Racial and Economic Disparities and the Correlation to Adverse Events in Minority Populations in the United States

THOMAS F. FREEMAN HONORS COLLEGE

SENIOR THESIS

BY

Jordan Davis

Health Administration

College of Pharmacy and Health Sciences

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APPROVED BY

Dr. Monica Rasmus — April 18, 2019

HONORS FACULTY FELLOW MENTOR — DATE

Dr. Denise Stallard — 4-18-2019

DEAN, HONORS COLLEGE — DATE

TSU

TEXAS SOUTHERN UNIVERSITY

Thomas F. Freeman Honors College

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VITA

May 15, 1998. . . . . Born- Plano, Texas

2012 - 2016. . . . . HS Diploma, Plano East Senior High

2017. . . . . A.N.D. Home Health Intern

2018. . . . .Customer Relations Intern,

Harris Health System

2016 - 2019. . . . . .B.S. Health Administration

Texas Southern University

Houston, TX.

Current. . . . . Account Associate:

Blue Cross Blue Shield of Texas.

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Abstract

The United States is a multiracial, multiethnic society. The major racial/ethnic categories in American society are white, African-American, Hispanic, Asian, and Native American. Racism, an insidious social problem in the United States since the founding of the country, is the belief that members of one or more races are inferior to members of other races. Racism in the United States has been directed primarily by the white majority against racial and ethnic minorities. Historically, the white majority has singled out racial/ethnic minority groups for differential and unequal treatment in the areas of housing, employment, education, and criminal justice. As a 20-year old young African American male, these racial disparities directly affect my future success and my peer group. Since the presidential election in 2016, racism in America has become more accepted, overt, and tolerated.

Criminal justice experts distinguish between legal and extralegal factors to explain racial disparities in criminal justice. Legal factors include seriousness of the offense and prior criminal record. These are legitimate reasons for disparities because they pertain to an individual's criminal behavior. Extralegal factors include race, class, and gender. These are not legitimate factors upon which to base decisions because they relate to group membership rather than criminal behavior.

One type of racial disparity occurs when there is a significant difference between the percentage of a racial group represented in the general population and the percentage of the same group represented at any point in the justice process. For example, African-Americans make up 12 percent of the U.S. population but account for about 40 percent of all arrests, 50 percent of the prison population, and 50 percent of the inmates on death row. Another type of racial disparity appears whenever there is a significantly larger percentage of members of a racial/minority group involved in a part of the criminal justice system than whites. For instance, more than 9 percent of all African-American adult males are in jail or prison or on probation or parole, compared with not quite 2 percent of all white adult males. To cite another example, blacks are four times as likely as whites to be arrested on drug charges—even though the two groups use drugs at almost the same rate.

America continues to become more diverse. Bias stems from racism, creating stress on the race that is being discriminated against, leading to issues with a person's bodily and mental health. Repeated stress overtime on one's body can lead to health problems such as depression, anxiety, insomnia, heart disease, skin rashes, and gastrointestinal problems, which are also more likely to develop in children. Racism has many detrimental effects on the health of Americans across the entire country, arising mainly from limited access to healthcare, mental health resources, and support. There are a wide range of patterns of health disparities that are caused by various levels of income across ethnic groups.

Health disparities explain that stress can be derived from many individualistic factors or experiences, has multiple effects on health. Stress is also associated with chronic diseases. Stress that is derived from racism has specific contextual factors, which adds a daily burden to African-Americans and other demographic groups that are discriminated against. These demographic groups do not often realize that these stressors may be contributing to the state of their mental health The twentieth century witnessed a great expansion of the upper bounds of the human lifespan. At the beginning of the century, average life expectancy in the United States was 47 years. By century's end, the average life expectancy had risen to over 70 years, and it was not unusual for Americans to exceed 80 years of age. However, although longevity in the U.S. population has increased substantially, race disparities in longevity have been persistent. African American life expectancy at birth is persistently five to seven years lower than European Americans. Most of studies focus on the black-white contrast, but a rapidly growing literature describes variations in health status among America's increasingly diverse racial populations. Today, Asian Americans live the longest (87.1 years), followed by Latinos (83.3 years), whites (78.9 years), Native Americans (76.9 years), and African Americans (75.4 years). Where people live, combined with race and income, play a huge role in whether they may die young. A 2001 study found large racial differences exist in healthy life expectancy at lower levels of education.

A study by Jack M. Guralnik, Kenneth C. Land, Dan Blazer, Gerda G.

Fillenbaum, and Laurence G. Branch found that education had a substantially stronger relation to total life expectancy and active life expectancy than did race. Still, sixty-five-year-old black men had a lower total life expectancy (11.4 years) and active life expectancy (10 years) than white men (total life expectancy, 12.6 years; active life expectancy, 11.2 years) The differences were reduced when the data were controlled for education. During the 20th century, the difference in life expectancy between black and white men in the United States did not decline

A study by the Brandeis University Institute on Assets and Social Policy which followed the same sets of families for 25 years found that there are vast differences in wealth across racial groups in the United States. The wealth gap between Caucasian and African-American families studied nearly tripled, from $85,000 in 1984 to $236,500 in 2009. The study concluded that factors contributing to the inequality included years of home ownership (27%), household income (20%), education (5%), and familial financial support and/or inheritance (5%).

Wealth can be defined as "the total value of things families own minus their debts." In contrast, income can be defined as, "earnings from work, interest and dividends, pensions, and transfer payments." Wealth is a crucial factor in determining the quality of both individual and family life chances because it can be used as a tool to secure a desired quality of life or class status and enables individuals who possess it to pass their class status to their children. Family inheritance, which is passed down from generation to generation, helps with

wealth accumulation. Wealth can also serve as a safety net against fluctuations in income and poverty

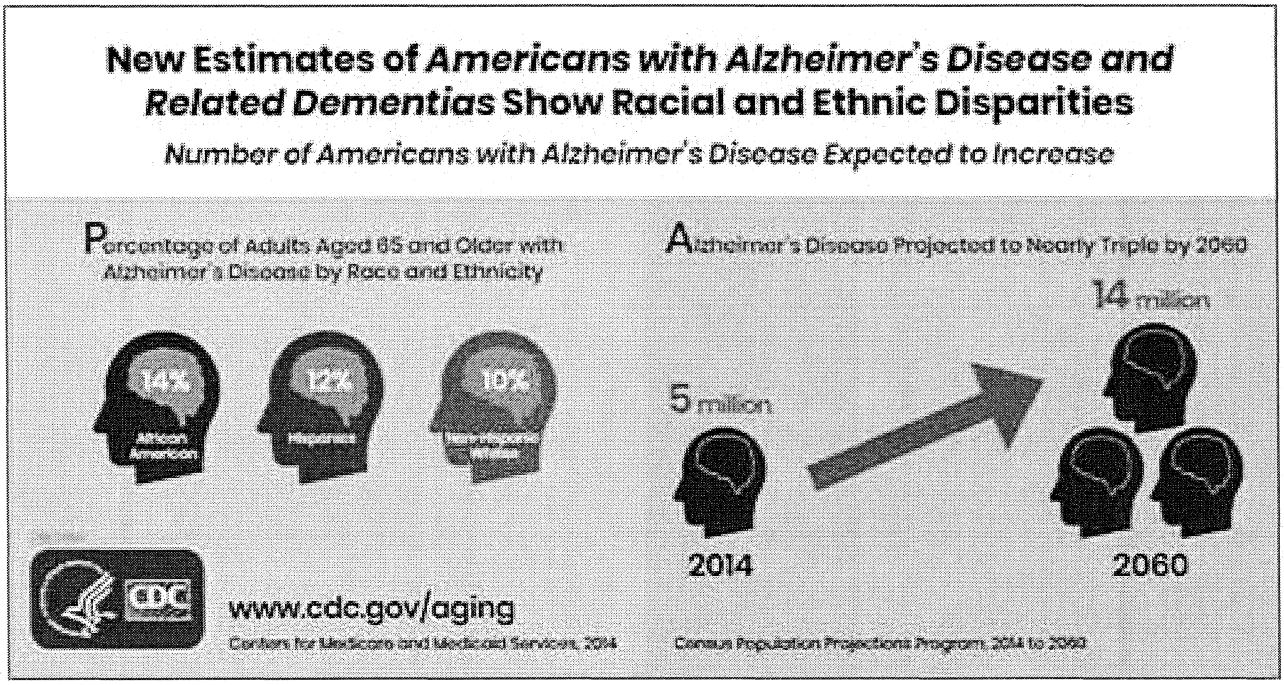
There are vast differences in wealth across racial groups in the United States. The racial wealth gap between white and African-American families nearly tripled from $85,000 in 1984 to $236,500 in 2009. There are many causes, including years of home ownership, household income, unemployment, and education, but inheritance might be the most important.

