# PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

## HEARING ON THE WESTERN STATES RESPONSE

The Hearing was held at the
San Francisco Department of Public Health
101 Grove Street, Room 300
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Friday, March 25, 1988

COMMISSION MEMBERS PRESENT:

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**MS. GAULT:** Good morning, ladies and gentlemen, distinguished guests, members of the Presidential Commission. My name is Polly Gault. I am the designated federal official here, and in that capacity it is my privilege to declare this meeting open. Mr. Chairman.

**CHAIRMAN WATKINS:** Good morning. Today the Presidential Commission on the HIV Epidemic begins its second and final day of formal hearings in the city of San Francisco. Yesterday, the Commission heard diverse and impassioned testimony from several of San Francisco's minority communities regarding their struggle to confront the epidemic within their populations. We also heard witnesses from community-based organizations from five western states with different population and funding bases, each with a unique message that helps the Commission understand local response in many different areas. These are organizations on the front lines of this epidemic, fighting it within different cultures and in many community settings on a day-to-day basis.

In the afternoon, representatives from several leading corporations and business organizations that have developed sound AIDS-related corporate policies encompassing employee education, employment practice and support of community-based organizations, all presented their testimony. That so many of the corporations demonstrating early leadership in the Bay Area is something for which San Francisco can be justifiably proud. Following yesterday's formal testimony, the Commission made site visit to the Shanti Project where we saw a success story in action. This visit was also helpful to the Commission as it allowed us to see individuals with many talents for many backgrounds working together to provide compassion and support for those in need.

Our brainstorming session there led to several recommendations that will assist the Commission as it continues to prepare a recommended national strategy to the President to deal with this epidemic. Site visits such as these are extremely valuable to the Commission, and this afternoon we are looking forward to visiting the San Francisco AIDS Foundation, San Francisco General Hospital, and Bayview Hunter's Point Foundation, all highly esteemed for their role in shaping a positive response to the epidemic.

Today, we are fortunate to have testimony from several individuals who have been responsible for developing AIDS-related health policy, and putting it to work in our cities. We asked to have this testimony presented to us here today because no city is more closely associated with an active municipal response to the epidemic than this one. The Commission is honored that Mayors from so many major California cities were able to bend their schedules to be with us today. We are particularly pleased

to have the former and current mayors of San Francisco, the Mayor of San Diego, and the Mayor of the state's capital, Sacramento.

So as we begin this final day in what has been a most interesting and successful visit for us, the Commission expresses its gratitude to the city of San Francisco and its people for their effective and aggressive response to the epidemic. All of us have studied and learned a great deal from the San Francisco model but the San Francisco model is really San Francisco people, and we salute all of you for your efforts.

For our first panel this morning, we have Dr. David Werdegar, Director of Health, City and County of San Francisco and Dr. Philip Lee, Director, Institute for Health Policy Studies, University of California, San Francisco. He is also President of the Public Health Commission, City and County of San Francisco. We have a little different sequence this morning in testimony from witnesses and I would like to try to adhere as closely to the time constraints as possible so that we can adjourn on schedule and proceed with our site visits. I do want to give deference to the time constraints placed on the Mayors that will be coming, so let those of us on the Commission try to restrict our questions accordingly. If necessary, we can correspond in writing with some of the witnesses. With that, we will start with opening remarks from Dr. Werdegar.

**DR. WERDEGAR:** Admiral Watkins, members of the Commission, thank you for your kind remarks about our community.

Those of us battling the AIDS epidemic in our local communities have been urging a cogent national response for too long it seems, to no avail. This dangerous epidemic requires a national response, guided by an organized plan of action, funded as we would a national emergency and benefited by the continuous oversight of a wise and representative Presidential Commission.

We have been greatly encouraged by the Preliminary Report of the Presidential Commission issued last December, and its interim report of February 24. We appreciate the earnest, open hearing process, and the sense of urgent national purpose conveyed by the Commission. We note particularly the attention in your February report to health care system issues, the need of accelerated research and clinical trials, and the call for substantial federal support for substance abuse intervention.

The theme of your two-day hearings here in San Francisco is, I believe, community response to the epidemic. In San Francisco, we have sought to develop an organized community response that involved public, private and volunteer sectors: health workers and health institutions, community based organizations, advocacy groups, schools, churches, labor and industry. We took the view that the epidemic involved all

segments of our population, gay and straight, minority and majority, friends, neighbors, families, lovers, AIDS affected us all and we would fight it on a united front. That was the theme of our community response.

The AIDS problem extends to our neighboring counties, and regional planning is therefore necessary. Our Health Departments are indeed engaged together in regional planning. Our community efforts have been remarkably helped by an informed media and enlightened political leaders. The Health Department, this building here and all of its parts, has been the focal point, the center of gravity for convening, planning, coordinating, and monitoring the city's AIDS program. It has worked closely with community hospitals and community-based organizations, and practitioners in the community, in all of our education prevention efforts as well as in the provision of health services. I would say an unrelenting community-based educational program has been the hallmark of the San Francisco program.

The Health Department itself is a major provider of services to those most in need. We have coordinated AIDS efforts in neighborhood health centers, maternal-child health care programs, substance abuse programs, mental health programs, jail health services which we provide, and services in the youth guidance center and many other health programs. The Health Department's acute care facility, the San Francisco General Hospital, has, of course, been a major center for AIDS care, teaching and research. We have never accomplished all that we could have or should have, or wished we had.

Nevertheless, we have been constantly motivated by our tragedy to develop a model program, an ideal program that would not only benefit our own community, but by way of example and through shared experience, other communities as well. This community resolve has been the foundation for the intensity and generosity and creativity which has characterized the San Francisco response. I say this to the Commission out of the personal conviction that the best of programs and plans will not reach fruition unless we can reach into the collective psyche of the nation to summon for, similarly, a national will and resolve. A call for collective dedication was a phrase in your preliminary report that caught my eye.

Only 10 days ago, the Health Department of San Francisco submitted to its seven member Health Commission a detailed report on the current status of AIDS in our community with estimates of needs over the next five years, and I have left this approximately 200 page document on your desk. In estimated needs through 1993, authoritative epidemiological studies portray the epidemic and provide carefully considered projections for the next five years. I submit this document for whatever help it may

be in your own endeavors. I believe it is a document that could well be emulated by other agencies.

No city in the United States has suffered the AIDS epidemic so severely as San Francisco, where 10 percent of the nation's epidemic has been centered. The number of cases since the epidemic began seven years ago now approaches 5,000; the number of deaths close to 3,000. The number of cases in racial and ethnic minority groups, now 16 percent of the total, is climbing more rapidly than in the white population.

We believe the epidemic will peak in the mid-1990's, and then mercifully decline. The intervening years will be enormously difficult. We foresee by 1993, barring major medical breakthroughs, a three to fourfold increase in the number of cases. By 1993, we shall have 6,000 with AIDS under care in San Francisco, as compared to 1,700 at present. While we plan diligently so as to be prepared, it must be stated that our health service system is under severe strain now, and without substantial federal assistance, it will be overwhelmed in the years soon ahead.

One interesting analysis in the report depicts spending on AIDS in our community from all sources. It is now running at a rate close to $100 million annually, and it is projected to rise to $400 million by 1993. These figures exclude all volunteer services and social support, disability insurance and the like. AIDS is now the third leading cause of death in San Francisco, after heart disease and cancer, far and away the leading cause of death in terms of years of life lost.

I would like to mention some bright spots in a bleak picture. In reviewing this AIDS report, one of our Commissioners asked, are there any bright spots in it all? Let me suggest a few. Startling as it might seem, the AIDS epidemic in San Francisco has largely been arrested, which is to say, and without suggesting any sense of complacency or ignoring population groups where it is not altogether the case, the rate of new HIV infections has been remarkably lowered, both in the gay community and in the IV substance abusing community. We ascribe this success to a vigorous educational program, ready availability of anonymous and confidential testing, prohibition of mandatory testing, and policies locally at least to prevent discrimination against persons who are HIV positive.

A second bright spot is the lengthening duration of life of persons with AIDS. A third is that we have demonstrated that the cost of AIDS care can be contained by sparing the use of the acute hospital, and developing an extensive network of out-of-hospital services. Fourth, organizational structures are developing in racial and ethnic minority communities as they have in the gay community, effective in education, prevention and

support services. They greatly need funding support. The Health Department has teamed up with the school system for education of our youth. We have a conceptual framework, we believe, an organized plan, a network of services, and a community resolve to bring us through the difficult years ahead. We will need help.

There are significant gaps in our continuum of services, largely owing to problems of resources, and I will mention just a few that seem to me most important. One that looms large to me because of its expense is the very serious impending shortage in funding for various aspects of the longer-term care of persons with AIDS. That is not just funding, but personnel and facilities. We need appropriate skilled nursing care facilities, psychiatric facilities, day care programs. We have a growing population of persons with AIDS who are severely debilitated, cannot be cared for at home, and need help with all activities of daily living. The problems of AIDS dementia and AIDS psychoses, our clinicians tell us, is growing, and we need the facilities in which to provide the care. We also need facilities or supervised residential care facilities for those who have concurrent substance abuse problems.

We have virtually no skilled nursing care beds. Period. We have a growing problem of homeless persons with AIDS, often individuals who have substance abuse or behavioral problems. Many of the supportive services such as those of Shanti, which you saw, have generously been provided by volunteers. The residential part of Shanti is subsidized by the Health Department, but meals at home, transportation, help with activities of daily living, psychosocial support, are all provided by volunteers. We are reaching the point where these supports cannot be maintained through volunteer efforts alone.

I believe Dr. Lee will discuss some of the aspects of federal health services, financing, and how they affect us in the AIDS epidemic. We have prospective of obtaining a Public Health Service Hospital which is now vacant in the city for use as a skilled nursing care, day care, ambulatory care facility. It would be a Godsend to us, and we are hoping the Congress will provide us that facility and the necessary federal subsidy to operate it.

Another gap is the care for asymptomatic individuals who are HIV positive of which we have some 30,000 in our community. Many of these now recognize that medical supervision has something to offer, and there will be a surge in the demand for care. We need, in the substance abuse field, massive assistance at all levels: education, especially in schools in minority communities; early family oriented intervention; outreach services; methadone treatment slots; demonstration programs; research. It is the most poorly funded program of all.

I will skip ahead in my written testimony and move to some brief recommendations. I offer these knowing that some of these have been said before, and some have actually been incorporated in your reports. I think most important for the nation is a comprehensive plan, implemented with executive leadership, and benefited by the continuous oversight of a Commission like your own with scientific advisory panels. Of course, the plan and the Commission will be of no help unless it is backed by resources that are commensurate with the magnitude of the epidemic. We would greatly benefit by federal block grants directly to cities that are severely impacted by the epidemic, that would come to the Department, that could be used flexibly for education, prevention, surveillance, treatment. We subsidize many aspects of education and treatment by our Department, usually with city dollars which have been the most flexible. The city dollars are no longer there.

I mentioned the problem of long term care services, and the need for governmental help with regard to this issue. I believe we need greatly accelerated clinical trials. When you look at our projections to 1993 you can see that the clock is ticking. The current national cooperative drug trial system is cumbersome, and unduly long. It just will not produce the results fast enough, and there are other approaches. We could do community based trials in high prevalence areas. We would be perfectly happy to do it here in San Francisco under Health Department auspices. We could get clinical trials in a large scale with controls going tomorrow. The current clinical trials, I am afraid, are just leaden-footed.

I would like to see commitment to continuous support of anonymous and confidential testing. These have been a very important part of our educational program. They have clinical value as well. We have the sense that support is apt to be waning just at the time when we are expanding the use throughout the community.

Lastly, we need legislation to prevent discrimination. I am sure you have heard this before, but the importance of discrimination laws at the national level, strong ones, to prevent discrimination in jobs, housing, health insurance. This legislation is important from a public health point of view because that will allow people to come, seek care, be tested, receive counselling. It is all part of our work in public health.

I have just a final observation before I run over my time. The preliminary report of the Commission describes creating a national climate, and I quote from you, "setting aside prejudice and fear in favor of compassion and a sense of community responsibility." If the reports of the Presidential Commission can help create such a national climate, we will all

have reason to be grateful. The next several years, all our projections indicate, will be exceedingly difficult and will require our best effort. I believe the AIDS epidemic, for all its tragedy, has things to teach us about the bonds that bring our diverse community together as in about education of our children, about our health care system, the many research aspects that will benefit, all of these may one day allow us to view the epidemic in some ways as having repaid our society for the many precious lives lost. Thank you.

**CHAIRMAN WATKINS:** Thank you very much, Dr. Werdegar. Dr. Lee?

**DR. LEE:** Thank you, Mr. Chairman. I am delighted to join with Dr. Werdegar in welcoming the Commission. I do have a fairly detailed statement which I am submitting to you that I will not recite in detail.

I do, at the outset, want to commend those who have gone before us here, and particularly note former Mayor Feinstein; members of the Board of Supervisors, who provided the political leadership; and Dr. Mervyn Silverman who was the Director of Public Health in San Francisco from 1978 to 1985 when the San Francisco model took shape and, who provided very strong and effective leadership. The media has been critically important in San Francisco, underappreciated. The business community, the community organizations, and especially the gay community in San Francisco, and whose participation in research has helped us identify risk factors, modes of transmission, behavior change needed to prevent the spread of infection, and what a community must do to sustain that behavior change. More importantly, they have taught us a lesson we must never forget, and that is how to care for one another. For that lesson, we all owe a great debt of gratitude to the gay community, particularly in San Francisco, but also in other communities.

I want to briefly summarize my statement, Mr. Chairman. First of all, the AIDS epidemic is occurring at a time of a growing crisis in health care financing and in the health care delivery system. We have a growing number of uninsured. At the same time, we have an increasing number of health insurance companies that are shifting from providing health insurance to other activities. We are in very serious condition in terms of health care financing. We also have a second epidemic that may, in fact, be worse than the AIDS epidemic, and that is the cocaine and drug abuse epidemic. You have touched upon that in your previous report, but I think you cannot underestimate the intersection of those two epidemics for the future because I believe, as Dr. Werdegar does, that in the gay and bisexual community, we have largely controlled or developed a means to control the epidemic, but we have not done that with respect to the IV drug user community.

Second, AIDS health care costs are not disproportionate to other high cost illnesses, and this is documented in background materials in my testimony. We have estimated in studies we have done here in San Francisco that the lifetime cost of care for an AIDS patient is about $45,000. Some others have estimated costs slightly higher than that. If you project costs to 1991, as has been done by Anne Scitovsky and Dorothy Rice who work with us at U.C. San Francisco, it is estimated that between $8 billion and $16 billion will be expended nationally in 1991--about one to two percent of our total health care spending. That could easily be handled if we bear it nationally and bear it equitably. If it has to be borne by the communities, that burden is intolerable as shown by the evidence in the report that Dr. Werdegar and the Department of Public Health presented to the San Francisco Health Commission--$90 million this year, $350 million by 1993. We cannot afford, in San Francisco, to increase the local tax monies that have been the glue holding the whole thing together so far. That glue is being spread very, very thin today, and we cannot sustain the effort without more adequate state support, private sector support, and federal support.

You have addressed two, I would say, the two most critical issues in your previous report, and I hope you will develop those recommendations more fully, one, with respect to IV drug abuse, and the other, that Dr. Werdegar has mentioned, the long term care services, including social services, housing, practical support, and other services that nobody pays for, with the result that the individuals are paying out of pocket. Donations are supporting those services, or local tax dollars in San Francisco are supporting those services, but that cannot be sustained without a much broader base of support, and without a national policy.

Third, in addition to the financing issues, there are critical issues in housing, and again you identified these in your last report. We have a number of homeless in San Francisco, who are sick with AIDS, and that is true in every other major city where the AIDS epidemic has been particularly explosive. This is an area of social services, practical supports, again, those things that are not supported by traditional private health insurance dollars or Medicaid dollars, where funds are short. And then of course, there is the funding needed for research, for education, the various other activities that are funded at the federal and state levels.

However, it is not enough to just provide money. There needs to be a national plan. I think this Commission is moving towards that and developing the framework for a national plan. There is not a single state that has developed a state plan. California does not have a state plan for AIDS. Most of the counties in California are moving towards developing plans, and

San Francisco is the first county to develop a comprehensive and detailed plan. We need adequate resources for planning. We also need adequate resources for the administration of grant funds. We are finding prolonged delays in the administration of federal funds and state funds because the staffing has not kept up with the funding, either at the federal level or at the state level. There are delays of months in implementing contracts and in working through the signing of those contracts, and the problem is compounded when there is an attempt to limit personnel. I know, Admiral, you are very familiar with this kind of problem. At the federal level, at the state level, it is seriously impairing the capacity of country to respond to the epidemic.

Finally, this is not just a public sector responsibility. We have to have a public-private partnership at every level. You heard from the business community and the community organizations yesterday. We have, I think, moved very well to develop that kind of partnership in San Francisco, but we need to strengthen it here, we need to strengthen it at the state level, and certainly we need to strengthen it at the federal level.

There needs to be cooperative planning around financing. What is the role of private health insurance? Increasingly, the burden of financing care for persons with AIDS is moving from private health insurance to Medicaid. In California, we have seen that go up from 10 percent in 1984-85, to 20 percent in 1986-87, to 30 percent today. An increasing burden is being placed on the local taxpayers, not only in San Francisco, but in Atlanta, in New Orleans, in Dallas, in communities around the country where the local public hospitals are picking up the tab. That cannot continue. We cannot say that this is a local problem. Private insurance has to play a very substantial role, and it is going to take cooperative planning at the highest levels to achieve that. Thank you very much.

**CHAIRMAN WATKINS:** Thank you very much, Dr. Lee. We thank both you and Dr. Werdegar for appearing before us this morning. We are going to be following a different protocol this morning. We normally would like to spend a lot of time chatting with you, but it is impossible with this schedule. We have to keep moving right along. On the other hand, Dr. Werdegar and Dr. Lee, both of you, we would like to keep this door open and dialogue between us and we will find your submitted documents, I think, very valuable, particularly if we go into our cost analysis and financial section which is going to be an important part of our report. We are chartered to keep a close eye on that, and I think you have given us some opportunities to demonstrate cost effectiveness in care that not only is beneficial for those afflicted with the epidemic, but also for all health care delivery for the future of the nation. I think

your broadened view is one that the Commission shares is an opportunity, a unique opportunity we have to take advantage of, not only addressing in a compassionate way the care and handling of the epidemic, but also, importantly, we are exposing significant flaws in the health care delivery system as you mentioned, and it is very clear to us as we watch it, and as we evolve in our deliberations.

So thank you for appearing before us. Thank you for your written testimony and your oral testimony, and we will be communicating with you. I know that the Commissioners will have questions, and if you will be willing to respond to those in writing, you can be assured that they will get close attention in our final report. Thanks very much for coming today.

**DR. LEE:** Thank you, and we would be delighted to work with your staff and with the Commission. Thank you very, very much.

**CHAIRMAN WATKINS:** Our next witness coming before the Commission today is the Honorable Dianne Feinstein, former Mayor of San Francisco. Mayor Feinstein and I got to know each other many years ago as we brought the fleet back to San Francisco together. The only disagreement we ever had was that Dianne wanted to paint the fleet white and I asked her to give me the paint and she would not do it. She said that the budget would not permit it in San Francisco. So at any rate, we are honored to have you with us, Mayor. You have a reputation among all of your people here as being a courageous, involved and sensitive leader in dealing with this epidemic. You were here at a tough time, and we were particularly pleased that you would be willing to take time off of vacation to come and chat with the Commission this morning so let us have your statement.

**MAYOR FEINSTEIN:** Thank you very much, Mr. Chairman and members of the Commission. The first point that I would like to make is that your interim report is truly a giant step forward. The 60 pages, the 180 recommendations, I think are thoughtful, considered, very acceptable, and necessary. If I were to look back at what the past has typified since San Francisco's beginning with AIDS in 1981 when the first 50 or 60 cases were discovered and San Francisco expended its first $184,000 until today, we have expended cumulatively more than $50 million and are expending about $20 million this year. We saw the community, particularly at that time the gay and lesbian community, obviously overwhelmed and struck by the terrible lethal nature of this disease, really come together in a positive way, and I think that was the beginning of what has become a model program for the nation. Dr. Werdegar, Dr. Lee, I think described it to you, and we have been very proud to be in the forefront of compassionate care for AIDS.

But there is one thing that has really struck me increasingly, and initially I did not really believe it was going to be the case, but that is the really profound need for protection against discrimination. Every day we see the stories and every day we personally know the cases. Housing, employment, and insurance; there is an overwhelming need. I think one of the problems in effectively approaching a prevention and education program is that people really are frightened. Leave the mythology aside. They are frightened to know what might happen to them, and they do lose housing and they do lose their job. I know of somebody, even in this city, just last week, was diagnosed as having AIDS, was up front about it, told their employer and they found an excuse not to have him employed.

And perhaps the worse thing is the insurance. We now have drugs that can prolong life, namely, AZT. The cost of AZT runs about $10,000 a year. There is a one-time federal pot to pick up some of this, but in many states, the individual has to spend down to the poverty level before they qualify for the drug. That seems to me to be grossly unfair. And then, of course, insurance can be cancelled, even on the remotest possibility that somebody has AIDS or a friend of someone has AIDS, and I think there is a very real need for strong federal action. As you know, Congressman Waxman has a bill, HR-3051 which takes care of many of these problems. I would hope that in this Commission's final report, there would be definitive statements on the need for the Federal Government to take this kind of action. I think that once people are secure in the workplace, in their homes and with insurance, that removes a great deal of the fear that the AIDS patient has himself.

On another point, testing, I think most of us who have dealt with the disease for a long time believe that the most important part is mandatory education, education beginning early, beginning in the public school system, appropriately presented based on the grade, that deals with the high school youngster in an era of certainly liberalized sexual habits and opportunities. The true facts are very important to get across. It is very difficult because everybody believes it is going to happen to somebody else, and I think this is particularly true in the heterosexual population. People believe it is not going to happen to my child, and it is not going to happen to me, and whoever I am with is not going to give me the disease. Of course, that is not true. So getting the appropriate education out there is extraordinarily important.

Today, testing in America is really only available in the major urban centers. What we know of this disease indicates that its great spread and increase is going to take place outside of the major centers of New York and Los Angeles and San Francisco. Therefore, having the appropriate medical care, enabling people get counselling and education in their own

communities, it seems to me should be a number one priority of this Commission.

I just had, and I would like to submit to you, someone send me through the mail something that I thought was rather interesting. There is a laboratory here in California that is putting forward a mail test. I would like to submit the original of the letter to me that describes the test, and also the kit that is sent to you by mail. I would be interested in knowing, frankly, the Commission's evaluation. This is now before the FDA for approval, and essentially what it consists of is rather interesting. It has the alcohol swab, the gauze, a cold pack, and it is all coded so all the individual does is use a small device which is capable of pricking the skin and there is a small collection vial with the code number, in this case it is 197. You put this back in the styrofoam next to the cool pack, and you send it in. There is telephone counseling required, both before and after, and this kit could be made available in areas where people do not have access to testing. I think your evaluation of this kind of thing could be most useful and so I would just like to leave this with you.

**CHAIRMAN WATKINS:** Thank you. I will accept that for the record, and we will be pleased to take a look at that.

**MAYOR FEINSTEIN:** I understand a number of laboratories are in the process of producing this kind of mail order kit. The important part in testing, as you know, is confidentiality. Because of discrimination, people are so afraid. They are afraid to get the results because there may be a breach in the confidential processing and therefore they lose whatever they have: home, job, insurance, etc. If I had to assess something that is really necessary to overcome, to move to the next steps in dealing with AIDS, I would have to say it is the fear of discrimination.

This city has been very proud of its large public-private effort. In dollars, it totals about $89 million. Every private hospital in the city does take AIDS patients as well as the very large direct care commitment that the city has made. We have detailed in the written testimony which we will leave for you every program that the city sponsors, and a chronology of effort. I was privileged, while I was Mayor, to be the chairman of the AIDS Task Force of the United States Conference of Mayors, and I found that it was a very important effort because it was an opportunity to bring together mayors across the nation to trade information and notes, and, frankly, to ask questions. One of the things that became very evident in the early days was how little people knew about the disease. I think a very necessary national, well, attribute if you will, is an information sharing device that perhaps this Commission may be able to continue.

San Francisco took the lead in information sharing through the Conference of Mayors and through our health officials. Our health officials played a major role in terms of transmitting information to other cities, and, of course, San Francisco has been in the forefront of doing some of the controlled studies. But of very deep concern to all of us is the lengthening period of incubation and therefore people are substantially in jeopardy. That exists for the gay community, and it will also exist, we believe, for the heterosexual community. The next great challenge is to begin to work with the minority communities, the at-risk communities and be able to get past the discrimination fear, into an area where people periodically are willing to test themselves, and are willing to make the lifestyle changes that are necessary to prevent the spread of the disease. As Dr. Lee said, the cities have really been hampered by the absence of money with which to deal with this, and what we find is that people have to travel to get help. They do not have it in their own community. They are afraid in their own community, they have to leave families and friends and support mechanisms. This Commission can see to it that there is an effective transmittal of funds. I know you have spoken about a 50-50 match; I frankly think that that match will not work. I think it has to be something like 80-20 because of the way costs are.

As you know, San Francisco was able to obtain the Public Health hospital. It is going to be impossible, in my opinion, to operate it. The proposal that we have made to the Federal Government is an 80-20 percent match with 20 percent coming from the local jurisdiction and 80 percent from the Federal Government. I really believe that that is the only way it is going to be effective.

I would also urge the Federal Government to develop direct relationships with the cities and the communities. Federal matches are fine, but very often we see that the state matches get siphoned off, and do not really reach the communities that need the help. In sum, I think the number one issue is removal of anti-discrimination; secondly, the building of the kind of education and prevention campaign which can permeate the rural hamlets and the more isolated areas of this country; and then, thirdly, the kind of federal commitment of dollars which can enable people to get treatment and care, information and counselling and not have to go hundreds of miles to do that wherever they live in America.

I would just like to say thank you very much for taking such a positive position. I know when this Commission was first put forward, many people did not believe it would be able to come up with the kind of work that you have come up in your interim report and I think you are to be very much complimented. It is a

major step forward, and I know that all of us that care very deeply about the people afflicted by this disease and by what it is doing to people, would like to help establish this partnership in any way we possibly can. Thank you.

**CHAIRMAN WATKINS:** Thank you very much, Mayor. I would like to at least take the 15 minutes, if it is satisfactory with you, to allow Commissioners to ask questions. So, Dr. Lilly, would you like to begin?

**DR. LILLY:** I am just wondering about your recommendation about adding discrimination legislation. If you can expand a little bit on that, and perhaps tell us why local measures would not be sufficient, have not been sufficient.

**MAYOR FEINSTEIN:** Well, I think it is a national problem. There are not just, AIDS is not restricted to New York and Los Angeles and San Francisco. AIDS is going to hit in Kansas and Texas and virtually every state in the Union. I think when one talks about discrimination, and the fact that people in their homes, when they find they have AIDS, very often want to come to a city for care where they are going to be protected, and we find that that is the case. Therefore, I think it is very important to have a national overlay of protection for people in the workplace, for people in their housing as well as the overwhelming insurance problem.

**DR. LILLY:** Thank you.

**CHAIRMAN WATKINS:** Mrs. Gebbie?

**MRS. GEBBIE:** First, just the comment that I hope will give you some encouragement, working as I do with states all across the country. I think there is a growing network of services available, even in very small counties and localities that has come a long way in the last couple of years so some of that is starting to happen. I would be interested in hearing you discuss a little more this issue of what size match is necessary to get people at state and local government levels to participate. To some people, an 80-20 federal match sounds exorbitantly high on the federal side. To others, the 50-50 sounds like no local government could ever come up with their half of it. Can you just talk a little more about how you got to where you did on thinking 80-20 might be what would work?

**MAYOR FEINSTEIN:** Well, largely because of the dollars that are involved, the minute you open a facility, as you know, you are into several million dollars. Most communities, and communities particularly in California, which is a Proposition 13 state, as well as others that have restrictions, do not really have the ability to raise local revenues to handle great new programs, and because it is not enough just to have a hospital,

because hospital care is so high, you also have to have community care so I think then when you look at, for example, if you are going to open a regional center, and you are going to find that the cost of operating that regional center runs anywhere from, dependent upon how you look at it, from $1 million to $4 million dollars a year, that is a difficult amount of money for a community to come up with for a new program, even 50 percent of that is difficult to come up with.

**MRS. GEBBIE:** Thank you.

**CHAIRMAN WATKINS:** Dr. Lee?

**DR. LEE:** Mayor Feinstein, may I congratulate you and Dr. Werdegar and Dr. Philip Lee? You are constructive, you are nice, you are unified in your approach to this. Where I come from, New York City, everything is confrontational, and this really hampers progress. A specific question on the insurance. It is my observation that confidentiality in the insurance industry is fiction, complete fiction, but they do have a problem, and what is your idea of how they are going to solve it? If you want the private insurers to pick up the costs, how should they do it? Should they distribute it? Should they not test for the HIV? Should they put in higher premiums? How do you think that they should handle it?

**MAYOR FEINSTEIN:** I suppose you would say that the correct way is not to test for HIV, to take the person as a whole person when you are granting insurance. You see, I happen to philosophically believe that people should be entitled to catastrophic health insurance as a national standard, that one of the great tragedies is that we are all susceptible to catastrophic diseases that go on and on, and very often people get cancelled from their insurance when they come down with that disease, and I think that is a kind of basic protection that has to be afforded people. I think what is complicating here is the fact that you have a young, healthy population, generally a good risk otherwise for health insurance, and therefore what companies have done is the minute they hear about the problem, the individual loses their health insurance unless the individual is able to become so secretive about it that the company does not know, and that undermines education and testing. I really believe that people should be entitled to health insurance. Now, I know that is probably going to mean some premium jump, but it is certainly better than having to take on costs that exceed many times $10,000 a year in your own personal care.

**DR. LEE:** What do you feel about Medicare funding for this problem?

**MAYOR FEINSTEIN:** I think Medicare funding would be excellent if it would be consistent and if it would provide the

amount that is necessary. One of the problems with Medi-Cal, we have been finding in other areas is that the rates are not enough to handle the problem, and therefore there is a gap that needs to be filled.

**DR. LEE:** Thank you.

**CHAIRMAN WATKINS:** Dr. Walsh?

**DR. WALSH:** I do want to commend you for your leadership and especially for your candor on facing what the federal responsibility should indeed be. Now, my question is directed to you, and I would welcome, if you have no objection, if Dr. Philip Lee also may want to comment because of his long years in Washington, he understands the system very well. That is that in the strategy that the Commission must follow in its final report, about recommendations for federal assistance, whether in urging this assistance that we should in some way consider broadening the base of the problem in order to get positive action, particularly from those states which are just like, the Senators are just like the Mayors you met, in states that do not have the problem, it is very difficult to get those Senators excited, into broadening the base whereby using AIDS as an example and as a wedge, whether we could not address the broader base of the problems, of the shortage of nursing care, the problem of home health care, the problems that have to be addressed by the nation as a whole, and AIDS as an example of how our health care system has been strained by just one disease, and that we are long overdue in addressing the needs, not only of this group, but the general problem.

I have a gut feeling, living in Washington, that we have a better chance of getting legislation passed that way than an isolated way, and I would welcome your thoughts on it as well as if Dr. Lee wants to comment.

**MAYOR FEINSTEIN:** Maybe Phil ought to comment on that, Dr. Walsh. I am not sure I understand your point.

**DR. WALSH:** Well, the thing is that I am fearful that if we press firmly and directly for a specific legislation, I am not worrying about discriminatory legislation. That is, the discriminatory legislation is fine. That you have no problem with. But I am worrying about funding legislation. If we try to press it for one disease, is that going to be the wise strategy or should we in some way take a broader strategy which will benefit, which will achieve what you want, but will also force the Congress to face the problem of the uninsured, face the problem of what the states can do in Medicaid and Medicare. They are just not facing it. That is what I am getting at.

**MAYOR FEINSTEIN:** I would be very frank with you. I would probably take it any way I could get it but I think the concern I have is that if money is not earmarked for AIDS, that it will not go to AIDS, that others will find other priorities. I think in some communities, with a problem like this, it is much easier to hide it than in other communities and that is a deep concern I have. Dr. Lee was part, when I was Mayor, I had what was called an AIDS Task Force, and every couple of weeks, all of the doctors as well as some of the community people came in and kind of brought me up to date on everything that was happening with respect to AIDS and it proved to be a very valuable vehicle to address concerns as they happened, and also to watch the changing statistics.

Essentially, there has been very little federal help as you know, virtually none, and consequently, and I believe this is going to happen in every city. I think a city has to identify a problem, submit a plan and then the Federal Government, as part of a national or health emergency, ought to be willing to put x dollars of what it is estimated to take care of that, just as I believe very strongly the Federal Government ought to pick up the cost of AZT. I know it cost Burroughs about $80 million, well, maybe they should be recompensed for their costs and in some way a system devised that people have access to a life prolonging drug.

DR. PHILIP LEE: Bill, to comment further, I think that the Mayor, when she responded to Dr. Lee's question about insurance, put her finger on the problem because we have a generic problem with health insurance, growing numbers of uninsured, and, as she pointed out, many people with catastrophic illness, including the elderly who have Medicare but with certain high cost illnesses, they are now paying as much out of pocket as they did before Medicare was enacted.

**DR. WALSH:** That is what I am getting at.

DR. PHILIP LEE: And some of them are paying 40 percent of their income for their medical care. If any of us were paying 40 percent of our income for medical care, there would be a revolution in this country, but if it is poor old people, they can, we will let them do that. So we have a generic problem on financing, and it is particularly with respect to high cost illness. A very small percentage of the population accounts for 40, 50, 60 percent of medical care costs. That population is not protected and I think we need policies to protect persons with AIDS as well as to protect others with high cost illness.

The second problem that she pointed out that is a generic problem is the intergovernmental relationship problem. We do not have a clearly sorted out set of relationships between federal, state and local government. The 80-20 match I think is

an absolutely necessity if we are going to do something with the AIDS epidemic. Local government, you look at Texas, you look at Louisiana, $800 million deficit they are facing. They cannot come up with that kind of money so that is a second.

The third is organization at the local level, the public-private partnership that has developed here that unfortunately, as Dr. Lee pointed out, has not been achieved in New York, unless you achieve that, and that takes a transformation in the health care system, a much more open system, a much greater willingness to work with community groups, to create organized systems so that we have three generic problems, and I would agree with you, Bill, and I think this Commission has to be looking at the total context as it makes its recommendations or as you make your recommendations. Particularly, I think, AIDS is a wedge that is pointing out these very, very serious problems.

**DR. WALSH:** Why I asked that, Mayor, was that the worst thing we could do is to get into a fight, say, with the Gray Panthers, and everyone else about where the dollars are going to go, and that is why I think Phil's thoughts on it will affect it, and you can still earmark funding for AIDS. If the legislation is worded properly, you can earmark it if you will.

DR. PHILIP LEE: But an even higher priority ought to go to prenatal care.

**DR. WALSH:** That is right, absolutely.

DR. PHILIP LEE: We have millions of women who do not have any health insurance, pregnant women, and they do not get care until they go to deliver.

**MAYOR FEINSTEIN:** Doctor, if I might say, I think there is one overwhelming thing that has to be guarded against, and that is setting group against group.

**DR. WALSH:** That is right. That is what I am afraid of.

**MAYOR FEINSTEIN:** You know, you do not want the elderly fighting AIDS victims, and I think that that is a very important thing because it could conceivably happen, and that is one of the reasons, I think, clearly stated, AIDS is the nation's number one public health emergency, and therefore it really has to be addressed as that.

**DR. WALSH:** Okay. Thank you.

**DR. PRIMM:** Mayor Feinstein and Dr. Lee and Dr. Werdegar, I, too, want to join the Commission's sort of symphony

of certainly admiration for what has been done here in San Francisco, and also to congratulate a very sympathetic and dedicated staff of Commissioners and others who have helped to make that possible, and I have often suggested to other cities in the nation that I visit, that they ought to take a book out of the page of San Francisco's chronicled successes, and begin to duplicate them in other cities around the nation.

I do have some concern about do-it-yourself testing. My concern is that San Francisco has proven that as long as there are support systems that are there and personal support systems, we have visited some projects, for example, the Shanti Project, where people who have diseases that lead to death or are supported by individuals and maybe post-test these personal involvements with individuals have a tendency to do more good than if they were alone by themselves when they heard or got back in the mail or whatever, the results, say, of a do-it-yourself test. I know in the past that hotlines have been certainly effective in aiding people who were at the point of committing suicide or had other kinds of crises. I am concerned greatly about this particular one, that I think one needs a more personal kind of contact with individuals at the time that results may be become known. It is a concern that probably could be worked out with a little bit more thinking, although you had indicated that this particular manufacturer would have counselling were a telephone available. I feel that we ought to have something personal.

Again, I commend you and commend your staff and I have no questions for you. I just thank you for your pioneering work in this field.

**MAYOR FEINSTEIN:** Thank you, Doctor. I do not want you to misunderstand me. I do not know whether this is a good idea or not. It is an idea that I think has to be looked at. You know, people, I think, said that at one point about pregnancy tests, too, particularly for young people, and yet now you can get a home pregnancy test. I think that the important thing is because the way drugs seem to be going, the earlier you can catch the disease, the better the opportunity you have of prolonging the life of the individual. Therefore, everything we do as a society ought to be to get people to help themselves and have access to something that will prolong their life and help them.

**DR. PRIMM:** One other mention here. I have often visited the Tenderloin District when I come to San Francisco. I have a friend there who runs the Cadillac Hotel. Leroy is a former New Yorker, as you may know.

**MAYOR FEINSTEIN:** My friend, too.

**DR. PRIMM:** I was there last night and visited the park very close by that hotel, and saw in another block a number of obvious intravenous drug abusers who obviously could possibly be infected with HIV. I am concerned about those homeless IVDAs here in San Francisco, and would like to see somehow, something that could be developed in terms of housing which I know is terribly difficult, I mean, I am concerned about it in my own city, too, believe me. But he has done some very innovative things, as you very well know, and I thought maybe something in that form of the thing that he is doing with the developmentally disabled, the mentally disabled, could be duplicated for housing for some of these people who are infected with the virus who will just die in the streets, and it is sort of pitiful in a town as wonderful as this. So I was hoping that to bring this to fore and maybe Dr. Werdegar or Dr. Evans or Dr. Lee could suggest something.

**MAYOR FEINSTEIN:** You do know, Doctor, that as part of the homeless program, and maybe Dr. Werdegar would like to address that, there is an effort made, and a major effort made by the Department of Public Health to find special placement for people who are homeless with AIDS and then also to provide them with medical services at the same time. Doctor, do you want to address that?

**DR. WERDEGAR:** Thank you. Commissioners, let me introduce Dr. Patricia Evans who is the Associate Medical Director of our AIDS office who I think is best informed on this.

**DR. EVANS:** Dr. Primm, I would like to address what you have just talked about in terms of the IV drug using community. In the plan that you were given, you will see in there that we do have a number of programs that we are trying to institute, and some of these have actually been put into place. We do have Baker Places which is housing for IV drug users who are HIV infected, who have AIDS and ARC. There is also a hotel for the homeless who are IV drug users and have AIDS, and Catholic Charities has just purchased a building and is in the process of renovation and will have spaces available for this particular population here in San Francisco. So there are things which are being done here in the city and county. Again, this does cost money and we do need more in terms of providing more services to this community, though.

**DR. PRIMM:** Thank you.

**CHAIRMAN WATKINS:** Thank you very much. We are going to move on to our next Mayor, the Mayor of Sacramento, the Honorable Anne Rudin. Thank you very much, Mayor Feinstein, for coming today, and thank you, Dr. Werdegar and Dr. Lee, for staying with us. As you know, Mayor Agnos will be here later on, and perhaps he will need you also. Welcome, Mayor Rudin, to the

panel. We would like very much to hear your statement this morning.

**MAYOR RUDIN:** Good morning, Admiral. Thank you very much for giving me the opportunity to speak before you. Good morning, Commissioners. I am Anne Rudin, Mayor of Sacramento, and I want to say that I have reviewed your interim report. It is a very comprehensive and well written report, very thorough, and I want to commend the Commission on its thoroughness in investigating and exploring the implications of AIDS and the HIV epidemic. I do not know if my comments will present anything new to you because you have covered an awful lot of ground, but perhaps they will reinforce your findings, validate your conclusion and let you know that Sacramento has the same problems that other cities have. If not to as great an extent, at least the potential is there.

Sacramento, as you know, is the capital of the largest state in the United States, and we are facing the most serious health problem of our nation, human immunodeficiency virus infection is something we are taking very, very seriously. The population of the Sacramento area is close to one million. HIV is a threat to over 10 percent or approximately 100,000 of our people. According to the Sacramento County Health Department, to date, 182 individuals have been diagnosed with HIV infection, 72 have died. Statistics from that department show that there will be over 600 people with AIDS by 1991. Ordinarily, municipal governments would not be expected to take more than a modest role in addressing a public health issue because we do not have that responsibility. It has been given to the county in most places in California except for unique situations like San Francisco's because we have overlapping city and county here. We do not have a direct health care role in our city, but the AIDS crisis has forced a shift in the usual patterns of responsibility and cities all over now are awakening to a new role of leadership in the coordination of service delivery and in the funding and lobbying for program support from the private sector and other levels of government.

The people of Sacramento have addressed this need for involvement. Volunteers, health care providers, and political leaders have developed a well-integrated community that provides services for those with HIV, their families and their partners. Our first AIDS cases were diagnosed early in 1983, at which time the AIDS Foundation was formed in Sacramento, and which today provides a variety of services, including education to high risk individuals and to health care workers and to the general public. It also operated an AIDS information hotline and is establishing minority outreach programs and gay outreach programs.

The Sacramento County Health Department administers a variety of programs including condom distribution which costs

$11,000 a year, education at adult detention facilities, HIV testing at alternative sites, and a variety of social services. We also have the Stop AIDS project, the Clinic for AIDS-Related Disorders, Home Health Care program, and a program called Hand to Hand. These are just a few of other community services that are available in California.

In 1985, I organized the Mayor's Task Force on AIDS to gather information to enable us to formulate public policies to address the problems associated with AIDS and ARC. Many of these recommendations have been implemented in Sacramento, and an ordinance has been enacted which prohibits discrimination against those with HIV infection with regards to employment and housing. Training has been provided to all our emergency response employees and police officers. Sacramento County has established an ongoing AIDS Education Prevention Task Force to help solve the AIDS crisis, and it has recommended an AIDS prevention unit be formed to implement these recommendations, and this unit has been funded and it active.

Although we believe the programs and services we provide in Sacramento are having a positive effect in deterring the spread of AIDS, they are not enough. Prevention programs and services are underfunded, and it is time now for other sources of funding, and we, of course, look to the Federal Government as we do in so many programs that are nationwide, to help us provide adequate funding. We need only look ahead to see that the money we spend today will save money in the future. I know that we all have priorities that may vary, and other things that take as high priority but we have to look at what we can save in the future by spending money on AIDS prevention today. For each HIV infection that occurs in Sacramento during this year, we figure that government will spend approximately $15,000 for health care for each person over the next ten years.

The Sacramento AIDS Foundation has estimated that it is seeing 18 new clients a month, and the University of California Medical Center clinic is seeing nine new patients a week. There is overwhelming evidence that education is the key to prevention. According to Dr. Neil Flynn, who is the Associate Professor of Clinical Medicine and the Director of the AIDS Clinic and AIDS-related disorders at the University of California Medical Center, in New York City, 60 to 70 percent of IV drug users are infected with HIV. It is not the same proportion in California. We understand that in San Francisco, 15 to 20 percent of IV drug users are infected, 10 percent in Los Angeles, but only 5 percent in Sacramento.

