

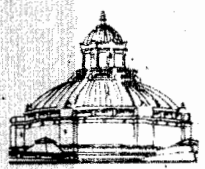
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AIDS: AN OVERVIEW OF ISSUES

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by

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AIDS: AN OVERVIEW OF ISSUES

SUMMARY

Many medical experts consider AIDS to be the gravest public health threat of this century. Statistics on cases and deaths are already alarming, and are projected to worsen: the current U.S. count of over 56,000 cases and 31,000 deaths is predicted to rise to 270,000 cases and 179,000 deaths by 1991, while the worldwide total of AIDS cases, now estimated at between 100,000 and 150,000, may rise to between 500,000 and 3 million by 1991.

Public policy issues concerning AIDS arise in a number of areas. Policy debates on educational efforts have focused on the explicitness and value content of AIDS information, the relative roles of Federal and local controls, and the effectiveness of mass education versus efforts targeted at risk groups including drug users, minorities, and young people. Public health measures to control the spread of the disease have involved debates over the usefulness and scope of testing in the absence of a cure or vaccine, and over the utility of quarantine. Research on an AIDS vaccine is progressing, but scientific, legal, and social difficulties promise to be important obstacles in its development.

There is growing concern about resources available to provide adequate treatment and support services to those infected. Severe strains may be felt from mounting costs for Government-financed health care, disability payments, health insurance, and losses on uninsured patients. In addition, the physical capacity of the health care system may prove inadequate to meet the needs of AIDS patients for long-term care, home and community-based health care, and hospice services.

Many difficult legal issues have arisen from attempts to control the spread of AIDS. There is strong legal authority to protect the public health; however, certain situations and proposals have led to charges of illegal discrimination against people infected or thought to be infected with the AIDS virus. Privacy issues have also been raised. Many States have incorporated AIDS into their laws or regulations, either specifically or by linking it to other communicable diseases. In the workplace, employers and labor unions increasingly are concerned with AIDS policies.

The U.S. Public Health Service has developed a set of objectives to control AIDS by the year 2000, has published an AIDS Information/Education Plan, and is coordinating a National AIDS Information Campaign. The Presidential Commission on AIDS has made an interim report with broad recommendations on drug abuse, health care, and research. Many public health experts and health officials have been critical of the Government's response, alleging lack of leadership and coordination in the fight against AIDS. International efforts on AIDS include the World Health Organization's leadership on a global strategy and the incorporation of the disease into population, health, and education programs in many countries.

Over 65 bills on AIDS have been introduced in the 100th Congress addressing such issues as the establishment of a National Commission on AIDS; authorization of programs for AIDS education, prevention, treatment, care, and research; and support of counseling and testing services, together with the establishment of certain privacy, confidentiality, and nondiscrimination requirements.

ISSUE DEFINITION

Associated with the AIDS epidemic are some of the most difficult policy dilemmas our society faces. Past Congresses have provided funds to support research and education efforts, but have not dealt legislatively with more comprehensive approaches to the disease. Issues for the 100th Congress include strategies for controlling the spread of the AIDS virus, especially measures directed toward people already infected as well as those at high risk of infection; methods and resources available for the care and treatment of persons with AIDS; concerns about AIDS education, civil rights, and other legal issues; the potential economic impact of the epidemic; and the U.S. role in the global response to AIDS.

BACKGROUND AND ANALYSIS

Introduction

Acquired Immune Deficiency Syndrome (AIDS) is a virus-caused condition which compromises the natural disease-resisting systems of its victims, thus rendering them extremely susceptible to infections. At present, the disease has proven fatal to most of its victims within two years of clinical manifestation. Over 56,000 cases of AIDS, and over 31,000 deaths, have been reported in the United States alone. The World Health Organization (WHO) estimates that the worldwide total of AIDS cases is between 100,000 and 150,000. It is currently estimated that 1 to 1.5 million Americans, and 5 to 10 million persons worldwide, are infected with the AIDS virus.

By the end of 1991, according to Public Health Service estimates, more than 270,000 cases of AIDS, with more than 179,000 deaths, will have occurred in the United States. The National Center for Health Statistics predicts that AIDS will be one of the 10 leading causes of death by 1991, and that it will be the leading cause of death for people between the ages of 25 and 44. Of the estimated 54,000 to 64,800 people who will die of AIDS in this country in 1991, 75% will be between the ages of 25 and 44. Direct medical costs for the estimated 174,000 people alive with AIDS during 1991 could amount to \$8-16 billion; earnings lost due to illness and premature death from AIDS in 1991 could total another \$55 billion. The future international AIDS situation is expected to be at least as serious. WHO estimates that by 1991, between 500,000 and 3 million currently infected individuals will develop AIDS.

While homosexual men account for 65% of current U.S. AIDS victims, the rising numbers among intravenous (IV) drug users, minorities, and infants are of growing concern. Cumulative pediatric AIDS cases, currently numbering 900, are projected to increase to more than 3,000 cases by the close of 1991. There is also concern about the spread of the disease among heterosexuals. While quantification of the magnitude and rate of spread of the disease is less than precise and subject to revision, it is clear that the disease already has profound policy consequences.

