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Research Article

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Healthcare Discrepancies Between Multiple Racial and Ethnic Groups in The US

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Abstract

The research for this paper began several years ago in a graduate medical statistics class where I was told that "certain ethnic and cultural groups just have worse medical outcomes than others". This paper looks at the different major divisions of our population and then; 1) develops a framework for understanding which groups are affected by the differences in medical access and outcomes, 2) attempts to document some of the reasons for these differences, and 3) offers some conclusions and possible first steps to improve the health of these groups ***and*** *our society's ability to provide care for the entire population.*

Keywords: Race, Nationality, Culture, Ethnicity, Heritage

1. Introduction

Much has been published about the disparities of healthcare access among minority groups in the United States. Most of the available information focuses on ethnicity or race which is usually tied to trust, treatment receptiveness, culturally distinctive beliefs, and insurance coverage. This paper first defines the differences between ethnicity, race, and culture and then explores how each of these factors influence access and the quality of care across our healthcare system. The same journals and publications that were used to identify these issues also offer solutions in many cases. This paper attempts to apply them to the individual issues and shows how this might be different from current, conventional practices.

2. Ethnic Groups

According to the Farlex Partner Medical Dictionary, an ethnic group is defined as:eth•nic group (**eth'nik grūp**), A social group characterized by a distinctive social and cultural tradition maintained from generation to generation, a common history and origin, and a sense of identification with the group; members have distinctive features in their way of life, shared experiences, and often a common genetic heritage; these features may be reflected in their experience of health and disease [1].

This definition for ethnicity was chosen because it best reflects the current way of dealing with a complex social issue in the United States today. One should note that even though the terms race, nationality, ethnicity, culture, and heritage are often used interchangeably, they all mean something different. The Department of Health and Human Services, Office of Minority Health has proposed a mixture of these traits as a better explanation for differences in health behavior and health outcomes [2]. As a level-setting exercise, I will elaborate on each of these terms so that we can use them in our following discussion.

• Race - is similar to ethnicity, but relates more to a person's appearance, especially the color of their skin. Race is determined biologically and includes other inherited genetic traits such as hair and eye color, bone, and jaw structure, as well as many other things.

• Nationality – Most of the time nationality refers to the place where a person was born and holds citizenship. However, nationality is often determined by a person's place of residence, ethnicity, or national identity. If a person was born in Country A, but immigrated to Country B while still a toddler, he or she might identify with Country B nationality, by having been raised there. Another point regarding nationality is that there are some nations that do not have a state or international recognition as such, yet people may still point to it as the source of their nationality.

• Ethnicity – is based on a group (usually called an *ethnic* group) that is normally based on similar traits, such as a common language, common heritage, and cultural similarities within the group. Other variables that can play a role in ethnicity are geographical connections, common foods, or diet, and perhaps a common faith. Race is a word with similar meaning though it is usually used to describe more physical traits as opposed to the cultural traits of ethnicity.

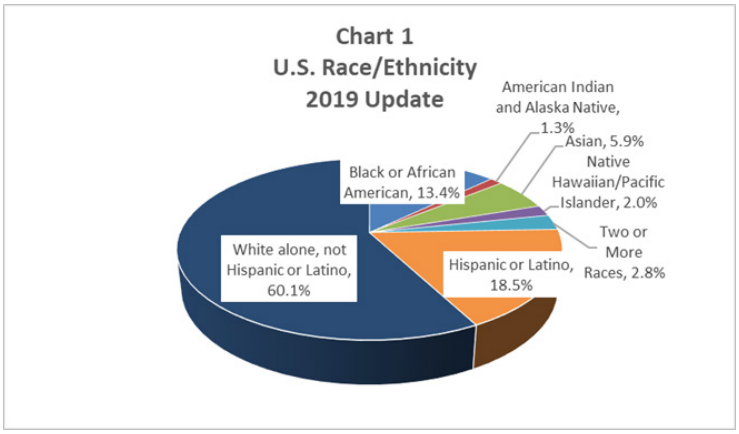
• Culture – is also similar to ethnicity, yet more of a microcosm of it. Culture may involve one trait or characteristic, sort of like a

subset of the various traits that make up ethnicity. A person may be ethnically Jewish, or they could simply embrace one or two things of Jewish culture, such as wearing a kippa; this person may not necessarily relate with the entire macro-ethnicity that is "being Jewish".