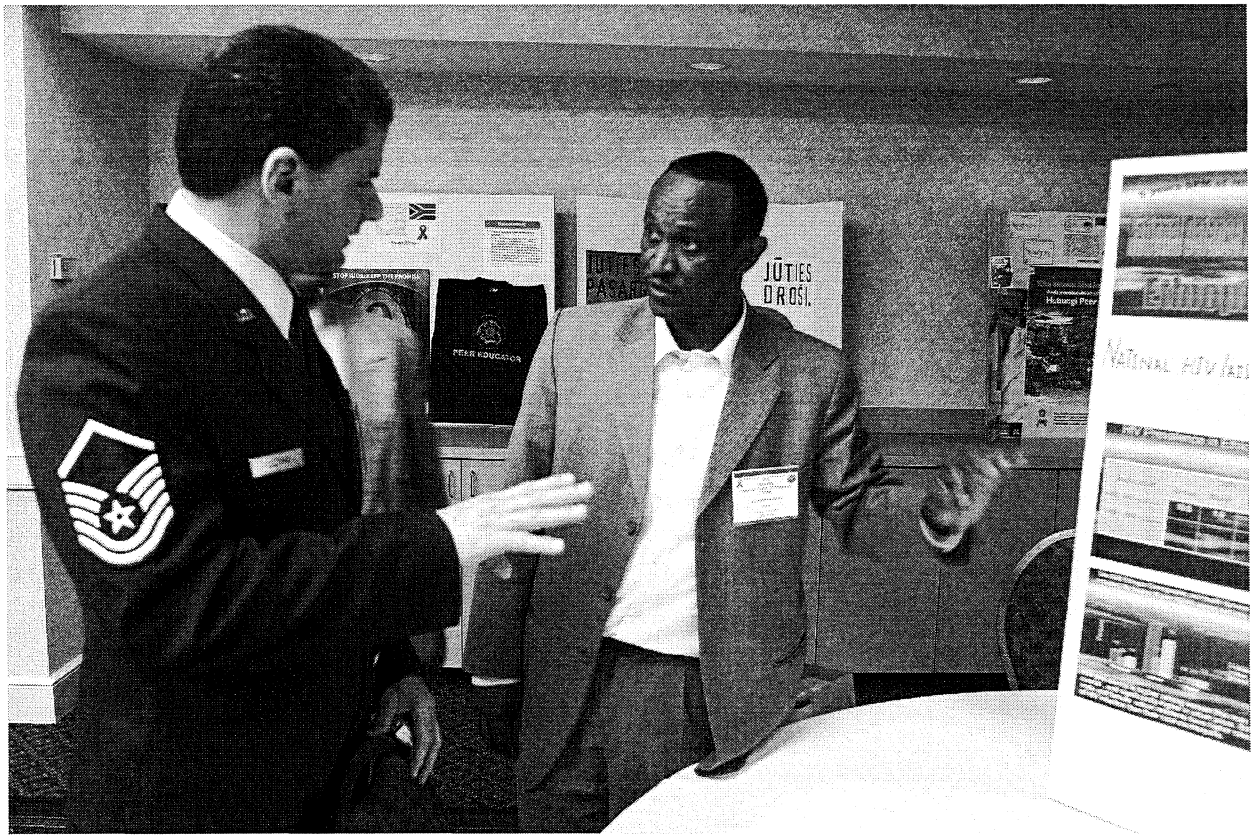
Conley states that differences between African American and White American wealth begin because people with higher asset levels can take advantage of riskier investment instruments with higher rates of returns. Unstable income flows may lead to "cashing in" of assets or accumulation of debt over time, even if the time-averaged streams of income and savings are the same. African Americans may be less likely to invest in the stock market because they have a smaller parental head-start and safety net. Chong, Phillips and Phillips state that African Americans, Hispanics, and Asians invest less heavily in stocks than White Americans. Hispanics and in some ways African Americans accumulate wealth slower than White Americans because of preference for near-term saving, favoring liquidity and low investment risk at the expense of higher yielding assets. These preferences may be due to low financial literacy leading to a lack of demand for investment services.

The racial wealth gap is visible in terms of dollar for dollar wage and wealth comparisons. For example, middle-class Blacks earn seventy cents for every

dollar earned by similar middle-class Whites. Race is the "strongest predictor" of one's wealth. I conclude that racial inequality in the United States refers to social advantages and disparities that affect different races within the United States. These inequities may be manifested in the distribution of wealth, power, and life opportunities afforded to people based on their race or ethnicity, both historic and modern. Racial disparity refers to a difference that may or may not be related to discrimination.

Frontispiece





Chapter 1

Introduction

What are Racial Disparities?

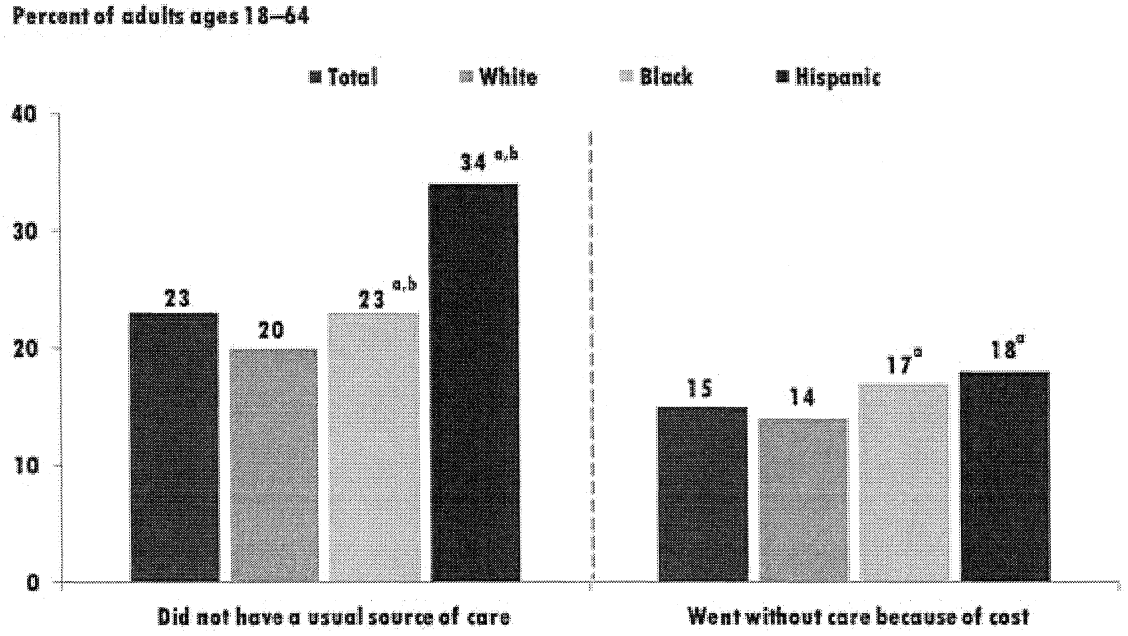
The Institute of Medicine (IOM) report on unequal treatment concluded "racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable." The IOM report defined disparities in health care as "racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention."

What are Preventable Adverse Events?

Preventable adverse events are when harm is done to a patient caused by their medical care rather than their underlying medical issue (disease, illness, injury).

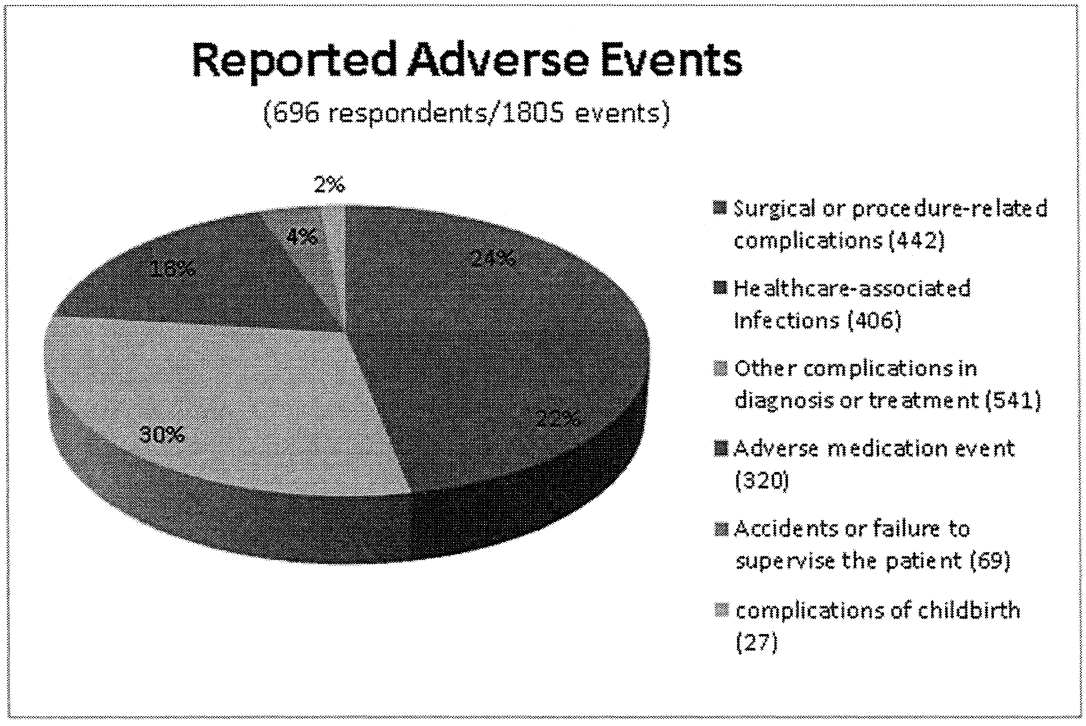
Tables and Figures

Disparities in Health Care Access by Race or Ethnicity Persist Even After Accounting for Income and Other Factors (2012–13)



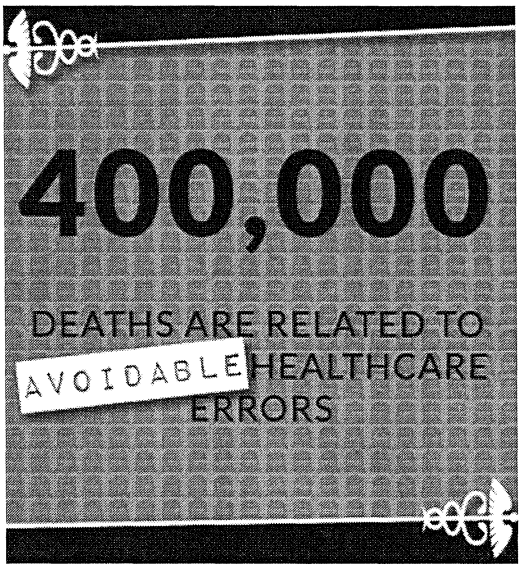
Notes: Black and white refer to black and white non-Hispanic populations. Hispanics may identify as any race. Adjusted means controlled for respondents' age, sex, health status, and income. Differences are statistically significant at the 0.05 level: (a) minority population compared with white; (b) black compared with Hispanic.
Source: 2012 and 2013 Behavioral Risk Factor Surveillance Survey (BRFSS).

