assurance that that system is just for them?

DR. RODRIQUEZ-TRIAS: I absolutely agree with what

you say.

But let me mention another piece of it, because I was actually involved in some of the discussions where, when the CDC guidelines came out for early intervention vis-a-vis prophylaxis of PCP, there was much discussion, and if we get this information out to people, we would be battered down, you know, by some sort of multitudes in New York City, multitudes battering our doors when we are not really providing care for those who are already sick.

This may be philosophical, but my position on that is we have absolutely no right -- in fact we have an absolute obligation to whatever information we have got to diffuse it as broadly and wisely as we can. I mean, I think we should attempt to reach everybody with that information. But that the other piece of that information ought to be what we know of the system and its inability to respond, you know, so that people have to know.

And I think this because I have always been concerned about the class divisions about who gets information and who can read the pamphlets, and who, you know, listens to the public broadcasting system station, and so on and so forth, and what efforts are made where the people are at to

really let people know what is going on. So I was very concerned about that point of view, which I've heard expressed at very high levels by the way. But I absolutely agree with you that unless we as Public Health people be permitted to access and to I think high quality care for everyone, our credibility is not very good.

COMMISSIONER GOLDMAN: Would anyone else like to comment?

MS. GEBBIE: I would agree that credibility rests on both the day you work with that, tell people what is going on, and then on pulling together systems that deliver services.

I think the difficult issue from all Public Health officials in this epidemic is sorting out, having agreed to that, to agree to advocate, then, that all is done for all, sorting out which direction you give to yourself and which pieces you try to get done somewhere else, and where there isn't someone else there, it is pretty hard to decide how much to try to take on. And that is where the credibility flounders and where people have struggled, and I don't think there is any crisp, clear answer to that except everybody sees you doing it and understand it is a difficult situation.

CHAIRMAN OSBORN: Eunice.

COMMISSIONER DIAZ: I was just thinking as I sat here looking at the four of you what a beautiful presentation from the trio of professions working for Public Health, two of you are physicians, one woman a dentist, and the other woman a nurse. I think that is a very beautiful thing.

We here today understand the roles go to all people. I've been a rank-and-file Public Health provider for most of my professional life. It is a very difficult question, very thought provoking.

Tow of you I would like to ask the questions, because I think it hit at something Dr. Evans alluded to.

In metropolitan areas affected by HIV, how do you perceive now the input of the Commission on AIDS and continuing with the Los Angeles Commission on AIDS be supportive of all things that have been asked from the Commissioners in terms of further advocacy, expansion of the Public Health concepts and kinds of things I think that Kristine Gebbie and others mentioned.

DR. MYERS: I will start.

In New York City, we are fortunate to have several organizations that are very much involved that are based in

Black and Hispanic communities; Hispanic AIDS Task Force, Latino Commission on AIDS, Black Leadership Commission on AIDS, Minority AIDS Task Force, all has as special focus how this epidemic has affected how they might intervene within minority communities.

I view all of those organizations as a major adjunct to what we are trying to accomplish in the Health Department. We, in fact, are funding -- I can't give you the exact amounts -- to help us in a variety of areas.

I have met the leadership of each of them. I believe very strongly they are very helpful to the city and need to b e encouraged. We need their continued participation and should work more closely with them to get the job done.

COMMISSIONER DIAZ: Do you see them as a critical role shaping public policy in HIV?

DR. MYERS: I do. I think the questions that you have are policy questions that we struggle with answers, are questions that cannot and should not be solved by government officials.

We are trying to steer our city in the most appropriate direction, given all constraints that are keeping us bound. So I look forward to continued advice from those

kinds of individuals.

DR. EVANS: My comment would really be quite similar, Los Angeles County has a ward supervisor appointed Commission on AIDS with minority representation on it. I won't list them all, but there are several planning groups and interest groups, and coalitions in the community representing minority interests, and I have from the very outset worked to promote more of that type of public involvement. And as I said in my presentation, I think the future of our ability to have a positive impact on this epidemic will depend largely on our effectiveness in working with minority communities and their leadership.

I think the effectiveness of those groups of them, I think we need to work with them so they can in fact be more effective even in their community, we need more grass roots organizations, more church involvement. We need more community involvement across the board.

We certainly welcome that which we have. I think we need a lot more of it and I would think in fact can be very helpful and effective in shaping policy as we go along.

CHAIRMAN OSBORN: Harlon.

