ADDENDUM TO AIDS/ARC

DISCRIMINATION PUBLIC HEARINGS

TRANSCRIPTS
Acquired Immune Deficiency Syndrome, AIDS related complex, human t-cell lymphotrophic virus-III, and opportunistic infections are all terms fairly new in lay English. Because of the rapid spread of the AIDS epidemic and the associated media presentation of the epidemic's horrors, these terms have become part of all of our lives. These words bring to life a new and very mysterious kind of terror at the same time.

With this terror has come a public hysteria which manifests itself in ways unknown to American society since the collera epidemic of the 1830's and 40's. Principally, this hysteria has supported new and very egregious forms of discrimination in our society. Over the past two years during which I have been chair of BALIF's AIDS Legal Referral Panel, I have seen this discrimination move from mild discrimination against a few citizens to major, public discrimination against whole classes of American people.

In late 1983 and early 1984, the AIDS Legal Referral Panel represented some persons with AIDS who were being evicted from their homes because of the fears by landlords that the disease could be transmitted by the AIDS virus' being present in the air or walls of a structure tenanted by a person with
AIDS. At the time, medical practitioners could not provide us with a well-substantiated and well-reasoned explanation of the virus' spread. Thus, as a lawyer, I could only argue that the evictions were unlawful procedurally.

As the epidemic spread, the paranoia rose, and the discrimination mounted. At the same time, however, medical science gave us new answers to questions we had posed about the birth, spread, and death of the virus. Now we can be assured that the AIDS virus cannot be contracted by casual contact and that its effectiveness as a contagious agent is eliminated once the virus is exposed to air. Similarly, the AIDS virus survives but minimally in bodily fluids like saliva and tears so it is exceptionally unlikely that those fluids can cause the communication of the disease. The only justifiable fear about the spread of the disease lies in the contact between blood and semen, blood and blood, or blood and an intravenous drug needle contaminated with the virus.

While medical technology was developing answers to questions concerning the spread of the disease, the media was providing the public with sometimes misleading information about the disease. At the same time, citizens who already desired to exercise their prejudices against homosexuals, Haitians, and intravenous drug users seized upon the information put out by the press to fuel the growing paranoia about the disease.
By 1985 and 1986, discrimination engendered an epidemic of its own. This discrimination spread beyond persons with AIDS to persons with AIDS related complex, homo-sexuals, intravenous drug users, and people suspected of being in high risk of developing the disease.

For example, in the early part of 1985, several large real estate brokerage firms in the Bay Area began requiring real estate sellers to disclose to prospective buyers whether a prior tenant, owner, or resident of the structure to be sold was diagnosed with AIDS. At that time, attorneys for the AIDS Legal Referral Panel threatened suit and deftly explained to these discriminating brokers that such policies were illegal. The brokers, probably fearing both litigation and bad press, either rescinded such policies or denied that they existed. Nonetheless, by the close of 1985, the California Association of Realtors had established a policy requiring this same disclosure. Media pressure forced the CAR to deny this policy, but, as of this writing, several large real estate brokers in San Francisco are maintaining it.

Although, during 1984, some larger and more enlightened employers instituted sensitive and well-informed training programs to educate their staffs about the truth of the AIDS epidemic, many other employers did not follow suit and have instead shown blatant disregard for the rights of persons with
AIDS, persons with AIDS related complex, and homosexuals. Major airline companies have blatantly fired persons with AIDS and homosexual men, though members of both classes were perfectly capable of performing their job functions. In several such cases, flight attendants with Karposi's sarcoma were put on disability leave during their chemotherapy treatments but were refused reinstatement once the KS was in remission.

Similarly, several upscale San Francisco employers have moved persons with AIDS from their "frontline" jobs to warehouse and storeroom jobs with less pay so that the person with AIDS will not be in the public eye.

In the employment context, this paranoia has reached such heights that employers have fired homosexual men solely on the fear that the men might have AIDS, though later diagnoses are of Hodgkin's disease, candidiasis unrelated to AIDS, and lymph node syndrome unrelated to AIDS. Similarly, though state legislation passed in 1984 prohibits the use of HTLV-III tests as conditions of employment, some employers are still requiring this test of their gay male employees. Finally, though San Francisco, Los Angeles, and West Hollywood recently passed local ordinances prohibiting discrimination against persons with AIDS and against persons at risk of contracting AIDS, many employers have blatantly failed to abide by these ordinances. As litigation against these employers is usually very quickly and
very simply settled by a cash payment to the person against whom the discrimination was effected, it appears that the paranoia on which the discrimination is based is so enchanting to the employer that the employer will pay money rather than keep the employee in the work force. Some employers so readily pay off damage claims in these matters that they don't seem to care whether they violate the law.

The unfortunate ramification of this break-the-law, pay-the-damage scenario is the psychological effect it has on the employee with AIDS. A significant number of these employees want to keep their jobs for reasons other than the acceptance of wages. For many persons with AIDS, particularly those with Karposi's sarcoma or AIDS related complex, the job gives them the connection with society and the fulfillment they need to keep their spirits high. Sometimes, if the person with AIDS sees the cash settlement as a vindication, the fulfillment can be maintained. However, for a significant number of other persons with AIDS, even settling these employment termination cases amounts to an insult.

An increasingly difficult corollary in employment has been arising as the result of complaints by co-workers about persons with AIDS. In several employment cases taken by the AIDS Legal Referral Panel over the past year, the employer discharged the person with AIDS because his co-workers refused
to work in the same workspace. This situation should be treated no differently than situations in which the decision to terminate was made by the employer alone. In fact, there is some argument that the co-workers themselves might be sued for intentionally interfering with the contractual employment relationship between the person with AIDS and his employer. In this situation, employers are well advised to ignore the complaints of co-workers unless the complaints rise to a real and serious health threat to other workers.

A similar situation arises when health care workers discriminate against patients with AIDS on the fear that the health care worker will contract the disease. Again, protocol guidelines from the Center for Disease Control indicate that, although in certain situations, the health care provider should take certain precautions to make sure that the disease is not transmitted, there is no reason to excuse health care workers for their refusal to treat persons with AIDS in the same dignified, respectful, and sensitive way that they treat other patients. For example, several nurses at San Francisco General Hospital filed a complaint in 1985 with the California Occupational Safety and Health Administration in the hopes of changing San Francisco General's protocol to require gloves, sterile clothing, face masks, etc. while treating a person with AIDS. Cal-OSHA rejected the nurses' claims because there was
not adequate medical evidence to indicate that the AIDS virus could be transmitted to a health care worker by casual contact with the person with AIDS. The rationale for that decision should apply to protect children with AIDS, restaurant patrons with AIDS, and other persons with AIDS using public accommodations.

Although several school districts across the United States, including the Monterey School District, the Kokomo, Indiana School District, and several school districts in New York City have issued guidelines limiting the education of children with AIDS, the School Board of the San Francisco Unified School District has issued guidelines prohibiting such discrimination against children with AIDS in San Francisco. Nonetheless, at least one institution of higher learning has required the removal of a student with AIDS from a community college classroom during 1985. Such discrimination violates both the San Francisco AIDS ordinance and state law prohibiting discrimination against persons with physical handicaps.

Although not numerous, there have recently been some complaints against private health care providers about their discrimination against persons with AIDS. For example, some dentists in San Francisco will not treat persons with AIDS, and some dentists are now requiring hepatitis testing for even minor dental work if the dentist believes there is some
possibility that the prospective client might have been exposed to the AIDS virus. Here, however, the Center for Disease Control protocol guidelines encouraged dentists to at least glove up before performing work on the mouth of a person with AIDS. Beyond this mere cautionary steps, any treatment of a person with AIDS which differs from other clients should be considered discrimination in violation of the San Francisco ordinance.

Although the complaints of public accommodation discrimination have been decreasing over the last year, there still arise instances in which business people discriminate against persons with AIDS in the provision of services. For example, some restaurateurs, wanting to avoid publicity about serving persons with AIDS, have been refusing service. Despite their argument that such service would drive away their other customers, this sort of discrimination should be seen as in violation of San Francisco's AIDS ordinance.

As many people with AIDS related complex are aware, the Social Security Administration very rigidly distinguishes between persons with AIDS and persons with AIDS related complex in issuing Social Security, disability, and supplemental security income grants. Unfortunately, this distinction is a function of the rigid and rather bizarre guidelines by which the Social Security Administration determines disability and,
because the federal government has preempted this field through the Social Security Act, San Francisco's AIDS ordinance and California state law do not apply. Only lobbying by persons with AIDS related complex could eventually change this bureaucratic nightmare.

Apparently, the other grant providers and public entitlement institutions in California are not quite so difficult in their service to persons with AIDS and AIDS related complex. Although there is apparently a need for an increased number of case workers and intake workers for all state agencies dealing with AIDS and AIDS related complex, there doesn't appear to be any serious discrimination question in the dissemination of state funds to individuals with AIDS. However, because of the shortage of funds for some AIDS provider grantees, there does seem to be a lack of service provision to a significant number of persons with AIDS related complex. Again, it appears that this problem can be addressed only through lobbying governmental institutions for more funds across the board.

The biggest battle to be faced by persons with AIDS over the past year and for the next several years will be fought against life, disability, and health insurance companies and their reinsurers. Recent statistics from the Center for Disease Control in Atlanta indicate that the average national cost for care of a person with AIDS from the date of diagnosis until
death is $150,000.00. This figure varies widely from community to community across the United States with the cost of care in San Francisco being significantly less than the cost of care in other cities. The reason health care costs less in San Francisco is because of the well-integrated and well-established hospice and home health care programs in this city. Nonetheless, insurance companies are very worried about what payment of substantial AIDS-related claims will do to their fiscal integrity.

One major insurance company recently published statistics indicating that, although persons with AIDS amounted to only one percent (1%) of the persons insured by the company in 1985, AIDS-related claims amounted to five percent (5%) of claims paid during the same year. This sort of statistic is being used by insurance companies to rationalize their desire to reduce payment to persons with AIDS. Similarly, life and disability insurers have lately been mourning a drastic increase in claims paid for life insurance and disability insurance on men under 50 years of age. Previously, men of this age were good insurance risks for these companies, and they depended upon premium payments from this group to support the payment of claims to elderly men and women across America. This change in claims has upset insurance company underwriting guidelines so drastically that life and disability insurance companies are
also beginning to establish policies by which they can reduce AIDS-related claims.

While at first some insurance companies were threatening red lining on the basis of zip codes (based on studies showing that more homosexuals live in zip codes 94117 and 94102), no insurance company to date is actually using such a procedure because of the threat of expensive and long-term litigation. Insurance companies have, however, been proposing less obvious, but no less egregious, methods of discriminating in the application process against persons at risk of getting AIDS. For example, one national disability and life insurance company recently put out new application guidelines which would require a separate application questionnaire for those single men with no dependents who are employed in such occupations as florists, interior designers, beauticians, etc. The additional questionnaire requires answering vague but clearly discriminatory questions concerning past sexual history.

Another leading national insurance company is now requiring single men with no dependents to undergo AIDS antibody testing before the company will issue a disability or life insurance policy whose face value is in excess of $100,000.00. In five of the states in which they require this AIDS antibody testing, this company is requiring the HTLV-III test. In California, because the HTLV-III test is prohibited, this
company is requiring other similar, but even less reliable, testing.

Insurance companies are further discriminating against persons with AIDS through their claims review process and through limitation clauses in insurance policies issued. One major California health insurer has been routinely placing AIDS-related claims under claims review, which procedure requires a long and detailed analysis of the claim in light of the insurance company's underwriting guidelines. Of course, if the claims review procedure takes but a short time, there is no litigable issue to be resolved. However, this insurance company has been putting these claims under review for periods in excess of six (6) months. In the meantime, the health care provider for whom the claims were made have been making collection attempts directly against the person with AIDS. The trauma and economic impact of this procedure is often devastating to the person with AIDS.

Similarly, a significant number of health insurers have been denying AIDS-related claims on the basis that said claims result from a condition which preexisted the application for insurance. For example, in one such instance, an insurance company denied an AIDS related claim because the insured had had a spleen condition (unrelated to AIDS) some three years prior to the health insurance application and this spleen condition was
not disclosed in the application. Health insurance companies also use the restrictive insurance clause which prescribes payment for unnecessary, experimental, or costly treatment. Using this clause, some insurance companies have been denying treatment for candidiasis because the treatment, which consists of three modified gammaglobulin shots, is too expensive because only one drug manufacturer in the United States is licensed by the FDA to provide the treatment. Similarly, many AIDS treatments (like suramin and ribavirin) are considered experimental and therefore not covered by health insurance.

The real underlying problem in the insurance industry arises from the query as to who should be required to pay for treatments during this epidemic. On the one hand, insurance companies were perfectly willing to take advantage of young, healthy, gay men under 50 during years preceding the AIDS epidemic because such men were good risks and paid their premiums in a timely fashion. On the other hand, now that these same men are making claims on their insurance policies, the insurance companies do not want to carry the risk for these insureds. At the same time, because of the high cost of AIDS research, federal, state, and local governments cannot afford to pick up all the costs of AIDS treatment on programs like MediCal and MediCare. Thus, the dispute is over whether tax money or
insurance premiums should pay for the high cost of AIDS treatment.

Predictably, the insurance industry has already begun heavy lobbying in both the state legislature and the federal government to shift the burden of this cost to parties other than insurance companies. While this battle continues, we must watch closely to insure that persons with AIDS do not face any further discrimination during these difficult times they face.

In conclusion, despite our best efforts to educate, mollify, and sensitize the general population about the plight of persons with AIDS, paranoia and the resulting discrimination remain very serious and as yet unsolved problems even in a society like San Francisco's, which is rumored to be so open minded and liberal. To eradicate this problem, it is incumbent upon us all to support the efforts of such institutions as the Human Rights Commission, the AIDS Legal Referral Panel, the AIDS-in-the-Workplace project sponsored by the Employment Law Center, and the AIDS Project of National Gay Rights Advocates in their efforts to insure that persons with AIDS can maintain a peaceful, respected, and productive place in American society.
I thank the Human Rights Commission for this opportunity to testify and for its laudable efforts to eliminate discrimination against persons with AIDS, persons with AIDS related condition,
persons at risk of getting AIDS, and homosexual men and women in the City and County of San Francisco.
1221 Folsom Street
San Francisco, California 94103
February 12, 1986

Dear Commissioners:

Please accept this statement as part of the record of testimony regarding sexual orientation and AIDS-related discrimination in employment.

Kelly Services, San Francisco, employed and assigned me to Campeau Corporation California, San Francisco, from May 6 to 10, 1985. Campeau employed me directly May 23, 1985. On both occasions I worked under the direction of Mr. Floyd A. Rowley, Jr. On both occasions Mr. Rowley harassed me while I attempted to perform my job doing word processing.

I am gay. While I did not tell Mr. Rowley directly of my status as a sexual orientation minority, I am certain he was aware of this fact, based on his behavior towards me.

During the first period, May 6 to 10, 1985, Mr. Rowley directed me to enter accounts payable data into word processing equipment, to interface the word processor with a computer at a different location to create checks, and finally to print the checks. The deadline for check production was Thursday, May 9th. On Friday, May 10th, Mr. Rowley directed me to use the word processor to write instructions for the entire process of check production for the use of a new, permanent employee.

Mr. Rowley expected me to recreate the steps of this process without instruction; apparently, the individual who usually performed this function suddenly ceased to be available and left no notes. Mr. Rowley asked me to repeatedly telephone a previous operator of the word processor and also a computer consultant for instructions. While I did my best under the circumstances, the task was beyond my training or experience.

Mr. Rowley repeatedly attempted to interfere while I operated the equipment. Specifically, he sat immediately behind me and kicked my chair. On Thursday, May 9th, he attempted to adjust the printer while I was printing the checks which resulted in a misprint and loss of consecutively numbered checks. Oddly, he shook my hand in an exaggerated manner after I completed each step of the process. While his attitude was overall hostile, his repeated handshaking was puzzling. I believe Mr. Rowley
was attempting to show re he was not afraid of contact with me, which inclines me to believe he perceived me to either have AIDS or the potential of acquiring AIDS.

On May 10th, Mr. Rowley asked for my home phone number. He said he wanted to have me come in May 23rd to help a new, permanent employee process checks. I told him I would likely be on another assignment.

Mr. Rowley called me the evening of May 22nd. I told him I was on another assignment. He very specifically said he didn't want me to call in sick on that assignment just so I could come to Campeau the next day, but when I said I was therefore unable to help him, then, he said I should do so. He offered me a higher rate of payment, in cash, than I earned from Kelly. While I take responsibility for calling in sick to Kelly, I feel Mr. Rowley was urging me to participate in an unprofessional business practice.

When I was unable to successfully advise the new, permanent employee how to produce checks on May 23rd, Mr. Rowley practically accused me of sabotage. Apparently, my ten pages of written instructions--written in one day (May 10th)--were inadequate. He even indicated he wanted my work telephone number, apparently to harass me on my regular assignment, with questions I would not have been able to answer in any case.

In short, Mr. Rowley expected me to know and operate a very complicated system I had no experience on before. He seemed to take pleasure in my limitations in that regard. When he placed total blame for the system not working on my shoulders alone, I had had enough.

I understand the Commission is investigating Campeau's employment practices with particular regard to Mr. Terry Todd. I found Mr. Todd to be very helpful while I was at Campeau. He was openly gay at work, which apparently did not sit well with Mr. Rowley. Mr. Rowley would give Mr. Todd "the silent treatment" by not responding to ordinary office conversation. Todd was obviously in control of his desk inspite of the then recent loss of his lover of several years due to AIDS, which we discussed from time to time at Campeau. On May 23rd, Mr. Todd showed me, and other employees as well, a travel brochure for those who have lost a loved one due to AIDS, sponsored by Shanti.
In conclusion, I believe Mr. Rowley is homophobic. Campeau Corporation California discriminated against me because of my sexual orientation. I hope the Commission finds this statement helpful in bringing to an end sexual orientation and AIDS-related discrimination in San Francisco.

Sincerely,

[Signature]

Terry W. Bjerkelund
AIDS AND DISCRIMINATION — AN OVERVIEW

Benjamin Schatz
Director
AIDS Civil Rights Project,
National Gay Rights Advocates

As of January, 1986, approximately 16,000 Americans have contracted acquired immune deficiency syndrome, or AIDS. An estimated 160,000 others have contracted a milder form of the disease called AIDS-related complex (ARC). Furthermore, it is believed that another one to two million Americans have been exposed to the HTLV-III virus, the probable cause of AIDS.

FACT #1 — AIDS IS NOT CASUALLY TRANSMITTED. The spread of AIDS has occurred only through the exchange of blood, blood products or semen between individuals. Numerous medical studies of families in which one or more members have been infected with HTLV-III show not a single case in which the AIDS virus has been spread to other family members, other than through sexual intercourse or from mother to fetus in utero. Medical studies of hospital personnel caring for AIDS' patients show no spread of the AIDS virus other than through needle sticks.

FACT #2 — MOST PEOPLE WHO HAVE BEEN EXPOSED TO THE AIDS VIRUS WILL NOT DEVELOP AIDS. Current medical research indicates that only 5-10% of those who show antibodies to the HTLV-III virus go on to develop AIDS within five years. Consequently, employer or insurer use of an HTLV-III antibody test in order to screen out people with AIDS is ineffective and inappropriate. Indeed, the U.S. Food and Drug Administration, when approving the use of the HTLV-III antibody test for the purpose of protecting the nation's blood supply, warned that "it is inappropriate to use this test as a screen for AIDS or as a screen for members of groups at increased risk for AIDS in the general population."

FACT #3 — AN EPIDEMIC OF AIDS-RELATED DISCRIMINATION THREATENS TO BE AS DEVASTATING AS AIDS ITSELF. Problems include:

-- Employment Discrimination: automatic dismissal of employees with AIDS and ARC without medical benefits; conditioning employment on employee agreement to take the HTLV-III test; refusal to hire individuals suspected of belonging to "high risk" groups.

NGRA
National Gay Rights Advocates, 540 Castro Street, San Francisco, CA 94114, (415) 863-3624
-- **Insurance Discrimination**: misuse by insurers of the HTLV-III test to screen out "high risk" applicants; blanket denial of life, health and disability insurance to unmarried men who name unrelated males as life insurance beneficiaries, or who live in certain geographic regions or work in stereotypically gay professions; cancellation of already-existing health insurance policies; refusal by insurers to pay legitimate AIDS-related claims to those already insured, on the grounds that AIDS is a "pre-existing condition" or that medical treatments are "experimental"; attempts by insurers to delay health insurance payments until their insureds have died; setting exorbitant rates for converting from group to individual health insurance; attempts to exclude AIDS-related claims from policy coverage.

-- **Discrimination by the Military**: mandatory blood testing of all military personnel; refusal to allow recruits who test positive for the HTLV-III antibody to enlist; misuse of evidence disclosed to military physicians to discharge AIDS victims and their sexual partners on grounds of homosexuality; attempted public disclosure of names of recruits testing HTLV-III positive.

-- **Discrimination in Education**: exclusion from the classroom of teachers, students, and siblings of students with AIDS, ARC, or positive HTLV-III test results.

