

THE LEGAL AND PUBLIC POLICY IMPLICATIONS OF HUMAN IMMUNODEFICIENCY VIRUS ANTIBODY TESTING IN NEW ZEALAND

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I INTRODUCTION

AIDS, the emotive acronym for Acquired Immune Deficiency Syndrome, is now commonly acknowledged to be a global pandemic. It is increasingly the case that AIDS is being perceived not merely as a medical and public health issue but as having economic and civil rights aspects as well. Legislators and public policy-makers of many countries are grappling to strike the right balance between the community's interest in health through control of the spread of the disease and the individual's interest in personal freedom and privacy.¹ Balancing these interests in the context of AIDS is particularly difficult as each interest is so fundamental.

As AIDS and Human Immunodeficiency Virus (hereafter referred to as "HIV") infection have now reached the shores of New Zealand, the author considered it a favourable time to produce this discussion paper which is intended to help provide New Zealanders with a framework within which fair and balanced decisions on HIV antibody testing can be developed. AIDS cuts across a number of legal fields including criminal law, tort law, constitutional and human rights law, family law, employment law, insurance law and public health law. The present paper sets out to reach tentative recommendations on who might be tested, on what basis, and the extent to which AIDS-related policies should receive a statutory underpinning. These recommendations are based upon current medical knowledge (as understood by a lawyer) and may need to be modified as new medical and scientific knowledge emerges.

II HIV INFECTION AND ANTIBODY TESTING

1 *The Nature of HIV Infection*

In order to better understand the legal and public policy implications of AIDS, one needs to know something about its medical history and prognosis. The disease itself was first identified in 1981. As a mark of the rapid worldwide spread of AIDS and concomitant concern, the World Health Organisation, a specialised agency of the United Nations, has recently established the Special Programme on AIDS which has been active in supporting national AIDS prevention programmes. The ubiquitous and fatal qualities of AIDS, combined with the absence of any prospect for an immediate cure or preventive vaccine,² make it a particularly frightening pandemic.

AIDS is caused by a virus known as HIV or HTLV-III (Human T-lymphotropic

- 1 Countries have developed a variety of policies and programmes, legislative or otherwise. Some, particularly in Western Europe, believe public education is the only effective control method. Others, including some Asian countries, believe foreigners are responsible for AIDS and that it can and must be driven out with legislation: *Time*, 25 May 1987, 54.
- 2 Most experts agree that it will be at least five years before a mass vaccine is developed.

Virus Type III.³ All persons exposed to the AIDS virus fall into one of the following three categories:

(i) AIDS

AIDS impairs the proper functioning of the body's immune system, leaving the victim unable to combat infection. As a result, persons with AIDS are susceptible to illnesses which do not usually affect those with normally functioning immune systems. These illnesses are often referred to as "opportunistic" infections.⁴ The opportunistic infections most commonly found in AIDS victims are Kaposi's Sarcoma, a form of skin cancer, and a severe, atypical form of pneumonia called Pneumocystis Carinii Pneumonia. AIDS is usually accompanied by persistent swelling of the lymph glands, persistent fatigue, a succession of recurring infections such as colds or influenza, frequent fevers and night sweats, weight loss, and/or persistent diarrhoea. Death usually occurs within two to three years of diagnosis.

As a conservative estimate, between five percent and twenty percent of individuals infected with HIV will develop AIDS.⁵ As of early 1987, AIDS had struck over 30,000 Americans and killed over 17,000 and is projected to cause over 50,000 deaths each year in the United States by 1991.⁶ The US Public Health Service estimates that 270,000 Americans will develop AIDS by the same year.⁷ Researchers believe that at least 50,000 people have already died of AIDS in Africa.⁸ As of mid-May 1987, 108 countries from all regions had notified the World Health Organisation of a total of 49,329 AIDS cases.⁹

(ii) AIDS-Related Complex (ARC)

Approximately twenty to thirty percent of those individuals infected with HIV will develop ARC, a syndrome characterised by a weakened immune system and much the same symptoms described above which accompany "full blown" AIDS.¹⁰ Although a milder form of AIDS in the sense that infected individuals do not develop

3 Physicians at the New Jersey University of Medicine and Dentistry recently reported the first case in the US of infection by a second deadly AIDS virus, HIV-2: *Time*, 8 February 1988, 45.

4 Acquired Immunodeficiency Syndrome (AIDS) Update - United States 32 Centers for Disease Control: *Morbidity and Mortality weekly rep* 309 (June 24, 1983).

5 Landesman, Ginzburg and Weiss, *Special Report: The AIDS Epidemic*, 312 *New Eng Med* 521-525 (No8 1985). More recently, US experts have estimated that twenty to thirty percent of infected persons will develop AIDS or AIDS symptoms within five years of exposure, and the proportion appears to rise sharply thereafter (*New York Times*, 8 June 1987, C14) possibly to at least fifty percent (*Time*, 16 February 1987, 40).

6 *Time*, 16 February 1987, 37.

7 *AIDS Policy and Law (BNA)*, 18 June 1986, 1.

8 *Time*, 16 February 1987, 46.

9 *Time*, 25 May 1987, 54.

10 Landesman et al, *op cit*.

life-threatening illnesses in the short-term, ARC can make common illnesses much more severe. ARC is sometimes referred to as "pre-AIDS" since some ARC patients go on to develop AIDS.

(iii) HIV Infection

This is the third and least serious level of diagnosis. Fifty percent or more of those individuals infected with HIV will be entirely asymptomatic with no clinical evidence of AIDS.¹¹ Many such individuals will be unaware of their condition and may carry HIV and transmit it to others for years before developing symptoms. Even asymptomatic HIV carriers are generally presumed capable of transmitting HIV and, once acquired, it is believed HIV will remain in the body for life. The Atlanta, Georgia-based Centers for Disease Control (hereafter referred to as "CDC"), the main US federal agency charged with tracking the spread of epidemics, has estimated that, as of early 1987, over one million Americans had been infected with HIV.¹² World Health Organisation officials have estimated that between five million and ten million people around the world carry HIV, and that as many as 100 million will become infected during the next ten years.¹³

2 *Modes of HIV Transmission*

There is as yet no evidence to suggest that HIV is transmitted by casual daily contact at home, at work, in public places and so forth.¹⁴ Unfortunately, much of the public has overlooked or is unaware of this fact. The resultant fear which is the source of many problems concerning AIDS must be countered by a cautious approach in dealing with the crisis. Compared with other infectious diseases, HIV is relatively difficult to transmit and this quality must be borne in mind from the legal and policy standpoint.

Although HIV has been found in blood, semen, vaginal secretions, saliva, tears, urine and faeces,¹⁵ blood and semen are probably the only infectious fluids. The methods of transmitting HIV are:

- (i) penetrative sexual intercourse and exchange of semen or blood between men or between a man and a woman, one of whom is infected;¹⁶

11 *Idem*.

12 *Time*, 16 February 1987, 37.

13 *Ibid*, 40.

14 Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome, 34 Centers for Disease Control: Morbidity and Mortality Weekly Rep 5 (11 January 1985).

15 Saliva and tears have been discounted as bodily fluids capable of transmitting HIV: Sande "Transmission of AIDS: The Case Against Casual Contagion" (1986) 314 *New Eng J Med* 380.

16 Artificial insemination using infected semen is related to this method of transmission.

- (ii) the exchange of infected blood by the sharing of improperly cleansed injection needles and syringes between intravenous drug users;
- (iii) the transfusion of infected blood or blood products;¹⁷
- (iv) the transplantation of infected tissues or organs;
- (v) from an infected mother to her baby before or during birth through transplacental contact, and possibly by breast-feeding;¹⁸
- (vi) the exposure of broken skin or mucous membranes to infected blood.¹⁹

3 *Who is at Risk?*

While in Africa and Haiti, AIDS has primarily afflicted heterosexuals with no history of intravenous drug use, homosexual and bisexual men and intravenous drug users account for ninety-one percent of AIDS cases in the United States, with heterosexual intercourse accounting for a mere four percent.²⁰ Thus far, in most developed countries, heterosexual HIV transmission accounts for only a small percentage of AIDS cases.²¹ The heterosexual community is increasingly threatened, however, by intravenous drug users and bisexuals as vectors for spreading HIV. In the United States, for example, the percentage of cases resulting from heterosexual transmission is expected to more than double to nine percent by 1991.²³

Other individuals at risk of contracting HIV infection include prostitutes and their clients, children born to an infected mother, the sexual partners of infected individuals, and haemophiliacs receiving transfusions of blood or blood clotting products and other transfusion recipients.²⁴

4 *HIV Antibody Tests*

The two main commercially available HIV antibody blood tests, the enzyme-linked immunosorbent assay (hereafter referred to as the ELISA test) and the Western blot test, have been developed to screen blood donors as well as to identify carriers diagnostically.²⁵ These tests detect the presence in blood of antibodies specific to

- 17 This method of HIV transmission has now been largely controlled by the introduction of effective blood tests and administrative procedures designed to screen donors and their blood.
- 18 Otherwise, HIV transmission within the family is virtually unknown where no sexual relationship has existed.
- 19 Recently in the US, three health care workers were found to be infected and their exposure was attributed to their work where skin or mucous membranes were accidentally contaminated with infected blood. Such instances of infection remain rare however.
- 20 New York Times, 11 May 1987, B5 (Federal health officials' estimates).
- 21 Time, 25 May 1987, 54.
- 22 Time, 8 June 1987, 21.
- 23 Newsweek, 24 November 1986, 31.
- 24 But see n 17 above concerning the latter group.
- 25 These two tests have also been used for research and surveillance purposes. The tests have only recently been developed, the ELISA having become available for the purpose of screening donated blood in March, 1985.

HIV, the virus which is thought to cause AIDS. The presence of these antibodies infers infection of the body by HIV.²⁶ A true positive test result means that an individual has been infected by HIV and has developed antibodies to it. Scientists assume that those who test positive are still carrying HIV and are capable of transmitting it. American medical experts have stated that a positive ELISA test result once confirmed by a second ELISA test and by a Western blot test is more than ninety-nine percent accurate.²⁷

Any decision to implement widespread HIV antibody testing, however, must acknowledge the shortcomings of the tests currently utilised. The tests do not directly detect the presence of HIV and, in respect of AIDS itself, they are of no prognostic value since they can neither directly detect HIV-related illness nor predict who will succumb to AIDS. The tests also yield "false positive" and "false negative" results. Some individuals will test positive when, in fact, they have not been infected by HIV; others will test negative even though they have in fact been infected by HIV. The tests will identify most, but not all, HIV carriers. While the tests taken in conjunction are extremely accurate, they are far from perfect. Although these false results represent a small percentage of all testing results, their implications are serious both from an individual and legal standpoint.

Negative test results can pose particular problems. A small but significant percentage of individuals exposed to HIV fail to produce antibodies.²⁸ Other individuals exposed to HIV may not show antibodies since HIV takes a prolonged period of time to provoke antibody production. Thus, early in the course of HIV exposure, antibodies will not be present and negative results will be misleading. The duration between HIV exposure and detectable antibody presence is not precisely known and estimates vary.²⁹ In any event, HIV carriers will be falsely reassured and preventive measures may be impeded. According to one recent study,³⁰ the number of false negative test results increases dramatically when a population with a high preva-

26 Antibodies are substances the blood produces to defend against invading micro-organisms. In the AIDS context, the antibodies are largely ineffective in destroying HIV.

27 New York Times, 21 January 1986, B4. The more expensive, sophisticated and time-consuming confirmatory Western blot test is generally regarded as more accurate and specific.

28 This has been estimated to be as high as five percent: see the interim working paper "Human Immunodeficiency Virus Antibody Testing in Canada" (24 August 1987) prepared by Dr M Somerville and Dr N Gilmore for consideration by the National Advisory Committee on AIDS of Health and Welfare Canada (hereafter referred to as "Canadian Working Paper") at 14.

29 Estimates include two weeks to three months after exposure: US Dept of Health and Human Services, Surgeon General's Report on AIDS 10 (1986); six days to eight weeks: Cooper, Gold and Maclean "Acute AIDS Retrovirus Infection" [1985] LANCET 537, 537-540; and in some cases as long as three to six months: Canadian Working Paper at 13.

30 MJ Barry, PD Cleary and HV Fineberg "Screening for HIV infection: risks, benefits, and burden of proof" (1986) 14 Law, Medicine and Health Care 259-267.

lence of HIV infection is tested.³¹

The rate of false positive results also appears to vary with the prevalence of infection in the population being tested. When persons who are not at high risk for HIV infection are tested, the proportion of false positive results increases.³² The same study³³ has confirmed this to be the case, although greater accuracy can be expected from persons at higher risk.³⁴

5 *The Merits and Demerits of Coercive and Voluntary Antibody Testing*

A *CLASSES OF ANTIBODY TESTING*³⁵

- (i) **Voluntary Testing:**
Testing is done only with the informed consent of the individual, and does not fall into any other class of testing.
- (ii) **Routine Testing:**
Testing is normally required of an individual unless he or she has a specific, cogent and bona fide objection. In that event, the individual can avoid testing.
- (iii) **Mandatory Testing:**
Testing is either a necessary prerequisite for an individual to obtain a specified status, benefit, service or access to a given situation, or is a consequence of being provided with one or more of these. The individual cannot avoid testing unless he or she is prepared to forego the benefit etc.
- (iv) **Compulsory Testing:**
Testing is required either by law or by policy, and the individual cannot legally avoid, or has no choice to refuse, testing.

In terms of a continuum, then, the coercive nature of testing increases as one proceeds from voluntary testing through to compulsory testing.

- 31 When ELISA and Western blot testing is performed on a population of 100,000 individuals with a thirty percent infection rate, 1,980 individuals will be falsely labelled negative when in fact they are infected. This compares with only two false negative results when the same population but with only a .03 percent infection rate (ie, only thirty infected individuals per 100,000) is tested: idem.
- 32 Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome, 34 Centers for Disease Control: Morbidity and Mortality Weekly Rep 1-5 (11 January 1985).
- 33 Above, n 30. When ELISA and Western blot testing is performed on a population of 100,000 individuals with a mere .03 percent infection rate (i.e., only thirty infected individuals per 100,000), eleven false positive results will be yielded compared with twenty-eight true positive results (with two false negative test results). This compares with only eight false positive results and 28,080 true positive results (with 1,980 false negatives) when the same population but with a much higher thirty percent infection rate is tested: idem.
- 34 According to Dr James Allen of the Centers for Disease Control, "When ELISA is administered to someone in one of the high-risk groups, it is more than 99 percent accurate.": New York Times, 17 May 1987, Pt IV, 26.
- 35 Adapted from the Canadian Working Paper at 36.

B PERSPECTIVE

As the AIDS death toll continues to mount, more and more jurisdictions are turning either to compulsory testing or mandatory testing for certain groups perceived to be at high risk of contracting HIV and AIDS.³⁶ In the United States, various state and local officials have begun to agitate for widespread mandatory and even compulsory testing.³⁷ The US Defence and State Departments have already commenced mandatory workplace testing and, in his first speech devoted exclusively to AIDS, President Reagan called for mandatory tests of selected groups.³⁸ Nevertheless, antibody testing, especially where an element of coercion is involved, is a complex and sensitive issue and should not be undertaken lightly or indiscriminantly. The author shares the concern of the World Health Organisation that "while screening for HIV may appear a relatively simple approach to some of the complex problems associated with AIDS and HIV infection, in fact screening for HIV is extraordinarily complex from an epidemiological, economic, legal, logistic, political and ethical perspective."³⁹

C TESTING RATIONALES

The main arguments put forward to support antibody testing in general are:

- (i) There is an urgent need to collect and analyse testing data to improve our understanding of AIDS and HIV infection and transmission. Surveillance and research activities based thereon will better enable us to measure the prevalence of AIDS and to monitor how and where HIV is spreading.⁴⁰
- (ii) Information obtained from testing can contribute to the control of HIV transmission. This can be achieved in at least two ways. First, HIV antibodies can be detected in blood, organs, tissues and semen thereby preventing potentially dangerous transfusions, transplantations and conceptions. Sec-

36 For example, the Bavarian State Government of West Germany has begun compulsory testing of prostitutes, prisoners and drug addicts. Hungary has also introduced compulsory testing for those of its citizens most likely to suffer from AIDS: *New York Times*, 31 March 1987, A16.