The COMMONWEALTH FUND



Tables and Figures cont.

	Patients		Adverse events	Preventable adverse events
	n	%	per 100	per 100
Age				
0–14	159	8.1	5.0	4.4
15–29	197	10.0	11.7	8.1
30–44	248	12.6	12.5	8.9
45–64	417	21.2	12.0	7.2
65 +	946	48.1	13.6	9.9
Sex				
Male	893	45.4	11.6	8.0
Female	1074	54.6	12.8	9.1
Total	1967	100.0	12.3	8.6



All these bits and pieces of information relay a very important part to healthcare and their efficiency with patients. Many people go to hospitals looking for valuable care that can change and turn around their lives and current condition. But there has been a noticeable trend that this standard is not being fulfilled. People are losing their lives off of many preventable events such as procedure related complications, adverse medication, or accidents or failure to supervise the patients. These are risk people take when going in to care of an entity, however we must attempt to minimize these events, especially in to underrepresented populations.

Chapter 2

Rates of Medical Errors and Preventable Adverse Events Among Hospitalized Children Following Implementation of a Resident Handoff Bundle

Amy J. Starmer, MD, MPH1 ,2; Theodore C. Sectish, MD1 ; Dennis W. Simon, MD1 ,3; et al

Core Context Literature

The above point is the starting point in this research, this shows the ponderance about repetitive medical errors that have lead to many patient complications and even death. This one is directed towards children. I choose this one in particular to show that even children, who people and medical professionals have more empathy and are more careful around, are still making unnecessary mistakes. This exploits the bit of corruption that causes patients to utilize more money, more surgical time for more procedures, or causing a even more devastating event to occur. This intervention study was used to see a typical procedure in a inpatient hospital and was monitored using a daily systematic surveillance. The study shows many greater benefits after locating the where this hospital and many other health systems could improve to avoid similar errors. Most adverse event do arise from Inpatient, and that could partially because that is when professionals must provide on going care. But this causes a huge problem because this is where patients are in a critical state and need flawless care in order to prolong their life and cure the proclaimed sickness they entered with.

We can also analyze another piece of information here to show once the intervention was made the rate of medical errors decreased, but shows many health systems that are not audited make the initial rates or even higher in effect of carelessness.

"Comparing preintervention and postintervention periods, implementation of the resident

handoff bundle was associated with a reduction in overall medical error rates from 33.8 (95% CI, 27.3-40.3) to 18.3 (95% CI, 14.7-21.9) per 100 admissions (P < .001) on both units combined. Preventable adverse events decreased from 3.3 (95% CI, 1.7-4.8) to 1.5 (95% CI, 0.51-2.4) per 100 admissions (P = .04), nonintercepted potential adverse events decreased from 7.3 (95% CI, 5.0-9.6) to 3.3 (95% CI, 1.85-4.7) per 100 admissions (P = .002), intercepted potential adverse events decreased from 15.0 (95% CI, 11.2,18.7) to 8.3 (95% CI, 6.0-10.7) per 100 admissions (P < .001), and errors with little or no potential for harm decreased from 8.3 (95% CI, 5.4-11.1) to 5.2 (95% CI, 3.3-7.2) per 100 admissions (P = .04) (Table 2)

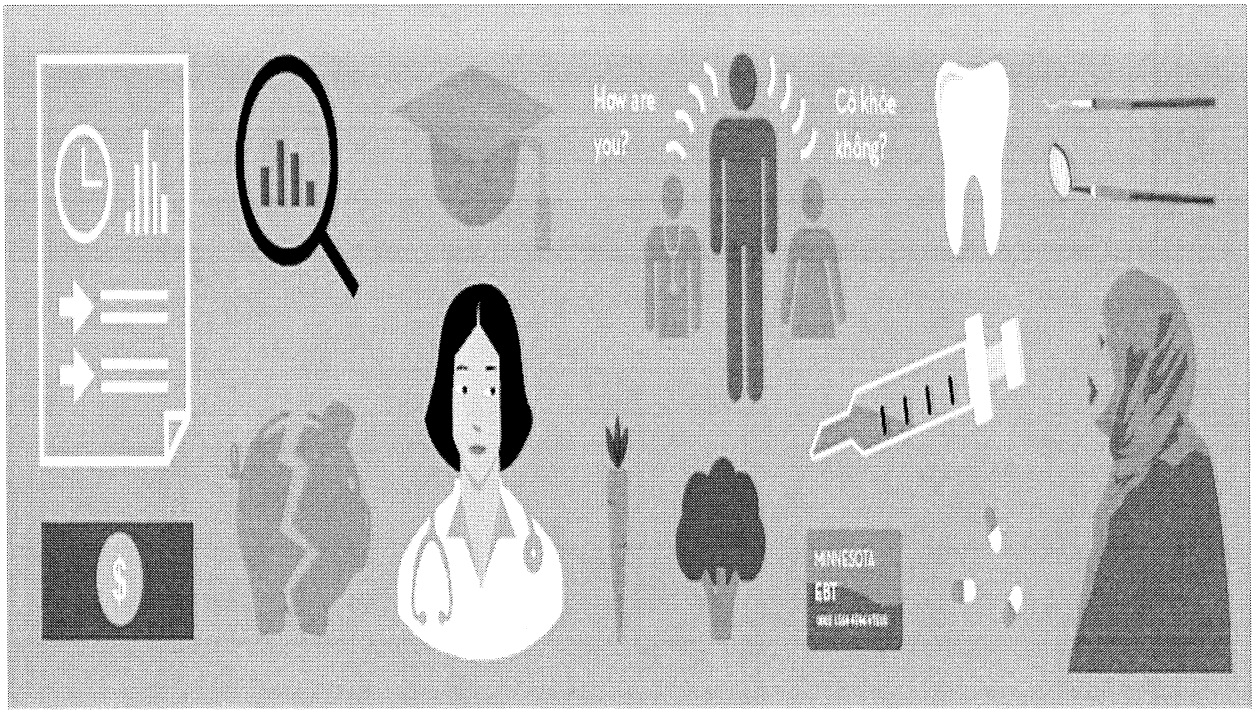
(Starmer). This piece of information reflects so much alone in its entirety. This reflects that first the intervention was very effective effective. As the medical error rate went down 15.5%. That is a tremendous decline that could save many lives. Now granite, not all medical errors lead to an all out adverse effect. But through these errors are how occurrences that shouldn't happen, happen. Just experimenting with two units from the hospital, they even had a 2% decrease regarding actual adverse event occurring. These proportions must be minimalized to provide optimal care. Not only when being experimented upon.

Social Sources Of Racial Disparities In Health

David R. Williams and Pamela Braboy Jackson

In this text, it reveals various reasons why racial disparities are present. Indeed these factors do have some influence such as residential segregation, socioeconomic

status, income, and health practices. Residential segregation plays a huge role in disparities and breaking that barrier would probably lower the disparity and adverse event rate. This factor is something that could change many instances in society, as many people in the same community utilize the same healthcare locations, this could be directly correlated to the performance of that specific health system. For example, if a black community lives in a place with a hospital up the street, in any emergency most likely the people of that community will go there to receive care. That being said, if that facility has many medical errors and preventable adverse events, this will cause a drastic increase in disparity and health performance towards African Americans. However, if this community diversified itself to other communities, if one community hospital was performing poorly, it would not solely effect the Black community and lower the percent of African Americans disparity. "The persistence of racial differences in health after individual differences in SES are accounted for may reflect the role that residential segregation and neighborhood quality can play in racial disparities in health. 11 Because of segregation, middle-class blacks live in poorer areas than whites of similar economic status, and poor whites live in much better neighborhoods than poor blacks" (Williams 15). This shows that because of segregation, people with equal socioeconomic status to not receive equal resources because of community choice, which directly places influence on racial disparities.



Systematic Review on the Incidence and Characteristics of Preventable Adverse Drug Events in Ambulatory Care By Linda Aagaard Thompson etc.

Ambulatory care is something that is very important aspect to adverse events as this is the first response of care in any emergency setting. Some procedures and actions actually harm the patient or cause side effects that were not necessary. This is another opportunity for errors that could be apart of racial segregation. Given this noticeable trend, creating a mistake-proof common procedure in this process of ambulatory care would definitely decrease adverse events that arise from human error. " Cardiovascular drugs, analgesics, hypoglycemic agents together accounted for 86.5% of pADEs and 77.2% of pADEs resulted in symptoms of the central nervous system, electrolyte/renal system, and gastrointestinal tract (Thompson 4)." This result is a very

important piece of information. By finding out the areas were these instances happen the most often, we are able to understand what aspect we need to put our emphasis on, and establish a solid protocol and ensure extra attention to these areas to prevent in the future. Ironically but upsetting, the places where we make preventable adverse events are the same places that are very vital such as cardiovascular areas that in essence effect the central nervous system.

Literature Conclusion

In conclusion to all the text many things were revealed in how and why some many odd things happen the way the happen. Lack of attention, no universal procedure, and sometimes just outright faulty health professionals are exposed and focused on

through these studies and interventions. There are many cases and instances that we cannot control. Some people get sick and even with proper treatment they cannot be saved. However, our national healthcare goal that should be the only reason we cannot somebody could not make it. Not because of something that was indeed preventable. Minorities are already socially oppressed and having many there opposing energies in American society. Healthcare should not be one of these aspects. As our healthcare is not universal, our healthcare performance toward our patients is blatantly shown. One thing that can be concluded is more than race, our society and performance of care is driven off of money/socioeconomic status. Therefore lower class people which are typical people of color, take the biggest hit of scarce resources and underperforming facilities. But this can be changed and reformed to make a balanced standard of care.