-- **Discrimination in Health Care**: refusal by hospitals, nursing homes, dentists, doctors and nurses to treat patients with AIDS; unwillingness on the part of HMO's to develop their programs or facilities to handle their clients who have AIDS or ARC; refusal by ambulance drivers to pick up people with AIDS; unnecessary isolation and degradation of people with AIDS; refusal by hospitals to allow the lovers of gay men with AIDS to visit their loved ones; refusal to perform autopsies; public disclosure of confidential doctor-patient communications concerning HTLV-III results; refusals by hospitals to allow AIDS support groups to meet on their premises because of fears about public reaction.

-- **Discrimination by Prison Authorities**: harassment and forced isolation of prisoners with AIDS, ARC and positive HTLV-III test results; inadequate medical treatment of prisoners with AIDS and ARC.

-- **Discrimination by Funeral Homes and Cemeteries**: refusal to embalm; refusal to bury people with AIDS; institution of
mandatory cremation or closed casket policies.

-- Discrimination by Business Establishments: Denial of goods, services, and accommodations to people with AIDS and ARC, and to perceived members of "high risk" groups.

-- Discrimination by government agencies, fire fighters and police officers: refusal to assist people with AIDS; maintenance of public lists of people with AIDS; burning of the property of people with AIDS or ARC out of fear of contagion; refusal to fingerprint people with AIDS, ARC, or HTLV-III seropositive test results.

-- Housing Discrimination: refusal by landlords and real estate agents to rent to, sell to, or buy from people with AIDS; evictions and lockouts of tenants with AIDS and ARC; refusal to rent office space to physicians treating people with AIDS and to AIDS service groups.

-- Judicial Discrimination: refusal by judges to allow people with AIDS to stand trial; excusing jurors afraid to sit in the same court room as a person with AIDS; use of HTLV-III test as a "punishment" instead of prison term; requirement that HTLV-III antibody-positive criminal defendants wear masks, gloves, and surgical garb while in court.

-- Discrimination against gay fathers: denial of custody and visitation rights to (divorced) gay and bisexual fathers who cannot prove that they have not been exposed to the AIDS virus.

-- Discrimination in Immigration: asserted intention of the U.S. Immigration and Naturalization Service to prevent people with AIDS from entering the United States.

-- Censorship of AIDS Education Information: impounding of tax-supported "safe-sex" pamphlets because of fears that they "promote homosexuality."

-- Threat of Quarantine: of people with AIDS who engage in any sexual activity; of all people with AIDS; of all people who test positive for HTLV-III; of all members of "high risk" groups.

-- Invasions of Privacy: Mandatory reporting of all positive HTLV-III antibody test results to state officials; disclosure of these records to researchers, funeral homes, insurers and others. police monitoring of the sexual activities of all people with AIDS under threat of felony prosecution for any sexual activity;
possible police monitoring of private sexual activities in hotel rooms; proposals to trace and contact the sexual partners of all people testing HTLV-III antibody positive.

-- Legislative Backlash: legislative attempts to quarantine people with AIDS; to ban employees testing HTLV-III positive from working as health care workers, food handlers or teachers; to prohibit children with AIDS from attending public school; to make it a felony for "high risk" individuals to donate blood; to screen and identify all HTLV-III positive prison inmates; to require HTLV-III testing of all people seeking marriage licenses; to require adult bookstores to record the names, addresses, and social security numbers of all people entering their businesses; to cut off federal revenue-sharing funds to cities which do not close gay bathhouses -- even those in which only "safe sex" is practiced.

-- Anti-gay Backlash: Repeal and defeat of gay and lesbian rights legislation; increased anti-gay violence; use of AIDS issue to justify criminalizing homosexual sexual relations; increasing discrimination against lesbians and gay men; efforts to close all gay and lesbian businesses; public proposals that all gay men be killed or castrated.

-- Sexual Backlash: efforts to close bathhouses, adult bookstores, hotels and parks frequented by gay and bisexual men; attempted reinstatement of sodomy laws.

-- Hysteria Regarding the Transmissibility of AIDS: discontinuation of shared communion cup in churches because of fear of spreading AIDS; refusal by political candidates to shake hands in public; opinion polls indicating majority of Americans believe AIDS can be spread merely through shared living quarters.

Conclusion

At present, the number of cases of AIDS is continuing to double every 12 months. If this trend continues, over 300,000 Americans will develop AIDS within the next five years. As the number of cases of AIDS continues to increase, so too does the potential for a major assault on civil rights. In order to circumvent the spread of both AIDS and AIDS hysteria, five major steps need to be taken:

1) INCREASED GOVERNMENT SPENDING on research, patient care, and social services.
2) PUBLIC EDUCATION AND RESPONSIBLE LEADERSHIP: government, media, business and community leaders should take the lead in demonstrating compassion towards people with AIDS and in showing that they are not afraid to live, work and socialize with them. In addition, a massive government-funded "safe sex" AIDS prevention campaign should be implemented as soon as possible.

3) STRONG PROTECTIVE LEGISLATION TO PROHIBIT AIDS RELATED DISCRIMINATION, especially in the areas of employment, education and insurance.

4) REPEAL OF SODOMY LAWS AND ENACTION OF GAY CIVIL RIGHTS LEGISLATION: as long as gay men live in fear of discrimination and criminal prosecution, many will continue to be forced into the very kinds of anonymous, unsafe sexual encounters which are most likely to spread AIDS; anti-gay discrimination further forces gay men into sham marriages, thereby increasing the spread of AIDS into the heterosexual population.

5) INCREASED POLITICAL AND FINANCIAL SUPPORT BY THE HETEROSEXUAL COMMUNITY FOR GAY RIGHTS AND AIDS-SERVICE ORGANIZATIONS which are working to achieve goals one through four.
January 30, 1986

San Francisco Human Rights Commission
Attn: Ms. Jackie Winnow
1095 Market Street, Suite 501
San Francisco, CA 94103

Re: AIDS/ARC Hearings

Dear Ms. Winnow:

Please find enclosed a copy of the testimony of Jeffrey Levi, Director of Governmental and Political Affairs of the National Gay Task Force, before the U.S. House of Representatives Committee on Government Operations Subcommittee on Intergovernmental Relations and Human Resources, on September 13, 1985. In his testimony on behalf of the National Gay Task Force, Mr. Levi stressed the appropriate role of the federal government in dealing with the AIDS crisis while assessing the response of the federal government to the various social and legal issues generated by this disease. Discrimination born of ignorance and homophobia must be effectively dealt with and prohibited at all levels of government, but most especially within the federal government itself. Unfortunately, while the Task Force was successful in gaining the Food and Drug Administration's cautionary labeling on the HTLV-III AIDS antibody test that it is inappropriate to use the test as a screen for AIDS or as a screen for members of groups at increased risk for AIDS in the general population, this did not prevent the Department of Defense from initiating mass screening of all military recruits and personnel.

The National Gay Task Force is currently working to obtain a ruling from the Department of Health and Human Services Office of Civil Rights declaring AIDS/ARC a handicap under Section 504 of the Rehabilitation Act of 1973. To help bring pressure on the Office of Civil Rights, the San Francisco Human Rights Commission may want to make sure that cases that come to its attention that might fall under Section 504 are also brought, simultaneously, before Health and Human Services. Ultimately the Task Force would like to see regulations where any federally funded facility that discriminates against PWAs would be denied federal funds, and that states failing to enforce nondiscrimination policies would not be recertified for federal Medicare/Medicaid reimbursement.
San Francisco Human Rights Commission
January 30, 1986
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Thank you for the opportunity to present testimony on behalf of the National Gay Task Force on Tuesday, February 4, 1986. If I can be of any further assistance, do not hesitate to contact me.

Very truly yours,

[Signature]

Peter N. Fowler, Esq.
Co-Chair, Board of Directors
National Gay Task Force

Enclosure: Testimony of Jeffrey Levi (copy)

cc: Jeffrey Levi
Differences in Local Responses to AIDS

This committee's field hearings in New York and San Francisco have served to point out the differences in the governmental response to an epidemic in the two highest incidence communities. The gay communities in both cities have responded with a tremendous outpouring of money and support for efforts to meet the needs of those affected by AIDS. There have been differences in the level and timing of government response that have made the work of some community groups a little more difficult. Nonetheless, both New York and San Francisco are in a special category, because they began this crisis with a strong, large gay/lesbian community that could be mobilized in a relatively sympathetic political and social environment, where it was economically and socially possible to fill in where the government was unwilling and afraid to tread -- and also possible to create the political pressure to increase the government's response.

In the vast majority of cities and states, however, in low- and high-incidence communities, the social and political climate is such that even where there is a high level of gay community organization, it has been impossible to generate the support needed to create service agencies, education programs, and comprehensive approaches to the health needs of people with AIDS. In many communities too much energy is spent in fighting off those of the right wing who wish to make political capital out of this crisis and intimidate political officials into thinking that providing comprehensive services in fighting this disease will be interpreted as condoning homosexuality. As a contrast to the New York and California examples examined by this committee, I want to cite two examples of where the response is quite different, primarily because of the sociopolitical climate, and thus slowing down our ability to stop the spread of this disease. The first example is of a low-incidence state, Nevada; the second is a high-incidence city, Houston.

Nevada, according to the CDC, had 14 cases of AIDS in August 1985. To give a sense of the problems coming the way of Nevada public health officials, we might compare the experience of the District of Columbia, a jurisdiction about the same size as Nevada. Washington, D.C. had 17 cases two years ago; it now has 266 cases. Nevada, unlike Washington two years ago, has an opportunity to perhaps mitigate the scope of the problem and prevent many of its citizens from becoming infected by HTLV-III. Yet, despite all that we know about AIDS, when I visited Nevada last month I found that there was no state program for education about risk reduction, no state plan for services for people with AIDS, and no community-based organizing for those with AIDS. State and local health officials are frightened by the political implications of dealing with AIDS in a politically conservative state. How does a public health official support education of gay men about safer sex in a state that still has sodomy laws on the books, with law enforcement officials still willing to enforce them? How does a public health official reach out to an affected community to plan a joint response to AIDS—when the community is poorly organized because gays are fearful of being openly identified in a social climate that still accepts discrimination based on sexual orientation and there are no legal means to fight it? Some very dedicated public health officials are finding themselves in a serious bind: they want to help people with AIDS, they want to carry out their professional responsibility of doing all they can to prevent the spread of an epidemic in their jurisdiction, but they are limited by a social and political climate that works against open collaboration with an affected community, let alone the provision of fiscal resources to do the job.
I do not mean to single out Nevada—there are many other states in similar situations. And yet if we are to successfully prevent the continued growth of those awful statistics CDC gives us each week, then it is in the low incidence states like Nevada where the battle must be waged forcefully—where the likelihood of infection is probably lower and therefore we can prevent many from becoming infected, so that in two years' time Nevada's statistics don't resemble Washington, D.C.'s.

The city of Houston is another example of politics interfering with an appropriate response to a major crisis. Houston is a high-incidence city, with over 314 cases in the SMSA, making it the seventh highest incidence city in the country. The local gay/lesbian community has been supportive of a community-based foundation working on AIDS education and services. However, the social climate in Houston has prevented government and non-gay support for social service work. Indeed, the New Right has focused a good deal of attention on Houston—attempting to generate and capitalize on public concerns about AIDS, spreading untruths about casual contagion, and presenting AIDS as a gay disease that is God's judgment on homosexuality. During a recent referendum campaign on a city ordinance designed to protect city employees from discrimination based on sexual orientation, an ordinance that was defeated at the polls, opponents sought to link protection from discrimination with the spread of AIDS. It was in the climate generated by this campaign that the United Way in Houston turned down the KS/AIDS Foundation for inclusion in its annual fundraising drive. A relatively well organized gay/lesbian community has had to spend precious time and resources fighting repression in the false name of public health—instead of being able to devote energy to helping its own who are victims of AIDS. The gay/lesbian community, in its lobbying efforts, encounters a local and state government that is afraid to provide assistance of its own for fear of appearing too generous to a group who's basic rights were recently rejected at the polls.

The point of this comparison is to suggest that New York and San Francisco, along with a select few other cities, are miles ahead of most cities and states in this country in coping with the AIDS epidemic—whatever problems these hearings may identify in their responses. The point is also to raise the issue as to whether, in light of such a national health crisis, the federal government cannot do more to promote a strong local and state response to the crisis. For, ultimately, the federal government will pay a very high price for this delayed and inadequate local response—directly in Medicaid costs and indirectly in lost productivity of individual citizens. Indeed, this discrepancy in responses from community to community represents a failure of our nation's public health system that is being paid for in the unnecessary loss of lives.
TESTIMONY

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Subcommittee on Intergovernmental Relations & Human Resources
Committee on Government Operations
U.S. House of Representatives

Member: Leadership Conference on Civil Rights
Mr. Chairman, I want to thank you for this opportunity to appear before your committee in its continuing assessment of the federal response to the AIDS crisis. The National Gay Task Force is the nation's oldest and largest gay and lesbian civil rights organization. Since the beginning of this crisis we have been working within our community and with all levels of government on the full range of issues associated with AIDS—but most particularly in assuring an adequate government response to this disease and its social and legal consequences. It is from this perspective that I wish to focus on three areas in this morning's testimony.

First, it is important to understand the social and legal issues that have arisen in the context of AIDS—some finding their genesis in fears associated with a mysterious disease, others having their origin in the special vulnerability of gay men and lesbians in American society as a minority group without traditional civil rights guarantees and historically subjected to social and legal discrimination.

Second, the federal government's response, while improving, remains severely deficient in key areas, most particularly in funding research on potential treatments for AIDS and in addressing health care costs and services for persons with AIDS.

Third, it is important to understand the tremendous variance in response to this crisis at the local and state levels—and to suggest that, whatever deficiencies may have been identified by this committee in its hearings in New York and San Francisco, the level of consciousness and response to AIDS in both communities is significant in comparison to what exists in the majority of the country, even where the incidence of AIDS is quite high. That represents a failure of our nation's public health system of frightening proportions and which will be paid for in the lives of many who will contract this disease unnecessarily and will suffer unduly because of inadequate services.

Social and Legal Issues.

AIDS has served to place in far too graphic relief the legal and social vulnerability of those at risk to AIDS, including gays. Irrational fears about AIDS—born out of ignorance and exploited by some for political gain—have resulted in increased discrimination and violence against people with AIDS and gay men. We have witnessed efforts to restrict and rescind civil rights guarantees for gay men and lesbians in the name of public health, even though there is no public health basis for such moves. And unfortunately, leadership has often been lacking from politicians, public health officials, and the media when it has been time to stand up to the ignorant and the bigoted.

AIDS has been a terrible and frightening mystery to the medical community and to the public. It is not surprising, therefore, that some would fear contagion through casual contact—even though it has been effectively shown that intimate contact is required for the HTLV-III virus to be transmitted. It is a demonstration of a lack of faith in our public health community or our inability to communicate effectively health messages that so many people still fear casual contact with those who have AIDS or might have been exposed to it. When children are involved, emotions run highest—as the recent controversies around the country regarding admission of children with AIDS to the schools has demonstrated. We have been unsuccessful in turning the message around: that the general public is not placed at risk through exposure to someone with AIDS,
it is the person with AIDS who takes a risk from casual contact with the
general public because he or she cannot fight off as easily the germs that we
are never harmed by.

To successfully accomplish that goal will require a major public education
campaign that goes far beyond what we have seen to date. It will require more
than technical scientific statements. It will be necessary for public
officials to stand behind their scientists without wavering before mass
hysteria—whether those officials are the Mayor of New York, the Secretary of
Health and Human Services or the President of the United States. The Public
Health Service must be willing to confront directly misinformation and
apprehension—from Kokomo, Indiana to Queens, New York.

Almost three-fourths of the people with AIDS are gay or bisexual men.
When people want to deny their vulnerability to AIDS, when people want to focus
their fears on someone else—gay men, and also lesbians—become a convenient
target. The various gay/lesbian civil rights organizations and AIDS service
organizations around the country, have received countless reports of
discrimination—against people with AIDS and those considered at risk to AIDS.
Organizations monitoring anti-gay/lesbian violence have also measured a
significant increase in such acts of bigotry that can be correlated with
increased public concern about AIDS.

Let me briefly outline a small sampling of instances of AIDS-related
discrimination that have come to our attention. They give a sense of the scope
of the problem, if not its full extent.

- A gay man with AIDS in Jersey City, New Jersey applying for food stamps
  was told by state social service personnel—acting out of unwarranted fear
  of contracting AIDS—to leave the office without completing an
  application; when he insisted on his rights security guards and eventually
  the police were called to remove him; after some discussion he was allowed
  to complete his application.

- A naval enlistee diagnosed with AIDS, confided his homosexuality to a
  military physician, who conveyed the information to naval intelligence and
  tried to pressure him to identify his sexual contacts.

- At a funeral service for a person with AIDS in Badenton, Florida, the
  county health department forbade the family to have pall-bearers and
  restricted attendance out of irrational fear of the airborne contagion of
  AIDS.

- The Broward County executive fired two employees with AIDS on grounds
  that they posed a contagious risk to co-workers, this despite medical
  testimony to the contrary; the cases are currently under administrative
  appeal.

- A gay male veteran applied for life insurance from a company offering
  coverage to former servicemen, but was rejected on grounds of the "extra
  mortality in homosexual males due to AIDS..." With assistance from legal
  advocacy groups, he is currently seeking redress.

- A heterosexual woman was dismissed from her job as a restaurant worker
  when her employer found out that she resided with her uncle who has AIDS;
her boyfriend and co-worker was also dismissed; apparently her employer based the action on the groundless fear that they posed a risk to himself and his patrons.

o A gay male nurse practitioner thought possibly to have ARC was dismissed from his job at a hospital because he was viewed incorrectly as presenting a risk to patients; he was later diagnosed as having neither AIDS nor ARC, but the employer refused to reinstate or consider him for a job in any other part of the hospital.

o A lesbian in Eugene, Oregon who was not at increased risk for AIDS was refused as a blood donor on the erroneous grounds that her "homosexuality" disqualified her from donation. (Subsequently, in San Diego, the director of a blood program, bowing to public misperception, vetoed a blood donor drive by a local lesbian organization, even though the CDC does not include any gay females among its reported cases of AIDS.)

Two things become clear from these examples: First, there is a consistent pattern of transference of fear of AIDS to discrimination against gays—as they represent the largest identified at-risk group. Second, many of the instances of unjustified discrimination and irrational fears of contagion came from government agencies and officials. How are we to expect better of individuals if those in a position to know better or at least learn otherwise behave in such an irrational and bigoted manner?

What is even more distressing and frustrating is the degree to which persons who are victims of such discrimination are limited in their recourse. It is much more difficult to control behavior based on irrational fears when that behavior is directed against a group that is legally and socially vulnerable. It is a cruel irony that in most jurisdictions in the United States, including the City and State of New York, gay men and lesbians do not have any legal protections from discrimination based on sexual orientation—and thus are not protected from AIDS-related discrimination against gays. But they are protected under the law once they develop AIDS, because then, in the eyes of the law, they are covered by statutes banning discrimination against the disabled.

The debate and concerns surrounding the HTLV-III antibody test highlight the degree to which the gay community and those in other risk groups associated with AIDS, are legally vulnerable. Because they raise serious questions about the behavior of several arms of the federal government, and because the test poses serious potential problems of a legal and social nature, these are worth exploring briefly.

The HTLV-III antibody test measures for the presence of antibodies to the HTLV-III virus, the virus associated with AIDS. It does not measure for the virus itself, it does not determine whether a person has AIDS or whether a person is going to develop AIDS or an AIDS-related condition. It does measure exposure to the virus. It was developed as a means to more effectively screen the nation's blood supply in the hopes of preventing transfusion-associated cases of AIDS. To that end, the gay community supported its implementation and worked with the PHS to assure safe introduction of the test. The National Gay Task Force and Lambda Legal Defense and Education Fund also worked with the Food and Drug Administration to include labeling language that would prevent misuse of the test beyond its intended application. As a result, the label
includes the statement, "It is inappropriate to use this test as a screen for AIDS or as a screen for members of groups at increased risk for AIDS in the general population." Because so many cases of AIDS involve gay men, and because initial studies have shown a relatively high rate of positivity for antibodies among gay men as compared to the rest of the population, it was our fear that some might try to use the test as a surrogate marker for gays—hiding behind a desire to identify those at increased risk to AIDS.

Our fears could not have been more justified. For example, in Broward County, Florida, the county executive sought to initiate screening of new employees—trying to justify this with the incorrect claim that this would predict who might get AIDS and thus save the county the expense of hiring someone who would not serve for any length of time. He was stopped only by a state law forbidding HTLV-III antibody testing of employees. (Only Wisconsin and California have similar laws.) And most recently, the Department of Defense has announced that they will begin screening new recruits for HTLV-III antibodies—and are considering doing the same for all current personnel.

