Examining Class-based and Race-based Inequities within the American Healthcare System

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Abstract

Utilizing the concept of all persons living in America being endowed with "life, liberty, and the pursuit of happiness" as claimed by the United States Declaration of Independence, this project examines the healthcare sectors and variables that may undermine the efficacy of equitability. Researching the healthcare sector revealed potential connections with the collusion between healthcare access and equity amongst different socioeconomic status strata and ethnic minorities. An analysis of data from 2000-2023 using the Affordable Care Act (ACA) as a midline demonstrates the intersection between the inequities of people in the United States socioeconomic status (SES) status and certain ethnic minorities. Equitable healthcare services across the United States have displayed a disproportionate amount of access within different strata of socioeconomic status. Socioeconomic status has intertwined within ethnic groups due to the prevalent inevitabilities experienced within lower strata of socioeconomic groups. Data introduced within the thesis demonstrates the number of uninsured individuals within the United States and illustrates a trend of dissatisfaction with healthcare and regression of uninsured rates due to the continual lack of transparency and manifested insecurities within the United States healthcare system. More specifically, ethnic minorities within the United States are put at a disadvantage due to language barriers, health insurance premiums, and overall lack of accessibility and transparency when utilizing healthcare services. Due to a lack of trust within the healthcare sector, ethnic minorities are put at a continual disadvantage.

I. Introduction

Utilizing the concept of all persons living in America being endowed with "life, liberty, and the pursuit of happiness" as claimed by the United States Declaration of Independence, this project examines the healthcare sectors and variables that may undermine the efficacy of equitability. Researching the healthcare sector, potential connections with the collusion between healthcare access and equity amongst different socioeconomic status strata and ethnic minorities. An analysis of data from 2000-2023 using the Affordable Care Act (ACA) midline demonstrates the intersection between the inequities of people in the United States socioeconomic status (SES) status and certain ethnic minorities.

Ethnic minorities identify as the non-dominant race within the country; for the United States, ethnic minorities would include the groups labeled African American, Hispanic, Asian, Native American, and Alaskan/Pacific Islander. Despite the strides toward the equitability and accessibility of healthcare, there is a disproportionate rate of uninsured individuals spread across these ethnic minorities. In comparison, White Americans, or the ethnic majority, retain one of the lowest percentages of uninsured individuals/families.

The trends in satisfaction and trust in healthcare from these ethnic minority groups have declined due to factors relating to how these minority groups have received care, increased costs of healthcare services, and the organization of the system, which causes unreasonable rates and may prohibit these groups from fully utilizing the healthcare benefits provided. Overall, the healthcare sector carries inequalities that are ingrained within the system and cause dissatisfaction within ethnic minority groups, which has led to a regression of lower uninsured rates within these groups.

Current Situation

Surveys and data about uninsured rates, healthcare satisfaction levels, and the population's socioeconomic strata measured at the federal level were cross-assessed within the project. Furthermore, utilizing the Affordable Care Act as a middle point for the data gathered, it is established that the project's background is from 2000 to 2023, with a centralized focus from 2010 to 2023. Additionally, there will be a focus on California to reference satisfaction levels within an expansionist state. Following the term expansionist state is if policies are enacted within the select state that grow the coverage given to households near the observed federal poverty level. Following this, the project established the focal topic of the research in 2010-2023 to discuss developments in the healthcare sector after the inclusion of the ACA that allowed predisposed conditions to receive “equitable” healthcare.

Importance

This study aims to contribute to the existing literature by examining the intersection of socioeconomic status and ethnic minority groups' ability to access equitable healthcare. It will establish a clear foundation for the disproportionate equitability of uninsured ethnic minorities while also investigating the causes of the increased rates of uninsured individuals within these groups. The study will also compare healthcare equitability across different ethnic minority groups, including Hispanic, African American, Alaskan Indian, and American Indians (AIANs). Additionally, it will explore the relationship between rising healthcare costs, distrust, and lack of transparency in the healthcare sector and the subsequent increase in uninsured rates, particularly during and after the COVID-19 pandemic.

Research Questions

The problem that established the basis for this research was determining the potentiality of inequities in healthcare and whether the United States Declaration of Independence has upheld

those rights. These research questions addressed the following question: How does the satisfaction in healthcare of the ethnic minority groups in the United States decline as the individuals' socioeconomic status decreases? If there is a disproportionate amount of healthcare services received among different socioeconomic classes, will there be fewer available services for the lower socioeconomic classes? How are healthcare services distributed within the United States and disproportionately among different ethnicities within the same socioeconomic class? These questions supported the problem and specialized the research question towards finding intersections between inequities in healthcare and whether lower socioeconomic minorities are exclusively affected by inequities displayed within the healthcare system.

A hypothesis was developed in which the studies would suggest that the satisfaction of United States' ethnic minority groups has declined as individuals near or at the poverty line will not be able to receive adequate and equitable healthcare. Furthermore, they will be more likely to be uninsured or have negative perceptions of healthcare services. There will be a disproportionate distribution of services and accessibility towards ethnic groups, reflecting the nature of lower SES. Following this, minority groups such as Hispanics and African Americans will have disproportionate access to healthcare services and will more likely receive healthcare services from programs or company premiums. Moreover, The COVID-19 pandemic has harmed percentages of uninsured individuals, specifically targeting minority groups.

The project will first examine the intersectionality between socioeconomic status and ethnic minorities. This will establish a basis in the research to illustrate that descending into socioeconomic status, insured rates amongst individuals have decreased. Federal poverty levels will be examined to demonstrate the collusion between the information offered and the disparities of ethnic minorities with majority percentages in lower socioeconomic strata.

This project will then measure the levels of satisfaction in healthcare and potential reasons affecting the percentages of insured rates of individuals. Ethnic minorities will be cross-examined with percentages of White individuals to develop a synopsis of satisfaction rates. Likewise, this project will develop data gathered from surveys with a unique specialization in California. It will further develop the notion of dissatisfaction with the healthcare sector for ethnic minorities.

II. Literature Review

Overview

This research's validity is based on a review of a core set of studies, which describe the fundamental questions of whether certain ethnic or socio-economic groups are receiving equitable access to health institutions and whether the United States is upholding constitutional values toward American citizens. The following articles observe the potential socioeconomic and ethnic disparities that may be examined within the United States healthcare system. The research themes follow the parameters of examining racial disparities in healthcare, class-based disparities, and how racial and class-based disparity ties manifest insecurities within the healthcare domain. These core subthemes will assess the American healthcare system, which may carry discriminatory policies or barriers that exclude certain cultural demographics.

Main Focus: This discussion will not cover welfare comparisons from other nation-states and will solely focus on the healthcare system within the United States. Accordingly, there will not be any notable comparisons to international humanitarian laws, like the United Nations. Still, these will be mentioned to make a comparable analysis of constitutional values. It will also have a specialized focus on healthcare in California, which will be discussed later in the thesis. It will generalize the United States as a whole yet not fully include other states' healthcare policies to

demonstrate systemic fluctuations of equitable health services; furthermore, it will focus on California's healthcare system and its ability to provide equitable healthcare to its citizens.