Chapter 3

Methodology Justification

For many reasons this piece of text was chosen. One of the main reason these sparked interest in the message conveyed because first and moreover, they exposed the main problem in need to be solved, disparities. Also showing and illuminating the presence of racial disparities that occur in the healthcare setting, but it also showed the problems with other societal inefficiencies and how they can carry over into health disparities today. By doing such method I was able to give multiple perspectives, reasoning and angles on how all these thing correlate with one another. In a community, health is one of the most important aspects. No one would desire to live somewhere the health levels were just not up to par. Living in a sickly community reveals a lot. Similar to living with a really healthy community. Restaurant availability, hospital locations, and community exercise events are very different in each community. Therefore, recognizing these differences and utilizing them as support was almost vital in order to highlight the complex situation. In order to maneuver and support and analyze underlying reasons is necessary to create a thurow Thesis. Matter of fact, recognizing different but relative subjects and how they all matriculate to have the same pattern of data really puts things into perspective and gives a 360 degree view of the subject. That being said, yes, my thesis was to evaluate and provide solutions to racial disparities. But when you realize other disparities are all interrelated to racial ones, then you understand the solution to subjects aren't so simple.

Approach

My approach in gathering this data had various components and aspects to consider. Because of that I figured the best way to go about this gathering literary content was to search among the topic from a broad perspective to a sharper one. This includes the minor societal influences that do have a role in the statistics. But afterwards in sample search it would cut the excess information and create a more tailored search. The reason I chose to not directly search my Thesis subject initially
was because I desired to look and review the outer shell of the problem, gather all relevant information and outer portions of data that may be applicable to this redundant problem, and then seep into the more direct searches that reveal micro energies that play a part in the dysfunction.

Context Literature

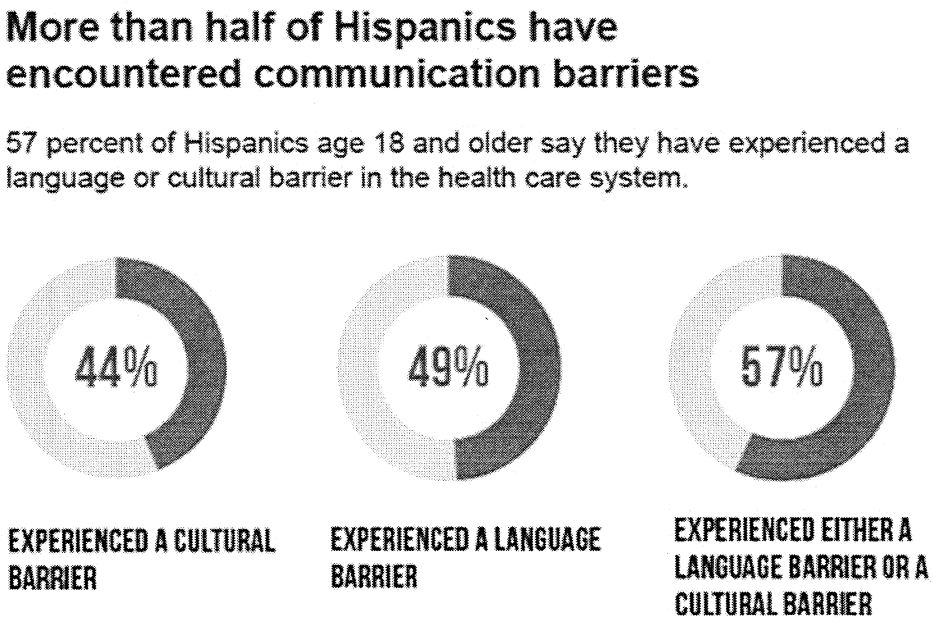
A REVIEW OF LANGUAGE AND OTHER COMMUNICATION BARRIERS IN HEALTH CARE By SHARON M. LEE, PH.D. DEPARTMENT OF SOCIOLOGY
PORTLAND STATE UNIVERSITY

As we analyze America and other cultures within the United States, another problem that may affect healthcare delivery methods are communication barriers. With the United States be a melting pot of many cultures and ethnicities, sometimes minorities first language may not be English. Because of this, it would be very wise to make sure the healthcare professionals are working to be culturally competent with the community the serve. A big barrier that affects America (Especially the southwestern regions) is a language barrier. " Various studies show that language barriers are

associated with lower access to health care. In a report by the Institute of Medicine, language barriers were ranked among the top three barriers" (Lee 6). This reveals that our population makeup is changing. Furthermore, if our professional makeup does not change, we will struggle to give superior care to our communities because of the lack of communication. Some aspects can be complex to achieve, others just take some flexibility and effort. This is one of the aspects that with accomodations people are able to fix and alleviate this barrier which would make a tremendous difference. Being anywhere without communication can be very hard, ordering food and not speaking the same language can be difficult, so imagine attempting to treat someone and communication is little to none. So obviously this is a barrier that need to be accommodated for and cannot be ignored if we plan to improve healthcare as a nation.

Another barrier that is intertwined with other barriers are cultural barriers. Cultural barriers become a difficulty because it leads to things a grey are interpretation. In one culture one thing can mean something and in another it can mean the complete the opposite. This is something professionals must be aware of and act upon consciously because no one wants to send mixed messages that could further problems at hand. Moreover, we must understand there is more to culture than language. That being said, just because we understand the language the patient may be speaking, does not mean we understand the culture. "Research on cultural diversity and barriers in patient-physician communication typically use race or ethnicity or language to indicate culture. Oomen et al. (1999) studied cultural barriers in health care by comparing Latino patients interacting with non-Hispanic White physicians, and report lower quality of care for Hispanic women related to cultural norms. Dibble et al. (1997) compared Black, Asian,

White, Latina, and Pacific Islander women on ethnic (cultural) differences in rates of breast cancer screening, with lower rates among Latina and Asian women related to embarrassment during the procedure" (Lee 7). This reflects that some cultures have stronger and more prevalent rituals than other cultures. Some are so unique that in result they will receive lower quality of care, and patients may even refuse care because of the ignorance to a topic or the assumption that such treatment may be against their culture.



Chapter 3

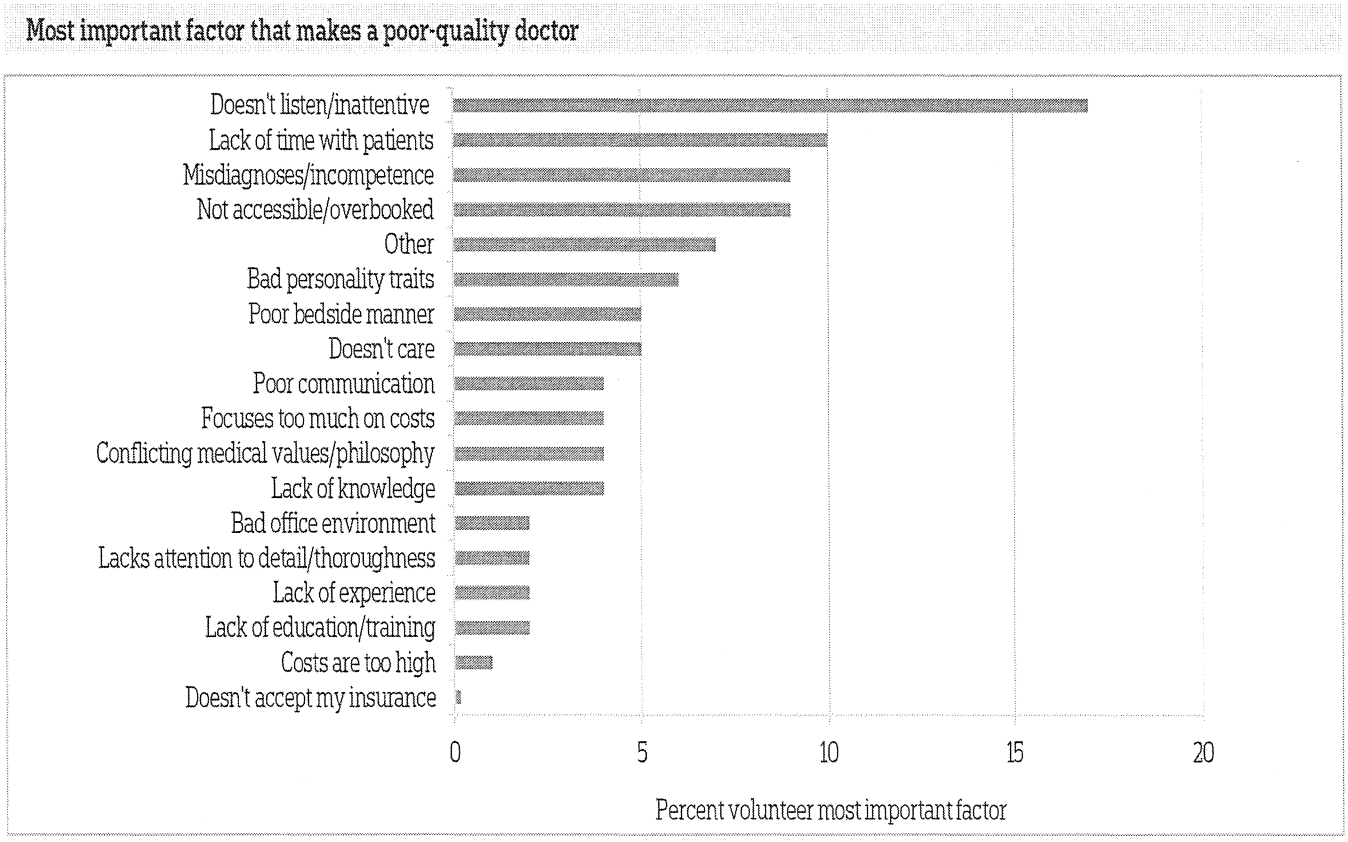
Clinical Procedure and Quality of Care

Throughout many studies and observations, hospitals systems have continuously struggled with quality of care for many reasons. These issues usually transpire from budget issues, resulting in allowing lower qualified positions care for patients for an

