The Ongoing Widespan Inequalities in Healthcare and between Racial Groups

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As of 2017, thanks to the Affordable Care Act (ACA) of 2010, uninsured Americans have gone down from 50 million to 27 million. However, there continue to be significant disparities in health care access, affordability, and quality of care. The decades-old wealth inequality between racial and ethnic groups dating back to slavery and severe racial segregation has only worsened these disparities (Dickman et al., 2017, 1431). A striking area of wealth inequality's effect on health is the life expectancy gap between the rich and poor. Currently, “the difference between the richest and poorest 1% [is] now standing at 10.1 years for women and 14.6 years for men” (Dickman et al., 2017, 1431). To begin to understand the causes of this vast gap, in their article, *Inequality and the health-care system in the USA,* Samuel L Dickman, David U Himmelstein, and Steffie Woolhandler explore the issues of access to care, the usage of cost-sharing/private insurance in the U.S., geographic accessibility issues, quality of care issues, and financial hardships due to medical bills.

The Affordable Care Act provided a massive expansion of the public insurance program Medicaid, promising to cover millions of previously uninsured. While this seemed promising at the time, numerous issues remain. In 2012 the Supreme Court ruled that states could opt out of Medicaid expansion in their state, resulting in, as of 2016, 19 states opting out. Resulting in 5 million Americans being cut out of receiving health insurance. The ACA also specifically excluded 5-6 million undocumented immigrants from insurance in its coverage expansion (Dickman et al., 2017, 1433).

Uninsured individuals “are far more likely than the insured to forgo needed medical visits, tests, treatments, and medications because of cost” (Dickman et al., 2017, 1432). These cost barriers are particularly unfortunate for individuals with chronic conditions and psychiatric disorders. This likely makes life expectancy worse by default. Even for those insured under Medicaid, there is continuous difficulty getting the care they need. This difficulty is because Medicaid pays only low fees to physicians resulting in physicians turning Medicaid patients away. In a nationwide study conducted, 76% of orthopaedist offices turned away Medicaid-insured children with a fracture versus only 18% of privately insured children were turned away (Dickman et al., 2017, 1433).

Even individuals under private insurance find medical care access challenging at times. This difficulty in access is because of a significant rise in copays, and since 2006 annual deductibles being 2.5 times higher. Over the years, private plans have restricted patients' choice of providers to a narrow network of hospitals and doctors. This often excludes academic and cancer referral centers leaving individuals with the option of either lower-quality care or more specialized care at academic or cancer centers financed entirely by themselves (Dickman et al., 2017, 1433). Currently, medical bills have become collection agencies' most significant business. 530,000 people declare medical bankruptcy every year as they simply can not pay the high out-of-pocket fees or unexpected high copays (Amadeo, 2022). Additionally, among children and over 65-year-old patients, caregivers have had to borrow money or cut back on other necessities to pay for high medical costs.

Another significant issue is continuing issues of having access to care simply due to geographical location, as providers tend to be in affluent suburbs and cities mostly. At the moment, many Americans living in rural areas or the South have had issues finding care. This challenge of finding care is prevalent in the mental health field, where currently "jail remains the largest so-called inpatient mental health facilities in the USA" (Dickman et al., 2017, 1434).

It is agreed upon that poverty itself causes ill health; however, despite this, there continues to be worse care provided to low-income individuals in comparison to higher-income individuals. While it is hard to fully measure the quality of care in every area of medicine, in a classic study done in 1984, uninsured patients were at a much higher risk of receiving substandard medical care. Unfortunately, studies examining surgical quality and safety between different income groups were inconclusive. Still, it is essential to note that risk-adjusted outcomes appear worse for poor patients across various surgical procedures. These risks can be seen when looking at the administration of drugs, screenings, and vaccinations. Where "27% of low-income Medicare beneficiaries with dementia, hip or pelvic fracture, or chronic renal failure received contraindicated medications compared with 16% of higher-income individuals. Poor Americans over 50 years are also far less likely than their affluent counterparts to

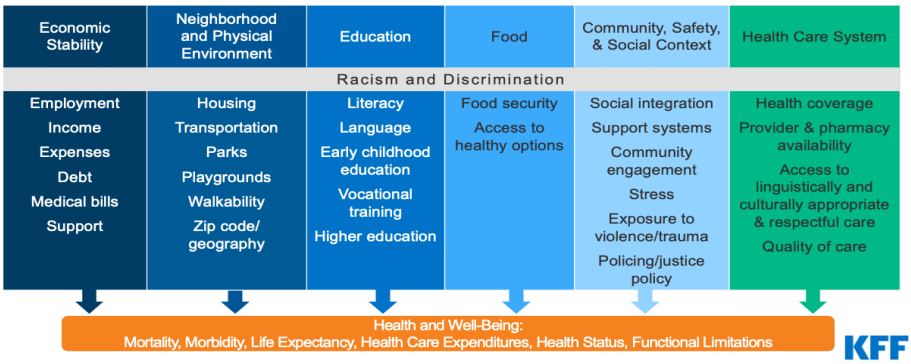
receive recommended influenza and pneumonia vaccinations, and cancer screening tests" (Dickman et al., 2017, 1435).