37 These demands have prompted vigorous opposition from civil rights lawyers, gay-rights advocates and public health officials who urge, instead, voluntary testing that includes informed consent, confidentiality and counselling: *Time*, 2 March 1987, 44.

38 Speech dated 31 May 1987, as reported in the *New York Times*, 1 June 1987, A1. This proposal contradicted the advice of President Reagan's public health advisers who generally favoured voluntary testing.

39 Communication from the Director-General of the World Health Organisation, Ref: CL8 1987, 7 April 1987, Geneva.

40 Some US public health officials argue that there are better ways to obtain this vital information than by testing. The US Centers for Disease Control, for example, have tested anonymous blood samples discarded by hospitals. Moreover, more might be learned about the potential spread of HIV from the study of the prevalence of high risk behaviour than by the study of current HIV infection prevalence.

only, it is argued that neither testing nor education by themselves will halt the spread of HIV. Testing is argued to be an indispensable adjunct to education when aimed at altering patterns of "unsafe behaviour". Although no definitive studies have been published on the effects of testing on behaviour modification in halting HIV spread, it is argued that "A test result can sometimes change behaviour in a way generalized warnings might not."⁴¹ Dr James O Mason, Director of the Centers for Disease Control, has stated that "the primary public health purpose" of testing and counselling is "to induce behavioural changes that minimize" the risk of HIV transmission.⁴² Testing helps to protect uninfected individuals by identifying HIV carriers so that the latter will not continue to spread HIV unwittingly.⁴³

- (iii) Although no cure exists for HIV infection, it is argued that testing can lead to the provision of at least some treatment, education and counselling for HIV carriers at an earlier stage.

D COERCIVE TESTING

A number of public opinion polls conducted in the United States in mid-1987 revealed that the majority of the general public favoured mandatory or compulsory testing, particularly of those individuals in high-risk groups. Proponents of widespread coercive testing cite the pressing need for more detailed and reliable data on the extent to which HIV has spread.⁴⁴ Nevertheless, there are at least four persuasive arguments that oppose coercive testing, particularly when it is proposed to be done on a widespread basis:

- (i) Ineffectiveness as a public health measure:

At a major conference on antibody testing convened by the US Centers for Disease Control at Atlanta, Georgia in February, 1987 (hereafter referred to as the "Atlanta Conference"), the 800 or so state and local health officials were almost unanimously opposed to either widespread coercive testing or coercive testing of any group, reasoning that, *inter alia*, such testing would fail as a public health measure and would be unlikely to detect many more cases. Widespread coercive testing is appropriate only when it provides access to a cure, as in the case of tuberculosis. In the absence of a cure for HIV

41 H Dowling, Wisconsin Department of Health and Social Services AIDS Project, quoted in P Reidinger "A Question of Balance: Policing the AIDS Epidemic" ABA Journal (1 June 1987) 69, at 72. The authors of the Canadian Working Paper also acknowledge the possibility that test results may motivate or convince individuals to avoid unsafe behaviour.

42 New York Times, 11 May 1987, B5.

43 New York Times, 1 June 1987, A1.

44 Opponents of such testing argue that random testing is preferable to the questionable testing of unrepresentative groups which widespread coercive testing would entail. Dr James O Mason, Director of the US Centers for Disease Control, maintains that widespread coercive testing is not justified by current knowledge of how HIV is spreading: New York Times, 11 May 1987, A1, B5.

infection, it is not appropriate. Dr Stephen Joseph, New York City's Health Commissioner, opposed any type of mandatory testing, citing the inability of such testing to stem the spread of syphilis until treatment was available.⁴⁵ Physicians of the United States Veterans' Administration also question the efficacy of widespread coercive testing in curtailing the spread of HIV infection.⁴⁶ It is argued that such testing is not necessary since HIV is not spread by casual contact and, indeed, is relatively difficult to spread compared with other infectious diseases. Unless repeated frequently and systematically, widespread coercive testing would fail to record accurately seroprevalence trends, since a negative result can be rendered meaningless where the individual tested engages in a high risk activity afterwards. Moreover, the shortcomings of any type of antibody testing, whether coercive or voluntary, including the delay between HIV exposure and antibody production and the prospect of false positive results,⁴⁷ are particularly acute in the context of widespread coercive testing. Such testing of the general population, where the incidence of AIDS and HIV infection is still relatively minimal, would result in a larger number and proportion of false positives.⁴⁸

- (ii) Coercive testing would drive potential HIV carriers underground: Men who have sex with other men and intravenous drug users, the people currently most at risk of HIV infection, already live at the edge of social tolerance and their cooperation in changing their own behaviour is critical in retarding HIV spread. Coercive testing is perceived by many public health officials and civil rights advocates as the surest way to discourage the very persons most in need of testing and counselling from seeking them. This was the main concern behind the Atlanta Conference delegates' virtual unanimous rejection of coercive testing. Senior officials of the US Public Health Service and Surgeon General C Everett Koop also consider coercive testing inappropriate in view of the considerable risks of discrimination and social stigmatisation inherent in such testing and the consequent "chilling" effect on potential HIV carriers who might otherwise come forward.⁴⁹

45 Time, 2 March 1987, 44.

46 New York Times, 24 June 1987, A1, A22.

47 See Section II.4 above.

48 See Section II.4 above, and M Weldon-Linne, C Weldon-Linne, MD and J Murphy "AIDS-Virus Antibody Testing: Issues of Informed Consent and Patient Confidentiality" Illinois Bar Journal (December 1986) 206 at 207.

49 New York Times, 11 May 1987, A1; Time, 8 June 1987, 20, 22. See also the paper entitled "AIDS: Discrimination and Public Health" written by Dr J M Mann, Director of the World Health Organisation's Global Programme on AIDS, and delivered to the IV International Conference on AIDS at Stockholm.

- (iii) Widespread coercive testing is not cost effective: Various health officials⁵⁰ and politicians⁵¹ maintain that widespread coercive testing is not the best use of resources and, as such, would be disproportionately costly to the public health advantages secured. This concern is founded not only upon the reasons⁵² for the alleged ineffectiveness of coercive antibody testing as a public health measure, but on the significant direct and indirect costs of such testing as well. These costs include the costs associated with testing and counselling,⁵³ record-keeping, support services, loss of employment and consequent loss of revenue and productivity, and loss of insurance and housing, possibly leading to the creation of a class of individuals dependent upon society for their welfare.⁵⁴ These considerations have prompted a call for more closely targeted testing which represents, it is argued, a less scattered and more focused use of health care resources.
- (iv) Coercive testing is unduly costly in human terms: Coercive testing denies to the individual being tested the opportunity to refuse and, as such, raises serious legal and ethical questions⁵⁵ and is arguably inconsistent with the rights and freedoms enjoyed by individuals who live in a free society. A positive test result can have a devastating impact upon a person's life in terms of emotional and psychological costs. This impact may be less in the case of voluntary testing which is founded upon the co-operative attitudes of those seeking health care and their willingness to rely on the associated counselling services. Widespread coercive testing also runs the risk of heaping unfair discrimination onto the illness and suffering of those persons with AIDS and HIV carriers who pose little or no danger of spreading HIV. A positive test result might be construed falsely as evidence that the individual belongs to a high risk group for transmission. As a Florida court has recognised, "AIDS is the modern day equivalent of leprosy. AIDS, or a suspicion of AIDS, can lead to discrimination in employment, education, housing and even medical treatment."⁵⁶

50 The US Public Health Service, *New York Times*, 11 May 1987, A1; the Atlanta Conference.

51 Henry A Waxman, *Californian Democrat*, Chairman of the Subcommittee on Health and the Environment of the House of Representatives Energy and Commerce Committee, has asserted that widespread coercive testing is "the most expensive and least effective way of educating the public": *Evening Post*, Wellington, New Zealand, 1 June 1987.

52 See Section II.5.D. (i) above.

53 A recent US Centers for Disease Control study found that testing and counselling cost on average U.S. \$45. per person: *New York Times*, 3 June 1987, B8.

54 Canadian Working Paper, at 21-22.

55 See Section II.8. below.

56 *South Florida Blood Service Inc v Rasmussen*, 467 So 2d 798, 802 (Fla Dist Ct App 1985). See also Section III.2. below.

E. VOLUNTARY TESTING

Three American medical commentators recently argued that “[c]ontrol of the AIDS epidemic must continue to rely on voluntary measures encouraged by vigorous and widespread counselling and education.”⁵⁷ There is substantial support today amongst public policy-makers, health officials and interested organisations in the United States, the United Kingdom, Australia and Canada for the testing philosophy which this quoted statement embraces. Despite the preference of the US Government for wider routine testing and selective mandatory testing, key health officials and organisations in the US advocate voluntary testing. These include the US Surgeon General C Everett Koop, Robert E Windom, Assistant Health Secretary and Head of the US Public Health Service, the American Public Health Association, and the Trustees and House of Delegates of the American Medical Association.⁵⁸ Dr James O Mason, Director of the US Centers for Disease Control, has called for a major increase in voluntary testing⁵⁹ while the American Foundation for AIDS Research advocates voluntary, confidential testing accompanied by “intense counselling”.⁶⁰ Most delegates who attended the Atlanta Conference favoured encouraging more people to undergo voluntary testing, provided that it is purely an adjunct to counselling and that confidentiality was assured. Conference discussions concentrated particularly on “targeted” testing of high risk groups and in areas of high prevalence of AIDS.⁶¹ Groups concerned with civil rights such as the American Civil Liberties Union favour broad access to voluntary testing, anonymously if possible, but with confidentiality ensured in any event.⁶² Indeed, on 30 July 1987, legislation having bipartisan support and providing for selective, voluntary testing was introduced in the US Congress.⁶³

Current United Kingdom policy includes free and confidential voluntary testing and counselling services through National Health Service family doctors and hospital clinics.⁶⁴ The current voluntary testing policy of the Australian Federal Government

57 M Mills, Dr C Wofsy and Dr J Mills “AIDS: Infection control and public health law” (1916) 314 *New England Journal of Medicine* 931, 936.

58 *New York Times*, 21 June 1987, A26 and 24 June 1987, A22.

59 *New York Times*, 11 May 1987, A1, B5.

60 *New York Times*, 1 June 1987, A15.

61 *New York Times*, 26 February 1987, B7.

62 *New York Times*, 23 May 1987, A27.

63 *New York Times*, 31 July 1987, A12. See the Health Omnibus Programs Extension of 1988, Public Law 100-607 enacted by Congress on 4 November 1988.

64 Address by John Moore, Secretary of State for Social Services, to the United Nations on AIDS, 20 October 1987, at 4. Nevertheless, in what can amount to selective compulsory testing, pursuant to s35 of the Public Health (Control of Disease) Act 1984 c22, and The Public Health (Infectious Diseases) Regulations 1985, a Justice of the Peace (acting, if he deems it necessary, ex parte at the instance of health authorities) may order a person to be medically examined if satisfied that there is reason to believe that that person is suffering from AIDS or is an HIV carrier, and that it is expedient in the public interest, his/her interest, or that of his/her family that such examination take place.

is based on a general statement of principles jointly agreed to and announced on 15 July 1986 by Dr Neal Blewett, the Minister for Health and Community Services, the Chairpersons of the National Advisory Committee on AIDS and the AIDS Task Force respectively, the Presidents of the Victorian AIDS Council and the AIDS Council of New South Wales respectively, and officials of the Commonwealth Department of Health.⁶⁵ At the time of writing, the Canadian Federal Government's position on testing was still being reviewed on an ongoing basis.⁶⁶ Voluntary testing programmes have been operating in New Zealand for the past three years through New Zealand AIDS Foundation clinics and general practitioners.

Most of the arguments against coercive antibody testing⁶⁷ implicitly lend their support to voluntary testing on a more selective or targeted basis. It is submitted, therefore, that voluntary testing offers a more effective and less restrictive alternative to coercive testing. By emphasising education and cooperation rather than compulsion, persons voluntarily tested are more likely to afterwards engage in behaviour modification regardless of the test results. Nevertheless, to be fully effective, voluntary testing must be accompanied by counselling and by assurances of confidentiality and guarantees against discrimination.⁶⁸ Consequently,

Recommendation: The use of coercive antibody testing is unacceptable, unless it can be clearly justified. As a general rule, voluntary antibody testing is preferable.

6 Counselling

All individuals at risk⁶⁹ should be encouraged to seek confidential counselling from private physicians, sexually transmitted disease clinics and special AIDS clinics where the testing option may be raised with each person. Indeed, individuals should not be tested unless they have received appropriate counselling.⁷⁰

Counselling is necessary or advisable for the following reasons:

65 Subsequently, Dr Blewett announced plans to develop a national strategy for dealing with the AIDS problem, including the issue of antibody testing. At the state level, the New South Wales Privacy Committee, a body established by statute, adheres to the view that all antibody testing should be voluntary, except where the law provides to the contrary: "Privacy and AIDS: The Guidelines" Privacy Bulletin Vol 2, Pt 2 (1986) 2.

66 However, the authors of the Canadian Working Paper (at 35) conclude that as a general principle, compulsory testing is unwarranted.

67 See Section II. 5. D. above.

68 See Sections II. 6., III. 1. and III. 2. respectively.

69 See Section II. 3. above.

70 According to Dr James O Mason, Director of the United States Centers for Disease Control: New York Times, 11 May 1987, B5. The current policy of the United Kingdom is to provide free and confidential counselling services: Address by John Moore, Secretary of State for Social Services, to the United Nations on AIDS, 20 October 1987, at 4.

- (i) it can educate individuals about what AIDS and HIV infection are, their symptoms, and what test results mean;
- (ii) since prevention through behaviour modification is critical in controlling the spread of HIV, counsellors should explain fully to individuals the currently accepted view of the best measures available to control its spread;
- (iii) it can help to alleviate the emotional and psychological stresses that may accompany testing, particularly where the test result is positive. Counselling can also help to diminish social isolation and economic dislocation which may result in some cases from testing;
- (iv) it can educate individuals about what, if any, legal consequences flow from a positive test result;⁷¹
- (v) the British Medical Association asserts that "With counselling, the majority of infected individuals can be persuaded voluntarily to inform their ... sexual partner(s) of their infected status."⁷²

Recommendation: Testing should be performed only when educative counselling before and following testing are available and offered by trained health care personnel, irrespective of the test result.

7 Education

In the current circumstances, in which there is no cure or vaccine and no possibility of their development in the immediate future, laws and policies should concentrate primarily on promoting the preservation of human life through prevention of HIV transmission.⁷³ Much of the AIDS crisis revolves around the personal choices which individuals should be encouraged to make after appropriate education designed to persuade them to change their behaviour. Indeed, education, as opposed to antibody testing, should be our first line of defence against AIDS, not only in view of its intrinsic merits but because it constitutes, with or without voluntary testing, a less restrictive alternative to coercive testing. Most public health officials believe that the best way to contain HIV spread is not through widespread coercive testing but through education on how to prevent HIV exposure.⁷⁴ As two Canadian commentators have recently pointed out:⁷⁵

71 For example, any legal disabilities that flow from the status of an HIV carrier, such as the prohibition on donating blood, or criminal liability attaching to the act of wilfully transmitting HIV.

72 L Beecham "Support for Confidentiality for AIDS Patients" 294 *British Medical Journal* 1177 (2 May 1987). There has been a similar co-operative contact tracing system operating in New Zealand.

73 The authors of the Canadian Working Paper have concluded (at 15) that preventing HIV transmission is the only effective control strategy.

74 Dr Stephen Joseph, New York City's Health Commissioner and a testing critic, states that "Our problem is not finding out who's infected, but educating everyone about the risks.": *Time*, 2 March 1987, 44.