The military assures us that such mass screening is necessary to protect the health of their personnel. We question some of that reasoning—but more importantly, we question whether the ultimate use of this test will be for health reasons only, however misguided. The military does not observe standard confidentiality protections for medical records. There are already several instances on record where the Navy, for example, has sought to discharge under less than honorable conditions, persons diagnosed with AIDS—after they admitted to their physicians that they had engaged in homosexual activity, thinking doctor-patient confidentiality applied. Indeed, the Navy's own lawyers have stated that a physician has an affirmative responsibility to inform naval intelligence if he learns that someone is gay. Based on this record, what basis do we have for believing that the military will not, at some point, use antibody test results for nonmedical reasons, to the detriment of the personnel involved? Further, the mass screening by the military sets a dangerous precedent that other employers might seek to use as justification for their efforts to identify those they think might be at higher risk to AIDS and/or gay.

Such a mass screening of personnel is a clear violation of the FDA's own labeling. This raises the very serious question of why the FDA allows another government agency to initiate a policy that could affect millions of people in violation of its own guidelines. If the military proposed administering a drug to all personnel in contravention of FDA recommendations, it is hard to imagine the FDA would remain silent. But because people are so frightened about AIDS, government and society seem more willing to overlook abuses of law and rights—even when there is no medical rationalization for it.

In conceding to the military, it becomes easier for the FDA to accept further abuses down the line. If the Defense Department can screen because they are afraid of AIDS, why not restauranteurs fearful of hiring gay food handlers or hospitals fearful of hiring gay nurses—even though neither profession has been shown to be a source of transmission of the disease, public misperceptions to the contrary?

The insurance industry poses the most difficult questions in this area. Insurance representatives have made clear that they are seeking ways of identifying individuals at higher risk to AIDS, and then deny them life or
health insurance—and that they consider the antibody test one useful measure. So far, while there have been scattered instances of gay men being denied insurance, no insurance company has sought to require the blood test. Nationwide Insurance did state last month that they would seek to identify "potential homosexuals" who applied for insurance, but quickly backed down from that position. But this issue is far from resolved, and we are finding that state regulatory agencies have limited authority to prevent this kind of actuarial decision making. We as a society are going to have to make a clear decision as to whether entire classes of individuals will be denied health or life insurance simply because they fall into a high risk group for AIDS. California, Wisconsin and Florida have made that decision in part by banning use of the antibody test by insurance companies; similar measures will be needed in all the other states. Such moves are not unprecedented: California, for example, has an analogous law for those with sickle cell anemia. If we do not take such steps, millions of people could lose their health insurance—and become dependent on public Medicaid programs, thus increasing even more the public sector's financial burden associated with AIDS.

These are examples of heightened vulnerability of gays to discrimination that are directly AIDS related. It should be reemphasized that many of these issues would not arise if gays were afforded the same civil rights protections as other Americans. But there are those who are seeking to use AIDS as a means for accomplishing just the opposite: furthering the oppression of gay men and lesbians in this country by further limiting their legal rights. Hiding behind a false mask of concern about public health, there have been efforts to use the fear of AIDS to oppose or repeal civil rights protections for gay men and lesbians. In Houston, for example, where voters considered a referendum repealing protections for city workers, a group called Doctors for Houston falsely alleged that civil rights protections for gays and lesbians would cause an AIDS epidemic in Houston. Similarly, AIDS has been used as the basis for challenging repeal of sodomy statutes—or to seek their reinstatement.

What these reactionary efforts are suggesting is that there is somehow a link between civil liberties for gays and lesbians and the spread of AIDS, that there is an inevitable tension between responsible public health policy and respect for traditional civil liberties protections—tension that is simply not there. Most public health officials reject the need to restrict civil liberties, such as through quarantines, because they have no basis in sound public health practice.

The Federal Response

As this committee knows all too well, the pattern of the federal government's response to AIDS has been a consistent game of catch up—with the disease and with the resource needs of those trying to fight it. The Administration has only reluctantly spent the money its own scientists have said is necessary to do the job, and has done so only when forced into it by Congress.

Each year, the Administration has submitted a budget proposal for the forthcoming fiscal year that was considerably lower than the money spent in the current fiscal year, saying this was all Public Health Service scientists had requested—only to be embarrassed into having to amend that request once it was learned that PHS scientists had in fact requested a larger amount. But even in requesting a larger appropriation, the Administration has played games with the
public health by choosing to reprogram funds from other PHS activities, rather than seek new monies. Dealing with the AIDS emergency should not require risking the lives and well being of other individuals because funds are being diverted to a health issue receiving greater public attention.

We would not have reached the current level of spending, $108 million, or the amended Administration request for fiscal year 1986 of $126 million, without the leadership of the Congress: in calling attention to the deficiencies of the Administration's approach, in bringing to national attention the needs of the PHS's scientists, and in rejecting the Administration's reprogramming approach. However, because of this robbing-Peter-to-pay-Paul mentality, it will be critical for the Congress, in making future appropriations decisions, not to rely exclusively on the internal requests of PHS scientists. Knowing that they will then be forced to choose between funding AIDS-related activities and other programs vital to the public's well being, it is clear that PHS officials are being overly conservative and requesting only that amount they feel they can absorb.

The increased public attention to AIDS that has occurred in the last few months has had the beneficial effect of increasing pressure for increased funding for AIDS. I hope the Administration, and the Congress, will not focus on AIDS at the expense of other diseases, including other sexually transmitted diseases, that are also taking lives unnecessarily and are in need of increased funding.

We have certainly seen a dramatic growth in the government's spending on AIDS over the last four fiscal years—from $5.5 million to $108.9 million—which raises in some minds questions about the need for still more money. But we are far from solving a medical riddle that threatens the lives of literally millions of Americans. We have almost 13,000 cases of AIDS—with the rate doubling at least every 12 months—several times that number with AIDS related conditions, and perhaps a million already infected with the HTLV-III virus. That warrants a full-scale attack on AIDS comparable to the Manhattan Project or the Sputnik program. Clearly our nation's scientists see it as such a challenge. The problem is to get this Administration to see it in similar terms and initiate the sort of massive and coordinated approach needed to resolve this issue.

Despite the Administration's parsimonious approach to funding, we have made amazing progress on the science of the disease in relatively short time—thanks to genius and serendipity the virus believed to cause AIDS has been identified and a blood test for antibodies to the virus has been developed and implemented to help protect the nation's blood supply. The next great challenge in the area of basic science is to develop treatment therapies and a vaccine that are safe and effective in halting the further spread of HTLV-III infection.

This very significant progress has been achieved despite the insufficient resources and insufficient coordination of effort—identified by this committee two years ago and a problem that continues to this date. What is frightening, however, is that the continuing challenges of this disease are even more dependent on effective coordination and cooperation of efforts within the public sector and between the public and private sectors. That coordination and cooperation does not exist and threatens a speedy resolution to this problem, most particularly in developing a safe and effective treatment for
AIDS.

Research into treatment therapies for those with AIDS, those with ARC, and those with HTLV-III infection pose tremendous challenges to the medical community. But they also hold out incredible potential that goes way beyond treatment of AIDS. Any discoveries regarding restoration of the immune system will have carry over into treatment of many other devastating illnesses. And yet, there is serious question whether sufficient resources are being spent on developing and testing potential treatments, or whether the government is providing the leadership necessary to accomplish this end.

There are numerous potential drugs that might be appropriate for testing in the treatment of AIDS—either as antivirals, capable of stopping replication of the HTLV-III virus, or as immune modulators, capable of restoring the immune system to its normal functioning. While these drugs are usually held in the private sector under patents, the Food and Drug Administration should not be waiting for drug companies to come to them seeking permission to do clinical trials. FDA should be working with NIH scientists and others to identify potentially useful drugs and establishing expedited procedures to encourage rapid testing. In the face of a crisis of this magnitude, a passive approach is totally inappropriate.

Once drugs are identified and their toxicity determined, the FDA must again be willing to move at a more rapid pace to test potential therapies. We are in no way asking them to authorize testing of drugs that might be harmful. But we are suggesting that, in a disease that is invariably fatal, a little more flexibility may be appropriate—particularly when there are so many individuals willing to participate in trials in the hope that they might be helped in the short term and others might benefit in the long term. We need not wait for the development of the AIDS equivalent of penicillin to begin larger scale trials. As we have learned from cancer chemotherapy, it will take experimentation with various types of drugs and various combinations of drugs before an effective treatment may be found. The FDA should not be waiting for the miracle cure before expediting trials.

Those trials will require considerably more research money than the Administration currently contemplates. In the absence of an antigen test, our only measure of the success of an antiviral agent is through viral isolations—a costly and difficult process. Some estimates have been as high as $500 per isolation and with trials that could involve hundreds of individuals over long periods of time for literally dozens of drugs, we can anticipate fairly high expenditures—either directly through research conducted at or funded by the NIH, or in federal support given to private companies conducting trials. We understand private drug companies have already indicated that they will be looking to the federal government to support these trials. Funding for these efforts have not been included in the Administration's requests for fiscal 1985 or 1986 and significant increases will be needed. (In fiscal year 1985, for example, the Office of Technology Assessment estimates that only $13.7 million was allocated for therapeutic interventions—$8.1 million for AIDS and $5.6 million for associated opportunistic infections.)

The PHS must play a coordinating role for these clinical trials. While some of the trials will involve proprietary information, in a crisis of this magnitude there must be flexibility so that the maximum information possible can be shared with all researchers to afford the greatest likelihood of
progress. The Food and Drug Administration is still in the process of trying to compile a comprehensive list of clinical trials that are underway in the United States—something they should have had from the start of research efforts. Absence of such a list leaves practitioners in the dark as to where they might refer their patients with AIDS for participation in trials and it leaves researchers wondering, but for an informal grapevine, just what other work is being done besides their own. This level of confusion is appalling—no matter what the disease under investigation. It becomes even more frightening when it is realized that the ultimate therapy for AIDS will most probably involve a combination of drugs—antivirals and immune modulators—and will require a vast array of combined therapy trials where coordination and cooperation will be essential.

What each aspect of the treatment research issue points out—whether it is identifying potential therapies and starting up trials, dealing with the potential cost of trials, or facing the issue of combining therapies—is the tremendous need for coordination and direction. It seems apparent that the Public Health Service must find a mechanism for providing that coordination and direction. But given its reluctance or inability to do so in the past, and given the consistent difficulty the Administration has in correctly identifying the fiscal needs of its own AIDS efforts, it is time to consider once again, creation of an independent panel that would oversee and coordinate the Public Health Service's response—and also identify more accurately the resources needed to do the job. That panel should include scientists from within the Public Health Service and those working on AIDS in the private sector. This is not an idea designed to bypass the hard-working PHS medical community; it is designed to provide a forum where they, as scientists not constrained by the political considerations of the Administration, can work with their colleagues in developing a real plan of attack and identifying the resources needed to carry out that battle plan—so we can finally remove budgetary politics from the war on AIDS. While it would be nice if the initiative for this independent panel would come from the Administration itself, we hope the Congress will not await that unlikely event and will itself demonstrate once again its foresight on the issue of AIDS and mandate that the Administration empower such a panel.

In the absence of a vaccine and an effective treatment for AIDS, our only line of defense against its further spread is public education. We have no magic bullet, but we do have ways of halting the spread of HTLV-III infection if we can get the message about risk reduction and safer sex out to those at risk to AIDS. The Administration's July budget amendment finally incorporates a $22 million community risk reduction program based at CDC. That amount begins to meet the real need and represents one far greater than the combined spending in the first three years of this crisis. (The fiscal 1985 CDC education budget totalled $4.1 million, more than half of which is being spent on information and technical assistance on the HTLV-III antibody test, an important goal but not risk reduction education.) We regret the Administration's belated conversion to the importance of risk reduction education, but applaud its most recent efforts. We feel that the effectiveness of educating individuals at risk to AIDS has been demonstrated again and again through the privately and locally funded efforts of gay community groups across the country. In cities like New York and San Francisco, where major education campaigns have been undertaken, the rate of sexually transmitted diseases among gay men has dropped dramatically—demonstrating that fewer and fewer gay men
are engaging in behavior that could lead to transmission of viruses, including the HTLV-III virus. Unfortunately, these programs have reached only a small portion of those at risk to AIDS and they have generally been implemented only in the major cities. We must expand their scope in high-incidence areas and replicate their successes throughout the country and reach out to all those at potential risk to AIDS.

It is our belief that the most effective public education programs are those that are targeted at specific risk groups and run by community based groups that best understand the target group. Until we get the information about how to slow the transmission of AIDS to the public—and then work with those at risk in incorporating that information into their everyday lives—we will not slow the spread of this epidemic. We are hopeful, therefore, that the CDC has chosen to target their efforts through community based programs and urge expeditious development of guidelines for these programs, in consultation with representatives of targeted groups, so as to avoid any delay in disbursement of these funds.

The question remains, however, as to whether even $22 million is sufficient money devoted to public education. There is no doubt that this increase is a significant one. For some jurisdictions, these federal funds will be an important supplement to already planned efforts. Our fear is that in some low-incidence states the federal funds—providing a minimum of $75,000 per state—will be the only education monies available. While $75,000 may be a significant amount for initiating a pilot program, it is hardly enough to assure a comprehensive and ongoing education campaign that reaches the general public and targets individual risk groups. Additional funds to low-incidence areas must be provided to assure a real education campaign and incentives must be employed to encourage localities to supplement the federal programs—in both low and high incidence areas.

In the area of health care costs and providing comprehensive care for persons with AIDS, it is hard to discuss a federal response—since there has been none. In this regard, this committee's visit to New York and San Francisco affords an illuminating contrast in terms of the differences in services provided by local governments. But the level of local responses aside, the issue of health care costs and care delivery is one that the federal government has simply not addressed in relationship to AIDS—at considerable cost to American taxpayers because federal support of a comprehensive care package for people with AIDS would ultimately reduce Medicaid costs—half of which are born by the federal government.

According to a study by the CDC, the average cost per patient with AIDS is $140,000. Multiply this by the nearly 13,000 cases and we have an incredible direct cost of AIDS of $1.82 billion, let alone the indirect costs of lost productivity, etc. But this study also offers some interesting contrasts: while the mean length of initial hospitalization nationwide was 31 days, in New York City it was 50 days and in San Francisco, 12 days. Another study showed that the average cost of hospitalization for a person with AIDS in San Francisco was only between $25,000 and $22,000—as compared to the national average of $140,000. What accounts for this vast difference? San Francisco has chosen to offer comprehensive services that reduce the amount of time spent in the hospital. They have an AIDS ward that reduces the amount of time spent in intensive care, an AIDS outpatient clinic, residential facilities, hospices,
etc.—in other words, alternatives less expensive and also, importantly, psychologically more positive for the patient. At San Francisco General, over 60 percent of patients with AIDS are on Medical (California's version of Medicaid). If this average applies nationwide, then the federal government's one-half share of Medicaid could be as high as $546 million. If the San Francisco model were adopted nationally, then costs could be dramatically reduced—even if it cost federal dollars to support some of the alternatives to hospitalization.

Despite these mindboggling figures, it is not clear that the Health Care Financing Administration can estimate how much Medicaid money is going to people with AIDS. Indeed, most localities do not compute Medicaid costs along those lines. It is also difficult to assess the impact of Medicaid's refusal to cover experimental treatments, and how that might affect the level of coverage for people with AIDS, for whom many treatments are experimental.

It is time for the federal government to take its head out of the sand and begin to face the budgetary and human impact of not providing comprehensive health care for people with AIDS. If the number of cases continues to double every nine to twelve months, we will be paying a tremendous budgetary price for this Administration's unwillingness to acknowledge the federal government's responsibility to provide decent health care for its citizens. While the human aspect of this matter might be the most convincing to some, an Administration that has been so fiscally conservative in other aspects of the AIDS crisis, should at least respond to the fiscal realities of care costs as they affect the federal budget. If the Administration will not respond on its own, then Congress should mandate a study of the impact of health care costs on the budgets of the federal government and localities—and assess whether the San Francisco model, or some other, might be more cost effective and how the federal government might provide incentives, through the Medicaid program or directly, to localities to adopt such a cost effective model. Any solution to this problem should probably include adoption of the Public Health Emergency Treatment Fund (H.R. 232) that you have proposed, Mr. Chairman, that would provide the equivalent of impact aid to those state and local governments that have been most seriously affected by the exorbitant health care costs associated with this epidemic.

In addition to Medicaid, the other major entitlement programs of importance to persons with AIDS are Social Security Disability Insurance and Supplemental Security Income. In the past two-and-a-half years, the Social Security Administration, working with local AIDS service organizations, has been partially successful in making benefits readily available to persons with AIDS related disabilities. We urge the SSA to build upon these successes by encouraging all localities with a significant incidence of AIDS to emulate the procedures developed in a number of cities—such as New York, Chicago, San Francisco, and Los Angeles—that clearly have helped to expedite benefits to those in need and entitled to them. Local district offices should continue to counter misinformation about AIDS and promote sensitive claims processing among their personnel with staff education programs. Those at SSA headquarters and charged with establishing national standards for disability determination should proceed with all due urgency to develop a workable definition for disability determination that encompasses all those with AIDS-related disabilities—including severe AIDS-related complex—and not merely AIDS as originally defined by the CDC.
Employers, insurance companies, and the military are currently examining the use of the HTLV 3 antibody test as a screening device to exclude applicants for employment, insurance, and military service. The HTLV 3 antibody test determines whether blood has been exposed to HTLV 3, the causal agent for Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related conditions (ARC). A positive result on the test does not indicate that the individual tested has AIDS or a related condition or even that such an individual will develop AIDS or a related condition. Although there has been no litigation to date concerning the use of the test for employment purposes, it seems clear that California law would prohibit such use.

The Fair Employment and Housing Act Prohibits Use of the Test

An applicant with diagnosed and symptomatic AIDS or AIDS-related conditions (ARC) would be considered handicapped for the purposes of the FEHA (Gov't Code sec. 12926(h); 2 Cal. Admin. Code sec. 7293.6). Similarly, an applicant who tests positive for exposure to the HTLV 3 virus (whether or not that person does in fact have or is likely to develop AIDS or ARC) and is rejected on that basis would be covered as someone who “is regarded as having a physical handicap” (2 Cal. Admin. Code sec. 7293.7(i)).

Under the FEHA, using a medical standard in determining one’s suitability for employment is unlawful unless such a standard is permissible as a bona fide occupational qualification (“bfoq”). The FEHA permits classwide exclusion from employment (i.e., a bfoq) where the employer can prove that all or substantially all the members of the class are unable to safely and efficiently perform the job in question and because the essence of the business operation would otherwise be undermined. (Sterling Transit Co. v. FEPC (1981), 121 Cal. App.3d 791, 797, citing 2 Cal. Admin. Code sec. 7286.7(a)).

As we have mentioned, the HTLV 3 test does not determine whether an individual has any disease. Since a positive test result for exposure to the virus does not reliably predict whether a person has AIDS or ARC, it cannot be said that all or substantially all persons who test positive on the test are “unable to safely and efficiently perform” any particular job. Even if a test were developed to accurately predict whether a person will develop AIDS or ARC, its general use as an employment screening device would be questionable. Most jobs can be safely performed by persons with AIDS or ARC when given reasonable accommodation as required by the FEHA.

Employers may not refuse to hire persons who have been exposed to the HTLV 3 virus on the basis that they endanger the health and safety of others, because test results alone would not satisfy FEHA regulations (Gov't Code sec. 12940(a)). Employers would need to make an individual determination that the applicant could not perform the essential functions of the job safely. The antibody test does not indicate that the applicant has AIDS, will develop AIDS, or still carries the AIDS virus in his or her bloodstream. The test is useless in making individualized determinations.

The Centers for Disease Control (CDC) recently published guidelines for preventing transmission of HTLV 3 among persons in the workplace. (CDC, Recommendation for Preventing Transmission of Infection with Human T-Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, MMWR, 681 [Nov. 15, 1985]). The major concern of employers who hire persons exposed to HTLV 3 is whether they will spread the virus to coworkers, customers, or clients. The CDC report unambiguously stated that routine HTLV 3 antibody screening was not recommended as a means to prevent the spread of the virus, even for health care, food service, and personal service workers. Because AIDS is a blood-borne, sexually transmitted disease that is not spread by casual contact of the type present in the employment context, routine screening of workers is not warranted.

Recent legislation (AB 403, Agnos) also prohibits the use of the HTLV 3 test for employment or insurance purposes. AB 403 was passed when, shortly after the development of the antibody test, blood banks began to administer the test to screen blood for exposure to HTLV 3, and alternative sites were established as a public service to test for exposure in the general population. The statute, Health & Safety Code sec. 199.20 et seq, protects the person tested against unauthorized use and disclosure of test results, and includes a specific prohibition against use of the test for employment or insurance purposes. It authorizes civil penalties of up to $1,000 and actual damages for negligent disclosure of results, and $1,000 to $5,000 and actual damages for willful disclosure. Any disclosure that results in bodily, economic, or psychological harm is also a misdemeanour and subject to a fine of up to $10,000 and/or up to one year in jail. In addition to state protections, some jurisdictions have adopted local ordinances prohibiting discrimination against persons with AIDS and ARC. (See Legal Update, this issue.)

