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Proposition 64: The AIDS Initiative in California

Senate Office of Research

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Prepared by:

Senate Office of Research
Elisabeth Kersten, Director
September 1986

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C A L I F O R N I A L E G I S L A T U R E

SENATE OFFICE OF RESEARCH

Elisabeth K. Kersten, Director

September 1986

The Honorable David Roberti, President pro Tempore of the Senate
The Honorable Members of the California State Senate

Dear Mr. President and Members:

California voters have before them on the November ballot an initiative concerning our response to the public health threat posed by Acquired Immune Deficiency Syndrome (AIDS).

In light of the significance of Proposition 64's subject matter, Senator Roberti requested the Senate Office of Research to prepare a report, with special emphasis on interpretation of the Initiative's text and analysis of its expected effect on AIDS prevention and treatment efforts. In addition to analyzing the specific AIDS initiative before us, this report puts the measure into a larger, factual context relevant to any well-informed discussion about AIDS policy in California. Specifically, the report contains:

- Basic information about AIDS, transmission of the AIDS virus, and California's response to AIDS;
- General information on the Initiative's proponents, "PANIC";
- Discussion of the widely varying interpretations that flow from the Initiative's vague and confusing text;
- Estimates of the Initiative's fiscal impact;
- Explanation of the medical and public health community's widespread opposition to the Initiative.

We trust you will find this report a useful compilation of information and analysis relevant to Proposition 64.

Sincerely,

Elisabeth Kersten

ELISABETH KERSTEN

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About things on which the public thinks long it commonly attains to think right.

Samuel Johnson, Lives of the Poets, 1778

We are not used to thinking of illness as political. Even when we recognize the political dimension to health care and research -- for example, the fact that prevention of lead poisoning or curing sickle-cell anemia is less glamorous and less well financed than heart transplants -- it is still difficult to conceive of disease itself as a political construct.

Dennis Altman, AIDS In The Mind Of America, 1986

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THE AIDS INITIATIVE IN CALIFORNIA

I. EXECUTIVE SUMMARY

The Prevent AIDS Now Initiative Committee (PANIC), working closely with Lyndon LaRouche's national organization, has placed on the November ballot a short, seemingly simple initiative measure whose stated purpose is to protect people with Acquired Immune Deficiency Syndrome (AIDS) and protect the public health. Although no one could criticize such a purpose, PANIC's initiative uses ambiguous, unclear language that can be interpreted in strikingly different ways, with widely varying effects on public health AIDS prevention efforts.

If the Initiative is approved by the voters, we can expect intense and lengthy litigation over the many legal questions raised by its confusing language. But no matter how it is ultimately interpreted by the courts, the medical and public health community are deeply worried about the Initiative's impact on their current AIDS prevention and treatment efforts. They fear that the Initiative will divert time and resources from important AIDS prevention and research work already under way, and will subject local public health officers to political pressure that prevents them from following their best professional judgment and good public health practice. For these reasons, California's major medical and public health organizations are strongly opposed to PANIC's AIDS Initiative. There are no known medical or public health organizations, and no AIDS experts with recognized medical credentials, who support this Initiative.

While health experts fear the impact of PANIC's Initiative on current AIDS programs, economists and financial analysts are trying to decide which of several legal interpretations might be given to the Initiative, and how much money each of these might cost the public. If the Initiative is interpreted to have only limited impact on California's current health law and practice,

the fiscal impact would be minimal. If, on the other hand, the Initiative is given its most far-reaching interpretation, there would be substantial implementation costs to the public.

Is Proposition 64 worth the lengthy litigation and potentially enormous public costs that will follow from it? The Initiative's proponents express concern about the devastating impact of AIDS, and claim their measure is essential to an effective AIDS prevention program in California. At the same time, California's medical and public health community, drawing on their experience with AIDS and other life-threatening diseases, fear that this Initiative will only add to the AIDS problem and will not prevent a single case of AIDS or HTLV-III infection.

If the public believes in PANIC's approach and in the AIDS program advocated by Lyndon LaRouche's national organization, Proposition 64 will be voted into law and no doubt initiate a wave of similar efforts throughout the nation. If, however, the public takes to heart the statements of recognized AIDS experts and the concerns of the medical and public health community, Proposition 64 will be soundly rejected by the voters.

II. INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) is a serious, frightening disease that has already brought great changes to medical budgets and public health policy in this State and many other parts of the world. Our response to AIDS reveals a great deal about our personal and public priorities in health policy, public spending, personal liberties, and individual values.

This November, California voters have before them an Initiative measure with significant symbolic and perhaps substantive impact on public health policy in California. Proposition 64, the Acquired Immune Deficiency Syndrome (AIDS) Initiative, is a one-page measure whose provisions are being interpreted in widely varying ways. Some analysts say that this measure could result in mandatory, periodic testing of the entire state population, resulting in layoffs and quarantine of tens and perhaps hundreds of thousands of adults and children. At the same time, other analysts insist that the measure would have no real effect on existing law and current public health AIDS prevention activities.

In spite of widespread confusion over the potential impact of Proposition 64, there are two points that seem clear. First, passage of the measure would lead to many lawyers and public health officials spending time in litigation, seeking judicial interpretation of the many uncertain but important public health implications that lie within the measure's seemingly simple wording.[1] Secondly, the fact that Proposition 64 addresses the subject of preventing the disease most feared by Californians[2] and, by implication, the subjects of drug abuse and sexual intercourse, ensures extensive media coverage of this measure as well as highly emotional public discussion.

III. TEXT OF THE AIDS INITIATIVE

SECTION 1. The purpose of this Act is to:

A. Enforce and confirm the declaration of the California Legislature set forth in Health and Safety Code Section 195 that acquired immune deficiency syndrome (AIDS) is serious and life threatening to men and women from all segments of society, that AIDS is usually lethal and that it is caused by an infectious agent with a high concentration of cases in California;

B. Protect victims of acquired immune deficiency syndrome (AIDS), members of their families and local communities, and the public health at large; and

C. Utilize the existing structure of the State Department of Health Services and local health officers and the statutes and regulations under which they serve to preserve the public health from acquired immune deficiency syndrome (AIDS).

SECTION 2. Acquired immune deficiency syndrome (AIDS) is an infectious, contagious and communicable disease and the condition of being a carrier of the HTLV-III virus is an infectious, contagious and communicable condition and both shall be placed and maintained by the director of the Department of Health Services on the list of reportable diseases and conditions mandated by Health and Safety Code Section 3123, and both shall be included within the provisions of Division 4 of such code and the rules and regulations set forth in Administrative Code Title 17, Part 1, Chapter 4, Subchapter 1, and all personnel of the Department of Health Services and all health officers shall fulfill all of the duties and obligations specified in each and all of the sections of said statutory division and administrative code subchapter in a manner consistent with the intent of this Act, as shall all other persons identified in said provisions.

SECTION 3. In the event that any section, subsection or portion thereof of this Act is deemed unconstitutional by a proper court of law, then that section, subsection or portion thereof shall be stricken from the Act and all other sections, subsections and portions thereof shall remain in force, alterable only by the people, according to process.

IV. BASIC INFORMATION ABOUT AIDS

A. AIDS and the AIDS Virus. Acquired Immune Deficiency Syndrome (AIDS) is a viral infection that destroys the body's immune system, leaving it vulnerable to diseases that would normally not be a problem for an immunologically healthy person. The virus that causes AIDS has been called many names, the most common of which are HTLV-III or LAV. A committee of international experts has recommended that the virus be named Human Immunodeficiency Virus (HIV), and this term is used by a growing number of health officers and physicians who work with AIDS. However, to avoid confusion, this analysis will use the same nomenclature as Proposition 64 does: HTLV-III.

B. Seropositivity, ARC, and AIDS. A person infected with HTLV-III does not necessarily have AIDS or any other medical symptoms. These people are often referred to as "seropositive" because they will have positive results when their blood serum is tested for HTLV-III antibodies. Scientific studies of infected individuals indicate that 20%-40% of them will develop AIDS in five to seven years. Conversely, 70% of seropositive people do not have any other AIDS symptoms. In between these two ends of the spectrum are individuals with a range of health problems -- fever, fatigue, weight loss, diarrhea, and enlargement of the lymph glands -- often referred to as AIDS-Related Complex (ARC).

C. AIDS Transmission. HTLV-III is not transmitted in the same way as the common viruses that we are more familiar with like the cold or flu viruses. The overwhelming consensus of the scientific and medical community is that HTLV-III is spread by exchange of body fluids through sexual contact, receiving infected blood or blood products, sharing needles or equipment when using illegal drugs, or from an infected mother to her infant prior to or during delivery. People who live, work, or eat in

close but non-sexual, non-needlesharing contact with HTLV-III-infected people are not in danger of being infected.

D. Increasing Number of AIDS Cases and Deaths. The number of AIDS cases has increased dramatically since AIDS was first reported in the medical literature in 1981. In March 1983, California became one of the first states to make AIDS a mandatorily reportable condition.[3] At the end of July 1986, California had reported a cumulative total of 5,444 AIDS cases. Of these cases, slightly less than half of those people have died. For that portion of the cases reported more than two years ago, there is a much higher fatality rate of roughly 2/3-3/4 of the cases.

California AIDS cases have consistently represented about 20-25% of all AIDS cases in the United States. For example, for the past twelve months (reporting period July 28, 1985 - July 28, 1986), California had 2,608 AIDS cases (23.5%) of the nationwide total of 11,113. For the cumulative total of all AIDS cases reported from June 1981 to July 28, 1986, California had 5,350 cases (23.1%) of the total of 23,115.

Although no one knows what the rate of new AIDS cases will be, it is clear that we can expect a growing number of AIDS patients and AIDS-related deaths until an effective vaccine or treatment method is developed. Scientists caution this could take several years, and that we must concentrate on public health preventive measures until that time.

E. Estimates of Future AIDS Cases and Deaths. Any projection of the future number of AIDS cases must be pieced together based on a number of assumptions. These assumptions include estimates of the number of infections that have already taken place, the number of cases that will develop as a result of those past infections, the number of new infections that will take place in the

future, and the number of cases that will develop from these new infections. This means that even if all exposure to HTLV-III were eliminated tomorrow, there would still be more AIDS cases -- no one knows how many -- developing in the future.

With this in mind, we note that the California Department of Health Services has estimated that approximately 300,000-500,000 Californians are currently infected with the AIDS virus (seropositive). By way of comparison, the U.S. Centers for Disease Control has estimated there are currently 1-1.5 million seropositive people in the United States. If we assume that 20% of those people will have AIDS within five years, we can project 250,000 AIDS cases in the U.S. by 1991, with 80,000 of those cases in California.

F. AIDS Risk Groups. All but a small proportion of AIDS cases reported in this country have been traced to people who fall into one of the designated "high risk" groups and are therefore assumed to have engaged in AIDS high-risk activities. The risk groups/activities are: homosexual or bisexual man, intravenous (IV) drug abuser, hemophiliac, recipient of a blood transfusion, heterosexual contact with an infected person, parent with AIDS or in a high-risk group. For those seropositive people or AIDS patients who refuse to be interviewed by health officials or who say they do not belong in any of these risk groups, medical custom dictates that they be classified in the None Apparent/ Unknown/Other category.

