3. Cade WT, Reeds DN, Mondy K # at Centers for Disease Control and Prevention (CDC). Vital signs: HIV prevention through care and treatment, United StatesMMWR Morb Mortal Wkly Rep011;60(47):1618-1623.

4. Hanna DB, Buchacz K, Gebo KA, et al; North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD) of the International Epidemiologic Databases to Evaluate AIDS. Trends and disparities in antiretroviral therapy initiation and virologic suppression among newly treatment-eligible HIV-infected individuals in North America, 2001-2009lin Infect Dis 2013;56(8):1174-1182.

5. Nakagawa F, May M, Phillips A. Life expectancy living with HIV: recent estimates and future implicationsCurr Opin Infect Dis2013;26(1):17-25.

6. Centers for Medicare and Medicaid Services. Clinical diagnostic laboratory fee schedule. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html. Accessed February 28, 2013.

Editor's Note

Directing Resources to Where They Are the Most Needed

Old habits die hard. Since the 1980s, when we first came to understand that CD4 cell depletion is one of the hallmarks of immune deficiency in persons with AIDS, we clinicians have checked the CD4 counts of our stable patients every 3 months (more often for those who were sick or starting new therapy). Our patients (and we) worried from visit to visit whether their CD4 counts (we called them T-cells then) rose or dropped (mostly they dropped), and our spirits rose and fell with their counts.

That was then. Today we have highly effective antiretroviral treatment for human immunodeficiency virus (HIV) and a much better marker of how our patients are doing: the HIV save \$10 million a year in the United States. We could use that money in ways that would likely have a much greater impact on the population of HIV-infected persons, including early HIV detection and linkage to medical care, medication adherence counseling (so that CD4 counts do not drop owing to missed doses), substance abuse treatment, and supportive housing.

Resources are finite. We should always seek to spend them in ways that bring the greatest good. Eliminating unnecessary CD4 counts and providing treatment with more impact is a good way to start.

Mitchell H. Katz, MD

Trends in the Earnings of Male and Female Health Care Professionals in the United States, 1987 to 2010

Nearly 40 years after the adoption of the Title IX Amendments of the US Civil Rights Act, women account for almost 50% of US meit2(TJ T* -.014 Tc [(in)14.8(gs)-162.4(of)-162.4(male)-162.4(and)-162.4(fem

Disclaimer: The views expressed herein are those of the author and not necessarily the views of the County of Los Angeles, California.

987 to 2010 ^a	-	-	-
Variable	Adjusted Annual Earnings, Median, \$		
	1987-1990	1996-2000	2006-2010
hysicians			

Table. Trends in Adjusted Annual Earnings offealth Care Professionals According to Occupation and Sex,

Results| Our sample included 1 334 894 individuals, including 6258 physicians and 31 857 other health care professionals. The percentage of physicians surveyed who were female increased from 10.3% in 1987-1990 to 28.4% in 2006-2010, consistent with prior reports. ⁷ Men accounted for a majority of workers in other health care occupations except for registered nurses and physicians assistants.

Adjusted earnings of male physicians in 1987-1990 exceeded those of female physicians by \$33 840 (20.0%) (Table). There was no statistically significant improvement over time in the earnings of female physicians relative to male physicians. The physician earnings gender gap was \$34 620 (16.3%) in 1996-2000 (P = .65, compared with 1987-1990) and was \$56 019 (25.3%) in 2006-2010 (P = .46, compared with 1987-1990). Overall, the gender gap fell considerably outside of the health care industry

but inconsistently within it. The gender earnings gap for registered nurses and pharmacists was smaller than for physicians and workers overall, and it fell over time. For dentists, physician assistants, and health care executives, the gender gap was greater than for workers in a non...health care occupation and fell consistently only for health care executives.

Discussion A gap in earnings between male and female US physicians has persisted over the last 20 years. Although we adjusted for differences in hours worked and years of experience, our study was limited because the CPS does not include data on specialty, practice type, procedural volume, and insurance mix, all of which could influence our findings. Our inability to adjust for these factors likely explains why we found a gender gap in earnings in 1987-1990, while a previous analysis in this period that adjusted for these factors did not. ¹ Re-