extended amount of time. Because of such hospitals in minority communities typically acquire less revenue and are occasionally underfunded, this malpractice happens even more often. The problem seems like it has a quite simple solution, just staff higher professionals to professionals. And in a perfect situation that would be the easy fix, but this where budgeting causes a quality crash. Many higher professionals are not willing to take a pay cut, and the organization expresses that they are not able to afford to staff that level of professionals for extended periods of time. " Among medical patients, a higher proportion of hours of care per day provided by registered nurses and a greater absolute number of hours of care per day provided by registered nurses were associated with a shorter length of stay ($P=0.01$ and $P<0.001$, respectively) and lower rates of both urinary tract infections ($P<0.001$ and $P=0.003$, respectively) and upper gastrointestinal bleeding ($P=0.03$ and $P=0.007$, respectively). A higher proportion of hours of care provided by registered nurses was also associated with lower rates of pneumonia ($P=0.001$), shock or cardiac arrest ($P=0.007$), and "failure to rescue," which was defined as death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis ($P=0.05$). Among surgical patients, a higher proportion of care provided by registered nurses was associated with lower rates of urinary tract infections ($P=0.04$), and a greater number of hours of care per day provided by registered nurses was associated with lower rates of "failure to rescue" ($P=0.008$)" (Needleman). These results reveal a direct correlation between of lower rates of incidents and higher professionals overwatch. Accommodations should and could be made of course. But at what cost? Cutting revenue? Acquiring more high level staff? These types of sacrifices many upper management, and shareholders most likely

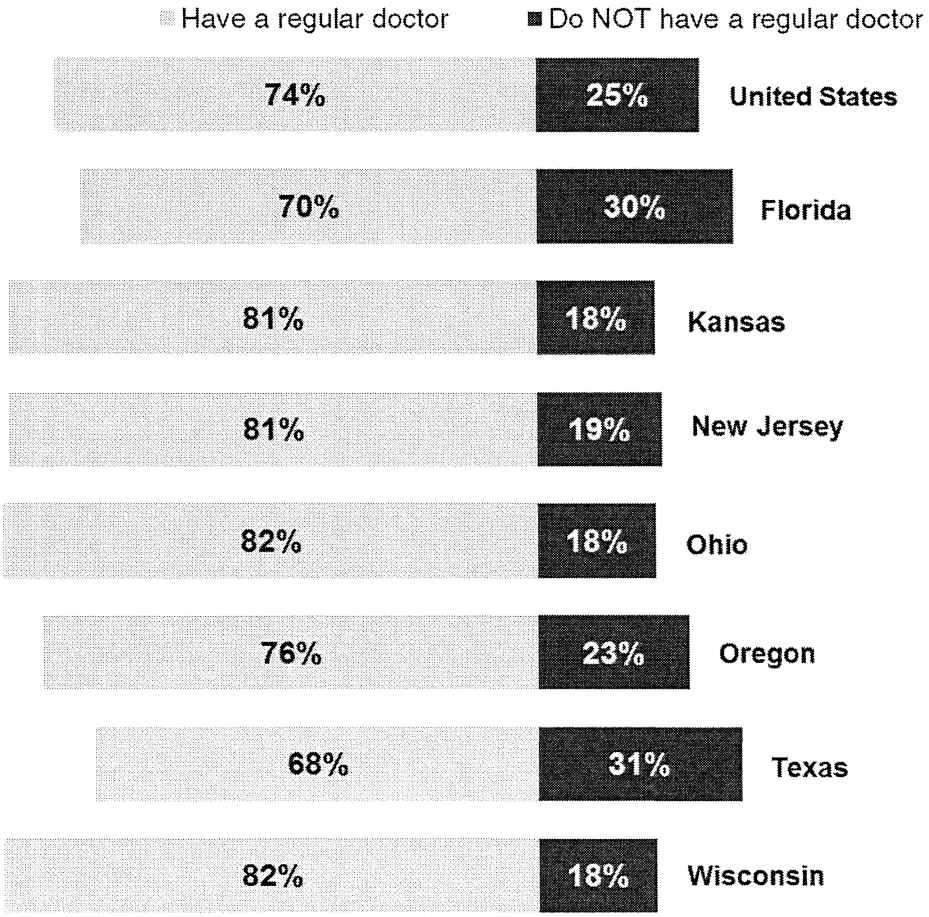
do not approve of it because it cuts initially into the ending goal or any business, maximum profits. Because of this conflict of interest, it causes a bit of a tear.

Many times in research of quality of care and necessary procedure we try to complicate things and attempt to bring higher reasoning into why our quality of care suffers. But sometimes you just have to look at the obvious skills and procedures and notice what parts professionals are neglecting. According to the figure above the biggest problem seems to be the lack of listening. This is a trait the reveals itself in a plethora of professions, but can really cause a problem by overdoing procedures, proceeding in

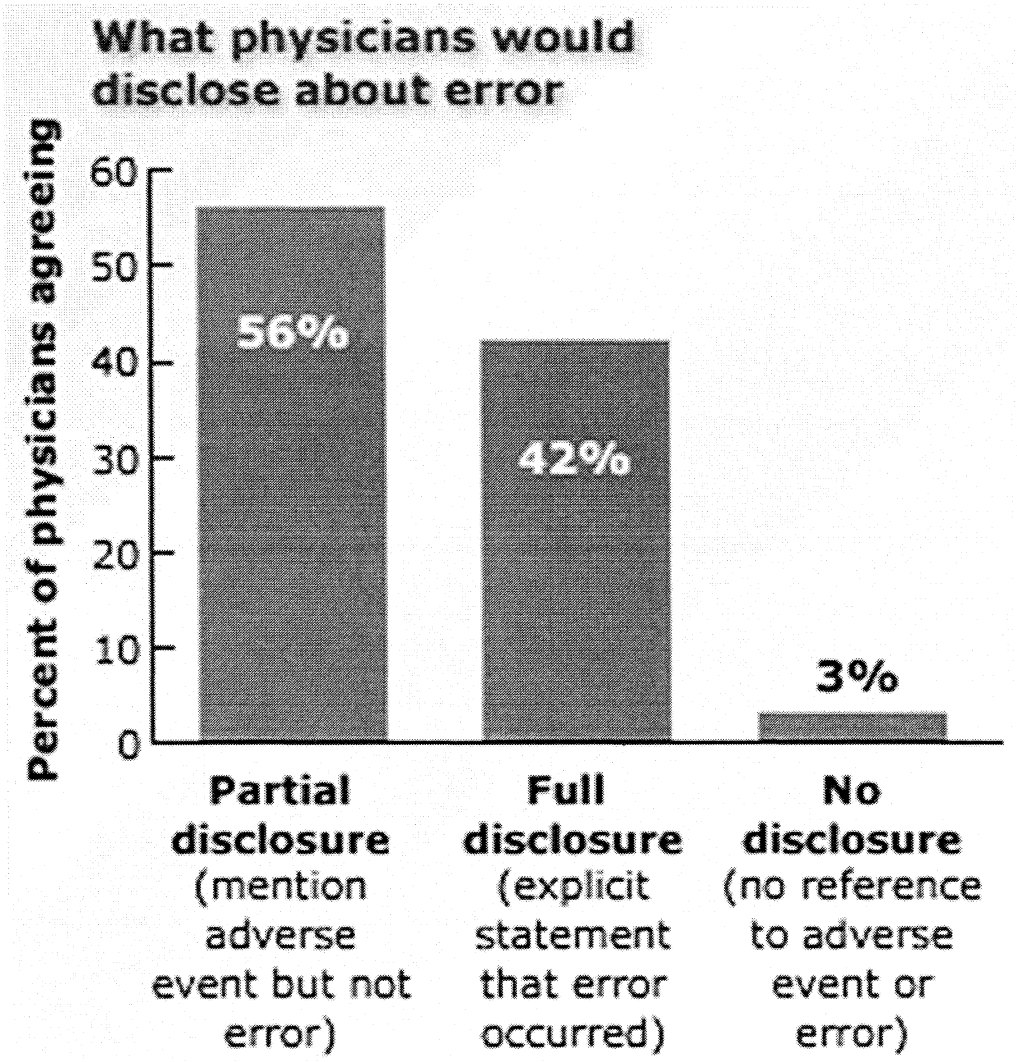


treatments that do not treat the problem, or simply underestimating the severity of ones pain.