The insurance industry has targeted AB 403 and a similar Wisconsin provision in an effort to amend out this protection. Even if such efforts are successful, it is important for employers, employees, and the public to understand that, in the area of employment, the FEHA provides many of the same protections against test use as does the Agnos bill. Amending the bill to delete the protection against employment use of the test would not change the prohibition under the FEHA against such use.
AIDS/ARC
DISCRIMINATION PUBLIC HEARINGS

NANCY L. MERRITT
VICE PRESIDENT - PROGRAM MANAGER
PERSONNEL RELATIONS
HUMAN RIGHTS COMMISSION
FEBRUARY 4, 1986
I AM PLEASED TO BE HERE REPRESENTING BANKAMERICA AS VICE PRESIDENT - PROGRAM MANAGER - PERSONNEL RELATIONS. I HAVE BEEN INVOLVED IN THE DEVELOPMENT AND IMPLEMENTATION OF OUR STRATEGY THAT ADDRESSES LIFE-THREATENING ILLNESSES INCLUDING AIDS, THAT I WILL BE SHARING WITH YOU.

BANKAMERICA'S CORPORATE CULTURE STRESSES RESPECT FOR OUR EMPLOYEES AND A SINCERE INTEREST IN UNDERSTANDING THEIR CURRENT AND POTENTIAL NEEDS. WE WANT TO, AS POSSIBLE, ANTICIPATE AND PLAN FOR SITUATIONS THAT COULD IMPACT EMPLOYEES IN THE WORKPLACE. CONSISTENT WITH THIS, WE DEVELOPED GUIDELINES IN MID-1983 TO ADDRESS AIDS-RELATED WORKPLACE ISSUES THAT MIGHT ARISE. IN MID-1985, I BROUGHT A GROUP REPRESENTING THE DIFFERENT DISCIPLINES WITHIN HUMAN RESOURCES TOGETHER TO RELOOK AT THIS STRATEGY. I FELT IT WAS
IMPORTANT TO INVOLVE PERSONNEL RELATIONS AS WELL AS REPRESENTATIVES FROM CORPORATE HEALTH, BENEFITS PLANNING, BENEFITS ADMINISTRATION AND OUR LEGAL DEPARTMENT TO LOOK AT THE COMPLEXITIES OF DEALING WITH AIDS AS WELL AS OTHER LIFE-THREATENING ILLNESSES. WE DETERMINED THAT WE WANTED A VERY VISIBLE POLICY THAT ADDRESSES WHAT WE CONSIDER OUR CORPORATE RESPONSIBILITY, EDUCATION AND INFORMATION FOR ALL EMPLOYEES, AS WELL AS INDIVIDUAL SUPPORT THAT MAY BE NECESSARY IN SPECIFIC CASES.

AS A PART OF OUR STRATEGY, OUR POLICY, ASSISTING EMPLOYEES WITH LIFE-THREATENING ILLNESSES AND GUIDELINES FOR ITS USE, HAS BEEN DISTRIBUTED TO ALL MANAGERS WITHIN BANKAMERICA. TO PROVIDE
EDUCATIONAL INFORMATION TO ALL EMPLOYEES WE HAVE
PUBLISHED AN ARTICLE IN OUR EMPLOYEE NEWSLETTER THAT
ADDRESS THE DISEASE OF AIDS, INCLUDES INFORMATION
FOR EMPLOYEES ON OUR POLICY, AND CONVEYS INFORMATION
ON THE SUPPORT THAT EMPLOYEES CAN ACCESS THROUGH
PERSONNEL RELATIONS, CORPORATE HEALTH OR IN THE
COMMUNITY. (ATTACHMENT I.) MORE EXTENSIVE TRAINING
WAS PROVIDED TO SPECIFIC GROUPS WITHIN THE
BANKAMERICA HUMAN RESOURCE FUNCTION. A RESOURCE
CENTER IN CORPORATE HEALTH FOR EMPLOYEES, HUMAN
RESOURCE PROFESSIONALS AND MANAGERS WAS EXPANDED TO
INCLUDE MORE INFORMATION ON LIFE-THREATENING
ILLNESSES AND ADDITIONAL COMMUNITY RESOURCES WERE
IDENTIFIED. THE BANKAMERICA MEDICAL PLAN WAS ALSO
REVIEWED AND CHANGES ALREADY APPROVED FOR 1986
PROVIDED COVERAGE IN AREAS SUCH AS HOME CARE AND
HOSPICE THAT ARE ESPECIALLY RELEVANT FOR
LIFE-THREATENING ILLNESSES.
THE FOLLOWING IS OUR POLICY, ASSISTING EMPLOYEES WITH LIFE-THREATENING ILLNESSES; BANKAMERICA RECOGNIZES THAT EMPLOYEES WITH LIFE-THREATENING ILLNESSES INCLUDING BUT NOT LIMITED TO CANCER, HEART DISEASE, AND AIDS MAY WISH TO CONTINUE TO ENGAGE IN AS MANY AS THEIR NORMAL PURSUITS AS THEIR CONDITION ALLOWS, INCLUDING WORK, AS LONG AS THESE EMPLOYEES ARE ABLE TO MEET ACCEPTABLE PERFORMANCE STANDARDS, AND MEDICAL EVIDENCE INDICATES THAT THEIR CONDITIONS ARE NOT A THREAT TO THEMSELVES OR OTHERS, MANAGERS SHOULD BE SENSITIVE TO THEIR CONDITIONS AND ENSURE THAT THEY ARE TREATED CONSISTENTLY WITH OTHER EMPLOYEES. AT THE SAME TIME, BANKAMERICA HAS AN OBLIGATION TO PROVIDE A SAFE WORK ENVIRONMENT FOR ALL EMPLOYEES AND OUR CUSTOMERS. EVERY PRECAUTION SHOULD BE TAKEN TO ENSURE THAT AN EMPLOYEE'S CONDITION DOES NOT PRESENT A HEALTH AND/OR SAFETY THREAT TO OTHER
EMPLOYEES OR CUSTOMERS.

CONSISTENT WITH OUR CONCERNS FOR EMPLOYEES WITH
LIFE-THREATENING ILLNESSES, BANKAMERICA OFFERS THE
FOLLOWING RANGE OF RESOURCES AVAILABLE THROUGH
PERSONNEL RELATIONS:

- MANAGEMENT AND EMPLOYEE EDUCATION
  INFORMATION ON TERMINAL ILLNESSES AND
  SPECIFIC LIFE-THREATENING ILLNESSES.

- REFERRAL TO AGENCIES AND ORGANIZATIONS
  WHICH OFFER SUPPORTIVE SERVICES FOR
  LIFE-THREATENING ILLNESSES.

- BENEFIT CONSULTATION TO ASSIST EMPLOYEES
  AND IN EFFECTIVELY MANAGING HEALTH, LEAVE,
  AND OTHER BENEFITS.
BANKAMERICA RESPECTS THE CONFIDENTIALITY OF AN
EMPLOYEE'S MEDICAL CONDITION. WE MAKE EVERY
REASONABLE EFFORT TO ENSURE THAT THE CONDITION OF THE
EMPLOYEE WITH AIDS/ARC REMAINS CONFIDENTIAL UNLESS
THE EMPLOYEE WANTS TO VOLUNTARILY INFORM OTHERS ABOUT
THE ILLNESS.

OUR APPROACH TO ADDRESSING AIDS IN THE WORKPLACE IS
BASED ON OFFERING EMPLOYEE AND MANAGEMENT ASSISTANCE
APPROPRIATE TO EACH SITUATION. WE HAVE NOT HAD
MASSIVE TRAINING SESSIONS FOR ALL EMPLOYEES OR
MANAGERS. WE HAVE HAD INTENSIVE TRAINING FOR OUR
PERSONNEL RELATIONS SPECIALISTS. PERSONNEL RELATIONS
 SPECIALISTS ARE HUMAN RESOURCES PROFESSIONALS THAT
WORK DIRECTLY WITH EMPLOYEES AND MANAGERS THROUGHOUT
THE COMPANY. THEY OFFER ADVICE AND DIRECT SUPPORT ON
BANKAMERICA POLICY AND PROCEDURES FOR A BROAD RANGE
OF WORKPLACE-RELATED ISSUES, ASSISTING LINE MANAGERS
TO DEAL WITH THE WORKPLACE ISSUES THAT ARISE WHEN AN EMPLOYEE HAS AIDS IS AN EXAMPLE OF THE SUPPORT THEY OFFER. THEY ARE ALSO INVOLVED WITH MANAGEMENT IN DETERMINING THE LEVEL OF EDUCATION AND INFORMATION SHARING ON THE DISEASE OF AIDS THAT IS APPROPRIATE TO ADDRESS CONCERNS THAT MAY EXIST IN A WORK UNIT.

WE HAVE DEVELOPED AN EXTENSIVE RESOURCE CENTER WITHIN CORPORATE HEALTH THAT IS COMPRISED OF BROCHURES, VIDEO TAPES, CURRENT ARTICLES AS WELL AS A LISTING OF OUTSIDE PHYSICIANS WHO CAN TALK WITH A WORK UNIT IF THAT IS NEEDED. IT IS IMPORTANT TO MAINTAIN THE APPROPRIATE LEVEL OF RESOURCES TO DO THE KIND OF EDUCATION THAT WE FEEL A SITUATION WARRANTS. OUR EXPERIENCES HAVE SHOWN CO-WORKERS TO BE VERY SUPPORTIVE, AND UNDERSTANDING, WITH WORK UNITS RESPONDING POSITIVELY AND RALLYING AROUND EMPLOYEES WITH AIDS DURING THESE DIFFICULT TIMES.
DATE WE HAVE NOT FOUND THE NEED TO BRING A MEDICAL
EXPERT ON SITE TO CALM CO-WORKER CONCERNS.

ANOTHER ELEMENT OF OUR STRATEGY IS TO ACTIVELY SHARE
OUR POLICY AND STRATEGY FOR ASSISTING EMPLOYEES WITH
AIDS AND OTHER LIFE-THREATENING ILLNESS WITH THE
BUSINESS COMMUNITY ON A LOCAL AS WELL AS NATIONWIDE
BASIS. THIS HAS BEEN ACCOMPLISHED THROUGH
PUBLICATIONS THAT DISCUSS OUR POLICY AND STRATEGY AS
WELL AS NUMEROUS SPEAKING ENGAGEMENTS. WE WANT TO
SHARE THIS INFORMATION ON OUR STRATEGY TO POSITIVELY
IMPACT THE WAY THAT THE BUSINESS COMMUNITY APPROACHES
THE DIFFERENT ASPECTS OF EMPLOYEES WITH AIDS OR ARC
IN THE WORKPLACE.

ANOTHER EXAMPLE OF BANKAMERICA'S ROLE IN THE LOCAL
BUSINESS COMMUNITY IS AS A MEMBER OF THE BUSINESS
LEADERSHIP TASK FORCE. THE BLTF IS COMPRISED OF FIFTEEN OF THE MAJOR EMPLOYERS IN SAN FRANCISCO. ONE OF THE ISSUES THAT THIS GROUP HAS IDENTIFIED FOR SHARED FOCUS IN 1986 IS AIDS IN THE WORKPLACE. WE ARE WORKING WITH THE SAN FRANCISCO AIDS FOUNDATION TO PREPARE AN EDUCATIONAL PROGRAM - VIDEOTAPE, MEETING LEADER'S GUIDE AND BROCHURE - THAT CAN BE USED WITH EMPLOYEES IN THE WORKPLACE. THIS EDUCATIONAL PROGRAM WILL BE INTRODUCED AT A CONFERENCE WE ARE SPONSORING FOR COMPANIES IN THE EIGHT BAY AREA COUNTIES ON MARCH 21ST. THE CONFERENCE IS TENTATIVELY TITLED, AIDS: DEVELOPING AND IMPLEMENTING A CORPORATE STRATEGY.

IN ADDITION TO INDIVIDUAL AND CO-WORKER SUPPORT WITHIN THE WORK ENVIRONMENT, AND ACTIVE INVOLVEMENT IN THE BUSINESS COMMUNITY, BANKAMERICA CONTINUES TO BE AN ACTIVE SUPPORTER OF THE SAN FRANCISCO AIDS
FOUNDATION AND OTHER COMMUNITY-BASED ORGANIZATIONS THAT PROVIDE ASSISTANCE TO INDIVIDUALS WITH AIDS/ARC AND OTHER LIFE-THREATENING ILLNESSES. AS AN EXAMPLE, OUR SUPPORT OF THE SF AIDS FOUNDATION BEGAN IN 1983 WHEN WE DONATED SPACE ON 10TH STREET THAT HOUSED THE FOUNDATION FOR TWO YEARS.

IN CONCLUSION, WE AT BANKAMERICA FEEL THAT THERE IS A VERY POSITIVE ROLE FOR OUR ORGANIZATION TO PLAY IN DEALING WITH THE HUMAN DEVASTATION THAT IS THE DISEASE OF AIDS. WE SEE OUR RESPONSIBILITY AS HAVING TWO ASPECTS. FIRST, THERE IS THE IMPORTANT ASPECT OF EDUCATING OUR EMPLOYEES ABOUT THE DISEASE AND IT'S PREVENTION. SECOND, WE WANT TO OFFER THE NEEDED SUPPORT TO THOSE EMPLOYEES WHO HAVE CONTRACTED THE DISEASE AND WISH TO REMAIN IN THE WORKPLACE AND CONTINUE TO CONTRIBUTE TO THE ORGANIZATION.
Understanding AIDS

by Molly Laughlin

Irresponsible headlines call out in huge type from newsstands across the nation: "Now No One is Safe from AIDS" and "AIDS: The Epidemic is Spreading Like Wildfire." We read newspaper and magazine stories about parents who refuse to send their children to school because another child is afflicted with AIDS. Recently, prompted by the death of Rock Hudson from AIDS, the Screen Actors Guild in Hollywood issued new guidelines about actors involved in on-screen kissing scenes.

No disease in modern times has created such fear, largely fueled by misinformation, Dr. Mervyn Silverman, former director of the San Francisco Department of Public Health, says, "The primary way to prevent further spread of the disease is by education and information. The more we know about it, the more we can protect ourselves and can show compassion and understanding toward those with this deadly illness. For one thing is clear: AIDS is everyone's concern."

AIDS: A background

AIDS stands for Acquired Immune Deficiency Syndrome. The AIDS virus, known variously as HTLV-III and LAV, was identified in 1981. Since then, some 75,000 people have been diagnosed as having the disease. The AIDS virus enters the body and cripples lymphocytes, white blood cells necessary for immunity. The weakened immune system then becomes susceptible to a wide range of infections and tumors, many of which are serious and potentially fatal. Among the most common of these is a parasitic lung infection, Pneumocystis carinii, and an unusual form of cancer, Kaposi's sarcoma.

The illness can run a short, aggressive course lasting weeks or a few months, or may last for years. Although there is no current cure for the disease AIDS, there are several available treatments for most of the afflictions suffered by the AIDS patient during the course of the illness. However, because AIDS so destroys the immune system, medications cannot be boosted by the body's natural defense system, and will eventually lose their effectiveness.

Fiction: I could get AIDS from someone on the bus or by using the telephone of a co-worker with AIDS.

Fact: AIDS is very difficult to catch and no evidence points to transmission through casual contact, such as that found in the workplace. The virus is fragile and requires a warm, moist environment to survive. Exposure to the air kills it. Dr. James Curran, a world-renowned AIDS expert from the Center for Disease Control in Atlanta, says, "No scientific evidence supports AIDS transmission by casual contact, by the airborne route (such as colds and flu), by objects handled by persons with AIDS, or by contaminated environmental surfaces." Medical experts agree that AIDS is far less contagious than hepatitis, colds, and flu. Despite this, a New York Times/CBS News poll showed that nearly half the population thinks they can catch AIDS by sharing a glass with a person with the disease.

So how is the virus transmitted? By direct transmission of blood or blood-contaminated tissue fluids from a person with the virus to one without it. Typically this occurs through the use of shared intravenous needles where blood is exchanged and through sexual contact with an infected person. But, says Dr. Linda Hawes Cleverly, Chairman of the Department of Occupational Health at Pacific Presbyterian Medical Center in San Francisco and an expert in the field of AIDS, "The virus has to enter the body through one of two places—the skin or through a damaged mucous membrane. In addition, researchers believe the virus usually strikes someone whose immune system already is exhausted or weak due to previous infectious illnesses or substance abuse.

The AIDS virus may be present not only in blood and semen, but also in other body fluids, including saliva, tears, and sweat. However, medical experts believe that daily activities—working in a group setting, shaking hands, swimming at public pools, and eating at public restaurants—pose no AIDS threat. This is because the AIDS virus is fragile and it must get outside of the bloodstream of an infected person, into the bloodstream of another person.

Fiction: Only homosexuals and drug abusers get AIDS.

Fact: This is not true. Others not considered in the "high risk" groups also have contracted AIDS. However, over half of researchers have found most people with AIDS are either homosexuals or drug users. Of the reported cases of AIDS in the United States, about 73 percent are homosexual or bisexual men; 17 percent are intravenous drug users; 2 percent are recipients of blood transfusions where the blood contained the AIDS virus; 1 percent are heterosexuals who have had sexual contact with an infected carrier; another 1 percent are hemophiliacs who may have had blood transfusions; and 6 percent are classified as "other/unknown." This last group reflects mainly the patients who have not had a history taken, or who choose not to disclose their private lives or habits.

Current statistics show that 90 percent of the stricken adults are between the ages of 20 and 49; 94 percent are men. Children also may get AIDS. Usually, these are infants whose mothers were infected with the AIDS virus and passed it on during pregnancy or hemophilic children who become infected through a blood transfusion. However, Dr. Cleverly points out that the chance of contracting AIDS through a blood transfusion was minuscule today, as blood banks carefully screen all blood donations, the chances are reduced further.

Fiction: If I am infected with the virus, I will get AIDS.

Fact: You might, but you also might not. Many healthy people will develop antibodies to the virus, remain healthy, and display none of the symptoms of AIDS, though they might transmit the disease to others. About 10 to 15 percent may develop what is called ARC (AIDS Related Condition), characterized by mild to severe illnesses. Finally, another 10 or 15 percent may develop AIDS. It can take anywhere from a few months to several years after infection for diseases to develop.

Prevention is key

Because the primary transmission of AIDS is through sexual contact and intravenous drug use, it is imperative that individuals practice safe sex habits and refrain from sharing needles. Those in the high risk groups should protect themselves and their sexual partners in the same way they would for other sexually transmitted diseases. The referral agencies listed in the accompanying sidebar may provide assistance in methods of protection.

How one lives his or her life also plays a preventive role. Substance abuse, including alcohol abuse, poor nutrition, and inadequate rest and activity may contribute to the development of AIDS. "The point is that AIDS is predominantly a sexually transmitted disease, and that means it's a disease of lifestyle," says Dr. Silverman. "People who don't do certain things very likely will not get it. People who do certain things risk getting it." He adds that the same points are true for intravenous drug users.

Fiction: People with AIDS should not be allowed to work.

Fact: Employees with AIDS, like persons with other life-threatening illnesses, should be allowed to work if they choose, as long as their condition does not interfere with their job. BankAmerica's policy states that as long as employees with any life-threatening illness, including AIDS, are able to meet acceptable performance standards and medical evidence indicates they are not a health threat to themselves or others, they may work.

Often, says Dr. Cleverly, an employee with AIDS may have to adopt a work schedule to accommodate a greater susceptibility to fatigue. "The most important point is for everyone in the work site to show a caring attitude and..."
AIDS
Continued from front page
not to pass judgment on the person. Be supportive in whatever way you can. The disease itself takes a tremendous emotional toll, and it is imperative for persons with AIDS to have a circle of support around them."

Fiction: A person with AIDS might pass along infectious illnesses to coworkers or because that person's immune system is weak, he or she might be more susceptible to the normal "bugs" that strike an office.

Fact: The person with AIDS does have a lowered immune response to fight off infections, but is unlikely to pass along the AIDS-related illnesses, such as pneumocystis, because most adults already have been exposed to this infection sometime earlier, and have a built-in immunity. As far as contracting diseases, the person with AIDS may have a slightly higher-than-normal susceptibility to such contagious diseases as colds and flu, but usually does quite well. Although most of the immune response is destroyed in AIDS, there usually remains a fraction of immune ability to fight off these less serious illnesses.

Where can a BankAmerica with AIDS turn for assistance?

BankAmerica offers a range of resources through Personnel Relations for employees with life-threatening illnesses, including AIDS. Among the services are: management and employee education and information on terminal illness and specific life-threatening illnesses; referral to agencies and organizations that offer supportive services for life-threatening illnesses; and benefit consultation to assist employees in effectively managing health, leave, and other benefits.

Is an employee with AIDS eligible to receive BankAmerica benefits?

