Health Care Disparities

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Introduction

Health Care disparities are commonly discussed in today's society. Health care disparities can be defined as the quality and availability of one's access to healthcare, and it depends on the social determinants that define a person. These determinates include socioeconomic status (SES), mental health status, the community one lives in, and race. 'The term "health disparities" is often defined as "a difference in which disadvantaged social groups such as the poor, racial/ethnic minorities, women and other groups who have persistently experienced social disadvantage or discrimination systematically experience worse health or greater health risks than more advantaged social groups'" (Racial and Ethnic Health Care Disparities, n.d.). Although Healthcare disparities have recently gained more attention by the healthcare community such as the Department of Health and Human Services' Healthy People 2010, and the Healthy People 2020 initiative, further efforts must be applied to fully understand how to significantly reduce disparities. To begin to understand the deeply-rooted effects of health care disparities, the past treatment of low-socioeconomic and racial minorities must be explored. Gaining an understanding of the atrocities from the past, can lead to an appreciation of how those experiences shape how present day medical care is viewed. Moving forward, healthcare professionals must develop ideas on how to reduce these disparities by diversifying the field, and truly practicing with cultural competence.

Tuskegee Syphilis Study

The history in treatment of low-socioeconomic and racial minority populations within the United States is not favorable for these populations. Back in the antebellum period, slaves were used for experimental medical tests and procedures by their slave masters. Moving into the early

1900s, when racism and discrimination were abundant, an infamous research study proved that scientists in the healthcare system would take advantage of less advantaged populations for personal gain. This research study was titled "Tuskegee Study of Untreated Syphilis in the Negro Male" (CDC, 2015). The U.S. Public Health Service Syphilis Study at Tuskegee's article states,

"The study initially involved 600 black men – 399 with syphilis, 201 who did not have the disease. The study was conducted without the benefit of patients' informed consent. Researchers told the men they were being treated for "bad blood," a local term used to describe several ailments, including syphilis, anemia, and fatigue. In truth, they did not receive the proper treatment needed to cure their illness. In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance. Although originally projected to last 6 months, the study actually went on for 40 years" (U.S. Public Health Service Syphilis Study at Tuskegee, 2015).

This study created controversy within the medical world. For 40 years, these participants who were not informed of the actual study, were suffering from syphilis. Penicillin was discovered to treat syphilis in 1945, but the study continued until 1972, and participants who had syphilis were not treated. Many participants died from the disease. Sadly, the populations used for this research study were an easy target. Most of them had minimal education and needed money. The researchers enticed them with promises of free food and other services. It has been explained that the research subjects were poor, uneducated, and did not question the physicians. They found the incentives of free food, bus passes, free physical exams, and a fifty-dollar stipend at death for their family all as benefits for participating in this study. The physicians chose this population of men for their beliefs that these men came from a "syphilis-soaked race" (Skloot, 2011, pg.50). This

blatant racial bias caused unsuspecting young males to die from syphilis that they were unknowingly exposed to in a research lab. Because of this disregard for basic human rights, and the subsequent treatment of this population, the actions of this study produced fear and distrust. Furthermore, one would think an atrocity such as this would promote the medical community to address how they treated their patients, or conducted research studies.

Henrietta Lacks

Another famous research study on a Black female by the name of Henrietta Lacks would prove racism and exploitation of lower socio-economic patients was prevalent. In 1951, cervical cancer cells were taken from a woman by the name of Henrietta Lacks. She lived in the poorer neighborhood of Baltimore and had gone to John Hopkins Hospital because she was experiencing what she described as a 'knot in her stomach' and became worried. She was diagnosed with cervical cancer. During one of her visits, tissue samples were taken without her knowledge, which the physician then used to conduct research on tissue samples of carcinoma in situ and invasive carcinoma. The physician along with the head of Tissue Culture Research at Hopkins cultivated the cells in a tissue medium. Unlike other tissue samples he had been experimenting with, her tissue samples kept dividing and did not die. The cell line was named HeLa for the patient's first and last names (Skloot, 2011). The researchers realized the importance these cells had, and ran experiments on them throughout their career, even selling the cell samples to other scientists. The HeLa cells created a medical revolution generating large amounts of money for the researchers because it was one of the only cell lines researchers could use to study experiments due to its unusual cell division behaviors. The cell sample helped create the polio vaccine, herpes medications, and treatments for hemophilia and Parkinson's disease to name a few (Skloot, 2011). As mentioned, Henrietta herself did not give consent for these cells to be taken, and since her

death, the cell line has gone on to generate a large profit. Even worse, her family has never seen any of the profit and cannot afford medical insurance for the care they themselves need.