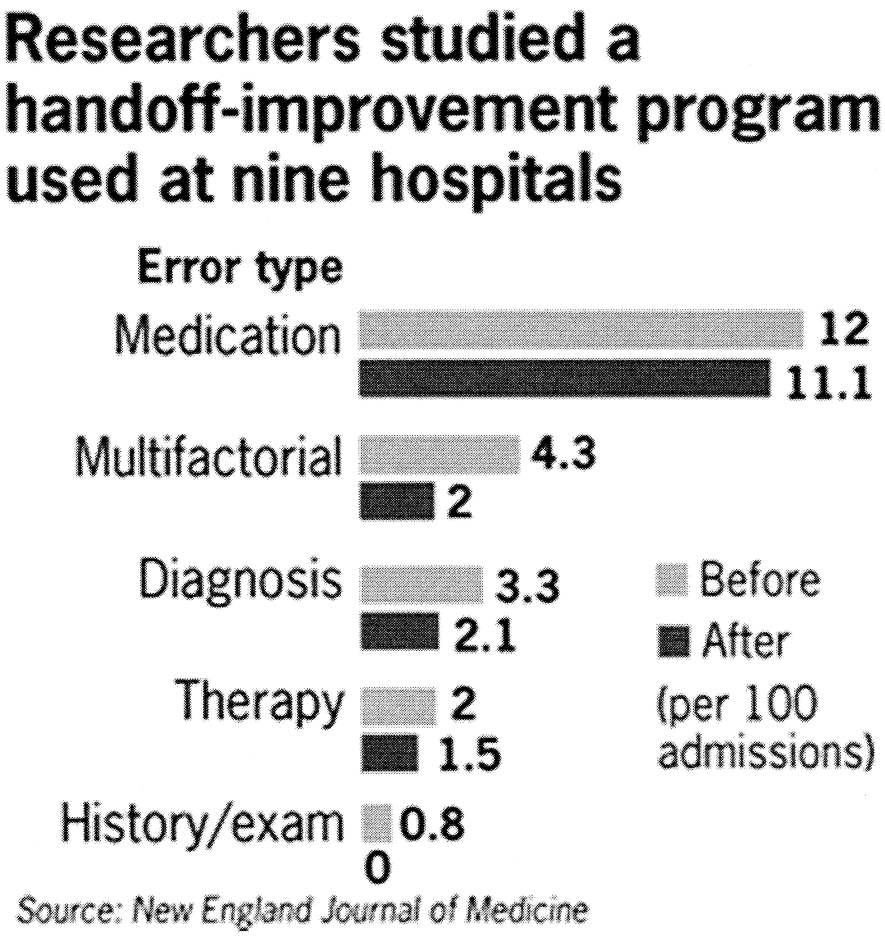
Percent of adults in the U.S. who say they do or do not have a regular doctor that provides most of their care when they are sick or have a health concern



Speaking of poor quality care, we must consider the fact populations that even have a regular doctor. Depending on the state this varies at a very high rate and makes it difficult for professionals to continuously treat or accommodate care because they may leave out allergies or past information from last doctors make is difficult to avoid adverse events, especially in minorities with cultural and language barriers.



Many times things unfold in a bias manner that is not in the favor of the patient in any form of fashion. This can be to protect the professionals job, to prevent embarrassment, or complete denial of the actual situation. Obviously this doesn't benefit the healthcare system because it doesn't report the whole factual story, therefore it would be hard to solve. More than half of the physicians give a partial truth. This statistics reveals the authenticity and clarity of the people stories and the format of things relayed.



As programs develop things change and create a correlation of benefits of these programs and how they can minimize and adjust the proposed problems and solutions of such ideas. In this program they tested this program at nine different hospitals to see it effectiveness and decrease rates of adverse events. Consequently, there has been a major shift and decrease in the rate of adverse events, signifying their importance.

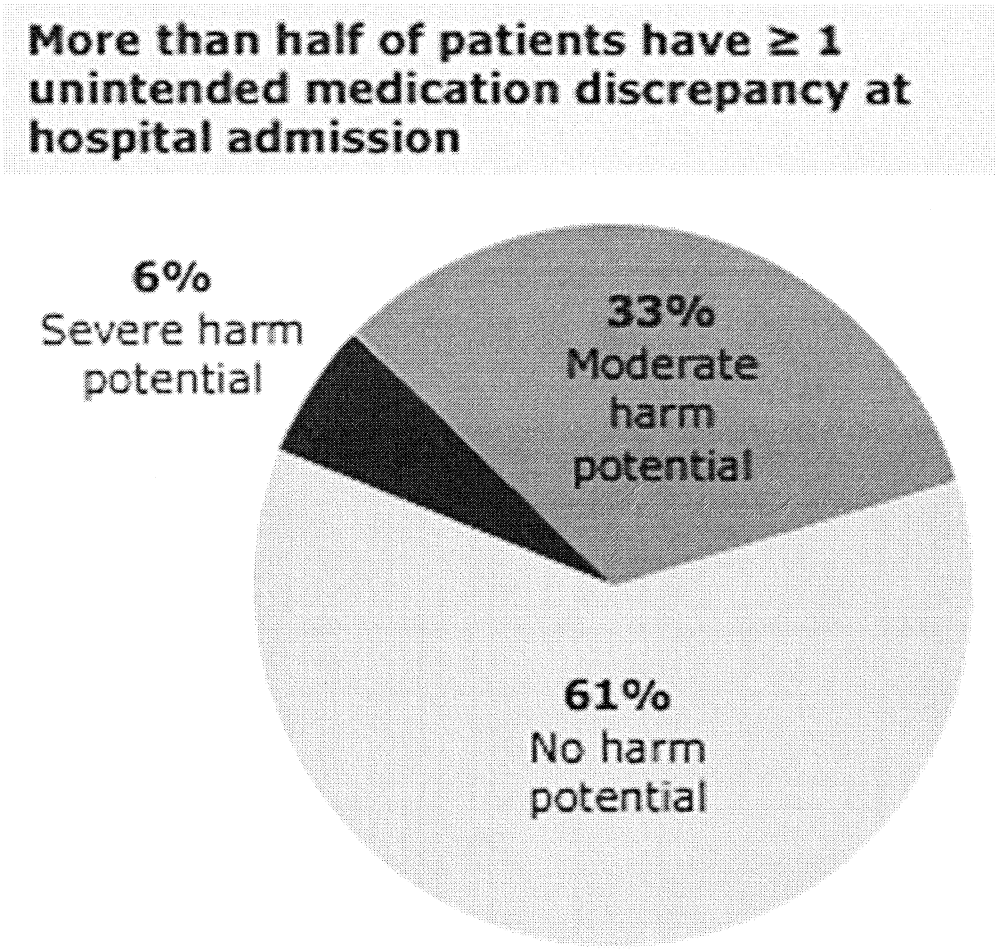
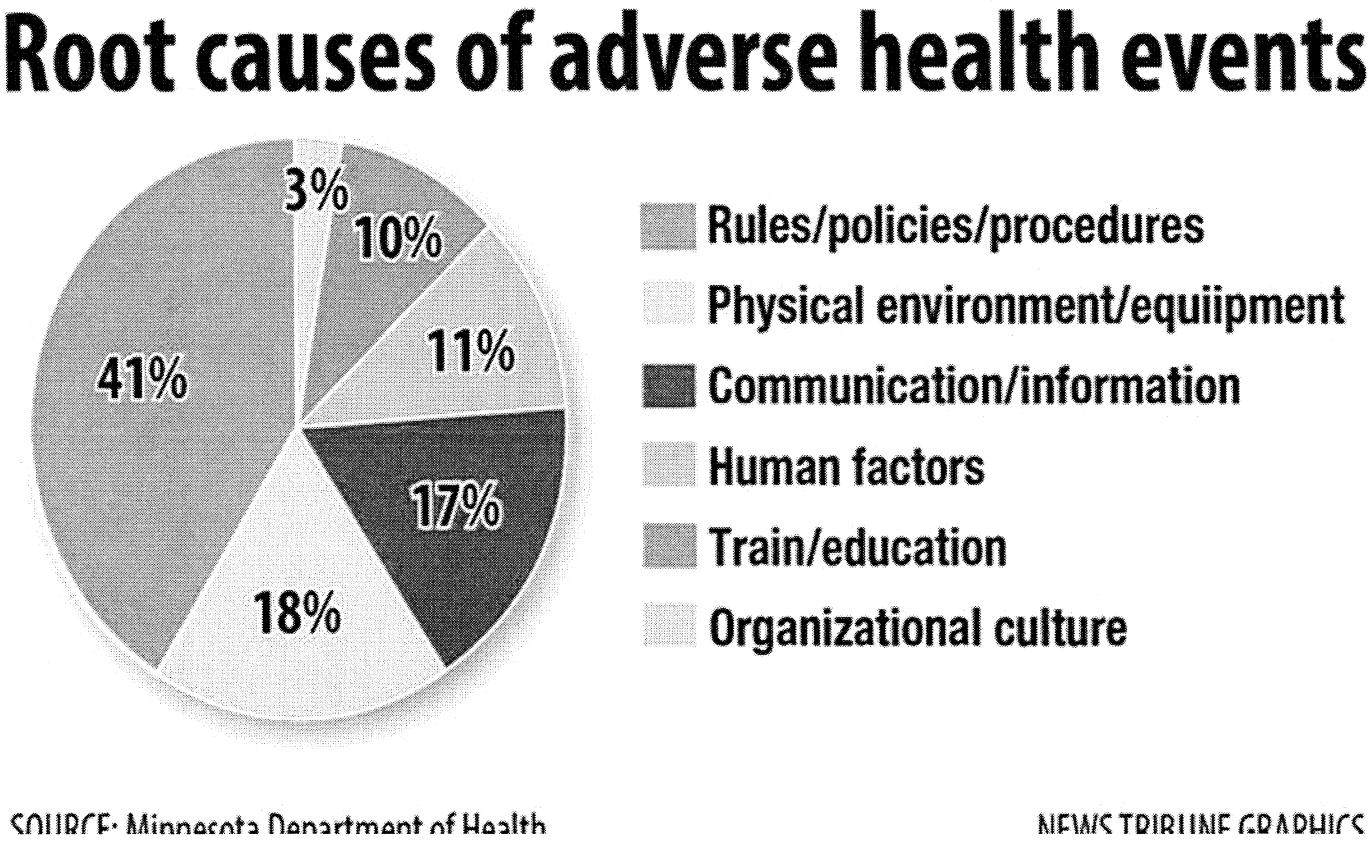


Figure after figure relay things how many unintended motions and errors play a role in adverse events. And this says about 40% of the these unintended actions can have some harm. That is a large percentage considering that these are considering discrepancies upon hospital admissions. As such problems add to the fire it just creates

more room for events to happen in minority communities to which are already under resourced and ignorant to health precautions and procedures.