Yes. The corporate benefit plans treat life-threatening illnesses (including AIDS) the same as other medical conditions. Employees who are disabled from working may be eligible to receive income protection through accrued benefits and the Long Term Disability Plan. When employees are out on an approved medical leave of absence, benefits continue as follows:

- Coverage for health plans (medical, dental, vision) continues at the pre-disability rate as long as the employee continues to make monthly contributions (see page 11 of the "Health Care" benefits booklet).
- Basic (employer-paid) life insurance continues and so do employee-paid life insurance benefits as long as the employee makes monthly contributions (see page 32 of the "Protection" benefits booklet).
- Employee banking privileges continue as long as the person is considered an employee of the company.
- BankAmerica account benefits continue. Employees continue to earn pay-based credits as long as they receive sickness benefits. If sickness benefits have expired, credits are earned as long as they are receiving Social Security disability payments.
- BankAmerica retirement benefits may continue as long as an employee receives sickness benefits. Long-term disability benefits are not considered eligible earnings for BankAmerica.

Important resource groups within the corporation are Personnel Relations in each division. These groups can provide information on referral services and benefits information.

—Katherine Armstrong, Corporate Health Programs, and Nancy Merritt, Personnel Relations, contributed to this article, which is intended to present Bank of America employees with current information regarding AIDS. This article is a composite of data from various sources including articles, current statistics, and the opinions of leading AIDS experts throughout the United States. Bank of America will continue to make an effort to monitor new opinions and information concerning AIDS and will endeavor to remain alert to any significant new developments that affect our employees.
TESTIMONY

SAN FRANCISCO HUMAN RIGHTS COMMISSION

AIDS/ARC DISCRIMINATION PUBLIC HEARINGS

Submitted by: LAMBDA INSTITUTE
Don Tombe, Exec. Dir.

Submitted on: February 4, 1986

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For information or reprints: (415) 431-9802
AIDS/ARC EMPLOYMENT DISCRIMINATION

Testimony submitted to:
The San Francisco Human Rights Commission

As a part of:
The Commission’s AIDS/ARC Discrimination Public Hearings
February 4, 1986

I DESCRIPTION OF TESTIMONY

The purpose of this written testimony is to formally document, for the San Francisco Human Rights Commission, examples of AIDS/ARC related discrimination (as well as other related problems) which we are aware of as a service agency dealing with these issues. Additionally, this testimony addresses what we believe to be the underlying causes of such discrimination; and what might be done to address these issues and problems.

II DESCRIPTION OF SUBMITTING AGENCY

Lambda Institute is a non-profit, charitable, educational and scientific corporation. Our goals are straightforward: to dispel myths, stereotypes and misinformation about gays and lesbians throughout the United States. We accomplish this through a wide range of professionally designed educational programs, video tapes, resource materials and scientific research projects.

Our "Understanding Diversity" programs were developed as a pioneer effort to help corporations create a work environment that minimizes conflicts between workers with diverse sexual orientations. Our staff has provided over 550 programs to an estimated 15,000 non-gay people since 1981. Based on this experience (as well as the most current scientific information about homosexuality, conflict resolution and performance management techniques) we have developed a highly effective process for helping organizations identify often "invisible" problems and gain a clear sense of when and how to intervene. A great deal of this experience has gone into the development of our AIDS educational services.

Our "Understanding AIDS" services are a logical outgrowth of our "Understanding Diversity" corporate management series. Long before the term "AIDS Hysteria" was in common use, we predicted this hysteria would surface and recognized the impact it would have on american corporations. Thus, as early as 1983, we became one of the first organizations to offer education to non-gay people about AIDS.

III DESCRIPTION OF EXHIBITS

EXHIBIT B: ISIS brochures, "AIDS, The Blood Supply and Homosexuality" and "Medical Aspects of Homosexuality." Included as examples of nationally distributed "hate campaign" materials which use AIDS as a weapon for promoting prejudice, intolerance and discrimination toward gays and lesbians.

EXHIBIT C: Assorted news articles which tend to be alarmist or promote public fear and misunderstanding.

EXHIBIT D: Assorted news articles documenting various forms of discrimination that individuals with AIDS experience.

EXHIBIT E: Benefits of implementing "Understanding Diversity" educational programs.

EXHIBIT F: AIDS-Phobia, Homophobia and Locus of Control, research study by Edwin D. Gabay and Andrea Morrison.

IV AIDS HYSTERIA: THE UNDERLYING CAUSE

The necessity for recognizing the role that "AIDS-phobia" plays in employment discrimination, as well as in the increased displays of homophobic and homonegative behavior is dramatically reflected in recent scientific studies, public opinion polls and numerous daily events. One study which documents the correlation between "AIDS Hysteria" and homophobia was done by Edwin D. Gabay and Andrea Morrison of the Wright Institute in Berkeley. In their paper presented to the 33rd Convention of the American Psychological Association (August 1985) they found, "AIDS-phobia is strongly associated with prejudicial attitudes toward homosexuals." They went on to conclude, "The prevalence of negative attitudes and beliefs toward homosexuals in the United States may be so much a 'part of the landscape' that the essentially prejudicial nature of these feelings is obscured. Under the threat of an epidemic, however, this underlying belief system may be reflected through a phobia... [thus] latent homophobia may be finding an expression in AIDS-phobia." (The complete study is provided as Exhibit F.)

The idea that AIDS Hysteria is linked to homophobia is also demonstrated by recent Gallup opinion polls which show that in light of AIDS there is a visible erosion in the commitment to fair treatment, equality and job protections for gays and lesbians by a substantial number of Americans. (See Exhibit A.)

Such trends are also becoming the rallying point for organized and well financed "hate campaigns". Groups and individuals which have a history of advocating oppression, intolerance and discrimination toward gays and lesbians are using the issue of (and fear about) AIDS as "proof" that such oppression is warranted. This is not surprising since the most common means of justifying prejudice
toward any minority has historically been the claim that the targeted minority poses some form of threat to society at large. What is surprising is the high profile, professional and psychologically effective, "Madison Avenue" type of campaign being waged. (For an example of such a campaign see the "ISIS" brochures listed as Exhibit B.)

Finally, our professional experiences, in working with corporations, government Institutions and public service agencies have provided us with "hands on" documentation of this trend. There is no doubt that homophobic and homoprejudicial attitudes and behavior prevail in most work settings, and that AIDS Hysteria is the latest "stepping stone" to rationalize, attempt to justify and even condone such attitudes and behavior. This is clearly evidenced by the number of on-the-job conflicts and concerns generated by AIDS. Further, despite being provided with factual information, by qualified medical professionals, (that AIDS is not transmitted casually in the workplace and that sufferers should NOT be excluded from ANY job) over 50% of employees and co-workers have continued to display the negative behavior which generated the conflict in the first place. It has been our experience that until the underlying issues of homophobia are dealt with, the negative behavior does not dissipate. Thus, it is our belief that AIDS Hysteria and AIDS-phobia are symptoms of a larger problem — HOMOPHOBIA.

AIDS-HYSTERIA: EFFECTS IN THE WORKPLACE

Homoprejudicial behavior including AIDS Hysteria results in serious and costly ramifications for employers, employees and society in general. The fact that such problems are widespread is reflected by the number of cities, counties and states (e.g., San Francisco, New York, Los Angeles, West Hollywood, Berkeley, Hayward, Santa Clara County etc.) which are implementing AIDS related non-discrimination ordinances and legislation. Every day the media reports specific instances of discrimination in employment, housing, insurance benefits, the military etc. (For specific examples see Exhibit D.) Additionally, media reports often take an "alarmist" approach which only tends to escalate public misunderstanding and fear. (For examples of such items see Exhibit E.)

The following briefly addresses some problems which we have seen occur because of myths and stereotypes about AIDS and homosexuality.

STRESS
Increased stress (based on myths and stereotypes about AIDS and homosexuality) is evident among non-gay employees who work with openly gay and lesbian employees. Stress in and of itself results in higher medical insurance & disability premiums, burn out with
associated rehire and retraining costs, disability leaves and lost productivity due to increased absenteeism and reduced office harmony. The current AIDS crisis and the resulting intra-office conflicts, tensions and discord are timely examples of unfounded fears that can cause serious and costly problems for American corporations and businesses. The fact that myths and stereotypes about homosexuality are a co-factor in AIDS related conflicts is easily demonstrated by the number of non-gay employees who fall victim to AIDS hysteria. We have received numerous calls based on the fact that someone was perceived to be gay or lesbian and was suffering from a cold, the flu or other non-AIDS related illness, which resulted in workplace conflicts and concerns. The stereotypical myth that all gay men and lesbians look, dress or somehow act alike often results in many non-gay people being "identified" as gay or lesbian. They then suffer the same discrimination as open gay and lesbian employees. Another "myth" which often causes problems is the belief that gays and lesbians somehow started AIDS or are responsible for causing it. This is almost always associated with the belief that they also somehow "deserve it" and thus are not eligible for understanding, compassion or sympathy. None of these beliefs are in any way based on fact or scientific information, yet they continue to cause major problems and conflicts in workplaces throughout the United States.

Fear is not, however, limited to non-gay and lesbian employees. Studies demonstrate that gays and lesbians fear that discovery of their sexual orientation will result in employment discrimination, job harassment and alienation. This fear increases occupational stress in gays and lesbians which may interfere with the quality of their work and their striving for suitable higher positions. Another area of stress is generated by employees who have lost someone close to them, due to AIDS, and have no way of releasing their grief for fear of their co-workers' reactions. In addition, concealing such deep feelings of grief often leads to eventual feelings of resentment and anger toward co-workers.

PERFORMANCE & PRODUCTIVITY
Impaired workplace teamwork, lack of cooperation and poor communication clearly reduce employee job satisfaction, morale, performance, productivity and company profits.

DISPUTES & CONFLICTS
Workplace disputes, conflicts, tension, wrongful discharge, inadvertent and overt acts of discrimination generate serious morale problems which often lead to mediation, arbitration or civil litigation.

INSURANCE REGULATIONS AND EMPLOYERS
One of the common areas of discrimination, with tragic and far reaching implications, is in insurance coverage and
qualifications. It is bad enough that many people are being "Red Lined" because of the area in which they live or work and their marital status. But, this is just the beginning; many insurance carriers are now pursuing policies which would require an employer to disqualify "high risk" individuals from group coverage programs. Employers refusing to do so could be threatened with insurance fraud should an AIDS related claim be filed with the insurance carrier. Thus, added pressure is being placed on employers to discriminate against employees.

VI REMEDIAL RECOMMENDATIONS: LEGISLATION & EDUCATION

The ability to confront and eliminate homophobia and homonegative behavior is clearly essential to developing an organization's most valuable resource - its people. Corporate Management, Personnel Divisions, Human Resources Departments, Internal Training and Organizational Development departments are prime vehicles for helping organizations cope with ever increasing shifts in societal values toward homosexuality and the increasingly open nature of homosexual lifestyles. Understanding Diversity can help managers, who are not yet ready to facilitate change in this sensitive area, by reducing their own personal stereotypes and misconceptions. Moving toward more successful futures along with reducing prejudice and discrimination depends upon the corporation's readiness and ability to appropriately manage these crucial change issues.

METHOD

To alter homophobic attitudes and behavior, issues are considered from the perspectives of social psychology and our professional experience. From this foundation, Lambda Institute has developed and tested innovative techniques which have proven effective in dissolving common, highly charged barriers to harmonious gay/non-gay interactions. Most evaluations show a marked reduction in negative, discriminatory and even hostile behavior toward gays and lesbians. These evaluations were used to develop and refine our current "Understanding Diversity" and "Understanding AIDS" program content and format. At Lambda Institute, we are keenly aware of our responsibilities as pioneers in educational programs about homosexuality. We constantly strive to update, improve and increase the relevance and effectiveness of our services.

The value of a group approach and learner-centered training in facilitating attitude change has been well documented. Attitudes which stimulate strong feelings in an individual are effectively influenced by the attainment of insight into one's own motivation. Also essential in modifying attitudes is the degree to which group members can resolve problems and make decisions as a group.
Inclusion of both gay and non-gay trainers is mandatory in effecting attitude change. Discrimination is reduced through interaction with people who occupy roles and behave in a way which is incongruent with their stereotype. This incongruence weakens beliefs about those stereotypes, allowing positive role expectations to be perceived and feelings to change as people realize the conflict between reality and stereotype. Further, the integrated training team models appropriate gay and non-gay interactions.

Finally, we have found that programs which are client responsive, and provide services based on a coordinated educational approach, are more effective than "Pre-Packaged" or "Off The Shelf" programs. Thus, we begin with an organizational performance analysis and needs assessment done in conjunction with the client company's management or training staff. Based on this, we design a program suited to the company's specific and unique needs. Lambda Institute's "Understanding Diversity" and "Understanding AIDS" programs range from half-day 'specific focus' presentations, to full day and even multi-day workshops and seminars.

KEY PROGRAM OBJECTIVES

To help corporate management personnel learn how to maximize employee performance by creating an environment of compatibility between gay and non-gay co-workers. Understanding Diversity addresses conflicts and concerns, often based on misinformation, which commonly arise between these two groups. Effective techniques of identifying frequently "invisible" homonegative behavior and the appropriate interventions are also examined.

Understanding Diversity addresses management concerns and issues about gay and non-gay workforce interactions. With regards to AIDS concerns, these include:

- What the facts are about the illness, how it is and is NOT transmitted, and what precautions are appropriate and rational

- How fear of AIDS costs corporations millions of dollars annually in lost productivity, employee insubordination, and wrongful discharge litigation.

- Why factual information about AIDS alone is almost never enough to eliminate problems and conflicts generated by "AIDS Hysteria".

- What new Anti-AIDS discrimination laws exist and how they effect businesses.

- When (if ever) it is legal to ask, suggest or require
employees or job applicants to take the AIDS antibody test.

* Understanding Diversity is designed to collaborate with any company’s EEO or personnel Diversity program, to enhance the existing program’s effectiveness with gay and lesbian issues.

* Understanding Diversity will prepare managers to effectively manage gay/lesbian work groups. The program uncovers and highlights specific "hidden issues", such as stress and fear factors unique to this group. Also, the Institute teaches effective managerial techniques and co-operative peer behavior.

* Understanding Diversity will strengthen the company’s ability to tap the existing and expanding business market presented by the gay/lesbian employees and population at large.

PROGRAM DESCRIPTION

(A) TOPICS ADDRESSED
We have found that the most successful programs are the ones which present a format that addresses common workplace concerns. Issues which should be covered include: myths and stereotypes about gay and lesbian employees, health issues in the workplace - including AIDS, corporate legal issues and responsibilities, gay and lesbian employee concerns, insight into one’s own attitudes and behavior toward gay and lesbian employees, religious attitudes as they relate to workplace behavior, social and sexual workplace conflicts, as well as the knowledge of how and when to intervene accordingly.

(B) PROGRAM PROCEDURE

Training Approach
Training exercises reflecting these topic areas and demonstrating effective supervision techniques are used. Our approach utilizes "Learner-Centered Training" techniques, including lecture presentations, discussion periods, modeling, written and video materials, and experiential learning i.e., role plays, practice sessions and value clarification exercises. Seminars and workshops also include a detailed seminar manual as well as post seminar follow up and "crisis intervention" services. These programs are provided by various specialists, gay and non-gay, including: medical professionals, psychologists, lawyers, educators, corporate executives, police officers, clergy and trained community representatives.

Evaluation
Program evaluation includes both pre and post training tests (which have been scientifically proven to be statistically reliable) as well as a participant evaluation form. Audience feedback and role-play results are also used as a means of
determining overall program effectiveness.

VII CONCLUSION

To effectively combat workplace discrimination based on AIDS-phobia and Homophobia requires a two pronged approach. (1) Legislation and corporate policies banning such discrimination must be implemented on a wide scale; and (2) effective educational programs designed to deal with the issues of AIDS AND HOMOPHOBIA in the workplace must be implemented. Legislation banning discrimination by itself is not enough to counter problems occurring in corporations, governmental institutions and public service agencies. This position is based on experience we have gained from providing programs which have proven effective in dealing with homophobia, homoprejudicial behavior and AIDS-phobia related problems.

Lambda Institute's educational programs represent a critical departure from the techniques used in other, more traditional, minority relations programs. Our programs are designed to deal specifically with the unique dynamics and highly charged issues arising from the subject of homosexuality.

LAMBDÁ INSTITUTE, P.O. Box 590162, San Francisco, CA 94159 (415) 431-9802 Telex (WUI) 6502191937 MCI
AIDS AND INSURERS: A CLASH OF RIGHTS

Market conditions have dominated the insurance trade news and have affected the public at large to such an extent that news stories concerning insurance are appearing with unaccustomed frequency in newspapers and on radio and television.

Few of these news stories have put insurers in a favorable light. As a result, questions about the inviolability of the McCarran-Ferguson Act are being raised. Insurance representatives are once again trekking to Capitol Hill, explaining the intricacies of insurance to skeptical public officials. We knew a hard commercial market would follow the soft market, as surely as morning follows night. So other than a dramatic contraction of property/casualty capacity, it looked as if the game of insurance would still be played using the rules developed over centuries.

Not quite.

Working its way out of Africa (by all accounts) was a disease very probably unparalleled in its complexity, lethality and potential for throwing the world back into an ethical dark age.

AIDS -- Acquired Immune Deficiency Syndrome -- is by now known to most Americans. Most know its modus operandi: once it has infected its host, the immune system is destroyed, leaving the victim vulnerable to diseases of opportunity.

AIDS is a cruel disease for a number of reasons. It is cruel because the diseases that eventually kill the AIDS victim -- for example, Kaposi's sarcoma and pneumocystis carinii pneumonia -- are not normally virulent enough to gain a foothold in a healthy individual. Indeed, it was an extraordinary increase in deaths by such diseases that brought AIDS to the attention of doctors and the federal Centers for Disease Control.

Many see in AIDS another cruelty, because of what it has done to the group most closely associated with the disease in this country -- gays. Over the past several decades, society has come to tolerate, if not accept, the homosexuality of some of its members. But now, as a result of the fear, uncertainty and -- some would say opportunity -- created by the AIDS crisis -- homophobia (meaning not a fear of gays, but an extreme prejudice against gays) is resurfacing. Given the fatal nature of AIDS, the most extreme example of homophobia soon may not be limited to "gay-bashing" and snide whispers. AIDS threatens to make yesterday's expressions of homophobia seem mild by comparison.

"AIDS kills. It's as simple as that. If you don't want to
contract AIDS, the only way to avoid it is to stay out of its way. How do you do that? You stay away from those who have it or who are likely to have it. And who's likely to have it? Gays."

As a result of such simplistic reasoning, gays are in danger of becoming more isolated from mainstream society. Political strides made by gays in recent decades are threatened. Old alliances between organized gays and politicians are withering.

AIDS, it is often pointed out, is not a gay disease. It is documented that in other parts of the world, it is a heterosexual disease, transmitted by heterosexual contact. In this country though, AIDS has befallen the homosexual community because, through some epidemiological quirk of fate, it is transmitted by -- among other methods -- homosexual contact.

AIDS cannot be spread casually. Despite this, instances of discrimination -- based in part on the new, AIDS-related homophobia, and based in part on deeper seated fears and hatreds -- occur hundreds of times daily. Stories of parents pulling their children out of school -- because the sibling of an AIDS victim attends the same school -- are common-place. Adults who test positive for AIDS are being fired -- leaving them uninsured, uninsurable and unemployed at the same time. There's scant evidence of sympathy for victims when a society is running scared from a plague.

Clearly, individual homosexuals are suffering greatly from the disease itself and the stigma the disease creates. This is 1985, though, and homosexuals as a group are greatly more organized and vastly more sophisticated than they were even 10 years ago. They are moving quickly and assuredly to present their arguments and to flex their political muscle in response to the AIDS crisis. They are determined to prevent AIDS from erasing the strides they've made in securing their rights.

At the same time, non-gay individuals and organizations are springing into action to assist gays in their struggle against AIDS. AIDS is overwhelmingly viewed as a health and human rights issue affecting all people -- not just gay men.

Until now, the NILS NAIC Dialog has presented either contrasting views within the insurance community, or the views of a single industry regulator. Beginning with this, the 1985 Winter Meeting, we are altering that format somewhat. Instead of three separate issues of Dialog, we are presenting only one. And instead of presenting opposite sides of an argument, we are presenting just one.

The subject is AIDS and the clash of rights resulting from AIDS -- between insurers and the homosexual community.

At a gathering such as the NAIC, the views of the industry are well known. With presentations by HIAA and ACLI due to be made this week, any industry views not already known soon will be.

The editorial staff of NILS NAIC Dialog is not instituting this format change merely in order to produce a controversial publication. It does so only in the hopes that a wider dissemination of any opposing viewpoints will assist in lasting solutions to major problems confronting the insurance industry.

Therefore, this NILS Dialog brings you the views of the "other" side only -- the people living the nightmare, and their advocates.

NILS NAIC Dialog is meant to stimulate discussion and examination of issues facing the insurance community. The views expressed in NILS NAIC Dialog do not necessarily reflect the views of NILS Publishing Company, ABC Publishing or the...
AIDS AND INSURANCE

by
Benjamin Schatz
Carl Heimann
W.L. Warner, M.D.

As of December 1985 over 15,000 Americans were diagnosed as having AIDS.

Because this disease is almost always fatal, the American public has responded with fear. Unfortunately, this understandable fear has all too often been translated into hysteria. People with AIDS and people thought to have a high risk of getting AIDS are increasingly being fired from their jobs, kicked out of their homes, and shunned by their families and friends.