• Heritage – can overlap with ethnicity and nationality at times, but it generally refers to the ancestors of a person, and what they are identified with. For example, a child born to naturalized U.S. citizens hailing from Venezuela could say that they have a Venezuelan heritage, even if they do not share the ethnicity (and perhaps do not speak the language), and they are American as far as nationality [3].

3. The General Health of Minorities and Ethnic Groups

There are multiple racial/ethnic groups in the United States and there are health disparities associated with most of them. Below is a chart representing seven (7) of the major racial/ethnic groups in the U.S. based upon the 2019 Census estimate update [4].



One way of understanding the divisions is to use a combination of race and culture. According to the 2019 census update and the Kaiser Family Foundation (KFF) publication based upon it 60.1% of all Americans are Non-Hispanic White [4]. The other minorities (comprising the other 34%) are made up of Hispanic (18.5%), Black/African American (13.4%), Asian (5.9%, American Indian/ Alaskan Native (1.3%), Native Hawaiian/Pacific Islander (2.0%), or are made up of a combination of 2 or more races (2.8%) [4]. As a group, Hispanics, Black/African and Native Americans generally fare worse in both healthcare access and outcomes [5]. See below for a sampling of the differences associated with the different races/ethnic groups for a particular health issue (HIV/AIDS). For a full breakdown of this report on the CDC's publication on health disparities see Appendix 1 for a chart listing of the CDC's findings and Appendix 2 for the charts that compare these findings.

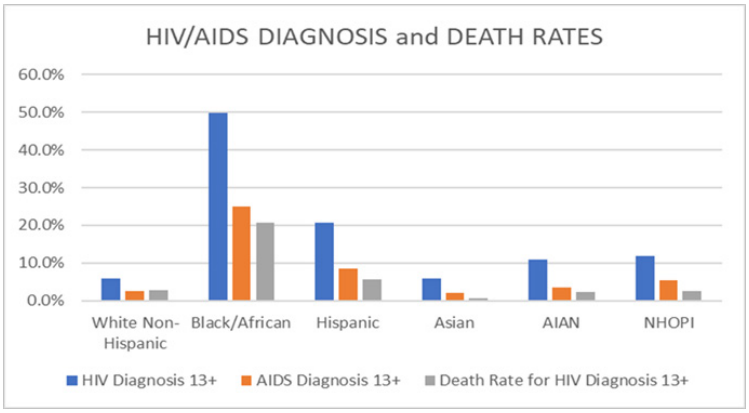


Chart 2 : Data From Artiga And Orgera (KFF.org) 2019

4. Reasons for Health Disparities Among Groups

4.1. Insurance

Health insurance coverage rates vary significantly by race/ethnic group. Many minorities, especially Hispanic and Black/African American families are less likely than whites to have health insurance. Non-elderly Hispanics have the highest uninsured rate, with almost one-third of them (32%) lacking coverage, followed by American Indians/Alaskan Natives (27%), Black/African American (21%), and Asian/Pacific Islanders (18%). These groups are significantly more likely to be uninsured than Whites (13%). Medicaid fills some of the gaps in coverage for these groups, but coverage for many minorities; especially Hispanics, Blacks, and American Indians/Alaskan Natives are lacking [6]. Coverage for these groups is particularly bad in the states that declined to expand Medicaid after the Supreme Court's ruling in 2014 [7].

It is quite common for minorities that have health insurance to be enrolled in plans that provide less coverage and limit the types of services and treatments that they can receive. The resulting reduction to access that is created by these plan limitations most certainly affects outcomes for these groups, but insurance is not the only factor that affects this group's access and quality of care [8].