TABLE 1

Distribution of AIDS Cases in California

	Total Cases	% of Total
Homosexual/Bisexual Male	4,979	91.5
Intravenous (IV) Drug User	120	2.2
Heterosexual Contact	37	0.7
Hemophiliac or Transfusion	155	2.9
Parent at Risk	9	0.2
None Apparent/Unknown	144	2.7
	5,444	100.2%[1]

[1]Result of rounding errors.

Source: California Department of Health Services, Acquired Immune Deficiency Syndrome (AIDS) Monthly Field Activities Report, January 1981 - July 31, 1986.

TABLE 2

Distribution of AIDS Cases in the United States (including California)

	Total Cases	% of Total
Homosexual/Bisexual Male[1]	16,762	72.5
Intravenous (IV) Drug User	3,889	16.8
Heterosexual Contact[2]	862	3.7
Hemophiliac or Transfusion	632	2.7
Parent at Risk	254	1.1
None Apparent/Unknown	716	3.1
	23,115	99.9%[3]

[1]This includes 1,823 cases which fall into both the Homosexual Male and IV Drug User categories. California assigns such cases to the "Homosexual Male" category, so these categories are combined here for purposes of comparison.

[2]Includes 379 persons who have had heterosexual contact with a person with AIDS or at risk for AIDS, and 483 persons without other identified risks who were born in countries in which heterosexual transmission is believed to play a major role although precise means of transmission have not yet been fully determined.

[3]Result of rounding errors.

Source: Centers for Disease Control, Center for Infectious Diseases, AIDS Program, Acquired Immune Deficiency Syndrome (AIDS) Weekly Surveillance Report, July 28, 1986.

Table 1 shows the distribution of AIDS cases in California by risk group/risk activity, and Table 2 for the entire United States. The main difference between these two distributions is the higher proportion of IV drug abusers in the U.S. figures. Until now, the spread of AIDS among drug abusers has been more of a problem on the East Coast than in California, although that situation is unfortunately changing now in California, which is seeing an increased proportion of AIDS in IV drug abusers at the same time that the proportion of cases among homosexual men is decreasing due to AIDS prevention education and counseling activities.

G. California Spending on AIDS. Since 1983, state support for activities aimed at controlling the spread of AIDS has dramatically increased. The Department of Health Services has created an Office of AIDS to give more attention to AIDS efforts and coordinate existing programs, and the Department's AIDS budget has gone from $500,000 to more than $13.5 million, a twenty-seven-fold increase. At the same time, the University of California's budget for AIDS research has more than tripled to a total of $9.6 million in the 1986-87 fiscal year.

Although total FY 1986-87 spending on AIDS by all state departments (including Health and Corrections) will be an impressive $19.2 million, this is nevertheless far short of the $49 million budget proposed by the Legislature. The California Senate and Assembly will continue to work with the Governor to increase funding for an "all-out effort to prevent the further spread" of AIDS, including funds targeted for IV drug programs, education, and mental health.

V. PROPOSITION 64: PANIC AND LAROUCHE

A. The AIDS War Plan. The proponents of Proposition 64 are the Prevent AIDS Now Initiative Committee (PANIC), an organization whose members have close ties with the Lyndon LaRouche organization that calls itself the National Democratic Policy Committee (no connection with the Democratic Party). Mr. LaRouche's Policy Committee has devoted considerable attention and resources to the AIDS Initiative,[4] and the Initiative proponents have referenced a LaRouche organization publication, Executive Intelligence Review (EIR), as background material for their Initiative. Recent statements in EIR indicate that the Initiative is a centerpiece of Mr. LaRouche's broader political agenda:

> At the center of the debate in Europe, as in the United States, is the ballot initiative in the state of California--Proposition 64.... According to Le Monde's August 7 article, Lyndon LaRouche, the originator of the California initiative, "is on the verge of actually reaching the rank of a political star." [5]

In Mr. LaRouche's EIR article, "A program to stop the AIDS pandemic,"[6] he refers specifically to the California ballot proposition on AIDS, tying it into larger issues of international monetary policy, neo-Nazi groups, twentieth-century fascism and bolshevism, the "neo-Malthusian" movement centered around the Club of Rome, and the Club of Rome's interface with the Soviet KGB. He states, "My knowledge about AIDS is based on the work of a special scientific task-force, which has been working for about a year, reviewing the facts with leading medical specialists around the world."

The task force referred to here is the Executive Intelligence Review (EIR) Biological Holocaust Task Force, described in EIR as

having been formed at the initiative of Mr. LaRouche. On February 15, 1986, the Task Force published an EIR Special Report presenting "An Emergency War Plan to Fight AIDS and Other Pandemics." According to Warren Hamerman, Director of the EIR Biological Holocaust Task Force:

> We are at a unique historic moment. The combination of the PANIC Initiative in California, the acknowledgement of the general threat to "non-risk" populations, the Supreme Court decision against sodomy, and a growing movement in Ibero-America against the IMF [International Monetary Fund] have created an opening for concerted action. [7]

The Task Force's 140-page War Plan concentrates on these twelve points:

1) Declaration of war mobilization
2) Universal screening
3) An Apollo Moon-shot-scale crash biomedical research program
4) Full state-of-the-art medical treatment for all confirmed cases
5) Universal "classic" public-health measures, including quarantine
6) An all-out war on drugs
7) A Biological Strategic Defense Initiative (BSDI) utilizing the most modern laser and other optical-biophysics technologies for defense of the health of the world's populations
8) Upgrading of the nutritional intake of the world's populations to enhance immune function
9) Worldwide mosquito, insect, and vermin control
10) Emergency upgrading of sanitation, housing, and water systems
11) Activation of the National Disaster Medical System (NDMS)
12) U.S. withdrawal from the Soviet-dominated World Health Organization (WHO).

The statements by Mr. LaRouche about his California AIDS Initiative, taken together with the War Plan proposals, give Proposition 64 a prominent role in the LaRouche organization's larger political goals. Having placed Proposition 64 within this larger context, the rest of this report will concentrate on the text and

interpretation of that Proposition without further reference to its potential significance within the LaRouche organization.

B. History of the Proposition 64 Ballot Arguments. The ballot pamphlet arguments and rebuttals that are being published by the State (see Appendix A) are the result of an unprecedented lawsuit by the Secretary of State to clarify the state's responsibility to avoid publishing "false" or "misleading" statements in the ballot pamphlet. After receiving the text of the Initiative proponents' Rebuttal to the Argument Against Proposition 64, the Secretary filed suit to remove statements alleged to be false and misleading. The California Medical Association and the California Nurses Association later joined the Secretary in officially objecting to these statements.[8]

The three statements in question were: "AIDS is not 'hard to get'; it is easy to get;" "Potential insect and respiratory transmission has been established by numerous studies;"[9] and "Transmission by 'casual contact' is well established." The Initiative proponents had already agreed that this last statement concerning casual contact was incorrect, and sought to amend their original text with this statement, "There is no evidence for the assertion that AIDS cannot be transmitted by casual contact."

In addition to deciding whether or not these statements were false or misleading, the court was also asked by the Initiative proponents to restore the name of Dr. Ken Kizer to their rebuttal argument. Dr. Kizer, Director of the California Department of Health Services, had previously written to the Secretary of State, objecting to the use of his name without permission in the proponents' rebuttal argument.[10] The Secretary had complied with Dr. Kizer's demand, so the Initiative proponents sued to restore the deleted sentence containing Dr. Kizer's name.

After hearing the legal arguments, Sacramento Superior Court Judge James T. Ford ordered all three statements regarding AIDS transmission removed from the ballot pamphlet arguments because they were "false" or "misleading," even when the "clear and convincing" standard of proof (a higher standard of proof than is usually used in civil suits) was applied. He also ordered that the statement using Dr. Kizer's name be restored to the text, ruling that this particular use of Kizer's name was linked only to a call for "more reporting and testing" and did not carry the assertion or implication that Dr. Kizer supports the Initiative, which in fact he has publicly opposed.

VI. WHAT DOES PROPOSITION 64 MEAN? QUESTIONS OF INTERPRETATION

A. Overview. **The Initiative's ambiguous wording creates several important problems of legal interpretation, each one subject to extensive litigation.**

The remainder of this report discusses the legal, fiscal, and medical/public health effects of Proposition 64 being approved by the voters and upheld by the courts. The difficulty in such a discussion is that a realistic forecast of the medical/public health effects and fiscal effects depends on knowing what the legal effect of the Initiative's passage would be, but that question is precisely the one that has no clear answer. Nevertheless, one can talk in general terms about a range of possible effects, with the understanding that this range extends so far as to include, at the one end, very little substantive effect, and at the other end, a massive change in existing public health programs, relocation of thousands of people, and a major redistribution of public expenditures on health, welfare, and education.

This report will touch on eight general questions of Proposition 64's legal interpretation and effect.

- Amending an initiative-generated law.
- Interpreting the Initiative's intent.
- The effect of "enforc[ing] and confirm[ing]" existing law and requiring public health officials to "fulfill all of the[ir] duties and obligations" regarding specified public health laws.
- The effect of language in the Initiative stating as its purpose the protection of "AIDS victims" and the general public health.
- The definition of an HTLV-III "carrier."
- Reporting duties under the Initiative.
- The effect of declaring people who have AIDS or are a "carrier" to be "infectious, contagious and communicable."
- Mandation of widespread testing and quarantine.

It is safe to assume that each of these questions will be vigorously and extensively litigated, with an unknown effect on AIDS public health policy during the months and, more probably, years that it will take for the courts to resolve these questions.

B. Amending an initiative. **An initiative-made law is harder to amend than most other laws.**

Many people do not realize that a law resulting from voter approval of an initiative is different from a law coming out of the usual legislative process. One important difference is the fact that an initiative-made law cannot be amended in the usual way (unless the text of the initiative specifically allows this), but must instead be amended by another initiative.[11] The practical implication of this difference is that the public should expect an extra amount of care and thought to go into drafting an initiative because of the practical and financial demands of going back before the voters if any changes, however minor, are needed to clarify or improve that law.

The remainder of the Legal Interpretation section of this report will examine issues raised by Section 1 and Section 2 of the AIDS Initiative. Section 3 needs no discussion, as it is a routine "severability" clause that becomes operative only if part of the Initiative is ruled unconstitutional. If this happens, Section 3 prevents the rest of the Initiative from automatically becoming invalid by requiring that the constitutionality of each legal issue in the Initiative be litigated separately.

C. PANIC's Intent. **Legal interpretation of the "statutory intent" of the AIDS Initiative: What will be considered and how much weight will the courts give it?**

If there is a question about the meaning of a law, a judge or attorney will often look to the "statutory intent" for guidance in interpretation.[12] If the statute is the result of the legislative process, the judge can look to the official record of the legislative author's prior statements on the purpose of the law, and can often look at transcripts of public hearings in which the purpose of the then-proposed law was discussed and recorded. If, however, the statute in question results from the initiative process, there is no written legislative history to consult, and the judge must rely on other sources to determine the initiative's "statutory intent."

One would expect an easy job of determining the AIDS Initiative's "statutory intent" because all of Section 1 is a statement of its purpose. Unfortunately, this Section uses broad and ambiguous phrases that add more confusion than clarification to the question of intent.

