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AIDS: CONTACT TRACING

House Bill 4103 as enrolled
Third Analysis (1-23-89)

Sponsor: Rep. Thomas G. Power
House Committee: Public Health
Senate Committee: Health Policy

THE APPARENT PROBLEM:

To fight the spread of sexually transmitted diseases, the Department of Public Health (DPH) has statutory authority and procedures for reporting cases of venereal disease, and for tracing the partners of those who have been found to have certain venereal diseases. Currently, however, there is no state law requiring that the DPH be notified in cases when someone tests positive for acquired immunodeficiency syndrome (AIDS), the final and fatal stage of human immunodeficiency virus (HIV) infection. Although HIV infection is not a venereal disease, it is spread primarily through sexual contact (both heterosexual and homosexual), as well as through the exchange of infected blood (through blood transfusions and through needle sharing among intravenous drug abusers) and by HIV-infected pregnant women to their fetuses. Some people believe that the DPH should be authorized to use the same tactics to fight the spread of HIV infection as they now use to fight the spread of venereal disease.

THE CONTENT OF THE BILL:

The bill would amend the Public Health Code to require that certain information be reported to the Department of Public Health when someone tests positive for HIV and to require local health departments to help HIV-infected people notify their sexual and needle-sharing partners.

Reporting requirements. Under the bill, a health care provider, within seven days of getting an HIV test result showing that the test subject is HIV-infected, would have to report certain information to the Department of Public Health (DPH) and to the appropriate local health department on a form provided by the DPH. The information would include:

- The name and address of the reporting agent;
- the age, race, sex, and county of residence of the test subject;
- the test date, result, and purpose;
- whether or not (if known) the test subject had ever tested positive for HIV infection before;
- the way the subject probably was infected;
- any other medical or epidemiological information (to be specified by administrative rules) the DPH considered necessary for monitoring, controlling, and preventing HIV infections; and
- (to the local health department only) the test subject's identity, in the form of his or her name, address, and telephone number.

Any person, health facility or agency licensed by the DPH (except for licensed clinical laboratories) would have to follow these reporting requirements. However, people tested in their private physician's office (or HMO office) could ask the physician not to report their identity to the local health department if they tested positive for HIV. The physician would have to comply with the patient's request for anonymity, unless the physician believed that the patient (if indeed HIV infected) needed help with notifying his or her sexual (or needle-sharing) partners.

Partner notification. When a health care provider reported the identity of an HIV-infected person to a local health department as required by the bill, the local health department would have to:

(a) Try to interview the infected person within 14 days of receiving the report (or, in the case of babies infected in utero, try to interview the baby's parent or legal guardian, or both) and offer to contact the infected person's sexual and (where applicable) needle-sharing partners (this interview would have to be voluntary on the part of the infected person); and

(b) Contact ("confidentially, privately, and in a discreet manner" and within 35 days of the above interview) each identified partner about his or her possible exposure to HIV; and

(c) Give each HIV-infected person interviewed and each partner contacted information about medical tests for (and any other indicators of) HIV infection, how to avoid transmitting HIV, and any other information the local health department considered appropriate.

If someone tested positive for HIV and if the health care provider that administered the test believed the patient needed help with partner notification, the health care provider would have to refer (not just report) the infected person to the appropriate local health department for that help, and provide any information (including the infected person's identity) the local health department believed necessary to carry out partner notification. When someone was referred this way to a local health department, the local health department would have to warn that person that he or she:

(a) is legally obligated, before having sex, to warn each of his or her sexual partners of his or her HIV infection, and

(b) may face criminal penalties if he or she fails to do so.

A partner notification program operated by a local health department would have to include notification both of an infected person's sexual partners and of his or her hypodermic needle-sharing partners. Partner notification would be "confidential and conducted in the form of a direct, one-to-one conversation between the employee of the local health department and the partner of the test subject." The local health department could not tell the contacted partners the infected person's identity unless "authorized to do so by the individual who named the contact, and if needed to protect others from exposure to HIV or from transmitting HIV."

Information acquired under the bill. Information acquired by the DPH or a local health department under the bill would be exempt from disclosure under the Freedom of

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Information Act. Local health departments could keep information on HIV-infected people for no more than 90 days after receiving it (or as otherwise specified by DPH rule), and could not keep a list of names of HIV-positive test subjects (the identities of the test subjects would instead be protected by coded individual case files).

Biennial legislative report. The DPH, in consultation with local health departments, would submit a report every two years to the House and Senate committees on public health. The report would review the effect of the bill on the department's efforts to monitor and control HIV infection and would include:

- statistics (broken down by local health department jurisdiction) on the total number of cases reported, the total number of cases reported that identified the test subject or his or her partner, and the total number of partners actually contacted;
- an assessment of the effectiveness of the program, and
- recommendations to improve the effectiveness of the program, if any.