A critically important part of the U.S. commitment to the fight against AIDS is its biomedical research program, led by the National Institutes of Health (NIH). NIH support of research on AIDS has increased from \$44 million in FY84 to \$467 million in FY88. Avenues of research at NIH and elsewhere have included identification and characterization of the virus, epidemiologic investigations, and research on vaccines and antiviral drugs. Intensive work is ongoing in all of these areas. In addition, the National Academy of Sciences has recommended an expansion of social science research relating to AIDS, particularly in the field of behavioral change.

The remainder of this issue brief will discuss several policy issues: education; public health measures; health care delivery and financing issues; legal issues; State laws and regulations; labor and employment issues; and international efforts. Actions by the Administration and Congressional activities are summarized. Details about each of these issues are provided in other CRS publications, listed in the **For Additional Reading** section.

Education and Risk Reduction

Most persons carrying the AIDS virus were infected either through sexual contact or through the sharing of needles by IV drug abusers. Public health experts agree that the chief way of reducing further spread of the virus is through educational efforts intended to induce voluntary changes in "high risk" behavior. Although funding for education activities has been substantially increased in the FY88 appropriation, the methods and content of information and risk reduction activities remain the subject of debate.

Current educational efforts involve both the use of mass media to provide the whole population with information about how AIDS is spread and how infection can be prevented, and more concentrated programs aimed at members of the higher risk groups. The Supplemental Appropriations Bill for FY87 (P.L. 100-71) included \$20 million for a mass mailing to all American households, and there are proposals for a television campaign, possibly using paid commercial time. The Department has delayed the mailing, but it has been directed by the FY88 Continuing Resolution to complete the mailing by June 30, 1988. The FY88 Appropriation also includes substantial increases in funding for school-based education, from \$11.3 million in FY87 to \$29.9 million in FY88. Some people, pointing to recent claims that the risk of transmission in the general population may have been exaggerated, suggest that such broad-based approaches, which could be costly, might simply heighten public fears without significantly influencing behavior among members of high risk groups. Others argue that, while targeted efforts are needed, education of the general public is equally important. They contend that people may engage in high risk behavior without conceiving of themselves as members of a risk group and that, for this reason, information about the behaviors must be disseminated as widely as possible. Education could prove helpful in preventing the spread of AIDS into younger populations and others experimenting in sexual relations.

There are particular concerns that educational efforts reach minorities. The black and Hispanic populations are disproportionately affected by AIDS, largely because of the higher rate of IV drug abuse in these groups. Efforts to change high risk behavior are reported to have been hampered by a continuing perception that AIDS is a disease affecting only white homosexuals. The FY88 appropriation sets aside special funds for assistance in minority education projects.

Debate over the content of AIDS information has centered on two major questions. The first, familiar in discussions of sex education, is explicitness, particularly in materials aimed at school age children. The Administration has emphasized local control over content; critics argue that this could lead to vague or euphemistic presentations with limited impact.

The second issue is that of values. Behavioral changes to reduce the risk of transmission of the AIDS virus could involve either complete abstinence from high risk activities or the adoption of safer practices, such as the use of condoms or the avoidance of needle sharing, by persons continuing to engage in those activities. Some people argue that providing information about safer practices would put the Government in the position of implicitly condoning and offering counsel on behaviors which many find objectionable or which are actually illegal. Others say that it is unrealistic to expect the entire population to abandon extramarital sexual activity or drug abuse and that neutral, nonjudgmental discussions of protective measures have a greater chance of changing behavior in the short-term. Language in the FY88 appropriation for the Centers for Disease Control (CDC) prohibits funding for educational materials which directly promote or encourage homosexual activity, and requires that such materials emphasize abstinence. (The Senate has approved stronger language, barring even "indirect" encouragement.)

Drug abuse presents special problems. Needle sharing is common partly because many States have outlawed the non-prescription sale of drug paraphernalia, making needles and syringes hard to purchase. Some people have argued that repealing these prohibitions, or even furnishing free needles to drug users, could reduce the rate of transmission. New York is now experimenting with needle distribution and other localities are providing information on how to disinfect needles. Opponents of these measures argue that the effect is to promote continued drug abuse, and that abusers should instead be encouraged to enter treatment programs. The Presidential Commission on the HIV epidemic has noted that treatment is presently unavailable or available only after long waiting periods. It has recommended a "treatment on demand" policy, which could require an estimated \$1.5 billion increase in drug treatment funding over current levels.

Public Health Measures

The AIDS epidemic has focused attention on the effectiveness of traditional public health responses to disease. Among these responses are screening of persons possibly exposed to infection, quarantine of infectious individuals, and preventive measures such as vaccines.

Testing for AIDS antibodies is one of the more controversial public health measures used to control the spread of AIDS. The most widely used blood test is called an enzyme-linked immunosorbent assay (ELISA). It involves a color change in the presence of AIDS antibodies; larger amounts of antibody result in greater intensity of color. A blood sample is positive when a predetermined level of color intensity is reached. While the blood tests used to detect AIDS antibodies are very accurate, there is no absolute cutoff point for a positive test. The chance of detecting AIDS infection increases when the cutoff point is low, but this also raises the number of false positive results. A higher cutoff point will increase the number of false negatives. The test currently being used was developed for use by blood banks and the cutoff point was determined with their objectives in mind. Because of the serious nature of a positive test result, confirmatory tests are usually performed.