4.2. Economic Factors

Economic factors also affect the quality and access to healthcare for minorities. Low-income affects a broad cross-section of Americans regardless of race/ethnicity, but minorities make up a distinct majority of this group. Even though most Hispanics, Black/African Americans, and American Indians/Alaskan Natives have at least one full time worker in their family, they are more than twice as likely to be poor than their White counterparts [5]. Moreover, these same minority groups are more likely to be employed in blue-collar jobs and have a family that is below the Federal Poverty Level (FPL). At least one-third of all Hispanics, Black Americans and Native Americans are below the FPL [5]. Blue-collar jobs that many low-income minorities are often drawn to because of their lower education requirements are generally low wage and less apt to be offered health coverage by their employer, and when it is offered, low wage minorities are often not able to afford their share of the premium costs [6,5].

To further aggravate the problem, the best quality healthcare services and providers are not usually found in minority communities. This lack of access, coupled with either reduced or non-existent coverage explains a great deal of why minorities receive a lower quality of care [8,9].

4.3. Cultural Differences

Cultural differences are often cited as the reason for less than optimum outcomes when treating minority patients. These cultural differences often exist because of differences in the way the medical industry in the US trains medical personnel to search for sufficient data to form a diagnosis by using 1) data, 2) intuition, 3) experience and 4) the patient's ability to describe their complaint and answer questions (to the best of their ability). This is often an arduous process even when both the patient and doctor are members of the same culture/class/race, but it is significantly more so when they have no common frame of reference [10,11].

This cultural clash is even more pronounced when the patients come from a culture that has trouble trusting providers from another culture *and* a language barrier exists. Studies have shown repeatedly that when there are communication problems and/or trust issues, healthcare delivery is very often refused or ignored by the patient [8,11].

4.5. Stereotypes and Prejudice

Patients' attitudes and behaviors can contribute to disparities in access and delivery of quality healthcare, but there is also evidence that healthcare provider's biases, prejudices and uncertainty when treating minorities can contribute to healthcare disparities. Stereotyping is a process by which people use social groups (such as gender and race) to gather, process and recall information about other people. Stereotypes are, in other words, labels that we give to people based on what groups that we think they belong to [8,11].

The word "stereotype" is usually considered to be negative, but often times, these "labels" can be useful. Stereotyping is just one of the organizational tools that our brain can use to help organize the mountain of information that we are faced with every day. Their use often gives us a better grasp of a situation and provides us with more confidence in our abilities to understand situations and respond to them. The negative aspects of stereotyping are that they can be negative or unfair. Stereotyping often carries some level of judgment – which can either be positive or negative [8,11].

It is easy to recognize negative stereotypes; they are often associated with bigotry. But everyone stereotypes others, even though most people do not even realize that they are doing so. Problems occur when stereotypes are negatively biased. When this happens, the resulting prejudice can affect the quality of healthcare that these stereotyped individuals receive. It is likely that most healthcare providers are not overtly prejudiced. After all, they have dedicated their lives to helping people to stay healthy, but like many people, healthcare providers may not recognize evidence of a lack of understanding or prejudice in their own behavior [8,11].

4.6. Possible Solutions

Since there is more than one issue to be addressed, there must be multiple solutions. The first (and simplest) issue that can be dealt with is *insurance coverage*. The Affordable Care Act was a good beginning with its standardization of medical benefits and its removal of issues associated with pre-existing medical conditions, but because many states declined to expand Medicaid and the proliferation of high deductible health plans, which are often preferred by less affluent groups; many minorities, cultures, and ethnic groups are actually worse off now than they were prior to the passage of the ACA (See Effects of ACA) [5]. Today, ten years after the passage of the ACA, many of its provisions are still in a state of flux. As of July 2020, there is still a court battle raging as to whether the ACA should be ruled "unconstitutional" and there are still 13 states that have refused to expand Medicaid. There are two states as of this writing that have approved the expansion (Oklahoma and Nebraska), but the change has not yet taken effect [12,13]. This is a key issue for improving healthcare access for poor Americans (of which minorities are a higher percentage) because those states that have not expanded Medicaid effectively prohibit low-income individuals (those making between 100% and 138% of the FPL) from receiving any federal subsidies [14,10]. Medicaid expansion to all 50 states would immediately offer subsidized insurance to over 2.3 billion people Overcoming *cultural differences* will have to be a joint effort by healthcare providers *and* patients [10]. The physicians and other healthcare providers must recognize that disparities exist despite their best intentions. More importantly, there needs to be cross-cultural education (to create cultural intelligence) that can prepare the healthcare community for interaction with patients that have a

