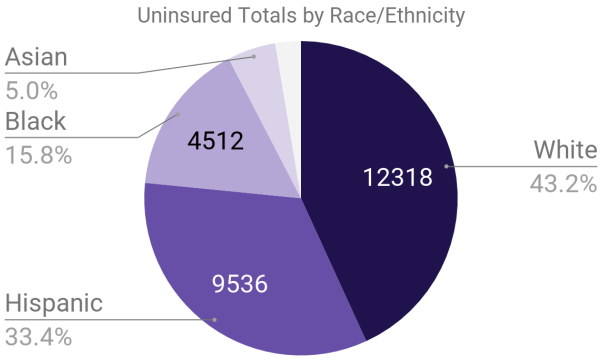
Course: PSAA 630, Program Evaluation
Writers: David Barrera, Rachell Davis, William Horton, Lesleigh Lee, Blanca Macareno, Nicholas Partipilo, Morgan Seekatz
Objective: **Problem Structuring**

PROBLEM INTRODUCTION

Due to the complexity of the United States (U.S.) healthcare system, there are many problems that citizens face when trying to receive healthcare services. The overarching theme of these problems is the inequity of healthcare faced by certain subpopulations in the United States. Sridhar (2005) stated in the United Nations 2005 Human Development Report that although the United States as a whole shows overall high capacity in all healthcare indicators, disparities among certain populations remain hidden. In a wealthy country, those who suffer the most and go without their basic needs tend to go unseen in national reports and continue to suffer (Sridhar, 2005). Contemporaneous research has shown, historically, marginalized groups have been excluded from study and that indicators of "race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location" play major roles in revealing disparities in the healthcare system (Agency for Healthcare Research and Quality, 2018).

This paper seeks to explain and understand the issue of healthcare inequity in the U.S by (1) examining demographics of insured and uninsured Americans; (2) by understanding facts, worldviews and assumptions of our current healthcare system; and (3) by providing a causal path model that is explained by a hierarchical analysis and analysis of the consequences of inequity in healthcare.

DEMOGRAPHICS (Boundaries)



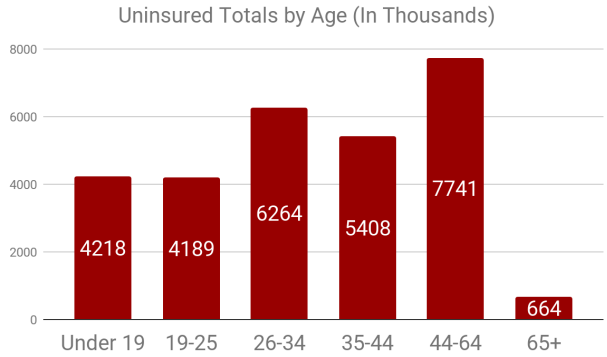
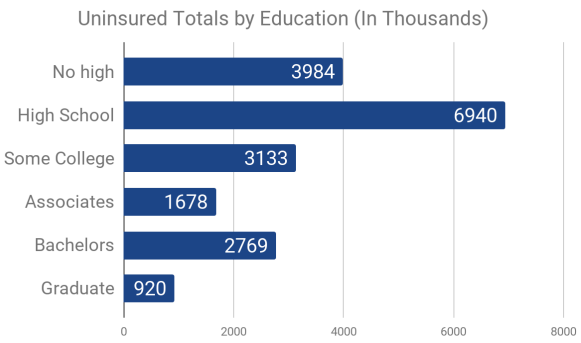
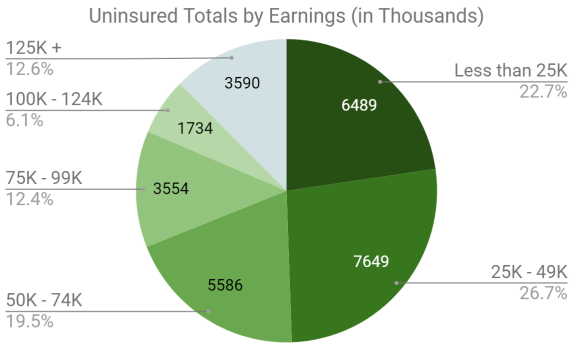


Figure 1 & 2: The following images are totals within respective demographics. It is important to note that percentages and totals illustrate different aspects of problems of healthcare provision. There may be more white Americans who are uninsured, but by percentage minorities have disproportionate amounts of uninsured within respective populations (larger graphs can be found in the appendix).