The AIDS antibody test has been used since 1985 by blood banks, greatly improving the safety of blood used for transfusions. It is also being used, in both voluntary and mandatory settings, to determine the antibody status of various groups of people. Individuals wishing to have their blood tested can go to centers offering testing and counseling. There is a high demand for these services in areas in which they are available. Mandatory testing has been a source of considerable controversy. The Federal Government screens the military as well as certain employees of the State Department and the Department of Labor. The Department of Defense has established guidelines for testing, education, counseling, providing health care services, protecting the blood supply, protecting the rights of HIV-infected personnel, and retaining or separating HIV-infected personnel. "AIDS and infection with the AIDS virus" recently was added to the list of contagious diseases for which immigrants and aliens can be denied entry into the United States. A testing program for all incoming and outgoing Federal prisoners began on June 15, 1987, and the States have been asked to require the AIDS test for State and local prisoners as well. The States are also being encouraged to offer the AIDS test to marriage license applicants. Other Federal programs, such as veterans' hospitals, are being reviewed to determine if AIDS testing would be appropriate.

Proponents of increased routine and mandatory testing applaud these new policies, arguing that the gravity of the AIDS epidemic demands more aggressive public health measures. They argue that to evaluate the effectiveness of various public health measures it is vital to monitor the incidence of AIDS virus infection in the population. Periodic testing is justified, proponents say, by the long latency of the AIDS infection and by its communicability during that period. Many believe that individuals who test positive will change their behavior in order to avoid infecting others. However, there is little evidence to support this view. In fact, one study indicated that knowledge of test results, if unaccompanied by counseling, could cause people to behave in a more reckless manner. A report by the Centers for Disease Control concluded that premarital testing for AIDS on a large scale is not likely to be very effective even in areas of high prevalence of AIDS infection because most high risk persons are already sexually active and are not likely to marry. In areas of low prevalence, large numbers of people would have to be tested to find a few infected individuals.

Critics feel that the focus on mandatory testing by the Government and others is misguided. They argue that since there is no cure or vaccine for AIDS there is little to be gained by more widespread testing. Many fear that the AIDS test will be used to discriminate against individuals for employment, insurance, and other purposes, and that it will be difficult to ensure confidentiality and safeguard civil liberties. In addition, critics believe that the expense involved in increased testing would divert funding away from other public health measures.

Over the course of the epidemic, there have been a few proposals suggesting quarantine as a possible measure for controlling the spread of AIDS. However, those dying from AIDS do not pose as great a danger as the asymptomatic carriers of the virus. Identification of these carriers, which PHS estimates at 1.5 million people, would require screening the entire population of the United States on a regular basis, perhaps every 6 or 12 months. The cost of the testing alone would be extremely high, and the ethical and practical problems of such a program would not be easily resolved. Because the predominant modes of transmission generally involve voluntary behaviors, most public health officials believe that quarantine is an unnecessarily harsh measure which has limited utility in controlling the AIDS epidemic.

Many believe that an AIDS vaccine will be the primary tool in preventing the disease, but much additional progress in virology and immunology will be necessary before an effective vaccine can be realized. Vaccines are currently under development by researchers pursuing several different strategies, and one has begun preliminary clinical trials in uninfected volunteers. These initial tests will check for side effects and determine whether the vaccine can raise an immune response. Testing the vaccine for its effectiveness in protecting against AIDS will occur if the safety of the vaccine is established. However, many expect that the legal and social obstacles to further tests and to eventual use of any vaccine will be formidable.

Testing a vaccine in humans will probably take at least 3 years, and possibly much longer because of the long latency period. A large volunteer test group of people at high risk of AIDS infection, who are not already infected but will be continuing their high risk practices, will have to be recruited and monitored for long periods of time to make sure that the vaccine is safe and effective. Potential manufacturers of an AIDS vaccine will be extremely wary of their liability for vaccine-related complications. The fear of large awards for vaccine injuries has already driven many manufacturers away from the production of existing vaccines against familiar infectious diseases. Some have suggested that the Federal Government may have to assume much or all of the risk as was done with the swine flu vaccine in 1976.

Health Care and Social Services

While greater public attention has been devoted to means of preventing the further spread of AIDS, there is growing concern about the problems of providing adequate treatment and support services to those

already infected. It has been estimated that in 1991 there will be 174,000 persons with AIDS alive at some time during the year. Meeting the needs of this population will be costly for both the public and private sectors, and may strain limited health and social service resources.

One burden on Federal and State Government will be the cost of providing support to those no longer able to work. Persons diagnosed with AIDS and unable to work are presumed eligible for Social Security disability payments if they have sufficient employment history. Others may qualify for Supplemental Security Income (SSI), the joint Federal-State program for low-income beneficiaries. If half the AIDS patients in 1991 received payments under either program for just 6 months each, total costs to Federal and State Government could be in the range of \$200 to \$300 million.

More significant, however, will be the costs of health care. Persons qualifying for SSI are automatically eligible for Medicaid, the Federal-State health insurance program for the indigent. In many States, the disabled who are not receiving SSI may also qualify for Medicaid if their insurance or personal resources are insufficient to cover their medical bills. Disabled Social Security beneficiaries may receive Medicare, but only after a 24-month waiting period. At present, few AIDS patients live long enough to qualify. This could change if new therapies are developed that prolong life without reducing disability. There are also current legislative proposals to eliminate the waiting period for persons with AIDS (H.R. 276 and S. 24).