75 The Canadian Working Paper at 17.

Simply informing persons that they are HIV antibody seropositive will not, alone, prevent HIV transmission. Prevention requires everyone, regardless of whether they are or are not infected, to behave safely and to avoid engaging in risk-producing activities. This does not, of itself, require HIV antibody testing.

Recent policy and practice in a number of jurisdictions confirms the perceived value of education in preventing HIV transmission. As the death toll from AIDS continues to mount in the United States, policy-makers and health care officials are turning more vigorously and desperately to educational measures to curb HIV spread. The US Surgeon General C Everett Koop is a leading advocate of the view that sex education is the most effective way to contain AIDS, arguing that candour and condoms are more effective public-health tools than chastity sermons.⁷⁶ The House of Delegates of the American Medical Association recently approved several Board of Trustees' recommendations concerning the need for greater educational efforts aimed at physicians, students and the general public on the modes and prevention of transmission.⁷⁷ The educational campaign has already spurred a broad awareness of AIDS throughout much of the United States and important changes in behaviour among some individuals thought to be most at risk.⁷⁸ A new wrinkle to this campaign was announced recently by Assistant Health Secretary Mr Robert Windom concerning US Administration plans to follow a United Kingdom Government precedent by mailing a brochure on AIDS prevention to every household in the country.⁷⁹

The United Kingdom Government has also recognised that in the absence of medical defences against AIDS, the influencing of personal behaviour through public education is the main weapon in the fight to limit its spread. Accordingly, the UK Government committed \$US 33 million in November, 1986 to a mass media campaign to raise public awareness about AIDS and safe behaviour and particularly to dispel myths about the modes of transmission. The campaign also included the distribution of a leaflet to all 23.5 million households in the United Kingdom.⁸⁰

The Australian Federal Government and interested organisations such as the Australian National Advisory Committee on AIDS have also acknowledged that

76 Time, 8 June 1987, 22.

77 New York Times, 24 June 1987, A22.

78 New York Times, 19 March 1987, A1. The most urgent target of the US prevention campaign, according to many US health officials, is the intravenous drug abusers who have lagged behind male homosexuals in organising themselves, and who are regarded as posing the greatest immediate threat of spreading HIV to the heterosexual population: New York Times, 19 March 1987, B10.

79 Time, 8 February 1988, 45.

80 Address by John Moore, Secretary of State for Social Services, to the United Nations on AIDS, 20 October 1987, at 3. As with any campaign aimed at changing deep-rooted patterns of behaviour, however, a long, sustained effort is anticipated by United Kingdom health authorities to be necessary.

education and information campaigns aimed at prevention are likely to be the most effective. In New Zealand, the Department of Health, the New Zealand AIDS Foundation and gay community groups have published and distributed brochures recommending safe sex particularly by the use of condoms as well as other measures to reduce the risk of being exposed to HIV. The New Zealand AIDS Foundation also sponsored the first "National AIDS Awareness Week" (19-26 September 1987) aimed at promoting safe sex particularly through condom use and greater community awareness. The Hon Justice Michael Kirby, President of the New South Wales Court of Appeal, has urged that "social policy and the law must give a high priority ... to promoting the use of the condom and to explaining ... 'safe sex'"⁸¹ arguing that "in this time of crisis, the defence of life requires that delicate feelings must give way to the necessities of the moment".⁸² The New Zealand Government has also introduced the "Needle Exchange Programme" to facilitate the exchange by drug users of used needles and syringes for clean ones at pharmacies.

Recommendation: Public education, especially for young persons and individuals engaging in high risk behaviour, is essential in containing the spread of HIV and should include information about the modes of HIV transmission and safe and unsafe activities, including the encouragement of safer sexual practices, *inter alia*, through the use of condoms.

8 *Informed Consent*

The general requirement of informed consent is premised on the patient's right to exercise control over his or her body by deciding whether or not to undergo a proposed treatment. The physician's duty to disclose relevant information to the patient is said to be based on the fiduciary nature of the physician-client relationship.⁸³

A number of jurisdictions have enacted laws or developed policies or practices which require the informed consent of the patient prior to antibody testing. The California Legislature has enacted Assembly Bill 403 (1985) which requires written, informed consent before testing can be administered⁸⁴. Dr James O Mason, Director of the United States Centers for Disease Control, has cautioned that individuals should not be tested unless they have given explicit consent and understand that they have a right to choose not to be tested.⁸⁵ The Australian Federal Govern-

81 M D Kirby "AIDS Legislation - Turning up the Heat?" (1986) 60 ALJ 324 at 330.

82 M D Kirby "The Five Commandments for New Legislation on AIDS", Paper delivered to the World Health Organisation Symposium on AIDS, Annecy, Switzerland, 20-21 June 1987, at 9.

83 M M Weldon-Linne, C M Weldon-Linne, and J L Murphy "AIDS-Virus Antibody Testing: Issues of Informed Consent and Patient Confidentiality" Illinois Bar Journal 206 at 208 (December 1986).

84 1985 Cal Legis Serv ch 1519 199.38. See also 1985 Wisconsin Laws Act 73 146.025.

85 New York Times, 11 May 1987, B5.

ment's testing policy includes the requirement of informed consent, and the New South Wales Privacy Committee, a statutory body, has urged that "valid informed consent should be obtained from the person whose blood is to be tested."⁸⁶ Conversely, the British Medical Association approved at its 1987 Annual Conference a motion that antibody testing "should be at the discretion of the patient's doctor and should not necessarily require the [informed] consent of the patient."⁸⁷ Concern was expressed by some physicians that testing without consent could constitute an assault⁸⁸ as well as an invasion of the tested individual's privacy. If it is a basic tenet of medical ethics that physicians do not treat patients without their consent, then antibody testing without the patient's full knowledge and consent would also constitute a breach of medical ethics. Physicians opposing the motion argued that patients with suspected HIV infection should not be treated differently from other patients concerning medical procedures, and that informed consent should be obtained from the patient or guardian before any tests are carried out which could have adverse effects.⁸⁹ Failure or refusal to obtain informed consent could also create mistrust of physicians resulting in avoidance of consultation for any purpose or concealment of information by "at risk" patients. Two British commentators maintain that there is no chance of defeating the AIDS epidemic if that trust is non-existent.⁹⁰ One of them, Professor Michael Adler, a leading AIDS specialist at the Middlesex Hospital, London, warned that "allowing potential patients to feel that they may be tested for AIDS infection without their consent will inevitably drive underground those most at risk"⁹¹ and thereby seriously undermine the United Kingdom's efforts to contain the spread of AIDS. Furthermore, given the imperfections of the antibody tests and the often extreme implications - medical, socio-economic or otherwise - of a positive test result, fully informing patients of the risks involved is critical.⁹² Consequently,

Recommendation: Physicians, clinics and hospitals administering antibody testing should as a routine matter secure the patient's informed consent prior to testing.⁹³

86 "Privacy and AIDS: The Guidelines" Privacy Bulletin Vol 2, Pt. 2 (1986) 2.

87 The Times, 3 July 1987, 1.

88 Section 2(1) of the Crimes Act 1961 defines "Assault" as the act of intentionally applying or attempting to apply force to the person of another, directly or indirectly, or threatening by any act or gesture to apply such force to the person of another, if the person making the threat has, or causes the other to believe on reasonable grounds that he has, present ability to effect his purpose.

89 The Times, 3 July 1987, 3.

90 M Adler and D J Jeffries "AIDS: a faltering step" 295 British Medical Journal 73, 74 (11 July 1987).

91 The Times, 3 July 1987, 24.

92 Weldon-Linne and Murphy, op cit at 207. Adler and Jeffries, op cit at 74, have attempted to refute the rationale behind testing without consent - viz. the need to protect the health of physicians, other health care personnel and their families - by arguing that the risk of health care personnel becoming infected is very small and can be countered by adopting careful procedures with all patients, that testing without consent will do little, if anything, to reduce the chances of becoming infected, and that most patients suspected of carrying HIV will consent to a test when properly counselled while those who do not consent can be treated as if they were infected.

93 Accord the Canadian Working Paper at 33.

Counselling services should be available and offered to facilitate obtaining such consent. Such services should include information describing antibody testing, its benefits and limitations, a realistic evaluation of the limitations of confidentiality guarantees, and the possible adverse effects of any release of test results and any other risks and potential testing harms. The informed consent should not be deemed part of "blanket" consent form procedures but should instead include specific reference to the antibody test and a signed acknowledgement from patients that they consent to submit to the test after having been offered counselling services.⁹⁴ All individuals tested must have access to their results and the care and counselling that their results require, and must also be given a guarantee of confidentiality of results in the absence of anonymous testing.⁹⁵

III THE IMPACT OF HIV ANTIBODY TESTING

1 *Confidentiality*

Personally identifiable AIDS-related information may wind up in many hands including medical offices, hospitals, clinics, blood-banks, public health agencies and private organisations offering advice and support to persons with AIDS and HIV carriers. Violations of confidentiality, many of them inadvertent, do occur resulting in the disclosure of testing information of a highly personal and intimate nature. The vulnerability of those individuals who have undergone testing to certain adverse consequences⁹⁶ underscores the importance of confidentiality in the AIDS context.

The need for confidentiality or anonymity in AIDS antibody testing has been argued on three related footings:

- (i) The public interest in controlling the spread of AIDS and HIV:

So long as a vaccine and an effective treatment remain undeveloped, and a better understanding of the various modes of transmission is necessary, the need for more accurate information about HIV remains urgent to impede its further spread. Potential participants may hesitate to contribute to the information-gathering process because they fear invasions of their privacy and consequent stigmatisation and discrimination. Without strict confidentiality guarantees, members of stigmatised groups, who already experience discrimination, are not as likely to undergo

94 Association of State and Territorial Health Officials Foundation, *Guide to Public Health Practice: HTLV-III Antibody Testing and Community Approaches 4* (1985).

95 Canadian Working Paper at 28.

96 See below Section III. 2.

voluntary testing.⁹⁷ Fuller participation in testing and information-gathering programmes will be encouraged by protecting potential participants against improper disclosures of sensitive AIDS-related information. This will in turn promote the success of efforts to control and cure the pandemic.⁹⁸ US federal disease-control officials recognise the critical role of confidentiality in the development of an effective public health strategy against AIDS, concluding that “the ability ... to assure confidentiality - and the public confidence in that ability - are crucial to efforts to increase the number of persons requesting testing and counselling.”⁹⁹

- (ii) Unauthorised possession/disclosure of personally identifiable AIDS-related information may lead to discrimination:

A general lack of understanding about the modes of HIV transmission has led to unfounded fear and over-reaction. As Justice Kirby states, “without strict and effective laws and practices to prevent the spread of the knowledge of a positive result ... the risk must be run in current conditions of anxiety and alarm, that those found positive will suffer discrimination heaped upon natural anxiety and possibly illness.”¹⁰⁰ Indeed, it seems unreasonable to expect individuals to respond to medical advice by seeking testing if, in so doing, they risk social isolation and economic dislocation. Anonymous testing or the confidentiality of test results would secure protection not only for individuals with “true positive” results but for the significant number of those individuals with “false positive” results as well.¹⁰¹

- (iii) Unauthorised possession/disclosure of personally identifiable AIDS-related information may constitute an invasion of privacy:

The literature on AIDS is replete with references to considerations of privacy and the notion that the release of such sensitive personal information without consent abrogates the individual right to control information about oneself. Although New Zealand law does not recognise any general right to privacy, specific rules of law and legislation do protect some aspects thereof. The trend in some overseas jurisdictions appears to be towards the fuller development of this right.

Some overseas jurisdictions have adopted the principle of confidentiality either as

97 Even individuals outside these groups are understandably reluctant to come forward for testing as society is often quick to infer from statistics illustrating the majority of AIDS victims and HIV carriers are homosexual or bisexual males that any individual with AIDS or HIV is homosexual or bisexual.

98 P Nanula “Protecting Confidentiality in the Effort to Control AIDS” (1986) 24 *Harvard Journal on Legislation* 315.

99 Additional Recommendations to Reduce Sexual and Drug Abuse-Related Transmission of HTLV-III/LAV, 35 *Centres for Disease Control: Morbidity & Mortality Weekly Rep* 152 (1986).

100 M D Kirby, *op cit*, Paper, at 14.

101 See Section II.4.

a matter of policy or as a statutory prescription. Both the United Kingdom and Australian Federal Governments favour confidential testing as a matter of policy.¹⁰² At the Australian state level, the New South Wales Privacy Committee, a statutory body independent of government which acts as a sort of privacy ombudsman, believes that "great emphasis must be placed on assuring complete confidentiality to likely AIDS and 'at risk' groups. Only this will encourage the maximum number of people likely to be affected to come forward for testing."¹⁰³

Several American state legislatures have gone further and embodied the confidentiality principle in legislation.¹⁰⁴ The California Legislature has enacted legislation which prohibits compelling the identification of any individual who has taken an antibody test and provides civil and criminal penalties for unauthorised disclosures of the test results to third parties.¹⁰⁵ Similarly, Florida legislation provides that no person shall be compelled to identify any individual who has taken an antibody test, and only the test subject can consent to the disclosure of a test result.¹⁰⁶ The Wisconsin Legislature has also enacted legislation¹⁰⁷ providing for the confidentiality of test results. The Wisconsin statute requires informed consent for the disclosure of any test result, imposes civil penalties for negligent disclosure and criminal liability for intentional disclosure, and restricts permissible disclosures to the test subject and certain other persons or agencies.

In terms of the scope of permissible disclosure, few would question the inclusion of the test subject and his or her personal physician within the class of authorised disclosures. However, other disclosures are more controversial when conflicts arise between respect for confidentiality and a duty to warn others of possible risks of HIV transmission. Some commentators argue that the traditional confidentiality of the physician-patient relationship should be upheld in the case of persons with AIDS and HIV carriers such that personal health data should not be disclosed to anyone for any purpose other than the health care of that patient, unless the patient has previously consented.¹⁰⁸ Nevertheless, this traditional rule of ethics may not be entirely appropriate in the case of a new and fatal disease such as AIDS when others, such as spouses and other sexual contacts, are at substantial risk. Three American

102 Address by John Moore, Secretary of State for Social Services, to the United Nations on AIDS, 20 October 1987, at 4; see also n 65 above and the accompanying text.

103 "AIDS And the Law: Privacy Issues Paramount" *Privacy Bulletin* Vol 1, Pt. 3 (1985) 2.

104 At the federal level, a bill containing protections to keep testing and counselling records confidential was introduced in Congress on 30 July 1987. Negligent unauthorised disclosure would entail a civil fine of up to US \$2,000 while wilful unauthorised disclosure would constitute a criminal misdemeanour involving a US \$10,000 fine or a year in jail.

105 1985 California Legislative Service ch 1519 s 199.35 and California Health & Safety Code s. 199.21(a)-(d) respectively.

106 1985 Florida Laws ch 85-52 381.606(4).

107 1985 Wisconsin Laws Act 73 146.025.

108 L Beecham "Support for Confidentiality for AIDS Patients" (2 May 1987) 294 *British Medical Journal* 1177 (British Medical Association's advice on confidentiality).

commentators argue.¹⁰⁹

Doctors who reasonably believe that the patient's contacts would be jeopardized if there were no disclosure should seek the assistance of public health authorities. If that assistance is unavailable or unavailing, disclosure after careful consideration and consultation, in our view, would be morally and legally defensible.

In deference to the concern that confidentiality not be allowed to override health dangers, proposed federal legislation on AIDS introduced in the US Congress in July 1987 permitted notification of the risks involved to the spouses and sexual contacts of infected individuals. Life itself becomes the overriding consideration here.

AIDS research also presents conflicting considerations. Such research can involve the study of identifiable medical records. Some argue that the duty to protect the public health and the necessity to collect data warrants an overriding of the right to confidentiality to facilitate research into AIDS and HIV transmission. Nevertheless, the legislatures of at least three American states do not accept this argument. In Florida, test results may be disclosed during medical or epidemiologic research but without the test subject's name or other identifying characteristics.¹¹⁰ A New York law bars publication of AIDS research data in such a way that the identities of test subjects could be inferred,¹¹¹ while a California law protects against disclosure of all personally-identifiable research records unless the written consent of the research subject has been obtained beforehand.¹¹² It is difficult to see how these statutory requirements could unduly impede AIDS research efforts.

