

University of Michigan Law School

University of Michigan Law School Scholarship Repository

Book Chapters

Faculty Scholarship

1993

AIDS and the Public Policies Bearing on Children and Families

David L. Chambers

University of Michigan - Ann Arbor, dcham@umich.edu

Available at: https://repository.law.umich.edu/book_chapters/208

Follow this and additional works at: https://repository.law.umich.edu/book_chapters

Publication Information & Recommended Citation

Chambers, David L. "AIDS and the Public Policies Bearing on Children and Families." In *The Social Impact of AIDS in the United States*, edited by A. Jonsen and J. Stryker. Washington, D.C.: National Academy Press, 1993.

This Book Chapter is brought to you for free and open access by the Faculty Scholarship at University of Michigan Law School Scholarship Repository. It has been accepted for inclusion in Book Chapters by an authorized administrator of University of Michigan Law School Scholarship Repository. For more information, please contact mlaw.repository@umich.edu.

8

Public Policies on Children and Families

The HIV/AIDS epidemic has touched American law at many points, both in legislation and litigation, in many jurisdictions. Most of the legislation has dealt with public health issues, which are discussed in [Chapter 2](#). In litigation, a recent article states (Margolick, 1991:1): "A wave of AIDS-related lawsuits has swept over the courts. Most involve discrimination, the blood supply, and criminal prosecutions, but there are innumerable other permutations concerning everything from free speech to child custody to libel to will contests." Although the existence of litigation is unquestionable, the quantity is, in fact, unknown. Whether the "wave" is a tidal wave or a large surf is unclear. Nevertheless, U.S. law, at the legislative and judicial levels, has had to face difficult and sometimes unprecedented problems. The panel could have attempted an entire survey of the effect of AIDS on the legal system, but judged that the evidence, apart from public health legislation, was still too slim and scattered; we chose, instead, to focus on one area of legislation and litigation, namely, that which establishes public policy regarding families and children. This may be but a small corner in the world of law and public policy, but it is, in our judgment, of great importance in view of the populations most affected by the HIV/AIDS epidemic.

All societies have sets of norms that define what relationships count as *family* and dictate permissible forms of intimate interaction. In the United States and other industrialized nations, governments cast many of these norms into statutes and other formal rules that prescribe such matters as

who can marry, who is financially responsible for the care of children, and what reproductive control methods are permissible. Governments also use less coercive policies to guide or reward family-related behavior. They use tax laws and welfare programs to recognize the needs and costs of those living in certain family configurations and to validate their acceptability. They use public health and school programs to encourage people to engage in behaviors considered socially desirable.

When the AIDS epidemic began, many U.S. policies bearing on families and other intimate relationships were in a period of transition, and AIDS raised difficult, often inconvenient, questions of family policy of at least three sorts. First, because AIDS is transmitted by sexual acts, governments had to come to grips with widely varying public attitudes about sexual behavior and about the appropriate role of government in influencing behavior. Everyone knew that many young people have sex (Hayes, 1987) and that many men have sex with other men (Fay et al., 1989). Some officials were not alarmed by these behaviors or, if they were, were willing to acknowledge they existed and urge precautions. Others, however, were unwilling to appear to condone the behaviors at all. School boards wrestled and are still wrestling with whether to distribute condoms to high school students (Galst, 1992), and states and the federal government responded variously to requests for support of programs that sought to eroticize safer sexual practices among gay men (Barnes, 1989). States have similarly wrestled with the degree to which they should rely on compulsory rules to induce desired sexual behaviors. Thus, many states considered and two states adopted and then repealed legislation requiring HIV antibody testing before marriage (Joseph, 1989).¹ And many states adopted statutes making it a felony for persons who knew that they carried the virus to engage in sex without informing their partner (Hermann, 1990; see also [Chapter 2](#)).

Second, since AIDS is also transmitted perinatally, it necessarily involves the relationship between a woman and a fetus she is carrying. Government officials have thus struggled with the appropriate advice to give HIV-infected women regarding decisions about birth control and abortion (Bayer, 1990). Many women with HIV have been offered tortured advice wrapped in euphemisms to "postpone" having children (Centers for Disease Control, 1985). And, as described in [Chapter 4](#), scientists who have wanted to administer AZT to HIV-infected pregnant women to learn whether they could prevent transmission of the virus to the fetus have encountered hostility from women's advocates seeking to ensure that the pregnant woman's health is in no way compromised in the name of trying to protect the unborn child.

Third, since AIDS is a protracted illness and invariably leads to death, family-related policy issues arise during the last stages of the disease and at the point of death. Disputes have erupted between gay men's lovers and

parents over such issues as hospital visits or the authority to make decisions about life-prolonging medical procedures (Steinbrook et al., 1986). Women with HIV have wanted to keep their children with them as long as possible under welfare programs that provide little financial support and to control the placement of their children when they are no longer able to provide care.

This chapter presents case studies of the relationship between AIDS and two sets of family policies affected by AIDS; even more narrowly, it concentrates on these policies in a few selected cities and states. The first case study is that of public issues distinctly related to newborns and children with AIDS. In programs to keep children with their biological parents and in programs to respond to children who must be placed with others, New York and Florida have had to contend with familial issues under strained circumstances—issues of financial responsibility and parental control. The two states sometimes responded similarly and sometimes rather differently, but both of their responses reveal anomalies in public policies that bear on low-income families with children.

The second case study describes the efforts to gain legal recognition of nonmarital relationships, particularly the recognition of gay male and lesbian couples. We examine efforts in San Francisco to pass an ordinance to permit unmarried couples, including gay and lesbian couples, to register their relationship with the city and the quite different efforts in New York courts, legislatures, and agencies to expand the list of relatives entitled to remain in a rent-regulated apartment after the death of a tenant who had signed the lease. In each city, the issues had been debated before AIDS was a central feature of the city's life, but AIDS reshaped the debate in many ways.

NEWBORNS AND CHILDREN

Infants and children with AIDS pose different problems of social and family policy than adults with AIDS. Most of the differences stem from the necessarily dependent position of all young children. They must be cared for by others and decisions must be made for them. Policy makers have long debated how responsibilities for children and control over children should be divided between parents and the state (Mnookin and Weisberg, 1988).

In the context of AIDS, problems of social policy arise in painful, problematic, and revealing manners because AIDS persistently pushes to extremes the burdens and responsibilities of caretakers and the state. Every newborn who is HIV positive has a mother who is HIV positive, a woman who is probably poor and may already be ill herself, a woman who has probably been an intravenous drug user. Mothers of HIV-infected babies commonly feel both depression and anxiety due to their own illness and the illness of their children, and knowing that the child became infected through

them, they frequently experience guilt and the need for denial (Seibert et al., 1989; Septimus, 1989).

All babies born to an HIV-infected mother carry passively acquired maternal antibodies to HIV. However, in only about one-third of such cases is the infant actually infected with HIV; those infants who are not infected will gradually lose maternal HIV antibodies, although they may persist until 15 months of age. Since standard tests for HIV detect HIV antibodies and not the virus itself, they cannot be used reliably to determine which infants born to HIV positive mothers have been infected until the child has lost the maternal antibodies. Even the use of less common and more expensive viral cultures is inappropriate in newborns because a negative culture is not sufficient to exclude HIV infection (Hardy, 1991). Therefore, the HIV status of infants born to HIV-infected mothers cannot be known by foster agencies or foster parents until well after birth.

All children who are actually HIV-infected need extra attention from the point of birth (Hegarty et al., 1988). Unlike adults with HIV, roughly 20 percent of newborns with HIV become ill with AIDS-related infections within a year of their infection. Once ill, they tend to spend more days in the hospital than adults with AIDS. They typically have chronic growth problems, as well as developmental problems in both motor and language skills (Falloon et al., 1989). And all the required care will be delivered by someone who knows that it is highly probable that the child will die.

Pediatric AIDS thus provides an occasion to examine the impact of a new, chronic, and fatal illness on two strands of U.S. social policy relating to children and families. First, it raises the question of how much resources the nation is willing to devote to the care of children and their caretakers. AIDS tests the nation's commitment because the resources required for each child are large, and the children to whom the resources are devoted are among those who are most likely to be otherwise disenfranchised: babies with AIDS are overwhelmingly poor and African American or Hispanic. Yet, although they are the powerless offspring of powerless parents and pediatric AIDS cases (children under 13 years of age) represent less than 2 percent of all cases of AIDS (Centers for Disease Control, 1992), these children have received a substantial share of the public funds expended in response to the epidemic.

Second, pediatric AIDS permits an examination of the allocation of responsibility for children among parents, extended family, foster parents, and the state in regard to where a child will live, medical decisions, and financial costs. AIDS tests the strength of the state's traditional commitment to helping children remain with their biological parents and to affirming the authority of biological parents to control medical care decisions relating to their children (Gaylin and Macklin, 1982; for recent collections

of essays on the responses to pediatric AIDS in the United States, see Schinazi and Nahmias, 1988; Seibert and Olson, 1989; and Anderson, 1990).

Resources and Special Programs

This section draws for illustrations on the responses to pediatric AIDS in New York City and Miami, Florida (and Dade County, of which Miami is a part), the two U.S. cities with the most cases of pediatric AIDS.² As of December 1991, 852 cases of pediatric AIDS had been reported in New York City and 198 cases in Miami.³

For half a century, the government's principal program of support for low-income families with children has been the program of Aid to Families with Dependent Children (AFDC). AFDC provides basic income support in the form of cash payments. Since the 1960s, Medicaid has been expected to meet the basic medical needs of AFDC families. Even with the social services that regularly accompany it, however, AFDC has never been sufficient in most states to meet the minimal requirements of poor families. In 1988, for example, two-thirds of states did not provide AFDC grants equal to the state's own determination of children's minimal needs. Even in states that did meet their own standard of need, the standards and grants were often very low.

In the early days of the HIV/AIDS epidemic, it became clear that the basic programs of AFDC and Medicaid would be so insufficient to meet the needs of infected parents and infants that additional governmental assistance was imperative. It was also apparent that traditional foster care programs and subsidies would be insufficient to attract foster families for HIV-infected children who could not live with their biological parents. Thus, states with growing numbers of pediatric AIDS cases began to develop new programs and, beginning in 1985, Congress began providing extra money to the states for services and foster care programs for children with AIDS.⁴ With that money, New York City and Miami developed or expanded programs to provide added support to biological parents who were taking care of HIV-infected children and to provide noninstitutional settings for the children who could not live with their parents.

New York City

Special programs and resources created to respond to children with AIDS in New York City have been varied and substantial.⁵ Nearly every public institution that regularly deals with families with children has developed task forces or programs for children with HIV disease. The state's Department of Health, for example, designated 10 hospitals in New York City as "AIDS centers." In those hospitals, every AIDS patient is assigned

a caseworker, as case manager, who serves as the patient's advocate within the hospital and coordinates all eligible services; some workers are especially trained to work with mothers and children (AIDS Institute, 1990a). Other hospitals have created special units for HIV-infected mothers and their children. Harlem Hospital, for example, where, by early 1990, between 3 and 4 percent of all newborns had HIV antibodies, established a unit for women and children with HIV, which had a staff of 20.

To serve adults and children with AIDS during periods when they are not hospitalized, New York City's Human Resources Administration formed the Division of AIDS Services in 1985. By 1990, the division had a staff of 285. In turn, the division established a demonstration project, the Family and Children's AIDS Case Management Project, to coordinate all public services for any family with children in which one or more family members has been diagnosed with AIDS. Caseworkers in this unit carry much smaller caseloads than usual—1 caseworker for every 15 families rather than 1 worker for every 30 families. Most of the families in the program are under such stress from problems other than AIDS that they need the extra help wholly apart from AIDS. Thus, AIDS, which evoked a more sympathetic response than, for example, drug addiction, has opened services that other problems alone had not.

