Legal Issues in Using the Public Health Powers to Protect the Elderly from HIV-AIDS

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Introduction

"VD is for Everyone!" proclaimed a 1960s health education poster. While political sensitives demanded that VD (venereal disease) be replaced by STD (sexually transmitted disease), the lesson still holds: STDs affect every age and class, including the elderly. The stakes are high for the elderly. Medical studies show that HIV progresses faster in the elderly, with a much higher proportion of the elderly dying within a month of diagnosis of AIDS. The stakes are also higher for transmission because they often live in homogenous communities with extensive sexual contact networks that can quickly spread STDs, including HIV, to many people.

The key public health problem is that neither the elderly themselves nor society recognize the magnitude of this risk. Societal stereotypes about sex in the elderly, combined with the mistaken belief that HIV is only a disease of the homosexuals and drug addicts, blind us to the risks of HIV transmission in the elderly. These factors demand that public health authorities be proactive in searching out HIV infections among the elderly and in using all appropriate strategies to prevent and treat infection. This presentation discusses the legal questions raised by the use of public health disease control strategies in elderly populations and the appropriate balancing of individual rights to privacy and autonomy with the community's right to control the spread of a communicable disease.

HIV cases in the Elderly

Public health professionals and lawyers who entered the field to work with HIV/AIDS tend to see HIV as a unique disease, with no useful antecedents to guide legal and public health practice. Those with a longer view of history, usually because they were personally working with STDs

before HIV, see HIV as an STD, sharing the epidemiology of other STDs, and susceptible to control strategies that have proved useful with other STDs and communicable diseases in general. From this perspective, it would be expected that HIV would be a problem for the elderly precisely because they are a microcosm of the larger society in every meaningful way: gay men do not cease being gay because they are older; subject to the depredations of nature, men and women do not quit having sex because they are older; and with diabetes and other conditions, the elderly have more opportunities to share needles than the young, all of which are an opportunity to transmit HIV.

What is different about the elderly is society's perception of them, and their perceptions of themselves. Younger people do not think of the elderly as having sex, being gay, or sharing needles. The elderly know better about their behaviors, what they are blind to is that the STDs that afflict the young are not limited to the young. Not only are the elderly susceptible to the same diseases, often times they are more susceptible because of frail health. The result is that the elderly are a classic hidden population for STDs, especially HIV because it is seen as a disease of gay men and illegal drug users. While it is understandable why the elderly may not be properly informed about STDs and HIV, these misperceptions are shared by their doctors. This exacerbates the problem because if physicians do not look for the STDs and HIV in the elderly, the diseases will not be diagnosed and this will perpetuate the misperception that these are not diseases of the elderly. At least as regards HIV, these misperceptions stem from the early period of the HIV epidemic.

The Evolution of the HIV Epidemic

AIDS is not a disease. The acronym stands for acquired immuno-deficiency syndrome and, like all syndromes, it refers to a collection of symptoms or other conditions that are grouped together for diagnostic and clinical purposes. In 1980, before AIDS was defined, physicians in large cities began to see a collection of unusual diseases and symptoms in a small number of gay men. The only common denominator of these conditions was that they usually only seen in persons with impaired immune systems. Since there was no evidence that these men had been born with weakened immune systems, it was assumed that they had somehow acquired the defect in their immune systems that left them susceptible to these different diseases.

The Centers for Disease Control (CDC) developed a list of conditions and symptoms that were found in these men with this seeming defect in their immune systems. The CDC then requested that all physicians who found patients with some combination of these AIDS-defining conditions report these patients to the CDC. This facilitated the initial case finding that showed that the condition was not a rare epidemiologic accident, but something that affected many people and which seemed to be increasing in frequency. Within a short time it was determined that the common element in these cases must be an infectious agent, and soon after that, the human immunodeficiency virus (HIV) was identified.

The relatively long latency between infection with HIV and the development of symptomatic disease skewed the initial presentation of the disease. The first cases were among gay men, secondary to exposure in the bath houses. Many of these infected men were also blood donors. Soon after the first cases of AIDS were identified in gay men, cases began to appear in persons who had received blood transfusions. Since the elderly received proportionally more transfusions than other populations, the persons older than 50 soon accounted for 10% of the

AIDS cases. While these were assumed to be because of blood transfusions, it is clear that some of the cases were primary homosexual and heterosexual contacts.

