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interim Hearing on AIDS: Past, Present, and Future

Senate Select Committee on AIDS

AIDS: PAST, PRESENT, AND FUTURE

CALIFORNIA LEGISLATURE
SENATE SELECT COMMITTEE ON AIDS
GARY K. HART, CHAIR

October 26, 1987
State Capitol
Room 113
Sacramento

California Legislature

SENATE SELECT COMMITTEE ON AIDS

Senator Gary K. Hart, Chairman

Interim Hearing On

AIDS: Past, Present, and Future

State Capitol
Room 113
Sacramento, California
October 26, 1987
9:30 a.m. - 12:00 noon

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California Legislature

SENATE SELECT COMMITTEE ON AIDS

SENATOR GARY K. HART
CHAIRMAN

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SENATE SELECT COMMITTEE ON AIDS
"AIDS: Past, Present and Future"
State Capitol, Room 113

9:30 - 10:15 **Don Francis, M.D., D.Sc.**
U.S. Centers for Disease Control AIDS Advisor to the California Department of Health Services.

Overview of the history and epidemiology of AIDS; roles of the federal, state and local governments; current and future medical and policy issues.

10:15 - 10:45 **Neil Flynn, M.D.**
Director of Clinic for AIDS and Related Disorders, U.C. Davis Medical Center.

Basic information on the different levels of HIV infection as they affect the patient and as they are revealed by diagnostic procedures; the perspective of a physician treating AIDS and ARC patients in a public hospital setting in an area such as the Davis-Sacramento area.

10:45 - 11:15 **William Walker, M.D.**
Health Officer for Contra Costa County; Executive Committee Member of Health Officers Association of California.

Overview of a local health department's responsibilities, including AIDS-related activities; summary of practical and policy issues most relevant to the local health officer's role in monitoring, treating and preventing HIV infection.

11:15 - 11:45 Alex Kelter, M.D.
Acting Deputy Director, Public Health;
California Department of Health Services

Discussion of the state's role in AIDS monitoring, treatment, and prevention activities; history of the Office of AIDS and its resources and responsibilities; summary of other departments' AIDS-related activities.

CHAIRMAN GARY HART: The title of our hearing today is "AIDS: Past, Present and Future." This committee is a new one, formed by the Senate near the end of this year's session to coordinate the Senate AIDS-related activities and to deepen our understanding of AIDS and related state policy issues. This is, for those of you not familiar with the legislative process, this is a select committee, not a standing committee, which means that a select committee doesn't actually hear and vote on legislative bills; it is meant to be a research, fact-finding committee. The major time of its work is during the interim session which we're underway in right now.

As chairman of this committee, I have four principle objectives for the next three months of the legislative hearings and this is our first such hearing. There will be others in November and December. The four main objectives that I have are as follows:

1. To learn more about the AIDS epidemic and the virus that causes AIDS;
2. To better understand the effectiveness of existing programs, particularly those implemented by the State of California;
3. To develop appropriate legislation; and
4. To better coordinate our legislative and administrative efforts to respond to the AIDS challenge.

We all know the story about the group of blind men describing an elephant, each convinced that the particular part of the elephant that he knew represented the whole animal. In the same way many of us on this Select Committee have come to the elephant of AIDS familiar with only one or two particular aspects of the animal. However, I'm confident that we will behave differently from the blind men in that story by combining our particular areas of experience and knowledge about AIDS into a composite picture of a whole animal. A picture that takes into account such varied subjects as education, medical care, substance abuse, prisons, public health practices, and a variety of legal issues.

A final note, I was interested to note recently, that the eminent historian, Barbara Tuchman, began the research on her book A Distant Mirror intending to examine the effects of the plague on the entire social fabric in 14th century Europe. Although I believe there are important differences between the plague in medieval times and AIDS in modern times, I also believe there are two important similarities. Both are

reminders of humankind's growing but still imperfect mastery of disease, and both have forced society to confront our deepest fears and reaffirm our deepseated social values. I know we all want to help shape an AIDS policy that history will judge to have been the most effective health policy and the most positive affirmation of basic social values in these difficult circumstances.

Since this is a new committee, before we actually get underway, I would like to make a couple of introductions. With our two colleagues that have joined us that are on the committee, Senator Marks and Senator Doolittle, but I also want to introduce the staff to the Select Committee; first, Kathryn Duke, who is on my right, who is a consultant to the Select Committee, who is on leave from the Senate Office of Research to provide staff to the committee. Kathryn is a graduate of UC Berkeley; has a Masters in Public Health, and also is a graduate of Boalt Hall Law School at Berkeley. And on my left is the Committee Secretary, Debra Smith; this is her first hour on the job. She's new to the State Capitol and I think the members and the public will enjoy working with Debra.

With that in mind, we turn to today's activities. Today we will begin to get both specific AIDS information and the big picture of AIDS by hearing from health and AIDS experts. These people will talk about the past and future of the AIDS epidemic and will give us federal, state and local government perspectives on confronting this epidemic.

Our plans are to hear from four witnesses this morning. Before calling forward our first witness, Dr. Francis, I'd like to ask Senator Marks or Senator Doolittle if they would like to make any comments or have any questions before we get underway.

SENATOR MILTON MARKS: I'd just like to make one very brief comment. I'm delighted that this committee has been started 'cause I think it's absolutely necessary that the Legislature look at the problem of AIDS, determine what can be done about a serious problem which affects not just one community but affects the entire community of the State of California. I'm not even discussing how it affects people in an international basis or a national basis, but obviously has a tremendous effect in California. And I think it is important that we discuss the issues which are of concern to us.

Now, Senator Doolittle and I are sitting next to each other, but we differ very greatly upon, I believe, upon the way in which we must solve this problem, and I think we must determine what can be done to resolve the problem which is of concern to all of us who want to do, at least I want to do it and I hope he does, want to do it in a way which will not cause extra problems for those who have AIDS; problems that I don't think it should be a criminal matter; I think it's a matter of health, and therefore I'm very pleased to be here.

CHAIRMAN HART: Thank you, Senator. Senator Doolittle?... Okay. With that, I'd

like to ask Dr. Don Francis to come forward, he's our first witness. A number of us heard Dr. Francis on other occasions; he's a recognized expert on this disease; he's associated with the Centers for Disease Control and I think it'd be interesting to other members of the committee to note that Dr. Francis has his Medical Degree from the Northwestern University School of Medicine; he is a Doctor of Science and Microbiology from Harvard University; board certified in pediatrics, and has been involved in a number of issues relating not only to AIDS but a variety of other health epidemics in this country and around the world. Dr. Francis.

DR. DON FRANCIS: Thank you, Senator Hart. You didn't mention that I also went to Redwood High School and the University of California, Berkeley; you only mentioned the out-of-state education that I had.

CHAIRMAN HART: We've already given too much play to Berkeley this morning.

DR. FRANCIS: (laughter)

CHAIRMAN HART: (inaudible)

DR. FRANCIS: Oh, no wonder, see, I should have known. I will spend most of my time this morning regarding prevention, as I think that is the major issue set forth to us to deal with in terms of the most difficult issues.

The issues of prevention that I -- and the way to stop this virus from moving from one person to another and continuing to invade our population, I think, is critical. No doubt, the treatment issues are also. But one that is not my specialty and if I, best, I think, leave that to those individuals who deal with it. But I'd be happy to field questions outside my specialty subsequent to my presentation, so I will stress prevention.

In terms of prevention, all the reviews of the American response to AIDS or HIV infection regarding stopping its transmission, have been quite condemning. That comes from the Office of Technology Assessment, it comes from the National Academy of Sciences, or from journalistic reviews. I think it's been clear that we have NOT met our goals that we want, that is to decrease substantially the movement of this virus from infected people to uninfected individuals.

I generally agree with that review; however, in California I'm optimistic that we can change that. I think the reasons for that are several. One, I have a commitment personally. I not only went to the University of California, but I'm a third generation physician in California with my grandfather a physician, my father a physician, my mother a physician, and now I add to it my wife a physician, all of California.

CHAIRMAN HART: No wonder none of my friends can get into medical school. (laughter)

DR. FRANCIS: And actually my parents went to Stanford. So I just thought that that would make the other side of the aisle here happier.

But not only am I committed to California, 'cause I think California can make a difference. I think California, and the reason I'm here now, is that California has made a difference. And much of that is due to the guidance that the Legislature has given AIDS and the forthright approach that is taken despite being stormy, I think is still a true national model, and it is certainly what attracts me as a Fed to come and help the State of California, not only my home, but one that is clearly moving ahead.

But the challenge that I see right now, and again I'm optimistic, the challenge is a political one. Scientifically, we've made tremendous progress in understanding this virus and we know now that transmission of this virus may not be 100% stoppable right now with the tools we have, but it is close to it. It is clear that we have tools that will allow us to stop transmission. There are more tools we need that require more scientific input, specifically vaccines and therapies that might help in either preventing infection or treating disease once it occurs.

But the breakthroughs now, the difficulties now in the coming couple of years, are going to be policy and politically associated. And that is the challenge for committees like this, I think, to put the policy issues forth, I think, as an observer of history, that that ability to put the policy issues of AIDS forth in a reasonable way will have great ramifications for our society, not the least of which will be AIDS. But when you look at the reviews now, in terms of what we have done as a society and the failures we have done in society, and the fact that it's government responsibility to do this, the whole respect for government on a relatively simple issue like AIDS will fall tremendously if we do not respond, and we've got much more complex issues scientifically in the coming biotechnological revolution, etc., etc. If we can't deal with the relatively simple issues of AIDS, I think it will be a true scar.

Now my prescription for this disease, if we indeed admit that we have shortfalls in terms of prevention. I, in the middle of night last night, got up and made my prescription, and my prescription as a physician, is for CPR. And I add another R on the end of that to make it CPRR, in terms of what needs to be done. And that is, first the C, is to Care. I can't emphasize how much lack of interest, lack of care has done in terms of the AIDS epidemic; just people saying it will take care of itself, it'll be something simple, it'll be a quick fix, we'll deal with it cheaply, and it'll go away tomorrow. We have to care.

P, Policy. Policy based on science instead of on hysteria. Relatively straightforward, again, from our side in public health, but allow us to work, take off the shackles, provide the resources to move ahead.

The first R is Resources. We have been shortchanged in public health from the beginning on this issue and it continues to be a major problem. We need the resources necessary to carry out the policies that hopefully groups like this put forth.

And the last R, a small R, is Realism. The road to this will not be entirely smooth. It will continue to be difficult and we must expect it to be difficult. Stand tall, move ahead without being battered from one pillar to the next post, and losing the ultimate direction of the program. Let me deal with them in terms of each individual of the CPRR.

Care: We have to look at this disease in the long term. I look at this disease, not for me, but for my children -- that their life in California's going to be very different than mine. And that we have to look ahead for all the children of California; all the people of California, <u>now</u>, in terms of truly caring, not just for our own individual success, whatever that field may be, in politics or science, but for the society as a whole. That we have to care for the prostitutes who get infected. We have to care for the gay men who are infected and are going to get infected. The IV drug users, the hemophiliacs, and all of their loved ones, and wives, and sexual partners, that we indeed have to care for them, really basically and understand that these individuals, and that they are humans in this society, and truly care for their future. Why?

There's one -- if I had to get over one statement in terms of prevention of HIV infection, is to give the individual the opportunity to not get infected. My kids are 6 and 9 and they're already being started on that opportunity. That they -- individuals, are going to take the responsibility for preventing themselves from getting this infection. We must give them the best of all those possibilities of opportunity.

Clearly, as I read the polls in California, the people want it. The people want that opportunity. They understand it, they're willing to pay the money, they're willing to make the difficult decisions. The question is can we transmit that political will of the grassroots level, that individual will, through the political process and back down to the street where we can maximize the effect. That's care.

P, our Policy. The issues of policy based on what we know about this virus are terribly important, instead of basing policy on what we don't know about this virus and fear. We know a great deal about this virus and how it's transmitted.

One, we know that it is dangerous. It is a virus that is in a league well beyond the league of agents that we are accustomed to dealing with in the United States. Any virus that is going to kill in excess of half the people infected, is a very dangerous infection.

We know now, that from the cohorts of individuals you can, you can predict that a sizable proportion, much different than polio or hepatitis B or any other, it's somewhere in excess of 50% more than likely of individuals infected with this virus will develop AIDS - a 100% fatal condition. <u>THAT</u> is a dangerous virus on anyone's list.

Two, we know about the transmission. Really remarkably well, and I want to base

the prevention of this virus on the transmission. It transmits effectively, maybe not efficiently, but effectively, through sexual activities of both homosexual and heterosexual and bidirectionally heterosexually, through the sharing of blood, and from mother to infant. Those are the ways it's transmitted, and those are essentially the only ways that it's transmitted. We should base prevention policies on those means of transmission. If there's a few exceptions hither and thither, it's remarkable how few there are in terms of this infection.

We must not base the policy of AIDS prevention in the United States on 6 rather extreme cases of infection in the United States, let's say by blood spilling onto open lesions of the hand of a hospital worker, but we should base them on the 42 plus thousand cases that we know about the transmission. Let's be sensible and take the information we have and move forth. It's terribly important to stress that it's not transmitted outside of these settings by mosquitos, by casual contact, etc., etc., because that changes our entire program in terms of prevention.

Now, important issues. We must decide in the government what we're going to do. And the number one is whose role prevention is. It is clearly not a good private sector business. Prevention of diseases falls upon the government. At a time when there's much interpretation that the government should be a lower profile instead of a higher profile. That has hurt us from the beginning of this disease and continues to hurt us. That defense, defense against an invading organism, is the same as the defense against an invading foreign invader. This is a foreign invader and we must take appropriate government action.

That this does not fit well, maybe ultimately it will in terms of the HMO (health maintenance organization) type maintenance of health, but right now it is clearly a public health which is clearly a government sector of all federal, state, and local that needs to be supported.

The Policy. If it is, if we accept it as a government role, what is the government's role? I think it's terribly important to look at how we in public health use the government role in public health. There's two real extremes; one is the government responsibility for preventing the disease, and the other one is the individual's responsibility for preventing a disease.

The government responsibility we take for diseases, they're by and large dangerous, that are transmitted through nonconsensual acts. That is, if I had bubonic plague, I could transmit it to you; if I had typhus and there were insects or plague and there were fleas in the room, it could be transmitted. The government takes responsibllity of finding those infected individuals and removing them from the society so they do not infect other individuals who do not consensually, essentially volunteer for this infection.

