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AIDS AND GOVERNMENT: A PLAN OF ACTION?

Taunya Lovell Banks*

REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC. Washington: U.S. Government Printing Office. 1988. Pp. xix, 201. \$11.

A recent *New York Times* article noted that “[a]mong the changes wrought during the Reagan years, few may turn out to be so profound and irreversible as the reshaping of health care.”¹ Now more than ever before, budgetary considerations significantly constrain major health care decisions.² Yet in contrast to the Reagan administration’s usual miserly attitude on health care spending, the final *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic* argues that as much as \$3 billion must be spent annually over the next ten years if the epidemic is to be stemmed (p. 171). President Reagan’s final AIDS budget request for fiscal year 1990 was \$1.4 billion short, although the Office of Management and Budget estimates that \$2.1 billion will be spent on AIDS in fiscal year 1990.³ Indeed, the obstacles to success identified by the report reflect a far broader failure on the part of American society to provide adequate access to health care for the poor, racial and ethnic minorities, and individuals with chronic diseases. Not surprisingly, the Commission chair, in a portion of the draft unfortunately omitted from the final commission report, calls for a revamping of this country’s health care delivery system.⁴

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1. Malcolm, *In Health Care Policy, the Latest Word Is Fiscal*, N.Y. Times, Oct. 23, 1988, at E3, col. 1.

2. A major change came with the overhaul of the Medicare payment system five years ago. The government established Diagnostic Related Groups, or DRGs, a system in which the prices Medicare would pay for almost 500 different types of illnesses and treatments was set by the government. Hospitals complained because these prices often did not allow them to make any profit. The Reagan administration also set up peer review organizations whereby some treatments were approved in advance and reviewed afterward for cost containment purposes. *Id.*

3. Johnson, *The View on AIDS: Money Will Tell Much*, N.Y. Times, Jan. 29, 1989, at E24, col. 1.

4. As an editorial in the *Journal of the American Medical Association* noted, “the . . . final report contains a section that essentially is urging nothing less than revamping some of the health care system in the United States.” *AIDS Recommendations Leave Federal Officials to Ponder: Where Do We Go From Here?*, 260 J. A.M.A. 16 (1988). The editorial was referring to chapter 12 of the draft final commission report which contained Admiral Watkins’ personal assessment of the AIDS epidemic and which the full Commission ultimately reduced to two pages.

In June 1987, President Ronald Reagan, vowing to "send AIDS 'the way of smallpox and polio'"⁵ issued an executive order creating the Commission.⁶ The commissioners were officially designated in September 1987⁷ and ordered to submit a preliminary report to the President in ninety days.⁸ But the Commission almost fell apart before it started. Reports circulated that its chair, Dr. W. Eugene Mayberry, chief executive officer of the Mayo Clinic, was a poor leader.⁹ First he was forced by other Commission members to oust Linda D. Sheaffer, a government health officer who had been appointed by Mayberry as the Commission's executive director.¹⁰ Then three weeks later Dr. Mayberry, along with the Commission's vice chair and only staff physician, abruptly resigned without explanation.¹¹ Dr. Mayberry was immediately replaced by James D. Watkins, a retired admiral and former Chief of Naval Operations.¹²

To the surprise of many, under Admiral Watkins' leadership the Commission submitted a preliminary report to the President in December 1987 outlining its plan of action.¹³ After hearing testimony from more than 200 people, the Commission identified four critical issues which would be the subject of its interim report: (1) the need for reliable information about the incidence and prevalence of HIV; (2) the need for out-of-hospital patient care programs at the local level; (3) new drug development and availability; and (4) the problem of substance abuse and HIV.¹⁴ Admiral Watkins' transmittal letter said that

5. Boffey, *Panel on AIDS Turns Voices of Criticism Into Songs of Praise*, N.Y. Times, Mar. 7, 1988, at A1, col. 1.

6. Exec. Order No. 12,601, 52 Fed. Reg. 24,129 (1987).

7. Transmittal letter from James D. Watkins to President Reagan (Sept. 2, 1987), *Interim Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic*.

8. Exec. Order No. 12,201, 52 Fed. Reg. 24,129 (1987).

9. See, e.g., Boffey, *U.S. Panel on AIDS, Citing Challenges, Ousts Staff Chief*, N.Y. Times, Sept. 15, 1987 at A1, col. 4. Another article written after the release of the final commission report strongly suggests that Mayberry's successor, Admiral Watkins, was a catalyst for the change in leadership. It was reported that Watkins expressed concern at the first commission meeting that no executive director had been hired, no plan of action developed, and no background information prepared for the commissioners who had known little about HIV before their appointment. After the meeting Watkins left for Miami, but some other commissioners met for dinner and talked about proposing Watkins as a replacement for Mayberry. Squires, *The Admiral Who Took on AIDS*, Wash. Post, June 20-26, 1988, at 6, col. 1 (national weekly ed.).

10. Boffey, *supra* note 9.

11. Boffey, *Executive Director Named for President's AIDS Commission*, N.Y. Times, Oct. 14, 1987, at B8, col. 2; Boffey, *Panel on AIDS Turns Voices of Criticism into Songs of Praise*, N.Y. Times, Mar. 7, 1988, at A1, col. 1 [hereinafter Boffey, *Panel on AIDS*]. Later reports suggest that Dr. Mayberry's resignation was prompted by his realization that he could not run the Commission from Minnesota. Because he spent most of his time in Minnesota and knew little about Washington, Commission members felt that the Commission lacked strong leadership and focus. Boffey, *Panel on AIDS, supra*.

