

# Responding to Racial and Ethnic Disparities in Use of HIV Drugs: Analysis of State Policies

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## SYNOPSIS

**Objectives.** The objectives of this study were to assess racial/ethnic trends in surveillance data in four states—California, New York, Florida and Texas, identify structural barriers to and facilitators of access to HIV pharmaceuticals by individuals in Medicaid and the AIDS Drug Assistance Program (ADAP), and identify treatment education and outreach efforts responding to the needs of ethnic minority HIV patients.

**Methods.** State surveillance and claims data were used to assess trends by race/ethnicity in AIDS cases and mortality as well as participation rates in Medicaid and ADAP. Key informant interviews with state program administrators and local clinic-based benefit eligibility workers were used to identify social and policy barriers to and facilitators of access to HIV drugs and state strategies for overcoming racial/ethnic disparities.

**Results.** Racial/ethnic disparities in the reduction of AIDS-related mortality were identified in three of the four states studied. Policy barriers included Medicaid requirements for legal immigration status and residency, limits on Medicaid eligibility based on disability requirements, and state-imposed income and benefit limits on ADAP. Social barriers to accessing AIDS medications included lack of information, distrust of government, and HIV-related stigma. State strategies for overcoming disparities included contracting with community-based organizations for treatment education and outreach, the use of regional minority coordinators, and public information campaigns.

**Conclusions.** State policies play a significant role in determining access to HIV drugs, and state policies can be used to reduce racial/ethnic disparities in pharmaceutical access. Overall, eliminating racial/ethnic disparities in access to HIV pharmaceuticals appears to be an achievable goal.

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This study was designed to explore why members of racial/ethnic minority groups, particularly African Americans, may not be using HIV/AIDS pharmaceuticals at the same rate as non-Latino whites, and what policy strategies may work to decrease or eliminate such disparities. National data assembled in 1998 (Unpublished data, Office of Science and Epidemiology, Health Resources and Services Administration) indicated that African Americans participated at a lower rate in the AIDS Drug Assistance Program (ADAP) than in other programs for HIV care supported by the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act. This finding led the Congressional Black Caucus to ask why this was the case and what could be done about it.

One potential explanation for the low participation of African Americans in ADAP is the possibility that, as a group, they are more likely than non-Latino whites to meet state income and other eligibility criteria for Medicaid. Being Medicaid-eligible means having health insurance coverage and therefore not meeting the criteria of being uninsured or underinsured required for ADAP enrollment. National-level data on ADAP and Medicaid programs are not sufficient to understand the interaction of eligibility for the two programs because the rules for eligibility and benefits are made at the state level. Therefore, in order to understand under-representation of African Americans in ADAP programs, it was necessary to adopt a case study approach that could analyze the interaction of Medicaid and ADAP programs in sample states.

A review of literature on the effect of race/ethnicity on the use of HIV medication found substantial evidence of racial and ethnic disparities in the use of HIV pharmaceuticals.<sup>1</sup> A study of a nationally representative sample of individuals in HIV care found that African Americans and Latinos, taken together, were less likely to receive protease inhibitors than non-Latino whites, and African Americans were also less likely to have recently been on prophylaxis for HIV-related pneumonia.<sup>2</sup> African Americans and Latinos also reported fewer outpatient medical visits.

We report in this article on the findings of case studies in four states on racial/ethnic access to HIV pharmaceuticals, with a particular emphasis on the two largest publicly supported programs for access to HIV drugs, Medicaid and ADAP. The states—California, Florida, New York, and Texas—have their own distinct policy environments that have played a role in how the programs in each state function and respond to racial/ethnic disparities in HIV care and treatment. These case studies were part of a larger project that also involved an assessment of differential patterns of

program participation by race/ethnicity in Medicaid and ADAP<sup>3</sup> and community perceptions toward HIV testing and care in clinics serving African Americans and Latinos.<sup>4</sup>

The four case studies assessed state policies and how these related to the goal of eliminating racial/ethnic disparities in HIV care. The specific objectives of this study were to: (a) assess racial/ethnic trends in surveillance data in four states; (b) identify structural barriers to and facilitators of access to and utilization of HIV pharmaceuticals by individuals in publicly supported programs; and (c) identify treatment education and outreach efforts responding to the needs of racial/ethnic minority HIV patients.