different attitude and point of view [15,16]. It is also particularly important that patients learn to understand that they have the power to make a difference in their own care by asking questions and getting answers that they understand [11,17]. *Stereotypes and cultural ignorance* can only be dealt with as our society improves in understanding diversity in the healthcare industry. The American Medical Association's National Quality Forum recently endorsed 12 new quality measures that pertain to disparities and cultural competency. Seven of these measures came from an AMA resource designed to help hospitals and large group practices meet the needs of a diverse patient population. This resource is an assessment toolkit that can be used to evaluate organizational performance in communication, by focusing on health literacy, language services, workforce development and cross-cultural communication [18].

5. Effect of ACA on Minority Groups in the US

One of the key goals of the Affordable Care Act (ACA) was to reduce the number of uninsured through Medicaid expansion and the creation of Health Insurance Exchange marketplaces with advance premium tax credits that will help moderate to low-income individuals pay for coverage [16]. To date, there are substantially less uninsured Americans than ever before, but many, especially minorities and the poor are worse off now than they were prior to the passage of the ACA. Given that minorities are disproportionately at risk for being uninsured and having low incomes, the expansion of Medicaid (as originally intended by the ACA) could significantly benefit these communities and reduce disparities [13].

The ACA provisions that specifically apply to increased minority group coverage deal with Medicaid expansion and ACA subsidies that extend to families that are making less than 400% of the Federal Poverty Level. Today there are significant differences in Medicaid eligibility among states and protected groups. Multiple states have already expanded coverage for children and expectant mothers through CHIP and Medicaid, but eligibility for other groups is much more limited. In many states, adults without dependent children cannot qualify for Medicaid, regardless of how little their income is. Beginning in 2014, the ACA was supposed extend the minimum qualification for Medicaid to 138% of the Federal Poverty Level, but in 2012 the Supreme Court ruled that the Federal Government could not mandate state eligibility beyond 100% of the FPL. Many of the states had already made provisions to adhere to the new rule and kept the provision even though it was no longer mandated. To date, 13 states still have not [12].

One minority group that will still face eligibility restrictions under the ACA are immigrants. Many of them that are legally in the country still will face a five-year waiting period for Medicaid or CHIP and some of them will remain ineligible regardless of their length of stay in the US. Lawfully present immigrants are however eligible to buy coverage in the insurance exchanges and receive tax credits without a waiting period, including those that will not be eligible for Medicaid or CHIP for five years. Undocumented immigrants are still ineligible for either Medicaid or to purchase coverage through the exchange even though approximately half of undocumented immigrants have insurance coverage that is either provided by state government plans (for children or pregnant women), employee benefit plans, student health plans or private coverage [16,13].

6. Conclusions

The disparities in Healthcare Access for minority groups are the combination of many different issues that can best be grouped into socio-economic and cultural. The socio-economic issues are the most pressing and probably the easiest to fix (if there is money available). In fact, many of these issues have begun to be addressed by the Affordable Care Act, but this is just a start. By continuing to expand Medicaid coverage to those with a low income up to 138% of the FPL and offering subsidies to families up to 400% of the FPL, the ACA will allow millions the chance to get insurance coverage that up until now could not afford it. It is not a perfect fix, but it is a great start.The social and cultural issues are a bit harder to deal with. Overcoming these obstacles will take time, effort (and money). As long as there are misunderstandings, there will be roadblocks to access for those who are not quite mainstream. Healthcare providers will have to see the need for increased cultural sensitivity before they will train for it and communication skills must be learned or provided by professional translators (as mandated by The Health Insurance Portability and Accountability Act of 1996 (HIPPA)) in the interim. It will take a while but in the long run the best solution for the cultural issues might be more diversity in the health professions, so that patients can select those providers with whom they have the best fit [19,20].

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