Americans without Healthcare

The most visible, and documented, inequities that exist in healthcare in the United States are between those that have some form of insurance and those that have none. According to a recent U.S. Census study, 8.8 percent of the U.S. population, or 28.5 million, do not have healthcare insurance (Berchick, Hood, & Barnett, 2018). 14% of males and 11% of females, under the age of 65, were uninsured (Kaiser Family Foundation, 2017). The most insured state in the United States was Massachusetts, with 5% (96,700) of males and 3% (62,000) of females uninsured, respectively (Kaiser Family Foundation, 2017). Texas is the most uninsured state, with 25% (2,037,700) of males and 22% (1,887,900) of females uninsured, respectively (Kaiser Family Foundation, 2017). White, Black, Asian, and Hispanic American populations have uninsured rates of 6.3% (12,313,539), 10.6% (4,456,240), 7.3% (1,369,481) 16.1% (9,284,870), respectively (Berchick et al., 2018). The largest uninsured age group in the United States is between 26 and 34, with 15.7% (4,452,708) uninsured (Berchick et al., 2018). The smallest uninsured age group in the United States is over 65, with 1.2% (612, 960) uninsured (Berchick et al., 2018).





Figures 3 & 4: the totals of respective demographics (bigger graphs can be found in the appendix)

The largest uninsured education group, by percentage, in the U.S. are those without a high school diploma, at a rate of 26.3%, (3,984,450) (Berchick et al., 2018). The smallest uninsured education group in the U.S. are those with a graduate or a professional degree at 4.2% (919,548) (Berchick et al., 2018). For income, 25.7% of those that earn less than 50K are uninsured (14,137,799), while only 4.3% of those with an income of 125K are uninsured (3,589,941) (Berchick et al., 2018). 86% (24,573,000) of uninsured people live within metropolitan areas, while the remaining 14% live outside of metropolitan areas (3,970,000) (Berchick et al., 2018).

Americans with Healthcare

In 2017, 91.2% of Americans had some form of healthcare coverage. 67.2% (217,160,000) were covered by private health insurance while 37.7% (121,830,000) were covered by government health insurance (Berchick et al., 2018). Americans under the age of 65, 25% reported difficulty in paying medical bills (an estimated 68,019,000 by Census standards). Of that 25% facing difficulties, 15% (10,202,000) had to take out high interest loans, leading to a significant depletion of disposable income, trends of delayed medical care which becomes costly to reconcile later, and debt (Dickman, Himmelstein, & Woolhandler, 2017). Data on racial, educational, and income demographics may be difficult to understand because of the difficulty in evaluating quality of healthcare, and for this reason, is not included in this section. Difficulty in assessment of quality

of care, as well as the effects race and income have on healthcare quality will be discussed in later sections.

FACTS AND WORLDVIEWS

Fact: Health care is getting more expensive.

As the costs of common goods such as home appliances or cars has declined relative to inflation, the price of healthcare has skyrocketed. From 1958 to 2012, the price of healthcare has quadrupled (Conover, 2012). This has continued after 2012 as healthcare prices have risen past the general economic inflation that other goods and services tend to follow (Claxton, Rae, Levitt, & Cox, 2018).

Fact: Enforcement of civil rights legislation has increased access.

Hahn, Truman, and Williams (2018) compiled data from multiple academic resources and noted a trend in the enforcement of civil rights increasing the healthcare quality for minority populations, particularly in the African American community. The same also held true that when denied civil rights, these minority communities saw a decline in the quality of healthcare provided by the government or private entities. Hahn et al. (2018) demonstrate that civil rights increase access to hospital resources and provide a better quality of life for future generations when civil rights are enforced.

Fact: It is difficult to assess what Quality healthcare is.

In 1945 Roosevelt's successor, Harry Truman, enacted policy to improve the condition of healthcare across America by building new hospitals, spreading doctors to rural areas, establishing national health standards for hospitals and doctors, and increasing medical research (Griffin,

2017). While this served to improve access and quality of care, contemporaneous research finds that is difficult to assess what "quality healthcare means".

