LEARNING FROM HISTORY: WHAT THE PUBLIC HEALTH RESPONSE TO SYPHILIS TEACHES US ABOUT HIV/AIDS

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INTRODUCTION

In June and July of 1981, the first reports of a new immune deficiency syndrome, now known as the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS), were described in homosexual men in New York City, Los Angeles, and San Francisco.[1] By 1983, scientists had isolated the cause: the human retrovirus, HIV-1.[2] Within a few years, the modes of transmission were identified as sexual contact, the sharing of contaminated blood, and from mother to baby, either in utero or through breast-feeding.[3]

The pathogenesis of HIV/AIDS was discovered to involve the infection and eventual destruction of helper T-cells, a cell sometimes referred to as the "traffic cop" because it directs immune responses against germs, cancer, transplanted organs, and foreign bodies.[4] By destroying these cells, HIV leads to the progressive deterioration of the immune system, resulting in susceptibility to myriad opportunistic infections and cancers that define the syndrome known as AIDS and lead to death, in the vast majority of HIV/AIDS infected persons, within eight to ten years.[5] Drugs directed at crippling the virus by blocking its reproduction within infected cells, known as anti-retroviral therapies (ARTs), were quickly developed after the discovery of HIV/AIDS, and within a decade, these drugs dramatically changed the disease from a certain killer to a chronic disease that could be managed for years.[6] But neither these drugs, nor any other intervention currently available, can cure this viral infection.[7] In other words, once an individual is infected with HIV/AIDS, with our currently available treatments, they will always be infected.[8]

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1. GERALD L. MANDELL ET AL., MANDELL, DOUGLAS, AND BENNETT'S PRINCIPLES AND PRACTICE OF INFECTIOUS DISEASES 1635 (7th ed. 2010).

2. *Id.* at 1645-49.

3. *Id.*

4. *Id.* at 1687.

5. *Id.* at 1706-08.

6. MANDELL, *supra* note 1, at 1833.

7. *Id.* at 1849.

8. *Id.*

Despite modern medicines that offer infected patients marked prolongation of life, HIV/AIDS continues to rage on.[9] Today, over thirty-three million people—nearly half-a-percent of the world's population—are infected.[10] Worldwide, there are approximately five million new infections and over two million HIV/AIDS-related deaths each year.[11] Over two-thirds of these infections and deaths occur in sub-Saharan Africa,[12] while in the United States, there are approximately 1.2 million persons currently living with HIV/AIDS, with roughly 55,000 new infections diagnosed each year.[13]

In brief, HIV/AIDS is a lifelong disease that can be sexually-transmitted, transmitted through contact with contaminated blood, or transferred from mother to child during pregnancy.[14] Today, treatment with ARTs has dramatically changed the prognosis from sure death to the likelihood of a prolonged, nearly normal life.[15] The pandemic continues to expand worldwide and in the United States, however, affecting the social fabric, economic stability, and political environment of communities, especially in high-prevalence countries. As a result, emphasizing a reflexive response after people are infected is much less effective at reducing the incidence of new cases than implementing comprehensive prevention methods (even if

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9. CDC, HHS, HIV/AIDS SURVEILLANCE REP.: CASES OF HIV INFECTION & AIDS IN THE UNITED STATES & DEPENDENT AREAS (2007) [hereinafter HIV/AIDS SURVEILLANCE REPORT]; *see generally* Wafaa M. El-Sadr et al., *AIDS in America — Forgotten but Not Gone*, NEW ENG. J. MED. (Feb. 10, 2010), *available at* http://content.nejm.org/cgi/content/full/NEJMp1000069v1.

10. MANDELL, *supra* note 1, at 1619; U.S. CENSUS BUREAU, U.S. & WORLD POPULATION CLOCKS, http://www.census.gov/main/www/popclock.html (last visited April 18, 2010).

11. *Id.*

12. *Id.* at 1620.

13. HIV/AIDS SURVEILLANCE REPORT, *supra* note 9.

14. MANDELL, *supra* note 1, at 1488.

15. Ard van Sighem et al., *Life Expectancy of Recently Diagnosed Asymptomatic HIV-infected Patients Approaches that of Uninfected Individuals*, Paper 526 (Conference on Retroviruses and Opportunistic Infections 2010); Charlotte Lewden, *Time with CD4 Cell Count above 500 cells/mm^3 Allows HIV-infected Men, but Not Women, to Reach Similar Mortality Rates to Those of the General Population: A 7-year Analysis*, Paper 527 (Conference on Retroviruses and Opportunistic Infections 2010).

they are not one-hundred percent effective) that block infection before the infection occurs. Recognizing the need for more effective preventive methods, the Ryan White Care Act funds treatment for those infected with HIV/AIDS as part of a federal effort to deal with the burgeoning crisis.[16] While this legislation provides the largest single grant of money for HIV/AIDS research,[17] its fundamental weakness is that it does not make funds uniformly available to all those infected with HIV/AIDS.[18]

Historically, there is another disease whose impact and progression was eerily similar to HIV/AIDS: syphilis. Before the advent of curative penicillin treatment in the 1940s, between eight and fourteen percent of adults living in major cities of the United States and Western Europe were infected with syphilis.[19] At that time, ten to twelve percent of cardiovascular disease,[20] many fetal deaths,[21] and ten percent of cases of adult mental illness were attributed to syphilis.[22] Like AIDS, syphilis had a direct and extensive impact on public health. The mode of transmission for syphilis also is the same as HIV/AIDS—sexual intercourse, contaminated blood, and mother-to-child.[23] Because the two diseases have nearly identical epidemiological parallels, public health professionals should apply the lessons learned in the battle to control syphilis to the present fight against HIV/AIDS, thereby reducing the incidence of new HIV/AIDS cases until a vaccine is developed.

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16. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576, 579.

17. HEALTH RES. AND SERV. ADMIN., HHS, THE HIV/AIDS PROGRAM: FUNDING, *available at* http://hab.hrsa.gov/reports/funding.htm (last visited April 9, 2010).

18. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576, 586-89; *see also* Posting of Mary Wakefield to blog.AIDS.gov, *Responding to Concerns Over Ryan White Emergency Housing Policy*, http://blog.aids.gov/2010/02/responding-to-concerns-over-ryan-white-emergency-housing-policy.html (Feb. 11, 2010).

19. MANDELL, *supra* note 1, at 2769, 3036.

20. THOMAS PARRAN, JR., SHADOW ON THE LAND 17 (1937).

21. *Id.* at 21.

22. *Id.* at 18-21.

23. MANDELL, *supra* note 1, at 3036.

This Article proposes a new public policy approach to HIV/AIDS modeled after the federal government's response to syphilis in the 1930s and 1940s. Section I examines the public health response to syphilis and concludes that its success was due to a three-prong approach that emphasized broad testing, universal treatment, and comprehensive education. Section II discusses the current HIV/AIDS crisis and explains why a plan of action modeled after the public health response to syphilis would effectively blunt the transmission and public health problem posed by HIV/AIDS. Section III analyzes the legal implications of this proposal, examining the competing interests of personal privacy and government action. Section IV addresses some pragmatic issues related to this proposal, postulating the most effective means of accomplishing and funding these recommendations. Section V concludes with a recapitulation of the dire situation posed by HIV/AIDS, the inadequacy of the current public health response to this disease, and the need for a test-treat-educate solution modeled after the response to syphilis in the twentieth century.

I. The Public Health Response To Syphilis

In the pre-antibiotic era before 1945, the public health response to syphilis was driven principally by the United States Surgeon General, Thomas Parran, Jr.[24] When Parran began serving as Surgeon General in 1936, syphilis was at the height of its prevalence, and there were few treatment options, all of which had serious side effects.[25] Parran advocated for a new public health response to syphilis, the basic tenets of which can be summarized as follows: early diagnosis, widespread treatment, and comprehensive education of both medical professionals and the lay public.[26,27]

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24. Parran, *supra* note 20.

25. Mandell, *supra* note 1, at 3036.

26. N.R. Ingraham, Jr., Spirochaeta Pallida and the Etiology of Syphilis (Publication No. 6, American Association for the Advancement of Science, 1938).

27. Parran summarized his philosophy on the treatment of syphilis thus:

> No matter how excellent the alibis for the little that we have done to control syphilis, nobody denies that it can be done. Great as are the unsolved scientific problems of syphilis, desirable as it would be to discover swifter, less complicated, less costly methods of cure, nevertheless we know enough now to save the victim and the society which is burdened by him. . . . First, every early case must be located, reported, its source ascertained, and all contacts followed up to find possible infection. Second, enough money, drugs, and doctors must be secured to make treatment possible in all cases; it is not in the public interest

The first step in Parran's plan involved locating, reporting, and ascertaining the source of infection for every case of syphilis, in order to track, diagnose, and treat all cases of syphilis.[28] To do this effectively, Parran proposed that a syphilis test be conducted whenever a patient had contact with the medical profession, including at admission to the hospital, when applying for a job in public service or in the private sector, when applying for insurance, when applying for a marriage license, or during any interaction with law enforcement.[29] To cover the costs of testing, Parran proposed government support and successfully pushed for finding in the Social Security Act of 1935 and the National Venereal Disease Control Act of 1938.[30] Armed with these laws, universal testing became the norm.[31] Under the Social Security Act of 1935, Congress allocated millions of dollars each year (as adjusted for inflation)[32] for testing to diagnose cases of syphilis and other sexually transmitted diseases.[33] The National Venereal

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> for treatment, which is our most practical means of control, to be retarded or precluded by cost. Third, both public health agencies and private physicians throughout the country must be realigned to form a united front and re-educated to use modern methods in their joint fight against syphilis. In addition, citizens must be informed as to the means and methods required for individual and public protection . . . Zealot though I may be concerning the advantages of universal blood testing, I realize it is not practical to set up the machinery for tests on the whole population. The next best thing is make a blood test whenever and wherever physical examinations are given, as routinely as the doctor now takes pulse and blood pressure and listens to the heart action.

PARRAN, *supra* note 20, at 246-49.

28. PARRAN, *supra* note 20, at 247.

29. *Id.*

30. Social Security Act of 1935, 49 Stat. 620 (1935); National Venereal Disease Control Act of 1938, 52 Stat. 439 (1938).

31. Raymond A. Vonderlehr & Lida J. Usilton, *The Extent of the Syphilis Problem at the Beginning of World War II*, 43 N.Y. ST. J. MED. 1825 (1943).

32. The Social Security Act of 1935 allocated $2,000,000 for disease testing. Social Security Act of 1935, 49 Stat. 620, 635 (1935). Adjusting for inflation, this is approximately $32,000,000 in 2010 dollars. *See* U.S. Department of Labor, Bureau of Labor Statistics, CONSUMER PRICE INDEX, *available at* ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt (last visited April 18, 2010).