Some of the questions raised by the Initiative's "purpose" language are discussed in Subsection E below. Other questions include: What does it mean to "enforce and confirm" a declaration about AIDS? Does the enforcement language change existing law in any way? What purpose is served by stating an intention to "utilize the existing structure" of state and local health officers and the laws "under which they serve"? If no change in existing public health structure and laws is intended, what is the purpose of the initiative? If there is an intention to remove from health officers' discretion what is currently left to their best medical judgment, why not state this clearly and directly?

In addition to looking at the Initiative's statement of purpose, a court will probably look at the accompanying ballot pamphlet arguments to clarify statutory intent. (See Appendix A for the text of these arguments.) These arguments carry no weight if they imply a result different from the meaning of the statutory language (as interpreted by the court), but courts will sometimes turn to ballot arguments if their text can shed light on statutes that are otherwise unclear. This is one reason that the Secretary of State, the California Medical Association, and the California Nurses' Association sued to remove false and misleading statements from the Initiative proponents' ballot arguments. (See Section V(B) of this report for details of this.)

One final interpretive question unique to this Initiative involves the acronym chosen by the Initiative proponents: PANIC. "Panic" means "a sudden, unreasoning, hysterical fear, often spreading quickly".[13] Courts will sometimes include in their legal opinions a consideration of whether or not a certain outcome is "against public policy" and therefore to be avoided. If a court found the promotion of public panic to be against public policy, how would this influence its consideration of the AIDS Initiative's "intent"?

D. Mandated Activities vs. Discretionary Activities. **Does the Initiative allow health officials to continue using their best medical judgment in exercising their professional powers, or does it take away this flexibility by mandating activities that are discretionary under existing law?**

A central question in the interpretation of both Section 1 and Section 2 is the extent to which state and local public health officials would no longer be allowed to use their professional judgment in carrying out their duties. Several phrases in the Initiative imply this intent without speaking directly to the

actions that would be mandated. For example, in Section 1 of the Initiative, the words "enforce" at the beginning of Part A and "utilize" at the beginning of Part C could be seen as a mandate for some unspecified action, arguably a mandation of activities that are currently discretionary. Similarly, the language in Section 2 that "all personnel of the Department of Health Services and all health officers shall fulfill all of the duties and obligations specified in each and all of the sections of [H&S §3123 and C.A.C. Title 17, Part 1, Chapter 4, Subchapter 1]" could be interpreted as taking away from public health officials all discretion in carrying out the activities referred to in the referenced laws.[14]

Alternatively, a more limited legal interpretation of these phrases would allow public health officials to continue using their discretionary powers according to their best professional judgment about effective AIDS prevention measures. This is not to say that the practical effect of the Initiative's passage might not be more far-reaching as a result of ensuing political pressure on local health officials to respond to the expressed "political will," but that is a different issue.

E. Effect of Section 1 (B) of the Initiative. **What is the effect of Initiative language stating as the Initiative's purpose protection of people with AIDS and the general public health?**

Section 1(B) declares it to be part of the Initiative's purpose to:

> Protect victims of acquired immune deficiency syndrome (AIDS), members of their families and local communities, and the public health at large[.]

Similarly, the last part of Section 1(C) declares that it is the Initiative's purpose to have health officials utilize existing laws "to preserve the public health from AIDS."

The interaction of this Subsection with the "mandatory vs. discretionary powers" issue presented above leads to some interesting questions. If the Initiative were given its more far-reaching legal interpretation (for example, changes in health officials' discretionary powers regarding testing and quarantine, and changes in confidentiality safeguards), and if some -- or all -- health officials determined that the actions required by this interpretation would protect neither the public health in general nor people with AIDS in particular, could the health officials use the intent language above to support their refusal to carry out the newly-mandated activities? Such an action would not be surprising in light of the public health and medical community's widespread conviction that implementing the more far-reaching interpretation of the Initiative would not assist AIDS prevention efforts, but would, instead, make it more difficult to detect and prevent the spread of AIDS.

F. HTLV-III "Carriers". **Who is an "HTLV-III carrier" and how would this be determined? What implications does this have for current AIDS-prevention efforts?**

The Initiative makes declarations and imposes requirements concerning both AIDS and "the condition of being a carrier of the HTLV-III virus."[15] Although there is a clear and widely-used medical definition of who does or does not have AIDS, there is no widely available method of determining who is carrying the virus HTLV-III.

If the intent of the Initiative is to use currently-available tests to determine whether HTLV-III antibodies are present, it would have been less confusing to state that directly, while acknowledging that people with HTLV-III antibodies may or may not be "carriers." Any proposal for widespread use of the HTLV-III antibody test (blood test) to screen for "carriers" must take

into account the fact that these tests are not very specific and were developed to protect the blood supply even at the expense of mistakenly discarding healthy, acceptable blood. This means that the antibody tests yield a certain rate of false positives, especially when used on a wide-scale basis for the general population.[16]

Alternatively, the Initiative could be interpreted as speaking to a future development, namely, the widespread availability of a method of testing directly for presence of HTLV-III. The virus tests (tissue cultures) that are currently performed on antibody-positive individuals are able to culture the virus only 60% of the time, which could indicate that the number of seropositive people in California is much larger than the number of actual virus carriers. Unfortunately, the virus test is time-consuming, expensive (approximately $300 per test), and somewhat experimental. Consequently, it is not widely used at this time.

Obviously, the "carrier" interpretation that is used has implications on the Initiative's impact. If it is interpreted to refer to people with HTLV-III antibodies, there could be changes in the stringent confidentiality safeguards that are part of California's Alternative Test Site program. This program was established last year to protect California's blood supply by encouraging high-risk people to be confidentially tested at an "alternative" test site instead of having to use blood donation sites to determine their antibody status. There are currently 53 Alternative Test Sites in operation, with approximately 40,000 people having been tested in this program. People who visit one of these sites receive not only a blood test, but also medical and behavioral counseling on reducing the risk of exposure to and transmission of the AIDS virus. These test sites also serve as a referral point for people who need medical, public health, or support services.

If the Initiative were interpreted as eliminating or significantly relaxing the confidentiality safeguards in the Alternative Test Site program, there would be a sharp drop in the number of people voluntarily participating in its testing and risk-reduction counseling services, and the program would no longer be able to operate as it currently does. Alternatively, if the Initiative's "carrier" language were interpreted to refer to people known to carry HTLV-III, there would be little impact on the Alternate Test Site program because it tests for HTLV-III antibodies.

No matter what definition of "carrier" is eventually adopted, and no matter when a test for HTLV-III becomes widely available, the key public health issue here should be how HTLV-III is transmitted from a "carrier" to a non-infected person, and the most effective way of preventing that transmission. This issue is too important to be left to implication, and it deserves to be addressed directly in all discussions about AIDS and the AIDS Initiative. Not coincidentally, this is the issue on which PANIC and LaRouche disagree most dramatically with prevailing medical and public health opinion.

G. Reporting Requirements. **What effect will the Initiative have on hospitals' and health officials' duty to report AIDS cases? How might it affect the duties and actions of members of the public who "suspect" someone has AIDS or is a "carrier"?**

Proposition 64 requires that both carriers and AIDS cases "shall be placed and maintained...on the list of reportable diseases and conditions mandated by Health and Safety Code Section 3123..." With respect to AIDS reporting by physicians, health officers, and hospitals, the Initiative would have no real effect. To understand why requires a brief explanation of mandatory disease reporting in California.

There are two ways in which a disease becomes mandatorily reportable: being reported as an Administrative Code Section 2503 "unusual disease," or appearing on the more permanent, Section 2500 list of diseases.[17] For physicians, health officers, and hospitals, there is no effective difference between reporting a disease that appears on one list or the other. One list contains such recently-recognized diseases as AIDS and listeriosis, and the other includes the more "traditional" concerns of public health officers such as leprosy, malaria, rabies, and tuberculosis.[18]

With respect to making "carriers" mandatorily reportable to the State, the first point to bear in mind is the confusion -- already discussed -- over who should be treated as a "carrier" and how that status would be established. However, even if the "carrier" language were restricted to those people who have positive results on a test for HTLV-III (not just its antibodies), the reporting requirements might nevertheless apply very broadly because Section 2500 requires reporting by "every physician, practitioner,...or <u>any other person</u> knowing of...a case or <u>suspected case</u>." (Emphasis added.)

If this language is given its broadest interpretation, everyday citizens could be required to report people suspected of being "HTLV-III carriers" by reason of their antibody test status, or perhaps even due to suspicions that they are engaging in AIDS high-risk behavior, such as IV drug abuse or certain kinds of sexual intercourse. Although such a far-reaching interpretation of the Initiative's reporting requirements seems unlikely, it is not impossible, and could very well be argued during the extensive litigation that is expected if the Initiative passes.

Finally, it is worth remembering that if the Initiative is eventually interpreted as effectively elevating specified regulations

to the status of statutes, the language in these regulations would no longer be subject to the usual administrative change process, or even the usual statutory amendment process.

H. Effect of "Communicable" Language. **What is the effect of declaring people who have AIDS or are an "HTLV-III carrier" to be "infectious, contagious, and communicable"?**

The basic interpretation question here is the effect of Title 17 regulations §§2526 and 2530 using mandatory language, while statutory provisions of the Health and Safety Code leave health officials with more discretion. More specifically, what is the effect of regulations that prohibit any person "with a communicable disease or suspected of being infected with a communicable disease" from engaging in commercial food handling? What is the effect of regulations requiring a school principal to exclude "any child or other person affected with a disease presumably communicable"?

Both of these regulations allow the health officer to use his or her professional judgment about allowing school attendance and food handling by a person with a "communicable" disease, but the language suggests this be done on a case-by-case basis. Presumably, local or state health officials would not be allowed to make a blanket declaration similar to the one made by the Centers for Disease Control prescribing the conditions under which a food handler or school child should or should not be considered to present a public health threat.[19] The AIDS Initiative seems to be the first initiative to incorporate statutes and regulations by referring to them in the initiative text.[20] For this reason, legal analysts disagree about the effect of this incorporation. The following are some of the unanswered questions posed by the incorporation of regulations.

What is the effect of incorporating regulations that may be invalid by reason of exceeding the authority of the statute to which they refer? Does the incorporation of regulations into an initiative insulate them indefinitely from the normal process of regulatory review and update, or is it impossible to achieve such a result with language as indirect as this Initiative's language? If the Initiative insulates regulations from established administrative review procedures, would the regulations be subject to amendment through the legislative process, or must they be brought back before the voters for approval of suggested updates and changes?[21] Could only the regulations specifically referenced by the Initiative be elevated to the status of statutory law, or could other regulations also be included as a result of the reference in Section 1 of the Initiative to "the statutes and regulations under which [local health officers] serve to preserve the public health from AIDS"? Full discussion of these legal questions is beyond the scope of this report, but certain to be relevant in the litigation that is expected if the Initiative is approved by the voters.

I. Quarantine. **Does the Initiative give health officials new quarantine powers? What would be the impact of quarantining all people in California who have AIDS or are "carriers"?**

Many state and national news media articles have referred to Proposition 64 as a new "quarantine measure," but this is simply not true. The Department of Health Services has always possessed the power to quarantine people "whenever in its judgment such action is necessary to protect or preserve the public health."[22]

What the Initiative adds to existing quarantine powers is unclear. On the one hand, it may do nothing more than emphasize the state's existing, discretionary quarantine powers, but on the other hand, it may take away some of that discretion by requiring

quarantine of "persons or animals that have been exposed to a communicable disease."[23] Of course, even if the Initiative were interpreted to require quarantine in circumstances that are currently left to health officials' discretion, there remain important questions on defining "exposure" and determining how quarantine would be carried out.

