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City's AIDS Services Caseload Growth Slows

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SINCE ITS ESTABLISHMENT TWO DECADES AGO in response to the expanding AIDS epidemic, the number of individuals and families receiving services from the city's HIV/AIDS Services Administration (HASA) has risen steadily from a few hundred cases in the first year to over 30,000 today. In recent years this increase has begun to slow, largely due to changing trends in the AIDS epidemic. These same trends have also required HASA to provide more long-term services to its client population.

The slower growth in the AIDS services caseload in recent years has not resulted in slower growth in expenditures. Total spending at HASA increased from $117 million in fiscal year 1999 to $193 million in 2004, the most recent year for which spending data is complete. This total does not include the cost of providing other benefits or services to HASA clients such as public assistance and Medicaid.

HASA was originally established by New York City in 1985 as the Division of AIDS Services and Income Support to assist individuals with advanced HIV-related disease or AIDS to access public benefits and services provided by the city's Human Resources Administration.[1] In 1997 the City Council passed legislation requiring that certain benefits and services be available to indigent New Yorkers with HIV-related diesease or AIDS. Among the services available to HASA clients are intensive case management; home and hospital visits; direct linkage to public assistance, Medicaid, and food stamp benefits; emergency, transitional, and permanent housing assistance; rental assistance; home care and homemaking services; service planning; and counseling.

To become eligible for HASA services an individual must be a permanent city resident and must have been diagnosed with clinical symptomatic HIV or AIDS as defined by the federal Centers for Disease Control and Prevention and the New York State AIDS Institute.[2] Individuals who have tested positive for HIV but do not meet the criteria for clinical symptomatic HIV or AIDS are not eligible. Clients who request financial assistance must also meet the income and resource guidelines for the specific programs requested.

After Large Increases, HASA Caseload Growth Slows. By the middle of 1986 HRA's newly established AIDS services program served 617 cases (a case can be comprised of a single individual or an entire family).[3] From that point on the caseload grew steadily in response to the spreading AIDS epidemic, reaching 10,000 in 1992, moving past 20,000 in 1997, and topping 30,000 in 2002.

While the HASA caseload has shown nearly continuous growth over two decades, the growth began to slow in the mid-1990s. Although a number of factors have contributed to this slowdown, probably the most significant was the introduction of new methods for treating people with HIV and AIDS. (See discussion below.) From 1992 through 1994, the period just

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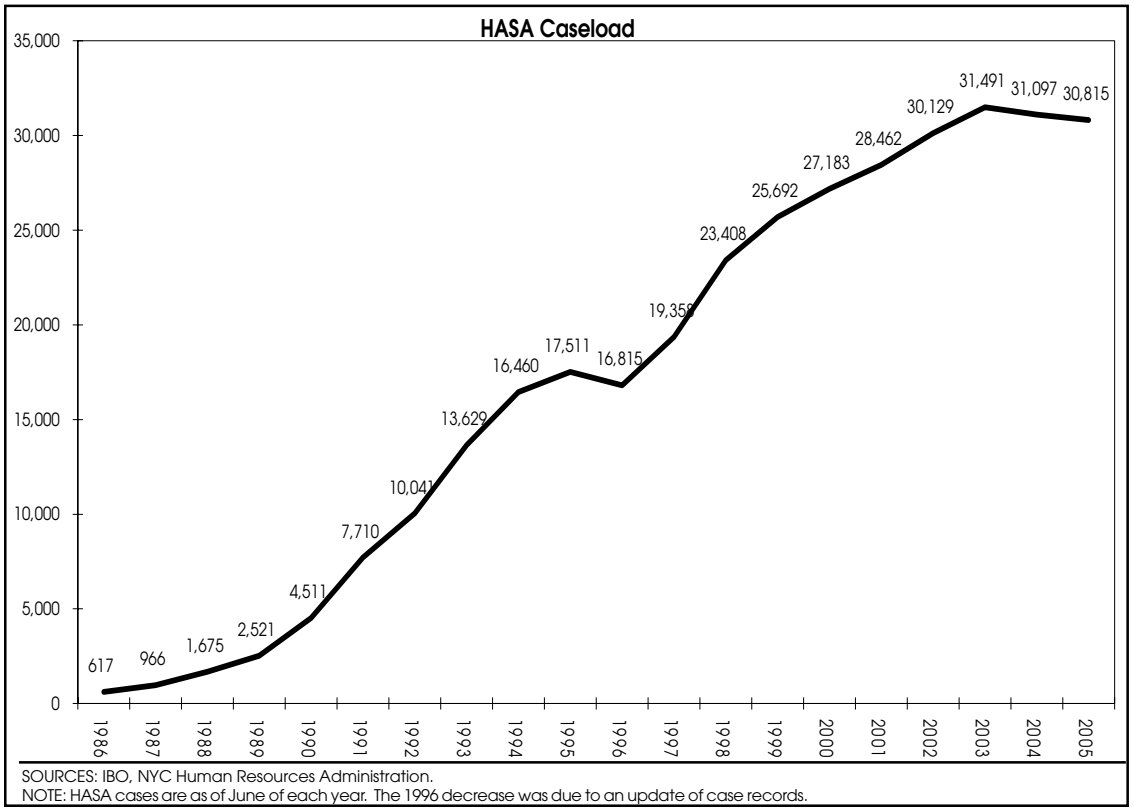