Henrietta's medical care while at Hopkins was full of social issues regarding her visits, and the practitioner labeled her 'non-compliant' due to her inability to follow orders. Rebecca Skloot who conducted research on Henrietta Lacks and the Lacks' family wrote in her book, *The Immortal Life of Henrietta Lacks,* "It was no surprise she hadn't come back all those times for follow-up. For Henrietta, walking into Hopkins was like entering a foreign country where she didn't speak the language. She knew about harvesting tobacco and butchering a pig, but she'd never heard the words cervix or biopsy…She, like most black patients, only went to Hopkins when she thought she had no choice" (Skloot, 2011, pg. 16). This recurring theme of the unknown surrounding the hospital was evident. Henrietta's hesitancy towards medical care was only strengthened due to the inadequate care she received. Skloot's book reveals, "Towards the end of her treatments (radiation treatments), Henrietta asked her doctor when she'd be better, so she could have another child. Until that moment, Henrietta didn't know the treatments had left her infertile" (Skloot, 2011, pg. 47). In Henrietta's medical record, one of her doctors wrote about discussing infertility with Henrietta, however, if Henrietta had known; she explained she never would have had the treatments. This miscommunication not only changed her life, but it also fostered fear, questioning what the doctors would do to her at future visits without her understanding. Another example included treatment for her cancer. After an x-ray, the doctors caring for her determined the cancer could not be operated on. Even though weeks prior she was sent home to bed, as she seemed to be suffering from pain but otherwise healthy (Skloot, 2011). This disregard for her medical care was prevalent during the 1940s for many minority patients. Hospitals were segregated, and minorities could only seek treatment at designated hospitals. The care minorities received was incomparable to their

white counterparts. *The Immortal Life of Henrietta Lacks* reads, "…several studies have shown that black patients were treated and hospitalized at later stages of their illnesses than white patients. And once hospitalized, they got fewer pain medications, and had higher mortality rates" (Skloot, 2011, pg. 64). In addition, "This was the era of Jim Crow- when black people showed up at white-only hospitals, the staff was likely to send them away, even if it meant they might die in the parking lot. Even Hopkins, which did treat black patients, segregated them in colored wards, and had colored only fountains" (Skloot, pg. 15). Aside from not receiving the proper medical care before her death, her medical information became public without her consent after her death.

Scientists ended up publishing Henrietta's medical information and the studies they had conducted on her cells. They even published her name along with the results, and her family was left in the dark. An excerpt from *The Immortal Life of Henrietta Lacks* explains,

'On March 25th, 1976, when Mike Roger's Rolling Stone article hit newsstands. It was the first time anyone had told the true story of Henrietta Lacks and her family, the first time the mainstream media had reported the woman behind HeLa was black. The timing was explosive. News of the Tuskegee study was still fresh; the Black Panthers had been setting up free clinics for black people in local parks and protesting what they saw as a racist health-care system; and the racial story behind HeLa was impossible to ignore…It was a story of white selling black, of black cultures "contaminating" white ones with a single cell in an era where a person with "one drop" of black blood only recently gained the legal right to marry a white person' (Skloot, 2011, pg. 197).

The Lacks family was once again exploited by the medical community. The magazine could have been sued by the Lacks family, but the Lacks family did not have a lawyer, let alone

know their DNA was studied, and the results published (Skloot, 2011). The exploitation of Henrietta Lacks, her family, and her cell line fostered doubt within the Black community; doctors and scientists within Johns Hopkins became mistrusted. Therefore, it is not surprising that those living in the same community as Henrietta Lacks, or people who share similar socioeconomic or racial ties to her began to question the care they received at hospitals. Stories passed down by community members painted pictures of hospitals preying on weak patients, so they could take advantage of them for medical advancement.