If every one of the estimated 300,000 to 500,000 seropositive Californians had to be quarantined, there would be unimaginable logistical problems. How would these people be identified -- by wide-scale, mandatory testing? How would such a gigantic medical effort be accomplished so that nobody could slip through the testing net? Even if health officials carried out one mass testing, how often would they have to do repeat testing to assure identification of people who become seropositive at a later time?

Once mass testing took place, would all seropositive people be brought together in one or two central locations so they could be more effectively isolated and observed? If so, would one or two cities the size of Sacramento be evacuated to make room for these new "quarantine cities," or would makeshift internment camps be built? If we assume that the AIDS virus has an incubation period of at least five years and probably a lifetime, how long would these people be quarantined?

Any person who begins to think through these questions can quickly see the wrenching implications of widespread quarantine. According to Dr. Donald Francis, a Centers for Disease Control scientist and physician who has participated in medical quarantines in other countries, "Some people in this country remember short-term quarantines from their childhood for scarlet fever or measles and they don't think the idea of an AIDS quarantine is such a bad one. Unfortunately, these people don't understand how different a large-scale AIDS quarantine would be, both because of

the massive disruption it would cause, and the lack of public health benefit in preventing AIDS exposure."[24]

J. Conclusion. The drafters of the Initiative -- whether by design or accident -- have used ambiguous language whose meaning is open to a number of interpretations with widely different results. If the Initiative is voted into law, the public can expect intense and lengthy litigation over the many questions raised by each of the legal questions mentioned above.

VII. FISCAL IMPACT

A. Legislative Analyst's Report. Appendix D contains the full text of the Legislative Analyst's five-page report on Proposition 64's fiscal impact. Unfortunately, the Initiative's uncertain language prevents the Analyst from coming to any definite estimate of its financial costs. To quote from the analysis:

> The fiscal effect of this measure could vary greatly, depending on how it would be interpreted by state and local health officers and the courts. If existing discretionary communicable disease controls were applied to the AIDS disease, there would be no substantial net change in state and local costs as a direct result of this measure.... [However] the fiscal impact could be very substantial if the measure were interpreted to require changes in AIDS control measures by state and local health officers, either voluntarily or as a result of a change in medical knowledge on how the disease is spread, or as a result of court decisions which mandate certain control measures. (Emphasis in original.)

B. U.C. Berkeley Study. A recently-released report by two University of California professors uses some assumptions about the Initiative's interpretation and legal effect to arrive at more precise cost estimates of Proposition 64's effect on California's economic output and on state and local government finances.[25]

The authors assume that advances in medical technology will soon produce a widely-available and inexpensive test for the presence of HTLV-III, so that the estimated 300,000 Californians currently estimated to be seropositive would be considered "carriers" under the Initiative's provisions. The authors further assume that all people in the education and food handling sectors who carry HTLV-III or have AIDS would be dismissed from their jobs, either because passage of the Initiative is ultimately interpreted as mandating such dismissals or because of the political pressure resulting from Proposition 64's passage.

Using these assumptions, the economists estimate that 36,000 workers would lose their jobs as a direct result of the Initiative's enactment, and another 72,000 people (with no HTLV-III infection) would be laid off due to the multiplier effect of the original dismissals. This would lead to economic costs in the first year of $2.35 billion in lost output in the State. In addition, state and local governments would experience another $628 million in losses due to reduced tax revenues, unemployment insurance payments, and testing costs. These costs would increase sharply over time, leading to a cumulative total in the first four years of $14 billion in foregone output and $2.39 billion costs to state and local government.

The economists then examine the costs of testing the entire population of California and quarantining those people who are seropositive. They estimate these direct costs to be $7.9 billion in the first year, plus $19 billion in foregone output.

Finally, the report examines the consequences of mass testing in the education and food handling sectors, with particular attention to the estimated 22,000 false positive test results among the adults tested and the estimated 47,000 false positive results among school children.[26]

In summary, the two University of California economists conclude that passage of Proposition 64 would result in an estimated $2.3 billion loss of economic output in the first year, and $14 billion over four years. Estimated tax losses and other fiscal costs to California taxpayers would be $630 million in the first year, and $2.4 billion over four years. These are high costs, although it should be remembered that they are based not only on economic assumptions, but also assumptions about the Initiative's legal effect that may or may not be accepted by the courts.

Having made these disclaimers, it is still worth noting that if these cost estimates are anywhere near being accurate reflections of Proposition 64's fiscal impact, they have sobering implications for our state and local budgets. Would these additional costs be covered with a tax increase, or would the Governor and Legislature be unwilling to raise taxes and instead begin to redistribute money within the existing allotments for health, education, and other budget items?

VIII. MEDICAL/PUBLIC HEALTH EFFECTS

A. Opposition from the Medical and Public Health Community. The attitude of the medical and public health experts toward Proposition 64 can perhaps best be summed up in a comment made by Dr. Donald Francis, an international health expert and the U.S. Centers for Disease Control AIDS Advisor to California. "Proposition 64 would cripple this state's effort to control AIDS. The measure is an incredible waste of time, an absurdity."

Dr. James Chin is another experienced public health official who finds Proposition 64 an "absurd" approach toward a serious public health problem. Dr. Chin, Director of the Infectious Disease Branch and Acting Director of the Sexually Transmitted Diseases Section of the California Department of Health Services, listened at a recent AIDS Task Force meeting to lawyers and economists discuss interpretive questions surrounding the AIDS Initiative. When the discussion turned to the Initiative's impact on public health, Dr. Chin expressed amazement that rational people could seriously discuss different methods of implementing an Initiative whose effect would be "disastrous." He continued, "If this Initiative were to pass and we [health officials] had to redirect our efforts to school children and food handlers, we wouldn't prevent one single AIDS case. That's why this Initiative is absurd."[27]

Indeed, the list of groups who have already expressed their formal opposition on Proposition 64 reads like a "Who's Who" of the public health sector: California Medical Association, Health Officers Association of California, California Nurses' Association, California Hospital Association, California Public Health Association, Hemophilia Council of California, Association for Practitioners in Infection Control, California Council on Mental

Health, California State Psychological Association, California Psychiatric Association, Los Angeles County Medical Association, San Francisco County Medical Society, Santa Clara County Medical Society, Orange County Practitioners in Infection Control, and the Union of American Physicians and Dentists. At the date of this report, there are no medical or health organizations supporting or known to be considering support for the Initiative.

Why is the medical and public health community so united in their concern about Proposition 64? The short answer is that these physicians and health officials feel that PANIC and the LaRouche organization have drafted a law that is aimed more at deep-seated, sometimes irrational public fear about AIDS than at an effective AIDS prevention and treatment effort. Some health officers have already announced that they would quit before complying with such a counter-productive order. "It would make our job a lot harder and cause a lot more people to be infected," explained Dr. Dean Echenberg, Chief of Infection and Disease Control for San Francisco.

B. Effect on existing AIDS prevention and treatment efforts. Local health officials are concerned about Proposition 64 becoming law and being interpreted in a way that would seriously undermine their existing AIDS and other public health programs. These health officials fear that passage of the Initiative would destroy the relationship of trust that health officers have so carefully been building with people in high risk-groups for AIDS.

At the current stage of medical knowledge, health officials must rely heavily on the cooperation of these people to come forward and be tested, and to change their behavior to reduce the risk of acquiring or transmitting the AIDS virus. If that relationship of trust and confidentiality is destroyed, health officers fear that AIDS will be driven underground because no one will volun-

tarily cooperate in health programs when that participation could lead to unemployment and quarantine. It would indeed be ironic if the effect of the Initiative were that those individuals who are most cooperative with health officials were most penalized with economic and social sanctions.

Beyond the question of AIDS prevention programs, public health officials fear that passage of the Initiative would inevitably lead to many hours spent in court and litigation instead of in public health activities. If the Initiative became law and a public health officer decided that the limited legal interpretation (limited effect on existing public health activities) was the correct one, that official would no doubt be sued by someone with a different interpretation. The result would be that the local official would be involved in at least one, and possibly many lawsuits, with correspondingly diminished time for direct public health activities. Conversely, a local health officer might interpret or be instructed to give the Initiative a more far-reaching interpretation (mass testing, undermining of existing confidentiality safeguards, large-scale quarantine). That official would no doubt also be sued, with the same result of increased time spent in litigation and decreased time in direct public health efforts.

C. Threat to the blood supply. In addition to deep concerns about Proposition 64's effect on public health programs, physicians and blood bank officials are worried about the Initiative's threat to our blood supply. If the Initiative is voted into law, these officials fear that the general public, and particularly people who work in schools or in food handling, will be reluctant to donate blood even though they are healthy and do not engage in any AIDS high-risk behavior. These people will hear of the small but nevertheless inevitable number of false positive test results, and will not want to expose themselves to the risk of

being falsely labelled a "carrier" as a result of performing the altruistic act of blood donation.

Dr. Sylvia Hoag, Chairman of the Committee on Blood Banks, California Medical Association, put it this way. "If you were a school teacher who didn't belong to an AIDS risk group, and you had heard about false positive test results, would you risk losing your job and being quarantined just so you could give blood? It doesn't take much to dissuade people from giving blood, and the threat of false positives could significantly disrupt our whole blood supply, which would have widespread repercussions throughout the medical care system."[28]

In addition, health officials worry that the Proposition 64 campaign will increase public fear about AIDS without educating people on what is and is not a high-risk activity. If people know that AIDS is transmitted "through the blood," will they understand that there is no reuse of needles at blood donation sites, and therefore no risk of "catching AIDS" as a result of donating blood?

Does PANIC want to educate people about the truly high-risk activities, or only whip up public hysteria about AIDS? These are the questions and concerns of health and blood bank officials.

IX. CONCLUSION

Californians have every reason to be frightened and concerned about the recently-recognized disease known as Acquired Immune Deficiency Syndrome (AIDS). The Prevent AIDS Now Initiative Committee (PANIC), working closely with Lyndon LaRouche's national organization, has put onto the November ballot an initiative proposition that addresses the public's deep-seated fears about AIDS in a short, seemingly simple measure that in reality is filled with ambiguity and uncertainty. If the measure is given its most limited interpretation, it would have little legal effect on current public health practices, but could effectively pressure local health officials into taking steps they feel are medically unwise but politically necessary. If the measure is given its most far-reaching legal interpretation, there would be a major redirection of current medical and public health activities, large increases in public spending, and disruption of our entire social organization without any corresponding decrease in the number of AIDS cases.

Proposition 64 has already put demands on the time and resources of the medical and public health community representatives who are concerned about the effect of PANIC's proposal on our AIDS prevention policy. If Proposition 64 is passed by the voters, it will represent a landmark rejection of the prevailing medical and public health wisdom on a disease with great significance for the health of all Californians.