The individual responsibility approach is used when diseases are transmitted by individual, consensual acts. That is, when an individual, or two individuals, for infectious diseases are required to both undertake in terms of HIV transmission, either sex or intravenous drug use, then they are essentially volunteering for infection. In that situation, public health would say let's move to the individual and convince them through information, through motivation, and through the skills to one, if they are infected, not to transmit it to somebody else, and two, if they're uninfected, prevent yourself from being exposed to this virus.

Now, those are two very, very important concepts. You have the government screen test, find the infected individual, separate them from society. And the volunteer, get the information, the motivation, and the skill going out to the individual.

Now, which one of those we put in place depends on the transmission of the agent that we're dealing with -- be it plague, movement of the government, or something else where we stress to the individual to take the responsibility. We look at the epidemiology of HIV, the virus that causes AIDS, there are both sides of this. I think you could say that the individual receiving a transfusion, the baby born to an infected mother, are not agreeing to be infected with this virus, they're not agreeing to being exposed.

So we move in, especially in the transfusion setting, and the government makes a decision that there shall be no blood given in California that is from a donor of a high risk group and/or that has antibody in that blood. That blood shall not be used, it shall be disgarded. Very appropriate move of government to move through.

The mother/infant issue is a little more difficult and it's just evolving in California.

But, so we use the government role. But to use that role for the consensual transmission as has been hinted to, and in some, at least federal political circles, overtly mentioned, that is, to screen everybody and put them in quarantine, and isolate in an involuntary setting the positives from the negative. It will work -- it clearly will work if you do it effectively. But it would require such an expense and such a social disruption, that I don't think, as a public health advisor to the State of California, that I would recommend it.

It would mean keeping everyone in their house for a week, let's say county by county by county, using police force; testing them; turning those results around; determining who's positive and who's negative; put the positives on one side of the fence and the negatives on the other side of the fence and keeping them there. We could do that. But it has to be done right, it can't be done half-way, because the message that you've given these two sides of this are very different.

When you screen out the individuals on the quarantine side, you say the government

has said that there are no infected people out there. You may do as you wish. You may undertake risk behavior that would transmit HIV infection because there's no HIV infection out there. If you blessed everyone out there as being clean.

On the individual's side, we're giving the exact opposite message. We're saying you must assume that everybody out there is infected. So if you're going to undertake the type of risk-provoking behavior that could transmit HIV, you better assume that they're infected, and if you choose to do it, which is up to you, you must take protective measures. So it's very different, the message, and if you confuse the public on what method you are using, you will confuse this message and ultimately increase transmission.

Now, the confusion on this has centered around testing. Because testing performs -- serologic testing has a very great role in both sides of this. There is no doubt that having individuals come forth to be tested, to be counseled and change their behavior, both if they are uninfected and if they are infected, has tremendous public health implications, and we encourage that. There's hardly a person in public health who doesn't want large, expanded use of the serologic test, to see if people are infected or uninfected because it clearly has a beneficial role in terms of decreasing transmission and educating individuals if it's linked with counseling.

But what happens is, people don't realize it's the counseling that's important in that process, and they confuse it with the government responsibility side and say it's the testing that's important and testing is easy; let's test everybody and get rid of this virus. If that were possible, I would recommend it tomorrow.

But if you're going to test and you want to get rid of this virus, you must go all the way to that extreme, or you're going to buy all of Sacramento and put 300,000 infected people in there and maintain them for a lifetime; away from the other individuals, and anybody coming into this now clean society by airplane, by bus, by car, is going to have to go through an appropriate quarantine and testing procedure before they'll be allowed to get into our clean California.

If you do that, it will cost a tremendous amount of money, would be so socially disruptive, to have great injury on the economy and obviously, I think, is not justified, because we've already seen that the individual responsibility approach can have tremendous effect.

If you look at the gay community alone, in a place like San Francisco, and indeed across the country now as a result of much of the work in San Francisco, you can see the rates of infection dropping dramatically. We are talking about 1% or less of infection a year by using voluntary testing.

CHAIRMAN HART: Senator Doolittle.

SENATOR JOHN DOOLITTLE: Doctor, are those the only two approaches that you're

aware of?

DR. FRANCIS: No, there's gray approaches in between, no doubt. No doubt that there are grays between the whites and the blacks and that you get into a difficult situation when you have an individual who's infected and what you're going to do. That's my simplification to, I think, clarify the issue. Has it not clarified it?

SENATOR DOOLITTLE: I was just going to observe, I'm not aware of anybody who's advocated the one extreme that you were talking about. I mean, it's an absurd proposition to begin with. And it seems like, if that leaves us with the other alternative which is the status quo, that certainly is becoming unacceptable, I think, to a number of people. I just wondered if, if you saw any role for expanded testing, or if you feel content with the present situation.

DR. FRANCIS: The whole purpose of my being here, Senator, is not to push for the status quo; when I finish I would hope that there would be a momentum that we cannot accept the status quo, because transmission carries on and that we MUST not accept the status quo. Absolutely.

And that expanded testing is a very, very important part of that. But, in terms of the involuntary nature of it, I can tell you. I would really ask that you look at the data scientifically, that if you have the Big Brother approach on this voluntary system, then you scare the people away from the program and that is not without documentation; that the issue of potential discrimination against individuals inappropriately if we in public health want to remove someone from society who's a risk to someone else in an involuntary setting, that is discriminatory, no doubt, and perfectly appropriate.

But it's the -- it's the fear of the inappropriate outside of the recommendations of public health that literally drives this virus underground, reverses the messages, and confuses the individuals and, I think, ultimately increases transmission. But, I do not want the status quo; I didn't mean to say that.

I think I would like a system where every person at possible risk of this virus would come forth, be tested, enter a program, enter counseling programs, where both the negatives and the positives could be convinced, as I think has been shown to decrease their activity, even shown in IV drug users who, although addicted to drugs and cannot get off of it, can indeed change their behavior to minimize HIV transmission.

So, no, I do not mean the status quo, and I agree that there are gray areas, but the important aspect of this is that in California, where well over 90% of the infections occur in purely consensual acts where you have two people, if you can get to one of those people, you can stop transmission. It only has to be a 50% effective program, and you'll end up stopping transmission or decreasing it dramatically.

SENATOR MARKS: I -- could I just say one thing.

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: As I understand his testimony; he said that unless you have a test, of everybody, if you're going to have testing, you should have everybody, to use Sacramento as an example, 300,000 people, you have to test them all. The test that, all due respect, that Senator Doolittle has suggested, I do not think of the subject matter that he's talking about, that you're testing some people, not all people, therefore, I think you've indicated rather strongly, that those tests of a partial nature are ineffective.

SENATOR DOOLITTLE: Now, is that your testimony, Doctor?

DR. FRANCIS: I think if you use mandatory testing on a partial basis, it would not be effective. If you want to actually test and isolate individuals, you have to test everyone.

Now, all of public health and all of government, for that matter, we direct our money toward the highest payback, because you don't want to waste money through testing, or working in areas of low risk. If you have your pot that's only so full, you first want to take the layers of the highest priority. And so, in terms of testing, the first people to bring forth in testing are your highest risk groups which, right now in California, are gay men and IV drug users. And then you work your way down that process and ultimately I wouldn't be surprised if we got lower, as we got more money on the prevention side, that lower risk groups -- for example, mothers planning on getting pregnant, women planning on getting pregnant, women of the child-bearing ages, they are in family-planning clinics -- it would be recommended that they be tested. I think, again, I think you have to do this on a recommended basis; I don't think it needs to be done on a mandatory basis. Why? Because, right now we haven't gone through the maturity process of deciding exactly, in terms of government, what's going to happen to these individuals. Once it's clear, once there are laws to protect people against inappropriate discrimination who have HIV, then I think you can make broader and broader recommendations, and in that matter if the government so desires, to say that every woman needs to be screened who enters the child-bearing age to prevent perinatal transmission of the virus. There's all sorts of variations on that theme, but I think the issue should be that this is recommended. And by and large, people recommend what their physicians -- which becomes a standard in medical practice and very few people decline.

But again, it's the aura, it's the aura, it's the negative retribution, it's this -- it's the big brother coming down with laws that you get an extra 3 years for this or you get penalized for that, which are a whole negative, instead of the government working with the people to help them prevent this disease, you end up with an adversarial situation and I think it's terribly important to avoid that.

The last issue under P is Policy. I think it's very important and it's been

shown over and over again that the ultimate control of this disease and the policy that needs to be tailored is tailored for the individual community at the county and community basis; that we've had more and more difficulty at the federal and state and even county levels sometimes, in government in moving things through. But when you turn it over to the community and get the individuals who know the community and know the activities of that community, that you can have a tremendous effect. Again, the big brother versus the -- the neighbor approach.

Let me move, then, to the first R of the CPR process which is Resources. The National Academy of Sciences has recommended that somewhere in the neighborhood of $5.00 per person per year be spent on prevention of AIDS. That dollar figure will vary over time as we get more of a feeling of what it's truly going to cost and, and what the evaluations are going to be required in terms of seeing how effective the given program is, but I think that's a reasonable target to head for.

CHAIRMAN HART: Is that $5.00 per year, or...

DR. FRANCIS: Per person per year.

CHAIRMAN HART: Per person...

DR. FRANCIS: I think I would see that for the next 5 years until you get an established base and then you could have your, hopefully, your student as the kids come into the cohort with information as they come out of school, then it's possible that that can be decreased.

CHAIRMAN HART: So on a nationwide basis we have over 200 million people so you're talking about an annual appropriation in excess of a billion dollars.

DR. FRANCIS: Right.

CHAIRMAN HART: How much, if you put all the different funding sources together, are we currently spending in the United States on AIDS, do you believe?

DR. FRANCIS: It depends on state, obviously and, and right now the next year's budget for prevention of AIDS will be about a quarter of a billion dollars, is the proposal.

CHAIRMAN HART: That's the federal level...

DR. FRANCIS: Right.

CHAIRMAN HART: ...there are various states that are involved in AIDS programs so you add that in, I presume, and so you probably approach a half a billion dollars?

DR. FRANCIS: Nationally as a result of that small amount, if you think about AIDS prevention today, we all think that we in public health are out there taking care of the people. At best we have a skeleton prevention program. And the term that is used repeatedly with reviews used by the National Academy of Sciences is that the entire program is woefully inadequate. We have only a skeleton of AIDS prevention out there now and the people, I think, expect a lot more and deserve a lot more. For example...

CHAIRMAN HART: The billion dollars that you're talking about, that's for AIDS prevention.

DR. FRANCIS: Prevention alone.

CHAIRMAN HART: And does that include research or is that just education?

DR. FRANCIS: No, the recommendation by the National Academy of Sciences was another billion dollars a year annually for research.

CHAIRMAN HART: I see.

DR. FRANCIS: The -- as an example of this skeleton program, right now, we have intravenous drug users who know about AIDS, who want to stop sharing needles, who want to get off the streets, intravenous drug use, who want to get on Methadone programs where they can take oral instead of intravenous medications, and cannot do it without months of delay. Is that an effective AIDS prevention?

As a result of the skeleton AIDS prevention, we have sexually transmitted disease patients -- clearly, individuals at risk -- who have gonorrhea, or chlamydia, or syphilis, or whatever it is now, coming to sexually transmitted disease clinics and getting little or no information on AIDS prevention. We know, from the history of AIDS, that it is these patients who are the cases of AIDS tomorrow. We know that the people who have AIDS today have been to our sexually transmitted disease clinic and still, the sexually transmitted disease clinics do not have the staff to aggressively counsel these individuals as they come forth.

We have people lining up to take testing as the climate improves and California looks more positive towards testing and lack of inappropriate retribution on these individuals, that there is a lineup for people being tested, but that process can take weeks before the individual actually gets testing because of lack of resources.

We have no long-term counseling follow-up process for positive individuals and I think that's terribly important that that ultimately be integrated. We don't have, with even a patient of AIDS as reported now, we don't have a system in place now that his or her sexual contacts are counseled on how to avoid infection. Their ongoing sexual contacts, in terms of how to avoid infection from this virus of individuals we know, get increasingly infectious with time.

In summary, the basics for prevention are missing. There's some there, there's a skeleton there, but there's no muscle, there's no skin, there's no movement, and it's just starting. In California it's far ahead, indeed, of other areas. But you can't sit and wait for resources at the federal level. That it is clear from Vice President Bush's discussion that I read in the paper about four or five days ago, as he spoke in San Francisco, that the federal government is going to turn more and more of the responsibility for these kinds of activities on the states. Now, unfortunately, with AIDS it was caught right in the middle of this transition and that the classical federal

money, federal policy coming down through states to local health departments for the prevention of disease has changed, and AIDS got that change right in the middle and has made it very difficult. So I think the expectations of where the monies come from -- I think you have to be very careful in terms of the future of expecting too much from the federal government.

The last R is Realism. That we have to be realistic. That the system is not going to be perfect. That there are going to be individuals who are out there who don't care about infecting other people. That's a very important issue that'll come up. What do we do with a known infected person who's still having sex? Again, if we put the responsibility on the individual instead of the government, we hope that the individuals with whom that individual comes in contact would actually prevent transmission by not having sex with the individual.

The other thing in terms of realism that is so difficult for us to deal with, and it's an issue that has come up again and again and again, that there are homosexual men in this society, there are intravenous drug users in this society, there are people having heterosexu--, sex in this society, and the government program that tries to intervene in the transmission of HIV by all of these individuals is not advocating any of these practices. We are not advocating heterosexual sex; that's not our role in government. We are not advocating homosexual sex; that's not our role in government. What our role in prevention in the public health sector is to recognize that these risk factors exist and that we must deal with these on a very realistic level. It is clear in my mind that homosexuality has existed for a long period of time, will continue to exist as long as man will be around and we must recognize this. We must be realistic that these individuals are here in society, are part of society, and we must care for them as we do other parts of the society. But we must realize that we're not going to please everybody. If we try to have an AIDS program that will prevent all of us from getting nasty letters on our desks because we talk about anal intercourse or vaginal intercourse or something that offends people, then I'm sorry that it offends some people. But some of that is going to exist and there are many more offensive things in our everyday life -- we just have to deal with reality and move ahead with it. We cannot expect to have AIDS prevention programs that do not mention sexual activity and intravenous drug use and teach these individuals how to avoid HIV infection should they want to practice this.

The other thing that I think is a, is a great deal of concern in terms of -- of reality is time. That with all of our restrictions in government spending, not to mention allocations, like getting of money, allocating and actually spending, that a year or two can go by very, very quickly between the time that you people make resources available and the actual individual is hired on the street. That any decisions you make

you have to realize that you're making tomorrow's decisions and yet we needed a program two years ago.