General Observations

Observations recorded within the research on healthcare inequities indicate a difference between the treatment and accessibility of healthcare for ethnic minorities within the United States. Observing this, there is a noticeable decline in the satisfaction and usage of healthcare services with minority populations, specifically African American and Hispanic communities. There is a lack of equitable healthcare services for all socioeconomic strata. There are also noticeable disparities in these communities' trust in healthcare services, with surveys reporting that due to manifested insecurities within healthcare they report that ethnic and racial minorities feel that it is their responsibility to actively speak up about what ailments they may possess, as many have reported that they may be overlooked or ignored.

Democratic Governance and Equity

The progression toward universal health care has been slow in the United States. The Affordable Healthcare Act (ACA) was a law signed in 2010 to provide the public with affordable, quality healthcare coverage; this act was designed to protect consumers from discrimination within the healthcare sector (HHS 2022). It has allowed many minority groups who once had little to no access to healthcare, like African Americans, Latin, Native Hawaiians, and Pacific Islanders, to be insured through programs like Medicaid. Medicaid is a government program that allows low-income households access to healthcare through the Affordable Healthcare Act, which sought to expand the services for low-income families.

Although the programs and services that the Affordable Care Act (ACA) enabled lowered the percentages of uninsured individuals within the United States, there was still a

disproportionate amount of African Americans who were uninsured in 2018, which was 9.7% in comparison to 5.4 percent among White individuals (Taylor, 2019). Taylor's analysis continued to discuss the effects of Medicaid and the ACA and how they have impacted uninsured populations. Furthermore, in their discussions, they would go more in-depth regarding the challenges and improvements made after the induction of the ACA. The study included the discussion of statistics regarding the disproportionate rates of minority groups' access to healthcare. The survey data within the article examines the increase in the annual cost of healthcare premiums, reaching almost 20% of the average household income, which substantially affects minorities already plagued with economic challenges (Taylor, 2019). However, they do not include further statistics regarding other racial groups and focus on African American communities. This article established the basis in brief discussions regarding uninsured populations and how they were affected by government laws and policies.

Despite the ACA expanding coverage, it is discussed that non-elderly American Indian and Alaska Native (AIAN), and Hispanic groups had uninsured rates, respectively being 19.1% and 18.0%, and Native Hawaiian and other Pacific Islanders at 12.7% as of 2022 (Hill, Atriga, et al., 2024). Although Medicaid has reduced the difficulty of affording private coverage, Medicaid eligibility for parents was limited to those with very low incomes or adults without dependent children- regardless of how poor the household/individuals may be (Hill, Atriga, et al., 2024). Democratic governance and equity within the United States have been undermined by the lack of transparency and affordability towards low-income households, specifically affecting minorities. The lack of healthcare expansions, like Medicaid, has developed health disparities, which are dramatically worsened within southern states that do not have any developing healthcare programs specialized towards low-income households. Exemplified by the statistics of

socioeconomic status and *Access to Healthcare: Interrelated Drivers for Healthy Aging* discusses the variances in healthcare access within the United States between the socioeconomic status of older generations:

Older adults in higher socioeconomic brackets are more likely to access preventative care and screenings; for example, older adults of higher SES experience a greater likelihood of having a hearing screen and use a hearing aid (43). Lower SES is associated with longer wait times in countries with centralized healthcare systems (McMaughan 2020).

The variances in governance in relation to equitable access to healthcare shift in a negative slope corresponding with lowering levels of socioeconomic status. Access to healthcare is lower towards descending levels of socioeconomic status; not only does it affect access to healthcare, but it also affects the timeframe in which individuals can receive proper healthcare with their accessible insurance premiums. Equitable access to healthcare, across various studies and procedures aforementioned, has demonstrated the collusion between sociocultural factors and equitable access to healthcare, specifically, access to private insurance. Although the government implements programs that target aid towards lower SES, some groups still cannot receive adequate coverage from healthcare providers. Furthermore, observing the Federal Poverty level (FPL) demonstrated the collusion between out-of-pocket visits and increased insurance premiums, disallowing lower socioeconomic strata from receiving their optimal form of health.

Racial and Class Disparities

Racial and Class Disparities within Healthcare have increasingly become more interconnected in the correlation between individuals who are properly insured across respective ethnicities. Certain socioeconomic status (SES) have impacted the lives of minorities and

negatively affected their access to healthcare. *National Healthcare Disparities Report 2008* goes in-depth on racial differences in insurance coverage where “[In the pre-retirement] years, Hispanics and American Indians are much less likely than Whites, African-Americans, and Asians to have any health insurance." (American Psychological Association, 2017). The data displayed within the research shows the various points of discrimination against SES, such as education, physical health, and psychological health. Still, the substantial difference between specifically the insurance coverage aforementioned in the previous section discusses the racial disparities in health care coverage, supported by the notion of certain ethnic groups having an increased likelihood of being uninsured. Not only do racial disparities manifest within healthcare services, but minority racial groups display an increased likelihood of experiencing multidimensional poverty in contrast to White racial groups (American Psychological Association, 2017). Through the Williams analysis, the discussion between racial and class disparities being intertwined becomes more salient as lower-income individuals are less likely to be insured and even more unlikely if they are a minority (Willaims, 2010).

During the COVID-19 pandemic, more evidence of discrimination in healthcare coverage was revealed. Although the topic and prioritization of combating racial and class disparities are not a new concept within the United States, uncovering the deep-rooted injustice and systemic inequities has contributed to the reanalysis of racial and SES discrimination. Various studies support the notion of systemic inequalities within healthcare and how COVID-19 has reversed the gradual progress towards combating discrimination within the healthcare sector. For example, many eligible individuals through Medicaid, CHI, or the ACA marketplaces faced many barriers during enrollment due to confusion about eligibility policies, language, and literacy issues (Ndugga, 2023). This, in turn, made it difficult for those from lower

socioeconomic standings to register properly within these healthcare programs due to the barriers that restricted access to healthcare.

Although Medicaid was designed to help lower SES communities receive healthcare services, the difficult barriers set in place to restrict the accessibility of the services have become a deterrent for those seeking services. COVID-19 saw an uptick in deaths and hospitalizations of minorities during 2019-2022 as minorities were more susceptible to contracting COVID-19 (Ndugga, 2023). Following this, data emerged relating to the decline of life expectancy through various racial groups, with AIAN, Hispanic, and African American populations having a greater decline in life expectancy in comparison to White populations' life expectancy. With the restrictions towards healthcare services, the decrease in life expectancy can be attributed to the barriers that had greater impacts on minority populations during 2019-2021, which was the height of the COVID-19 pandemic within the United States.