### Funding for HIV drugs

Medicaid, a health care and long-term care program funded jointly by federal and state governments, is the single largest source of financing for HIV/AIDS care in the U.S.<sup>5</sup> Among people living with AIDS, Medicaid covered 55% of adults (more than 160,000) and 90% of children (more than 3,000) in 1999.<sup>6</sup> Among adults living with HIV in 1998, 29% were estimated to be receiving regular care through Medicaid.<sup>7</sup> Each state operates its own Medicaid program within broad federal guidelines. The resulting variations across states in part determine access to HIV care.

The Ryan White CARE Act was designed to provide access to HIV care and support services for people living with HIV who are uninsured or underinsured. One of the primary benefits of this program is access to prescription drugs through ADAP. This drug access program is financed by the federal government through annual Congressional appropriations, and is often augmented by state and local governments. Again, each state operates its own program and variations across states in part determine access to HIV pharmaceuticals.

### METHODS

The four states—California, Florida, New York, and Texas—were selected because they had the largest AIDS case populations, including 57% of the nation's ADAP participants,<sup>8</sup> and because they represented diverse parts of the country with distinctly different policy environments. Each state also had extensive surveillance and claims data helpful to this policy analysis. The state health departments in each of the four states agreed to participate and provide requested data.

The approach used to understand state policy environments involved triangulation: looking at the same state policies from three different sources of informa-

tion.<sup>9</sup> Data sources included: (a) surveillance and claims data provided by states to quantify trends; (b) key informant interviews with state health program administrators to assess the views of those running CARE and ADAP programs; and (c) key informant interviews with local clinic-based benefit eligibility workers to get the views of those assisting clients in enrolling in programs. This approach allowed the research team to develop an understanding of how state policies related to racial/ethnic disparities.

#### **Surveillance and claims data**

The state health department in each state was asked to provide race/ethnicity data for diagnosed AIDS cases and deaths by year. Enrollment of HIV-infected individuals in Medicaid and ADAP was derived from claims data.<sup>3</sup> In addition, the states' comprehensive HIV services plans (required for funding under the Ryan White CARE program) were obtained from each state health department and reviewed to obtain descriptions of specific programs and their characteristics.

#### **Interviews with state administrators**

We conducted a total of 16 key informant interviews, four in each state, with state program administrators. First, the AIDS Director for each state was contacted by telephone. Each director provided the names of three other key administrators in the state, including the director of state AIDS health care services, the state ADAP director, and the person identified by other informants as the administrator most knowledgeable about the coverage of HIV care in the state's Medicaid program.

#### **Interviews with eligibility workers**

We conducted a total of 16 key informant interviews, four in each state, with eligibility workers. Administrators of clinics serving predominantly African American or Latino HIV patients were contacted and asked to identify two staff members who assisted people with HIV/AIDS in gaining access to HIV-related benefits via ADAP or Medicaid. Two eligibility workers from each clinic were contacted by telephone and asked to participate in the study.

Neither the state administrators nor the eligibility workers were reimbursed for these interviews. We obtained written informed consent for all interviews. Respondents were given the option of providing comments "on the record," which would allow us to quote them directly, or "off the record." Interviews lasted from 40 to 65 minutes. Interviews with the state administrators were conducted by telephone by two members of the research team; one person conducted the

interview and a second person took detailed notes. Notes from the interviewer and note taker were combined into an interview report for each state administrator. For purposes of consistency, the same procedures and interview guide were used for eligibility worker interviews, except these telephone interviews involved only one set of notes, taken by the interviewer.

Respondents were asked to describe their perspective of HIV/AIDS care in their states with the following open-ended questions: What is the current standard of care? How would you describe access to HIV care? To what extent do people who would be eligible for programs actually use them? What are the greatest barriers to getting HIV pharmaceuticals? What factors facilitate getting HIV drugs? What has the state done to increase access and utilization for racial/ethnic minorities? What is the most important thing the state could do?