That is the end of my CPR and I, again, restress what Senator Doolittle says, and I think, I stress, nicely, that we do: we should not be happy with the status quo. That we must move ahead with a scientifically-based, agressive program for HIV prevention.

CHAIRMAN HART: Okay, thank you, Dr. Francis. Senator Marks.

SENATOR MARKS: Senator Doolittle's sitting right next to me so he can disassociate himself with my comments, if he wishes to do so; I'm sure he will. As I understand his bills -- basically his bills call for partial testing of some people. Some people would be tested, others wouldn't. Now, what effect, if any, will that have by partial testing?

SENATOR DOOLITTLE: Let me just interject since we don't want to set up a straw man we have to knock down.

SENATOR MARKS: Okay.

SENATOR DOOLITTLE: The bills, with the exception of criminal acts where AIDS may be transmitted or in involuntary settings like state prison or confinement, long-term to mental health facility, are basically prescribed, voluntary, routine screening at certain intervals; it is not mandatory. So, you know, I think that you should understand that as you address the question. Reasons I do not want to get involved with...

(inaudible due to cross-talking)

SENATOR MARKS: ...disagree with you, I don't think that is the -- those are the bills, but, if you say they are the bills, we'll -- I'll look at them again.

DR. FRANCIS: I know that the members of this committee are intelligent, able individuals who are -- know AIDS very well, and that a concensus can be moved along that widespread use of voluntary testing should be; that's what one Senator wants, certainly what we want in public health, if you can protect the individuals who get tested from everything from losing their jobs to having their house burn down, then I think people will come forth and I don't think anybody will disagree with it.

SENATOR MARKS: You're telling me, Senator Doolittle, that your bills are voluntary, they're not compulsory at all?

SENATOR DOOLITTLE: With the stated exceptions, they're voluntary. The individual, if he chooses not to be tested, will not be. But in the absence of his objection, the doctor may test him just as he can test an individual for any which number of things today.

SENATOR MARKS: And they're, and they're confidential?

SENATOR DOOLITTLE: It would be disclosable to other medical personnel involved in the treatment of the person and to the public health official. To that extent, such

disclosures today would violate California law.

SENATOR MARKS: And you're supportive of the present California law?

SENATOR DOOLITTLE: I am NOT supportive. I am actively seeking to repeal the present California law.

SENATOR MARKS: That's the point that I'm trying to make, that uh,...

SENATOR DOOLITTLE: But then your objection, Senator, doesn't go to the voluntary routine screening. It would go to the issue of modifying the confidentiality. And perhaps modifying the prior written consent, which are, you know, two issues that need to be discussed.

SENATOR MARKS: Well, the issue that I've been trying to raise is whether or not your bills, which I think call for not complete testing -- partial testing, if I understand that correctly, I think I do; those bills which call for partial testing will help. Are they not partial testing?

CHAIRMAN HART: Well I think, I mean, we're not here to debate...

SENATOR MARKS: I'm not trying to debate...

CHAIRMAN HART: Senator Doolittle's bills at this point...

SENATOR MARKS: I'm trying to find out...

CHAIRMAN HART: I think, you know, maybe we ought to look at those bills at some appropriate time, get a proper understanding of what's in the bills. We've got different representations of what's in the bills, but we do have other witnesses. I mean, I want to give the members an opportunity to, in a sense, make their positions clear, but this is not the forum to spend a great deal of time debating bills that have either already passed or defeated this House of the Legislature.

SENATOR MARKS: What I was trying to do was -- I'm not trying to debate his bills, we'll have an opportunity to do that again, but, I was trying to find out whether or not the testing which is called for by this, these bills, if I'm understanding correctly, which is a partial testing, is from this doctor's standpoint, satisfactory. Now, maybe I don't understand the bills, I think I do.

DR. FRANCIS: I think that if you're going to do the large scale screening and quarantine, it has to be complete. Targeted from then on is targeted by, by what you have in your prevention pot.

CHAIRMAN HART: The concern of the testing, as I understand it, it's like these services that were established to -- so you can go get a card, so you can tell your potential sexual partner that you got tested two weeks ago, that that's terribly irresponsible, because there's no assurance. And your point is that if you're going to test with the idea of giving people some degree of certainty or assurance, then you better do it 100% of everybody, and properly quarantine people who test positive, and if you're not willing to do that then you're giving false senses of assurance and

potentially going to lead to increased transmission. Isn't that the point?

DR. FRANCIS: If it is the government heavy-handed approach. What I would agree with in Senator Doolittle's proposal is that if you put voluntary routine or voluntary testing together with counseling, where you change behavior on the personal approach towards AIDS prevention, then the testing has a large role and I think should be readily available rapidly for people who choose to use it. So the testing cuts both ways. The problem as I see it is, if you have the Big Brother "We're going to take care of you once you are infected with this virus" approach, then you will not have the individuals coming forth that you need to be tested. That is very clear from the data. That in California's primarily gay men, will run from the testing program. And what we're trying to do and what the gay community is trying to do, by and large, is to encourage people to change their behavior, and testing is a tool linked with counseling to do that.

SENATOR DOOLITTLE: And that's the premise of our bills. The bills don't address quarantine. Nor do they address mandatory testing outside of the exceptions that I mentioned.

DR. FRANCIS: I think the issue of testing is, it cuts across, gets to be a very heated one, but the issue gets confused because we're trying to think about which side of this approach we're using. If we're using the voluntary approach linked with good, top of the line, modern behavioral science in terms of counseling, I don't think anybody in public health would object to having testing on a large scale available. The test for the human immunodeficiency virus is a part of our social nature... (void in tape) ...behavior and needn't be tested at all. They know that; they needn't come forth. But they're individuals who, through various programs, are found to -- this could be useful to them and certainly could be useful in terms of medical care. Now, I think that's getting more and more solid, that there is going to be a desire for people who possibly have been exposed to this virus to come forth to be tested, because early intervention medically is probably going to prolong their quality of life and that's going to be very important in the future. I don't think we're going to have to encourage this test. We're doing 12,000 tests a month in California; it's not a matter of encouraging the testing, it's a matter of making the program first class so it has the maximum effect, which is not just testing people. That's the naive thing; if you just recommend testing and say that'll take care of AIDS, that is not the truth; I don't think anybody here recommends that. You have to put it together with a rational program of counseling individuals to avoid high-risk behavior.

CHAIRMAN HART: Thank you very much, Dr. Francis.

Our next witness is Dr. Neil Flynn, who's currently the Director of the Clinic for AIDS and Related Disorders at UC Davis Medical School. He's an Associate Professor of

Medicine at UC Davis; involved with the treatment of numerous AIDS patients; is monitoring the spread of HIV infection among IV drug users in Sacramento; Senator Seymour and I heard Dr. Flynn's testimony last week in San Francisco on that issue. He also will be monitoring the administration of AZT to inmates at the Vacaville State Prison; and is preparing for an AIDS vaccine trial with people infected with HIV but without other disease symptoms. Dr. Flynn, welcome.

DR. NEIL FLYNN: Thank you, Senator Hart.

My charge this morning, in a half an hour, and I realize that that is no longer possible, but we'll try to keep it to 20 minutes, here, is to talk about (void in tape) ...described. That those who become infected with this virus have a high probability of eventually developing full-blown AIDS. If we look at studies that are 7 or 8 years old now, 40% of the people that were infected 7 years ago have now developed full-blown AIDS. And another 30% have developed AIDS-related complex; they are ill. Ill enough that they can no longer carry out their usual daily activities. So we're looking at over 2/3 of individuals who were infected 7 years ago, being ill.

CHAIRMAN HART: Senator Doolittle.

SENATOR DOOLITTLE: Doctor, is it your belief that that percentage, as time goes on, will continue to increase? I've read, depending on some scientific and medical experts, that if given enough time that figure would be virtually 100%.

DR. FLYNN: It may come close. I don't say that because of my respect for my patients' hope, that they may have a little bit of hope. That there may be 10 or 20% of individuals who are able to resist this virus life-long. We know that's true of all other viral diseases and all other infectious diseases; there are individuals who can resist genetically, who are in some way genetically resistant to the virus. But yes, it's going to approach 80 to 90% who eventually develop AIDS in the absense of good treatment that will slow down the progress of the infection.

SENATOR DOOLITTLE: Do the -- from your knowledge and experience, do the people that have ARC, do those always, then, progress to AIDS eventually?

DR. FLYNN: Well, we haven't observed them long enough, but most of them do. People who have full-blown ARC, who are quite ill, and have any one of four or five particular symptoms, over half of those people will have AIDS within 18 months. And the other half, within probably 2 to 3 years. But, most of the ARC individuals will develop AIDS.

SENATOR DOOLITTLE: Thank you.

DR. FLYNN: Which brings us to the point that in California, with perhaps 200 to 300,000 people infected, we can look at the next 10 years as half of those individuals developing full-blown AIDS. At least half of them and another 1/3 developing symptoms of ARC, becoming ill.

Now there are a number of things that happen to an individual throughout the progress of their infection. For a long time, perhaps 2 or 3 years, 4 years, the individual has no symptoms whatsoever, other than perhaps enlarged lymph nodes, which are swellings in the neck or under the arms. If we look at their laboratory tests, however, we see that the lymphocytes that are in their blood begin to fall. Even within the first 1 to 2 years of infection, there is some small fall off, die off, if you will, in the lymphocytes, and that continues for the duration of the infection on until AIDS -- full-blown AIDS, those individuals have very, very, very few lymphocytes of the type that we assume help with immunity left. They are almost all gone.

Now the patient goes through a complex process, both psychologically and physically. As the immunity goes down over 3 or 4 years, the individual is subject to infections that ordinarily don't occur. Individuals may get yeast in the mouth without having taken an antibiotic; they may get what are called shingles, which is chicken pox come back in a nerve, very painful; they may have fevers and night sweats from time to time; lose weight and gain it back; have periods where they're severely fatigued and then recover again for a few months at a time. But eventually, most of these individuals go on to develop full-blown ARC, AIDS Related Complex. And this is weight-loss, fatigue, diarrhea, 8 or 10 liquid stools a day, which makes it very difficult for an individual to hold down a job, particularly if they've lost 20 pounds, feel fatigued all the time, have nearly continuous diarrhea, etc.

In addition, the effects of the virus on the brain produce a depression syndrome, and we see depression in individuals even before they are aware that they have the virus; even before we make a diagnosis of infection of the virus. One can imagine that after we've made the diagnosis of infection with the virus, an individual has a right to be depressed for a year or two or longer because that individual is aware of what's coming. But even before we make that diagnosis, there is depression. The virus infects the brain...

CHAIRMAN HART: Always, or sometimes, or usually?

DR. FLYNN: Most of the time, Senator Hart. Probably 70-80% of the time we can find evidence of infection in the brain, either at autopsy or at brain biopsy if we are in a position to take a brain biopsy for some other reason.

SENATOR DOOLITTLE: I have a question on that, Mr. Chairman. Does that happen before there are other manifestations at -- for example, a person that becomes infected with HIV, but before there's objective manifestations of ARC, or something...

DR. FLYNN: It can. There can be depression and/or loss of some mental functions -- very, very mild dementia that can only be picked up on very sophisticated testing such as IQ testing and things like that. There is some very mild changes.

SENATOR DOOLITTLE: Anything that, from what we know about, that would say, impair

judgement or that kind of thing?

DR. FLYNN: As it progresses, in some people, yes, it will impair judgement. Depression impairs judgement as well as the loss of intelligence and intellectual capacity. Both of those things will impair judgement.

CHAIRMAN HART: Doctor, let me make sure I understand -- you're saying, if I -- correct me if I'm wrong, that this depression comes before people know they have the disease and did you say 70-80% of the cases?

DR. FLYNN: No, the depression is less than that before the disease is diagnosed, perhaps 20% or 30%. My statement about 70-80% is that the virus involves the brain in that percentage of people infected with the virus eventually.

CHAIRMAN HART: So the depression comes before knowledge of the disease in 20% of the cases and in 70-80% the virus does affect...

DR. FLYNN: ...affects the brain. Right. Either to produce the mood changes such as depression; we've seen patients with psychosis who had developed paranoid schizophrenia and we've had other patients who have become demented. And that is maybe the only manifestation of their infection for a long time. It may be months to years before they develop infections or cancer from the AIDS virus.

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: You may have asked this question before, but those who get ARC -- what percentage of them eventually get full, the full degree of AIDS?

DR. FLYNN: The majority of them will have AIDS within 18 months. Now there are some who have gone 2 or 3 years with ARC and still don't have full-blown AIDS. But if you look again at their blood parameters, their lymphocyte counts go down continuously during that time and die off.

CHAIRMAN HART: So, if someone has ARC, will they eventually get full-blown AIDS?

DR. FLYNN: Probably.

CHAIRMAN HART: But we just don't know yet, because the disease is...

DR. FLYNN: We don't know what percentage. And again, to remove hope from 10, 20, or 30% is not good for people. We have to...

SENATOR HART: You mentioned...

DR. FLYNN: ...hope that they will escape full-blown AIDS.

CHAIRMAN HART: Well, you mentioned also, I wanted to make sure I understood this term, that people have ARC-related symptoms. I don't quite know what that means. If someone has ARC-related symptoms, does that mean that they...

DR. FLYNN: ...have ARC. Yeah, if you add up a few of the symptoms, say, 3 or 4 of them -- diarrhea, fatigue, weight loss -- and a person has all of those, we would call them ARC. They have ARC. AIDS-related conditions or AIDS-related complex.

SENATOR DOOLITTLE: Are those in conjunction with a positive HIV test?

DR. FLYNN: Usually, yes. Yeah.

CHAIRMAN HART: Senator Marks.

DR. FLYNN: ...in very few exceptions, there are individuals who have a negative test, but, who are carrying the virus.

SENATOR MARKS: I'm not sure I understood your answer to the question of Senator Hart. If 10 to 20% will not get AIDS? Is that what you're telling me? Or you...

DR. FLYNN: We're...

SENATOR MARKS: Or you...

DR. FLYNN: We're hoping. The studies are not long enough, Senator Marks, to know what percentage will eventually develop AIDS. Remember that we've been studying the disease for only 8 years now. And we've really had scientific data going back to only about 1979, 1980.

SENATOR MARKS: So you don't have enough information to know whether or not that is so, but it is a possibility...

DR. FLYNN: ...that some will escape.

SENATOR MARKS: Some will escape it.