So we still have time to arrest this. If HIV infection is allowed to spread rapidly among IV drug users on the West Coast, we will be setting ourselves up for an enormous financial burden as well as needless loss of human lives. We know the role

of education, that education can play here. It is clear that once IV drug users become affected, we know what happens. The virus spreads to their sexual contacts, who might not be IV drug users, and to their children. It is estimated that if Sacramento had a million dollars for prevention programs for IV drug users, we could arrest the spread. Currently, we have about $150,000 available for this year, and it is totally inadequate.

We need to better fund education programs for members of other high risk groups, and the general public. And target groups for education and prevention should include gay men, adolescent gay men, IV drug users, their potential sexual partners, and multi-partnered heterosexuals. We think it is still manageable because we can still find the people who are infected, and trace their contacts, especially the heterosexual contacts of high risk individuals.

We also look at the need for the development of a vaccine, and I know that there are many considerations. Your report pointed that out. The question of liability, legal liability in the development and the use of a vaccine, the economics of developing a vaccine, competition between companies and so forth, and the secrecy that they engage in, but Dr. Flynn has told me that some of the simpler vaccines have not been tested because they are not patentable because they do not use a new technology. They are simply a killed whole virus vaccine which is not profitable for the companies to produce so his feeling is that these are not being tested. They could be tested, they could be used, and they could be used to advantage.

We would like to see the National Institute of Health overcome the obstacles toward finding new vaccines which might be tested immediately. We have a population for which such a test could be used, and it is an ideal population because we know many of the IV drug users, who they are and who share drug paraphernalia without using disinfectants, and who are at high risk.

I want to say something about the services that are needed. The major problems with services in Sacramento at this time revolve around reimbursement issues for care. Since approximately half of the people with AIDS are on Medi-Cal, which reimburses at a very low rate, close to 44 percent of actual charges in our city, hospitals and health care providers have been reluctant to provide care for people with AIDS. At this rate, a considerable amount of money is lost in the care of people with AIDS, and as a result, the pressures are tremendous to constrict and restrict the AIDS clinics or cut financial losses.

This problem can be addressed in two ways. First, Medi-Cal reimbursements must be increased. Secondly, a regional

center for AIDS should be established, and in the model proposed by Dr. Flynn, this center would bring together AIDS physicians, social services, case managers and home nursing personnel. The center would house a clinic facility, transcription services for physicians who use the facility, a special billing system which allows private physicians to bill from the center through their own private offices so using resources they already are paying for. It could provide an AIDS library and social services to coordinate lower cost home care. Private physicians could come to the center to see their patients instead of seeing them in their own offices, and they could pay a use-of-facility fee which could be slightly lower than their overhead for their own offices. The supplemental funds to run the center would be provided by grants from federal, state, local and private grants and donations, and all administrative and support services then could be provided at one center.

Another urgent problem in Sacramento is the lack of beds in skilled nursing facilities for people with AIDS who are unable to care for themselves. As a result, they are staying unnecessarily at acute care hospitals and taking up those beds instead of the skilled nursing facilities because of the low reimbursement rate. So precious acute hospital beds are lost, the cost of care was double or triple what it could have been had skilled nursing facilities been available. So we must raise that cost, the reimbursable cost of Medi-Cal needs from the $44 a day that is being paid.

Sacramento has also some special problems in providing services to people with HIV infection due to its high military populations, the rapid growth of the metropolitan area, and the low cost of living. On the first item, the high military population, civilian health and social services in Sacramento have no formal ties to the military establishment. Now that the military is screening troops who live in Sacramento for HIV antibodies, it is important that these patients receive information and referrals to local providers who can assist them and their family members with health care delivery with emotional support with health care planning information and resettlement information should they be discharged to the Sacramento area.

The population of Sacramento is increasing at a brisk pace. This also enlarges the population at risk for HIV infection and those currently infected. This increase in numbers is going to cause heavy demands on existing and newly created services. It is also a less expensive place to live than other cities in the metropolitan areas of California, like San Francisco and Los Angeles. Therefore, people with HIV infection who are symptomatic move to Sacramento when their incomes are reduced because they can live more economically there.

Specifically, I want to just list some current services that need expanding that we see the need to expand and a list of new programs and services which need to be developed in Sacramento. The current services that need to be expanded are acute hospital beds, unless other forms of facilities are provided; non-ambulance patient transportation services like paratransit or some auxiliary form; home delivered meal services; social work case management services; clinical social work for assessment, patient, and patient family therapy; IV drug use prevention and education; volunteer buddy services for both emotional and practical support; people to look in on patients to cook and clean and shop for them; a network of support groups for patients, for patient families and children, especially for women IV drug users with children; home health nursing and attendant care; legal defense and advocacy services; and legal assistance and planning.

New programs that we would like to see develop, new services include residential skilled nursing facilities; licensed board and care and group homes; residential intermediate care facilities; an AIDS outpatient service with mobile outreach; street outreach for IV drug users; inpatient psychiatric services; 24-hour AIDS patient emergency services; outreach in minority communities for IV drug users; development of ethnic-specific education; and outreach and prevention information services for minority patients, especially in their languages.

We think Sacramento has done exceedingly well to meet the demands of the HIV epidemic. We believe that we know everything there is to know about the HIV to halt its spread. We must be able to apply that knowledge for education and prevention. More must be done, but the financial support is needed to meet the crisis head on. We must educate the high risk individuals and the general population. We must provide funding for this now so that we can end the spread of this deadly disease. What will the next generation think about those of us who had the knowledge in the 1980's to virtually stop the HIV epidemic dead in its tracks but did not apply that knowledge? They are going to wonder what kinds of irresponsible fools we were to let this virus spread to the point where the next generation will not be able to eradicate it. Thank you very much.

**CHAIRMAN WATKINS:** Thank you very much, Mayor. We will open the questions with Dr. Crenshaw.

**DR. CRENSHAW:** I will just thank you for that comment. I think that we all need to have a thorn under our saddle to get moving a little faster and use the resources that we have got. No questions.

**MAYOR RUDIN:** Thank you, Dr. Crenshaw.

**CHAIRMAN WATKINS:** Mayor Rudin, would you please provide us with your Sacramento ordinance on discrimination? You probably do not have it with you, but if you could forward it to the Commission, I would like to review it and look at its words. I am sure it was sensitively arrived at and sometimes when we average those across the nation, it might be useful in our own deliberations as we close in our final report.

**MAYOR RUDIN:** I will be happy to send it to you. We used the U.S. Conference of Mayors' model, adapted it to Sacramento, I will be happy to send you a copy.

**CHAIRMAN WATKINS:** Fine, thank you. Would you tell me what happens to the potential recruit for the military in your region who is examined at the military entrance point, found HIV positive. I would like to know how the military transfers that knowledge back to competent counselling and other authorities in the private sector back in the Sacramento area. Are you familiar enough with that to know what the process it, and if it is a good process, if it is a sensitive process or is it one that is rather casually done?

**MAYOR RUDIN:** I had a, I reviewed the process. I am not able to repeat step by step what happens. My impression is that it is not thorough enough. There is not enough follow through. It is casually done. There is not the follow through to the source of help, both the emotional support and medical care. Often people are transferred out of the area before they are able to follow through on their medical care so there is not a continuity for each one of these, for every person who is identified as carrying the HIV.

**CHAIRMAN WATKINS:** Has the military attempted to come to you as the Mayor or your community-based organizations to find the proper networking and the proper referral, both for pre-test counselling and post-test counselling?

**MAYOR RUDIN:** There is a person on the staff of the AIDS Foundation who is a social worker who has made the effort. He has made the outreach effort to the military because he knows people in the military just through social contacts who have turned out to be carrying the HIV and has learned from them that the process is really very sketchy, not as reliable in following through on each person. No, the military has not come to me.

**CHAIRMAN WATKINS:** Would you be willing to ask your social worker to prepare some sort of a review of how you view the military's response, and I am particularly interested to know not the ones that are in the military, those ones that have attempted to come into the recruiting office and then found in

their medical exam at the entrance point that they are HIV positive and are now rejected back to society. How, then, does that transition take place back into the Sacramento society?

**MAYOR RUDIN:** Yes, and to whom are they referred for treatment.

**CHAIRMAN WATKINS:** Right, and how well is it done. We are going to be talking with some of the Defense people, and it would be good to have some specific information so that we can ask the same questions when we go to those in the Department of Defense.

**MAYOR RUDIN:** I will be happy to provide that information to you.

**CHAIRMAN WATKINS:** Thank you very much. Dr. Lilly, do you have questions?

**DR. LILLY:** No questions.

**CHAIRMAN WATKINS:** Ms. Gebbie?

**MRS. GEBBIE:** Yes, and this is one, too, where you probably will want to consult with some additional people. Your comments highlight what is an issue for lots of us, and that is the mobility of patients. With much funding currently being based on the number of patients reported to CDC which means it is their point of original diagnosis, often the funding does not match to where the patients are, in addition some people have raised the question about basing prevention money distribution on currently diagnosed patients because, in fact, it may be those areas with low prevalence that could benefit the most from a big bubble of education money. If you and your staff have done any thinking about what would be a logical basis for distribution of increased funding, what formula or system ought to be used that would make certain the money got out appropriately and where it could be well used, I would appreciate receiving that or hearing some comments today if you have thought about it.

**MAYOR RUDIN:** I cannot give you that today, but I can get that information to you also. I do not work directly with the programs but I am in contact with them. I am not working with them but I am in contact and I get information and I am sure that Dr. Flynn, the epidemiologist who has done widespread work on this, will be happy to provide that information. Thank you.

**MRS. GEBBIE:** Thank you.

**CHAIRMAN WATKINS:** Dr. Lee?

**DR. LEE:** First of all, a question about your constituency. Sacramento sits right in the middle of maybe our finest farming area in the United States of America. We went to Belglade in Florida where they have terrific problems with the migrant workers, very high HIV rates and drug addition. Do you have that problem in Sacramento?

**MAYOR RUDIN:** It has not been identified as a problem. In California, what used to be the migrant workers are not as migrant as they used to be. They are tending to stay in one place to find jobs. Sacramento's agriculture has declined somewhat as urbanization has increased. We still have farming in the central valley, but we do not see the migrancy that we used to see so that has not been identified as a major problem.

**DR. LEE:** Some specific questions. When you said Medi-Cal, $44 a day, for what? Is that for outpatient services?

**MAYOR RUDIN:** Oh.

**DR. LEE:** You could not possibly be talking about inpatient. It must be outpatient services. Is that what they pay?

**MRS. GEBBIE:** I think she said long term care.

**DR. LEE:** Anyway, if you do not know, I was interested because it certainly is spectacularly low figure.

**MAYOR RUDIN:** I am sorry, I do not know. It is very low. I think it inpatient, Doctor.

**DR. LEE:** It is inpatient?

**MAYOR RUDIN:** Yes.

**DR. LEE:** That speaks for itself. One of the issues that I am personally very interested in is these residences for PWA's because they are so necessary for people who have been kicked out of their houses or are too sick to work but do not have to be hospitalized. These are so cost effective, and the models we have seen elsewhere in the country are so excellent. Two other people here in San Francisco have made the comment, one that there was some kind of residential support by the local Health Department here in San Francisco. That was told to us this morning, I think by Dr. Werdegar. I mean, how does that happen? Do you have that? Do you have funds for that?

**MAYOR RUDIN:** We do not have funds for that. We have lost much of our housing subsidies. But a private, non-profit organization has established a house. Someone donated an old, large Victorian house that can accommodate about 12 or 13 people.

This is a group associated with the Catholic Church, and the Lutheran Church is joining them in providing services to the homeless, but this one is particularly geared toward people with AIDS. They do not get any medical care there. People do go in as volunteers, and it is fully occupied now. It is called the Hope House.

**DR. LEE:** But you have no public or county or funds of any kind that apparently they have in San Francisco.

**MAYOR RUDIN:** No. We do not have the money for it.

**DR. LEE:** AAAnother thing I did not have time to track down is what the witness from Hawaii mentioned, that there was Medicare funding for the same kind of residential housing there. You certainly do not have any Medicare funding for that.

**MAYOR RUDIN:** I am not aware of it.

**DR. LEE:** And no Medicaid stream there at all.

**MAYOR RUDIN:** No.

**DR. LEE:** Thanks.

**CHAIRMAN WATKINS:** Dr. Walsh, do you have any questions?

**DR. WALSH:** I just need a one-word answer. May we assume that you would subscribe to the recommendation of Mayor Feinstein that the ratio, if we recommend federal funding, be 80-20 as a realistic ratio for, you will recall in our interim report we felt, we at first felt 50-50 between states and Federal Government. She suggested that because of the laws and like that your ability to raise that much revenue is impossible. Can we assume that you would subscribe therefor?

**MAYOR RUDIN:** I agree with that. I am assuming you are saying that the 80 percent on the part of the Federal Government.

**DR. WALSH:** Yes, of course.

**MAYOR RUDIN:** Yes, Doctor, I do subscribe to that.

**DR. WALSH:** It is important for us to know that legislation prevents you from it, even if you wanted to do 50, you cannot get it.

**CHAIRMAN WATKINS:** Thank you very much, Mayor Rudin, for being with us this morning. We have the Mayor of San Diego with us so we are going to proceed with our next panel. Thank you very much.

**MAYOR RUDIN:** Thank you.

**CHAIRMAN WATKINS:** We are pleased to have the Mayor of San Diego, the Honorable Maureen O'Connor with us this morning, and Mayor, welcome to the Commission and we look forward to your statement.

**MAYOR O'CONNOR:** Thank you, Admiral Watkins. I understand you are a fellow admirer of San Diego.

**CHAIRMAN WATKINS:** Yes, I spent many, many wonderful years there. It is, well, it is not my hometown, but it is so close to it in my professional career. I have the greatest admiration for the city and what you have done there, and not only that, I think you have a unique county in this state that has been in the forefront of aggressive education and other programs, integrated programs, and a variety of partnerships in your region that have almost been a model for the nation. I know we are leaning on San Diego County, for example, to set the tone in so many areas where we are running major national pilot efforts for education programs for the handicapped or the youth at risk groups and all others, so we applaud what you are doing there. It is a great city, and we are honored to have you with us.

**MAYOR O'CONNOR:** Thank you. Unfortunately, I do not think it is enough. Admiral Watkins and members of the Presidential Commission, I am Maureen O'Connor, Mayor of the City of San Diego. I am grateful for this opportunity to discuss the AIDS epidemic as it impacts San Diego. Our area is ill prepared to deal with the scope of the impending crisis, lacking a coordinated effort and realistic funding to deal with the mounting tide of AIDS and ARC cases which are estimated to number around 10,000 today and will approach 50,000 according to projections by 1991. As AIDS raises national and social concerns and has caused profound local and individual impact, we applaud the steps outlined in your interim report as necessary in addressing the whole fabric that must constitute the national effort. We must have a national approach to AIDS which stops the spread of the disease, protects the civil rights of the afflicted, provides for medical care, (PWA's and PW-ARC's, should be given expedited coverage under Medicare and be provided with hospitalization, outpatient and prescription services), addresses the medical concerns of medical insurers and those who need insurance, provides for the social service requirements of PWA's and PW-ARC's, and communicates effectively to all segments of the population about risk and behavior.

States and localities need clear direction. In California, for example, we face over 120 bills on AIDS pending before the legislature going in every conceivable direction, and the citizenry must address proposition 69, the LaRoche initiative

on the June ballot. Let me now briefly speak to immediate local needs from a Mayor's perspective in coming to grips with the AIDS problem.

City and county governments are separate entities in San Diego. Responsibility for health issues rests with the county. As Mayor of the city, I have no control beyond persuasion over the marshalling of resources to combat this disease. Because AIDS has significant impact on only one of the five county supervisorial districts, the county is unresponsive to the burgeoning crisis. Dr. Cox, the County Health Director, recently, as of Tuesday, flatly declared there was no AIDS emergency in San Diego and that AIDS merited no special consideration in relation to other health issues.

Due to a lack of resources, there is no action plan in place for dealing with this disease, no prioritization of programs, and no caseload projections beyond 1991. While state and federal programs provide for basic medical care and educational programs, the major burden for social services and outreach continues to be carried by the private sector, which by and large means the gay community in San Diego.

The city has begun to assist the various social organizations in providing AIDS and ARC sufferers with the most essential food, shelter and counselling needs as the demand overwhelms the ability of the private donations to keep pace. The city subsidizes approximately 60 percent of the food bank costs for PWA's and PW-ARC's earning less than $850 a month. The city funds a van for transportation. Through its Housing Commission, the city is providing a house to PWA's and PW-ARC's, for low cost housing. The city subsidizes the rent on another house used for low income housing by AIDS agencies. The city assists in providing education-counseling for those at risk and who test HIV positive.

The city funds its very modest effort, assisting perhaps five percent of the PWA's and PW-ARC's, through allocation of 10 percent of the Community Development Block Grant Funds available for social services. Only $1.5 million of such funds were available to the city in 1988 for all city social service programs. CDBG funds were fully subscribed before the addition of AIDS programs. The rapid growth of AIDS requirements will quickly displace all other social programs, every one of which is essential to some segment of the community. Compounding the problem is the fact that the Federal Government is reducing CDBG funding to the cities each year. Federal cuts are also threatened in other areas, such as public transportation. Such cuts have a direct impact on the services needed by the AIDS and ARC populations. Cities cannot compensate for diminished federal programs and fund an increasing AIDS program.

Cities such as San Diego are jurisdictionally constrained in their ability to respond to a health crisis and are fiscally powerless to address needs. Where the population affected is currently concentrated in the major urban areas, the tools must be provided to the city governments to act where others fail to step in, and where the private sector's willingness to participate is overcome by the need for services.

The requirements of various urban areas will vary based on the make-up and size of the immediately at risk population, and existing local, medical, and social agency resources and various peculiarities in the local, political and social environments. San Diego, for instance, must deal with the Navy and Marine Corps recruits discharged as HIV positive. We urge the immediate enactment of federal legislation such as Senate Bill 1220, Senator Kennedy's AIDS Research Care and Treatment Bill, which will give direction, scope, and funding in sufficient scale to formulate a national AIDS policy. Funding provided should go directly to the level of government best positioned to administer programs.

Specifically, we need direct assistance to the cities through programs such as those contained in Senate Bill 1220, the increase in social service funds available to existing programs such as CDBG or other pass-through mechanisms, San Diego needs such funds now to provide for the fundamental structure to sustain human existence within the bounds of decency. Examples of our specific requirements are: a PWA; PWA-ARC licensed adult socialization facility; low income housing; facility for AIDS agencies to allow for adequate client servicing; meals on wheels programs; food bank funding; visiting nurse and health care capability; counseling services and clean needle programs.

Admiral Watkins, members of the Commission, these are just our minimal requirements. We would like a lot more funding to address what we consider is a serious problem in our community and I want to thank you for the opportunity and courtesy extended to me today to address you.

**CHAIRMAN WATKINS:** Thank you very much, Mayor. I would like to open the questions from the Commissioners with Dr. Crenshaw.

**DR. CRENSHAW:** Not only as a Commission member, but as a resident of San Diego, I have a real special interest in our town, and you have mentioned many of the rather unique problems that we have which include the second highest incidence rate in the nation of new AIDS cases, and you mentioned the military. Not the military recruits, but the people in the military who are triaged through Balboa Naval Hospital which is equal in numbers approximately to our public health count, and then we have people who come there to be close to the Mexican border to get drugs.

**MAYOR O'CONNOR:** That is correct. Our population, those coming across through Mexico and the number of drug users, that is correct.

**DR. CRENSHAW:** Well, that is also true, and what I was thinking of but I did not express very well is the people who could not get certain drugs in the United States to treat their disease who go down there and go back and forth across the Mexican border in order to get drugs to save their lives and give them hope, and then we have got the drug traffic on top of that.

**MAYOR O'CONNOR:** I am sorry, as Mayor I always think of drug traffic.

**DR. CRENSHAW:** No, it is all true.

**MAYOR O'CONNOR:** It is always coming this way and not going that way in my mind.

**DR. CRENSHAW:** It is all true, and then on top of that, we have got an unknown number of illegal aliens about whom we do not have a clue as to what is going on so the concerns that I have are severalfold.

I think we have got a volatile and largely unrecognized problem in the sense that they are all separate pieces of the puzzle, that when they come together could make San Diego one of the most serious areas in the entire nation for this problem, and in the area of prevention and education, I think we are making headway there as far as treatment and care is concerned, and you mention facilities, but we just heard three individuals from the San Francisco Bay area demonstrate the incredible work that has been done by the city itself up here, with a budget of $50 million and another $20 million to come this year. How much money has the city of San Diego allotted to AIDS education?

**MAYOR O'CONNOR:** Okay, you have to understand that with San Francisco, the city and county are one, so they receive all health care funds, and you also have to understand that the city of San Francisco is $170 million in deficit right now. The city of San Diego is not allowed the luxury of running a deficit. We have to balance our budget and we receive none of the monies available for health services under that. We do through our program, I cannot give you the specific number, but the city, through its print shop, we have released our own educational pamphlets, and have distributed them throughout the city as it relates to the AIDS education program, in conjunction with the county.

**DR. CRENSHAW:** So we have got the pamphlets, but basically the city has no funding as yet.

**MAYOR O'CONNOR:** No, the city has no funding, and I will tell you, if you want to get a little quick synopsis of the problem with all cities in California, we are constrained by the Gann Initiative, we are constrained by proposition 13, we have to cut out of our budget $30 million this year just to balance, and basically the money that we use for social service programs is funded through CDBG which is continually being cut back by the Federal Government. So our modest contribution to the AIDS overall project is in the roughly $200,000 category, not counting the money that we are giving to provide for the housing facilities through our Housing Commission.

**DR. CRENSHAW:** So basically what I am understanding from you is that alone, you cannot spring things loose in San Diego to address a problem that you see as really serious from what you have obviously described and what can we do to help, short of a large check of federal funding that we would love to make available tomorrow, but in the interim, what can we do to get the powers that be, and the people running policy in San Diego to commit funds and energy and effort in a big way to educational prevention?

**MAYOR O'CONNOR:** Well, the first thing you can do is under the Gann Initiative if they would declare, the county would declare AIDS an emergency, they can lift the Gann waiver and spend money that they have that they cannot spend under the law so if you could convince them, to this point they have not been convinced to declare an emergency in San Diego, that would be a big step forward that would give them the opportunity to spend some of their unallocated reserve which is roughly $6 million and focus that on AIDS education but if you, ma'am, really think that the local government, whether it is city or county, have the resources to address this problem, even minimally, and I am talking about minimally, I have to tell you that is not the case. The city's budget never anticipated the epidemic, we do not have the responsibility, but we do have the moral responsibility, but we do not have the means based on our limited finances, nor the authority because we are not the health agency, to address it. So that is one specific example of where you could really help us in the community because to this point, we have not been able to convince the Health Director and the Board of Supervisors to declare an emergency.

**DR. CRENSHAW:** All right. That is very helpful, and I will say it is a terrible dilemma because you have a balanced budget and little money for AIDS, and San Francisco is pouring their heart and their soul and their money into it, but they have got an enormous deficit to confront so I am glad we have got the Admiral leading us over there.

**MAYOR O'CONNOR:** And I am glad the Admiral is here because I think it is a prioritization on the federal level. You know, they could take a look at their budgets and re-prioritize because I am sure if the Federal Government had to act like cities, we just cannot keep having the cities become the scapegoat for all the budget balancing in Washington because our cities are having some severe problems. I do not care whether it is the issue of AIDS or just the survival of our infrastructure. We need help. I have often thought about declaring us a foreign country so we could get loans. I mean, it is a serious problem that we are facing, and then we get the addition of the AIDS emergency, which it is throughout the country, and then we have to address that, too, with our limited resources, plus we are getting cut back at the federal and state level. We are in an untenable position.

**DR. CRENSHAW:** Well, I agree that the Federal Government is obviously going to have to pitch in in a lot of different areas, but I do think that your point of the $6 million available, given emergency declaration is really a good one, and all of the cities have to suffer financially in some way if they are contending with this AIDS epidemic.

**MAYOR O'CONNOR:** And we are doing that in that we are taking from existing programs, other social programs, ma'am, we are taking it from them to address this crisis and now I am down to, in the next year's budget, do I fund my after school recreation program for children at $650,000 a year? What it addresses is our problem with drugs and juvenile delinquencies. Do I take that money and put it into the AIDS emergency? That is a tough call for a Mayor to make, and I am saying we need some support nationally, and that is why this Commission is, frankly in my opinion, our only hope.

**CHAIRMAN WATKINS:** In follow up, Mayor, could you tell us a little bit more about the county's reticence. Do they also have the same problem and therefore they cannot come to grips with it? They are sympathetic with the issue but they simply do not have the dollars or what is the obstacle? Is it local or is it federal?

**MAYOR O'CONNOR:** Well, I think it is a little bit of policy. It takes three votes to do anything on the Board of Supervisors. There is only one supervisorial district that encompasses the city itself so the other supervisors, rightly or wrongly, they understand that the problem is out there, but it is technically not in their district, they also are under a lot of financial constraints, and I am not here to tell you that they are not, but they are the lead agency. They are the health agency responsible to try to address this problem so I think it is a combination of both.

**CHAIRMAN WATKINS:** Is there any technical element in the existing statutes in the county that talk about the emergency, the medical emergency that would preclude the HIV epidemic from falling under that if a decision were made in that direction?

**MAYOR O'CONNOR:** No, I do not think so. I think the county mayors in 1987 requested the regional task force on AIDS, that is, a combination of city and county representatives, they addressed the Board of Supervisors in their program to declare it an emergency and frankly, it is just on somebody's desk and the desire is not there at this point.

**CHAIRMAN WATKINS:** If, at the national level, advantage was taken of the existing law that deals with medical emergencies in the nation, giving the Secretary of Health and Human Services certain powers under that Act. It has not been enacted, but were it to be enacted, would that be a trigger mechanism at all for the county to move out more aggressively and declare it?

**MAYOR O'CONNOR:** I would think so. It would certainly help us in the city to then move to the county and assert the position that it is declared an emergency and therefore we must go along with the national policy.

**CHAIRMAN WATKINS:** Thank you. Dr. Crenshaw?

**DR. CRENSHAW:** Thank you, no. That covers it, and I just hope that if any other ideas occur to you where we as a Commission can help bring some support and pressure to bear to accelerate the process in San Diego, I would really appreciate receiving it in writing or getting a call.

**MAYOR O'CONNOR:** I appreciate that, Dr. Crenshaw. I do think San Diego, as far as a community, we have a lot of good programs that are addressing the issue of AIDS, a lot of volunteers, a lot of church organizations, but they are running out of funds.

Where, in other cities, there are problems about putting the homes in neighborhoods, we have a very good program where we go out and we talk to the community first, we get a lot of community support. Our first home basically is going in without opposition from the neighborhood. We take a lot of time and care in selecting the facilities. We do have a lot of volunteers, but there is what is called burn-out. We have the Owen Clinic, Dr. Crenshaw, that you are well aware of, at U.C.S.D., that is doing an excellent job. For example, they are just stretched to the point where a computer that costs $6,000 would really help them doing their patient caseloads so they are constantly one step

ahead of, I do not want to say financial bankruptcy, but it is kind of emotional bankruptcy because there is a lot of good people out there addressing this, that they need some support from our government.

**DR. CRENSHAW:** Thank you.

**CHAIRMAN WATKINS:** Dr. Primm? Dr. Walsh?

**DR. WALSH:** I think any Mayor with the name Maureen O'Connor is going to solve all the problems.

**MAYOR O'CONNOR:** Oh, that is what my constituency thinks. They keep telling me that.

**DR. WALSH:** Now, Mayor, may I just ask one question? We have had much advocacy for giving or recommending direct federal grants to cities. Give me just a brief technical answer. We know, in some states, the grants go to the state, then to the county, then down, by the time you get it, everyone, the crisis is either past or become so magnified that you need twice as much as you asked for in the first place. If such a recommendation were made and accepted on the part of the Federal Government, does this in any way, would you be prevented from making an application for such a grant without violating some kind of state law or state rule or county rule or would it destroy the discipline of the county health system or public health system? It seems to me it would be a ridiculous rule, that is why, but yet there are organizational reasons. Can you apply if there is money available for direct city grants?

**MAYOR O'CONNOR:** If it is community specific in that if it is health care, I mean, that obviously is the direction of and jurisdiction of the county, but if it is social service programming, transportation, housing, outpatient care, food programs, yes. I mean, I think we can, through the U.S. Conference of Mayors and the National League of Cities, we could help carve legislation that will be more specific and the dollars can get directly to the source and can be expedited.

**DR. WALSH:** That is what I meant. Do you actually need new legislation to do that? In other words, I think we have all been appealed to and understand the less bureaucracy, the better, and if you could deal directly with the affected cities, it makes sense, but will you have to frame legislation to make our recommendations possible or is the existing legislation on the federal level good enough?

**MAYOR O'CONNOR:** Senator Kennedy's Senate bill, I think, with a few modifications would satisfy everybody's needs, yes, sir. I think there is existing legislation that is going through the process that can be worked on from the mayor's standpoint.

**DR. WALSH:** Thank you.

**CHAIRMAN WATKINS:** Would you be willing to give us those modifications, mark up a copy and send it to us?

**MAYOR O'CONNOR:** Yes, Admiral, be glad to.

**DR. WALSH:** It is very important. We would like to respond to this. We do not know how.

**MAYOR O'CONNOR:** Okay, I will be glad to send you --

**CHAIRMAN WATKINS:** It will be very helpful, I think, Mayor, if you could do that, take that bill and then bring it in line with what you and your colleagues in the mayoral business believe is right for the cities and is worded in the right way that makes the sense, and any additional information you have surrounding that to justify that would be very helpful to us.

**MAYOR O'CONNOR:** Okay, that is fine. Our city as a whole, the city council, has actually adopted a resolution in support of the Senate bill with the modifications that we are discussing so I would be happy to do that for you.

**CHAIRMAN WATKINS:** I would like to know if you have the detailed knowledge of what happens to the aspirant for the military that goes to the local military entrance command, is examined medically and found to be HIV positive. How is that individual returned to San Diego and properly counselled and worked into your social service network to deal with the AIDS epidemic? If you know that, I would like to have any details.

**MAYOR O'CONNOR:** I do know that, Admiral, and I think we handle it very sensitively. The military works very well with the organizations, the regional task force, AIDS projects, AIDS assistance. We give them assistance through the mayor's office in that once they are identified, they are told that there is help on its way, and we do integrate them into the system so it is a very quiet, coordinated effort. We work very closely with the military.

**CHAIRMAN WATKINS:** We received information from Mayor Rudin of Sacramento that she felt it was not sensitively handled in her region, and I am trying to build up enough information to know because it has been raised to me on a number of occasions that where sometimes it is plus and sometimes it is very minus where there is less sensitivity to the transitional mode and make sure that the pre- and post-test counselling and transition is sensitively handled. So you are saying it is in San Diego.

**MAYOR O'CONNOR:** It is, and I can send you, how we handle it.

**CHAIRMAN WATKINS:** I would like to have that. If you could include that in your letter to us with the other recommendation, it would be very helpful to know exactly how it is handled and that may be something that I can chat with the Department of Defense officials on.

**MAYOR O'CONNOR:** That would be wonderful.

**CHAIRMAN WATKINS:** Mrs. Gebbie?

**MRS. GEBBIE:** I am tempted to ask you to reread that quote from your County Health Director, except I think I would get too embarrassed to listen to it again, and do have some concerned about a County Health Director in a major metropolitan area who does not seem to understand what is going on, and I guess I wish if I had a chance to talk directly with him, I would find out there was some other dynamic operating that could explain it because in general, County Health Directors, at least in metropolitan areas have grasped the need to get ahead of this problem and to react.

A couple of questions, first related directly to that. Has your county established any kind of a task force or group that is in a position to work with the county level government to try and break this log jam?

**MAYOR O'CONNOR:** We have a regional task force on AIDS that was established before I was mayor. We have been very effective in getting an anti-discrimination ordinance. Just as recently as last Tuesday, the city adopted an ordinance to control and regulate bath houses. I felt they should be closed. The County Health Director said no, they should be regulated and that is when we got into the dialogue that AIDS is not an emergency. The regional task force is somewhat successful but it is not at all as successful as it would like to be in explaining their position to the Board of Supervisors.

**MRS. GEBBIE:** Is it an official body in the sense that it was appointed and has legitimacy on account of government or is it a more spontaneous thing that happened?

**MAYOR O'CONNOR:** It is an official body but it is advisory in nature and you know how that goes.

**MRS. GEBBIE:** Yes, and people do not always take the wise advice that is given to them. We are struggling to do that here. The other piece relates to what you have already been asked about several times, and that is this structuring of grants. The piece that tends to worry me about grants directly

to cities is that it will end up like a giant federal bureaucracy to monitor lots of grants to small and medium-sized cities. Money going to 50 states might be more manageable if there were a way to explode it through the system so that it worked, and obviously you do not think that is a workable model.

**MAYOR O'CONNOR:** Can I just give you an example, and it is not related to AIDS, it is related to drugs. I was elected Mayor of the city of San Diego about 20 or 21 months ago. Mayor Koch called me two weeks after I was sworn in and said, you have to come back to Washington, we have a war on drugs. We need the Administration to start helping us. We went back to Washington and we fought real hard to get $1.5 billion legislation passed to address the drug problem, and the war that we are losing in our streets and our cities.

We just now received the funds in city of San Diego. I think we are now the sixth largest city in the country. We just received our first allocation. The Justice Department had to take care of it, and then it had to go to the state, and then from the state it gets to the city. We just now received roughly $400,000, 22 months later. AIDS patients are going to die by the time you start getting the funds to the source in which it is needed. And every time you go through a governmental layer, you are adding on administrative costs to that dollar that has to be taken off before it gets to the patient in this case.

**MRS. GEBBIE:** Do you have a good trail of that money and that decision that could highlight the spots at which it stopped along the way?

**MAYOR O'CONNOR:** Oh, certainly. I can get it for you.

**MRS. GEBBIE:** I think that would be very helpful.

**MAYOR O'CONNOR:** Just do not attach my name to it. I have to get more money out of Washington.

**MRS. GEBBIE:** However you want to get it, send it in a plain brown wrapper but I think it would be helpful as we struggle because there will be forces that do not like that direct local funding idea.

**MAYOR O'CONNOR:** Well, you have to understand, and I am in politics and this is not a disparaging remark to my colleagues in politics, but everybody at every level feels that they are the only ones that can protect the taxpayer's dollar to make sure it is well spent, and I have been in the business long enough to know that the dollar is better spent by the people who know the problem and how to address it than the farther removed it is. The further the decision makers are removed from the problem the more waste you have. So if there is some way you can get it down

to the cities, you are going to be more cost effective in the long run.

**MRS. GEBBIE:** Thank you.

**CHAIRMAN WATKINS:** It would be very useful, and we have just described enclosure three to your good letter to us that we need because we have run into this many times before, and I think if we put enough of these together, we may see a pattern of sluggishness in the bureaucracy that we can attack, and certainly I think when we have what really is a national health emergency, this is a time when we should perhaps put in new processes into effect, and allow that kind of direct application where we have the highest density of health problems so it would be useful to us. We are getting this from other sources as well, that I think we will probably come up with some kind of recommendation to facilitate the process under these kinds of conditions.

**MAYOR O'CONNOR:** And, Admiral, I think we mayors stand ready to help this Commission in any way possible because I think you are our united hope that we will have a responsive ear in Washington because if we do not, people are not going to realize the epidemic proportions that this thing can lead to in the next five to ten years without proper planning so I, the Mayor of San Diego, would be more than willing to go back and support your cause in Washington because I think we need everybody because there is not a sense of emergency in Washington.

I mean, they do not have to see the mother coming in to the mayor's office that has a hemophilic child that is subject to AIDS that was just released from the day care center because the other parents do not understand that you cannot get it from hand shaking. I had a meet-the-mayor session to just talk to anybody that wants to talk to the Mayor of San Diego, and Wednesday night a woman was convinced that someone put AIDS in her coffee. You know, the education that everybody thinks is going on that everybody understands we have a long way to go. We have come a long way, but we have a long way to go, and we cannot afford to wait for a five year, six year, seven year, long term plan. It will be too late.

**CHAIRMAN WATKINS:** Dr. Lee?

**DR. LEE:** Let me persist with that line of thought. By the way, your County Health officer reminds me of our New York State Health Officer who says that HIV infection is not an infectious disease. Clearly, he has some political agenda there which is completely unrelated to the problem.

Let me ask you to think a little bit theoretically here. You have painted a beautiful picture about the cities. Now, as I remember, and please correct me if I am wrong, when some seven to

eight years ago, there was a program where there was direct federal grants down to the cities.

**MAYOR O'CONNOR:** Model Cities program.

**DR. LEE:** Yes, and so that instead of going through the process that we have been talking about, there was a system where federal tax dollars, everybody realized the cities had to handle their problems, they are the ones that know their problems. They get the dollars up front and forget about it. Now, that went sour someplace, did it not? That dried up. What happened to that program or is it operating?

**MAYOR O'CONNOR:** No, Model Cities, I was on the City Council of the city of San Diego when it was implemented. I think it went sour, like all programs, some people saw some abuses and the Federal Government got tired of it and they wanted to take back control. You know, the politicians for whatever reasons, decided that we were allocating the funds, that they wanted to have another, different kind of program so it just fell out of favor but it was a very good program.

**DR. LEE:** It seems to me that this type of program would be an incredibly good way to rectify it. Because, in my reflection here, listening to you talk, the way monies are handled in the United States, goes back to the way they were handled a long time ago when we were sort of rural societies and non-mobile, etc., etc. Now you have these terrific concentrations of populations in the cities, and terrific concentrations of needy populations going to the cities, and the system just does not seem to be working any more.

**MAYOR O'CONNOR:** It is not.

**DR. LEE:** So maybe if you got a really good idea and it seems like you have your finger on it, could you let me or Admiral Watkins know? Do you have a recommendation on putting that direct federal funding back to local government?

**MAYOR O'CONNOR:** I think that you will be hearing from Mayor Agnos, and I know he is talking along the same lines, and I think he has a proposal that he will be presenting to you that I can give you from our perspective in San Diego what we need, and we can give you a dollar amount, and I can check my record. I am a woman of my word. I keep within the budget. I will spend it for exactly for what I need it for. I am convinced that every mayor in this country can come up with a program and stick with it, if given the opportunity, but our problem is we are stagnated by all of the layers that we have to go through to get permission to do what is important in the first place. We have all of the responsibility for this problem because we are on the firing line on the cities and we have none of the authority.

**DR. LEE:** Thank you.

**CHAIRMAN WATKINS:** Thank you very much, Mayor. We are going to close this particular panel out and take a short recess. I would like the Commissioners to stay in the general vicinity here so as soon as Mayor Agnos arrives, we can proceed with these hearings. Thank you very much, Mayor, for coming before us today. We appreciate very much your testimony.

I want to thank again Mr. Allan Harris and George Seegers of the U.S. Public Health Service for the wonderful support they have given us here. Dr. David Werdegar and Ann Schlegel, San Francisco Department of Public Health who have given us so much support, and particularly the host of our site visits to the Shanti Project, to the San Francisco AIDS Foundation, San Francisco General Hospital, Bayview-Hunter's Point Foundation and the Mid City Consortium. We thank you again for all of the courtesies you have extended to this Commission. It has been very informative for us. Thank you.

[BREAK])

**CHAIRMAN WATKINS:** The Commission members will now come back in. We will commence our final panel this morning before we adjourn to the site visits. We have with us this morning the Honorable Art Agnos, Mayor of San Francisco. We are very pleased, Mr. Mayor, that you take time out of your schedule here to come and chat with us today. This is an important city. We have learned a great deal here. We have had your predecessor here talking a little bit about her experiences prior to your arrival on the scene as Mayor and we look forward to your statement, sir.

**MAYOR AGNOS:** Thank you very much, Admiral, and members of the Commission. Welcome to San Francisco. We want you to know, I feel like I am back in the legislature here. I have not done this in a few months. It feels good.

**CHAIRMAN WATKINS:** We are much more friendly, Mr. Mayor.

**MAYOR AGNOS:** We want you to know about AIDS and San Francisco and what we think needs to be done. You have already heard from our fine Public Health Director as well as the President of our Health Commission and former Mayor of San Francisco who has lived through most of the entire history of what you have been hearing about in our city so I think you have gotten a good handle, and I hope that we can add a little bit to what I am sure has been some outstanding presentations not only from our local officials here in the city but also from around California.

San Francisco has already lost more young men to AIDS than all San Franciscans who died in World War I, World War II, Korea, and Vietnam combined and doubled, to give you some sense of what the proportions are. The word decimate means literally one out of ten, and in San Francisco, by the end of this year, one out of ten gay men in our city will have died of AIDS or be diagnosed as having AIDS, and within five years, it will be one out of four in our city. They are San Franciscans in the prime of their lives, hard working, good citizens, whose contribution to our city is without question.

But the pain and suffering you hear from those of us who have lost friends and loved ones in this city to AIDS is not just a San Francisco story, and if you remember nothing else from this Mayor today, please remember that. AIDS is not a San Francisco story, it is a California story, it is an American story, and it is a world story. Today, there are perhaps 30 American cities who have the same level of AIDS cases that San Francisco had just three years ago, and while the level of new infections is almost levelling off here in our city, in the gay community, that has not been the same experience elsewhere. The results for those cities are inevitable and indisputable, and what our city has to offer them and to offer you is not a picture of what the epidemic in their city is going to be like five years from now. What we offer is a model of how to meet the epidemic in ways that involve people which are cost effective and which care about people.

I want to particularly single out to you the important role that people with AIDS and ARC themselves have played in San Francisco. They are not AIDS victims. They are people who are living with AIDS and who are fighting to see more of us alive. They staff the hotlines that guide people who are newly diagnosed, they help counsel families trying to deal with grief, and they educate in every part of our city, including our high schools, to wage war against new infections. I commend them to you, and I strongly recommend that you consider their contribution when others urge you to treat people with AIDS as a danger to our society or as helpless victims who have no role in determining their own needs.

My own involvement with AIDS public policy includes my work as a member of the California State Assembly before coming into the Mayor's office. It dates back to 1982 when California had fewer than 100 cases statewide. I sponsored an AIDS education forum in San Francisco and sent mailers to communities in Fresno and Modesto, and I did it because no one else would. No state money, and no federal money. In 1983, as Chairman of the state legislature's Ways and Means Subcommittee on Health, I provided the first state funding for AIDS education. We did it alone in California at that time because there was no federal help, and in 1984 I doubled the funding to $1 million, and we still had no federal AIDS education funding. In 1985, I authored

the first law here in California setting public health standards for the use of the AIDS antibody test within months after it was released by the federal Food and Drug Administration, including consent and confidentiality provisions. The Federal Government did not provide that leadership, they left it to the states and we were the first to respond.

Finally, in March of 1987 I requested and won approval for a special joint session of the California state legislature, a very rare occurrence in our state capital, on the AIDS epidemic. The Surgeon General of the United States, Dr. C. Everett Koop, and a Nobel Laureate, Dr. David Baltimore, the co-chair of the National Academy of Science Institute of Medicine panel on AIDS came to the California State Capitol and spoke in a highly unusual session. I was dismayed then that Dr. Koop, our nation's top Public Health officer, had not been invited to bring his message directly and personally to the President of the United States who has appointed him, and I am still dismayed, a year later, that Dr. Koop has not been invited to fully brief the President of the United States on our nation's most serious health crisis, nor has he been invited to play a lead role in setting our nation's policy, and I respectfully urge this Commission, without delay, to recommend to the President as part of your recommendations, that he meet personally with his Surgeon General and that they appear publicly to end the impasse that public health officials face from those who hold political office.

I understand and have experienced that impasse. As a state legislator, I worked with Public Health Officials on every AIDS bill that I authored, and there was never one that was not supported by them and the medical community. Without exception, those bills had the support of the public health community with AIDS care providers and the entire coalition of health professionals and consumers. But time after time, what the public saw was a political, partisan line being drawn. I think that was an artificial line drawn for artificial reasons, but the delay results in deaths which are not artificial.