A study of 29 different articles focused on evaluating healthcare quality of service found that, while inequities did exist across populations, there was a lack of consensus on what constituted "good" and "bad" coverage. There are two explanations: (1) authors had different definitions of patient satisfaction and (2) quality reported metrics often had to be proxy variables that ranged from financials, to processes of care, to patient reported experiences (al-Abri & al-Balushi, 2014). Quality becomes especially difficult to assess when insurers provide incentives for "higher performing" providers, because socioeconomic factors may serve to explain negative score indicators, such as mortality rates, better than competence of doctors and practitioners (Dickman et al., 2017).

Worldview: The debate on should healthcare be a right.

The debate on whether the government or private markets should provide healthcare can be traced back to 1854. President Franklin Pierce vetoed a bill regarding government provision for mental health issues on the basis that it was unconstitutional to regard individual's health as anything but a private matter (Igel, 2008). However, ideological stances on the issue began to form, with liberals leaning toward some form of government funded healthcare and conservatives leaning toward limited-government intervention on the matter, and the majority of insurance handled by individuals, private charities, and religious institutions (Igel, 2008). The Affordable Health Care Act's (ACA) passage in 2009 marked a major victory for those in support of government sponsored healthcare, but 50.4% of voters opposed the bill while 39.7% favored it on the day it passed (RCP Poll, 2010). As of October 2018, 50% of Americans now support the ACA, a shift towards favorability of government sponsored health provision (RCP Poll, 2010). While

views on whether the government should provide healthcare, and if it is a right, are changing, it is important to note that currently 37.7% (121,830,000) are covered by government health insurance (Berchick et al., 2018).

Assumptions: Stakeholders and the U.S Model of Healthcare.

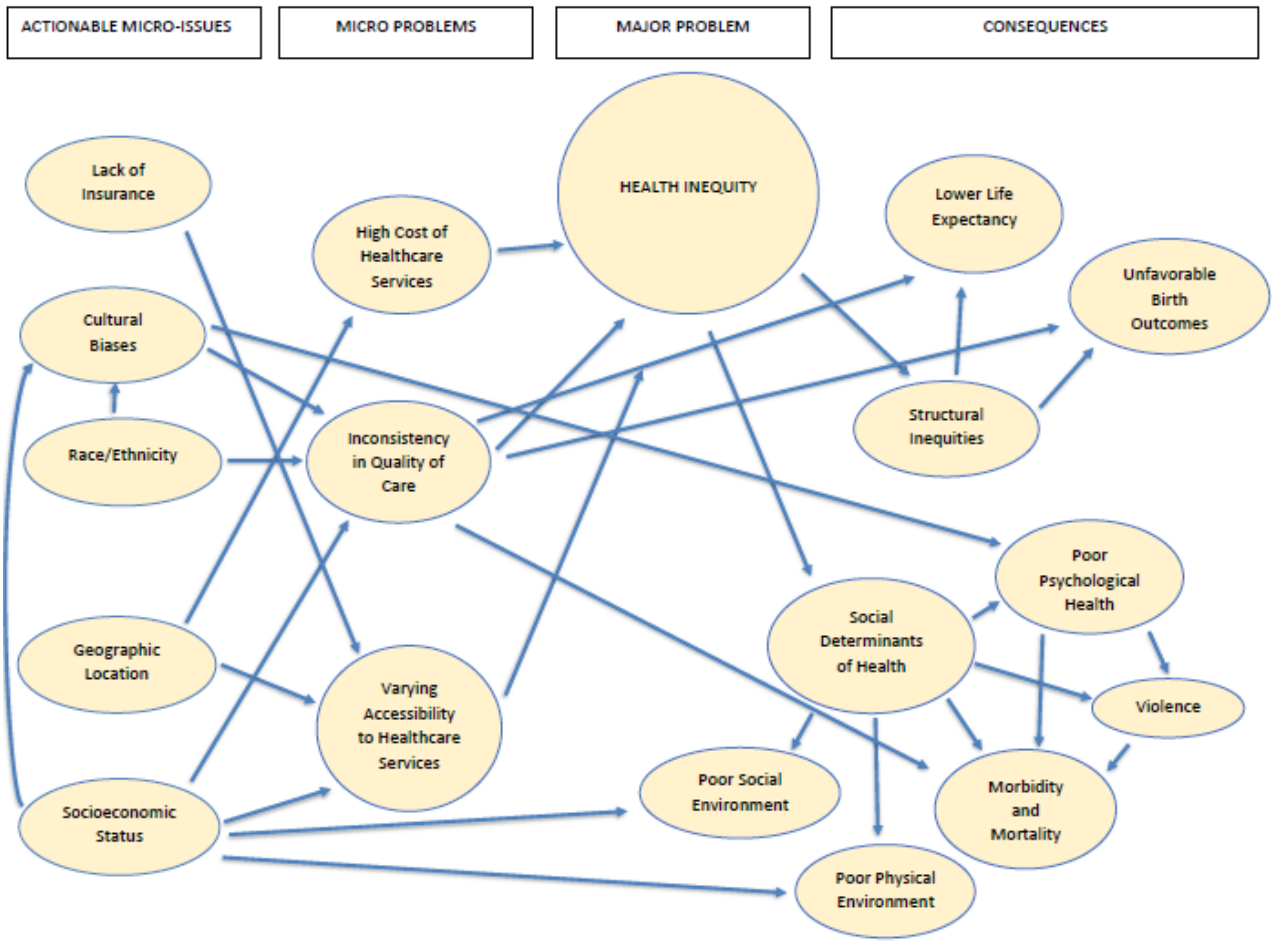
Defining "actors", a group that encompasses decision makers, citizens, and clients, is key to framing healthcare provision and responsibility. The availability of resources, power dynamics, bases of actions, and values all determine how these worldviews are shaped and what assumptions are made (L. Bright, personal communication, January 30, 2019). The Government and the private market are motivated by different values leading to different approaches to health care provision. Government is motivated by a desire for healthy citizens, and healthcare providers are motivated by payment for services (i.e., profit). Citizens and clients have an altogether different view, insofar as they represent the demand-side of the equation as opposed to supply. These three sets of stakeholders all have different values and goals, and it is necessary to make sure that each group is given due attention so that the problem is described accurately (Newcomer, Hatry, & Wholey, 2015).