DR. FLYNN: Yes, sir.

SENATOR MARKS: Thank you.

SENATOR DOOLITTLE: Can I ask one related question, something that...

CHAIRMAN HART: Senator Doolittle.

SENATOR DOOLITTLE: ...that he mentioned, I just wanted to clarify. We say we discovered AIDS in 1981, but you, with the medi-scientific community, knew they had something they didn't understand related to this that went back beyond that, isn't that right? Back into '79 -- doesn't that go back even -- aren't there cases that they're thinking that they saw even in the late 40's, maybe, that turned out to be this?

DR FLYNN: Well, it's possible. That data is still suspect, but we can trace antibodies back to 1976 in the United States.

SENATOR DOOLITTLE: And then -- and Africa would go back beyond that, wouldn't it?

DR. FLYNN: Uh, back to the early 70's. And there are isolated instances in the medical literature of people who look like they had AIDS in the 50's and 60's. In that particular article I reviewed for publication and the journal decided not to publish it, so, we will have to see whether we can trace it back further.

SENATOR DOOLITTLE: Thank you.

DR. FLYNN: Now, all along the way the individual who's infected with the virus, once they find out, suffers the psychological effects of believing or feeling that they will eventually get AIDS. Most of these individuals, since they're high-risk individuals, have seen either friends or lovers or someone else die of AIDS, that

is very close to them. So they know what AIDS is about, and they internalize it and it becomes a cloud, if you will, over their futures, and those individuals require a great deal of counseling and psychological and psychiatric help to become functional again. It is as if you members of the panel here were told that you have about 4 or 5 years to live. You have a disease that will kill you and integrate it into your lives. So that's another aspect that these patients go through as they become ill. They know what's in store because they've seen it in their friends.

I've mentioned to you the progression of the disease that, over time, it may be inexorable; that all individuals may eventually develop full-blown AIDS. Some problems of caring for people who become ill with the virus, ARC and AIDS; we have difficulties in finding resources in the community for those individuals. If they are completely disabled, at the present time, we often rely on volunteer help. The AIDS foundations in various areas provide a tremendous amount of volunteer help. But in San Francisco, for instance, those agencies are losing their volunteers because the volunteers are burned out. They have been working with the disease for 4 or 5 years, they've been through numbers and numbers of their clients dying and they are burned out. They can't stand it anymore, particularly since many of them are infected themselves and don't want to be shown the future over and over again for themselves. So we'll be facing a crisis in home care, we already have a crisis in some areas of home care and in skilled nursing facility care.

Yesterday one of my patients died at home after a 2 1/2 year illness with AIDS. At his bedside were 4 volunteers -- hand-to-hand counselors, his parents, his physicians, a physician assistant, all the people who had grown to love this man over 2 1/2 years. He was a fortunate man. He had all of these people available. Other patients of ours don't have those resources available. They have no family; their lover or significant other has left because they have AIDS and they can't deal with it and those individuals are left for the system to cope with. Frequently we have to keep them in the hospital longer than would be necessary. We may go 4 weeks, 5 weeks, 6 weeks in the hospital when all that was really necessary was 1 week because we can't find a place to put them. They're not strong enough to have their own apartments; no skilled nursing facility in the Sacramento area -- and it's the same in Los Angeles and San Francisco with rare exception -- will accept an HIV-infected individual. And so acute care hospitals such as UCD or San Francisco General or Los Angeles County have to keep these patients much longer than necessary. Now that translates into a Medi-Cal bill; UCD does receive administrative days for these individuals at a reimbursement rate of $200 a day where the ordinary skilled nursing facility rate is $40 per day. So it costs 5 times as much to warehouse those individuals in our hospitals as put them in skilled nursing facilities.

CHAIRMAN HART: The position of skilled nursing homes in not accepting AIDS patients; is that good public health policy or is that...

DR. FLYNN: No, it's not. It's a very good question. It is not a -- the individuals will not spread the AIDS virus within their skilled nursing facility. There do have to be increased infection control procedures carried out in those facilities and they cost extra money. But there's no reason, no logical reason, that individuals can't be placed in a skilled nursing facility with an upgraded infection control and education of the nursing staff. It is not a problem...

CHAIRMAN HART: Would that be preferable than just having a sort of segregated skilled nursing unit for AIDS patients?

DR. FLYNN: I don't know the answer to that. The problem with an area like Sacramento, even with a million people, we have need for between 5 and 10 beds today, is all. And you can't run a profitable skilled nursing facility on 5 or 10 beds; it needs to be up in the hundreds area. Los Angeles and San Francisco, yes, it is a good option.

CHAIRMAN HART: Senator Doolittle.

SENATOR DOOLITTLE: I was going to ask, what do you believe would be the reason that these facilities aren't accepting the patients?

DR. FLYNN: Money. It boils down to reimbursement.

SENATOR DOOLITTLE: What, what, it is what?

DR. FLYNN: Money. Reimbursement from Medi-Cal.

SENATOR DOOLITTLE: Is it true that caring for an AIDS pa-... I don't know how it compares to some of the other serious problems they face, but I'm of the impression it takes more care than the normal situation.

DR. FLYNN: It does and skilled nursing facilities take a broad range of patients, all the way from those who are ambulatory and require very little care to the very high-care individuals. They try to keep their patient mix down toward the ambulatory end and so they try to keep out the more severely ill. Not just AIDS but all types of disease. AIDS is a specific example of being severe. And once they see that, it is not profitable for them to take those individuals.

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: These -- this is Medi-Cal? These people are under Medi-Cal?

DR. FLYNN: The majority of my patients are. I see about half the patients in the city, and all of them with few exceptions, are Medi-Cal. So, in most cities, about 40 to 50% of AIDS patients eventually become Medi-Cal.

SENATOR MARKS: Now, these people who will not accept the care of the people; they have the authority to do that?

DR. FLYNN: Yes, they do. They can reject...

SENATOR MARKS: On what, on what ground rules...

DR. FLYNN: ...any patient that they don't want and accept any patient that they want. Medi-Cal will reimburse at $40 per day, and we've worked through with our nursing homes here in Sacramento, that at a $100 a day they can break even or even come out a little bit ahead.

SENATOR MARKS: I'm not suggesting what we'll do 'cause I have to think about it, but if we were to adopt legislation that would require them to take patients... (void in tape)

DR. FLYNN: (void in tape) ...more care of the patient.

SENATOR MARKS: What about the people's ability to get insurance? Are they very drastically affected? It's my understanding, from a number of people who have talked to me, that oftentimes if they're working, their insura-, and they have insurance that is being paid for by their employer, their insurance ends.

DR. FLYNN: If they have been enrolled prior to the time that they are found to be HIV positive, the insurance company will continue them. If they try to get new insurance health care or life insurance after it is known that they are positive, or if the insurance company or employer finds out that they're positive, they're often denied health care insurance.

SENATOR MARKS: Are there other diseases that you can think about where places like -- places refuse to take patients like they do not take people who have AIDS or ARC or other...

DR. FLYNN: There are other...

SENATOR MARKS: What other diseases are there?

DR. FLYNN: There are instances in my own practice of elderly people who are bedridden and require a great deal of care to prevent bedsores that nursing homes don't want. They're high-care patients, and if the nursing home can fill with a lower-care patient, it's to their advantage to do that and most of them are full in Sacramento. There is a waiting list for beds in Sacramento. So they're able to turn down the higher-care patients.

SENATOR DOOLITTLE: Senator Hart and I just came fr-, well you -- we all came from a CMA conference about uncompensated care problems. This certainly...

SENATOR MARKS: We did.

SENATOR DOOLITTLE: ...says the same thing.

SENATOR MARKS: Well what, if anything, would you recommend to make certain that facilities such as this take people.

DR. FLYNN: Become available?

SENATOR MARKS: I beg your pardon?

DR. FLYNN: Become available...

SENATOR MARKS: Yes.

DR. FLYNN: ...to these patients? My recommendation would be to increase reimbursement for these patients to a level that skilled nursing facilities can break even on it; somewhere between 80 and $120 a day.

SENATOR MARKS: Thank you.

SENATOR DOOLITTLE: What is the, may I just ask, Mr. Chairman, what's the rate for primary care hospitals; what do they get reimbursed from Medi-Cal?

DR. FLYNN: Well, we have looked at our reimbursement versus our charges today; if we charge $100, we get reimbursed about $40 from Medi-Cal. We can probably break even somewhere with our volunteers and aides, we can probably break even somewhere around 55 or $60. So we take a loss, the University of California Davis Medical Center takes a loss on every AIDS patient and virtually, other than DRG's, on virtually every Medi-Cal patient.

Some other problems that these individuals suffer; testing, as you mentioned, if they are tested and found positive, they need to keep that secret if they're going to become employed, if they're applying for a new job or for insurance and many times they do. Because the other option is that they will be denied both employment and insurance if they are known to be positive. So, the effects of being HIV infected are both psychological, they are social, they involve employment long before the individual becomes ill and then after they become ill, they involve finding resources which often aren't available, and then trying to manipulate those resources. It's very difficult for our patients to manipulate their Social Security and Medi-Cal to the extent where they can survive in their day-to-day living. Another problem that we have had is the share-of-cost for Medi-Cal. Our patients are usually getting by on a total of about $550 a month on Social Security and they are asked to pay $200 a month of that for share-of-costs for Medi-Cal and one can live in Sacramento on about $350 a month but it is in destitute circumstances. One can have a very small apartment, a bachelor apartment, and survive food-wise; no transportation, very little entertainment, so on. So most of my patients become relatively destitute before they die. And their standard of living goes way, way down.

Some other issues that I was asked to comment on was the problem of vaccine and AZT. Vaccine development is going apace in California as well as nationally; California, I think, is way out ahead in the Legislature having provided some liability insurance in a way to vaccine developers. No vaccine is going to be 100% effective. The vaccine is going to reduce the risk of infection but not eliminate it. So we're going to still have to have the education prevention programs that Dr. Francis alluded to. A vaccine, a good vaccine, is 80% effective, and if we were to be able to develop one at 80% effective, we would be very, very happy.

SENATOR DOOLITTLE: Is that about -- let's say the polio vaccine would be...

DR. FLYNN: Polio is that or a little bit better. Polio is slightly better and relies partly on the mass immunization effect. If one immunizes the entire community then the virus doesn't get a chance to start. And that effect probably has some effect in AIDS as well. It will certainly slow the spread of it; of the virus heterosexually. But I don't think we can expect a perfect vaccine, and so, one will still have to contend with education of prevention for the virus.

AZT is a major issue, which you'll be facing in the next few years. It looks like AZT is effective. It slows down the process of ARC to AIDS. Individuals take longer to develop AIDS, they are less ill, they are more functional, when they're receiving AZT. AZT prolongs the lifespan of people with AIDS, with full-blown AIDS, and they feel better that last year, year and a half of life. We don't have the information yet, on whether AZT slows down the progress from no symptoms but infected to AIDS or ARC. We just don't have the data; it will probably be available next summer. My impression is that AZT will work there as well; that it will slow down the progress of the disease all along the way. So, it becomes almost a standard of care, if that's true, for those who can tolerate the drug to take it. And that means literally, thousands and thousands of Medi-Cal and medically indigent individuals needing the drug within the next year of two. In Sacramento County alone, if we were to do widespread testing among high-risk individuals, we would probably find around 2-3,000 infected individuals in Sacramento County today. Theoretically...

SENATOR DOOLITTLE: Now...

DR. FLYNN: Yes.

SENATOR DOOLITTLE: Excuse me, I was going to ask if I could address -- 2-3,000 if we did the widespread testing amongst high-risk groups and we have identified, right now, how many do you recall?

DR. FLYNN: Oh, I'd only estimate that we probably have 7 or 800 identified in Sacramento today through all the various programs. It may not be quite that high. So Medi-Cal and counties are going to be faced with providing AZT to infected individuals. AZT costs, currently, $10,000 per year -- to provide $10,000 per year per patient.

SENATOR DOOLITTLE: Is part of that cost the -- to deal with the side effects for those people who are infected?

DR. FLYNN: A small part. About 10 or 20% of that cost is to deal with the side effects.

SENATOR DOOLITTLE: How many do have; the side effects are nausea, and some people have to have blood transfusions, right?

DR. FLYNN: Correct. And we believe that to be dose-related. We think that by

reducing doses, we can get some benefit to these patients without the severe side effects. The drug is new, and we won't know for several years whether that's true. So...

CHAIRMAN HART: Doctor, could I ask -- you mentioned that it's your hunch that AZT will slow the process all along the way.

DR. FLYNN: Yes.

CHAIRMAN HART: Is there a possibility that AZT would prevent people who are HIV positive from getting ARC or AIDS?

DR. FLYNN: It's not my belief that it will. It will simply slow the progress. Now, there it may tip the balance for a few to such a long time that they die of other causes before they develop AIDS.

CHAIRMAN HART: And the cost, you said, of AZT is $10,000 per year...

DR. FLYNN: Approximately 10,000.

CHAIRMAN HART: As we have more and more people who will become sick, will that drive the cost of AZT up?

DR. FLYNN: It may drive it down. If it's able to be synthesized, and Burroughs Wellcome, and other pharmaceutical companies are working on synthetic AZT that will be less costly. Currently it's derived from a natural product that's in relatively limited supply. So hopefully, synthesis will help. It's still going to remain expensive.

CHAIRMAN HART: Is this aforegone -- I mean it's -- if it's in limited supply and you don't develop the synthetic product, then the price...

DR. FLYNN: Then the price will remain high.

CHAIRMAN HART: ...will go much higher, won't it?

DR. FLYNN: Yes, it may. It's already very high...

CHAIRMAN HART: What are the prospects of getting the synthetic. Does that look pretty good?

DR. FLYNN: I think they're pretty good within a few years. But that leaves us in Sacramento County, if we were to identify all of the infected people, with 3,000 people costing $10,000 a year, and over half of those people being either medically indigent or on Medi-Cal; that's a huge amount of money for a county the size of Sacramento. And medically indigent funds for the county of Sacramento cannot, at the present time, sustain that kind of additional cost. They would have to take resources from other programs provided that...

SENATOR DOOLITTLE: So that would be what, about 30 million dollars, then?

DR. FLYNN: 30 million dollars a year for a county the size of Sacramento, yes. And the current medically indigent funds are only about 120 million for that county. It would be putting an additional 10-15% for medically indigent treatment of HIV.

SENATOR MARKS: If you, uh...

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: ...take AZT and you're under Medi-Cal; your doctor puts in a claim under Medi-Cal for it?