COMMISSIONER DALTON: This is certainly an

interesting panel.

It's interesting to watch the women rush to the defense of the men. Perhaps they need it. But I would like to suggest both Dr. Rodriquez-Trias and Kristine Gebbie, that you may have misapprehended the need for inquiry of Larry Kessler.

Dr. Rodriquez-Trias, you suggested that perhaps we should treat each other with more compassion if we are to be compassionate ultimately with people affected by HIV.

I didn't take Larry's questions to not appreciate the difficult b ind that Public Health officials are in, whether they operate in a clinical environment, but rather to ask about whether there comes a point at which that bind in fact constrains their ability to operate, the fact does produce compassionate public policy, and when we reach that break, what do we do?

Similarly, I did not hear Larry to be unaware of the fact that every day of the Commissioner's life is one that involves calm as well as science and health care, but rather again to ask the question of then what is your role as a part clinician/part scientist?

It seemed to me what was going on was discussion

about the role of Public Health and to what extent should Public Health restriction, like this gentleman, be in a sense activist in the process while recognizing they are appointed officials?

Dr. Evans says talk about what does Hollywood thing, and Dr. Evans says as funds become available more.

The question is is there a role you should be playing in making more funds become available?

You cannot get ahead of the public -- well, it is, of course, true that the people care a lot more about police and crime in New York City than they do about hundreds of people who are black who die with AIDS.

B ut that simply to me raises the question, what is it people like we all can do to in fact get the public fired up and keep the public fired up about the so-called problem of AIDS and does the fact -- it doesn't necessarily have to be in the press, that might not be the way you would handle it, but how do you imagine Public Health people, people in high reaches, like yourself, in fact playing politics, so that we can in fact -- that's what I hope you will glean from the conversation.

I think it is not really an occasion for

defensiveness, so much as a case for rapid activities that Ms. Gebbie and Dr. Rodriquez-Trias put their fingers on.

DR. MYERS: Activities for what disease today? For what issue today?

Is it Monday mortality, Tuesday AIDS day, Wednesday heart disease?

You get into trouble when you have a commissioner, I think, take on the role of being an activist for a particular issue, specific disease, when there are so many issues and so many diseases that one has to deal with.

Certainly it is a very concern about the HIV epidemic. I think one who is in the position of having to deal with a multitude of problems has to be as concerned about that individual with X as the individual with Y. And I think we have to demonstrate our sensitivity to all of the other people who need our services. So I think that to be an activist in the sense of exclusively dedicating our time and energy in an aggressive way to one issue, I don't think that is what a commissioner ought to do.

COMMISSIONER DALTON: I don't mean in that way.

DR. MYERS: What do you mean by "activist?

If you mean testifying before panels in Washington,

D. C., I mean, advocating more funding? That is something we do all the time.

COMMISSIONER DALTON: Leadership.

DR. MYERS: Synonymous.

COMMISSIONER DALTON: Maybe "activist" is not the best word; "leadership."

DR. MYERS: Well, I don't see a lack of leadership on the part of Public Health officials; they have been at the forefront of moving us forward, of communicating with government and getting us to the point where we are today.

It is clear many people are not satisfied with where we are today. We are not satisfied. But there has been a great deal of movement. There has been progress. There has been a great deal of money attached to the issue over the past decade. So I think that you have to give a lot of credit to the people who have been at the forefront of that and that has been primarily those of us in Public Health. And so if you are saying that there is an absence of leadership in Public Health on HIV, I think that is incorrect.

COMMISSIONER DALTON: Well --

CHAIRMAN OSBORN: Please, we have so many now. Unless we --

COMMISSIONER DALTON: One question.

All I would suggest is the issue joined here is what form should that leadership take, given the constraints all of us have indicated before the break, respectful conversations we have had.

DR. EVANS: Can I give a quick response to that as a practical example?

In Los Angeles County, beyond the $60 million budget which [indicating] referenced in my comments, the Board of Supervisors allocated an additional $5 million on top of the budget request as part of our funding need.

I would suggest to you that that additional allocation of $5 million was not achieved by accident. I would suggest that it was not achieved by the Public Health leaders of the county sitting back and playing less than a leadership position. I would suggest that it came about as a result of some hard work.

Is the $5 million sufficient for all the needs? Certainly it is not. It is certainly an addition what is needed. But those are the kinds of things that come about through effectively working with political leaders, effectively working with their staffs and getting them to

alter their priorities accordingly, again within the available resources that they have to live with.