12. Boffey, *Panel on AIDS, supra* note 11.

13. PRELIMINARY REPORT OF THE PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC (Dec. 12, 1987).

14. *Id.* at 17-23. There was some criticism about the Commission's focus on the prevalence

the four issues "cr[ie]d] for early resolution."¹⁵

I. THE INTERIM REPORT

In March 1988 the Commission submitted its interim report.¹⁶ That report covered only three of the four previously identified areas: intravenous drug abuse, patient care, and research and drug development.¹⁷ Citing the need to curb drug abuse as "imperative to deter the progression of the HIV epidemic," the report called for an additional \$1.5 billion a year for ten years to provide treatment on demand for intravenous drug users.¹⁸ That sum almost equalled the Reagan administration's total 1989 AIDS budget request for the U.S. Public Health Services.¹⁹

The report also pointed out that many people believe the health care delivery system as currently structured and financed fails to provide adequately for the needs of people with HIV and other chronic illnesses.²⁰ This conclusion does not surprise those familiar with America's health care delivery system. The same concerns have been expressed by others, including previous presidential commissions.²¹

of HIV. For example, Jeffrey Levi, executive director of the National Gay and Lesbian Task Force, thought that "[t]rying to decide the real level of AIDS-virus seroprevalence in this country is not the role of this commission. They don't have the expertise. . . . That should be left to scientists . . ." *AIDS Commission's Next Report Focuses on Four Critical Issues*, 259 J. A.M.A. 169-70 (1988) [hereinafter *Four Critical Issues*].

15. *Four Critical Issues*, *supra* note 14, at 169.

16. INTERIM REPORT PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC (Mar. 15, 1988) [hereinafter INTERIM REPORT].

17. *Id.* at 1. The Commission determined that it would be premature to make recommendations about the incidence and prevalence of HIV at this stage since other issues like testing, confidentiality, and discrimination "are closely intertwined with collecting such data." *Id.*

18. *Id.* at 6. The report suggested that, as an interim emergency measure, minimal service or holding clinics may be needed. *Id.* at 7. It also pointed out that addicted women of childbearing age need programs to address their special needs. *Id.* The report noted that it would be difficult to formulate a sound policy since data on the drug abusing community is not being collected in any uniform manner. *Id.* at 12.

19. Fineberg, *The Social Dimension of AIDS*, 259 Sci. Am., Oct. 1988, at 128, 132. "Total Federal expenditures for AIDS in fiscal 1989 are projected to exceed \$2 billion" and include: \$400 million for the Centers for Disease Control and \$600 million for the National Institutes of Health to cover scientific research, disease surveillance, prevention, and control measures. An additional \$600 million was requested to pay the federal share of patient care provided through Medicaid, but this amount should not be included in the total AIDS expenditures since it is not calculated in expenditure totals for other diseases like cancer. *Id.*

20. INTERIM REPORT, *supra* note 16, at 28; *see also* 1 U.S. DEPT. OF HEALTH AND HUMAN SERVICES, REPORT OF THE SECRETARY'S TASK FORCE ON BLACKS AND MINORITY HEALTH (1985) (Executive Summary) [hereinafter SECRETARY'S REPORT ON BLACKS AND MINORITY HEALTH] (excessive deaths of minorities from cancer and cardiovascular disease).

21. *See, e.g.*, 1 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICAL AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 88, 97-98 (1983) (racial and ethnic minorities and the indigent traditionally have been denied access to adequate health care); A. BRANDT, NO MAGIC BULLET (1985); SECRETARY'S REPORT ON BLACK AND MINORITY HEALTH, *supra* note 20, at 17-18 (more blacks and Hispanics than whites have no usual source of medical care). In September 1988 a panel of

To the surprise of many, the interim report recommended that an additional \$1.6 billion, \$924.5 million in federal funds alone, be spent to deal with the three areas discussed.²² A few commissioners expressed concern that government might not be willing to spend this kind of money, and recommended that the panel eventually prioritize its recommendations to guide public officials in deciding which expenditures were most important.²³ In justifying the large expenditures, the Commission indicated that HIV-related basic research is expected to result in beneficial discoveries to aid in the treatment and cure of other diseases.²⁴

The interim report estimated that implementation of its recommendations would cost \$2.2 billion per year. Yet a commitment to that level of spending seemed unlikely, given the Reagan administration's policy of reduced spending for domestic health-related programs.²⁵ With a growing national debt and a public set against a tax

experts, in a 218-page report, *The Future of Public Health*, commissioned by the National Academy of Sciences, "expressed 'great concern and some alarm' that the nation's public health programs had fallen into disarray." Boffey, *Panel Finds U.S. Failing in Safeguarding Health*, N.Y. Times, Sept. 8, 1988, at B13, col. 1. The panel concluded that there has been an "erosion of support, weak leadership and disorganization," but said this problem "could not be attributed to any one Presidential administration." The panel said that a major overhaul of the public health system was needed so that each state health department would have more control over all health-related functions. *Id.*

22. INTERIM REPORT, *supra* note 16, at 75. The report recommended \$1.5 billion for treatment services (\$750 million in federal funds and \$750 million in state funds); \$18 million in federal funds for treatment research; \$30 million in federal funds for drug abuse prevention; and \$126.5 million in federal funds for outreach education. *Id.* Specifically, the report recommended that \$20 million federal dollars be appropriated to provide primary medical and dental care for persons infected with HIV. An additional \$50 million in federal and matching state funds was recommended to assist community-based organizations develop housing and day care facilities and other support services for people infected with HIV. *Id.* at 29. A total of \$25 million in federal and state matching funds was recommended for home health care. *Id.* at 30. \$25 million was recommended for hospice or other long-term care for patients from ages twenty to forty since, as the Commission recognized, most long-term institutional care in this country is designed for the elderly. *Id.* at 31. \$35 million was recommended for medical services for HIV-infected infants. \$20 million in federal and state funds was recommended for infant foster care programs; \$5 million in federal funds for pediatric demonstration projects; and \$10 million in federal funds for demonstration comprehensive family care centers in regions with a high prevalence of HIV infection. *Id.* at 30-31.

23. Boffey, *AIDS Panel Backs Wide Drive in U.S.*, N.Y. Times, Mar. 4, 1988, at B5, col. 1.

24. "HIV-related basic research is expected to have high yield benefits to Americans who suffer from cancer, viral diseases, and immune diseases, which collectively kill an estimated 650,000 individuals each year." P. 38.