Now, focusing on the socioeconomic disparities in the United States while referencing certain health indicators and socioeconomic groups, The study used 5 nationally representative samples of data: the National Longitudinal Mortality Study, the National Health Interview Survey, The National Health and Nutrition Examination Survey, and the Behavioral Risk Factor Surveillance System (Braveman, 2010). These national data sources examined 11 health indicators, analyzing the patterns of socioeconomic disparities that represented the results of health conditions and health-related behaviors. Focusing on national data on infant mortality, health status, activity limitation, sedentary adolescents, and healthy eating found links between social advantages and health. They found that "health in the United States is often, though not invariably, patterned strongly along both socioeconomic and racial/ethnic lines, suggesting links between hierarchies of social advantage and health" (Braveman, 2010). Indications of the

gradient patterns of disparities in health equities exemplify the connections between receiving quality healthcare and socioeconomic status and ethnic/racial profiles. Although the data listed is outdated in terms of not addressing current issues and policies that have been implemented, it provides an adequate background for the quantity of data on socioeconomic disparities before the induction of the Affordable Care Act.

Retaining healthcare information before implementing programs and policies like the ACA and Medicaid established trends that illustrated social hierarchies within socioeconomic status and quality healthcare. Studies conducted with updated information after the implementation of the Affordable Care Act provided estimates of health indicators by income and education by analyzing children, young and middle-aged adults, and other adults (Kim, 2023). They obtained this information using four nationally representative data sources: the National Health Interview Survey (2015-2018, the National Health Nutrition Examination Survey (2017-2020), the Behavioral Risk Factor Surveillance System (2016-2020), and the Health and Retirement Study (2016) to examine socioeconomic differences in racial and ethnic access to health services. Within the study, it is found that “prevalence rates of poor health were often the highest among those in the lowest income and education categories regardless of age cohort and race/ethnicity”(Kim, 2023). This concludes that inequities of health within the healthcare system, regardless of one's race/ethnicity, there will be a consistent rate of poor health among lower levels of SES. This does not disrupt the interpretation and collusion of SES and Racial/Ethnic population; data suggests SES disparities of health across age and race/ethnicity groups. Although the study does not contain comparative data before 2010, it contains a robust representative sample demonstrating the collusion between SES and racial disparities. Overall, studies have displayed that racial and SES disparities have gradually become more intertwined as

time has continued, although the implementation of ACA and programs like Medicaid has reduced the disparities among ethnic groups; still, the aftermath of COVID-19 has revealed systemic inequities of implemented programs that restrict access towards lower SES and racial/ethnic groups.

Racial and Class-based disparity manifests in the domain of healthcare

Distinctions within the treatment domain of healthcare have developed inequities in treatment and healthcare services. The study associated with James B. Kirby discussed the implications of health insurance coverage and socioeconomic differences amongst various racial and ethnic minority groups. The study uses data pooled from the 2000 and 2001 Medical Expenditure Panel Survey and census data from the Health Services Resource Administration to view the association of insurance status with socioeconomic differences and the disparities that manifest. Furthermore, the data gathered from the various census data creates data sets that allow for a generalized understanding of satisfaction with healthcare and prevalent disparities within the healthcare system before the implementation of the Affordable Care Act. During the cross-analysis of the data within the surveys, there were variations in dissatisfaction with healthcare and the decrease of services related to healthcare among ethnic and racial population groups of White, Black, Hispanic, Mexican, Puerto Rican, Cuban, and other Hispanics (Kirby, 2006). The unique specialization of data about the dominant minority groups allowed for the cross-assessment of data after the enactment of the ACA to demonstrate any gradient or stagnant perceptions of insecurities within the healthcare system. Although the data collected pertains to two main groups of minorities, the data gathered allows for baseline perceptions of healthcare and the analysis of prevalent disparities within the healthcare system.

Information and surveys illustrate the perception of healthcare services of racial/ethnic minorities and examine factors contributing to health inequities within the United States, specifically California. The study that used a sample size of around 3,325 Black Californians focused on the experiences of minorities, specifically African Americans within California, and their experiences of healthcare services. The studies illustrated a concern about receiving adequate healthcare and putting effort into speaking up when the doctor does not ask about certain concerns (Taylor, 2019). Due to the health inequities, Black Californias have adopted measures to mitigate negative experiences when at a healthcare visit. More specifically, 66% of Black Californians from the surveys reported researching a health condition or concern before meeting with a healthcare provider. (Cummings, 2022). The opinions of Black Californians convey that healthcare disparities have manifested insecurities within the population and necessitated the need to develop strategies to receive adequate healthcare. The information gathered from the surveys targets the opinions of Black Californians and their perceptions of healthcare within the United States. Although the data collected is limited to a smaller sample size and a select minority population, it clarifies opinions about healthcare received within California.

The perception of healthcare and the inequities in access to healthcare for lower SES have limited their approach to receiving aid. In a study conducted in California, which aimed to update public opinion of healthcare, the limited approach is reinforced. The surveys reveal that in late 2021, 49% of survey takers responded to either postponing or skipping treatments due to the cost (Catterson, 2022). The notion of healthcare inequities creating barriers towards programs like Medicaid manifests in refusing treatment due to costs. Although the survey does not record the racial/ethnic groups' public opinion of healthcare during the COVID-19 pandemic, it does

note that COVID-19 was detrimental due to income loss, and the lockdown of services negatively affected those in lower SES. In turn, it made treatment plans more costly for lower-income households. Following this, families are forced to pay healthcare premiums and out-of-pocket copays, prescription drugs, and uncovered medical bills that, for some, may average out to a substantial amount of their annual income (Taylor, 2019). Likewise, uninsured individuals do not have access to healthcare that will be able to cover the treatment plans for ailments and would rather skip or cancel the treatments due to the cost of healthcare or the need the time to work in replacement of treatment. Overall, the studies listed provide an overview of race and class-based disparities that have manifested insecurities towards healthcare within minority groups.

III. Methodology

Within this project, the project used data from 2000 to 2023 but segmented dates and periods based on impacts or laws impacting the United States healthcare sector. More specifically, I separated two data timelines to establish a background of information regarding the topic and survey data to analyze the changes and perceptions of the healthcare sector within the United States. Following this, I used data and information from 2000 to early 2010 to establish the timeline before the enactment of the Affordable Care Act, giving background to racial and socioeconomic situations and societal expectations from the given timeline. Using information before the ACA gives information and background as to why there was a noticeable decline in uninsured individuals, specifically ethnic minorities and socioeconomic strata, after late 2010. After gathering background information from late 2010 to 2023, information from specifically survey data was used to supplement the knowledge of information detailing from

2000-2010 to give more background information regarding the inequities and insecurities that manifested before the introduction of the ACA.