MS. GEBBIE: Let me also add the answer to that question is as complex as any thing that we have tackled; that is, what is real leadership in Public Health in any jurisdictional level will vary by the political nature of that level and the way its government works. Some areas work better by taking to the air waves and having a press conference a week, and there are those who do that. In other areas, you work better through citizen advisory boards. And some places across the country you will find a citizen advisory board for every disease used as a mouth speaking for a life style. In other areas, you would do things by fat reports. In other places, you meet with them behind closed doors, if the mayor wants you, when they are making decisions. Some places you work directly with legislatures; others you don't.

There is no single answer. No simple yardstick to measure any one of us for effectiveness is not measured against one another here or what you may have carried into the room in your head, but against the yardstick of what works in each of our jurisdictions based on the differences

there.

That's the nature of the beast. And any textbook on leadership can give you some of the ranges of leaders that you ought to be able to work for and you will find some of all; of the above in all of us in the mixes.

CHAIRMAN OSBORN: Diane.

COMMISSIONER AHRENS: I just want to thank you, every one of you, for representing Public Health realities as I know them.

I think you walk a highwire and the people in the bleachers, be they politicians or advocates or community out there that live where you live, are just waiting for you to stumble and fall. I am sure you know that every day as you have lived and worked.

DR. EVANS: Certainly.

COMMISSIONER AHRENS: When this Commission goes home, we should all run for public office.

Thank you for being here.

CHAIRMAN OSBORN: I am going to give Dave Rogers the last word to sum up.

COMMISSIONER ROGERS: You all have a difficult job, because the issues that we are dealing with here are highly

emotional, so I simply wanted to say I am also grateful to all four of you.

Eunice Diaz and I live in the same town and we disagree. We sure don't disagree on the fact we are struggling very hard to find a solution for them.

Thank you all for your contributions.

CHAIRMAN OSBORN: Indeed, we very much appreciate your time and input.

We will now break for lunch.

[Whereupon, at 1:15 p.m., the meeting recessed for lunch, to reconvene at 2:00 p.m. the same day.]

AFTERNOON SESSION

[2:40 p.m.]

CHAIRMAN OSBORN: I have been doing sort of an informal check of plane times. I think Diane has to be out of here by 3:30, and many people have to be out of here by 4:00. That doesn't give us a lot of time. I think we've got to proceed nevertheless.

We were thinking that it might be reasonably easy for the Commission to agree in principle to a letter from the Commission to the full Committee of Labor/HHS. The subcommittee had recommended no new money in the Care bill, and we would say that we were distressed to know that and in essence wanted to remind them that the whole momentum behind the initial large majority supporting this was that indeed we had a disaster and that the appropriate response was disaster-style, not Gramm-Rudman.

COMMISSIONER KONIGSBERG: What do you mean by no new money--I have a reason for asking. Let me tell you why I am asking--will we wind up with the responsibilities in the Care Act with no new money at all? That is going to be a disaster.

MS. BYRNES: Well, Charlie, there is a law that no

money--that is what the statement is about.

COMMISSIONER KONIGSBERG: That's why I raised the question. The way you phrased it, June--

CHAIRMAN OSBORN: That's what the statement is about. That is precisely the situation at the moment. That is precisely the situation, and that is why it was so distressing to hear some of the testimony, and I think it just intensifies the need to send the statement. What you just said is exactly right, and therefore it is a crisis.

So the idea is that we would say so as succinctly as possible, urge them to recognize the appropriate recognition of crisis that motivated the large majorities as the authorization act was voted and signed by the President, and that that is still appropriate, and anything less is even more inappropriate since the crisis continues to deep with each month--something along those lines that we could then have as a statement to the appropriate officials of the full Committee, because the basic theme in our discussions was let's not crystallize trouble before we've got it, let's not declare an emergency before we've done everything we can to ameliorate the thing that is worrying us, and that this is probably the best approach to the Care bill issue.

Now, we also discussed the article that I read at the beginning of the meeting today, and the best we can tell, that was a Reuters release; it was not widely carried; it is probably not at all a good idea to back the President into a corner that he may not have meant to get into in the first place.

If you read that a couple of times, it looks as if he sort of thought he was talking about a research budget, and the timing is such that we thought he was talking about the Care bill as might Congress, so we can't not respond. But there, we thought that we might handle it with a relatively low-key--well, low-key in terms of what we do with it--but a letter from David and me to him saying, "You were wise to have signed the authorizing legislation, and this confusion could come from the statement you just made, and it must not be allowed to get in the way of all these people who are working urgently in this disaster"--something that not only does not back him into a corner, but gives him a way out of the corner.