25. For example, as the interim report points out, the problems of minority and underserved communities disproportionately affected by the HIV infection were made worse by the elimination of National Health Service Corps (NHSC) physician scholarships in 1981. The NHSC had been created in 1970 to provide primary medical care to isolated or underserved areas and to people who, due to economic or geographical barriers, race, language, culture, or other constraints, do not have access to basic health care. Most of the NHSC physicians work in Community Health Centers, Migrant Health Centers, and Indian Health Services. The program reached its peak in 1986 with an enrollment of 3200 providers. Yet because the Reagan administration was phasing out the program, less than 100 NHSC providers will be available in 1994 compared to the current enrollment of 2800. INTERIM REPORT, *supra* note 16, at 40. In addition, the new loan repayment plan established by Congress in 1987 is not expected to substantially alleviate the

increase, many doubted that the recommendations would bring about any meaningful change.

II. THE FINAL REPORT

A. Major Recommendations

Stressing its attempt to strike the "proper balance" between society's obligation toward diseased and nondiseased persons, the Commission submitted its final report to the President on June 24, 1988. The report contains 600 recommendations on a wide range of topics — discrimination, nursing shortages, therapeutic drug development, intravenous drug abuse, and education. While two-thirds of the recommendations are new, the report also includes some topics covered in the Commission's interim report. The Commission lists its most important findings in the Executive Summary, emphasizing the need to (1) provide accessible, confidential, voluntary testing accompanied by "appropriate counseling"; (2) treat HIV as a disability, whose victims deserve strong legal antidiscrimination protection; (3) formulate stronger confidentiality standards at both the federal and state levels to protect those persons infected with HIV; (4) institute immediate confidential partner notification by public health officials for sexually transmitted diseases, including HIV, and notification of all persons who have received blood transfusions since 1977 that they may need to be tested; (5) make prevention and treatment of intravenous drug and alcohol abuse "a top national priority"; (6) provide drug and alcohol abuse education to school children; (7) provide scholarships and other financial assistance for nursing education; (8) expand and extend the National Health Services Corps and recruit more minority health professionals; (9) give NIH greater administrative flexibility to aggressively pursue biomedical research; (10) provide "more equitable and cost-effective financing of care for persons with HIV"; (11) provide health professionals with complete information about HIV, adequate protective materials, and a safe work environment; and (12) further

problem, since it will create only forty new providers and return to service a number of earlier scholarship recipients. *Id.* at 40-41.

The Reagan administration was unwilling, until very recently, to even target HIV-related programs to the black and Latino communities. See, e.g., Nickens, *AIDS, Race, and the Law: The Social Construction of Disease*, 12 NOVA L. REV. 1179 (1988). For example, as noted by the Commission, transfusion-exposed individuals, women, and children (most of whom are black and Latino) have generally been excluded from the HIV drug clinical trials. P. 56.

As another commentator points out:

[W]hen NIH did take up the problem of AIDS, research funding was inadequate. In 1982 and 1983 the administration did not budget any money for AIDS research; nevertheless, Congress allocated \$33 million. The following year, the administration asked for \$39 million. Congress appropriated \$61 million. In 1986, Congress allocated \$234 million, but the Reagan administration proposed cutting this to \$213.2 million; this, despite the fact that cases have been doubling every year.

Brandt, *AIDS: From Social History to Social Policy*, 14 LAW, MED. & HEALTH CARE 231, 238 (1986).

education efforts to emphasize that HIV can be transmitted heterosexually (pp. xvii-xix).

A cornerstone of the final Commission report is the recommendation to combat discrimination against those who are infected with HIV. According to the report:

HIV-related discrimination is impairing this nation's ability to limit the spread of the epidemic. . . . Public health officials will not be able to gain the confidence and cooperation of infected individuals or those at high risk for infection if such individuals fear that they will be unable to retain their jobs and their housing, and that they will be unable to obtain the medical and support services they need because of discrimination based on a positive HIV antibody test. [p. 119]

News accounts of the report highlighted its recommendation for a new federal law to protect persons infected with HIV from discrimination in employment, housing, and health insurance.²⁶ In the past, the Reagan administration and many conservative members of Congress stiffly opposed extending federal antidiscrimination protection, believing such measures should be left to the states.²⁷

Another cornerstone recommendation is that new federal and state confidentiality laws be enacted to encourage more people to volunteer to be tested.²⁸ The Commission emphasizes voluntary as opposed to mandatory HIV testing as an effective means of preventing transmission of the virus, but says voluntary measures will fail without adequate confidentiality laws. The recommendation on confidentiality stresses that identifying information obtained through HIV testing and counseling should only be disclosed with the written consent of the individual except in certain very narrowly drawn circumstances.²⁹

26. See, e.g., *Prescriptions Aplenty to Defeat AIDS*, U.S. NEWS & WORLD REP. June 13, 1988, at 7; Boffey, *AIDS Panel's Chief Urges Ban on Bias Against Infected*, N.Y. Times, June 3, 1988, at A1, col. 6 [hereinafter Boffey, *Ban on Bias*]; *White House Aide Studying AIDS Commission Recommendations: Reports to President Soon*, 260 J. A.M.A. 602 (1988) (pointing out that the commissioners approved the broadening and extending of antidiscrimination laws by a narrow 7-to-5 margin).

The Commission rejected the notion of providing antidiscrimination protection only for persons suffering with HIV infection, noting that "[f]or the long term, federal legislation which clearly provides comprehensive antidiscrimination protection for all persons with disabilities, including those with HIV infection, is needed." P. 121. The Commission recommended that "[t]he President . . . issue an executive order banning discrimination on the basis of handicap, with HIV infection included as a handicapping condition." P. 121. The Commission also recommended that the federal disability laws be extended to the private sector. P. 123.