* * * * * * * *

 It was prepared by Kathryn Duke, J.D., M.P.H., who takes full responsibility for its accuracy and analysis, while gratefully acknowledging the many people who provided assistance in its preparation, including Senate Office of Research colleagues and the following individuals who commented on an earlier draft: Matthew Coles, J.D.; Dean Echenberg, M.D., Ph.D.; Donald Francis, M.D., D.Sc.; Anne Jennings, J.D.; Mark Madsen, M.P.H.

FOOTNOTES

[1]At least one health official has referred to the AIDS Initiative as the "1986 Full Employment Act for Lawyers."

[2]"The AIDS Epidemic," a Field Institute poll published December 1985.

[3]See Section VI(G) of this report for discussion of AIDS reporting in California.

[4]For example, the LaRouche organization states that it was LaRouche supporters who gathered the approximately 700,000 signatures that put the AIDS Initiative on the ballot. Executive Intelligence Review, July 18, 1986, p.36.

[5]EIR, Executive Intelligence Review, August 22, 1986, p.8.

[6]Executive Intelligence Review, July 18, 1986, pp. 32-37.

[7]Id. at 31.

[8]Election Code §3576 reads, in part:

> Not less than 20 days before he submits the copy for the ballot pamphlet to the State Printer, the Secretary of State shall make such copy available for public examination. Any voter may seek a writ of mandate requiring any such copy to be amended or deleted from the ballot pamphlet. A peremptory writ of mandate shall issue only upon clear and convincing proof that the copy in question is false, misleading or inconsistent with the requirements of this code or Chapter 8 (commencing with Section 88000) of Title 9 of the Government Code....If the proceeding is initiated by the Secretary of State, the State Printer shall be named as the respondent. (Emphasis added.)

[9]Initiative proponents have acknowledged that the question of insect transmission has no direct relationship with the text of Proposition 64. Instead, they say it touches on the "larger issues" of the Initiative: the Centers for Disease Control's response to AIDS.

[10]See Elections Code § 3564.1.

[11]Art.II, §10(c) of the California Constitution provides:

> The Legislature may amend or repeal referendum statutes. It may amend or repeal an Initiative statute by another statute that becomes effective only when approved by the electors unless the Initiative statute permits amendment or repeal without their approval.

[12]The phrase "legislative intent" is the more usual one, but confusing when used for a law resulting from the initiative instead of legislative process.

[13]Webster's New World Dictionary of the American Language, Second College Edition, 1982.

[14]These regulations discuss such topics as reporting of diseases, quarantine, exclusion from schools, public food handlers, and funerals. See Appendix C for the full text of these statutes and regulations.

[15]"HTLV-III" stands for Human T-Lymphotrophic Virus, Type III. For that reason, it is redundant to refer to "the HTLV-III virus," and this phrase will be used only when quoting from the Initiative.

[16]Some groups of people, such as pregnant women, are especially prone to false positives on the HTLV-III antibody test. See Section VIII(C) of this report for more discussion of the problem of false positives.

[17]See California Administrative Code Title 17, §2500 and §2503.

[18]Appendix B contains the list of reportable diseases drawn up earlier this year by the Disease Control and Epidemiology Committee of the California Conference of Local Health Officers as part of its periodic review of the Section 2500 list of reportable diseases. It is clear from this list that health officers consider AIDS and listeriosis, which are reportable under Section 2503, to be reportable in the same way as diseases listed in Section 2500. The Committee has recommended that the Department of Health Services make the technical change of transferring AIDS and listeriosis to the Section 2500 list at the same time that other additions and deletions are made.

[19]The U.S. Centers for Disease Control's Recommendations are as follows:

> Food-service workers are defined as individuals whose occupations involve the preparation or serving of food or beverages (e.g., cooks, caterers, servers, waiters, bartenders, airline

attendants). All epidemiologic and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or beverages, and no instances of HBV [Hepatitis B virus] or HTLV-III/LAV transmission have been documented in this setting...

Food-service workers known to be infected with HTLV/LAV need not be restricted from work unless they have evidence of other infection or illness for which any food-service worker should also be restricted.

Routine serologic testing of food-service workers for antibody to HTLV-III/LAV is not recommended to prevent disease transmission from food-service workers to consumers. (Emphasis added.)

United States Centers for Disease Control, "Morbidity and Mortality," 1985 Nov.15; 34:681-86, 691-95.

Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited.... Mandatory screening as a condition for school entry is not warranted based on available data. (Emphasis added.)

United States Centers for Disease Control, "Morbidity and Mortality Weekly Report," 1985 Aug.30; 34:517-521.

[20]The Initiative requires all health officers to "fulfill all of the duties and obligations specified" in Administrative Code Title 17, Part 1, Chapter 4, Subchapter 1 "in a manner consistent with the intent of this Act." See Appendix C for the complete text of statutes and regulations referred to by the Initiative.

[21]See fn.11.

[22]Health and Safety Code §3051.

[23]California Administrative Code, Title 17, Section 2521.

[24]Statement made at the California Department of Health Services AIDS Task Force Meeting, August 13, 1986.

[25]Robert M. Anderson and John M. Quigley, "The Economic Impact of the Adoption of Proposition 64, The LaRouche Initiative," Graduate School of Public Policy Working Paper #119, University of California, Berkeley, August 1986.

[26]Using the best available technology for HTLV-III antibody tests, approximately 1% of the positive results are false positives, which is to say that the person who tests positive does not actually have HTLV-III antibodies. Because the percentage of false positives is larger when the test is administered on a large-scale basis to the general population, a much larger percentage of false positive test results would be expected if all school children were tested.

[27]Statement made at the California Department of Health Services AIDS Task Force Meeting, August 13, 1986.

[28]Personal communication, August 19, 1986.

APPENDIX A

PROPOSITION 64

BALLOT PAMPHLET ARGUMENTS

64 Acquired Immune Deficiency Syndrome (AIDS). Initiative Statute

Arguments in Favor of Proposition 64

Proposition 64 extends existing public health codes for communicable diseases to AIDS and AIDS virus carriers. This means that the same public health codes that already protect you and your family from other dangerous diseases will also protect you from AIDS. Proposition 64 will keep AIDS out of our schools, out of commerical food establishments, and will give health officials the power to test and quarantine where needed. These measures are not new; they are the same health measures applied, *by law,* every day, to every other dangerous contagious disease.

Today AIDS is out of control. There are at least 300,000 AIDS carriers in California, and the number of cases of this highly contagious disease is doubling every 6 to 12 months. The number of "unexplained" AIDS cases—cases not in "high-risk" groups, such as homosexuals and intravenous drug users—continues to grow at alarming rates. Indeed, the majority of cases worldwide fall into no identifiable "risk group" whatsoever. The AIDS virus has been found living in many bodily fluids, including blood, saliva, respiratory fluids, sweat, and tears, and it can survive upwards of seven days outside the body. There presently exist no cure for the sick and no vaccination for the healthy. It is 100% lethal.

AIDS is the gravest public health threat our nation has ever faced. The existing law of California clearly states that certain proven public health measures *must* be taken to protect the public from *any* communicable disease, and no competent medical professional denies that AIDS is "communicable." Despite these facts, politicians and special interest groups have circumvented the public health laws. For the first time in our history, a deadly disease is being treated as a "civil rights" issue, rather than as a public health issue.

The medical facts are clear. The law is clear. Common sense agrees. You and your family have the right to be protected from *all* contagious diseases, including AIDS—the deadliest of them all. If you agree, vote YES on Proposition 64.

KHUSHRO GHANDHI
California Director, National Democratic Policy Committee (NDPC), and Member-elect, Los Angeles County Democratic Party Central Committee

JOHN GRAUERHOLZ, M.D., FCAP
(Fellow, College of American Pathologists)

California law today makes it illegal for public health authorities to be informed of a large number of those (about 385,000) who can spread the deadly AIDS virus to others. How can they take the necessary steps to slow its spread as long as this is true?

Under existing law, a physician who encounters any of 58 reportable diseases is required to report to health officials. Included are several venereal diseases, such as syphilis and gonorrhea. Contact tracing is conducted. But, for those with the AIDS virus, not yet developed into AIDS, a special state law passed at the request of the male homosexual lobby prohibits contact tracing. Proposition 64 will require that those with the AIDS virus be reported as are other communicable diseases. It does not require quarantine.

The cost of the AIDS epidemic in California, it is estimated, will be at least 59,400 lives by 1991 and almost $6 billion to be paid by insurance and/or taxpayers. Let's reduce those statistics by voting YES on Proposition 64.

WILLIAM E. DANNEMEYER
Member of Congress, 39th District

Rebuttal to Arguments in Favor of Proposition 64

Would you let a stranger with no medical training or medical background diagnose a disease or illness that you have? Would you let a political extremist dictate medical policy? *OF COURSE NOT.*

The followers of Lyndon LaRouche suggest that the hands of the medical community have been tied. *THIS IS NOT TRUE! In fact,* the California Medical Association, the California Nurses Association, the California Hospital Association and other health professionals believe that Proposition 64 *would seriously hurt* their ability to treat and find a cure for AIDS. These health professionals are seriously concerned that years of research will be undermined by fear generated by this irrational proposition.

NO ONE has contracted AIDS from casual contact at a restaurant, grocery store, or in the workplace. Think for a moment. If it were true that AIDS is casually transmitted, clearly many more men, women and children would be ill. *This is just not the fact.*

The followers of Lyndon LaRouche are at it again! Using partial truths and falsehoods, they are attempting to create panic in California. Say NO to PANIC. Vote NO on Proposition 64.

HELEN MIRAMONTES, R.N., M.S., CCRN
President, California Nurses Association

C. DUANE DAUNER
President, California Hospital Association

GLADDEN V. ELLIOTT, M.D.
President, California Medical Association

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Argument Against Proposition 64

Proposition 64 must be defeated for the *safety* and *public health* of all Californians. It is an irrational, inappropriate and misguided approach to a serious public health problem. The proponents of this measure are followers of *extremist* Lyndon LaRouche. They want to create an atmosphere of *fear,* misunderstanding, *inadequate health care* and *panic.* In fact, the acronym of their campaign committee is PANIC.

Public health decisions must be left in the hands of the medical profession and public health officials or we will endanger the lives of Californians. The California Medical Association and county public health officials recognize the danger of allowing political extremists to dictate state public health and medical policy.

This type of repressive and discriminatory action forced upon Californians by followers of Lyndon LaRouche will not serve to limit the problem, *but rather could prolong the spread of this terrible disease.* The fear of quarantine or other discriminatory measures, including loss of jobs, will make people reluctant to be tested. Fearing social isolation, individuals at risk will avoid early medical intervention, or even infection testing, driving AIDS underground.

Enforcement of this measure *could cost the taxpayers billions of dollars* to quarantine and isolate AIDS carriers and could require public health officials to do so. Quarantine would serve no medical purpose because *there are no documented cases of AIDS ever being transmitted by casual contact.*

Californians from all walks of life know they must unite to end this dreadful epidemic. Californians can be proud that doctors and public health officials have acted in a professional, rational and responsible manner to protect the health of Californians and have taken all appropriate precautions as they are needed. *This kind of initiative can only divide, create panic and force thousands not to get tested or treated because of fear.*

Join us, the *Los Angeles Times, The Los Angeles Herald Examiner, San Francisco Examiner, the California Medical Association,* and many others in opposing the extremes of followers of Lyndon LaRouche. Vote NO on *Proposition 64!*

GLADDEN V. ELLIOTT, M.D.
President, California Medical Association

ED ZSCHAU
Member of Congress, 12th District

ALAN CRANSTON
United States Senator

Rebuttal to Argument Against Proposition 64

Opponents of Proposition 64 have spent a great deal of rhetoric, while avoiding medical issues.