Since nearly all mothers of children with HIV antibodies served by the Division of AIDS Services are at risk of becoming disabled or dying from HIV while their children are young, caseworkers try to involve the mother's extended family, particularly grandparents or siblings of the mother, in helping while the mother is well enough to provide some care for the child and in providing care for the child when the mother is unable to continue. The New York project is particularly proud of these efforts. According to its director, in the first 3 years of operation, only four of the dozens of children the project had served had to be removed from the mother and placed in foster care with nonrelatives while the mother was still alive.

For the minority of children with HIV antibodies who could not remain with their parents or other family members, agencies in New York City have mobilized to find appropriate settings for them to live. Incarnation House, for example, was created to care for children so ill that they need to live in a setting in which they can have close medical supervision, but not so ill that they need to be in a hospital all the time. For the great majority of children with HIV antibodies who could not live at home, however, the goal was to find appropriate foster families. A crisis had arisen at several New York City hospitals in 1985 when a substantial number of babies medically ready for release became long-term hospital residents because their parents were unable or unwilling to take them home. The boarder babies, believed to be HIV-infected, were initially even harder to find homes for than other children unable to live with their parents. They became the

most visible manifestation of a foster care system already under severe stress due in substantial part to the growing number of parents with drug-addiction problems (Joseph, 1988).

Prodded by a lawsuit, New York City made two responses to the boarder baby situation. First, in 1987 it established a federally supported Hospital Baby Project to monitor all babies held at any hospital for more than 3 days after being medically ready for release. Once alerted to the presence of such a baby in a hospital, the project investigates the reasons for the delay and initiates the process for finding another placement. By 1989, according to the administrators of the project, almost no babies testing positive for HIV were being held as boarders in the city's hospitals.

Second, again supported by federal funds, the city's Human Resources Administration's Child Welfare Administration created a Pediatric AIDS Unit in 1988 to increase the number of qualified foster placements. The unit entered into contracts with 5 of the 74 private agencies through which foster children are placed in the city to create special programs for babies with HIV antibodies. By September 1990, the unit was overseeing the foster care placements of 426 children with HIV antibodies, about half of whom had been placed through the 5 specialized agencies and half through the other 69.

Under the special foster care program, foster parents receive much higher payments for caring for a child with HIV antibodies than they receive for caring for a healthy child without special problems (as of November 1990 \$1,281 per child per month, compared with \$400 to \$500 a month for most other foster children). In addition, foster parents of children with HIV antibodies receive an annual clothing allowance of about \$800, a modest additional amount to pay for respite care, and free equipment, such as carriages and cribs. A foster family caring for two children with HIV antibodies would thus be given about \$32,000 a year, out of which they are expected to provide for all the children's needs apart from their medical care, which is paid for through Medicaid.

The largest AIDS foster care program in New York City is administered by Leake and Watts Children's Home, a private agency that began working with children with HIV antibodies in 1985 and, by 1990, had placed about 110 children into about 45 foster families.⁶ A high proportion of the foster parents have worked as nurse's aides or have other nursing training. The foster parents receive high payments and attentive social services. To support its foster families, the agency employs a staff of social workers and nurses who make frequent home visits and are readily available for consultation. The agency is proud of the foster parents' record of taking care of the children: no child with HIV antibodies had been removed from a foster parent because of inadequate care by the foster parent and, of the 110

children with HIV antibodies placed through them since 1985, 104 were still alive in 1990.

The foster care relationships established through Leake and Watts have also been remarkably enduring and stable. Despite the traditional goal of foster care as a short-term intervention while efforts are made to reunite a child with the biological parents, only 4 of the 110 children placed with them had returned to their biological families. In fact, only a small proportion of the children are visited by their mothers or other biological family members. The agency attributes the small rate of reunions and visits primarily to the family situations of the newborns who come to them: the majority enter foster care directly from the hospital shortly after birth, and virtually all test positive not only for HIV, but also for heroin or cocaine. Thus, nearly all have mothers who are both drug users and HIV-infected, and according to the agency, nearly all also have mothers who decided to leave their children at the hospital rather than take them home.

Because returning children with HIV antibodies to their biological parents is not often possible (or often is not in the infants' best interest), a further goal of New York City's program has been to arrange adoptions for as many of the foster children as possible. In the fall of 1990, roughly two-thirds of the children cared for through Leake and Watts were in some stage of the adoption process, nearly all of them proposed for adoption (or already adopted) by the foster parents with whom they had been living. In New York, for hard-to-place children like children with HIV antibodies, foster parents who adopt them continue to receive all the benefits and services they received as foster parents (except for the allowance for respite care).

Miami

Many of the same services provided for HIV-infected children in New York City have been developed in Miami.⁷ Services there are provided through the state's Department of Health and Rehabilitative Services, the South Florida AIDS Network, Jackson Memorial Hospital, and private agencies. Jackson Memorial is a 1,250-bed public hospital; it provides care for more children with AIDS than any other hospital in the United States. As of the summer of 1990, it was providing inpatient and outpatient care to 198 HIV-infected children and to an additional large number of infants with HIV antibodies who were still too young to determine whether they actually carried the virus. Of the 198 children, 75 percent were living with one or both biological parents and another 14 percent were being cared for by grandparents or other family members.

Like Harlem Hospital in New York City, Jackson Memorial developed teams to provide coordinated services to women and children with HIV

disease. To coordinate public services for families and children outside the hospital, the hospital undertook a demonstration project, similar to New York's, that was serving 160 families as of the summer of 1990. Project caseworkers carry smaller caseloads than usual, 30 families per worker (twice as high as New York's demonstration project but still substantially lower than the usual caseload in Miami). The project has been staffed to address the highly diverse cultural mix of Miami's population. As in New York, very few of the children in the demonstration project have been removed from a caretaking parent during the parents' lifetimes.

For the children who cannot remain with their biological parents, Miami has also established much the same range of foster care programs and support as New York City (Coppersmith, 1990). In Miami, nearly all children who have HIV antibodies and who require foster care are placed through a private agency, the Children's Home Society of Florida, which as of February 1991 was overseeing 36 children living in 21 foster homes; since January 1988 it had overseen the placement of 73 children.⁸ As in New York, the substantial majority of the children in foster care are African Americans, were born with traces of heroin or cocaine in their systems, and were the children of women who were HIV-infected and had at some point been drug users. Florida pays foster families that care for children with AIDS at an even higher rate than New York. The rate paid in the two states for an asymptomatic child is similar (about \$1,300 per month), but because the Medicaid administrators in Florida have approved payments to foster parents for each day that a child is not in the hospital, foster parents caring for a child with AIDS receive a total of \$2,621 per month (\$31,452 annually).⁹

Adoption plays a much smaller role in policies for children with HIV antibodies in Florida than in New York. In Florida, the state has arranged adoption for only about 8 of the 73 children placed in foster homes through the Children's Home Society. Why so many more children have been adopted in New York is easy to explain: in New York foster parents adopting a hard-to-place child continue to receive nearly all the payments they received as foster parents; in Florida, on adoption, nearly all payments cease. Thus, in Florida, the only children in the HIV program who have been adopted have been a few of those who, on later testing, had seroconverted and were HIV negative. New York's principal goal in subsidizing adoptions has been to ensure continuity of care for hard-to-place children, but not one of the symptomatic children placed in foster care in Florida through the Children's Home Society has left the foster family even without an adoption subsidy program; thus, it is unclear whether New York's system of subsidized adoption has been needed to ensure continuity. The more significant value of New York's program, also unmeasured, may lie in helping children, through adoption, feel more a part of a family and in encouraging

the foster and adoptive family to form as strong an emotional bond with the child as possible.

Anomalies in the Allocation of Resources

Miami and New York have developed impressive programs for responding to the needs of children with HIV infection. The projects just described are only part of the cities' extensive efforts. And yet, as ever, there are anomalies and inconsistencies in the public response. This section discusses some of the principal anomalies; although there are sometimes persuasive explanations for each of them, their cumulative effect remains troubling.

As a starting point, the very scale of the public commitment to infants with HIV infection may itself seem anomalous both as an absolute commitment of resources and in relation to expenditures for adults with HIV. The costs of caring for a baby with AIDS are very high. The medical costs alone often exceed \$50,000 a year for children who spend many days in the hospital (Hegarty et al., 1988). If a child is in a foster home, the foster parents will be paid between \$15,000 and \$30,000 per year for the child's care. Whether or not the child is in foster care, social workers and other public employees who help oversee the child's care cost an additional several thousand dollars per child each year. The public commitment is also high when measured not in dollars but in people—specialized hospital staff, foster parents, social workers who serve biological and foster parents, and specially assigned agency staff. Some indication of the scale of such programs is the size of the Sixth Annual National Pediatric AIDS Conference, a five-day conference held in Washington, D.C., in February 1991, at which more than 200 papers were presented, a large proportion of which dealt with local programs of care around the country.

According to U.S. Department of Health and Human Services (1988), federal expenditures for children with AIDS in 1988 totalled \$98 million, not including AFDC grants. State and local expenditures total several thousand more per child. In a nation frequently criticized for its uneven commitment to the well-being of children, and particularly to African American and Hispanic children, this expenditure of resources is substantial by any standard.

The commitment of high expenditures for HIV-infected children is in part easy to explain. As to hospital costs, for example, no special congressional appropriation was needed in the late 1980s to expend tens of millions of dollars each year on HIV-infected children. When the AIDS epidemic began, the Medicaid program was already in place to provide medical care for low-income adults and children; the critical public decision to respond to the medical care of the poor had been made in the mid-1960s. And even

before Medicaid, public hospitals had been assigned the responsibility of treating the sick and dying who could not afford care.

More complex to explain are the new programs authorized by Congress that were specifically addressed to HIV-infected children—the programs, for example, that provided funds for the extra services in New York and Miami for HIV-positive children living with their biological parents and the funds for special foster care programs. The funds for these programs are not only substantial in themselves, but also in comparison with funds appropriated for extra services for adults with HIV. In the 1989 federal budget, for example, programs for out-of-hospital social services for children with HIV received \$7.8 million; in comparison, such programs for adults received \$14.7 million, even though there were over 40 adults with AIDS for every child with AIDS. In the 1990 budget, the support for such services for children nearly doubled to \$15 million, but the budget for adult services increased only to \$17.4 million, even though the number of pediatric cases had not increased as a proportion of all cases (Kirp, 1990). State budgets have also often been disproportional in their support of child-related HIV programs.

Because of their greater dependency, children may well require more expensive social services than adults, but that is hardly the total explanation for the proportionately greater commitment of resources to children. Part of the answer is simply that programs for poor children have always garnered more money than programs for poor adults. For example, neither the AFDC program nor any other federal program provides income support to nondisabled adults without children, no matter how poor they are. In one sense, the usual justification for higher public expenditures for children than adults does not apply in the context of AIDS: the usual justification, similar to the justification for public education, is that children are the nation's future, and income support and other programs are investments in that future, a way of providing opportunity. But sadly, of course, most children with HIV have very limited futures.

Thus, the better explanation for the higher expenditure for HIV-infected children is simply that as a nation, Americans are more sympathetic to their plight than to the plight of HIV-infected adults. Children with HIV may be viewed with more sympathy than adults because they are seen as morally blameless for the behavior that led to their illness. Moreover, to a degree vastly dwarfed by their number, the pediatric AIDS cases that have been brought to Congress's attention most forcefully have remained, even in 1990, the children with hemophilia or children who have received transfusions, not the children of heroin-injecting minority mothers. The major AIDS funding legislation of 1990 for both adults and children—the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act—was, for example, named for a white, middle-class child with hemophilia.