27. See Boffey, *Ban on Bias*, *supra* note 26. Currently, according to Presidential advisor Dr. Ian MacDonald, 36 states have laws protecting people infected with HIV. *Educators Fault Reagan's Hesitation To Endorse Steps Against AIDS Bias*, SCHOOL L. NEWS, Aug. 18, 1988, at 5.

28. P. 126. "A federal statute that carefully balances the need for confidentiality of HIV information against the protection of the public health is a necessary and appropriate response to confidentiality concerns. . . . In addition, state model confidentiality legislation must be developed and passed as reinforcement to federal confidentiality protection." P. 126.

29. P. 127. More specifically, disclosure would only be required (1) to "members of the individual's direct care giving team"; (2) to "health care workers accidentally 'exposed to the blood or blood contaminated body fluids'"; (3) for purposes of "statistical reports if used in such

Breaches of confidentiality would be classified as misdemeanors under the federal statute and would be punishable by fines of up to \$10,000 (p. 127). The Commission also recommends that any federal confidentiality provision should not be construed as preempting any consistent state statute, recognizing that a number of states have enacted laws to protect the confidentiality of HIV test results.³⁰

Both the discrimination and confidentiality recommendations are covered in chapter nine of the report, which is devoted to legal and ethical issues. In this chapter the Commission also addresses the criminalization of HIV transmission, and HIV transmission in the context of sexual assault and correctional facilities (pp. 119-40). The recommendation which is most disappointing for civil libertarians is that states enact HIV-specific statutes to punish individuals "who know of their status and engage in behaviors which they know are, according to scientific research, likely to result in transmission of HIV . . ." (p. 131). While several legal writers agree with the Commission's conclusion that current criminal laws are of limited value in preventing the transmission of HIV,³¹ there are similar disadvantages to an HIV-specific criminal law.³²

The report also calls for stricter enforcement of prostitution laws (p. 131). It lists the lenient and erratic enforcement of prostitution laws as an obstacle to progress, yet fails to explain how strict enforcement of these laws would help stem the transmission of HIV. The prostitutes most frequently arrested and subjected to these laws are women, and medical evidence suggests that female prostitution alone, at least in the United States, may not be a major mode of HIV transmission.³³ Several studies examining the extent to which female prostitutes in the United States are at increased risk of becoming infected with and transmitting HIV conclude that the rate of HIV infection among female prostitutes who are not drug users is minimal, while

a way that no person can be identified"; (4) "to blood, organ, semen, or breast milk banks"; (5) "to a spouse or sexual partner when the individual will not inform such party"; (6) "by a court order issued pursuant to application of a state public health officer"; and (7) "to the victim of a sexual assault." P. 127.

30. P. 27. See Gostin & Ziegler, *A Review of AIDS-Related Legislative and Regulatory Policy in the United States*, 15 LAW, MED. & HEALTH CARE 5, 13 (1987) (citing the confidentiality laws of California, Florida, Hawaii, Kentucky, Maine, Massachusetts, and Wisconsin).

31. See, e.g., Robinson, *AIDS and the Criminal Law: Traditional Approaches and a New Statutory Proposal*, 14 HOFSTRA L. REV. 91 (1985); Field & Sullivan, *AIDS and the Criminal Law*, 15 LAW, MED. & HEALTH CARE 46 (1987).

32. See generally, Field & Sullivan, *supra* note 31, at 54-56.

33. The prevalence rate for HIV among female prostitutes in the U.S. ranges between zero and 65%, with intravenous drug use being the single most important risk factor. This compares to studies of female prostitutes in East Africa which found a prevalence rate of 65% which appears to be related only to sex. Rosenberg & Weiner, *Prostitutes and AIDS: A Health Department Priority?*, 78 AM. J. PUB. HEALTH 418, 420-21 (1988); see also *Antibody to Human Immunodeficiency Virus in Female Prostitutes*, 257 J. A.M.A. 2011 (1987) [hereinafter *Antibody to HIV*].

female prostitutes who also use intravenous drugs have a higher rate of infection. At least one writer contends that most female prostitutes engage in oral sex as opposed to vaginal intercourse with their customers, so that there is minimal risk that they will transmit the virus.³⁴ Further, female-to-male transmission of HIV is believed to be more difficult than male-to-female transmission.³⁵

The Commission's recommendation regarding prostitution laws seems inconsistent with its own warning "that criminal sanctions for HIV transmission must be carefully drawn, must be directed only toward behavior which is scientifically established as a mode of transmission, and should be employed only when all other public health and civil actions fail to produce responsible behavior" (p. 130). Early in this century, social hygiene reformers and physicians assumed that women, especially prostitutes, were the primary transmitters of venereal disease.³⁶ During World War II, prostitutes, "promiscuous" women, and even the "girl-next-door" were often portrayed in Army posters as the source of venereal disease.³⁷ The Commission's recommendation only perpetuates the stereotypical assumption that women are the chief agents of sexually transmitted diseases, including HIV.

The report further recommends that criminal justice officials, "under the guidance of public health officials, should develop a mechanism to order that a sexual offender submit to an HIV test at the earliest possible juncture in the criminal justice process" (p. 133). However, the report does not indicate whether this test is to be performed at the time of arrest, later but still before conviction, or after conviction. This distinction is extremely important since arguably mandatory HIV testing prior to conviction might be unlawful infringement upon the suspect's constitutional rights.³⁸

Another troubling recommendation is that all convicted sex offenders be tested for the HIV antibody prior to their parole hearing or release from prison (p. 133). Although the report indicates that a positive HIV test result should not be used as the sole basis for the abridgement of any right to parole or furlough (p. 135), the Commis-

34. Decker, *Prostitutes as a Public Health Issue*, in *AIDS AND THE LAW* 81, 84 (H. Dalton & S. Burris eds. 1987).

35. Guinan & Hardy, *Epidemiology of AIDS in Women in the United States*, 257 J. A.M.A. 2039, 2041 (1987); Rosenberg & Weiner, *supra* note 33, at 421 ("Probability of spread [of HIV] from women to men remains unquantitated but is probably lower than that from men to women."). The risk of transmission from an infected male to a female is estimated by some to be 0.001 per contact. Rosenberg & Weiner, *supra* note 33, at 421. The risk of transmission of HIV is further reduced by the use of condoms.