There are widely varying estimates of the relative share of public and private payers in the costs of caring for AIDS patients. Most estimates suggest that Medicaid may be covering 20% to 30% of the costs, Medicare, 1% to 3%. If these proportions went unchanged, the Federal share of direct medical care cost could be about \$1.5 billion by 1991. The State share will be almost as large.

Private health insurance continues to be the major source of funding for the medical care of AIDS patients, covering an estimated 40% to 60% of all costs. Health insurance is less likely than life insurance to be denied on the basis of AIDS testing, because most health insurance is purchased through employee groups rather than on an individual basis. Under group insurance, the costs for the sick are spread across all members of the group. Some people are concerned, however, that the costs for AIDS could create imbalances in the private insurance system. For example, small to medium sized firms may fear that a single case of AIDS could drive up premiums for all their employees; this could increase incentives for discrimination. This concern has led to calls for a greater role for public financing on the grounds that AIDS is a national problem whose costs should be borne by the nation at large. Finally, there is some proportion of AIDS patients who have neither public nor private insurance coverage, or whose coverage fails to pay the full cost of their care. Some public hospitals have reported mounting losses because of uninsured AIDS patients or because of inadequate Medicaid reimbursement, and there have been charges that private hospitals are refusing to accept AIDS patients.

Even if financing problems prove to be manageable, some people say that the health care system simply may not have the physical capacity to meet the needs of persons with AIDS. Others argue that the system presently has substantial unused capacity; many hospitals, for example, tend to have a high number of unoccupied beds. It is possible, however, that the excess capacity and the caseload are not evenly distributed; there have already been reports of strains on facilities in New York and San Francisco, where AIDS has had the greatest impact to date.

These strains could be exacerbated by a lack of alternatives to inpatient hospital care. Few nursing homes or other long term care facilities are willing to accept AIDS patients, because of inadequate reimbursement, the extra services some AIDS patients require, or concern about potential infection. The problems in placing those patients who continue to be IV drug abusers are especially severe. As a result, many patients remain in acute hospitals long after they could have been discharged to other kinds of facilities.

While some AIDS patients -- particularly those suffering from dementia or other central nervous system problems -- may require ongoing institutional care, many are only intermittently in need of hospitalization or other acute services. The rest of the time they could remain at home, with adequate home health care, regular visits from nurses or other health professionals and personal care, such as assistance with cooking, cleaning, or bathing. Those in the final stages of the disease could benefit from hospice services. San Francisco's innovative system of coordinated acute care and community services for AIDS patients is reported to have reduced average per patient costs while at the same time providing more humane care. Both the Public Health Service and private sources have supported efforts to develop similar systems elsewhere.

Community-based approaches face at least two major problems. First, reimbursement for home health services and care coordination is often inadequate under both public and private insurance. Some State Medicaid programs are working to improve funding; 1986 Medicaid amendments gave States greater latitude to develop special services for persons with AIDS. Second, the successful community models have relied heavily on volunteer services, often through support groups established by the homosexual community. As the number of patients increases, it may become less feasible to depend on these private resources.

The problems of developing adequate care systems are compounded by difficulties in finding community living situations for patients who may be without family or friends. Placement problems are especially severe for infants with AIDS, often abandoned by mothers who are themselves sick. Potential foster parents are unwilling to accept the burden and perceived risk of caring for these children, some of whom spend their entire lives in hospitals. The Senate has approved the Abandoned Infants Assistance Act (S. 945), which would provide grants to local Governments for demonstration projects to address this problem.

Legal Issues

Attempts to control the spread of AIDS have raised numerous legal issues, few of which are easily resolved. The major issues briefly touched upon here are the legal authority to protect the public health, present protections against discrimination, and legal issues raised by blood testing for antibodies to the AIDS virus.

There is strong legal authority, both constitutional and statutory, to support actions taken to protect the public health. In the leading case of Jacobson v. Massachusetts, 197 U.S. 643 (1904), the Supreme Court upheld a local government's requirements for compulsory smallpox vaccination where the disease was already prevalent and increasing. In addition, the Public Health Service Act at 42 U.S.C. Section 264, authorizes the making and enforcement of regulations to prevent the spread of communicable diseases. However, the mere allegation that public health interests are involved would not automatically indicate sufficient legal authority for all actions. Courts have tended to evaluate first the nature of the risk, i.e., was there a compelling State interest, and, then to look at the methods used to achieve the chosen action to determine if they were the least restrictive. See e.g., Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985).

People who have AIDS, AIDS-related complex (ARC), a positive antibody test for the AIDS virus, or who are thought to have AIDS, are sometimes treated differently on that basis. This has led to allegations of illegal discrimination based on both constitutional rights and rights under Federal statutes including Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, and the Education for All Handicapped Children Act, 20 U.S.C. Sections 1400 et seq. They have surfaced in numerous situations, the most common being blood testing, employment, education, insurance, and proposals for quarantines. The constitutional rights which could arguably be implicated include the equal protection and due process guarantees of the Fourteenth Amendment, rights to privacy, and rights to interstate travel (see e.g., Shapiro v. Thompson, 394 U.S. 618 (1969)).

Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794, prohibits discrimination against an otherwise qualified person solely by reason of handicap in any program or activity that receives Federal financial assistance or in an executive agency or the United States Postal Service. One of the most discussed legal issues relating to AIDS is whether Section 504 would apply to persons with AIDS, ARC, or a positive blood test for antibodies to the AIDS virus.