Folklore and Generational Stories

Folklore and generational stories were shared within ethnic and socio-economic based communities throughout history. These stories served as a way to warn the members of the dangers surrounding hospitals and doctors. They fostered fear within the community, and created mistrust of the doctors. Some of the oldest stories came from plantation owners trying to frighten their slaves about ghosts carrying disease and death. The plantation owners created fear in the slaves, so they did not run away (Skloot, 2011). But even in more modern times, such as the era of Henrietta Lacks, her family members discussed some of the stories they heard as children. Sonny Lacks, (Henrietta's son) and Bobette Lacks, (her daughter in law) had a conversation explaining how they had heard stories growing up about Johns Hopkins 'snatching' people off the streets and experimenting on them. Bobette said many people had disappeared when she was a young girl in East Baltimore. Therefore, the community warned it residents to stay away from Hopkins, especially at night. The children were expected to be on the "front steps" of their homes to ensure their safety (Skloot, 2011, pg.165). Furthermore, "The Lackses aren't the only ones who heard from a young age that Hopkins and other hospitals abducted black people. Since at least the 1800s, black oral history has been filled with tales of "night doctors" who kidnapped black people for

research. And there were disturbing truths behind those stories" (Skloot, 2011, pg. 165). Although some of these stories may seem like fables to scare low-socioeconomic or Black populations from seeking out healthcare, these events actually happened. Therefore, the reality of the situation conjured up real fears for the people of the poorer communities of Baltimore. Skloot further explains,

> "Many doctors tested drugs on slaves and operated on them to develop new surgical techniques, often without using anesthesia. Fear of night doctors only increased in the early 1900s, as black people migrated north to Washington, D.C., and Baltimore, and news spread that medical schools were offering money in exchange for bodies. Black corpses were routinely exhumed from graves for research, and an underground shipping industry kept schools in the North supplied with black bodies in the South for anatomy courses. The bodies sometimes arrived, a dozen or so at a time, in barrels labeled *turpentine*" (Skloot, 2011, pg. 166).

In all, when beginning to understand the depth of healthcare disparities, the past provides insight on why low socioeconomic or racial groups had a fear, or did not trust institutionalized medicine. Whether it be the era of slavery, or more recent times in the past, such as the 1970s and Tuskegee, it is without a doubt that medical advances have occurred due to the exploitation of these vulnerable populations. History reinforces the idea that these populations were treated more like test subjects than patients who were respected as human beings. This disrespect in turn affects how modern-day populations of these same socioeconomic determinants may believe their medical care is prioritized by medical professionals.

Current Situation

The Department of Health and Human Services proposed Healthy People 2010 which was formed in 2000 and projects healthcare goals for the upcoming decade. "The 2010 plan focused on two overarching goals: increasing the quality of life (including years of healthy life) for Americans and eliminating health disparities. Preliminary analyses show that life expectancy has in fact increased (during the period from 2000 to 2006) by 1.2% when measured at birth and by 5.1% when measured at age 65. However, the goal of eliminating disparities remains unmet" (Koh, 2010, "Perspective," para. 3). Healthcare disparities have been recognized as a shortfall in healthcare. Within the past decade, more focus has been allotted to determine how to reduce disparities. As evidenced by the Department of Health and Human Services' research, healthcare disparities still exist despite effort to decrease them. The Healthy People 2020 goal continues to strive towards providing equal healthcare to all groups and eliminate disparities. The continued focus on healthcare disparities into the next ten years is an important strive towards creating awareness of these shortcomings and ultimately reducing the current inequalities.

Current statistics emphasize how prevalent healthcare disparities are. One of the biggest trends differentiating those who have access to healthcare and those who do not receive proper care is socioeconomic status. Racial and ethnic minorities also experience differences in the level of care they receive. Socioeconomic status not only defines the amount of money an individual makes, but it also determines the type of community one lives in, and the resources that community provides its people. Therefore, when trying to improve healthcare disparities, it is important to understand the economic, social, and educational effects living in a less advantaged community provides.

Socioeconomic status directly effects the health care insurance one can afford. When comparing poverty statistics among minority populations and Caucasian Americans, 25% of

Hispanics and 27% of African Americans live in poverty, while only 12% of Caucasians live in

poverty. (Racial and Ethnic Health Care Disparities, n.d.). Furthermore, unemployment rates

reflect these economic struggles. Caucasian Americans face half the rate of unemployment that

African Americans do. In addition, when comparing earnings, African American men only make

72% of what a Caucasian male would make for comparable jobs. (Ethnic and Racial Minorites

and Socioeconomic Status, n.d.). If a population is proven to be statistically disadvantaged in the

economy, how can they afford the same level of care as their counterparts? "Low SES and its

correlates, such as lower educational achievement, poverty, and poor health, ultimately affect our

society…communities are often segregated by SES, race, and ethnicity. These communities

commonly share characteristics: low economic development; poor health conditions, and low

levels of educational attainment…" (Ethnic and Racial Minorites and Socioeconomic Status,

n.d.). An example of the disparities faced by minority and low socioeconomic status is a

community by the name of Sandtown in Baltimore, Maryland. Jay Hancock, the author of 'In