Working with the United States Surgeon General, I drafted an omnibus AIDS bill that incorporated the recommendations from his 1986 report to the people of America. I also worked with the National Academy of Sciences Institute of Medicine. The bill was hailed as a model for the nation, a measure that could save lives. While Dr. Koop does not endorse state legislation, he confirmed that he had worked on each draft and we prepared it and said the bill was the most compassionate he had ever had presented to him, and in the California State Assembly, only one Republican voted for it, and he was the only physician in the legislature. In the California State Senate, not even one Republican would vote for the bill.

The centerpiece of that legislation was the creation of a California Commission on AIDS. It would bring together the public sector and the private sector, the many agencies of state and local governments and a range of individuals who are affected as employers, police, insurance executives, physicians, nurses and people with AIDS themselves. The same approach has been recommended by every public health association for the nation, but it has yet to happen. This Commission is a temporary stopgap, not the national body that we need to oversee all parts of our policy on AIDS. It is overdue, and it should not have to wait for an election to happen. In the interim, I urge you as a Commission to call for the establishment of a powerful body that can review existing programs of every kind to see whether they might be put to work to help us combat AIDS and to provide the assistance we need for demonstration programs and rule changes where the need is already evident.

In San Francisco, we have a model program called Open Hand. Volunteers, including professional chefs from some of our city's finest restaurants prepare meals that are taken to people with AIDS who are still able to live at home, but unable to prepare nutritious meals for themselves. It is very much like an older, more established program called Meals on Wheels except that Meals on Wheels is barred from helping people who are under the age of 65.

We have no nursing facility for people with AIDS in San Francisco. Indeed, we have virtually no facility in all of northern California. The reimbursements rates simply are too low for the cost of care. The fear of other patients and their families is too high. We are seeking to have the Public Health Service Hospital in San Francisco converted into a facility that can help meet that need, particularly those that face the dual diagnosis of AIDS dementia. But the process of winning federal approvals for such an innovation and the help that we need for the operating costs will take years before the project is complete. Those who need it this year and the next likely will not live long enough to find it of service.

Too often, federal rules prohibit demonstration project funds from going to programs that have already been launched. We call that here the San Francisco penalty. Our city begins a program, proves its effectiveness, uses our own funds, and then a federal demonstration program is created but only for new efforts that come after it, using us as the model. When the Commission proposed a $1.5 billion program for AIDS and substance abuse, you called for local and federal match.

San Francisco wants and needs such a program. We have less than a dozen beds for women who have child care needs who require residential substance abuse programs. We have an aggressive street outreach program to meet IV needle users,

informing them of detox programs, counselling programs, and how to clean needles with bleach. I helped start those programs with a state pilot that is now being expanded statewide. But the federal component comes from a block grant that was a one-time appropriation from the War on Drugs. Your proposal could help us put in the residential treatment program we need while keeping families intact. We could continue our model street outreach programs but unless you make it clear that there will be no penalty for programs like ours that are already started, the announcement you made intending to encourage us all will be an incentive for further delay.

Cities simply will stop innovations, stop bridging the gap, and wait for the pipeline which may never open. San Francisco will not do that, but you can remove the issue from the table by simply including an ability for programs like ours to be grandfathered in. The burden on cities such as ours in San Francisco is going to grow greater, even though the new infections level off. The incubation period guarantees that the pipeline will continue to bring new cases.

But, beyond that, a major shift is taking place in meeting AIDS costs. Two years ago, about 30 percent of San Francisco's caseload were publicly funded cases, including through our state Medical program. Today, there is almost 50 percent whose costs must be borne by the public sector. As insurance redlining increases, as employers feel free to limit health benefits so that AIDS is not covered, or worse, discriminate against those with AIDS, the costs are going to fall straight on the cities. This will continue to be a particularly true situation in states like California, and about 35 others where a no-risk pool program exists for those unable to help obtain health care. They drop straight on to the public roles. The Federal Government has an opportunity to play a major role in creating federal incentives to states to create risk pool or stop loss programs including case management that can spread the cost of AIDS care sensibly and equitably between employers, insurance and the public sector.

I particularly want to call to your attention to the fact that one out of every two dollars paid for by California employers for health care comes from a self-insured plan that they underwrite on their own. The state and cities have no authority over such programs. The conditions of benefits, whether home care and hospice, is reimbursable, even whether certain diseases, such as AIDS, could be redlined out, are issues to be reviewed by the U.S. Department of Labor. I have yet to see policy guidelines to employers on AIDS in ERISA plans. The federal-state share of AIDS care, according to the Health Care Financing Administration, is only 53 cents on the dollar. The other 47 cents is absorbed by the doctors, hospitals, and charities. For us that means San Francisco taxpayers because our

major hospital, San Francisco General, is a part of our city's health department.

The specifics of our needs are long. We need help for homelessness with AIDS. In San Francisco, we estimate that number at somewhere between 200 and 600 people. We have fewer than 80 beds. We need significant funding for case management, including money management, and eligibility workers for those who should receive veterans' benefits or SSI. We need to create health centers capable of monitoring and possibly providing early intervention for those who are antibody positive, something many San Franciscans with independent incomes are doing through the private sector but which is still out of reach for those who rely on the public sector for help.

We need better coordination of new drugs, and better access to investigational drug opportunities. We need a federal consumer protection program to halt AIDS fraud, just as we are doing through the Attorney General of California and his AIDS fraud task force, which John Van de Kamp created last year. Most of all, we need committed leadership in the White House itself. Cities like San Francisco have shown what can be done. I cannot tell you how many visitors I get through City Hall from all parts of the world as well as all parts of the country who are coming to see what we have created with our own unique enterprising public-private sector cooperation.

What threatens to overwhelm San Francisco is not the increased caseload of AIDS but the continued lack of leadership from the Federal Government, and we hope that you will provide that with your recommendations to the government. Thank you very much.

**CHAIRMAN WATKINS:** Thank you very much, Mr. Mayor. I would like to open our questioning with Dr. Lilly.

**DR. LILLY:** Good morning, Mayor Agnos. I would like to ask for a little clarification of what types of anti-discrimination measures for people with AIDS exist in San Francisco on any level, federal, state and local. Do they work, and what do you, what role have they, have they helped in the crisis? Do we need more?

**MAYOR AGNOS:** Yes, we have a city ordinance that prohibits discrimination against people with AIDS in employment, housing, I believe, and public accommodations. At the state level, I have tried to include a similar provision in employment, and that has not been signed into law by the Governor even though his own Fair Employment and Practices Commission has decided that AIDS is a handicap, someone with AIDS has a handicap and is protected under the existing law so the Governor has used the rationale since it is already protected under existing law, we

do not need to specify AIDS and single that out. So at the state level, people can apply for the Fair Employment Practices Commission if they have AIDS and are the subject of discrimination in employment and housing I believe. Right? And housing.

Yes, I think they do help because if people are discriminated against, and people do not feel protected, obviously they are going to go underground with their illness and I think that that simply adds to the possibility that the infection will be spread.

**DR. LILLY:** Do you think that the current laws are adequate to prevent discrimination? Do you think that there is residual discrimination?

**MAYOR AGNOS:** I think here in San Francisco they are, and at the state I would like a little stronger statement. In fact, when I was pursuing the legislation that I was describing that I worked up under the, with the cooperation and assistance of the Surgeon General of the United States, part of that was AIDS discrimination. We were supported by that by the business community, by people who traditionally are not seen as civil rights advocates because they wanted a clear statement from the government that would spell out just what the ground rules are. Today, we do not have that. We have kind of a patchwork of local ordinances that make it confusing for business in particular and employers to know what the law is and to be guided by that, so I think it would be helpful, yes, sir.

**DR. LILLY:** Okay, and I am a little surprised to hear you say that you really do think that your measures are adequate in San Francisco. I suspect you are, perhaps, better off than many other parts of the community but we have heard that there are problems.

**MAYOR AGNOS:** Well, of course there are always problems when you have laws that protect people, but the laws are in place here. They are not elsewhere so people have a remedy that they can seek in San Francisco that does not exist elsewhere.

**DR. LILLY:** The 20 percent increase, increase from 30 percent to 50 percent in the number of cases that fall on the public role then for support, is that in any sense related to discrimination perhaps with respect to availability of insurance, medical insurance.

**MAYOR AGNOS:** I have no doubt that is part of it.

**CHAIRMAN WATKINS:** Mrs. Gebbie?

**MRS. GEBBIE:** Two different areas I would like to ask questions on. The first is related to what Dr. Lilly was just asking. In discussions around this whole issue of discrimination and how we should define the groups to be protected, generally people are pretty clear that they mean people with AIDS, diagnosed patients, and that seems to be where everybody rallies to very quickly, and people who are HIV positive, that is, test positive. Another group that is at times included are people who may be discriminated against because they are thought to be at risk of the disease. That then would often extend to protection against discrimination for somebody who might lose their housing because a man looked like he was gay and therefore was at risk of AIDS and got thrown out, not fitting into one of the earlier categories because he may or may not be gay, may or may not be HIV positive, but just kind of looked that way. How far along that list would you carry the anti-discrimination protections? Do you see that last group as appropriate to include, and how would you word that protection if you did?

**MAYOR AGNOS:** Well, certainly the first part should be included. The second part, and I think the federal legislation which Congressman Waxman has introduced and is moving through the Congress, is worthy of your attention and support. It has mine. As to the second part of your question, I am not sure if it is, if I would limit it to someone who looks gay, whatever that means, or I think it is all human beings who are at risk so I think that we have to define the law in a way that anyone who is discriminated against because they are thought to have AIDS, be they man, woman or child of any race, creed or color, are the ones that have to be protected so I would think that I would draft the law in a way that just speaks to the illness that is at risk rather than --

**MRS. GEBBIE:** Have or thought to have.

**MAYOR AGNOS:** --rather than a particular type of individual that we originally may have thought was the person who was at risk because clearly you know, as a Commission, that that no longer is the case.

**MRS. GEBBIE:** But the thought to be at risk or thought to be in there is something that you would --

**MAYOR AGNOS:** I think that I would try to, my brain is over here whispering to me. Mr. Bush, Larry Bush, who is one of my advisors on this tells me that the California law says that people are protected if they are perceived to be at risk. That might be one way of dealing with it.

**MRS. GEBBIE:** I think receiving a full copy of that language would be helpful to us.

**MAYOR AGNOS:** I will see to that.

**MRS. GEBBIE:** Good. The other area that I have a question about is the issue of regional needs. We have heard a lot today about cities, but in an urban area like this, as in many parts of the country, people's daily lives are carried out almost in ignorance of where city boundaries stop and start.

**MAYOR AGNOS:** Absolutely.

**MRS. GEBBIE:** They live, work, play in several different areas. Concentrating funding solutions on cities, therefore, may not be right because a city might be surrounded by some relatively small areas that would not ever qualify as a city but which are a part of that area's pattern. How would you suggest we tackle that or how have you tackled that here in the Bay Area?

**MAYOR AGNOS:** I agree with you. I do think we need a regional approach. I think that especially in our region, San Francisco is seen as the city to come to if you have AIDS. In fact, in our country it is seen as the city to come to because of our very extraordinary programs to help people with that, and I think giving the kind of regional help that you are suggesting in your comments would go a long way to equalizing the kind of services that are out there. As I said, our services have been developed internally and/or originate with our own community and we need your help to spread them out by funding out by funding ours as well as those regionally. San Francisco has already got a regional approach to this. Our Public Health Director meets on a regular basis with other Public Health Directors and people who are concerned around this problem to develop regional responses to the AIDS issue so we are doing that here, and I think we are going to move further down that road under my administration

**MRS. GEBBIE:** Would you, in looking at the economic side of that, recommend finding a way to channel funds to that sort of central city to reach out and define its region or would you do both separately or how would you start with that?

**MAYOR AGNOS:** I would like to see us do both. I would like to see us fund some programs that are up and running. I hope you will remember the San Francisco penalty.

**MRS. GEBBIE:** Yes, that was a well made point.

**MAYOR AGNOS:** And we need to fund our programs that are up because we are truly educating the world. We have had members of the West German Parliament here, I have had the British Secretary of State for Health and Welfare here. People come from different parts of the world because they have heard, and are directed by Washington, by the way. They send them to San Francisco from Washington to see what we are doing so that they

can learn and take that back to their respective countries and we also have, as I said, people coming from other states and cities to see what we are doing so we are educating the country and the world on what a good response is in terms of care as well as compassion for AIDS victims, and I think we need to be recognized and supported in those efforts.

At the same time, I think we have to create a track that encourages your correct point of approaching this on a regional basis rather than a kind of patchwork basis that occurs now if you only look at cities in desperate need. I think your funding stream could make that happen by saying we will fund this kind of overall approach through a regional kind of task force, and leave it up to us to create it or not be eligible.

**MRS. GEBBIE:** Thank you.

**CHAIRMAN WATKINS:** Dr. Lee?

**DR. LEE:** Mayor Agnos, this Commission has made every effort to approach this problem on a non-partisan basis. You have had difficulties with partisan politics which comes through in your talk. If there is one thing that I want to send you, the message is that we are not going to approach this problem on a partisan basis. We are going to approach it as we see and so please do not except us as part of the problem. We are going to be part of the solution.

I have two ideas which I would like to run through you. The first is an idea that we talked about with Mayor O'Connor. What do you think about the original Model Cities federal grants? I understand from one of my associates here that one of the major reasons it went sour was corruption, local corruption. What did go wrong with that program, and why is it not a good idea?

**MAYOR AGNOS:** You are talking about Model Cities in housing?

**DR. LEE:** I am talking about direct federal grants to localities rather than going through this process that currently we seem to be going through where you apply for something and three years later, you start getting part of the money.

**MAYOR AGNOS:** I would have to go back and study the history of what happened under Model Cities. That was about 20 years ago, was it not?

**DR. LEE:** No, it is not 20 years ago.

**MAYOR AGNOS:** Fifteen years ago? You are talking about Model Cities that was proposed under the Johnson Administration I think.

DR. LEE: And they had direct federal grants.

MAYOR AGNOS: Yes, I understand. I remember the concept. What I am trying to say is I do not remember what went wrong, and I do not think it was corruption in our city although that may have occurred in other cities. I am very open to that suggestion and would welcome pursuing that idea. I think our city should be a Model City in how to provide compassionate care, and I do not think we can afford to go through this laborious process that now exists in terms of getting the funding because we got the programs working. We just need the help to expand them, and use them to show the rest of the country and, as I have said, the world, how to do it so I would welcome that suggestion and would be anxious to work with the Commission or whomever you deem appropriate to try and develop it.

DR. LEE: I notice in your report and from your comments that you are an admirer of Surgeon General Koop.

MAYOR AGNOS: I think he is terrific.

DR. LEE: We share that admiration. One of the crazy thoughts that I have had that I would like to put across to you is if there was a national effort and a national community drive on this problem, would not he be the logical, or the Surgeon General be the logical head of that, number one, and number two, what would you think about bringing health out of HHS and making the Secretary of Health a Cabinet position. Would not that enormously strengthen the health industry and the hand of the Surgeon General?

MAYOR AGNOS: Absolutely. I think they are both outstanding ideas.

DR. LEE: We have a bipartisan position, sir.

MAYOR AGNOS: I was known for that in the legislature.

DR. LEE: The other guys did not --

MAYOR AGNOS: The other guys did not like it, that is all.

CHAIRMAN WATKINS: Dr. Walsh?

DR. WALSH: Mayor Agnew, Agnos, again --

MAYOR AGNOS: That was the Republican.

DR. WALSH: Mayor Agnos, on the -- he was Greek, though, too --

**MAYOR AGNOS:** Yes.

**DR. WALSH:** Again, we find ourselves commending the city of San Francisco for what it has done and the foresight that it has had. I just have a couple of very brief questions. First, in regard to your suggestion about a permanent oversight commission at the federal level, I find myself very concerned about this because I wonder if you would not be recreating the ogre that you are trying to get rid of which would namely be a permanent body that would have extreme difficulty in staying non-partisan. One of the strengths that this Commission has is that we can be very free and totally non-partisan and recommend with a flair if we wish because none of us have permanent ambitions.

Having lived in Washington as long as I have, I find permanent oversight commissions are something that states wish they had never heard of once they got them but I just wanted to comment on that.

**MAYOR AGNOS:** Well, I think that is a thoughtful idea that I see at the city level. When you talk about commissions, you see people, even ongoing commissions, people get on the commission and sort of invest themselves in those, and try to become the very embodiment. I think you can handle those kinds of problems by limiting the term in the creation of the commission saying no one will serve more than two terms or four years or two years or whatever you set. I think you can also put a sunset on the commission itself and say it will have to be renewed in four years or eight years or ten years. With AIDS, we know that this is going to be with us for the foreseeable future. We have no cure, we have no answers, and I think a commission would depoliticize to a much greater extent this disease which has become so politicized.

In the state legislature today, there are some 100, in the California state legislature, there are some 170 different bills introduced by politicians from all parts of the spectrum politically. I want to tell you, with all due respect to my colleagues, they do not know a hell of a lot about AIDS. They are listening to various special interest groups, be they police officers, firemen, consumers, doctors, nurses, religious figures and they all introduce their very narrow, special interest. I do not think that is the best way to form public policy in this state or in this country. We need to depoliticize that process, and we need to put it in the hands of people who will use one single criteria, and that is a public health approach. Every single piece of legislation that I introduced and passed always used that criteria. It was not political, it was not consumer oriented. It was what is in the best interests of public health. That must be the only criteria, and I think a balanced commission

would depoliticize to that extent that that is possible in a much greater way the current situation that we have where we have everybody from the left to the right proposing their solutions to the AIDS crisis and I do not think they have a public health orientation.

**DR. WALSH:** I understand that, and you know we have 45 bills alone before the Congress written by the same type of people in most part that you are talking about.

**MAYOR AGNOS:** That is right. I think we also help the legislature --

**DR. WALSH:** My only concern is, you know, the concern I have raised was, we have seen and heard amply before this Commission the problems even that we have an Interagency Advisory Group in the Federal Government headed by the Assistant Secretary of Health and so on. Basically, they are career people. They are theoretically apolitical and so on, and we have found, at least, I cannot speak for the whole Commission, I certainly have found in my experience that this has slowed progress rather than advanced it. This is my personal feeling, and that is why I raise that concern.

Just a quick question that I want to ask you is several of the mayors who have been before us today pointed out that our recommendation of the 50-50 state-federal division in our interim report simply would be impossible for most states or cities to cover, and they seem to come out with a ratio of 80 percent federal, 20 percent state as something more realistic. Do you subscribe to the fact that, we know that you have a terrible deficit here.

**MAYOR AGNOS:** I was just going to say, Dr. Walsh, I am looking at $172 million deficit in our city.

**DR. WALSH:** I know, but again I mean it would help us because I think we recommended what we did, I think, in good faith thinking it was a very realistic division. We do not want to go in with our final report than less than a realistic recommendation if it is going to have any impact. Would you want to comment on that?

**MAYOR AGNOS:** I do not want to, I think that at least 75-25, if not 80-20 kind of ratio would be the kind of thing that would make it workable for us, 50-50 simply we just cannot handle it. We are going broke right now, and part of our deficit is because of the increased caseloads that we have, and the programs that we have right now dealing with AIDS so I would subscribe in general with the same idea.

**DR. WALSH:** And the other thing that has been raised, I would like your opinion on, is a mechanism to get grants directly to cities without going to counties or states. Do you subscribe to that?

**MAYOR AGNOS:** Yes, I think that is what Dr. Lee was suggesting with his Model Cities approach. I think that our city would be an extraordinary Model City. We already are, we are just not being compensated for it, and we are looking at cutbacks in some of those model programs or at least stopping their growth simply because we cannot afford it and that would be a tragedy.

**DR. WALSH:** Thank you.

**CHAIRMAN WATKINS:** Dr. Primm? Excuse me, Mr. Mayor, we have used up a lot of time, but if you can stay just a little bit longer, I think we will have a few more questions. Do you have a cutoff time?

**MAYOR AGNOS:** No, sir.

**CHAIRMAN WATKINS:** Good. Dr. Primm?

**DR. PRIMM:** Yes, you had indicated this before in your testimony that when you sponsored a bill in the legislature it always had a public health benefit to it. Currently we have been notified that there was such a bill sponsored where you would forbid physicians from telling another physician the HIV antibody status of a patient and also that you would forbid a physician to tell a spouse or a significant other of the HIV antibody status of a patient. Can you comment on that?

**MAYOR AGNOS:** Sure. That was March of 1985, when the Federal Drug Administration issued the HIV test prematurely because there was a kind of hysteria in our state, in our country, around contaminated blood, where people had in good faith earlier donated blood that we then were realizing was contaminated with the AIDS virus. We needed a response to stem the hysteria around blood banks and all of the implications with that.

The FDA rushed this test which they admitted and acknowledged publicly was imperfect, had a high false positive rate, but nevertheless, it was worth throwing out the good blood with the bad blood in a high proportion in order to protect the nation's blood supply. They recognized those weaknesses in this early test, and recommended that procedures be put in place that would protect the people who were taking the test or who were the subjects of the test at that time. So I jumped on it very quickly because we were having the problem here to protect the confidentiality and the security of those people who were the subjects of the tests. It was done with the full knowledge,

support and cooperation of the medical community, both public and private. There was no opposition. In fact, it rolled through the legislation almost unanimously and was signed by the Governor who has not signed many pieces of AIDS legislation in this state so there was no controversy at that time. As I said, it was supported by public health officials, private groups, blood banks, American Red Cross, you name it, they were there. I think only Jerry Falwell opposed it, that type of person but I think he more opposed whatever I did rather than the issue.

So at that time, there was no controversy around it. As the test was refined and improved a little bit and the medical community became aware of some of the uses of it that we discovered there were not the kinds of problems that we initially anticipated which the FDA concurred in, by the way. So over the last two years, I have introduced several pieces of legislation, including one that is right now in the final step of the legislative process waiting to go to the Governor that would loosen up those confidentiality procedures, that would allow for the medical team to discuss among themselves without getting a written permission from each person that was affected by the HIV tests so that a doctor could talk to another doctor or to a nurse or to someone while retaining the information in a separate part of the medical jacket so we have been trying to loosen that up. However, since that legislation also included a restatement of the anti-discrimination portion, the Governor has not seen fit to support it in the past. I am hoping, this year, as the more information is made known to him about discrimination, that he will sign it.

There are other pieces of legislation that are going through now in the legislature since I have left to loosen this up but I just want you to know that over the last two years, as we have become more knowledgeable, this is a disease, as you have learned, we are learning something new every week, every month and so initially, you are correct. We were very restrictive because we just did not know what was going to happen with this imperfect test. As we have seen it put into use, we have learned that we can loosen up those restrictions and I have proposed doing that.

However, let me say in saying that, I do not think that we ought to treat this test like a blood pressure test. I have great faith in the doctors but I do not think they are the gods that they would have us believe they are. We are mandating and seeking to give AIDS education in our high schools as a way of preventing this disease, yet we do not mandate that for doctors who are administering these tests. They are going back on what they learned in medical school in 1952, and certainly we are learning things about AIDS every week that doctors are not mandated to learn but we are saying our high school kids should. I think we ought to balance that before we give the doctor carte

blanche with this kind of information that has so many implications in the social well being, the professional well being, of the patients that they are working with.

**DR. PRIMM:** I appreciate your forthright response and certainly your candor.

**MAYOR AGNOS:** Thank you, sir.

**CHAIRMAN WATKINS:** Dr. Crenshaw?

**DR. CRENSHAW:** I would appreciate a little further clarification perhaps on some of the bills that are before the legislature to amend the original law because as I recall, when attempts were made to amend it so that spouses could be told, that you were not in favor of that, and eventually it was amended and I do not recall whether you supported that or not.

**MAYOR AGNOS:** We did.

**DR. CRENSHAW:** What is your current point of view since the law is still on the books that does not allow a physician to warn a sexual partner? On contact notification, do you still hold the original position that sexual partners should not be told, or are you proposing an amendment and supporting a change in that so that sexual partners can be warned?

**MAYOR AGNOS:** I am sorry, I have had a few other things on my mind in the last three months, and I am not up to date on what the current status of those bills are in the legislature. A colleague of mine, I think it was Assemblywoman Teresa Hughes, was pursuing that spousal notification bill. There was some controversy around that because people were afraid that if it was freely given without the kind of information that should accompany that kind of notification on the part of the doctor, that people would be afraid to go to their doctors. I wanted to see us mandate certain AIDS educational components for doctors who were going to use this test and then inform the spouse about it because right now they can do a lot of damage if they are not properly informed and well educated about AIDS and this test. So I was opposing it because we were not building in the kind of informational educational protections that I think the consumer needs in that kind of circumstance.

You were talking about contact, I am sorry.

**DR. CRENSHAW:** The second part was what is your current opinion or position on duty to warn the sexual partners because the spousal part is being treated separately from sexual partners. What is your current position on notifying sexual partners and duty to warn there?

**MAYOR AGNOS:** Well, I think we ought to use the Public Health model and in using, in informing people, and I think whatever protects the public health, as public health defines those procedures is what we have to follow, and as a politician, I do not want to tell them how to do it. I think they have to tell us.

**DR. CRENSHAW:** But you would not oppose or object to contact notification if it were thought wise by the Public Health Department?

**MAYOR AGNOS:** You know, Dr. Werdegar, who testified earlier, could give you a more specific answer to that because we do have a very good contact model, tracing model in this city, and it is working well, and I am sure he could give you the specifics of it.

**DR. CRENSHAW:** For heterosexuals primarily I believe, but perhaps I need to be updated on that. And then after this, I have one quick bit of advice I need from you. Yes.

**DR. WERDEGAR:** We do contact notification in San Francisco, but it is of a limited nature. We provide contact notification, this is all voluntary of course, as you do not get the information in any other way, to the opposite sex partners of those identified as HIV positive who indicate to us that they would like this information conveyed. It is usually in the circumstance of a man who is HIV positive who either through drugs or through homosexual exposure to the virus has also had female heterosexual contact.

Our view is that the female heterosexual contacts may not have been aware, through educational programs and so forth, that they might be exposed in this way so we provide the notification. We mainly think that, to summarize it briefly, that contact notification, at least in our community, is mainly of value in preventing perinatal transmission of AIDS, and we use it for that purpose.

There is one important point to be made about contact notification to distinguish it from that which is used for other venereal diseases, syphilis, over the years, in the public health context. Those were usually for illnesses that had a short incubation period, and where you could trace and do contact notification over the last weeks or months in which there might have been infectious exposure. Here, we are dealing with a situation where one may have acquired infection from a sexual relationship that dates back six, seven, eight, nine years, and that provides a major practical impediment to doing widespread contact tracing and notification. I might say further that it is an extremely expensive public health measure. We would say that for each attempt at contact tracing and notification, at a

minimum for each person in terms of personnel time and hours, it is perhaps in the order of $200 so when you are looking at resource expenditures for prevention, this would not be high on the list.

**DR. CRENSHAW:** This is one of the things the Commission is trying to struggle with because balancing the $200 budget figure against not reaching someone in time and then the cost of treating them is really quite a dilemma.

**DR. WERDEGAR:** In setting the priorities, therefore, just so I could reiterate, I would use it where there is possibility of preventing perinatal transmission. That is what I think is the most effective use of contact notification on a voluntary basis.

**DR. CRENSHAW:** Gosh, I would hope you would use it to protect the women along the way. I am advocating a lot of attention to women that sometimes I think get overlooked and we skip right to the babies, but be that as it may, one thing I would really appreciate your help on, Mayor Agnos, is that we just heard from Mayor O'Connor, who is having a very difficult time releasing any funding from San Diego for AIDS education and prevention. You succeeded in letting or getting funding, the million dollars you talked about to begin with when you had no federal support and no outside help, and managed to do that before you were Mayor. Can you give any practical recommendations to a Mayor in San Diego who is trying very hard to get local funding as federal funding is not yet available there to get more action, more effort, more energy, devoted to this problem? She indicated that since the Public Health Department had not declared it an emergency locally that $6 million that they are holding cannot be attributed to the disease because of the Proposition 13 restrictions but I would think with your being very street wise, and having had to fight these battles up here, there might be some methods that would not have yet occurred to us yet in San Diego.

**MAYOR AGNOS:** I just met Mayor O'Connor a couple of days ago. I will call her and see what we can do about giving her some advice. I need more advice from her than I can give to her about how to deal with some issues so maybe we can work together.

**DR. CRENSHAW:** I would really appreciate that.

**MAYOR AGNOS:** Thank you.

**CHAIRMAN WATKINS:** One quick follow up and then we must close.

**MRS. GEBBIE:** Just a follow up question to Dr. Werdegar. We have heard a couple of different cost calculations on contact

notification programs, either on a cost per unexpected case found or cost per contact, and it would be helpful to have your figures from your program here in San Francisco, if you could supply them to us, just for comparison with the other information we have gotten.

**DR. WERDEGAR:** I will ask Dr. George Rutherford, the head of our AIDS office, to furnish these to the Commission.

**MRS. GEBBIE:** Thank you.

**CHAIRMAN WATKINS:** Mr. Mayor, we thank you for the warm reception the Commission has received here in San Francisco. It has been a very useful and fruitful event for us. We have learned a great deal from a great city, and we thank you very much for your courtesies.

**MAYOR AGNOS:** Thank you, sir.

**CHAIRMAN WATKINS:** That will complete our hearings here in San Francisco, and we now stand adjourned, as we depart for site visits at the San Francisco AIDS Foundation, San Franciso General Hospital, and Bayview-Hunter's Point Foundation.

(WHEREUPON THE HEARINGS WERE ADJOURNED.)

# APPENDIX

Asian AIDS PROJECT

Presentation before the Presidential Commission on AIDS

Davis Y. Ja, Ph.D.
Executive Director
Asian AIDS Project

The Asian AIDS Project since its recent inception early last year is the only Asian specific program in the United States providing health education, prevention, training and research. It currently has an operation budget of $229,000 annually and a staff of six.

The bulk of our activities this year is in AIDS education; we will target all the major Asian ethnic groups such as Pilipino, Chinese, Japanese, Korean and Vietnamese. While some of our education outreach will be conducted through our health education staff, we will also be utilizing educators of the various sub-contracted community agencies.

Our education activities include presentation, media outreach, and brochure development and distribution. In addition to educating the lay public, we will also train Asian health, human service professionals and community leaders. Another major component of our education program is an Asian model of the "Stop AIDS Project," where we will educate Asian gays through facilitators recruited from the Asian gay communities.

To date, little is known regarding knowledge, attitudes and risk behavior around AIDS in our community. However, we need this information in order to effectively educate the community. To meet this need for information, we have and will conduct several needs assessment and research projects.

We were awarded a contract in 1986-87 to conduct focus groups with the Chinese, Japanese, Korean and Pilipino communities to determine the best method of measuring the attitudes and behaviors that may place their communities at risk from AIDS. We are now applying for a proposal to conduct a baseline survey of knowledge, attitudes and risk behavior around AIDS in our community. Currently, we are also conducting a survey of Asian gays and bisexual funded

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A project of Asian American Recovery Services, Inc.

by the Center for AIDS Prevention Studies (CAPS) through the National Institute of Health. The pilot study titled "AIDS-associated high risk behaviors among Pilipino and Chinese gays and bisexuals in San Francisco," will provide information vital to our program planning and development.

Besides providing education in and assessing the needs of our community, we are also organizing an extensive task force with a total membership of over 300 individuals comprising of professionals, activists and individuals concerned about AIDS.

The most difficult aspect of our efforts to educate the Asian community is the heterogeneity within our community. There are 32 distinct ethnic groups with different languages, attitudes, traditions and behaviors. The vehicles and processes to reach this distinct communities would have to be different. This diversity is often overlooked in the past in program development, resulting in inappropriate and inaccessible services.

The need for culturally specific services for our community is crucial, given the presence of cultural attitudes regarding AIDS in most of our communities. Issues such as difficulties with discussion of sex, contraceptives and terminal illnesses are prevalent in most Asian communities. There is also widespread misconceptions regarding the disease throughout the community; AIDS is often perceived as a "gay white" disease. This perception is certainly exacerbated by much homophobia in the community.

It is clear then that education and prevention programs need to be responsive to issues of diversity in language and culture, differences in channels of accessing the community and cultural attitudes that are barriers to education in order to be effective.

Questions for the Presidential AIDS Commission

1. What are the most significant problems that AIDS has brought about in the Asian community?

2. What are the barriers ot AIDS education in your community?

3. What are the most effective strategies of educating the Asian community about AIDS?

## Presentation before the Presidential Commission on AIDS

Davis Y. Ja, Ph.D.
Executive Director
Asian AIDS Project

Recommendations:

1. AIDS education programs should be responsive to the heterogeneity within our community. The diversity of ethnicity, culture, sexual orientation, national origin and social economic status should be considered.

2. AIDS education and prevention resources for Asians needs to be expanded. Existing community-based organizations in the Asian communities should be provided with these resources since they have access to the population.

3. In order to provide better services, AIDS surveillance programs such as the Center for Disease Control needs to break out the data into specific Asian ethnic groups and other sub-groups.

4. There should be a coordination of efforts in developing educational material (whether it is audio, visual or print) for the Asians nation-wide.

5. As the number of Asian AIDS cases increase, agencies providing direct services should be made more responsive to the Asian community. Furthermore, support groups and counselling programs for Asian PWA's should be established.

6. More AIDS sero-prevalence, attitudinal and behaviorial research should be conducted in the Asian community.

7. There should be increased funding for training of providers working in the Asian community. Asian providers need to be trained on basic AIDS knowledge, homophobia and sexuality issues, while non-Asian providers need to be educated on cultural sensitivity.

The Black Coalition on AIDS has existed since early 1986 when Noami Gray, a San Francisco Commissioner of Health, brought together Black leaders around the Bay Area Black to discuss the impact of AIDS on our communities . From her perspective on the Commission she had seen spiraling funding for AIDS education and few activities directed toward the Black population. Her invitation was a challenge to the Black community to define and advocate for our own needs. Out of that challenge we have created a broadly based organization including over 200 individuals and agencies committed to the education and service needs of our community.

The aim of the Coalition is to insure aggressive, culturally grounded, education and service to the Black community. However, we do not wish to become an educational or service program. Rather we foster and support the expansion of the work already being done in community-based agencies to include a focus on HIV infection. Many of these organizations have the expertise to identify and intervene with specific persons at risk, but have not had the awareness or technical skills to tackle AIDS up to now.

We have worked for the inclusion of the needs of all people at risk in ongoing city AIDS efforts, the elimination of institutional barriers to care (such as racism, sexism and homophobia), for increased research on the course of HIV infection done by Black researchers, and for the appropriate level funding of indigenous programs for education and service delivery. Moreover, the Coalition has become a resource for the development of new strategies to combat AIDS among Black Americans. Much of our activity, therefore, has been advocacy.

However, specific activities of the Coalition have included a press campaign to publicize the problem in minority communities and the lack of response by the City Department of Health; the development of a consensus paper on antibody testing; AIDS Awareness Month November 1986 in the Black Community; creation of personalized educational media e.g "Black people get AIDS too" buttons; assistance in the development and implementation of the nations first population-based survey of knowledge, attititudes, and behaviors in the Black community; On-going efforts to affect responsive and responsible public policy in the San Francisco AIDS Activity Office; technical assistance in the creation of informational brochures for the expanded anonymous antibody testing program; creation of a speakers bureau to reach Black people.

We began as administrators, researchers, ministers, health care professionals, health officials, and have with time reached more broadly into the community. The independent, volunteer-run organization now consists of both gay and heterosexual members including people with AIDS/ARC and families and loved ones of PWAs. With that expansion come new concerns and direction for the Coalition efforts: The facilitation of support groups for Black PWAs and families; the creation of resource lists of Black therapists, lawyers, hairdressers, etc. available to work with PWAs;

outreach and networking with those key groups within the community which reach significant members at risk; the development of a patient bill of rights for people tested for HIV. We are increasing being asked to take on a resource and referral function, and the role of the BCA will continue to change as the needs and awareness in the community change.

You will hear it said that massive homophobia and denial among Black people is responsible for the poor success of city efforts in our community. In fact we are asking Black heterosexuals to take on AIDS with all its phobias, and the Black people of San Francisco, gay and straight, have come together to struggle with this epidemic in a way unparalleled in the White community.

We bring several concerns to this Commission today. The first is the challenge of the now popular notion that AIDS is an new issue in the Black community. In fact the earliest reports to the CDC included a substantial proportion of Black and Latino gay men and health anomalies were seen in IV drug users not long after. Our community has simply been the last addressed not the last infected. Similarly, we must do away with the distinctions between the Black populations at risk and the so-called "general public". The subtle "them-us" racism in such typology only serves to feed avoidance in the Black community. Nor should AIDS in minorities be considered an secondary issue as if there exists two diseases, AIDS and Minority AIDS. The media as well as public and professional educational forums isolate all discussion of people of color to a single program or workshop. Certainly important cultural, economic and psychological issues distinguish AIDS in different communities, and these differences must be understood and utilized; however, the many peoples and cultures which are homogenized under the term minority can only be wholly served when their disease is viewed as an integral part of the American AIDS epidemic, not a sidebar issue. Nor should White America be assuaged by the sense that AIDS only effects others.

Having said that, there are specific education and service needs for our community. We believe that the most effective resources for outreach have been untapped. It is not true that Black churches are an obstacle to our work; we regularly recieve calls from clergy and church members asking to become involved. The process is slow, and every one will not join the effort, but if taken on their own terms they have much to give. Rather than belittle them we must actively engage them at a national level as a source of credibility, man-(or should I say woman-) power, and spiritual support in the Black community. Black PWAs tell us of their desire to be embraced by the Church as a statement that they are not abandoned by the community. If we are to keep the cost of AIDS down we must enlist the wonderful, loving men and women who serve the church on a volunteer basis. A national initiative to affect this involvement is necessary.

Other frontline workers must also be top priority for federal and local support. A centralized AIDS program will never be as effective in the Black community as the funding of many small organizations dealing with drugs, alcohol, teens, women and children, and sexually transmitted disease. All the clever brochures in the world does not change behavior as does the personal contact with people we trust. These community programs already know the people, the needs, the language; they do not need sensitivity training. Funding and technical assistance will ultimately be the fastest, most effective and cheapest strategy. After all, these organizations are the ones who will bear the brunt of the growing epidemic anyway and who are probably already serving PWAs.

Teen education is crucial to us. The data on STDs and drug use among Black adolescents makes it clear this population, our future, is at risk and unreached.

We feel AIDS is not just an IV problem, it is a drug problem. The sexual risk to non-IV women, for example, is extremely high. They have more partners, riskier partners and do more unsafe sexual activity. They may trade sex for drugs with men who are IV users. Yet this largely cocaine- and crack-using population considers itself outside danger because they have heard needles are the transmission risk. The national initiative on drugs must be strengthened by the awareness of the connection of these two epidemics.

However, the majority of Black PWAs in SF are gay or bisexual, as are the substantial number of those Black persons infected across the country. We believe these men have fallen between the cracks. They have remained underserved by gay or Black programs. The incredible figures on knowledge and behavior change among gay men do not reflect the isolated, Black-identified gay man. They do not recieve the same education and service and they are continuing to become infected at an alarming rate. In the haste to declare the epidemic over in the gay community, we must not forget these men who have been left behind.

Finally we know from our involvement with service programs around the state that the Black PWA presents new care management issues. They are dying alone, frequently only coming for medical services when they are too sick to walk, incontinant, demented. They then require crisis care or intensive support and complex case management. We must have specific studies of the cost of care to minority PWAs because allocations now set will probably not be sufficient to these needs. We must support active outreach to infected persons regardless of diagnosis to encourage early intervention and inclusion of family support. We must expand in-home services with Medicaid and other third party funding to keep the costs of treatment down and provide the ill or dying persons of our community with on-going care and dignity.

INSTITUTO FAMILIAR DE LA RAZA, INC.

ADDENDUM TO ORAL TESTIMONY

**TOWARD A RESPONSIVE APPROACH TO THE LATINO COMMUNITY: NEEDS & RECOMMENDATIONS TO ADDRESS THE AIDS CHALLENGE**

Concha Saucedo, PhD
Excutive Director Instituto Familiar de la Raza
San Francisco, CA
March 24, 1988

It is common knowledge that the incidence of AIDS is disproportionately greater in the Hispanic and Black community than in the dominant culture (together we number 19% of the population, yet our incidence rate is nearly 40%). What are not so common knowledge are the unique problems and needs our community faces in halting the spread of the epidemic and in insuring quality services for Latinos with AIDS. This presentation briefly outlines some of the problems and needs the Instituto Familiar Latino AIDS Project has documented through the casework, educational and investigative services our program has provided during the last year.

**AIDS EDUCATION**

Two of the main reasons for the continued increase of AIDS cases in the Latino community continue to be the lack of sufficient educational resources and a culturally appropriate educational strategy.

Existing AIDS educational policy and resource allocation focuses attention on minority high risk behavior groups and ignores our community's most valuable resource, our community-at-large. The Latino community requires educational resources for both high risk target groups as well as those other segments of our community which could become motivated to become layperson AIDS educators, such as church people, mothers, youth, etc. Due to the strong cultural denial of Latino homosexuality and drug use, there is an even greater need for holistic AIDS education for our communities -- AIDS education that also includes such areas as communications, sexuality, community/family responsibility, etc.

Our need is for policy and financial resources to engage in a proactive AIDS education strategy, an educational approach that not only seeks to halt the epidemic, but to motivate Latinos to serve and care for those in our community who become infected with AIDS. This need for inspiring community responsibility is critical given the lack of sufficient bilingual/bicultural health professionals with our present medical/health systems. Interviews with 14 of the main AIDS service programs in San Francisco underscored both the lack of sufficient bilingual health professionals and the dire need for Latino volunteers who could serve to provide emotional support.

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**AIDS SERVICES**

The AIDS epidemic is casting a light on the existing deficiences of our various health care systems-- one of the greatest is the lack of bilingual/ bicultural health workers. Consequently, Latinos with AIDS have experienced the following hardships in San Francisco:

- o Patient dying over a course of 6 weeks with no Spanish-speaking professionals or volunteers on staff.
- o Patient's reluctance to use services because there were no Latinos present who he felt could understand his situation.
- o Patient leaving hospital against medical advisement due to the harsh manner in which diagnosis was given and the general lack of explanation of what was being done to him.
- o Patient unable to secure a Latino therapist.
- o Patient being discharged without clearly understanding diagnosis or how to care for self.
- o Patient unable to find a Spanish speaking support group.
- o Patient unable to find a volunteer AIDS program in which he could serve Latinos and also feel the support of Latinos.

The healing process requires that patients understand their illness and treatment options and are able to participate with medical staff in improving their health. Such healing becomes compromised if communications are not possible. This is often the case for Latinos who are monolingual Spanish speaking or limited English speaking, and whose number is typically greater than most realize. For example, in San Francisco up to 66% of Latinos with AIDS are either monolingual Spanish speaking or prefer Spanish for communicating on such critical or emotional issues as illness and health. While a number of AIDS services in San Francisco have sought to remedy this need, a considerable number still have NO bilingual staff whatsoever.

The staffing problem is multi-faceted. Some programs need to be encouraged to hire Latino staff. Others have sought to employ bilingual/bicultural nurses and social workers, but the demand is greater than the pool of professionals available. There is a tremendous need for a strategy to recruit and retain Latinos into the health professions, particularly in medicine, nursing and social work.

Until appropriate numbers of Latinos can be trained and employed within the health systems, there is need to provide for cultural sensitivity training for existing health professionals. In our survey of San Francisco's AIDS programs, all concurred with their staffs' need for general cultural sensitivity training, and especially, training and consultation for working with Latinos. In particular, they expressed their need for cultural understanding and skills for the following:

- o How to do risk assessment among Latinos?
- o How to communicate the diagnosis with sensitivity?
- o How to work with the denial often related to the diagnosis?
- o What words to use to educate regarding AIDS and safe sex?