Finally, the last major issue addressed in the article was financial hardship brought on by medical bills. In 2015 alone, one in four elderly adults under 65 reported having difficulty paying medical bills. From these individuals, more than half owed more than $2500. At the moment, "34% of uninsured Americans with difficulty paying medical bills were unable to pay for food, heat, or housing, 15% took out high-interest payday loans, and 42% took on extra jobs or worked additional hours" (Dickman et al., 2017,1437). Not only is this sacrificing of other essentials and piling on sleep deprivation to work more hours bound to result in worse health, but it also results in individuals delaying medical care or skipping out entirely on care (Dickman et al., 2017, 1437). This is only bound to increase downstream health problems and only raise the costs put on these individuals.

A second article from the Kaiser Family Foundation tries to address the effect of racism and Covid-19 on health disparities between racial groups. First off, the authors attempt to represent the vast array of factors affecting health disparities by providing this first figure below [1].

Figure 1

Health Disparities are Driven by Social and Economic Inequities



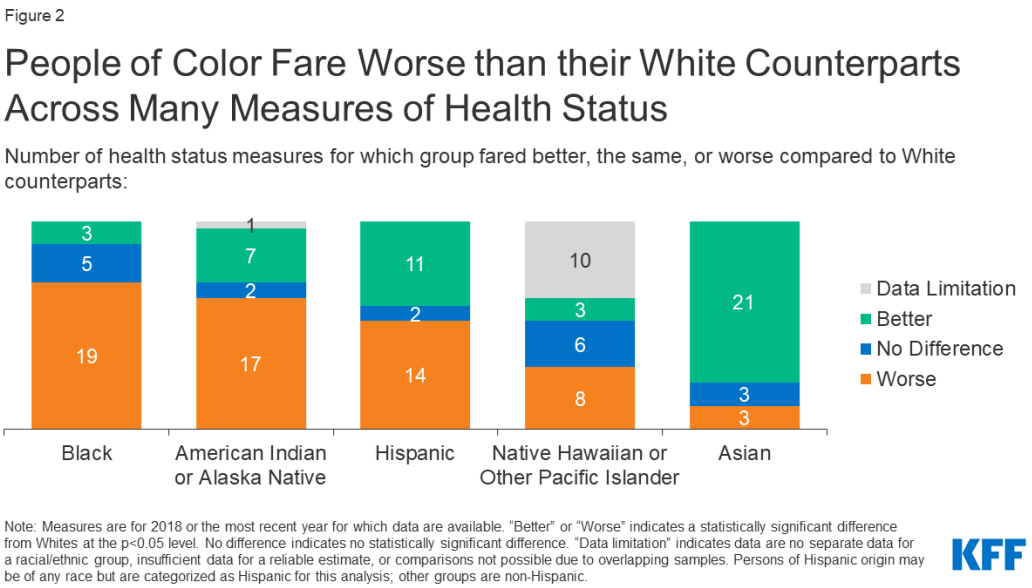
While broadly put social determinants and economic factors are accredited as the primary drivers of disparities, more factors are

[1] Figure 1 (Ndugga & Artiga, 2021)

involved. This figure provides a great start at showing that each of these broad categories can be broken down into many additional factors and opens your mind up to more.

When looking more closely at these social determinants, it becomes clear that racism has significantly negatively impacted mental and physical health by creating inequality across all these areas previously noted. A striking graphic also provided in this article looks at different racial groups that fare worse than their white counterparts[2].