While government agencies and private organisations might be left free to develop their own formal procedures to guarantee confidentiality or anonymity of test results, legislation requiring anonymous or confidential testing is arguably needed for the following reasons:

- (i) to help create an atmosphere conducive to voluntary participation by individuals at risk in testing, counselling and education programmes.¹¹³ This will be achieved by denying access to AIDS-related information to those who might use it to discriminate against potential victims.¹¹⁴ The information-

109 M Mills, Dr C Wofsy and Dr J Mills "AIDS: Infection control and public health law" (1986) 314 *New England Journal of Medicine* 931 at 932.

110 1985 Florida Laws ch 85-52 381.606(4).

111 New York Public Health Law 2776(2) (McKinney 1984).

112 California Health & Safety Code 199.39 (West 1985).

113 Many of these individuals would arguably be unwilling to be tested unless they were assured that strict statutory confidentiality safeguards had been set in place.

114 Leading public health officials and civil liberties advocates voiced unanimity at the Atlanta Conference on the need for strong legislation to protect those who take the AIDS test from unauthorised release of their names which could lead to discrimination.

gathering process will thereby be enhanced and thus further the research and treatment goals that underlie testing programmes.¹¹⁵

- (ii) to provide authoritative guidance by prescribing the permissible uses, holders and disclosures of AIDS-related information and whether or not the written consent of the test subject must be procured in any particular case.
- (iii) to provide appropriate penalties designed to deter the unauthorised release of AIDS-related information.¹¹⁶

In addition to, and, *a fortiori*, in the absence of, legislative provisions on confidentiality, clinics and other health care institutions involved in testing should adopt clear and specific confidentiality guidelines. Anonymity has been found in the American experience to be the best guarantee of confidentiality whereby codes or numbers substitute for names or other identifying criteria for the duration of the testing process.¹¹⁷ This type of system has been endorsed by the New Zealand AIDS Advisory Committee and is used in New Zealand AIDS Foundation clinics. In the absence of legislation and anonymous testing, clinic or laboratory records of test results should not be released, as a general rule, without the signed consent of the test subject in order to avoid a charge of breach of confidentiality.

Recommendation: As a general principle, testing should only be performed when confidentiality of test results, whether positive or negative, or anonymity of testing, can be guaranteed.¹¹⁸ AIDS-related personal information disclosures should be limited to those which are absolutely necessary to control the spread of HIV. Accordingly, legislation should be enacted to prohibit the disclosure of identifiable test results to anyone except:¹¹⁹

- (i) the test subject;
- (ii) the physician who required the test and other health care personnel directly responsible for treatment;
- (iii) a blood bank or centre which has subjected a person to a test to determine the medical acceptability of blood or blood products secured from that person or to investigate HIV infection;
- (iv) the spouse and/or sexual partners of a test subject (provided the physician who required the test is reasonably satisfied that the health of the former would be

115 Nanula, *op cit*, 343.

116 Dr James O Mason, Director of the US Centers for Disease Control, has urged US state governments to pass "stringent legislation" to punish the unauthorised disclosure of test results: *New York Times*, 11 May 1987, B5.

117 Concern about discrimination has resulted in most voluntary tests offered in the U.S.A. being done anonymously: *Time*, 2 March 1987, 44. New York City has expanded its anonymous testing sites recently to encourage greater voluntary participation in testing programmes.

118 Canadian Working Paper at 5 at 33.

119 The test subject should have the option of authorising in writing the disclosure of his or her test results to anyone.

threatened if no disclosure were to be made).

2 *Discrimination*

Discrimination in the AIDS context can occur in a wide range of areas including employment, insurance coverage, housing, education, the public and private provision of health care, transportation and other goods and services, trade union membership, and access to public places. Ostracism by family and friends and inevitable inferences regarding sexual orientation are also common byproducts of the public concern surrounding AIDS, a concern which is intensified by the belief that HIV can be spread through casual contact. In New York City alone, 314 AIDS discrimination complaints were filed in 1986.¹²⁰ In the United States, employers have dismissed persons with AIDS and HIV carriers, persons perceived as having AIDS or HIV, and members of high-risk groups, either on their own initiative or at the request of co-workers.¹²¹ The New South Wales Anti-Discrimination Board has received complaints from not only those who have AIDS or HIV but from those who are assumed to have AIDS or HIV. Included in the latter category are homosexuals or persons perceived as homosexual, haemophiliacs, some ethnic minorities, and health care personnel treating such persons.¹²² The Board has received in particular numerous reports of on-the-job harassment, dismissal and attempted segregation of homosexuals and of efforts to force them to undergo tests.¹²³

Discrimination in the workplace is particularly noxious to the extent that it is based on fear through misinformation. It is difficult to discern any justification for testing on the ground of protecting others in the workplace when medical science has not established that HIV is spread by casual contact.¹²⁴ Dismissal of employees in these circumstances will only increase the psychological and emotional harm and the risk of their becoming burdens on the public welfare system. Unless the stage of affliction of HIV carriers and AIDS sufferers impinges on their ability to satisfactorily fulfil work duties or the workplace requires participation in activities through which HIV could be transmitted, mere uneasiness by co-workers, customers and employers is insufficient to override the important rights at stake. The US Department of Health and Human Services has issued guidelines for AIDS in the workplace which discourage routine blood testing and restrictions on employees who have AIDS or HIV.¹²⁵ Pending the enactment of appropriate anti-discrimina-

120 *Time*, 2 March 1987, 44.

121 Leonard "Employment Discrimination Against Persons with AIDS" (1985) 10 *U Dayton L Rev* 683, 685-686.

122 Australian Law Reform Commission [1986] Reform 9.

123 *Time*, 25 May 1987, 60.

124 See n 15 and accompanying text.

125 Summary: Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace, 34 *Centers for Disease Control: Morbidity and Mortality Weekly Rep* 681 (15 November 1985).

tion legislation, government-sponsored education would help to quell the unfounded fears of employers and employees alike.

Several US state legislatures have passed comprehensive AIDS anti-discrimination legislation. California legislation prohibits employers from demanding that an applicant for employment or current employee submit to testing or divulge test results to determine suitability for employment.¹²⁶ Wisconsin legislation similarly prohibits employers requiring testing as a condition of employment of any employee or prospective employee and also prohibits termination of employment of a tested employee.¹²⁷ Florida legislation also prohibits testing to be used to determine suitability for employment as well as unlawful discriminatory practices against persons with AIDS by education authorities, insurers, labour organisations, and persons offering rental accomodation.¹²⁸

Recommendation: Legislation should be enacted to minimise irrational differential treatment of persons with AIDS, HIV carriers, and persons commonly perceived as falling into these categories by virtue of their belonging or allegedly belonging to certain at risk groups.¹²⁹ Pending the enactment of such legislation, government-sponsored public education programmes¹³⁰ designed to correct misconceptions concerning the modes of HIV transmission should be devised and implemented.

IV REPORTING OF AIDS AND HIV ANTIBODY RESULTS

Various jurisdictions have had to confront difficult questions concerning whether reporting should be confined to cases of AIDS itself or include as well positive HIV

126 199.21 of the Health & Safety Code, as amended by Assembly Bill No 488 of the 1985-86 Regular Session.

127 1985 Wis Laws Act 73 103.15.

128 1986 Fla Laws HB 482. At the local government level, the Los Angeles City Council unanimously passed Ordinance 160289 (19 August 1985) banning discrimination against persons with AIDS or any condition related thereto in employment, housing, medical and dental services, business establishments, city services and other public accomodations. In the employment context, discrimination in hiring, promotion and termination practices and the segregation of employees is prohibited.

129 As Justice Michael Kirby has cautioned, however, AIDS discrimination laws may not be a panacea since it is difficult to prevent discrimination happening in practice under current conditions of community alarm; discrimination laws, moreover, generally operate slowly to change community attitudes: see MD Kirby "The Five Commandments for New Legislation on AIDS", Paper delivered to the World Health Organisation Symposium on AIDS, Annecy, Switzerland, 20-21 June 1987, at 14. At the time of writing, the New Zealand Government was considering, but had not yet decided on, a Human Rights Commission recommendation that the prohibited areas of discrimination under the Human Rights Commission Act 1977 be widened to include "AIDS or AIDS related conditions or HIV virus" and "sexual orientation". See *Review of the Human Rights Commission Act 1977: Report to the Minister of Justice* (21 August 1987).

130 See Section II.7. above.

antibody test results, whether reporting should be performed on a "name-specific" or anonymous or confidential basis, and whether reporting should be compulsory or voluntary in nature.

The arguments put forward in support of case reporting and the information it provides include:

- (i) better overall control of the spread of AIDS and HIV infection through measurement of their spread and distribution patterns;
- (ii) the facilitation of discovery of a cure, vaccine and/or other preventive or treatment measures;
- (iii) better planning of future health care requirements;
- (iv) identification of high risk areas enabling appropriate education programmes to be implemented where most needed;
- (v) where reporting is name-specific, the facilitation of adequate treatment of victims and, if such treatment is impossible or unavailable, ensuring that they are warned and, if necessary, isolated, and that their partners are identified and tested.

Reporting of cases of HIV infection and particularly of AIDS itself has become a common legal response in various overseas jurisdictions to the AIDS pandemic. In Denmark, Iceland, Norway, Sweden, France and South Korea, AIDS has been made a notifiable disease whereby physicians are legally required to notify cases to public health officials. Physicians, hospitals and laboratories throughout the United States are required by law to report AIDS cases to public health authorities, failure to do so entailing fines and, in a few cases, prison sentences.¹³¹ Since 1982, AIDS cases have been reported in the United Kingdom on a voluntary and confidential basis. AIDS was proclaimed a notifiable disease under New Zealand's Health Act 1956¹³² in 1983, and proclaimed an infectious disease under New South Wales's Public Health Act 1902 in 1984. Several Canadian provincial public health statutes have included AIDS as a notifiable disease to be dealt with similarly with other communicable diseases.

A legal requirement to report cases of HIV infection does not appear to be as common although the trend is towards such a requirement. Ontario's Health Protection and Promotion Act, SO1983, c 10 requires physicians to report the names and addresses of persons diagnosed as having either AIDS or HIV to the local

131 Update: AIDS-United States, 33 Centers for Disease Control: Morbidity and Mortality Weekly Rep 661-662 (1984).

132 Pursuant to The Infectious Diseases Order 1983, SR 1983/146, AIDS was added to the list of infectious diseases contained in the First Schedule, Section B of Part I of the Act that are notifiable to the local Medical Officer of Health.

medical officer of health. Some jurisdictions have opted for confidential or anonymous reporting of positive HIV antibody test results while others have insisted on name-specific reporting. Since 1982, cases of HIV infection have been reported in the United Kingdom on a voluntary and confidential basis. Sweden requires mandatory reporting of cases of HIV infection as do a number of Canadian provincial public health statutes, with or without identification of the test subject. Pursuant to a recent amendment to New South Wales's public health legislation, a positive HIV antibody test result is now a notifiable condition requiring physicians to report cases in a coded form to public health authorities.¹³³ South Korean legislation requires physicians to submit to the appropriate authorities the names of those patients who have been infected with HIV as well as those who have AIDS. As of February, 1987, nine US states¹³⁴ had already required that the names of all people who test positive for HIV be reported to health authorities. Trustees of the American Medical Association, however, favour the reporting of cases of HIV infection to public health officials only "on an anonymous or confidential basis."¹³⁵

In view of the severe consequences of AIDS and the need to acquire more information to better control it, an argument can be made for the compulsory reporting of all cases of AIDS and HIV infection. Nevertheless, it is submitted that the usefulness of reporting name-specific information to public health authorities does not outweigh the adverse social and economic consequences to infected persons of possible disclosure of the fact of their infection. Indeed, compulsory name-specific reporting may have a chilling effect on persons voluntarily undergoing testing because of a perceived fear that leakage of information concerning victims and carriers could result in an invasion of their personal privacy and discrimination.¹³⁶ This potential discouragement of some individuals from undergoing testing may undermine research efforts by diminishing the representativeness of the sample of known persons with AIDS and HIV carriers. As one US commentator contends:¹³⁷

133 Public Health (Proclaimed Diseases) Amendment Act 1985. Provision for disclosure of identity is made whenever necessary to safeguard the public health.

134 Arizona, Colorado, Idaho, Kentucky, Minnesota, Montana, New Jersey, South Carolina and Wisconsin.

135 New York Times, 21 June 1987, A26.

136 Dr. Blewett, the Australian Federal Health Minister, has suggested that compulsory reporting, at least in the absence of confidentiality guarantees, might be "counter-productive" in turning away the very people who need to be identified: Sydney Daily Telegraph, 25 September 1985, 8. The New South Wales Privacy Committee has argued strongly for confidentiality guarantees in this context.

137 Nanula, *op cit*, 339. Nanula argues in n 107 that: "Counselling and treatment of AIDS victims is normally carried out by the personal physicians of the victims, who already know the names of the victims from dealing with them prior to the illness. The use of numbers to identify patients in official reports from these doctors to the public health authorities would suffice to ensure that the doctors receive all the latest knowledge about AIDS from public health authorities and provide proper care for their patients."

Yet, the inclusion of victims' names in official [physicians'] reports does not significantly contribute to research, counselling or treatment, while it does increase the chances of infringing victims' privacy interests ... Reporting of AIDS cases without including information about identity furthers the public interest in gathering information necessary in the scientific pursuit of a cure for the disease, without imposing any costs on the individual.

It does not appear to be unreasonable to impose a legal duty upon physicians, hospitals, clinics and laboratories to report cases of AIDS and HIV infection to public health authorities provided confidentiality can be ensured. Should difficulties be encountered in providing sufficient safeguards against disclosure of identifiable test results to unauthorised parties, the reporting of test results should be done on an anonymous basis.

Recommendation: All cases of HIV infection as well as AIDS should be reported to the Department of Health pursuant to a compulsory legal requirement. Reporting should be done on an anonymous basis unless confidentiality of identifiable test results can otherwise be ensured.

V CONTACT TRACING

Contact tracing has been used extensively in North America in sexually transmitted disease control programmes. Contact tracing is essentially a search for the past and present sexual partners of an infected individual in order to facilitate their treatment and cure. In the AIDS context, the main goal of tracing differs since there is no cure. Sexual or needle-sharing partners of HIV carriers and persons with AIDS would be notified that they may have been exposed to, and infected with, HIV, and advised to seek testing and counselling. Responsibility for informing contacts may rest with the individual, the personal physician, or the public health authorities.

There are two main types of contact tracing - voluntary notification by the patient or personal physician, and statutory notification by public health authorities. The US Centers for Disease Control has recommended voluntary notification¹³⁸ which is arguably the least intrusive since it occurs within the confidential health care physician-patient relationship and relies upon the patient's cooperation.¹³⁹ Voluntary notification has also been recommended by the New Zealand AIDS Advisory Committee and encouraged by the New Zealand AIDS Foundation. Pursuant to statutory notification, public health officials have a statutory power or duty to

138 "Additional Recommendations to Reduce Sexual and Drug-Related Transmission of Human T-lymphotropic Virus Type III/Lymphadenopathy-Associated Virus," 35 Centers for Disease Control: Morbidity and Mortality Weekly Rep 152-155 (14 March 1986).

139 W Curran and L Gostin "The Limits of Compulsion in Controlling AIDS" Hastings Center Report, Vol 16, (6, Special Supplement) 24 at 29 (December 1986).

ascertain the identity of the relevant partners of an infected individual with a view to preventing further spread of the disease, usually through treatment of these partners. The two US cities with the most cases of AIDS, New York and San Francisco,¹⁴⁰ have begun notification programmes, as have state health departments in Colorado, Idaho, Minnesota and South Carolina. However, none of these programmes is comprehensive and most mainly rely on having the infected individual notify partners, with no certainty that this happens or is accompanied by counselling.¹⁴¹

The advantages cited by proponents of contact tracing include:

- (i) Notification and counselling of partners provides them with an opportunity to seek testing and to modify sexual or drug-abusing behaviour.
- (ii) Although some argue that educational efforts are a more cost-effective¹⁴² means of preventing additional cases of HIV infection than the tracing of contacts when so many individuals are already infected, others argue that tracing efforts amongst heterosexuals have been warranted since the prevalence of infection in that group is much lower, education is more sporadic, and the perception of risk is much less.¹⁴³ Indeed, the case for contact tracing for all groups may be stronger for New Zealand where the number of cases of AIDS and HIV infection to date is relatively manageable compared with that of the United States.