Tie-bar. The bill is tie-barred to four other AIDS bills: House Bill 4008 (PA 471), House Bill 5026 (PA 490), House Bill 5189 (PA 488), and Senate Bill (PA 491), which deal, respectively, with "high risk" crimes, recalcitrant HIV carriers, prior informed consent to HIV testing, and expense of care.

MCL 333.5114, et al.

FISCAL IMPLICATIONS:

The Department of Public Health estimates that the bill will cost the department $5,550,000 to carry out the counseling and contact tracing portions of the bill, excluding costs for development, printing and dissemination of the report forms required by the bill.

The department breaks down the costs as follows: It takes $105 to to interview each reported HIV infected person (with seven hours per interview at $15 per hour). Based on current estimates that 30,000 individuals are now HIV infected, the total cost for these interviews would be $450,000. Contact notification would cost $2,700,000, assuming that each primary case (those who test positive for the presence of HIV or an antibody to HIV) identifies two contacts, and that it would require three hours to conduct field investigations to locate, refer, and counsel each contact, at $15 per hour. The department estimates that it would cost $2,400,000 for pre- and post-test counseling sessions, at a cost of $40 per partner. (6-1-88)

The House Fiscal Agency estimates first year costs of $591,300 to $769,600, while emphasizing that these estimates are subject to many unknown conditions. These estimates include costs based on Ingham County Health Department estimates, which assume (a) that one-half of the primary cases (those who test positive) provide contacts; (b) that of these primary contacts, each identifies 3.3 contacts and (c) each contact requires 9.6 hours per interview at a cost of $20.28 per hour, for a total cost of $195 per interview; and that between 3,500 and 4,000 people will test positive.

It would therefore cost between $341,300 to $420,000 for contact interviews and field investigations, (at $195 per interview at the lower range of the scale and Department of Public Health estimates of $105 per interview at the upper range (3,500 x 1/2 = 1,750 x $195) to (4,000 x $105).

Similarly, total costs for pre- and post-test counseling, using the DPH figure of $40 per partner, would range from $232,000 to $320,000, using Ingham County estimates at the lower range (1,750 x 3.3 = 5,800 x $40) and DPH estimates at the upper range (4,000 x 2 x $40).

In addition to the costs of the contact interviews, field investigations, and counseling costs, the agency estimates that laboratory tests will cost an additional $18,000 to $29,600, for a total of $591,300 to $769,600.(6-1-88)

ARGUMENTS:

For:

If the spread of AIDS is to be controlled, it is imperative that HIV-infected people become aware of their infection and that partners of HIV-infected people become aware of their possible exposure to HIV so they can modify their behavior (either to avoid spreading the infection further or to avoid getting infected if they are not yet infected). But if people "at risk" for HIV infection are to be contacted and helped, they must be able to trust their local public health departments. In particular, should they test positive for HIV, they must trust that their identities will be kept confidential. The bill would provide for a uniform system of HIV reporting and contact notification, and would identify HIV-infected people only on the local (and not state-wide) health department level. Information gathered under the bill's provisions would be exempted from Freedom of Information Act requests, and only local health departments would know who, in their jurisdictions, was identified as HIV-infected. No lists of HIV-infected people would be kept by the local health departments, and data would be destroyed 90 days after it was received. Other than local health departments, identifying information would be released only to sexual or needle-sharing partners of the infected person, and then only if "authorized to do so by the individual who named the contact, and if needed to protect others from exposure to HIV or from transmitting HIV."

Against:

Because breach of confidentiality is so common in AIDS cases, anonymity, not just confidentiality, in the reporting of HIV test results is crucial if many of the people most at risk for HIV infection are to get testing and counseling. Recent news articles have indicated that at least 75 cases of AIDS-related breaches of confidentiality — mainly by hospital staff members — and 233 acts of AIDS-related discrimination have been reported. When a breach of confidentiality occurs, the results are often emotionally, socially and economically devastating to the victim. Because of the socially unacceptable ways in which HIV often is transmitted in this country (promiscuous sexual contact with bisexual or homosexual partners and illegal IV drug abuse) identification as HIV-infected can (and has) resulted in punitive and sometimes illegal reactions by other people, including expulsion from school, loss of jobs, ostracism by friends and neighbors, an inability to get medical care, and disruption of family life.

Not only does the bill not guarantee anonymity, it requires or allows the identity of an HIV-positive test subject to be revealed to quite a number of people — almost guaranteeing that there will be breaches of confidentiality. The bill requires the immediate reporting of the identities of HIV-infected people to local health departments and allows the local health department to reveal their identities to their sexual or needle-sharing partners, who, in turn, presumably may tell anyone they wish. So in addition to

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the health care provider who ordered the test (and possibly other staff, medical or otherwise, at the physician's office or health care facility), the HIV-positive person's identity also is known to local health department staff, possibly to some or all of the infected person's sexual and needle-sharing partners, and then to whomever these partners choose to tell. The possibility (not to mention probability) of breach of confidentiality is enormous. The bill could do more harm than good by scaring away many people, who might agree to anonymous testing, but who fear that their identities will be inappropriately revealed under confidential testing. Anonymous reporting of HIV test results, without personal identifiers, should be available to anyone who wants it.