IV. Discussion

Democratic Governance

Decisions in democratic governance on whether healthcare coverage should be decided privately or federally is a large topic of discussion within the United States. In the United States, polarizing opinions relate to the federal government's responsibility toward health insurance

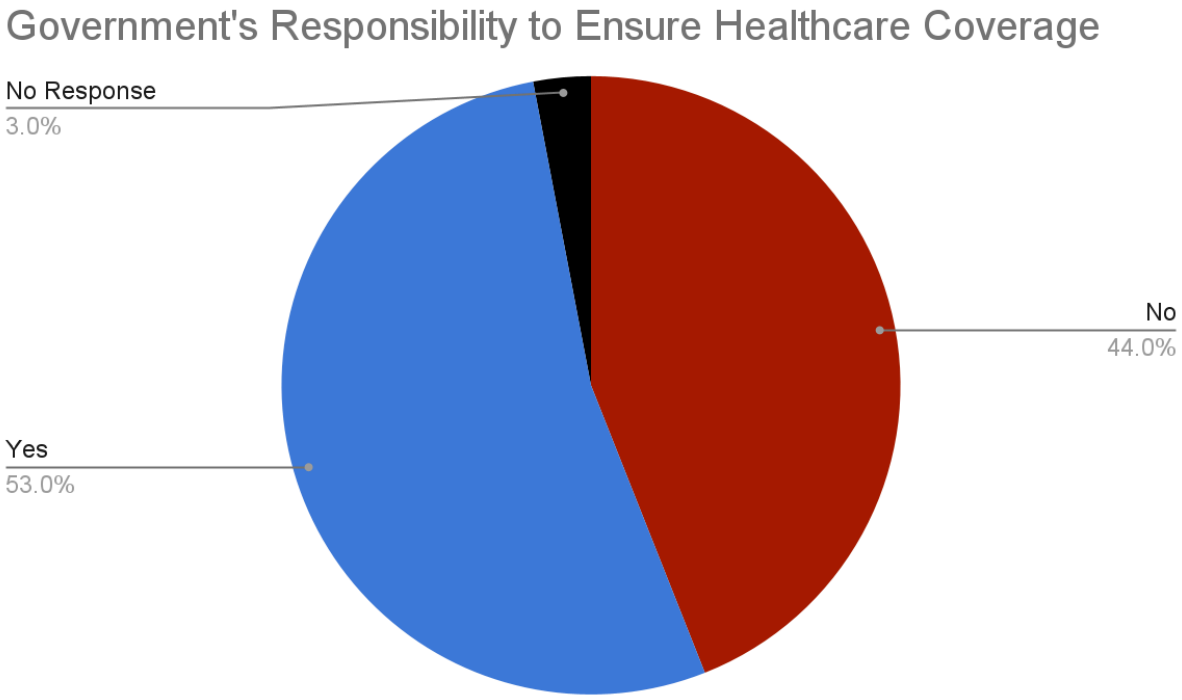


Figure 1. Utilizing the sample data from the Pew Research Center, 53% of those surveyed stated that it was the federal government's responsibility to make sure that coverage for all Americans was being properly enforced, while 44% stated that it was not the government's responsibility to ensure healthcare coverage for United States citizens. Referencing the same data observed, 81 percent of Democrats or Democrat-leaning individuals believed it was the government's duty to

ensure healthcare for its citizens. The two dominant political parties in the United States, Democrat and Republican, have failed to reach a conclusion on governing a healthcare system. The polarizing effects have caused an inability to ensure American peoples healthcare, lacking to provide equitable healthcare for all.

This is also inherent in surveys demonstrating an increase in insured individuals receiving equitable healthcare services where expansive policies regarding Medicare are observed. For instance, expansive states like California, with a composition of more than ⅓ of those identifying as liberal, saw Medicare expansion and policies implemented that sought to decrease the eligibility for uninsured adults near 138 percent of the observed federal poverty level (Pew Research Center, 2014; Taylor, 2019). Expansive and non-expansive states are willing to enact legislation that follows the trends of increasing or decreasing an individual's eligibility for healthcare based on their observed poverty level status. In comparison, 77% of Conservatives or Conservative-leaning surveyed individuals would believe it was not the United State's responsibility to ensure healthcare for all its citizens (Dunn, 2019). The polarization of the United State’s democratic governance over the federal government's responsibilities makes consensus on healthcare policy and implementation difficult for non-expansive states. Although decisions are made to aid individuals near the observed federal poverty level, the government’s responsibility to uphold healthcare equity relies on the political ideology and environment within the select state. It can be determined that within non-expansive states like the southern states, the implementation of equitable healthcare services would either be decreased or nonexistent, resulting in a decline in accessibility for lower socioeconomic strata (Taylor, 2019). Furthermore, the continual observations of the lack of legislation passed to aid individuals within southern states have been observed.

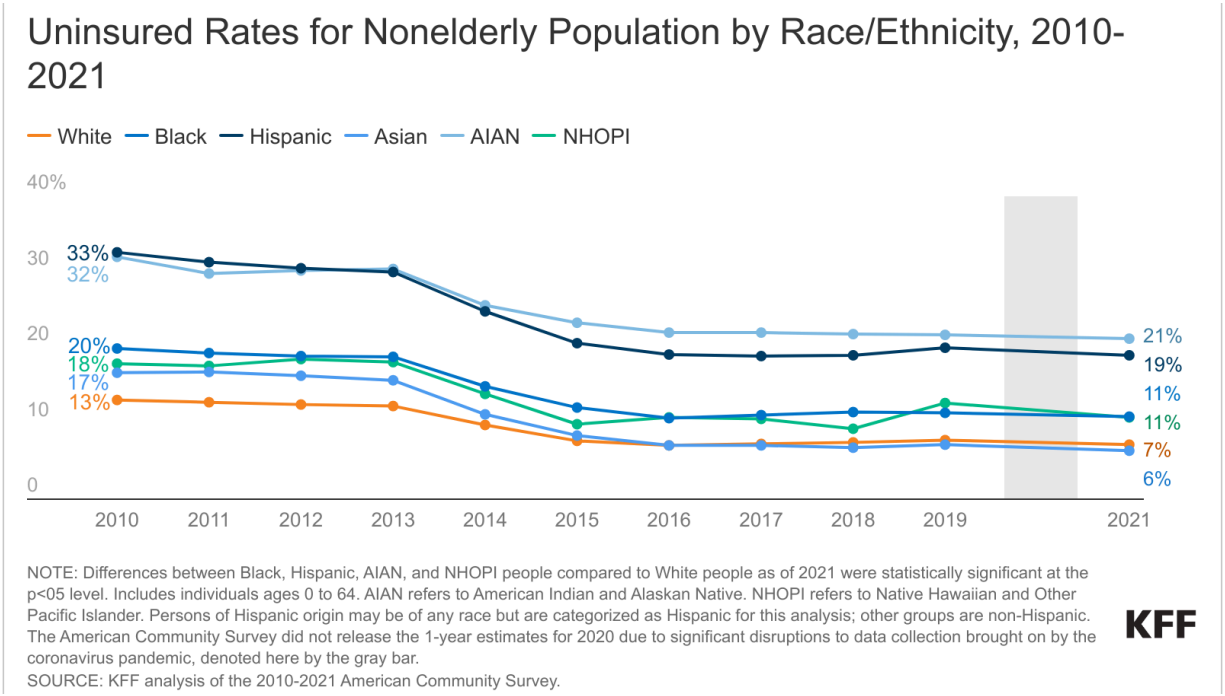
Equitability

Healthcare within the United States is a complex and evolving concept. With the ebbs and flows of American society, culture, and current events, healthcare's equitability has diversified in meaning. Implementing the Affordable Care Act (2010) was a significant welfare policy, and its expansion became a leap of progress in addressing contemporary healthcare disparities. The Affordable Care Act ensured that individuals with pre-existing conditions would no longer be discriminated against and could receive health insurance. This provision led to a significant decrease in the rates of uninsured individuals, particularly aiding in lower socioeconomic strata and elderly population groups. While there are still challenges to overcome, the ACA (Affordable Care Act) has had an undeniable positive impact on American healthcare.