- o What to do when the patient is dying and doesn't want his family to know about the AIDS, yet the family wants to understand what is happening to their son?
- o How to facilitate reconciliation among the patient and family, or patient, lover and family?
- o How to communicate to the family regarding issues of death and timing of death?
- o How to support the Latino patient work through issues of guilt, coming out and death?

**SOCIAL SERVICE AND MENTAL HEALTH NEEDS**

Responsive health care requires responsive social and mental health services.

In a study conducted by the Instituto, we found the following needs as paramount to Latinos at the time of intake -- soon after their initial hospitalization and AIDS/ARC diagnosis:

- o Financial assistance 63%
- o Access to support services (e.g., homecare, hospice, etc.) 34%
- o Housing 30%
- o Aid to resolve insurance issues 20%
- o Legal or immigration assistance 16%

Subsequently, during the course of the illness almost 60% encountered tremendous difficulties insofar as maintenance of housing. Their problems included:

| | |
|---|---|
| o Need for immediate money to pay rent coming due: | 21% |
| o Need to move because of inadequate housing (overcrowded, lack of cooking facilities, inadequate heat, etc.): | 21% |
| o Housing became unaffordable because of diminished income: | 15% |
| o Illness left person without housing: | 15% |
| o Person living alone, now needs roommate for care, companionship or to help pay rent: | 15% |
| o Already homeless: | 6% |

Insofar as mental health services are concerned, the Instituto has documented up to 70% of their AIDS casework population as in need of "mental health sensitive" casework and counseling, and periodic psychiatric consultation. Critical to appreciate is the need for a more holistic mental health or casework approach to serving Latinos with AIDS, which is evidenced by the multiplicity of services which have been required by Instituto's caseworkers. These services have included:

- o Advocacy to obtain needed resources (i.e., benefits).
- o Advocacy to insure patient rights.
- o Advocacy to obtain needed services (i.e., residential care).
- o Being a friend: providing support, hospital visitation, sharing humor and respect.

- o Brief counseling and psychotherapy.
- o Coordinating services.
- o Consultation to other providers on cultural issues or community resources.
- o Education and information concerning benefits of AIDS.
- o Enlisting or providing spiritual support (i.e., conventional, traditional and non-traditional).
- o Facilitating family reconciliation.
- o Home outreach.
- o Mobilizing or developing a support system.
- o Planning assistance regarding finances, life and funeral arrangements.
- o Providing support to remaining partner or family.
- o Securing volunteer work.
- o Translation.
- o Transportation.

**AIDS TRAINING FOR LATINO PROFESSIONALS**

There is need for greater mobilization of Latino professionals to respond to the AIDS challenge. This requires necessary education, outreach and training programs. Several recent outreach efforts illustrates this need.

o Instituto Latino AIDS Project surveyed 95 Spanish-speaking counselor/therapists in San Francisco for their willingness to work with AIDS clients. Only 18 responded positively. Yet, the key reason for reluctance to respond appears to be the need for education/training, given that 90% of the respondents expressed an interest in AIDS related training, and in particular on how to work with Latinos with AIDS.

o The Instituto also conducted interview surveys with 24 Latino Community agencies, of which 79% expressed an interest in AIDS in-service training. In particular, many of the program representatives expressed the need for their program staff to work through issues of AIDS myths, fears of contamination, homophobia and difficulty in accepting IV drug addicts.

o The Spanish Speaking Hotline of the San Franisco Foundation mailed out 200 letters to potential Latino referral sources; e.g., attorneys, counselors, doctors, dentists, etc. The outcome was a list of only 20 who were willing to be considered as a referral source. Their analysis was that more educational outreach is necessary in the community.

**FOCUSED LATINO PROGRAMS**

The following programs are seen as necessary for the Latino community.

o The need for culturally appropriate and language relevant educational material; e.g., brochures, home training packages, posters, radios programs, videos, etc.

- o The establishment of several regional and national clearinghouses for the collection, cataloguing, general availability and disbursement of relevant Latino eduational material.

- o Priority use of Spanish radio and television programs for education. The Fairbank, Bregaman & Maullin Study (1987) indicated that "Spanish language television/radio programs" were the greatest source of health information for Latinos in San Francisco.

- o Priority use of the schools for AIDS education. The same Fairbank study indicated that 82% of Latinos in San Francisco felt that AIDS education should be done in the schools. The Latino AIDS Project Survey of Community Agencies has also highlighted the schools as one of the most effective ways of mobilizing community education.

- o Prioritize the need for local and regional trainer-of-trainer programs. The Latino AIDS program has received numerous calls from concerned Latinos throughout California requesting services to train AIDS educators. The pool of Latino Educators could be dramatically increased with a Statewide trainer-of-trainer program.

- o Prioritize the need to develop and document therapeutic and mental health strategies particular to the Latino population. The Instituto Latino AIDS Project has already begun to identify the unique cultural, familial, economic, social and spiritual needs experienced by Latinos with AIDS that indicates the need for a particular therapeutic approach. The same issue relates to the need for theory to explain the most appropriate ways for engaging Latinos in community eduation.

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# AIDS AND THE LATINO COMMUNITY

Testimony to the Presidential Commission on HIV Epidemic

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## Demographic Profile

The United States has the six largest "Hispanic" population in the world, exceeded only by Mexico, Spain, Colombia, Argentina, and Peru. According to the official U.S. census, between 1970 and 1980 there was a 61% increase in the Latino population in the United States from 9.1 to 14.6 million persons. Including estimates of uncounted, undocumented persons and adjusting for growth since 1980, there are probably more than 20 million Latinos, or 8% of the total population in the United States. Demographic projections buttress the contention that Latinos may become the largest minority group in the United States by the year 2000.

Latinos of Mexican origin are the largest subgroup with 59.8% of the total, followed by Puerto Ricans (13.8%) and Cubans (5.5%). The category of "other Hispanics" comprised 20.9 % of U.S. Latinos in 1980, and this many now actually be greater as a result of the recent influx of immigrants from Central America. Most Latinos live in urban areas (87%), and 82.9% are concentrated in eight states with California and Texas containing 51.6% of the total. In 1980, nearly a third of Latinos were foreign-born and approximately 25% spoke little or no English.

In California, 20% of the population is Latino and most are of Mexican origin. Los Angeles and San Jose have the largest proportion of Latinos, who make up nearly 30% of their populations. In San Francisco, Latinos of the other Hispanic category outnumber those of Mexican origin.

## Epidemiology of AIDS and HIV Among Ethnic Minorities

Nationally, 41% of all reported AIDS cases are Black, Latino, Asian, Pacific Islanders or Native American. The disproportionate representation of Blacks and Latinos is most pronounced in three transmission categories: 1) Heterosexual intravenous drug users; 2) Heterosexual partners of persons at risk for AIDS; 3) children of parents at risk for AIDS. Specifically, 80% of all heterosexual intravenous drug users with AIDS are Black or Latino, 84% of AIDS patients who acquired HIV infection heterosexually are Black or Latino, and 87% of children with AIDS who acquired HIV infection perinatally are Black or Latino. Additionally, Blacks and Latinos comprise 74 % of women with AIDS and 56% of adolescents with AIDS.

Thus, nationally while AIDS cases among homosexual and bisexual men are relatively evenly distributed by race, AIDS cases among heterosexual intravenous drug users, their sexual partners, and children are predominately diseases of Blacks and Latinos.

**The Latino Community AIDS Education and Prevention Project**

In late 1985, a half-dozen Latino activists began to meet informally to discuss their concerns about the impact of AIDS on Latinos. They shared a frustration about the lack of AIDS programs that were linguistically and culturally relevant to the Latino Community of San Francisco. In May 1986, these activists convened a day-long __conocimiento__ (knowledge) that assembled a cross-section of the Latino Community. The __conocimiento__ was a conclave to share our awareness and understanding of AIDS and to assess our community's needs. A tangible outgrowth was the formation of the Latino Coalition on AIDS/SIDA. The Coalition consists of community-based Latino agencies, gay and straight individuals interested in promoting AIDS awareness within the Latino Community.

In June 1986, the Instituto Familiar de la Raza, Inc. on behalf of the Latino Coalition, responded to a state request for AIDS education projects targeted to minorities. El Instituto is the only bilingual/bicultural program providing mental health services to San Francisco's Latinos. Its objectives include direct outpatient services targeted to prevent family disintegration and institutionalization, as well as the promotion of cultural values, and customs to strengthen the community.

In July 1986, the state approved a grant of $ 131,000, and the Latino Community AIDS Education and Prevention Project started in August. The Project is the city's only AIDS organization specifically for Latinos,its first goal is AIDS education and prevention for Latinos, but it does far more. The Project has become a clearinghouse for all AIDS related matters in the Latino Community.

At first the Project tried to educate the entire Latino Community about AIDS, but now they are concentrating on specific high risk groups: men engaging in high-risk behavior; intravenous drug users; and youth - especially those out of schools.

The Project has created a model educational vehicle, that is culturally sensitive to Latinos. The product is a 51-minute video "telenovela" called "OJOS QUE NO VEN", (EYES THAT FAIL TO SEE) a Spanish language soap-opera that includes characters from several high risk groups.

The Project's health educators travel all over the city and throughout the Latino Community to make their presentations. Meetings are held in churches, English as a Second Language classes, schools, confidential house meetings, worksites, health fairs, businesses and organizations. The Project also provides individual peer counseling. Each talk is tailored to the audience, be it

recent immigrants, school kids and teenagers, straight couples, gay men, women or IV drug users.

$162,000 is slated for education, prevention and outreach among Latinos this year. Unlike last year, this year the money comes from the San Francisco Department of Public Health (DPH). This is the first time the DPH has ever given funds to a Latino AIDS Service Organization. In addition to engaging in preventative education, the Project is conducting a need assessment study and is involved in case-management/counseling. The need assessment study is a survey to determine the availability of bilingual/bicultural therapists to San Francisco's Latino population with AIDS, their experience in working with Latinos with AIDS and their training needs.

Minorities need special educational approaches which take language and cultural norms into account. For educational materials to have the maximum desired effectiveness, it is essential to have not only bilingual staff but also bicultural staff participating throughout all stages of development. The message must originate in Spanish, and with appropriate Latino Cultural values. Translating into Spanish a message that is in English and targets the general public will have little effectiveness with Latinos.

I foresee the AIDS epidemic settling into the incidence patter of many communicable diseases - that it will be more prevalent among minority and low-income groups. As educational efforts take hold the more educated, more easily reached populations will change their behaviors and more effectively prevent the illness. Chronic drug users who are hardest to reach and least likely to change their behaviors will continue to get the disease. Poor and minority groups who are also less likely to be reached by a general public education campaign will also be slow to learn prevention methods and will continue to get the disease at a highly rate.

Recommendations:

1) Board of Directors of CBO's determine mission policy, direction, priorities, allocation of resources and staffing patterns of their agencies. Significant minority participation at the highest policy level of federally-funded AIDS service programs could provide the perspective and leadership needed for programs to be more responsive to the needs of minorities.

2) Prison populations in this country have disproportionate high numbers of minority inmates. AIDS has been diagnosed among prison inmates. Many inmates of penal institutions come in

contact with the justice and corrections systems as a consequence of their direct or indirect involvement with IV drug abuse. These facts state the need for increased education about high-risk behaviors and for training prison officials and personnel about AIDS, the care and needs of incarcerated PWA's/PWARC's, and to calm unfounded fears about HIV transmission.

3) The greatest need is for Spanish language information, but much English language, culturally-sensitive information is also lacking, especially for adolescents. Adolescents are at risk because they often experiment with drugs and sex. Schools need to be encouraged to develop AIDS education programs for inclusion into their curriculum as one of many sexually transmitted diseases that adolescents should know about.

4) In order to successfully market AIDS prevention to the Latino Community, it will be necessary to identify and target specific subgroups within the community for particular messages, given through certain channels. Messages for teens must be linguistically relevant, often given by age peers, in formats that attract attention, such as RAP contests, creation of videos, or comic books. Rather than focusing exclusively on AIDS, such messages and activities might include issues like pregnancy, drug use, and other risk behaviors that tend to cluster with AIDS risk.

6) Women are at risk if they use IV drugs or have high risk sexual partners. It is important to target this group for educational efforts because many women do not realize that they are at risk and do not realize that they can pass the virus to their children during pregnancy and childbirth. Counseling and testing for antibodies to the AIDS virus should be routinely offered at federally-funded prenatal and family planning clinics.

7) Given the stigmatization of AIDS and the potential for discrimination, antibody testing needs to be anonymous and voluntary.

8) Where necessary, expand or supplement existing AIDS information hot-line telephone services to meet the needs for bilingual services.

9) There is a demonstrated value and need for workshops and training on racism, homophobia, and cultural sensitivity.

10) Institute a program of information and education to funding sources, public and private, about the need to support AIDS funding in general and targeted programs for minorities in particular.

11) Work with federally-funded AIDS service programs and appropriate government agencies to establish evaluation criteria and strategies to monitor the efficacy of AIDS related programs with respect to minority communities.

12) Minorities need special educational approaches which take language and culturally norms into account. It is essential to have staff that is bilingual <u>and</u> bicultural design and develop educational materials intended for Latinos. The message must originate <u>in Spanish</u> and be culturally sensitive. Translating into Spanish a message that is English in origin and that targets the general public will have limited effectiveness with Latinos.

13) Commission stafff member, Frank Hagen, facilitated a screening of the Project's telenovela "OJOS QUE NO VEN", by Gilbert Cardona, Chief of Resources & Clinical Branch, New York Regional Office, U.S. Public Health Service. Mr. Cardona has hailed the video as "...a valuable tool for educating Latinos because it is sensitive to the cultural values of the audience which it is intended..." . Mr. Cardona recommends that the Public Health Service make use of the video at federally-funded prenatal, family-planning clinics, and other health care clinics.

Report
to the

President's Commission on AIDS

March 24, 1988
San Francisco, California

by

Phil Tingley, MSW
on behalf of:
The Native American Community

It must be noted that most of the top ten (10) causes of early sexual debut are related to alcohol and drug abuse and that Native American populations have the highest levels nationally for alcohol and other substance abuse. Not surprising then was the report from the National Center for Health Statistics that showed a Native American teen pregnancy rate of 20.8% nationally.

Additionally, it was not surprising that the Center for Disease Control's 1985 study of seven (7) States with large Native American populations reported sexually transmitted disease rates that were ten (10) to one hundred (100) times higher than the national average.

One must understand that the nation's American Indian and Alaska Native population is relatively small, and for this reason, prevention is critical.

Projecting from our high levels of substance abuse, STD's and teen pregnancies, if our populations do not receive a 100% level of AIDS prevention education, we will be looking at the final chapter in Native American history after the year 2000.

Report to the

President's Commission on AIDS

March 24, 1988

The Indian Health Service, who has the primary responsibility for health care for the nation's Native American population, has repeatedly refused to deal with this issue. Indeed, as late as August of 1987 the Indian Health Service stated that "AIDS is not as Indian problem" at the Center for Disease Control's Conference on Minorities and AIDS.

Yet we know that there are American Indians who have AIDS. Unfortunately, the Center for Disease Control only reports 53 current cases. It is surprising that they have any data at all. There is presently no uniform method of reporting AIDS cases from Counties to States or from States to the CDC, anywhere in the Union.

Even under such adverse conditions, however, the local American Indian and Alaska Native community has proved to be very resourceful. All of the local Indian community-based organizations and AIDS activists have come together to combat the epidemic and to prevent the spread of AIDS within the community. We have trained local Native American community members as emotional support counselors and community prevention educators. We have begun to develop AIDS prevention and education materials that are culturally relevant and appropriate. And we are developing community-based support networks for persons with ARC and AIDS and their families and love ones. In keeping with our concerns, we therefore have the following recommendations.

## Recommendations:

A. Prevention, Education and Information

1. Prevention education must be culturally relevant and culturally appropriate.

2. Dollars must be made available to Indian community-based organizations and tribal governments.

3. Non-indigenous care systems must recognize the reliance of Indians on traditional Indian medicine practices in additional to western medical practices.

4. Indian Health Service substance abuse prevention and treatment programs must include funding for drug abuse prevention and treatment.

B. Direct Services to Persons with AIDS

1. Funds must be available for case management services since the majority of the Indian population relys on tribal government, Bureau of Indian Affairs, or community-based organization social services agencies as their primary services agencies.

2. Fund for emergency, transitional, and permanent housing must be made available for persons with ARC and AIDS.

3. Funds for home care services that are culturally sensitive must be made available.

4. Funds for peer counseling and culturally appropriate psychotherapy must be made available.

## Recommendations:

C. Research

Funds need to be appropriated for:

1. Studying the level of intravenous drug use among American Indians.

2. Studying the Seroprevalence among American Indians.

3. A discrete category for "American Indian-Alaska Native" must be established in all reports from states and especially from counties to states on AIDS and ARC cases specifically and all sexually transmitted diseases generally.

AIDS

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## PRESIDENTIAL COMMISSION TESTIMONY

## COMMUNITY-BASED AIDS EDUCATION---THE NATIONAL PERSPECTIVE

Bea Kelleigh, Executive Director
Northwest AIDS Foundation

My name is Bea Kelleigh and I am the Executive Director of the Northwest AIDS Foundation. I appreciate the opportunity to speak with the commission this morning on behalf of our community response to the AIDS epidemic.

The Northwest AIDS Foundation was established in June of 1983 by leaders of the gay and medical communities to respond to the AIDS epidemic in Seattle-King County and Washington State. At that time, only seven people had been diagnosed with AIDS in Seattle and King County.

Our mission is two-fold: to provide the education that can stop the spread of this disease and to build a network of home and community-based services to allow the thousands of people who are seropositive and will require care to stay in their homes and communities as much as possible and out of expensive hospital beds.

Our social services for People with AIDS are based on a continuum of care approach with the recognition that those living with this disease need assistance with a broad spectrum of services ranging from case management, low-cost housing, and chore services to home health care and emotional support. The Northwest AIDS Foundation directly provides case management services, Information and Referral, housing assistance and emergency financial assistance. The Case Management program, which has as its goal preventing crises such as unnecessary hospitalization and eviction, is now serving 105 people with AIDS in the area. Over the past two years, we have served 40% of the people with AIDS in our area. 70% of our clients live on less than $400.00 per month, 90% are unemployed when they come to us, and 15% are people of color.

In the interests of building the network of needed services, the Foundation acts as a lead coordinating

agency for the range of community-based social services. The Northwest AIDS Foundation acts as a grant maker and funding source for Chicken Soup Brigade which provides voluntary chore services, meals, and transportation assistance, and Shanti Seattle and the Seattle AIDS Support Group which offer emotional support.

AIDS prevention is the number one goal of our education programs. We work directly with gay and bisexual men, offering public education like the "Please Be Safe" and "Be Well Equipped Campaigns," workshops focusing on healthy lifestyles, peer support groups, and trained community volunteers who help other community members make and maintain a commitment to a safe lifestyle. The Northwest AIDS Foundation also collaborates with multicultural groups like the People of Color Against AIDS, the Women & AIDS Task Forces, and the Seattle King County Department of Public Health to provide and support AIDS education for other communities.

Each of the collaborating organizations working on preventing the further spread of this disease seeks to help people at risk maintain safe behaviors over time. In doing this we ask individuals to set the highest possible personal goals that are achievable and can be sustained. For many of those at highest risk, gay and bisexual men, and people who use IV drugs, a monogamous married relationship is not possible or realistic. We encourage those for whom marriage and abstinence are not realistic, to use condoms consistently. In our education materials we have used language and illustrations that are straight-forward and easily understood to help people substitute low risk activities for high risk activities. This approach has been effective. Over the past 4 years we have seen a reduction of 80% in sexually transmitted disease among gay men.

In 1987, 800 volunteers contributed over 70,000 hours to the education and service programs of the Northwest AIDS Foundation, the Chicken Soup Brigade, Shanti Seattle and the Seattle AIDS Support group. Like other communities across the country, we are concerned that the volunteer resources will not be able to keep up with the rapidly growing need. Even in Seattle and King County with 573 people diagnosed as of March 2, 1988, people with AIDS are staying in the hospital unnecessarily long for lack of nursing home beds and personal care services.

In conclusion, the Northwest AIDS Foundation has helped build the beginning of the public-private corporate partnership in Seattle-King County and Washington State, necessary to respond effectively to the AIDS epidemic, and as a community-based organization, the NWAF has worked with health officials and others throughout the state to (1) assure that AIDS education is straight-forward and effective, and that services programs are sensitive and responsive to the needs of those most affected by the AIDS epidemic, (2) encourage the high level of volunteerism that is helping people with AIDS remain in their homes, and (3) develop corporate support for AIDS education and care through mutual education and fundraising projects.

My name is Sandra Long. I am the executive-director of Aid for AIDS of Nevada, commonly referred to as AFAN. I would like to start by giving you a brief overview of our State, our community and our organization.

Nevada has a population of 1,007,000. It's principal industry is gaming which brings in yearly gross revenues in excess of 8 billion dollars. Approximately 27 million visitors come to Nevada annually giving it the distinction of the top tourist state in the nation. Approximately 32 percent of the jobs in the state are gaming related.

Las Vegas is in Clark County, which happens to be the most densely populated county in Nevada. Clark County has a population of 631,920. This figure represents 63 percent of the state's population. Prostitution is legal in various counties outside of Clark County. The proximity from Las Vegas to the closest county which has legalized prostitution is 69 miles.

AFAN is a non-profit volunteer organization that began operating in late 1985 in Las Vegas. AFAN's primary mission is education and client support. Education is particularly important to our community because of our daily interaction with the millions of visitors to the state. AFAN provides a speakers bureau and conducts seminars on "AIDS in the Workplace" for private business concerns. It also has a telephone hotline, a newsletter and media network.

The client support mission is also vitally important because the gaming industry attracts large numbers of transients and indigent people; some who are infected and have no support system. Our client support programs include transportation, residential housing, hospital visitation, food bank, client counseling, financial assistance, companion placement (Buddy Program) and several others emerging programs.

AFAN has two full-time paid staff positions and one part-time clerical positions. I should note that the second full-time staff position was funded just last month. The rest of our 103 members are volunteers.

In 1987, volunteers donated 39,518 hours of service. That translates to $132,365 worth of service based upon minimum wage computations. Moreover, through grants, fundraisers and private donations gross revenues was approximately $58,000. Our client expenditure increased by over 100 percent from the previous year to $237.00. AFAN served 77 clients during the period. This amount is exclusive of other benefits clients received directly from volunteers. Accordingly, it is evident that our volunteers are the mainstay of our organization. We are confident that if grant money was to become available to fund Volunteer Coordinator and Client Service Director positions, they would generate even greater community volunteer participation. The benefits would greatly exceed the cash outlay. Accordingly, we make the

following recommendation: Government grants for home-based AIDS organizations specifically targeted for volunteer coordinator and client service director positions.

With respect to the issue of prostitution, let me state that AFAN does not promote or endorse the practice. There are between 37 and 40 brothels in Nevada which employ approximately 350 legal prostitutes. Each prostitute services an average of ten patrons per day. In a recent article by Patrick Buchanan appearing in the Washington Times on 12/2/87, he asserted that "it is unusual for a woman to get AIDS from an infected male through normal sexual intercourse." He corroborated the assertion by citing that not one single case of AIDS had been reported in 37 Nevada brothels. The citation, although accurate, is a poor basis for supporting the assertion. The Nevada Brothels Association, an association made up of brothel owners, voluntarily undertook extensive health precautions to prevent the spread of all STD's. Each woman is tested for the presence of HIV antibodies monthly and for other STD's weekly. During a recent 18 month period, nine women were rejected based upon positive test results. In addition, condoms are mandatory and the practice is strictly enforced. There are no exceptions. Accordingly, insofar as it appears to us that the brothels are adequately monitoring their activities, we make no recommendations in this area. AFAN is concerned, however, with misleading commentaries which relegate the likelihood of contracting AIDS through heterosexual contacts. Our concern primarily focuses on high school and college age people who are

influenced by such commentaries, particularly since the view is aligned with what they desire to hear. Therefore, AFAN makes the following recommendation: Target specific AIDS information programs which can be taught in homes, churches and schools that deal with methods of protection other than abstinence.

Finally, as part of AFAN's services, we assist clients through the ponderous and burdensome bureaucratic maze for social services. However, hearings, decisions, appeals, adjudications are all procedures that persons with AIDS have little time to battle. It is not uncommon for clients to die prior to receiving their first social service award; thereby leaving their families and significant others in debt with hospital and burial expenses. AFAN makes the final recommendation: Establish programs which grant immediate benefits to people with AIDS.

It has been my privilege to address you today and I thank you for considering our recommendations.

Testimony to the President's AIDS Commission
By Gretchen Miller
For the Willamette AIDS Council
Eugene, Oregon

I am here on behalf of the Willamette AIDS Council, a community organization in Eugene Oregon. Eugene and its suburbs have a population of about 200,000. Willamette AIDS Council serves that area, plus much of southwestern Oregon, seventy miles west to the ocean, seventy miles east to the crest of the Cascade Mountains, and south to the California border. We provide information and referrals to medical care. We work closely with Shanti in Oregon, which provides direct personal support services.

For moral reasons and also utilitarian reasons, we cannot afford to write off any group as doomed. As we see the infection continuing to spread in gay men and as we see boys experimenting with their sexuality and joining that group, we see a need for our efforts. As we see drugs in our streets and jails, we see people deserving of the respect we can offer to each human being, and a need for our efforts. We do not have the resources we need to organize and extend the volunteer energy which is available. We do not have the money to provide written information and answers to questions, outreach workers to go to the bars and the drug corners on Saturday night, recovery programs for drug users who want them, a way to share a sense of self-worth and possibility for those who may be inclined to write themselves off. Our message is, "There is no town where AIDS is not happening, no family which is untouched by this virus. This is not a gay problem, a minority problem, a drug abuse problem, a big city problem, a problem caused by immorality, a problem which anyone deserves, or anyone else's problem." This virus is in Main Street USA and that is where we need to carry the fight against it.

The wheel is being reinvented in ten thousand communities across the nation. We do not have a good way to transfer experience. What San Francisco and Seattle dealt with a couple of years ago is now becoming our problem, and we work more than we should on the basis of rumor, anecdotal reports, and magazine articles. This provides us with great opportunities for innovation and imagination, but it isn't efficient.

Some problems which plague us in our community:

<u>AVAILABILITY OF MEDICAL CARE:</u> Our physicians sometimes feel as if they are at the end of a long and leaky pipeline--there is no access to experimental treatment outside big cities and it is hard to keep up with the latest information in order to care for your single AIDS patient. Referral patterns can be difficult. Some services and care options are simply not available. The amount of time which this care requires is not compensated. Our sons and brothers are coming home to the smallest towns all over the country, especially people with intact and loving families, coming home to live with AIDS and coming home to die. One AIDS

patient can be a tremendous burden on the family doctor, the local hospital, the family, and on whoever else is involved. There are simply inadequate programs and facilities to care for these patients. The necessary services are too often not available.

AMOUNT OF INFECTION, AMOUNT OF KNOWLEDGE. In less populated areas, we are earlier on the curve. Fewer people are infected and fewer are symptomatic. If, in our area, 25% of gay men who are tested test positive, 75% are uninfected. We still have many opportunities for education. We cannot wait for events to roll over us. Once the numbers are there, it is too late. We know that the infection curve will flatten when an entire population is infected. The challenge is to stop the epidemic before that.

We are earlier on the learning curve, too. Despite our best efforts, a lot of people who are at risk have not changed their behaviors. Behavior change is hard. In a small community, even education can be difficult, because gay people and drug users tend to be better integrated into the community, or they are hiding better (depending on how you look at it). In some towns smaller than Eugene, there is no community and no obvious source of support. There may be nowhere a gay man, whether he is worried well or infected, can go in his hometown and be sure of support, or get accurate information. If a person is HIV positive in Myrtle Creek or Deadwood, Oregon, or a man goes back to his parents there after he learns he is infected, he is entirely dependent on the support of the non-infected and so-called not-at-risk community. This is two-sided--if the person and his family have lived there a long time, his family may be supported by friends and neighbors. Or, if he is shunned, he has very few options. He may be driven out of town.

There are a lot of people who think that AIDS won't happen in their neighborhood or group and that they don't have to worry. They can still look at people at risk as "other" and not deserving of respect. We have miles of education ahead of us.

EDUCATION OF GAY MEN is critically important in our communities. These are the people who are, right now, sero-converting in the largest numbers and this is where we can have [illegible]

GAY TEENAGERS. We have scarcely begun to address the problems of gay teenagers. We have trouble as a society admitting that they exist. Our doctors are seeing boys who are sexually active with men or other teenagers who have sexually transmitted diseases. They are highly at risk. Who is going to provide education in a way that will reach a teenager? Gay men are afraid to--and with good reason. A gay man can talk to another gay man explicitly about safer sex, make jokes about it, offer to help him on with his condom. They can make it fun. That gay man would be smart to stay miles away from a gay seventeen year old, much less to have that same conversation. But do you think that teenager is going to have that conversation with me? We know this is a population seriously at risk.

However successful our educational effort is, there is always a new crop of children becoming sexually active who haven't heard it yet. Why did Pepsi Cola get ahead of Coca Cola in sales? Pepsi sold to a new group which hadn't noticed last year's ads. If I may mix my metaphors, every year there arises a new generation, which knows not Joseph.

DRUG USERS. The IV drug of choice in Oregon is methamphetamine. We know there is a relatively low rate of seropositivity now and a short doubling time. There is a lot of needle sharing going on. Meth users are not necessarily poor or black. They are found all through society, and they usually become aggressive and dangerous. This population is extremely difficult to reach. Resources are inadequate to provide treatment programs for those who want them, much less to reach other users.

ISSUES OF INCLUSIVENESS. Obviously, though they are a very high priority, we don't limit our efforts to gay men. For support groups, for example, nongay people might be uncomfortable in a same-sex group. In a big city you could organize another support group. In a small town you can't fragment that much. There aren't enough people; everyone can't be his own group and we can't find volunteers to staff a group for each splinter. We have to work together.

We have seen the gay community deal with this epidemic in a tremendous, democratic way, people organizing themselves to deal with their own health education and risk reduction, without much help from the government. Willamette AIDS Council has excellent representation from gay men and lesbians, from health care workers of all sorts--doctors, nurses, pharmacists, social service workers, youth counsellors, substance abuse workers, and all kinds of people. We have an accountant who volunteers professional assistance, a journalist who has helped out with public relations efforts--people from all kinds of jobs and backgrounds. We aren't big enough to exclude anyone.

RESOURCES AND ACTIVITIES. We have done a lot with a little. Shanti in Oregon had an outreach worker [illegible] to the smaller communities a few times a year, connecting with HIV positive people who live in Drain, Noti, Coquille, Coos Bay, Remote, and who just live on a road up in the woods, bringing them some news from the rest of the world and offering support. Donations bought his gas and oil, and when he drove his VW van into the ground the newspaper ran the story and a family gave Shanti the car they had been planning to sell. This is a ridiculous, hand-to-mouth way to run a major public health effort. In our community we have a smaller resource base, so we have to make do with smaller contributions, which are of course harder to raise.

Some examples of our low budget efforts:
We go to every place we can think of where people will be. We

have worked with the Chamber of Commerce to send speakers to businesses, to sponsor a conference, to print and distribute posters. We have worked with the school districts. We have sent speakers to unions, to day care workers, to personnel managers, to the hospital, to anyone who will listen. We gave away helium balloons and condoms in safer sex informational wrappers at the county fair. We go to all kinds of gatherings with our helium tanks, our lapel pins, our condoms, our AIDS quiz, and so on. We have T shirts; we have coasters for bars to put under drinks as they serve them. And we have done this with volunteers and a half-time poorly paid staff person. We will not be able to keep up this level of effort indefinitely without more paid staff.

Prevention is vastly cheaper than providing services to persons with AIDS, and we can't afford it.

STATEMENT OF JOHN E. WAHL

TO THE

PRESIDENTIAL COMMISSION

ON THE

HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

March 24, 1988

Admiral Watkins and Commissioners:

For the better part of a year I was Co-Chair of the National Steering Committee of Mobilization Against AIDS, a grass-roots organization formed to advocate action -- when state and federal governments were doing little or nothing in research, education, and treatment concerned with the AIDS epidemic. I have been a community activist for many years, currently serving on the boards of the Council on Religion and the Homosexual, the San Francisco Council of Churches, and the San Francisco Night Ministry. However, my testimony is my own, and does not necessarily represent the view of any organization.

I speak to you today from a point of view which is probably different from any you have heard in your formal proceedings. I am a gay man, openly gay, and happy to be who I am. I do not see my sexual orientation as a drawback, defect, disability, or demerit. I am unique as I have been created, just as each of you is unique in your difference from me and from each other. The only difficulties that my homosexuality, my gayness, causes, are artificial difficulties created by those people in society who are hostile to gay, lesbian, or bisexual people.

Discriminatory laws and economic policies have historically been imposed on gay, lesbian, and bisexual people. Laws have long been used to make same-sex sexual activity criminal, even though approximately ten percent of the population are only sexually attracted to members of our own sex. Economic

policies have long been used to punish our people: Homosexual and bisexual people lose their jobs, in many parts of America, if our sexual orientation is discovered, and we cannot get other jobs. We face eviction from rented houses or apartments, or refusal to rent to us, except for enlightened areas, like San Francisco, where such discrimination has been made illegal.

When the AIDS epidemic began, and when it became clear that AIDS was primarily a threat to gay and bisexual men, it also became clear to many of us that the epidemic would be used to reinforce discriminatory attitudes against us. And, of course, there are many people who have tried to do just that: We have been bullied by individuals and groups (principally on the far right) who have made the illogical and malicious charge that homosexuality is the cause of AIDS, and/or that AIDS is God's punishment for being the way we are made: Homosexual or bisexual. These individuals or groups then call for quarantine, or internment, of us, or at least those of us who may test positive for the presence of the HIV antibody.

I am here today to outline a clear and present danger, which is presented by the use of the AIDS epidemic against the gay community. That danger is potentially as great as the danger presented by the virus itself. The danger I speak of is the danger inherent in the alienation and disaffection of potentially millions of people.

Gay, lesbian, and bisexual people no longer believe, nor will we pliantly accept, the discredited old notions that we are somehow defective, and must hide who we really are. We insist on our right to live just as full a life as you live. We insist on living a full, responsible, sexual life. We will not accept second-class humanity, anymore, nor will we hide a basic aspect of who we are. Many of us are committed to fighting for equality, and as more and more of us realize that we don't have to accept the old homophobic attitudes, it becomes impossible to attempt to suppress us, without grave social dislocation.

Homophobia, and biphobia, are clearly just as much of an obnoxious obstacle to human progress, as is racism. We all know the horrendous struggles, including our own Civil War, that have been directly or indirectly related to racism. Should sexual orientation become another violently divisive factor in our society? Of course not. But there are a number of people who apparently are prepared to let sexual orientation become such a violently divisive factor.

This Commission is in a good position to work against the misuse of fear of AIDS, as a tool for those who want to suppress gay and bisexual people. The AIDS epidemic will not destroy our liberation movement, but attempts to misuse the fear of AIDS to suppress us will be very destructive to social peace. For that reason, it is clearly in the national interest to work against such misuse of fear of AIDS.

Finally, I want to talk about responsibility. Our people, as most of you know, have been in the forefront of efforts to prevent the spread of the virus. Our organizations began the work of educating our people concerning safe sex, and even now we run into governmental resistance to this kind of education. This Commission should not, for one minute, shrink from its responsibility to promote safe-sex education. To deny Americans safe-sex education, because of somebody's ideological or religious views about who should have sex, means that one is willing to expose Americans to lethal risks, rather than let them know how to have sex safely. Sadly, there are many people who are willing to do just that. I hope that this Commission will condemn that kind of dangerous obstruction to public health education. Those who obstruct safe-sex education can fairly be said to be responsible for any disease and death which results from lack of safe-sex knowledge.

Thank you for the opportunity to address the Commission.

Biographical Sketch February 1988

ROBERT N. BECK
Executive Vice President
Corporate Human Resources
Bank of America
San Francisco, California

As Executive Vice President of Bank of America's Human Resource Division in San Francisco, Robert N. Beck has worldwide responsibility for all Human Resource matters for the corporation and its subsidiaries, as well as the BankAmerica Foundation, Corporate Community Development, and Corporate Security. Bob assumed this position in August 1982, after serving as IBM director of Benefits and Personnel Services for International Business Machines (IBM) for the previous four years.

Joining IBM in 1967 as a personnel trainee, Beck was named manager of Employee Relations Research for Corporate Staff in 1971. A year later, he was named manager of Personnel and Communications for the Advanced Systems Development Division. He became Director of Personnel for the division in 1973. For the next five years, Beck held positions as Director of Compensation for the Corporation and Director of Personnel for the General Business Group/International. In 1978, he was named IBM Director of Benefits and Personnel Services.

Bob earned his bachelor's degree in business administration and master's degree in behavioral science and industrial relations at San Diego State University. He served in the U.S. Navy from 1961 to 1963, and later managed supermarkets for Winn-Dixie and Safeway.

Bob is a member of various key committees within the bank including: Managing Committee; Senior Management Council; Social Policy Committee; Human Resources Committee; BankAmerica Foundation Board of Trustees. He is Chairman of the Employee Benefits Administration Committee and Employee Benefits Finance Committee and is Secretary to the Executive Personnel and Compensation Committees of BankAmerica's Board of Directors.

He also serves as a board member and advisor on a large number of professional, educational, and business organizations and foundations. He frequently lectures at leading universities across the U.S., and has been actively involved for several years in the fields of health care and aging. He has published numerous articles and co-authored two books. He was the recipient of the ASPA Personnel Executive of the Year award in 1985.

Current Positions:

Board of Directors

- Blue Shield of California
- American Federation of Aging Research
- National Fund for Medical Education
- National Council on Aging
- University of California - San Francisco - Trustees
- INROADS of San Francisco
- American Assembly of Collegiate Schools of Business
- San Francisco Chamber Orchestra

Associations

- Labor Policy Association -- Executive Committee
- Employee Relations Council -- Business Round Table
- Alpha Group -- Banking
- Personnel Forum
- Business Institute on Aging-USC -- Chairman
- Institute of Medicine - Charles A. Dana Awards Committee
- Senior Executives Personnel Forum
- University of California - Berkeley -- Graduate School of Business Advisory Council
- University of California - Berkeley - School of Public Health - Center for Health Promotion and Disease Prevention - Advisory Board
- American Society For Personnel Administration -- Human Resource Strategies and Issues Council
- Brigham Young University National Advisory Council -- Member
- Northwestern University Advisory Council -- Member
- Charles Dana Awards Committee - Institute of Medicine

Past Positions

- White House Conference on Aging -- Delegate
- U.N. World Assembly on Aging -- NGO Delegate
- North American Conference on Aging -- Sub-committee Chair
- Washington Business Group on Health -- Board
- National Dialogue for the Business Sector -- Sub-committee Chairman
- Center for Consumer Health Education Board
- Center for Industry and Health Care-Boston University
- San Francisco General Hospital Advisory Committee
- Business for Higher Education Forum Advisory Committee

**Bank of America**

San Francisco Headquarters

## Assisting Employees with Life-Threatening Illnesses

BankAmerica recognizes that employees with life-threatening illnesses including but not limited to cancer, heart disease, and AIDS may wish to continue to engage in as many of their normal pursuits as their condition allows, including work. As long as these employees are able to meet acceptable performance standards, and medical evidence indicates that their conditions are not a threat to themselves or others, managers should be sensitive to their conditions and ensure that they are treated consistently with other employees. At the same time, BankAmerica has an obligation to provide a safe work environment for all employees and customers. Every precaution should be taken to ensure that an employee's condition does not present a health and/or safety threat to other employees or customers.

Consistent with this concern for employees with life-threatening illnesses, BankAmerica offers the following range of resources available through Personnel Relations:

- o Management and employee education and information on terminal illness and specific life-threatening illnesses.
- o Referral to agencies and organizations which offer supportive services for life-threatening illnesses.
- o Benefit consultation to assist employees in effectively managing health, leave, and other benefits.

Guidelines - When dealing with situations involving employees with life-threatening illnesses, managers should:

1) Remember that an employee's health condition is personal and confidential, and reasonable precautions should be taken to protect information regarding an employee's health condition.

2) Contact Personnel Relations if you believe that you or other employees need information about terminal illness, or a specific life-threatening illness, or if you need further guidance in managing a situation that involves an employee with a life-threatening illness.

3) Contact Personnel Relations if you have any concern about the possible contageous nature of an employee's illness.

4) Contact Personnel Relations to determine if a statement should be obtained from the employee's attending physician that continued presence at work will pose no threat to the employee, co-workers or customers. BankAmerica reserves the right to require an examination by a medical doctor appointed by the Company.

5) If warranted, make reasonable accommodation for employees with life-threatening illnesses consistent with the business needs of the division/unit.

6) Make a reasonable attempt to transfer employees with life-threatening illnesses who request a transfer and are experiencing undue emotional stress.

7) Be sensitive and responsive to co-workers' concerns, and emphasize employee education available through Personnel Relations.

8) No special consideration should be given beyond normal transfer requests for employees who feel threatened by a co-worker's life-threatening illness.

9) Be sensitive to the fact that continued employment for an employee with a life-threatening illness may sometimes be therapeutically important in the remission or recovery process, or may help to prolong that employee's life.

10) Employees should be encouraged to seek assistance from established community support groups for medical treatment and counseling services. Information on these can be requested through Personnel Relations or Corporate Health Programs.

# On Your Behalf

JULY 1987 — PERSONNEL NEWS FOR BANK OF AMERICA EMPLOYEES

## Living with AIDS

AIDS is changing America and the world in ways that are both dramatic and subtle. The number of AIDS cases is increasing, but medicine is making advances in understanding and dealing with the disease. Although there is no vaccine or cure yet, some drugs may be proving effective in treatment. And it is clear that education can change attitude and behavior. Because of new treatment strategies, more people are living longer after being diagnosed with the disease. Over all, however, more of us are going to know someone who has the disease—a friend, a co-worker, a family member, a business associate, a neighbor.

More than ever, we all need to understand this disease, and what it means to us in today's world.

**What is AIDS?**

AIDS stands for Acquired Immune Deficiency Syndrome.

**Aquired:** This means that it is not an inherited or genetic condition.
**Immune:** The immune system is the body's natural ability to protect against infection and disease.
**Deficiency:** Incomplete or lacking.
**Syndrome:** A characteristic combination of signs and symptoms.

In other words, AIDS is a weakening of the body's ability to fight disease. It leaves an individual vulnerable to illnesses that a healthy immune system could protect against.

The AIDS virus, known as HIV (Human Immundeficiency Virus), was identified in 1981. It enters the body and cripples certain lymphocytes—white blood cells necessary for immunity. People with AIDS are susceptible to diseases known as "opportunistic infections," and to certain tumors. The infections are caused by organisms that do not usually cause disease in people with strong immune systems. The most common is pneumocystis pneumonia (PCP). Kaposi's Sarcoma (KS) is the most common tumor associated with immune deficiency. The direct effects of the virus on the nervous system, independent of immune deficiency, also are increasingly seen.

Some people with AIDS may experience for years alternating periods of illness and wellness; others may die within a year of diagnosis. Although currently there is no cure for AIDS, treatments are available for most of the afflictions suffered by the AIDS patient during the

*Continued on page 2*

## Your New Employee Handbook

Health care plans. Retirement benefits. Life Insurance. Disability Benefits. BankAmerishare. Tuition assistance. What do all of these programs have in common?

They are some of the programs that round out your compensation at BankAmerica. And they are among the benefit programs that you can learn more about by reading the new edition of *Your Employee Handbook*, published this month.

The new easy-to-use one-volume edition of *Your Employee Handbook* replaces the previous handbook kit of six booklets. Among its features are charts to help employees quickly find out how certain events (marriage, divorce, child birth, etc.) affect their benefits. Another feature that will help employees use the new handbook for quick reference is the new, expanded index.