As the HIV epidemic has evolved, the percentage of cases due to IV drug use increased, and in the last decade, heterosexual transmission has increased greatly. At this point in time, heterosexual transmission accounts for more than 50% of new cases. Transfusion and blood product related cases decreased to insignificance after the routine testing of blood began in 1985. Most of the remaining cases are related to homosexual activity and drug use, with a small number due to in-utero spread from infected pregnant women to their unborn children. More than 10% of the cases are still in persons older than 50, but these are now due to sexual transmission and to sharing needles, ether secondary to drug abuse or when giving themselves drugs such as insulin. Heterosexual transmission is expected to increase with the spread of the African subtype of HIV, which is easier to spread heterosexually. Since some of these cases are coming across the Mexican border from epidemics in central and south America, this will pose a special risk to the sun belt elderly communities. As discussed later, the U.S. public health reporting system has not properly identified these cases, keeping them hidden from both physicians and their elderly patients.

The Problem of Hidden Cases

With the identification of the causal agent, the term AIDS should have been dropped in favor of HIV infection. It persisted, however, for various political reasons and has caused much confusion in the epidemiologic analysis of HIV infection. Most states never amended their AIDS reporting laws to parallel their other disease reporting laws and require the reporting of newly identified HIV infection. In these states, a person who is tested and found to be HIV

infected will not be reported unless that person also has developed the symptoms that define AIDS. People can be infected with HIV for months to years before developing symptoms that are on the list defining AIDS. This means that the data on HIV transmission and prevalence are estimates based on data about infections that were acquired years earlier, and do not properly reflect current transmission patterns. The result is that the reported data always underestimates the spread of HIV in communities where the spread of HIV is increasing, especially if the increase is from low levels.

The first indication that the problems of the elderly are not properly addressed by existing AIDS and HIV programs is that most of the epidemiology lumps all age groups over 50 together. This can mask the real problems of the elderly because persons in their early 1950s are more likely to be epidemiologically similar to younger populations. The most brutal measure of the problems in the identification of HIV infection and AIDS in the elderly is the mean time between diagnosis and death. HIV is usually a slowly progressive disease. Months to years can elapse between the initial infection and the first complications that would trigger a diagnosis of AIDS. Once the signs of AIDS appear, prompt medical treatment can arrest the disease for years. Thus in a system that effectively identifies HIV infection, the mean time between diagnosis and death will be years. In the elderly, the mean time between diagnosis and death is much shorter than in younger age groups, with 13% of the persons > 50 years old dying within one month of diagnosis, as compared to only 6% of persons < 50 years old. Even this underestimates the magnitude of the problem because many of the elderly die of HIV related illnesses without ever having their condition diagnosed.

One study found that of all the patients over the age of 60 who died in the hospital without either being diagnosed with AIDS or tested for HIV, 5% were infected. This is a startling finding

because these were mostly persons with long histories of medical treatment, both inside and outside the hospital. Their physicians had never thought that they might have HIV, and their death certificates did not indicate that HIV was a factor in their deaths. Had the researchers not gone back and run HIV tests on stored blood from these patients, they would never have been identified as being infected with HIV and would not have been reported as potential AIDS deaths. To the extent that this study is representative of general practices concerning the diagnosis of HIV in the elderly, it indicates that there are substantially more cases of HIV infections and AIDS deaths in the elderly than are indicated by the official reports of AIDS cases.

Missing the Diagnosis

Since recognizing that a person is infected with HIV is the first step in both collecting good data about HIV and in trying to control the spread of the disease, it is important to identify the factors that cause HIV to go unrecognized in the elderly. Ironically, the most important factors are the same ones that allowed AIDS to go undetected in Africa for a decade before being discovered on the streets of American cities: First, a debilitating and ultimately fatal disease can only go undetected in a population where death and disability are common. Second, the disease must blend in with the expected diseases.