A second anomaly in the deployment of resources is the differences in expenditures among the states. The AFDC program rests on federal legislation, but it is partially funded by the states, and the states are largely free to fix the grant levels. States are also free to vary the range of care provided through Medicaid. New York and Florida aptly illustrate the gross disparity of payments among the states. In New York, in early 1991, the basic AFDC grant for a parent and one child was \$439 per month; in Florida, the same family would have received \$211 per month. This difference cannot be explained by differences in the costs of living—Florida does not estimate that children need less to live on than New York estimates; rather, the difference lies in fundamental differences in the political environments of the two states. New York taxes its citizens at high rates (compared with almost all other states) and supports one of the nation's most extensive social welfare systems. Florida, without a state income tax, has chosen to spend much less on the needs of the poor and on services of all sorts. Florida ranks 48th among the states in expenditures per capita for health and social services, and it ranks 47th in Medicaid expenditures per capita for eligible poor people (Preston, Andrews, and Howell, 1989). In this light, Florida's unusually high payments to foster parents caring for HIV-symptomatic children is particularly anomalous.

AIDS arose in the context of a welfare system already widely divergent among states. In some respects, the federal response to AIDS has ameliorated the differences among states, for Congress has accepted the burdens of AIDS as so extraordinary that it has agreed that the federal government should bear nearly all the costs of special demonstration projects, such as those to provide extra services for HIV-infected children living at home. The Ryan White CARE Act similarly provides extra federal money to heavily affected cities, such as New York City and Miami, without regard to variations in the financial commitment that the particular cities and states have already made. Still, even with these extra infusions of money, a child with HIV who is eligible for AFDC in Florida and living with his or her mother has less income available and probably will be helped by a caseworker with a substantially larger caseload than a similar child in New York.

The disparities among states are matched by disparities within states. Even within Florida or New York, a child with HIV disease living in some settings receives much more support from the state than a child living in other settings. Some of these differences are the inevitable product of large bureaucracies and patchwork programs. In New York City, for example, some children with HIV disease are in the enriched, low-caseload demonstration programs for families operated by the Department of AIDS Services. Other children receive help from the division but not through a special program and have a caseworker with a larger caseload. Still others, particularly children who have HIV disease who live in a family in which

no one is yet symptomatic, are not eligible to receive services from the division, and no special attention may be devoted to their HIV-related needs, such as prophylactic treatments that might delay progression of illness.

Some other within-state differences faced by HIV-infected children are more deliberate and more dramatic in their scale. As noted above, a child living with a foster family will receive vastly greater financial support from the state than a child living with a biological parent: in Florida, \$2,621 each month to the foster mother, \$211 in AFDC payments to the biological mother. The child living with his or her mother remains in poverty; the other child joins the middle class. Wide disparities exist even in the social services that these HIV-infected children receive. In New York, for example, a caseworker with Leake and Watts Children's Home will carry a caseload of only 9 to 12 HIV-infected foster children, even though the children are living with well-trained foster parents, while a caseworker for an HIV-infected child living with his or her mother will have a caseload of 15 to 30 children.

The gap in expenditures on HIV-infected children living with and living apart from their biological parents is, from one perspective, easy to explain, but it rests on assumptions about family responsibilities and the responsibilities of others that are rarely examined. In this country, states do not expect to have to pay biological parents to help them care for their children. When governments provide modest cash payments through AFDC and support for food through food stamps, most Americans think of the benefits not as compensation but as charity—the "dole"—or, at best, a social investment in the future of children (Marmor, Mashaw, and Harvey, 1990). In contrast, except in the context of adoption, government not only expects to have to pay strangers to take care of the children of others but also to pay them amply to take care of other people's children who are sick. The high payments for foster care for HIV-infected children have been based largely on an estimate of what it would take to attract a decent quality of care for a very needy group of babies. Foster care payments to third persons have always been higher, even for robustly healthy children, than AFDC payments to biological parents. With AIDS, the disparities are simply at their greatest. And the gap in the rate reveals a deep irony: a child is much better off when supported by the state to live with strangers than when supported by the state to live at home, although the latter is the setting governments claim to prefer. Legislators and policy makers extol the nuclear family, but in the context of AIDS they create a set of financial arrangements under which a mother who deeply loves her child might decide that she can show her love best by placing the child in foster care. Conversely, state officials, facing the huge difference between the payments to biological and foster parents, have an incentive to create policies that

encourage leaving children with their biological parents even when a particular child seems at substantial risk of harm in that setting.

The disparity between payments for foster parents unrelated to a child and AFDC payments for biological parents provides the foundation for another nagging and more mundane problem of resource allocation that is also particularly visible in the context of AIDS. New York has repeatedly struggled with the appropriate foster payment scheme for children, with and without HIV disease, who are placed with a relative who has no legal obligation to care for the child but who nonetheless takes the child in. As described above, when a mother of a child with HIV disease becomes too ill to care for the child, the state tries to find another biological family member willing to provide the care. Biological relatives are preferred as caretakers when the parents are unable to provide care for some deeply rooted reasons of policy: to carry out the probable desires of the parents themselves, to preserve the child's emotional attachments with persons who have been significant to them, and to preserve cultural and blood ties for their own sake. Relatives are also preferred for a less flattering reason: they are expected to be willing to care for children for less money than strangers have to be paid to perform the same task. Thus, the goal in setting foster care payments for relatives, as it is for unrelated foster parents, seems simply to be to find the lowest rate that will induce enough relatives to become caretakers in a world in which many relatives will do so without special support and others will need an inducement.

In New York, a solution to the problem of foster payments for relatives was reached, after acrimonious litigation outside the context of AIDS (*Matter of Eugene F. v. Gross*, Sup.Ct., N.Y. County, Index No. 1125/86), that reflects the ambivalence of both policy makers and relatives: if a parent places the child with a relative, such as a grandparent, without the intervention of the state, the grandparent is eligible for AFDC payments only, but if the state intervenes first, on the grounds that the child is without an appropriate caretaker, and arranges for the grandparent to take the child, then the grandparent (or aunt or other relative) is compensated at the higher foster parent rate. There is a rough logic to this compromise position: it distinguishes, it appears, between a relative who wants to take care of a child and a relative who has to be recruited. In practice, however, what often occurs is that families with relatives willing to help nonetheless contrive to get the state to intervene so that the relatives, often themselves living in poverty, can be eligible for the much higher foster parent payments.

In the context of AIDS (and other problems that make children especially hard to place), the disparity between foster care and AFDC payments is at its greatest, and thus the incentives are greatest for relatives to enlist the state's aid in arranging placements. Indeed, the incentive is such that it might induce a biological mother to agree to the state's placing her child

with a relative and then secretly continuing to live with the relative so that the child can receive the benefit of the most generous levels of payments and the care of her or his mother.

Anomalies in Policies Regarding HIV Testing and Medical Decisions

The anomalies in the allocation of financial resources for HIV-infected children are matched by anomalies in the allocation of responsibilities for making decisions on behalf of children. The anomalies are particularly apparent in policies regarding testing children for HIV antibodies and the participation of HIV-infected children in clinical trials.

For testing, most clinicians now believe that it is important to identify in infancy children who may be infected in order to begin prophylactic treatment and to monitor them for signs of treatable infections (Cabat, 1990; Oleske, 1990). In March 1991, for example, the CDC issued guidelines for early prophylaxis for *Pneumocystis carinii* pneumonia (PCP) in HIV-infected children and called for testing of pregnant women and newborns (Centers for Disease Control, 1991). The Institute of Medicine also recently issued a report calling for a program of offering tests to all pregnant women in areas with a high prevalence of HIV (Hardy, 1991). Despite the wide agreement on the desirability of testing, hospitals in many states, even hospitals in areas of high incidence, do not routinely offer HIV antibody testing to all pregnant women. To some extent the problem is one of resources. Some hospital staffs would like to offer tests but lack the funds to hire the pre- and posttest counselors required by law and good medical practice. Recently, New York provided special funds to 23 hospitals as a part of a broad program of voluntary testing in the context of prenatal and postpartum care (AIDS Institute, 1990b), but many states, although providing care to children known to be ill with HIV disease, do not seek to identify all those who need care.

Even when hospitals do offer testing to pregnant women, however, many women decline to be tested and thus many infected newborns remain unidentified. In one study in a high-incidence area of New York City, for example, a hospital offered tests to 221 women who gave birth at a hospital without having previously received prenatal care. Of this group, a group thought likely to include an especially high level of HIV infection, only about one-half the women agreed to be tested (Hiranandani et al., 1991). Neither New York nor Florida imposes testing on pregnant women, and both refuse to test a child without parental consent. The Institute of Medicine, in its recent report, stressed the urgency of identifying infected children, but came out strongly against imposing testing on women and children (Hardy, 1991). The AIDS task force of the American Academy of

Pediatrics has concurred in this position, as has the Working Group on HIV Testing of Pregnant Women and Newborns (1990) at Johns Hopkins University.

The reluctance to impose universal testing on pregnant women is generally justified by concern for the dignity and autonomy of women. If the motive for testing is for a woman's own sake, then the objections to doing so without her consent are the same as the objections to imposing other medical procedures on adults even when the state is confident that the procedure would be in the adult's best interest—a respect for individual choice and a skepticism about the motives of the state when it purports to act in such a paternalistic manner (Levine and Bayer, 1989). Thus, nearly all states impose testing on unwilling adults only in very narrow circumstances,¹⁰ and the federal Ryan White CARE Act prohibits states' receiving funds under certain sections of the act from imposing testing on unconsenting adults except in a few instances (Section 2661 (b)).

If the state's motive for testing a pregnant woman is solely to identify candidates for a program to reduce transmissions to children or for early medical intervention, then the objections are somewhat different. In these circumstances, the state is, in the view of many, using the woman simply as a vehicle for reaching her child. The hostility expressed toward testing for such purposes is similar to the objections that have been raised to clinical trials using zidovudine (AZT) on HIV-infected pregnant women solely to learn whether it is possible to prevent the transmission of the infection to their children (see [Chapter 4](#)).

Finally, if the state waits until after birth to test a newborn (but not her or his mother) without the mother's consent, it imposes two forms of intrusion on the mother. First, it compels her to learn her own status, which may be objectionable for the reasons just discussed. Second, even if it were possible to test a child without revealing the HIV status of the mother, imposing the test overrides the mother's control over her child in a society that leaves nearly all decisions about children to parents. States leave the control of children to parents in part because they believe that parents in general know better than anyone else what is good for their particular child. Even when the state believes it knows a child's needs better than the parents, it is reluctant across a very broad range to impose medical or other decisions over a parent's objections. They tend to do so only in circumstances, such as an emergency blood transfusion for a child of parents who are Jehovah's Witnesses, in which the child's life is at immediate risk (Bennett, 1976; Goldstein, 1977).¹¹

The reasons that states do not impose such decisions reflect the most elemental views about parenting and the role of the state. Children are born to—come from the bodies of—particular parents, and most parents regard begetting and raising children as one of life's most fulfilling activities.

Affirming the responsibility of parents for making decisions on their children's behalf acknowledges this fundamental, socially useful drive. When the Supreme Court speaks of a constitutional presumption of biological parents' control over a child's life, it is speaking of rights that belong to the parent, not rights that belong to the child (*Smith v. Organization of Foster Families for Equality and Reform*, 431 U.S. 816 (1977)). Affirming the authority of parents also affirms, in general, the acceptability of diverse childrearing practices in a nation without a single orthodoxy about appropriate ways to raise children, and it helps preserve racial, ethnic, and religious identities in a nation of diverse cultures.

Yet empowering parents to refuse HIV testing for their newborn appears to pit the interests of parents against the interests of children since a child cannot be treated if her or his illness is not known. If early prophylaxis becomes increasingly effective for children, the tension between children's and parents' interests will become increasingly acute. At this time, the great reluctance to override parental choice is probably defensible. Arguments for state-imposed testing of newborns that rest on available treatments for the children who are identified have moral force only if the state actually makes such treatments available to all children who need them. But large numbers of children in the United States live in families ineligible for Medicaid and not covered by any type of private medical insurance: these children would be unlikely to receive appropriate care for HIV disease or AIDS. Even those children who are covered by Medicaid face obstacles to adequate care in many places (Hopkins, 1989).