The issues come when the act's provision that individuals with predisposed conditions would no longer be discriminated against and could receive health insurance has led to a decrease in the rates of uninsured individuals. Specifically aiding lower socioeconomic strata and elderly population groups. Its profound impact on lower SES and older populations is not just a statistic but a harsh reality, leading to decreased life expectancy (McMaughan, 2020). According to the most recent data from KFF, the implementation of the ACA has led to a substantial decrease in uninsured individuals and has significantly aided in promoting equitable healthcare (Ndugga, 2023). Furthermore, the implementation of the ACA has allowed more than 20 million people within the United States to gain coverage, with 2.8 million among that population being African American. (Taylor 2019). However, there is still a disproportionality among various ethnic groups about uninsured rates measured by ethnic/racial groups in the United States. **Figure 2.** conveys the disproportionality amongst various ethnic groups by displaying regressing

percentages of uninsured individuals and denoting the variance of percentages relating to each ethnic group (Ndugga, 2023).

Additionally, increased uninsured rates amongst Hispanics are indicated to be increased due to immigration complications with generalized complications of insurance amongst lower socioeconomic strata (Ndugga, 2023). The studies mention insurance like Medicaid and Children's health insurance plans, which are plans under the ACA that "provide free or low-cost



health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities (Healthcare.gov, 2024). These insurances are federal healthcare policies that aid individuals near the federal poverty level (FPL), while some states may retain more expansive policies to cover more impoverished individuals. Insurances like Medicaid and Children's Health Insurance Plan (CHIP) are designed to help these inequities by assisting low-income individuals or SES. Still, due to language barriers and lack of transparency about healthcare services, they aid in the stagnant rates of uninsured minorities.

Elderly populations, often among the most vulnerable, are also affected by barriers that restrict access to healthcare. Their Socioeconomic Status heavily influences the quality of health within the Elderly population in the United States. Consequently, limited healthcare access among poorer older adults significantly reduces the quality of health and access to preventative measures. With limited access to healthcare, a cross-sectional study reported that among "almost 50,000 non-institutionalized older adults, costs were cited as a major reason for not obtaining needed care" (McMaughan, 2020). Inequities among older adults, particularly those related to income and healthcare access, profoundly impact their life expectancy and quality of life, as evidenced within the population. Affordability is consequently the most evident amongst ethnic and racial elderly populations, with ethnic groups citing that 16 percent of older black adults and 14 percent of older Hispanic adults report problems paying for healthcare (Hamel, 2024). Additionally, the older White adult population groups report that only 8 percent have problems when paying for healthcare, and older Asians report only 11 percent (Hamel, 2024). The disparities reflect the nature of income disproportionality in income and socioeconomic status. The overall decrease in life expectancy during COVID-19 was observed, with an overall decrease in life expectancy of 2 years, with the average age in 2021 being 76.1 years (Ndugga 2023).

The assessment of the broad perceptions of healthcare equitability and the federal government's responsibility dictates a need for perceptiveness in cohesion amongst various sample populations. There is a split examining the political perceptiveness of the government's duty to ensure healthcare. Inequities within the United States healthcare system have specifically targeted ethnic minorities and lower socioeconomic strata. With continual polarizing opinions on how the government should operate and ensure equity within the healthcare sector, limitations

towards states that are not seen as “expansive” are seen to have limited services and an increased amount of uninsured individuals within their state, particularly southern states. This underscores the urgent need for all stakeholders to actively promote healthcare equity for all ethnic and racial groups and lower socioeconomic strata.

Racial Disparities

Disparities within healthcare have become evident due to the systemic barriers and public opinions towards the United States healthcare system, as policies and limitations have been put in place that have specifically affected ethnic minorities. Before the introduction of the Affordable Care Act, numerous surveys accounted for the potential variables that aid in the disparities experienced amongst ethnic and racial minorities. This is partly due to the lack of healthcare equitability within lower socioeconomic status, as individuals who seek healthcare cannot afford it due to increased costs and the potential notion that they would not receive full healthcare coverage. In comparison, an individual with a higher socioeconomic status can pursue the market-based healthcare system in the United States. Although there has been a regression in uninsured individuals within ethnic and racial minority groups after the introduction of the Affordable Care Act, there are still disparities that have been aggravated due to new variables that have been exposed after its implementation. These new variables include language barriers and increased premiums, which have significantly hindered the attainment of equitable healthcare services for ethnic and racial groups like African Americans, Hispanics, and Asians.

Although there are efforts to make insurance coverage more broad and accessible to all socioeconomic strata within the United States, continual observations offer insight that uninsured rates would only decline and not fully disappear. Insurance status is not the only factor that encourages disparities within racial and ethnic groups, but “income, education, and other

individual-level sociodemographic factors [that] also account for a significant part of the racial and ethnic disparities [that are] observed" (Kirby, 2006). Although increasing insurance rates would help remedy the disparity gap amongst various ethnic and racial minority groups, the lack of educational attainment and other socioeconomic factors have limited the progress toward healthcare equity. This is not only due to societal verticality but also America's market-based healthcare industry, which strives towards profit and actively discriminated against predisposed conditions before the enactment of the Affordable Care Act. The utilized private healthcare system also sponsors inequities if income disparities exist within the United States (Leach, 2009). Before the ACA, the privatized healthcare sector limited individuals who had predisposed conditions to be discriminated against, affecting individuals who could not afford increased healthcare premiums or insurance in general. Discrimination against predisposed conditions affected the coverage individuals had access to and specifically affected those with lower socioeconomic status who could not partake in the market-based healthcare system.

Also, before the induction of the Affordable Care Act, research on ethnic and racial disparities was limited due to the labels conveyed during the utilization of sample data, as there was a significant correlation between socioeconomic status and disparities experienced amongst ethnic and racial groups before the ACA. The census data pertains to four groups when analyzing poverty rates by race: Black, Hispanic (any race), Asian, and Non-Hispanic White. The data gathered illustrates that poverty rates in 2019 were 18.8 percent for Black population groups and 15.7 percent for Hispanic population groups (Creamer, 2020). When conducting a comparative analysis with data gathered in 2009 analyzing the 13.4 million low-income status of families with children living less than 200 percent of the federal poverty level, it found that 4 million (30 percent) were Hispanic, 2.9 million (22 percent) were black or African American, and 800,000 (6

percent) were non-White (Henderson, 2009). Utilizing the assessment of data when conducting analyses of observed poverty rates, there are comparative disparities amongst ethnic and racial minority groups when compared with non-Hispanic White population groups. In comparison, there was a comparative analysis of Asian population groups retaining the lowest percentage of poverty rates amongst both surveys, with percentages of 7.3 percent (Creamer, 2020). When specializing in the analysis of ethnic/racial population groups closer to the observed federal poverty level, there is an increase in the variance of the racial population proportion, illustrating disproportionate representation for ethnic/racial groups in lower socioeconomic strata. Due to the market-based healthcare sector, individuals who pertain closer to the observed federal poverty level but do not cross the threshold 138 percent (for adults) of the FPL for healthcare assistance limit their access to healthcare and increase the rates of uninsured ethnic/racial populations (Covered California, 2024).