DR. FLYNN: Correct.

SENATOR MARKS: The state has to pay it?

DR. FLYNN: Currently the state will pay for AZT in people with AIDS. We don't know yet whether we'll get reimbursed for ARC. We think so. We will not get reimbursed at the present time for asymptomatics, the ones who are infected but have no disease yet.

SENATOR MARKS: But if they have the disease, the state must pay it.

DR. FLYNN: That's correct. Medi-Cal pays it. And all of my AIDS and ARC patients are on AZT. We lose perhaps 10-20% to side effects; very low number to side effects.

SENTOR MARKS: Is AZT made by one company?

DR. FLYNN: It is currently by Burroughs Wellcome. They are also licensing another pharmaceutical company to produce it because the demand is so high that they can't keep up with the demand themselves.

SENATOR MARKS: How was AZT developed? I mean, how -- was it approved by the federal authorities -- how...

DR. FLYNN: Yes, AZT...

SENATOR MARKS: ...how many years did it take?

DR. FLYNN: AZT has been around since the mid-60's on the shelf looking for a home. And like many other drugs, it has been pulled down from the shelf and tested against the AIDS virus and found to be active. From that point on, it took about 3 years for it to become available. The FDA speeded up the process of evaluation of that drug.

SENATOR MARKS: I'm not suggesting that you would tell us or that you would do it, but are there some -- is there medicine of some kind that's not been approved that you're using? Or...

DR. FLYNN: Not that I've tried...

SENATOR MARKS: ...or others are using; I'm not saying that you're doing something that's improper.

DR. FLYNN: Yes.

SENATOR MARKS: Others may be using.

DR. FLYNN: There are several other drugs that many people are using, and my philosophy for my patients is to try to discourage that unless they're taking AZT. I know AZT does something, but I don't know about the others. If they're taking AZT and they want to add something else, I will monitor them for it. I don't prescribe it, I

don't advocate it. There are a number of drugs that need to be evaluated, and they need to be evaluated more quickly than they are currently.

SENATOR MARKS: But I mean, is the federal government, which I gather does the one -- does the approval of drugs -- is their process a very slow one and too slow?

DR. FLYNN: Well, they've speeded it up for AIDS drugs and it is still cumbersome, it is still slow and that is to protect the recipients of the drugs. My patients' contention is that they will be dead in 18 months anyway from their AIDS -- those that have full-blown AIDS. And they -- if they want to take the drug and test it and don't care that their lives are shortened, then why does the federal government stand in the way? That is their contention.

SENATOR MARKS: Thank you.

CHAIRMAN HART: Could I ask on the -- one of the questions on the state's payment for AZT, your testimony was that they will pay for people who have AIDS; you think they will, I presume, will soon be...

DR. FLYNN: We hope so, it would...

CHAIRMAN HART: ...issuing an administrative ruling that they will pay for people with ARC, that they will not pay for people who are HIV positive who do not, at this point, have...

DR. FLYNN: That's my understanding at the present time, yes. We haven't tested that. We can't really afford to test it; we're testing it with just ARC right now.

CHAIRMAN HART: I see.

DR. FLYNN: See. Med center can't absorb that much. In conclusion then, the person with AIDS suffers from -- and from HIV infection -- suffers from social ostracism, including loss of job and insurance, from ill health that is progressive to full-blown AIDS; from psychological problems that involve knowing that eventually they will probably get AIDS and die of it; and the second psychological problem is they've been through it with someone else and they know what it's like and it is not something that they want to think about.

Our resources are limited; volunteerism helps a great deal, it makes the quality of life of our patients much better, but as in San Francisco, volunteerism has a limit. People get burned out. And eventually it will fall to insurance and Medi-Cal and medically indigent funds to provide some of those services that volunteers are now providing.

CHAIRMAN HART: Doctor, could I ask one final question, and I don't mean to appear ghoulish, but this thought has crossed my mind; could you describe how AIDS compares to other terminal illnesses, to a lung cancer or to other things that we all sort of have some abstract fear of, in terms of how the disease progresses. I sort of have this impression that AIDS is particularly debilitating and awful but is it really any more

awful than some of these other awful diseases that we, we dread?

DR. FLYNN: You've made a very good point. One can compare it best, I think, to cancer; to an incurable cancer with a terminal illness time of about a year and a half. That would be things like lung cancer -- often kills quicker than that; disseminated cancer is metastatic cancers of the breasts and other organs -- take about a year and a half often to kill the individual. It's a similar course, as well. They lose weight, they become weak, they require treatment frequently, they're hospitalized frequently; so the cancer model's a very good one.

Now, for cancer patients we've developed hospice, and we've developed fairly sophisticated hospice programs that rely on families, that rely on people having other people in the home. Our hospice, for instance, requires that there be an average of 1.7 care-givers in the home for the person who's going to enter hospice. We've been able to get some of our AIDS patients into hospice now, because they have that kind of support. But remember that many of our patients are gay men who have -- whose families have severed their ties with them for one reason or another, usually out of prejudice and fear that their son is gay, as well as their lover has left because their lover can't stand to see them die of this disease that they're going to go through as well, and they're left alone. They don't have resources that can plug into hospice type programs and so we're again left with putting them into the hospital and various stop-gap measures to try and take them through those last months.

So there's the difference, I think. AIDS is feared and there is prejudice against it that doesn't occur as much with cancer. It used to; in the early part of this century, cancer was treated by the general public much as AIDS is today. People with cancer were shunned and ostracized, and that has changed.

SENATOR MARKS: Let me add...

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: ...to this just one more question. What percentage of your patients, that you've estimated, are not gay people?

DR. FLYNN: Probably 20-30% of my patients are not gay. I have IV drug users, many of whom have come home from New York City to be with their families as they get ill and die; many of them picked up the virus in New York City, which as you know, is the center of drug abuse for the United States, and many of our addicts have been in New York City at some time between 1979 and 1985 and picked up the virus there. I also have some people who received the virus through transfusion. Perhaps, of AIDS, perhaps 3%, and of AIDS-related complex perhaps 5% of my patients are...

SENATOR MARKS: So, it is correct that a certain percentage, maybe 20, 30% or maybe 3%, whatever figure you want, some percentage of this, of the people faced with this problem, are not gay.

DR. FLYNN: That's correct. And many of those currently are IV drug users; others we estimate about 200 people in Sacramento who have the virus through transfusion. They're small, they're less than 10% of the total, but they will develop AIDS at the same rate...

SENATOR MARKS: Thank you.

DR. FLYNN: ...in general.

CHAIRMAN HART: Thank you very much, Doctor.

DR. FLYNN: Thank you.

CHAIRMAN HART: Our next witness is Dr. William Walker. Dr. Walker here?

MS. KATHRYN DUKE: Yes.

CHAIRMAN HART: Dr. Walker is the Medical Director for Contra Costa County; is a member of the Executive Committee of the Health Officers Association of California; is a member of the Board of Directors of the California Conference on Local Health Officers and Staff Physician at Merrithew Memorial Hospital, which is Contra Costa's County Hospital. Senator Marks, you will be pleased to know he's a Graduate of Stanford University...

SENATOR MARKS: Must be a very fine man. (laughter).

CHAIRMAN HART: He's got a red tie on and... A Medical Degree from University of Colorado, he's Board Certified in Family Practice. Pleased to have you with us, Dr. Walker. We particulary wanted to get the views of a Health Director outside of San Francisco and Los Angeles, which are obviously the areas of greatest impact in California from whom we've heard on previous occasions; we appreciate your being here today.

DR. WILLIAM WALKER: Thank you, Senator. I'm going to try in a short period of time to give you some perspective on the impact of AIDS on a local Health Department, and what I -- Health Department from the medium-sized county, mainly a population of about 700,000 in Contra Costa, with also a medium-sized burden of AIDS patients; what we are doing, how we are dealing with our current problem; it gives you some perspective of perhaps what the average county's experience is.

We currently have 150 cases of AIDS in Contra Costa County. Of those, 83% are gay males, another 7% are IV drug users, another 4% are hemophiliacs, and 4% are transfusion-related cases. We, at the present time, have been lucky from a county perspective in that more than half of those patients have been privately insured, and therefore, a substantial number are being cared for in the private community. We don't expect that to remain that way. We're seeing a beginning increase in IV drug abuse cases in our county and by the nature of our county facility, by the nature of our county responsibility, we expect more of those cases to be cared for in the county health system.

Dr. Flynn has alluded to the financial problems that Sacramento County's facing;

our problems are really no different. We are underfunded both by Medi-Cal and by the medically indigent adult program, and unless some alternative way can be found to finance the care of AIDS patients, our programs soon will be bankrupted by the burden that seems to be coming down the line. I told you we have 150 cases now; we anticipate in the area of 700 cases by 1991. We, at the present time, are dealing with an aging county facility, a county hospital that should've been replaced 20 years ago, that absolutely needs to be replaced now, and are going through the planning stages of looking at how much of that facility needs to be devoted to the care of AIDS patients. It's become a major planning issue for our county.

We are also dealing with the issue of AZT funding; there has, as you know, been a one-time-only amount of money made available to the State of California from the federal government and Contra Costa has its share of that money. The problem is dealing with what will look to be only a one-time funding issue; we will be able to start patients on it, but not necessarily continue patients beyond the 1 year funding level. Again, we're talking about $10,000 per patient per year of AZT funding and if the county remains having to pick up the burden of that, that quickly rolls up the cash register for us.

From the point of view of impact on Public Health Department, I would like to share with you what a medium-sized county has been able do with limited resources in the area of prevention and in the area of dealing with the community impact. We've had to pull together resources from throughout our system: from mental health division, the public health division, home health care from the Nursing Department; pull together our hospice resources, pull together physicians from any county hospital system, and then also involve community resources in our efforts; the AIDS Task Force, a number of private hospitals and private physicians who are carrying a major role in Contra Costa County.

What we're looking at in terms of the focus of our efforts, is what's been alluded to today, and that is, the main weapon that we have is focused education. We're dealing with broad community-wide education in a number of forums throughout the county, educating interested groups, educating health care workers, educating peace officers, emergency room responders. But in terms of preventing the actual transmission of the disease, the most effective agent we have is one-to-one counseling with identified patients. Now that means being able to identify the patients to begin with, and for the most part, that means allowing patients the confidence and freedom to come forth voluntarily to be tested, to be counseled, both before and after their testing, and then, hopefully to have an impact on the behaviors which will affect their knowledge in their progression either to AIDS or their ability to avoid it. We are approaching this in a number of ways. We are doing screening in our STD clinics on a voluntary basis, we are

also doing -- excuse me -- STD is 'sexually transmitted disease' clinics -- we are doing blind testing, that is unlinked testing, in our STD clinics and finding about a 9% positivity rate of those patients who are positive for syphilis. That is 9% of the patients who have a positive blood test for syphilis are also positive for the HIV virus.

CHAIRMAN HART: Let's back up on that, on the -- when -- you were saying that when people come to the STD clinic, they are voluntarily asked if they care to undergo an AIDS test?

DR. WALKER: That's correct. An HIV test, pardon me.

CHAIRMAN HART: But then in addition to that you...

DR. WALKER: In addition to that we're taking the blood samples which we're drawing for VDRL's, for syphilis testing, and testing those for HIV positivity. Those are not linked to the patients names, but that gives us an understanding of what the percentage of HIV positivity is in that particular subset of the population.

CHAIRMAN HART: What percentage, well, when people come into the clinic, what percentage are willing to undergo the test?

DR. WALKER: A majority of the people who are coming into the clinic are willing to undergo the test, given the confidentiality that exists around that test at the present time. We are also continuing to do work with the Sheriff's Department in the jail, and we're doing voluntary screening in the jail at the present time, trying to get some idea of the problem as it presents in our health care facility within the jails, also within the wider jail population.

CHAIRMAN HART: Is that voluntary testing?

DR. WALKER: That's voluntary testing.

CHAIRMAN HART: Of every jail inmate, or only those that you think are in a high-risk category?

DR. WALKER: That's voluntary testing of every jail inmate who chooses to be tested, and we also have an extensive education program going on in the jail advising inmates of what AIDS is all about, how it can be prevented. And we're finding as a result of that education program, many are wanting to find out their level of positivity while they are in the jail.

CHAIRMAN HART: And what percentage are voluntarily testing in your jail?

DR. WALKER: The percentage is well over 60%, at the present time, who are stepping forward to have the test done.

CHAIRMAN HART: And if someone tests positive, what happens then to that person?

DR. WALKER: He's extensively counseled with regard to the risk of his disease, he is not physically isolated in the jail at the present time. The issue that one gets into in mandatory across-the-board screening in jails is that you have to decide what

you're going to do with the results. And if in fact you're going to take it upon yourself as an institution or as a county to separate the jail into two populations, positive and negative, then you have to assure that you're able to keep those two populations apart and you have to be assured that your testing mechanism and repeated testing mechanism is good enough to make sure that those people are kept apart. We...

CHAIRMAN HART: So, you don't keep them apart because -- you don't have the facilities to keep them apart or you don't think it's good public policy?

DR. WALKER: We don't have the facilities, nor do we think it's good public policy at the present time.

CHAIRMAN HART: Why do you think it's not good public policy if you, let's say, you did have the facilities, why would you think it would be bad public policy?

DR. WALKER: If -- for one -- for the matter that I just alluded to -- I think that keeping people apart obligates us to assure that the people whom we've declared as negative are indeed negative. And that involves, because of the nature of HIV positivity, retesting over a period of time because the patient, for example, may come into the jail negative and convert after he's been tested since there's up to a 6 month lag period between infectivity of the virus and conversion to an HIV positivity. I think that that's a major problem even in and of itself. And I think that the problem is better addressed by extensive education in the jail, by making inmates aware of what they can do to prevent not only being infected but also prevent passing on the virus to other inmates.

CHAIRMAN HART: Are the people who work in the jail made aware of who is HIV positive, I presume that's -- would be a violation of state law unless the person agreed to that information being shared.

DR. WALKER: That's right. That's up to the individual inmate to share that information. What we've done is extensively educate our peace officers with regard to precautions in handling or being -- having contact with body fluids of any inmates and those precautions really need to be instituted across-the-board.

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: Let me say that I agree with the admonition of the Chairman that we shouldn't debate the Doolittle bills, we're not -- I'm not trying to do that here. But I do think it would be helpful to us, at least to have some indication from a medical standpoint, which you are, as to why the Health Officers were opposed to all of his bills. That would be helpful to us to know, from a medical standpoint, why it is that you were concerned with the bills because that would be helpful to us in determining where we should go.

