

GOVERNMENT POLICY AND LEGISLATIVE INITIATIVES ON AIDS

Mr Bill Dillon MP

Chairman of the Justice and Law Reform Select Committee

Introduction

I have been invited to discuss the legislative and policy initiatives being taken by the Government to control the spread of HIV infection. Let me begin by providing some background. The first case of AIDS in New Zealand was reported in 1984. Now a total of 126 people with AIDS has been reported. Half of these people are known to have died, most of whom were between the ages of 20 to 50. The tragedy of this epidemic is the loss to society of the talents and energies of people during the most productive phase of their lives. The prevalence of AIDS in New Zealand appears to be similar to the United Kingdom and parts of Australia. Although most people with AIDS in New Zealand at present are gay men, HIV infection has been reported amongst intravenous drug users and heterosexuals. Some transmission of HIV infection via blood transfusion and blood products occurred before blood-donor screening was introduced three and a half years ago. So far, no instances of mothers passing the infection on to their babies has been reported. The full extent of HIV infection in New Zealand, or indeed anywhere in the world, is unknown. There is only limited data from AIDS testing. So far, more than 400 of us have the HIV antibodies. And this number does not include those of us who may be infected, but have not been tested. The spread of AIDS is kept under review by an AIDS Epidemiological Group. This group is supported by the Medical Research Council and the Department of Health and is based at the University of Otago Medical School. In addition to routine surveillance, the group is involved in collaborative studies of HIV infection in New Zealand.

The Government Response

I would now like to focus on the Government's response to the challenge of HIV infection and AIDS in New Zealand. Plagues are not new in human history. We have learned from both our failures and successes. We have failed when we have blamed the spread of past infections on groups such as prostitutes or the poor. Racism, sexism and xenophobia provide no answers. However, a notable success was achieved with our troops fighting in the First World War. The use of physical prophylaxis severely curtailed the spread of venereal disease. Our allies took note and followed suit. Our geographic isolation has also given us some time to gauge the responses of other governments to the problems of AIDS. We have learned from their mistakes. In many other countries, notably in North America and Africa, AIDS

took governments and health care systems by surprise. In New Zealand we have been fortunate in that we had a bit of lead time to plan our response before the first instances of people with AIDS and HIV infection were reported. The Government has responded rapidly, appropriately and with innovation. We have balanced individual rights and liberties with our duty to protect public health.

1 *Blood Screening*

The protection of the blood supply was our first priority. Screening of all donated blood at blood transfusion centres began in October 1985. Donors with HIV infection and those who may have engaged in high risk behaviours have been discouraged from giving blood for several years. Surveys show there has been excellent co-operation from the homosexual community. To date one person has developed AIDS and 13 have developed HIV antibodies as a result of transfusions before the current donor screening programmes were introduced. It is possible that more cases of AIDS may occur among those who received transfusions before the advent of blood donor screening. The Accident Compensation Corporation has awarded compensation to at least six people who acquired HIV from blood transfusions. The claimants were mostly haemophiliacs who received infected blood from Australia before blood screening was introduced. Compensation was paid on the grounds of medical misadventure.

2 *Needle Exchange Scheme*

The Government acted promptly on the advice of the AIDS Advisory Committee, which presented two major reports to the Minister of Health. Its recommendations were:

- to establish AIDS outpatient clinics;
- education/prevention programmes focused on high risk *activities* rather than high risk groups; and
- to introduce a needle exchange scheme.

The Needles and Syringes Exchange Scheme is one example of New Zealand's realistic and innovative approach to curbing the spread of the epidemic. The sharing of HIV-infected needles and syringes is a highly effective means of transmitting the virus. Also, because intravenous drug use is illegal and carries a social stigma, intravenous drug users may not disclose their activities to sexual partners. The risks of intravenous drug users spreading HIV to the wider community via sexual activity or sharing drug-injecting equipment is very significant. With these factors in mind, the Government introduced the Misuse of Drugs Amendment Act which legalised the possession of approved needles and syringes. The Needles and Syringes Exchange Scheme is the first nationwide scheme of its kind in the world. The objectives of the scheme are:

- to provide all intravenous drug users with easy access to suitable needles and syringes at an affordable price;

- To encourage the return of used needles and syringes and to dispose of them safely; and
- To convey basic health messages to intravenous drug users and to direct them to counselling agencies.

Co-operation has been excellent so far, and there are more than 120 outlets in New Zealand where needles and syringes can be exchanged or sold. The scheme is being monitored and evaluated.

Continuing Education to Prevent Further Infection

For the past five years, the Government has spent a lot of money on AIDS prevention and control. The Health Department has conducted a series of multi-media AIDS education campaigns. Also, an extensive support network has been developed at the local level by the Department's health development units, area health boards and other agencies. The campaigns have been aimed at informing us all about AIDS. The goal is to change attitudes, to persuade people to adopt safer sexual practices and to be supportive of those already infected.