You know, the combination of details that were in that Reuters thing makes me think that he probably was thinking about research, and he off-handedly referred to the

trouble Sullivan had had, probably never gave a minute's thought to the fact that the Care bill is in committee right now, because that is not necessarily--this evidently was a press conference about Iraq primarily, and then somebody tossed one question to him, and that was the response, which is probably the top two things--it is too bad that those are the top two things on his mind about AIDS--but nonetheless it may not have had anything to do with the Care bill, and rather than getting real mad and making statements right now, our sense is it would be wiser to take an approach that allows him an out from having said something that wasn't so cool.

COMMISSIONER KONIGSBERG: I think you are right in terms of hoping and acting as if that is the case, but I think we shouldn't be naive, either. The other may be exactly what he intended was to take the pressure off the editorials and so on and to let the people at Andrews know that it is not his highest priority.

CHAIRMAN OSBORN: Oh, yes. Whatever he intended, that is certainly going to be one of the effects, and what I am describing is a pair of quick things to do but by no means suggesting it be the sole thing we do if this turns out to be

a deepening crisis.

COMMISSIONER KONIGSBERG: Well, it would be interesting to see why--if it only appeared in the New York Times, then it is not going to be as effective.

CHAIRMAN OSBORN: It evidently was not in the Post from what I am told.

COMMISSIONER ROGERS: And it is in part because of that that we feel we must in essence say you have confused, and that clearly your intent is to back that--

MS. BYRNES: And interestingly enough, I remember hearing not that long ago, it almost gives the Commission an opportunity to make these distinctions. That article quotes a $1.6-$1.7 million figure--but lots of times, you will hear outside organizations and in-house Federal agencies then talk about our investment in research, as though all of that 1.6-1.7 is an investment in research, and that we are funding adequately our scientific capabilities without a lot of simple explanation that that also includes prevention, education, health care, we hope, and those kinds of things. I think that is a confusion that is still being made in the minds of many national leaders, if you will. It might be a nice opportunity to almost make that distinction and talk

about the different kinds of programs and services that that 1.6-1.7 hopefully lacks more because the Care bill money goes toward.

COMMISSIONER GOLDMAN: If I may, the kind of response that I think would be appropriate to the kinds of things you are talking about are precisely the kinds of things that would be part of the case statement that I discussed yesterday and is a further reason why we ought to being that process during it. If we had such a thing right now, we could probably take it apart, pick apart chunks of it, and so we could put that together, and it would be done.

CHAIRMAN OSBORN: I guess what I would hope, if the Commissioners feel comfortable about it, given the press of time and business, would be that you would let us proceed with the specific language in the two contexts that I described--a statement to the full committee on the one hand, and a letter from David and me, expressing the concern of the Commission--excuse me--a letter to the committee and a letter to the President, in each instance, and focusing on different things--to the committee, focusing on the committee's business, and the letter to the President, reinforcing the wisdom that he showed in signing the authorizing legislation

and stating that to fail to fund it would deepen the disaster that motivated it in the first place.

COMMISSIONER SCOTT ALLEN: And not mention anything he said in the press.

CHAIRMAN OSBORN: Right. I think given that we are so vague on context, given that it is not headline news, to mention it much would be to back him into a corner and get him to defend himself at a point when we don't want him defending that corner.

COMMISSIONER JAMES ALLEN: June, let me just clarify. "The committee" is the Senate Appropriations Committee--

CHAIRMAN OSBORN: No; Labor/HHS.

MR. LEE: This will be to the full Committee on Appropriations.

CHAIRMAN OSBORN: Full Appropriations, that's right. I'm sorry.

COMMISSIONER JAMES ALLEN: Should a copy go to the House, also?

COMMISSIONER GOLDMAN: Yes, that was going to be my next question, and that is, what is the status of the House?

MR. LEE: It will be widely circulated, but the

House has already acted, which we reported on last time, which had no money for this bill because it was not signed at that time, but it did have a vague number, $1 billion, set aside for various social programs, specifically mentioning the AIDS--

COMMISSIONER GOLDMAN: Has that gone to the full committee of the House yet?

