Disparities in Healthcare Accessibility and Distribution: the Multiple Jeopardy Facing the Victims & Causes

The distribution of healthcare services in the United States is unequal, adversely affecting those occupying disadvantaged social groups. Among these groups, the impoverished population constitutes a significant portion. A closer examination of the demographic background of the impoverished reveals that minority status, geographical location of rural areas and certain southern states, and gender are the identities that the impoverished commonly share, indicating an intersectionalized dilemma facing the impoverished. Aiming to provide a detailed account of healthcare inequity among the impoverished, this essay discusses the profile of the impoverished population, the causes of unequal distribution of healthcare services, and a mitigating factor that emphasizes individual agency.

Background

Around the globe, income is a significant predictor of the level of access to the healthcare system and other medical resources (Kim et al., 2017). The United States is not exempt from this association either. The landscape of the U.S. healthcare system is featured by its drastic disparities between different racial and ethnic groups and income groups. Past research evidence has found that socioeconomic status dictates the level of access to the healthcare system among Americans (McMaughan et al., 2020). Besides, Dickman et al. (2017) suggest that the wealthiest Americans outlive the poorest Americans by more than 10 years on average. While the healthcare disparity exists in all countries, the fact that the U.S. lags behind other high-income countries in terms of providing equal access to healthcare

stands in stark contrast to its status as the largest economy in the world (MacKinnon et al., 2023). This is not only a violation of human rights but also poses detrimental effects on the impoverished as a whole when their health outcomes, mortality rates, and other factors that are indirectly affected by their inaccessibility to the healthcare system are suffering as consequences of their socioeconomic status.

Profiling the impoverished population

It is imperative to adopt a more nuanced approach to identifying the target population of this essay instead of simply identifying them as 'the impoverished' or 'those living in poverty'. Although socioeconomic status has been found to be the most reliable predictor of access to the healthcare system (Williams et al., 2016), a more detailed profile of the impoverished population yields a clearer picture of the demographic and geographical factors that accompany poverty, which in turn enhances the precision of the corresponding measures and helps us to grasp the intricacies of the matter itself. The 2020 report done by the U.S. Bureau of Labor Statistics (2022) suggests that Latinos, Hispanics, and African Americans make up the majority of the working poor compared to Whites and Asian Americans. Another evidence regarding the racial wealth gap found that the median income of African American families is just one tenth of the income of White families (Kamali, 2021). Hispanic or Latino households, though earning more than Black households, still receive significantly less income than their White and Asian counterparts (Percheski & Gibson-Davis, 2020). Therefore, minority status, specifically African Americans and Hispanics or Latinos, is one of the components that contribute to the profile of the impoverished.

Gender and within-nation geographical location are other factors that feature the profile of the impoverished. Specifically, research evidence focusing on the gender pay gap confirms that women in the workforce earn less than their male counterparts (Rotman & Mandel, 2022). This gender pay gap is still valid when the factor of race is controlled, with Black women having lower socioeconomic status than Black men (Kamali, 2021). In addition, there is also a wealth gap between rural and suburban or urban areas in the U.S. (Thiede et al., 2020). When grouped by the state, southern states such as Louisiana, Oklahoma, and Alabama have the lowest median family income, suggesting their worst-hit status (NIH, 2024). With all the aforementioned evidence combined, it is safe to argue that the impoverished population is dominated by minorities (i.e., Blacks, Latinos, and Hispanics), females, and those living in rural areas or southern states such as Louisiana and Alabama. Thus, the issue of the inaccessibility of the healthcare system is, to a large extent, racial, gendered, and geographically shaped. The impoverished population is placed in multiple jeopardy, comprised of not only their income but also other identities.

Causes of inaccessibility to healthcare and the unequal distribution

Absence of health insurance

One of the main culprits for inaccessibility to the healthcare system and medical resources is the absence of health insurance. As of 2023, about 25 million Americans are living without any health insurance, and more than half of these uninsured individuals live at or below the poverty line (CDC, 2023; Simon, 2023). Given how the current medical system operates, the absence of health insurance in almost all cases equates to paying out-of-pocket, the cost of which is often significantly higher than co-payment or full coverage provided by

the insurance provider. The burden of the cost on those without health insurance is further compounded by the prevalent low income level among the group. Notably, the primary reason for being uninsured in the U.S. is that the insurance is not affordable (CDC, 2020). Following the unaffordability is the ineligibility to be insured medically, which is more common among Hispanics (CDC, 2020). A small portion of the CDC's survey participants reported not wanting or needing insurance (CDC, 2020). Unwilling to access healthcare due to high cost is one thing (Weinick et al., 2005), but being uninsured while living in poverty surely poses greater deterrents to accessing healthcare. The absence of health insurance is undoubtedly one of the main reasons for healthcare inaccessibility.