33. Social Security Act of 1935, 49 Stat. 620, 635 (1935).

Disease Control Act of 1938 also appropriated huge sums of money for the research, study, testing, and treatment of syphilis and other venereal diseases.[34] Additionally, this Act vested the Surgeon General with the authority to "allot such sum to the several States upon the basis of (1) the population, (2) the extent of the venereal-disease problem, and (3) the financial needs of the respective States."[35] Armed with these funds, many state health departments soon began providing test kits and performing the tests at no expense to the patient or the practitioner.[36]

To ensure widespread treatment, the second step in Parran's plan, he proposed that the government provide enough funding so that all who were infected could be treated.[37] Parran wrote that "it is not in the public interest for treatment, which is our most practical means of control, to be retarded or precluded by cost."[38] In other words, treating all patients was in the interest of everyone's individual health and in the interest of the general public's health.[39] Furthermore, effective treatment reduces the circulating viral load in the patient, rendering the patient significantly less likely to infect his or her sexual partner.[40] To gain the far reaching public support needed to underpin the acceptance of these intrusive, interventional steps, Parran proposed the third element of his plan—the need to educate all sectors of society about: (1) the reasons for testing and treating syphilis; (2) the

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34. National Venereal Disease Control Act of 1938, 52 Stat. 439 (1938).

35. *Id.*

36. At this early date, the federal government did not keep records with sufficient detail to note conclusively the extent to which states took such actions. Furthermore, this type of information is not the sort that is even likely to have been published. Nevertheless, by examining the current practices and the little historical data that actually exists and by noting the mere existence of this statutory funding, it can be surmised that such funds were utilized in this manner; *see* U.S. Preventive Serv. Task Force, HHS, Screening for Syphilis Infection, *available at* http://www.ahrq.gov/clinic/3rduspstf/syphilis/syphilrs.htm (last visited April 9, 2010).

37. PARRAN, *supra* note 20, at 259.

38. *Id.* at 247.

39. *Id.*

40. MANDELL, *supra* note 1, at 1650-53.

methods used to diagnose and treat the disease; and (3) the means by which people could protect themselves to help retard disease transmission.[41]

Of note, one of the major accomplishments of the near universal testing for syphilis was that it identified the vast majority of infected individuals for follow-up treatment with penicillin, an antibiotic discovered in 1928—and widely available by the end of the 1940s—that cures syphilis and helped drive down the prevalence of the disease.[42] Indeed, the decrease in the prevalence of syphilis that resulted from Parran's method of testing, treatment, and education was astounding, with cases falling from a peak of 580,000 cases in the United States in 1942 to 120,000 cases ten years later, to 50,000 cases in 2002, in spite of the doubling of the U.S. population.[43]

II. WHY THE PUBLIC HEALTH RESPONSE TO HIV/AIDS SHOULD BE PATTERNED AFTER THE PUBLIC HEALTH RESPONSE TO SYPHILIS

The major impediment to implementing a comprehensive, strategic public health response to HIV/AIDS has been the inability to foster early diagnosis and treatment. Although the federal government, under the Ryan White Act, and the states, under Medicaid, underwrite treatment of HIV/AIDS for the poor and uninsured patients, neither federal or state action address universal testing.[44] For universal testing to become accepted and widespread, one cannot rely on private insurance to fill the gap between funding treatment and funding testing.[45] This is especially true when the financial obligation of early diagnosis and treatment becomes a substantial burden on insurance companies by making coverage of costly and frequent medical visits, frequent tests, and expensive treatments their responsibility.

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41. PARRAN, *supra* note 20, at 262.

42. MANDELL, *supra* note 1, at 281, 2769.

43. *Id.* at 3037; U.S. CENSUS BUREAU, POPULATION ESTIMATES (Oct. 1, 2004), *available at* http://www.census.gov/popest/archives/pre-1980/PE-11-1940s.pdf; U.S. CENSUS BUREAU, POPULATION ESTIMATES (Dec. 31, 2002) *available at* http://www.census.gov/popest/archives/2000s/vintage_2002/files/NA-EST2002-01.pdf.

44. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576, 579; Jennifer Kates, THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAID AND HIV/AIDS (The Henry J. Kaiser Family Found., Washington, D.C., Oct. 2006), at 1, *available at* http://www.kff.org/hivaids/upload/7172-03.pdf.

45. *Id*.

Another impediment to introducing a comprehensive public health response to HIV/AIDS, similar to Parran's approach to syphilis in the 1930s and 1940s, is the recent rise of individual privacy-rights policies.[46] Coupled with the stigmatism that often goes along with being infected with HIV/AIDS, and the weak laws intended to protect infected people from discrimination, public health priorities have been hampered by the increasingly litigious issue of personal privacy and autonomy.[47]

Nevertheless, in 2003, the Centers for Disease Control and Prevention (CDC), an agency within the United States Department of Health and Human Services (HHS), took the fist step toward wide-scale testing, when it recommended routine "opt-out" HIV testing in all health care settings, in place of the existing pretest permission requirement.[48] Opt-out screening involves notifying patients over thirteen years of age that an HIV test will be performed and offering the patient the opportunity to decline or defer testing.[49] Appropriately applied in emergency rooms, during doctor and clinic visits, and upon hospital admissions, this approach could identify an increased number of infected individuals, provide better counseling and treatment to these patients, and markedly reduce the rate of transmission of HIV/AIDS.[50] Unfortunately, opt-out testing has not been widely implemented.[51]

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46. *See generally* Health Insurance Portability and Accountability Act of 1996, P.L.104-191 (1996).

47. *Id*.

48. CDC, HHS, ADVANCING HIV PREVENTION: NEW STRATEGIES FOR A CHANGING EPIDEMIC 329 (2003) [hereinafter HIV PREVENTION].

49. LOUISA E. CHAPMAN ET AL., CENTERS FOR DISEASE CONTROL AND PREVENTION, *Morbidity and Mortality Weekly Report*, "Recommendations for Postexposure Interventions to Prevent Infection," 9, vol. 57, no. RR-6 (Aug. 1, 2008).

50. HIV PREVENTION, *supra* note 48, at 329.

51. This information can be deduced from the marginal increase in screening tests. CDC has no direct information on the extent to which states have implemented opt-out testing. Nevertheless, CDC can deduce that opt-out testing has not enjoyed wide implementation given the nature of what cases are reported. For instance, testing in Washington, D.C. has been high in recent years given the increased press and government attention to the problem of HIV/AIDS in that area. Conversely, testing in Little Rock, Arkansas, for example, is extremely low, because the HIV/AIDS problem in that area receives little national attention, comparatively. Telephone interviews and personal conversations with CDC officials, Bethesda, Md. (February to April 2010).

Although the present day treatment for HIV/AIDS does not cure the infection, the impacts of anti-retroviral therapy and other treatments have been dramatic.[52] Not only do these treatments prolong the expected lifespan of infected individuals,[53] the treatments reduce the transmission of HIV from an infected mother to her baby by almost one-hundred percent, and between intimate partners by approximately eighty to one-hundred percent.[54] Simply stated, effective treatment is, in and of itself, an extraordinary means of preventing transmission from one infected person to another. Moreover, interaction with appropriately motivated medical personnel would emphasize and encourage the implementation of other preventive measures, such as abstinence, monogamy, male circumcision, condom use, microbicide use, the prevention and treatment of drug and alcohol abuse, and the treatment of other sexually transmitted diseases.[55]

A comprehensive educational program that is widely available and consistently communicated would result in decreased stigmatization, greater acceptance of infected individuals, and the political will to fund a comprehensive public health response that emphasizes diagnosis, treatment, and education.[56] This kind of educational program would also further a general understanding that it is in the interest of every member of society to reduce the overall incidence of HIV/AIDS.[57] This education must occur in two stages. First, the education program must focus on infected individuals,

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52. MANDELL, *supra* note 1, at 1833.

53. SIGHEM, *supra* note 15, at 1; LEWDEN, *supra* note 15, at 1.

54. Patrick Sullivan et al., *Reduction of HIV Transmission Risk and High Risk Sex while Prescribed ART: Results from Discordant Couples in Rwanda and Zambia*, Paper 52bLB (Conference on Retroviruses and Opportunistic Infections, 2009); Furthermore, three recent modeling studies support this test-treat-educate approach. *See* R.M. Granich et al., *Universal Voluntary HIV Testing with Immediate Antiretroviral Therapy as a Strategy for Elimination of HIV Transmission: A Mathematical Model*, 48 LANCET 373 (2009); *see also* Bradley G. Wagner & Sally Blower, *Voluntary Universal Testing and Treatment is Unlikely to Lead to HIV Elimination: A Modeling Analysis*, NATURE PROCEEDINGS, 29 October 2009.

55. MANDELL, *supra* note 1, at 1650-54.

56. *See* LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC 69-75 (1997) (emphasizing the importance of a comprehensive education program in preventing HIV/AIDS).

57. *Id*.

providing them with the knowledge necessary for their psychological support and equipping them with information so they can avoid transmitting the disease to others. Second, the general public must also be educated about HIV/AIDS prevention methods. All prevention methods, including abstinence, monogamy, condom use, anti-retroviral treatment, and microbicide use, to name just a few, require a decision by the individual. For some prevention methods, the individual needs to make the decision to use the preventative measure only once. Vaccine use (if one were available for HIV) and male circumcision would fall into this category. Because the preventative decision needs to be made only once with vaccines, it has led to the successful reduction of other communicable diseases, such as polio and measles.[58] On the other hand, some prevention methods require the individual to make this decision repeatedly. Condom use, abstinence, and monogamy are three prevention methods where the individual must repeatedly decide to take preventative action with each encounter. It is at this stage that prevention education begins to crumble—requiring repeated individual decision-making is difficult to maintain. For this reason, the ability of education to influence repeated individual decision-making requires repetitive and redundant exposure to accurate information, or the education program can lose effectiveness. While there will always be some individuals who are uneducable, the comprehensive education program described here is integral to a successful response to HIV/AIDS.[59]

In short, learning from the past and implementing a comprehensive public health approach patterned after the successful response to syphilis in the 1930s and 1940s would reduce the incidence of HIV/AIDS in any country where such a program is implemented. By diagnosing infected persons through a widespread testing network, public health officials can implement early treatment and provide counseling to affect responsible behavior. These efforts would reduce transmission rates and blunt the deleterious public health effects of HIV/AIDS.[60]

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58. MANDELL, *supra* note 1, at 2031, 2141.

59. As Richard Posner has noted, "most people are ignorant about most matters." RICHARD A. POSNER, THE PROBLEMS OF JURISPRUDENCE 112 (1990); *see generally* SUSAN JACOBY, THE AGE OF AMERICAN UNREASON (2008). This does not mean that all education efforts are doomed, however. Just because some individuals will simply choose not to act on their knowledge, this is no reason not to implement an education program focused on equipping as many as possible—most of whom *will* act on their new-found understanding.