Even if care were assured, there remain some child-centered reasons why a mother, especially a mother who does not know her own HIV status, might refuse testing for her child. The mother might justly worry about breaches of confidentiality and the stigma that would attach to her and to her child if others—neighbors, unsympathetic relations—learn that she and the baby have HIV. She might also worry about her own ability to cope with learning her status and the depression and anxiety that might then interfere with her capacity to parent. She and her child might both be better off if she could surmount those fears and learn her own status and the status of her child, but it cannot be claimed that a refusal to permit a child to be tested is always a selfish and unloving act. In addition, imposing testing on a woman who is poor may reinforce her own sense of powerlessness, while making testing within her control may not only give her some sense of power, but also encourage hospital staff to provide information about the values to the child of learning his or her status. A mother who has voluntarily consented to a child's testing, moreover, may be more likely to participate actively and enthusiastically in planning for meeting the medical needs of the child long after the test (Nolan, 1989).

The control that parents are accorded over HIV testing extends to other

decisions about the children's health care, including decisions to permit a child to receive an experimental drug and decisions to authorize surgery and other invasive procedures. All research on children poses difficult ethical issues (Gray, 1989), and this section considers those issues in the context of a final anomaly: Why is it that foster parents for HIV-infected children (who are usually well trained and under less stress than the biological parents of the children) and other agents of the state are not permitted the same authority as the biological parent regarding experimental drugs and surgery? For a child in foster care in New York, an agency that receives a request for testing from a foster parent first tries to locate and obtain consent from the biological parent(s). Without a biological parent's consent, the agency has to make a determination that testing will be in the child's interests. In a few states the policies are so restrictive that no HIV testing of a child in foster care is possible without consent of the biological parent(s), and some parents cannot be found to give consent (Baughman et al., 1989).

The reasons that broad powers are accorded to parents were examined above. To accord the same powers to foster parents might be seen as undercutting or denigrating the authority of biological parents, even in circumstances in which the powers of the biological parent have largely been suspended by placing the child in foster care.¹² The powers of foster parents are kept limited not only to recognize the authority of the biological parents, but also because foster parents are, after all, paid agents or employees of the state, performing a job for the state. Although encouraged to shower an HIV child with attention and affection—"Hugging and kissing will help keep your [foster] child healthy," says one information sheet for foster parents—they may inappropriately put their own interests ahead of those of the child. Outside the context of AIDS, states have on several recent occasions been sued by biological parents because of the abusive treatment that a child suffered at the hands of foster parents (Oren, 1990). Within the context of AIDS, however, it is questionable whether these reservations about foster parents have a reasonable foundation. At least in New York and Florida, the child placement agencies believe that the highly paid foster parents are exceptionally committed to their foster children's well-being and exceptionally well informed about the children's medical and other needs.

With regard to experimental drugs, even the state distrusts itself as caretaker and seeks to protect children against any interests being taken into account other than a specific child's. Thus, in New York, when a proposal was made to permit children in foster care to participate in an experimental drug trial, such as the initial proposals to give AZT to infants, the question that the state agency put to itself was not whether all infants with HIV would be benefited by the knowledge to be gained from the experiment, but, rather, whether there was a sound basis for believing that the particular

children for whom the experimental drug was proposed would themselves receive a medical benefit from participating in the test. On that basis, foster children have not been permitted to participate in a clinical trial in which they might receive a placebo. Biological parents are not subject to such limits. For example, they might agree to a child's participation in an FDA-approved experimental protocol motivated not solely by concern for their child but also by altruistic concerns for other children, present and future, who might benefit from the treatment. It may seem paradoxical that biological parents are permitted to be less concerned for the welfare of their children than the state, but the state's self-imposed restraint is surely wise—at least in ordinary circumstances. It is wise because of the risk that the state will consider children for broader social goals without giving adequate weight to an individual child's needs.

There is, however, a problem with too much restraint in the context of AIDS. AIDS is a disease in which the current treatment of choice is often a drug still in the experimental stages. Restraint may prevent HIV-infected children in foster care from gaining access to drugs that will permit them longer lives. One study found that very few children in foster care have been among children included in clinical trials—no foster children in Florida, for example, had participated in clinical trials as of 1989—and concluded that many states needed new procedures to increase foster children's access to experimental medications (Martin and Sacks, 1990; see also U.S. Department of Health and Human Services, 1988).

LEGAL RECOGNITION OF UNMARRIED COUPLE RELATIONSHIPS

San Francisco and New York, the two U.S. cities with the largest numbers of cases of AIDS among gay men, provide opportunities for examining family policies that primarily affect adults. They provide particularly rich opportunities to examine efforts to gain legal recognition for gay, lesbian, and other unmarried couples and the role of AIDS in the debates that accompanied those efforts. Although it is impossible to tell whether the changes in law that have occurred would have occurred anyway, it is at least certain that AIDS played a central role in framing the context for, and in shaping the public discourse that accompanied, those changes.

In both San Francisco and New York City, recent efforts to extend protections to people in unmarried relationships, heterosexual and homosexual, were an outgrowth of efforts that preceded the AIDS epidemic but were given new impetus by it. The 1970s and 1980s were a time of ferment in U.S. political and social history over the meaning of marriage (Bernard, 1972; Glendon, 1989) and the position of homosexual people in society (Altman, 1983). Until quite recently, in most states, most forms of sexual

activity with another consenting adult of the same sex have been illegal, and only one sort of "couple" has been recognized by the law—the couple of a man and a woman married in a ceremony sanctioned by the state (Barnett, 1973).

Even today, in most states a couple, whether of the same or different sexes, who live together outside of marriage have no more rights or entitlements through their relationship than any two friends or roommates (Weitzman, 1981). They cannot file a joint tax return. If one dies without a will, the other will not inherit his or her property regardless of the nature of their relationship. And, even with a will, the survivor cannot obtain the benefit of state and federal estate tax laws that permit passing property to a spouse without payment of a tax. Nor can the survivor obtain Social Security survivor benefits.

In the two decades preceding the first reported cases of AIDS, changes had begun in some states' responses to unmarried couples in general and to gay and lesbian couples in particular. Those changes occurred largely in the courts, rather than the legislatures. A few courts began to provide relief to unmarried partners, heterosexual and homosexual, on the breakup of a relationship when they could prove some sort of explicit or implied agreement between the partners to share property or support each other (Blumberg, 1981). And some other state courts invalidated (and several state legislatures repealed) laws making voluntary sexual relations between persons of the same sex a crime (*Harvard Law Review*, 1989).

Efforts to gain more formal recognition of ongoing gay and lesbian relationships were more halting. The critical difference between the position of gay and lesbian couples and the position of heterosexual unmarried couples is that heterosexual couples, except in unusual circumstances, are free to marry if they choose but homosexual couples are not. Thus, some gay men and lesbians have fought for the recognition of homosexual marriage. In an effort to force recognition, some gay male couples have sought marriage licenses and, when a license was refused, have filed actions in court claiming that their state's statutes ought to be read to permit persons of the same sex to marry or, in the alternative, that denying same-sex couples a marriage license unconstitutionally deprived them of the equal protection of the laws. As of 1991, no courts had accepted the arguments. Nor had any state legislatures amended their marriage statutes to permit persons of the same sex to marry.

For many, the issue is highly symbolic. Marriage is a central public and communal ritual: if people of the same sex can marry, they can consider themselves brought within the community of respectable persons in the society (Stoddard, 1989). Other homosexual people, however, found aspects of the symbolism of marriage deeply troubling. Some lesbians, in

particular, view marriage in its traditional terms as a state in which women are dependent, dominated, and systematically exploited (Ettelbrick, 1989).

Regardless of their views about marriage, however, nearly all gay and lesbian activists agreed that there were important pragmatic reasons for wanting to gain some sort of legal recognition for gay and lesbian partner relationships: the many benefits, such as access to health insurance and various government benefits, that one person can obtain through another or that two persons treated as a couple can obtain at lesser cost than two persons treated as individuals. Although in some sense, fighting for the right to obtain benefits through another person may reinforce images of dependency, most advocates viewed the issue as one of simple justice, of securing the advantages widely made available to heterosexual married couples.

In recent years, gay activists who work on issues relating to couples have largely focused their efforts on getting courts and legislatures either to recognize a special status for unmarried persons—often termed domestic partnership—or, more narrowly, to recognize the unmarried couple relationship for some particular purpose. For those who are uncomfortable with the social meaning of marriage, the term partnership conveys an attractive image of two persons as equals, not of two persons arrayed in a hierarchy. As described below, efforts to gain legal recognition for domestic partners have taken place in San Francisco and New York since the epidemic of AIDS began and seem to have been affected by the epidemic.¹³

San Francisco

In November 1990 voters in San Francisco approved an ordinance to permit unmarried persons to register with the city as domestic partners. The ordinance was adopted by a wide margin, and the gay community of San Francisco regarded the vote as a triumphant affirmation for all gay persons. The road to its passage, however, begun eight years earlier, had been strewn with potholes and detours.

The Early Years

The first effort in San Francisco for a domestic partnership ordinance occurred in 1982, after some cases of AIDS had been reported, but before AIDS had deeply imprinted itself on the minds of most San Franciscans. On that occasion, Harry Britt, at that time the only gay member of the city's Board of Supervisors, proposed legislation to permit unmarried couples to register with the city if they affirmed that they shared "the common necessities of life" and that they were each other's "principal domestic partner." The bill prohibited the city from treating domestic partners and married persons differently.

The Board of Supervisors passed the bill, but the city's major newspapers and the Catholic church opposed it, and then Mayor Dianne Feinstein, who had supported many initiatives favored by gay men and lesbians, vetoed it. Mayor Feinstein objected to what she considered the broad potential reach of the bill and expressed fears about the impact of the bill on the institution of marriage. When Supervisor Britt introduced essentially the same bill the following year, the mayor announced that she would veto it again if it was passed, and the bill was withdrawn. AIDS played little role in the debate, although by 1983 many cases of AIDS had been identified, and some of those who opposed the bill argued that it would lead to medical insurance coverage for the partners of gay city employees and thus, eventually, to increased medical care costs for the city.

Six years passed before domestic partnership legislation was introduced again. In 1989 the effort was renewed, and an ordinance was initially adopted, rejected by the voters, proposed again, and finally adopted. Supervisor Britt continued to lead the efforts in a social and political context that had changed in the intervening years. A few smaller cities in California, including Berkeley, Santa Cruz, and West Hollywood, had by then adopted ordinances to provide health insurance coverage for domestic partners of city employees. Harry Britt was now president of the Board of Supervisors, and the city's new mayor, Art Agnos, had run on a platform supporting domestic partnership legislation. And AIDS had by then taken the lives of nearly 4,000 gay men in San Francisco alone and tens of thousands of others were HIV positive. By 1989, many believe, AIDS had substantially reshaped the meaning of nearly all political issues in San Francisco, including the issue of domestic partnership legislation, although it is, as ever, impossible to know what would have occurred over the 6 years in the absence of the HIV/AIDS epidemic.

Both proponents and opponents of the legislation believe that an initial broad way in which AIDS had altered the context by 1989 was that the epidemic had made gay and lesbian people more politically aware and active across a whole range of issues affecting their lives. Even in 1982 San Francisco had the most politically powerful gay and lesbian community among all large U.S. cities, and many lesbians had long been active in women's political forums. In the years after 1982, however, the number of gay men who became involved in political efforts grew substantially because of the large number whose lives were affected by AIDS and who believed that government needed to respond more forcefully to the epidemic (Altman, 1988). For many gay men through the early 1980s, if they were politically involved at all, their goal was to persuade the government to leave gay people alone to live their lives as they pleased. By the late 1980s, however, many gay men sought a far more active and responsive role from the state.