1 Education by Non-Government Organisations

The Health Department also provides funding for those people whose *activity* puts them most at risk. It contracts appropriate groups to educate those people to take preventative measures. The New Zealand AIDS Foundation is one of these groups. It is the main non-government organisation involved in AIDS-related activities, particularly for gay and bisexual men. Its broad role includes:

- education for prevention;
- providing anonymous and confidential antibody testing; and
- counselling and support for people with HIV infection and AIDS and those who fear that they are infected.

The Department also funds community-based intravenous drug outreach workers in Auckland, Palmerston North, and Christchurch. Their aim is to advise the intravenous drug using population on ways to reduce the spread of HIV infection, manage their drug use and stay healthy. Examples of other groups funded by the Department include:

- the Te Roopu Tautoko Trust, which employs field workers to help Maori groups with AIDS prevention on request;
- the Haemophilia Society, which receives funding for counselling of those who have become infected with HIV by blood transfusion; and
- and the New Zealand Prostitutes Collective, which is developing AIDS-prevention projects relevant to workers in the sex industry, such as those working in massage parlours.

In addition to the above, the Justice Department has encouraged the introduction of AIDS/HIV education in prisons and the Education Department screens an AIDS awareness video in all secondary schools.

2 National Strategy

We are also working on a comprehensive network of national strategies to prevent and manage HIV infection and AIDS. The Chief Health Officer and the AIDS Task Force focus this network. The Task Force provides the basis for an effective team approach to AIDS/HIV prevention strategies. The AIDS Advisory Committee has been replaced by the National Council on AIDS, a more broadly representative body. This Council is responsible for advising the Minister and the Health Department on the scientific, social, legal and ethical issues involved in HIV and AIDS control. Earlier this week the Council sponsored a national AIDS conference at which the Council presented a discussion document, "The AIDS Epidemic: Toward a New Zealand Strategy".

Submissions from interested groups and individuals are being sought over the next two months. The final strategy is to be presented to the Minister of Health in November.

3 Global Strategy

The Department of Health maintains links with other Government agencies in New Zealand and overseas, particularly the Australian health services and the World Health Organisation. The World Health Organisation Global AIDS Strategy emphasises the need to protect the rights and dignity of HIV-infected persons. It has produced a number of consensus statements on difficult social and ethical issues concerning HIV prevention. New Zealand participates in the Global Programme on AIDS at both international and regional levels. We have sent a number of people with expertise to help countries in the region develop their AIDS programmes. Last year we made a special contribution of half a million dollars to the Global Programme on AIDS in addition to our usual contribution to the World Health Organisation.

Dilemmas

The AIDS epidemic has raised unparalleled legal, medical, social, economic and ethical dilemmas. AIDS has challenged everyone's perceptions of themselves and others, particularly those groups which are stigmatised by society. Some may still regard AIDS as a justifiable outcome of the "immoral" behaviour of homosexual men and intravenous drug users. HIV infection and AIDS in these groups is seen as self-inflicted. By way of contrast, the haemophiliac or child who becomes infected with the virus is viewed as an "innocent victim". We must ensure that discrimination is not tolerated and that individual rights are respected. I will briefly outline this

Government's response to these challenges.

1 *Discrimination*

The enactment of the Homosexual Law Reform Act in 1986 amended the Crimes Act. Sex between consenting men or women in private is no longer an offence provided both parties are aged 16 or older. This Act has made the homosexual community much more open to education efforts to prevent HIV. It has also allowed official agencies like the Health Department to work with organisations based in the homosexual community. However, this amendment does not provide legal protection from discrimination against people infected with HIV. Cases of discrimination are known to occur in employment, housing and access to other goods and services. HIV infected individuals currently lack any legal means of redress. The Human Rights Commission believes that the failure to include discrimination on the grounds of disability is an important deficiency in the present anti-discrimination provisions of the Human Rights Commission Act. The Government is presently considering its response.

2 *Antibody Testing*

Antibody testing is a highly sensitive issue. Diagnostic tests have been made available through laboratories, on request from general practitioners, hospital staff, and venereologists, and through staff at the New Zealand AIDS Foundation clinics, drug clinics and Family Planning Clinics. The Government accepts that the following principles should apply to HIV antibody testing:

- the test should be voluntary and with informed consent;
- pre- and post-test counselling is essential;
- laboratory request forms should be anonymous;
- records should be confidential; and
- the results should be given face to face (not by telephone).

We remain convinced that public education is the only means to limit the spread of HIV. Antibody testing *alone* cannot limit the spread of the infection. Compulsory HIV antibody screening programmes for the general public is vigorously opposed by both this Government and the World Health Organisation. Mass screening is an expensive and ethically chilling option. It accomplishes nothing while diverting resources which could be better spent on education and prevention of the spread of HIV infection. The opinion polls show that the public is quick to call for compulsory screening of sectors of the population which it considers to be at risk. This view does not recognise the implications of compulsory testing. Either way, it will be interesting to observe the Bulgarian government carry out its proposed 8.7 million tests. The fact is that most coercive and restrictive measures have little impact on the spread of HIV. Coercive testing alone will not prevent people from acting inappropriately. We do not want AIDS to become a law and order issue. AIDS is a health issue.