60. At the 17th annual Conference on Retroviruses and Opportunistic Infections (CROI) in February of this year, Dr. Moupali Das-Douglas, of the San Francisco Department of Public Health, presented a paper concluding that HIV incidence rates can

be meaningfully reduced through the widespread use of ARTs. Moupali Das-Douglas et al., *Decreases in Community Viral Load Are Associated with a Reduction in New HIV Diagnoses in San Francisco*, Paper 33 (Conference on Retroviruses and Opportunistic Infections 2010). Since then, many news sources and magazines have touted the use of ARTs as the solution to the AIDS crisis, claiming that the use of such therapies could eliminate AIDS within thirty or forty years. *See* Jessica Berman, *Plan Would Eliminate AIDS/HIV Within 30 Years*, VOANEWS.COM, Feb. 24, 2010, http://www1.voanews.com/english/news/health/Plan-Would-Eliminate-AIDSHIV-within-30-Years-85222292.html; Ian Sample, *Blanket HIV testing 'could see Aids dying out in 40 years'*, GUARDIAN, Feb. 22, 2010, at 1 *available at* http://www.guardian.co.uk/world/2010/feb/21/blanket-testing-hiv-aids; Steve Connor, *Aids: is the end in sight?* THE INDEPENDENT, Feb. 22, 2010, at 1, *available at* http://www.independent.co.uk/news/science/aids-is-the-end-in-sight-1906467.html. Taking a broader, more generalized view of the problem, Dr. Deborah Donnell, of the Fred Hutchinson Cancer Research Center, also presented a paper at CROI this year, arguing that HIV/AIDS rates can be drastically reduced through a widespread testing and treatment plan. Deborah Donnell et al., *ART and Risk of Heterosexual HIV-1 Transmission in HIV-1 Serodiscordant African Couples: A Multinational Prospective Study*, Paper 136 (Conference on Retroviruses and Opportunistic Infections, 2010). Her conclusions have also garnered significant press, with many magazines and news outlets postulating that this idea, which incorporates an aggressive use of ARTs in treating HIV/AIDS, may drastically cut down on the transmission and incidence rates of the diseases. *See* Loretta McLaughlin, *A 'test and treat' approach to fighting HIV*, THE BOSTON GLOBE, Feb. 26, 2010, at 17 , *available at* http://www.boston.com/bostonglobe/ editorial_opinion/oped/articles/2010/02/26/a_test_and_treat_approach_to_fighting_hiv/; Deirdre Shesgreen, *More Evidence That ART Is Treatment & Prevention,* SCIENCE SPEAKS: HIV & TB NEWS, Feb. 20, 2010, http://sciencespeaks.wordpress.com/2010/02/20/more-evidence-that-art-is-treatment-prevention/; *Global HIV/AIDS news and analysis, SOUTH AFRICA: New research fuels "test and treat" debate,* PLUSNEWS, Feb. 22, 2010, http://www.plusnews.org/report.aspx?ReportID=88200; Ed Susman, *Antiretroviral Therapy Can Reduce Risk of HIV Transmission to Uninfected Sexual Partners: Presented at CROI*, DGDISPATCH, Feb. 19, 2010, http://nuvisworldwide.com /news/content.nsf/MedicalNews/852576140048867C852576CF006E6E3E?OpenDocument&id=FEAAC2EFB4EBFD3785256D9E004FE339; Crystal Phend, *CROI: Couples Strategy Cuts HIV Transmission*, MEDPAGE TODAY, Feb. 18, 2010, http://www. medpagetoday.com/MeetingCoverage/CROI/18541; Erika Check Hayden, *'Seek, test and treat' slows HIV*, NATURE 463 (7284):1006 (2010), *available at* http://www.nature.com/news/2010/240210/full/4631006a.html. One critical step that none of the position papers or news articles reach, however, is the pragmatic consideration of how to actually establish such a scheme at the national level. Such is the aim of this Article.

III. LEGAL IMPLICATIONS OF THE PROPOSED PUBLIC HEALTH RESPONSE—THE COMPETING INTERESTS OF PERSONAL AUTONOMY AND STATE ACTION

The problem of HIV/AIDS, and the solution this article proposes, pose some provocative legal questions. Foremost among them is the issue of individual privacy rights and how this interest relates to the government's duty to protect the public health. As appealing as this proposed solution may sound, in theory, if its necessary elements cannot be legally sustained, then this solution is no more valuable than a stimulating mental exercise. Would the privacy rights of individuals be violated by testing all those admitted to emergency rooms, seeking life and health insurance, or undergoing a physical examination prior to employment? How far can the government go in order to protect the health and welfare of the American populace?

In order for the government to effectively protect public health, it needs accurate, comprehensive, and current information.[61] At times, this need can compete with the interests of private individuals to their privacy and autonomy.[62] As the Supreme Court of the United States noted in *Katz v. United States*, "[v]irtually every governmental action interferes with personal privacy to some degree. The question in each case is whether that interference violates a command of the United States Constitution."[63] This section will analyze the constitutional rights of individuals as it relates to government action in the area of HIV/AIDS prevention and treatment.[64]

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61. KENNETH R. WING ET AL., PUBLIC HEALTH LAW 280 (2007).

62. *Id.*

63. Katz v. United States, 389 U.S. 347, 350 n.5 (1967); *see also* WING, *supra* note 61, at 284 (stating that "[t]he threshold legal question in surveillance is whether the state can compel information to be reported without the consent of the person the information is about… or the person holding the information").

64. The solution proposed in this Article would place the onus on the government, either federal or state, to mandate and fund testing, treatment, and education for HIV/AIDS. As a result, this solution does not place additional requirements on physicians or other hospital staff, aside from the mere administration of these tests and treatments. This proposed solution places no additional medical malpractice considerations on physicians and medical personnel. While tests and treatments may be administered by private physicians contracting with the government, the testing and treatment recommended in this Article would be mandated, funded, and supervised by the government, not by private physicians. While normal medical negligence standards will still apply to all aspects of the testing and treatment proposed here, this solution is accomplished through government action, not through the unitary acts of private

A. Individual Privacy Rights

This discussion of individual privacy rights will provide an overview of the constitutional right to privacy and then examine the law relevant to specific privacy rights regarding medical information and testing. Courts have recognized that individuals have a constitutional right to privacy over their personal information and their autonomy.[65] Personal medical information is constitutionally protected under this right to privacy.[66] Although courts have found that the government may infringe upon this right, such government action is subject to a heightened level of constitutional scrutiny.[67]

The United States Constitution does not explicitly mention privacy rights.[68] Nevertheless, since the late-1800s the Supreme Court has recognized that the Constitution does contain an individual right to privacy.[69] This right is present in the First Amendment, according to *Stanley v. Georgia*,[70] in the Fourth and Fifth Amendments, according to *Terry v. Ohio*,[71] in the penumbra of the Bill of Rights and in the Ninth Amendment, according to *Griswold v. Connecticut*,[72] and in the Fourteenth Amendment,

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physicians on their own. Consequently, medical malpractice liabilities are neither heightened nor lessened by the proposed solution laid out in this Article.

65. Cantu v. Rocha, 77 F.3d 795, 806 (5th Cir. 1996).

66. Planned Parenthood v. Danforth, 428 U.S. 52, 80-81 (1976).

67. Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747, 766-68 (1986).

68. Roe v. Wade, 410 U.S. 113, 152 (1973) (holding modified by Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992)) (stating that "[t]he Constitution does not explicitly mention any right of privacy"); Carey v. Population Serv., Int'l, 431 U.S. 678, 684 (1977).

69. *Roe*, 410 U.S. at 152 (citing Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891)).

70. Stanley v. Georgia, 394 U.S. 557, 564 (1969).

71. Terry v. Ohio, 392 U.S. 1, 8-9 (1968).

72. Griswold v. Connecticut, 381 U.S. 479, 484-86 (1965).

according to *Meyer v. Nebraska*.[73] Citing precedent in *Palko v. Connecticut*,[74] which referenced each of these cases, the Court in *Roe v. Wade* similarly stated, "[t]hese decisions make it clear that only personal rights that can be deemed fundamental or implicit in the concept of ordered liberty are included in this guarantee of personal privacy."[75]

Generally, there are two categories of constitutional privacy rights: (1) informational privacy, where individuals have a right against the misuse of their personal information by the government; and, (2) autonomy privacy, where individuals have a right to make intimate decisions without government interference.[76] An individual's interest in protecting their medical information would fall under the category of informational privacy.[77] This interest is twofold.[78] Privacy interests in information are implicated both when the government collects and stores information, as well as when the government releases that information to the public.[79]

Although the constitutional right to privacy recognized by the Supreme Court creates a threshold below which any government action would be unconstitutional, states are free to enact their own privacy protections above this constitutional minimum.[80] Many states have done so, expressly recognizing a zone of privacy rights beyond the guarantees in the United States Constitution.[81] One reason many state constitutions provide

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73. Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

74. Palko v. Connecticut, 302 U.S. 319 (1937).

75. Roe v. Wade, 410 U.S. 113, 152 (1973) (citing Palko v. Connecticut, 302 U.S. 319, 325 (1937)) (internal citations omitted).

76. Cantu v. Rocha, 77 F.3d 795, 806 (5th Cir. 1996).

77. Nelson v. Nat'l Aeronautics and Space Admin., 530 F.3d 865, 877-78 (9th Cir. 2008).

78. In re Rausch, 197 B.R. 109, 115 (Bankr. D. Nev. 1996), *aff'd*, 213 B.R. 364 (D. Nev. 1997), and aff'd, 194 F.3d 954 (9th Cir. 1999).

79. *Id.*

80. *See* State v. Mariano, 160 P.3d 1258, 1268 (Haw. Ct. App. 2007); WING, *supra* note 61, at 286.

81. *See* People v. Givens, 892 N.E.2d 1098, 1107 (Ill. 1st Dist. 2008); State v. Planned Parenthood of Alaska, 171 P.3d 577, 581 (Alaska 2007); State v. Ellis, 210 P.3d

heightened protection of individual privacy rights is due to the fact that the American system of federalism allows most government interaction with individuals to occur at the state and local level.[82]

In addition to the general constitutional protections of individual privacy, there are several specific statutes and regulations, as well as case law, that protect personal privacy specifically with regard to medical information, testing, and treatment.[83] Because there is no single, overarching statute governing medical privacy, the law on this subject must be pieced together from various sources.[84] The following list of federal statutes all speak to the issue of medical privacy rights: the Privacy Act of 1974,[85] the Computer Matching and Privacy Protections Act,[86] the Electronic Communications Privacy Act,[87] the Freedom of Information Act,[88] the Federal Food, Drug and Cosmetic Act,[89] the Health Research Extension Act,[90] the Public Health Service Act,[91] and the Health Insurance Portability and Accountability Act.[92]

144, 148 (Montana 2009); In re Carmen M., 46 Cal. Rptr. 3d 117, 125-26 (Cal. 2d Dist. 2006).

82. *See generally* Warfield v. Peninsula Golf & Country Club, 896 P.2d 776, 798 (Cal. 4th 1995); State v. Conforti, 688 So. 2d 350, 357-59 (Fla. Dist. Ct. App. 4th Dist. 1997); In re Detention of D.A.H., 924 P.2d 49, 53-54 (Wash. Div. 1 1996).

83. *See infra* notes 85-92.

84. WING, *supra* note 61, at 285.

85. Privacy Act of 1974, 5 U.S.C. § 552a (1974).

86. Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a(o) et seq. (1988).

87. Electronic Communications Privacy Act of 1986, 18 U.S.C. § 2510 (1986).

88. Freedom of Information Act, 5 U.S.C. § 552 (2006).

89. Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301 et seq. (1938).

90. Health Research Extension Act of 1985, 42 U.S.C. § 241 (1985).

91. Public Health Service Act, 42 U.S.C. § 201 (1944).

92. Health Insurance Portability and Accountability Act of 1996, P.L.104-191, 42 U.S.C. 201 et seq. (42 U.S.C. 1320d-2) (1996).

The diversity of this list should convey the complexity of the governing legal authority in this area.