#### **Analysis**

We used existing AIDS surveillance data in each state and developed a consistent framework for looking at racial/ethnic trends in the epidemic across these states. To assess racial/ethnic representation in the epidemic, we compared the racial/ethnic distribution of people living with AIDS in the state to the racial/ethnic distribution of the state population. To assess trends over time, we looked at the percentage of new AIDS cases diagnosed by race/ethnicity in 1990, 1994, and 1998 in each of the four states. We used surveillance data on AIDS-related deaths in each state to assess reduction in mortality by race/ethnicity from 1996 to 1998. We also used state Medicaid and ADAP claims data to assess enrollment in Medicaid and ADAP by race/ethnicity.<sup>3</sup>

Key informant interviews with state program administrators and eligibility workers were summarized as interview reports. Two independent reviewers coded the themes in the interview summaries, and differences in coding were resolved through discussion. A theme was coded as a "barrier" if it described decreasing either access to or utilization of HIV drugs. Conversely, a theme was coded as a "facilitator" if it described increasing access or utilization. Then these barriers and facilitators were further coded as "policy" if they involved a state rule, regulation, program, or resource allocation decision (e.g., income eligibility, requirements for co-payments for drugs). Other responses were coded broadly as "social" if they involved community or individual perception (e.g., distrust of government or medicine, or characteristics of individuals or communities, such as high levels of substance abuse). Descriptions of strategies for overcoming dis-

parities were identified from each interview summary and listed.

**RESULTS**

**Racial/ethnic representation in the epidemic**

In each state, African Americans represented a higher proportion of people living with AIDS than their proportion in the overall population: California (19% vs. 7%), Florida (46% vs. 15%), New York (42% vs. 18%), and Texas (33% vs. 11%). Latino representation in the epidemic differed from state to state; the proportion of people with AIDS who were Latino was higher than the proportion of Latinos in the population in New York State (30% vs. 15%). They were roughly proportionate in California (30% vs. 29%) and Florida (17% vs. 14%), while in Texas the proportion of Latinos among people with AIDS was lower than among the general population (21% vs. 31%).

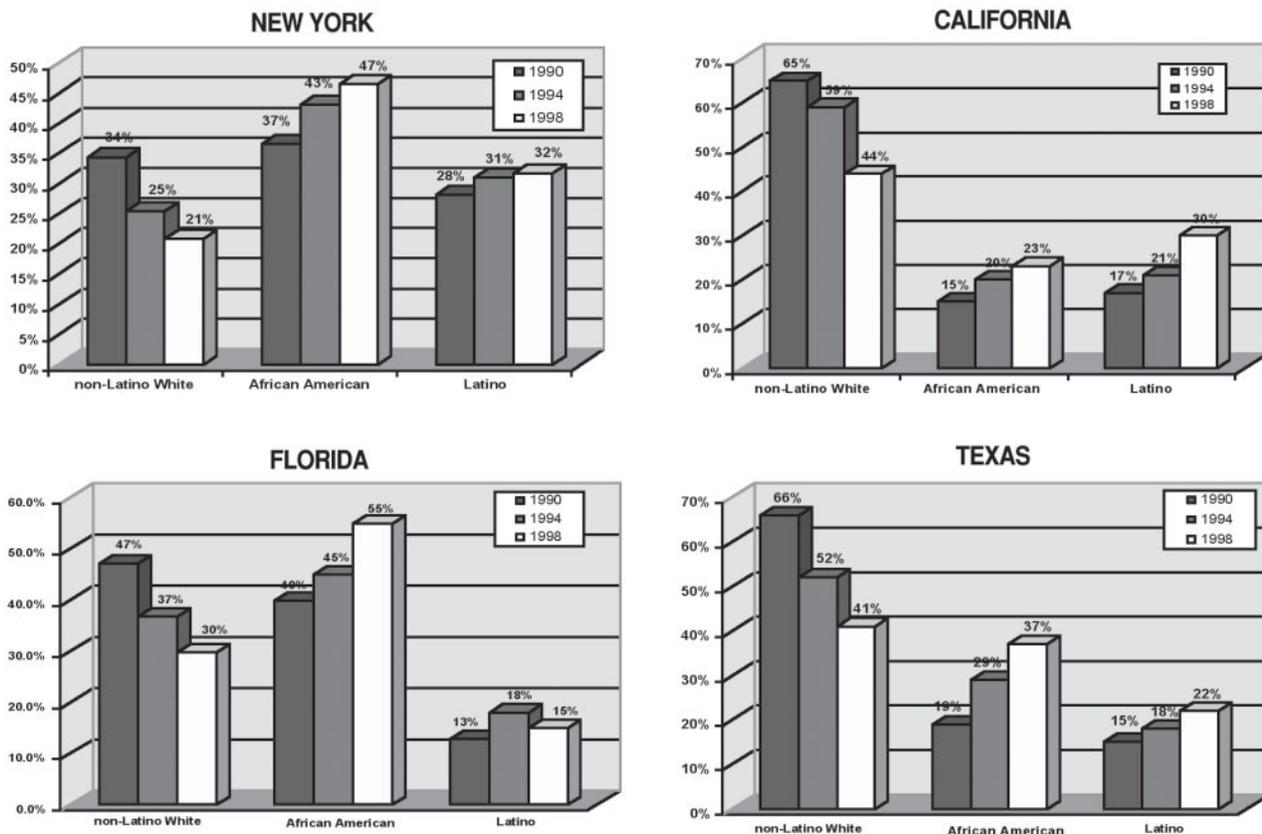
Non-Latino whites accounted for the largest number of cases, although the percentage of the epidemic they represented in 1998 was slightly less than their