Just as AIDS made people more politically aware in general, so it also helped determine the particular political issues in which they became involved. Some issues were new and directly related to AIDS, such as efforts to persuade the California legislature and U.S. Congress to provide more funds for AIDS research and treatment programs and efforts to head off legislation that would have led to mandatory testing of people believed to be at high risk for infection. What was distinctive about Supervisor Britt's domestic partnership legislation was that it was an old issue infused with new content because of AIDS, in much the same way that efforts to provide legal protections for handicapped people have been enlarged by the inclusion of people with AIDS among those believed to deserve protection against discrimination.

For gay men and lesbians, AIDS altered the significance of the domestic partnership issue in two particular ways. In the widest sense, the large number of gay people who had cared for their ill partners made many homosexual people appreciate an aspect of their lives that had always been there but had never before seemed so salient. Jean Harris, a lesbian activist and assistant to Harry Britt, observed: "AIDS made us realize that our lovers are our support systems. It made us more aware of the importance of primary relationships. It made love and relationships even more important than they had seemed before" (interview, May 31, 1990). However, in some ways, especially for gay men, the very notions of domesticity and mutual dependence associated with long-term relationships seemed inconsistent with the spirit of liberation for which they had strived in the 1970s.

Much more specifically, AIDS also brought home the price that homosexual people had been paying for the social and legal nonrecognition of their relations. That price revealed itself when the biological families of gay men with AIDS tried to exclude their sons' partners from hospital visitation or from participating in decisions about life-prolonging medical treatment. It revealed itself, after death, in struggles over burial and property (Eisenberg, 1991). And, most urgently for many gay men, it revealed itself in access to medical insurance: many employers provided coverage to the spouses of their workers, but none provided coverage to a worker's unmarried partner. Many people with AIDS ceased to be able to work, lost their health insurance coverage, and could not obtain coverage through their partners (Padgug and Oppenheimer, 1990).

For people outside the gay and lesbian communities, AIDS had also altered the meaning of the domestic partnership issue. In San Francisco, many people knew and most had read about gay men who were providing care for a dying partner. They had heard about and seen pictures from the "Names Project," the quilt pieced from panels commemorating those who died of AIDS. For many, their image of the gay male community had expanded beyond hedonism to include tenderness, self-sacrifice, and suffering.

With familiarity, they became more responsive to claims of a need to recognize gay partners than they had been in 1982.

For others, the association between AIDS and gay men remained different and negative. What came to mind when they thought about gay men's relationships was not the sympathetic image of bedside care but the sexual acts that were the means of HIV transmission. The public service ads posted all over San Francisco to encourage gay men to use condoms reminded some people not of lives that might be saved but of conduct they considered immoral. Some people who were unsympathetic also worried, more mundanely, about the financial costs of responding to the people with HIV disease. They rejected the idea of sharing the cost of providing benefits for people whose sexual behavior they abhorred.

During the campaign of 1989 (and 1990), the various conflicting images of AIDS helped shape the proponents' approach to drafting and promoting the domestic partnership legislation, as well as the response of the opponents. Thus, in the spring of 1989, when the domestic partnership bill was first reintroduced, it was framed slightly differently than the 1982 version. As before, the bill prohibited the city and county from drawing legal distinctions between married persons and persons who had registered as domestic partners. This time, however, to direct attention to the affective aspects of relationships, it defined domestic partners as "two people who have chosen to share one another's lives in an intimate and committed relationship of mutual caring." A new provision, clearly drawing on images from the epidemic, provided that, if a person was hospitalized and had made no designation of desired visitors, a person registered as a domestic partner would be permitted to visit.

The bill did not address medical insurance benefits for domestic partners because insurance matters were beyond the authority of the supervisors, even for city employees. Thus, even though the new bill prohibited discrimination on the basis of marital status, it would not, if passed, have imposed new health insurance costs on the city. By a separate action, the mayor, at the Board of Supervisors' direction, established a Task Force on Family Policy to study, among many issues, the feasibility of making insurance benefits available to domestic partners and other extended family members living with an employee and to make recommendations to the Health Services Systems Board, the agency with the authority over insurance benefits for city employees.

The Board of Supervisors unanimously passed the new domestic partnership bill in May 1989, and the mayor promptly signed it. Many conservatives were deeply dismayed. A group of Catholic and conservative Protestant clergy and laypersons banded together and gathered the signatures needed to place the ordinance on the ballot for the November election. A

campaign then began to persuade voters to support or defeat the legislation. The HIV/AIDS epidemic affected the tactics of both sides.

The proponents placed images from the epidemic at the center of their campaign. The principal flyer distributed by the Domestic Partnership Campaign Committee began as follows:

Imagine having spent a lifetime with a partner, sharing a home, sharing responsibilities. Your partner becomes ill—and you don't even have the right to visit him or her in the hospital. Your partner dies—and you don't even have the right to leave work for the funeral. That's the cruel reality for many San Franciscans.

A few paragraphs later, the pamphlet subtly boosted the legislation as a tool to reduce the spread of AIDS. It asked, "Should the City of San Francisco encourage long-term, stable relationships, especially in the time of AIDS?" and then answered its own question, "Yes, of course." In much the same terms, a letter in campaign materials signed by a group of Republicans supporting the bill argued, "We believe it is good governmental policy to encourage the strengthening of stable, interdependent, caring and lasting relationships—particularly in the era of AIDS." The San Francisco Democratic Central Committee in its own campaign letter was more direct. The bill, it said, "helps in the fight against AIDS. It promotes long-term stable relationships."

Some people in the gay and lesbian communities were quite ambivalent about promoting the bill as a tool for encouraging gay men and lesbians to enter stable relationships. To be sure, they wanted to use whatever messages would attract voters, and there was something attractive about this appeal: it invited people by their vote to do their personal bit to halt the spread of AIDS, a civic gesture that had no cost in dollars. But many proponents resented the implication that gay men and lesbians needed legislation to learn to appreciate the values of loving relationships. Tens of thousands of lesbians and gay men in San Francisco were already in long-term relationships, and this group believed that most San Franciscans knew it. In their view, what gay people needed was recognition and equal treatment for relationships that already existed, not a public health gimmick to encourage monogamy.

The proponents also addressed AIDS in another way, by seeking to allay fears about the costs associated with the legislation. The pamphlet and other ads argued that the passage of the legislation would not, in itself, provide health or pension benefits to domestic partners. The point about costs would have been important to make even if AIDS had not existed, but it was especially important because it did.

At each stage of the political process, the proponents were thus responding to needs created by the epidemic and to the sympathies and fears

that the epidemic had engendered. Although the legislation applied to unmarried heterosexual couples as well as to homosexual couples, to lesbian couples as well as to gay male couples, to domestic partners who were well and domestic partners who were ill, the most frequent image conveyed by the proponents of the bill was of gay men and their partners in the context of AIDS. The proponents would have favored the legislation, just as they had in 1982, without regard to the epidemic, but AIDS had increased the urgency of recognition of partnership and affected the way they presented it to the public.

In mirror fashion, AIDS and the fear of AIDS did not provide the central motivation for those who organized the opposition to the ordinance—they would have opposed it without the existence of AIDS. But the opponents also evoked their own images from the epidemic in their efforts to defeat the ordinance.

The Catholic and conservative Protestant clergy who were the principal opponents were not concerned about the prospects of higher health costs—the Catholic church had, for example, long favored generous social programs to respond to health needs. What they disliked about the legislation was its central messages: that homosexual relationships and nonmarital relationships were socially acceptable. They believed that the traditional American family and traditional Christian values were under siege, and they viewed the legislation as encouraging their further disintegration. For them, calling a relationship a "domestic partnership" did not change the issue into an innocuous secular matter of shared finances. Whatever the relationship was called, it remained a direct affront to marriage. They were concerned about the high rate of divorce, the large number of children born outside marriage, and the temptations of homosexual life for children struggling with their sexual identity. They viewed the legislation as endorsing a style of life that they repudiated—wholly without regard to AIDS.

The campaign the opponents waged against the legislation was modest in scope. Several of the organizers refused to speak to the press. They did not purchase ads in the local papers or on local radio or television. They did, however, distribute two flyers widely. The Catholic archdiocese distributed about 25,000 copies of one flyer through parish churches. The pamphlet never mentioned AIDS or homosexuality. It stressed instead that marriages deserve special treatment "in order to provide a secure and nurturing environment for raising children," and it argued that the bill would give protection to transitory relationships and thus "cannot help but erode the commitment of marriage in the public mind."

The other flyer, supported by conservative Protestant groups, was mailed to 90,000 voters they hoped would be sympathetic. This flyer evoked images from the epidemic, although it did so subtly. Its cover showed a silhouette of two men holding hands, with a caption reading "The Domestic

Partners Law. It isn't FREE ... and it isn't FAIR." Except in two brief quotations, one from the Catholic archbishop, the other by the president of the Kong Chow Benevolent Association, the pamphlet made no explicit references to the traditional values that were the opponents' central concerns. Nowhere did it refer to homosexuality as immoral. Nor did it make unsympathetic references to people with AIDS. Instead, what it stressed repeatedly was the hidden dollar costs of the bill—that it would force an immediate increase in the medical insurance premiums that married city employees pay for insurance for their spouses and that it would serve as the opening wedge for forcing the city, and hence the taxpayers, to pay the premiums for unmarried partners. To bring AIDS to mind, the opponents claimed that the bill invited abuse. "City workers," the pamphlet warned, "might be pressured into claiming partnerships as a means of helping friends suffering from AIDS and other chronic diseases to obtain insurance." Echoing and reinforcing the cover of the pamphlet, the back showed a pyramid of silhouettes of men holding hands—2 men in the top row, 4 in the second row, 22 in the eighth row, each man with a dollar sign superimposed on his torso.

By election day, nearly all political organizations, newspapers, and television stations in San Francisco had announced themselves in favor of the legislation. Nevertheless, on election day, the bill went down to defeat—a narrow defeat by a margin of 1 percent, but defeat nonetheless. It had received overwhelming support in the Castro district, the predominately gay residential area, but it was roundly rejected by older voters in the western part of the city and narrowly rejected by the largely black community in Hunters Point.

The 1990 Election

Harry Britt would not give up. In the summer of 1990, he and three other members of the Board of Supervisors voted to again place the domestic partnership ordinance on the ballot in the November election. The ordinance they proposed was a variant of the one defeated the year before. It appeared to be the original bill stripped to its core. Gone were the provisions barring discrimination by the county between married couples and domestic partners. Gone was the special provision regarding hospital visitation. Retained was the central section defining a domestic partnership and setting up the mechanism for registering a partnership with the county clerk. Retained also was the section requiring partners to agree to be jointly responsible for basic living expenses for food and shelter, together with new language that permitted the agreement to be enforced by anyone to whom such expenses were owed. New also was an introductory section declaring that the purpose of the ordinance was "to create a way to recognize intimate

committed relationships, including those who otherwise are denied the right to identify the partners with whom they share their lives." The idea was to invite a vote for the legitimacy of gay and lesbian relationships. One of the principal opponents viewed it more broadly—simply as "a referendum on homosexuality."

Each side geared up for another campaign. The opponents were somewhat more outspoken this time, and the proponents somewhat more muted, but in most respects the campaigns were the same. The proponents again emphasized the justness of treating all loving relationships equally and again claimed, as to costs, that there "was no bill to come due for tomorrow's taxpayers." Opponents warned again of the threat to family, but also continued to express their disbelief that there were no hidden costs to taxpayers. They widely distributed a similar pamphlet, using again the silhouettes of hand-holding men wearing dollar signs across their torsos. And, as before, all the city's newspapers and principal radio and television stations endorsed the proposal.