Freddie Gray's Baltimore, the Best Medical Care is Nearby but Elusive,' writes of a poverty-

stricken town, Sandtown, and how the residents of this community face averse health problems

despite living in the same city as the well-known Johns Hopkins. This article helps form an

understanding on how poorer communities are at a disadvantage, and how the community

members feel about healthcare. This community serves as an example. Sandtown does not

represent just Baltimore, but it can represent any poverty-stricken town that is surrounded by

wealth in neighboring communities. Hancock writes, "Residents of the ZIP code including

Sandtown accounted for the city's second-highest per-capita rate of diabetes-related hospital

cases in 2011, the second-highest rate of psychiatric cases, the sixth-highest rate of heart and

circulatory cases and the second highest rate of injury and poison cases. Asthma, HIV infection

and drug use are common" (Hancock, 2016, pg. 4). Unfortunately, the health of the residents in these neighborhoods depend heavily on the set up of the community.

Hancock's article served to gain insight into the people of the Sandtown neighborhood, to understand the aspects in their society they see as barriers to seeking healthcare, and how they feel healthcare practitioners treat them when they do get medical treatment. Some of the most significant factors include legal trouble, access to proper food, and transportation issues. One resident, Derrick DeWitt explains how the town is surrounded by liquor stores and sub shops, explaining that on one block there is four liquor stores, but there are not supermarkets near the community, and many residents lack vehicles. This causes low nutritional diets. (Hancock, 2016). This exemplifies how the environment of this community does not promote healthy habits. If the supermarket is not directly within the community, and shops providing a quick meal are closer, it is understandable how residents may not get proper food. Likewise, transportation to get to the market could be difficult. Another barrier to care suggested by the residents was the threat of legal trouble. In a community that is exposed to drugs, there is most likely legal issues associated with the environment. One of the excerpts from the article states, "Two miles away, residents such as David Johnson start to provide an answer. Johnson, 52, sits in the nave of First Mount Calvary Baptist Church, waiting for food-bank vegetables and talking about being newly out of jail, lacking identification and trying to qualify for Medicaid…. But he can't, Baltimore jail authorities lost his identification cards, he said, before releasing him in October from an 11-month stay related to a drug arrest. He spent weeks reapplying for a Motor Vehicle Administration identification card, which social workers said he needed to qualify for Medicaid" (Hancock, 2016, pg. 5). This identifies how an individual is trying to help their situation by obtaining the necessary documents, but is hindered by lack of community resources

to help through the transition process. Hancock further writes, "It's about inadequate transportation to get to appointments and jail stays that cut patients off from family doctors. It's about avoiding medical institutions often seen in the same light as the justice system that held Freddie Gray when he died: as biased, haughty and dangerous" (Hancock, 2016, pg. 3). Again, the trend of insufficient community resources serves as a barrier for seeking medical care. Lastly, the article suggests residents may fear the repercussions of legal consequences. One example from the article was that families may be receiving aid for care and by going to a doctor social services may become involved in their situations and take away the assistance they had been receiving (Hancock, 2016, pg. 6). Therefore, people may not seek medical care for fear of it disrupting the care others in their family may have. In reference to the quote on Freddie Gray, a Baltimore resident who lived in Sandtown, and suffered a spinal injury while being arrested in Baltimore, explains how residents may not feel protected by the healthcare community-much like they did not feel he was protected by the law enforcement. Recent racial events, including this situation, emphasize how minorities still do not have the same equality that other groups of people have, such as whites. When examining healthcare disparities, race does play a factor and should be discussed. With all the racial tension today, healthcare practitioners must remember to not let biases reflect on patient care.

As important as statistics are in understanding the gap between healthcare, the views of people living in these communities such as Sandtown are equally important. Numbers can show the disparities, but human experience is the better illustrator of the disparities. "As with so much else, there are two Baltimores when it comes to health. One population is well off and gets the best results from elite institutions on the city's west and east sides, The University of Maryland Medical Center and the Johns Hopkins Hospital. The other is a poor minority that gets far less

even as it uses hospital services at higher-than-average rates. One indicator: The Typical

Sandtown resident lives a decade less than the average American" (Hancock, 2016, pg. 2).