The facts:

- Health officials' failure to implement existing public health laws has resulted in nearly 500,000 people infected in California, each capable of infecting others.
- AIDS is the most rapidly spreading lethal disease in the country.
- Of those infected, between 40% and 99% will probably die—between 200,000 and 500,000 deaths in California —and AIDS is doubling every year.
- The vast majority of AIDS cases worldwide lie *outside* "high risk" groups. The victims are *not* homosexuals, and are *not* intravenous drug users. In Haiti, three years ago, 70% of AIDS cases were in "high risk" groups. Today, over 70% are *not* in "high risk" groups. Could this happen here? It can and it will, unless we stop it.
- Do we know with certainty how AIDS spreads? We do not. The majority of cases have *never been studied.*
- Many health officials are demanding public health measures. Dr. Kizer, California's top health official, has called for more reporting and testing powers.
- The AIDS virus exists in many bodily effluents and survives outside the body.

Proposition 64 implements the *existing* health laws; laws scientifically designed to protect your health; laws which have been ruled constitutional by courts for decades.

Don't gamble with human life. Vote YES on Proposition 64.

GUS S. SERMOS
Former Centers for Disease Control Public Health Adviser with AIDS Program in Florida

NANCY T. MULLAN, M.D.
Burbank

JOHN GRAUERHOLZ, M.D., FCAP
(Fellow, College of American Pathologists)

APPENDIX B

LIST OF MANDATORILY REPORTABLE DISEASES IN CALIFORNIA

DISEASES CURRENTLY REPORTABLE
SECTION 2500
CALIFORNIA ADMINISTRATIVE CODE

AIDS[1]
Amebiasis
*Anthrax
*Botulism (All Forms)
Brucellosis
Chancroid
*Cholera
Coccidioidomycosis
Conjunctivitis, Acute Infectious of the Newborn
Dengue
Diarrhea of the Newborn
*Diphtheria
Disorders Characterized by Lapses of Consciousness
Dysentery, Bacillary
Encephalitis, Viral
*Food Poisoning, Other than Botulism
German Measles (Rubella)
Gonococcal Infections
Granuloma Inguinale
*Hepatitis A
Hepatitis B
Hepatitis Non-A, Non-B
Hepatitis Unspecified
Leprosy
Leptospirosis
Listeriosis[2]
Lymphogranuloma Venereum
Malaria
*Measles (Rubeola)
Meningitis, Viral
Meningococcal Infections
Mumps
Paratyphoid Fever A, B, and C
Pertussis
*Plague
*Poliomyelitis, Paralytic
Psittacosis
Q Fever
*Rabies, Human or Animal
*Relapsing Fever
Reye Syndrome[3]
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Salmonella Infections
Scarlet Fever
Shigella Infections
*Smallpox (Variola)
Streptococcal Infections
Syphilis
Tetanus
Trachoma
Trichinosis
Tuberculosis
Tularemia
Typhoid Fever Cases and Carriers
*Typhus Fever
Viral Exanthem in Pregnant Women
*Yellow Fever

Note: Those diseases marked with an asterisk should be reported immediately; for food poisoning report immediately only if food may still be available for others to consume; for hepatitis A report immediately only if disease occurs in food handlers.

[1]Made reportable under Section 2503 CAC, March 1983.

[2]Made reportable under Section 2503 CAC and by laboratories, Section 2505 July 1985.

[3]Made reportable by amendment of Health & Safety Code July 1984.

A SUSPECTED OUTBREAK OF ANY DISEASE SHOULD BE REPORTED IMMEDIATELY!!

July 1, 1986

APPENDIX C

TEXT OF STATUTES AND REGULATIONS RELEVANT TO PROPOSITION 64

APPENDIX C

TEXT OF STATUTES AND REGULATIONS RELEVANT TO PROPOSITION 64

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Chapter 1.10 was added by Stats.1983, c. 1257, p. ——, § 1.

§ 195. Legislative findings and declarations

The Legislature hereby finds and declares the following:

(a) Acquired Immune Deficiency Syndrome is a serious disease threatening the lives of men and women of all segments of society.

(b) The advancement of knowledge about Acquired Immune Deficiency Syndrome will reveal fundamental information that may lead to treatment, prevention, and ultimately a cure which will be of great benefit to society.

(c) As of August 8, 1983, the reported cases in the United State totaled 2,008.

(d) About 40 percent of the victims have died of Acquired Immune Deficiency Syndrome, but it appears to be far more lethal. Of cases diagnosed a year ago, more than 60 percent have died, and the toll may go far higher.

(e) There is growing agreement that an infectious agent may be at fault but none has been found. There is no definitive test for diagnosing Acquired Immune Deficiency Syndrome.

(f) Although cases have been reported in 33 states, they have been concentrated in New York (48.7 percent) and California (21 percent). The cases reported in 20 California counties since 1979 exceed 450.

(Added by Stats.1983, c. 1257, p. ——, § 1.)

Library References

Health and Environment ⇐22, 23.
C.J.S. Health and Environment §§ 18 to 21.

§ 3123. List of reportable diseases; establishment by department; rules requiring quarantine; quarantine by health officer

The state department may establish a list of reportable diseases and this list may be changed at any time by the state department. Those diseases listed as reportable shall be properly reported as required to the state department by the health officer.

The state department may from time to time adopt and enforce rules and regulations requiring isolation (strict or modified) or quarantine for any of the contagious, infectious, or communicable diseases if in the opinion of the state department such action is necessary for the protection of the public health.

The health officer may require isolation (strict or modified) or quarantine for any case of contagious, infectious, or communicable disease when such action is necessary for the protection of the public health.

(Added by Stats.1957, c. 205, p. 854, § 20.)

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2636.	Venereal Diseases
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SUBCHAPTER 1. REPORTABLE DISEASES AND CONDITIONS

Article 1. Reporting

2500. Reporting to the Local Health Authority.

It shall be the duty of every physician, practitioner, dentist, coroner, every superintendent or manager of a dispensary, hospital, clinic, or any other person knowing of or in attendance on a case or suspected case of any of the following diseases or conditions, to notify the local health authority immediately. A standard type report form has been adopted and is available for this purpose.

Amebiasis
Anthrax
Botulism
Brucellosis (Undulant Fever)
Chancroid
Cholera
Coccidioidomycosis
Conjunctivitis, Acute Infectious of the Newborn (Gonorrheal Ophthalmia, Ophthalmia Neonatorum)
Dengue
Diarrhea of the Newborn
Diphtheria
Dysentery, Bacillary (See Shigella infections)
Encephalitis, Acute
Epilepsy
*Food Poisoning (other than Botulism)
German Measles (Rubella)
Gonococcus Infection
Granuloma Inguinale
Hepatitis, Infectious
Hepatitis, Serum
Leprosy (Hansen's Disease)
Leptospirosis (including Weil's Disease)
Lymphogranuloma Venereum (Lymphogranuloma Inguinale)
Malaria
*Measles (Rubeola)
Meningitis, Meningococcal or Meningococcemia
*Mumps
Paratyphoid Fever, A, B and C (See Salmonella infections)
Pertussis (Whooping Cough)
Plague
Poliomyelitis, Acute Anterior
Psittacosis
Q Fever
Rabies, Human or Animal
Relapsing Fever
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Salmonella Infections (exclusive of Typhoid Fever)
*Scarlet Fever
Shigella Infections
Smallpox (Variola)
*Streptococcal Infections, Hemolytic (including Scarlet Fever, and Streptococcal Sore Throat)
Syphilis
Tetanus
Trachoma
Trichinosis
Tuberculosis
Tularemia
Typhoid Fever, Cases and Carriers
Typhus Fever
Viral Exanthem in Pregnant Women
Yellow Fever

For outbreak reporting and reporting of occurrence of unusual and rare diseases see Sections 2502 and 2503.

NOTE: Authority cited for Subchapter 1 (§§ 2500 to 2640, inclusive): Sections 102, 208, 2571, and 21100, Health and Safety Code. Additional Authority cited: Sections 3110–3125, Health and Safety Code. Reference: Section 555(b), Business and Professions Code.

HISTORY

1. Originally published 8-15-1945 (Title 17).
2. Amendment filed 12-22-69; effective thirtieth day thereafter (Register 69, No. 52). For prior history, see Register 66, No. 39.
3. Amendment filed 12-14-79; effective thirtieth day thereafter (Register 79, No. 50).

2501. Reports by Local Health Officer to State Department of Public Health.

(a) Individual Case Reports: Each local health officer shall report at least weekly, on the prescribed form, to the Director of the State Department of Public Health each individual case of those diseases or conditions not marked with an asterisk (*) in the above list (Section 2500) which have been reported to him in the last seven days.

(b) Summary Reports: For diseases marked with an asterisk (food poisoning, measles, mumps, scarlet fever and streptococcal infections), the local health officer shall prepare and send to the State Department of Public Health once each week a report on a prescribed form showing the number of cases of each such disease that have been reported to him during the past seven days.

(c) Immediate Reports by Telephone or Telegraph: Cases and suspect cases of cholera, botulism, dengue, plague, relapsing fever (louse-borne), smallpox, typhus (louse-borne epidemic type), and yellow fever, are to be reported by the local health officer to the Director of the State Department of Public Health immediately by telephone or telegraph. (See Sec. 2589, Health and Safety Code.)

HISTORY:

1. Amendment filed 5-24-55; effective thirtieth day thereafter (Register 55, No. 8).

2502. Reporting of Outbreaks.

Any person having knowledge of any outbreak or undue prevalence of infectious or parasitic disease or infestation whether or not listed in Section 2500, shall promptly report the facts to the local health officer, who shall investigate the circumstances and if he finds that an epidemic or undue prevalence does in fact exist, he shall report the outbreak to the Director of the State Department of Public Health. The following are examples of diseases, outbreaks of which are to be so reported:

Epidemic gastroenteritis (other than food poisoning)
Epidemic keratoconjunctivitis
Fevers of unknown etiology
German measles
Impetigo
Infectious mononucleosis
Influenza, epidemic
Lymphocytic choriomeningitis
Pneumonia, infectious
Ringworm

HISTORY:

1. Amendment filed 5-24-55; effective thirtieth day thereafter (Register 55, No. 8).

2503. Occurrence of Unusual Diseases.

Any person having knowledge of a case of an unusual disease not listed in Section 2500 shall promptly convey the facts to the local health officer. Examples are: glanders, herpangina, histoplasmosis, toxoplasmosis, echinococcosis, listeriosis, cat scratch fever, and rickettsialpox.

HISTORY:

1. New section filed 5-24-55; effective thirtieth day thereafter (Register 55, No. 8).

2516. Strict Isolation. If the disease is one requiring strict isolation, the health officer shall insure that instructions are given to the patient and members of the household, defining the area within which the patient is to be isolated and stating the measures to be taken to prevent the spread of the disease.

Strict isolation shall include the following measures:

(a) The patient shall have a separate bed in a room protected against flies.