One of the few major differences between the 1989 and 1990 campaigns bore on the issue of AIDS. Shortly before the election, the wisdom of adopting the ordinance was strongly questioned by several groups the proponents had counted on as their allies. In early October, Clint Hockenberry, the director of the AIDS Legal Referral Panel of Bay Area Lawyers for Individual Freedom and a vocal advocate of gay rights, warned of potential adverse effects of the bill for people with AIDS. Pointing to the section in which partners had to agree to be responsible for each other's basic necessities, he worried that partners of people with AIDS would find themselves hounded by the creditors of their dying friend—and he labeled the bill "a creditor's bill of rights" (O'Loughlin, 1990). He also worried that the size of grants that a person with AIDS was eligible to obtain under various federal programs might be affected by the attributed income of the partner. Hockenberry did not object to unmarried partners accepting responsibility for each other. Rather, he was concerned that people with AIDS might not understand the possible consequences of registering and that the bill as drafted imposed responsibilities on domestic partners without providing any concrete benefits of the sorts accorded to married persons. Two weeks before the election, the city's Human Rights Commission, an agency responsible for protecting gay persons against discrimination, issued a staff memorandum entitled "Domestic Partnerships: Obligations without Benefits? Recognition without Equality?" that echoed many of Hockenberry's fears.

Hockenberry's attacks and the doubts of the commission staff left the proponents with little time before election day. Britt's staff regarded Hockenberry as a traitor. On the merits, they believed that, as a practical matter, very few people with AIDS would be hurt if the ordinance was adopted.¹⁴ They

also believed that Hockenberry was wrong in claiming that the bill gave no immediate benefits. One benefit was obvious—the symbolism of recognition. Another was more subtle but no less important. Although the bill did not in itself provide any financial benefits for domestic partners, the proponents believed that passage of the bill would goad San Francisco's Health Services Systems Board into arranging with insurance companies to permit city employees to obtain health insurance benefits for their partners. The language about joint financial responsibility had in fact been included to make providing insurance coverage more attractive to insurance companies.¹⁵ Once the city provided access to insurance to domestic partners, private employers might be encouraged to follow.

Even though the proponents saw and believed in these benefits, they were nonetheless in an awkward position to respond. They could claim that the risks were not what Hockenberry forecast, but they were reluctant to advertise the bill as an opening wedge for insurance benefits for domestic partners of city employees, since they had been claiming, accurately if somewhat misleadingly, that nothing in the bill imposed any new costs on the taxpayers. The irony was that a provision in the bill that was intended to help pave the way for insurance coverage for the partners of city employees (some few of whom at any given time would have AIDS) had led to the condemnation of the bill as a whole by some other AIDS advocates who worried about a poorer group of people with AIDS, who were not partners of city employees—and that this condemnation might have jeopardized the entire bill.

The worries in the end proved groundless. For reasons that are not entirely clear, the city's newspapers gave little coverage to the dispute, and the coverage they gave made the matter seem technical and speculative. On election day, the ordinance carried by a wider margin—9 percentage points—than any other proposition on the ballot. A poll before the election had indicated that younger registered voters were overwhelmingly in favor of the ordinance and older voters overwhelmingly against it. In a survey conducted by the *San Francisco Chronicle*, of registered voters aged 18 to 34, 70 percent favored the bill and 24 percent opposed it; of voters aged 55 and over, 25 percent favored the bill and 65 percent opposed it. Voters aged 35 to 54 favored the bill 56 to 35 percent. Disparities that wide based on age are quite unusual—and one major difference between the 1989 and 1990 elections was that the 1989 elections had been in an "off year" when little else was on the ballot and fewer younger people eligible to vote actually did so.

The 1990 elections as a whole were regarded by San Francisco's gay political community as a triumph. In addition to the passage of the domestic partnership ordinance, two lesbians won positions on the Board of Supervisors, and a gay man was elected chair of the School Board. Some of

the proponents of the domestic partnership bill believed that the popularity of the bill had helped secure the victory of the gay and lesbian candidates. In December 1990, as the proponents had quietly hoped during the campaign and the opponents had ominously forecast, the Health Services Systems Board voted to make health insurance available to domestic partners of city employees, an action that carried a \$1.1 million initial cost to the county.¹⁶ And, pushing one step further toward equality for domestic partners, the San Francisco Board of Supervisors, now with three gay or lesbian members, passed a unanimous resolution to recommend to the California legislature that it alter the marriage laws to permit same-sex persons to marry.¹⁷

New York City

The issue of domestic partnerships arose in New York in a quite different context, a context in which it was the judiciary, not the legislative or executive branches or the voters, that took the dominant role. In 1989, in the case of *Braschi v. Stahl Associates Co.*, New York's highest court, the New York Court of Appeals, decided that, for certain purposes, a same-sex companion counted as a member of his or her partner's "family" (74 N.Y. 2d 201, 543 N.E. 2d 48 (1989)). Here again, the particular issue might have arisen without regard to AIDS—in fact, had arisen often outside the context of AIDS—but AIDS made the problem seem more urgent and affected the tone of the debate and possibly even its resolution.

Succession Rights Before the Epidemic

The *Braschi* case arose in the context of New York's complicated schemes of rent control and rent stabilization and involved the problem often called succession rights. Succession questions arise on the death of a tenant in a rent-regulated apartment. For example, a tenant's spouse, partner, daughter, or mother has lived with the tenant for years but has never been a party to the lease and, after the tenant's death, wants to remain in what has become the family home. The person wants to remain in the apartment at the regulated rent, which is far below the rent for comparable unregulated apartments. The landlord in turn typically wants the person evicted because the rent regulation statutes provide that, once such an apartment becomes empty, the landlord is free to raise the rent for a new tenant to whatever the market will bear and to continue to raise rents annually at the percentage rate provided for rent-stabilized or, in certain cases, for free-market apartments. New York law provides different schemes of regulation for rent control and rent stabilization. Under both schemes, the regulations prohibit landlords from dispossessing some relatives on the death of a tenant. In the

context of rent stabilization, landlords have persistently challenged the authority of the state's Division of Housing and Community Renewal to issue any regulations and have often been successful in the courts.

Over the years before the *Braschi* case, the Division of Housing and Community Renewal and the legislature had struggled with defining a group of family members who would be entitled to remain in a rent-stabilized apartment on the death of the tenant. At least six proposals had been adopted by the agency or passed by one house of the legislature over a period of a few years. None of the proposals, however, included a nonmarital partner among the protected survivors. The legislative and administrative efforts had centered on which persons related by blood or marriage would be covered and how long such a person would have to have lived in the apartment to be eligible for protection.

The struggle in the legislature over succession was less a public debate over the appropriate definition of *family* than simply one more skirmish in the unending political battles between tenants and landlords. In general, landlords detested rent control and rent stabilization and found a sympathetic ear in the state senate, which was controlled by Republicans and which typically supported landlords' positions. Landlords had no particular moral view to purvey about whether stepparents or siblings or even gay or lesbian partners deserved protection. They simply wanted a profit from their investments, and in that context any successor posed an impediment. Many tenants did care about protecting their family members, but succession rights were simply one of many matters about which tenant groups cared each time the legislature was considering rent regulation issues. In their lobbying, tenant groups had never given any special priority to protecting the interests of unmarried partners in general or gay and lesbian partners in particular. Tenants obtained their principal support from Democrats in the Democrat-controlled state assembly. On three occasions, the assembly voted for some form of succession rights for family members, and on each occasion, the senate refused to act on the proposal.

Succession Rights in the Context of AIDS

Between 1985 and 1989, while the legislature and the housing agency grappled fumblingly with a series of proposed solutions, the number of AIDS cases in New York City increased severalfold. The Legal Aid Society, which provides legal services for the poor, and the Gay Men's Health Crisis, a large HIV/AIDS service organization in New York City, began to receive frequent requests for help from men who had lost their partner (the tenant) to AIDS and wanted to remain in the apartment they had shared. In many cases, the surviving partner had taken care of the tenant over the course of a long illness and was now sick himself.

Thus, during this period, the lower courts in New York began to hear cases involving the gay partners of persons who had died of AIDS. The great majority dealt with rent-stabilized apartments, not rent-controlled apartments, because vastly more units in New York City are covered by the rent stabilization program. Facing cases of a surviving gay partner in a rent-stabilized apartment, a few judges started providing relief. One court, for example, held that, so long as a state agency continued to give protection to a list of relatives such as stepchildren or fathers-in-law, the equal protection clause of the Constitution required that a long-term gay domestic partner be given the same protection (*Two Associates v. Brown*, 502 NYS 2d 604 (Sup. Ct. 1986)). The court reasoned that there was simply no rational basis for giving relief to a stepchild or father-in-law, who may have depended little on the deceased, while denying it to a life-long gay companion, who was much more likely to have been emotionally tied to the deceased. Some lower courts agreed, but others did not.

During this same period, the only legislative proposal that would have provided succession rights to an unmarried partner came from Governor Cuomo. In January 1989 he proposed that succession rights be made available to any person (partner or otherwise) who had lived in the tenant's apartment for 5 years or more. The governor's proposal was never introduced into the legislature. By the summer of 1989, the agency's powers to issue protective regulations of any sort were still in doubt and the legislature, caught in the usual crossfire, enacted no legislation. In fact, some politicians and agency and other officials were by this time looking to the New York Court of Appeals in hopes of a resolution.

The *Braschi* case, the case that everyone watched when it came before the Court of Appeals, arose under the rent control program, the smaller, older, and more rigorous rent regulation scheme, a program that was in disfavor with the legislature and that was slowly being phased out. Since the 1940s that program had included a specific regulation that dealt with succession. In the mid-1980s, the succession section provided that, on the death of a tenant in a rent-controlled apartment, the landlord could not dispossess "either the surviving spouse or some other member of the deceased tenant's family who had been living with the tenant" (New York City Rent and Eviction Regulations). An unresolved question the state agency and courts faced was whether a domestic partner counted as part of the tenant's "family." The agency had consistently interpreted the term to include only a list of people related by blood or marriage.

The particular case that came before the Court of Appeals involved a gay man, Miguel Braschi, who had lived with his partner, the tenant, for 10 years and had cared for him through a long illness. At Braschi's request, the papers filed with the court were silent about his partner's illness, but anyone reading the record would have inferred that the partner had died of

AIDS. In preparing to bring the case before the Court of Appeals, Braschi's lawyers believed that the many accounts in newspapers and on television of gay partners taking care of a partner with AIDS were likely to have made sympathetic impressions on the judges, impressions that could be helpful as the court decided how expansively to interpret the term "family." Thus, in their brief, Braschi's lawyers emphasized the close and loving relationship between the partners and the "painstaking care" that Braschi had provided during his partner's illness and hospitalizations (*Braschi v. Stahl Assoc. & Co.*, Brief of Plaintiff-Appellant, p. 2). They urged the court to reject a narrow and technical view of family based on blood or marriage and to accept instead a functional definition more in keeping, in their view, with twentieth century living patterns. In oral argument before the court, the lawyers drew on examples from the HIV/AIDS epidemic to remind the judges of the many partners who faced eviction, and the judges in turn responded with questions that drew on the epidemic.

To drive home the AIDS-related concerns in this case, a group of AIDS care providers, including organizations from several boroughs of the city, filed a brief with the court that stated that, while exact numbers were impossible to calculate, there were surely thousands of gay men with AIDS living in New York with partners much like Braschi (*Braschi v. Stahl Assoc. & Co.*, Brief of Gay Men's Health Crisis, pp. 15-19). They also brought in materials on the growing problem of homelessness among people with AIDS. They referred the court, by name, to 16 other cases involving succession rights then pending or recently decided in the lower New York courts, all of which involved an unmarried partner, nearly all of which involved a tenant with AIDS, and some of which involved a surviving partner who was himself ill and desperate to remain in the joint apartment (pp. 23-24). The City of New York filed a similar brief emphasizing the problem of homelessness for HIV-infected people (*Braschi v. Stahl Assoc. & Co.*, Brief of City of New York, pp. 2-3).