Once the symptoms were evident, AIDS was quickly identified in young gay men because they were expected to be healthy. Even a small number of young people afflicted with a debilitating and fatal disease are very obvious. In contrast, the elderly are a population where death is expected and many people are chronically ill, as were the initial victims in Africa. Only careful epidemiology can detect excess deaths in a population with a high background death rate. For

example, one can only judge the severity of a flu epidemic in the United States by retrospectively examining the death rates in the elderly during the period of the epidemic. In a severe epidemic there may be several thousand excess deaths over the winter, but these will be hidden by background death level. Health care practitioners in a given community may not even notice the increase.

The disease must also blend in, if it is to go unnoticed. In this regard, HIV has inherited the mantle of syphilis as the "great pretender." HIV causes illness in two ways. It has a direct effect on the brain, causing a dementia that often occurs before any other signs of illness. Depending on its severity, this can lead to death on occasions. It is a non-specific dementia that is hard to distinguish from other dementias that affect the elderly. Alzheimer's disease is especially hard to distinguish from HIV on pure clinical grounds because it is often a diagnosis of last resort, i.e., it is diagnosed when no other cause can be found. If the health care practitioner is not testing for HIV, then there is no way to determine that the diagnosis of Alzheimer's disease is incorrect.

The second effect of HIV is to impair the infected person's immune system. On its own, this does not produce symptomatic disease. It does prevent the patient from fighting off what are termed opportunistic infections, infections with disease causing organisms that would not be able to infect a person with a normal immune system. The patient is also more susceptible to several types of cancers, and any communicable diseases that normally infect the elderly will be much more severe in HIV infected persons. This is very important because while the underlying cause of death for many elderly is chronic illness such as diabetes, the precipitating cause is often infection. Thus HIV infected patients can look very much like diabetic patients because they both are very susceptible to infections. The same is true of pneumonias in patients with chronic lung disease or congestive heart failure.

The necessary third factor is sociological. Unlike many younger persons who have limited access to health care, most of the elderly are covered by Medicare and have good access to health care. Those without Medicare coverage are likely to be covered by Medicaid. If HIV testing were a routine part of an illness workup in the elderly, there would be few hidden cases of HIV in the elderly because the elderly do seek out medical care on a regular basis. Physicians do not test the elderly for HIV and other STDs because they do not think of the elderly as sexually active or engaging in other high risk behaviors. This is not a new problem. Research reports on STDs in the elderly show that these diseases were under diagnosed well before HIV was a significant issue.

Demographics of the Elderly

It is difficult to determine a historical baseline on the incidence and prevalence of STDs in the elderly. While much as been made of the sexual revolution and its changes on sexual behavior, data on STDs and pregnancies show that sex outside of marriage is a problem as old as mankind. Nonetheless, it is clear that the problem of STDs in the elderly is increasing, as well as the specific problem of HIV. There are three demographic factors that contribute to this increase. First, whatever the problems of the U. S. health care system, it is very good at keeping older people alive and healthier than in the past. The number of elderly people is increasing dramatically and, at any given age, they are healthier. This makes them both more interested in sex and better able to participate in it. There is probably no better index of this than the incredible sales of Viagra.

The second factor is that there remain a lot more elderly women than men, and that death has left many men as well as women without their marriage partners. Divorce has also increased, and

there are and always have been a substantial number of elderly gay men. These play into the third demographic factor, the concentration of the elderly into retirement communities.

The second half of the 20th century has seen an increase in communities that are predominantly or exclusively made up of the elderly. This increases the possible sexual contacts for both heterosexuals and homosexuals. As described in several news stories, many elderly men who are still sexually active and who can drive a car, especially at night, have become condominium Casanovas. These communities also attract prostitutes. Since many prostitutes are infected with HIV and other STDs, they provide an ongoing source of infection into the retirement communities.

The Public Health Police Power

As discussed later, there are three fundamental public health strategies in controlling HIV infection: identifying persons who are infected or at risk of infection; helping those persons get proper medical treatment or education on how to prevent spread; and, in some limited situations, preventing infecting persons from endangering others. These strategies are difficult to implement in any group, but are more difficult in populations where there is limited recognition of the risk of the disease. All these strategies pose a conflict between individual privacy and autonomy and the community interest in controlling the spread of HIV. The legal authority for these actions derives from the state's two fundamental powers to protect health: *parens patria* authority and the police power.