Regrettably, there are some in the insurance industry who have panicked as well. Although the vast majority of health, life and disability insurers have responded calmly and rationally, a small minority of companies have hastily drafted shortsighted, unjust and often illegal underwriting policies in order to protect themselves from potential liability.

Some insurers would like to deny coverage to all gay men, or to all single men in certain cities, states and zip codes. Others have proposed using the HTLV-III antibody test to screen out applicants whom they believe to be "high risk." As we shall see, both approaches are impractical, unjust, and of questionable legality.

Consistent Underwriting: Says Who?

The problem of wholesale denial of coverage to gay men is already very real: increasingly, reports come into the National Gay Rights Advocates from men around the country who have excellent medical histories, and yet -- because of their occupation, martial status, zip code or living arrangements -- are identified as gay, and thus denied health, life or disability insurance.

The insurers involved assert, of course, that their practice is consistent with accepted underwriting principles. After all, they point out, health insurers have traditionally charged higher rates to cigarette smokers than to non-smokers because they present a higher risk of developing any number of serious illnesses. Why, then, should insurers not discriminate against gay men, who are similarly at a higher risk of contracting AIDS?

"AIDS IS NOT A GAY DISEASE. IN AFRICA...THE VAST MAJORITY OF AIDS CASES HAVE BEEN TRANSMITTED HETEROSEXUALLY"

The answer, is that the analogy simply does not hold. While smoking is itself a medical indicator of health risk, an individual's sexual orientation or marital status tells us nothing about his health. Many gay men are in long-term, monogamous relationships; or are celibate; or engage in AIDS-safe sexual practices -- all of which place them at a much lower risk of getting AIDS than many heterosexuals. Indeed, as officials with the U.S. Centers for Disease Control have repeatedly explained, AIDS IS NOT A GAY DISEASE. In Africa, where the disease appears to have originated, the vast majority of AIDS cases have been transmitted heterosexually. Here in the U.S., literally thousands of heterosexual men and women -- as well as children -- have already been diagnosed with AIDS.

The screening of gay or unmarried men and only gay or unmarried men, even though the vast majority of gay men will not develop AIDS and many thousands of heterosexuals will, is surely the sort of "unfair
practice" forbidden by most state insurance codes. To permit such a practice is equivalent to allowing insurers to screen only Blacks for hypertension, only Chinese-Americans for cancer of the throat and esophagus, only women for diseases of the gall-bladder, or only men for heart disease or smoking-related disorders.

Gays Not Alone in Sharing AIDS Risk

That the singling out of gay men by insurers is unfairly discriminatory is made even more obvious by the fact that other groups which also have high AIDS risks are not similarly scrutinized. Gay males bisexual males, intravenous drug users, hemophiliacs, prostitutes, recipients of blood transfusions, and their sexual partners -- all are known to have a heightened risk of developing AIDS. There is no epidemiological or legal justification for allowing insurers to reject a man because he has had sex with another man, but not reject a woman who has had sex with the same man, or, for that matter, anyone who has had sex with a bisexual male, drug user, hemophiliac, blood transfusion recipient or prostitute.

Since it is illegal in virtually all states for insurers to treat differently groups or individuals which present similar risks, we encourage insurance commissioners to oppose the discriminatory targeting of gay men. Insurers would rightfully object that it would be both impractical and an outrageous invasion of individual privacy for them to attempt to identify all of their applicants' sexual partners. But it is no less impractical or outrageous for insurers to attempt to learn whether unmarried male applicants are sleeping with members of the same sex.

Many who have developed AIDS are not gay -- they are bisexual men, intravenous drug users, hemophiliacs, etc. These people often are married, and thus would fall through an insurer's lifestyle, zip code or other gay-oriented screen.

"THE AIDS EPIDEMIC IS STILL YOUNG AS EPIDEMICS GO..."

Furthermore, while it is true that at this moment the majority of people with AIDS are gay or bisexual men, it is important to note that the AIDS epidemic is still young as epidemics go, and epidemiological patterns are likely to change. For insurers to make long-term decisions about insurability on the basis of preliminary and easily changeable epidemiological patterns is short-sighted and inconsistent with accepted underwriting practices.

Our system of insurance laws was designed to ensure that insurers not be allowed to substitute purely demographic factors such as race, marital status, or sexual orientation as proxies for sound medical indicators of health risk. Insurers must be required to base their decisions about health, life and disability insurance on medical questions applied to all applicants equally: Has a person been diagnosed as having AIDS? Has he or she had prolonged night sweats, diarrhea, or dry cough? An answer of 'yes' to such questions -- by man or woman, heterosexual or homosexual -- would then justify further medical inquiry by the insurer.

HTLV-III Test Not a Diagnostic Tool

This brings us to the issue of the HTLV-III antibody test. The fact is that the test is not and was never intended to be a diagnostic tool. Rather, it was created solely for the purpose of protecting the nation's blood supply. Indeed, the U.S. Food
and Drug Administration, when licensing the test, specifically warned in its labelling language that "it is inappropriate to use this test as a seren for AIDS." Thus, any use of the HTLV-III test by insurers would directly violate F.D.A. labelling restrictions.

There are enormous practical problems involved with the proposed misuse of the HTLV-III test as well. Perhaps the greatest problem with the test is its inaccuracy. Because it was designed only to screen blood, it is by nature oversensitive. As a result, a significant percentage of people testing positive to the ELISA version of the test are, in fact, "false positives." Indeed, the Pentagon, during three months of testing, found that only 8.8% of those recruits initially testing HTLV-III positive continued to test positive upon repeated examination.

Even when the test is accurate, however, it is not at all clear what it indicates. Because the test only measures the presence in the blood of antibodies to the AIDS virus, it merely indicates a past exposure to the AIDS virus. It does not indicate the presence of the retro-virus, and most certainly it does not indicate whether a person is likely to develop AIDS. In fact, studies indicate that as few as 5% of those testing positive to the HTLV-III antibody go on to develop AIDS.

The actual percentage may indeed be even lower: the studies performed to date have not been controlled, and many of those studied who went on to develop AIDS may have continued to engage in high-risk activity long after their blood was sampled. It is thus unclear to what extent their AIDS diagnoses were statistically linked to their repeated exposure to the AIDS virus, and not simply to their development of HTLV-III antibodies.

Now that community education campaigns have led more and more gay men to abandon unsafe sexual practices, the percentage of HTLV-III antibodypositive gay men who go on to develop AIDS may be much lower than presently believed.

Cost Considerations

Not only scientific shortcomings make the HTLV-III antibody test inappropriate for use by insurers. The fact is that it will cost insurers far more to test all of their applicants than it will for them to pay all their AIDS-related claims! The cost of a single ELISA HTLV-III test is approximately $15 per person; the cost of repeating the test and confirming it with a more accurate but more expensive "Western blot" test approaches $100. Because the tests are so expensive, insurers may attempt to lower their examination costs by limiting HTLV-III antibody testing to men they think are gay. This, as we have shown, would be arbitrary, unfairly discriminatory, and epidemiologically unjustifiable.

"IT WILL COST INSURERS FAR MORE TO TEST ALL THEIR APPLICANTS THAN IT WILL TO PAY ALL AIDS-RELATED CLAIMS."

There are additional reasons for refusing to allow insurers to test their applicants for evidence of HTLV-III antibodies. There presently exists widespread public misunderstanding about both the nature of AIDS and the meaning of the HTLV-III test results. Several people are known to have committed suicide upon learning that they tested antibody-positive. Given the present state of near-hysteria, it seems unwise to allow insurers to force emotionally-unprepared applicants to take a test the results of which can be so seriously misinterpreted. This is especially true since insurance companies are unlikely to offer the professional counselling available at federally-funded alternate test sites.
FDA Labelling Violations

Not only must insurers be denied the "right" to independently test their applicants, but they must also be denied the "right" to ask whether their applicants have been tested somewhere else. The problems of F.D.A. labelling violations and scientific uncertainty continue, regardless of who administers the test.

Furthermore, the public health is likely to be directly harmed if insurers are permitted to ask their applicants if they have tested HTLV-III positive. Allowing insurers access to heretofore confidential HTLV-III testing information is certain to discourage the voluntary testing which many public health officials believe is crucial to slowing down the spread of AIDS. Insurer access is also likely to result in decreased donations of blood, as potential donors refuse to take the chances that, by donating blood, they may become uninsurable. (At present all donors testing HTLV-III positive are notified of their results.)

Finally, as the New York Times warned in an editorial opposing use of HTLV-III antibody test by insurers, "When an individual's insurer is also his employer, there's no way to hide his medical records.... It's easy to envisage employers wanting to hold down costs by not hiring, or even firing, people who tested positive."

"ALLOWING INSURERS ACCESS TO HTLV-III TESTING INFORMATION IS CERTAIN TO DISCOURAGE VOLUNTARY TESTING... CRUCIAL TO SLOWING DOWN THE SPREAD OF AIDS."

Insurance Commissioners should use their authority to require all insurers to follow the lead of the vast majority of insurance companies which have not sought to use the HTLV-III test and which have rejected "lifestyle screening" as impractical and unjustly discriminatory. Most companies have realized that they can still maintain highly profitable operations by spreading the costs associated with AIDS.

Moreover, even if insurers could successfully weed out all of their applicants who will later develop AIDS, the high price society is paying as a result of AIDS would hardly disappear. Already, 60% of AIDS victims depend upon medicaid to pay their medical bills. To allow insurers to avoid the cost of AIDS is simply to thrust the burden of payment onto the shoulders of America's already overburdened taxpayers. The insurance industry will benefit far more in the long run if it devotes its resources to supporting the struggle against AIDS through education and medical research, instead of struggling to avoid the unavoidable.

The following is a list of considerations insurance commissioners should be aware that gays consider important during these stressful times:

1. No lifestyle underwriting. Single males in urban areas are under close scrutiny by insurers. But it is not who or where or how many people with whom the applicant has had sex. AIDS is transmitted because of what the applicant does during sex.

2. Guard the confidentiality of all medical information. Sensitive information has been and will be gathered during the underwriting process. Information of this nature -- in insurer files and in the files of the Medical Information Bureau -- concerning sexual preference can be used against people.

3. Recognize that the HTLV-III test is not diagnostic. Insurers should not be allowed to use results of this test to deny coverage.
4. Recognize that AIDS is not a gay disease.

5. Do not allow any insurer to exclude coverage for AIDS as a disease in major medical policies.

6. Update and extend conversion privileges in group contracts to all states. Only eight states now have conversion laws. Coverage is absolutely vital to the public welfare.

7. Monitor claims and policy cancellation procedures more closely. Some of the symptoms of AIDS — such as swollen glands — do not necessarily indicate the first stages of AIDS. Insurers should not be allowed to panic and cancel policies at the first signs of immune responses.

8. Let's face facts. In order to properly underwrite any health or life insurance risk, an insurer would need to know with whom the applicant has had sex; whether there was an exchange of bodily fluids with the applicant's sexual partners; each partner's sexual history over the previous five year period and, whether there had been an exchange of bodily fluids with any other partner within the past five years.

9. We demand our right to stay in the insurance pool. Our society has already determined that health insurance and life insurance will protect people with sickle cell anemia, blindness, hemophilia and certain kidney disorders. AIDS has hit one group first. Homosexuals are part and parcel of the American profile. We have been part of the risk pooled through polio, swine flu and a host of fertility malaises. We demand our right to stay in that pool.

NGRA, Schmidt and Schmidt, and Consultants for Health Care appreciate being given the opportunity to present our views on this matter. We strongly encourage the National Association of Insurance Commissioners to adopt a resolution and take other action opposing AIDS-related insurance discrimination. We would be more than happy to discuss the matter further with individual Commissioners or with the National Association. For more information, please contact:

Carl Heimann, graduated from the University of Illinois, in 1969 and is currently an Account Executive at Schmidt & Schmidt Insurance Associates, Inc. Heimann has been in the insurance industry for over 10 years and is a past-president of the Surety Forum, San Francisco. Mr. Heimann can be reached at 1-800-292-9992 (in California, (415) 981-3915.)

Benjamin Schatz J.D. is Director of the AIDS Civil Rights Project of the National Gay Rights Advocates. Schatz took his undergraduate degree at Harvard and received his J.D. there in 1981. He is a member of the California Bar and is based in San Francisco. Mr. Schatz can be reached at (415) 863-3624.

W.L. Warner M.D. is president-elect of Bay Area Physicians for Human Rights. A graduate of SUNY, Syracuse, 1960, Warner has more than 20 years experience with pharmaceutical company research in drugs, devices and diagnostics. He currently operates his own consulting firm, Consultants for Health Care. Dr. Warner can be reached at (415) 453-5281.

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David S. Hubbard, M.D.
Senior Vice President
Medical Director

September 23, 1985

Clients of MARC-Life and Other Life
Insurance Companies Using MARC-Life
Underwriting Guidelines

Re: Acquired Immunodeficiency Syndrome (AIDS)

Gentlemen:

The weekly increasing accumulation of written material on the subject of AIDS is becoming somewhat confusing to evaluate. While medical and lay published articles sometimes prove to be at odds with actual observation, both express serious and justified concern, which we all share, about the deadly nature of this disease.

Our Executive Vice President and Chief Actuary, Mr. D. M. Holland, has summarized the AIDS threat in an article ("The AIDS Peril") written for The Actuarial Digest, and we are happy to enclose a reprint, for your information.

MARC-Life has incorporated much of its AIDS information into guidelines for our underwriters. In the hope that it will be helpful to you, we are enclosing a copy of these guidelines.

As new data becomes known about AIDS and ARC (AIDS Related Complex) our guidelines will be expected to change also.

Any exchanges of ideas concerning the underwriting of this disease are welcome, and we will be happy to hear from you.

Sincerely,

[Signature]

David S. Hubbard, M.D.
Senior Vice President
and Medical Director

DSH/srb
Enclosure
Interoffice Memorandum

To: MARC-Life Underwriters
From: C. R. Edmiston, J. C. Broshar, D. S. Hubbard, M.D.
Subject: Underwriting Guidelines for AIDS - Acquired Immunodeficiency Syndrome

Date 09/23/85

There is, and should be, great concern in the insurance industry about possible increases in mortality and morbidity resulting from the spread of AIDS. Since current knowledge with respect to AIDS is rapidly changing, almost on a daily basis, these underwriting guidelines should be used very carefully and conservatively until different handling is justified by new information.

It is unlikely that you will see cases where there is an admission of having AIDS, ARC (AIDS Related Complex), Lymphadenopathy Syndrome, or abnormal blood tests that indicate an exposure to HTLV-III (Human T-Cell Lymphotrophic Virus-III) or exposure to a person capable of transmitting the HTLV-III virus. However, if you do get this type of admission, the case should be declined. Without a full explanation you should generally decline risks who admit to having had their blood tested with ELISA (Enzyme Linked Immunosorbent Assay) or a Western Blot test or for T-Helper and T-Suppressor lymphocyte ratio.

Underwriting Factors

Listed below are several non-medical factors and several medical factors that are potentially indicative, but not diagnostic, of an AIDS risk. It will be important to look for these factors, and where a number of them are present, investigate thoroughly. If there is a strong suspicion that AIDS might be present or that there is a high probability of exposure to AIDS by the proposed insured, the risk should be declined.

I. Non-Medical Factors


2. No demonstrated insurable interest. Beneficiaries such as friend, roommate, siblings, parents (where large amounts are applied for), estate, employer, charitable organization should be questioned. (Note: While "parents" is a fairly common beneficiary designation, particularly among young unmarried adults making
their first insurance purchases, you should not automatically accept such a designation without question. The naming of a non-dependent parent of the insured/applicant as beneficiary requires a satisfactory explanation.)

3. Amount of insurance appearing to be in excess of needs or expected losses.

4. Sexually promiscuous or illicit lifestyle.

5. Residence. Note that metropolitan areas of New York City, San Francisco, Los Angeles, Houston, Miami, Newark, and Atlanta currently have the highest incidence of AIDS in the country.

6. Present or past use of drugs intravenously that have not been prescribed by a physician (17% of AIDS cases are from intravenous drug users).

II. Medical Factors

The following medical factors, while not in and of themselves diagnostic of AIDS, should be considered as symptoms of some unknown disorder that it is not possible to rate without further explanation or diagnosis.

Non-Specific Medical Factors

1. Unexplained fatigue, malaise, loss of appetite, weight loss.

2. Unexplained lymphadenopathy.

3. Chronic Diarrhea or recent onset of diarrhea.

4. Unexplained infections.

5. Unusual skin lesions.

6. Depression or other psychoneurotic disorders with no known cause.
III. Specific Medical Factors

Following is a list of diseases or disorders that are unusually common in persons who have been diagnosed with AIDS. Any mention of these or suspicion of these would require you to refer to the Medical Director. These will generally result in declination unless adequate medical information indicates the individual is not an AIDS risk.

1. Hemophilia (with frequent infusion of blood products).
2. Kaposi's Sarcoma.
3. Pneumocystitis Carinii Pneumonia (PCP).
4. Cytomegalovirus.
5. Candida.
6. Coccidiomycosis, Toxoplasmosis
7. Isospora Belli.
8. Legionella.
9. Epstein-Barr Virus (EB).
10. Cryptococcus.
11. Papovavirus.
15. Hepatitis B
Note that until June 1985 donated blood was not tested for the HTLV-III virus. Therefore, when a medical history indicates the proposed may have received blood during surgery or for other loss of blood after about January 1, 1980 and before June 1985, exercise caution and refer freely before accepting.

Again, you should be very cautious and consider declining any risk that indicates promiscuous or illicit sexual behavior. Evaluate very carefully where there is any indication of venereal disease such as gonorrhea, syphilis, venereal warts (condylomata acuminata), scabies, lymphogranuloma, nonspecific urethritis, herpes genitalis, crabs (pediculosis pubis), molluscum contagiosum, chancroid, granuloma inguinale. If the condition is present or less than five years in history, consider declining.

Perhaps our most effective selection method is still a traditional one: decline those applications that seem to be speculative and therefore selecting against the insurer. You should require an explanation of the monetary loss to be suffered by the beneficiary at the death of the proposed insured. Similarly, whenever an application specifies "estate" as beneficiary, you should identify the ultimate beneficiary of the estate and apply the same principle of loss and needs to that ultimate beneficiary. If the loss expected does not seem to justify the amount of insurance applied for, particularly where a number of the factors listed above are present, then you should probably decline the case.

Please bear in mind that the foregoing are guidelines to assist you in identifying potential AIDS risks. The various medical and nonmedical factors enumerated, while generally not indicative if found alone, point to a high probability of AIDS exposure when several are found together. Acquired Immuno-Deficiency Syndrome is spreading rapidly and will have a severe effect on general mortality, and as underwriters we must do our best to avoid accepting such risks.
AIDS, the Worst Case Scenario

In a feature article on AIDS, Newsweek, quoting Dr. Ward Cates of the U.S. Centers for Disease Control (CDC), said "Anyone who has the least ability to look into the future can already see the potential for this disease being much worse than anything mankind has seen before." Harvard biochemist, Dr. William Haseltine has said AIDS could become the worst worldwide epidemic since "Black Death" swept Europe. Considering approximately one-third of the population between India and Iceland perished in the fourteenth century as a result of Black Plague, such potential devastation from AIDS is virtually incomprehensible.

The AIDS virus is generally thought to be transmitted by direct contact with blood and other body fluids. In A Distant Mirror, Barbara Tuchman indicates the bubonic plague of the 14th century was present in two forms: "one that infected the bloodstream, causing buboes and internal bleeding, and was spread by contact; and a second, more virulent pneumonia type that infected the lungs and was spread by respiratory infections". Because of presumed transmission only by direct contact, AIDS has not been as contagious as it would have been in a respiratory form.

Tremendous progress has been made in AIDS research, and more is being learned every day. The Wall Street Journal (August 5, 1985) reported "Gains Against AIDS Have Come Rapidly, But a Cure Is Distant". From the point of view of humankind, it is hoped that speculations relating AIDS to the plague are a worst case scenario which never comes about.

AIDS and the Insurance Industry

AIDS, even at its current level, has serious implications for the insurance industry. One reinsurer reported approximately 5% of its 1984 claims by amount were AIDS related. Other companies are reporting AIDS related claims, and widespread industry concern is developing.

Prepared by:

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In addition to the effects on life insurance, the health insurance potential is astounding. The first 9,000 AIDS victims were hospitalized for 1.5 million days at an estimated cost of $1.25 billion.

It has been estimated that a million people have already been infected with the AIDS virus and the number of new cases of full-blown AIDS over the next five years may be 100,000 or more. Actuaries and other insurance executives need to take a proactive position with respect to the population in general.

AIDS, the Disease

AIDS stands for Acquired Immune Deficiency Syndrome. Through mid-1985, approximately 12,000 cases of full-blown AIDS had been reported in the U.S. alone. From these 12,000 cases, there have already been 6,000 deaths. Once AIDS has fully developed, death from AIDS is virtually certain within two or three years. No one has been known to recover from AIDS, and once infected a person must be considered infectious.