Against:

Not only does the bill not offer anonymous testing, the one provision for keeping one's identity out of state records, should one test positive for HIV infection, blatantly discriminates against poor people. The bill does have a provision that allows someone who gets tested for HIV in a private physician's office (or in an HMO office) to ask that the physician not report his or her name to the local health department should the test results prove positive. (And even this limited protection of one's identity depends on whether or not the physician decides that the patient needs "help" in notifying his or her sexual partners about his or her positive HIV status. The private patient's name, address, and telephone number still may be given to the local health department if the physician decides that the patient needs "help" in contacting his or her partners.) Otherwise, all other health care providers must immediately report to the appropriate local health department the identity of anyone who tests positive for HIV. Equal access to equally confidential HIV testing should be available to everyone, rich or poor.

Response: The issue here is not one of discrimination against people who cannot afford to have private physicians, but rather the availability of good medical information for people who test HIV positive. In the case of private (or HMO) physicians, presumably the patient will have an ongoing relationship with the physician that will guarantee that the patient will continue seeing the physician after an HIV infection is diagnosed and will be able to get appropriate information and medical care. In the case of public health clinic patients, however, no such ongoing physician-patient relationship can be assumed and so there is a need to be sure that the local public health department follows up on reported positive HIV test results. The bill actually appropriately protects different people in different physician-patient relationships.

Against:

While gathering epidemiological information on HIV infection and offering assistance in notifying partners is good public health policy, the bill also has a needlessly punitive provision that requires local health department staff to destroy the very trust they need to do their work effectively. The bill allows private physicians to decide whether or not to refer a private patient who tests positive for HIV to the local health department for "assistance with partner notification." But in addition to the usual request for an interview and offer to contact the infected person's sexual and needle sharing partners, the local health department is required to warn these referrals of possible "criminal sanctions" should they fail to inform their sexual partners.

In the first case, threatening "criminal sanctions" at a time when a person likely will be emotionally devastated by the knowledge that they have this deadly infection seems needlessly cruel. But in the second place, requiring the local health department to, in effect, threaten people like this would seem to be counterproductive, since such a negative contact by the health department would seem almost to guarantee that the infected person will refuse any kind of cooperation in identifying his or her sexual (much less needle-sharing) partners.

If a private physician believes that a private patient cannot or will not inform his or her sexual partners, then the physician should simply report the patient to the local health department and the local health department should be allowed to proceed as it does in all other cases referred to it (namely, by attempting to interview the infected person and offering to notify his or her partners). Punishment is an inappropriate response to what is a public health problem.

Response: The only HIV-infected people that the local health department is required to tell about their legal obligation to warn sexual partners are those people whose physicians (who, presumably, know them) believe will either fail or refuse to tell their partners this vital information. If someone is so demoralized or angry as to not be able or willing to tell his or her sexual partners of the infection, then maybe the warning by the health department will jolt the person into taking some responsibility for stopping or slowing the spread of this terrible infection. The warning of possible criminal sanctions may seem harsh, but it would be callous indeed not to try to protect the partners of such people.

Against:

The bill doesn't go far enough. The local health department can only try to interview someone who has been reported to the department as HIV-infected, and the interview will take place only if the infected person agrees to it. The local health department or perhaps the state health department should be given the authority to interview identified HIV-infected people, whether or not the people want to be interviewed, and to trace known partners, whether or not this information comes from the infected person. AIDS is too serious to fool around with hoping that people will voluntarily cooperate.

Response: It is understandable that people react with fear and alarm to the spread of a virus that apparently always is fatal and for which there is no known vaccine or "magic bullet" cure. But in addition to the death sentence many people think of when they hear "AIDS," the primary ways in which HIV so far has been transmitted in this country (though not in other parts of the world) have been socially sanctioned: not only promiscuous sex, but promiscuous sex with partners who either are bisexual or homosexual or who are illegal intravenous drug users. (This is reflected in the language of guilt and innocence that is applied to people, depending on how they became infected with HIV. People regularly refer to the "innocent" victims of infected blood transfusions and the "innocent" babies infected in utero by their infected mothers. Presumably, in contrast, those who are infected through illegal IV drug use or through sex with infected partners are somehow "guilty" of HIV infection.) But despite the fear generated by AIDS and the disapproval attached to certain "at risk" behaviors, fear and disapproval should not cloud the fact that the spread of HIV infection is a grave public health problem that is best dealt with by professionals with expertise in public health.