Healthcare policies by the U.S. government

To date, the U.S. has made great progress in the last few decades in terms of increasing health insurance coverage. In 1965, Medicare and Medicaid were implemented and have tremendously increased the affordability of medical expenses as well as the coverage rate in the nation (DeWalt et al., 2005). Expanding upon the two, the Affordable Care Act (ACA) under the Obama administration also helped increase the amount of coverage and establish a marketplace for private insurance options (Ercia, 2021). Despite the overall improvement, the unequal distribution of healthcare services persists.

The majority of Americans are covered by health insurance sponsored by employers. However, the seemingly convenient all-in-one package that comes with the employment puts those low-income employees at a disadvantage because their insurance does not offer coverage that is on par with their high-income counterparts. Not only are low-income employees unable to receive high-quality medical insurance, when they choose to opt out and

switch to private insurance plans or Medicaid, the latter of which is primarily for lower to middle class individuals, they are deemed ineligible for doing so because of "ACA firewall", a socially termed policy practice aimed at maintaining the share of employer-sponsored insurance markets (Yearby et al., 2022). This is an example of how unequal distribution of healthcare is upheld by the healthcare policy proactively. At the same time, the healthcare policy also sparked limitations that are reactive in nature.

To put it into perspective, the Medicaid program is not accepted by all the medical service providers. In fact, there have been fewer numbers of non-Federally Qualified Health Centers that accept Medicaid since its inception in certain states (Ercia, 2021). Given that these private medical providers make up a large portion of the sector in the U.S. (Kim et al., 2023), the choice of those seeking medical services is limited (Ercia, 2021). Ercia (2021) also suggests Federally Qualified Health Centers in states like Arizona and California are experiencing an inability to meet the demands, which further confines the choice of patients to private service providers, who in turn may not accept Medicaid. Hence, healthcare policies exert both proactive and reactive influence on producing unequal healthcare distribution, especially for the impoverished.

Discrimination within healthcare settings: povertyism and structural racism

The impoverished oftentimes do not have the resources to access healthcare services. Nonetheless, even when they make it to the healthcare providers, the overall quality of the diagnosis and treatment they receive can be ineffective or dehumanizing because of stigmas associated with Medicaid or poverty, as well as the medical malpractice stemming from structural racism. Starting with stigmas associated with Medicaid and poverty, Allen et al.

(2014) examined the experiences of 574 low-income participants who were either on Medicaid or uninsured upon accessing healthcare services. Among the qualitative data extracted from the interviews with the participants, some overarching themes include participants feeling judged because of their uninsured status, being followed by the security guard in the hospital, and being told not to "getting in the habit of" using Medicaid funds to access treatment (Allen et al., 2014). The study argues that such discrimination based on one's social class and insurance status functions as a substantial barrier to healthcare access among the poor for mainly two reasons: the off-putting doctor-patient interaction may not be desired by the low-income individuals in the future, and the low-income individuals who have had such experiences may internalize the stigma and avoid seeking treatment.

Structural racism, whether carried out overtly, covertly, or unconsciously, on individual levels or by social agencies or the government, is yet another barrier to accessing healthcare services among the poor. A question may arise as to how structural racism relates to this essay's focus of unequal distribution among the impoverished. It relates to the earlier sections where the discussion of the demographic background of the impoverished was made, in which it identifies that the impoverishment is closely related to race. By incorporating structural racism in this section, this essay ultimately addresses the impoverished, for minorities are overrepresented in the low-income population.

Becker and Newsom (2011) conducted a qualitative study that recruited 60 African American participants who had experience getting their chronic illnesses treated by healthcare providers. A majority of the participants described being unsatisfied with their experience. Notably, among these participants, a commonality is their low income level.

These participants reported experiencing inattentive or neglectful services from either physicians or other medical personnel and in a few cases being denied treatment because the doctor held that they should go see their regular physician instead (Becker & Newsom, 2011). The findings also suggest that many of these low-income participants express that there was discrimination present during the patient-doctor interaction, but it remains unknown whether the doctor really possessed such discrimination, whether it is against the participants' race or income level.

Furthermore, certain medical professionals, alongside other factors, base their practices on the healthcare users' racial background, which may also bring minorities negative feelings toward the whole process and produce ineffective diagnosis and treatment (Yearby, 2020). For instance, some hold that African American genes predispose people to heart diseases, obesity, and some other health conditions (Tishkoff & Williams, 2002). While such theories are not entirely false, medical professionals holding such views and basing their diagnosis, treatment, and prescription solely on the patients' race ultimately overlook other factors that contribute to the disease as a whole. For instance, minority individuals may be more likely to live in neighborhoods and communities that are infused with fast food chains and tobacco and liquor stores, which is entirely true in reality (LaVeist & Wallace, 2000), and as a result, they are at an increased likelihood of developing certain illnesses. In addition, food deserts, regions that have limited resources of fresh and healthy food, exist mainly in minority neighborhoods (Sansom & Hannibal, 2021). This may also render minorities more susceptible to developing health conditions. Besides, the low socioeconomic status alone produces a wide array of health risks, including living in drafty homes that are awash with