SOURCES: IBO, NYC Human Resources Administration.
NOTE: HASA cases are as of June of each year. The 1996 decrease was due to an update of case records.

prior to the introduction of these new treatment methods, the number of HASA cases increased at an annual average of 2,917. From 1995 through 1999 annual growth fell to an average of 1,846 cases, and from 2000 through 2003 annual growth declined again to 1,450 cases. More recent data suggest a possible stabilization of the caseload, with very little change in the number of cases between June 2003 and June 2005.

Rising Costs. Despite the slower growth in HASA's caseload in recent years, total agency spending has increased 65 percent between 1999 and 2004, from $117 million to $193 million. This increase does not include the cost of providing other benefits to HASA clients such as public assistance and Medicaid.

The significant increase in spending has resulted primarily from rising housing costs for HASA clients. While some of this cost increase has resulted from rising real estate rents, HRA has also significantly increased the number of housing units used by HASA clients and their families during this period. At the same time, HASA has been working to meet its mandate to provide medically appropriate housing for those who require it, by shifting from a reliance on emergency housing to more expensive supportive housing, which provides more services. In the long run, spending levels will depend on both the size of the HASA caseload and the mix of services the caseload needs.

Underlying Trends in the AIDS Epidemic. Since eligibility for HASA services depends on a medical diagnosis of clinical symptomatic HIV or AIDS, explaining changes in the HASA caseload requires an examination of the underlying epidemiological trends. Historical information on AIDS cases is available from the city's Department of Health and Mental Hygiene (DOHMH) going back to the beginning of the AIDS epidemic in the early 1980s.[4]

The data reflect not just the spread of the disease and the efforts by public health officials to contain this spread, but also the impact of advances in treatments for people with HIV and AIDS. Over the years since the beginning of the epidemic, doctors and medical researchers have made a number of advances in treating HIV, AIDS, and a variety of conditions and diseases that can result from the effects of HIV on a person's immune system. Perhaps the most important of these treatment breakthroughs occurred in the mid-1990s. In 1995 and 1996 the U.S. Food and Drug Administration approved three of a new class of anti-retroviral drugs known as protease inhibitors. These drugs act to inhibit the spread of HIV in the human body by interrupting the last step in the process that the virus uses to form new copies of itself. Also in 1996, HAART (Highly Active Anti-Retroviral Therapy) rapidly emerged as the new standard of HIV/AIDS care. HAART involves taking three or more drugs that fight HIV at the same time, usually including one protease inhibitor. When taken by people who are HIV positive but not yet symptomatic, HAART can delay the onset of AIDS, thereby delaying the movement of the affected individuals onto the HASA caseload. For people who have been diagnosed with AIDS, HAART can extend life, thereby swelling the HASA caseload.

The impact of these medical advances can be seen in the epidemiological data from DOHMH. The number of newly diagnosed AIDS cases in the city increased from 162 in 1981 to 7,742 in 1990, and then continued upward in the early 1990s to a peak of about 12,600 in 1993 and 1994. Starting in 1995 the number of new AIDS cases began a downward trend that eventually reduced the annual total by more than half, with 5,056 new cases diagnosed in 2003. Similarly, the annual number of deaths among people with AIDS increased