MS. BYRNES: Yes. It passed the floor. The Labor/HHS bill for FY91 has passed the floor of the House, with no specific funding for the Care bill because the Care bill has not been signed into law yet. A block of money for a variety of programs including AIDS was set aside.

Once the Senate bill is passed, the House and Senate will go to conference, and they'll need to make a decision between the two bodies.

COMMISSIONER JAMES ALLEN: That block was what-- $800 million?

MR. LEE: Yes, it is over $800 million.

CHAIRMAN OSBORN: Eight seventy-five.

Does anybody have any concerns about our proceeding with power of the pen?

COMMISSIONER GOLDMAN: I think it is fair to say

that you should feel free to be as strong as you think productive and constructive under the circumstances.

CHAIRMAN OSBORN: We were planning to use the word "dismayed".

MR. LEE: Staff can't hear the discussion unless you use the mikes.

COMMISSIONER GOLDMAN: I'm sorry. What I said was I would just hope that June and David would be as strong as possible consistent with the concept of what is likely to be most effective. And I think that June had said that the language she was contemplating using was the term, "dismayed".

COMMISSIONER MASON: What about "horrified"? I guess that's a little strong.

[Laughter.]

COMMISSIONER ROGERS: I used "disbelief".

MR. LEE: We may well use two. I did pass out a summary of the Care Act as the P.L., Public Law, so that is the final version of this document which you have seen, and also a packet on some of the editorials around the Care bill funding issue from New York, San Francisco, Dallas, and I believe Los Angeles Times did one last Saturday but I have not seen it, and the Atlanta Constitution has indicated they

were going to do one, and Macon County--the Macon Telegraph News did one. I also have a copy, for those who want it--I can pass them out--of the final version; the Public Law is the Americans with Disabilities Act.

COMMISSIONER GOLDMAN: Do you have the final version of the Care bill?

MR. LEE: No, it hasn't been published yet. I will send it.

CHAIRMAN OSBORN: What next?

MS. BYRNES: Actually, if I could just mention quickly, and then I think we should go to the working group report, there is another letter from Catherine Wilpert [phonetic] that I am going to circulate that was sent to the Commission. Some of you may remember Dr. Catherine Wilpert from Duke University testified at one of our hearings. We have gotten a lot of feedback from a lot of different people about the most recent report. Dr. Wilpert is one of the people who was a little concerned about some of the things that were said in the recent portion of the report.

The letter was send to Dr. Osborn, but Dr. Wilpert indicated in the letter that she would like to share it with the Commissioners, so I'll circulate that letter as well.

COMMISSIONER MASON: Are we doing certain things in order here?

CHAIRMAN OSBORN: Well, I think our main business needs to include the working group outline and discussions, because that is sort of the biggest--

COMMISSIONER MASON: I have a quick thing.

CHAIRMAN OSBORN: Okay.

COMMISSIONER MASON: My quick thing is--and this might not be the appropriate form--but I still have a great deal of concern that we haven't employed a staff member who is HIV infected or who is a publicly-identified person with AIDS.

I have a lot of concern around that. I think you've got to start practicing what you preach at home, and I wish that we could do that. I think that that would be a very powerful statement to people with AIDS and would demonstrate our commitment to help people with AIDS maintain their lives in a productive manner.

CHAIRMAN OSBORN: Belinda, would you help me with something about that because we had extensive discussions about that as the original staffing was concerned. And given our position on confidentiality,, I'm not sure how we do that.

COMMISSIONER MASON: I understand that.

CHAIRMAN OSBORN: I don't know how we adequately publicize the availability of such a position and interview people properly.

COMMISSIONER MASON: But there are people who are publicly-identified. And what I am saying is that we may have to do some kind of creative thinking--like we may need to let people work a couple days a week. But there are people in this town who are publicly-identified and who are quite skilled, and some of them actually applied for positions, I think.

COMMISSIONER DALTON: June, you two are way ahead of at least me. What is the problem with confidentiality?

CHAIRMAN OSBORN: The problem was in staffing the Commission, short of posting for we want somebody who is HIV-infected, never mind what else you do--we needed to try and be sensitive to that issue in the context of the jobs that were available, doing our best to try and include somebody who might well be HIV-infected. But to sit and say "Are you HIV infected, because that is one of the criteria for this position" strikes me as going beyond reasonableness in terms of confidentiality, a stance that we want very much to

protect in other contexts.

COMMISSIONER DALTON: It never occurred to me that that would be the way that one would recruit somebody who was publicly-identified.