DR. WALKER: I won't address the bills specifically; I will address the general principles by which we evaluate all legislation, particularly as it comes to HIV test-

ing. The primary reason for the testing is, at the present time, is focused education. We feel, and I think that our experience has been borne out in a number of studies, that any testing that requires mandatory testing will simply drive those people underground who need to be tested.

Second, if the testing that's done is not either anonymous or strictly confidential with antidiscrimination policies in place, people will not come forward for that either. So, we evaluate testing legislation on those two principles to begin with. We further look at testing with regard to what it will do from a public health perspective. Now, for example, premarital testing; although premarital testing can be done, we've done it with syphilis, we've required premarital testing in a mandatory way. In fact, the most recent study that's been done shows that premarital testing across the nation would pick up .1 of 1% of HIV positive patients at a cost of well over 100 million dollars. That same effort would produce about 200 patients who are infected and yet have been told they're negative; it would produce another 350 patients who are negative and yet have been told they're positive. And from a point of view of public health, that doesn't make any sense.

What does make sense is what we've done as a Legislature and as a State, and that is make HIV testing voluntary at the time of getting married so that this specific issue is raised for married couples; that focused education can occur; that if counseling can occur a few questions can be raised, and for those patients who consider themselves at risk, then voluntary confidential testing can be done. That makes sense. We, across-the-board as Health Officers, recommend and encourage widespread voluntary testing for anyone in the population. Anyone who feels they're at any risk whatsoever should be allowed to come forth, be tested, be counseled.

We're opposed to anything which will in any way make it difficult for people to come forth voluntarily or make them afraid to come forth voluntarily. And those are the general principles by which we're evaluating all legislation at the present time with regard to testing.

SENATOR MARKS: Thank you.

DR. WALKER: I'd further like to say that there have been some very good pieces of legislation come forth with regard to education and unfortunately not many of the pieces have made it through the entire process and some of them have made it with a veto.

I'd like to share with you that, at a local level, we've been able to do some things on our own working at one-on-one with the local school districts, and we've developed a model curriculum in Contra Costa County and with the cooperation of the school administration, the PTA's, the teachers, that involve very explicit education for junior high and high school students. We've developed a curriculum which will be used

throughout the county and we're going one by one to all the school districts to get approval of that.

I think that if the state could look to what is the most important thing to be done, it would be to require counties to come up with a plan for AIDS. Namely, require county health departments which really are the arms of the State Legislature and the State Administration -- we're the troops in the field; require us to come up with a plan, put some requirements on what that plan ought to entail, and then provide us with the resources of how to carry out that plan.

I have before me a 49-page document which is the 3 year plan for Contra Costa County which is in its final draft stage; it will be going to our Board of Supervisors in the next few weeks. That is an ambitious plan which will, I think, effectively deal with AIDS in Contra Costa over the next several years. It will only happen if we have the resources to do it. It will only happen if we get the resources in a way that can be used to meet the needs of our county. Now, the most effective way for the state to pass resources onto us, truthfully, is in the form of block grants with minimal requirements in terms of reporting back to the state. Some of the education money that we have received has been helpful, but frankly, some of the hoops that we've had to jump through to use that money, namely getting all of our pieces of educational material approved; having, for example, the test kits -- were leaving the jail to go back for approval by the state; in my opinion, simply, roadblocks to doing an effective program. If you could simply trust your local health departments enough to give them the credit for having insight into what's going on in their own counties, give us the money to do the job; I think we can do the job very effectively for you.

Now, that doesn't address where you're going to get the money. Dr. Flynn has talked about the problems of money on the acute care side. Public health is no different. The resources are going to have to come ultimately, I think, from the federal government. We are, in Contra Costa, looking at a proposal now which we'll be taking to the Bay Area Health Directors at our monthly meeting and ultimately to our Board of Supervisors for proposed legislation to begin to fund AIDS in a pattern similar to the Short-Doyle program.

Short-Doyle, in addressing the mental health needs of the state, in many ways has some of the same problems facing it that the AIDS program does. That is, it's a problem that impacts the entire community; it's a problem that the community cannot handle on its own with its own resources; it's a problem that could be best addressed by Advisory Boards from the local community; it's a problem that the state could, in fact, lay out a general plan for and require the county to come up with a plan, an AIDS plan just like we've come up with a Short-Doyle Plan; it's a problem where the county pays part of the share, the state pays part of the share, and ultimately, hopefully, the federal

government could pay part of the share.

This is a completely independent funding for AIDS outside of the context of normal public health funding, outside of the context of normal acute care funding. But it's going to take something innovative to get it off the ground for us to begin to have the resources in place to do what we need to do. So I'd ask you, as you develop legislation, to look at broad methods of being able to pass on money to counties in the form of block grants. I would ask you that when you come up with specific proposals with regard to policy on AIDS, with regard to testing on AIDS, that you view it in the context of the broad problem; that you view it in the context of the principles you need to look at in evaluating testing proposals, and that you consult with your professional staffs, both at the state level and at the local level, with regard to professional public health input in developing new legislation. Thank you.

CHAIRMAN HART: Questions?

I'd like to ask 2 questions if I may. You mentioned syphilis and marriage requirement. Could you comment on the -- I mean, oftentimes here we ought to deal with AIDS like we deal with other diseases like syphilis. To what extent, from your standpoint, is that an appropriate analogy and, if not, why not? Why does it break down?

DR. WALKER: I disagree with the argument that AIDS is simply another sexually transmitted disease. It's much more than that; it's much different from any other sexually transmitted disease we've ever had. For the first reason being it's not treatable at the present time, and that the programs we've had in place for STD's in the past including screening, including contact follow-up, have been with the promise of being able to offer treatment for those people who are found, and also there have not been big issues of discrimination or nondiscrimination with regard to those diagnoses; that's number one. Number two, AIDS, from a national viewpoint, has tremendous social and political overtones to it that are much different from any infectious disease we've ever faced before; particularly much different from any STD. So I think that using the STD model to deal with AIDS is wrong.

CHAIRMAN HART: Okay. The other question that I wanted to ask is could you comment on contact tracing? Is your county involved in that at all, and can you help us understand that a little bit better; how it works or should work or what the pitfalls are?

DR. WALKER: We're doing limited contact tracing in our county at the present time, particularly following up contacts of transfusion-related AIDS, hemophiliac-related AIDS as well as IV drug use-related AIDS. The reason that we have done less contact tracing in the gay population is that it's our opinion that efforts are best spent in that population on individual focused education and addressing the population as a whole. We think that our education efforts in the gay community have been good and primarily that has to do with the organization that exists within the gay community.

We find that the other problem in contact tracing is simply the incubation period of this disease. We're talking about a disease that has an incubation period on the average of 5 years. We're talking about contact tracing into the distant past which isn't always do-able, it's difficult, it's expensive and in our view, the resources that we would need to put into that aren't warranted given the potential outcome.

CHAIRMAN HART: So given the 5 year period and given the fact that you're not doing much of it in the gay community 'cause you don't think it's the most effective way, does that mean that you're not doing contact tracing?

DR. WALKER: No, as I said, we're doing it in other focused areas. We're doing it in heterosexual contacts of people who would be unaware that they were at risk. I think, there's one thing that can be said, at the present time, across-the-board I don't think there's a gay person alive who doesn't think he -- or shouldn't know that he's at risk and that he should come forth for testing and be tested. That can't be said of people who have been anonymously in contact with an HIV positive person and those are the people, I think, who need to be sought out in the population since they're out there not knowing they've come in contact, and where contact follow-up is appropriate on a one-on-one basis.

SENATOR DOOLITTLE: I have a question on that.

CHAIRMAN HART: Senator Marks and then Senator Doolittle.

SENATOR MARKS: I don't quite know how to word this, but there are some statements that've been made by a number of people relating to the manner in which you can get AIDS. Can you get AIDS by shaking hands with somebody?

DR. WALKER: No. I think that the overwhelming evidence, I think you can say for certain, is that AIDS (void in tape) get it from the air, you can't get it from an AIDS patient sneezing in your presence, you can't get it from shaking hands of an AIDS patient, and as Dr. Francis said, there have been now some 9 cases out of 42,000 cases where there's been transmission from what's been less than intimate contact; those have been IV -- correction -- those have been needle puncture cases in health care workers, and a few cases of what's called 'splash contact' where the body fluid or blood of an AIDS patient has been 'splashed' on either an open sore or mucous membrane of a health care worker. Those cases have occurred; more of those few cases will continue to occur. Health care workers are at risk, but I think that the overwhelming sense of what we're looking at is it's a very, very small number of cases given the hundreds of thousands of health care workers that have been in contact with AIDS patients.

SENATOR MARKS: Can you get AIDS from mosquitos?

DR. WALKER: No.

SENATOR MARKS: Can you get AIDS from sitting on a toilet?

DR. WALKER: No, you can't.

SENATOR MARKS: Trying to think of some of the other excuses that have been spread relating to AIDS. Do you know any other examples of ways in which you cannot get AIDS?

DR. WALKER: I can only tell you the ways you can get AIDS, and everything else...

SENATOR MARKS: All right, why don't you tell us that.

DR. WALKER: Okay. The ways you can get AIDS are, number one, having intimate sexual contact with a patient who is HIV positive. There are risk behaviors of that intimate contact, the biggest risk behavior is anal intercourse; it's much more difficult to transmit it from a female to male but it does occur, but very rarely; it -- that's the first way you can get it, therefore, is sexual contact.

The second way you can get it is by IV exposure; IV drug exposure from a contaminated needle, for example. The sharing of a needle with an AIDS patient exposes you to the virus because the virus gets directly into your bloodstream when you inject the drug. The same transmission, note, applies to people who've received the virus through transfusions; through a contaminated blood source. That includes hemophiliacs, it includes people who have had transfusions during surgery.

Those are the -- as I alluded to, there have been a few cases of transmission of splash contact to open sores or to mucous membranes, and those are the only ways that you can get AIDS.

SENATOR MARKS: Thank you.

CHAIRMAN HART: Senator Doolittle.

SENATOR DOOLITTLE: Do you accept the CDC's report that some 88% of HIV infected people are unaware of their infection?

DR. WALKER: Yes, there is a -- the number that's being used, is that there is a perhaps 10-1 ratio of HIV positive people in the population versus those that we have identified.

SENATOR DOOLITTLE: Of 10-1, okay. So, do you feel that -- I guess you don't feel, as the health officers have taken that position pretty clearly but, don't you think we need to do something more in order to call to the attention of those people who are infected, that they have a problem? I mean isn't that when people really become receptive to listening to the educational message?

DR. WALKER: Absolutely. And the only way you're going to be able to give that education to them is if they come forth and get tested.

SENATOR DOOLITTLE: Well, since this tends to be -- I mean we didn't go into this before, but, a lot of people tend to assume that this is something that always happens to the other guy. And isn't that a psychology in serious diseases?

DR. WALKER: Yes, it is. I think that the message is beginning to get out there though. I think the evidence is somewhat in our alternative test sites in our county,

where we've done some 5,000 tests in the last couple of years. That the percentage of positivity of those tests are going down. So that initially we had people who were coming in who were quite at risk coming forth to get tested. As we go along, the percentage of positivity is decreasing and that's because more people who might have casual contact in the past, 'scuse me, might have had intimate contact with a potentially HIV positive person, are coming forth to be tested; their risk has not been great. We also have a lot of worried well out there who are concerned that any symptoms mean AIDS. So as they come forth to get tested and find that they're negative, that allows us to do a couple things. Number one, it allows us to counsel them about how never to get positive. And it also has allowed us to talk to them in an anonymous way, where they can enjoy complete confidence; they can come forth, find out their status, be counseled, and go away with valuable information. My feeling is if we don't have that kind of test site available, and if we try to do the tests in a mandatory way, we'll simply drive people away from being tested -- drive them away from coming forth for that kind of education that they need.

SENATOR DOOLITTLE: What about adding the possibility of having more widespread routine screening in addition to what is now going on?

DR. WALKER: I don't like the word routine. It's too open to interpretation. I think that testing is either anonymous, confidential, or there's open access to anyone. There's no such thing as routine.

SENATOR DOOLITTLE: But by routine I mean applying the same standards to that blood test as are applied to the other blood tests.

DR. WALKER: I disagree with using the test that way. Primarily because with other blood tests, for example, if I want to know whether I'm positive for rheumatoid factor, that's not a confidential test; it'll be in my medical record, it'll be open to any one of a number of parties who want to request my medical record for insurance purposes or whatever. But there's one thing that's true, and that is -- will not be discriminated against because I have a positive rheumatoid factor.

SENATOR DOOLITTLE: Well...

DR. WALKER: That's not true for the HIV virus and until we have the antidiscrimination policies in place, one cannot think of, quote, routine testing.

DR. DOOLITTLE: So until we have such policies in place, you would oppose a proposal that would allow a physician to disclose to his nurse or to other medical personnel assisting that patient that that patient test positive?

DR. WALKER: No, I think we're very close to being able to do that. In fact, we almost did it, I think, with AB 67.

SENATOR DOOLITTLE: Well, yeah, but I'm saying -- I mean your price for that is antidiscrimination language?

DR. WALKER: Yes.

SENATOR DOOLITTLE: In the absence of antidiscrimination language you as a health officer and a physician, would oppose a line of disclosure of such information to the other health personnel.

DR. WALKER: I can tell you, in reality, the people who are having hands-on contact with patients in the hospital now; we're talking about the nurses, we're talking about the treating physicians; by and large know that patient's antibody status if, in fact, a test has been done. The problem we get into there is whether every patient that enters a hospital should be tested, and again, I would not want to approach that until we had in place protections against what, I fear, is the absolute worst discrimination which can occur and which, I think, we're beginning to see. And I have some concerns about members of my own profession. I'm seeing physicians come forth asking for testing with the implication that, with a positive test, they'll refuse to treat the patient. Now right now, there's no piece of legislation; there's no law that requires a physician or a hospital to treat a patient. He could be discriminated against. And until we have legislation in place which says you cannot discriminate against an AIDS patient because of his antibody status or anything else, I would oppose the kind of screening that's being proposed for hospitalized patients.

SENATOR DOOLITTLE: Well, if we had such antidiscrimination language, would you be concerned that that could require a hospital to maintain on its staff a surgeon who tests positive, or a restaurant that maintain on its staff a person who tests positive, I mean, would that concern you?

DR. WALKER: No, it wouldn't concern me.

SENATOR DOOLITTLE: Well, I would suggest it would concern me and a number of other people in the state who are very concerned about the transmission of AIDS in those cases to other people. And that...

