

policy perspective is that no single facility should be designated as an AIDS detention center. It is often the case that, where society doesn't know what to do with unwanted people, psychiatric hospitals operate as a receptacle of last resort. But mental health professionals have long criticized a social system that used their hospitals not for treatment, but for preventive confinement.<sup>2</sup> If persons with HIV, because of the neurological effects of the virus or otherwise, have distinct psychiatric symptomatology that is capable of treatment or amelioration, then psychiatric hospitals can be the appropriate place. In that case, Dr Smith and Ms Smith's point about special training, program development, and additional resources makes good sense.

Legislation designating an AIDS detention facility would be premature. To date, I am aware of only one case where isolation was used in the United States (a prostitute in Florida), and that was only for a brief period. Apart from Cuba, which has a more widespread system of isolation,<sup>3</sup> I am aware of only one further case, the brief isolation of an AIDS patient with uncontrolled bleeding in England.

The reason there are so few cases is that isolation is usually highly inappropriate, with many questions remaining unanswered. How can we accurately predict future dangerous behavior? Under what conditions should a person be isolated? For how long a period?

The paucity of cases of isolation and the constitutional difficulties in isolating persons suggest that further legislative action in this area is unnecessary.

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1. Gostin LO. The politics of AIDS: compulsory state powers, public health and civil liberties. *Ohio State Law J.* 1989;49:1017-1058.

2. Stone AA. *Law, Psychiatry and Morality: Essays and Analysis.* Washington, DC: American Psychiatric Press Inc; 1984.

3. Bayer R, Heaton C. Controlling AIDS in Cuba: the logic of quarantine. *N Engl J Med.* 1989;320:1022-1024.

### Positive HIV Antibody Test Results After Treatment With Hepatitis B Immune Globulin

*To the Editor.*—The Brief Report entitled "Passive Transfer of HIV [Human Immunodeficiency Virus] Antibody by Hepatitis B Immune Globulin"<sup>1</sup> presents important findings that concern transient positive test results for HIV antibody. I do not understand how the authors claim to "report two cases where true-positive HIV tests were obtained in two newborns after immunization with hepatitis B immune globulin." A "true positive" refers to a positive

laboratory test result that accurately reflects infection in the donor of the test specimen. Case 1, as reported, had transiently positive antibody test results. Follow-up studies on case 2 do not follow the same time sequence as in case 1, and positive viral cultures are not reported for either infant. There is nothing provided in the article on which one could conclude that these infants were infected with HIV. Therefore, by definition, these seem to be false-positive test results.

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1. Schlech WF, Spencer SHS, Cook J, Rozee KR, MacIntosh N. Passive transfer of HIV antibody by hepatitis B immune globulin. *JAMA.* 1989;261:411-413.

*In Reply.*—From the point of view of the clinical epidemiologist, Dr Isaacman is correct that our patients did not have true-positive HIV test results in the absence of documented infection. Viral cultures were not performed on blood samples from the infant, but p24 antigen assays subsequently carried out on all serum samples had negative results. From the point of view of the clinician involved in patient care, all patients with positive results of enzyme immunoassay followed by a positive Western blot for HIV-specific antibodies are considered to be actively infected in the absence of clinical or epidemiologic information to the contrary. Our serum samples met the criteria for probable HIV infection on that basis, particularly because both mothers were in high-risk groups for HIV infection. Therefore, we trust that Dr Isaacman understands from his own practice that until the specific details of the events described in our article were defined, the test results were dealt with as true positives.

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### What Should Be Done About the Uninsured Poor?

*To the Editor.*—Dr Blendon's<sup>1</sup> article entitled "What Should Be Done About the Uninsured Poor?" outlines a proposal to cover the uninsured poor that the author believes would enjoy popular support. Dr Blendon calls for employer-mandated coverage with federal subsidization of the premiums of low-income wage earners and the nonworking poor.

Dr Blendon, however, dismisses another proposal to resolve the problems of the uninsured poor, the establishment of national health insurance. The reasons he gives are that (1) people are not willing to pay the higher taxes that such a program would entail to cover the costs of expanding health benefits coverage to the whole population and (2)

people are not convinced that they personally would benefit from such a universal insurance program, since the majority already have access to health insurance coverage.

In support of the first proposition, Dr Blendon quotes polls that show that while the majority of people are in favor of a tax-funded program for universal health insurance, very few of them are willing to pay the taxes that could make such a program possible. Dr Blendon writes that "when questioned further, however, less than 30% are willing to pay more than \$50 per year in new taxes to see this happen." It is important to clarify, however, that the questioner in this poll asked whether the respondent would be willing to pay more than \$50 a year in higher taxes or increased insurance premiums to cover the cost of health care for those who cannot afford it.<sup>2</sup> The question addresses the issue of compassion and concern for others. But it does not measure the degree that people are willing to support the establishment of a national health insurance program that will respond to the respondent's interests and concerns as well as to the concern of others. If the questioner had asked whether the respondent would be willing to pay more than whatever amount below the current taxes or premiums that people pay to cover the overwhelming majority of benefits for everyone in the country, including the respondents themselves and their families, it is likely that the response would have been quite different. The way a poll taker phrases the question shapes the nature of the answer. The outcome of the poll showing that the majority of people do not want to pay more than \$50 to cover the uninsured does not prove that people are not willing to pay higher taxes to establish a national health insurance program that would guarantee coverage to everyone, including the uninsured.

Polls show that people are concerned about high costs and limited coverage in the health sector. That concern appears even though there is evidence that people overestimate the degree of coverage they have. Thirty-four percent of people are not aware, for example, that current government programs do not cover costs for long-term care. And 54% wrongly assumed that they could pay for such care, not realizing that care in a nursing home can cost \$20 000 to \$30 000 a year, an amount out of reach of the great majority of people.<sup>2</sup> People are indeed concerned about high costs and limited coverage. They would be even more concerned if they knew how limited their coverage is in comparison with the experience of comparable