Residents of Sandtown question why they have drastically lower life expectancies

compared to neighboring towns when they are essentially neighbors to Johns Hopkins, a

renowned hospital in Baltimore (Hancock, 2016). One of the residents of Sandtown provides

why he feels his healthcare is not taken as seriously. William Ferebee explains how he feels as if

the doctors do not assess him thoroughly, and instead pass on orders to other members of the

healthcare team without explaining the plan of care to him. This causes him to feel as if his

health is not taken seriously (Hancock, 2016). As a professional in healthcare, it should be

devastating to hear a patient feel as if their care seems unimportant to the person taking care of

them. Additionally, that they feel their care is passed on to someone without feeling adequately

treated or explained. Although medical care involves collaboration of several healthcare

professionals, each patient interaction should involve respect and explanation on the progression

of their care. Residents in the community expressed how respect plays a role in their encounters

with physicians. They feel like the physicians want respect from the people in the community but

do not reciprocate the respect to the residents (Hancock, 2016). Another resident of Sandtown

touches on the respect issue stating, "When you walk into a hospital, it's like walking into a

courtroom. You know who's in charge, and you know who's not -William Honablew Jr."

(Hancock, 2016, pg. 2).

Institutional Factors Affecting Care

While exploring healthcare disparities, research showed how discrimination today

continues to explain why disparities exist. Access to healthcare can be restricted by institutional

discrimination, the quality of care one receives can ultimately be undermined by cultural racism.

(Ethnic and Racial Minorites and Socioeconomic Status, n.d.). "Racial and ethnic minorities have worse overall health than that of white Americans. Health disparities may stem from economic determinants, education, geography and neighborhood, environment, lower quality care, inadequate access to care, inability to navigate the system, provider ignorance or bias, and stress" (Ethnic and Racial Minorites and Socioeconomic Status, n.d.). Therefore, even if they have access to care, which is statistically lower, the care that is provided is consistently inadequate. This relates to the communities not readily seeking care and the incidence of distrust between patients and their healthcare providers. Additionally, this discrimination does not only affect their emotional health, but research suggests discrimination and perceived racism impacts a person's physical health. Brondolo, Gallo, and Myers (2008) addressed how racism correlates with health. "Much of the research on racism and health has examined the effects of racism on physiological systems, testing hypotheses about close linkages between exposure and biological outcomes. For example, both laboratory and ambulatory monitoring studies have documented the relationship between racism and psychophysiological reactivity, including cortisol, blood pressure and heart rate responses" (Brondolo et al., 2008, pg. 4). Interestingly, African Americans have a higher incidence of hypertension. Their research suggests, this health trend among other health conditions, could be attributed to social factors like racism. "These patterns of reactivity have been linked to the development of stress-related disorders, such as hypertension and other cardiovascular diseases. These alterations in the degree of frequency of physiological stress responses may represent one pathway through which racism ultimately affects health outcomes" (Brondolo et al., 2008, pg. 4). The more understanding there is of social and physical factors associated with healthcare disparities, the better the outcomes for those whom it effects.

Future Issues

After understanding historical issues that have created healthcare disparities and how residents of lower socioeconomic communities feel, current forms of improvement on this issue must be addressed. Ultimately, society would benefit from reducing gaps in socioeconomic status (Ethnic and Racial Minorites and Socioeconomic Status, n.d.). The healthcare system, has begun to take greater interest in reducing these disparities. "Since 2002, research has greatly expanded our understanding of how health care disparities arise. It has confirmed that many factors play a role, including patients' and providers' biases, stereotypes, attitudes, and expectations; geographic inequities in the availability and accessibility of high-quality care; and institutional and systemic issues, such as policies and practices that contribute to cultural and linguistic barriers to care" (Smedley, 2012, pg. 933). Additional research surrounding the prevalence of healthcare disparities has shown not only is it a social issue, but there is also an economic burden posed by these disparities.

"A 2011 study estimates that the economic costs of health disparities due to race for African Americans, Asian Americans and Latinos from 2003 thru 2006 was a little over $229 billion. In a report issued in September 2009, the Urban Institute calculated that the Medicare program would save $15.6 billion per year if health disparities were eliminated. The study examined a select set of preventable diseases among the Latino and African American communities, including diabetes, hypertension and stroke, and concluded that- if the prevalence of such diseases in the African American and Latino communities were reduced to the same prevalence as those diseases occur in the non-Latino white population- $23.9 billion in

healthcare costs would be saved in 2009 alone" (Racial and Ethnic Health Care

Disparities, n.d.).