The Supreme Court has also spoken directly to the issue of medical reporting law and created two general rules with regard to medical privacy issues. First, the Supreme Court has held that there is a zone of privacy between a patient and a physician.[93] Due process considerations protect the interests of individuals in avoiding disclosure of their personal information within this zone of privacy.[94] Second, the Supreme Court has found that when disclosure of information threatens the exercise of personal autonomy rights, the court must review the state's purpose for infringing those rights under a heightened level of scrutiny to determine if the government action is warranted.[95]

The issue in *Whalen v. Roe*, which is the key decision in the line of cases that define a zone or privacy, was whether New York State could record the names and addresses of each individual who filled a prescription for drugs for which both legal and illegal markets exist.[96] The Supreme Court held that the state statute requiring disclosure of such identifying information did not violate constitutional privacy rights.[97] In reaching this conclusion, the Court recognized that "zones of privacy" do exist,[98] but found that the particular state program in question did not infringe on them.[99] In discussing these "zones of privacy," the Court affirmed that this conception of privacy included the two general categories of constitutional privacy rights noted above—informational privacy and autonomy privacy.[100]

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93. Whalen v. Roe, 429 U.S. 589, 599 (1977).

94. *Id.*

95. Planned Parenthood v. Danforth, 428 U.S. 52, 79-81 (1976); Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747, 765-66 (1986); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 848-50 (1992). It should be noted, however, that federal courts disagree as to the level of scrutiny that this heightened standard should accord. *Danforth*, 428 U.S. at 79-81; *Thornburgh*, 476 U.S. at 765-66; *Casey*, 505 U.S. at 848-50.

96. *Whalen*, 429 U.S. at 591.

97. *Id.* at 603-04.

98. *Id.* at 598.

99. *Id.* at 603-04.

100. *Id.* at 598-600.

After recognizing these privacy interests, the Court went on to discuss the state action taken by New York, specifically, and the concept of state action with regard to public health and medical information, generally.[101] The Court noted that the very nature of modern health care requires some invasion of personal privacy, going so far as to recognize that mandatory reporting requirements may be necessary in order to responsibly protect public health.[102] One passage of the Court's decision is especially blunt:

> Unquestionably, some individuals' concern for their own privacy may lead them to avoid or to postpone needed medical attention. Nevertheless, disclosures of private medical information to doctors, to hospital personnel, to insurance companies, and to public health agencies are often an essential part of modern medical practice even when the disclosure may reflect unfavorably on the character of the patient. Requiring such disclosures to representatives of the State having responsibility for the health of the community, does not automatically amount to an impermissible invasion of privacy.[103]

Although legal scholars have disagreed over the extent to which this passage should rightfully be interpreted, the language speaks for itself.[104] At the very least, this statement stands for the proposition that there are times when a state's interest in protecting the public health of its citizens can outweigh an individual's interest in withholding certain personal information from the government.[105]

The second general rule that pertains to medical privacy rights is found in another line of case, in which the Supreme Court has concluded that the disclosure of private information requires a higher scrutiny over the government action compelling the disclosure.[106] In *Planned Parenthood v. Danforth*, the Court struck down certain provisions of a Missouri state statute that required spousal or parental consent before a pregnant woman

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101. *Whalen*, 429 U.S. at 600.

102. *Id.* at 602.

103. *Id.*

104. WING, *supra* note 61, at 296.

105. *Whalen*, 429 U.S. at 602.

106. *See generally* Planned Parenthood v. Danforth, 428 U.S. 52, 79-81 (1976); Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747, 765-66 (1986); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 848-50 (1992).

could receive an abortion.[107] Nevertheless, after examining the mandatory reporting requirement of the statute, the Court concluded that this specific provision was reasonable in pursuit of the state's interest in preserving maternal health.[108]

Ten years later, the Supreme Court revisited the issue of mandatory reporting laws in *Thornburgh v. American College of Obstetricians and Gynecologists*.[109] In this case, the Court struck down provisions of a Pennsylvania statute that required medical practitioners to report abortions, because this provision was not narrowly tailored to further the government's interest in promoting the public health.[110] Referencing the *Danforth* holding, the Court in *Thornburgh* stated that "the reports required under the Act before us today go well beyond the health-related interests that served to justify the Missouri reports under consideration in *Danforth*."[111] Unlike the law under review in *Danforth*, the Pennsylvania statute required reporting information regarding the method of payment for the abortion and the patient's personal medical history.[112] The Supreme Court found that this information was unnecessary in furthering a legitimate state concern for the protection of public health.[113]

The Supreme Court visited the issue of medical notification again in *Planned Parenthood v. Casey*,[114] another case that dealt with a Pennsylvania abortion reporting law.[115] Although the Court ultimately struck down the reporting requirement in this statute, due to a provision requiring that the

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107. *Danforth*, 428 U.S. at 52-53.

108. *Id.* at 80 (stating that "[r]ecordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible").

109. *Thornburgh*, 476 U.S. at 747-48.

110. *Id.* at 772.

111. *Id.* at 766.

112. *Id.*

113. *Id.*

114. Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

115. *Id.* at 844.

woman seeking the abortion give a "reason for failure to provide notice to her husband,"[116] the Court found that the statute's requirement that other information be reported did not violate a woman's privacy rights.[117] Referring to information regarding the performing physician, the facility, the woman's age, the number of prior pregnancies and abortions, the type of abortion procedure, the date of the abortion, the woman's pre-existing medical conditions, and the weight of the aborted fetus, the Court noted that the reporting requirement for this type of information was constitutionally legitimate because it could help the state protect women's health.[118] The Court stated that "collection of information with respect to actual patients is a vital element of medical research, and so it cannot be said that the requirements serve no purpose other than to make abortions more difficult."[119]

While the Court has reached varying outcomes with regard to mandatory reporting laws, depending on the specific facts of each situation, these cases demonstrate how the Court uses a heightened standard or review in assessing the constitutionality of statutes that may infringe on an individual's personal autonomy. It is important to note, however, that the Supreme Court has reviewed mandatory reporting laws solely in the context of drug crimes and abortion, and has not yet examined this issue with regard to contagious diseases.[120] The principles laid down in these cases are certainly applicable to mandatory reporting laws dealing with HIV/AIDS and other diseases or conditions, but the Court has yet to address this issue explicitly.[121]

B. Government Action to Protect Public Health

The government has a duty to protect public health and an interest in doing so.[122] Although individuals have a personal right to privacy and

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116. *Id.* at 901 (internal quotations omitted).

117. *Id.* at 900-01.

118. *Id.*

119. *Id.*

120. WING, *supra* note 61, at 300.

121. *Id.*

122. *See infra* Section III.B.

autonomy, these interests can conflict with a state's efforts to protect the health and welfare of its citizens, as evidenced by the cases examined in Section III.A, above.[123] This section will examine the issue of state action, discussing the situations in which the federal and state governments can lawfully infringe on individual privacy rights, and outlining what the government action must look like if such interference occurs.

1. Federal Government Action

The federal government has a fundamental interest in protecting the health of the American people and it can compel individuals to act, or not act, in certain ways in order to protect the common good.[124] The United States Constitution vests this power in the federal government.[125] There are two sources of constitutional authority for such power—the General Welfare Clause, found in the taxing and spending passage in Article 1, Section 8,[126] and the Commerce Clause, an enumerated power also found in Article 1, Section 8.[127] These constitutional provisions give Congress the power and authority to pass legislation protecting the general welfare of the American people and to regulate interstate commerce, an area frequently affected by public health policy.[128] Congress has consistently exercised its power to pass laws governing public health under these two clauses since the early days of this nation's history.[129]

The General Welfare Clause states, "Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide

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123. *See generally* Whalen v. Roe, 429 U.S. 589 (1977); Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747 (1986); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

124. WING, *supra* note 61, at 328.

125. *See* U.S. CONST. art. I, § 8.

126. *Id.*

127. *Id.*

128. *Id.*

129. *See generally* Wendy Parmet, *AIDS and Quarantine: The Revival of an Archaic Doctrine*, 14 HOFSTRA L. REV. 53 (1985).

for the common Defence and general Welfare of the United States . . . ."[130] The applicability and interpretation of this clause has been vigorously debated by many of the greatest minds throughout American history.[131] Nevertheless, the Supreme Court lay to rest any disagreement that existed on this matter in a 1936 decision.[132] After discussing the two different positions on the interpretation of this clause, in *United States v. Butler* the Court stated that the General Welfare Clause should be understood as an additional grant of congressional power above and beyond the other enumerated powers granted in Article 1, Section 8.[133] The Court noted that the General Welfare Clause, as interpreted, accords Congress "a substantive power to tax and to appropriate, limited only by the requirement that it shall be exercised to provide for the general welfare of the United States."[134] The Court later noted that in pursuing the general welfare, Congress must adopt "general, and not local" legislation.[135]

The Supreme Court revisited this issue a year later, in *Helvering v. Davis*.[136] This decision marks the Court's current interpretation of the General Welfare Clause.[137] In this case, the Court recognized that the concept of general welfare can change depending on the circumstances in which the nation finds itself.[138] The Court also noted that discretion to

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130. U.S. CONST. art. I, § 8.

131. *See* United States v. Butler, 297 U.S. 1 (1936). James Madison and Alexander Hamilton were two of the most prominent thinkers who disagreed on this issue. *Id*.

132. *Id*.

133. *Id.* at 65-67.

134. *Id.* at 65-66.

135. *Id.* at 66-67 (quoting Alexander Hamilton's Report on Manufactures).

136. Helvering v. Davis, 301 U.S. 619 (1937).

137. PAUL BREST ET AL., PROCESSES OF CONSTITUTIONAL DECISIONMAKING 567 (5th ed. 2006).

138. *Helvering*, 301 U.S. at 640-41. "Nor is the concept of the general welfare static. Needs that were narrow or parochial a century ago may be interwoven in our day with the well-being of the Nation. What is critical or urgent changes with the times." *Id*.

ascertain the general welfare sits with Congress.[139] Therefore, courts can only intervene when Congress has acted in a manner that "is clearly wrong, a display of arbitrary power, not an exercise of judgment."[140] In these two cases, the Supreme Court judged that the General Welfare Clause was itself an independent grant of power and that Congress has the jurisdiction to decide what spending or congressionally-permissible actions further the general welfare.[141] Courts can review this decision, but must defer to congressional action unless it is clearly arbitrary.[142] Thus, under the General Welfare Clause, Congress can pass public health laws that involve a tax or an allocation of federal funds.[143]

In addition to the General Welfare Clause, Congress can also pass public health laws under its authority to regulate interstate commerce. The Commerce Clause, also found in Article 1, Section 8, states that "Congress shall have the Power To . . . regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes."[144] Beginning with the New Deal legislation, Congress began relying more heavily on the Commerce Clause to justify its actions.[145] Although the Supreme Court addressed this issue numerous times, some of its recent decisions have significantly clarified the extent and boundaries of Commerce Clause jurisdiction.[146]

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139. *Id.* at 640.

140. *Id.* The Court went on to state that "When such a contention [regarding the General Welfare Clause] comes here we naturally require a showing that by no reasonable possibility can the challenged legislation fall within the wide range of discretion permitted to the Congress." *Id.* at 641 (quoting United States v. Butler, 297 U.S. 1, 67 (1936)).

141. *See generally Butler*, 297 U.S. at 1; *Helvering*, 301 U.S. at 619.

142. *See generally Butler*, 297 U.S. at 1; *Helvering*, 301 U.S. at 619.

143. *Butler*, 297 U.S. at 1; *Helvering*, 301 U.S. at 619.

144. U.S. CONST. art. I, § 8.

145. *See* BREST, *supra* note 137, at 558-64.

146. *See infra* notes 147-69 and accompanying text.