proportion of the state’s population in two states: California (44% vs. 51%) and Texas (46% vs. 55%). The numbers and proportion of non-Latino whites with AIDS were much lower than the proportion of non-Latino whites in the population in New York (24% vs. 65%) and Florida (37% vs. 63%). Asian/Pacific Islanders represented a relatively small part of the epidemic and the state populations in states other than California, where representation of this group in the epidemic was much lower than its proportion of the population (2% vs. 11%). Native Americans represented less than 1% of the AIDS population and overall population in each state.

**Racial/ethnic trend data**

Trends over time in diagnosed AIDS cases document a shift toward an increased proportion of African American cases (Figure). This trend in all four states is consistent with national data<sup>10</sup> suggesting a decline in non-Latino white cases and a corresponding increase in African American cases over the decade. A trend toward increased representation among AIDS cases for

**Figure. Percentage of new AIDS diagnoses by race/ethnicity—1990, 1994, 1998**



Latinos was found in California and Texas, but not in New York or Florida.

#### **Racial/ethnic differences in reduced mortality**

We found a 64% reduction in adult AIDS deaths from 1996 to 1998 in California, evenly distributed across the three major groups: African American (63%), Latino (62%), and non-Latino white (65%). In New York, we found a similar reduction in deaths (61%) in the same time frame, but with differences across the racial/ethnic groups: African American (57%), Latino (59%), and non-Latino white (71%). In Florida, we found a lower overall reduction in deaths (54%) and less reduction among African Americans: African American (51%), Latino (61%), and non-Latino white (60%). In Texas, we found the lowest overall reduction in deaths (52%) of the four states, and some differences across groups: African American (48%), Latino (49%), and non-Latino white (57%).

#### **State policy differences**

A summary of the number of people living with AIDS and enrollment figures for HIV-related care under Medicaid and ADAP across the four states as well as a comparison of policies for eligibility, pharmaceuticals covered, and distribution arrangements are presented in Table 1.

At the end of 1998, New York reported 46,792 people living with AIDS and a combined estimate of 65,662 individuals covered in the two major programs, or about 40% more people having coverage (e.g., for HIV pharmaceuticals) than people living with AIDS. California reported 39,894 people living with AIDS and 42,709 enrolled in the public programs, or about 7% more people being covered than living with AIDS. Florida does not have reliable numbers for ADAP enrollees in the state because there were several mini-ADAP programs operating separately from the state-wide program. Texas reported 20,870 people living with AIDS and 14,284 in the two major public programs, or 68% of the reported number of people living with AIDS. Thus, differences across states in the extent to which individuals were covered by publicly supported programs were quite dramatic.