Referencing **Figure 2.** Due to the implementation of the ACA, there was a sizable regression in percentages of uninsured individuals following the increase of insurance coverage amongst lower socioeconomic strata. Although it could be argued that there is no correlation between the data, there are quantifiable factors that relate to the disadvantages that non-White racial groups have experienced that would, in turn, associate the data with the regression of uninsured individuals after 2010. Following this, the repeal and replacement of policies that expanded coverage during 2017 saw a noticeable uptick in percentages for ethnic and racial minority groups. This was due to the introduction of the American Healthcare Act, which sought to actively reduce the percentage of insured individuals by 14 million by 2018 (Congressional Budget Office, 2017). Discussing the figure, there has been an increase in percentage in 2017 brought by the slight repeal of the Affordable Care Act to reduce the number of those insured by

the expanded coverage of the ACA with the American Healthcare Act (AHA). Policies that have inhibited the progress made by previous expansive bills have negatively affected not only lower socioeconomic individuals but also ethnic and racial groups that have a higher percentage of the population within lower socioeconomic strata.

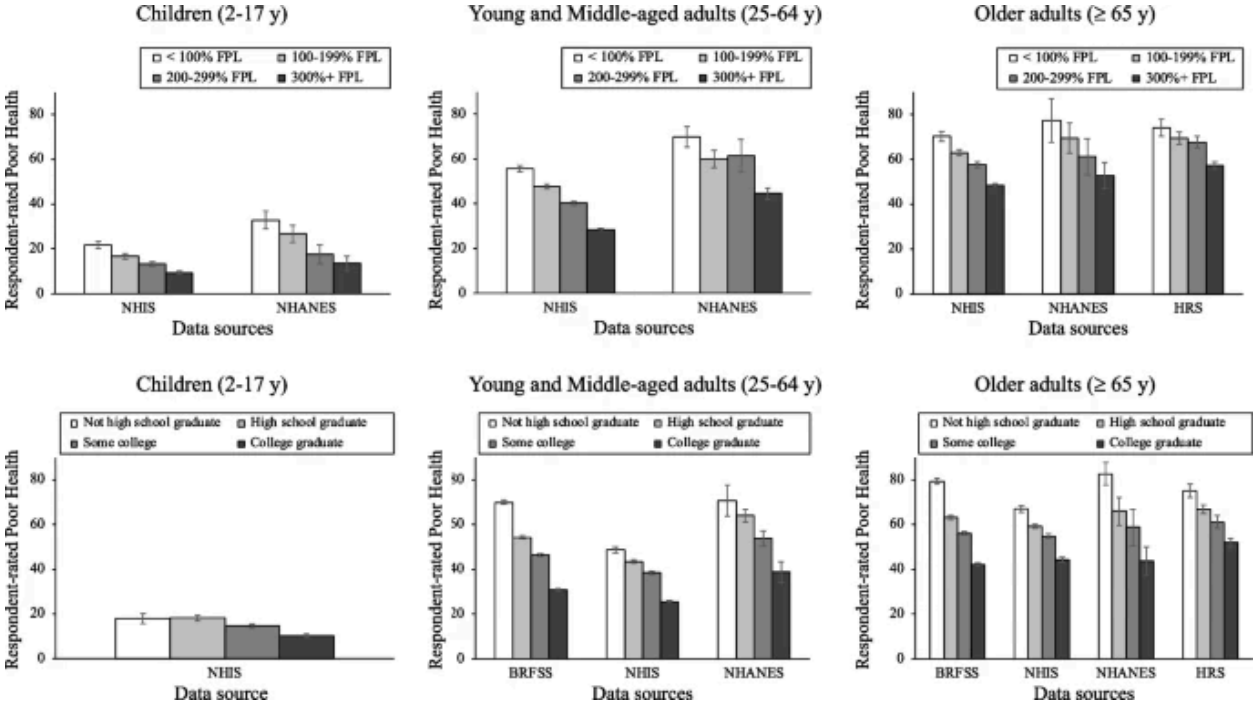
With sizable comparisons towards the rates of uninsured individuals within singular unit percentages, there is a large correlation between the total population proportion a select ethnic group possesses and the data gathered. This correlates with the notion that before the enactment of the Affordable Care Act, there were speculations that there would be sizable improvements in uninsured rates for ethnic and racial minority groups. Furthermore, it would not be the complete solution to eliminating disparities within the healthcare sector. Still, the retention of nominal values above 10% between various minority groups and White-identified individuals illustrates the disproportionate access to healthcare. Policies and acts were created to reduce the number of insured individuals, insecurities, and a lack of confidence within the market-based healthcare system, where individuals are upset or unwilling to afford the cost of healthcare.

For instance, as of 2021, more than half the population of the United States identified themselves as White; although containing the largest racial population group, they exhibit a lower percentage of uninsured individuals within the category, retaining only six percent of the uninsured rates examined within some surveys. Greater variances in population would negatively impact the results found within the population. Instead, the opposing result could be found where White individuals are more likely to be insured in contrast to uninsured rates of 19% for Hispanic population groups (Ndugga, 2023). Following this, there are greater variances in the type of healthcare received among Asian populations when the comparative analysis is made among White population groups. When referencing statistics regarding ethnic and racial

population groups, Asian Americans and Pacific Islanders have a lower chance (19.4 percent) to report having a personal doctor in contrast to White Americans (12.9) not having a "usual source of healthcare" (Pfizer, 2017). Ethical and racial disparities limit the quality of healthcare ethnic/racial minority groups receive due to prevalent inequities in healthcare access when compared with White individuals.

Socioeconomic and Class Disparities

Disparities are prevalent within racial and ethnic-racial groups and generalized socioeconomic status, observed by their relation and percentages to the federal poverty level (FPL). Per the FPL of household incomes, percentages have been assigned to establish poverty thresholds that aid in researching individuals who are affected by poverty and assist accordingly (ASPE, 2024). Numerous studies that utilized the threshold to assign socioeconomic stratification to categorize individuals better will be mentioned. For example, visualizing the poverty level threshold by <100%,100%-199%,200%-299%, and >300% gives stratified data



that visualizes the percentages of uninsured or impacted groups from the surveyed data.

Demonstrated in **Figure 3.** the data pooled from the surveys of national health studies like the National Health Interview Study, National Health and Nutrition Examination Survey, Health and Retirement Study, and Behavioral Risk Factor Surveillance System gives an overview of variables of the respondent's poor health (Kim, 2023). Additionally, the information gathered from the surveys illustrates a regression of poor health that impacts individuals who are farther from the FPL. Respondents from the survey demonstrate the impact socioeconomic status has on the well-being of individuals who are near or at the federal poverty level.

Furthermore, poor health trends are negatively impacting households that are <100% of the federal poverty level, with a unique focus towards educational attainment specifying from the data that examining the “education gradient[s] by race/ethnicity, the education gradient was consistently observed in the White sample across all data sources, but the Black, Hispanic, and Asian samples showed different trend patterns"(Kim, 2023). Gradients within the data illustrate inequities within the healthcare system, as those near the FPL display irregular poor health trends in relation to groups farther from the poverty level.