bacteria and harmful chemicals, not having regular physical check-ups, an overall lower level of health literacy, and delayed treatment-seeking behavior due to the fear of not being able to afford the expenses (Fleary et al., 2013; McMaughan et al., 2020). Basing medical practices on the patients' race is essentially overlooking these factors. The consequences may be that minority, low-income individuals will avoid seeking healthcare services due to distrust, switch physicians or healthcare providers in the middle of suffering from acute or chronic illnesses, or receive ineffective services that do not help their condition, if not worsen it. In fact, past research has confirmed that African Americans and Hispanics have a lower rate of trust in medical providers compared to Whites (Gaskin et al., 2011).

The way that healthcare facilities operate and the extent to which healthcare facilities are funded play a significant role in undermining equal distribution of healthcare to low-income minority populations. This is evidenced by the decreased quality of healthcare services, including inpatient service and nursing homes, that are racially isolated (Sarrazin et al., 2009). Moreover, inferior healthcare services also prevail in low-income, minority residential areas, mainly inner city areas that are racially isolated (Becker & Newsom, 2011). The inferiority largely stems from these healthcare facilities being underfunded and understaffed and having lower numbers of registered nurses and medical personnel, including psychiatrists and surgeons, resulting in various demands from the healthcare users going unmet (Yearby et al., 2022). Perpetuating the predicament is a series of social practices that target minority communities, such as redlining, a financial practice that denies access to loans because the applicant resides in a predominantly minority neighborhood (Lynch et al., 2021). Such

practices limit the upward social mobility of minority, low-income individuals, keeping them where they are, where food deserts and inferior healthcare services abound.

Mitigating the detriments of unequal healthcare distribution

Unequal healthcare distribution can be detrimental for the impoverished or more broadly, the disadvantaged groups that face multiple jeopardy of race, socioeconomic status, age, and gender, especially for those who already have health conditions. Poverty in and of itself is correlated with poorer health outcomes, as the impoverished are often unable to pay for medical expenses and reside in areas where the crime rate is high and the housing condition is drafty or unclean, as mentioned before (Beech et al., 2021). Unequal distribution of healthcare services undoubtedly exacerbates the already poorer health outcomes. Structural changes are certainly warranted to mitigate this issue. These can be reforming the ACA to eliminate the ineligibility of low-wage populations to switch from employer-based health insurance to Medicaid or other private health insurance, eradicating structural racism by regulating discriminatory practices within healthcare settings, and more thoroughly eradicating practices such as redlining.

However, this essay also aims to accentuate the role that the agency of impoverished populations plays in this matter. It starts with a fact that defies the quintessential notion that low-income, minority groups always endure poorer health outcomes. The Hispanic Paradox is a phenomenon wherein foreign-born Hispanics living in the U.S. fare better in terms of health than their U.S.-born counterparts (Ferraro et al., 2017). This difference tends to lessen over generations and the longer the foreign-born Hispanics live in the U.S., which suggests that the transitioning of lifestyle and diet contribute to the changing health outcome (Ferraro

et al., 2017). Nonetheless, given that Hispanics are economically disadvantaged and have less access to the healthcare system compared to Whites, it is perhaps advisable for us to refrain from being overly fixated on equalizing the distribution of healthcare resources and instead, put equal emphasis on the individual agency as well as the sociocultural factors that shape the health outcome among the impoverished. More specifically, by adopting a healthy lifestyle free of vices and unhealthy food, individuals can expect better health outcomes. It is to be done with the assistance of health campaigns and workshops because low income populations may not have the health literacy to guide their inherent agency in the first place. Notably, past research evidence has also pointed the cause of the Hispanic paradox to the close-knitted community value among the Hispanics, whereby Hispanics tend to have a stronger support system comprised of family members and friends (Fenelon, 2016). Akin to Hispanics, Chinese and Korean Americans share this support system, which results in better mental health outcomes among them (Morey et al., 2021). Therefore, when structural changes towards equalizing healthcare resources may prove more difficult, we can perhaps shift attention to individual agency among the impoverished and be aware of how they also have a say in offsetting the detriments that the unequal healthcare distribution brings.

Conclusion

The disparity in accessing healthcare services is not only the experience of the impoverished but also a reality for minorities and people living in rural areas and certain southern states. The impoverished are to be looked at not only through a socioeconomic lens but also through a lens that attends to their race, gender, and geographical location. The causes of the unequal distribution of healthcare services and inaccessibility to healthcare

services are mainly the absence of health insurance, insurance policies, and povertyism and structural racism both within and outside the healthcare system. Instead of being fixated on equalizing the distribution through system-level reforms, we can emphasize individual agency among the disadvantaged by promoting healthy lifestyles and communal values in order for them to cope with the disparity before systemic changes take place.

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