The role of the Medicaid program varied extensively across the states as well. In New York, 79% of the combined total number of individuals in publicly supported programs were covered by Medicaid, compared to 58% in California and 40% in Texas. While the income requirements are the same across the states, New York does not require that individuals meet a federal categorical eligibility requirement such as medical disability under the Supplemental Security Income

program or qualifying for Temporary Assistance for Needy Families (welfare).

Table 1 illustrates both the policy differences across states and the dynamic interaction between Medicaid and ADAP programs. While New York invests heavily in Medicaid, California invests heavily in ADAP, spending nearly \$42 million in state discretionary funds (compared to \$6 million in New York). Differences across the states in ADAP policies are also striking in terms of income requirements, ranging from \$16,500 (for single person households with no co-payments) to \$44,000; number of drugs covered, ranging from 32 to over 400; and number of participating pharmacies, from fewer than 250 to nearly 3,000.

#### **Social and policy barriers and facilitators**

Key informant interviews with state administrators and clinic eligibility workers identified a range of social and policy barriers and facilitators to access to HIV drugs (Table 2).

Even in policy environments most favorable to those identified as HIV-positive, significant social barriers to utilization of HIV pharmaceuticals were found across the states. The social barriers that were identified, particularly for African Americans and Latinos, included: lack of information, misinformation, lack of knowledge about HIV status, immigration, migration, denial, distrust of government, and intense HIV-related stigma. As with the differences in the epidemic profiles, these findings provide justification for racial/ethnic-specific responses. Social facilitators identified were bilingual and culturally appropriate services, dedication and commitment of providers in clinics, and having a vocal community of people living with HIV.

#### **Policy barriers and facilitators identified**

Respondents identified numerous policy barriers and facilitators to access to HIV drugs. Whether a particular policy was described as a barrier or facilitator depended on the respondent's perception of the adequacy of program coverage, eligibility requirements, number of drugs covered, and responsiveness of delivery systems. Some policies identified were state-specific. Policy barriers and facilitators in each state are described below.

*California.* Barriers identified were again mainly social rather than policy-related. California Medicaid requires federal categorical eligibility (i.e., disability). Facilitators of access were identified as extensive state ADAP funding (\$81 million federal; \$42 million state in 1999), generous financial eligibility (share of costs up to \$50,000/year), extensive drug coverage (144 drugs),

**Table 1. Comparison of state epidemiology, enrollment in publicly supported HIV drug access programs, and related policies**

	California	Florida	New York	Texas
Epidemiology/program participation 1998				
Number of people living with AIDS (through December 1998) <sup>10</sup>	39,894	30,815	46,792	20,870
Number of HIV-related Medicaid recipients 1998	24,688	20,343	51,617	5,741
Number of ADAP recipients 1998	18,021	8,517 <sup>a</sup>	14,045	8,543
<i>Medicaid eligibility/coverage 1999</i>				
Medicaid categorical eligibility	Disabled, on welfare, or other federal categorical requirements	Disabled, on welfare, or other federal categorical requirements	No categorical requirements	Disabled, on welfare, or other federal categorical requirements
Federal Poverty Level (FPL) <sup>b</sup> requirements <sup>11</sup>	Below 75% (\$6,180)	Below 75% (\$6,180)	Below 75% (\$6,180)	Below 75% (\$6,180)
Number of Medicaid drugs covered	All approved HIV drugs	Limited to 4 name brand drugs per month (excluding ARTs); unlimited generic drugs	All approved HIV drugs	Limited to a total of 3 drugs per month
ADAP eligibility/coverage <sup>12</sup> 1999 <sup>c</sup>				
State funding	\$41,972,700	\$7,997,325	\$6,003,041	\$13,813,363
Federal funding	\$81,476,419	\$53,520,561	\$114,057,774	\$39,314,956
Income requirements	Below 400% of FPL (\$32,960) <sup>d</sup>	Below 300% of FPL (\$24,720)	Below \$44,000	Below 200% of FPL (\$16,480)
Number of drugs covered	110 drugs	26 drugs	395 drugs	19 drugs
Number of participating pharmacies	2,400 pharmacies or by mail order	Statewide numbers not available	Approximately 2,900	244 pharmacies

<sup>a</sup>Florida also has local mini-ADAPs, which are not included in the statewide number.