The handbook includes updated and revised information about such subjects as:

- New features in the BA Medical Plan, such as the hospital utilization review program, prescription drug programs, non-duplication of benefits, and the preferred hospital program.
- Expanded information about medical absences.
- Current information on the voluntary life insurance program, as well as a description of the dependent term life insurance program.
- Updated CareerAccounts (BankAmerishare and BankAmeraccount) chapters that include the most recent changes in the tax laws.
- Highlight section at beginning each chapter, providing a capsule summary of the programs described in the chapter.
- More information about programs such as assisting employees with life-threatening illnesses, the Alcohol and Drug Program, ridesharing,

*Continued on page 2*

*AIDS continued*
course of the illness. Also, new drugs such as AZT in some cases are able to bolster an individual's immune system, fending off more severe attacks of the opportunistic infections.

Several medical problems are related to AIDS, but are not a basis for an AIDS diagnosis. These are known as AIDS Related Conditions. Although these conditions are not considered AIDS, people with them have many of the same medical and psychological and social needs as individuals with AIDS.

Many people exposed to the AIDS virus stay well for a long time. Some AIDS carriers may never get sick. The only sign of exposure to the AIDS virus may be a positive blood test for antibodies to the virus. It is not known how many people who are antibody positive will actually become ill. Currently, the best knowledge indicates about 30 to 60 percent. Full-blown AIDS may appear years after the initial infection, whether or not AIDS Related Conditions occur.

**Who gets AIDS?**

Consistently, since the disease was identified in 1981, only people who engage in specific at-risk activities have contracted AIDS. The at-risk activities are:

- Sexual activity through which semen or blood or vaginal fluids are exchanged.
- Sharing IV (intravenous) drug needles with an infected person.
- Injection of contaminated blood products, such as in blood transfusions. (This method of transmission has been checked by blood-screening programs put in place in 1985. You CANNOT get AIDS by *donating* blood.)
- A woman infected with the AIDS virus who becomes pregnant or breastfeeds can pass the virus to the baby.

**What about casual contact?**

AIDS is difficult to get. The virus is not easily spread from person to person, and has never been shown to be spread by casual contact. The AIDS virus is not passed through the air. The virus is fragile and must be transmitted from the infected person directly into the blood stream of another person.

Sneezing, breathing, or coughing do *not* spread AIDS. Touching, hugging, holding, or shaking hands do *not* spread AIDS. Daily activities—working in a group setting, shaking hands, eating at public restaurants, swimming in public pools—pose no AIDS threat. No one has ever contacted AIDS in a work environment such as Bank of America's.

**What is BankAmerica's policy regarding AIDS?**

BankAmerica's policy states that as long as employees with any life-threatening illness, including AIDS, feel well enough to work and can meet acceptable performance standards—and their condition is not a health threat to themselves or others—they should be treated like other employees. The company may make reasonable accommodations for the employee—flexible work hours, for example—as long as these do not hamper a unit's business needs.

"We offer a wide range of resources to employees with life-threatening illnesses, as well as to managers and employee groups," says Katherine Armstrong, Health Programs Manager, Corporate Health Programs.

"These include management and employee education and information on terminal illness and specific life-threatening illnesses; referral to agencies and organizations that offer supportive services for life-threatening illnesses; and benefit consultation to assist employees in effectively managing health, leave, and other benefits. Sometimes, we assist employees in getting help such as grief counseling or advice on how to talk to and treat a co-worker with AIDS."

BankAmerica has received nationwide recognition as a leader in the issue of dealing with AIDS in the workplace. BankAmerica Foundation supported the "AIDS in the Workplace" project, developing informational materials used by companies worldwide. Bank of America also provided free office space for the San Francisco AIDS Foundation. Nancy Merritt, Manager of Equal Opportunity Programs, as spokesperson for BankAmerica on the subject, has testified before the California State Senate and the San Francisco Human Rights Commission, and has discussed in national newspapers and magazines the role that corporations can play in managing the impact of the disease.

"It is not a contagion issue," says Merritt. "An employee can come back and work as long as he or she is able. Providing a supportive work environment for people with life-threatening illnesses not only helps them financially, it can even prolong their lives."

She adds: "Medically, we have learned nothing to indicate that we should change our policy. Last month's International Conference on AIDS in Washington, D.C. confirmed what we know about the transmission of AIDS. The fact remains that some employees may be uncomfortable with a co-worker's life-threatening illness. However, this apprehension is usually based on a lack of information."

On the job, there is no need for special protection against the AIDS virus. No cases of AIDS have ever been linked to sharing typewriters, telephones, tools, papers, waterfountains, bathrooms, vehicles, uniforms, desks, coffee pots, or eating facilities. AIDS is not transmitted through preparation or serving of food or beverages.

"The most important point is for everyone in the work site to show a caring attitude and not to pass judgment on the person," says Dr. Linda Hawes Clever, Chairman of the Department of Occupational Health at Pacific Presbyterian Medical Center in San Francisco, and an expert in the field of AIDS. "Be supportive in whatever way you can. The disease itself takes a tremendous emotional toll, and it is imperative for persons with AIDS to have a circle of support around them."

BankAmericans have been supportive of their co-workers who have contracted AIDS. Employees with AIDS have said that the support they received from their managers and co-workers, from Personnel Relations Specialists and Human Resources

*Continued on page 5*

*Handbook continued*
service awards, the Child Care Referral Program, and personal crisis intervention.

The new 1987-88 *Your Employee Handbook* is designed to be a ready reference for employees to use when they have questions about their benefits. Remember, it is in your interest to understand the provisions of the various programs, because, unless the proper procedures are followed, you can risk losing benefits or coverage. All units received copies this month for their employees. Managers who need additional copies may contact Stationery and Supplies. ■

# Your Benefits

**BANKAMERISHARE**

Here are some questions that employees have asked about BankAmerishare.

*After Employment Ends*

**Q I've been contributing to BankAmerishare. If I leave the company, what am I entitled to from my BankAmerishare account? Is there a vesting period?**

**A** All BankAmerishare contributions—including employee and employer matching contributions and all investment results—are immediately 100 percent vested. This means that you are eligible to receive your entire account balance after you leave the company, no matter how long you've been an employee. You do not have to be retiring in order to receive your account balance—only ending your employment.

Receiving your account balance doesn't happen automatically though—see below for the steps that must be completed first.

**Q If I leave, how and when will I receive my BankAmerishare account balance?**

**A** First, your personnel record must be updated by your manager to reflect your termination from employment. ***Because BankAmerishare #3994 cannot pay you until this step has been completed, make sure that your EDP-480 record has been changed by your unit.*** Nothing else can be done until your manager has completed this step, so it will be to your advantage to make sure that your record is updated as soon as possible.

Then you must submit an *Immediate Lump Sum Distribution Form (EXEC 916)* to BankAmerishare #3994 within six months of your termination date in order to receive payment of your BankAmerishare account balance. This payment is called your "distribution." ***Otherwise, you will not be able to claim your benefits until your 65th birthday,*** or until your 55th if you have 15 years of covered service.

If you are going to roll over your lump sum distribution (whether cash or stock certificates) into an IRA, or into another qualified plan, you should check the box on the form indicating "do not withhold taxes from my distribution."

The value of your BankAmerishare account is determined on the last working day of the month in which BankAmerishare #3994 receives your distribution form. They will send you a confirmation notice verifying that your form was received and the date that it will be valued. You will receive your distribution no later than 60 days after that valuation date, and most distributions arrive within 30 days. For example, if your form was received anytime in June, the value would be determined at the end of June, and you'd receive your distribution by the end of July—or before the end of August at the latest.

**Q If I qualify as a retiree, can I defer my BankAmerishare distribution until a later time?**

**A** Yes. If you are at least 55 and have 15 years of covered service, or if you are least 65 (regardless of your years of covered service), you will have additional choices.

You may defer your distribution past the age of 65, if you choose. You must submit the *Retiree Deferral Form (EXEC 655)* to BankAmerishare #3994. On this form you will need to indicate the date to which you wish to defer your distribution. On that date you will be requested to either settle your account, or further defer your distribution. You may defer your distribution up to April first following the year in which you reach 70 ½. For example, if a retiree reached 70 years plus six months in June of 1990, they would be able to defer up to April 1, 1991.

As a retiree who has chosen to defer your distribution, you also will have the choice of withdrawing part of your distribution ahead of time, but you should be aware that doing so may jeopardize your eligibility to use special forward averaging tax treatment. It would be to your advantage to check with a tax advisor first. And you may also make transfers among the investment funds.

If you are planning to receive your retirement funds in monthly annuity payments, you may transfer a portion of your BankAmerishare balance to BankAmeraccount, so that your monthly pension payments are larger. Either your Retirement Counselor or CareerAccounts Customer Service Representatives can tell you the maximum amount that may be transferred (it cannot include your tax basis). This step should be completed before your first monthly payments start, whether this will happen shortly after

*Continued on page 4*

# Shareholder Investment Plan

Recently, BankAmerica Corporation announced the launching of the BankAmerica Corporation Shareholder Investment Plan (SIP), an improved stock purchase and dividend reinvestment plan.

Those eligible to participate include employees who own BAC common or preferred stock in their own name, or who have shares of BAC common stock in their account in BankAmerishare or the BankAmerican Stock Purchase Plan. Prospectuses describing the plan and enrollment forms were mailed to eligible BankAmericans.

To clarify some questions that have been asked by employees: SIP is not part of the BankAmerishare Plan. It is an independent plan. Participation in SIP will not in any way affect participation in BankAmerishare. SIP account information will not be reflected in the quarterly CareerAccounts statement, but will be accounted for by Corporate Agency #9510 through a separate statement sent to SIP participants.

Corporate Agency is the coordinating department for the management of the SIP program. All inquiries, including eligibility requirements, should be directed to them at BankAmerinet S.F. 624-4013 or by using the 415 area code. ■

# Need documentation of your employment?

Under the new federal immigration law, people who have been considered unauthorized aliens may apply to the Immigration and Naturalization Service (INS) for legalization in order to change their status. One requirement is that they can prove that they have been living in the United States continuously since December 31, 1981.

One way to prove continuous residence during that time is by providing an employment record. If you need a record of your employment with BankAmerica, all you have to do is write a letter saying that you are requesting employment verification for legalization. Include this information:

- Your full name
- Your Social Security number
- Your unit's name and number
- Your work telephone number.

If possible, also include the date that you were hired. If you had any breaks in service, it would be helpful to include the dates that you left and came back to work for BankAmerica again.

Enclose a self-addressed interbranch envelope with your letter. Then send your letter and envelope by interbranch mail to Earlieen Rayford, Personnel Records #5766. Once your letter is received, it will be acted upon quickly, so you should expect to have your reply within ten days (to allow for mailing time).

By law, the deadline for accepting applications for legalization will be May 4, 1988. The Immigration and Naturalization Service (INS) has recorded a series of messages about the new immigration law. If you call 800-777-7700, their 24-hour, toll-free number, you will be able to choose which messages you want to hear, in English or in Spanish. You will hear a list of subjects, and you can choose what you want to know more about simply by dialing or punching that message's number. Included are messages that tell you where you can go for further help in your area, including non-government private organizations or individuals and INS special legalization offices. —A.W. ■

*Your Benefits continued*

retirement or whether you are deferring your pension payments until later. You will receive more information at the time of your retirement.

**Q What about taxes? What choices do I have?**

**A** Upon receiving your distribution, you have several options.

1. You can roll over your taxable amount into an Individual Retirement Account (IRA). Essentially, that means that you can defer paying taxes until later by redepositing the taxable amount with a financial institution that acts as custodian of your IRA, as long as you do it within 60 days after you receive your distribution.
2. If you are working, another possibility is to roll it over into the qualified plan of another employer. Again, this must be done within 60 days after you receive your distribution.
3. You can keep the money and pay current taxes.

You will need to find out if you are eligible to use special tax treatments (forward averaging or partial long term capital gains). *Your Employee Handbook*'s chapter on BankAmerishare has the specific details.

As tax matters are complex and each person's situation is different, we suggest that you consult a qualified tax advisor for advice.

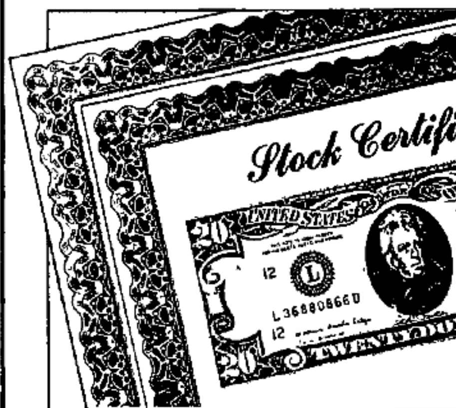
**Q Am I entitled to interest and/or earnings during the time between my termination and distribution of my account?**

**A** No, the amount of your distribution is determined at the end of the month in which your distribution form is received. After that cutoff date, administrative tasks are carried out so that your distribution payment can be sent to you. The BankAmerishare Plan does not pay interest during this processing time.

**Q I already know I'm able to roll over the taxable portion of my BankAmerishare final distribution into an IRA. But, what if I choose to receive stock certificates rather than cash? Will I be able to roll over the stock?**

**A** Stock certificates may be rolled over into an IRA handled by a brokerage house, within 60 days. However, you should contact the administrator of the IRA to see if that IRA will accept the certificates. You would then sign them over to the IRA custodian. Sometimes this can be done through an electronic transfer, instead.

You also can sell your stock certificates through a stock broker, and then you have 60 days to roll over the taxable amount into an IRA, so that you can defer paying taxes until later. If you don't choose to deposit the sale proceeds into an IRA, you will be liable for ordinary income taxes, and possibly a 10% penalty tax. ■




If you have any further questions, please refer to the chapter on BankAmerishare in the new and revised 1987 *Your Employee Handbook* (EXEC 40). It will be distributed to all employees by the end of July.

For additional help, you may call the CareerAccounts Customer Service Representatives at 624-2314, using BankAmerinet or the 415 area code.

# Good Ideas

During May, the following good ideas were suggested by employees through Ideas In Action, a write-in suggestion program, and through Quality Circles, groups of employees who identify and solve work related problems. In total, they earned $4,399. Some of their suggestions are listed below. The total savings to the corporation for the year comes to $371,913. Employees' cash awards are based on the percentage of the resulting savings—direct or indirect—and the cost of implementation.

## Ideas In Action

**Nancy L. Burns**
CREIG-Sacramento
- Eliminating the procedure of sending promotional material to bank groups with limited customer contact: **$630**

**Patricia Ward**
Pleasanton Branch
- Eliminating an Officer Change of Status Form for promotions of officers grade 75 or above: **$532**

**Diane Ellson**
BA Canada—Foreign Currency Services
- Inserting a clause in contracts with multinational equipment manufacturers to enable offshore BA managers to take advantage of U.S. equipment contracts: **$500**

**Jacquelyn Ferguson**
Capitol Proof Center
- Revising carrier envelopes to include clear windows on both sides: **$390**

**Patricia Bell**
Rancho Encinitas Branch
- Eliminating call-backs from Item Processing Operations to branches for rejected items except when branch-endorsed for unpaid returned items over $2,500: **$370**

**Amy Kiss**
Southern California Audit
- Eliminating the Quality Information Report and Swingshift Mail Bag Tags: **$350**

**Jennifer Carlson**
Teleservicing Center
- Placing adhesive stickers on VERSATEL® machines that state: "Under no circumstance would any BofA representative ask you for your PIN number": **$340**

**Sandi Eastwood**
Loma Linda Branch
- Revising the Vault Sheet to improve recording procedures: **$200**

**Baoing Seto**
BA Cheque Corporation
- Consolidating write-off entries for escheatment by adding a flag in Paid Cheque Processing systems: **$150**

## Quality Circles

**Matthew Amorosano, Audrey Buziecki, Wayna L. Gray, Linda Lowman, Marilyn Miller, Marcie Packard, Rebecca Palmer, Rose Williford, Kirsti Yeazell, Vickie D. Zelmer, Jeanette Byl (facilitator)**
"BARE PATROL"—BARE Residential Mortgage Banking Group
- Creating a communication form to provide customers with weekly progress reports of telephone requests: **shared $250** ■

*AIDS continued*

managers, and from the Benefits Department "played a key role" in their return to comparative good health after their initial convalescence. They all feel that the opportunity to return to work and be productive was important to them both physically and psychologically.

One employee with AIDS wrote that, as a volunteer counselor, he has encountered "the great sense of hopelessness experienced by those whose support systems have let them down. This factor, in my opinion, is as deadly an enemy as the virus itself. Bank of America most assuredly has not let me down."

### What benefits are available to employees with AIDS?

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

- Coverage for health plans (medical, dental, vision) continues at the pre-disability rate as long as the employee continues to make monthly contributions.

- Basic (employer-paid) life insurance continues and so do employee-paid life insurance benefits as long as the employee makes monthly contributions.

  Employee banking privileges continue as long as the person is considered an employee of the company.

- BankAmeraccount benefits continue. Employees continue to earn pay-based credits as long as they receive sickness benefits. If sickness benefits have expired, credits are earned as long as they are receiving Social Security disability payments.

- BankAmerishare benefits may continue as long as an employee receives sickness benefits. Long-term disability benefits are not considered eligible earnings for BankAmerishare.

### Learning about AIDS

"Education is critical," says Katherine Armstrong. "Companies such as Bank of America have an important role to play in educating employees and in helping inform the communities in which we operate about the facts concerning AIDS.

All of us can be sure that we are informed on the subject, that we avoid behavior that puts us at risk, and that we provide support to individuals who need it.

"We can start today to help stop the spread of AIDS, as well as the unnecessary panic and fear. We can help educate others—including children and teenagers—about AIDS. We can support research and education. And, if at some point one of our friends or colleagues has the disease, we can treat him or her not with fear, but with compassion." ■

**Toll-free AIDS Information Hotlines:**

Northern California: 800-FOR-AIDS
Southern California: 800-922-AIDS
National Public Health Service:
1-800-342-7514

The Personnel Relations Specialists for your unit can provide information on referral services and benefits information.

More information about AIDS is available from Bank of America Corporate Health Programs. If you would like to receive some pamphlets and/or to borrow the ¾ " video "AIDS in the Workplace," call them on BankAmerinet 622-1113, or use the 415 area code.

# Employee Benefits WORD JUMBLE

How well do you know your employee benefits? You can win prizes just by reading the new *Your Employee Handbook* and completing the Word Jumble below. Fill in the letters correctly and you'll have a chance to win one of these prizes in our random drawing.

- **One grand prize:** An outing kit from The Company Store. The navy insulated case with carrying handles contains a 100 percent wool plaid blanket and Aladdin thermos. Terrific for picnics or football games.
- **Three first prizes:** A quartz travel alarm clock with a night light, snooze button, and carrying case. From The Company Store.
- **Five second prizes:** A business card carrying case with solar calculator (no battery needed). The case is black, full-grained leather with silk lining. From The Company Store.
- **25 third prizes:** Easy Bankercise rubber band exercise how-to charts, complete with giant rubber bands. These 7-minute stretching and relaxing exercises can be done at work or at home. From Corporate Health Programs.

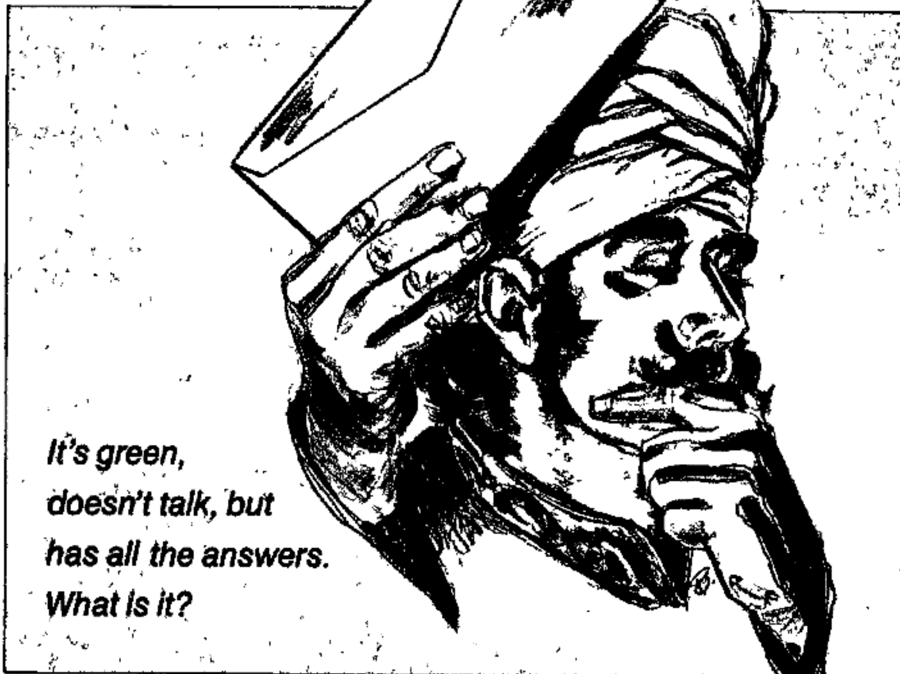
**How to enter**

Complete the Word Jumble with the help of the new *Your Employee Handbook,* which you'll receive in July. Return the completed Jumble with the coupon below to Benefits Planning #3609.

**Rules:**

- All active employees are eligible to enter the Word Jumble contest, (excluding Benefits Planning and Personnel Communications).
- Entries must include name and department number.
- Entries must be received by August 14, 1987.
- Prize winners will be determined by a random drawing from correct entries. If there are not enough correct entries, the balance of prize winners will be drawn from the remaining entries.

Answers to the Word Jumble will appear in September's *On Your Behalf* along with a list of the top prize winners.




## Employee Benefits Word Jumble

1. Unscramble these 8 Jumbles, one letter to each square. To help, we have inserted a few letters in their proper places. (Hint: Each word or pair of words is related to the various employee benefits offered at BankAmerica.)

| Jumble | Squares |
|---|---|
| TTNIOECPOR | ○ R ○ □ □ C □ □ ○ N |
| ALDNTE | ○ □ □ □ □ ○ |
| CTAVNOAI | □ A □ □ □ □ ○ □ |
| UNRACISEN | □ N □ ○ □ □ ○ □ E |
| MOH | □ □ ○ |
| ERFE | □ □ □ ○ |
| HCCKNGIE | C ○ □ □ ○ □ □ G |
| EERYLOPM | ○ □ P □ □ ○ □ ○ |
| TCAMH | ○ □ T □ □ |
| NEBFTSIE | ○ □ □ ○ □ □ □ S |

2. Now arrange the *circled letters* above to form the surprise answer. You'll find a clue in the drawing.

**Answer:** Y □ □ □   □ □ □ □ □ □ □ □   □ □ □ □ □ □ □ □

My Name ______________________

Unit/Branch ______________________ Dept# __________

Location ______________________

Phone ______________________

Send with completed Word Jumble by interbranch mail to:
Benefits Planning #3609, Attn: VG

**Open Line** is a program for confidential upward communication between employees and management. Answers of general interest may be published in *On Your Behalf*, sometimes in condensed form but only with the permission of the writers and all marks of identification removed. If you use **Open Line** and identify yourself, you will receive a reply whether or not your question and answer are published here. **Open Line** forms (EXEC-772) may be ordered from Stationery and Supplies #3048.

Number of **Open Line** questions since the program began in April 1972: 11,830. Percentage of questions signed: 96%.

If you need help on a Personnel Relations matter, contact your division Human Resources group.

## SAFE DEPOSIT

**I would appreciate your giving me the bank's thoughts behind our charging a key deposit on safe deposit rental for employees. It is now $10, over our prior $2.50. When an employee transfers from one branch to another, it seems the key deposit would be waived or "transferred" with the box. Currently, they credit the $2.50 at the old branch and charge the $10 at the new.**

**This would also apply to old-time customers. Imagine customers' feelings when they leave one area after a lengthy time, transfer accounts to another branch of Bank of America, only to find their key deposit has gone to $10! This could prove to be a customer relations problem...especially if the branch from which they are transferring fails to mention this fact ... s has happened.**

**With the benefits Bank of America employees receive, this may seem like a small item, but many feel it has merit. Why can't we add yet another benefit for us?**

**Thanks for your help.**

*Answer from Ilze C. Grace, SVP, Individual Financial Markets*

We appreciate your concern regarding the 1985 safe deposit key increase. This increase (from $2.50 to $10.00) was initiated as an incentive for customers to return their keys and properly close their safe deposit boxes. We have discovered that a number of customers will not go to their branch to close out their safe deposit boxes and receive their $2.50 key deposit. These boxes would go delinquent and eventually be drilled and require a new lock at bank expense. With the key deposit of $10.00, there is a stronger incentive for customers to come into the branch and close out their boxes.

If you have customer relations problems resulting from this price revision, refer customers to your Branch Administration Officer or Manager.

We have reviewed your request to maintain the $2.50 key deposit for transferred employee safe deposit boxes and see the additional benefit as negligible, in comparison to the cost to implement the change. We view the 50% discount on the established safe deposit box rate as an appropriate employee benefit for safe deposit boxes.

## CUSTOMER ID

**I felt very disappointed after hearing calls to a local radio station. Most of the calls complained about BofA's services related to credit cards.**

**One caller said he couldn't open a "savings" account with BofA because he didn't have a credit card. He ended up depositing his money with Wells Fargo. Another caller was told by a BofA teller that he couldn't cash his checks with just his driver's license.**

***I think public relations is quite crucial to our success as a retail bank domestically.* Besides, there's no reason to make it a necessity to carry a "credit card."**

*Answer from Larry McNabb, Senior Vice President, Retail Payments*

I share both your concern and disappointment that a potential customer may perceive that our bank requires a credit card for identification purposes. When providing banking services, we generally require two forms of identification to identify a customer who is not known to us. Customers who are not regular bank customers, or who are transacting services at a branch, other than their own, may be asked to present two pieces of I.D. Our identification procedures serve to protect both the customer and the bank by ensuring the requestor of any transaction is, in fact, entitled to its value.

A credit card is only one of the eleven forms of acceptable identification listed in the "Opening New Accounts" manual (PM-117). The most common forms of identification are the California driver's license and major credit cards. However, if an individual does not possess these, alternative forms such as a U. S. passport or an Armed Services identification card are acceptable.

We agree that positive public relations is critical to our success. Thank you for taking the time to bring this issue to our attention. Your interest in the quality of service we provide is important to maintaining the integrity of our first priority—customer service. ■

Why look in a crystal ball to see what's in your financial future, when all you need to do is open an envelope?

Just as your pay stub represents your present financial benefits from working at BankAmerica, your CareerAccount statement shows you what's being set aside for your retirement.

This statement gives you the clear picture you need to make ongoing decisions about your investment choices. And it also helps you by giving you information to decide whether or not to change your level of participation in CareerAccounts.

But maybe you're still not convinced that your CareerAccounts statement is important for you.

Have you ever taken a vacation and realized you had neglected to set aside enough money to do all you'd planned? Without careful planning, retirement can resemble a bad vacation, or worse. And the resemblance wouldn't end in a week or two, because retirement encompasses a significant portion of our lives.

It's your future, and BankAmerica helps you make it a better one by providing an employer-paid retirement plan, BankAmeraccount, and a matched savings plan, BankAmerishare.

Soon you will receive your quarterly CareerAccount statement. Along with it will be an explanation of each line of a typical statement, including cross-references to the new employee handbook.

So take a few moments to read your statement. Keep it with your other important papers. As you plan your future, it will be a useful tool. ■

**Be Your Best**
CORPORATE HEALTH PROGRAMS

## August Challenge: Be in charge!

Accurate, up-to-date personal and family health records can save lives. Getting accurate data quickly is an important part of our daily work in the bank. It makes us more efficient, helps reduce errors, and gives us a sense of being in control. You get the same benefits when you keep an accurate, up-to-date personal health record, for yourself and each member of your family. The August Challenge could even be a lifesaver!

It's easy to forget the date you or a family member last saw a doctor, had a physical exam, tetanus booster, or an X-ray taken. And remembering the names of illnesses, laboratory tests, and medicines is a challenge for most of us. If you have more than one physician providing care for you, this information should be gathered by you in a personal home health record. In an emergency, this information is vital to obtaining accurate and appropriate treatment.

- If you need guidelines for reviewing the types and frequency of your immunizations and would like a copy of Corporate Health Program's Personal Health Record, send a self-addressed interbranch envelope to "Health Record" #3666.

### August Challenge: Be In Charge

Yes, during August I helped improve my health care by:

1. Organizing a personal health record for each member of the family.
2. Reviewing my immunization status and arranging to get any that I need.
3. And checking with my family for any history of diseases and entering the information in my record.

Signature ______________________

Name ______________________ No. of family members _____

Unit (name & number) ______________ Phone ______________

To qualify, you must complete this Challenge and send:
1. This coupon
2. And a large (10x13"), self-addressed interbranch envelope to Corporate Health Programs #3666.

(Sorry, available only in the United States)

Complete the August Challenge by doing the following:

1. Organize a personal health record. If you have a family, be sure to include everyone.
2. Review your immunization status (that's right, they're not just for youngsters) and make arrangements for any needed immunizations.
3. Check any family history of disease and include it in the record.

If you complete this month's Challenge and mail in the coupon below, you will be rewarded with the helpful booklet "Protecting Adults Against Disease: Immunization." And in addition, it will be put in our random drawing for 50 free copies of the popular book *Take Care of Yourself—A Consumer's Guide to Medical Care.* ■

# By request

Taking responsibility for your health includes learning how to be a wise consumer of health care systems—doctors, clinics, hospitals, or other health care professionals. A 3/4" video on this subject is available to borrow from Corporate Health Programs #3666. "Only the Best" is an entertaining and informative presentation on how a family finds out ways to keep their costs under control and still get the best care for themselves. A pamphlet for each viewer accompanies the video; let us know how many you will need. Perhaps your unit would like to see it during lunch break? Sorry, it is not available in home viewing size.

Request for "Only the Best" video and ________ pamphlets (number of viewers)

Name ______________________ Phone ______________

Unit name & number ______________________

1) Send this coupon, and

2) A large 10"x13", self-addressed inter-branch envelope to "Only the Best" #3666

Note: Due to the limited number of videos, requests will be filled on a "first come, first served" basis. Sorry, available only in U.S.



Published by Personnel Communications #3651

# On Your Behalf

For Bank of America employees — January 1986


# Understanding AIDS

by Molly Laughlin

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

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

## AIDS: A background

AIDS stands for Acquired Immune Deficiency Syndrome. The AIDS virus, known variously as HTLV-III and LAV, was identified in 1981. Since then, some 15,000 people have been diagnosed as having the disease. The AIDS virus enters the body and cripples lymphocytes, white blood cells necessary for immunity. The weakened immune system then becomes susceptible to a wide range of infections and tumors, many of which are serious and potentially fatal. Among the most common of these is a parasitic lung infection, *Pneumocystis carinii*, and an unusual form of cancer, Kaposi's sarcoma.

The illness can run a short, aggressive course lasting weeks or a few months, or may last for years.

Although there is no current cure for the disease AIDS, there are several available treatments for most of the afflictions suffered by the AIDS patient during the course of the illness. However, because AIDS so destroys the immune system, medications cannot be boosted by the body's natural defense system, and will eventually lose their effectiveness.

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

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

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

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

### *Fiction: Only homosexual men and drug abusers get AIDS.*

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

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

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

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

## Prevention is key

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

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

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

Fact: Employees with AIDS, like persons with other life-threatening illnesses, should be allowed to work if they choose, as long as their condition does not interfere with their job

BankAmerica's policy states that as long as employees with any life-threatening illness, including AIDS, are able to meet acceptable performance standards and medical evidence indicates they are not a health threat to themselves or others, they may work.

Often, says Dr. Clever, an employee with AIDS may have to adopt a work schedule to accommodate a greater susceptibility to fatigue. "The most important point is for everyone in the work site to show a caring attitude and


*Continued on page 2*


## Toll-free AIDS hotlines

| | |
|---|---|
| Northern California | 800-FOR-AIDS<br>TDD—(415) 864-6606 |
| thern lifornia | 1-800-922-AIDS |
| National Public Health Service | 800-342-AIDS |
| U.S. Centers for Disease Control | 1-800-447-AIDS |

# Roll up your sleeves

The decision to give blood is an individual one. For some, donating blood is a charitable contribution that doesn't involve much time or money; it's also a way to repay blood that was given to a friend or family member in a crisis.

Some people would like to donate, but can't because of medical restrictions, such as being under the 110-pound minimum weight limit, recent pregnancy, or prior exposure to a communicable disease. Others are afraid of needles or faint at the sight of blood—genuine considerations.

The only out-and-out bad reasons not to donate are the ones based on misconceptions. The latest and most harmful myth involves AIDS (Acquired Immune Deficiency Syndrome). Fear of contracting AIDS is causing a serious decline in donations while the need for blood continues to rise. In many areas, more than 50 percent of the ...d used for transfusions comes ... blood drive donations—and misconceptions are keeping people away, particularly in urban centers.

**Donating blood does not cause AIDS. If you are at risk to contract or carry AIDS, don't give blood. If you're not, the blood banks can use your help.**

"All blood collection agencies use new needles for each donor," says U.S. Surgeon General C. Everett Koop, M.D. "That needle is sterile and is thrown away after a single use. You *cannot* get AIDS by giving blood."

Many blood banks follow the procedure used by San Francisco's Irwin Memorial Blood Bank, where each needle used in donation comes sealed in its own protective casing. The covering is not removed until the appropriate spot on your arm has been cleaned with an antiseptic solution. After the donation, a nurse detaches the needle from the blood bag and discards it in a special waste bag so it can be destroyed at the end of the day.

How did this fear of contracting AIDS by donating blood come about? Probably because a small percentage of people who *received* blood have developed AIDS. To make donating safer for you, blood banks review your medical history with you to ensure you're in good health; they also examine you for physical or laboratory signs essential to qualify you as a donor. Check with your local blood bank for information on their procedures.

*Reprinted with permission from Pacific Bell* UPDATE.

# Having fun and feeling good!

This is what a group of employees from the Los Angeles Dealer Center is saying about the aerobics class they head off to after work. VP and Area Administration Officer Robert Mandela says it's a great way to reduce the stress after a busy day in this production-oriented unit. Employees agree. Four days a week, 28 of them gather for an hour after work to stretch, bend, jump, and even shout in the pursuit of physical fitness.

The pilot class was made possible through a new program developed by Corporate Health Programs. The class accommodates both the beginner and the more experienced fitness buff. The convenience of exercising right after work allows employees to work off steam in a positive way, and then head for home feeling relaxed. The price of $2 per class seems well worth the personal benefits.

Other classes are underway for employees at Willow Glen Branch in San Jose, Salinas Main Office, Slauson-Pacific Branch in Huntington Beach, Bay Area Loan Center, and for several administrative units in San Francisco. Interested managers can obtain information on starting an aerobics class by contacting Corporate Health Programs #3666, San Francisco 622-1113.

## AIDS

*Continued from front page*

not to pass judgment on the person. Be supportive in whatever way you can. The disease itself takes a tremendous emotional toll, and it is imperative for persons with AIDS to have a circle of support around them."

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

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

***Where can a BankAmerican with AIDS turn for assistance?***

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

***Is an employee with AIDS eligible to receive BankAmerica benefits?***

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

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

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

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

# PACIFIC GAS AND ELECTRIC COMPANY

PG&E + 77 BEALE STREET • SAN FRANCISCO, CALIFORNIA 94106 • (415) 781-4211 • TWX 910-372-6587

March 18, 1988

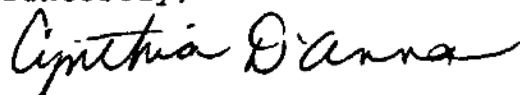
Enclosed is my resume and a description of my current position in the San Francisco corporate headquarters of Pacific Gas and Electric Company, a major Northern California Utility.

I am a licensed Marriage, Family and Child Therapist working with PG&E's Employee Assistance Program. This department is responsible for providing AIDS education and prevention services for employees and for consulting with management and supervisors on AIDS related issues within the workforce. The program is committed to updating this material with the most current information available. Additionally, we offer psychological interventions and referral services to employees with AIDS as well as support services for their family members. The department also assists management in program planning and policy development and implementation.

In my former position as the director of a large outpatient chemical dependency clinic in Santa Cruz County, California, I worked predominantly with chronic I.V. drug users. This work also involved developing AIDS education and awareness programs and assisting in the establishing of The Santa Cruz AIDS Project.

I am delighted to have the opportunity to speak at the Presidential Commission about PG&E's experience in addressing the issue of AIDS in the Workplace.

Sincerely,



Cynthia D'Anna M.A.,M.F.C.C.

# C Y N T H I A   D' A N N A

375 Eleventh Avenue, #1 . San Francisco, California 94118
415/751-5436 Home . 415/972-1628 Office


## EXPERIENCE:

1985 to Present — **EMPLOYEE ASSISTANCE SPECIALIST, Pacific Gas & Electric,** Corporate Headquarters, San Francisco. Provide consultation, crisis intervention and psychological referral services to management, employees and their families.

* Design and present educational Wellness and Prevention Programs with a mental health or behavioral focus.

* Consult on fitness for duty issues as impacted by social, emotional and family problems.

* Evaluate treatment resources and utilize diagnostic skills to assist in treatment, referral and case management.

1982-1985 — **DIRECTOR / Program Development Specialist, California Health Associates,** Santa Cruz. Directed out-patient substance abuse program. Supervised Counseling, Medical and Clerical Staffs, and Interns; designed and facilitated in-service training; chaired staff meetings; assigned workload. Interviewed and evaluated applicants. Participated in team management, and planning for regulatory compliance.

1982-1984 — **CONSULTANT** - on Call, **Santa Cruz County,** working in out- and in-patient psychiatric facilities. Made clinical assessments, diagnoses [using DSM III] and appropriate referrals for chronically mentally ill and acute crisis clients.

1981-1985 — **LICENSED PSYCHOTHERAPIST,** Santa Cruz. Built private practice with emphasis on Consulting and Training. Dealt with such issues as communication, conflict resolution, stress management, team building, creative problem solving, decision making, and substance abuse, working one-to-one and with groups.

1976-1982 — **Santa Cruz Community Counseling Center.**

**COORDINATOR,** Out-Patient, 1979-1982. Coordinated central intake. Developed policy. Designed and implemented recruitment and outreach programs. Screened/interviewed service applicants; made referrals. Provided individual/group/family drug treatment and educational programs.

**SUPERVISOR / COUNSELOR,** Residential [Oranda], 1976-1979. Supervised and evaluated Interns and employees. Developed training programs and seminars utilizing team building and peer feedback. Member of Board of Directors; chaired Personnel Committee. Marketed programs to the community.

## EDUCATION:

1980 — **M. A., Psychology, Antioch University West,** Pacific Grove, California.

1977 — **B. A., University of California,** Santa Cruz.

## PROFESSIONAL CREDENTIALS and AFFILIATION:

State of California Marriage, Family & Child Therapist License #MW 15829.

California Community College Credential: Psychology and Counseling.

Member, California Personnel and Guidance Association.

**REFERENCES** available upon request.

# AIDS IN THE WORKPLACE - OUTLINE

By Cynthia D'Anna M.A., M.F.C.C.

I. Introduction:

This presentation provides an overview of how PG&E successfully manages AIDS in the Workplace.

II. Managing AIDS in the Workplace.

How do you do it? - The nuts and bolts of the process.

What are the issues? - A review.

Why should companies take responsibility?
(why they cannot afford complacency?)

III. PG&E'S position.

CDC's guidelines- No health risk to other employees.

IV. Key elements in the development of the AIDS program.

1. Know your company's concerns.
2. Communicate the company position to employees.
   example, AIDS policy.
3. Provide ongoing educational services to employees.
4. Keep current with updated information on a regular basis.

V. Historical Perspective.

PGandE first became aware of the crisis in 1983 when several service employees were concerned about going into the homes of customers.

The program grew out of a need to dispel myths and minimize fear that surrounds the fatal disease.

Contracted with experts who addressed employees concerns.

VI. **The Role of EAP within the company.**

**Confidential and voluntary benefit to employees and their families.**

Provides assistance for a broad range of personal problems. ie: Family/marital, psychological and drugs and alcohol.

Consult with management and supervisors when a mental health perspective is needed.

Provides prevention and educational programs to employee groups management and supervisors.

VII. At PG&E, EAP is the designated department to carry out the AIDS services to the employees.

Psychological services.

Educational services.

Additional services.

VIII. New focus/trends.

Prevention.

The impact on the family.

IX. Questions and answers

PACIFIC GAS AND ELECTRIC COMPANY

77 BEALE STREET • SAN FRANCISCO, CALIFORNIA 94106 • (415) 781-4211 • TWX 910-372 6587

PG&E has long been recognized as taking a proactive approach in addressing the issue of AIDS and AIDS related complex (ARC). The Company's position reflects the position of the U.S. Department of Health and Human Services Centers for Disease Control that employees with AIDS do not present a health risk to other employees in the workplace.

The AIDS Education Program was first developed in 1983 when several service employees were concerned about going into the homes of some customers. Many employees were afraid that AIDS could be transmitted through casual contact. To address these concerns, PG&E developed a three step approach; communicate, educate and provide current and updated information on a regular basis. This strategy has been extremely successful in reducing fear and changing misconceptions of how the disease is transmitted. It has also served to replace fear and panic with sensitivity and concern for employees with AIDS/ARC.

Our current AIDS Prevention Education is provided by our Employee Assistance Program (EAP). The program includes a nine minute videotape entitled, "AIDS in the Workplace," which was prepared by PG&E's EAP, with the technical assistance of Dr. Paul Volberding, National medical expert on AIDS. We also use "An Epidemic of Fear: AIDS in the Workplace" videotape developed by S.F. AIDS Foundation and local businesses headquartered in San Francisco. During the educational program, we distribute various informational pamphlets from local resources. A major portion of the program is devoted to addressing individual employees' concerns or questions.

62-6218 (REV. 10/83)

**PGandE**

**FOR INTRA—COMPANY USES**

From Division or Department VICE PRESIDENT - HUMAN RESOURCES

To Division or Department

FILE NO. 705

RE: LETTER OF

SUBJECT AIDS

July 16, 1987

OFFICERS:

For some time now, PGandE has been a corporate leader in providing information to its employees to help them understand the nature of AIDS and related issues. Due to the magnitude of the problem, its costs, and its impact on family, friends, co-workers, and others, we must do more. In spite of all the media coverage and other available information, there are still many misconceptions about AIDS.

To help combat the AIDS problem, we are changing our focus and educational efforts to concentrate more on prevention and high risk behavior. This reflects a shift of emphasis from training of what AIDS is and is not to one of prevention. We must help our employees reduce their exposure to the AIDS virus.

These three steps are:

1. <u>Communication</u>

   Implementation of a comprehensive AIDS facts and general education communication program for our employees developed in cooperation with the Corporate Communications Department.

2. <u>Education</u>

   This is the most critical step and can be the most productive. Effective immediately, we are recommending that Company-sponsored AIDS training for all PGandE employees be conducted as follows:

   - Provide a one-hour formal presentation by an Employee Assistance Program (EAP) counselor. If your employees have not had AIDS training within the last 12 months, please contact your Human Resource Managers to coordinate a program. Your Safety Engineering Representatives also are available to assist with AIDS training or to answer supervisors' questions.

   - Supervisors are encouraged to give their employees a brief AIDS update quarterly. The AIDS Bulletin, soon to be published by EAP, may be used as the basis for this update. Bulletins will be published as additional information is available, but at least quarterly. The first update should start with a review of our AIDS policy (Attachment 1) and an update of the questions and answers (Attachment 2) issued last year.

- We recommend that AIDS training be offered to employees' families, after hours and on weekends. Our EAP staff is available to assist in conducting these sessions. In addition, EAP's video on AIDS is available to employees to take home and share.

- Include the AIDS policy and latest Bulletin as part of the new employee orientation program.