36. A. BRANDT, *supra* note 21, at 92.

37. *Id.* at 167-68 and plates 14, 18, 19, 20.

38. One might argue under the fourth amendment that, absent probable cause, an HIV blood test would be an invasion of privacy. It is doubtful that probable cause can be established based on scientific evidence since even the Commission admits that no empirical data exists regarding the prevalence and incidence of HIV among sex offenders. Pp. 131-32.

sion believes that "a positive test result should affect the degree of supervision the sexual offender receives following release [from prison]" (p. 133). However, despite the Commission's caution, if the parole board has knowledge of the offender's positive test result, this information may unduly prejudice any decision.

The HIV crisis adds a new dimension to traditional legal problems like discrimination, insurance, tort liability, health care issues, and housing. Judging by the number of legal problems mentioned in the final Commission report, any law professor or student could find an AIDS-related topic for research in almost any area of the law.³⁹

B. *Other Recommendations*

1. *HIV Screening and Testing*

The final Commission report makes no mention of one important screening and testing issue — mandatory HIV antibody testing of applicants and employees by employers. However, the report, emphasizing that testing and counseling should be used primarily as a prevention strategy to encourage behavior change, sets forth five reasons for HIV antibody testing: (1) to facilitate early clinical diagnosis of HIV infection; (2) to screen donated blood, organs, breast milk, and semen; (3) to establish incidence and prevalence data to monitor the epidemic; (4) to warn sexual partners of their exposure to HIV; and (5) to use in conjunction with counseling to encourage positive behavior changes (p. 73). Perhaps the Commission is silent on employer testing because its outlined justifications do not support the federal government's own current practice of mandatory testing of recruits and members of the military, peace corps applicants, and State Department employees and dependents.

The Commission also hedges on whether medical authorities should test a patient who does not consent after being informed that a health care worker has been exposed to the patient's blood or blood-contaminated bodily fluids, stating only that "[i]n the unusual case of denial of consent, competent medical authorities should make the determination whether testing should be done and, if done, should note the rationale in the medical record" (p. 139). Throughout the report, the Commission stresses the need for informed consent and counseling for HIV testing, yet it fails to hold that line here on the grounds that in this instance the right of the health care worker to know is more im-

39. Issues one might research include liability problems related to worker safety (pp. 39-40); ethical issues surrounding the potential exploitation of certain groups participating in vaccine clinical trials, such as minority and third world populations and intravenous drug users (p. 47); and liability protection for manufacturers trying to develop vaccines for HIV (p. 47). See also Weisenhaus, *The Shaping Of AIDS Law*, Natl. L.J., Aug. 1, 1988, at 1, col. 1. More than 170 AIDS-related laws have been passed by the states. Gostin, *Public Health Strategies for Confronting AIDS*, 261 J. A.M.A. 1621 (1989).

portant than the patient's right to privacy. Yet some hospitals, precisely because the consequences of a positive test result are so severe, respect the privacy and autonomy of the patient in these situations and simply do a base line test of the health care worker with periodic retests. Moreover, testing the patient at the time of the exposure to the health care worker will not necessarily reveal that the patient is infected, because there is a window period between the time of the patient's exposure and the time that antibodies to HIV are detectable by current HIV tests. Hedging on such an important question will not make it go away.⁴⁰

The Institute of Medicine (IOM) takes a clearer stand on HIV testing and screening. In a report released simultaneously with the final Commission report, IOM says that mandatory HIV screening should be limited to blood, tissue, and organ donations.⁴¹ In fact, IOM believes that the consequences of HIV screening and testing are so serious that formalized rules and regulations are needed in addition to antidiscrimination and confidentiality provisions.⁴² On the other hand, the IOM calls for a conference on the ramifications of routine HIV antibody testing of health care workers⁴³ and takes no position on mandatory testing of prisoners.⁴⁴ IOM also concludes that "mandatory testing of prostitutes at the time of arrest or as a condition of release is not warranted at this time."⁴⁵ Nevertheless, several cities and states require mandatory HIV testing of prostitutes either at the time of arrest or as a condition of release.⁴⁶

Both the Commission and IOM favor reporting of positive HIV antibody test results to public health officials. However, the IOM is against mandatory reporting with identifiers,⁴⁷ whereas the Commission suggests omitting identifiers only in the context of reporting to the

40. Kristine Gebbie, a member of the Commission, has been quoted as saying: "A lot of people in this country are just hoping that AIDS will quietly go away, and I'm afraid President Reagan is one of them." Lichtblau, *Reagan Rejects Federal AIDS Anti-Bias Law*, L.A. Times, Aug. 3, 1988, at 1, col. 4.

41. INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, *CONFRONTING AIDS: UPDATE 1988* at 10, 75 [hereinafter *CONFRONTING AIDS: UPDATE 1988*]. This report is an update of an earlier report, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, *CONFRONTING AIDS: DIRECTIONS FOR PUBLIC HEALTH, HEALTH CARE, AND RESEARCH* (1986).

42. See *CONFRONTING AIDS: UPDATE 1988*, *supra* note 41, at 8-9, 71-74.

43. *Id.* at 15, 101.

44. *Id.* at 10.

45. *Id.* at 10; see *id.* at 78-79.

46. *CONFRONTING AIDS: UPDATE 1988*, *supra* note 41, at 78-79; see *Antibody to HIV*, *supra* note 33, at 2012 (Nevada has required monthly screening of prostitutes in licensed brothels and Florida has required all convicted prostitutes to be tested for sexually transmitted diseases including HIV); Milne, *Two Detroit Judges Mandate AIDS Screening for Prostitutes*, *Oncology Times*, July 1, 1987, at 16; Narvaez, *Newark Moves to Test for AIDS Virus*, N.Y. Times, Jan. 7, 1988, at B1, col. 4.