The record before the court also included a submission from Russell Pearce, general counsel of the city's Commission on Human Rights, who reported an increasing number of complaints of discrimination against people with AIDS—414 complaints in the first six months of 1988, nearly as many as in the entire preceding year. Pearce argued that if the court did not rule for Braschi, "thousands of people affected by AIDS who live in non-traditional family units will face eviction at a most difficult time in their lives" (*Braschi v. Stahl Assoc. & Co.*, Affirmation of Russell Pearce).

The apartment Braschi wanted to retain was owned by a real estate company. The company's lawyers, in their briefs and arguments to the court, tried to stay away from AIDS (*Braschi v. Stahl Assoc. & Co.*, Brief of Defendant-Respondent). They mentioned the disease only once in their brief, in a footnote that seemed to try to deflect sympathy based on AIDS

by pointing out that there was no evidence in the record that Braschi's partner had AIDS. They also sought to undercut sympathy for Braschi in particular by pointing out that his partner was a rich man and that, as his heir, Braschi could afford other housing at prevailing market rates. On the legal issues, they urged the court to accept a traditional definition of family, one that would be more consistent with the agency's practices and more certain of application. Unlike the opponents of the domestic partnership ordinance in San Francisco, they were not motivated in their opposition by moral concerns about family values or about homosexuality, and they did not make such appeals to the court. Nor did the Roman Catholic archdiocese or other religious groups appear before the court to make such arguments.

The court, in its decision, accepted Braschi's position. Cutting through all that the legislature had been unable to resolve, the court began by observing that the term "family" in the rent control statute was neither defined elsewhere in the statute nor discussed in any legislative materials over the years. With such a vacuum, the court believed that it would be most consistent with the legislature's purpose of protecting "a narrow class of occupants other than the tenant of record" to look not to "fictitious legal distinctions or genetic history" but rather to the "reality of family life" (*Braschi v. Stahl Assoc. & Co.*, p. 53). Accordingly, the court decided that the proper definition of family should include, among others, "two adult life-time partners whose relationship is long-term and characterized by an emotional and financial commitment and interdependence" (*Braschi*, p. 54). The court prescribed a list of factors for the lower courts to consider in deciding individual cases—factors such as the longevity and exclusivity of the partners' relationship, their level of emotional and financial commitment, and the reliance the couple placed on one another for daily services.

The court ended its decision by sending Braschi's case back to the trial court to permit the trial judge to determine whether Mr. Braschi met the new criteria, but in summarizing the facts alleged by Braschi, the court left little doubt about the appropriate outcome. If Braschi could prove what he had alleged—a relationship of 10 years, with the partners regarding each other as "spouses," holding themselves out as a couple to friends and relatives, and sharing finances, and with Braschi the primary heir of his partner's estate—he should be considered a member of the tenant's family and assured succession. The court never mentioned AIDS, but almost everyone with any connection to the case believed that AIDS had been on the judges' minds.

By any standard the decision of the New York Court of Appeals was adventurous. As a dissenting judge pointed out, the decision seemed inconsistent with the legislature's overarching goal of phasing out the rent control program as original tenants of apartments died, inconsistent with the

traditional definition of family, and inconsistent with the practice of the agency administering the rent control statute, which had always limited its interpretation of family to a small group of relations by blood or marriage. Worse yet, the dissenting judge complained, while the narrower view of family merely requires a simple determination of a blood tie or a link by marriage, the new interpretation placed an already overworked agency in the unfortunate position of having to make inquiries, on a case-by-case basis, into a number of highly personal, subjective factors, such as two persons' level of emotional commitment to each other (*Braschi*, pp. 55-57).

The decision, when announced in July 1989, received a great deal of attention in the press. Legislators had predictably opposing reactions. Many in the Assembly praised the decision. In contrast, conservative State Senator Marchi proposed an amendment to New York's constitution that would have limited the meaning of "family" in all statutes and regulations to spouses, their children, their parents, and their in-laws. No legislation was ever seriously considered in either house. In the succeeding months, nearly all official activity shifted once again to the rules relating to rent stabilization, the larger rent regulation program, for nothing in the *Braschi* case, a rent control case, dealt directly with rent stabilization, and the legislature remained as paralyzed as ever in deciding between the conflicting demands of tenants and landlords.

Impact of the Braschi Decision

After months of delay and intense lobbying from a variety of groups, including gay rights organizations, the Division of Housing and Community Renewal in 1990 issued new regulations to cover rent-controlled and rent-stabilized apartments (Title 9, New York City Rent Regulations, Subtitle S, Subchapters A and B (1990)). Despite intense resistance from representatives of the landlords, *Braschi* carried the day for rent control and rent stabilization. The new regulations began with findings of fact to support the regulations. In its findings, the agency emphasized the general problems of homelessness and the HIV/AIDS epidemic, which, by the estimates on which it relied, had infected between 124,000 and 235,000 New Yorkers. Of this group, the great majority, the agency stated, were gay men or members of "low-income groups ... two groups most likely to live in nontraditional households" and were thus most in peril of losing their homes. In the new rules themselves, the agency expanded its old list of people related by blood, marriage, or adoption and provided succession rights to other persons "who can prove emotional and financial commitment and interdependence" with the tenant. The regulations went somewhat further than *Braschi* and made clear that a sexual relationship between the parties was irrelevant; thus, a long-term resident who had a relationship with the tenant much like

that of a child or a sibling would also be protected. Finally, in a provision reminiscent of San Francisco's domestic partner registration, the new regulations provided that people who wished to be in a position to claim succession rights could file with the landlord a form provided by the agency informing the landlord of the familial relationship.

At the time the new rules were issued, William Rubenstein, Braschi's attorney in the Court of Appeals, exulted that they were "the most far-reaching recognition of lesbian and gay relationships ever granted by any government agency in the United States." After extended litigation, the new regulations have been upheld (*Rent Stabilization Association of New York v. Higgins*, 562 NYS 2d 962 (App. Div. 1990)).

Braschi may have already exerted some effects in New York beyond rent regulations. Immediately after *Braschi* was decided, then Mayor Edward Koch announced another form of recognition of the domestic partnership relationship. By executive order, he expanded the policy on "bereavement leave" available to city employees to cover bereavement leave for a domestic partner (or a domestic partner's child or parent) in the same manner as bereavement leave for a spouse (Executive Order No. 123 (1989)). City employees who might want to take such leave under the policy were to register their partnerships with the city's Department of Personnel. The changes in bereavement policies were already being drafted in the mayor's office when *Braschi* was announced, but the generally positive public response to *Braschi* may have encouraged the mayor's office to proceed with releasing them and helped to create a positive climate at the time they were released.

CONCLUSIONS

Newborns and Children

The most significant effect of AIDS on social policies bearing on newborns and children has been to force a response by social service systems that are already under stress to families who are similarly already under stress. The responses have often revealed basic tensions, inconsistencies, and anomalies in governmental policies that relate to children and their families.

Children with HIV arrive into a world of social services and legal doctrines formed before they were born and shaped without children like them in mind, shaped by compromises among many conflicting social goals. It should thus hardly be surprising that high points and gaps appear in the public response to them: model programs, generously funded and of which cities can be proud, reach only some of the affected children, while large numbers of other children have needs that are not met at all or are met much

less well. Funding for children with HIV disease is more generous in many regards than funding for adults with HIV disease, but it is uneven in ways that reflect society's ambivalence about the parents of these vulnerable children.

Children with HIV disease or AIDS might be better off if most of the policies discussed in this chapter were different—if there were not wide disparities among states in support programs for families, if within states the payments to biological parents caring for a child were closer to the payments to foster parents, if all pregnant women were tested for HIV infection whether they wanted to be tested or not, if foster parents for HIV-infected children had as wide authority as biological parents to make decisions on behalf of the children in their care. Yet each of these policies is supported by deeply held beliefs about the roles of government and parents in an individualistic democracy, and thus far, the HIV/AIDS epidemic has not led to any fundamental reappraisal of those beliefs. What the long-term effect of the epidemic will be on these policies is as yet impossible to say. At this time, it seems likely that the epidemic will simply serve as another example of the durability and resilience of long-held public values in the United States regarding families and the state.

Recognition of Unmarried Couple Relationships

Looking back, what role did AIDS play in shaping the political and judicial struggles that led to the new, broad housing rules to protect domestic partners and other nontraditional family members in New York City and to the domestic partnership ordinance in San Francisco? That question cannot be confidently answered. It can at least be said, however, that it is highly unlikely that the state agency in New York would have acted when it did to protect such families if it had not been for the *Braschi* decision and for the lobbying of the agency by gay rights and AIDS groups, who were outside the usual political fights between tenant and landlord groups.

The question that is harder to answer is whether *Braschi* itself would have been decided the way it was but for the epidemic of AIDS. The case that came before the New York Court of Appeals, the case of Miguel Braschi, not only evoked some sympathy in itself—a loving partner who had cared for his dying companion—but also surely evoked images of many other similar companions and of yet other homeless persons dying of AIDS in city shelters. In their briefs, the supporters of *Braschi* had certainly gone out of their way to evoke such images in the belief that they would affect the judges. More globally, in the years that immediately preceded *Braschi*, what AIDS had also done, as it had done in San Francisco, was to raise the political consciousness of many gay men and lesbians and lead to the creation of organizations that urged the courts and legislatures to adopt an enlarged view of families.

It thus seems quite possible that AIDS contributed in New York and in San Francisco to the recognition of domestic partnerships and to the recognition of other nontraditional family relationships for which no lobbying voice exists. In both New York City and San Francisco, the recognition of domestic partnerships would have been important to gay and lesbian couples even if AIDS had never happened, but AIDS, for all its tragic effects, may have led the larger community in both cities to confront and accept, at least for certain purposes, families who had once been unseen or, if seen, rejected as different. If this has been the role of AIDS, it is in some sense an amiable paradox: a fatal disease, associated in the public mind with promiscuous sexual acts, a disease so stigmatizing that Miguel Braschi had not wished its name to be mentioned, nonetheless contributed to the recognition and acceptance of a variety of emotionally intimate and interdependent family ties that were once outside the law.

NOTES

1. Illinois and Louisiana passed and later repealed statutes mandating premarital HIV antibody screening, largely because of their lack of cost effectiveness (Childress, 1991).
2. Northern New Jersey is the geographic area with the third largest number of pediatric AIDS cases; for a brief description of the response to AIDS in Newark, see Williams (1989).
3. Pediatric AIDS cases constitute about 1.7 percent of the cumulative U.S. total through December 31, 1991 (Centers for Disease Control, 1992); in December 1991, they constituted about 3.2 percent of the cumulative cases in Miami and 2.3 percent of cumulative cases in New York City.
4. For example, see the provisions for pediatric AIDS health care demonstration projects in P.L. 100-202 administered by the Office of Maternal and Child Health of the Health Resources and Services Administration.
5. The information in this section is based on the materials cited and interviews with staff members of state and city agencies and private foster care agencies.
6. The description is based on interviews with staff members of the Leake and Watts Children's Home and on Gurdin (1990).
7. The information in this section is based on the materials cited, presentations made at hearings by the panel in Miami on July 1, 1990, and interviews with the staff of Jackson Memorial Hospital and other agencies in Miami.
8. Some of the children left the program when, after initially testing positive for the HIV antibodies, they later seroreverted to HIV negative.
9. A few years ago, payments for foster parents caring for a child with AIDS were even higher. Florida's pattern of high payment rates was set at a time when Jackson Memorial had many boarder babies. Payments of even \$3,000 per month per child seemed a bargain to many public officials in comparison with the even higher costs—\$800 to \$1,000 per day per child by some estimates—and the negative publicity they received when housing children in the hospital.
10. To protect mothers, Jackson Memorial Hospital in Miami generally will not permit a biological father to give consent to test a child in circumstances in which the hospital is not certain whether the father knows the HIV status of the mother (interview with Dr. Terry Mastrucci, October 1990).