The Supreme Court, in School Board of Nassau County v. Arline, 94 L.Ed.2d 307 (1987), held that a person with the contagious disease of tuberculosis may be a handicapped individual under Section 504 and that the fact that a person with a record of an impairment is also contagious does not limit the coverage of the section. The Court further found that the issue of whether such contagious individuals are protected by Section 504 is determined by whether such an individual is "otherwise qualified."

In a footnote, the Court observed that "the handicap here, tuberculosis, gave rise both to a physical impairment and to

contagiousness. This case does not present, and we therefore do not reach, the question whether a carrier of a contagious disease such as AIDS could be considered, solely on the basis of contagiousness, a handicapped person as defined in the Act."

The Court observed that the Rehabilitation Act was "carefully structured." The definition of individual with handicaps is broad but Section 504 covers only individuals who are both handicapped and otherwise qualified.

Justice Brennan found that to determine whether an individual is otherwise qualified, a district court will generally need to conduct an individualized two-step inquiry. First, findings of fact must be made concerning the nature of the risk, the duration of the risk, the severity of the risk and the probabilities the disease will be transmitted. Second, the court is to evaluate, in the light of these medical findings, whether reasonable accommodation by the employer is possible. Since these findings were not made by the District Court in Arline case, the Supreme Court remanded the case to determine if Gene Arline was otherwise qualified.

It would appear likely that the Supreme Court's reasoning in Arline would be applicable to persons who are antibody positive for the AIDS virus and who manifest physical symptoms of their disease. The issues regarding individuals who are only antibody positive are less certain but an argument could be made that such individuals would also be handicapped persons covered by Section 504 since arguably discrimination against them would thwart the purposes of Section 504 as expressed by the Supreme Court. This argument could also find support in the language of the contagious disease amendment to S. 557 which recently passed the House and Senate.

Many similar issues relating to discrimination are also raised in other contexts, notably the access by a child with an HIV infection to education, and blood testing. In a recent California case, an injunction was issued based on Section 504 precluding the exclusion of a HIV infected child from attending his kindergarten class on the grounds that he was otherwise qualified in the absence of evidence that the child posed a significant risk of harm to his classmates or teachers. (Thomas v. Atascadero Unified School District, 662 F. Supp. 376 (C.D. Calif. 1987)). It is also possible that the exclusion of a child from school would raise issues relating to the Education For All Handicapped Children Act, P.L. 94-142, a grant statute which provides Federal funds to the States and conditions the receipt of these Federal funds on the provision of "free appropriate public education."

The testing of blood for the HIV virus raises other legal issues in addition to the issues already generally discussed. One of the principal legal issues raised by proposals for blood testing concerns the right of privacy of the person who is tested. In addition, issues could be raised concerning liability due to the possibility of inaccuracies or unreliabilities concerning the test itself. The various privacy issues raised by blood testing for antibodies to the HIV virus involve questions of rights granted by Federal and State constitutional and statutory

provisions, as well as of rights that have been developed by the courts in common law actions for defamation and invasion of privacy. These issues are complex and unsettled and, like the other legal issues relating to AIDS, may turn on a variety of factors.

Generally, regardless of whether the issue presented is one involving constitutional, statutory, or common law aspects of privacy, the approach of a court will often involve a balancing of the individual's interest in privacy against the need of society in certain situations for disclosure of the results of the blood test. The outcome of the balancing process might be affected by a variety of factors. For example, the courts may consider the deadly and contagious nature of disease, the extent to which notice to public health authorities and/or the sexual partners of an AIDS victim might help prevent the spread of the disease, and the statutory guarantees, if any, to minimize the persons and entities to whom disclosure is made. The outcome of the balancing process may also depend on the specific provisions of the constitutional or statutory guarantee of privacy involved.

State Laws and Regulations

State legislatures and officials have responded to the AIDS emergency by enacting laws which address specific issues concerning AIDS. A number of States, including Arkansas, California, Colorado, Connecticut, Illinois, Iowa, Louisiana, Maine, Maryland, Michigan, New York, Oregon, and Pennsylvania, as well as the District of Columbia, have enacted legislation promoting the education of the general public regarding AIDS. California, Hawaii, and Virginia require that AIDS information and the opportunity to be tested is presented to all marriage license applicants. Illinois and Louisiana require testing for the presence of HIV prior to the issuance of a marriage license; Pennsylvania and Rhode Island have set up studies concerning the feasibility of such a requirement. Texas will automatically require testing prior to issuing a marriage license when the rate of HIV infection reaches 0.83% in the State. Utah prohibits marriage and declares a marriage void when a person has AIDS.

The following jurisdictions have established statutory requirements governing whether or not insurers may use or require AIDS antibody testing to determine the insurability of applicants: California, District of Columbia, Florida, Hawaii, Illinois, Maine, Oregon, and West Virginia.

Numerous States have also addressed such concerns as insuring the safety of the blood supplies, protecting the confidentiality of individuals who are tested for AIDS and prohibiting discrimination in employment toward individuals with AIDS. A great deal of state legislation was passed in 1987 and legislative interest in AIDS is likely to continue.

Some States have developed ways to deal with this major public health issue without enacting statutes specifically mentioning AIDS. AIDS is a communicable, sexually transmitted disease. Traditionally, bodies of law exist within each State which govern certain aspects of the control and treatment of such diseases. State health departments may add a disease to

their list of contagious diseases; such an addition immediately generates all the controls and protections, such as reportability, testing, and in certain instances, isolation/quarantine, whenever a diagnosis is made of that disease. It is also possible that AIDS may qualify as a handicap under certain State statutes which generally prohibit discrimination against disabled persons.