47. *CONFRONTING AIDS: UPDATE 1988*, *supra* note 41, at 11, 82.

Centers for Disease Control for incidence and prevalence reasons (p. 4). The Commission does question the Immigration and Nationalization Service's addition in 1987 of HIV to the list of "dangerous contagious diseases" justifying excluding refugees and refusing asylum except under extraordinary circumstances (p. 156). Rather than condemn the policy, however, the Commission recommends that the policy be reexamined twelve months after its implementation (p. 156).

2. Access to Health Care/Financing Health Care

Previously, Admiral Watkins had been critical of physicians and dentists who refused to care for persons infected with HIV.⁴⁸ However, while the final commission report indicates that this problem continues,⁴⁹ it fails to take a strong stand on this issue. The Commission reaffirms that health care providers have an ethical obligation to "provide care, within the limits of their competencies, to all persons who need it, regardless of their HIV status" (p. 137) — but this recommendation simply repeats the language of the American Medical Association⁵⁰ and fails to point out that physicians may in some circumstances be under a legal duty to treat.⁵¹ Further, the Commission ignores the problem of health care providers denying nonemergency but critical life-sustaining treatment to individuals who lack health care insurance.

As mentioned previously, a key component of the final commission report was that much more money needs to be spent to help stem the transmission of HIV.⁵² The Commission admits that the epidemic has simply "magnified [the] flaws in the methods and mechanisms of the health care financing system in this country . . ." (p. 141). However, it devotes only seven pages to the financing issue. The recommendations contained in chapter ten are merely stopgap measures that do not squarely address the real problem — an inadequately financed health care system which is not structured effectively to care for the chronically ill, the uninsured working poor, and racial/ethnic minorities, especially minority group members who also fall within one or both of the preceding categories.⁵³

48. *AIDS Policy in the Making*, 239 SCIENCE 1087 (1988) (discussing Watkins' comments at a meeting with reporters on February 24, 1988).

49. Pp. 136-37; see, e.g., Banks, *AIDS and the Right to Health Care*, 4 ISSUES IN LAW & MED. 151, 151-52 (1988); Gianelli, *Issue of AIDS Control vs. Civil Rights Explored at Commission Hearings*, Am. Med. News, May 27, 1988, at 2, 4.

50. See CONFRONTING AIDS: UPDATE 1988, *supra* note 41, at 99 (the American Medical Association adopted a policy statement in 1987 that "a physician 'may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence' merely because the patient has AIDS or is seropositive" (citation omitted)).

51. See generally Banks, *The Right To Medical Treatment*, in AIDS AND THE LAW, *supra* note 34, at 175-81.

52. See *supra* notes 22-25 and accompanying text.

53. See CONFRONTING AIDS: UPDATE 1988, *supra* note 41, at 16, 110-11.

Once again IOM has more comprehensive recommendations to deal with the financing problem. Perhaps this reflects a fundamental difference in philosophy between IOM and the Commission. While the Commission is trying to "end up with a better system which will be more responsive, more humane, and more able to direct its manifest strengths quickly and efficiently to where they are most needed" (p. 17), IOM believes "that all individuals have a right to equitable access to adequate medical care and that society has an ethical obligation to ensure such access."⁵⁴ IOM consequently recommends four principles to be used in developing any kind of financing strategy: (1) coverage should begin at the time of HIV infection; (2) special consideration should be given to "hard-hit" communities; (3) the public and private sectors should share responsibility for financing medical care; and (4) payment proposals should encourage "cost-effective" care.⁵⁵

While both reports agree that more effort should be directed at minimizing transmission of HIV among intravenous drug users and their sexual and needle-sharing partners, there are significant differences. Both groups endorse the expansion of drug abuse treatment programs,⁵⁶ a long-term and costly strategy, but IOM additionally proposes some immediate intervention programs such as instruction in the use of bleach to sterilize drug equipment and the distribution of sterile needles to drug users.⁵⁷ Likewise, both reports agree that clinical drug trials need to be broadly available to minorities, women, IV drug users, and children in a wide range of geographical areas.⁵⁸ But the Commission recommends community-based clinical trials (pp. 56-59), while IOM favors clinical trials "within well-established sites for drug testing."⁵⁹ Traditionally women of child-bearing age have been denied access to clinical drug trials because of alleged harm to the reproductive system and hormonal differences between men and women. The blanket exclusion of women is unjustified, since male reproductive systems can also be harmed by experimental drugs; if there are hormonal differences between women and men, separate trials for

54. *Id.* The IOM report states:

The problems of financing care for persons with AIDS and other HIV-related conditions reflect the inequities in the entire U.S. health care system in relation to the uninsured and uninsurable, the plight of the poor in getting care, continuing underfunding for disease prevention, insufficient capabilities for care outside of institutions, and inadequate care for the chronically ill.

Id.; see also *id.* at 110-11.

55. *Id.* at 17, 118.

56. See p. 95; see also *CONFRONTING AIDS: UPDATE 1988*, *supra* note 41, at 12, 84.

57. See *CONFRONTING AIDS: UPDATE 1988*, *supra* note 41, at 12, 85-87.

58. See pp. 54-59; *CONFRONTING AIDS: UPDATE 1988*, *supra* note 41, at 136-40.

59. *CONFRONTING AIDS: UPDATE 1988*, *supra* note 41, at 140. IOM believes that "[c]ommunity-based trials need to be carefully supervised to yield useful results" and should be used only at the final phase of the trials. *Id.*

women are a more appropriate response.⁶⁰

C. Government's Response to the Epidemic

In February 1988, shortly before the release of the interim report, Admiral Watkins admitted in a meeting with reporters that the Reagan administration had not developed a national policy for AIDS.⁶¹ Neither the interim nor the final commission report contains criticism of the Reagan administration. Critical references to the Reagan administration in the final draft that Admiral Watkins submitted to the Commission were deleted when the final version was submitted to the White House.⁶² Nevertheless, criticism of some units of the federal government appear in several sections of the report.⁶³ Few would deny that to date many states have been much more deeply involved in

60. COMMITTEE ON GOVERNMENT OPERATIONS, AIDS DRUGS: WHERE ARE THEY?, H.R. REP. NO. 1092, 100th Cong., 2d Sess. 21-22 (1988).