The state may act as *parens patria* - as a parent - to protect an individual because the state believes that it is good public policy to protect the individuals involved. Archetypical *parens patria* laws are those that mandate the proper care of minors. Mental health commitments made

to protect the patient from "harm to self" are *parens patria* actions. As discussed in *Addington*, mental health commitments illustrate the overlap between *parens patria* and the police power:

> "The state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill."

When the state shifts from preventing "harm to self" to preventing "harm to others," it shifts from its *parens patria* authority to the police power. Yet most state actions to protect public health and safety also have a component of the *parens patria* power. As the *Addington* court noted, even the mental patient involuntarily committed for posing a danger to others benefits from the treatment and housing provided. The protection of minors under the *parens patria* authority also has a police power component because it weakens the state to have injured citizens. This tension is evident in the old mayhem laws which forbid self-mutilation, not to protect the individual - *parens patria* - but to protect the state's ability to raise an army - police power.

Public health law has always been seen as an expression of the police power because it is concerned with the protection of the community's health and safety, whether from nuisances or communicable diseases. Public health interventions can infringe both an individual's privacy and autonomy. This was the philosophical issue in *Jacobson*, one of the few pure human disease control cases decided by the United States Supreme Court. (There are a lot of cases involving cows, meat, milk, and other food stuffs because of the tension between allowable public health enforcement and unconstitutional state interference with interstate commerce.) Mr. Jacobson was fined by Massachusetts for not getting his smallpox vaccination. He raised two points on appeal that are at the heart of public health enforcement. First, he argued that he had a

constitutional right to resist any bodily intrusions. Second, he claimed the right to contest the underlying basis of legislature's decision to require smallpox vaccination. The court disposed of his first claim in language that was adopted as the primary support for the restrictions in the *Hendricks* case:

> "[T]he liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly free from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members."

Mr. Jacobson's second point, that he should be able to contest the scientific basis for the smallpox immunization law, is more technical, but potentially more damaging to the exercise of public health authority. Public health interventions are seldom perfectly effective magic bullets with no adverse consequences. The chlorination of public water supplies has prevented untold numbers of deaths from water borne illnesses such as cholera. At the same time, chlorination increases the formation of organo-halogen compounds that are carcinogenic in some circumstances. Mr. Jacobson's claim had some merit: smallpox vaccination at that time posed not insignificant risks. If every person affected by a public health regulation is allowed to contest its validity and the cost-benefit analysis underlying its selection, public health enforcement would be paralyzed. While deference to agency decisionmaking is a key principle in all judicial review of administrative action, it is carried farther in public health jurisprudence than in most areas of administrative law because of the immediacy of the risks of communicable disease and their peculiar power to frighten the public.

The United States Supreme Court relied reaffirmed *Jacobson* by using it as the key precedent in the 1997 case upholding the constitutionality of the Kansas sexual predator law, *Hendricks v.*

Kansas. Mr. Hendricks was a child molester who was about to be released from prison at the completion of his sentence. Under a newly enacted law, the state of Kansas instituted a proceeding to have Mr. Hendricks declared a danger to the community and confined in a secure facility (prison) until such time as this dangerous mental defect was cured. Since it was conceded that there is no widely acknowledged treatment for this disorder, the confinement would likely be for life. After a trial on the issue, the jury found that Mr. Hendricks was a danger to the community and should be confined. The Kansas Supreme Court reversed, finding this proceeding was unconstitutional.

The United States Supreme Court reviewed the decision and reversed, finding that the indefinite detention of sexually dangerous persons to prevent future harm a valid exercise of the police power. This was justified on pure public health grounds, relying on the precedent set in the *Jacobson* case. From the individual rights perspective, *Hendricks* is the worst case scenario: the individual is locked up in a prison psychiatric facility for an indefinite sentence, with little hope cure and thus release. Even the benefit to society is difficult to quantify. While such offenders are highly like to repeat, it is far from a certainty, and it is possible that this tendency could be reduced by community treatment and supervision. While the United States Supreme Court was willing to accept this as constitutional, it was in the context of a proceeding that gave the individual nearly as comprehensive procedural due process as a criminal trial. If such due process were to attach to all public health interventions, then it would be impossible to act against all but the most politically egregious risks.

