"It was the best of times, it was the worst of times... we had everything before us, we had nothing before us..." [1]. In short, the period Charles Dickens described is reminiscent of the current state of the human immunodeficiency virus (HIV) epidemic in the United States and throughout the world. There is now concrete evidence that, as never before, we are in the “best of times” for the HIV epidemic. Over the past 2 decades, dramatic improvements in HIV treatment have led to significant declines in HIV-related mortality in the United States, from a peak of 50,876 deaths in 1995 to 8,369 in 2010 [2]. Globally, the scale-up of antiretroviral therapy (ART) has led to similar reductions in mortality [3]. Finally, the recognition that suppression of HIV replication to below the limit of detection with ART reduces the risk of HIV transmission by nearly 100% [4] provides a roadmap to effective control of the epidemic. However, approximately 20% of Americans and close to 50% of the global population who are infected with HIV do not know their status. Moreover, the majority of those diagnosed with HIV are not engaged in care [5]. Despite data demonstrating that “treatment is prevention,” there continue to be about 50,000 new infections per year in the United States and >2 million globally with evidence of increasing incidence among men who have sex with men in this country, suggesting that enormous challenges remain ahead and that it may be naïve or at least premature to be talking about the “End of AIDS” [6]. In fact, this may be the “worst of times” for ultimate epidemic control.

In an article by Mugavero et al., published in this issue of Clinical Infectious Diseases [7], the authors review the current state of engagement in care in the United States, propose existing evidence-based interventions to improve care outcomes, and call for increasing the research agenda to study strategies to improve linkage, engagement, and retention in care. There is a wide array of reasons why some HIV-infected patients are not effectively linked or retained into care, ranging from untreated depression to unstable living conditions, to stigma, to active substance abuse. Because the US epidemic disproportionately affects people of color, structural issues, such as perceived racism and medical mistrust of healthcare providers, may also impair optimal linkage and retention in care. There is an increasing array of evidence-based interventions that can result in improved clinical outcomes, ranging from case management that links people into care after diagnosis [8], to improved screening for the diagnosis and treatment of concomitant mental health and substance abuse conditions [9], to the use of peer health system navigators that assist patients to efficiently access needed services [10].

The Mugavero paper is particularly timely as we are currently at a critical juncture in healthcare in the United States that may create a perfect storm for patients with HIV. At a time of increasing hope, we are also facing a healthcare system with decreasing resources. In the current fiscal environment, the congressional sequestration has already impacted many programs through its automatic 5.1% cuts in funding, translating into about 424,000 fewer HIV tests that the Centers for Disease Control and Prevention can provide to health departments and community-based organizations compared to prior years and 7,400 people not being able to access antiretroviral medication through the federal AIDS Drug Assistance Program. Medicaid expansion, critical for providing care for those most at need as part of the Affordable Care Act (ACA), is opposed by governors and/or legislatures in some of the most affected

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(See the HIV/AIDS Invited Article by Mugavero et al on pages 1164–71.)
states in the southern United States [11]. These are only a few examples of the impact of sequestration. Furthermore, although full implementation of the ACA will meet the basic healthcare needs of all Americans, including those living with HIV, the need for additional services will persist. The Ryan White Comprehensive AIDS Resources Emergency Act, which is set to expire at the end of 2013, will need to continue playing a central role providing access to additional resources such as housing, case management, food, and transportation for those at risk of not being able to benefit from advances in ART despite improved health benefits because of other structural challenges. Many advocates have suggested that allowing the current act to be maintained through continuing resolutions, rather than through formal reauthorization, is the best outcome for now, given concerns that its vital funds for primary care, supportive services, and subsidized medication costs might be swiftly gutted in the current Congressional environment.

The National HIV/AIDS Strategy (NHAS) for the United States released by the White House in July 2010 has 3 lofty goals to be achieved by 2015: to reduce the annual number of new infections by 25%; to increase the proportion of newly diagnosed patients in clinical care within 3 months of diagnosis from 65% to 85%; and to increase the proportion of Ryan White HIV/AIDS Program clients who are engaged in routine HIV care from 73% to 80% [12]. To know what are the critical data indicators that need to be monitored in order to measure whether the goals of the NHAS are met and to monitor the impact of the ACA on...
improvements in HIV care, the Office of National AIDS Policy requested that the Institute of Medicine (IOM) convene a committee to make recommendations to the US Department of Health and Human Services. The reports of this committee have been recently released and will undoubtedly help us monitor if the aspirational goals of the NHAS are being achieved and if we are indeed increasing access to care and optimizing health outcomes and to reduce HIV-related health disparities [13]. The IOM committee’s recommended indicators for HIV clinical care and mental health, substance use, and supportive services can be seen in Figure 1.

Dickens’s words prove to be applicable across centuries. The epidemic can realize the best of times—an evidence-based HIV treatment and prevention paradigm that could be reasonably expected to meet the goals of the National AIDS Strategy, if fully implemented. Yet, public health officials and clinicians are hampered by the inability to mount a national response to arrest the depredations of the current slash-and-burn legislative environment, arguably the worst of times. Ironically, many thoughtful economic analyses have suggested that increasing upfront costs to identify and engage HIV-infected persons in care will be more expensive in the short term, but the gains in workforce productivity and a reduced rate of new infections will more than compensate for the initial investment [14]. We hope that you, the readers of Clinical Infectious Diseases, will work with established organizations such as the HIV Medicine Association and other partners to educate our peers and the broader community about the current dilemma. The stakes are currently high. We must ensure that the results of clinical trials translate into sustained programs that address the social determinants of health related to HIV, and the need to support comprehensive treatment and prevention programs. The public health benefits will be apparent.

Note

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