On the other hand, the disadvantages of contact tracing cited by its opponents include:

- (i) The public health benefits would be marginal since investigation of partners is most effective when there is a treatment available. Unlike gonorrhoea or syphilis, HIV infection is incurable.¹⁴⁴

140 The San Francisco Department of Public Health administers a limited contact tracing programme to reach those who have been exposed to HIV through heterosexual contact. The programme is not coercive as no one is obliged to reveal the names of sexual partners, and those traced are not required to submit to testing.

141 New York Times, 23 February 1987, A15.

142 According to the U.S. Centers for Disease Control, the cost of finding and counselling sexual partners of infected persons ranges from US \$90 to \$98 for each partner: New York Times, 3 June 1987, B8.

143 Mills, *op cit*, 933. Another high priority group for contact tracing might be women of child-bearing age since they may not be aware of their exposure to HIV and may proceed to become pregnant with concomitant risk to others as well as themselves: see the statement on contact tracing by the Canadian National Advisory Committee on AIDS (CDWR 1987; 13: 13-14).

144 According to Dr Stephen Joseph, New York City's Health Commissioner, "Until treatment was available ... [sexual] contact tracing did nothing to stem the spread of syphilis": Time, 2 March 1987, 44. The San Francisco Department of Public Health has not undertaken routine tracing of the sexual contacts of homosexual men with AIDS because there is no evidence that such tracing would slow the spread of the disease.

- (ii) Contact tracing is impractical since the extended incubation periods are not so definitive as to allow precise identification of relevant contacts. Moreover, as persons with AIDS and ARC may be infectious for a considerable period of time prior to being diagnosed, HIV transmission may have occurred too long ago to make tracing practicable.
- (iii) The unduly high costs of professional contact tracing in terms of financial and personnel resources.¹⁴⁵
- (iv) Breaches in the confidentiality of contact lists could lead to discrimination.

In addition to the foregoing disadvantages of tracing, whether voluntary or statutory, at least two more can be added which are specific to statutory notification:

- (i) Coercive statutory tracing measures would seriously undermine other public health strategies to contain AIDS based on the voluntary cooperation of infected individuals concerning testing and behaviour modification, and their trust in the confidentiality of the physician-patient relationship. High risk individuals would thereby be discouraged from coming forward to be tested.
- (ii) In the absence of the patient's consent, contact tracing by anyone, other than by the patient or (with consent) his or her physician, is a significant intrusion into individual rights of privacy.

Recommendation: In the absence of an effective treatment for HIV infection, contact tracing can only provide, at best, a useful complement to risk reduction information programmes targeted at the wider community. Tracing should neither be coercive nor statute-based, but should rather seek to encourage infected individuals to cooperate with their personal physicians and public health authorities in notifying sex or needle-sharing partners for the purposes of counselling and testing. Physicians should encourage their infected patients to notify their contacts. Alternatively, with their patient's consent, physicians should notify these contacts themselves or seek the assistance of public health officials for this purpose. Physicians should retain a discretion to inform unsuspecting contacts when there is a real possibility that they have been exposed to HIV, despite the infected patient's refusal of consent to such notification.¹⁴⁶

145 See n 142 above. These costs would vary, of course, with the general prevalence of infection and the health system in a particular jurisdiction.

146 An example of when a physician's duty to protect the confidentiality of an infected patient's test results might be overridden by a duty to warn others might be the case of an infected male who refuses to inform his spouse of child-bearing age: 34 Centers for Disease Control: Morbidity and Mortality Weekly Rep 721-726; 731-732 (1985).

VI QUARANTINE

As a public health infection control measure, a quarantine is designed to prevent a carrier from transmitting a (usually highly contagious) disease by physical isolation. In recent US history, quarantines have been instituted to control the spread of severe and highly communicable diseases such as typhoid, smallpox and tuberculosis.¹⁴⁷ Quarantine has been used only rarely for persons with sexually transmitted diseases¹⁴⁸ and most quarantines of this type have been aimed at prostitutes due to the frequency of their sexual activity.¹⁴⁹ In the AIDS context, a number of countries have either instituted, or are seriously contemplating, quarantine measures.¹⁵⁰

Although a case will be made shortly for limited quarantine measures, the following arguments against *widespread* quarantine can be mustered:

- (i) Quarantine of all HIV carriers would require a disproportionately high level of public resources. Such a quarantine would have to be supported by a widespread, coercive and periodic testing programme which, in itself, would involve a commitment of public resources of unacceptable magnitude.
- (ii) Any widespread quarantine programme would have to be founded upon coercive measures which would tend to discourage persons from seeking testing. This would undermine the alternative public health strategy of securing voluntary compliance by persons at risk.¹⁵¹
- (iii) Generally, quarantines have only been deemed necessary when the disease was communicable by casual contact. HIV infection is not spread through such contact.¹⁵²
- (iv) Quarantine of persons with AIDS or HIV would be for an indefinite and lengthy period since HIV may persist in a person for life. So long as an effective treatment remains unavailable, those persons under quarantine would have no way to restore themselves to their previous condition in order to rejoin society.¹⁵³ Long-term quarantine of large populations in isolated communities has been invoked in this century only for leprosy, and that use

147 J A Gleason "Quarantine: An Unreasonable Solution to the AIDS Dilemma" (1986) 55 U of Cincinnati Law Review 217, 221.

148 Mills, *op cit*, 934.

149 Gleason, *op cit*, 224.

150 In Sweden, anyone who knowingly transmits HIV may be isolated against their will in a hospital. In India, the Tamil Nadu state government is holding under virtual house arrest 24 prostitutes who tested HIV positive. In Iceland, the government is planning to quarantine persons who continue to have sexual relations with uninfected partners despite their knowledge that they carry HIV. See *Time*, 25 May 1987, 58.

151 Curran and Gostin, *op cit*, 28.

152 See n 14 above and the accompanying text.

153 Curran and Gostin, *op cit*, 27.

- is now widely thought to have been unjustified.¹⁵⁴
- (v) "False positive" results could result in the lifelong involuntary confinement of healthy persons. Notwithstanding the subsequent discovery of the mistake, a debilitating stigma might well endure for life. On the other hand, "false negative" persons would continue to remain in the community at large.
 - (vi) Involving as it does an involuntary incarceration, quarantine would *prima facie* infringe individual liberty,¹⁵⁵ the right to privacy, the freedom of association and the right to cohabit with one's spouse and children. Moreover, quarantine would involve stigma, discrimination and disruption to the lives of not only HIV carriers but to those of their immediate family as well. A long-term, widespread quarantine must surely entail significant adverse economic consequences as well. Therefore, governments should implement, and only when demonstrably justified, the least intrusive means to control the spread of HIV infection by selecting those options which impair individual rights to the least degree consistent with the protection of public health. Widespread quarantine would needlessly confine many HIV carriers since only a small proportion of the entire population of HIV carriers would be likely to intentionally engage in unsafe sexual behaviour or the shared use of contaminated needles. Hence the desirability, indeed the necessity, for narrowly targeted quarantine laws.

The foregoing arguments underline the need for quarantine laws to be targeted in their application with precision in order to avoid overinclusiveness and consequent injustices. A law authorising the quarantine of all HIV carriers of a particular high risk group would be overinclusive since it would unduly limit casual contacts that are harmless in terms of risk of transmission.¹⁵⁶ Statutory criteria must consider both the unwillingness or inability of proposed quarantine subjects to behave in a responsible manner. Health professionals concede that some patients are so incompetent that no voluntary measure is adequate to protect the public health. Similarly, a quarantine of HIV carriers who are already engaged in unlawful conduct and are unable or unwilling to avoid high risk activities - viz some prostitutes and intravenous drug abusers - arguably is targeted with sufficient precision. A 1985 amendment to the Connecticut Public Health Statute, for example, authorises a local health director to order the confinement of a person if he or she has reasonable grounds to believe that the person is infected with a communicable disease and is unable or

154 A S Benenson (ed), *Control of Communicable Diseases in Man* (American Public Health Association, Washington, D.C., 1980, 13th ed) 192.

155 Two American commentators describe quarantine as "the most serious form of deprivation of liberty that can be used against a competent and unwilling person" since, *inter alia*, "it is not subject to the same rigorous due process procedures as in a criminal charge" and "[i]t is based upon what a person *might* do in future rather than what he or she has done". See Curran and Gostin, *op cit*, 26.

156 As John Gleason aptly states, "an individual who ... is infected with the AIDS virus is not a threat to others simply by being in the general public." See J A Gleason, *op cit*, 232.

unwilling to act so as not to expose others to infection.¹⁵⁷ Pursuant to New York Public Health Law 2120(1)-(3), the New York Board of Health has power to quarantine individuals afflicted with, or carrying, a communicable disease who are unwilling or unable to conduct themselves in a manner so as not to endanger others. Prostitutes, mental health patients and infected individuals who knowingly continue to maintain an active multi-partner sex life would presumably fall within the ambit of these statutory provisions. Similarly, in the United Kingdom, pursuant to sections 37 and 38 of the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Diseases) Regulations 1985 enacted thereunder, a justice of the peace (acting, if he deems it necessary, ex parte at the instance of health authorities) may order an individual to be removed to, and detained in, hospital if satisfied that he or she is afflicted with AIDS and that proper precautions to prevent the spread of infection cannot or are not being taken thereby causing serious risk of infection to others.¹⁵⁸

US courts have held that the quarantine of prisoners is a valid state action because of the extraordinary conditions obtaining in prison. In *La Rocca v Dalsheim*,¹⁵⁹ the Department of Correctional Facilities instituted a plan to segregate persons with AIDS from the other prisoners to inhibit its spread. The court noted that prisons have both a high rate of sexual contact, much of it by force, and intravenous drug use. This, added to the fact that the prison population is constantly changing, makes it foreseeable that infection will spread if precautions are not taken.¹⁶⁰ The court thus held that the prison had acted reasonably in its attempt to stop HIV transmission and that it was "the state's obligation to provide a safe and humane place of confinement for its inmates."¹⁶¹ Consistent with *La Rocca*, the court in *Cordero v Coughlin*¹⁶² upheld the constitutionality of the quarantine of persons with AIDS, concluding that the quarantine was a reasonable method of attaining the legitimate governmental interest of keeping both the infected and uninfected safe from the harm and tensions that could result if the persons with AIDS were not segregated, and that the rights of privacy and free association are already limited in the prison setting.¹⁶³

Recommendation: Public policy must concern itself with the welfare of those at risk of exposure to HIV as well as with those whose civil liberties may be threatened. Consideration should be given, therefore, to the enactment of limited quarantine legislation that requires, as a condition of quarantine, a determination after a full and fair hearing that a person with AIDS or HIV carrier will not, or cannot, refrain from

157 Curran and Gostin, op cit, 27. Cf s 70(1)(f) of the Health Act 1956 (NZ).

158 HIV carriers do not appear to fall within the ambit of the provisions, however.

159 467 NYS 2d 302 (NY Sup Ct 1983).

160 Ibid 309.

161 Ibid 310. The court implied (at 311) that the quarantine of AIDS victims precluded their sexual contact with others and thus diminished the spread of the disease.

162 607 F Supp 9 (DCNY 1984).

163 Ibid 10-11.

engaging in conduct likely to spread HIV. Such a limited use of the quarantine power would not be overinclusive since there would be a reasonable and demonstrable relationship between the restriction to be applied and a compelling public health purpose.¹⁶⁴

VII THE IMPOSITION OF CRIMINAL LIABILITY FOR HIV TRANSMISSION

Recently a West German court found an HIV carrier guilty of grievous bodily harm and sentenced him to a one-year jail term for having unprotected sexual intercourse with a woman even though he knew of his antibody status.¹⁶⁵ In Ottawa, Canada, an HIV carrier was charged, after a considerable interval, with common mischief after having knowingly donated infected blood to the Red Cross. Prosecutors had delayed in laying criminal charges because of a lack of precedents and laws dealing specifically with AIDS and HIV.¹⁶⁶

It is a common feature of public health legislation to provide for offences concerning the wilful failure to adhere to accepted measures to avoid exposing others to an infectious disease. A number of US states, including Texas, New York, California, Pennsylvania, Colorado and Florida, have statutes which make it a crime for an individual who knows he or she has an infectious venereal disease to have sexual intercourse with another.¹⁶⁷ These statutes provide a precedent for the use of the criminal law in the AIDS context. Nevertheless, the imposition of criminal liability for HIV transmission has been opposed on a number of grounds, including:

- (i) The inherent limitations of the law in modifying behaviour. As one Australian commentator recently observed, "our experience in such areas as alcohol prohibition ... prostitution and drug use should teach us that the criminal law ... is ... relatively ineffective as a mechanism for modifying the behaviour stigmatised."¹⁶⁸
- (ii) The difficulty in bringing a successful prosecution due to evidentiary and enforceability problems. Those who engage in statutorily prohibited sexual conduct are scarcely deterred due to the extreme underenforcement of such laws.¹⁶⁹ Even if AIDS prosecutions could reach the courts before the demise

164 Curran and Gostin, *op cit*, 27. A separate recommendation concerning prisoners appears in a subsequent section.

165 The Dominion (Wellington, New Zealand), 22 April 1988, 4.

166 The Ottawa Citizen, 27 February 1988, B16. The other existing criminal charges that were considered potentially applicable included attempted murder and criminal negligence (which includes intentional or reckless disregard for the safety of other persons).

167 Curran and Gostin, *op cit*, 28.

168 M D Kirby "The Five Commandments for New Legislation on AIDS", Paper delivered to the World Health Organisation Symposium on AIDS, Annecy, Switzerland, 20-21 June 1987, at 21.

169 Nanula, *op cit*, 329.

of the offender and/or victim, it would be difficult to prove beyond a reasonable doubt that an individual intentionally or recklessly transmitted HIV especially in those cases which turn on the uncorroborated evidence of the victim who usually would not realise that a former sexual partner exposed him or her to HIV until months or even years later.¹⁷⁰

- (iii) The perception of health officials that criminalising such behaviour would discourage those individuals who suspect they have been exposed to HIV from coming forward and cooperating with them.
- (iv) The objection to the use of criminal law to penalise private sexual encounters between two consenting adults.¹⁷¹

Yet the imposition of criminal liability for HIV transmission has been supported on the following grounds:

- (i) Knowingly spreading HIV is a cruel and anti-social act given the debilitating and deadly character of AIDS, and is just as dangerous as other behaviour that the criminal law already proscribes.
- (ii) The criminal law with its attendant advantages¹⁷² offers a "tighter fit" between means and the relevant public health objective. Each convicted individual will have demonstrably fallen short of what the law has already proscribed as unacceptable conduct; conversely, alternative public health measures, such as the quarantine of individuals who *might* engage in the proscribed conduct in the future, almost invariably have an overinclusive impact on individuals who will not pose an actual risk to public health.¹⁷³

Despite the disadvantages outlined above, public policy-makers in numerous jurisdictions have considered it necessary to criminalise the wilful transmission of HIV. Bills have been introduced in several US states which would criminalise wilful exposure by an HIV carrier of another either through sexual contact or blood donation. Recent Queensland legislation¹⁷⁴ subjects a person who knowingly infects any other person with AIDS to a penalty not exceeding \$10,000 and/or imprisonment for a period not exceeding two years. Pursuant to recent New South Wales legislation,¹⁷⁵ a person who knows he or she has AIDS and has sexual intercourse with another unsuspecting person commits an offence carrying a \$5,000 penalty.