Most public health interventions are much less restrictive than the sexual predator laws, and many have benefits to the individual. *Addington v. Texas*, a case reviewing the standard of proof for a civil commitment, is more typical. The defendant was unable to care for himself, as well as

posing some threat to others. The United States Supreme Court found that the balance of individual right to autonomy versus societal protection shifted toward society when there was also a benefit to the individual:

> "The heavy standard applied in criminal cases manifests our concern that the risk of error to the individual must be minimized even at the risk that some who are guilty might go free. The full force of that idea does not apply to a civil commitment. It may be true that an erroneous commitment is sometimes as undesirable as an erroneous conviction. However, even though an erroneous confinement should be avoided in the first instance, the layers of professional review and observation of the patient's condition, and the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected. Moreover, it is not true that the release of a genuinely mentally ill person is no worse for the individual than the failure to convict the guilty. One who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma. It cannot be said, therefore, that it is much better for a mentally ill person to "go free" than for a mentally normal person to be committed." (citations omitted)

Thus the *Addington* calculus has three parameters: benefit to society; harm to the individual; and benefit to the individual, even if the individual would prefer to forgo the benefit. Legally robust public health measures should address these three parameters in a way that minimizes harm to the individual while maximizing benefit to both society and the individual. This is very different from a "least restrictive alternative" analysis, which weights harm to the individual more heavily than benefit to either the individual or society.

Applying the Police Power to HIV

The term disease control conjures up visions of pith-helmeted scientists battling disease carrying insects in jungles, or lines of school children getting immunizations that will assure that the

disease under attack will never bother them again. The great popular success in disease control was the eradication of smallpox and the ultimate end of the need for smallpox immunizations. These heroic notions of disease control are very destructive when they carry over to public policy debates about the control of HIV and other STDs. There is no realistic way to eradicate HIV or the other STDs. While bacterial diseases such as syphilis and gonorrhea can be cured in individuals, there is no immunity and the individuals can quickly become reinfected from the huge reservoir in the community. There are treatments that reduce the virulence of HIV and extend the life of HIV-infected persons, but these do not cure the disease and may even facilitate its spread. The best that any public health strategy can do is to reduce the spread of HIV to new victims, reduce the spread of treatment-resistant strains of HIV to those already infected, and help identified infected persons get the most effective treatments possible. Even hepatitis B, the only STD with an effective vaccine that confers long-lasting immunity, is still at epidemic proportions in the U.S. If STD control strategies are measured against the effectiveness of smallpox immunizations or the chlorination of water, they must be seen as lacking. This poses the key legal question: what is the appropriate balancing between individual rights and societal protection against the spread of HIV and other STDs?

Traditional Public Health Measures

The least intrusive public health measures are often those that have the greatest effect. The great reductions in communicable disease mortality in the nineteenth and early twentieth centuries were due to drinking water and food sanitation, including such measures as pasteurization of milk. Further progress was made with immunizations, which, Mr. Jacobson notwithstanding, are minimally intrusive. In HIV control, testing blood in blood banks for HIV and other blood-

borne illnesses has almost completely eliminated transfusion related HIV transmission. Controlling the use and disposal of needles and other sharps, coupled with universal precautions against exposure to blood and bodily fluids has greatly limited the spread of HIV and hepatitis in medical environments. Unfortunately, these are the limits of general precaution solutions in HIV and STD control.

Disease Reporting

The cornerstone of disease control for diseases that are spread from person to person is the identification of infected persons. Such identification is directed at three factors. The first is the prevalence of the disease; the total number of persons infected at a specific point in time. The second is the incidence of the disease; the change in the number of cases over a period of time. The third is the demographics of the disease; who it affects and their social characteristics. The interrelationship of these factors differs greatly, depending on the nature of the disease. For example, measles is a disease with a short lifetime, about two weeks. The prevalence of measles will always be close to its incidence because there are no chronic cases of measles, someone who is sick this month is well next month. Incidence will also fluctuate greatly because the disease is very infectious (easy to catch), leading to spikes of new cases. These cases will be linked in time and will have geographic links so it is easy to identify the index cases – the first cases that triggered the epidemic.

The epidemiology of HIV is very different because the disease has a long lifetime and because, in most circumstances, new infections are not clinically evident until months or years later. The prevalence will be much higher than the incidence, and the incidence will be very difficult to determine without a comprehensive reporting system and societal policy encouraging HIV

testing. In the elderly population, cases are often missed because there is no emphasis on testing or reporting. This increases transmission and results in premature death and unnecessary suffering in the persons who are infected with HIV but not diagnosed and not given proper treatment.