Continuing inequities within the healthcare system, in relation to ethnic and racial minorities, are also generalized towards socioeconomic status as groups that are closer to the FPL have declining lifespans. For instance, individuals farther from the FPL than groupings closer to the FPL are “1.5 times more likely to die before the age of 85, among those with a lower socioeconomic status… this study also estimates that lower socioeconomic status can shorten life expectancy by 2.1 years” with the discussion regarding the risk factors like hypertension, high alcohol consumptions, obesity, and a sedentary lifestyle (Hu, 2021). Reference to ethnic and racial disparities describe similar declines in life expectancy as the overall decline for life expectancy by race/ethnicity was a 2.7-year decline in life expectancy

(Ndugga, 2021). The margins between the two case studies were 0.6 years variance when comparing the analysis toward ethnic groups like African Americans and Hispanics, respectively, 4 years and 4.2 years. Showing the correlation between the inequities of uninsured individuals of ethnic and racial groups, there is a greater variance towards ethnic minorities within the United States.

Racial and Class-based disparity manifests in the domain of healthcare

Observing the healthcare domain within the United States illustrates that the continual inequities and disparities experienced by racial and class-based groups have manifested insecurities and caused dissatisfaction towards their healthcare. Following this, due to the long historical context of the United States, systemic issues inspired by the refusal of services for ethnic and racial minorities have created societal conditions that have limited the peak healthcare ethnic and racial minorities can experience, in contrast to White individuals. Surveys and assessments that used methods to analyze the satisfaction and causes of socioeconomic and racial disparities within the healthcare domain illustrate the insecurities that have evolved from the continual mistreatment of the market-based United States healthcare system. Disparities and Inequalities within the healthcare domain have manifested insecurities due to variables like the increased costs of insurance premiums, dissatisfaction with healthcare due to barriers within the healthcare industry, and generalized societal insecurities within the healthcare sector overall.

Increased Premiums

The increased premiums and lack of adequate income to supplement healthcare costs are insecurities that have manifested for those in lower socioeconomic strata. Referencing the federal poverty level (FPL), for a household of one being observed with an income of $15,060 as of 2024, being increased by $5,380 per individual added to the household, those close to the

observed FPL are concerned with the increased insurance premiums households have to pay (ASPE, 2024). With the average American family paying around 11 percent of their annual income on healthcare premiums, unplanned medical bills destabilize the economic security of various families. Following this, Black Americans are faced with an average annual cost of healthcare premiums reaching nearly 20 percent (Taylor, 2019). Income inequalities exasperate the inability to pay healthcare bills due to the lack of income flexibility within lower socioeconomic households. With households now containing percentages of about 41 percent middle-class and 30 percent in lower-class neighborhoods, an increase in environmental conditions is more commonplace. It affects the quality of healthcare for those whose neighborhoods will receive more equitable healthcare compared to those higher in the socioeconomic strata. (Baciu, 2017).

Furthermore, with higher concentrations of ethnic minorities in lower socioeconomic strata, individuals from lower socioeconomic households are dissatisfied with healthcare due to not having access to their optimal health. With increased costs to insurance premiums, in self-reported health status on Black, Hispanic, Asian Indian, and Alaskan Native (AIAN), reports demonstrated that 29 percent of AIAN adults, 23 percent of Hispanic, and 21 percent of Black reported fair or poor health compared to the health status of 16 percent of White adults (Catterson, 2022). The healthcare system's inequalities affect minorities, showing that ethnicity and race have affected how individuals are receiving healthcare, experiencing disparities, and causing improper access to optimal health.

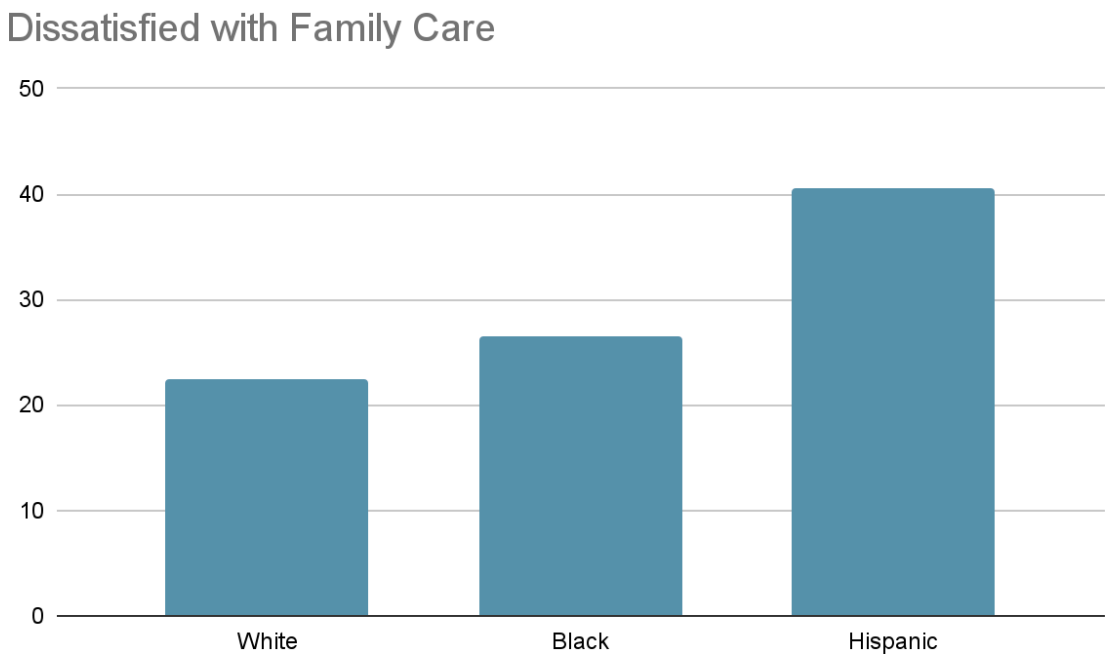
Postponed Care

The lack of adequate income has created inequities within the healthcare system, as lower socioeconomic classes cannot receive quality healthcare. The economic ineligibility to pay for

raised insurance premiums, surveys conducted during the time of 2021 by the California Health Care Foundation report that from among those who had been surveyed, “half of Californians (49 percent) skipped or postponed some type of healthcare in the last 12 months due to cost. Among those who postponed care, 47 percent report that their condition worsened, an increase from last year’s survey (41 percent)” (Catterson, 2022). The correlation between those ineligible to pay for care is that they are driven to postpone care that would otherwise give them optimal health status. For those in the lower economic strata, the importance of being paid and work is prioritized over their own health.