3. Keep Current

EAP counselors and Safety Engineering Representatives will be trained and kept current in the latest AIDS information. The Employee Assistance Program maintains a contract for consultation service with Dr. Paul Volberding, Assistant Professor at the University of California, San Francisco and Chief of the AIDS Activities Division at the San Francisco General Hospital. EAP counselors will share this information with you as it becomes available.

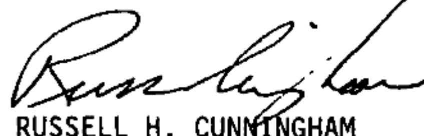
Three auditorium sessions have been scheduled. Each session will be videotaped with copies forwarded to your Human Resource Managers.

| Date | Subject | Speaker |
|---|---|---|
| July 30 | AIDS Update | Dr. Volberding |
| August 10 | AIDS Prevention | Dr. Wofsie |

The third session will be on AIDS in Children and Teens. However, the date and speaker have not been confirmed.

AIDS is an increasing problem and one that we cannot ignore. Currently, we have approximately ten confirmed AIDS cases and 100 AIDS-related complex (ARC) cases at PGandE. We project that in five years these figures will be 175 and 1750, respectively, unless a prevention program works to significantly impact the exposure of our employees to AIDS. (See Attachment 3 for more information.) We project 56 new AIDS cases per year will add $4.3 million to our health care costs. Aside from the humanistic concerns, these statistics reinforce the fact that it makes good business sense for us to provide preventive educational information on AIDS to our employees.

If you desire additional information, please contact your Human Resource Manager or Joe Mattox (Extension 222-2634), Administrator of our Employee Assistance Program.



RUSSELL H. CUNNINGHAM

RHC:tm

cc: Merek E. Lipson
Regional/G.O. Human Resource Managers
G.O. Human Resource Directors/Supervisors

Attachments

ATTACHMENT 1

# PACIFIC GAS AND ELECTRIC COMPANY
# POLICY STATEMENT AND GUIDELINES ON
# AIDS IN THE WORKPLACE

In keeping with two of our Corporate objectives to ensure a safe, healthy work environment for our employees and the public we serve, and to prohibit all forms of arbitrary discrimination in employment, we have developed the following policy statement and guidelines on how to handle personnel matters related to employees afflicted with AIDS. The policy statement and guidelines are based on the most current medical information on this subject available. If any significant medical developments occur, we will revise the statement and these guidelines accordingly.

## Policy Statement

It is PGandE's position that employees afflicted with AIDS do not present a health risk to other employees in the workplace under normal working conditions. Employees with AIDS are subject to the same working conditions and performance requirements as any other employee. However, if there is supervisory concern that an employee with AIDS is not able to perform assigned duties, a medical clarification examination may be required to determine the employee's fitness for work. Lastly, employees with AIDS, provided that they are otherwise eligible, are entitled to coverage under the Company's sick leave, medical leave of absence, disability benefits, and equal employment opportunity policies.

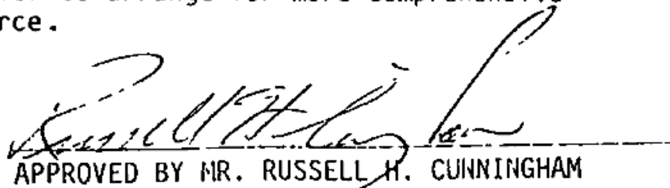
## Guidelines

1. Employees afflicted with AIDS should be treated the same as any other Company employee. However, if their medical or physical condition affects their ability to perform their assigned duties, they should be treated as any other employee who has a disability that prevents them performing the duties of their job.

2. If a supervisor has a reasonable basis to believe that an employee with AIDS is unable to perform the duties of their position, the supervisor must request the employee undergo a medical clarification examination. The results of the medical clarification examination shall guide future personnel decisions affecting the employee.

3. Employees afflicted with AIDS, to the extent they are otherwise eligible, are entitled to coverage under the Company's sick leave, medical leave of absence, disability benefits, and equal employment opportunity policies. When requested, supervisors and personnel department representatives should furnish information regarding those policies to affected employees.

4. If employees who share the same work environment with an employee with AIDS express concerns over their personal safety and health, supervisors must explain that, based on guidelines issued by the United States Public Health Service and expert medical opinions, causal contact with a coworker with AIDS poses no threat of transmission. If necessary, supervisors should contact an appropriate EAP counselor to arrange for more comprehensive education efforts for the work force.



APPROVED BY MR. RUSSELL H. CUNNINGHAM

July 16, 1987

DATE

Attachment 2

# QUESTIONS AND ANSWERS ABOUT AIDS

## What is "AIDS"?

"AIDS" stands for "Acquired Immune Deficiency Syndrome," a disease first recognized by the medical profession in 1981. AIDS is caused by a virus, commonly known as HTLV-III (human T-lymphotropic virus type III), which infects and destroys T-helper lymphocytes, a type of white blood cell which maintains a person's immune system. By destroying T-helper lymphocytes, the HTLV-III virus causes a severe suppression of the affected person's immune system, thereby leaving that person vulnerable to a variety of opportunistic infections and malignancies. Some of the opportunistic illnesses which a person afflicted with AIDS may suffer include Kaposi's Sarcoma (a rare form of skin cancer) and Pneumocystis carinii pneumonia (also a usually rare illness). There is currently no known cure for AIDS.

## How is AIDS transmitted?

Current medical information establishes that the transmission of AIDS has occurred only through the exchange of blood, blood products, or semen, between individuals. The exchange of these specified bodily fluids is normally associated with sexual intercourse, blood transfusion, and sharing of hypodermic needles by intravenous drug users. No evidence exists to indicate that the AIDS virus can be transmitted by the types of casual person-to-person contact that takes place within the household, school, or work environment.

The AIDS virus has also been found in bodily fluids such as saliva, urine, and tears. However, there has been no case reported where those fluids have been found to transmit the AIDS virus from one person to another.

## How widespread is the AIDS disease?

As an initial point of clarification, federal guidelines basically specify that an individual must suffer from one of the opportunistic infections or malignancies which normally afflict AIDS patients before an AIDS diagnosis is made. Based on those guidelines, as of the end of 1986 there were 25,000 reported cases of AIDS nationwide. Almost one-third of those cases were reported during the first nine months of 1986. Based on current trends, the number of AIDS cases can be expected to double over the next twelve months. About 14,000 AIDS patients have died since their diagnosis, and approximately 80 percent of those deaths occurred within two years of the diagnosis.

Medical statistics compiled thus far also reveal that, for every patient diagnosed with AIDS, approximately ten individuals suffer from milder forms of the disease called AIDS-Related Complex (ARC). Some of the symptoms of ARC patients are generalized swelling of lymph nodes, unexplained weight loss, unexplained fevers, and a general feeling of ill health. It is unclear at this time whether ARC patients will eventually develop AIDS or whether they will continue to suffer from their current symptoms as a milder variant of AIDS.

Is it safe to work with AIDS patients?

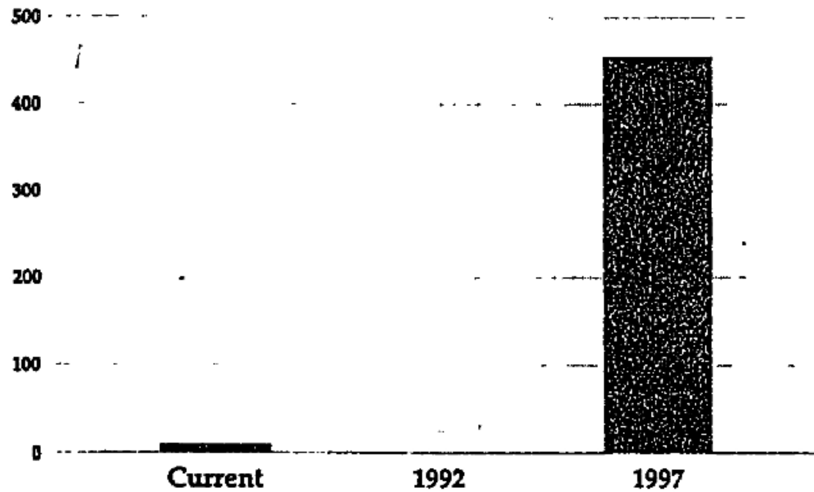
According to the Surgeon General's Report of the U.S. Public Health Services (USPHS), and several studies conducted by medical experts in this field, the answer is yes. Specifically, the USPHS guidelines make the following points regarding this issue:

- No known risk of transmission to coworkers, clients, or consumers exists from individuals with AIDS in work settings such as offices, schools, factories, and construction sites.

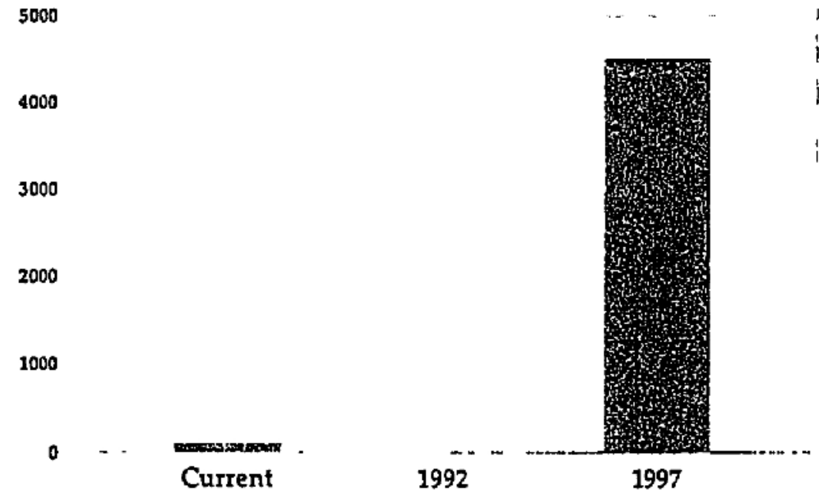
- AIDS infection is spread by sexual contact with infected persons, injection of contaminated blood or blood products, and by prenatal transmission.

- Workers with AIDS should not be restricted from work solely because they suffer from AIDS. Moreover, they should not be prohibited from using telephones, office equipment, toilets, showers, eating facilities, and water fountains.

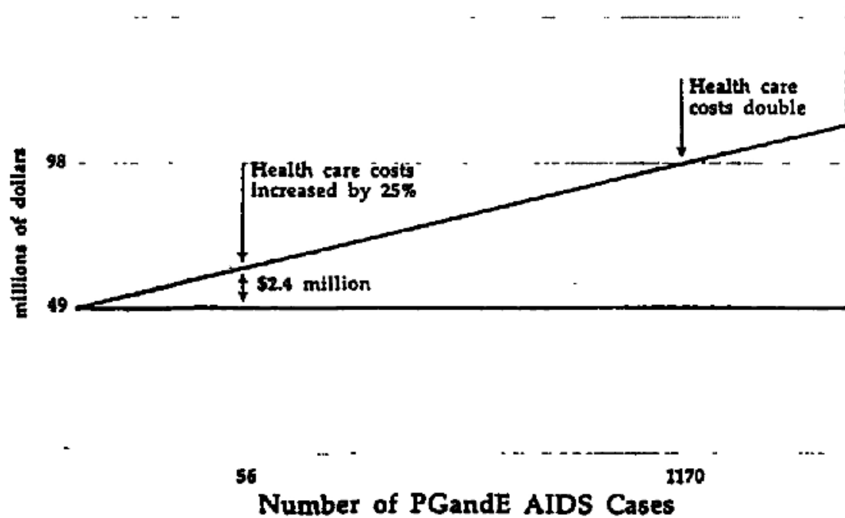
## Current Status & Expected Cumulative Number of AIDS Cases at PGandE



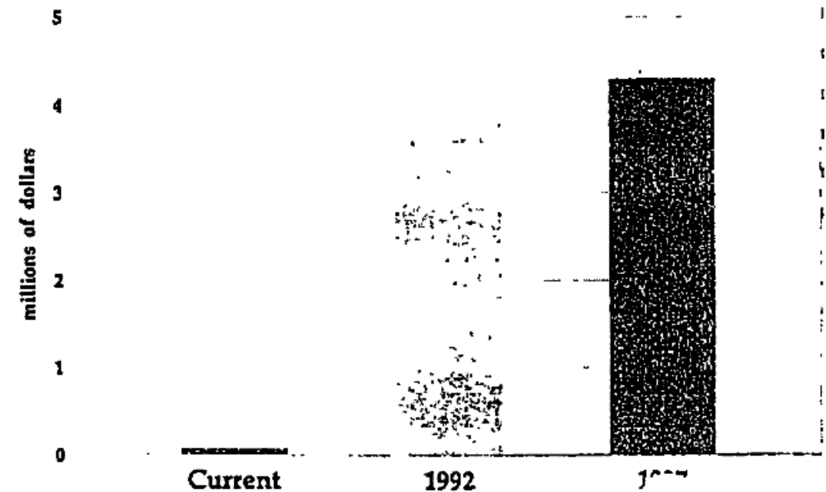

## Current & Expected Number of ARC Cases at PGandE




## Annual Health Care Costs Associated with AIDS Cases Compared to Standard Health Care Costs




## Annual Expected Health Care and Related Costs for AIDS Cases at PGandE



**TESTIMONY FOR THE PRESIDENT'S AIDS COMMISSION**

**DELIVERED BY**
**KPIX VICE-PRESIDENT AND GENERAL MANAGER CAROLYN WEAN**

**THURSDAY, MARCH 24, 1988**
**SAN FRANCISCO, CALIFORNIA**

A Public Se

SINCE 1985, KPIX HAS BEEN INSTRUMENTAL IN BRINGING AIDS EDUCATION AND INFORMATION TO THE BAY AREA AND MOST RECENTLY TO THE NATION THROUGH A NATIONAL PUBLIC CAMPAIGN WE PROVIDE TO LOCAL TELEVISION STATIONS.

I BELIEVE WE ARE HERE TODAY TO DISCUSS OPENLY WHAT WE CAN DO TOGETHER - TO CHANGE THE COURSE OF AIDS.

I WOULD LIKE TO SHARE A TAPE WITH YOU THAT FOCUSES ON EFFORTS TO PROVIDE INFORMATION TO THE PUBLIC. THESE EFFORTS WERE SUPPORTED BY CORPORATE SPONSORSHIP AND THE EXPERTISE, TIME AND ENERGY OF MANY PEOPLE IN COMMUNITY ORGANIZATIONS

T A P E

THERE IS MORE NEED, THAN BEFORE, TO EDUCATE AND INFORM. THE PUBLIC IS CURRENTLY BOMBARDED BY DIFFERENT OPINIONS AND VIEWS, SOME CREATING REAL ALARM AND PANIC, OTHERS COMPLACENCY.

AS YOU SAW, KPIX MADE A COMMITMENT TO INFORM THE PUBLIC ON THE AIDS CRISES. HOWEVER, LAST YEAR WITH MORE THAN A THOUSAND NEWS REPORTS BEHIND US, WE HAD TO ASK OURSELVES WERE WE INFORMED? DID WE HAVE UNANSWERED QUESTIONS... POINTS OF CONFUSION... AREAS OF FEAR. WERE WE AS MANAGERS PREPARED TO DEAL WITH AIDS IF IT WAS ONE OF US OR ONE OF OUR EMPLOYEES?

WITH THE HELP OF EXPERTS, THE SAN FRANCISCO AIDS FOUNDATION, WE SET UP A SERIES OF SEMINARS. THE FIRST TO GIVE INFORMATION TO ALL OF US AT KPIX. THE SECOND TO MAKE SURE OUR MANAGERS UNDERSTOOD OUR POLICY AND TO ALLOW THEM TO DISCUSS HOW TO DEAL WITH AN EMPLOYEE WHO HAD AIDS. SIMPLY PUT, OUR POLICY IS, AN EMPLOYEE WITH AIDS IS TO TREATED THE SAME AS ANY PERSON WITH A DEBILITATING DISEASE. INSURANCE COVERAGE WOULD BE THE SAME. DISABILITY WOULD BE THE SAME. AS LONG AS THE PERSON IS ABLE TO PERFORM HIS JOB, HE CAN WORK.

PERSONAL STORY

WE WERE ABLE TO BECOME MUCH BETTER INFORMED WITH SUPPORT OF COMMUNITY GROUPS.

IT IS JUST THIS TYPE OF PARTNERSHIP THAT HAS ALLOWED US TO MEET THE NEEDS OF KPIX, TO HELP INFORM OUR COMMUNITY AND TO PROVIDE A NATIONAL INFORMATION CAMPAIGN TO LOCAL T.V. STATIONS ACROSS THE COUNTRY.

SOME EXAMPLES OF OUR PUBLIC PRIVATE PARTNERSHIPS:

IN 1985, THE SAN FRANCISCO AIDS FOUNDATION AND KPIX CREATED AND DISTRIBUTED THE AIDS LIFELINE BROCHURE; NOW IN FOUR LANGUAGES AND BRAILLE. THERE ARE MORE THAN 1/2 MILLION IN CIRCULATION.

IN 1986, AMFAR, THE SAN FRANCISCO AIDS FOUNDATION AND KPIX CO-PRODUCED 62 PUBLIC SERIVCE ANNOUNCEMENTS WHICH WERE DISTRIBUTED THROUGHOUT THE NATION TO LOCAL TELEVISION STATIONS FREE OF CHARGE.

IN 1987, TOGETHER WITH THE NAMES PROJECT, KPIX PRODUCED AN HOUR LONG PROGRAM IN PRIME TIME TO BRING TO THE BAY AREA "THE NAMES QUILT" IN ITS FIRST SAN FRANCISCO SHOWING THE SAN FRANCISCO EXAMINER JOINED IN THIS EFFORT. WE CALLED THAT SPECIAL "THREADS OF LOVE". IT SHOWCASED BAY AREA PEOPLE WHO GIVE THEIR TIME TO HELP AIDS PATIENTS. THE SPECIAL OFFERED THE PEOPLE A DIRECTORY TELLING THEM HOW TO VOLUNTEER. ONE HUNDRED TWENTY THOUSAND DIRECTORIES WERE DISTRIBUTED.

WHEN THE NAMES PROJECT NEEDED MONEY TO TAKE THE QUILT ON TOUR ACROSS THE COUNTRY, WE CREATED WITH THEM, THE "ADOPT-A-QUILT FUND. NEXT WEEK, THIS PROJECT FEATURES A NEW NATIONWIDE PUBLIC SERVICE ANNOUNCEMENT WITH COMEDIAN ROBIN WILLIAMS.

WITH THE HELP AND FUNDING OF METROPOLITAN LIFE, AND WITH THE COOPERATION OF THE WORLD HEALTH ORGANIZATION OUR CAMPAIGN, AIDS LIFELINE, IS NOW A NATIONAL EFFORT BRINGING INFORMATION TO MORE THAN 50 TELEVISION MARKETS. IT CAN POTENTIALLY RAISE OVER A MILLION DOLLARS FOR PATIENT CARE IN LOCAL COMMUNITIES.

WE ENCOURAGE ALL STATIONS IN THE AIDS LIFELINE NETWORK TO FORM WORKING RELATIONSHIPS WITH THEIR OWN COMMUNITY ORGANIZATIONS. FOR EXAMPLE, IN SAN FRANCISCO, ALL OF OUR MATERIALS ARE MADE AVAILABLE FREE OF CHARGE TO THE CATHOLIC TELEVISION NETWORK AND TO THE SAN FRANCISCO UNIFIED SCHOOL DISTRICT.

IN 1988, WE WILL PRODUCE APPROXIMATELY 50 PUBLIC SERVICE ANNOUNCEMENTS, AND WE ALSO WILL SPONSOR SAN FRANCISCO'S LARGEST AIDS FUND RAISER, "AIDS WALK - SAN FRANCISCO." NONE OF THIS COULD HAVE BEEN ACCOMPLISHED ALONE.

IN WASHINGTON, WE SUGGESTED THREE THINGS:

1) THAT A NATIONAL NEWSLETTER BE PRODUCED. THIS NEWSLETTER WOULD BE A WEEKLY DIGEST ON THE LATEST DEVELOPMENTS WITH AIDS, PROGRESS WITH TREATMENT, MODEL PROGRAMS, THE LATEST INFORMATION FROM THE CDC, THE NIH AND THE PUBLIC HEALTH SERVICE.

WITH A CENTRAL AIDS INFORMATION OFFICE, THE MEDIA COULD SPEED UP LIFESAVING INFORMATION TO THE GENERAL PUBLIC. IF YOU NEED AN EXAMPLE OF A MEDIA ALERT, LOOK TO THE SAN FRANCISCO AIDS FOUNDATION. ITS NEWSLETTER IS SIMPLE, EASY TO PRODUCE, YET IT KEEPS US CURRENT ABOUT AIDS IN SAN FRANCISCO. A NATIONAL NEWSLETTER COULD SERVE THE SAME PURPOSE FOR THE NATION

2) NEXT, WE SUGGESTED THAT YOU USE THE BAY AREA AS A MODEL AND SET UP A NATIONAL SEMINAR FOR THE MEDIA. WE WOULD BE HAPPY TO HELP COORDINATE SUCH A SEMINAR. RADIO, T.V. AND NEWSPAPERS COULD SEND THEIR PEOPLE TO MEET WITH NATIONAL AND LOCAL EXPERTS TO DEVELOP WAYS TO IMPROVE THE FLOW OF INFORMATION AND TO ADDRESS LOCAL AUDIENCES AND REACH GROUPS SUCH AS I V DRUG USERS. THE DEVELOPMENT OF PUBLIC PRIVATE PARTNERSHIPS COULD BE THE THEME OF THE MEETING.

3) LASTLY, WE ASK THAT PRESIDENT REAGAN STEP FORWARD TO MOTIVATE AND UNIFY.

THAT HE BECOME A VISIBLE SUPPORTER OF AIDS EDUCATION AND OF VOLUNTEERISM.

THAT HE BECOME A VISIBLE SUPPORTER OF RESEARCH AND DRUG TREATMENT, ESPECIALLY WITH FEDERAL FUNDING.

THAT HE BECOME A VISIBLE LOBBYIST FOR A CRISES INCREASING DAILY... THE CHILDREN WITH AIDS.

I BELIEVE THAT WE MUST HAVE SUPPORT AT THE HIGHEST NATIONAL LEVEL. IF WE DO, WE CAN TAP WHAT IS BEST IN THE AMERICAN SPIRIT - THE DESIRE "TO MAKE IT BETTER". THAT SUPPORT MEANS MONEY AND THE WILLINGSNESS TO STAND UP.

YOU HAVE BEEN CHARGED TO MAKE RECOMMENDATIONS - THIS IS AN AWESOME RESPONSIBILITY. YOU HAVE THE POWER TO HELP US CHANGE THE COURSE OF THIS DISEASE, TO INTERVENE AND REWRITE THE FUTURE.

# AIDS LIFELINE

KPIX-TV is a leader among Bay Area corporations in AIDS education, education not only of the public but of KPIX employees as well. As journalists, we felt a responsibility to educate internally before launching a national effort to educate the country. This in-house education program will be one of three topics addressed when Carolyn Wean, Vice President and General Manager of KPIX, testifies before the President's Commission on the HIV epidemic. Although this is her second appearance before the Commission, the testimony will be very different.

Ms. Wean has already told you how KPIX has launched a national public service campaign called AIDS Lifeline. Now in fifty cities, AIDS Lifeline is an on-going series of primetime specials, news reports, public service announcements and home videos. The license fees which stations pay for Lifeline programming are donated to AIDS caregiving organizations.

In her new testimony, Ms. Wean will address KPIX employment policies on AIDS, the ways in which KPIX has educated its employees, and the unique relationship KPIX has with the Bay Area's numerous community-based organizations. That relationship is truly significant. No other bay area media outlet has done more to assist local community groups in educating the public Working closely with the San Francisco AIDS Foundation and The Names Project, KPIX has sponsored numerous events, publicized those events and kicked in financial assistance to insure their success. It is an unprecedented partnership which can and should serve as a model to local television stations throughout the country.

# News Release

23 March 1988

Contact: David Landis
Celeste M. Alleyne
(415) 765-8874

*********************
MEDIA ADVISORY
*********************

**KPIX-TV VICE-PRESIDENT AND GENERAL MANAGER CAROLYN WEAN TESTIFIES BEFORE "PRESIDENT'S COMMISSION ON THE HUMAN IMMUNO-DEFICIENCY VIRUS EPIDEMIC"**

**WHAT:** KPIX-TV Vice President and General Manager Carolyn Wean testifies before the "President's Commission on the Human Immuno-Deficiency Virus Epidemic."
Her testimony will include: an update on the National AIDS Lifeline campaign activities and productions; KPIX employment policies on AIDS; how KPIX has educated employees on AIDS; KPIX'S support of community based organizations regarding AIDS; suggestions for a national AIDS newsletter

**WHERE:** San Francisco Department of Health
101 Grove Street
Third Floor

**WHEN:** Thursday, March 24, 2:15 p.m.

**WHO:** Representatives from the following major San Francisco corporations will give testimonies: KPIX-TV; Pacific, Gas & Electric; Bank of America; Wells Fargo; Transamerica Insurance and Levi Strauss

*********************

KPIX-TV Vice President and General Manager Carolyn Wean testifies before the "President's Commission on the Human Immuno-Deficiency Virus Epidemic," at 2:15 p.m., Thursday, March 24 at the San Francisco Department of Health. For further information on Ms. Wean's testimony, please phone KPIX at (415) 765-8874.

-30-

855 BATTERY STREET, SAN FRANCISCO, CA 94111-1597 (415) 362-5550

To: Don Mitzner

Carolyn Wean

December 8, 1987

Employee Awareness on AIDS

In response to your memo, the following measures have been taken to insure that all employees are informed about AIDS and that managers and supervisors are aware of the company policy regarding AIDS related concerns in the workplace:

1. Seminars were given in September 1987 for all employees regarding AIDS. An additional series of AIDS classes (5) are scheduled for December. The presenters are from S.F. AIDS Foundation. The classes are being held during all hours of the day to insure maximum attendance from employees working different shifts. Another series will be conducted in January/February 1988.

2. Additional classes are being held specifically for managers and supervisors to discuss the ramifications of AIDS in the Workplace and to familiarize them with Group W's guidelines. Speakers are from the S.F. AIDS Foundation. Attendance at the general AIDS classes and those for managers and supervisors are mandatory for individuals supervising employees.

3. Brenda Lowe has reviewed the case study of "Rowena" (used during the Group W training modules) with department heads and their management staff.

After speaking to all the department managers, we feel that there is a general awareness of AIDS among our employees due to distributed materials (from S.F. Aids Foundation and Group W), classes and the programs about AIDS from the news and programming departments.

The best defense against AIDS and against the fear of AIDS i nformation.....Its the responsibility of the stations t... commit themselves to educating the public, also commit to implementing an internal education program for their managers, supervisors and employees.

1. Company policy:

   a. Develop policies that fall within the confines of existing laws.
   b. Keep abreast of laws in different jurisdictions where company branches are located.
   c. Consider types of potential litigation arising from employer or employee action.
   d. Develop standard guidelines that apply policies consistently throughout departments.
   e. Secure senior management approval and support of the policies and programs.
   f. Alleviate anxiety of employees with AIDS by clearly stating company expectations and policy.
   f. Plan ahead to avoid a crisis and decrease response time to an actual case.

Excerpts from "AIDS in the Workplace" Business Leadership Task Force of the Bay Area

2 Employee Education Programs

Develop a series of employee meetings with the local AIDS agency. The most effective meetings were the ones that communicated the "basics" of AIDS and encouraged employees to ask questions. Although the meetings were not mandatory, employees were strongly encouraged to attend by their supervisors. Vary meeting times and dates so that all employees find a convenient time to attend during their work schedules.

Each meeting should last approximately between 45 minutes - 1 1/2 hours. The Human Resource manager should also attend all the meetings to reinforce company policies and guidelines and to keep a "pulse" on employee attitudes of AIDS in the workplace. A copy of the company guidelines and policy should be distributed to all employees. The Human Resource manager should communicate both negative and positive feedback to senior management.

## Management Education Program

Since managers and supervisors will be challenged by a number of issues having both legal and human resource ramifications, separate meetings should be held in addition to the general AIDS employee meetings. The attendance of supervisors and managers at the employee meeting and supervisory meeting should be mandatory (the supervisors and managers should attend the AIDS education class first). Again, the meetings are coordinated with a representative from the local AIDS community agency.

Three basic general principles are explored:
Rational, Humane Treatment
Legal Rights and Responsibilities
Medical Information

Discussions include but are not limited to the following areas:

1. Confidentiality
2. Testing
3. Employees with AIDS
4. Employees that Have Tested Positive
5. Refusal to Perform Job Duties
6. Facilities: A Safe Working Environment
7. Education
8. Counseling

## Questions And Answers About Aids – Related Concerns at Group W

As the AIDS epidemic continues, we at Group W are committed to responsible management of our concerns about AIDS both internally and in the communities we serve. Managers have been provided with an overview of the principles, policies and management practices for dealing with AIDS-related concerns at Group W.

This is the first in a series of communications aimed at providing all employes with the most current information about AIDS in the workplace.

• • • • • •

1. *What is AIDS?*

   The initials, AIDS, stand for Acquired Immune Deficiency Syndrome. This is a medical term that refers to an infection caused by a virus. It causes a collapse of the body's natural ability to fight other diseases. Because of the collapse, people with AIDS are vulnerable to diseases, including a rare type of cancer, and certain infections that do not ordinarily threaten people whose immune system is working normally.

2. *How Do You Get AIDS?*

   The only way to get AIDS is to get the virus in your blood. The four main ways that this can occur are (1) through sexual contact, (2) by sharing an infected hypodermic needle, as drug users often do, (3) by receiving AIDS infected blood or blood products through transfusion or injection, and (4) by an infected mother transmitting it to her baby during pregnancy.

3. *Can You Get AIDS from Food, Air or Water?*

   The answer is NO! There have been no known cases resulting from transmission by toilet seats, clothing, dishes, utensils, sneezing, coughing, touching, biting, kissing, or simple contact with someone who has AIDS.

   In families where children have played, eaten, slept, kissed and fought with a brother or sister with AIDS, there have been no cases of child-to-child or child-to-adult transmission. In fact, there are no known cases of family members being affected with AIDS by simply living with a relative who has the disease.

4. *Is There a Cure for AIDS?*

   No, not at the present time. No immediate cure is likely in the near future.

5. ***Are any AIDS-related blood tests (HIV antibody, T-Cell tests, etc.) given as part of a pre-employment physical or other medical examination requested by Group W?***

   The current state of medical knowledge presents no medically sound reasons to test employes or applicants to determine whether they have AIDS antibodies. Group W, therefore, has no plans and anticipates no future need for such testing.

6. ***If an employe has a medical history that includes an AIDS-related illness or a positive antibody test before they are employed by Group W, might they be denied employment or insurance coverage?***

   No

7. ***If an employe, program guest or any other person with whom work-related contact is required has AIDS or a positive antibody test, do other employes have a "need to know" this information?***

   No. The exception would be the unlikely case involving physical contact that could result in transmission of blood from an infected person, but such a situation would be very rare in our business. Based on numerous studies of transmission the U. S. Center for Disease Control has concluded that there is no likelihood of the spread of AIDS in a workplace such as ours, as casual contact does not spread the virus, the virus is not airborne (e.g. through coughs or sneezes), and the virus cannot penetrate unbroken skin. While the virus has been found in very low concentrations in saliva, the only known mode of transmission is through semen and blood, where it may be found in relatively high concentrations.

8. ***Do such employes have the right to refuse to work with such an employe or to take precautions (rubber gloves, face masks, etc.) that they feel are necessary?***

   No. Employes do not have the right to refuse to work with such employes because there is no danger of infection in the course of routine job duties. CDC recommends that no special precautions be taken regarding AIDS in ordinary workplace circumstances, except that in first aid situations appropriate precautions should be taken regarding contact with blood.

9. ***If I know or suspect that someone has AIDS or a positive antibody test should I notify Human Resources, management or any other employes?***

   No. The divulgence of such medical information is the sole province of the individual with the medical condition.

10. ***If I know or suspect that I have AIDS or might be at high risk for the illness, how should I handle this at work?***

    First, immediately seek appropriate medical assistance for confirming or negating such belief or suspicion, and follow your doctor's advice about prevention or treatment. The responsible approach at work would be to inform those who "need to know" at the appropriate time. The decision to communicate the exact nature of one's illness rests with the individual.

11. ***What kind of medical insurance does Group W provide for people with AIDS?***

    AIDS is a medical condition. As such, medical benefits are payable in accordance with the Westinghouse Insurance Plan or the employe's Health Maintenance Organization (HMO).

12. ***What if an employe with AIDS needs to be treated with expensive experimental drugs – is the cost covered?***

    Insurance carriers vary with regard to experimental treatments for AIDS. At this time, Equitable may under certain circumstances, pay for such treatments on a case by case basis. Many HMOs however, will not cover treatments deemed to be experimental in nature. Specifics on the treatments covered must be obtained through Equitable or your own HMO.

13. ***What if I become partially disabled or completely unable to work as a result of ARC (AIDS-related complex) or full-blown AIDS?***

    Disability benefits are payable under the terms and conditions outlined in the Westinghouse Insurance Plan. Other benefits may be payable under the Long Term Disability Program or the Management Disability Benefits Plan provided the employe is eligible and enrolled in the Program.

14. ***If my disability benefits through Group W insurance and/or social security would represent only a portion of my salary, should I consider getting additional coverage if I know I'm at risk for AIDS infection?***

    While we believe that Westinghouse benefits are adequately designed for those employes who meet the eligibility and enrollment requirements, it is up to the individual to assess if additional disability coverage is required.

15. ***What about life insurance? How do I know if my Group W coverage is enough?***

    It is important for each individual to decide how much life insurance is enough. Your Human Resource Representative can inform you of howmuch insurance coverage you have through the Westinghouse benefit plans.

**A Word of Advice...**

It is most important that each of us be intimately familiar with our insurance coverage, not only for ourselves, but for our dependents. There are some variations in benefits between HMOs and the Westinghouse Insurance Plan.

Likewise, there are several different disability plans, depending on employment category and whether or not we have elected to participate in a specific plan. So make it your business to fully acquaint yourself with your benefits. If you're not certain, see your Human Resources representative.

If you have questions about AIDS, that do not relate to benefits, I'll be happy to help.

Wade Williams
1-800-225-4299

## To Learn More About AIDS....

Free Publications (send a self-addressed, stamped, long envelope)

*"When A Friend Has Aids"*

*"I Can't Cope With My Fear Of Aids"*

*"Women Need To Know About Aids"*

Write: The AIDS Service and Education Foundation, Box 274, 132 West 24th Street, New York, N. Y. 10011

*"Acquired Immune Deficiency Syndrome: 100 Questions and Answers"*

Write: AIDS, N. Y. State Health Dept., Empire State Plaza, Corning Tower, Room 1931, Albany, N.Y. 12237

*"How To Talk To Your Children About AIDS"*

Write: Dept of Health Education, N. Y. University, 715 Broadway, New York, N. Y. 10003

*"The Surgeon General's Report On AIDS"*

Write: AIDS, P.O. Box 1452, Washington, D.C. 20044

Telephone Hotlines

AIDS Hotline – Public Health Service
800/342–AIDS

National Gay Task Force
AIDS Information Hotline
800/221–7044
212/807–0616 (New York State)

Information sources

U.S. Public Health Service
Hubert H. Humphrey Bldg.
Room 721–H
200 Independence Ave., S.W.
Washington, D.C. 20201

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For Other AIDS information and assistance call your RAP Hotline:
800/225–4299

# MANAGEMENT GUIDELINES

## AIDS-Related Concerns at Group W

As a leader in the communications industry, Group W has a long tradition of positive, forward-looking approaches to contemporary issues as they impact on our workplace. Publicity about acquired immune deficiency syndrome (AIDS) continues to grow, and we recognize the desirability of updating our guidelines for managers in dealing with work-related questions posed by AIDS.

These guidelines are intended to educate managers about the principles of conduct that we expect will be applied in AIDS – related situations, including situations where AIDS Related Complex (ARC) or seropositivity to the virus believed to cause AIDS may be involved. However, they are not intended to create legally binding contractual commitments to employes, are not intended for distribution to employes other than selected managerial personnel, and may be changed at any time by the company.

### GENERAL PRINCIPLES

There are three basic general principles underlying these guidelines:

1. Rational, Humane Treatment: Our goal of treating people (employes and non-employes) in a fair and compassionate manner.

2. Legal Rights and Responsibilities: Our responsibility to adhere to the requirements of all applicable federal, state and local laws both with respect to the legal rights of employes and applicants and to the duty to provide a safe working environment.

3. Medical Information: Our commitment to base our management practices to the latest responsible medical information available from public health officials, especially the Centers for Disease Control (CDC) of the U.S. Public Health Service, and other medical experts.

### Rational, Humane Treatment

Segregation, discrimination or humiliation of people are against the principles upon which Group W hopes to see people treated. In the context of AIDS, we cannot condone any inhumane or irrational conduct directed at a person who has AIDS, is thought to have AIDS, is thought to be at risk for AIDS or associates with any of these groups. Managers should understand that Group W's high standards for fair and equal treatment (of members of our workforce, applicants and members of the public in all contexts) extend to AIDS – related situations as forcefully as they do to any other.

## Legal Rights and Responsibilities

Although the issue has not been definitely settled on the federal level, it presently seems that AIDS qualifies as a handicap under the federal law, and many state fair employment practices agencies and a few state courts have declared AIDS, ARC and even positivity to the antibody to the AIDS virus to be a protected condition under state law. Some jurisdictions (e.g. the City of Los Angeles) specifically prohibit AIDS – related discrimination.

Federal law applicable to federal contractors and subcontractors prohibits discrimination in employment against otherwise qualified individuals based upon the individual's handicap, a perception that the individual has a handicap or the individual's record of having had a handicap. In addition, federal contractors and subcontractors must make reasonable accommodations if that will enable handicapped persons to perform their jobs. The laws of most states and many cities and countries have similar requirements.

Without necessarily conceding that federal, state and local law requires such conduct, our practice should be to assume that an individual with AIDS, ARC or who is seropositive (or who is perceived as such) is protected by the laws prohibiting employment discrimination against the handicapped.

In addition, managers should be aware that unwarranted behavior against individuals (typically arising from unawareness or prejudice) may give rise to other kinds of liability, either for the company, an individual or both. This could include suits for libel, slander, intentional infliction of emotional distress (sometimes called "outrage"), invasion of privacy, malice, assault, battery or malicious interference with contract relations.

## Medical Information

The CDC has issued official guidelines concerning AIDS in the workplace, premised on current medical information indicating that the AIDS virus is spread by sexual activity involving the exchange of infected body fluids, sharing needles in intravenous drug use, transfusions of infected blood or from an infected mother to a fetus during pregnancy.

Based on numerous studies of transmission, the CDC has concluded that there is no likelihood of the spread of AIDS in a workplace environment such as ours, as casual contact does not spread the virus, the virus is not airborne (e.g. through coughs or sneezes) and the virus cannot penetrate unbroken skin. While the virus has been found in very low concentrations in saliva, the only known mode of transmission is through semen and blood, where it may be found in relatively high concentrations. Repeated, rather than one, exposure appears to increase the likelihood of transmission.

CDC recommends, in effect, that no special precautions be taken regarding AIDS in ordinary workplace circumstances, except that in first aid situations appropriate precautions should be taken regarding contact with blood.

## SPECIFIC SITUATIONS

While these guidelines cannot be exhaustive, the following applications of the above principles in selected situations about which managers may have concerns may be illustrative.

1. **Confidentiality**

   Consistent with our general policies regarding medical information, all medical information regarding an employe who has AIDS, or ARC or who is seropositive should be kept strictly confidential. Medical information will not be shared with managers and supervisors except at the employe's specific direction. Managers and supervisors who obtain medical information regarding an employe will treat such information as confidential, and will disclose such information on a confidential basis only to the local Human Resources representative if guidance on medical matters is needed, and the Director of Human Relations Services (Wade Williams), in the event guidance on policy is needed.

   Insurance claim information is to be treated as confidential information.

   Respect for the privacy of non-employes (including actors and guests on programs) should be consistent with this policy. Unless an individual disseminates information about his or her health, discussion or speculation about the medical condition of non-employes who may be involved with our businesses for any reason is inappropriate.

2. **Testing**

   Under the current state of medical knowledge there is no medically sound reasons to test employes or applicants to determine whether they have AIDS antibodies, and Group W will not do so.

3. **Employes with AIDS**

   Any employe who is known or believed to have AIDS or ARC should be permitted (and indeed should be expected) to continue working as long as he or she is able to perform the job with reasonable accommodation; this is the same treatment we would give and expect of any employe having a handicap. Reasonable accommodation will be determined on the basis of financial cost and business needs. No negative decision regarding accommodation of an employe whose doctor certifies him or her as being able to work should be made without consultation with both the local Human Resources representative and Director of Human Relations Services.

Our accommodation to AIDS and AIDS – related conditions should be the same as, and performed with the same commitment as, our accommodation to any other medical condition, such as pregnancy. We do not "favor" AIDS – we treat it like any other medical condition on a case-by-case basis.

It should go without saying that any segregation, discrimination or negative treatment of any kind by any employe toward another person related to that individual's having or being perceived as having or being at risk for AIDS or ARC or being antibody positive is totally inconsistent with these guidelines and requires prompt and effective management intervention.

Any employe who is medically unable to work because of AIDS or ARC will, of course, receive whatever disability benefits he is entitled to, as well as his regular medical benefits as appropriate. Our insurance carrier has been instructed to undertake case management procedures in all cases, including AIDS, having catastrophic potential, in order to assure the delivery of appropriate medical care at the most reasonable cost.

## 4. Refusal to Perform Job Duties

As all job responsibilities and acceptable social interaction in the workplace requires only casual contact (of the kind CDC states does not give rise to the danger of infection), refusal by an employe to perform his or her job assignment because it involves dealing with people who have or are believed to have AIDS or ARC or who are known or thought to be AIDS-antibody positive is no more justified than any other refusal to perform assigned work and should be dealt with accordingly. This is true whether the refusal arises from dealing with the public (e.g. refusal to cover a story related to AIDS) or from interacting with a co-worker.

However, managers should be aware that the best way to fight this kind of behavior is through education and counseling about the medical realities of AIDS transmission.

## 5. Facilities: A Safe Working Environment

According to CDC guidelines, no special precautions are required with respect to facilities or equipment in offices, shops, cafeterias or restrooms, including telephones, documents, typewriters, tools and other equipment. Managers cannot permit special "precautions" involving tools, equipment or facilities if there is a danger that this will make handicapped or perceived handicapped people uncomfortable or subject to differential treatment.

Group W is committed to providing a safe workplace for all employes, and we are advised that special safety precautions related to AIDS are unnecessary.

## 6. Education

In conjunction with Wade Williams, Corporate Director of Human Relations Services, and local Human Resources managers, information can be distributed to employes and, if needed, extensive educational programs can be developed. This may include current publications from public health officials and responsible medical sources, and video programs such as the "AIDS Lifeline" series produced by our own Group W TV stations. It may also include utilization of authoritative federal, state or local health officials or other health professionals.

Managers are also strongly encouraged to attend Part II of the Group W Management Training Program, which includes case studies and decisions on Group W policies and procedures for dealing with AIDS – related incidents.

## 7. Counseling

Our RAP (Referral Assistance Program) provides completely confidential access to appropriate professional services (including medical, psychological and legal referrals). The assistance is available through local RAP representatives or by calling Wade Williams, Corporate Director of Human Relations Services, 212 – 307 – 3790. Mr. Williams may also be called anonymously on the RAP hotline, 1 – 800 – 225 – 4299.

## 8. Reporting to Management on AIDS – Related Incidents and Legal Developments

We are eager to keep abreast of developments as they occur in the communities we serve. Accordingly, managers are expected to report to Wade Williams any new legal developments in their areas relating to AIDs, as well as any major incidents involving our employes.