The legal underpinning for disease reporting is strong. The leading United States Supreme Court case is *Whalen v. Roe*, which was a challenge by patients and physicians to a New York law requiring physicians to report prescriptions for certain controlled substances. These reports were done on triplicate prescription forms, with one copy being sent to the state. The state entered the data into computers so it could check on the number of prescriptions written by each physician and the number filled by each patient. The objective was to identify the diversion of the drugs into the illicit market. The patients, and the physicians on their behalf, alleged that the law would violate the patient's right of privacy and would prevent them from receiving proper medical care for fear of being stigmatized by reporting that they were taking controlled substances. The court rejected both of these challenges. After reiterating the state's broad police powers to deal with local health and safety issues, the court noted that:

> "Even without public disclosure, it is, of course, true that private information must be disclosed to the authorized employees of the New York Department of Health. Such disclosures, however, are not significantly different from those that were required under the prior law. Nor are they meaningfully distinguishable from a host of other unpleasant invasions of privacy that are associated with many facets of health care. 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."

With the advent of managed care and the corporate practice of medicine, a patient's right of privacy has been substantially diminished since this 1977 decision. Moreover, the court characterized the triplicate prescription system as an experiment, but found that the state's police powers extended to trying such experiments. Communicable disease reporting is on much firmer footing, having been proven effective for many other diseases, in addition to being shown to be effective for HIV, and having been used for decades.

Case Finding and Intervention

Disease reporting alone provides useful public health information about the spread and nature of diseases. It was only through the systematic reporting of cases and characteristics of the infected persons that AIDS was originally identified and the method of transmission characterized. For some diseases, however, the process does not stop with reporting. The information in the reports is used to contact the infected person. They are offered education about how to avoid spreading the disease, how to best care for themselves, they are referred to medical care and social services if appropriate, and they are asked about who they have been in contact with who has also been exposed to the disease. Contact tracing and subsequent interventions are part of the state's police power. While quarantine is seldom an issue in STD/HIV control, the courts have repeatedly upheld the right of the state to intervene in the control of communicable diseases, even to the point of isolation and quarantine.

The request for information about contacts is always voluntary, there is no penalty for refusing to identify contacts. Coercion is not necessary because most people voluntarily cooperate with disease investigations, and because the nature of communicable diseases, especially STDs, is

that many people are exposed. If one person does not name a contact, the odds are that another person will name the contact. Thus most contacts are identified without forcing anyone to divulge information that they want to keep private. This same respect for privacy is carried over the second phase, contacting the persons who have been named. Public health investigators are trained to never divulge the identity of a person reporting a contact. They tell the person that has been named that they have been exposed to a communicable disease, but not who exposed them or named them as a contact. (The system is not perfect, if the disease is an STD and person named is monogamous, they are going to figure it out.)

Contact tracing is especially important in the elderly because of the rapid progression of the disease and the low probability it will be discovered. While the new antiviral agents can prolong life and improve the quality of life, the disease must be diagnosed and treatment begun before the patient is too debilitated to benefit from the treatment. The sexual patterns of the elderly in retirement communities also demand aggressive contact tracing and intervention. Any STD, including HIV, can spread quickly in a closed community where a core group of sexually active persons, the condominium Casanovas, have sex with many members of the community. Fortunately, HIV is much harder to spread than gonorrhea, so many persons will be identified as contacts before they become infected. For these persons, contact tracing and partner notification becomes a very targeted form of education: it tells the person that they are being exposed to a deadly disease and that they still have time to protect themselves. This will become more critical as the subtype of HIV that is easier to spread heterosexually becomes more widespread, reducing the time to do case finding before the exposed person is infected.

Conclusions

HIV/AIDS in the elderly population is a substantial and growing problem. The medical and sociological nature of the disease in this population make it difficult to detect and hard to manage. The elderly can only be protected against the ravages of HIV by aggressive public health measures, supported by the legal authority of the state. These may interfere with the privacy of some individuals, but the net benefit to the individuals and the community outweighs this individual detriment, making such measures both constitutional and morally inescapable.

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