<sup>b</sup>Federal Poverty Level in 1999 was \$8,240 per year for individuals.

<sup>c</sup>Interviews with administrators took place in 2000; numbers in the text will be different from those for 1999 in Table 1.

<sup>d</sup>California ADAP provides a share of cost up to income of \$50,000.

and nine emergency assistance grants to cities in the state providing extensive health and social support services. According to informants, the recent centralization of ADAP in California removed a significant barrier to access to HIV drugs. Alameda County, which includes the city of Oakland, previously had only two participating pharmacies and limited sites for ADAP

enrollment. Rural areas of the state had reported similar problems. In response, the state centralized the system so that ADAP patients could pick up drugs at more than 2,400 participating pharmacies—or by next-day home delivery—and could enroll at more than 200 sites in the state.

**Table 2. Identified policy and social facilitators and barriers**

<i>Policy facilitators</i>	<i>Policy barriers</i>	<i>Social facilitators</i>	<i>Social barriers</i>
<ul style="list-style-type: none"> <li>• Adequate federal and state funding</li> <li>• Availability of support services</li> <li>• Availability of specialty care</li> <li>• Extensive HIV pharmaceutical coverage</li> <li>• No caps on number of drugs covered</li> <li>• Presence of Title I funding</li> <li>• Establishing an extensive network of pharmacies</li> <li>• Mail order and home delivery option</li> <li>• State-based early intervention programs</li> <li>• Standards of care and quality assurance mechanisms</li> <li>• Standards for treatment readiness</li> <li>• Designation for HIV specialty care with enhanced Medicaid reimbursement</li> <li>• Programs to provide primary care for ADAP enrollees</li> <li>• Outreach and treatment education programs</li> <li>• Generous financial eligibility criteria</li> <li>• Ease of application</li> <li>• "Know Your Status" campaigns</li> <li>• Community involvement in planning</li> <li>• Provider education and training</li> <li>• Case management services under Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• Proof of residence requirements</li> <li>• Restrictive income eligibility</li> <li>• Disability requirement for Medicaid</li> <li>• Limited ADAP formulary</li> <li>• Co-payments for each ADAP drug</li> <li>• Centralized drug disbursement resulting in delays in patients' receiving of medication</li> <li>• Limited number of participating pharmacies</li> <li>• Limits on the number of drugs covered per month</li> <li>• Legal immigration documentation requirements</li> <li>• Lack of outreach programs for racial/ethnic minorities</li> <li>• HIV name reporting requirements</li> <li>• Cumbersome application process</li> <li>• Lack of training for benefit counselors and social workers</li> <li>• Limited number of ADAP enrollment sites</li> <li>• Low Medicaid reimbursement rate</li> <li>• Not always seeing the same doctor</li> <li>• Lack of reimbursement for case management for adherence</li> <li>• Lack of statewide uniformity of coverage</li> <li>• Lack of linkage between primary care and community-based organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Having a vocal community living with HIV</li> <li>• Bilingual services</li> <li>• Culturally appropriate services</li> <li>• Dedication and commitment of providers and clinics</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of information and misinformation</li> <li>• People don't know status</li> <li>• Denial</li> <li>• Cultural beliefs</li> <li>• Language other than English</li> <li>• Lack of literacy and limited education</li> <li>• Distrust of the system</li> <li>• Rural access to HIV specialty care</li> <li>• Transportation problems</li> <li>• Lack of family and community support</li> <li>• HIV-related stigma</li> <li>• Poverty, homelessness, and other survival priority issues</li> <li>• Histories of incarceration</li> <li>• Physicians hesitant to take on HIV patients for fear of what it would do to their practice</li> <li>• Drug addiction</li> <li>• Mental illness</li> </ul>