Labor Issues

AIDS is becoming an increasingly important workplace issue. Although most employers have not as yet developed explicit AIDS policies, more may be forced to do so as the number of diagnosed AIDS cases continues to rise. Those employers who have responded have generally taken these approaches: (1) accommodating employees with AIDS through flexible schedules, and through educating co-workers about the disease; (2) firing employees with AIDS; or, (3) initiating AIDS testing of employees.

To date these employer-instituted AIDS policies have primarily affected three groups of workers: (1) employees who have AIDS or who have tested positive for AIDS; (2) health care workers; and (3) Federal workers, including military personnel. Employees with AIDS are naturally concerned since an AIDS policy may result in their discharge. Health care workers are concerned because their work involves exposure to potentially contaminated blood, and hence there is a risk of contracting AIDS. Unions representing health care workers petitioned the Occupational Safety and Health Administration (OSHA) unsuccessfully to adopt emergency enforceable standards to protect health care workers who come into contact with blood. OSHA did agree, however, to initiate formal rulemaking procedures on this issue. Pending such rules, the Department of Labor and the Department of Health and Human Services published in the Federal Register of Oct. 30, 1987, a joint advisory notice that has been mailed to approximately 500,000 health-care employers. Entitled "Protection Against Occupational Exposure to Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV)," the notice advised employers of their legal responsibility to assure appropriate safeguards for health care workers. Federal workers have also expressed concern about workplace AIDS policies since several agencies and departments have instituted AIDS testing of employees. Federal employers argue that testing is necessary for the protection of national security as well as international good will in situations involving employees who represent the United States abroad. Federal employee unions have argued that these testing policies are unconstitutional and discriminatory.

A major issue arising from workplace AIDS policies concerns the avenues of redress available to employees who feel they have been unfairly treated as the result of an AIDS policy. Employees without union representation may seek redress through the courts. Employees covered by a union contract have access to arbitration in addition to the courts. In unionized workplaces an AIDS policy is likely to be considered a term or condition of employment and therefore a mandatory subject of bargaining unless the employer proves that such a testing program is necessary to maintain efficiency and/or safety of employees. In cases involving the discharge of an AIDS victim, arbitrators may well require evidence of impairment in job performance in addition to a positive AIDS test.

International Problems and Response

As of Jan. 31, 1988, 129 countries had reported a total of more than 77,000 cases of AIDS to the World Health Organization (WHO), of which over 51,000 were in the United States. Other countries reporting large numbers of cases to WHO include France, Uganda, and Brazil, with over 2,000 reported cases apiece, and Tanzania, West Germany, Canada, the United Kingdom, and Italy, each with over 1,000 reported cases. However, it is widely acknowledged that AIDS cases are underreported in many parts of the world. For example, WHO estimates that in Africa alone, 50,000 people are already showing symptoms of AIDS. Central Africa is the part of the world estimated to have the largest number of infected persons and deaths due to AIDS. In Africa, HIV is spread mainly among heterosexuals, leading to death for both men and women and growing numbers of children. In the Americas, Europe, and Oceania, the infection so far is largely confined to homosexual men and drug abusers, although this may be changing. Very few AIDS cases seem to have occurred in Asia.

Many development experts have expressed concern about the effect of AIDS on economic growth and development programs, especially in Africa. Because AIDS strikes the most productive members of society (20 to 49 years old) and because of the significant health problems it creates before it is fatal, many are concerned that heavily infected areas will have declining national incomes until the disease is brought under control. Another concern is the effect on families. Many children will lose one or both parents to AIDS. Moreover, because increasing numbers of children will die of AIDS, the gains of recent years made by the WHO's Child Survival Program may be reversed. Development agencies have also begun to address the effect of AIDS on development programs, including immunization, breast feeding, and population programs. In a more positive view, others believe that because the disease's spread can be contained somewhat by improved preventive health care practices, the AIDS epidemic may result in improved health care in developing countries in the future.

The last 2 years have seen a dramatic increase in the efforts of many countries to control the spread of the HIV virus. WHO, the lead organization for the international community, promotes the view that the disease will only be stopped in a coordinated effort by all countries. Western leaders meeting in Venice in June 1987 endorsed this view. It was endorsed at the January 1988 International Meeting of the Ministers of Health in London. WHO's Special Program on AIDS (SPA) was established by the Director-General and endorsed by the Executive Board of member governments in January 1987. The program will rely on voluntary contributions made by governments in addition to their regular contributions to WHO. WHO spent \$25 million during 1987, and expects to spend \$68.4 million in 1988.

The U.S. Agency for International Development (AID) is making AIDS a part of its ongoing population, health, and education programs. The agency is primarily working with WHO to develop a strong multilateral program. In FY86, AID allocated \$2 million to the WHO SPA. In FY87, the agency spent \$14 million for global AIDS control, including \$5 million to the WHO SPA, \$3 million to finance expected additional requests for

condoms, and \$6 million for technical support of bilateral prevention and control programs in collaboration with WHO. P.L. 100-202, the Continuing Appropriations Act of 1988 (H.J.Res. 395) appropriated \$30 million for activities related to international AIDS control, of which \$15 million would go to the World Health Organization and the Pan American Health Program.