In *United States v. Lopez*,[147] the Supreme Court struck down a federal law banning firearms in school-zones because it exceeded the constitutional bounds of the Commerce Clause.[148] This five-to-four decision marked the first time in almost sixty years that the Court struck down a federal law under the Commerce Clause, but it is most noteworthy for the Court's expostulation of three categories of commercial activities under which Congress has the power to legislate.[149] First, Congress can regulate "the use of the channels of interstate commerce."[150] Second, Congress can regulate intrastate activities and actions that threaten "the instrumentalities of interstate commerce, or persons or things in interstate commerce."[151] Third, Congress can regulate "activities having a substantial relation to interstate commerce."[152] As a result of this decision, all congressional action under the Commerce Clause must fall into one of these three categories.

Five years later, the same Justices, in an identical five-to-four split as *Lopez*, again invalidated congressional action under the Commerce Clause in *Morrison v. United States*.[153] In striking down part of the Violence Against Women Act,[154] the Court ruled that even though Congress had made significant factual findings concerning the economic impact of gender violence, simple factual-causation was insufficient to constitute a substantial relationship to interstate commerce.[155] According to the Court, Congress can only use the Commerce Clause to justify regulating actions that are truly economic in nature.[156] The logical question arising from this decision is

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147. United States v. Lopez, 514 U.S. 549 (1995).

148. *Id*. at 551.

149. *Id.* at 558-59.

150. *Id.*

151. *Id.*

152. United States v. Lopez, 514 U.S. 549, 558-59 (1995).

153. Morrison v. United States, 529 U.S. 598 (2000).

154. The Violence Against Women Act of 1994, P.L. 103-322 (1994).

155. *Morrison*, 529 U.S. at 613-14.

156. *Id.* at 613.

what constitutes "economic" activity. Federal courts have wrestled with this issue, and have yet to articulate a clear answer.[157]

The Supreme Court addressed the applicability of the Commerce Clause to public health law in *Gonzales v. Raich*.[158] In this case, the Court upheld a federal ban on the cultivation and use of medical marijuana.[159] The Court found that there was a rational basis for connecting medical marijuana with interstate commerce.[160] According to the Court, leaving the regulation of medicinal marijuana use to each state would impact the ability of the federal government to combat the illicit use of drugs, which would have a concurrent economic impact on the United States as a whole.[161]

The *Lopez*, *Morrison*, and *Raich* decisions each dealt specifically with the legitimacy of federal action under the Commerce Clause. However, the Supreme Court has also found that state action is reviewable under the Commerce Clause. This state-centric analysis—known as the "Dormant Commerce Clause" analysis—seeks to determine whether a state law wrongfully infringes on interstate commerce, thereby violating the Commerce Clause.[162] In the 2007 decision *United Haulers Association, Inc. v. Oneida-Herkimer Solid Waste Management Authority*,[163] the Court addressed the Dormant Commerce Clause implications of a New York state

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157. *See* Gibbs v. Babbitt, 214 F.3d 483 (4th Cir. 2000) (holding that Congress can use the Commerce Clause to protect a species of endangered wolves due to the tourist and scientific activity surrounding the endangered species); *but see Gibbs*, 214 F.3d at 506-10 (Luttig, J., dissenting) (arguing that the protection of a small population of an isolated species was not "economic" in nature).

158. Gonzales v. Raich, 545 U.S. 1 (2005).

159. *Id.* at 33.

160. *Id.* at 22.

161. *Id.* at 29-30.

162. *See* Granholm v. Heald, 544 U.S. 460, 493 (2005) (Stevens, J., dissenting) (stating "a state law may violate the unwritten rules described as the 'dormant Commerce Clause' either by imposing an undue burden on both out-of-state and local producers engaged in interstate activities or by treating out-of-state producers less favorably than their local competitors").

163. United Haulers Ass'n, Inc. v. Oneida-Herkimer Solid Waste Mgmt. Auth., 550 U.S. 330 (2007).

action designed to protect public health and local economic interests.[164] The Court found that the local ordinance did not violate the Dormant Commerce Clause, because it applied uniformly to all private ventures.[165] In reaching this conclusion, the Court stated that "we will uphold a nondiscriminatory statute like this one unless the burden imposed on interstate commerce is clearly excessive in relation to the putative local benefits."[166]

In following the holdings of these cases, Congress can pass public health laws under the Commerce Clause, as long as they fall into one of the three categories listed in *Lopez* and constitute "economic" activity under *Morrison* and *Raich*.[167] Furthermore, federal Commerce Clause power preempts state and local laws that have a substantial impact on interstate commerce if the state burden on interstate commerce outweighs the local benefits of the laws.[168] As evidenced by the number of court challenges on this issue, Congress has routinely used the Commerce Clause to justify legislation on a wide variety of issues, including public health.[169]

The Constitution confers upon Congress the authority to regulate public health under the General Welfare and Commerce Clauses.[170] It also provides that any law Congress passes on public health issues, or any other issue, preempts state or local law to the contrary.[171] The Supremacy Clause, found in Article VI, states, "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."[172] Consequently, any legislation passed by Congress will

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164. *Id*. at 330-33.

165. *Id.* at 346.

166. *Id.* (internal quotations omitted).

167. *See generally* United States v. Lopez, 514 U.S. 549 (1995); Morrison v. United States, 529 U.S. 598 (2000); Gonzales v. Raich, 545 U.S. 1 (2005).

168. *United Haulers*, 550 U.S. at 338.

169. *See supra* notes 147-66 and accompanying text.

170. U.S. CONST. art. I, § 8.

171. *Id.* at art. VI.

172. *Id.*

trump state and local laws, insofar as the nonfederal laws contradict the federal legislation.

2. *State Government Action*

Even though the federal government has the power to pass legislation governing public health, the individual states have the greatest amount of jurisdiction to regulate this area.[173] The states, unlike the federal government, have the power and duty to protect the health, welfare, safety, and morals of their citizens.[174] This power, often referred to as the "police power,"[175] is limited only by the respective constitutions of each state, essentially making it the most extensive and comprehensive power a state has to regulate in these areas.[176]

The Supreme Court explicitly recognized the police power of each state in the landmark 1905 decision *Lochner v. New York*.[177] In that decision, the Court said:

> There are… certain powers, existing in the sovereignty of each State in the Union, somewhat vaguely termed police powers… [that] relate to the safety, health, morals, and general welfare of the public. Both property and liberty are held on such reasonable conditions as may be imposed by the governing power of the State in the exercise of those powers.[178]

As recognized by the Court, the states can make reasonable impositions on the privacy and property rights of individuals in exercising police powers.[179] Even though *Lochner* has been overturned on other grounds,[180]

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173. *See infra* notes 177-214 and accompanying text.

174. Lochner v. New York, 198 U.S. 45, 53 (1905).

175. *Id.* at 53.

176. *Id.*

177. *Id.*

178. *Id.* at 53.

179. *Lochner*, 198 U.S. at 53-54. The Court went on to state that personal rights to privacy and property may sometimes conflict with the state's police power, and that the interests of the individual must be weighed against the interests of the state in determining the validity of the state's exercise of power:

> Therefore, when the state, by its legislature, in the assumed exercise of its police powers, has passed an act which seriously limits the right to labor or the right of

the *Lochner* Court's construal of the states' power to preserve the health, welfare, and morals of its citizens remains the current construction of the police power in use today.[181]

Although the police power cases decided during the *Lochner* Era predominantly dealt with labor laws regulating minimum wage or the number of work hours employers could demand of their employees, the Supreme Court continued to recognize the states' legitimate interest in protecting the public health.[182] Even if the Court may rule differently as to the validity of each state action in protecting the public health, such preservation is one of the chief goals of a state's exercise of its police power.[183]

> contract in regard to their means of livelihood between persons who are *sui juris* (both employer and employee), it becomes of great importance to determine which shall prevail—the right of the individual to labor for such time as he may choose, or the right of the state to prevent the individual form laboring, or from entering into any contract to labor, beyond a certain time prescribed by the state.

Id.

180. *See* West Coast Hotel Co. v. Parris, 300 U.S. 379, 392 (1937) (holding that a state can legitimately exercise its police powers to restrict liberty of contract).

181. *See generally* Dodger's Bar & Grill, Inc. v. Johnson County Bd. of County Com'rs, 32 F.3d 1436, 1441 (10th Cir. 1994) (noting that the states "require no specific grant of authority in the Federal Constitution to legislate with respect to matters traditionally within the scope of the police power").

182. *See Lochner*, 198 U.S. at 57-58; Jacobson v. Massachusetts, 197 U.S. 11, 38 (1905). The *Lochner* Court stated that:

> The mere assertion that the subject relates, though but in a remote degree, to the public health, does not necessarily render the enactment valid. The act must have a more direct relation, as a means to an end, and the end itself must be appropriate and legitimate, before an act can be held to be valid which interferes with the general right of an individual to be free in his person and in his power to contract in relation to his own labor.

Lochner, 198 U.S. at 57-58.

183. Barsky v. Board of Regents of Univ. of State of N.Y., 347 U.S. 442, 449 (1954); *see also* Lewis Food Co. v. State Dept. of Public Health, 243 P.2d 802, 804 (2d Dist. 1952); City of Kansas City v. Jordan, 174 S.W.3d 25, 40 (Mo. Ct. App. W.D. 2005).

The Supreme Court addressed the constitutionality of a state public health law in *Jacobson v. Massachusetts*,[184] decided the same year as *Lochner*. In *Jacobson*, the Court analyzed a Massachusetts state law that allowed municipalities to require vaccinations and to fine nonparticipants.[185] The Court held that the Massachusetts law was enacted as a legitimate effort to pursue public health, and that it is inherent in the police power of each state to determine the steps necessary to promote the public health and general welfare.[186] In the course of its analysis, the Court expostulated a standard for judicial review of public health laws.[187] The Court stated that public health laws promulgated under the state police power must have a "real or substantial relation to those [police power] objects" and must not impose something that is, "beyond all question, a plain, palpable invasion of rights secured by" the United States Constitution.[188]

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184. Jacobson v. Massachusetts, 197 U.S. 11 (1905).

185. *Id.* at 12.

186. *Id.* at 38 (stating that "[t]he safety and the health of the people of Massachusetts are, in the first instance, for the Commonwealth to guard and protect . . . we do not perceive that this legislation has invaded any right secured by the Federal Constitution").

187. *Id.* at 28.

188. According to the Supreme Court in *Jacobson*, legitimate government action to protect the public health must fall within certain constitutional limitations. First, government action must be reasonably connected to the end it is designed to achieve. The Court in *Jacobson* stated that "it might be that an acknowledged power of a local community to protect itself against an epidemic threatening the safety of all might be exercised in particular circumstances and in reference to particular persons in such an arbitrary, unreasonable manner, or might go so far beyond what was reasonably required for the safety of the public, as to authorize or compel the courts to interfere for the protection of such persons." *Id.* Second, the government action cannot patently invade a constitutional right. *Id.* at 31. The type of constitutional violation the Court envisioned here was more than a mere weighing of constitutional interests, but a clear violation of an explicit, inalienable constitutional right. *Id.* at 31-32. Third, the Court found that the actual existence of the danger the government action sought to avert was an additional factor that should be considered in support of a determination of constitutionality of the government's action. *Id.* at 27. Finally, any action by a state government is legitimate only insofar as it does not conflict with a federal law on the issue. *Id.* at 25. The Court revisited the limits on government action the same year it decided *Jacobson*. In *Lochner*, the Court noted that state government police power action must also be weighed against other constitutional considerations to determine whether the action is reasonable, whether it is necessary, and whether it arbitrarily interferences with personal liberty and privacy.