3 *Insurance Companies*

Antibody testing is also an issue for insurance companies. The life insurance industry believes it is obliged to differentiate between groups of risks. This ensures that policy holders who are not at risk do not have to pay unacceptably high premiums and protects insurance funds from financial difficulties. They argue that it is legitimate to try to identify, and if necessary, refuse to insure people at risk of contracting HIV. The New Zealand Life Offices Association has recently issued a voluntary "AIDS Code of Practice" for life insurance. The code emphasises the *activity* and not the sexual orientation, or lifestyle, of a person. The code recommends that applicants whose activities place them at risk of contracting HIV be requested to give informed consent to take an HIV antibody test. Confidentiality of records is also stressed. The Association is prepared to investigate claims of unfair discrimination.

4 *Prisoners*

Antibody testing of specific groups perceived to be highly at risk is an issue which is not easily resolved. Prison inmates provide an illustration. Prevention of the transmission of HIV poses particular challenges to managers of penal institutions. The Government has a three-pronged approach at present:

First, the Health and Justice Departments are conducting a prison survey to obtain basic data on knowledge, attitudes and behaviours which could influence the spread of HIV infection. The results will be used to plan and implement prevention strategies.

Second, special sessions on HIV and AIDS for all prison officers are part of staff education programmes. HIV infection guidelines have been disseminated to each institution along with a very good training video.

Third, inmates are offered health education on a voluntary basis, which includes information about HIV as well as other sexually transmitted diseases and Hepatitis B. Prisoners are informed about the needle exchange scheme which operates outside prisons and the techniques of cleaning drug injecting equipment.

HIV antibody testing is at present available to inmates on a voluntary basis. However, because there is a high turnover of prison inmates and they live in close proximity to intravenous drug users and homosexual activity, the safety of both inmates and staff has to be considered. Therefore, the Justice Department proposes to provide for the testing of inmates whose behaviour is considered to place them at high risk of HIV infection. In the Law Reform (Miscellaneous Provisions) Bill, now before the Justice and Law Reform Select Committee, there is an amendment to the Penal Institutions Act 1954. It provides for a prison medical officer to ensure an inmate undergoes an antibody test where the officer considers it desirable, "having regard to the personal circumstances of the inmate". If the inmate refuses to submit to a test, he or she may be dealt with administratively —

- (a) as if he or she was suffering from AIDS, in any case where, in the opinion of the medical officer, the inmate is displaying symptoms of AIDS; or

(b) as if he or she were carrying HIV antibodies, in any other case.

This amendment does not provide for compulsory testing. An inmate may refuse to undergo blood tests. Furthermore, it is not intended that this power be used for the blanket testing of the inmate population. The Government believes that prisoners should be treated in a manner similar to other members of the community. Prisoners should not be subjected to any discriminatory practice relating to HIV infection and AIDS, such as involuntary testing, segregation and isolation, except where that is required for the prisoner's own wellbeing. It is in the interests of us all that inmates have the right to:

- educational programmes designed to minimize the spread of the disease;
- antibody testing on request;
- health care services; and
- information on treatment programmes.

5 *Contact Tracing*

Other legal and ethical dilemmas include contact tracing and physician-patient confidentiality. Although partner notification has the potential to help prevent HIV transmission, it also has the potential to produce individual and social harm and detract from other AIDS prevention and control activities. Partner notification is acceptable only if:

- the human rights and dignity of the partners and the "index person" are respected;
- partner notification is voluntary, not coercive;
- partner notification is confidential;
- a balanced part of a comprehensive AIDS prevention and control programme;
- undertaken only when appropriate support services are available to index persons and partners.

The Government accepts that tracing should neither be coercive nor statute-based.

6 *Physician-Patient Confidentiality*

The issue of confidentiality between physician and patient is an ethical dilemma which legislation can only imperfectly address. If a person with HIV is unwilling to inform sexual partners of the risk of infection, are doctors free, or required, to inform unsuspecting sexual partners? I believe the following excerpt from *Duncan v Medical Disciplinary Committee* [1986] 1 NZLR 513 provides some guidance to medical practitioners who are faced with this dilemma. Jeffries J said (at 521):

There may be occasions, they are fortunately rare, when a doctor receives information involving a patient that another's life is immediately endangered and urgent action is required. The doctor must then exercise his professional judgment based upon the circumstances, and if he fairly and reasonably believes such a danger exists then he must act unhesitatingly to prevent injury or loss of life even if there is to be a breach in confidentiality.

Conclusion

Education is our best strategy for the prevention of HIV infection. Irrespective of what governments can do, it is up to individuals to change their behaviour, particularly their sexual behaviour. The term "high risk group" is an anachronism. Instead, we are focusing on high risk *activities*. What matters is not what you are — but what you do. We believe that co-operation with the people most affected by the disease is far more effective than ostracising, quarantining or punishing them. Our policies include, rather than exclude, the victims and those at risk. The World Health Organisation has described the AIDS epidemic as a world health problem of extraordinary scale and extreme urgency which represents an unprecedented challenge to the public health services of the world. I have outlined the Government's response to this challenge. We will continue to respond in order to reduce the spread of HIV, the illness and deaths associated with HIV and AIDS, and to provide a supportive social environment for those who are infected.