170 Curran and Gostin, *op cit*, 29.

171 Yet it may be argued that these sexual encounters are not consensual if the HIV carrier fails to inform the partner, and that the encounters are not wholly private since they clearly have wider public health implications.

172 These include, *inter alia*, proof beyond a reasonable doubt of a specific dangerous act which is objectively worded in the statute, a strict standard of procedural due process, rights of appeal, and a penalty proportionate to the gravity of the offence.

173 Curran and Gostin, *op cit*, 28.

174 Health Act Amendment Act 1984 (No 2), s 2 amending the Health Act 1937.

175 Public Health (Proclaimed Diseases) Amendment Act 1985, amending the Public Health Act 1902.

Recommendation: As a mechanism for controlling the spread of HIV, the criminal law does have a deterrent role to play but one which must be subordinate to that of public education, support services and counselling. The criminal law can and should be used to proscribe behaviour likely to communicate HIV when an individual knows that he or she is infected and appreciates the threat to health posed by the behaviour but nevertheless fails to inform sexual or needle-sharing partners of his or her antibody status. Although at least two existing New Zealand statutory provisions could be used¹⁷⁶ or amended¹⁷⁷ to address this problem, given the *sui generis* nature of the medical and social implications of AIDS and HIV, statutory provisions confined specifically to AIDS and HIV should be enacted.¹⁷⁸

VIII RECOMMENDATIONS ON HIV ANTIBODY TESTING IN NEW ZEALAND

The following recommendations relate to specific individuals or groups and are based on the presupposition that for testing to be justified:

- (i) the benefits of testing must outweigh the potential harm to individuals and the costs to society of testing;
- (ii) there must exist a reasonable perceived risk of HIV infection based on such considerations as the current prevalence of infection and the known modes of transmission;
- (iii) the selection of individuals or groups to be tested must be clearly defined and must not discriminate irrationally against them.¹⁷⁹

1 *Persons Entering New Zealand Permanently*

Some countries have already excluded, while others are planning to exclude, permanent entry applicants who test positive.¹⁸⁰ The US Government has instructed the Immigration and Naturalization Service to add HIV to the list of dangerous

176 The Crimes Act 1961, s 201 provides that "Every one is liable to imprisonment for a term not exceeding 14 years who, wilfully and without lawful justification or excuse, causes or produces in any other person any disease or sickness." At the time of writing, a Justice Department source advised the writer that it is proposed to retain s 201, as well as to introduce a general "endangering" offence, in the Crimes Bill shortly to be introduced in Parliament.

177 The Health Act 1956, s 92 provides that "Every person who knowingly infects any other person with a venereal disease, or knowingly does or permits or suffers any act likely to lead to the infection of any other person with any such disease, commits an offence and is liable ... to a fine not exceeding \$1,000 or to imprisonment for a term not exceeding one year, or to both." For the purposes of s 92, the definition of venereal disease could be extended to include AIDS and HIV.

178 In Canada, the federal justice department is now looking at ways to revise the Criminal Code to include provisions directed at individuals who knowingly transmit HIV to others.

179 See the Canadian Working Paper at 23-25.

180 South Korea and Saudi Arabia both require tests for foreigners applying for work permits or long-term residence: New York Times, 16 May 1987, A1.

diseases immigrants are tested for and concerning which a positive test result entails exclusion.¹⁸¹ The US testing programme covers all immigrants, refugees¹⁸² and illegal aliens applying for legal resident status. The rationales of these measures transcend the desire to slow the spread of HIV in the country concerned, for, as the authors of the Canadian Working Paper state:¹⁸³

The permanent entry of HIV-infected persons to [a country] could represent a potentially major burden for [its] health and welfare system. The exclusion of such persons may be justifiable where permanent entry to a country is considered to be a privilege. Consequently, mandatory or compulsory testing of anyone applying for permanent entry may be proposed as a method to diminish the additional cost of this disease...

Nevertheless, mandatory testing and exclusion of all positive applicants would be overinclusive in its reach. Exclusion criteria should also focus on evidence relating to a past history of high risk behaviour on the part of the particular applicant. Therefore,

Recommendation: All applicants for New Zealand permanent entry should be tested in their respective countries of origin. Testing should be performed by a New Zealand physician or other authorised health care provider pursuant to certified procedures to ensure the quality and accuracy of the testing. Only those applicants with AIDS (barring countervailing compassionate grounds) or those applicants who test HIV positive and whose past history evidences behaviour tending to put others at substantial risk should be denied entry. All successful applicants for entry, whether infected or not, should be informed about safe behaviour and the availability of counselling services prior to their arrival.

2 *Persons Entering New Zealand Temporarily*

Belgium, China¹⁸⁴ and India¹⁸⁵ now require tests for foreign student visa applicants while the Japanese Government has introduced legislation that would deny visas to foreigners who carry HIV and are considered likely to spread it in Japan.¹⁸⁶ Other nations, including the United Kingdom, have considered testing those travellers who come from areas where AIDS is widespread.¹⁸⁷

181 The House of Delegates of the American Medical Association has indicated its approval to testing of would-be immigrants: *New York Times*, 24 June 1987, A22.

182 Refugees might be considered in a special category, however, since they face serious danger if returned to their country of origin.

183 Canadian Working Paper at 77.

184 *New York Times*, 16 May 1987, A1.

185 *New York Times*, 1 March 1987, A35.

186 *New York Times*, 1 April 1987, A18. The groups targeted by the Japanese legislation include female prostitutes, male homosexuals and intravenous drug abusers.

187 *New York Times*, 5 March 1987, B6.

The World Health Organisation concluded in 1986, however, that testing of international travellers is not warranted as a measure to prevent HIV transmission and, accordingly, advised its member states against considering such measures.¹⁸⁸ In March, 1987, the WHO Special Programme on AIDS convened an expert group of epidemiologists and disease control experts to discuss various issues related to HIV infection and international travel which concluded that serious logistic, epidemiological, economic, legal, political and ethical problems are inherent in any proposal to test international travellers for HIV.¹⁸⁹ The expert group identified the following drawbacks to such a testing programme:¹⁹⁰

- (i) the extraordinary difficulties in implementation;
- (ii) its inability under any circumstances to prevent the introduction and spread of HIV infection;¹⁹¹
- (iii) it would divert resources away from more effective educational programmes on AIDS and measures to protect the blood supply from HIV contamination;¹⁹²
- (iv) it would, at best and at great cost, retard only briefly the spread of the HIV pandemic globally or with respect to any particular country.

The WHO itself has reaffirmed its view that testing of international travellers would be a costly and inefficient public health measure with minimal effect.¹⁹³ To the above list of concerns of the expert group over the testing of international travellers can be added the following:

- (i) because months can pass between HIV infection and the formation of antibodies, testing would not provide an infallible means of detecting antibody presence in a recently infected individual;
- (ii) the significant number of "false positive" test results will bar entry of a corresponding number of AIDS and HIV-free individuals;
- (iii) a programme to test international travellers would logically have to apply as well to returning nationals;
- (iv) the testing of international travellers with a view to their exclusion in the event of a positive test result would prevent many visitors who may have no intention or opportunity to transmit HIV from contact with family and friends or from pursuing short-term educational or employment opportunities;

188 WHO, *In Point of Fact* (1986) A-5.

189 Communication from the Director-General of the WHO, Ref: CL 8 1987, 7 April 1987, Geneva.

190 *Idem*.

191 No current screening system can prevent the introduction and spread of HIV infection.

192 Rather than test, the expert group recommended education programmes directed to both national and international travellers and conveying information on modes of HIV transmission and prevention, and areas of high HIV incidence.

193 See above n189.

- (v) apart from the huge direct costs involved in the testing of all international travellers, the loss of travel and tourism opportunities would affect locals as well as travellers.

Recommendation: Coercive testing of individuals entering New Zealand for the purposes of travel or short-term study or work would be too costly, impractical and inefficient. Nevertheless, they should be informed of HIV infection and safe behaviour and the availability of voluntary testing and counselling services. Likewise, New Zealanders travelling overseas should be provided with educational materials on how HIV is transmitted, specific preventive measures and areas of high HIV incidence.

3 *Prostitutes*

Prostitutes face an increased risk of HIV infection from their large number of sexual contacts, and therefore constitute a source of HIV transmission if infected. Prostitutes are considered possible vectors by which HIV is spread from homosexuals, via bisexuals, to the heterosexual community.

Calls have been made for the registration and testing of prostitutes and the quarantine or banning of those who test positive. South Korea and the West German State Government of Bavaria have begun the compulsory testing of prostitutes.¹⁹⁴ The state of Mississippi issued last year a quarantine order of indefinite duration against an HIV-infected male prostitute which prohibits him from donating blood and having sex without informing his partner of his condition as well as requiring him to attend a sexually transmitted disease clinic.¹⁹⁵ Consistent with the philosophy of this paper, however, generally such coercive measures should only be implemented as and when it is demonstrated that voluntary cooperation and self-policing by the individuals and groups concerned have failed.

Recommendation: Voluntary testing is strongly encouraged for prostitutes, particularly those who have engaged in unprotected sexual activities. Such testing should be supplemented by the promotion of safe-sex methods by and amongst prostitute groups.

4 *Prisoners*

In June 1987, the US Federal Government announced its intention to begin testing

¹⁹⁴ New York Times, 27 February 1987, B12.

¹⁹⁵ New York Times, 12 February 1987, B17. Breach of these conditions would entail a jail sentence and fine. Although touted to be the best public health measure consistent with the least restriction, problems of unenforceability might occur.

on a routine basis all individuals sentenced to Federal prisons.¹⁹⁶ The West German State Government of Bavaria has ordered compulsory testing for prisoners and individuals in police custody¹⁹⁷ while France tests prisoners in the course of routine medical examinations. There have also been calls for routine testing of prisoners in New Zealand.

The testing of prisoners has been proposed as a means of gauging the extent of HIV infection among prisoners and of protecting uninfected prisoners and prison personnel from HIV infection. The segregation of HIV-infected prisoners has also been advocated to protect not only the health of uninfected prisoners and prison personnel but the safety of the infected prisoners themselves. Proponents of testing and segregation of prisoners cite the special conditions which exist in prison including the closed and dependent nature of the prison environment, the high turnover of prisoners, and the incidence of intravenous drug use and both consensual and non-consensual unprotected sexual intercourse among prisoners.

Calls for testing of prisoners and the segregation of HIV-infected prisoners have tended to be overinclusive and this has been due in part to misunderstandings held by prisoners and prison personnel concerning HIV infection and its transmission. Testing and segregation measures should only be undertaken for medical reasons associated with the welfare of prisoners. The development and implementation of education programmes on HIV infection and safe-sex for both prison inmates and personnel might reduce the level of hostility towards those prisoners known or thought to be infected, thereby reducing the need for, and cost of, segregation. Indeed, segregation should not be ordered simply because a prisoner is seropositive since it is not the antibody status but the propensity for high risk behaviour which is the real concern. Prisoners, especially those who have engaged in high risk activities, should be encouraged to seek testing and counselling.

Given the impracticality of preventing high risk behaviour in prisons, the focus should instead be on eliminating the risks from such behaviour. Sterile needles and syringes should be made available to supplement expanded drug use rehabilitation programmes in order to reduce and ultimately eliminate the risk inherent in needle

196 This initiative was supported by the American Medical Association: see *New York Times*, 21 June 1987, A26.

197 *New York Times*, 27 February 1987, B12. At the time of writing, s 155 of the Law Reform (Miscellaneous Provisions) Bill proposes to add to s 36 of the Penal Institutions Act 1954 a provision enabling the medical officer of any penal institution to require an inmate to submit to tests to determine whether the inmate is suffering from AIDS or carrying HIV antibodies if the officer considers that, having regard to the personal circumstances of the inmate, it is desirable that the inmate have such tests. An inmate who refuses to be tested may be dealt with administratively as if he or she were suffering from AIDS in any case where, in the opinion of the medical officer, the inmate is displaying AIDS symptoms or, in any other case, as if he or she were carrying HIV antibodies.

sharing. Pending adoption of a needle exchange scheme, bleach should be made available and prisoners educated in its cleansing properties. Consideration should also be given to the availability of condoms to prisoners.

Recommendation: Education programmes on HIV infection and safe-sex should be implemented in prisons. Confidential voluntary testing accompanied by pre- and post- test counselling and informed consent should also be made available to prisoners. Segregation should be reserved for those prisoners who wilfully or negligently infect other prisoners through the use of force or duress in relation to sexual activity, or through the sharing of contaminated drug injection equipment, or in order to protect infected prisoners from victimisation by other prisoners.

5 *Armed Forces*

Sweden has instituted testing of its armed services recruits while France tests its armed services personnel in the course of routine medical examinations. Since October 1985, over three million US Armed Forces recruits and active-duty personnel have been tested on a mandatory basis; recruits testing positive are barred from joining the military while active-duty personnel testing positive are discharged.¹⁹⁸ The US Defense Department has sought to justify its testing and discharge policies on the following grounds:

- (i) infected recruits may have adverse reactions to a routine immunisation with multiple live virus vaccines;
- (ii) if infected personnel are assigned overseas, the risks of other infections and the unavailability of adequate health-care facilities increase;
- (iii) concern for the battlefield need for risk-free emergency blood transfusions;
- (iv) concern for the need to be able to deploy personnel anywhere on short notice without worrying about them being weakened by HIV and their possible exposure to various diseases in hostile environments.

These concerns, or some of them at least, might well apply to the New Zealand Armed Forces. Nevertheless, they hardly justify coercive mass (as opposed to selective) testing of recruits and current personnel. Moreover, since medical science has not established that HIV can be transmitted by casual contact, neither persons with AIDS nor HIV carriers should be automatically denied the opportunity to serve, or continue to serve, in the military so long as they are able to perform their duties and pose no risk to others. Therefore,

Recommendation: Coercive testing is unwarranted for individuals who are serv-

198 New York Times, 27 November 1985, at 11.

ing in, or are seeking entry to, the military, except where cogent reasons or specific benefits may justify this. The exclusion or discharge of an applicant or a member of the armed services respectively is unjustified in the absence of evidence of employment-related risk to others or to the health of the HIV carrier or person with AIDS concerned.¹⁹⁹

6 *Expectant Mothers*

The babies of HIV-infected mothers constitute the intended class of beneficiaries of the testing of women contemplating pregnancy, since HIV can pass from mother to infant before or during birth.²⁰⁰ US Surgeon General C Everett Koop's recommendation²⁰¹ that any woman who wants to have a baby should voluntarily undergo preconceptual testing appears overinclusive. Therefore,

Recommendation: Voluntary preconceptual testing should be encouraged amongst those women who plan to have children and are at special risk of HIV infection. These include women who have used illegal intravenous drugs or have had sex partners who have used such drugs, women who had sexual intercourse with a bisexual male, and women who reside in areas with a high incidence of HIV infection.²⁰²

7 *Premarital Testing*

France requires testing prior to the issuance of marriage licences to protect the prospective marriage partners as well as their future children.²⁰³ In June 1987, President Reagan announced his intention to encourage states to "offer routine testing for those who seek marriage licences" contending that this "might prevent at least some babies from being born with AIDS".²⁰⁴

Other possible advantages of premarital testing include the provision of counselling opportunities and valuable information about the spread of HIV infection through the general population. In terms of a possible precedent, numerous US states require a syphilis test for marriage licence applicants as a means of limiting the risk of infection to prospective spouses or children. Nevertheless, the trend has been to

199 See the Canadian Working Paper at 74-75.

200 See above n18 and the accompanying text. According to Dr. Walter Dowdle, CDC AIDS Director, there is a 30% to 50% chance of an infected mother transmitting HIV to the newborn: New York Times, 4 February 1987, A16.

201 New York Times, 25 March 1987, B4.

202 The thrust of this testing philosophy was generally supported by experts at the Atlanta Conference: New York Times, 25 March 1987, B4. Dr James O Mason, CDC Director, has also supported testing along these lines: New York Times, 11 May 1987, A1.