11. Some people and groups object to state-imposed testing over a mother's objections on broader grounds. They oppose mandatory testing of any group—babies, prisoners, health care providers, air traffic controllers, etc.—on the grounds that the arguments for it are tenuous and that the risks are great that approval of it will lead to even less justified mandatory testing of other groups and, ultimately, to greater discrimination against HIV-infected people.
12. Obtaining the consent of the biological parent(s) consent also protects the state from a lawsuit by the only people likely to sue if the test is performed.
13. This section is based on interviews with proponents, opponents, and observers in both cities and on examinations of legal materials, newspaper accounts, and political campaign literature.
14. Julia Lopez, head of San Francisco's Department of Social Services, issued a memorandum stating that "passage of the domestic partners initiative would not have any effect on the eligibility for benefit programs administered by the department." The Human Rights Commission staff though Lopez might have been hasty in her conclusions.
15. Some insurance companies insist that dependents of an employee to whom they provide coverage be a person to whom the employee has some legal obligation.
16. San Francisco's health plan for its employees does not provide coverage even for spouses; rather, it allows employees to purchase coverage for their spouses (and dependent children) at group rates. The board's action in December 1990 permitted employees with domestic partners to purchase insurance for their partners at the same rates. The extra \$1.1 million in costs to the county was due to the fact that the insurance companies demanded a higher premium for all dependents if domestic partners were to be covered, and the city wanted to make certain that adding domestic partners did not force employees with spouses to pay higher premiums than they already were.
17. A ballot initiative seeking to repeal San Francisco's domestic partnership ordinance failed in November 1991 (Chung, 1991).

REFERENCES

- AIDS Institute (1990a) Intensive Case Management Services for HIV Infected Women and Children: A Report for the Committee on the Care of Women and Children with HIV Infection. New York State Department of Health, New York.
- AIDS Institute (1990b) Obstetrical HIV/Counseling/Testing Care Initiative: Program Status Report. New York State Department of Health, New York.
- Altman, D. (1983) *The Homosexualization of America*. Boston: Beacon.
- Altman, D. (1988) Legitimation through disaster: AIDS and the gay movement. In E. Fee and D.M. Fox, eds., *AIDS: The Burdens of History*. Berkeley, Calif.: University of California Press.
- Anderson, G.R., ed. (1990) *Courage to Care: Responding to the Crisis of Children with AIDS*. Washington, D.C.: Child Welfare League of America.
- Barnes, M. (1989) Toward ghastly death: the censorship of AIDS education. *Columbia Law Review* 89:698-724.
- Barnett, W. (1973) *Sexual Freedom and the Constitution: An Inquiry into the Constitutionality of Repressive Sex Laws*. Albuquerque, N.M.: University of New Mexico Press.
- Baughman, L.N., C.H. Morgan, S. Margolis, and M. Kotler (1989) *Infants and Children with HIV Infection in Foster Care*. Washington, D.C.: U.S. Department of Health and Human Services.
- Bayer, R. (1990) AIDS and the future of reproductive freedom. *Milbank Quarterly* 68:179-204.
- Bennett, R. (1976). Allocation of child medical care decision-making authority: a suggested interest analysis. *Virginia Law Review* 62:285-330.

- Bernard, J. (1972) *The Future of Marriage*. New York: World Publishing.
- Blumberg, G.G. (1981) Cohabitation without marriage: a different perspective. *University of California at Los Angeles Law Review* 28:1125-1180.
- Cabat, T. (1990) The development of an early intervention model for HIV-infected women and their infants. In G.R. Anderson, ed., *Courage to Care: Responding to the Crisis of Children with AIDS*. Washington, D.C.: Child Welfare League of America.
- Centers for Disease Control (CDC) (1985) Recommendations for assisting in the prevention of perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy syndrome. *Morbidity and Mortality Weekly Report* 34:721-726, 731-732.
- Centers for Disease Control (CDC) (1991) Guidelines for prophylaxis against *Pneumocystis carinii* pneumonia for children infected with human immunodeficiency virus. *Morbidity and Mortality Weekly Report* 40(RR-2):1-13.
- Centers for Disease Control (1992) *HIV/AIDS Surveillance Report*. Atlanta, Ga.: Centers for Disease Control.
- Childress, J.F. (1991) Mandatory HIV screening and testing. In F.G. Reamen, ed., *AIDS & Ethics*. New York: Columbia University Press.
- Chung, L.A. (1991) SF apartment vacancy control proposition defeated; domestic partner repeal fails. *San Francisco Chronicle* November 6:A-5.
- Coppersmith, S. (1990) Foster care for children with HIV infection: special mission in a loving environment. In G.R. Anderson, ed., *Courage to Care: Responding to the Crisis of Children with AIDS*. Washington, D.C.: Child Welfare League of America.
- Eisenberg, R. (1991) Personal and estate planning. In P. Albert, R. Eisenberg, D.A. Hansell, and J.K. Marcus, eds., *AIDS Practice Manual: A Legal and Educational Guide*, 3rd ed. San Francisco: National Lawyers Guild.
- Ettelbrick, P.L. (1989) Since when is marriage a path to liberation? *Outlook* 2(6):9, 14-17.
- Falloon, J., J. Eddy, L. Wiener, and P.A. Pizzo (1989) Human immunodeficiency virus infection in children. *Journal of Pediatrics* 114:1-30.
- Fay, R.E., C.F. Turner, A.D. Klassen, and J.H. Gagnon (1989) Prevalence and patterns of same-gender sexual contact among men. *Science* 243:338-348.
- Galst, L. (1992) The right to a safe education: American's teens and AIDS activists push for condom availability in high schools nationwide. *The Advocate* February 11:46-48.
- Gaylin, W., and R. Macklin, eds. (1982) *Who Speaks for the Child?: The Problems of Proxy Consent*. New York: Plenum.
- Glendon, M.A. (1989) *The Transformation of Family Law: State Law and Family in the United States and Western Europe*. Chicago: University of Chicago Press.
- Goldstein, J. (1977) Medical care for the child at risk: on state supervision of parental autonomy. *Yale Law Journal* 86:645-670.
- Gray, J. (1989) Pediatric AIDS research: legal, ethical, and policy influences. In J.M. Seibert and R.A. Olson, eds., *Children, Adolescents and AIDS*. Lincoln, Neb.: University of Nebraska Press.
- Gurdin, P. (1990) Quality care for children: a specialized foster care program. In G. Anderson, ed., *Courage to Care: Responding to the Crisis of Children with AIDS*. Washington, D.C.: Child Welfare League of America.
- Hardy, L.M., ed. (1991) *HIV Screening of Pregnant Women and Newborns*. Committee on Prenatal and Newborn Screening for HIV Infection, Institute of Medicine. Washington, D.C.: National Academy Press.
- Harvard Law Review* (1989) Developments in the law—sexual orientation and the law. *Harvard Law Review* 102:1508, 1519-1537.
- Hayes, C.D., ed. (1987) *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*. Panel on Adolescent Pregnancy and Childbearing, National Research Council. Washington, D.C.: National Academy Press.

- Hegarty, J.D., E.J. Abrams, V.E. Hutchinson, S.W. Nicholas, M.S. Suarez, et al. (1988) The medical care costs of the human immunodeficiency virus-infected children in Harlem. *Journal of the American Medical Association* 260:1901-1905.
- Hermann, D.J. (1990) Criminalizing conduct relating to HIV transmission. *St. Louis University Public Law Review* 9:351-378.
- Hiranandani, R. et al. (1991) HIV counseling and testing in a high-risk post-partum population. Paper presented at the Sixth Annual National Pediatric AIDS Conference, Washington, D.C., February 2-12.
- Hopkins, K.M. (1989) Emerging patterns of services and case finding for children with HIV infection. *Mental Retardation* 27:219-222.
- Joseph, S. (1988) Adoption, foster care and day care issues in New York. In R. Schinazi and A. Nahmias, eds., *AIDS in Children, Adolescents and Heterosexual Adults: An Interdisciplinary Approach to Prevention*. New York: Elsevier.
- Joseph, S.C. (1989) Premarital AIDS testing: public policy abandoned at the altar (editorial). *Journal of the American Medical Association* 261:3456.
- Kirp, D. (1990) The politics of pediatric AIDS. *The Nation* May 14:666-668.
- Levine, C., and R. Bayer (1989) The ethics of screening for early intervention in HIV disease. *American Journal of Public Health* 79:1661-1667.
- Margolick, D. (1991) Tide of lawsuits portrays society ravaged by AIDS. *New York Times* August 23:1.
- Marmor, T.R., J.L. Mashaw, and P.L. Harvey (1990) *America's Misunderstood Welfare System*. New York: Basic Books.
- Martin, J.M., and H.S. Sacks (1990) Do HIV-infected children in foster care have access to clinical trials of new treatments? *AIDS and Public Policy Journal* 5:3-8.
- Mnookin, R.H., and D.K. Weisberg (1988) *Child, Family and State*. Boston: Little, Brown.
- Nolan, K. (1989) Ethical issues in caring for pregnant women and newborns at risk for human immunodeficiency virus infection. *Seminars in Perinatology* 13:55-65.
- Oleske, J. (1990) The medical management of pediatric AIDS: intervening in behalf of children and families. In G.R. Anderson, ed., *Courage to Care: Responding to the Crisis of Children with AIDS*. Washington, D.C.: Child Welfare League of America.
- O'Loughlin, R. (1990) Liability question makes Prop. K more controversial. *Bay Area Reporter* October 11:21.
- Oren, L. (1990) *Deshaney's* unfinished business: the foster child's due process right to safety. *North Carolina Law Review* 69:113-158.
- Padgug, R.A., and G.M. Oppenheimer (1990) AIDS health insurance and the crisis of community. *Notre Dame Journal of Law, Ethics & Public Policy* 5:35-51.
- Preston, B., R. Andrews, and E. Howell (1989) *Case Study of Miami AIDS Service Demonstration Project*. Final report submitted to the Health Resources and Services Administration. Washington, D.C.: McGraw-Hill/Systemetrics.
- Schinazi, R., and A. Nahmias, eds. (1988) *AIDS in Children, Adolescents and Heterosexual Adults: An Interdisciplinary Approach to Prevention*. New York: Elsevier.
- Seibert, J.M., and R.A. Olson, eds. (1989) *Children, Adolescents and AIDS*. Lincoln, Neb.: University of Nebraska Press.
- Seibert, J.M., A. Garcia, M. Kaplan, and A. Septimus (1989) Three model pediatric AIDS programs: meeting the needs of children, families and communities. In J.M. Seibert and R.A. Olson, eds., *Children, Adolescents and AIDS*. Lincoln, Neb.: University of Nebraska Press.
- Septimus, A. (1989) Psycho-social aspects of caring for families of infants infected with human immunodeficiency virus. *Seminars in Perinatology* 13:49-54.
- Steinbrook, R., B. Lo, J. Moulton, G. Saika, H. Hollander, et al. (1986) Preferences of homosexual men with AIDS for life-sustaining treatment. *New England Journal of Medicine* 314:457-460.

- Stoddard, T.B. (1989) Gay marriages: make them legal. *New York Times* March 4:27
- U.S. Department of Health and Human Services (1988) *Final Report: Secretary's Work Group on Pediatric HIV Infection and Disease*. Washington, D.C.: U.S. Government Printing Office.
- Weitzman, L. (1981) *The Marriage Contract*. New York: Free Press.
- Williams, L. (1989) Inner city under siege: fighting AIDS in Newark. (Second of a four-part series, "The Changing Face of AIDS.") *New York Times* 2/6/89:A-1.
- Working Group on HIV Testing of Pregnant Women and Newborns (1990) HIV infection, pregnant women, and newborns: a policy proposal for information and testing. *Journal of the American Medical Association* 264:2416-2420.