61. *AIDS Policy in the Making*, *supra* note 48. He suggested that the Commission was developing a policy.

62. The chapter of the draft report entitled, "Guidance for the Future: The Establishment of a Public Health Emergency System Within the Federal Government," contained the following language which is not found in the final version:

The Federal Government has not yet established a unified comprehensive discrete policy in response to the HIV epidemic. Rather, various policy statements and individual department policies have emerged throughout the Federal Government, and mostly in relation to ongoing activities within the agencies or circumscribed aspects of the epidemic.

...
The bureaucratic procedures of the Federal Government have acted as an impediment to a timely response to the HIV epidemic. Agency requests for increased personnel, facilities and funding have been repeatedly thwarted, leaving many agencies to respond by stealing personnel and resources from other functions. Many of the decisions about the Federal response the [sic] the HIV epidemic appear to have been made on the basis of criteria other than medical and scientific data about the needs of persons with HIV infection and AIDS or future projections about the epidemic. Rather, in some instances bottom line personnel ceilings and overall Government target budget figures appear to have driven the Federal Government's response to the epidemic. Quick decisions based on newly discovered facts about the HIV epidemic have been virtually impossible.

The commission is deeply concerned about the Federal Government's slow response to the HIV epidemic and believes that it is incumbent upon the Federal Government and the Congress to establish a public health emergency response mechanism for the future. With such a mechanism in place, the Federal Government would have the capacity to shift gears and move immediately into an emergency mode which would allow for quick decisions and a capacity to respond to emerging data and knowledge in a timely fashion, thus preventing unnecessary loss of life.

Excerpts from Report by AIDS Panel Chairman, N.Y. Times, June 3, 1988, at A16, col. 3; *cf.* ch. 12, "Guidance for the Future," in the final commission report at p. 157.

63. For a sampling of these criticisms, see p. 34 ("The Department of Labor should move expeditiously to develop a permanent and enforceable standard covering blood-borne diseases"); p. 41 ("[A]s stated in the Commission's interim report, a greater sense of urgency throughout the government is needed to implement the increased funds already approved by Congress and to supplement improvements already underway. . . ."); p. 66 ("CDC has lagged behind scientific understanding by not moving to an HIV infection-based data collection system when the antibody test was developed in 1985 to detect infection in asymptomatic persons"); p. 69 ("OMB should not undermine congressional intent"); p. 120 ("There is a lack of coordinated leadership from our public and private institutions on the issue of discrimination against persons with HIV infection. . . . Enforcement of existing anti-discrimination laws is slow and ineffective.").

the development of AIDS legislation and policies than has the federal government.

IOM also criticizes the uneven federal response and "the absence of strong federal leadership" in the fight against HIV.⁶⁴ However, IOM commends Surgeon General C. Everett Koop's efforts to fight the epidemic.⁶⁵ Its report also calls for strong federal antidiscrimination laws to protect persons infected with HIV and encourage them to seek treatment.⁶⁶ IOM echoes the Commission's concern that educational efforts should be effectively targeted to racial and ethnic minorities who are at great risk of infection.⁶⁷

Another controversial recommendation by Admiral Watkins which was not included in the final commission report was that the President designate the Surgeon General as the federal government's principal spokesperson in health care emergencies and give him authority to develop effective public policy in a speedy fashion.⁶⁸ The final version of the report favors "some special management oversight entity" to be responsible for seeing that an action plan is carried out.⁶⁹ The Commission also recommends establishing an independent federal Department of Health.⁷⁰ IOM, on the other hand, reaffirms its 1986 recommendation that a national commission on HIV infection and AIDS be established to assume a clearly spelled-out advisory role.⁷¹

III. THE GOVERNMENT'S RESPONSE TO THE REPORT

Instead of endorsing the Commission's recommendations immediately, President Reagan appointed White House drug policy advisor Dr. Ian MacDonald to develop a course of action within thirty days.⁷² Ultimately, the President set forth a ten-point action plan that stopped

64. CONFRONTING AIDS: UPDATE 1988, *supra* note 41, at 24-25. See generally R. SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE AND THE AIDS EPIDEMIC (1987); S. PANEM, THE AIDS BUREAUCRACY (1988), for a more detailed discussion of the government's response to the HIV epidemic.

65. CONFRONTING AIDS: UPDATE 1988, *supra* note 41, at 24.

66. *Id.* at 6, 62-64.

67. *Id.* at 67-68.

68. Boffey, *Ban on Bias*, *supra* note 26, at A16, col. 3.

69. P. 157. The Commission sets up a two-pronged management system: an external seven-person committee responsible for ongoing evaluation, and a single designated official to manage the implementation of the report within existing government structures. P. 158. At least one news article characterized Admiral Watkins' proposal as creating an "AIDS czar." Trafford & Thompson, *The Muddled State of AIDS Policy*, Wash. Post, Aug. 23, 1988, at 16 (Health). Interestingly, the other Commission members rejected the concept of an AIDS czar — but Congress subsequently created a "drug czar." See *infra* note 78 and accompanying text.

70. P. 158. The Commission also recommends that chief health officials have expanded powers in times of public health emergencies.

71. CONFRONTING AIDS: UPDATE 1988, *supra* note 41, at 24-26. The commission would have a five-year, renewable term. *Id.* at 25.