203 Time, 25 May 1987, 58.

204 New York Times, 1 June 1987, A15.

abandon the syphilis test as costly and unproductive.²⁰⁵ The Center for Disease Control and state public health officials similarly concluded at the Atlanta Conference that routine or mandatory premarital HIV antibody testing would be a very expensive way to turn up a few cases of HIV infection. This view is also held by the American Medical Association which has described premarital testing as "costly and inefficient".²⁰⁶

The Centers for Disease Control consider that widespread premarital testing "is unlikely to be very effective even in a community with a high general prevalence of HIV infection" because most HIV carriers are drug users and homosexuals who are already sexually active and in respect of whom the incidence of marriage is low.²⁰⁷

Premarital testing raises other concerns such as exposure to HIV between the test and marriage dates and the phenomenon of premarital sex. In areas or countries like New Zealand where there is a relatively low general prevalence of HIV infection, it cannot be considered a cost effective use of public resources to test a large number of individuals to identify a few infected individuals. Also, are applicants who test positive to be denied a marriage licence? Should the ultimate decision to marry and bear children in these circumstances reside with the State or the prospective spouses?²⁰⁸ Therefore,

Recommendation: Although widespread coercive premarital testing is unwarranted, testing should be readily available on a voluntary basis where one or both prospective spouses desire it, especially if they fall within a category concerning which there is a recognised high risk of infection.

8 *Blood, Organ, Tissue, Ovum, or Sperm Donors and Recipients*

The World Health Organisation has acknowledged that testing for HIV infection among blood donors is "a well-accepted and effective ... public health measure."²⁰⁹ This has been borne out by the effectiveness of current testing programmes in the United Kingdom, the United States, Australia and New Zealand in reducing the transfusion of infected blood. Such programmes must continue and be fully supported. Therefore,

205 *Idem.* New York recently dispensed with the syphilis test because only a minute proportion of syphilis cases were detected pursuant to premarital testing (and perhaps also because of the suspicion that some couples nowadays have sex before marriage).

206 *New York Times*, 21 June 1987, A26.

207 *New York Times*, 11 May 1987, B5.

208 It is submitted that it would be a brave legislature which would require officials to withhold a marriage licence if a prospective spouse tests positive in the face of persistence of both spouses in their desire to marry and procreate. Nevertheless, the Illinois legislature has introduced legislation to this effect: *Time*, 2 March 1987, 44.

209 See n 189 above.

Recommendation: Testing is essential for all donors of blood or blood products, organs and other tissues intended for transplantation, and for donors of semen or ova collected for artificial insemination or invitro fertilisation.²¹⁰ Warnings should be directed to intending donors in high-risk categories pursuant to public education campaigns to refrain from making donations. Voluntary testing should be encouraged for those individuals who received unscreened transfusions of blood or blood products in New Zealand within a period of three years or so prior to the formal commencement of HIV antibody testing for blood or blood products in New Zealand. Such testing is strongly encouraged for recipients of multiple transfusions such as haemophiliacs since a significant proportion of the recipients of unscreened blood and blood products in North America have been found to be infected. Such testing may prevent these individuals, if infected, from unknowingly transmitting HIV and lead to access to counselling and health care services.

9 *Intravenous Drug Users*

Recent medical evidence suggests that HIV transmission has been rapid among persons who share injection equipment when unlawfully using drugs intravenously. These persons constitute a threat both to others with whom they share contaminated injection equipment and to their sexual partners. HIV infection is now endemic among these persons in northeastern United States and particularly in New York City. Intravenous drug users constitute a significant public health threat as they are now considered to be an increasing source of HIV transmission into the heterosexual communities of developed countries.²¹¹ The reduction of the incidence of HIV infection among intravenous drug users would reduce the rate of HIV transmission to the heterosexual community as well as to newborns. The writer concurs with the views expressed by the American Medical Association Trustees and the AMA House of Delegates respectively to the effect that the coercive testing of all intravenous drug users "would only drive [them] underground and away from the health-care system"²¹² and that, accordingly, voluntary testing is likely to be more effective.²¹³ Despite earnest national and international efforts to curb drug abuse, the New Zealand Government is to be applauded for having recently introduced a scheme for the exchange of used needles and syringes for clean ones at pharmacies. The writer also concurs with the view that the preservation of life itself and the need for prompt and effective action to save that life justifies this hard policy decision.²¹⁴

210 This is the position of the New Zealand Medical Association as articulated in its position paper on AIDS as well as that of the authors of the Canadian Working Paper at 38.

211 The overwhelming majority of AIDS cases attributed to heterosexual transmission to date has been traced to intravenous drug abusers: New York Times, 19 March 1987, B10.

212 New York Times, 21 June 1987, A26.

213 New York Times, 24 June 1987, A22.

214 See M D Kirby "The Five Commandments for New Legislation on AIDS", Paper delivered to the World Health Organisation Symposium on AIDS, Annecy, Switzerland, 20-21 June 1987, at 10-11.

Therefore,

Recommendation: Voluntary testing of intravenous drug users, their sexual partners, and those with whom they have shared contaminated injection equipment is strongly recommended. Such testing should be offered as a matter of course through all drug rehabilitation clinics.

10 Foreign Service Officers

The US State Department requires testing of Foreign Service applicants, officers and their dependants. While applicants who test positive are automatically rejected, overseas officers and their dependants testing positive are restricted in their service abroad to postings where they would be assured of receiving adequate medical attention.²¹⁵ These measures are considered necessary to protect the health of Foreign Service officers and their families since live-virus vaccines, which can accelerate symptoms in HIV carriers, are required of them.

Recommendation: Voluntary testing of those Foreign Service applicants, officers and dependants who fall within a high-risk category is recommended. Those officers and dependants who test positive should only be assigned to those countries which can provide them with a standard of medical care requisite to their condition. It is not necessary to exclude applicants who test positive from the Foreign Service where their applications would otherwise succeed so long as their condition does not impair the performance of their duties and steps are taken to ensure that they are posted in countries with adequate health care facilities.

11 Persons Entering Hospital

President Reagan proposed in June 1987, that all persons admitted to Veterans Administration hospitals in the United States should be routinely tested for the HIV antibody.²¹⁶ Such testing might be thought to assist in more precisely determining the extent of HIV in the general population as well as to enable health care providers to better protect themselves against exposure. Nevertheless, a consensus emerged at the Atlanta Conference opposing mandatory or even routine testing for hospital patients.²¹⁷ The American Medical Association has described President Reagan's proposal as "costly and inefficient".²¹⁸ The costs of testing such a large number of patients appear excessive when compared with the actual low risk of HIV infec-

215 New York Times, 28 November 1986, A1 and A8.

216 New York Times, 24 June 1987, A22.

217 New York Times, 1 May 1987, A18.

218 New York Times, 21 June 1987, A26.

tion.²¹⁹ Indeed, prior to the Reagan announcement, the practice at Veterans Administration hospitals had been to test only those patients who displayed AIDS symptoms or who were considered to belong to high-risk groups.²²⁰ Therefore,

Recommendation: Given the low incidence of HIV infection in patients entering hospital and the potential to develop reliable safety practices to protect health care personnel by minimising the small risks involved, it is considered sufficient to confine testing in hospitals to those patients who display AIDS symptoms or belong to a high-risk group.

12 Employees and Job Applicants

Benefits of widespread mandatory testing of employees and job applicants might include the elimination of an actual occupational risk of HIV transmission to others,²²¹ the prevention of a health risk to an HIV-infected employee attributable to a particular occupation, and the reduction of economic costs to employers.²²² Nevertheless, unless there are good grounds to suspect that infected individuals would pose a threat to themselves or others because of the nature of the particular work environment, widespread mandatory employer testing would be costly and inefficient. Therefore,

Recommendation: Mandatory testing of individuals who are employed by, or are applying for work in, any private or public enterprise, is unwarranted unless there is persuasive evidence that infected individuals in the particular work environment concerned create a risk of HIV transmission to other employees or a risk of harm to themselves.²²³ The exclusion from employment or continued employment of an infected individual where the only operative reason for such exclusion is a positive test result is unjustified when this does not represent a demonstrated risk of HIV transmission to other employees, or of harm to that individual.²²⁴

13 Persons Seeking Insurance

AIDS is posing an increasing economic threat in the United States and it has already impacted on the health budgets of other developed and developing countries. The cost of caring for persons with AIDS in the United States many of whom have been

219 A large proportion of patients entering hospital are children or elderly persons who pose an extremely low risk of infection: *New York Times*, 11 May 1987, B5.

220 *New York Times*, 24 June 1987, A22.

221 As in the case of a lab technician, for example.

222 Canadian Working Paper at 71.

223 This recommendation might equally apply to educational organisations.

224 Canadian Working Paper at 72.

denied insurance, is already estimated to exceed one billion dollars annually.²²⁵ In their anxiety to remain financially stable, insurance companies have begun testing insurance applicants for the HIV antibody with a view to denying coverage or assessing higher premiums in respect of those testing positive. Passionate debates have been sparked over the appropriateness of insurer testing. Denial of medical and life insurance coverage shifts the medical costs of AIDS patients and the financial needs of their dependants onto the State. A public policy analysis in this context must weigh the cost to insurers of forbidding insurer testing against the cost to society of allowing it, in determining the respective shares of the economic burden which it is reasonable to expect governments and insurers to assume.

The arguments for and against insurer testing are finely balanced. Insurance company advocates cite the following arguments favouring such testing:

- (i) Without testing, insurers could face massive financial losses because of excessive morbidity and mortality. The financial stability of the insurance industry itself might be undermined.
- (ii) Insurer testing for the HIV antibody is consistent with time-honoured and actuarially sound underwriting principles and is done for a reasonable business purpose. Few would question the right of insurers to deny coverage to applicants suffering from heart disease or cancer, and HIV antibody testing provides reliable evidence for an objective determination of an individual's increased risk of contracting an invariably fatal disease.
- (iii) An insurer has a responsibility to treat all its policyholders fairly by creating classifications to recognise the many differences which exist among individuals so that each applicant will either be granted insurance at a premium rate corresponding to the quality of his or her risk or be denied insurance. Since HIV infection is a highly significant risk assessment factor, HIV carriers are in a different risk class than uninfected individuals. Failure to differentiate between these two classes would represent a forced and expensive subsidy from the healthy policyholder to the less healthy in the face of knowledge of existing HIV infection. The insurance industry has a responsibility to those who have not been infected and, if the insuring process is to remain fair and non-discriminatory to uninfected applicants and policyholders, insurers must be permitted to rely on HIV antibody testing in the same manner as they rely on tests for other diseases.²²⁶

Opponents of insurer testing have produced the following counter-arguments:

225 *Time*, 16 February 1987, 40.

226 K Clifford and R Iuculano "AIDS and Insurance: The Rationale for AIDS-Related Testing" (1987) 100 *Harvard Law Review* 1806 at 1810-1811.

- (i) Without any laws to regulate insurer testing, insurance companies will be free to create an uninsurable high-risk class of individuals whose expenses will have to devolve upon the latter and ultimately the State.
- (ii) Insurer testing could lead to economic and social discrimination because the confidentiality of AIDS-related records cannot be guaranteed in an imperfect world.
- (iii) It is unfair to deny insurance to individuals who carry HIV but nevertheless are healthy and may not go on to develop AIDS.²²⁷
- (iv) Insurer testing will endanger the public health since there is an inherent conflict between the threatening character of insurer testing policy and the efforts of most public health experts to convince high-risk individuals that testing can be beneficial and so should be undertaken voluntarily.²²⁸
- (v) Because testing is costly, insurers are likely to want to test only those applicants whom they consider to be in a high-risk category. Testing is almost certain to be applied, therefore, in a manner that discriminates unfairly against homosexual and bisexual males²²⁹ and it may even occur that all applicants believed to be homosexual or bisexual will be tested regardless of other relevant criteria such as degree of risk-producing behaviour.²³⁰
- (vi) Insurer testing is unreliable in view of the unacceptably high number of "false positive" test results.

In the United States, California, Wisconsin and Florida and the District of Columbia have enacted legislation to regulate the testing policies of insurers. In April 1985, California enacted a law²³¹ prohibiting insurers from requiring an applicant to undergo testing or to divulge previous test results for the purpose of determining the applicant's insurability. In July 1985, Wisconsin enacted a similar but more restrictive measure²³² in also prohibiting insurers from requiring an individual to reveal whether he or she has submitted to the test, or what the results of the test were.²³³ In 1986, the District of Columbia City Council enacted the most restrictive

227 It is, of course, early days for medical evidence to support or deny this argument in terms of an accurate percentage of HIV carriers, if any, who will not go on to AIDS.

228 B Schatz "The AIDS Insurance Crisis: Underwriting or Overreaching?" (1987) 100 *Harvard Law Review* 1782 at 1801.

229 *Ibid* 1799.

230 It would appear that a New Zealand insurer could with impunity deny insurance cover to a homosexual male simply on the ground that he is homosexual or believed to be so, since there is no legislation which bans discrimination against homosexuals: see A Borrowdale "Bearing the Financial Costs of AIDS" *NBR* (8 April 1988) 48. Note, however, the proposed amendment to the Human Rights Commission Act 1977 discussed in n 129 above.

231 *Cal Health & Safety Code* 199.21(f) (Deering Supp 1987).

232 1985 *Wis Laws* 73; *Wis Stat Ann* 631.90 (West Supp 1986).

233 Apart from this provision, the Wisconsin law prevents insurers from conditioning the provision of insurance coverage on taking the test, and from determining premium rates on whether an individual has tested positive or even taken the test.

legislation²³⁴ of its kind in the United States in prohibiting the use of all AIDS-related tests during a five-year moratorium period, including tests to appraise the condition of the immune system, and barring underwriting decisions based on sexual orientation. Florida has also banned the use of the test and its results by insurers.²³⁵

Numerous US states have recently passed risk pool legislation which is designed to make insurance available to high-risk individuals who would otherwise be considered uninsurable, as well as to assist the insurance industry by spreading the financial burden of these individuals more equitably among insurers, the individuals themselves and existing policyholders. Under a mandatory pooling system, each insurer is required to accept a share of previously rejected applicants proportionate to its share of the state's insurance market. Premiums for risk pool participants are usually statutorily limited to 150% to 200% of the average premium in the state for healthy insureds. The medical costs of risk pool participants often exceed this cap, and these excess costs are passed on to other policyholders.²³⁶

Perhaps as problematical as insurer testing is the practice of questioning applicants. Insurers could plausibly argue that answers to questions about submission to the HIV antibody test and test results as well as questions about sexual orientation are as relevant for risk-assessment purposes as answers to questions about smoking and drinking habits. Nevertheless, questioning applicants about the results of previous tests may discourage high-risk individuals from taking the test voluntarily. As the US National Academy of Sciences warned in its report on AIDS:²³⁷

The general threat of discrimination in ... insurance ... may deter individuals in high-risk groups from being tested to ascertain their antibody status. Since knowledge of antibody status may prompt some individuals to adopt healthier behaviour, social disincentives to testing should be minimised.

In US states which prohibit insurer testing, insurance companies have resorted to questioning applicants about their sexual orientation as a means of screening out those they suspect of being homosexual or bisexual whom they consider to fall in a high-risk category. It is submitted, however, that an applicant's sexual orientation in itself is not an appropriate underwriting tool for use either as a justification for testing or as the basis of a question on the application form since high-risk sexual activity is surely a more accurate risk assessment factor. Insurers' questions on

234 DC Act 6-132, 170 (1986). The DC legislation also forbids insurers asking applicants for the results of prior tests and denying coverage because an individual has tested positive or has declined to take the test.

235 Fla Stat Ann 381.606(5) (West 1986).

236 Schatz, *op cit*, 1796.

237 Institute of Medicine, National Academy of Sciences, *Confronting AIDS* 169 (1986).

sexual orientation and denial of coverage simply because the applicant is homosexual or bisexual must therefore be prohibited.