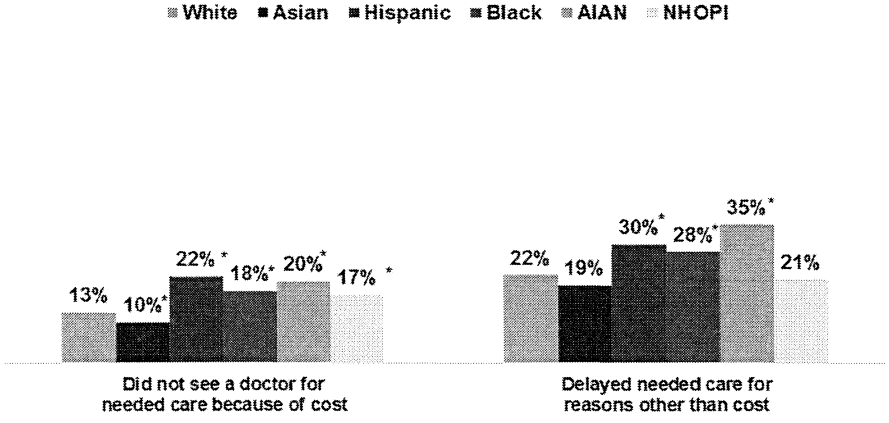
This image is really digging into the idea that of why these things happen. As it is obvious to see, the biggest portion that adverse event is rooted in breaching of the rules, policies, and policies. With a strong second position rooting from the physical environment. Because of these various aspects it's hard pinpoint the reason these unexpected events happen. But we can cut out a huge portion of the events that happen if we can just stick procedure. Procedure is important, but if we don't follow it, what purpose does it really serve?

Chapter 4

Is higher mortality in ethnic populations due to lack of care.

This is the question of the day, year, decade, and century. This is something that can be debated, researched, and seen in many different perspectives. But the fact of the matter is that it just depends. Based on my personal research it is a factor to why minority populations have higher mortality rates. However, it is not the sole reason for these rates and some can be seen as individual behaviors within the community.

Share of Nonelderly Adults Who Did Not Receive Care or Delayed Care in the Past Year by Race/Ethnicity, 2016



* Indicates statistically significant difference from the White population at the p<0.05 level.
NOTE: AIAN refers to American Indians and Alaska Natives. NHOPI refers to Native Hawaiians and Other Pacific Islanders. Persons of Hispanic origin may be of any race, but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 18-64 years of age.
SOURCE: Kaiser Family Foundation analysis of CDC, Behavioral Risk Factor Surveillance System, 2016.

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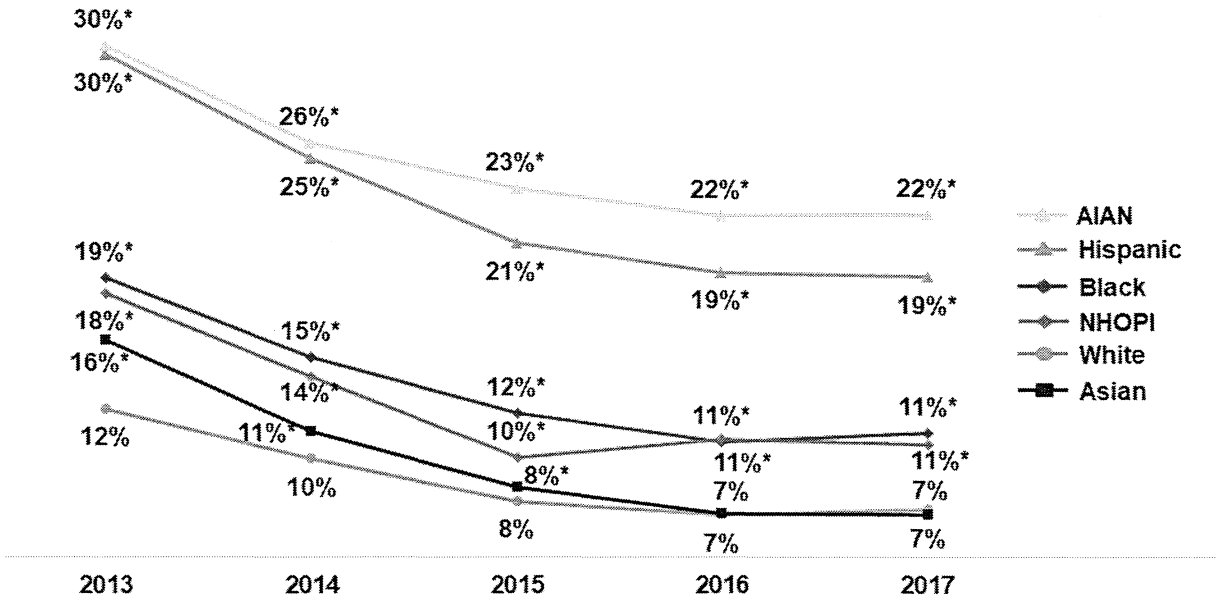
This information shows a lot, as the are present and considerably large percentages of people who did not receive care or receive care at a delayed for a plethora of reasons. As you can see, the Hispanic and Black populations of people have much higher rates of experiencing such subject over their White counterparts. We could

assume it was because of the poorer service in the minority communities, or we can assume it's about the poor choices made and individual behavior. Whatever you may suspect of believe the reason may be, we can not ignore such subjects.

Figure 2

Uninsured Rates Among Nonelderly Individuals by Race/Ethnicity, 2013-2017



Note: * Indicates statistically significant different from the White population at the p < 0.05 level. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age. NHOPI refers to Native Hawaiians and Other Pacific Islanders. AIAN refers to American Indians and Alaska Natives.
Source: Kaiser Family Foundation analysis of 2013-2017 American Community Survey, 1-Year Estimates.

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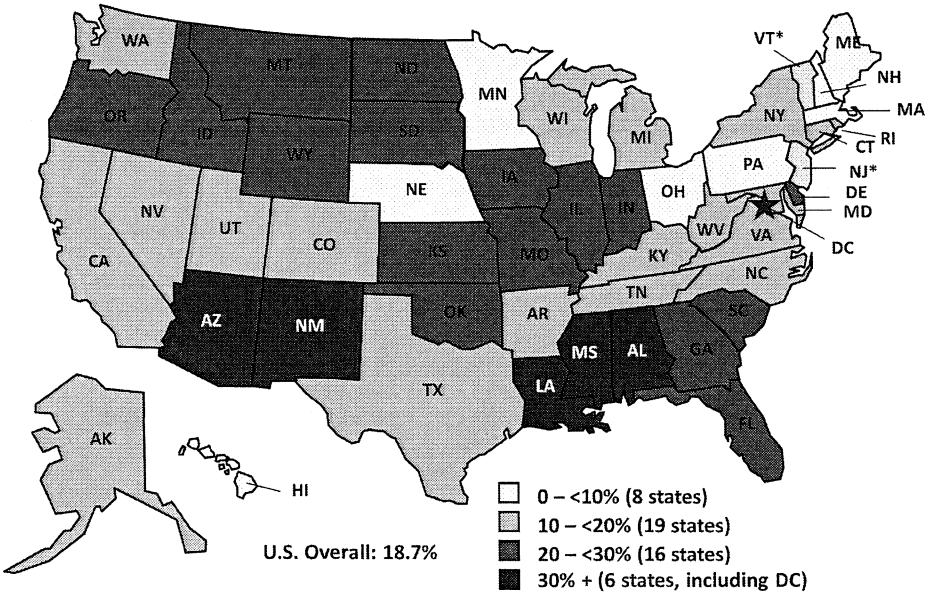
These graphs and instances reveal a lot. First that sometimes poorer care can be rooted from the lack of funds. When you have a lack of funds or are uninsured, it definitely does make it harder to receive the proper care needed. And I believe that because of such instance that may be partially why minorities do not receive the same level of care. In such data, this reveals that Hispanic populations are marginally less insured than their counterparts, but let's also notice that besides the asian population, all other people are above the White population, another factor that could have a solid role in the disparity of care.

Figure 1

Percent of Population Residing in Primary Care Health Professional Shortage Areas (HPSAs), 2014



NOTES: Includes populations in Geographic Area and Population Group HPSAs, but not Facility HPSAs.
*HRSA data show no population living in Geographic or Population Group Primary Care HPSAs in NJ and VT.
SOURCE: KCMU analysis based on HRSA *Designated Primary Care Health Professional Shortage Area Statistics* as of August 12, 2014 and the March 2014 Annual Social and Economic (ASEC) Supplement to the Current Population Survey (CPS).