Further data supports the financial strain of healthcare disparities. "The health consequences of

racial inequality present a significant economic burden for the nation: one estimate indicates that

$1.24 trillion were drained from the economy between 2003 and 2006 as a result of the higher

direct medical costs and indirect costs associated with health inequalities (ex. lost productivity

and tax revenue when people are too sick to work or die prematurely)" (Smedley, 2012, pg. 935).

Aside from monetary value, disparities also drain resources within the medical community

(Brondolo et al., 2008). Readmissions due to untreated medical conditions not only cost the

hospital more money to treat, but use up valuable resources and supplies that pose an additional

cost for the hospitals to cover. Furthermore, costs placed on the patient are increased with

healthcare disparities. This is alarming as medical bills are expensive. Sixty two percent of

people in 2007 filed bankruptcy due to medical expenses. (Racial and Ethnic Health Care

Disparities, n.d.). Therefore, attention to these disparities calls for social change and possibly an

alteration of the United States healthcare system to reduce associated costs, which will in turn

benefit the nation.

Provide Better Care, Reduce Readmissions

One of the biggest ways to reduce costs associated with disparities is to reduce the rate of

hospital readmissions. "A hospital readmission occurs when a patient is admitted to a hospital

within a specified time period after being discharged from an earlier (initial) hospitalization. For

Medicare, this time period is defined as 30 days, and includes hospital readmissions to any

hospital, not just the hospital at which the patient was originally hospitalized" (Boccuti and

Casillas, 2017, "Background," para. 1). Within the past five years, Medicare has implemented a

penalty program for hospitals with high readmission rates. Hospital readmissions can occur due to inadequate follow up care or discharging a patient before they are stable enough to resume care out of the hospital. Hancock provides examples of patient's who suffered from inadequate follow up. The patient is named Robert Peace, he had a broken pelvis. At UMMC his fracture was fixed in surgery, but he developed a bone infection and needed additional surgeries because his infection progressed severely without follow up care. (Hancock, 2016, pg. 8). Another example includes, "One homeless West Baltimore patient left an oral surgeon's office with a wired jaw and no way to pay for the liquid nutrition he needed to feed himself, said Carol Marsiglia, senior vice president at the Coordinating Center, a nonprofit consulting organization that is working to reduce readmissions and emergency visits in the neighborhood" (Hancock, 2016, pg. 6). This is alarming that patients are being discharged without proper resources to continue their care. Boccutti says, "A number of studies show that hospitals can engage in several activities to lower their rate of readmissions, such as clarifying patient discharge instructions, coordinating with post-acute care providers and patients' primary care physicians, and reducing medical complications during patients' initial hospital stays" (Boccutti and Casillas, 2017). These examples seem reasonable to provide for any patient receiving medical care. Especially if they are being discharged to home and need additional support to care for themselves. However, patients who may not fit the 'norm' may be receiving lower quality care. An example of this includes patients whose first language is not English. "Without effective health provider and patient communication in a language both can understand, there is an increased risk of misdiagnosis, misunderstanding about the proper course of treatment and poorer adherence to medication and discharge instructions. Health care providers…have reported language difficulties and inadequate funding of language services to be major barriers to access

to health care for limited English proficiency individuals and a serious threat to the quality of care they receive" (Racial and Ethnic Health Care Disparities, n.d.). These types of social issues create higher risks of readmission and unfortunately hurt the patient's overall health. To improve these issues, new policies must be put in place.

New Policies

Healthcare facilities in the United States are trialing new policies to determine what can be done to reduce disparities. One example is in the state of Maryland. "Maryland undertook an ambitious overhaul of hospital reimbursement, made possible by the federal health law, that is supposed to back that philosophy [keeping patients healthy and out of the hospital] with powerful incentives. Starting in 2014, hospitals have been assigned annual budgets for all government and private payers, instead of them being paid per admission or treatment" (Hancock, 2016, pg. 9). A payment plan like this does not reward the hospital for having more admissions, but creates an incentive for the hospital to have reduced admissions of recurrent patients because the cost will not be covered once the annual funds are diminished. By giving preventative care, patients are less likely to be admitted to the hospital. Hospitals with excessive readmissions, preventable infections and punctures are penalized for these actions. (Hancock, 2016). Further plans have been discussed nationally to address these issues. The goal is to meet the national health goals to eradicate healthcare disparities. "Seeking public guidance for a revitalized strategy to address health disparities, the HHS Office of Minority Health convened nearly 2,000 stakeholders from around the country at a National Leadership Summit for Eliminating Racial and Ethnic disparities in Health in 2008. The summit simulated the subsequent formation of the National Partnership for Action to End Health Disparities, which includes community- and faith-based organizations, businesses, health care and insurance

industries, academe, cities and counties, states, tribes, and federal agencies" (Koh et al., 2011,

pg. 1823). Including social aspects such as churches and businesses is a way to improve the

immediate community, to understand their struggles from a more intimate view. "The Action