AIDS may have a long incubation period; the period from infection to initial manifestation of the disease may be as long as five years. Most infected people are not yet aware they have the disease and may be actively spreading it. Because AIDS virus is prone to mutation, development of an effective vaccine may be extremely difficult.

AIDS has usually been associated with certain high risk groups. In the U.S., homosexual or bisexual men represent approximately 73% of the adult cases diagnosed, and intravenous drug users account for another 17%. Other cases include hemophiliacs and other individuals who required blood transfusions or blood products in the past five years (before screening for AIDS virus began). Although the disease has often been associated with homosexuals, it can also be transmitted heterosexually, although this has not been prevalent in the U.S.

A virus has been isolated as the probable cause of AIDS. In the U.S., this virus is usually referred to as Human T-cell Lymphotrophic Virus-III (HTLV-III). When HTLV-III infection is linked with a reliably diagnosed disease of underlying cellular immunodeficiency (such as Kaposi's sarcoma prior to age 60 or Pneumocystitis Carinii Pneumonia), the disease is considered full-blown AIDS.
Some infected with HTLV-III will develop an unexplained lymphadenopathy along with a minor illness and certain systemic symptoms; these cases are referred to as "AIDS Related Complex" or ARC. Although long term implications are not known, in one study over about five years, ARC cases developed into full-blown AIDS at a rate of 13% per annum. A recent study in the Journal of the American Medical Association followed 76 ARC cases for a median of 29 months; five (6%) developed AIDS, but none of the remainder returned to normal (clinically or serologically) during the period of observation.

Tests have been developed to detect antibodies to HTLV-III. In the first three months of testing these tests proved to be 99.8% accurate, and it is felt the problems of transfusion related to AIDS have pretty well been solved.

When a test such as the enzyme-linked immunosorbent assay (ELISA) indicates presence of HTLV-III antibodies, subsequent testing is required to insure that results are not a false positive. The ELISA test may be repeated along with the more labor intensive Western Blot test. Possible false positive results, along with lack of information regarding infectivity are reasons legislators are concerned about use of such tests other than for blood bank screening.

California and Wisconsin have already enacted legislation prohibiting use of such test result information for certain purposes including insurance underwriting.

What Can Be Done?

It is in the interest of the insurance industry, as well as society in general, to help prevent AIDS from becoming a widespread epidemic. With respect to AIDS at its current level of development, there are a number of actions which should be considered by insurance company management.

Encouraging and funding AIDS research should be a priority. AIDS is a disease which will affect the industry's existing portfolio of risks as well as future insureds. With the tools of modern medical research and genetic engineering, tremendous advances have been made in AIDS research in diagnosis and in developing tests to prevent spread of AIDS through the nation's blood supply. However, there is yet no vaccine to reduce the potential for developing AIDS, and there is no known cure once contracted. The most direct ways of helping medical research would be to help
with funding of medical research and influencing government to
increase support of medical research. Collection and analysis of
insurance industry data on AIDS could possibly be of assistance
in epidemiological research; this could be either an industry or
Society of Actuaries project.

Until a breakthrough in medical research, containment should be a
prime concern. Currently, AIDS appears to be spread by contact
and is somewhat limited to certain high risk groups. The
industry should take a leading role in educating the public about
how this disease is spread, and actively supporting measures to
limit the spread of AIDS both within high risk groups and the
spread to other groups.

AIDS related issues will no doubt have a high degree of political
visibility, as evidenced by recent legislation in California and
Wisconsin. There is concern over rights of individuals with
respect to health conditions versus rights of insurance companies
to obtain information necessary to underwrite the risk. Possi-
bility of antiselection in AIDS cases is severe, and accordingly
companies must strongly oppose any limitation of medical
information necessary to underwrite a risk. Such actions have to
be viewed in the interest of the current policyholders as well as
the company.

From an internal company management viewpoint, it is of utmost
priority that underwriters and medical directors are aware of the
implications of AIDS for insurance company risk selection.
Underwriters may see new or unusual terms such as references to
Kaposi's sarcoma, PCP or other opportunistic infections or
certain types of cancers rather than AIDS. Underwriters need to
be especially aware of certain infections and other signals that
an immune system deficiency exists.

Where possible, companies should consider redesign of the stand-
ard application to elicit information related to AIDS. Questions
should be included along the lines of "Have you had or been told
that you have any of the following:" and include a list of items
relating to AIDS, ARC, or other immune system deficiencies. This
is an area for policy form development and compliance.

Claims Department must carefully track cause of death to monitor
AIDS claims. Often cause of death will not be stated as AIDS,
but may be given as some other proximate cause of death such as
pneumonia. With respect to health insurance claims, some
companies have set up special AIDS case management programs.
Obviously, the field force must be involved in the company's overall strategy regarding AIDS management. Agents are on the front-line with policyholders and applicants. Field underwriting will be crucial in risk selection and avoiding antiselection by individuals who know or suspect they have AIDS related diseases.

Finally, the actuary must recognize the possibility of such exceptional mortality in pricing. For some time now, there have been significant improvements in general mortality. Based on developments reflected by term insurance wars, one would think the human species is rapidly approaching immortality (or at least a squaring off of the mortality curve). Actuaries have reflected past improvements in mortality, adopted significant reductions due to nonsmoker and preferred risk classifications, and projected further improvements in mortality in the future. The possibility of formidable extra mortality from AIDS, even without an epidemic of plague proportions, is strong evidence of the need for significant mortality margins in pricing and valuation.
Do not disclose the results of the HTLV-III/LAV test to anybody. Even your doctor. He or she must have your permission to do so.

A positive test result is not authorized for this kind of medical test. But, many doctors and patients are not informed about the results. This is called missed diagnosis.

The test result may be positive. This means you have the disease. But, you may not know it. You will not feel any symptoms.

If you have been told you have the disease, you may be able to get insurance. Contact your health insurance provider for details. They will tell you what they will cover.

Disability insurance is important. It helps you to live independently. It covers the cost of medical care and other expenses. It also covers the cost of lost income.

Disability insurance is expensive. It costs more than $1,000 a month. It is not available to everyone. It is not provided by employers. It is not provided by the government.

Disability insurance is not covered by Medicare or Medicaid. It is not covered by most private health insurance plans.

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Rejection

Stop looking for discrimination. Your health might actually be unacceptable. If you have a case, read the notice about your rights and exercise them vigorously.

However, realize that nothing happens in this industry in less than 30 days. You are going to be in for a protracted dialog with a huge, uncaring bureaucracy. Don’t wait for them to capitulate to your logic. Seek alternatives! Review options and keep shopping!

For Heaven’s Sake...

Don’t

... hide a diagnosis from your employer. Your disability income may be grim but things will be far worse if you get laid off. Sick gay men get fired quickly nowadays—even with years of service.

Don’t

... fight with your salespeople. If you aren’t comfortable, take your business elsewhere.

Don’t

... lie to the salespeople. They can’t do their job with partial information.

Don’t

... send lots of applications through many companies at the same time. It doesn’t work. The computer knows.

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Distribution facilitated by BAPHR.
Inspiration: SF AIDS Foundation
Date: January 6, 1986

From: Tom Smith, M.D.

To: Wayne Clark, Ph.D.

Subject: Residential Admission Policies for Substance Abusers with AIDS/ARC/HTLV III Statuses

Enclosed are policies developed by a subcommittee of the AIDS and Substance Abuse Task Force. We recommend:

1) That these policies be adopted by CSAS.

2) That a meeting be convened of representatives of a) all substance abuse residential and detox programs and b) all AIDS housing and residential programs. The enclosed policies would be discussed at that meetings.

TS/llp
RESIDENTIAL/HOUSING POLICIES FOR
S.F. SUBSTANCE ABUSERS AT RISK FOR
AND INFECTED WITH HTLV III

Tom M. Smith, M.D.
AETC, December, 1985

In planning for San Francisco At Risk and HTLV III infected populations among substance abusers, several basic principles should be followed when implementing residential/housing efforts:

- Provide residential services that are non discriminatory for substance abusers At Risk for and infected with HTLV III.
- HTLV III antibody testing not to be utilized as a screening criteria for admission.
- Develop a full spectrum of services for these individuals, working in conjunction with AIDS/ARC services.
- Reaffirm or implement infection control precautions (same as Hepatitis B precautions).
- Develop systems for appropriate screening and triage of these individuals.
- Educate and train staff in assessment, counseling, referral and prevention efforts of these individuals.
- Provide ongoing emotional and intellectual support to staff and clients of residential programs. Prepare staff and clients of these programs prior to the admission of these individuals. Provide on-site pamphlet and poster information about AIDS/ARC/HTLV III testing, especially in relationship to substance abuse.
- Provide substance abuse and AIDS related counseling to these individuals.
- Provide emotional support and education to the significant others.
- Prepare for residential services for a variety of substance abusers with AIDS/ARC/Seropositive or At Risk statuses, realizing that AIDS is a progressive disease with remissions and exacerbations.
- Facilitate the ease of admissions of these clients into residential programs, prioritizing these individuals into primary positions for admission due to their health and longevity statuses.

SPECIFICS:

A. Infection Control precautions - (attached).

B. HTLV III Antibody Status - Eventhough HTLV III antibody testing is primarily used to safeguard the blood supply, increasingly, test results are being utilized for other purposes that impact upon substance abuse services. The ELISSA test is known to give false positive and false negative results. Additionally, seropositive results would imply that the individual is infected with the virus but does not mean that the individual has or will develop AIDS or ARC. Currently the CDC suggest that "5% to 20% of those exposed will develop AIDS symptoms". Studies suggest that: 1) approximately 10% of S.F. heterosexual IV drug abusers are antibody positive, 2) 10% of S.F. AIDS cases have a history of I.V. substance use and 3) 40-60% of S.F. gay men are HTLV III
antibody positive. Since the incubation phase of AIDS is very long (1–8 years) and since substance abusers are at higher risk for AIDS, substance abuse residential agencies have been treating undiagnosed HTLV III seropositive, AIDS and ARC affected substances for the past several years.

In a brief review of admission criteria of agencies that have ruled on the HTLV III issue, their policies state that HTLV III antibody status not be included in screening procedures (policy of AMSADDD and CA State DAPP attached).

California State law defines HTLV III test results as confidential. Pressure (overt or covert) should not be presented to program applicants or clients about HTLV III antibody test results.

If a client reveals test results to agency staff then 1) the information must be handled confidentially, 2) this information must not be entered into the client’s records and 3) the client must receive ongoing, appropriate counseling about the meaning of the results (either positive or negative).

C. Spectrum of Services — Logically the progression of AIDS infections would evolve from individuals at risk to individuals with HTLV III seropositive statuses (asymptomatic or mild symptoms) to individuals with ARC to individuals with AIDS (CDC category I). These categories are helpful in planning the residential needs of substance abusers, however, other factors must be taken into account (e.g., motivation, decrease of physical incapacitation, current drinking/using status, motivation for substance abuse treatment).

The accompanying chart categories these individuals according to varying needs: the dying, the bed ridden, infirm, weak but not sick, able bodied, actively drinking/using, the motivated, the non motivated and detoxing client (ill from AIDS/ARC, or not ill from AIDS/ARC).

The more physically infirm AIDS/ARC substance abusers need a residential setting that has medical services and bedside substance abuse counseling. The weak and able bodied AIDS/ARC substance abusers can be treated in substance abuse residential programs. The physically ill person with AIDS/ARC that is detoxing needs a hospital or modified medical setting. The able bodied person with AIDS/ARC that is detoxing can receive services at alcohol or drug detox programs. The actively drinking or using individual with AIDS or ARC can reside in private residences or AIDS shelters. Violent, acting out substance abusers with AIDS/ARC can receive individual counseling or jail services (if behavior is not controlled).

Many substance abusers with diagnosis of AIDS/ARC or HTLV III seropositivity need services from both AIDS/ARC service agencies and from substance abuse service agencies, either simultaneously or in tandem (e.g., Shanti Housing with alcoholism outpatient treatment, Alcoholism Recovery Home with Shanti counseling and Ward 85 AIDS monitoring). This implies a cooperative and coordinated effort between AIDS and substance abuse providers.
D. Significant Others - Both substance abuse and AIDS/ARC are biopsychosocial/existential conditions. Support and education should be provided to significant others, fellow program participants and health provider staff utilizing a family systems approach. Particular importance must paid to social needs (both of the client and of others) in residential programs. Specific areas to address are AIDS phobia, AIDS hysteria, homophobia, scapegoating the identified patient, erotophobia, grieving, substance abuse "enabling", understanding physical illness (especially rapid changes of physical and social functioning) and appropriate social and emotional responses to individuals with life threatening illness (both in exacerbations and in remissions).

E. Gaps in Service - Existing programs in both the substance abuse services and in the AIDS service fields are adequately and appropriately treating many of the substance abusers in "Residential/Housing Needs" table. However, there are gaps (or weak links) in the chain of services:

- Traditionally, residential programs in both AIDS services and substance abuse services have waiting lists. Bed capacity in AIDS residential services is still expanding, however bed capacity in substance abuse services is at a steady state.
- Residential detox services for individuals with AIDS/ARC are non existent except for hospital settings (reserved for markedly ill individuals).
- Residential services for substance abusers with AIDS/ARC who are still drinking/using and who are poorly motivated for recovery efforts are difficult to find, especially if the individual exhibits antisocial behavior. Traditionally, the substance abuse treatment field utilizes a "currently drinking/using" status as a criteria to "not admit" or to "terminate treatment". Those individuals are referred to detoxification programs. "Currently drinking/using" clients who are violent are referred to the criminal justice system.
- Bedside counseling for substance abusers with AIDS/ARC is expensive and limited, eventhough a large number of clients need these services (and cannot or will not receive these services in more standard programs).

Substance abuse residential programs are mixed in their response to modify their services for substance abusers with AIDS/ARC, however substance abuser residential programs will have to adapt their programs to serve these clients, especially the "able bodied" and "weak but not sick" individuals. Substance abuse residential programs designated only for individuals with AIDS/ARC/aeropositivity would be prohibitive with current funding levels and, if funds were made available, would take approximately one year to implement. Program revenues and "fee for service" policies also need revision in regards to these clients because of deteriorating financial status due to illness and medical costs.

F. Residential Treatment Philosophy - The usual philosophy of substance abuse residential treatment (provide sober/supportive/educational environment for substance abusers who need more than outpatient services with goals of continued abstinence and integration into general society) must be expanded for these individuals. Since a high percentage of AIDS diagnosed individuals face a short life expectancy and are weak or sick, post treatment and activity goals are modified to "quality of life, socialization and appropriate time utilization" goals.
G. Admission Procedures – The following admission procedure for substance abuse residential treatment programs was developed in 1984 by a committee composed of staff from both AIDS and substance abuse agencies:

- If the substance abuser applicant with a diagnosis of AIDS or ARC is physically and financially able to participate fully in the program, then the admission procedure and treatment plan is the same as for other applicants.

- If the substance abuser applicant with a diagnosis of AIDS or ARC is unable to participate fully in the program, then the applicant would be screened by both the residential program staff and a staff from ASAP or Shanti. After the screening interviews, a treatment plan, appropriate to that particular applicant's needs, would be created. Judgements would be made about modifying the program or procedures for that particular client. Issues to be considered are diminished energy, inability to enter the work force, limited personal finances, ongoing medical treatments (both in terms of 1) time required by those treatments and 2) medications), transportation, diet and involvement with AIDS/ARC psychosocial programs. Each applicant's case would be considered on an individual basis.
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**RESIDENTIAL HOUSING NEEDS OF SUBSTANCE ABUSERS WITH HIV/III INFECTED STATUS**

- **Confidential But Not Bedridden**
  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)
  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)
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- **Confirmed But Not Sick**
  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)
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  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)

- **Phased But Not Sick**
  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)
  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)
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- **Client Bounded**
  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)
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  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)

- **Motivated To Change**
  - AETC, PRIV. RESID., SHANTI RESID., HOME (ALC./DRUG)
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- **Residency Education**
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION

- **Referral to I & E groups, AA, NA, Detox, Antabuse**
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
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  - S.A./AIDS EDUCATION

- **Bedside Counseling, Mental Health Services, "Intervention"**
  - S.A./AIDS EDUCATION
  - S.A./AIDS EDUCATION
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  - S.A./AIDS EDUCATION
The American Medical Society of Alcoholism and Other Drug Dependencies (AMSAODD) recognizes that some patients in need of treatment for alcoholism and/or other drug dependencies may have (AIDS), AIDS Related Complex (ARC), or may have a positive test for HTLV III antibodies. Intravenous drug users are a high-risk group for AIDS. The use of mood altering drugs (i.e., alcohol, marijuana and perhaps others) may depress the immune system and effect prevention and treatment of AIDS.

• (1) AMSAODD strongly recommends that physicians, other health professionals, and programs for the treatment of alcoholism and other drug dependencies provide treatment for these patients.

• (2) Case by case assessment of the medical status of each patient should be made to determine physical capacity to undergo treatment for alcoholism and other drug dependencies. Continuing medical followup by a physician familiar with AIDS is recommended.

• (3) Currently there is anxiety amongst staffs and other patients about associating with AIDS patients. All personnel, including clinical, dietary, maintenance and housekeeping, should be educated with the latest medical data.

• (4) Patients with AIDS do not require isolation techniques any different from patients with active Hepatitis B. Guidelines for the protection of staff and other patients from Hepatitis B should be followed. Caps, masks, gloves and other kinds of protective wear are not necessary in routine contact, e.g., blood pressure checks and group therapy.

• (5) Continued medical monitoring after detoxification period is recommended for these patients.

• (6) The principle of confidentiality, critical to all aspects of alcoholism and other drug dependencies treatment is particularly important with these patients.
The AIDS Health Project has identified three major target groups for service provision: Persons with AIDS (PWAs); Men with AIDS-Related Conditions (ARCS); and the Worried Well. The diagram at right may be helpful in understanding these groups.

1. AIDS: Those individuals who meet the Center for Disease Control's case definition are considered Persons with AIDS. This case definition is utilized primarily for epidemiologic and legal purposes.

2. ARCS: Those individuals with persistent and recurrent infections, indicative of a suppressed immune system, and perhaps unresponsive to treatment, are considered ARCS. Presently, there is no uniform definition for ARCS; therefore, it is important to understand that these conditions may present in a full range of viral, fungal, bacterial, and protozoal infections, as well as a range from mild to very severe.

   At this time, it appears that AIDS-Related Conditions are not prodromal; that is, they will not necessarily go on to develop AIDS. It is important to remember that the term "pre-AIDS" is a misnomer, as it implies an irreversible prognosis. However, secondary health prevention is crucial for an individual at risk and exhibiting symptoms.

3. Worried Well: This last category is comprised of those men who are at risk (gay, bisexual, and IV drug users), but who are not currently expressing overt physical symptoms. The outstanding features of this group include anxiety, stress, compulsive behaviours, social withdrawal, and depression.

The purpose of the following check list is to better identify those individuals with AIDS-Related Conditions.
October 22, 1985

AIDS POLICY
for Programs funded by the Drug Services Bureau

This policy becomes effective on November 1, 1985, and will be implemented by all treatment programs funded by the Drug Services Bureau on or before that date. Compliance will be monitored as part of the Annual Performance Review.

It is the policy of the Drug Services Bureau that no client will be refused treatment, or suffer discrimination in any way, as a result of contracting, or being suspected of having contracted, Acquired Immune Deficiency Syndrome or AIDS Related Complex (ARC).

It is expected that AIDS education will be given to all clients, particularly IV drug users and other high risk clients, (i.e., individuals with multiple sex partners, especially homosexual and bisexual men; hemophiliacs; sexual partners of such individuals; or other groups that may be identified by health authorities).

Program directors are responsible for the psychological readiness of their program staff to counsel and educate clients with AIDS or clients who are identified as at risk to contract AIDS.

Programs are to include AIDS inservice update training semi-annually.

Each program is to determine that its medical director is knowledgeable as to the symptoms of AIDS, and is able to provide guidance on measures needed to protect both AIDS clients and the clients and staff of the program from medical hazards resulting from the presence of an AIDS patient in the program.

Programs are to develop screening questions to be included in the admission process, especially in residential programs, designed to determine whether an individual has AIDS or ARC or is considered high risk for AIDS or ARC. It should be made clear that information gained is to support the treatment process, and will not result in any form of discrimination. Questions should elicit the following information:

Has the client been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

Does the client ever share needles?

Does the client have hemophilia or any other condition which requires the regular use of blood or blood products?

Does the client engage in sex with multiple partners?

Programs are to develop linkage agreements with the San Diego AIDS Project. When clients are referred there for services, an agreement should be developed defining specific services to be provided by the AIDS Project and the referring drug program. Even when the AIDS Project serves as primary service provider, the
referring drug program, or a substitute provider more able to deliver specific services needed, will continue to meet the drug abuse-related needs of the client. It is the responsibility of the referring agency to arrange for a substitute provider and to follow through on the availability of services in any case.

Program staff working with AIDS or ARC clients or with high risk clients are expected to obtain regular physicals to minimize their own chances of contracting AIDS or ARC as well as minimizing the likelihood they will pass on other diseases to these clients. It should be emphasized that good nutrition, exercise and rest are key to improving the resistance to AIDS.