Subsequent decisions have followed *Jacobson* for the proposition that the judiciary should show great deference to the findings of state legislatures that a particular infringing action is necessary to support public health.[189] For this reason, *Jacobson* is considered by many to be the most important decision in public health law.[190] As demonstrated in the following examples, states have exercised their police power to regulate public health by examining, quarantining, and, at times, involuntarily treating individuals.[191]

Throughout American history, states have acted to protect the public health of their citizens.[192] Some of these efforts have been more extreme than others, ranging from mere education about communicable diseases to quarantine of those with infectious diseases.[193] While quarantine may seem unnecessarily extreme, there is a long history of its use in the United

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The *Lochner* Court summarized the balancing between government interest and personal constitutional rights as follows:

> In every case that comes before this court, therefore, where legislation of this character is concerned and where the protection of the Federal Constitution is sought, the question necessarily arises: Is this a fair, reasonable and appropriate exercise of the police power of the State, or is it an unreasonable, unnecessary and arbitrary interference with the right of the individual to his personal liberty or to enter into those contracts in relation to labor which may seem to him appropriate or necessary for the support of himself and his family?

Lochner v. New York, 198 U.S. 45, 56 (1905).

Since *Jacobson* and *Lochner*, courts have distilled these requirements on government action into the general rule that any government remedy must be adopted in the least intrusive manner reasonably possible. Roe v. Wade, 410 U.S. 113, 155 (1973); *see also* WING, *supra* note 61, at 190.

189. WING, *supra* note 61, at 68-69.

190. *Id.* at 59 (stating "*Jacobson* is widely regarded as the seminal decision in American public health law, largely because it upholds the constitutional validity of the state's curtailment of individual liberty in the interests of public health").

191. *Id.* at 69.

192. Parmet, *supra* note 129, at 55-71.

193. *See id.* at 56.

States,[194] and the Supreme Court has sanctioned it as a legitimate public health power since the early-1800s.[195] Quarantine is just one example of deliberate state action taken to protect the general well-being and health of the citizenry. Since these early attempts at protecting the public health, states have taken a variety of approaches in this area.

Surveillance laws are one of the most commonly utilized state efforts for protecting public health.[196] Currently, every state has some form of public health reporting laws.[197] These laws generally require certain medical personnel to report to the state cases of infectious disease.[198] Which diseases physicians must report vary by state, but the CDC provides a recommended list of communicable diseases that should be reported when encountered.[199] Although this list is only a recommendation, it is highly influential and carries great weight.[200] HIV/AIDS, along with other sexually-transmitted infections, are on the CDC list.[201]

As noted above, public health surveillance is one of the foundations of modern health.[202] Because reporting requirements are so fundamental to the protection of the common good, most physicians accept their necessity, albeit with certain reasonable constraints.[203] As health sciences have

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194. Massachusetts passed a law establishing quarantine to combat the spread of infection in 1797. Act of June 22, 1797, ch. 16 GEN. LAWS OF MASS. (1822).

195. Gibbons v. Ogden, 22 U.S. 1 (1824).

196. WING, *supra* note 61, at 283.

197. *Id.*

198. *Id.*

199. CDC, HHS, NATIONALLY NOTIFIABLE INFECTIOUS DISEASES, UNITED STATES 2006, http://www.cdc.gov/ncphi/disss/nndss/phs/infdis2006.htm (last visited April 9, 2010) [hereinafter NATIONALLY NOTIFIABLE INFECTIOUS DISEASES].

200. WING, *supra* note 61, at 311.

201. NATIONALLY NOTIFIABLE INFECTIOUS DISEASES, *supra* note 199.

202. Ruth L. Berkelman et al., *Public Health Surveillance*, *in* 2 OXFORD TEXTBOOK OF PUBLIC HEALTH 759, 759-60 (Roger Detels et al., eds., 4th ed. 2002).

203. WING, *supra* note 61, at 310.

advanced, the way in which public health surveillance has been used has also progressed.[204] Instead of subjecting those testing positive for a disease on a state's watch-list to mandatory isolation, this information is now used to recommend treatment and other remedies based on the specific condition of the infected patient.[205]

Traditionally, states required personal information as part of disease surveillance.[206] This information was collected in case the state needed to take quarantine actions against the individual in order to prevent an epidemic.[207] While modern health care has rendered such fears largely irrelevant, when there is danger of a rapid spread of infection, personal information is critical in order for the state to protect the citizens at large.[208] As HIV/AIDS became more prevalent in the early-1980s, states began considering whether to require personal information in the reporting of HIV/AIDS cases.[209] Due to the limited medical information available at that time regarding HIV/AIDS transmission, and the fact that there was no effective treatment for the disease, many states found that it was unnecessary to equate HIV/AIDS with other communicable diseases and chose not to require that the reports contain personal information or that patients be effectively isolated for life.[210] States were also concerned that if they required personal information, individuals would not seek testing for fear of negative reprisals with regard to their employment, health insurance, or life insurance.[211] If these individuals did not seek testing, then there was a danger that infected persons might inadvertently transmit their disease to others, without knowing their own condition.[212] Today, however, there is

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204. *Id.* at 311.

205. *Id.*

206. *Id.* at 321.

207. *Id.*

208. *Id.*

209. WING, *supra* note 61, at 321.

210. *Id.* at 321-22.

211. *Id.* at 322.

212. *Id.*; Note also that the Institute of Medicine has provided an excellent summary of the issue of HIV/AIDS reporting:

effective treatment that reduces suffering, prolongs life, and reduces transmission.[213]

3. Limits on Government Action

As noted above, both federal and state governments have the legal authority to regulate public health. This power is not without limits, however. The government interest in protecting the health of its citizens must be balanced with the individual's interest in privacy and autonomy.[214] The Fifth and Fourteenth Amendments to the Constitution require federal and state governments to abide by the due process of law whenever taking action that deprives individuals of their life, liberty, or property.[215] Constitutional due process issues involve two considerations—procedural due process and substantive due process.[216] Procedural due process

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> Public health authorities justified reporting of HIV infection on several grounds. Reporting would alert public health officials to the presence of individuals with a lethal infection; would allow officials to counsel them about what they needed to do to prevent further transmission; would assure the linkage of infected persons with medical and other services; and would permit authorities to monitor the incidence and prevalence of infection. In the following years, CDC continued to press for name-based reporting of HIV cases, supported by a growing number of public health officials. Indeed, the Council of State and Territorial Epidemiologists adopted several resolutions between 1989 and 1995 recommending and encouraging that states consider the implementation of HIV case reporting by name. Political resistance persisted however, and HIV cases typically became reportable by name only in states that did not have large cosmopolitan communities with effectively organized gay constituencies or high AIDS caseloads. By 1996, although 26 states had adopted HIV case reporting, they represented jurisdictions with only approximately a quarter of total reported AIDS cases. By October 1998, name-based reporting had a stronger foothold with 32 states then reporting cases of HIV by name, although three states reported only pediatric cases.

INSTITUTE OF MEDICINE, MEASURING WHAT MATTERS: ALLOCATION, PLANNING, AND QUALITY ASSESSMENT FOR THE RYAN WHITE CARE ACT 78 (2004) (internal citations omitted) [hereinafter MEASURING WHAT MATTERS].

213. *See supra* notes 52-55 and accompanying text.

214. *See supra* notes 61-64 and accompanying text.

215. U.S. CONST. amends. V & XIV.

216. ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 545 (2006).

examines whether the government employs proper procedures in implementing the government action.[217] Substantive due process analyzes whether the government action, itself, is legitimate.[218]

The text of the Due Process Clause states that "[n]o person shall . . . be deprived of life, liberty, or property, without due process of law."[219] At its most basic level, the text indicates that a procedural due process analysis involves three inquiries: Was there a deprivation? If so, did the deprivation involve a right to life, liberty, or property? Finally, was there due process of law involved in the deprivation?[220] For most public health cases of the nature discussed in this article, government action will deprive people of liberty.[221] As a result, the third question noted above is key for a procedural due process analysis of this nature.[222] When analyzing what process is "due" in deprivations of civil liberties, courts have balanced the interests of the government with the infringements on individual liberty.[223]

The Supreme Court provided a model for procedural due process analyses in *Mathews v. Eldridge*.[224] In that decision, the Court outlined three questions that are integral to a procedural due process analysis. First, a court must ascertain what private interest will be affected by the government action.[225] Second, the court must assess the risk of an erroneous deprivation of that interest through the procedure used by the government, and must analyze the probative value additional procedural safeguards would add.[226] Third, the court must weigh these private interests with the government's

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217. *Id*. at 545-57.

218. *Id*. at 547-549.

219. U.S. CONST. amend. V.

220. CHEMERINSKY, *supra* note 216, at 545-57.

221. WING, *supra* note 61, at 165.

222. *Id.*

223. *Id.* at 166.

224. Mathews v. Eldridge, 424 U.S. 319 (1976).

225. *Id.* at 335.

226. *Id.*

interest in making the deprivation of liberty.[227] Though complex, the main purpose of this three-part test is to weigh the procedural fairness of the government action.[228]

Substantive due process deals with the nature of the government action. Again, as with procedural due process, courts employ a balancing test to determine whether the government has a valid reason for infringing on individual liberty.[229] In ascertaining how to balance government interest with personal liberties, courts use two different levels of scrutiny, depending on the nature of the rights being infringed by the government—rational basis scrutiny and strict scrutiny.[230] Rational basis scrutiny applies to all government actions that infringe on an individual's right to life, liberty, or property.[231] When analyzing government action under this level of scrutiny, courts ascertain whether the government action is rationally related to a legitimate government purpose.[232] This threshold is not particularly onerous, and the government generally meets this standard, so long as the liberty-infringing action has a reasonable connection to the proposed governmental purpose.[233] Whenever the government action infringes a fundamental right,[234] however, courts apply a strict scrutiny standard to the

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227. *Id.* The Court stated the three-part test as follows:

> [I]dentification of the specific dictates of due process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probative value if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

Id.

228. WING, *supra* note 61, at 167.

229. *Id.*

230. *See generally* CHEMERINSKY, *supra* note 216, at 539-43.

231. *Id.*

232. *Id.*

233. *Id.*

234. *Lawrence v. Texas* recognized the contemporary understanding of fundamental rights as those which are rooted in the history of the United States, stating "*only* fundamental rights which are deeply rooted in this Nation's history and tradition

government action.[235] Under this analysis, courts will only deem the government action constitutionally permissible if it is necessary to achieve a compelling government purpose, and if it is the least restrictive means of meeting that purpose.[236]

In making a substantive due process analysis, a court must first ascertain what is the precise state interest, and then weigh that interest against its infringement on life, liberty, or property.[237] If the rights being violated by the action are deemed fundamental, then the court must apply a strict scrutiny standard and seek to determine whether the action is the least restrictive means of accomplishing the government purpose.[238] If the rights do not rise to this heightened level, then the court only needs to determine whether the government action is rationally related to a legitimate purpose to hold that the action is permissible.[239] Any government action, be it federal or state, must abide by these Due Process Clause restrictions.