Plan proposes a common set of national goals and objectives for the public and private sectors.

The main principles include improving local awareness of health disparities, enhancing local

data collection efforts, and emphasizing public-private partnerships to improve access to care"

(Koh et al., 2011, pg. 1823). As mentioned in the earlier section, understanding how the

community members feel is crucial to understanding the depth of this issue. Also, by including

community members and their resources, it creates a well-rounded panel of people dedicated to

improving the current level of healthcare. Once the communities can begin to get better

resources such as education, food, and transportation, the community can begin to focus more on

their health status when their basic needs are met.

Further legislation in support of reducing the gap in healthcare includes the affordable

care act. "Sections 1311 and 2201 are intended to increase both access to and the affordability of

care for underserved populations. Section 3011 is designed to strengthen the healthcare system to

improve quality of care; section 10503 is to expand community-level care through health centers

and teams; and section 4004 to increase prevention efforts for underserved groups" (Koh et al.,

2011, pg. 1823). This excerpt on the Affordable Care Act sections exemplifies how several

sections are dedication to providing more care to underserved populations. The main goal of this

act is to increase availability of care. By reducing the cost of healthcare, it allows more people to

obtain a healthcare plan and gain control over their health status by going to see doctors, getting

treatments and medications. "Implementation of the Affordable Care Act should narrow

disparities in health insurance coverage and access and improve primary care services, care

coordination, and health care quality. In 2014, for example, Medicaid coverage will expand to cover individuals with incomes under 133 percent of the federal poverty level. Additionally, tax credits will help families and individuals with incomes below 400 percent of the poverty level purchase affordable coverage in the new state insurance exchanges" (Koh et al., 2011, pg. 1825). In addition to availability of care, further measures are being taken to ensure patients whose first language is not English are also taken care of. Medicare and Medicare plan to promote enrollment for Medicaid and the Children's Health Insurance Program by providing grants for better quality translation services online (Koh et al., 2011). Overall, the increased availability of care will help people who could not originally afford care to have an option for healthcare.

Diversify the Field

Moving into the future, one of the best things the medical field could do to reduce disparities is to support the future healthcare professionals. An article titled, Missing Persons: Minorities in the Health Professions, A Report of the Sullivan Commission on Diversity in the Healthcare Workforce (2004) states, "Today's physicians, nurses and dentists have too little resemblance to the diverse populations they serve, leaving many Americans feeling excluded by a system that seems distant and uncaring." Further stating health professionals will continue to not represent their patients if health professions education remains mired in the past and -despite some improvements-inherently unequal and increasingly isolated for the demographic realities of mainstream America" (Sullivan, 2004, pg. 1).

This begins by educating the youth on careers they can have in medicine. If children in these communities could grow up with a positive influence of the healthcare field in their life, they may go on to pursue these careers. This in turn would diversify the medical field to project a more realistic picture of the patients they serve. Sullivan (2004) explains,

"The problem is seen at the beginning of the pipeline where primary and secondary schools are failing too many students. On average, when compared to white students, racial and ethnic minority students receive a K-12 education of measurable lower quality, score lower on standardized tests, and are less likely to complete high school. Those who do graduate from high school are far less likely to graduate from a four-year college than white students" (pg. 6). "Even talented minority students who do succeed at primary, secondary and collegiate levels, and who are committed to pursuing a career in one of the health professions, often find it difficult to gain admission to a health professions school. The barriers they encounter include an over-reliance on standardized testing in the admissions process, unsupportive institutional cultures, insufficient funding sources, and leadership without a demonstrated commitment to diversity" (pg. 6).