*Florida.* Geographic disparities, in particular, rural access, emerged as a strong theme in Florida. Because of past funding shortfalls, six directly funded metropolitan areas in Florida had developed their own "mini-

ADAP" programs. These mini-ADAPs continued to operate and provided a larger formulary of drugs than the statewide ADAP. Thus, some administrators were concerned about potential geographic disparities in

access to HIV pharmaceuticals. Facilitators identified included the Disease Management Initiative under Medicaid, which provided extensive case management to patients in HIV care. As of 2000, informants perceived access to ADAP to be extensive. Previously, the state had problems with waiting lists, restrictive eligibility criteria, and a limited formulary. However, in 2000, there were no waiting lists. The eligibility criteria were changed in April 2000 from 300% to 350% of the federal poverty level; thus, individuals could earn nearly \$30,000 per year and still be eligible for the program. In January 2000, 20 drugs were added to the formulary, bringing the total to 54 drugs.

*New York.* Barriers to access to HIV pharmaceuticals identified were again more social than policy-related. Two exceptions were Medicaid requirements for legal immigration status and residency, and a requirement that Medicaid applications go through a county welfare office. Medicaid policies identified as facilitators included the lack of a categorical eligibility requirement, enhanced payments for AIDS specialty care, and the development of 33 AIDS Specialty Care Centers. ADAP facilitators identified were generous financial eligibility criteria (income of up to \$44,000/year), extensive drug coverage (over 400 drugs), extensive network of participating pharmacies, and the ADAP Plus program, which provides primary HIV care to uninsured individuals who are eligible for the drug reimbursement coverage.

*Texas.* Policy barriers were more extensive in Texas than those identified in other states. With regard to Medicaid, in addition to all of the barriers identified in California and Florida, Texas Medicaid limited beneficiaries to three drugs per month. Informants indicated that this limit created difficulties for patients with HIV, particularly if they had other medical conditions. Barriers to access were also cited for ADAP, and included limited financial eligibility (maximum income of \$16,700/year), a limited number of drugs covered (32 drugs), a \$5 co-payment required per prescription, and delays in receiving drugs. ADAP medications had to be ordered centrally by fax from a wholesaler. They were then shipped within 48 hours to one of 244 participating pharmacies throughout the state. The turnaround time for receiving the medications was between 7 and 10 days, which could cause breaks in therapy for some patients. Informants also reported that the lack of a nearby pharmacy created barriers for those who would have to travel long distances to pick up medications. Specialty care providers in rural areas were reported to be very limited.

### **Treatment education and outreach**

Several states have expanded their outreach efforts to racial/ethnic minority communities. Beginning in 1995, New York expanded funding for racially and culturally specific treatment, education, and outreach programs through community-based organizations. It was thought that these organizations play an important role in dispelling misinformation within their communities. Today, policy makers believe that those programs have been successful in reducing distrust, thereby increasing access to and utilization of care programs.

California has funded local jurisdictions to conduct culturally appropriate outreach to African Americans. For example, the state has funded and will evaluate an outreach project in South Central Los Angeles. Florida has also initiated a significant minority outreach program, targeting African American communities in particular. Activities include outreach at historically black colleges' and universities' football games, weekend beach events, and youth events. In Texas, informants reported that the state had instituted outreach efforts targeting racial and ethnic minority communities.

States used several other approaches to increase minority access to care. California is funding ongoing training for benefits counselors to increase the availability of accurate and current information. The California Office of AIDS has also established an African American advisory body to help shape a response. In 1999, the Florida legislature established a task force to promote HIV treatment and prevention in racial and ethnic minority communities. Florida has developed a system that includes seven regional minority coordinators whose job is to increase racial/ethnic minority participation in HIV care. At the time of this study, health department representatives in Texas attended conferences focused on African Americans and Hispanics, and were planning a mailing to 19,000 physicians across Texas.