C. Analysis—Is this Solution Legally Defensible?

As Professor Ruth Berkelman, the Director of the Center for Public Health Preparedness and Research at Emory University, has observed, "[p]ublic health surveillance is the epidemiological foundation for modern public health."[240] Contemporary health problems can only be dealt with effectively when the government has information about the character, extent, and rapidity of the spread of the disease.[241] The preceding discussions have demonstrated the compelling interest the government has in protecting the public from an HIV/AIDS epidemic. Previous government efforts to address

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qualify for anything other than rational-basis scrutiny under the doctrine of substantive due process." Lawrence v. Texas, 539 U.S. 558, 588 (2003); *see also* CHEMERINSKY, *supra* note 216, at 794-96.

235. CHEMERINSKY, *supra* note 216, at 539-43.

236. *Id.*; *see also* WING, *supra* note 61, at 167-69.

237. WING, *supra* note 61, at 167-68.

238. *Id.*

239. *Id.*

240. Berkelman, *supra* note 202, at 759.

241. *Id.* at 759-61.

the HIV/AIDS problem have been met with only marginal success.[242] In order to effectively combat the increasing transmission of HIV/AIDS in the United States, the government must institute a broad testing, treatment, and education program aimed at accurately ascertaining (to the extent possible) who is infected, effectively treating those with the disease to reduce the transmission rate and increase the comfort of the infected individual, and consistently and repeatedly educating infected persons and the public as to the nature of the disease and ways to avoid contracting it.[243] The government has a specific interest in implementing these efforts in order to protect the public health from the spread of HIV/AIDS.

In the past, the federal and state governments have pursued extreme actions to protect the common good.[244] Recognizing the government's responsibility to protect citizens generally, many courts have upheld government actions that incidentally infringe upon personal liberty and privacy because they were in furtherance of the public health.[245] With regard to state action involving mandatory testing, the North Carolina Supreme Court held that confidential disease testing did not violate the privacy rights of individuals because the state demonstrated that there was a compelling need for such information.[246] Furthermore, public health specialists have recognized that public health surveillance is based,

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242. *See supra* notes 9-18 and accompanying text. The District of Columbia recently adopted a new HIV/AIDS response. In collaborating with the National Institutes of Health, the Washington, D.C. government has instituted a study to measure how effective a test-and-treat program will be in combating new instances of the disease. As well intentioned as this program may be, it is missing the education prong, which is a critically important step in combating the spread of HIV/AIDS. It is hard to say what the ultimate result of this program will be, as the effects may take years and years to become quantifiable. Darryl Fears, *District, NIH Announce New Initiative Aimed at HIV/AIDS Epidemic*, WASH. POST, Jan. 12, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/01/12/AR2010011203163_pf.html.

243. *See supra* notes 48-60 and accompanying text.

244. Quarantine and mandatory vaccination are just two examples of government action, deemed lawful by the courts, that have severely limited personal freedom and infringed on individual privacy rights. *See* Jackson v. Indiana, 406 U.S. 715 (1972); Jacobson v. Massachusetts, 197 U.S. 11 (1905).

245. *See supra* Section III.B.

246. ACT-UP Triangle v. Comm'n for Health Servs. of North Carolina, 483 S.E.2d 388, 394-95 (N.C. 1997).

fundamentally, on the concept that individuals may be required to act or not act in a particular way, for the benefit of those around them.[247]

Additionally, the government may also have an interest in the actual identity of those tested.[248] As noted above, in *Planned Parenthood v. Casey*, the Supreme Court held that certain personal information obtained from actual patients is a necessary part of medical research, and, as such, disclosing the identities of such individuals to the government can serve a useful, important purpose.[249] In 1998, the Alabama Supreme Court applied this reasoning to mandatory HIV/AIDS reporting, when it held that the state had a compelling interest in the identities of the individuals tested.[250]

As of 2004, every state and territory in America had a confidential HIV reporting requirement.[251] While AIDS reporting generally utilizes a standard name-based system, states have adopted varied methods for HIV reporting.[252] Approximately two-thirds of states and territories use confidential, name-based systems for HIV reporting, similar to those used for other communicable diseases, while the rest use different methods to protect the confidentiality of the reported information.[253] What is most important for this discussion, however, is the fact that the vast majority of states and territories require the reporting of identities (which are then kept in confidence) in addition to mere instances of infection, while only state, New Hampshire, offers a completely anonymous option where no identifying patient information is collected.[254]

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247. Amy L. Fairchild, *Dealing with Humpty Dumpty: Research, Practice and the Ethics of Public Health Surveillance* 31 J.L. MED. & ETHICS 615, 615 (2003) (stating that "individuals may be compelled to do or not do things to protect the common good").

248. *See* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

249. *Id.* at 900-01.

250. Middlebrooks v. State Bd. of Health, 710 So.2d 891 (Ala. 1998) (finding that it is within the state's jurisdiction to compel individual physicians to disclose the identities of their patients with HIV/AIDS).

251. MEASURING WHAT MATTERS, *supra* note 212, at 78.

252. *Id.*

253. *Id.*

254. *Id.* at 78-79. For an excellent overview of the history of named reporting for HIV/AIDS in the United States, see Kevin M. Kramer, *A National Epidemic, A National*

So, is the proposed public health response to HIV/AIDS advocated in this article legally defensible? As noted in *Roe v. Wade*, whenever individual privacy and autonomy rights are implicated, the infringing government action warrants heightened scrutiny.[255] However, there is a convoluted history of government action that has constitutionally infringed on personal rights.[256] For example, in *Planned Parenthood v. Danforth*, the Supreme Court upheld mandatory reporting laws that infringed on individual privacy interests.[257] Conversely, in *Thornburgh v. American College of Obstetricians and Gynecologists*, the Supreme Court struck down a mandatory reporting law because it required the submission of payment methods and personal medical history, but noted that the reporting of other types of information, relevant to the government interest in protecting public health, did not violate individual constitutional rights to privacy and autonomy.[258] Finally, in *Planned Parenthood v. Casey*, the Supreme Court provided a list of specific types of information, the reporting of which would not violate privacy rights.[259]

The federal and state governments can regulate public health in ways that infringe on personal rights or liberties. The basis for the federal government's authority in this area is found in the General Welfare and Commerce Clauses of the United States Constitution.[260] The Supreme Court has interpreted the General Welfare Clause to be an independent grant of legislative power within the taxing and spending authority found in the text of the clause.[261] The Court has further noted that Congress has jurisdiction to determine what the general welfare is, a decision that courts can only

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Conversation, A National Law: In Support of Unique Identifier Reporting for HIV Surveillance, 16 J. CONTEMP. HEALTH L. & POL'Y 173, 182-90 (1999).

255. Roe v. Wade, 410 U.S. 113, 155 (1973).

256. Planned Parenthood v. Danforth, 428 U.S. 52, 79-81 (1976); Thornburgh v. Am. Coll. of Obstetricians and Gynecologists, 476 U.S. 747, 765-66 (1986); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 848-50 (1992).

257. *Danforth*, 428 U.S. at 79-81.

258. *Thornburgh*, 476 U.S. at 765-66.

259. *Casey*, 505 U.S. at 900.

260. U.S. CONST. art. I, § 8.

261. Helvering v. Davis, 301 U.S. 619, 640 (1937).

overrule if it is clearly arbitrary and unfounded.[262] Additionally, Congress can pass public health laws under its Commerce Clause jurisdiction, so long as the action falls within one of the three categories the Supreme Court identified in *Lopez*,[263] and is "economic" in nature.[264] Congress has used the Commerce Clause as a basis for passing public health laws in the past, and the Supreme Court has upheld this justification for those laws.[265] The state governments can regulate public health under their police power jurisdiction to protect the health, welfare, and morals of their citizens. According to the Supreme Court in *Jacobson v. Massachusetts*, a state exercise of its police power is legitimate so long as the government interest is directly related to the infringement on personal rights, and so long as the government action is not a "plain, palpable invasion" of a constitutional right.[266]

However, when government action infringes on personal liberties, Fifth and Fourteenth Amendment due process considerations are implicated. According to Supreme Court precedent in the *Mathews* decision, procedural due process rights are maintained when the process used by the government is fair in light of the private interest that the government action violates.[267] Additionally, in order to comport with substantive due process, government action that infringes on personal privacy rights must satisfy strict scrutiny.[268] Under this level of scrutiny, government action is constitutional if the action is necessary to achieve a compelling government interest and the action chosen by the government is the least restrictive means of meeting that interest.[269]

The public health response to HIV/AIDS proposed in this article would fall well within these legal boundaries. As demonstrated above, the

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262. *Id.* at 645.

263. United States v. Lopez, 514 U.S. 549, 558-59 (1995).

264. Morrison v. United States, 529 U.S. 598, 613 (2000); Gonzales v. Raich, 545 U.S. 1, 29-30 (2005).

265. *Raich*, 545 U.S. at 29-30.

266. Jacobson v. Massachusetts, 197 U.S. 11, 31 (1905).

267. Mathews v. Eldridge, 424 U.S. 319, 335 (1976).

268. CHEMERINSKY, *supra* note 216, at 638-746.

269. *Id.*; WING, *supra* note 61, at 167-69; *see also* Kramer, *supra* note 254, at 200-01.

government has a compelling interest in protecting the public health from the continued spread of HIV/AIDS. Requiring widespread testing, treatment, and education would directly support this public health interest. The public health response to the syphilis epidemic of the early twentieth century, as well as court decisions that have upheld similar government action, demonstrate that a government requirement of mandatory testing, treatment, and education of the nature prescribed in this article is constitutionally permissible.[270] Such action falls within the federal government's General Welfare and Commerce Clause powers,[271] as well as the state governments' police powers.[272] Government action of this nature would directly serve the government's interest in protecting the public health, and would, as a result, outweigh any privacy rights on which it may infringe. In fact, the proposed action in this article imposes no additional privacy impositions beyond the status quo. All states, except New Hampshire, require medical practitioners to report patient names for newly diagnosed AIDS cases,[273] but none of these states have any mandated action as a consequence of these results.[274] The proposal in this article would use this type of information in a more pointed, intentional effort at reducing HIV/AIDS transmission rates, helping those who are infected ascertain their

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270. The National Venereal Disease Control Act of 1938 mandated counseling, education, and treatment, much to the same extent as the proposal in this Article. The Act incentivized these actions at a state level by making federal funding for venereal disease treatment contingent on such counseling and education programs. National Venereal Disease Control Act of 1938, Pub. L. No. 75-540, 52 Stat. 439, 439-40 (1938).

271. Because this proposed action would involve federal spending, both the General Welfare Clause and the Commerce Clause would justify the proposed action.

272. While outside the scope of this Article, it should be mentioned here that some states have taken criminal actions against individuals infected with HIV/AIDS who knowingly had unprotected sex with others, and have enacted statutes criminalizing actions likely to result in the transmission of a sexually transmitted disease, such as HIV/AIDS. It will be interesting to observe the interpretation courts give to these statutes as HIV/AIDS treatments drastically reduce the circulatory viral load, lowering the possibility of transmission to a virtual nullity. *See* J. Kelly Strader, *Criminalization as a Policy Response to a Public Health Crisis*, 27 J. MARSHALL L. REV. 435, 438-40 (1994).

273. MEASURING WHAT MATTERS, *supra* note 212, at 78-79.

274. Mandatory reporting is just one small step out of many. Reporting, alone, makes an individual a statistic—it does not take the necessary, logical actions in response to such statistical information.

status so that they can receive treatment, thereby reducing the transmission of the disease to those who are not currently infected.