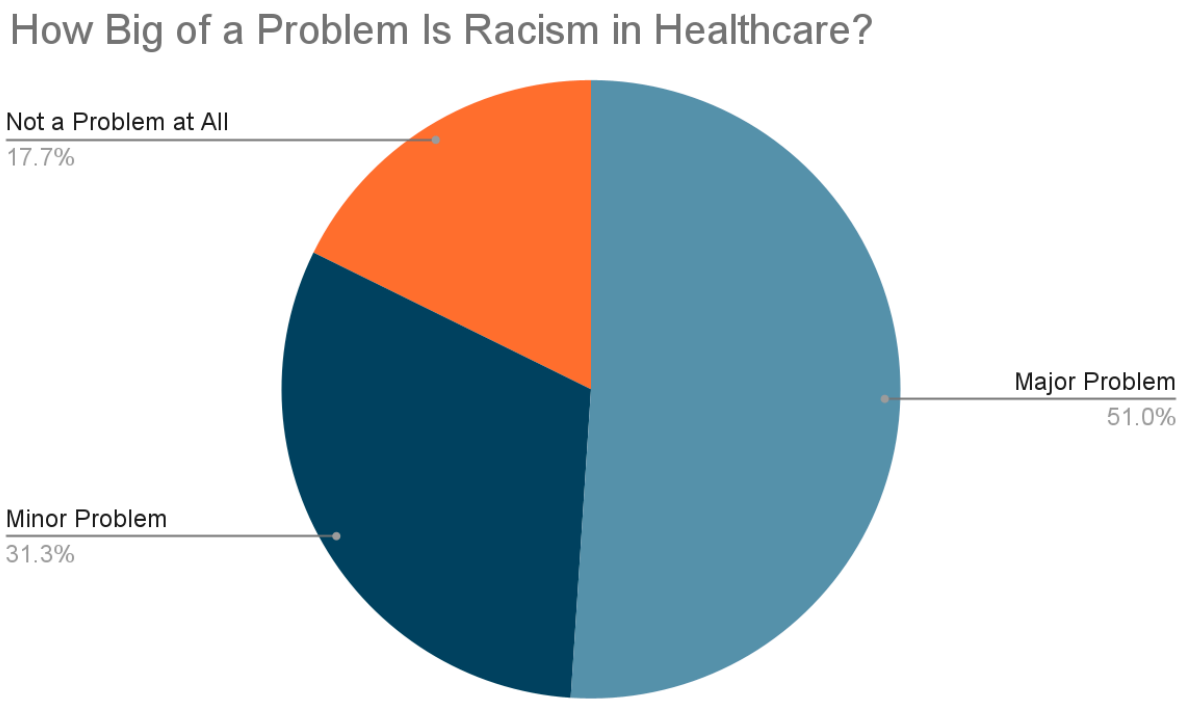
Dissatisfaction in healthcare

Following this, the type of dissatisfaction received from various surveys discusses a trend of dissatisfaction concerning healthcare before and after the enactment of the Affordable Care Act. In a 2006 survey, they surveyed the “percent of persons who are not satisfied that their family can get care,” which were then categorized by racial and ethnic groups (Kirby, 2006). As illustrated in **Figure 4**, it demonstrates the disparities in satisfaction with healthcare, in which a



specific interest is in the care family members can receive. With substantial differences amongst Hispanic percentages in contrast to White percentages, an 18.1 percent variance discusses the collusion between inequities experienced by ethnic and racial groups within the healthcare system. Before the enactment of the ACA, disparities amongst racial groups were more divergent as anti-discriminatory health laws towards predisposed conditions were not in enactment. Following this, the data collected from 2006 displays the variances among population groups and notices that the Hispanic population is particularly disadvantaged (Kirby, 2006).

Recent data concludes that ethnic and racial surveyed populations believe that ethnic/racial groups are receiving inequitable healthcare due to their racial/ethnic status. A 2022 survey conducted in California revealed that in a sample that included more than 3,000 Black Californians, 31 percent believed that their provider was mistreating them due to racial/ethnic



background (Cummings, 2022). This coincides with the research performed by various surveys in **Figure 5.** which depicts the relationship amongst ethnic groups and their perception of how

pertinent an issue of racism is within the United States after being mistreated within the healthcare sector. Population groups participating in the survey have demonstrated the collusion amongst higher percentages of minority groups within the United States. Additionally, with the implementation of acts like the American Healthcare Act (AHA), regression towards the beliefs that the United States is providing equitable healthcare is manifesting insecurities within the healthcare system. Although there are great strides towards the reduction of uninsured individuals and policies that have sought to reduce the barriers towards healthcare, insecurities amongst ethnic/racial population groups are still prevalent after changes that were made to lower the inequities in healthcare.

V. Conclusion

In conclusion, inequalities within the ethnic and racial minority groups are proven to be prevalent within the United States healthcare sector. By defining and observing the gradient trends of racial and ethnic minority access to healthcare, the project discussed the dominant inequities that minorities experience within the healthcare system. This project highlighted the components of healthcare accessibility within the United States through the timeline and discussion of 2000 to 2024, which discussed how integral the enactment of the Affordable Care Act was towards lower socioeconomic strata and ethnic/racial groups alike. The discussion of trends of satisfaction proved to harm the surveyed minority groups as the project revealed increased costs of healthcare, barriers that restricted individuals farther from the observed FPL from receiving their optimal healthcare, and the overall manifestation of insecurities within the healthcare sector that has developed societal and systemic inequities within the healthcare system. Furthermore, the project has explored the role of democratic governance in the

healthcare system and the societal expectations that shape it. It has examined how these factors can promote or hinder healthcare system equitability.

This research is important due to the discussion of not only systemic barriers that limit access for minorities to receive optimal healthcare but also the societal manifestations of insecurities that limit the satisfaction and perception of the United States healthcare system. Following this, research for these topics revealed data that does not fully include current data pertaining to Native Americans and Pacific Islanders, as data for the minority groups were not always covered within census data or surveys researched. Following this, with the proper visualization of the negative trends towards dominant minority groups like Hispanic and African American population groups, there is regression towards uninsured accounts; the population groups overall still have disproportionate percentages when compared with non-elderly White individuals. Data after the enactment of the Affordable Care Act examined sizable variances among the surveyed population groups, demonstrating the importance of policies that challenge discriminatory policies and how the introduction of the American Healthcare Act regressed the progress experienced by uninsured individuals.

It is imperative to continue the research in areas that this project has touched upon. The data presented here provides a solid foundation, but there is a pressing need to delve deeper and explore subgroups within the dominant minority groups. While this project has specified groups like African Americans and Hispanic population groups, it is crucial to further dissect the data. For instance, a more detailed analysis of the individual subgroups of Hispanic populations, such as Puerto Ricans, with a special focus on the territory of Puerto Rico, would be highly beneficial. Similarly, understanding the types of inequities experienced by United States territories is a vital area for future research. Additionally, research on Asian population groups would be warranted

as the surveyed population groups had comparative results to White population groups. The data had broad interpretations, but focusing on the African American and Hispanic populations was found during the project.

Furthermore, I found limitations in the data gathered regarding insecurities manifested within the United States healthcare system. This intertwined with the suggestions for further research, as data pertaining to the viewpoints and opinions of Native Americans and Alaskan Natives were not found and could not be supported by data. This project focused on the aspects of inequities and whether there are socioeconomic comparisons towards receiving care and ethnic minority groups receiving more inequities towards their optimal healthcare.

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