CHAIRMAN OSBORN: Well, but we at the moment are not in the position to recruit somebody simply because they are HIV-infected, nor is that what Belinda is talking about. She is talking about very talented people who happen to be HIV-infected.

COMMISSIONER DALTON: I wasn't saying you should include anybody who wasn't talented or couldn't perform the work; what I'm saying is if you wanted somebody who was talented and could perform the job, and the job was available, and you thought it would be useful to have somebody who was HIV-positive--it never occurred to me that you would ask every candidate "Are you HIV-positive?" That's not the way one does affirmative action.

CHAIRMAN OSBORN: But it might occur to you that we would not ask any candidate; they can volunteer or not.

COMMISSIONER DALTON: What occurs to me is that what one would do would be to go to places which have access to people who are publicly-identified as being HIV-positive

and ask if they had people who would be interested in a job that was available, with certain skills. Those people who had already identified themselves as being HIV-positive could then be interviewed--

COMMISSIONER MASON: It is not the easiest thing in the world to do, but I think it is important.

CHAIRMAN OSBORN: I think it is important, too, Belinda. I was simply trying to express the fact that it is also complicated to do, as I think you recognize. I think at the point at which, if ever, our budget expands, it is probably the highest priority on our list for additional staffing effort. And at that point as we stop working with what is really a very skeleton staff, where we did try to attend to that but without success, I think when we are in a position to expand, this probably would pop to the top because the staff has done wonderfully as a core group, and now we can add to it.

So it is not out of inattention even at the beginning, and at the moment, the reason for not necessarily doing it is that we don't have any money; but as soon as we have some, I think it would be a very, very high priority.

I am really speaking a little out-of-turn, because

this is Maureen's thing, but I thought it was perhaps better for me to say it because we conferred, and I was very concerned.

Harlon, what I'm talking about would be the same thing as if I felt--as I might well--that hiring somebody who is HIV-infected would be a very important thing for me to do as Dean of the School of Public Health.

I can post a position that gives a job description. I can go to a place where there are publicly-identified HIV-infected people, and I can then make sure that somebody is included in the mix. But as a public university official I cannot hire them strictly because they are HIV-infected if they do not also fulfill the criteria of the job description.

That was our circumstance at the beginning of this hiring process.

MS. BYRNES: Let me jump in here. This has clearly been a priority not only for Belinda but for other members of the Commission. I think it is something that we took very seriously when we put the initial group of people together. I did interview three people. I was just trying to think how many--three publicly-identified HIV-infected people. I did not think any of those three were appropriate--for a variety

of reasons I would be happy to share with people individually, not on the record in a public forum.

I think keeping that in mind as we look at hopefully expanding when we get additional help--and most of the new staff that you see come onto the Commission, I have been successful in detailing from other agencies, and we don't pay for them, as people who are being loaned to us, if you will, from other agencies.

But I certainly respect it being brought up again. I would encourage you, Belinda, and we will try, especially with Patricia and the outreach personnel, to let organizations and places where many PWAs who would be looking for part-time work or others, to keep having those people come to us, and when there is a position available, we certainly will consider them--and consider then with some special consideration. The National Commission is sort of a special place, and I think we can give that special consideration. I have to date done that, and the people that I interviewed were not appropriate for the positions available at the time.

COMMISSIONER DALTON: Let me just finish saying what my concern is about. I have just had too many experiences where someone says, "We ought to hire somebody who is

black," or "We ought to hire a woman" or whatever, and then people assume that that means because somebody is black, or a woman, or a person with AIDS, therefore they are unqualified. I did not hear Belinda at least today say we should hire somebody who is a PWA who has no skills. So I do not assume that PWA means lacking in qualifications for some job that we need done--which is why I was mystified about what the conversation was about.

COMMISSIONER DESJARLAIS: I don't think it is about consideration of skills--

COMMISSIONER GOLDMAN: No, I don't think so, either, but I have another problem with it and that is that I don't think it is any of my business or any of the Commission's business, and I have no idea whether or not any of our existing staff are infected with HIV or not, and I don't think they ought to be required to say that they are positive or negative so that we can determine whether or not we have to fulfill our affirmative action obligations--

COMMISSIONER MASON: No, no, no, no. What we said was people who are publicly-identified.

COMMISSIONER GOLDMAN: --and every time we hire somebody, we have to then go out and ask them, so we know

whether or not we then have to hire somebody else.

COMMISSIONER MASON: No; there is a difference.