IV. HOW TO ACCOMPLISH THIS TYPE OF RESPONSE

A. Legal Issues

In analyzing the legal methods of accomplishing this proposal, the threshold question is whether federal or state government should take the lead on this public health response. There are benefits and detriments to either option, but a federal response would be ideal, for the following reasons. While it may be harder to garner the political will to institute and fund a program of national proportions, a federal response would be uniform in all jurisdictions. State responses would be tailored to the specific needs of more-localized communities, but in order to truly accomplish the proposal in this article, each state would have to act in the exact manner prescribed here. The probability of fifty states passing laws that meet all the suggestions of this article is slim. Additionally, if this proposal is accomplished state-by-state, then state legislation and regulation would be subject to the respective state constitutions, which are often much more protective of privacy rights than the United States Constitution.[275] This is especially true with regard to medical information.[276] If even one state does not meet these suggestions, then the delinquent state could act as a pool of higher infection prevalence, which would then undermine the efforts of the other states in combating the spread of HIV/AIDS.[277]

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275. *See* In re May 1991 Will County Grand Jury, 604 N.E.2d 929, 934 (Ill. 1992) (stating that "the Illinois Constitution goes beyond Federal constitutional guarantees by expressly recognizing a zone of personal privacy"); Favalora v. Sidaway, 996 So. 2d 895, 899 (Fla. Dist. Ct. App. 2008) (stating that "Article I, section 23, Florida Constitution, affords Floridians the right of privacy and ensures that each person has the right to determine for themselves when, how and to what extent information about them is communicated to others") (internal citations omitted); *see also* People v. Givens, 892 N.E.2d 1098, 1107 (Ill. 1st Dist. 2008); State v. Planned Parenthood of Alaska, 171 P.3d 577, 581 (Alaska 2007); State v. Ellis, 210 P.3d 144, 148 (Mont. 2009); In re Carmen M., 46 Cal. Rptr. 3d 117, 125-26 (Cal. 2d Dist. 2006).

276. *See* Universal City Dev. v. Williams, 963 So. 2d 351, 354 (Fla. Dist. Ct. App. 5th Dist. 2007).

277. Another danger with the state-by-state response is that infected persons may fall between the cracks, so to speak, since persons are mobile. An individual may avoid testing and treatment, intentionally or unintentionally, by moving between states and seeking medical attention in a disparate geographical area.

This question of federalism aside, the proposals in this article could be accomplished through legislation or the actions of an administrative agency, at the federal or state level. As demonstrated by the Social Security Act of 1935,[278] the National Venereal Disease Control Act of 1938,[279] and the Ryan White Care Act,[280] responses to HIV/AIDS and other contagious diseases have traditionally been regulated through legislation. A legislative response embodying the proposals of this article would be preferable to an administrative response, because a discreet statute dealing specifically with this issue is more likely to address all the necessary considerations, such as funding, scope (including an anti-discrimination protection statute), administrative oversight, judicial review, and guidance on legal interpretation. Implementation of this proposal by an agency, such as HHS or a state equivalent, could be successful, but individuals would have more grounds on which to challenge agency action than they would for challenging a statute.[281] For this reason, in implementing the recommendations of this article, a legislative response would be preferable to an administrative response.

Therefore, the ideal method of government implementation of these recommendations would be federal legislation. Federal legislation would provide the greatest uniformity, coverage, funding, and legitimacy of any possible government response. Furthermore, the United States has a tradition of federal legislation regarding HIV/AIDS issues. While Congress faces a hugely disparate gulf of political will on contentious issues—and HIV/AIDS regulation is certainly a contentious issue—federal legislators also have national public policy concerns in mind when deciding how to vote, and as demonstrated above, the current public health response to HIV/AIDS is sorely lacking.

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278. Social Security Act of 1935, 49 Stat. 620, 635 (1935).

279. National Venereal Disease Control Act of 1938, 52 Stat. 439 (1938).

280. Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Pub. L. No. 101-381, 104 Stat. 576.

281. For example, challenges to agency action can include such issues as whether the agency action comports with the agency's forming statute, whether the action is arbitrary and capricious under the Administrative Procedure Act, and whether the action followed the proper procedures, such as the sufficiency of the comment period, the adequacy of the agency's reliance on expert testimony, and the compliance of the agency's action with other controlling statutes. *See* Administrative Procedure Act, 5 U.S.C. § 500 et seq. (2006).

B. Practical Issues

There are two practical issues implicated by the recommendations provided in this article that have yet to be discussed. The first involves the funding for this proposed response to HIV/AIDS and the second deals with the pragmatic implementation of the strategic test-treat-educate public health plan proposed here.

One of the first questions that is sure to confront a legislative implementation of this recommendation is how it will be funded. In order for this test-treat-educate response to be effective, the government needs to provide the necessary funding to get the response off the ground and to ensure its viability. There is a long tradition of federal funding of HIV/AIDS research and public health programs.[282] Currently, federal funding plays a huge role in driving both federal and state programs,[283] as well as incentivizing additional state actions to promote HIV/AIDS research and treatment.[284] An additional, critical reason why federal funding for this HIV/AIDS response is necessary is that any cost defrayed onto the infected individual will undermine the efficacy of universal testing, treatment, and education.[285]

While the public cost of such universal funding for HIV/AIDS testing, treatment, and education (between $21,500 to $32,000 per patient per year) seems staggering,[286] over time, the model recommended here would actually

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282. MEASURING WHAT MATTERS, *supra* note 212, at 241-46; WING, *supra* note 61, at 324.

283. MEASURING WHAT MATTERS, *supra* note 212, at 241-46.

284. *Id.* at 73-85.

285. Jim Kim & Paul Farmer, *AIDS in 2006—Moving Toward One World, One Hope?*, 355 NEW ENG. J. MED. 645 (2006). According to a recent article in the New England Journal of Medicine:

> The first lesson is that charging for AIDS prevention and care will pose insurmountable problems for people living in poverty, since there will always be those unable to pay even modest amounts for services or medications, whether generic or branded. Like efforts to battle airborne tuberculosis, such services should be seen as a public good for public health. Policymakers and public health officials, especially in heavily burdened regions, should adopt universal access plans and waive fees for HIV care.

Id.

286. For example, just considering the costs of anti-retroviral drugs, the cost of the commonly used antiviral drug Atripla costs approximately $59 per day, and another

save the government money. The federal government is already pouring huge sums of money into HIV/AIDS care and treatment.[287] The proposed response in this article would have a high up-front cost, but the ensuing reduction of the HIV/AIDS infection rate would save significant amounts of money in the long run.[288] By making a large initial commitment of funds, the federal government can ultimately save money by outlaying less and less for HIV/AIDS treatment as the transmission rate decreases, accordingly.

The second issue implicated here is how to incentivize this type of a response to the general public. As the Supreme Court noted in *Whalen*, individuals may avoid treatment in order to avoid reporting personal information to the government.[289] However, given the positive impact of treatment on longevity and quality of life of the infected person, such a personal decision may seem irrational. Nevertheless, the fact remains that the government will need to incentivize compliance by covering the cost of care and treatment, or punish noncompliance with this proposed response. In short, if the federal government passes legislation implementing this strategic proposal, the statute will need to include some type of incentive for compliance and penalty for noncompliance. The specifics of such incentivization and penalization lie in the hands of policymakers, but such a response requires consideration of these issues.[290]

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commonly used combination of atazanivir or darunavir, retonovir, tenofovir, and emticitabrine would cost approximately $83 per day, or between $21,500 to $32,000 per year. Telephone interview with NIH Pharmacy Staff, in Bethesda, Md. (April 2010); RED BOOK: PHARMACY'S FUNDAMENTAL REFERENCE (113th ed. 2009).

287. MEASURING WHAT MATTERS, *supra* note 212, at 241-46.

288. The bottom line is that by reducing the incidence and prevalence of HIV/AIDS, after a few years the costs of this strategic intervention will drastically drop, even below the current spending levels. For example, reducing the present-day prevalence of approximately 1.1 million cases by 25% would save approximately $7 billion per year in drug costs, a 50% drop would save $14 billion, and a 75% drop would save $21 billion, based on drug cost estimates alone. Telephone interview with NIH Pharmacy Staff, in Bethesda, Md. (April 2010); RED BOOK: PHARMACY'S FUNDAMENTAL REFERENCE (113th ed. 2009).

289. Whalen v. Roe, 429 U.S. 589, 602 (1977).

290. This incentivization issue is not new. Judge Simons noted in *Axelrod* that placement of a disease on a communicable or sexually transmitted disease list may trigger mandatory testing. State Society of Surgeons v. Axelrod, 572 N.E.2d 605, 608 (N.Y. 1991). Currently, the CDC recommends that HIV/AIDS should be reported. NATIONALLY NOTIFIABLE INFECTIOUS DISEASES, *supra* note 199. Such mandatory testing

V. CONCLUDING THOUGHTS

Today, over 1.2 million individuals in the United States are living with HIV/AIDS,[291] and over 55,000 more join their number each year.[292] These numbers speak for themselves—the current public health response to this controllable disease is insufficient. Something different needs to be done. The public health response to syphilis, spearheaded by Dr. Parran in the 1930s and 1940s, provides a ready example of a public health response to a disease with the same transmission and infection patterns as HIV/AIDS.[293] By modeling the current public health response to HIV/AIDS after the successful response to syphilis, the transmission and new incidences of HIV/AIDS will be reduced to negligible levels.[294]

All three elements of this response—testing, treatment, and education—are equally important.[295] Widespread testing will provide more reliable data on infection rates and tendencies, providing the foundation for better treatment and more effective education.[296] Free treatment for those who test positive for HIV/AIDS is also critical, as this reduces the likelihood of transmission to non-infected third parties and improves the quality and longevity of life for those infected.[297] The final step in this response is a comprehensive education program focused on counseling those who are infected, informing the general public how to avoid contracting and spreading HIV/AIDS, and enlisting the conviction of the medical profession.[298]

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and reporting has a long public-health pedigree, having been implemented by the government in response to diseases such as syphilis, gonorrhea, and canchroid, just to name a few. WING, *supra* note 61, at 310.

291. HIV/AIDS SURVEILLANCE REPORT, *supra* note 9.

292. *Id.*

293. *See supra* Section I.

294. *See supra* Section II.

295. *See supra* notes 26-41 and accompanying text.

296. *See supra* notes 48-51 and accompanying text.

297. *See supra* notes 52-55 and accompanying text.

298. *See supra* notes 56-59 and accompanying text.

While the response proposed in this article may require some slight burdens on individual privacy and autonomy rights, these burdens are legally necessary to reach the greater common good when weighed against the government's compelling interest in protecting the public health from the spread of HIV/AIDS.[299] There is a long history in the United States of government action that incidentally infringes on personal rights in order to benefit the public health.[300] The law, as it currently stands, would support government action to implement the proposals in this article.[301]

As promising as this response may sound, a test-treat-educate approach to HIV/AIDS will offer no better results than any one of the myriad other programs the government has instituted over the years unless all sectors of society join together behind such a response. Policymakers, medical personnel, support staff, bureaucrats, infected populations, and interest groups must all look to the general public health benefits served by this proposal.

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299. *See supra* Section III.C.

300. *See supra* Section III.B.

301. *See supra* Section III.C.