(b) All persons, except those caring for the patient, shall be excluded from the sick room.

(c) The persons caring for the patient shall avoid coming in contact with any other persons within the household or elsewhere until every precaution has been taken to prevent the spread of infectious material from the patient's room.

(d) The persons caring for the patient shall wear a washable outer garment and shall thoroughly wash their hands with soap and hot water after handling the patient or any object he may have contaminated. On leaving the room in which the patient is isolated, the attendant shall take off the washable outer garment and hang it in the room until disinfected.

(e) All discharges from the nose and mouth shall be burned or disinfected. The discharges should be received in pieces of soft tissue or cloth and dropped into a paper bag which can be burned.

2504. Report by Individual. When no physician is in attendance, it shall be the duty of any individual having knowledge of a person suffering from a disease presumably communicable or suspected of being communicable to report forthwith to the local health officer all the facts relating to the case, together with the name and address of the person.

2505. Notification by Laboratories. (a) To assist the local health officer in discharging his responsibilities (Health and Safety Code, Sections 3110, 3194, 3285), any person who is in charge of a clinical laboratory in which a laboratory examination of any specimen derived from the human body yields microscopical, cultural, immunological, serological, or other evidence suggestive of those communicable diseases significant from a public health standpoint listed in subsection (d) below, shall promptly notify the health officer of such findings on the same day that the physician who submitted the specimen is notified; this regulation need not apply to specimens examined for tuberculosis that are derived from reported cases under treatment in a licensed tuberculosis hospital. Notification as herein required shall be submitted by the person in charge of a clinical laboratory to the appropriate health officer in the health jurisdiction of the office address of the physician for whom such examination or test was performed.

(b) Each notification shall give the date and result of the test performed, the name, address and the age of the person from whom the specimen was obtained, and the name and address of the physician for whom such examination or test was performed. A legible copy of the laboratory report or telephone communication will satisfy the purpose of this regulation.

(c) Except when acting on the basis of information other than the laboratory notification, the local health department will not under any circumstances contact the patient or the potential contacts until a diagnosis has been reported to the local health officer by the attending physician. Nothing in this regulation, however, precludes the local health department from discussing the laboratory notification with the attending physician.

(d) The conditions or diseases to which this regulation applies are:

Diphtheria
Gonorrhea
Syphilis
Tuberculosis
Typhoid

(e) All laboratory notifications herein required are confidential and are not open to public inspection.

Note: Additional authority cited: Sections 102, 3110, 3194 and 3285, Health and Safety Code.

History: 1. New section filed 3-26-62; effective thirtieth day thereafter (Register 62, No. 6).
2. Amendment of subsections (a) and (b) filed 6-25-72 as an emergency; effective upon filing (Register 72, No. 27).
3. Certificate of Compliance filed 10-24-72 (Register 72, No. 44).

2508. Reporting by Schools. It shall be the duty of anyone in charge of a public or private school, kindergarten, boarding school, or day nursery to report at once to the local health officer the presence or suspected presence of any of the communicable diseases.

2509. Records of Local Health Officer. The local health officer shall maintain such records as he deems necessary in the performance of his duties, or as requested by the State Department of Public Health.

2510. Outbreaks of Nonreportable Diseases.

History: 1. Repealer filed 7-29-55; effective thirtieth day thereafter (Register 55, No. 11).

2511. Determination of Morbidity Level. It shall be the duty of the local health officer to determine the amount and kind of communicable disease occurring in his area by such methods as he deems necessary in order to obtain knowledge of the general level of morbidity in his jurisdiction.

History: 1. New section filed 5-24-55; effective thirtieth day thereafter (Register 55, No. 8).

Article 2. General Instructions

2512. Investigation of the Case. Upon being notified of a case, suspected case, or outbreak of a communicable disease, the local health officer shall take whatever steps he deems necessary for the investigation and control of the disease. If he finds that the nature of the disease and the circumstances of the case or outbreak warrant such action, he shall make or cause to be made an examination of the patient in order to verify the diagnosis, make an investigation to determine the source of infection, and take appropriate steps to prevent or control the spread of the disease.

If the disease is one in which identification of the source of infection is important, and the source of infection is believed to be outside his jurisdiction, the local health officer shall notify the Director of the State Department of Public Health or the health officer under whose jurisdiction the infection was probably contracted if known. Similar notification shall be given if there are believed to be exposed persons, living outside the jurisdiction of the local health officer, who should be quarantined or observed for evidence of the disease.

2514. Instructions to Household. It shall be the duty of the physician in attendance on a case considered to be an infectious or communicable disease, to give detailed instructions to the members of the household in regard to precautionary measures to be taken for preventing the spread of the disease. Such instructions shall conform to the regulations of the State Department of Public Health and the ordinances in effect in the local community. It is the responsibility of each practicing physician to keep himself informed as to the regulations and local ordinances which are in effect in the communities in which he practices.

2515. Definition of Isolation. Isolation is defined as separation of infected persons from other persons, for the period of communicability in such places and under such conditions as will prevent the transmission of the infectious agent. Isolation will be applied as instructed below.

2516. Strict Isolation. If the disease is one requiring strict isolation, the health officer shall insure that instructions are given to the patient and members of the household, defining the area within which the patient is to be isolated and stating the measures to be taken to prevent the spread of the disease.

Strict isolation shall include the following measures:

(a) The patient shall have a separate bed in a room protected against flies.

(b) All persons, except those caring for the patient, shall be excluded from the sick room.

(c) The persons caring for the patient shall avoid coming in contact with any other persons within the household or elsewhere until every precaution has been taken to prevent the spread of infectious material from the patient's room.

(d) The persons caring for the patient shall wear a washable outer garment and shall thoroughly wash their hands with soap and hot water after handling the patient or any object he may have contaminated. On leaving the room in which the patient is isolated, the attendant shall take off the washable outer garment and hang it in the room until disinfected.

(e) All discharges from the nose and mouth shall be burned or disinfected. The discharges should be received in pieces of soft tissue or cloth and dropped into a paper bag which can be burned.

(f) Objects which may have been contaminated by the patient shall be thoroughly cleansed before being removed from the contaminated area.

(g) The feces and urine of patients suffering from diseases in which the infectious agent appears in the feces or urine shall be disposed of according to instructions given by the local health officer.

2518. **Modified Isolation.** If the disease is one in which only a modified isolation is required, the local health officer shall issue appropriate instructions, prescribing the isolation technique to be followed. The isolation technique will depend upon the disease.

2520. **Quarantine.** Quarantine is defined as the limitation of freedom of movement of persons or animals that have been exposed to a communicable disease for a period of time equal to the longest usual incubation period of the disease, in such manner as to prevent effective contact with those not so exposed. If the disease is one requiring quarantine of the contacts in addition to isolation of the case, the local health officer shall determine the contacts who are subject to quarantine, specify the place to which they shall be quarantined, and issue instructions accordingly. He shall insure that provisions are made for the medical observation of such contacts as frequently as necessary during the quarantine period.

2522. **Observation.** For the purposes of definition, the term "observation," as used in these regulations, shall refer to a frequent check upon the person under observation to determine whether such person is free of the disease for which he has been placed under observation, or has contracted the disease. Unless otherwise specified, it does not mean the isolation or quarantine of the individual.

2524. **Terminal Disinfection.** Each person released from quarantine or isolation shall bathe and wash his hair with soap and hot water and put on clean clothes. The area of isolation shall be disinfected according to the instructions of the local health officer.

2526. **Exclusion and Readmission by School Authorities.** It shall be the duty of the principal or other person in charge of any public, private or Sunday School to exclude therefrom any child or other person affected with a disease presumably communicable, until the expiration of the prescribed period of isolation for the particular communicable disease. If the attending physician, school physician, or health officer finds upon examination that the person is not suffering from a communicable disease, he may submit a certificate to the effect to the school authority who shall readmit the person.

2528. **Contamination by Pathogenic Organisms of Milk, Milk Products or Products Resembling Milk Products.** (a) The State Board of Public Health finds that the presence of any of the following pathogenic organisms in milk, milk product or product resembling milk products make such product unsafe for human consumption: Mycobacterium tuberculosis, Brucella spp., Streptococcus pyogenes, group A hemolytic, Corynebacterium diphtheriae, Salmonella paratyphi, Salmonella schottmuelleri, Salmonella hirschfeldi, Salmonella typhi, Salmonella dublin, Salmonella typhimurium, Shigella spp. Whenever a health officer finds that milk, milk product, or product resembling milk products is unsafe for human consumption because it contains any of the above named organisms, he shall serve a written order to the producer or distributor of the product (1) summarizing the laboratory findings, and (2) prohibiting the sale or disposal of such milk, milk product or product resembling milk product, except by a method approved by him, until such time as he finds the product or products to be safe for human consumption.

(b) Whenever a health officer has evidence that milk, milk product, or product resembling milk products has caused human illness or contains toxins which make such product unsafe for human consumption, he may issue a written order to the producer or distributor of the product (1) stating the facts upon which his conclusions are based, and (2) prohibiting the use, sale, or disposal of such milk, milk product, or product resembling milk products, except by a method approved by him, until such time as he finds it to be safe for human consumption.

(c) The health officer shall immediately forward a copy of any order issued pursuant to this section to the State Director of Public Health.

(d) Any producer or distributor of milk, milk product, or product resembling milk products, subject to an order of a health officer pursuant to this section may appeal to the State Board of Public Health solely upon the question of whether such products are, in fact, safe for human consumption. Such appeal shall be made in writing, stating which of the facts set forth in the order are admitted and denied. Upon receipt of the written appeal, the State Director of Public Health, after such investigation of the matter as he deems necessary, may amend or rescind the order, or set the matter for hearing before a hearing officer designated by him. In the event the order is not rescinded or amended to the satisfaction of the appellant, the matter shall be set for hearing. The hearing shall, if possible, be set within 14 days from the date of receipt of the appeal, unless additional time is required by the appellant. Insofar as is practicable, the procedures of the Administrative Procedure Act (Ch. 5, Pt. 1, Div. 3, Title 2, of the Government Code) shall apply. The hearing officer shall submit a proposed decision to the State Board of Public Health which shall issue its decision in accordance with Section 11517 of the Administrative Procedure Act. The decision shall be subject to judicial review.

(e) The procedures of this section authorize a health officer to take immediate action to protect the public health in the event he finds that milk, milk products, or products resembling milk products constitutes an immediate threat to the public health. Nothing herein shall preclude the applicability of other provisions of law pertaining to the regulation of such products, including but not limited to, the provisions of the Agricultural Code and the California Pure Foods Act (Ch. 3, Div. 21, Health and Safety Code).

NOTE: Authority cited: Sections 102 and 208, Health and Safety Code. Reference: Sections 3110–3125, Health and Safety Code.

History: 1. Repealer and new section filed 12-22-69; effective thirtieth day thereafter (Register 69, No. 52).

2530. Public Food Handlers. No person known to be infected with a communicable disease or suspected of being infected with a communicable disease shall engage in the commercial handling of food, or be employed on a dairy or on premises handling milk or milk products, until he is determined by the health officer to be free of such disease, or incapable of transmitting the infection. (See Chapter 7, Article 1, Section 28295, Health and Safety Code.)