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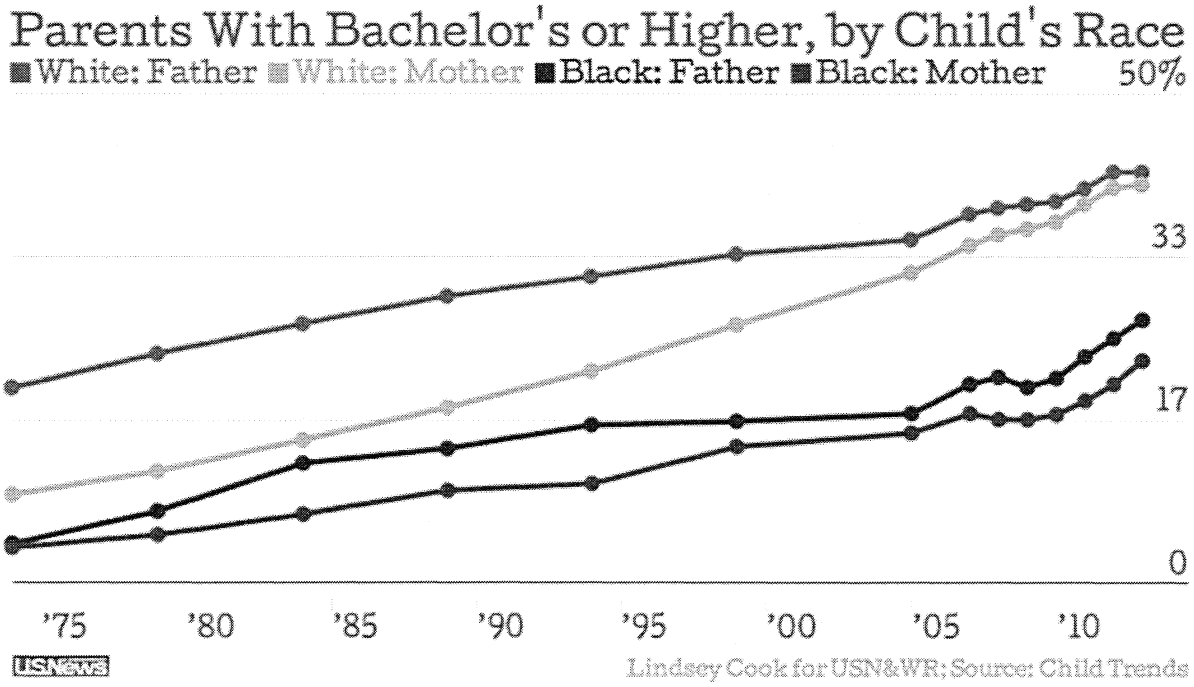
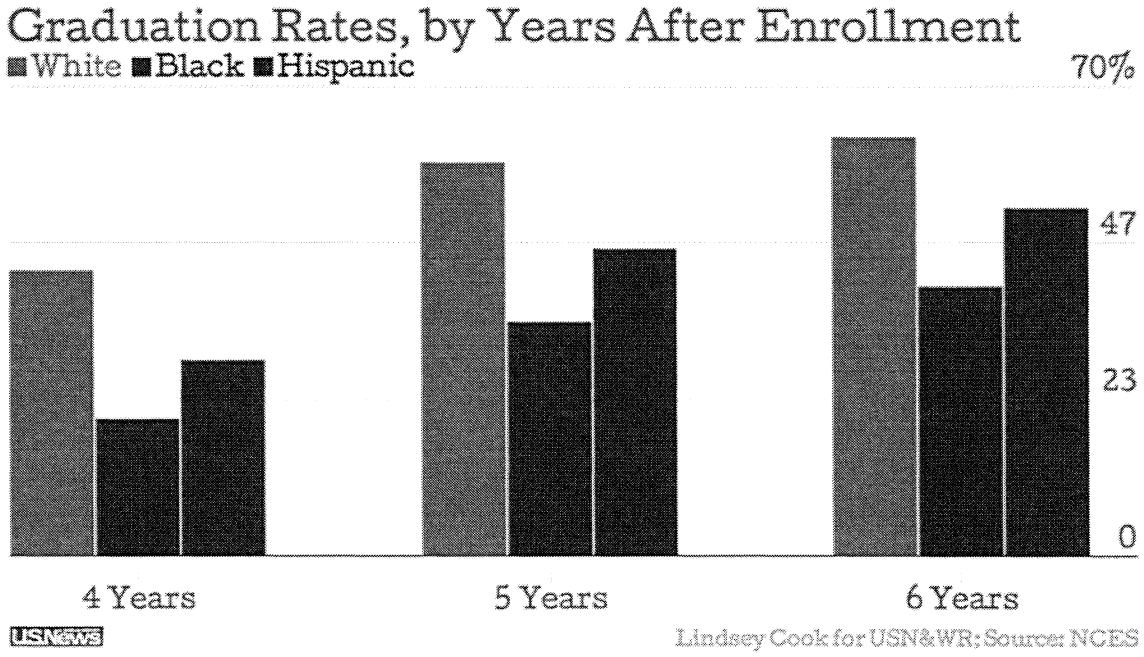
Sometimes we look at performance of care, other times we pay attention to individual behavior. But in some instances we have to realize that it is neither. Inability to realize that sometimes we soley just do not have the staff to reach every community and person, and unfortunately people in lower income areas are the ones to suffer. In Texas, yes, we do have this problem to some extent, but nowhere near as bad as some other states such as Arizona, New Mexico, Louisiana, Mississippi, and Alabama. In such instances as these places, especially areas like Louisiana and Mississippi and Alabama where minority communities are really big, and tend to be segregated from their white counterparts, its obvious to see which community which community will be neglected in care, especially if we add the aspect of quality into it also.



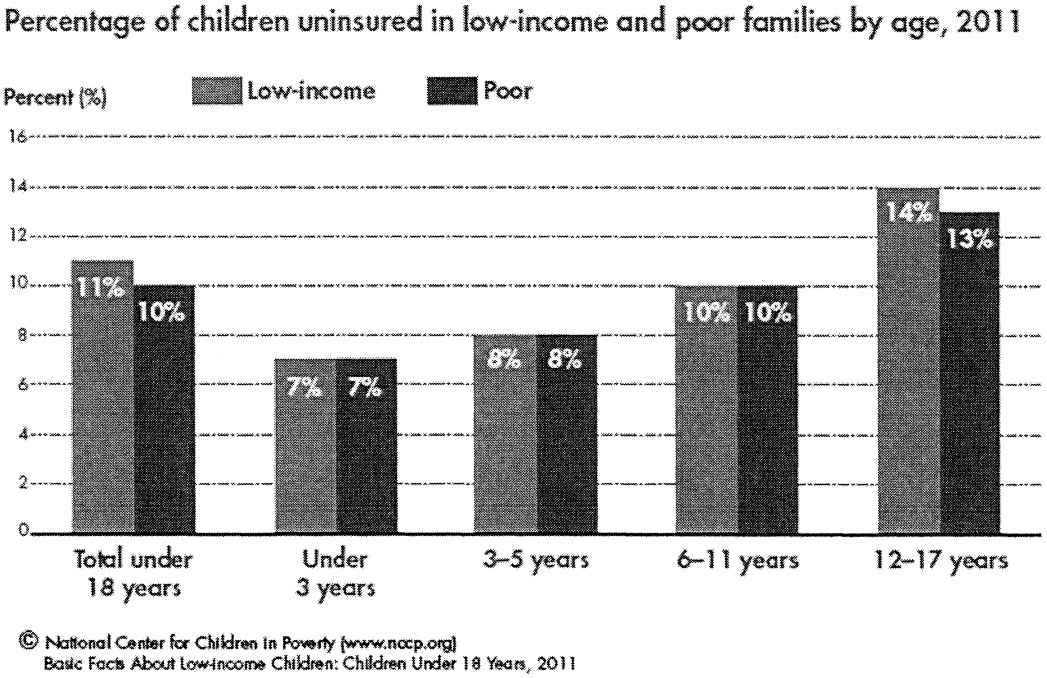
I really like this image because it say something that I truly feel like is key to have optimal health, and that is education. Not to say it is directly correlated to success, money, and common knowledge. But in modern education systems there are certain programs that are implemented and are free in order to make people aware and conscientious of their health. And missing out on this kind of information and resources can make it harder to be aware of your health. That being said this graph shows the educational disparity from white and black men and women and the percentages of them with bachelor's degree. As you can see the disparity is closing and Black women and men are increasing in rates of degree are increasing drastically higher rate than White woman and men, especially in the last 10 years. This is a great sign because with that increase in education also comes an increase in higher income, better health awareness, and reduce the disparity that comes for many different reasons.



Some people may wonder why that past graph had a shift in for blacks increasing and why the rate shifted so quickly. But in order to dig into such subjects, we must be able to understand how fast each demographic is finishing their education in order to begin the shift in the workforce. As shown, sadly, no race has over 50% completion of college rates in 4 years. Therefore, the traditional of seeing major shifts every 4 years is become not quite a fit because of the unfit to the production of graduates. Some could argue that 5 years could be a more arguable standpoint of shift because that is where at least two out of the three percentages have reached over the 50% mark. These types of subjects and factors must be taken into consideration for educated predictions and assumptions of why such societal shifts, problems, and reconstructions must take place. Ignoring such subjects make people opinions less likely to be accurate, and non-bias. Society has placed such an emphasis on education to not ponder and discover that that

has a key role on the way some of the instance play out the way they do would be very ignorant to conclude.

Sometimes we look at racial disparities, and automatically imagine they are speaking of the adult population. However we must realize that a large portion that supports the disparity is children. Many parents may not be insured, but for every adult that is uninsured averagely come with 2 to 3 three kids that are in the same predicament. But insurance status is not the only yielding factor, but socioeconomic status has an role. There also is a difference between low income children and poverty level children. As low income children may not be in the best position possible it is still higher than the children classified as "poor" which is below the national poverty line. And the difficult part about being low income but not necessarily poor is that usually you



do not qualify for the federal benefits of the people below the poverty line, but is strain to purchase private insurance if your place of employment doesn't provide it.

So in all these things we can see all the factors, influences, perspectives and aspects that create such a disparity and a confusion to solve it. Thing such as individual behavior, socioeconomic status, access to care, and quality of professionals all play a role in this disparity and all have many aspects within each factor intertwine with each other to create such a complex situation. There are many solutions that have been discussed in such in the previous text that could make solutions, such as education, health awareness, bringing such inequalities to people of power, and better individual

choices will create more opportunity for everyone and minimize this disparity. Lastly we need to understand that children are the largest population affected by this. And this is something they had no control over, just were place in such predicament. Therefore by people, professionals, and the government being proactive we can prevent such disparities and generational curses from continuing.

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