72. Johnson, *Report by AIDS Panel Gets Muted Reaction by Reagan*, N.Y. Times June 28, 1988, at A16, col. 1.

short of adopting the Commission's recommendations on antidiscrimination protection for persons with HIV. Instead he ordered federal agencies to adopt guidelines to prevent discrimination in the workplace against persons with HIV and directed the Attorney General to "conduct an expeditious review" of the Commission's antidiscrimination recommendations.⁷³

The Justice Department, following the Commission's recommendation (p. 123), subsequently issued a legal opinion reversing its earlier 1986 memorandum on the application of section 504 of the Rehabilitation Act of 1973 (as amended)⁷⁴ to persons infected with HIV.⁷⁵ The new memorandum follows the reasoning of the United States Supreme Court's decision in *School Board of Nassau County v. Arline*.⁷⁶

The President also called upon schools and businesses to "examine and consider adopting education and personnel policies" using the guidelines prepared by the federal Office of Personnel Management and Centers for Disease Control.⁷⁷ However, this attempt to, in effect, extend federal HIV workplace policy to the private sector was criticized for being less effective than the executive order recommended by the Commission.⁷⁸

The President's ten-point program also ordered: (1) the Department of Health and Human Services to set up conferences on AIDS public health issues; (2) the Food and Drug Administration to improve the procedures and accuracy of HIV blood tests; (3) accelerated development, approval, and distribution of vaccines and treatments; and (4) accelerated approval of AIDS budget requests. All of these measures were recommended by the Commission. The President avoided addressing the Commission's recommendation on increasing the number of drug treatment centers to facilitate treatment on demand, but Congress subsequently appropriated money for the construction of drug treatment centers. That drug bill also contained a provision which allows the death penalty for certain drug-related

73. Johnson, *Reagan, Spurning Tougher Move, Orders Anti-Bias Rules on AIDS*, N.Y. Times, Aug. 3, 1988, at A1, col. 1. "Rep. Henry A. Waxman (D-Los Angeles), chairman of a House subcommittee on health, accused the Administration of 'stalling' and said: 'We don't need another study.'" Lichtblau, *supra* note 40, at 12.

74. 29 U.S.C. 794 (1982).

75. Shenon, *Protection for U.S. Workers With AIDS is Widened*, N.Y. Times, Oct. 7, 1988, at A17, col. 1.

76. 480 U.S. 273 (1987).

77. Johnson, *supra* note 73, at B5, col. 2.

78. Although Leslye Arshat, a White House spokesperson, indicated that the President's actions had "exactly the same force" as an executive order, opponents contend that an executive order has symbolic weight and would have to be formally amended or overruled by a subsequent administration. The President's directive has no such staying power, and could simply be ignored. *Id.*

murders.⁷⁹ The Commission recommended harsher penalties for both sellers and buyers of drugs as a "realistic deterrent to drug abuse," but only mentioned "stiffer sentences, larger fines, and forfeiture of assets derived from drug trafficking" (p. 102).

In October 1988 Congress passed the first comprehensive AIDS bill.⁸⁰ The measure included legislation on HIV testing, research, and education.⁸¹ Confidentiality of HIV test results had to be sacrificed to ensure passage, but the bill does call for anonymous testing.⁸² Congress appropriated \$1.5 billion for programs that follow many of the recommendations of the Commission.⁸³

CONCLUSION

William A. McNeill, relating the devastating impact that smallpox had upon the Aztec Indians,⁸⁴ writes that the psychological implications of a disease, which "killed only Indians and left Spaniards unharmed," enabled the Spaniards to prevail, not only militarily, but culturally over the more numerous Aztecs.⁸⁵ His book concludes that infectious diseases invading virgin populations are "capable of destroying or crippling entire human communities"⁸⁶

Today the United States and many other countries have been invaded by a new deadly infectious disease, HIV. It remains to be seen whether this country will allow the HIV epidemic to destroy the vast network of civil rights and liberties laboriously developed over the

79. Mohr, *Drug Bill Passes, Finishing Business of 100th Congress*, N.Y. Times, Oct. 23, 1988, at A1, col. 6.

80. Molotsky, *Congress Passes Compromise AIDS Bill*, N.Y. Times, Oct. 14, 1988, at A12, col. 1.

81. *Id.* The monies are to be spent for HIV prevention programs; to develop care and treatment networks, and accelerate research efforts. Included along with the AIDS measures was a measure to alleviate the shortage of nurses.

82. *Id.*

83. *Id.* Specifically, over the next two years \$100 million per year will be spent on testing and the same amount will be spent for home health care for people with AIDS. Over the next three years \$285-300 million a year will be spent for research and \$250-300 million per year will be spent for education. *Id.*

84. W. McNeill, *PLAGUES AND PEOPLES* 1-2 (1976).

85. *Id.* at 2.

86. *Id.* at 13. According to Dr. Allan M. Brandt, noted medical historian:

The manner in which a society responds to a disease, and especially to those in need, reveals very deep and fundamental cultural and social values. A disease is shaped not only by its biological qualities, but by its cultural variables as well. A disease can become a symbol for ordering and explaining various aspects of human experience. Medicine and science are not only affected by social, economic, and political variables; medicine and science are, in fact, embedded in them.

. . . . Until we more fully recognize the ways in which social and cultural values and attitudes shape medical, scientific and public health problems, it will be difficult for us to deal with a problem as complex as AIDS in an effective and humane way.
Brandt, *Historical Analogies to the AIDS Epidemic*, in *AIDS AND PATIENT MANAGEMENT: LEGAL, ETHICAL AND SOCIAL ISSUES* 159, 163 (M. Witt ed. 1986).

years to protect the outsiders of society from the tyranny of government and a fickle and fearful majority, or whether the epidemic will result in a more equitable health care delivery system.

While the report is not perfect, it is a beginning for President Bush. At the very least, the report probably prodded Congress to take more decisive steps in stemming the spread of HIV. Perhaps over the next four years, when approximately 365,000 people may become infected with HIV, America really will become a "kinder, gentler nation," at least toward people with HIV.