Accordingly, any inquiries regarding AIDS policy and procedure or medical facts should be addressed to Wade.

# AIDS QUESTIONNAIRE

Circle the correct answer:

1. Can you legally fire an employee who has AIDS? yes or no

2. Can a company force an employee with AIDS to take a medical leave of absence? yes or no

3. Can a company force employees with AIDS to work in isolated areas? yes or no

4. Can you test employees and job applicants for AIDS? yes or no

5. Can you allow healthy employees to refuse to work with an employee who has AIDS? yes or no

6. Can a company dismiss an employee because he has the AIDS virus but hasn't developed the disease? yes or no

7. Can the company release AIDS test results to other employees? yes or no

8. Can a health insurance carrier test employees for AIDS? yes or no

9. Can the company's health insurance provider cancel a policy if it finds that the company has employees with AIDS? yes or no

10. Can you ask employees or job applicants if they have AIDS? yes or no

# AIDS PANEL LIST

Cherie Pies
Alameda County Department of Public Health
499 5th St.
Oakland, CA 94607

Ed Hilton
San Mateo County Department of Public Health
225 37th Ave.
San Mateo, CA 94403
573-2588

Bart Amarillas
~~Gay American Indians~~
AIDS Outreach Program
333 Valencia St. #207
San Francisco, CA 94103
621-3485

John Lorenzini
AIDS Project of the East Bay
400 40th St. Ste. 200
Oakland, CA 94609
420-8181

Anne Marie Madison
2210 Jackson St. #404
San Francisco, CA 94115
929-7577

David Burgess
Santa Clara Department of Public Health
2220 Moor Park Ave.
San Jose, CA 95128
408-299-5858
4151

Miguel Ramirez
P.O. Box 6182
San Francisco, CA 94101
864-4376

Catherine Maier
P.O. Box 6182
San Francisco, CA 94101
864-4376

Reggie Williams
Black and White Men Together
2269 Market St.
P.O. Box 199
San Francisco, CA 94114

Noel Day
Ursa Institute
China Basin Bldg. Ste. 6600
185 Berry St.
San Francisco, CA 94107

Peng Ngin
Asian AIDS Project
2024 Hayes St.
San Francisco, CA 94117

Edward Morales
Bay View Hunter's Point Foundation
6025 3rd St.
San Francisco, CA 94124

Connie Wofsy
San Francisco General Hospital
Co-director of AIDS Project
1001 Potrero Ave.
San Francisco, CA 94110

Greg Day
Shanti Project
525 Howard St.
San Francisco, CA 94105

~~Holly~~ Smith JOHN COLE
San Francisco AIDS Foundation
P.O. Box 6182
San Francisco, CA 94101
864-4376

# PRESIDENTIAL COMMISSION

# ON THE

# HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

Testimony presented by:

David Werdegar, M.D., M.P.H.

Director of Health

City and County of San Francisco

March 25, 1988

San Francisco, California

THE PRESIDENTIAL COMMISSION

Those of us battling the AIDS epidemic in our local communities have been urging a cogent national response -- for too long, it seemed, to no avail. This dangerous epidemic requires a national response, guided by an organized plan of action, funded as we would a national emergency, and benefited by the continuous oversight of a wise and representative Presidential Commission.

We have been encouraged by the preliminary report of the Presidential Commission issued last December, and its interim report of February 24th. We appreciate the earnest, open hearing process of the Commission and the sense of urgent national purpose conveyed. We note particularly the attention to health care system issues, need of accelerated research and clinical trials, and call for substantial federal support of drug abuse intervention programs.

Presidential Commission on AIDS
Testimony: David Werdegar, M.D., M.P.H.
March 25, 1988

COMMUNITY RESPONSE

The theme of your two days of hearings here in San Francisco is "Community Response To The Epidemic".

In San Francisco we have sought to develop an organized community response involving public, private, and volunteer sectors; health workers and institutions, community-based organizations, advocacy groups, schools, the churches, labor, and industry. We took the view that the epidemic involved all segments of the population: gay and straight; minority and majority; friends and neighbors, families and lovers. AIDS affected us all and we would fight it on a united front.

The AIDS problem extended to our neighboring counties, and regional planning was, therefore, necessary. Our health departments are indeed, engaged together in regional planning.

Our community efforts have been remarkably helped by an informed media and enlightened political leaders.

The Health Department has served as the focal point -- the center of gravity -- for convening, planning, coordinating, and monitoring the City's AIDS program. It has worked closely with community hospitals, community-based organizations and practitioners, both in education preventive efforts as well as provision of health services.

An unrelenting community-based educational program has been a hallmark of the San Francisco program. Within the Health Department, itself a major provider of health services, we have coordinated AIDS efforts in neighborhood health centers maternal-child health programs, substance abuse, mental health, forensic, and many other health department services. The department's acute care facility, San Francisco General Hospital, has of course been a major center for AIDS care, teaching and research.

We have never accomplished all that we could have, or should have, or wished we had. Nevertheless, we have been constantly motivated by our tragedy to develop a model program, an ideal program, that would not only to benefit our own community but, by way of example, and through shared experience, other communities as well. This community resolve has been the foundation for the intensity, generosity, and creativity which have characterized San Francisco's response.

I say this to the Commission out of the personal conviction that the best of programs and plans will not reach fruition, unless we can reach into the collective psyche of the nation to summon forth, similarly, a national will and resolve. "A call for collective dedication", was a phrase in your preliminary report that caught my eye.

## AIDS IN SAN FRANCISCO: CURRENT STATUS AND FIVE-YEAR PROJECTIONS

Only a ten days ago, the Health Department of San Francisco submitted to its seven-member Health Commission a detailed report on the current status of the AIDS effort in our community, with estimates of needs for the next five years -- to 1993. Authoritative epidemiological studies portray the epidemic and provide carefully considered projections for the next five years.

I submit to the Presidential Commission, herewith, copies of this recent report for whatever value it may have to the Commission and staff in its endeavor.

The report is the product of our AIDS Office staff, working in close association with colleagues throughout the department and a broad-based community advisory committee. The report might well be emulated by other counties, state health departments, and federal agencies.

No city in the United States has suffered the AIDS epidemic so severely as San Francisco, where 10% of the nation's epidemic has been centered. The number of cases since the epidemic began, seven years ago, now approaches 5,000; the number of deaths close to 3,000. The number of cases in racial and ethnic minority groups, now 16% of the total, is climbing more rapidly than in the white population.

We believe the epidemic will peak in the mid-1990s and then, mercifully, decline. The intervening years will be enormously difficult. We foresee by 1993, barring major medical breakthroughs, a three to four-fold increase in the number of cases. In 1993 we shall likely have more than 6,000 persons with AIDS under care in San Francisco, as compared to the 1700 at present. While we plan assiduously, so as to be prepared, it must stated that our health services system is already under very great strain. Without substantial federal assistance, it will be overwhelmed in the years soon ahead.

One interesting analysis in the report depicts the spending on AIDS programs and patient care from all sources. It is now at a rate close to $100 million annually, and projected to rise nearly to $400 million by 1993. These figures exclude all volunteer services, which can be valued in the millions, as well as income supports from General Assistance, Social Security Disability Insurance, sick benefits and private disability insurance. Nor does it attempt to estimate the value of work and productivity to our society through early death and disability. AIDS is now the third leading cause of death in San Francisco (after heart disease and cancer); far and away the leading cause of death in terms of years of life lost.

Presidential Commission on AIDS
Testimony: David Werdegar, M.D., M.P.H.
March 25, 1988

## BRIGHT SPOTS IN A BLEAK PICTURE

In reviewing the AIDS report, one of our commissioners asked, "Are there any bright spots in all of this?" Let me suggest a few.

Startling as it may seem, the AIDS epidemic in San Francisco has largely been arrested. Without wishing to suggest any sense of complacency, or to ignore population groups where it is not altogether the case, the rate of new HIV infections has been remarkably lowered both in the gay community and in IV substance abusers. We ascribe the success to vigorous education/prevention programs, ready availability of anonymous and confidential antibody testing (coupled with counseling), prohibition of mandatory testing, policies to prevent discrimination against persons who are HIV positive, and other factors.

A second bright spot is the lengthening duration of life of persons with AIDS. While the average extension of life is still measured only in months (from 10 in 1986 to 15 months currently) the increase is real, appears to be associated with quality of life, and is probably ascribed to newer medications (AZT, pentamidine, and others). There is prospect of further improvement.

We have demonstrated that the cost of AIDS care can be contained through more sparing use of the acute care hospital and continuous development of an extensive network of out-of-hospital support services.

Organizational structures are developing in racial and ethnic minority communities, as they have in the gay community, for effective education, prevention, and support services. They greatly need funding support.

The Health Department and the School system have teamed up successfully to develop curricula in which to teach our youth how to take responsibility for their health, giving meaningful attention to AIDS, substance abuse and other dominant health issues.

We have a conceptual framework, an organized plan, a network of services, and a community resolve to bring us through the difficult years ahead.

We have persuasive data on which to base requests for very substantial state and federal assistance.

GAPS IN SERVICES

There are significant gaps in our continuum of services, largely owing to problems of resources. I will mention some that seem most important:

(1) Long-term care: We face very serious impending shortages in personnel, facilities, and funding for various aspects of the longer term care of persons with AIDS. Appropriate skilled nursing care facilities, psychiatric facilities and day-care programs are especially needed as the numbers with AIDS dementia and AIDS psychoses increase. We also need substantial increase in supervised residential care facilities, especially for those with concurrent substance abuse problems.

We already have many patients who could benefit from skilled nursing care, but virtually none is available. We have a growing problem of homeless persons with AIDS, often those with substance abuse or behavioral problems.

Many supportive services have been generously provided by volunteers: meals for the home, transportation, and help with activities of daily living; we are reaching the point where these supports cannot be maintained through volunteer efforts alone.

In many instances, third-party reimbursement mechanisms fail to provide sufficient stimulus and support. Dr. Lee will, I believe, discuss these financing policies in greater detail.

The San Francisco region has prospect of obtaining a former U.S. Public Health Service Hospital for use as a skilled nursing facility with associated ambulatory care, day care, respite care, hospice care and other programs. We believe this facility, which would require full federal funding to be feasible, would be a God-send in terms of regional needs it would provide a remarkable opportunity to fashion model demonstration programs in long-term care and to offer training to all categories of health care workers involved in various aspects of long-term care.

(2) Medical care and psychosocial support for asymptomatic individuals who are HIV positive. There are some 30,000 asymptomatic HIV-positive individuals in San Francisco. Many have no established source of primary care. As evidence mounts for the benefits of medical supervision and psychosocial support starting early in the course of HIV infection, we expect a surge in demand for appropriate primary care services -- well beyond that currently available through public and private sectors.

(3) Substance abuse services: Massive assistance is needed at all levels. This would include vigorous educational programs, especially in schools and minority communities; early family-oriented intervention; outreach services; detoxification and treatment services; residential care; methadone treatment slots; innovative demonstration programs; research. In addition to the IV drug use problem, intimately related to AIDS, there must be attention to other substance abuse problems.

(4) A vigorous educational program which avails itself of every opportunity for AIDS prevention education must be maintained. Resources are still far too limited. Governmental restrictions pertaining to preparation of educational materials which are presented in frank, explicit and vernacular terms is also a serious impediment.

(5) Health care personnel: We are concerned about the availability of physicians, nurses, dentists, social workers, public health personnel, and all other workers to stay abreast of the needs for AIDS services. Here in San Francisco, we are constantly called upon to provide advice, consultation and training, based on our experience. Although always willing, we cannot realistically absorb these demands on top of existing responsibilities.

Presidential Commission on AIDS
Testimony: David Werdegar, M.D., M.P.H.
March 25, 1988

## RECOMMENDATIONS

Let me offer a number of recommendations, some of which doubtless reiterate those you've heard before -- or have already incorporated in your reports:

1. A comprehensive plan, implemented with executive leadership, and benefited by the continuous oversight of a representative commission, with scientific advisory panels is the nation's most critical need. Its implementation must be provided with resources commensurate with the awesome magnitude of the epidemic..

2. Federal Block Grants directly to the health departments of cities seriously affected by the AIDS epidemic, to be used flexibly for purposes of education, prevention and treatment programs -- especially in areas where categorical grants or third-party reimbursements are unavailable. The health departments should utilize such funds to support the activities of community-based agencies.

3. Financial incentives for the development and support of the continuum of long-term care services, including homecare, daycare, assisted residential care, and skilled nursing care.

4. Greatly accelerated clinical trials of potentially useful drugs to reduce the morbidity and mortality of HIV infection. The national cooperative drug trial approach is unduly long and cumbersome. It should be supplemented by speedier mechanisms. As our own projections show only too well, time is of the essence.

   Community-based trials in high prevalence areas is one such approach. The Health Department in San Francisco, for example, would welcome the opportunity to conduct large scale clinical trials locally, utilizing the San Francisco General Hospital, the Public Health Hospital, community hospitals and practitioners, and the University of California Health Science Center. These could get under way promptly.

5. Continued support of anonymous and confidential testing programs: These have been an important element of the educational effort. They are also vital in primary and secondary prevention. These tests, when properly coupled with education and counseling, are not inexpensive -- (approximately $85) but on a relative scale, are an excellent investment.

   We are concerned about waning support, just at a time the programs should be expanding to reach a broader segment of the population.

6. Legislation to prevent discrimination in jobs, housing and health insurance. This legislation is extremely important from a public health view as successful experience in San Francisco would attest. Relief from concern over such discrimination, would encourage many more individuals at risk of HIV infection to seek testing, counseling and care.

## FINAL OBSERVATIONS

The preliminary report of the Commission describes creation of a national climate, "setting aside prejudice and fear in favor of compassion and sense of community responsibility." If the reports of the Presidential Commission can help create such a national climate, we shall all have reason to be grateful. The next several years, all projections indicate, will be exceedingly difficult, and will call for our collective best effort.

For all its tragedy, the AIDS epidemic can open our eyes to needs in the education of our children about life and health; about fundamental weaknesses in our approaches to health care and our health care system; about the social needs of our minority populations. The epidemic can teach us about the bonds of brotherhood and sisterhood that unite our diverse population. The research on AIDS will have remarkable benefits in all aspects of viral diseases, addiction, dementia, cancer. Thus, one day the epidemic may repay society for the many lives lost to AIDS.

# STATEMENT
# OF

PHILIP R. LEE, M.D.
PRESIDENT
HEALTH COMMISSION
CITY AND COUNTY OF SAN FRANCISCO

BEFORE THE

PRESIDENTIAL COMMISSION ON THE HUMAN
IMMUNODEFICIENCY VIRUS EPIDEMIC

MARCH 25, 1988

SAN FRANCISCO, CALIFORNIA

Mr. Chairman, as President of the Health Commission for the City and County of San Francisco, I am pleased to join our Director of Health, Dr. David Werdegar, in welcoming you to San Francisco. I also want to commend the Presidential Commission on the Human Immunodeficiency Virus Epidemic and its staff for what you have accomplished to date. Particularly, I want to commend you for the last report of the Commission.

The job, however, has just begun. The Health Commission is proud of what San Francisco has accomplished in dealing with the HIV/AIDS epidemic. Dr. Werdegar has described some of our progress, as well as the problems we face, and Mayor Art Agnos also will address these problems. Former Mayor Dianne Feinstein will give you a more detailed picture of just how the progress we have made was accomplished. Former Mayor Feinstein, the Board of Supervisors, and Dr. Mervyn Silverman, who was Director of Health from 1978 to 1985, deserve a great deal of credit for what has been accomplished. The media -- newspapers, radio, and television -- deserve a great deal of credit. Even more credit, however, must be given to the members of the gay community in San Francisco who provided critical private sector leadership at a time of extraordinary stress and crisis. The nation owes a debt of gratitude to these individuals that cannot be measured. Through their efforts, moving in cooperation with public health officials and politicians, they have made significant contributions to our understanding of how the virus is transmitted, what behaviors put an individual at risk, how those

The particular issue that I will focus on today is the "who will pay" question. From the perspective of the Health Commission, this is the most critical question. We have reached the limit in San Francisco of what taxpayers can contribute through local ad valorem taxes to combat the AIDS epidemic and pay for the care of persons with AIDS.

Currently, in San Francisco, the sources of funding for AIDS activities include $24,453,243 through the budget of the City and County of San Francisco (Table 1 and Figure 1). $11.2 million of this amount is local tax funds. The remainder is primarily Medi-Cal payments and other federal/state programs, such as mental health, that are not AIDS-specific. In addition, there is $3,060,870 in state grants and $9,174,452 in federal grants to the City and County of San Francisco. Known funds through community hospital and community agencies total $52,575,959 for a total of $89,264,525.

The low estimates of the costs in San Francisco for 1992-93 are $159,379,798; middle estimates are $260,217,195; and high estimates are $376,401,529 (Figure 2).

The bulk of these costs are for hospital inpatient care, primary and specialized outpatient care, chronic care, housing, and related support services. The largest proportional increase between 1988 and 1993 will be in this latter category, where third-party payments (private health insurance, self-insuring employers, and Medicaid) are least available.

It will not be possible for local taxes to support the cost of these services as they are today. Currently, local taxes account for about 11 percent of total expenditures. This money

NUMBER OF PUBLIC VS. PRIVATE HOSPITALS IN THE PARTICULAR AREAS SAMPLED, AND OTHER FACTORS.

NATIONALLY, DURING 1984-1985, 55 PERCENT OF AIDS PATIENTS DISCHARGED FROM HOSPITALS EXPECTED PRIVATE INSURANCE TO PAY FOR THEIR CARE, AND AN ADDITIONAL 21 PERCENT EXPECTED TO USE MEDICAID; THUS, 76 PERCENT OF AIDS PATIENTS EXPECTED A THIRD PARTY TO PAY (TABLE 4). FOR THE REMAINING 24 PERCENT, EITHER THE INDIVIDUAL HAD TO PAY FOR CARE DIRECTLY OUT OF POCKET OR LOCAL GOVERNMENT WAS LEFT TO PICK UP THE TAB. THESE FIGURES DIFFER FROM ALL OTHER PATIENTS UNDER AGE 65 YEARS, WHERE 63 PERCENT OF TOTAL DISCHARGES INDICATED PRIVATE HEALTH INSURANCE COVERAGE AND A LOWER PROPORTION (13 PERCENT) LISTED MEDICAID.

SEVERAL OTHER STUDIES HAVE REVEALED A RELATIVELY HIGH PROPORTION OF PERSONS WITH AIDS WHO ARE ELIGIBLE FOR MEDICAID:

- IN SAN FRANCISCO HOSPITALS, PUBLIC AND NONPUBLIC, APPROXIMATELY 37 PERCENT OF AIDS PATIENTS DISCHARGED ARE COVERED BY PRIVATE HEALTH INSURANCE, 30 PERCENT BY MEDICAID, 4 PERCENT BY MEDICARE, AND 29 PERCENT SELF-PAY OR OTHER SOURCES (E.G., KAISER-PERMANENTE) (TABLE 5).
- THE SOUTHERN CALIFORNIA HOSPITAL COUNCIL REPORTED THAT 23 PERCENT OF THE PATIENTS IN SURVEYED SOUTHERN CALIFORNIA HOSPITALS WERE COVERED BY MEDICAID.
- IN NEW YORK CITY'S HEALTH AND HOSPITALS CORPORATION HOSPITALS, WHICH ARE THE PUBLIC HOSPITALS, 65 PERCENT OF THE AIDS PATIENTS WERE MEDICAID RECIPIENTS, 21 PERCENT WERE SELF-PAY (OR BAD DEBT), 13 PERCENT PRIVATE HEALTH INSURANCE, AND 1 PERCENT MEDICARE.

THE RELATIVELY HIGH PERCENTAGE OF PATIENTS CURRENTLY COVERED BY MEDICAID IS GROWING. IN CALIFORNIA, 12 PERCENT OF ALL PERSONS WITH AIDS WERE COVERED BY MEDICAID IN THE PERIOD FROM JULY 1983 THROUGH AUGUST 1986. IN AN ANALYSIS THROUGH DECEMBER 1987 IT WAS FOUND THAT 20 PERCENT OF ALL AIDS PATIENTS WERE COVERED BY MEDICAID. CURRENT ESTIMATES ARE THAT 30 PERCENT ARE NOW COVERED BY MEDICAID. IN SAN FRANCISCO, DATA FROM THE WEST BAY HOSPITAL CONFERENCE INDICATES A SIMILAR SHIFT FROM THE PRIVATE TO THE PUBLIC SECTOR. BETWEEN THE PERIOD 1984-85 AND THE FIRST THREE QUARTERS OF 1986, THE PROPORTION OF HOSPITAL COSTS OF AIDS PATIENTS PAID BY PRIVATE INSURANCE DECLINED BY 25 PERCENT, WHILE THAT ASSUMED BY MEDICAID GREW ABOUT 85 PERCENT.

IN ADDITION TO DIRECT MEDICAL CARE COSTS, THERE ARE DIRECT NONPERSONAL COSTS INCLUDING RESEARCH, TRAINING, BLOOD SCREENING, AND EDUCATION. THESE COSTS ARE BORNE LARGELY BY THE FEDERAL GOVERNMENT AND BY STATE AND LOCAL GOVERNMENTS. MY COLLEAGUE, ANNE SCITOVSKY, A HEALTH ECONOMIST, HAS ESTIMATED THAT TOTAL DIRECT COSTS RELATED TO AIDS WILL STAND AT $8 BILLION IN 1991.

FEDERAL EXPENDITURES

THE AIDS EPIDEMIC EMERGED JUST AS THE UNITED STATES WAS MOVING TO ADOPT PUBLIC POLICIES DESIGNED TO REDUCE THE ROLE OF THE FEDERAL GOVERNMENT IN DOMESTIC SOCIAL PROGRAMS.

IN THE UNITED STATES THE INITIAL FEDERAL POLICY RESPONSE TO THE AIDS EPIDEMIC IN 1981 WAS SHAPED BY A NEW SET OF POLICY GOALS:

GENERAL REVENUE FOR AIDS ABOVE THAT ALLOCATED FOR MEDICAID. CURRENTLY, CALIFORNIA AND NEW YORK ACCOUNT FOR 60 PERCENT OF THE TOTAL AMOUNT STATES SPEND ON AIDS. ADDING NEW JERSEY, FLORIDA, AND MASSACHUSETTS TO THIS ACCOUNTS FOR 75 PERCENT OF THE TOTAL. HOWEVER, AS MORE STATES EXPERIENCE INCREASES IN AIDS CASES, THE DISTRIBUTION WILL BECOME MORE EVENLY SPREAD. DR. MERRITT PREDICTS THAT IN THE FUTURE MORE MONEY WILL BE SPENT ON COUNSELING, TESTING AND SUPPORT SERVICES, AND LESS WILL BE SPENT ON RESEARCH AND SURVEILLANCE ACTIVITIES AT THE STATE LEVEL.

ALL STATES (EXCEPT ALASKA AND WYOMING) COVER PRESCRIPTION DRUGS AS AN OPTIONAL MEDICAID SERVICE. SOME STATES EITHER LIMIT THE NUMBERS OF PRESCRIPTIONS WHICH CAN BE REFILLED, THE TOTAL QUANTITY OF EACH PRESCRIPTION, AND/OR THE TOTAL COST.

VIRTUALLY ALL STATE MEDICAID PROGRAMS REQUIRE FDA APPROVAL BEFORE COVERING A NEW DRUG. MANY REQUIRE ADDITIONAL STEPS, SUCH AS APPROVAL BY A STATE COMMITTEE OR EVEN PUBLIC HEARINGS. CALIFORNIA RECENTLY ENACTED A LAW UNDER WHICH AIDS-RELATED THERAPEUTICS APPROVED BY THE FDA WILL BE GRANTED IMMEDIATE TEMPORARY APPROVAL STATUS ON THE MEDICAID DRUG FORMULARY WHILE THE FORMAL REVIEW PROCESS IS CONDUCTED. MEDICAID EXPENDITURES FOR A SINGLE DRUG, RETROVIR, TO TREAT AIDS RANGES FROM $41,000 IN MONTANA TO $26 MILLION IN NEW YORK.

IN ADDITION TO MEDICAID PAYMENTS FOR RETROVIR, THE HEALTH RESOURCES AND SERVICES ADMINISTRATION/PHS/DHHS IS IN CHARGE OF IMPLEMENTING A PROGRAM CREATED BY CONGRESS TO PROVIDE $30 MILLION TO ASSIST AIDS PATIENTS IN PAYING FOR RETROVIR. MONEY IS

5. IT IS NOT ENOUGH JUST TO PROVIDE MONEY. THERE NEEDS TO BE A NATIONAL AIDS PLAN, STATE AIDS PLANS, AND AIDS PLANS AT THE COUNTY-COMMUNITY LEVEL. WE NEED TO HAVE ADEQUATE RESOURCES FOR PROPER PROGRAM PLANNING AND ADMINISTRATION AT ALL THE LEVELS, IF THESE PLANS ARE TO WORK.
6. FINALLY, THE EFFORT IS NOT JUST A PUBLIC SECTOR RESPONSIBILITY. THERE NEEDS TO BE COOPERATIVE PUBLIC-PRIVATE SECTOR PARTICIPATION AT ALL LEVELS, IF WE ARE TO DEAL EFFECTIVELY WITH THE EPIDEMIC.

Table 1

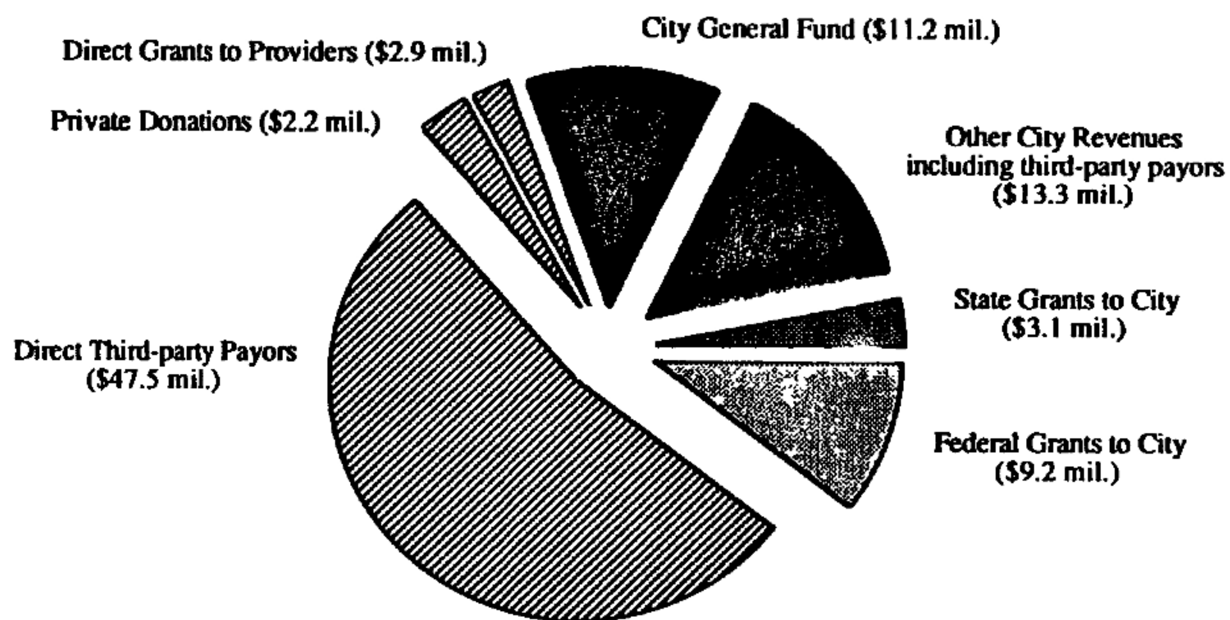
# FUNDING DISTRIBUTION FOR ALL AIDS SERVICES IN SAN FRANCISCO FISCAL YEAR 1987 - 1988

| SERVICE CATEGORY | CITY BUDGET | STATE GRANTS | FEDERAL GRANTS | KNOWN OTHER | TOTAL CONFIRMED |
|---|---|---|---|---|---|
| Surveillance, Epidemiology and Related Research | 125,933 | 118,544 | 2,531,712 | 2,098,643 | 4,874,832 |
| Public Education | 1,036,308 | 1,402,323 | 1,861,010 | 506,762 | 4,806,403 |
| Provider Education and Staff Support | 181,955 | 111,333 | 345,136 | 306,752 | 945,176 |
| Primary and Specialized Outpatient Care | 5,364,365 | 0 | 2,793,943 | 13,479,369 | 21,637,677 |
| Hospital Inpatient Care | 11,075,925 | 0 | 0 | 31,380,193 | 42,456,118 |
| Chronic Care, Housing and Related Support Services | 3,296,873 | 537,042 | 572,902 | 4,271,151 | 8,677,968 |
| AIDS-Related Mental Health Services | 2,519,946 | 156,097 | 38,499 | 433,089 | 3,147,631 |
| AIDS-Specific Substance Abuse Services | 27,131 | 735,531 | 1,031,249 | 100,000 | 1,893,911 |
| Administrative Support and Coordination | 824,809 | 0 | 0 | 0 | 824,809 |
| **TOTALS** | **24,453,245** | **3,060,870** | **9,174,451** | **52,575,959** | **89,264,525** |

Source: AIDS Office, San Francisco Department of Public Health, February 24, 1988.

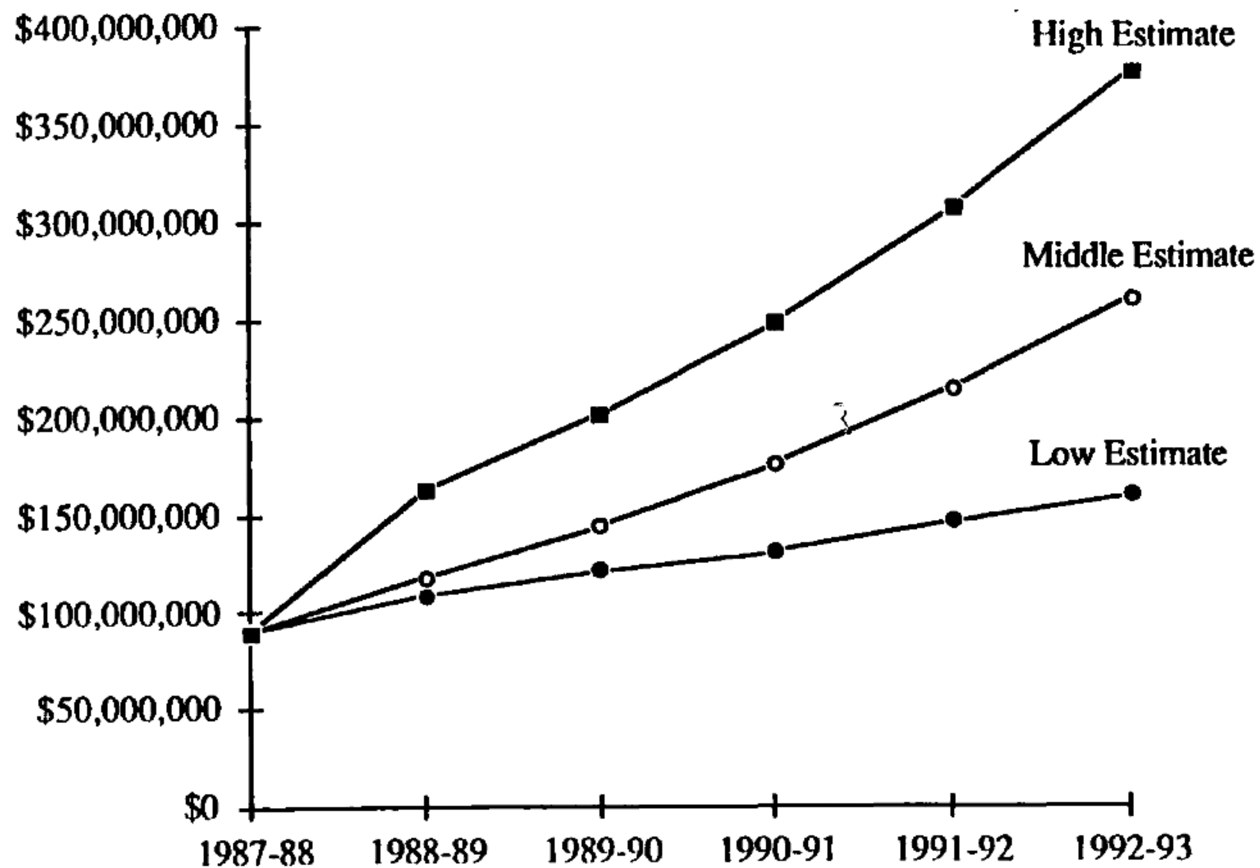
Fiqure 1

## Funding Sources for AIDS Services in San Francisco
## Fiscal Year 1987-88
## Total Amount: $89.3 million




Source: AIDS Office, San Francisco Department of Public Health, March 15, 1988.

Figure 2




Source: AIDS Office, San Francisco Department of Public Health, March 15, 1988

Table 2

PRIVATE SECTOR: PRIVATE HEALTH INSURANCE, AND SELF-INSURED EMPLOYERS, AND DIRECT OUT-OF-POCKET EXPENSES

1. STATE REGULATED
   - BLUE CROSS AND BLUE SHIELD
   - COMMERCIAL INSURANCE
   - GROUP PRACTICE - PREPAYMENT (NOW CALLED HEALTH MAINTENANCE ORGANIZATIONS)

2. EXEMPT FROM STATE REGULATION
   - SELF-INSURING EMPLOYERS REGULATED UNDER ERISA AND EXEMPT FROM STATE INSURANCE LAWS.

3. DIRECT OUT-OF-POCKET

Table 3

PUBLIC SECTOR AS INSURER, PURCHASER OF HEALTH INSURANCE, AND PROVIDER OF CARE

1. INSURER
   - -- MEDICARE (FEDERAL)
   - -- MEDICAID (FEDERAL/STATE)
   - -- CHAMPUS (FEDERAL)

2. PURCHASER
   - -- PUBLIC EMPLOYEE HEALTH INSURANCE (FEDERAL, STATE, LOCAL)

3. DIRECT PROVIDER
   - -- VETERANS ADMINISTRATION (FEDERAL)
   - -- DEPARTMENT OF DEFENSE (FEDERAL)
   - -- STATE GOVERNMENT: MENTAL HOSPITALS
   - -- LOCAL GOVERNMENT: PUBLIC HOSPITALS AND CLINICS

Table 4

## PRIMARY SOURCE OF COVERAGE FROM A SAMPLE OF U.S. HOSPITALIZATIONS, 1984-85

| | AIDS CASES | ALL HOSPITALS FOR PERSONS UNDER 65 |
|---|---|---|
| PRIVATE INSURANCE | 55% | 63% |
| MEDICAID | 21% | 13% |
| OTHER | 24% | 24% |

Source: National Hospital Discharge Survey Data, reported In _Hospitalizations For AIDS, U.S., 1984-85_, AJPLI, June, 1987

Table 5

## AIDS HOSPITALIZATIONS BY PRINCIPAL PAYOR
## SAN FRANCISCO, 1984-86

| | |
|---|---|
| PRIVATE INSURANCE | 37% |
| MEDI-CAL | 30% |
| OTHER* | 29% |
| MEDICARE | 4% |
| | 100% |

*OTHER IS SELF-PAY (60%) AND KAISER PERMANENTE (40%).

SOURCE: STRYCHAZ FM, "AIDS INPATIENT CARE IN THE WEST BAY, 1984-86."

Table 6

## AIDS HOSPITALIZATIONS BY TYPE OF PAYOR
## STATE OF NEW YORK, 1985

(SAMPLE OF 6,142 HOSPITAL DISCHARGES)

| Type of Payor | Percent |
|---|---|
| PRIVATE INSURANCE (OTHER THAN BLUE CROSS) | 9.0% |
| MEDICAID | 43.0% |
| BLUE CROSS | 30.0% |
| OTHER PRIVATE INSURANCE | 9.0% |
| SELF-PAY | 10.4% |
| MEDICARE | 1.8% |
| OTHER GOVERNMENT | 1.2% |
| UNCOMPENSATED (NO CHARGE) | 1.4% |
| OTHER MISCELLANEOUS | 2.3% |
| | 100.0% |

SOURCE: DATA PROVIDED BY THE NEW YORK STATEWIDE PLANNING AND RESEARCH COOPERATIVE PLAN. ANALYSIS CONDUCTED BY THE HOSPITAL STUDIES PROGRAM, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH.

Table 7

## PRIMARY SOURCE OF COVERAGE OF AIDS CASES IN PUBLIC HOSPITALS AND PRIVATE TEACHING HOSPITALS

| | PUBLIC HOSPITALS | PRIVATE TEACHING |
|---|---|---|
| PRIVATE INSURANCE | 7% | 45% |
| MEDICAID | 62% | 35% |
| SELF-PAY | 18% | 13% |
| OTHER | 13% | 7% |

Source: The Provision and Financing Of Medical Care For AIDS Patients in US Public and Private Teaching Hospitals, JAMA, Sept., 11, 1987

Table 8

Federal spending on AIDS (millions of current dollars).

| Type of spending | Fiscal year | | |
|---|---|---|---|
| | 1986 | 1987 | 1988 |
| Research and education | 234 | 494 | 931 |
| Treatment* | 155 | 243 | 433 |
| Medicaid | 130 | 210 | 375 |
| Veterans Administration | 24 | 30 | 52 |
| Federal Bureau of Prisons† | 1 | 3 | 6 |
| Blood testing | 79 | 76 | 55 |
| Defense Department | 79 | 74 | 52 |
| State and Labor departments | 0 | 2 | 3 |
| Income maintenance | 0 | 26 | 48 |
| Total | 468 | 839 | 1467 |

*These figures do not include Medicare expenditures. †Also includes spending on random testing of new inmates and universal testing of released inmates.

Source: Bloom DE and Carliner G. The Economic Impact of AIDS in the United States. Science, vol 239, pp. 604-610, February 5, 1988.

Table 9

EXPENDITURES FOR PUBLIC HEALTH AIDS PROGRAMS, SELECTED STATES*
FY 83-87

| | FY 83 | FY 84 | FY 85 | FY 86 | FY 87 |
|---|---|---|---|---|---|
| CALIFORNIA | $3,400,000 | $4,000,000 | $16,000,000 | $31,000,000 | $58,000,000 |
| NEW YORK | -- | 2,800,000 | 4,500,000 | 9,500,000 | 16,400,000 |
| NEW JERSEY | 530,000 | 920,000 | 2,000,000 | 5,000,000 | 8,000,000 |
| MASSACHUSETTS | -- | 1,500,000 | 1,600,000 | 4,100,000 | 7,600,000 |
| FLORIDA | 25,000 | 32,000 | 576,000 | 5,600,000 | 12,500,000 |

*NOT INCLUDING MEDICAID

SOURCE: INTERGOVERNMENTAL HEALTH POLICY PROJECT,
GEORGE WASHINGTON UNIVERSITY, 1988

ADDENDUM TO TESTIMONY OF DR. PHILIP R. LEE

CURRENT COSTS AND PROJECTIONS OF FUTURE COSTS

ECONOMIC COSTS ARE BOTH DIRECT AND INDIRECT. THE MAJOR COMPONENT OF DIRECT COSTS IS THE CARE OF PATIENTS IN AND OUT OF THE HOSPITAL, INCLUDING PHYSICIANS' SERVICES, DRUGS, NURSING AND HOME HEALTH CARE, AND RELATED EXPENDITURES. INDIRECT COSTS REFLECT THE ECONOMIC LOSS TO SOCIETY, GENERALLY MEASURED BY LOST WAGES DUE TO SICKNESS AND EARLY DEATH. DIRECT COSTS ARE HIGH IF HOSPITAL AND NURSING HOME CARE LOOMS LARGE IN PATIENT TREATMENT. INDIRECT COSTS ARE HIGH IF ILLNESS AND DEATH OCCUR IN YOUNG PEOPLE AT THE PEAK OF THEIR EARNING POWER. BOTH OF THESE CIRCUMSTANCES ARE CHARACTERISTIC OF AIDS.

THE DIRECT COSTS OF AIDS INCLUDE TWO MAJOR COMPONENTS:

1) PERSONAL MEDICAL CARE IN AND OUT OF THE HOSPITAL
2) NON-PERSONAL COSTS (E.G., RESEARCH, EPIDEMIOLOGIC, SURVEILLANCE, TESTING, ETC.).

THE ESTIMATES OF THE COST OF TREATING PERSONS WITH AIDS FROM DIAGNOSIS TO DEATH HAVE VARIED ENORMOUSLY. SOME RECENT ESTIMATES HAVE BEEN MADE BY:

- MEDICAL DIRECTOR OF THE AMERICAN INSURANCE CONSULTANTS (NATIONAL) — $200,000
- HARDY AND ASSOCIATES AT THE CENTERS FOR DISEASE CONTROL (CDC), U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (NATIONAL) — $147,000
- CALIFORNIA DEPARTMENT OF HEALTH SERVICES (CALIFORNIA)
  - MEDICAID (MEDI-CAL) — $36,000-$64,000
  - NON-MEDICAID (BILLED COSTS) — $61,000-$102,000
- INSTITUTE FOR HEALTH POLICY STUDIES, UCSF (SAN FRANCISCO) — $45,800

The most detailed study to date was directed by Anne Scitovsky of the Palo Alto Medical Foundation and the Institute for Health Policy Studies, University of California, San Francisco, and published in 1986. In this study of 445 AIDS patients admitted to San Francisco General Hospital (SFGH) during 1984 we found a median survival of 11.2 months and a lifetime cost of $41,500. When the higher costs of hospital care used by Hardy and her colleagues were applied as well, the average lifetime cost for SFGH patients increased to $45,800.

In that study at SFGH during 1984 we found that the bulk of costs--over 80 percent--were related to inpatient care. In our current study being conducted in San Francisco, we have found that for a group of private patients being seen by community physicians only about 66 percent of the costs are related to inpatient care. The remaining costs are for physicians' services, home care, and psychosocial support services. In this study we have not included the cost of drugs prescribed on an outpatient basis.

A study of projected AIDS costs was completed recently by Anne Scitovsky and Dorothy Rice for the Centers for Disease Control. They estimated that in 1991 direct costs will be $10.9 billion and indirect costs will total $55.6 million.

TESTIMONY OF DIANNE FEINSTEIN

BEFORE THE PRESIDENTIAL COMMISSION

ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

PUBLIC HEALTH BUILDING

SAN FRANCISCO

MARCH 25, 1988

I would like to congratulate the Commission on the 60 page interim report with its 180 recommendations. Its is a giant step forward in Federal participation, and I hope good recommendations will be taken seriously and that a new era of dynamic Federal leadership will result.

The Commission has set forth a number of comprehensive recommendations and I would like to comment on a few:

Research -- I agree with the Commission recommendation to eliminate wherever possible the use of placebo-controlled trials in patients with life-threatening HIV-related illness. Science protocols must not be used to deprive individuals with these fatal conditions of possible relief from suffering.

Testing -- Low or no cost testing must be widely available on a voluntary and confidential basis. Anonymous testing is

an incentive for those who fear others will have access to test results. Federal support will be necessary to realize this goal. Testing must also offer rapid results. When first offered in San Francisco, the waiting list was 4 to 6 weeks. I gave the directive to reduce that time to 48 hours. Tests are now done the same day in San Francísco. A new mail-in blood test kit is soon expected on the market. The individual takes his or her own sample and returns it to the lab in a cold pack. Results are mailed or phoned back. I hope this type of service receives FDA approval soon.

Education -- Funds invested in education and prevention pay the greatest dividends, but much later. Prevention should be part of every basic high school curriculum. It should become part of the consciousness of every teenager and adult. AIDS education should be mandatory.