Actions by the Reagan Administration

Having declared the fight against AIDS to be "the Nation's number one health priority," the Reagan Administration has taken steps in a number of directions to develop and implement plans for control of the epidemic. Administration efforts, however, have been faulted by many critics, including many public health experts, as "too little too late."

In 1985, the Public Health Services's Executive Task Force on AIDS published a comprehensive plan that included a set of objectives to control AIDS by the year 2000. An update and expansion of the plan, known as the Coolfont Report, came out of a June 1986 meeting convened by PHS. It is the source of the projections of AIDS cases, deaths, infections, and costs to 1991. In March 1987, PHS released its AIDS Information/Education Plan, specifying the audiences to be addressed (the public, school and college aged populations, persons at increased risk or infected, and health workers), the basic elements of AIDS information and education, and the means to accomplish this education (such as mass media campaigns, an information clearinghouse, and various special programs). In December 1987, PHS delivered a report to the President's Domestic Policy Council that reviewed current knowledge about the level of HIV infection in the United States and PHS plans for expansion of surveillance activities. The report indicated that the spread of the AIDS virus in recent years has slowed. It said that the "working estimate" of 1 to 1.5 million people infected, though probably somewhat high when it was derived in 1986, is still a good approximation given the lack of incidence and prevalence data.

In May 1987 the President announced his intention to establish a national commission on AIDS. By executive order on June 24 he created the Presidential Commission on the Human Immunodeficiency Virus Epidemic. The panel is to advise the President on the medical, legal, ethical, social, and economic impact of AIDS. In its first few months, the Commission was severely hampered in commencing its work by internal dissension, resignations of its chairman, vice-chairman, and executive director, and mounting criticism of its membership. In October 1987, a coalition of public health and civil rights groups filed a lawsuit against the Commission, alleging that its makeup violated the Federal Advisory Committee Act because it lacked a balance of viewpoints and representation of groups most affected by its work. Since that difficult start, the panel's new chairman, retired Admiral James D. Watkins, has successfully overseen the addition of new members and staff for the Commission, the formation of working groups to investigate and make recommendations on several priority areas, hearings in a number of locations around the country, and release in December 1987 of a preliminary "roadmap" report to guide the rest of the Commission's work. In March 1988, the Commission

issued an interim report to the President. It contained a package of recommendations on combatting AIDS among intravenous drug abusers, broadening health care services for people infected with HIV, and enhancing basic biomedical research and drug development. The report has been well received even by critics of the Commission, who express cautious optimism that the Commission's work will lead to an integrated national strategy on combatting AIDS in the United States.

The Centers for Disease Control have coordinated a National AIDS Information Campaign since the fall of 1987. With the theme "America Responds to AIDS," the campaign sponsored "National AIDS Prevention Month" in October. In the next year it will coordinate educational activities and events in cooperation with a national advertising agency and with national and local agencies, groups, and businesses, to increase AIDS awareness, reduce fear, and prompt group and individual prevention action. It will also test and evaluate strategies for delivering prevention information and education more effectively.

As reported by the General Accounting Office in August 1987, there has been criticism by public health experts, advocacy groups, and local health officials of the level of governmental response to AIDS. The criticism has focused on a perceived lack of Federal leadership, particularly in the AIDS prevention areas of education, testing, and counseling, and on a lack of coordination of Federal and State programs and funding. Health policy researchers cited in the GAO report have concluded that the Federal response to AIDS appears uncoordinated and insufficient because of systemic factors in our health care system. These include (1) multiple levels of government; (2) the relationship of government to the private sector; (3) the diffusion of authority within the Federal Government; (4) the absence of mechanisms to deal with emergencies; and (5) the tendency to fund AIDS by reallocating funds already appropriated to other existing health programs. (Philip R. Lee and Peter Arno, *The Federal Response to the AIDS Epidemic*, Health Policy, v. 6, 1986, p. 259-267.)

Congressional Actions

Before 1987, congressional activity on AIDS focused primarily on support of the Public Health Service's research and education programs through the appropriations process. Total PHS spending for AIDS was \$61.5 million in FY84, \$108.6 million in FY85, and \$233.8 million in FY86, and \$502.9 million in FY87. For FY88, the continuing resolution appropriates \$951.0 million for AIDS activities, an 89% increase over FY87. Previous Congresses also held numerous hearings on AIDS issues, and Members introduced a variety of bills, but no comprehensive legislation was considered.

In the 100th Congress, over 65 bills on AIDS have been introduced, and several are under active consideration. The range of topics covered includes testing various groups of people for AIDS virus infections, often accompanied by reporting and/or contact tracing; control of infected persons; controls on immigrants; protection of health care workers; public education; confidentiality of medical records; extension of Medicare

benefits; establishment of centers for pediatric AIDS; and outreach to minority populations and to IV drug abusers. The House has passed H.R. 2881 establishing a national advisory commission on AIDS, and the Senate has passed S. 945 concerning infants abandoned in hospitals because of AIDS or drug exposure. Comprehensive legislation authorizing \$635 million for programs in AIDS education, prevention, treatment, care, and research has been reported in the Senate and introduced in the House (S. 1220 and H.R. 2626). Companion bills called the AIDS Federal Policy Act of 1987 (H.R. 3071 and S. 1575) address issues concerning AIDS antibody testing and counseling and the protection of people infected with the AIDS virus from discrimination.