If laboratory procedures become available which improve the ability of a program to learn of the presence of the AIDS virus or increase the capacity for preventing or combating the virus, the costs of such procedures may be included in the contract negotiation process.

Programs are encouraged to keep a good supply of liquid bleach on hand for use in sterilizing areas where diseases are most likely to be transmitted (bathrooms and kitchen facilities, for example).
Wayne Clark
Community Substance Abuse Services
170 Fell Street
San Francisco, Calif. 94102

Dear Wayne,

The Residence Program has evaluated over 200 people with AIDS over the past 2½ years, and has had to refuse to accept a significant proportion because of serious substance abuse problems which made them ineligible for a group living situation. In attempting to refer those individuals for appropriate services (so that we could then provide them with housing), we have found most substance abuse agencies or the staff of those agencies unwilling to accept people with AIDS into their programs.

The inpatient programs in the city have been willing to accept people with AIDS who could afford to pay into their programs, but to my knowledge the Alcohol Evaluation and Treatment Center is the only inpatient program which has accepted people with polydrug problems. This poorly funded program has consistently opened its doors to people with AIDS with amphetamine and alcohol abuse.

It is critical that people with AIDS have access to substance abuse services. This can be assured through two recommendations, both of which are necessary: The first recommendation is that it be written into the contract of each agency receiving AIDS funds that its staff be AIDS sensitive and that the agencies be willing to accept people with AIDS into any of its programs, using the same criteria it would with any other client. The second recommendation is that the staff of the AIDS Substance Abuse Program be increased ad-
equately to assure that direct substance abuse services are available to people with AIDS who, because of their physical deterioration, are unable to participate in existing substance abuse programs. Home and hospital visits by ASAP staff are a vital component of services to people with AIDS.

In summary, I urge that the addition of $400,000 into the substance abuse service system in San Francisco assure that people with AIDS have access to services they need.

Sincerely,

Helen Schietinger, MA, RN
Residence Program Director

cc: Mark Young
AIDS Activity Office
Barbara Faltz
CITY AND COUNTY OF SAN FRANCISCO  
DEPARTMENT OF PUBLIC HEALTH  
INTER-OFFICE MEMORANDUM  

Date: April 25, 1985  
From: Nancy Presson  
Director, Division of Drug Programs  

To: Wayne Clark  
Chief, CSAS  

Subject: Need for Residential Services for People with AIDS and ARCS  

On April 23rd, I held a meeting with Peter Goldblum and Barbara Faltz of the AIDS Health Project, Alfonso Acampora of Walden House, and Mark Young of CSAS to discuss the needs of substance abusers with AIDS for residential services.  

Out of this meeting these areas of need were identified:  

- For extremely ill clients living in Shanti hospice residences, there is a need for a counselor to visit the residences and carry a caseload on an on-going basis. Originally this task was incorporated into the objectives for the AIDS Substance Abuse Project. When the staffing was reduced from the original request of four clinical staff to one and a half, this objective was reduced to assessment and technical assistance to the residences. The need for a counselor remains.  

OPTIONS  

- Add a one-half time clinical staff person to the AIDS Substance Abuse Project  

- Review the current network of drug and alcohol providers and identify one provider to add this objective to their current scope of work  

- Add a one-half time clinical staff person to a gay substance abuse program.  

- For clients identified with AIDS, there needs to be a short term program with adequate medical back-up for clients who have drug problems where alcohol is not the primary problem. Currently AETC will accept AIDS substance abusers only if alcohol is the primary problem. There is no similar facility for drug abusers even though the incidence of intravenous drug users is growing, particularly heroin and methamphetamine users. The only other facilities are run by the V.A. or private hospitals.  

OPTIONS  

- Enable AETC to admit a limited number of substance abusers who are not alcohol primary problem with AIDS.  

- Negotiate with another facility and add funds for this purpose  

- For clients who are detoxed but need residential treatment there is a need for a six to nine month residential facility with sufficient medical back-up to serve substance abusers with AIDS.
ACTION

Barbara Faltz and Alfonso Acampora will develop an Idea Statement to outline this program and present this statement to this office.

- Substance Abusers who are pre-AIDS, ARCS but without severe disfunction or are high-risk covers just about every intravenous drug user, the majority of the current residential community population. There is a need for on-going staff and client education about AIDS.

ACTION

Barbara Faltz and Alfonso Acampora will develop a plan for on-going training and consultation at Walden House by the AIDS Substance Abuse Project.

cc: Mark Young, CSAS
    Barbara Faltz, AIDS Substance Abuse Project
    Peter Goldblum, AIDS Health Project
    Alfonso Acampora, Walden House
    Tom Smith, AETC
    Mary Helen Dougherty, Division of Alcohol Programs
Date: May 2, 1985

From: Tom Smith, M.D.

To: Wayne Clark, Ph.D.

Subject: Memo: "Need for Residential Services for PWA and ARCS", dated 4-25-85

1. I am puzzled as to why I was not invited to the meeting on April 23, 1985 concerning residential services for AIDS. Reasons: I composed and signed the letter to you concerning this matter, AETC is a major provider of these services and AETC and Shanti have the most expertise with these services. This is not the first time that seemingly political action has superseded clinical experience in the matter of Substance Abuse and AIDS: that decisions were made by a group with abbreviated knowledge of this matter. I do not mean to imply misjudgements on the parts of Dr. Goldblum and Ms. Faltz for both are top notched clinicians and diplomats, but I truly do wonder why consultants with experience were not consulted. I realize that my statements are rash, but the creation of the Substance Abuse/AIDS Project proposal was a farce and we do not need to repeat those errors.

2. Concerning extremely ill clients with limited ability to ambulate, there still exist a high priority to provide bedside counselling services. Several originators of the proposal felt that this should be a top priority and not dependent upon members of staff of ASAP. I recommend the following:

   "Add a one-half time clinical staff person to ASAP. However until this happens (unlikely until January, 1986 at the earliest) then the priorities of ASAP be reviewed to address the bigger picture of unmet needs.

3. Concerning PWA with substance abuse problems, the option of creating a new facility is attractive but unrealistic in this day of limited funds to Substance Abuse and to AIDS. The most practical solution is modification of existing programs to take on this new unmet need until funds are available for additional facilities. I realize that this recommendation for modification is challenging and anxiety provoking, but without modification many special sub population within the substance abuser group would not be receiving appropriate services.

4. Concerning substance abusers diagnosed with ARC, education is truly needed.

5. I believe that CSAS should continue to act as a funding conduit for ASAP.

cc: Mary Helen Doherty, Nancy Presson, CSAS
Barbara Faltz, R.N., ASAP
Helen Schaitengor, R.N., Shanti Residences
Bea Tracy, Shanti Project

2120 hayes, room 86, SFCHMC
Women's AIDS Network

RECOMMENDATIONS

Contact: Andrea Aiello MPH
(916) 445-0553

1. SFDPH create a position to coordinate women's health throughout the City.

2. Establish a residential drug treatment program for PWA's/PWARC's which is women sensitive and has provisions for children.

3. Intensive AIDS education efforts aimed at health and mental health providers - including drug treatment people - be implemented.

4. IV drug user and AIDS prevention programs are funded and implemented.

5. AIDS education has to reach women where they are;
   - in the street- AIDS street workers are needed
   - family planning, prenatal, STD, well women GYN clinics and community mental health clinics all need to integrate AIDS education into their programs.

6. Women sensitive AIDS screening clinic needs to be made available.
   - staffed by women
   - equiped with necessary medical supplies and equipment for women.

7. AIDS service agencies need to not only begin providing services to women and Third worldpeople but these agencies need to be seen as accessible to women and Third world communities.

8. Housing must be made available for women with AIDS which is women sensitive and has provisions for children.
February 4, 1986

Eileen Gillis  
Lesbian/Gay Representative  
Human Rights Commission  
Office of Contract Compliance  
Office of Dispute Resolution  
1095 Market Street, Suite 501  
San Francisco, CA  94103

Dear Ms. Gillis:

Enclosed is a letter I sent to Dr. John Ziegler, Director of AIDS Activities at the University of California San Francisco, regarding certain often repeated issues surrounding AIDS and prostitution, an area in which I am conducting research. These issues should be incorporated into the materials you are assembling.

Sincerely,

Constance B. Wofsy, M.D.  
Co-Director, AIDS Activities  
Assistant Chief, Infectious Diseases  
San Francisco General Hospital

CBW:m

encl
November 25, 1985

Dr. John Ziegler, M.D.
Director, AIDS Activities
University of California
Veterans Administration Medical Center
4150 Clement Street (141)
San Francisco, CA  94121

Dear Dr. Ziegler:

The meeting on Friday, November 22 on IV Drug Use and AIDS was extremely valuable and I commend the organizers, Dr. Andrew Moss, yourself and Dr. Werdeger for quickly getting together a group of experts. You had asked for a short paragraph commenting on the issues described in the afternoon workshop. It is as follows.

Prostitutes have increasingly been named as a means whereby AIDS will enter the heterosexual population, though there is very little data amassed to confirm this point at this time. Small numbers which have been identified in published and unpublished series suggest a strong association between IV drug use and those prostitutes who have been identified as antibody positive. Inferential data suggests exposure to prostitutes as a potential source of AIDS in a group of none-risk men evaluated by the CDC, many of whom had multiple, multiple sexual partners and included exposure to prostitutes in their history. In Africa, prostitution and AIDS are closely connected by epidemiologic evaluation. The issues that are raised with IV drug use and prostitution are by and large identical to those raised for IV drug users at large. That is: how to get information to the population at risk expediently without organized agencies and through a network of trusted individuals via a communications network known primarily to the populations themselves; how to protect the individuals and the persons with whom they have contact given that sexual activity is a consensual act whether it occurs with prostitution or without the exchange of monies. It is projected that many prostitutes engage in prostitution to support drug habits, so that for those who choose to overcome their drug habit, treatment programs should be readily accessible and the information and access to the value of drug treatment should be made available.

Issues touched on is some detail that relate specifically to policies which were the topic of the afternoon consensus group include:

1) Condoms are used as evidence of prostitution by police and district attorneys in certain situations and are confiscated. On release from jail a supply of condoms may not be readily available putting the prostitute and the customer at risk.
2) There is great need for an elimination of the "delicate" avoidance of mentioning condoms in polite company, in the news media, in magazine advertising, and probably in school education. The role of condoms in prevention of infection, not just AIDS, but other venereal diseases, must be stressed separate from the issue of contraception. Safe sex must be advertised as potentially enjoyable sex. The policies involved here presumably involve decisions about advertising and education in schools.

3. The third issue involves the issue of disability and job retraining. Prostitutes who are seropositive will be counseled as all others to avoid sex, to inform sex partners of the potential risk, and at the very minimum to observe scrupulously safe sex guidelines. Since this population gains their means of living from sex, the issue of job retraining for those who will comply and for whom it is appropriate and alternatives to prostitution are very important. Since prostitution is illegal, disability and other means of survival are hard to come by. Individuals with AIDS have ready access to medi-cal and to disability programs but no such policies have been instituted for those who are seropositive.

4. And the last policy is the issue of quarantine. It is a philosophical and ethical issue whether there is anything different about a prostitute who is seropositive (i.e., a condition which is nonreportable, and in fact held in utmost confidentiality) who is sexually active, compared to another individual who is known or not known to be seropositive who continues to engage in sexual activities. Do different rules apply? Some feel that they do. The only cases of quasi-quarantine that have come up in the United States are related to female prostitutes even though prostitutes with AIDS are quantitatively extremely small in number. As policies are developed along the lines of existing policies for provision of safety of the public from infectious diseases, issues of reporting and criteria for limitations of personal freedom if any, should be applicable to the population at large, and considerable thought need be given about policies that are directed at one subsegment of the population without similar direction to other segments that might be at similar risk or putting individuals at similar risk.

I have enclosed resolutions of California N.O.W. concerning AIDS and a copy of 1985 Policies on AIDS Drugs, Pornography and Prostitution Laws put out by COYOTE in May of 1985. COYOTE is the national task force on prostitution, and their policies make the following particular points:
1. All persons are responsible for preventing AIDS.
2. Research on subgroups of the population is appropriate but blame of any one group is inappropriate.
3. Mandatory testing is opposed. Voluntary testing with absolute confidentiality is the right of the individual.
4. Quarantines are opposed because they foster the illusion that those who are not quarantined have not been exposed and cannot convey disease.
5. Forced sterilization and forced abortion is opposed.
6. Risk reduction should include safe sexual activity with a barrier and/or virucidal substances to protect customer and prostitute.
7. Harrassment and confiscation of condoms by police should be discontinued.
8. Funds should be allocated for massive public education campaigns about safe sex and risk issues.
9. Prostitutes would ideally serve as educators for safe sex as enjoyable sex.
10. Latex condoms should be widely available in vending machines and toilets.
11. Disability payments should be available to sex workers who are known to be positive, have ARC, or AIDS.
12. Retraining programs are needed for those who will avail themselves of them.
13. Issues of IV drug use--including evaluation of availability of clean needles, decriminalization of drug abuse, education of drug abuse, and adequate availability to drug treatment programs.
14. Pornography be better controlled to avoid degradation of women and children.
15. Evaluation of laws in a wide variety of issues related to pornography and the sex industry with evaluation for just whom they protect and how.
16. Prostitution laws should be re-evaluated.

Sincerely,

Constance Wofsy, M.D.
Co-Director, AIDS Activities
Assistant Chief, Infectious Diseases
San Francisco General Hospital

cc: Wayne Clark, Ph.D.
Director of Community Substance Abuse Services
San Francisco Department of Public Health

David Werdeger, M.D.
Testimony before the Human Rights Commission  
AIDS/ARC Discrimination  
4 February 1986  

William J. Brandy Moore

In April, 1984 the issue of discrimination by the City and County of San Francisco towards a population group became the concern of doctors, lawyers, community activists from various communities and specifically the lesbian and gay community.

The discrimination alluded to in this case was perceived more than experienced in actuality, in that a plan to close bathhouses and certain private clubs in San Francisco had been discussed by the Director of Public Health, Dr. Mervyn Silverman with the local broadcast and print media.

Many within the gay male population of San Francisco felt that in light of the little progress made in eradication of the disease by comparison with other diseases like Legionnaire's disease and Toxic Shock Syndrome and that not much attention was being paid to AIDS. Also the connections between the civil liberties gained over 20 plus years and the limits of mobility, whether sexual, social or otherwise carried the impetus to damage the secure feelings people had come to feel about life in San Francisco. Such was the initial challenge to civil liberties brought on by AIDS through efforts to close the bathhouses in San Francisco. Several other aspects have occurred since that time. More than that, it was felt that closing business establishments that clearly served the gay male population diminished the rights of gay men to associate freely and to have spaces wherein they could be among those like themselves.

When the story broke in the news it followed on the heels of a national hysteria that had begun traveling across the United States through rumor and hearsay. To date that hysteria has gained in momentum to the point that children who have contracted AIDS and related conditions are prevented from attending school and must suffer the psychological scars from ostracism by loved ones and friends...without so much as a meaningful excuse for why it's happening.
The advent of the news suggested that the closing of the baths was the beginning of the end. It was a frightening message for a community that had struggled to achieve a place in San Francisco civic life and signalled danger in that such an action might be taken with the approval of various men who were considered, by the media anyway, to represent ideals and concerns that mirrored the hopes of the gay male population. If the leadership was acquiescing so easily...then how could the rest of the population continue against such odds.

As the statistics regarding Acquired Immune Deficiency Syndrome grew and more and more people died who were lovers and friends of gay people, the need to take decisive action was believed to be more than rhetoric or a timely necessity.
Some response had to be made to Dr. Silverman's suggestion that he believed "that the spread of AIDS is related to multiple anonymous sexual activity, and to the degree that this takes place in certain facilities, then it poses a health risk."
S.F. Examiner, June 1, 1983

A proposal had been made by persons concerned over the epidemic conditions surrounding Acquired Immune Deficiency Syndrome and a perception that the most affected population groups were unprepared to facilitate the eradication of the disease or to prohibit its spread to quarters unimagined by the City's public health officials. Nobody had a clear idea about the causes associated with the spread of AIDS, except that the spread might include those who had participated in multiple sexual encounters or had shared needles.

It became clear to many people that whatever action to be undertaken must include a clear response from those most affected and that such a response must be provided in a public forum which allowed for diverse opinion as well as an opportunity to educate the community about the current statistics and facts relating to the disease. Several gay male activists met in my home in late March to facilitate the discussion whereby the community might respond to Dr. Silverman on the negative impacts such closure of these establishments might have upon the AIDS epidemic.

That meeting resulted in a Town Hall meeting held 4 April 1984 at the Pride Foundation. It gave way to subsequent discussions in order to better inform the community, in order to show strength for more remedial action to the AIDS crisis, and to support the positive efforts that the lesbian and gay community could make towards the protection of those civil liberties gained after so many years of struggle.

The AIDS crisis has grown much larger since that time. There have been more than 14,000 positive diagnoses of AIDS and related conditions nationally and there is still no cure in sight, even though there have been increases in funding for some research projects which have promise of some remedy.

The gay male population of the United States and the many loved ones and friends who have joined our fight time and again have waged a valiant fight to save lives, to change our lifestyles so that we accommodate death with dignity, to stand beside those who sleep outside in the cold begging for more funding to end this disease, or who wage the legal battles to protect the rights of the worried well against invasion of privacy.
However, many of the issues which surround this disease have a political and civil liberties import. The gay male population is one of the most vulnerable to discrimination and abuse in our society. What happens to us mirrors the danger that all people ultimately face if let without legal and political safeguards for our rights to mobility, to express our lifestyles, to employment, to worship, to create and to love.

For example, there have been numerous reports of firings and refusal to allow people diagnosed with AIDS to work. Upon learning that an employee has been given such a diagnosis, that person is no longer allowed on the job and in several cases such suspension or summary firing has resulted in the lack of appropriate medical insurance, disability pay or other benefits being paid.

Also, there is little case law at this time to consider or adjudicate the grievances based upon discrimination practiced against persons with AIDS or related conditions. Employees and litigants are currently forced to fight for rights which are constitutionally guaranteed to some, while denied to those who are in greatest need...and who have earned the benefits after years of continuous service to corporations and to the state.

It goes without saying, that there is a need for recommendation by the Human Rights Commission and other governmental agencies to take another look at the conditions where discrimination grows and is allowed to flourish. Many have judged the fear of the holocaust visited upon Jews, homosexuals, and other people during the 1930's and 40's occurring again as so much paranoia. In San Francisco, a law has recently been passed outlawing discrimination towards those with AIDS/ARC.

Which suggests that there is no getting away from the idea that those fears are joined today with the kinds of discriminatory acts that the federal government practices against people with AIDS/ARC, with the kinds of private sector attitudinal discrimination against lesbian and gay workers, and the outright disregard for sexual and civil liberties that issues like the closure of the baths engendered 2 years ago.

I respectfully submit that the Human Rights Commission should consider taking up the mantle of this human rights battle for people with AIDS/ARC and bringing suit against the United States government in those cases so clearly discriminatory. At least, consider joining as amicus curiae with those litigants who seek just funding for patients with AIDS/ARC in order to forestall the shortfall of available funds which will be needed by the City and County of San Francisco to care for these patients in the near future.
For example, the cost for daily care for patients is $800 or more, while the GRAMM-RUDMAN legislation will require significant cuts to programs in other arenas. There will surely be an impact upon the ability of the county to provide funding for all these programs under the cuts.

More than that, the Commission can resolve to oppose the efforts of United States in requiring testing of all immigrants who wish to enter at U.S. borders without diminishing its stature as a friend of the Constitution and human dignity. Or it may publicly refuse and lobby for laws prohibiting the testing by insurance companies of populations living in certain areas or of specific income groups.

On another level, the Human Rights Commission is in prime position to educate and elucidate the ramifications of unfair testing which invades the privacy of any patient, but in this case, those with AIDS who are victimized by employers who insist upon blood and urine testing of all prospective employees to ascertain their positivity to AIDS viruses under the HTLV-III tests. Without casting aspersions upon the HTLV-III test, let me say that there is a case to be made for not taking the test especially without guarantees of confidentiality under fictitious name and address. Recent accounts have pointed out patients who have subscribed to the test only to be later informed that they had been terminated from their employment. Here it is not a choice for these workers and the impacts of such testing can ruin the lives of people and their loved ones and families based upon the arbitrary approach given to these tests and their results by employers.

The gay community had its neck on the line at the inception of this dread disease into the United States a few years back. Today that story has changed. There are now significant numbers of women and children afflicted by AIDS/ARC situations. The civil liberties of these people are in danger of erosion by the fear, the myth, and the ignorance associated with the AIDS crisis. Tomorrow all of our liberties may be in question. The Human Rights Commission should have an proactive role in diminishing any attacks on human dignity.

The Human Rights Commission is mandated to work for the public good. By joining in efforts to educate San Franciscans and similar human rights activists around the country on the dangers of discrimination against people with AIDS and ARC, the Commission will signal a quantum leap towards assuring human dignity for all. Thank you for listening.