DR. WALKER: There's never been a restaurant-transmitted case in the history of AIDS.

SENATOR DOOLITTLE: Well, I mean, we know so little about, really, these cases; we know there's a good deal of evidence on the sexual transmission; I think the blood spilled on the chapped skin is a very, very serious example about AIDS and shows the potential for its transmissibility; the fact that there've only been a few examples, I mean how do you even document or prove something like that. It's going to be difficult in the first place but the very fact that we do have few documented cases suggests that we need to take a close look at this. Certainly, the people in the health care professions are very, very concerned. One of the leading surgeons in Los Angeles is wondering; what does he do every time he gloves up for surgery and goes in, 'cause you're talking to surgeons, they stick themselves about every other time, as I understand it in

surgery, and so their level of exposure is much higher than the typical person's in our society and, you know, do they treat every patient as if he has AIDS? This man happens to feel if they do that, it means wearing extra clothing, so it makes them hotter as they're going through the surgeries; he feels that makes him less effective as a surgeon in terms of being able to do all the concentration and application of skill and then if he has to double-glove, then all of that he feels there's less sensitivity. So there are some real trade-offs and, you know, I just think the health officers need to take a more critical look at this issue than blatantly or blanketly support the antidiscrimination provision without recognizing that there may need to be some exceptions, some adjustments as we go along the way. 'Cause there's some real trade-offs, I think, that we're making and we need to recognize we're making them as we go down this path.

DR. WALKER: I think we came very close to putting a bill across which we supported which would have provided for the confidential testing in the hospital; it would've provided for the passing out of information to the health care team. Unfortunately, in the final hours of legislation, it didn't make it. Let's hope that this time around it does make it.

SENATOR DOOLITTLE: Well, I don't hope that it does, I mean, I was the key party, I think, that made sure it didn't make it in the Senate. And the reason I did that was because it had this broad antidiscrimination language that didn't allow for any exceptions. For one thing, even if you look at it -- if we get beyond the actual medical issues -- hospitals are having a hard enough time as it is. What do you suppose happens if word leaks out the hospital's keeping on it's staff a doctor who has AIDS?

SENATOR MARKS: Chairman, can I just say something?

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: With all due respect to Senator Doolittle, and I have a lot of respect for him although I don't agree with him on this, he's not a doctor, he's not a health officer, he's not a nurse. The doctors of California, who I presume number among their people, Republicans and Democrats and Independents, or the health officers or the nurses have all (void in tape) who is opposed to these principles, but I cannot conceive of how we should pay attention -- he's a loyal like I am -- how we, on a medical matter, a matter involving the health of people, we should pay attention to his concerns -- obviously, we're all concerned, but will we pay attention to his views relating to the health aspects of this problem. I cannot conceive why we should not pay attention on a medical matter, to the medical societies, to the nurses, the health officers -- those are people who have an independent judgement of this problem.

SENATOR DOOLITTLE: Well, Mr. Chairman, if I might just comment on that.

CHAIRMAN HART: Briefly.

SENATOR DOOLITTLE: It is not the doctors or the nurses that make social policy in

this state, it is the Legislature and we look to the doctors and the nurses on medical issues to advise us. There's a significant division within the medical community. It's more significant than it's ever been with doctors coming forward and saying, "Hey, we need some protection; we're concerned that we have a more balanced approach," so I hope that you wouldn't create the impression that there's a monolithic attitude amongst the health professions 'cause there certainly is not.

SENATOR MARKS: No, I don't think it's a monolithic attitude; I'm sure that you'll be able to find people who agree with you here and there, but I'm saying as an organization; they are an organization which meets, I believe, democratically, determine its position on matters, and they are not people who are particularly involved in politics per se; they're involved in the medical or health matters involving the State of California and they come up forward with presentations, and they have, universally as a group, opposed your bills.

SENATOR DOOLITTLE: Well, I would just observe, there's more politics in this AIDS issue at every level than in any other issue we can probably think of today, both within these organizations and without.

CHAIRMAN HART: Okay, Dr. Walker, let me -- I'd like to ask one final question if I could, of your testimony as it relates to doctor's ability to reject an AIDS patient; you said there are no laws in California that preclude...

DR. WALKER: That's right.

CHAIRMAN HART: I was under the impression that there were BMQA rules that do apply and that if a doctor did refuse to see an AIDS patient, that they would be subject to licensure disciplinary actions, is that not the case?

DR. WALKER: I'm not aware of any BMQA rules. As you know, we had to face it in terms of emergency room treatment and in terms of patients being turned away from emergency rooms, and in fact, had to invoke anti-dumping legislation in that area, which imposed penalties on physicians who were refusing to treat. Those same kinds of issues, I think, are -- involve AIDS cases at the present time. The only thing that would govern a doctor's performance in the hospital is an individual medical staff ruling; that he was required to treat all patients who came in the front door. If the hospital and medical staff took on that ruling as a policy and a matter of being a member of the medical staff, then that would be in place. I don't believe that BMQA enters into that.

SENATOR DOOLITTLE: Okay, thank you very much.

CHAIRMAN HART: Our last witness this morning is Dr. Alex Kelter, representing the State Department of Health; he's the acting Deputy Director Public Health for the Department. Dr. Kelter, welcome.

DR. ALEX KELTER: Good morning, Mr. Chairman. There's an obvious advantage to

appearing late in an agenda like this, and that is that many of the important points have already been made, and they certainly have been.

The disadvantage of appearing late is that the important points have already been made, and they really have been. (laughter) So, what I would like to try and do is just briefly, use a couple of my prepared remarks to summarize some of the issues that have already been alluded to, and then cover a couple of items that you've requested, namely the history of AIDS funding, the organization, and the department, and those type things.

Mr. Chairman, members of the Committee, thank you for the opportunity to testify today. Dr. Kizer regrets not being able to be here personally; he has had a long-standing commitment that would not allow him to be here, but he did ask me to specifically apologize for that.

In the overall scheme of medical science, it's really phenomenal that we have progressed as quickly as we have, from the first recognition of a brand new disease of the human species to the identification of a previously unknown and unsuspected virus which causes it in a mere 4 years. Furthermore, it is possible that the first human trials of prototype vaccines and additional treatments, that is, additional to AZT, would be started in the next year or so. Another rather phenomenal development.

Yet, with all of this remarkable advance in human virology and immunology and therapy, the fact remains that everything we need to know to prevent virus transmission was known with virtual certainty by the end of 1982; before the virus itself was even discovered. All the scientific advances that have been in the ensuing months and years have confirmed and strengthened what we knew then.

AIDS, HIV infection, is a disease transmitted by sex and blood. The way to avoid transmitting it and acquiring it, is to avoid the exchange of specific body fluids, semen and blood, with another person. To the extent that it is possible to know this, all cases of infection off-rank AIDS have been acquired either through direct sexual contact with an infected person or through direct blood to blood exposure to an infected person's blood, and this would also include the maternal and child exchange of virus during gestation and delivery.

The challenges before us now are not materially different from other challenges we face; we know what must be done, but we're struggling over the best ways in which to do it. Some might question our collective commitment to prevent AIDS because they do not see their favorite methods being adopted and applied universally. We know enough about preventing AIDS, and we have for some time. What we're continuing to pursue is the mix of messages and methods that will make what we know meaningful to the people whose behavior will directly determine the level of AIDS prevention that we ultimately achieve in our society.

The current mixture that we and others administer in the Department of Health Services, at the national level and certainly at the local level, includes a number of different approaches. At the state level, we take responsibility primarily in the state where the compilation of statistics and the support of epidemiological and statistical research; we support special studies and we keep a finger on the pulse of AIDS incidence and prevalence and HIV infection in California; a level of activity which is sometimes called monitoring, if you will.

A very important element of that project and that program is the support of alternative testing sites. As you know, alternative testing sites have been available since the day the test was approved by the Food and Drug Administration in 1985. And at the current level, we are testing in excess of 11,000 people per month in alternative test sites around California.

In the area of medical care, we are supporting a number of pilot projects whose goals are several. Most importantly, they are to experiment with the providing of care to people with AIDS, and to some extent with ARC. And to develop reliable information about how much this care costs and how much, perhaps, can be saved by a more judicious mix of more cost-effective methods of treatment; and along these lines, we are applying to the federal government for a waiver from certain Medi-Caid rules, which would allow us to pay for some non-hospital care in the Medi-Cal program which is now not permitted.

Of course, I couldn't describe the State AIDS program without focusing on education and prevention. In the current year, almost 7 million dollars are being spent statewide to support specific education and prevention programs in communities and counties all over the state. In addition, there are a couple of elements of research support that we conduct through public health in addition to those that come to the University of California which involve a program to make funds available for testing of AIDS vaccines once they become licensed and approved by the FDA, and of course, the recently enacted AB 1952/SB 618 program to allow the state to award investigational new drug approvals to those who wish to test new drugs within California and not extend beyond the borders of California. So, you can see that the Department and state as a whole is deeply involved, and has been from the beginning, in a wide range of activities dealing with the identification of treatment and prevention of AIDS. I'll take a moment to review the history of funding of those programs because it's rather impressive. Going back to the 198-...

CHAIRMAN HART: Doctor, let me just -- one of the things that I wanted to ask, and I'm sorry Dr. Kizer isn't here; I have a general concern that the Department is not very visible on AIDS issues. I don't see the Department out there sort of (void in tape) education that the vaccine legislation that you made reference to, I believe, was an idea that came from the Attorney General, not from the Department of Health Services. I

mean, I sort of have a general impression of the Department of -- kind of gathering statistical data, which is very valuable, but it's fairly -- I mean, let's be blunt about it, it's a noncontroversial area. When you get involved in the controversies, I don't see much in the way of the Department of Health Services visibility one way or the other.

DR. KELTER: Well, I don't know, Senator, what I can say that would -- that might change your perspective, I think...

CHAIRMAN HART: I guess I raised it in the context of the vaccine. You were talking about the Department of Health's role, and I thought it was really the Attorney General who was responsible for that.

DR. KELTER: The Department has had the authority and has had the willingness to entertain that kind of activity for some time, but, I really have to view it as a program that's jointly been agreed to and is going to be carried out by the Legislature and the Administration. Certainly, the Governor had the opportunity to veto the measure and didn't, and the Department is forcefully and speedily beginning to carry out that program. So, I guess all I can really say is, that this has been a joint agreement between the Legislature and the Administration, that this activity would be undertaken, and it is being undertaken.

As far as our visibility is concerned...

CHAIRMAN HART: Senator Marks.

SENATOR MARKS: I'd just like to ask one question -- I'm not trying to make an issue, but just to follow along with what Senator Hart asked about; much of the legislation that has been passed, the Legislature calls for additional funds relating to AIDS. Much of that has been vetoed by the Governor. Has your Department recommended the vetoes?

DR. KELTER: Without having a list in front of me, well...

SENATOR MARKS: I don't have a list either.

DR. KELTER: Well, the Department's advice to the Governor has often been, I'm sure, instrumental in the Governor's deciding which position he takes, but he alone makes the final decisions about what bills will be signed and vetoed.

SENATOR MARKS: But do you recall that the Department has recommended vetoes of certain appropriations the Legislature has approved?

DR. KELTER: Senator, quite candidly, I don't recall which recommendations of the Department's were the ones the Governor finally accepted and which were not.

SENATOR MARKS: It'd be interesting to have you, sort of, submit to us sometime, a list of those bills that you've recommended disapproval.

DR. KELTER: Well, with all due respect, I think that's a request you'd have to make of the Governor's office, not of the Department.

SENATOR MARKS: Can I make it of you?

DR. KELTER: Again, with all due respect, Senator, it's the Governor who makes the final decisions about...

SENATOR MARKS: I understand that, but each Department makes recommendations. Are you telling me that the information relating to its recommendations -- I thought -- I understand the Governor makes a decision, but its recommendations are confidential? Recommendations?

DR. KELTER: My understanding is that they are privileged communications between the Department and the Governor.

SENATOR MARKS: Well, they shouldn't be.

DR. KELTER: Reviewing the pattern of funding over the years, going back to the 1983-84 fiscal year, the state's allocation to overall AIDS programs was about 3.4 million dollars. The net effect of subsequent decisions over subsequent budget years has been to double those expenditures virtually every year. And while this did not take place between '83-4 and '84-5, the subsequent change was a quadrupling so the net effect was (void in tape) and from '86-87 to the current year '87-8, there was a doubling in the overall state AIDS budget to the tune, now, of 63 million dollars in the current year. Of that, the Department receives about 2/3 of it, or 46 million dollars; University of California receives about 10 million, and the rest is distributed among other departments including Mental Health, Alcohol, Drug Abuse, Corrections for the total funding of 63 million in the current year. This is, far and away, a pace not exceeded by any other state in the United States, even the states that have more cases than us, mainly New York state, and is certainly not exceeded by the federal experience in AIDS funding.

What we should look forward to in the future has already been well described by previous witnesses and I don't want to belabor those points; they were well made by Dr. Francis, Dr. Flynn and Dr. Walker. There are hundreds of thousands of people infected in California; they will require medical care, they will require compassionate care, both from medical and health professionals and from all of us in California society.

CHAIRMAN HART: Dr. Kelter, can you -- in one of the statistics that's thrown around is that at a minimum, 300,000 people in California have the HIV virus and upwards of 50% or more of those people will ultimately get AIDS and die. We're talking 150,000 deaths, minimum for over the next (void in tape) people will actually get the disease. Are those accurate figures by your Department or personnel.

DR. KELTER: Yes, we agree with those estimates; they come from the Centers for Disease Control in Atlanta, but they're based on data that we and other states and counties and cities collect by programs like the Alternative Test Sites, by confidential testing in sexually transmitted disease clinics, and drug abuse clinics, and the

level of testing that we will see in our cities and counties all over the country is going to increase, and quite appropriately so, as the need for more seroprevalence data becomes (void in tape) but also for care.

CHAIRMAN HART: Is that $300,000 -- 300,000 -- (void in tape)

DR. KELTER: As I recall the range of estimate, it was from 1-500,000 and most tend to focus on the middle of that range as being the most accurate; 300,000 is the middle of the range. Some of the estimates were based on assumptions that our rate of infection, for example, in the IV drug using community, would follow the pattern that was seen in New York, New Jersey, and Florida. It's still too soon to tell whether or not we are repeating that pattern; there are some reasons to think at this point, we're not seeing as quick a rise in infection rates in the IV drug using population, but it's too soon to say that with any confidence. If we're slower than the east coast in that community, we might be slower in the overall estimate. And the estimate also was made for the year 1991, I believe.