LEGISLATION

P.L. 100-71, H.R. 1827

Supplemental Appropriations, 1987. Appropriates \$78.5 million for AIDS: \$20 million for a mass mailing of information to every household, \$27 million for testing, counseling, and minority education activities, \$30 million to pay for AIDS drugs, and \$1.5 million for evaluation and analysis of drugs, vaccines, and tests for treatment of AIDS. Reported by Committee on Appropriations (H.Rept. 100-28) Mar. 25, 1987. Passed House, amended, Apr. 23. Reported, with amendments, by Senate Committee on Appropriations (S.Rept. 100-48) May 1. Passed Senate, amended, June 2. Conference report (H.Rept. 100-195) filed June 27. Conference report agreed to by House June 30, and Senate July 1. Signed into law July 11, 1987.

P.L. 100-202, H.J.Res. 395

Continuing Appropriations Act, 1988. Includes provisions of the conference agreement for Labor-HHS-Education appropriations (see H.R. 3058). Reported by Committee on Appropriations (H.Rept. 100-415) Oct. 29, 1987. Passed House, amended, Dec. 3. Reported with amendments by Senate Committee on Appropriations (S.Rept. 100-238) Dec. 8. Passed Senate, amended, Dec. 11. Conference report (H.Rept. 100-498) filed and agreed to Dec. 21. Signed into law Dec. 22, 1987.

H.R. 2626 (Rangel)

Acquired Immunodeficiency Syndrome Education, Information, Risk Reduction, Training, Prevention, Treatment, Care, and Research Act of 1987. Amends the Public Health Service Act to provide for a comprehensive program on AIDS. Introduced June 8, 1987; referred to Committee on Energy and Commerce.

H.R. 2881 (Rowland of Ga.)

National Commission on Acquired Immune Deficiency Syndrome Act. Establishes a 2-year, 15-member commission charged with studying and making recommendations for national policy on AIDS research, testing, treatment, and prevention. Introduced July 1, 1987; referred to Committees on Energy and Commerce, and on Veterans Affairs. Reported, with amendments, by Committee on Veterans Affairs (H.Rept. 100-245, Part 1) July 28. Considered and ordered reported by Committee on Energy and Commerce Aug. 4. Passed House, amended, Aug. 4. Referred to Senate Committee on Labor and Human Resources Aug. 5, 1987.

H.R. 3058 (Natcher)

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1988. Reported by Committee on Appropriations (H.Rept. 100-256) July 30, 1987. Passed House, amended, Aug. 5. Reported with amendments by Senate Committee on Appropriations (S.Rept. 100-189) Oct. 1. Passed Senate, amended, Oct. 14. House and Senate conferees agreed Dec. 16 to funding levels which were then incorporated into the FY88 Continuing Resolution (see H.J.Res. 395).

H.R. 3071 (Waxman)

AIDS Federal Policy Act of 1987. Amends the Public Health Service Act to establish a grant program (authorized at \$400 million for each of 3 years) to provide for counseling and testing services relating to AIDS and to establish certain prohibitions to protect individuals with AIDS. Introduced July 30, 1987; referred to Committees on Energy and Commerce, on the Judiciary, and on Education and Labor. Hearings held by Subcommittee on Health and the Environment Aug. 6-7, 1987.

H.R. 3825 (Waxman)

AIDS Research Act of 1987. Amends the Public Health Service Act with respect to research programs on AIDS. Introduced Dec. 20, 1987; referred to Committee on Energy and Commerce.

S. 557 (Kennedy)

Civil Rights Restoration Act. Amends four civil rights statutes, including Section 504 of the Rehabilitation Act, to provide for a definition of program or activity that would define the term in a broader manner than done by the Supreme Court in Grove City College v. Bell. Also contains an amendment concerning contagious diseases which could imply Section 504 coverage of persons who are HIV infected but manifest no physical symptoms of their disease. Passed Senate Jan 28, 1988; passed House Mar. 2. Vetoed by President Reagan Mar. 16. Veto override votes scheduled in House and Senate for Mar. 22, 1988.

S. 945 (Metzenbaum)

Abandoned Infants Assistance Act of 1987. Authorizes grants to local governments for demonstration projects to provide respite home and other assistance for infants abandoned in hospitals, including infants with AIDS. Introduced Apr. 8, 1987; referred to Committee on Labor and Human Resources. Reported with an amendment in the nature of a substitute, without written report, Aug. 4. Passed Senate, amended, Aug. 5. Referred to House Committees on Energy and Commerce and on Education and Labor Aug. 7, 1987.

S. 1220 (Kennedy)

Acquired Immunodeficiency Syndrome Research and Information Act of 1987. Amends the Public Health Service Act to provide for a comprehensive program for AIDS information, prevention, care, treatment, and research. Introduced May 15, 1987; referred to Committee on Labor and Human Resources. Reported with an amendment in the nature of a substitute (S.Rept. 100-133) and placed on legislative calendar July 29, 1987.

S. 1575 (Kennedy)

AIDS Federal Policy Act of 1987. Amends the Public Health Service Act to establish a grant program (authorized at \$400 million for each of 3 years) to provide for counseling and testing services relating to AIDS and to establish certain prohibitions to protect individuals with AIDS. Introduced July 31, 1987; referred to Committee on Labor and Human Resources.

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