COMMISSIONER DALTON: That is why I said it is a question of recruitment.

COMMISSIONER GOLDMAN: That's correct; I agree.

COMMISSIONER DALTON: That is, if we take a position that we're not going to recruit anybody for a job--we simply take the people who walk through the door--that would be one thing, although I don't think it is a good policy. But the fact is that we do in fact go out and try to find people for particular kinds of jobs, and then the question is where do you look. If one of the places you look is in NAPWA, you are much more likely to find someone who is already publicly-identified and wants to be publicly-identified as being a person with AIDS; you are much more likely to find somebody there than if you go to the U.S. Navy. That's the only point I'm making.

MS. BYRNES: We have done that. It has not resulted in the outcome that again I think it is very appropriate for you to keep pushing me as Executive Director to do.

But I am telling you as a member of the Commission

and that other Commissioners that that has been done, and I will take that very seriously when we look at additional staff positions that will need to be created when we get the additional dollars to meet the priorities in the work plan that the Commission has put together.

COMMISSIONER MASON: Okay. I'm satisfied--but I thought that would be short.

Thank you.

CHAIRMAN OSBORN: Okay. Scott?

COMMISSIONER SCOTT ALLEN: This will be short. Let me just share with you where we are at with the working group. We met this morning for breakfast. We had put together a good, solid outline. However, since not all the commissioners were able to be at breakfast, I am hesitant just to pass it out because we are still in process with it. What we are going to do is Jeff is now on the road to finishing it up, and we will have this circulated within the working group itself and have it done by late October. And that is the whole thing--

COMMISSIONER DALTON: Scott, when you say "it"--

COMMISSIONER SCOTT ALLEN: The final report out of the working group. And it will be sent out to all of you,

and we will share at that time our recommendations, also recommending how we think it would be the most useful to the Commission, and then at the next meeting we will then discuss it.

COMMISSIONER ROGERS: Scott, is the outline quite similar, or is the proposed report quite similar to the outline we got--which I thought was very good.

COMMISSIONER SCOTT ALLEN: Right. It is going to be much like that. That is what the committee felt this morning. But we'll be passing it out from that point, and we'll be sharing it with the full Commission after we have completed it and circulated it and walked through it and walked on it, around October 20, 25th.

COMMISSIONER ROGERS: And the discussion will be at the November meeting?

COMMISSIONER SCOTT ALLEN: Yes.

MS. BYRNES: Scott, at the staff level I have been talking to Jason about this, and I don't want to confuse it or belabor it, but it hasn't been clear to me, and I think we need to be sure that we are clear with the Commissioners. At the point that the report is complete in October and owned by the working group, what is your expectation, then, of what

would happen at the full Commission?

COMMISSIONER SCOTT ALLEN: We will ask the Commission to receive the document, and with suggestions on how that best be utilized, and then hopefully the second phase will be the Commission taking it and incorporating it into a larger scheme. I think that was what we discussed early in our working group.

COMMISSIONER GOLDMAN: Yes. We had discussed that part of the recommendations that would be contained in the working group report would include recommendations to the Commission as to how it should in turn use the report, and that would be part of it.

COMMISSIONER SCOTT ALLEN: Thank you for reminding me to clarify that.

We're pretty excited about it. I think it is a good document from the outline and from the folks who looked at it, and I'm looking forward to the input that we'll have from the Commissioners on the working group and Jeff's expertise and Jason's expertise. We had three very good meetings, and out of that I think we'll come up with a very good document.

MS. BYRNES: Frank, do you want to give us an update on the annual report and what is happening with GPO?

MR. ARCARI: We sent 26 copies to GPO; in our existing contract with GPO, the contractor will reproduce, put a new cover on it and rebind it, and hopefully we'll have it Friday.

MS. BYRNES: Frank also brought over copies of--the Office of Technology Assessment just issued a report, and the hearing that Don DesJarlais was the star witness at this morning, on "The Effectiveness of Drug Abuse Treatment: Implications for Controlling AIDS/HIV Infection". I will pass around the Executive Summary, and we will mail you the entire report.

[Pause.]

MS. BYRNES: If there is no further business, I would just like to publicly acknowledge the work that Jane Silver and the rest of the program staff and all the staff of the Commission did on this particular hearing; I think it went quite well.

I would now like to adjourn this meeting of the National Commission on AIDS.

[Whereupon, at 3:07 p.m., the Commission business was concluded.]