The University of Maryland has begun programs to reach out to students and engage them in healthcare. "UMMC has workshops and internships for high schoolers interested in health careers. The University of Baltimore, Maryland, received a federal grant to mentor and train West Baltimore middle schoolers to increase the number of African-Americans in health care jobs" (Hancock, 2016, pg. 10). These programs prove to be beneficial in providing the youth with a position in healthcare, so they can provide a positive image for their communities and have the goals to further their education, so they can obtain a position in healthcare during adulthood. Students attending college also need support to make it through rigorous programs in the healthcare field such as nursing, and medical school. Opportunities identified to make studies in the healthcare field more realistic include scholarships instead of loans, and less importance placed on standardized tests for medicine, dentistry, and nursing. (Sullivan, 2004). These

changes would help with the opportunity to major in these programs. Some minority students may have had to overlook a career in the healthcare field due to the financial aspect of schooling for these majors. This causes well-qualified students to miss out on furthering their education because their families may have significantly lower incomes and not as many financial assets. (Sullivan, 2004). Therefore, it is suggested that qualified candidates who do not have the money for these programs must give up their goals or work that much harder to achieve them. Overall, education is one of the biggest factors to reducing healthcare disparities moving forward. If populations of minority students and people of lower socio-economic backgrounds can achieve the schooling they need, there will be a better reflection of diversity in the healthcare system. Furthermore, diversity and the ability to work with and understand different cultures is found to be essential to compete in the global economy today (Sullivan, 2004). The education system for healthcare professions needs to recognize the importance of a culturally competent body of employees, and apply that to assisting those of lower-socioeconomic backgrounds to achieve the proper education.

In addition to providing more opportunities for students to understand the opportunities in healthcare, improving the quality of the communities people live in will help to provide better health for low-socioeconomic populations. 'Innovative public policy approaches include a variety of policy and environmental initiatives designed to increase fruit and vegetable consumption in underserved areas.' Thus, elimination of "food deserts" in underserved communities can help eliminate chronic diseases, such as diabetes, and help achieve greater equity in health outcomes among racial and ethnic minorities' (Racial and Ethnic Health Care Disparities, n.d). When researching healthcare disparities, the topic of food desert was a common issue. Food desert means the community does not have an adequate source to get proper food

such as nutritious groceries and fresh fruits and vegetables. An area may have several fast food

stops but not a quality grocery store. When a community only has fast food places, the members

are at higher health risks. "Residents in these neighborhoods (food deserts) must rely on small

grocery stores or convenience stores, which carry few-if any- fresh fruits and

vegetables…People who live in food deserts are aware of their lack of accessibility to fresh fruits

and vegetables and indicate in surveys a desire to have good access to fresh produce. Thus,

unhealthy eating is often the result of structural inadequacies in assessing healthy foods and not

necessarily limited to personal dietary choices" (Racial and Ethnic Health Care Disparities, n.d).

Therefore, these populations understand the negative consequences associated with food

providing little nutrition, however, they have few other options. Well balanced diets and health

are directly related. Diabetes and hypertension are both chronic diseases that have a higher

prevalence in ethnic and racial minorities (Racial and Ethnic Health Care Disparities, n.d). The

importance of resources in the community is another determining factor for disparities.

<div align="center">**Conclusion**</div>

Healthcare disparities have been prevalent throughout history in the United States. The

past has unfortunately shaped our future where populations with less advantages receive poorer

quality care than their counterparts. Studies on lower-socioeconomic individuals such as the

Tuskegee Syphilis study and the cells taken from Henrietta Lacks provide a dark history in

healthcare. Even in present day, minorities and people living in less-advantaged communities

feel as if their care is not taken as seriously as those with more money. Current statistics support

that higher rates of hospital readmissions for these groups cost them even more money and

suffering due to untreated medical conditions. Health Advocacy groups recognize healthcare

disparities as a pressing issue in the field. Policies and programs have been created to try and

combat these issues. However, little progress has been made. Looking into the future, the conditions or lower socioeconomic communities needs to be improved. But one of the interventions that can be resolved in a faster manner is education for these populations. By encouraging and providing young kids and adults with the opportunity to pursue a career in the healthcare field, change can be made internally in these institutions. If healthcare practitioners begin to provide a more realistic picture of the United States population, I believe disparities will be decreased. There will be better understanding and practice of cultural competence. "The health professions have reached a crossroads; a point where dramatic change is required, and wise decisions must be made. Either health professions training will remain entrenched in the status quo and become increasingly out of touch with the demographic realities and health needs of the nation, or the professions can choose to change, and lead to a new era of excellence in healthcare" (Sullivan, 2004, pg. 11).

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