Universal HIV Treatment Access No Guarantee of Health for Socially Disadvantaged

July 28, 2010 By David Evans

Socially marginalized people living with HIV, despite universal access to care and treatment, are still dying of AIDS-related illnesses at a high rate, according to a study presented Tuesday, July 20, at the XVIII International AIDS Conference in Vienna.

San Francisco has long been a pioneer in HIV research and treatment. In some populations of people with HIV—notably financially stable gay and bisexual men receiving HIV care—the city has among the best treatment outcomes in the United States, due in part to laws providing universal health care to its residents. Recently, the San Francisco health department recommended intensive HIV testing and immediate treatment for all people found to be HIV positive. The idea is not only to prevent ongoing HIV transmission but also to benefit the health of people living with HIV.

A concern has remained, however, whether good health outcomes are the same for people who are socially disadvantaged—such as injection drug users and people with mental illness—compared with less marginalized groups. Other studies have indicated that reductions in AIDS cases and AIDS deaths have not fallen as much among disadvantaged populations as the general population of people with HIV.

To determine mortality rates and cause of death among socially disadvantaged HIV-positive individuals, David Dowdy, MD, and his colleagues from the University of California at San Francisco examined the medical records of 1,651 people with HIV being cared for at a “safety-net” clinic in San Francisco. These clinics, located throughout California, consist of an array of providers delivering a broad range of health care services to medically underserved and uninsured populations, regardless of a patient’s ability to pay.

Dowdy and his colleagues compared mortality data over two time periods, 2000 to 2004 (before the widespread availability of combination antiretroviral therapy) and 2005 to 2009.

The participants were predominantly male, just under half were white, and 40 percent had a mental illness diagnosis. The average CD4 count at the time the participants became eligible for the study was 205 cells, and 41 percent were on antiretroviral (ARV) therapy at the beginning of

the study period. Dowdy called the participants “among the poorest in the city.”

Unfortunately, the over-all mortality risk has not fallen among this population during the past decade. The cumulative risk of mortality over a four year period was the same during both of the study periods examined, though it was lower for those who were consistently on ARVs. While the number of deaths due to AIDS has fallen sharply in people with HIV in general in the United States, they did not decline as rapidly in this population. An AIDS-related disease remained the cause of death in 41 percent of the 182 people who died. Twenty-four percent of the deaths were non-AIDS related (suicide, overdose and trauma accounting for many of them), and 34 percent had an unknown cause of death.

As has been seen in previous studies, Dowdy’s team found that injection drug use (IDU) and alcohol abuse significantly increased the risk of death. In IDUs, the cumulative mortality rate was more than four times higher, and in alcohol abusers it was nearly seven times higher. Mental illness increased the death rate by nearly three times, while non-white race and being male-to-female transgender both increased the death risk by about 70 percent.

People who had achieved HIV suppression to undetectable levels at any point during the study had a substantially lower risk of death. The authors comment, however, that mortality over-all remained high during the full study period and did not increase over time.

Given that all participants had equal and universal access to care, it would appear that access to treatment alone will not be sufficient to ensure that people will use ARVs correctly and consistently.

“In developed countries, wide disparities in mortality still exist among people living with HIV and AIDS, with high mortality in socially disadvantaged populations despite linkage to highest-quality care,” stated Dowdy.

“Future research is needed,” he concluded, “to compare mortality in at-risk HIV-infected people with their non-infected peers, and to determine the efficacy of linkage and maintenance of care efforts.”

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