Federal Legislation to Prevent Discrimination-- Congressional action is needed now to extend civil rights protection to those infected with the virus. Victims have been summarily deprived of housing, jobs, medical care and insurance protection when others learn of their illness. Discrimination occurs at a time when compassion and support is desperately needed by the child, man or woman weakened by their infliction with this disease.

Federal Support -- While I believe the Federal share for treatment programs should approximate 80% instead of 50%, I strongly concur with the Commission's recommendation to increase Federal support for AIDS programs. We must recognize that the spread of AIDS cannot be stopped without substantial increases in Federal spending on every front--prevention, education, care and research. If we think we can't afford it now, try to imagine the cost and sacrifices we will face if we wait five years. If a modest Federal effort is projected to cost $2 billion today, it will cost perhaps $16 billion just for treatment in 1992.

Finally, the Federal Government must pick up the cost of AZT and other life-prolonging agents. Burroughs-Wellcome has said that the research and development costs of AZT was about $80 million. This investment averages $1,600 per patient today -- AZT treatment costs can reach $10,000 per patient. No one should be denied access to these life-prolonging drugs because of cost.

San Francisco is currently contributing more per capita for AIDS than any city in the nation and more per capita for substance abuse prevention and treatment than any other county in California. Local governments cannot and should not carry the burden for developing comprehensive and compassionate programs of AIDS care. Currently, the City and County of San Francisco is

spending an estimated $19 million on AIDS programs, about 22% of the total citywide public and private spending. Citywide public and private spending could triple by 1992 from $89 million up to an estimated $159 million to $376 million.

Similar AIDS programs must be made available elsewhere through federal funding so that quality regional treatment programs will be available for AIDS patients. The costs of care can be reduced by hospice and home care as alternatives to hospital care. Federal cost sharing should be offered on an incentive formula so that the cost burden is shared and victims are not forced from their homes for treatment and care. Cost sharing should be offered at 80% Federal match. This amount should also be offered to the new AIDS care hospital (the former Public Health Hospital) in San Francisco's Presidio. The City does not have the operating funds to open this badly needed regional care facility.

* * * * * *

Between 1981 when the first case of AIDS was diagnosed in San Francisco, and 1988 there have been over 4,300 cases of AIDS and over 2,500 deaths. The City has experienced an enormous amount of grief and suffering and there is more to come. In five years, the Health Department expects the caseload to triple or quadruple, to between 12,000 to 17,000 persons.

In June of 1983, there were 1,552 recorded cases of AIDS in the United States, 76 in San Francisco. At that time, there was little national attention focused on the problem, and health departments in a few large cities were struggling to develop effective responses to a new public health threat. Today, less than four and a half years later, there are over 47,000 reported cases in the United States and over 26,700 deaths.

Since 1983, San Francisco has mounted an unprecedented effort in the battle against AIDS and over $51 million in local funds have been appropriated for specific AIDS services, more per capita than any other city in the nation. In those early years, I convened a Task Force of health officials to meet regularly in my office. Our agenda covered mortality and infection rates, as well as prevention and education efforts. From these first efforts sprung a program that is a worldwide model for coordinated AIDS services -- including the nation's first AIDS outpatient clinic and inpatient ward at San Francisco General Hospital. Local health department experts and the medical and scientific staff at San Francisco General Hospital became international leaders in the fight against AIDS. I also had the opportunity to Chair the first AIDS Task Force of the U.S. Conference of Mayors where Mayors could come together and share vital information and separate fact from fiction.

The broad range of services in San Francisco also includes community education, counseling, housing and social services. The city pioneered what has become a model program of compassionate care -one that utilizes home and hospice care, thereby reducing acute hospitalization costs. Many of the initial services were offered through community agencies such as the AIDS Foundation and the Shanti Project. Volunteers were trained to provide emotional support to patients in the hospital, at home, and in hospices. Today, volunteers are still providing much of the supportive services that sustain AIDS and ARC patients. Successful programs require that the resources of the entire community be mobilized and supported at the highest level of local government.

The response from the gay community in San Francisco to the AIDS crisis has been unparalleled. Leaders in the gay community organized to develop an extensive AIDS network to educate the community on transmission of the disease, reduce its spread, and avert hysteria. The gay community worked with the Health Department to develop a sophisticated educational program that changed the social behavior that was producing AIDS.

The Health Department has been mobilizing for the second wave of the epidemic and the expected spread of AIDS beyond the original primary risk groups of homosexual and bisexual men to the IV drug abusing population. Through substance abuse, AIDS is

expected to impact the heterosexual communities, most especially the Black and Hispanic communities of our city. It is estimated there are 18,000 IV drug users in San Francisco and it is feared that San Francisco might be one and a half years away from a 50% rate of infection among IV drug users. For San Francisco, the task is to repeat the successful efforts in the gay community and halt the spread of AIDS in the IV drug user and minority communities. Intensive education and information programs are taking place with the drug using populations in all drug treatment programs and on street corners.

Cities like New York and Newark have seen the rate of infection among IV drug users soar as high as 70% in some neighborhoods. These cities have apparently lost the battle of IV drug users and AIDS.

In San Francisco, there have been major achievements in containing the further spread of AIDS. There have been demonstrated successes in the area of AIDS education and prevention as well as more limited successes in the area of treatment.

- Recent studies indicate San Francisco's extensive efforts to educate and inform the gay community about AIDS transmission have worked. Three large studies of gay and bisexual men show the rate of new infections is

now less than 1% of this population. This means that gay men have made important changes that do not lead to the spread of AIDS.

- There are preliminary indications that San Francisco will not experience the increase of cases of AIDS among intravenous drug users that cities in the eastern U.S. and elsewhere are experiencing.

- There were 18 reported new cases of AIDS among IV drug users in 1987. The rate of increase is the same as 1986 and has not spiraled as projected in earlier estimates. It now appears that earlier projections that AIDS education programs would not be as effective in the drug user community may not be true.

- The average life of an AIDS patient has grown longer with the use of AZT. The median AIDS patient lived 11 months from the date of diagnosis in 1980; today the average San Francisco AIDS patient lives 14.4 months.

- AIDS education efforts have had an impact. San Franciscans are relatively well-educated about the disease and know how to take precautions to keep it from being spread.

- In San Francisco, we have minimized AIDS hysteria. Nondiscrimination laws were enacted in 1985 and few examples of employment or housing discrimination have been reported. We can be proud that there are several children with AIDS attending our public schools in a safe and humane manner. AIDS education curricula have been implemented in our schools with little or no controversy.

- Minority communities in the City have mobilized to develop cultural and linguistic models that will work in their communities.

Most of the news about AIDS is still not good news.

- There is still no vaccine or long-term effective treatment and the effects of the development of this disease will be spread over a period of 20 years.

- Most of those currently testing positive to the virus were infected between 1978 and 1984.

- The incubation period is now believed to be an average of 5 years and as long as 10 years -- the 100 to 150 new cases of AIDS that are diagnosed each month are the

result of exposure to the virus five or more years ago when little was known about its transmission.

- The numbers of new cases of AIDS is not expected to begin descending until after 1993 or 1994.

* * * * * *

We have learned that AIDS is a preventable disease if social behaviors that cause the transmission of this fatal disease are changed. At this time, education and information are the only effective weapons to stop the spread of AIDS. The information gained from San Francisco's experience with the gay community must be duplicated to halt the spread of the AIDS virus throughout our nation.

***

# SUMMARY OF SAN FRANCISCO'S AIDS PROGRAM

August 1987

I. History of City Funding

| Year | Total # AIDS Cases Diagnosed as of July 1 | Total City Funds for Fiscal Year |
|---|---|---|
| FY 1982-83 | 76 | $ 180,447 |
| FY 1983-84 | 242 | $ 4,303,056 |
| FY 1984-85 | 581 | $ 7.4 million |
| FY 1985-86 | 1200 | $ 8.8 million |
| FY 1986-87 | 2853 | $12.9 million |
| FY 1987-88 | 3402 | $19.0 million |

II. Summary of Programs Funded by City - FY 1987-88

A. Contract Services Provided by Community Based Agencies

(1) Shanti Project

Fiscal Year 1987-88 Funding: $1,062,876

Description of Services: Provides free counseling, support and advocacy for the terminally ill and those affected by terminal illness. Services are provided by small paid staff and a large corps of volunteers. These services include:

General Psychosocial Counseling and Information Services: in group and individual sessions in person and on the phone to persons with AIDS, their families and loved ones;

- Counseling Services at San Francisco General Hospital (the County hospital): at both the outpatient clinic and the intensive care ward for AIDS patients;
- AIDS Residential Program: provides long-term low-cost housing to persons with AIDS who are evicted;
- Community Volunteer Program: provides support services to AIDS patients including transportation, shopping, meal preparation, housework, etc.

For further information: Jim Geary, Director; Shanti Project, 890 Hayes Street, San Francisco, California 94117, (415) 558-9644

(2) San Francisco AIDS Foundation

Fiscal Year 1987/88: $797,315

Description of Services: Services are provided by a relatively small paid staff and large group of volunteers. Services include: AIDS hotline to provide information on all aspects of AIDS and medical and psychological referrals; development and distribution of literature on AIDS targeted to a wide range of groups including special high-risk groups (i.e., gay men, intravenous drug users), health care providers and the general population; speakers bureau to provide experts on AIDS to speak to community groups, corporations and other agencies; public forums on AIDS for specific groups; trainings of health care professionals; media campaign to make information on AIDS fully accessible and to encourage high-risk groups to reduce high-risk activities; direct social services to assist people with AIDS to access various social service programs including food stamps, general assistance and emergency housing.

For further information: Dr. Tim Wolfred, Director, San Francisco AIDS Foundation, 333 Valencia Street, San Francisco, California 94103, (415) 864-4376.

(3) Counseling/Therapy Services and Related Education
Fiscal Year 1987-88 Funding: $639,496
Description of Services: Provides mental health, substance abuse and counseling services through several agencies and at several sites. Services are provided to both AIDS patients and worried well to address fears about AIDS, management of stress, proper nutrition, and to encourage reduction of high-risk practices through peer support.
For further information: Jeff Amory, Administrative Director AIDS, San Francisco Department of Health, 1111 Market Street, San Francisco, California 94103 (415) 864-5571

(4) Home Health and In-Home Hospice Services
Fiscal Year 1987-88 Funding: $918,468
Description of Services: Provides home health care services to AIDS patients unable to care for themselves, but who do not need hospitalization. Some services are reimbursed by Medi-Cal (Medicaid).
For further information: Jeff Amory, Administrative Director AIDS, San Francisco Department of Health, 1111 Market Street, San Francisco, California 94103 (415) 864-5571

(5) Garden Sullivan Hospital
Fiscal Year 1987-88 Funding: $417,000
Description of Services: Provides continuing care beds for patients who do not need acute care but who must still be seen on an inpatient basis. Some costs recovered through Medi-Cal and third party providers.
For further information: Jeff Amory, Administrative Director AIDS, San Francisco Department of Health, 1111 Market Street, San Francisco, California 94103 (415) 864-5571

(6) Other Contract Services
Fiscal Year 1987-88 Funding: $378,533
Description of Services: Surveillance; education to health providers; clinical screening.
For further information: Jeff Amory, Administrative Director AIDS, San Francisco Department of Health, 1111 Market Street, San Francisco, California 94103 (415) 864-5571

B. San Francisco General Hospital
Fiscal Year 1987-88 Funding: $10,500,000
NOTE: SFGH is the County-owned hospital. It is estimated that 50% of all San Francisco AIDS inpatients and a larger proportion of outpatients are served at San Francisco General. A significant portion of the costs are recovered through MediCal (Medicaid), Medicare and third party payers.

(1) Outpatient Services
Description of Services: Full-range of outpatient services to approximately 427 patients a week. Services include clinical care and related drugs and testing and lab work; dental care provided by dentists who donate their time but use hospital facilities, and epidemiologic research.

(2) Inpatient Services: Special AIDS Unit - 28 beds
NOTE: Because the AIDS Ward is usually full, AIDS patients are also treated in other areas of the Hospital.
Description of Services: acute care services provided in special AIDS ward staffed by persons who volunteered for assignment. Because services are centralized, ward is focus point for Shanti counseling services, donations from community, etc.
For further information: Alison Moed, Head Nurse, Ward 5A, San Francisco General Hospital, 1001 Potrero Street, San Francisco, California 94110 (415) 821-5318

C. San Francisco Health Department
(1) AIDS Office
Fiscal Year 1987-88 Funding: $538,583 (costs do not include administrative overhead or support services provided by various administrative units of department.)
Description of Services: for epidemiology, surveillance and related research; administration of Citywide AIDS program. AIDS Office serves as the central office for information on the City's AIDS program, operation of the AIDS Advisory Groups; dissemination of informational materials, coordination of health providers; development of public relations program. monitoring of legislation, etc.
For further information: Dr. George Rutherford, AIDS Medical Director, 1111 Market Street, San Francisco, California 94103 (415) 864-5571.

All Other Services
Fiscal Year 1987-88 Funding: $4,358,000

(2) Bureau of Disease Control and City Clinics
Description of Services: Screening, tracking and related epidemiologic and laboratory services for Citywide AIDS program.
For further information: Dr. Dean Echenberg, Director of Bureau of Communicable Disease Control, San Francisco Department of Health, 101 Grove Street, San Francisco, California 94102 (415).558-4046

(3) Community Public Health Division
Description of Services: surveillance, clinical screening services, services in schools, perinatal and family health, outpatient treatment, and related laboratory work provided at City-owned clinics.
For further information: Florence Stroud, Deputy Director of Health, San Francisco Department of Health, 101 Grove Street, San Francisco, California 94102 (415) 558-2023

(4) Community Substance Abuse Service
NOTE: Services are also provided through ongoing substance abuse programs.
Description of Services: provides information and training on AIDS and drug use to agencies dealing with substance abuse.
For further information: Dr. Wayne Clark, Community Substance Abuse Services, San Francisco Department of Health, 170 Fell Street, San Francisco, California 94102 (415) 558-2356

(5) Community Mental Health Services
Description of Services: Inpatient and outpatient psychiatric services for AIDS patients and for persons with psychiatric problems associated with AIDS. These include acute and subacute hospitalizations for AIDS/ARC patients with dementia, other neurological disorders, or other psychiatric problems.
For further information: Dr. Reiko True, Deputy Director of Health/Mental Health, (415) 558-4387

(6) Forensic Services
Description of Services: AIDS prevention, education and treatment, including occasional hospitalizations to incarcerated individuals in City jails or youth facilities.
For further information: Nancy Rubin, Program Chief, (415) 558-5127

III. State and Federal Funding - as of August, 1987
Fiscal Year 1987-88: *$14,955,262

| | |
|---|---|
| Surveillance, Epidemiology and Related Research | $ 1,240,979 |
| Public Education | 2,088,821 |
| Provider Education | 305,474 |
| Mental Health Services | 98,595 |
| AIDS Specific Substance Abuse | 874,267 |
| Chronic Care and Related Support Serv. | 1,047,126 |
| Minority Education | 600,000 |
| AIDS Research Laboratory (capital) | 5,700,000 |
| AZT Drug Treatment | 3,000,000 |
| Total | $14,955,262 |

*Does not include state Medi-Cal expenditures, federal Medicaid and Medicare expenditures, payments by private insurance companies, payments by individuals, or private contributions.

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Revised August, 1987
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**TESTIMONY SUBMITTED BY ANNE RUDIN, MAYOR, CITY OF SACRAMENTO**
**PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC**

**HEARINGS ON THE WESTERN STATES RESPONSE**

**MARCH 24-25, 1988**

**SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH**
**101 GROVE STREET, ROOM 300**
**SAN FRANCISCO, CALIFORNIA**

Good morning Chairman Watkins and commissioners. Thank you for the opportunity to speak on this most pressing issue. I am Anne Rudin, the Mayor of Sacramento.

Sacramento is the capitol of the largest state in America and we are facing the most serious health problem of our nation, Human Immunodeficiency Virus (HIV) Infection. The population of the Sacramento area is close to one million. HIV is a threat to over 10%, or 100,000 of these people. According to the Sacramento County Health Department, to date, 182 individuals have been diagnosed with HIV infection, 72 have died. Statistics show that there will be over 600 people with AIDS by 1991.

Ordinarily, municipal governments would be expected to take a modest role in addressing a public health issue. Except in regions where city and county governments overlap, there is no direct health care role for cities. The AIDS crisis, however, has forced a shift in the usual patterns of responsibility, and cities are awakening to a new role of leadership in the coordination of service delivery, funding and lobbying for program support from the private sector and other levels of government.

The people of Sacramento have addressed this need for involvement. Volunteers, health care providers and political leaders have developed a well integrated community that provides services for those with HIV and their families and partners.

Our first AIDS cases were diagnosed early in 1983 at which time the AIDS Foundation was formed and today provides a variety of services including education to high risk individuals, health care workers and the general public; operates an AIDS information hot line, is establishing minority outreach programs, and provides gay outreach.

The Sacramento County Health Department administers a variety of programs including condom distribution, which costs $11,000 annually, education at adult detention facilities, HIV testing, and a variety of social services.

The Stop AIDS Project, Clinic for AIDS Related Disorders, Home

Health Care, and Hand to Hand are a few of the other community services available in Sacramento.

In 1985 I formed a Mayor's Task Force on AIDS to gather information to enable us to formulate public policies to address the problems associated with AIDS. Many of these recommendations have been implemented and an ordinance has been enacted which prohibits discrimination against those with HIV infection in regards to employment and housing. Training has been provided to all our emergency response employees and Police Officers.

Sacramento County has established an ongoing AIDS Education/Prevention Task Force to help solve the AIDS crisis. It has been recommended that an AIDS Prevention Unit be formed to implement these recommendations. This unit was funded and is active.

Although we believe the programs and services we provide in Sacramento are having a positive effect on deterring the spread of AIDS, they are not enough. Prevention programs and services are under funded and it is time for the federal government to provide adequate funding now. We only need to look ahead to see that the money we spend today will save money in the future. For each HIV infection that occurs in Sacramento during 1988, government will spend approximately $15,000 for health care over the next 10 years. ~~Since 500 new HIV patients are expected in Sacramento County this year this translates to $7,500,000 worth of medical care over the next 10 years.~~

There is overwhelming evidence that education is the key to prevention. According to Dr. Neil Flynn, Associate Professor of Clinical Medicine and Director of the Clinic for AIDS and Related Disorders, at the University of California, Davis, Medical Center, in New York City, 60-70% of IV drug users are infected with HIV. In California this is not true. 15-20% of IV drug users in San Francisco are infected, 10% in Los Angeles and only 5% in Sacramento. If HIV infection is allowed to spread rapidly among IV drug users on the West Coast, we will be setting ourselves up for an enormous financial burden as well as a needless loss of human lives.

It is clear that once IV drug users become infected, the HIV virus is spread to their sexual contacts, who frequently are not IV drug users, and to their children. New York City has an horrendous problem with HIV infected infants born to HIV drug using mothers who are sexual partners of IV drug users. This must not be allowed to occur here. Massive education and prevention programs must be funded for cities like Los Angeles, San Francisco, Sacramento, Fresno and San Diego as part of a federal campaign to slow the spread of the AIDS virus.

It is estimated that Sacramento could use at least $1,000,000 for prevention programs for IV drug users. Currently about

$150,000 is available in Sacramento County for fiscal year 1988. This is inadequate.

There is also a need for better funding of education projects for members of other high risk groups and the general public. Target groups for education and prevention immediately should include gay men, adolescent gay men, IV drug users, their potential sexual partners, and heterosexuals who have many partners. The information in these educational programs must be aimed at the specific audience, be explicit, and contain practical information other than "Just Say No", to prevent spread of the virus. While most educators teach abstinence from the activities which place an individual at highest risk, we know that such perfection is rarely achieved. Therefore, they need to know that if they participate in these activities, they must do them as safely as possible. We must not trade the loss of lives for idealistic purity.

In Sacramento, the situation is still manageable in that it is still feasible to trace heterosexual contacts of high risk individuals such as bisexual men or IV drug users who have HIV. It is not possible to trace the sexual contacts of gay men because of the average number of sexual partners and the high prevalence of the virus among gay men.

The evaluation of vaccines for the prevention of HIV infection must be accelerated, according to Dr. Flynn. Some of the simpler vaccines have not been tested due to the fact that they are not patentable because they do not use new technology, and thus are not profitable. A killed whole virus vaccine is not patentable and therefore, has not been tested. The National Institute of Health must overcome the obstacles toward finding new vaccines which may be tested immediately. Sacramento has an ideal population for such a test because we have hundreds of IV drug users who share drug paraphernalia without disinfection and are therefore at high risk for acquiring HIV infection.

The major problems with services at this time in Sacramento revolve around reimbursement issues. Since approximately half of the people with AIDS are on Medi-Cal which reimburses at a very low rate, close to 44% of actual charges, hospitals and health care providers have been reluctant to provide care for people with AIDS. At this rate, a considerable amount of money lost in the care of people with AIDS As a result, pressures are tremendous to constrict and restrict the AIDS Clinics or cut financial losses.

This problem can be addressed in two ways. First Medi-Cal reimbursements must be increased. Second, a regional center for AIDS care should be established. In a model proposed by Dr. Flynn, this center would bring together AIDS physicians, social services, case managers, and home nursing personnel. The center

would house a clinic facility, transcription services for physicians who use the facility, a special billing system which allows private physicians to bill from the center through their own private offices, an AIDS library, and social services to coordinate lower cost home care. Private physicians would come to the center to see their AIDS patients instead of seeing them in their own offices. The physicians would pay a use of facility fee calculated to be slightly lower than their overhead for their own offices. The supplemental funds to run the center would be provided by grants from federal, state, local and private grants and donations. All administrative and support services could be provided at one center.

Another urgent problem in Sacramento is a lack of beds in skilled nursing facilities for people with AIDS who are unable to care for themselves. We are on the verge of acquiring some skilled nursing facility beds in the Sacramento area, provided more than the current $44.00 per day Medi-Cal reimbursement is available for the care of such patients. The skilled nursing facility owners in the area have said that they cannot care for people with AIDS with the needs for infection control and other special needs for less than $150.00 per day. This rate is less than the costs to keep a patient in the hospital.

AIDS patients are unnecessarily staying in acute care hospital beds instead of skilled nursing facilities because of the low reimbursement rate. Last year, The University of California at Davis, Medical Facility accounted for 1,500 bed days that were used by people with AIDS who could not be placed in skilled nursing facilities. These patients had to remain in the hospital at the cost of $300-400 per day. Precious acute hospital beds were lost and the cost of care was double or triple what it could have been in a skilled nursing facility had there been one available. The reimbursable cost by Medi-Cal needs to be raised from $44.00 per day.

The federal government can help solve this problem by accelerating the process for increasing the reimbursement rate. This is currently being negotiated by the state Health Department and Medicaid administrators. The procedure takes too long given the seriousness of the problem. AIDS is epidemic and consequently the process for handling this special circumstance needs to be adapted to this critical need.

Sacramento has some special problems in providing services to people with HIV infection due to its high military population, the rapid growth of the metropolitan area, and the low cost of living.

The civilian health and social services in Sacramento have no formal ties to the military establishment. Now that the military is screening troops, who live in Sacramento, for HIV antibodies,

it is important that these patients receive information and referrals to local providers who can assist them and their family members with health care delivery, emotional support, health care planning information and resettlement information should they be discharged to this area.

The population of the Sacramento metropolitan area is increasing at a brisk pace. This increase also enlarges the population at risk for HIV infection and those currently infected. This increase in numbers will cause heavy demands on existing and newly created services. We need to plan ahead.

Sacramento is a less expensive area to live than San Francisco, Los Angeles, and New York. Therefore, people with HIV infection and who are symptomatic move here when their incomes are reduced because the cost of living is lower here than in other large cities. For example, 70% or more of the clients with AIDS served by the Bay Area Legal Referral Services Foundation have incomes of less than $7,000.

Specifically, listed below are current services that need expanding and a list of new programs and services which need to be developed in Sacramento.

Current Services Needing Expansions:

- Acute hospital beds.
- Expanded (non ambulance) patient transportation services.
- Home delivered meal services.
- Social work case management services.
- Clinical social work for assessment, patient and patient "family" therapy.
- I.V. drug abuse prevention and education.
- Volunteer, "buddy" services for both emotional (look in on and talk to patients) and practical (shop, clean, food preparation) support.
- Network of support groups for patients, patient family and children (eg., women I.V. drug users with children).
- Home health nursing and attendant care.
- Legal defence and advocacy (eg., Job and housing discrimination, Office of Human Rights).
- Legal assistance and planning (eg., wills, Power of Attorney for health care).

New Programs and Services needing to be developed

- Residential Skilled Nursing Facility (SNF).
- Licenced board and care and group homes.
- Residential Intermediate Care Facility (ICF).
- An AIDS out-patient clinic with mobile outreach.
- Street out-reach for I.V. drug users.
- In-patient psychiatric services.

- 24 hour AIDS patient emergency services.
- Outreach in minority community for I.V. drug users.
- Development of ethnic specific education, outreach and prevention information services for minority patients (i.e., language - modes of services).

Sacramento has done exceedingly well to meet the demands of the HIV epidemic. More must be done but the financial support of the federal government is needed to meet this crisis head on. We must educate the high risk individuals and the general population. We must provide funding for this now so that we can end the spread of this deadly disease and reduce both the financial costs and needless loss of lives. What will the next generation think about those of us who had the knowledge in the 1980's to virtually stop the HIV epidemic dead in its tracks, but did not apply that knowledge? They are going to wonder what kind of fools we were to let this virus spread to the point where the next generation would not be able to eradicate it.

Thank you for inviting me to speak before the commission. It has been a privilege.

MAUREEN O'CONNOR
MAYOR OF THE CITY OF SAN DIEGO

TESTIMONY BEFORE THE PRESIDENTIAL COMMISSION
ON THE HUMAN IMMUNODEFICIENCY EPIDEMIC
MARCH 25, 1988

ADMIRAL WATKINS AND MEMBERS OF THE PRESIDENTIAL COMMISSION. I AM MAUREEN O'CONNOR, MAYOR OF THE CITY OF SAN DIEGO. I AM GRATEFUL FOR THIS OPPORTUNITY TO DISCUSS THE AIDS EPIDEMIC AS IT IMPACTS SAN DIEGO. OUR AREA IS ILL-PREPARED TO DEAL WITH THE SCOPE OF THE IMPENDING CRISIS LACKING A COORDINATED EFFORT AND REALISTIC FUNDING TO DEAL WITH THE MOUNTING TIDE OF AIDS AND ARC CASES, WHICH ARE ESTIMATED TO NUMBER AROUND 10,000 TODAY AND WILL APPROACH 50,000 ACCORDING TO PROJECTIONS BY 1991.

AS AIDS RAISES NATIONAL AND SOCIAL CONCERNS AND HAS CAUSED A PROFOUND LOCAL AND INDIVIDUAL IMPACT, WE APPLAUD THE STEPS OUTLINED IN YOUR INTERIM REPORT AS NECESSARY IN ADDRESSING THE WHOLE FABRIC THAT MUST CONSTITUTE THE NATIONAL EFFORT. WE MUST HAVE A NATIONAL APPROACH TO AIDS WHICH:

- STOPS THE SPREAD OF THE DISEASE

- PROTECTS THE CIVIL RIGHTS OF THE AFFLICTED

- PROVIDES FOR MEDICAL CARE. PWA'S/PWARC'S SHOULD BE GIVEN EXPEDITED COVERAGE UNDER MEDICARE AND BE PROVIDED WITH HOSPITALIZATION, OUTPATIENT, AND PRESCRIPTION SERVICES.

- ADDRESSES THE ECONOMIC CONCERNS OF MEDICAL INSURERS AND THOSE WHO NEED INSURANCE

- PROVIDES FOR THE SOCIAL SERVICE REQUIREMENTS OF PWA'S AND PWARC'S

°COMMUNICATES EFFECTIVELY TO ALL SEGMENTS OF THE POPULATION ABOUT RISK AND BEHAVIOR

STATES AND LOCALITIES NEED CLEAR DIRECTION. IN CALIFORNIA, WE FACE OVER 120 BILLS ON AIDS PENDING BEFORE THE LEGISLATURE GOING IN EVERY CONCEIVABLE DIRECTION AND THE CITIZENRY MUST ADDRESS PROPOSITION 69 (LA ROUCHE AIDS QUARANTINE INITIATIVE) ON THE JUNE BALLOT.

LET ME NOW BRIEFLY SPEAK TO IMMEDIATE LOCAL NEEDS FROM A MAYOR'S PERSPECTIVE IN COMING TO GRIPS WITH AIDS PROBLEMS.

CITY AND COUNTY GOVERNMENTS ARE SEPARATE ENTITIES IN SAN DIEGO. RESPONSIBILITY FOR HEALTH ISSUES RESTS WITH THE COUNTY. AS MAYOR OF THE CITY, I HAVE NO CONTROL, BEYOND PERSUASION, OVER THE MARSHALLING OF RESOURCES TO COMBAT THIS DISEASE. BECAUSE AIDS HAS SIGNIFICANT IMPACT ON ONLY ONE OF THE FIVE COUNTY SUPERVISORIAL DISTRICTS, THE COUNTY IS UNRESPONSIVE TO THE BURGEONING CRISIS. DR. COX, THE COUNTY HEALTH DIRECTOR, AS RECENTLY AS TUESDAY, FLATLY DECLARED THAT THERE WAS NO AIDS EMERGENCY IN SAN DIEGO AND THAT AIDS MERITED NO SPECIAL CONSIDERATION IN RELATION TO OTHER HEALTH ISSUES. DUE TO A LACK OF RESOURCES, THERE IS NO ACTION PLAN IN PLACE FOR DEALING WITH THE DISEASE, NO PRIORITIZATION OF PROGRAMS, AND NO CASELOAD PROJECTION BEYOND 1991. WHILE STATE AND FEDERAL PROGRAMS PROVIDE FOR BASIC MEDICAL CARE AND EDUCATIONAL PROGRAMS, THE MAJOR BURDEN FOR SOCIAL SERVICES AND OUTREACH CONTINUES TO BE CARRIED BY THE PRIVATE SECTOR, WHICH BY AND LARGE MEANS THE GAY COMMUNITY.

THE CITY HAS BEGUN TO ASSIST THE VARIOUS SOCIAL SERVICE ORGANIZATIONS IN PROVIDING AIDS/ARC SUFFERERS WITH THE MOST ESSENTIAL FOOD, SHELTER, AND COUNSELING NEEDS AS THE DEMAND OVERWHELMS THE ABILITY OF PRIVATE DONATIONS TO KEEP PACE.

- °THE CITY SUBSIDIZES APPROXIMATELY 60% OF FOOD BANK COSTS FOR PWA'S AND PWARC'S EARNING LESS THAN $850 PER MONTH.

- °THE CITY FUNDS A VAN FOR PWA/PWARC TRANSPORTATION.

- °THROUGH ITS HOUSING COMMISSION, THE CITY IS PROVIDING A HOUSE FOR PWA/PWARC LOW COST HOUSING. THE CITY SUBSIDIZES THE RENT ON ANOTHER HOUSE USED FOR LOW INCOME HOUSING BY AN AIDS AGENCY.

- °THE CITY ASSISTS IN PROVIDING EDUCATION/COUNSELING FOR THOSE AT RISK AND WHO TEST HIV POSITIVE.

THE CITY FUNDS ITS VERY MODEST EFFORT, ASSISTING PERHAPS 5% OF PWA'S/PWARC'S, THROUGH ALLOCATION OF 10% OF COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) FUNDS AVAILABLE FOR SOCIAL SERVICES. ONLY $1.5 MILLION OF SUCH FUNDS WERE AVAILABLE TO THE CITY IN 1988 FOR ALL CITY SOCIAL SERVICE PROGRAMS. CDBG FUNDS WERE FULLY SUBSCRIBED BEFORE THE ADDITION OF AIDS PROGRAMS. THE RAPID GROWTH OF AIDS REQUIREMENTS WILL QUICKLY DISPLACE ALL OTHER SOCIAL PROGRAMS, EVERY ONE OF WHICH IS ESSENTIAL TO SOME SEGMENT OF THE COMMUNITY. COMPOUNDING THE PROBLEM IS THE FACT THAT THE FEDERAL GOVERNMENT IS REDUCING CDBG FUNDING TO THE CITIES EACH YEAR. FEDERAL CUTS ARE ALSO THREATENED IN OTHER AREAS SUCH AS PUBLIC TRANSPORTATION. SUCH CUTS HAVE A DIRECT IMPACT ON THE SERVICES NEEDED BY THE AIDS/ARC POPULATION. CITIES CANNOT

COMPENSATE FOR DIMINISHED FEDERAL PROGRAMS AND FUND AN INCREASING AIDS DEMAND.

CITIES SUCH AS SAN DIEGO ARE JURISDICTIONALLY CONSTRAINED IN THEIR ABILITY TO RESPOND TO A HEALTH CRISIS AND ARE FISCALLY POWERLESS TO ADDRESS NEEDS. WHERE THE POPULATION AFFECTED IS CURRENTLY CONCENTRATED IN THE MAJOR URBAN AREAS, THE TOOLS MUST BE PROVIDED TO THE CITY GOVERNMENTS TO ACT WHERE OTHERS FAIL TO STEP IN AND WHERE THE PRIVATE SECTORS' WILLINGNESS TO PARTICIPATE IS OVERCOME BY THE NEED FOR SERVICES.

THE REQUIREMENTS OF VARIOUS URBAN AREAS WILL VARY BASED ON THE MAKEUP AND SIZE OF THE IMMEDIATELY AT RISK POPULATION, EXISTING LOCAL MEDICAL AND SOCIAL AGENCY RESOURCES AND VARIOUS PECULIARITIES IN THE LOCAL POLITICAL AND SOCIAL ENVIRONMENTS. SAN DIEGO FOR INSTANCE MUST DEAL WITH NAVY AND MARINE CORPS RECRUITS DISCHARGED AS HIV POSITIVE.

WE URGE THE IMMEDIATE ENACTMENT OF FEDERAL LEGISLATION SUCH AS S1220 (SENATOR KENNEDY'S AIDS RESEARCH, CARE, AND TREATMENT BILL) WHICH WILL GIVE DIRECTION, SCOPE, AND FUNDING IN SUFFICIENT SCALE TO FORMULATE A NATIONAL AIDS POLICY. FUNDING PROVIDED SHOULD GO DIRECTLY TO THE LEVEL OF GOVERNMENT BEST POSITIONED TO ADMINISTER PROGRAMS.

SPECIFICALLY, WE NEED DIRECT ASSISTANCE TO THE CITIES THROUGH PROGRAMS SUCH AS THOSE CONTAINED IN S1220, THE INCREASE IN SOCIAL SERVICE FUNDS AVAILABLE THROUGH EXISTING PROGRAMS SUCH AS CDBG,

OR OTHER PASS THROUGH MECHANISMS. SAN DIEGO NEEDS SUCH FUNDS NOW TO PROVIDE THE FUNDAMENTAL STRUCTURE TO SUSTAIN HUMAN EXISTENCE WITHIN THE BOUNDS OF DECENCY. EXAMPLES OF OUR SPECIFIC REQUIREMENTS ARE:

- °A PWA/PWARC LICENSED ADULT SOCIALIZATION (DAY CARE) FACILITY
- °LOW INCOME HOUSING
- °FACILITIES FOR AIDS AGENCIES TO ALLOW FOR ADEQUATE CLIENT SERVICING
- °MEALS ON WHEELS IN THE TRIPLE A (AREA AGENCY ON AGING) MODEL
- °FOOD BANK FUNDING
- °VISITING NURSE/HEALTH CARE CAPABILITY
- °COUNSELING SERVICES
- °CLEAN NEEDLE (BLEACH AND NEEDLE EXCHANGE) PROGRAMS

THANK YOU FOR THE COURTESY EXTENDED TO ME TODAY AND FOR YOUR INTEREST AND CONCERN.

BFD:evs<br>
a:watkins<br>
3/24/88

Office of the Mayor
SAN FRANCISCO

ART AGNOS

STATEMENT BY MAYOR ART AGNOS
PRESIDENTIAL COMMISSION ON THE HIV EPIDEMIC
SAN FRANCISCO HEARING
March 25, 1988

Admiral Watkins...Members of the Commission.

As Mayor of San Francisco, I welcome you to our City.

We want you to know about AIDS in San Francisco...and what needs to be done.

San Francisco already has lost more young men to AIDS...than all the San Franciscans who died in World War I...World War II...Korea...and Vietnam...<u>combined</u> and <u>doubled.</u>

The word "decimate" literally means one out of ten.

In San Francisco...by the end of this year...one out of ten gay men in our City will have been diagnosed with full AIDS...or died of AIDS.

Within five years...it will be one out of four in our City.

They are San Franciscans in the prime of their lives...hardworking...good citizens...whose contribution to our City is without question.

But the pain and suffering that you hear from those of us who have lost friends and loved ones in this City to AIDS...is not just a San Francisco story.

Today there are perhaps 30 American cities who have the same level of AIDS cases that San Francisco had three years ago.

While the level of new infections is almost leveling off in San Francisco's gay community...that isn't happening to the same extent elsewhere.



200 CITY HALL, SAN FRANCISCO, CALIFORNIA 94102
(415) 554-6141

We did it alone in California...because there was no federal help.

In 1984, I doubled the funding to $1 million...and we still had no federal AIDS education funding.

In 1985 I authored California's law setting public health standards for use of the AIDS antibody test...including consent and confidentiality provisions.

The federal government did not provide leadership.

Finally, in March, 1987, I requested and won approval for a Special Joint Session of the California State Legislature on the AIDS Epidemic.

The U.S. Surgeon General, Dr. C. Everett Koop, and a Nobel laureate, Dr. David Baltimore, co-chair of the National Academy of Science Institute of Medicine panel on AIDS...came to the California State Capitol and spoke at that highly unusual Joint Session.

I was dismayed then that Dr. Koop, our nation's top public health officer, had not been invited to bring his message to the President of the United States who appointed him.

I am still dismayed, a year later, that Dr. Koop has not been invited to fully brief the President of the United States on our nation's most serious health crisis...nor has he been invited to play the lead role in setting our nation's policy.

I urge this Commission, without delay, to recommend to the President that he meet with his Surgeon General and that they appear together publicly to end the impass that public health officials face from those who hold political office.

I understand that impass.

As a state legislator, I worked with public health officials on every AIDS bill that I authored.

Without exception, those bills had the support and enthusiasm of public health leaders and AIDS care providers.

But time after time, what the public saw was a partisan political line being drawn.

That was an artificial line...drawn for artifical reasons...but the delay results in deaths which are not artificial.

Working with the U.S. Surgeon General, I drafted an omnibus AIDS bill that incorporated the recommendations in his 1986 report.

I also worked with the National Academy of Sciences Institute of Medicine.

The bill was hailed by health officials as a model for the nation...a measure that could save lives.

While Dr. Koop does not endorse state legislation, he confirmed that he had worked on each draft and said the bill was the most compassionate he had ever had presented to him.

In the California State Assembly, only one Republican would vote for it.

He is the only physician in the Legislature.

In the California State Senate, not even one Republican voted for the bill.

The centerpiece of that legislation was the creation of a California Commission on AIDS.

It would bring together the public sector and the private sector, the many agencies of the state, local governments, and a range of individuals who are affected as employers, police, insurance executives, physicians, nurses and people with AIDS themselves.

That same approach has been recommended by every major public health association for the nation...but it has yet to happen.

This Commission is a temporary stop-gap...not the national body we need to oversee all the parts of our policy on AIDS.

It is overdue...and it shouldn't wait on an election to happen.

In the interim, I urge you as a Commission to call for the establishment of a powerful body that can review existing programs of every kind...to see whether they might be put to work to help us combat AIDS...and to provide the assistance we need for demonstration programs and rule changes where the need is already evident.

In San Francisco we have a model program called Open Hand.

Volunteers, including professional chefs from some of our city's finest restaurants, prepare meals that are taken to people with AIDS who are still able to live at home...but unable to prepare nutritious meals for themselves.

It is very like the Meals on Wheels program...except that the Meals on Wheels program is barred from helping people under 65.

We have no nursing home facility for people with AIDS in San Francisco...indeed, we have virtually no facility in all of Northern California.

The reimbursements are too low.

The fear of other patients and their families is too high.

We are seeking to have the Public Health Service Hospital in San Francisco converted into a facility that can help meet that need...particularly for those who face the dual diagnosis of AIDS dementia.

But the process of winning the federal approvals for such an innovation...and the help we need for operating costs...will take years before the project is complete.

Those who need it this year...or next...likely will never live long enough to find it of service.

Too often, federal rules prohibit demonstration project funds from going to programs that already have been launched.

We call that the San Francisco penalty.

Our city begins a program...proves its effectiveness...using our own funds...and then a federal demonstration program is created...but only for new efforts.

When the Commission proposed a $1.5 billion program for AIDS and substance abuse, you called for a local and federal match.

San Francisco wants and needs such a program.

We have less than a dozen beds for women who have child care needs who require residential substance abuse programs.

We have an aggressive street outreach program to IV needle users...informing them of detox programs...counseling programs...and how to clean needles with bleach.

I helped start those programs with a state pilot that is being expanded.

But the federal component comes from a block grant that was a one-time appropriation from the War on Drugs.

Your proposal could help us put in the residential treatment program we need...while keeping families intact.

We could continue our model street outreach programs.

But unless you make clear that there will be no penalty for programs like ours that are already started...the announcement you made intending to encourage us all...will be an incentive for further delay.

Cities will simply stop the innovations...stop bridging the gap...and wait for the pipeline which may never open.

San Francisco won't do that...but you can remove the issue from the table simply by including an ability for programs like ours to be grandfathered in.

The burden on cities such as San Francisco is going to grow greater...even though the new infections level off.

The incubation period guarantees that the pipeline will continue to bring new cases.

But beyond that, a major shift is taking place in meeting AIDS costs.

Two years ago, about 30% of San Francisco's caseload were public-funded cases, including through our state Medi-Cal.

Today it is almost 50% whose costs must be borne by the public sector.

As insurance redlining increases...as employers feel free to limit health benefits so that AIDS is not covered...or worse, discriminate aginst those with AIDS...the costs are going to fall straight on the cities.

This will continue to be particularly true in states like California and about 35 others where no risk-pool program exists for those unable to obtain health care.

They drop straight to the public rolls.

The federal government has an opportunity to play a major role in creating federal incentives to states to create risk pool or stop-loss programs, including case management, that can spread the costs of AIDS care sensibly and equitably between employers, insurers and the public sector.

I particularly want to call your attention to the fact that one out of every two dollars paid by California employers for health care comes from a self-insured plan that they underwrite on their own.

The state and cities have no authority over such programs.

The conditions of benefits, whether home care and hospice is reimburseable...even whether certain diseases such as AIDS could be red-lined out...are issues reviewed at the U.S. Department of Labor.

I have yet to see policy guidelines to employers on AIDS in ERISA plans.

The federal-state share of AIDS care, according to the Health Care Financing Administration, is only 53 cents on the dollar.

The other 47 cents is absorbed by the doctors, hospitals and charities.

For us, that means the San Francisco taxpayer, because our major hospital is San Francisco General, a part of our City's health Department.

The specifics of our needs are long.

We need help for the homeless with AIDS.

In San Francisco, we estimate that number at between 200 and 600.

We have fewer than 80 beds.

We need significant funding for case management...including money management...and eligibility workers for those who should receive veteran's benefits or SSI.

We need to create health centers capable of monitoring and possibly providing early intervention for those who are antibody positive...something many San Franciscans with independent incomes are doing through the private sector...but which is still out of reach for those who rely on the public sector for help.

We need better coordination of new drugs...and better access to investigational drug opportunities.

We need a federal consumer protection program to halt AIDS fraud...just as we are doing through an Attorney General AIDS Fraud Task Force started by Attorney General John van de Kamp in California.

Most of all, we need committed leadership at the White House itself.

Cities like San Francisco show what can be done.

But what threatens to overwhelm San Francisco is not the increased case load of AIDS...but the continued lack of leadership from the federal government.

Thank you.

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