Recommendation: A fair balance must be struck between absolute banning insurer testing and questioning, and allowing it unrestricted:

- * Insurers should be able to decline coverage to applicants who have AIDS just as they may decline applicants with cancer or other terminal illnesses.
- * Insurers should be prohibited from refusing coverage, charging a higher premium or requiring testing solely on the basis of an applicant's actual or alleged sexual orientation.
- * Insurers should be prohibited from requiring applicants to reveal whether they have obtained a test or the results of any test.
- * Insurers should be prohibited from conditioning the provision of coverage, or fixing the premium rate, on whether an applicant has obtained a test or on the results of any test except when there are valid medical reasons for doing so. Such reasons might include history of drug use, high risk sexual activity, or sexually transmitted disease as well as symptoms like swollen glands, weight loss and night sweats that often precede an AIDS diagnosis. Such reasons are less stigmatising than a positive test result and would therefore be less likely to discourage high-risk applicants from seeking voluntary testing beforehand.²³⁸
- * When insurers do test for valid medical reasons, testing must be accompanied by informed consent, when confidentiality of results can reasonably be guaranteed, and when counselling before and after the test is available and offered.²³⁹

14 Persons Resident in Non-Correctional Institutions

The differential treatment accorded individuals in correctional institutions vis-a-vis non-institutionalised individuals applies in the non-correctional context as well. Institutionalised individuals are placed in contact with other individuals whom they did not freely choose and cannot avoid; non-institutionalised individuals are free to place themselves in situations of their own choosing where a free and discriminating selection of partners can be made.²⁴⁰ Institutionalised individuals, therefore, require "enforced" or paternal protection in view of their closed environment and position of dependency.

238 Schatz, op cit, 1795.

239 Perhaps a more effective way for insurers to reduce their AIDS costs is to help prevent its further spread by contributing to educational efforts to control HIV transmission.

240 Canadian Working Paper at 66.

Selective testing and isolation in non-correctional institutions may be justifiable for those individuals with impaired mental incompetence and who are sexually active, and those who exhibit violent behaviour, since they might unknowingly or involuntarily expose their partners or victims to HIV or expose themselves to HIV.²⁴¹ Therefore,

Recommendation: Any type of coercive testing of individuals resident in non-correctional institutions is unwarranted, except where this could reasonably be expected to protect those individuals who are likely to be exposed to or expose others to HIV unknowingly or involuntarily because of sexual activity or violent behaviour. Voluntary testing may be advisable for all other resident individuals.²⁴²

15 *Persons Convicted of a Violent Sexual Offence*

In order to more effectively implement the previous recommendation concerning the imposition of criminal liability for HIV transmission, the Government may wish to consider the coercive testing of individuals convicted of violent sexual offences such as rape. Although no formal recommendation is being made, the knowledge of a positive antibody status would be beneficial in other contexts as well.²⁴³

16 *Males Engaging in Homosexual Activity*

A substantial number of New Zealand males who engage in homosexual activity have become infected with HIV and have gone on to develop AIDS.²⁴⁴ As prevention remains the only effective strategy to control HIV transmission, testing of these individuals can, *inter alia*, prevent them, if they are infected, from unknowingly transmitting HIV as well as providing them with access to counselling and health care facilities. Nevertheless, coercive testing could deter these individuals from being tested and seeking health care.²⁴⁵ Therefore,

Recommendation: Voluntary testing is strongly recommended for those individuals who have engaged in risk-producing homosexual activities, including unprotected sexual intercourse.

241 *Idem*.

242 This recommendation follows the thrust of the equivalent Canadian recommendation: see the Canadian Working Paper at 68.

243 For sentencing purposes on the conviction for the violent sexual offence as well as to enable victims to seek counselling and testing and, if required, to seek treatment and to adopt safe practices.

244 According to Department of Health statistics supplied to the writer, as at 5 April 1989, 109 out of 124 notified AIDS cases involved homosexual victims. As at 10 March 1989, 229 out of 292 cases of positive HIV antibody tests where the risk group could be ascertained were attributable to homosexual transmission: see appendix a.

245 It is the considered view of the Trustees of the American Medical Association that requiring testing for all homosexuals would "only drive people underground and away from the health-care system": New York Times, 21 June 1987, A26.

17 *Persons with Sexually Transmitted Diseases*

There is evidence that many individuals who are infected with HIV in North America have had a history of sexually transmitted disease.²⁴⁶ Testing may be useful, therefore, to prevent these individuals, if they are also infected with HIV, from unknowingly transmitting HIV to their sexual partners, apart from the obvious benefits to themselves. Several hundred sexually transmitted disease clinics in New York State are now required to offer their patients free, voluntary testing.²⁴⁷ Therefore,

Recommendation: Voluntary, confidential testing should be routinely offered to individuals seeking treatment at sexually transmitted disease clinics.²⁴⁸

18 *Health Care Personnel*

As two leading British medical commentators have recently stated:²⁴⁹

[T]he risk of health workers becoming infected is very small and can be countered by adopting careful techniques with all patients. Around the world hundreds of thousands of health workers have treated patients infected with HIV and only five have become infected as a result of broken skin or mucous membranes being exposed to infected blood. In addition, hundreds of health workers have suffered inoculation injuries while treating patients infected with HIV, and only four are known to have become infected. The risk is thus extremely small.

In view of this minimal risk to health care personnel, the testing of all such personnel is unwarranted. In the absence of a demonstrated risk of HIV transmission, voluntary testing is not necessary either. Nevertheless,

Recommendation: Voluntary testing is strongly recommended for health care personnel who may have been exposed to HIV by accident and for individuals who are alleged to be the source of accidental HIV exposures.²⁵⁰

19 *Children in School and Day-Care Centres*

So far children comprise a very small percentage of the total AIDS population with

246 Canadian Working Paper at 49.

247 New York Times, 28 February 1987, L33.

248 Proponents of such testing include President Reagan (New York Times, 1 June 1987, A15), Dr James O Mason, Director of the Centers for Disease Control (New York Times, 11 May 1987, A1, B5), and the Trustees of the American Medical Association (New York Times, 21 June 1987, A26).

249 M Adler and D Jeffries "AIDS: A Faltering Step" 295 British Medical Journal 73 at 74 (11 July 1987).

250 Canadian Working Paper at 52-53.

infants accounting for most of the cases. Children receiving contaminated blood or blood products and babies born to infected mothers may be infected with HIV.²⁵¹ It is considered that there is virtually no risk of acquiring HIV from a family member where no sexual or infected child birth relation exists. Although HIV-infected children could be considered to be a potential threat to other children or adults through play, injuries, incontinence, bleeding or violent behaviour such as biting, there is no evidence to suggest HIV has been transmitted between children under such circumstances, or that there is a risk of HIV transmission in the absence of sexual intercourse or blood transfusion.²⁵²

The US Centers for Disease Control have promulgated sensible and reasonable guidelines to assist in the formulation of policies concerning the care and education of children with HIV and AIDS.²⁵³ The thrust of the relevant CDC recommendations, which this paper adopts as its own, include:

Recommendation: Decisions regarding the type of educational setting for HIV-infected children are best made using the team approach including the child's physician, public health personnel, the child's parents or guardian, and school personnel. In each case, risks and benefits to both the infected child and to others in the proposed educational setting should be weighed and balanced.

- * Most infected school-aged children should be allowed to attend school since the benefits of an unrestricted educational setting would outweigh the risks of their acquiring potentially harmful infections in the setting²⁵⁴ and the apparent nonexistent risk of HIV transmission therein.²⁵⁵

251 In the latter case, HIV can be transmitted from mother to infant before or during birth or possibly through breast milk (see n 18 and the accompanying text). The mother's infection is often caused by her intravenous drug abuse or that of her sex partner.

252 Canadian Working Paper at 59.

253 CDC, "Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus," 34 Morbidity and Mortality Weekly Report 517 (30 August 1985). The CDC guidelines are based on medical evidence indicating AIDS is not communicable through casual contact.

254 When outbreaks of contagious illnesses do occur, HIV-infected children would remain at home for the duration.

255 The American Academy of Pediatricians has also recommended that most children with AIDS be allowed to attend school in a normal manner: New York Times, 24 October 1985, 16. Courts in several US states have held that schools should not exclude students with AIDS because the risk of transmission in a school setting is so slight. In *District 27 Community School Board v Board of Education of New York* No 14940/85 (NY Sup Ct, Queens Co 11 February 1986), a New York court was clearly influenced by the medical evidence supporting the conclusion that AIDS is not transmitted by casual contact in upholding a New York City policy, modelled after C.D.C. recommendations, allowing students with AIDS to attend school. This is as it should be since exclusion from school could entail lasting deprivation of the benefits of an education for a class of children not responsible for their positive HIV antibody status. As one American commentator has aptly observed, "Perhaps in no other instance would singling out AIDS carriers have as severe consequences as with children in school, and perhaps no other group of carriers is considered less

- * For HIV-infected, preschool-aged children in day-care centres and for some neurologically handicapped children who lack control of their body secretions or who display behaviour such as biting, and for those children who have uncoverable, oozing lesions, a more restricted educational environment is advisable until more is known about HIV transmission in these circumstances.
- * Concerning the testing of all children entering, or in, school or day-care centres, the danger of HIV transmission to uninfected children and caregivers is so slight that the benefits of testing do not appear to compensate for the harms and costs that flow from such testing.²⁵⁶ The rationale of most types of medical testing, a cure or vaccine, is also absent. Therefore, mandatory testing of these children is unwarranted; voluntary testing is not necessary either in the absence of a demonstrated risk of HIV transmission.²⁵⁷ Any testing of these children must be accompanied by the informed consent of the parents or guardian.
- * Persons involved in the care and education of HIV-infected children should maintain confidential records. To protect these children from ostracism, the number of school personnel who are aware of a child's infected status should be kept at a minimum needed to assure proper care of the child and to detect situations (eg, bleeding injury) where the potential for HIV transmission may increase.
- * The Departments of Education and Health should inform parents, children and school personnel about HIV transmission in order to secure the best care and education for infected children while minimising the risk of HIV transmission to other children.

20 *Children Being Considered for Adoption*

As the authors of the Canadian Working Paper have observed, adoption presents a distressing dilemma with respect to HIV antibody testing. A policy not to test children being considered for adoption may endanger public confidence in adoption programmes and lead to untested children not being adopted. A policy to test such children could result in HIV-infected children not being adopted since the latter may be perceived to be a potential risk of HIV infection to other family members, to have

blameworthy": [author's name not stated] "The Constitutional Rights of AIDS Carriers" (1986) 99 *Harvard Law Review* 1274 at 1292. Children with HIV should not be barred from attending school and subjected to social isolation merely to ease the minds of other students' parents whose concerns may be based on misinformation.

256 Canadian Working Paper at 60 at 62.

257 *Ibid* at 61 at 63. Where a demonstrated risk does exist, as in the case of a child suffering from haemophilia or one whose mother or father is an intravenous drug abuser, testing may enable the child to avoid infections within the school, to be educated about safe behaviour, and enable school personnel to protect themselves and other children.

a limited life expectancy, or to be an economic burden for the adopting parents.²⁵⁸ Nevertheless, adoption agencies should consider testing those children at increased risk of HIV infection before placement in the adoptive home, since the adoptive parents must make decisions concerning the medical care of the child,²⁵⁹ consider the possible social and psychological effects on their families, and take precautions against HIV transmission within the family. Therefore,

Recommendation: Testing is strongly recommended for those children who are being evaluated for adoption who are considered to be at increased risk of HIV infection.

IX CONCLUSION

It has been observed that a consideration of the history of earlier epidemics suggests that gross over-reaction can occur leading to social disruption and much personal injustice.²⁶⁰ In an atmosphere of public confusion and panic fuelled by misinformation, increasing pressure will be exerted on politicians and public health officials to confront this new and relentless pandemic by introducing more coercive and restrictive measures. In responding to this pressure through the hasty enactment of AIDS legislation, politicians risk inflicting the community with ineffective, ill-considered and overinclusive laws. As this discussion paper has attempted to illustrate, most coercive and restrictive measures would in fact impact little on HIV spread while imposing disproportionate constraints on the privacy of those individuals most vulnerable to HIV infection. Some such measures may be necessary, however, to deter irresponsible behaviour since even-handed law must enforce individual responsibilities as well as protect individual rights.

As a complex and pressing medical and public health problem which cuts across society, AIDS demands a bipartisan legislative approach based on compassion for the afflicted and solicitude for potential victims. Those who would unduly politicise AIDS could seriously delay measures to save lives. Yet the law may have only a limited, facilitative role to play. Any perception that legislation can provide a "quick fix" for such a complex and controversial public policy issue as AIDS is misguided.²⁶¹ The uncertainty and rapid changes in our understanding of AIDS and HIV infection, combined with the harms and costs associated with HIV antibody testing, underscore the need for caution in relying on legislation to deal with the pandemic.²⁶²

258 Canadian Working Paper at 75.

259 A child's previous exposure to HIV may determine whether it is safe to give the child certain immunisations since some vaccines may be dangerous for such a child.

260 M D Kirby "AIDS Legislation - Turning up the Heat?" (1986) 60 ALJ 324 at 326.

261 Canadian Working Paper at 27.

262 Ibid 80.

The effectiveness of AIDS policies and testing programmes will depend on the confidence of high-risk groups and the extent to which their voluntary participation therein can be secured. This will, in turn, depend upon the degree to which these groups perceive they will be guaranteed confidentiality and freedom from discrimination. Such a guarantee will require a legislative base to be truly effective.

Since the prevention of HIV transmission remains the only effective control strategy, aggressive, coordinated and well-thought-out public health measures are required. Behavioural changes must be encouraged through mass public education and precisely targeted voluntary testing combined with counselling.²⁶³ Public resources must also be earmarked for the support of community groups encouraging behavioural changes and for the provision of a sufficient number of drug and sexually transmitted disease treatment centers. The discussion and recommendations contained in this paper are intended to stimulate discussion on a wide range of AIDS-related issues, for the time has come for New Zealanders to formulate a comprehensive, effective, coordinated and systematic strategy to control HIV transmission and to deal with its devastating consequences.

263 Counselling can contribute significantly to making testing programmes effective in changing behaviour, regardless of test results.

(a)

**NZ HEALTH DEPARTMENT STATISTICS:
Notified cases of AIDS as at 7 April 1989**

1	Total no. of cases to date:	124
2	Annual notifications - 1984:	3
	1985:	11
	1986:	19
	1987:	30
	1988:	38
	1989:	23
3	Sex -	
	Male:	123
	Female:	1
4	Age group -	
	0-9:	0
	10-19:	1
	20-29:	24
	30-39:	48
	40-49:	37
	50-55:	11
	60+ :	3
5	Risk group -	
	Homosexual:	109
	Homosexual and IV Drug User:	2
	IV Drug User:	2
	Haemophiliac:	2
	Transfusion:	1
	Heterosexual:	1
	Not stated:	7
6	Clinical diagnosis -	
	Opportunistic Infection:	93
	Kaposi's Sarcoma:	12
	Opp. and Kaposi's:	1
	Opp. and other:	2
	Other:	16
7	Comment/outcome -	
	(this information is	
	<i>not</i> notifiable)	
	Deceased:	58
	Gone overseas:	6
	Alive:	57
	Unknown:	3

Confirmed Tests to HIV Antibodies as at 10 March 1989

1.	Total no. positive tests:	424
2.	Sex -	
	Male :	392
	Female:	13
	Not stated:	19
3.	Age group -	
	0-9:	6
	10-19:	11
	20-29:	111
	30-39:	151
	40-49:	71
	50-59:	16
	60+ :	7
	Not stated:	51
4.	Risk group -	
	Homosexual:	229
	Haemophiliac:	31
	Transfusion:	13
	Heterosexual contact:	6
	IV Drug user:	7
	Homosexual IV Drug user:	5
	Homosexual/Prostitute/IV Druguser:	1
	Not stated/Unknown:	132

The confirmed antibody positive figures are of limited epidemiological significance as they reflect the number of tests done; and because anonymity is a requirement for co-operation from the "at risk" groups the numbers will include a small (though unknown) number of duplicate tests for some individuals. These figures are collated from the monthly returns submitted by NHI, Auckland Virus Laboratory and Auckland Regional Blood Services Laboratory.