Figure 2



The disparities in health care are a well-known issue, but it's hard to truly realize how unequal care is till looking at this graphic—the graphic looks at all the broad people of color ethnicities. Before even looking at the actual data, it's important to note that with the exception of the "Native Hawaiian or Other Pacific Islander" group, when looking left to right, the groups' skin color gets lighter. My guess of why there is a break from this pattern is because, in general, data for "Native Hawaiin or Other Pacific Islander" individuals tends to be somewhat limited. Also, the graph is ordered in a downward curve model. In looking more at the data, it is very startling to see that in comparison from the worst to the best out of the 27 measures of health status taken, Black individuals approximately 70% of the time scored worse than their white counterparts. However, Asian individuals only approximately 11% of the time scored worse

[2] Figure 2 (Ndugga & Artiga, 2021)

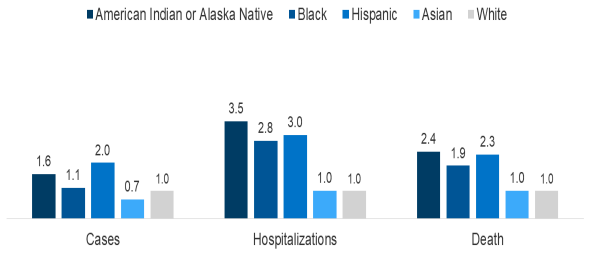
than their white counterparts. Additionally, around 77% of the time, Asian individuals scored better than their white counterparts. To fully understand the causes of Asian individuals' current health status, we would need to look into many different areas of life; however, this graphic serves as a powerful preliminary representation of just how high the health disparity truly is in the U.S.

In relation to Covid-19, the disparities in health care can drastically be seen when comparing minority groups to the more prominent groups, White or Asian individuals. The next two following graphics in comparison shows just how skewed towards more influential groups health care is [3,4].

Figure 4

People of color have had higher rates of infection, hospitalization, and death due to COVID-19.

Risk of infection, hospitalization, and death compared to White people in the U.S., adjusted for age:



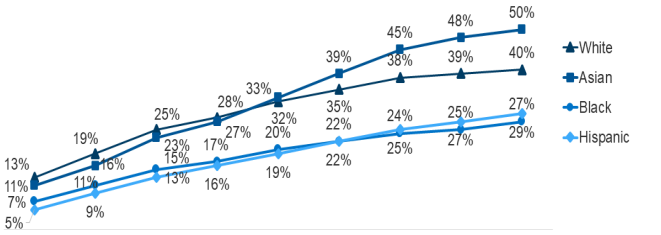
NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic.
SOURCE: CDC, Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity, as of 5/12/2021, www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html accessed 5/12/2021.

KFF

Figure 5

Although vaccination rates are increasing across groups, Black and Hispanic people face persistent gaps.

Percent of Total Population that Has Received a COVID-19 Vaccine by Race/Ethnicity, March 1 to May 10, 2021



SOURCE: Vaccination data based on KFF analysis of publicly available data on state websites; total population data used to calculate rates based on KFF analysis of 2019 American Community Survey data.

KFF

Figure 4 represents Covid-19 cases, hospitalizations, and deaths and Figure 5 shows the vaccination rates between different racial groups. From Figure 4, we can conclude that in minority groups such as American Indians, Blacks, and Hispanics, the rates for all three categories are significantly higher than their counterpart more influential groups, Asians and Whites. Unfortunately, despite, at times over three times higher rate of Covid-19 related issues in comparison to Asian and White rates priority has not gone to vaccinating these greater affected by Covid-19 racial groups. To the point that White individuals' rate

[3] Figure 3 (Ndugga & Artiga, 2021)
[4] Figure 4 (Ndugga & Artiga, 2021)

of Covid-19 vaccination is almost twice that of Black individuals. This is a massive problem, and while this article does not focus as much on the effect of other drastic inequalities between Black and White individuals, the continuous privilege given to White individuals is bound to create a more significant gap in many areas overall. Additionally, by 2050 people of color are projected to make up 52% of the U.S. population, meaning there needs to be even more pressure to create greater equality across all areas of life.

In general, both articles truly helped portray how massive health care inequality is in the U.S. among different racial and socioeconomic groups. The order of my source exploration was beneficial to me as the first article gave me an understanding of the more structural issues in healthcare currently seen. The second article, however, gave me a more in-depth representation of the racial inequality in healthcare. From a more broad viewpoint and focus on the positives, you might say great almost half the amount uninsured individuals in the U.S. now have health insurance with the Affordable Care Act. Still, the moment you dive deeper into the foundational issues of the legislation in place when it comes to healthcare access, it gives a different perspective to just how much work there is still to do. I think it's challenging to choose what areas to focus on first. Yes, of course, much work needs to be done in the layout of healthcare as clearly providing Medicaid to more of the population doesn't solve all the issues. Still, the question is, do we focus on those issues first or focus first on the significant disparity/inequality issue between the different racial groups' overall health and access to healthcare in the U.S?

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