We found that communication between community-based providers and state policy makers is important to reducing policy barriers. In California, communication between key stakeholders and state policy makers led to important policy changes. Advocates for African Americans in urban settings and for patients in rural settings defined access problems that were important in developing a policy response that resulted in a mail order pharmacy system for ADAP that increased access to HIV pharmaceuticals. In New York, the development of contracts with community-based organizations for treatment education and outreach grew out of a similar feedback process. These examples emphasize the importance of developing mechanisms for

communication between policy makers and representatives of racial/ethnic minority communities.

## DISCUSSION

African Americans represented a higher proportion of AIDS cases than their representation in the population in all four states studied. Trend data in each state also demonstrated an increase in the proportion of African American cases over the last decade. In three of the four states, the decline in mortality was less for African Americans than for non-Latino whites. Two of the four states demonstrated a trend toward an increased proportion of AIDS cases among Latinos, and in two states the decline in mortality was less for Latinos than for non-Latino whites. These findings provide justification for a strong public health response to racial/ethnic disparities.

The social barriers identified were often associated with specific racial/ethnic groups. For example, in African American communities, there may be relatively high rates of distrust of government and traditional medicine, lack of information or active misinformation, and intense HIV-related stigma. In Latino communities, distrust of government, immigration and migration issues, as well as a tendency to not discuss disease in general, and HIV in particular, were identified as important social barriers to access. Social barriers identified in both of these groups could interfere with utilization of public programs for which individuals may be eligible.

Each of the four states identified racial/ethnic disparities as an important public health issue, and each had developed strategies for responding to this challenge. Each state had HIV care information prepared for different racial/ethnic groups, and each had some form of social marketing of HIV testing and care using minority media. Each was also attempting to work with providers to respond to these concerns. Other promising approaches included outreach at community events, use of regional minority coordinators, and contracts with community-based groups to provide treatment education and outreach. In the article by T. Anne Richards et al. in this issue of *Public Health Reports*, we discuss individual-level and clinic-level strategies for overcoming some of the challenges to full participation in health care.<sup>4</sup> These strategies should be carefully evaluated, and the most promising approaches encouraged in other states.

Access to HIV pharmaceuticals depends greatly on the state in which an individual lives. Programmatic structures in the major publicly funded HIV care programs (eligibility criteria, number of drugs covered,

and delivery systems) can reduce disparities. This works in two ways: First, removing barriers to access for low-income people has a disproportionate effect on members of racial/ethnic minority groups who are more likely to be poor and dependent on publicly supported programs. Second, it appears that states focus more attention on racial/ethnic-specific treatment education and outreach strategies once some of the structural access problems have been resolved. It is clearly more difficult to do outreach when there are significant policy barriers to enrolling and participating in a program.

This policy analysis is limited by the constraints of the case study approach. It focused on the four largest states, and thus does not speak to the AIDS response in states with fewer AIDS cases. Second, because we used key informant interviews as a primary data source, we have largely assessed individuals' perceptions at one point in time; we realize that policy environments change with time. Third, while states are often referred to as the laboratories for policy development, there are limits to generalizing from what works in one state to what will work in another. Fourth, we were unable to clearly establish causal relationships between state policies and racial/ethnic disparities in health outcomes such as mortality. Finally, while we have identified some potential strategies for overcoming racial/ethnic disparities, a systematic evaluation of these approaches would be needed to reach any conclusions about program effectiveness.

Eliminating racial/ethnic disparities in health outcomes for people with HIV/AIDS is a top priority for the federal health agencies. A strength of this case study approach is that we have been able to identify some state-based strategies to reduce or eliminate racial disparities in HIV/AIDS care and health outcomes. The policy informant interviews suggest considerable optimism that racial/ethnic disparities can be overcome with focused attention, leadership, dedicated and increased resources, expanded use of community health centers and minority providers, investment in training more minority providers, and carefully evaluated strategies for treatment education and outreach. Overall, it appears that eliminating racial/ethnic disparities in access to HIV pharmaceuticals is an achievable goal.

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