CHAIRMAN HART: Course, there was a story in the New York Times last week that the AIDS IV drug cases in New York was badly underestimated; that it seems, now, to be much, much greater than was originally anticipated.

DR. KELTER: I understand, and we are working very hard, both as a department and jointly with the Department of Alcohol and Drug and with county health departments and county drug abuse clinics, to greatly expand our knowledge about the infection rate in drug abuse clinics and in drug abusers. At this point, we are on the verge of producing the results of an important seroprevalence study that we conducted with counties in the spring, and I look forward to much more in the way of investigations into the infection rate in those sub-populations.

I might also pick up one loose end that was left regarding the provision of medical care by medical and health professionals. Every year in the United States there are approximately 300 deaths from occupationally acquired hepatitis B infections among health care professionals. To this point, there has not been one AIDS death among health care professionals from an occupationally acquired infection. So, if health care professionals are concerned about acquiring infections that may kill them, at this point, their great concern should be with hepatitis B and not from HIV as far as risk is concerned. Both those diseases are transmitted largely in the same ways, in fact, the observation that they're transmitted the same way is what led virologists to be able to find the human immunodeficiency virus as fast as they did. The epidemiologists told them that this was transmitted the way that hepatitis B is, you should go look for a retrovirus transmitted the way hepatitis B is, and they found it. So hepatitis B, at least on a statistical basis and on a risk basis, is a much more important cause of death among health professionals who acquire their infections occupationally than

HIV is. With that, I will conclude my prepared remarks.

CHAIRMAN HART: Could I ask, from the Department's standpoint, having been in this battle now for at least a couple of years or longer, what is the most critical thing that we ought to be doing now -- I mean, there are a whole series of issues that we've heard about; from the Department's standpoint, at this point in the battle, what is the most strategic point that the State of California and Department's advice to the Legislature might be in terms of where we need to be focusing our attention, our resources -- is there a -- in other words, is there a game plan that the Department has to give us advice on where we ought to be going at this point in time.

DR. KELTER: I think the most sensitive issue at this crossroads in AIDS prevention, is the delicate balance between a continued positive relationship between the community and government, on the one hand, and yet our ability to see more and more people tested, more and more people counseled, more and more people educated about how they can prevent infection for themselves, or if they're already infected, how they can prevent transmitting it, and in a sense, that sensitive issue is dealt with by the exchanges between Senator Marks and Senator Doolittle earlier this morning.

Clearly, we have to maintain an open relationship with those portions of our population who are more infected; drug use community, gay community, people who exchange blood and sexual contact with people who engage in those behaviors; we must maintain a relationship of positivity, of trust, and of openness with them or we will lose our ability to compound our successes; successes that we've seen in the homosexual community.

Among gays, not only is the new sero incidence or the new conversion rate of HIV positivity down, dramatically down, the rate of gonorrhea is down, the rate of syphilis is down; the homosexuals in California have gotten the message that certain behaviors are risky, and the avoidance of those behaviors reduces your risk, virtually to zero. We have to maintain the ability to get the message out to the people who need to hear it and who need to learn it without keeping them at arms-length. And yet, at the same time, encourage testing, encourage confidential testing, which can be placed in the context of the medical care for that specific individual. Yes, we test 10, 11, 12, 13,000 people a month in Alternative Test Sites, and yes, it allows us to teach people the risk factors for infection when we see them at the sites. And yes, those individuals can, if they choose to, make their infection status known to their health care provider.

But I think everyone would be happier; I think the patients would be happier, I think the doctors and health professionals would be happier; I think we'd all be happier if such testing and such education were done directly in the context of day-to-day medical care between a person and his or her physician and health professional.

And I think anything we can do to move testing and education and prevention into the mainstream of day-to-day health care will improve our ability to get the word out and to prevent additional cases of infection.

So on the one hand, we want people to be tested, we want people to be educated, we want to maintain a positive relationship with them; we want to encourage more testing without introducing the idea that the price you pay for being tested is the possibility that you'll have a social or combined social and medical calamity in your life. We don't have a reward to offer people for testing. Syphilis and gonorrhea and chlamydia and all sorts of infectious diseases; we have a reward to offer people to be tested. And that is, we can treat them and cure them. Until we have a reward like that for HIV infection, we have to offer substitute rewards which are less potent, and at this point, the knowledge that your test is going to be personal between you and only people that you authorize, seems to be a factor which has brought thousands and thousands of people to testing who otherwise might not have been tested so far.

CHAIRMAN HART: Two other questions. I was impressed by the hearing that Senator Seymour had last week in San Francisco where the thrust of the testimony was that transmission to the heterosexual community is largely going to come through the IV drug using community. And yet -- and I know that, I guess, from the budget, you know we're doing more than other states, but the point was that we are today where New York was 5 years ago and New York didn't know where it was 5 years ago. And what we heard in the testimony was that we are -- if somebody comes in who's a heroin addict, possibly using dirty needles, and they come in and ask for treatment to get on Methadone or to go into some kind of treatment program, that in many of our existing centers, they are turned away, because we don't have the resources. And a week later, a month later, sometimes 6 months later, these people are going to be out on the street, using these drugs, they're ideal candidates for transmission to the heterosexual community; just strikes me as crazy given the nature of this epidemic, that there is a war declared and to ensure that people who want to get treatment, do in fact get treatment. And I'm curious what -- am I overstating the issue from the Department's standpoint and what steps are you taking to make sure that someone who is in this condition who wants treatment, gets treatment immediately and doesn't have to wait weeks or months, and in the meantime maybe infecting themselves and others.

DR. KELTER: I should leave most of that discussion to folks from the Department of Alcohol and Drug programs who have a much more working knowledge of what the wait and backlog is and what the demand has been for treatment. I do know that they have changed their regulations in the past year to permit easier access to Methadone programs for some clients who want to detoxify. But beyond that, I'm not as conversant in the details as I would like to be to answer your question. Whether we're at the point where

New York was 5 years ago is a terrific and important question whose answer we are in the process of developing with seroprevalence studies that involve the Department of Alcohol and Drug and local drug programs. We are hopeful that we're not quite where New York was 5 years ago; we're hopeful that the patterns of drug use and heroin addiction in California are not the same as they are in New York, and Newark, New Jersey, and Miami, and that we can be effective in teaching people who use drugs how not to transmit virus. But it is very difficult in any community to be rather open and forthright about discussions involving IV drug use; there are folks in every community who are, to some extent, rightfully upset about suggestions that if you follow certain practices that drug use is sort of O.K. in the point of view of AIDS transmission. And that was what I was referring to earlier when I said we are still trying to figure out what mixture of methods and information is really effective in curtailing spread of the virus in the drug using population.

CHAIRMAN HART: Course, Methadone is an accepted standard for the most part, it's already in law. I guess what concerns me, and I want to be fair -- I know you're here and Dr. Kizer is not -- but, if the testimony is accurate, that the way this is most likely to be spread to the heterosexual community, and from a general population standpoint, there's probably no greater public health interest or political question, that how can we avoid the spread of this to warn people and since most people are heterosexual not homosexual, it's an awfully key question. And what you're saying is, "Well, I don't really know the answer to that, you have to talk to the people in Drug and Alcohol." That's of concern to me, and one of the reasons why this committee was established, is to try and deal with, you know, all the different nitches in the bureaucracy. If we're dealing with something as fundamental as that, and the Department of Health Services doesn't have an answer to that, we have to go to some other bureaucratic agency to find it. It's distressing to me as to whether or not we have an overall strategy, do we have an overall person in charge; or did, sort of, different aspects of the problem get so compartmentalized, that we don't have a general in charge.

DR. KELTER: I may have not made quite clear what I was trying to say. I was referring you to the Department of Alcohol and Drug Abuse for statistics about how long the waiting list is in Methadone programs, etc. I think it's quite fair to say, there is an overall plan, and that is to identify those pockets of drug use in California with a high seroprevalence, and focus our education and intervention efforts in those areas. It's not going to be the same risk -- you're not going to have the same risk for infection in Fresno and Redding as you will have in San Francisco and Los Angeles, probably, but we're still collecting data to try and prove that. We will never have, and never agreed to provide, I'm sure, the resources that are necessary to educate every man, woman, and child in the United States about something that may or may not be

a great risk to them. And unless that statement is misinterpreted...

CHAIRMAN HART: That's not what I'm saying. I'm saying let's deal with the most high risk group, the IV drug use, it's a finite number, it's something that -- we would find those resources to be a tremendous pay-off, I would think.

DR. KELTER: Absolutely. Well, I disagree. We are doing it. We are identifying those...

CHAIRMAN HART: We're not doing it, because there's a waiting list. People who get turned away and we'll argue over the statistics and you don't know them, whether it's a day, a week, or a month or 6 months, but people are waiting substantial periods of time.

DR. KELTER: Well, I think you're assuming that Methadone treatment is an automatic cure for the passage of hepatitis or of human immunodeficiency virus from person to person. I don't know that that's the case. In fact, it clearly hasn't -- hepatitis B transmission has not effectively been interrupted by any reliable effective method in the drug using community. And we are going to have to be very novel and very insightful to find the way to prevent this virus transmission in a community where previous virus transmission has not really been possible.

CHAIRMAN HART: The last question I had was Dr. Flynn was talking about the skilled nursing care issue. Is the Department of Health Services involved or concerned about issues of cost upon people who are sick or going to be sick, and how do you -- do you think Dr. Flynn's suggestions, for example, that people ought to be able to go into skilled nursing homes, maybe there ought to be a differential rate given the severity of the illness; is that an issue that the Department is exploring? Do you have a solution?

DR. KELTER: We don't have a solution yet, but we are certainly exploring it, and that's one of the primary purposes for our pilot care programs. I should remind you and the committee that when we first made funds available in the pilot care setting to institutions to show us how much it costs and how costs can be estimated and reduced to take care of AIDS patients in a skilled nursing facility setting, we got no bidders, because there were virtually no skilled nursing facilities caring for AIDS patients 2 years ago. And it's very difficult to make these demonstrations when the activity is not taking place in the private sector. I should also respond by reminding the committee that while there's a shortage of skilled nursing facilities for AIDS patients, there is an overall shortage of skilled nursing facilities for <u>all</u> patients in California; and, I think, any attempt we made to make beds available for AIDS patients would have to be done in a way that we were satisfied would not displace other patients who also need skilled nursing facilities.

Whether a differential rate would accomplish that purpose, I don't really know. We have pilot studies underway, we have the waiver going to the federal government to allow

more out-of-hospital care, we have cost-of-care contractors -- University of California and others, to try and advise us on this very question. We've also written reports and estimates of future medical care costs from the Department; I'll refer you to the so-called quantitative analysis, which was prepared in 1986, and which is, I'm sure, in your possession and if not, we'll be happy to make it available to you, which outlines the effect, precisely, on Medi-Cal and from the acute care and the skilled nursing point of view.

CHAIRMAN HART: Thank you very much, Doctor. Any questions, Senator?

SENATOR DOOLITTLE: Are you familiar with the Colorado approach to HIV and the AIDS problem?

DR. KELTER: I've heard a fair amount about it; I was at the Centers for Disease Control within the last couple of weeks and heard a fairly extensive discussion by the Colorado officials.

SENATOR DOOLITTLE: I think that might be something that could be a benefit to this Committee, to have them come, 'cause a lot of the underlying assumptions and comments made about particularly mandatory testing, which basically my bills are not, although I favor a very greatly increased approach to testing, but the underlying assumption is that people would avoid seeking medical treatment and I think the statistics in Colorado are, despite the fact that I think all the cases they deal with that are HIV positive are reportable, that they do maintain confidentiality, and I don't mean the sort of confidentiality we have in California, which is, I think, overly strict, but the cases are handled with sensitivity and people don't seem to be avoiding medical treatment and indeed I think a number of the assumptions about this are proven false by that example in Colorado. I just wondered if -- you know, what did you hear in Atlanta, and how do feel about that?

DR. KELTER: I didn't hear a blow-by-blow description of their program or of their statute; I did hear a point of view which was that discrimination against people with infection and people with certain lifestyles is not a terrific problem in Colorado. And it was quite a different discussion from the discussion that, I think, would pertain to California where there have been a number of reports of a real life calamity for people whose lifestyle or whose infection status has been revealed. So, I guess what I got from that interchange was perhaps, if you will, a bit of a different world view between California and Colorado about what the reality is for people who maintain lifestyles and people who maintain behaviors that would put them at risk for HIV and actually get them infected for HIV.

SENATOR DOOLITTLE: Yeah, but are you comparing the same thing there, because one, we're talking about reporting to the appropriate health officials and the examples that I think that you're talking about here, where word has gotten out somehow to the general

public that somebody has HIV or AIDS.

DR. KELTER: Well, with all due respect, Senator, both in the area of HIV infection and in the area of hazardous waste control, and the area -- several other controversial areas; I know when I go into a community, I'm not really regarded as the Public Health Official or the Doctor or as the Epidemiologist. With apologies to Louis XVI, "L'etat c'est moi;" I am the state, and whether I'm...

CHAIRMAN HART: Louis XIV.

DR. KELTER: Sorry. (laughter) Apologies... you've seen one Louis, you've seen them all. (laughter)

I'm regarded as someone from the state; and whether it's my Department, or someone else's Department, or someone else's mistake, or someone else's slip-up that allowed one of these life calamities to take place, it's still on my head; it's still, as the state, my responsibility. And because of that, I know I and I know many other health officers, approach this problem very gingerly and try to maintain this balance of testing and trust that is so difficult to maintain.

SENATOR DOOLITTLE: I just can't believe that California would be fundamentally different in its reaction than the people of Colorado to this problem. If anything, one would expect the reaction would be more intense in Colorado than here.

DR. KELTER: Well, they've been different so far.

SENATOR DOOLITTLE: Well, I think the matter -- we need to look into, perhaps, a little further.

CHAIRMAN HART: Thank you very much, Doctor, and for your testimony.

This concludes our hearing. I do want to mention that the Committee was scheduled to have its next hearing in San Francisco to focus on the treatment issue, to actually visit some AIDS treatment centers, and to talk to people who are health care practitioners that are involved in the day-to-day care of AIDS patients. Unfortunately, the date of that hearing is the day the Governor has called the Legislature back into Special Session. And, so, we're going to have to reassess our dates and see if we can still have that hearing and -- but the date will probably have to be changed and we'll advise anyone who's so interested as soon as we get our act together.

Thank you all for attending and this hearing will stand in adjournment.