AIDS Population in New York City, 1981 to 2003

	New AIDS Cases	AIDS Deaths	People Living With AIDS	Survival Time in Months
Pre-1981	52	15	37	
1981	162	59	140	5
1982	543	202	481	6
1983	1,095	588	988	8
1984	1,841	1,096	1,733	10
1985	2,871	1,806	2,798	11
1986	4,212	2,692	4,318	12
1987	5,216	3,301	6,233	14
1988	6,447	4,233	8,447	16
1989	6,856	5,253	10,052	19
1990	7,742	5,595	12,198	22
1991	9,058	6,364	14,896	23
1992	10,864	6,840	18,931	24
1993	12,646	7,064	24,502	25
1994	12,591	8,023	29,068	28
1995	11,275	8,006	32,337	32
1996	9,283	5,912	35,712	37
1997	7,356	3,340	39,728	43
1998	5,611	2,699	42,638	50
1999	5,254	2,741	45,152	57
2000	6,335	2,418	49,068	62
2001	5,452	2,273	52,245	68
2002	4,492	2,182	54,555	75
2003	5,056	2,108	57,501	82

SOURCES: IBO, NYC Department of Health and Mental Hygiene.

from 59 in 1981 to 5,595 in 1990, before peaking at about 8,000 in 1994 and 1995. In 1996 AIDS deaths dropped to 5,912, and then continued downward to 2,108 in 2003, about a quarter of the mid-1990s peak.

Another important measure of the scope of the AIDS epidemic is the number of people living with AIDS at the end of each year. DOHMH data indicate that the number of people living with AIDS in the city has increased steadily from 140 in 1981 to 12,198 in 1990, 32,337 in 1995, and 57,501 in 2003. The therapeutic breakthroughs of the mid-1990s have had contradictory effects on this measure. By reducing the number of new AIDS cases the new drug regimens have slowed the growth in the number of people living with AIDS. At the same time, by reducing AIDS deaths they have acted to push the number of people living with AIDS upward. The data suggest, however, that on balance the new drug treatments have slowed the rate of growth in the AIDS population. From 1992 through 1994, the period just prior to the introduction of the new treatments, the number of people living with AIDS increased at an annual average of 4,724. From 1995 through 1999 annual growth fell to an average of 3,217, and from 2000 through 2003 annual growth declined further to 3,087.

This slower growth in the number of city residents who are living with AIDS has reduced the base of potential HASA cases. Thus, it is clear that the changing epidemiological trends help to explain the slower growth in the HASA caseload.

Increasing Survival Time. The DOHMH data include another important measure of change in the AIDS epidemic, survival time. This indicator looks at the population of people living with AIDS at the end of each year and measures the average length of time that has passed since their AIDS diagnosis. While survival time for people living with AIDS has improved steadily since the early years of the epidemic as a result of advances in medical care, the therapeutic breakthroughs of the mid-1990s seem to have accelerated the pace of improvement. Average survival time gradually increased from less than five months in 1981 to 28 months in 1994, and then jumped to 50 months by 1998 and 82 months by 2003.

The increase in survival time for people living with AIDS has had significant implications for HASA programs. While in its early years HASA was primarily an agency that provided services to people in their final stages of life, for the last several years the agency has been acting to provide more long term services to its clients and their families. These actions have included the development of additional non-emergency supportive housing and the expansion of vocational services to those who can and want to work. More recently HASA has added a Disability Appeals Unit to assist clients in applying for federal disability grants, and expanded access to Medicaid special needs plans as well as alcoholism and substance abuse counseling.

Written by Paul Lopatto

END NOTES

[1] All references to years pertain to calendar years, unless otherwise specified.
[2] A person who has tested HIV positive is diagnosed with AIDS when the person's CD4 cell count falls below 200 cell/ml, or the person is diagnosed with any of a variety of conditions or diseases that are considered AIDS indicator diseases.
[3] The focus of this report is on the number of HASA cases. A case can be composed of a single individual who meets the HASA medical eligibility criteria or a family or couple with at least one member who meets the medical criteria. The specific individuals who meet the medical criteria are referred to as HASA "clients." Since some cases include more than one person who meets the medical criteria, the number of HASA clients is somewhat higher than the number of cases. HASA also serves the other members of the families or couples that qualify as HASA cases.
[4] Specific city health department sources for data on the AIDS epidemic are as follows:
Data on newly diagnosed AIDS cases, AIDS deaths, and people living with AIDS at the end of each year are from *New York City HIV/AIDS Surveillance Statistics 2003. New York: New York City Department of Health and Mental Hygiene, 2005. Posted March 30, 2005.* They include all information reported to the agency by December 31, 2004.
Data on survival time in months for people living with AIDS at the end of each year through 2003 were provided directly to IBO from the health department on December 2, 2004, and include all information reported by September 2004.