2534. Laboratory Tests for the Release of Cases or Carriers of Communicable Diseases. Whenever laboratory tests are required for the release of cases or carriers, the tests shall be taken by the health officer or his representatives and shall be submitted to a public health laboratory approved by the State Board of Public Health. Specimens may be sent to laboratories not so approved, provided the specimens are divided and a portion of the specimens are sent to an approved laboratory. Release shall be considered on the basis of the report of the approved laboratory only.

2536. Transportation of Communicable Disease Cases. No person with a communicable disease subject to isolation nor any contact subject to quarantine shall travel or be transported from one place to another within the local health jurisdiction, without the permission of the local health officer, and no such person shall travel or be transported outside the area of jurisdiction of the health officer until the permission of the health officer into whose jurisdiction the patient is to be brought is obtained. An exception may be made in instances where the patient is to be admitted directly to a hospital for the treatment of the communicable disease, provided that the health officer from whose jurisdiction the case is to be transported shall insure that adequate precautions are taken to prevent dissemination of the disease by the patient or his contacts en route to the hospital.

History: 1. Amendment filed 5-24-55; effective thirtieth day thereafter (Register 55, No. 8).

2538. Funerals. Funeral services for individuals who have died of a communicable disease shall be conducted in accordance with instructions of the health officer. In diseases requiring quarantine of contacts, a public funeral service may be permitted only if the casket remains closed and those contacts subject to quarantine who attend the funeral are adequately segregated from the public.

2540. General Clause. In addition to the requirements stipulated in these regulations, the local health officer shall, after suitable investigation, take such additional steps as he deems necessary to prevent the spread of communicable disease or a disease suspected of being communicable in order to protect the public health.

Article 3. Specific Diseases and Conditions

NOTE: Sections 2550. - 2670. contain specific instructions for the diseases and conditions named at the beginning of this Appendix.

§ 3110. Duty of health officers to prevent spread of disease

Each health officer knowing or having reason to believe that any case of the diseases made reportable by regulation of the State Department of Health Services, or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his jurisdiction, shall take such measures as may be necessary to prevent the spread of the disease or occurrence of additional cases.

(Added by Stats.1957, c. 205, p. 853, § 20. Amended by Stats.1971, c. 1593, p. 3276, § 172, operative July 1, 1973; Stats.1977, c. 1252, § 270, operative July 1, 1978.)

§ 3111. Enforcement of orders, rules and regulations

Each health officer shall enforce all orders, rules, and regulations concerning quarantine or isolation prescribed or directed by the state department.

(Added by Stats.1957, c. 205, p. 853, § 20.)

§ 3112. Places of quarantine; establishment and maintenance

Each health officer, whenever required by the state department, shall establish and maintain places of quarantine or isolation that shall be subject to the special directions of the state department.

(Added by Stats.1957, c. 205, p. 853, § 20.)

§ 3114. Quarantine and disinfection of persons and property; destruction of property; compensation

Whenever in the judgment of the state department it is necessary for the protection or preservation of the public health, each health officer shall, when directed by the state department, do the following:

(a) Quarantine or isolate and disinfect persons, animals, houses or rooms, in accordance with general and specific instructions of the state department.

(b) Destroy bedding, carpets, household goods, furnishings, materials, clothing, or animals, when ordinary means of disinfection are considered unsafe, and when the property is, in the judgment of the state department, an imminent menace to the public health.

When the property is destroyed pursuant to this section, the governing body of the locality in which the destruction occurs may make adequate provision for compensation in proper cases for those injured thereby.

(Added by Stats.1957, c. 205, p. 853, § 20.)

§ 3115. Quarantine or isolation; cases of communicable disease

Upon receiving information of the existence of contagious, infectious, or communicable disease for which the state department may from time to time declare the need for strict isolation or quarantine, each health officer shall:

(a) Insure the adequate isolation of each case, and appropriate quarantine of the contacts and premises.

(b) Follow local rules and regulations, and all general and special rules, regulations, and orders of the state department, in carrying out the quarantine or isolation.

(Added by Stats.1957, c. 205, p. 853, § 20.)

§ 3116. Compliance with quarantine

When quarantine or isolation, either strict or modified, is established by a health officer, all persons shall obey his rules, orders, and regulations.

(Added by Stats.1957, c. 205, p. 854, § 20. Amended by Stats.1970, c. 67, p. 82, § 1.)

§ 3117. Leaving quarantined premises

A person subject to quarantine or strict isolation, residing or in a quarantined building, house, structure, or other shelter, shall not go beyond the lot upon which the building, house, structure, or other shelter is situated, nor put himself in immediate communication with any person not subject to quarantine, other than the physician, the health officer or persons authorized by the health officer.

(Added by Stats.1957, c. 205, p. 854, § 20.)

§ 3118. Exclusion of persons from school

No instructor, teacher, pupil, or child who resides where any contagious, infectious, or communicable disease exists or has recently existed, which is subject to strict isolation or quarantine of contacts, shall be permitted by any superintendent, principal, or teacher of any college, seminary, or public or private school to attend the college, seminary, or school, except by the written permission of the health officer.

(Added by Stats.1957, c. 205, p. 854, § 20.)

§ 3119. Raising of quarantine; treatment or destruction of property; disinfection of persons

No quarantine shall be raised until every exposed room, together with all personal property in the room, has been adequately treated, or, if necessary, destroyed, under the direction of the health officer; and until all persons having been under strict isolation are considered noninfectious.

(Added by Stats.1957, c. 205, p. 854, § 20.)

§ 3121. Report of local epidemic; contents

In the case of a local epidemic of disease, the health officer shall report at such times as are requested by the state department all facts concerning the disease, and the measures taken to abate and prevent its spread.

(Added by Stats.1957, c. 205, p. 854, § 20.)

§ 3125. Duty to report diseases to health officer

All physicians, nurses, clergymen, attendants, owners, proprietors, managers, employees, and persons living, or visiting any sick person, in any hotel, lodginghouse, house, building, office, structure, or other place where any person is ill of any infectious, contagious, or communicable disease, shall promptly report that fact to the health officer, together with the name of the person, if known, the place where he is confined, and the nature of the disease, if known.

(Added by Stats.1957, c. 205, p. 855, § 20.)

APPENDIX D

LEGISLATIVE ANALYST'S ESTIMATE OF PROPOSITION 64'S FISCAL IMPACT

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) INITIATIVE (PROPOSITION 64)

Background

Acquired Immune Deficiency Syndrome (AIDS) is a disease that impairs the body's normal ability to resist harmful diseases and infections. The disease is caused by a virus that is spread through intimate sexual contact or exposure to the blood of an infected person. As of the preparation of this analysis, there was no readily available method to detect whether a person actually has the AIDS virus. A test does exist to detect whether a person has ever been infected with the AIDS virus and as a result has developed antibodies to it. A person infected with the AIDS virus may or may not develop the AIDS disease after a period of several years. There is no known cure for AIDS, which is ultimately fatal.

As of June 30, 1986, there were 5,188 cases of AIDS and 2,406 deaths from the disease in California. The State Department of Health Services estimates that up to 500,000 persons in California are infected with the AIDS virus, and that by 1990 there will be approximately 30,000 cases of AIDS in the state.

Existing Laws Covering Communicable Diseases. Local health officers have broad authority to take measures they believe are necessary to protect public health and prevent the spread of disease-causing organisms. However, this broad authority is limited to situations where there is a reasonable belief that the individual affected has or may have the disease and poses a danger to the public. The kind of measure taken by health officers varies, depending on how easily an organism is spread from one person to another. For example, to prevent the spread of a disease, local

health officers may require isolation of infected or diseased persons, and quarantine of exposed persons. In addition, persons infected with a disease-causing organism may be excluded from schools for the duration of the infection and excluded from food handling jobs. In some cases, these measures may be applied to persons suspected of having the infection or the disease.

Current AIDS Reporting Requirements. Physicians and other health care providers are now required to report cases of certain listed communicable diseases to local health officers who, in turn, report the cases to the State Department of Health Services. At the time this analysis was prepared, AIDS was not on the list of communicable diseases that must be reported to local health officers. However, AIDS is being reported under a regulation which requires an unusual disease, not listed as a communicable disease, to be reported by local health officers.

Under other provisions of law, hospitals are required to report cases of AIDS to local health officers who, in turn, report the cases to the state Department of Health Services. Counties also report to the state the number of cases in which blood tests performed at certain facilities reveal the presence of antibodies to the AIDS virus, indicating that a person has been infected with the virus. Existing law does not allow the release of the names or other identifying information for persons who take the AIDS antibody test.

According to the State Department of Health Services, persons who have AIDS and persons who are capable of spreading the AIDS virus are subject to existing communicable disease laws. However, no health officer

has ever taken any official action to require persons infected with the AIDS virus to be isolated or quarantined, because there is no medical evidence which demonstrates that the AIDS virus is transmitted by casual contact with an infected person. In addition, no health officer has recommended excluding persons with AIDS, or those who are capable of spreading AIDS, from schools or jobs.

Proposal

This measure declares that AIDS and the "condition of being a carrier" of the virus that causes AIDS are communicable diseases. The measure also requires the State Department of Health Services to add these conditions to the list of diseases that must be reported. Because AIDS cases are already being reported, the measure would require the reporting of those who are "carriers of the AIDS virus." Currently, no test to make this determination is readily available.

The measure also states that the Department of Health Services and all health officers "shall fulfill all of the duties and obligations specified" under the applicable laws "in a manner consistent with the intent of this act." Although the meaning of this language could be subject to two different interpretations, it most likely means that the laws and regulations which currently apply to other communicable diseases shall also apply to AIDS and the "condition of being a carrier" of the AIDS virus. Thus, health officers would continue to exercise their discretion in taking actions necessary to control this disease. Based on existing medical knowledge and health department practices, few, if any, AIDS patients and carriers of the AIDS virus would be placed in isolation or

under quarantine. Similarly, few, if any, persons would be excluded from schools or food handling jobs. If, however, the language is interpreted as placing new requirements on health officers, it could result in new actions such as expanding testing programs for the AIDS virus, imposing isolation or quarantine of persons who have the disease, and excluding persons infected with the AIDS virus from schools and food handling positions.

Fiscal Effect

The fiscal effect of this measure could vary greatly, depending on how it would be interpreted by state and local health officers and the courts. If existing discretionary communicable disease controls were applied to the AIDS disease, there would be no substantial net change in state and local costs as a direct result of this measure. Thus, the primary effect of this measure would be to require the reporting of persons who are carriers of the virus which causes AIDS. Very few cases would be reported because no test to confirm that a person carries the virus is readily available. If such a test becomes widely available in the future, more cases would be reported.

The fiscal impact could be very substantial if the measure were interpreted to require changes in AIDS control measures by state and local health officers, either voluntarily or as a result of a change in medical knowledge on how the disease is spread, or as a result of court decisions which mandate certain control measures. Ultimately, the fiscal impact would depend on the level of activity that state and local health officers might undertake with respect to: (1) identifying, isolating and quarantining persons infected with the virus, or having the disease, and

(2) excluding those persons from schools or food handling positions. The cost of implementing these actions could range from millions of dollars to hundreds of millions of dollars per year.

In summary, the net fiscal impact of this measure is unknown--and could vary greatly, depending on what actions are taken by health officers and the courts to implement this measure.