The U.S. government provides healthcare to the poor and elderly through Medicare and Medicaid, and to the indigent through subsidized services at Emergency Rooms (Physicians for a National Health Program, n.d.). Other individuals not covered by these programs buy healthcare out-of-pocket or receive it through their employers (private insurers). American policy decision implies a belief that for certain individual's right to healthcare, but government policy encourages the remaining citizens to secure their own healthcare. In contrast to this worldview, other developed nations hold that it is the responsibility of the state to provide healthcare to all its

citizens. “Socialized medicine” refers to these systems that are popular in Canada, Europe, and other areas around the world. For the purposes of this paper, we only focus on the U.S model.

CAUSAL PATH MODEL

The following two sections will explain the significance and theory behind the model presented below (also found in Appendix B).



HIERARCHICAL ANALYSIS

In this paper, healthcare inequity is attributed to three micro-problems: high costs, inconsistency quality of care, and varying accessibility. From here, the micro-issues associated with these three micro problems are categorized as possible, plausible, and actionable (Bright, 2019b). Possible problems were determined by brainstorming, which may or may not have any basis in fact or theory (Bright, 2019b). On the other hand, the plausible problems listed are supported by research, facts, or personal experiences (Bright, 2019b). By evaluating the plausible problems, there is a small subset of this group that are actionable, meaning there is something legally, morally, or organizationally that can be or has been done to improve these issues (Bright, 2019b). The following list is not exhaustive. There are indeed many more micro-problems contributing to healthcare inequity. Nevertheless, this section of the paper provides an adequate discussion of the most commonly cited micro-issues contributing to the major three problems leading to healthcare inequity.

High costs are the first major micro-problem contributing to healthcare inequity. The possible problems producing high healthcare costs are: lack of insurance, poor-quality insurance, lack of transparency, upcoding, and unnecessary testing. The plausible problems are lack of insurance and lack of transparency. According to Kirby and Kaneda (2010), “compared with those who have health insurance, the uninsured more frequently go without needed medical care” because they cannot afford to go to the doctor (p. 339). Santa (2010) discusses the issues of transparency of cost for “ healthcare products and services” (p. 339). Santa (2010) notes that there has been an increase in the number of insured middle class families who file for bankruptcy due to outstanding medical bills. Hence, even in the case when individuals have insurance, healthcare is not affordable. Of the plausible problems, no insurance is actionable. This problem is actionable

because there are a variety of solutions designed to alleviate its effects. For example, The Affordable Care Act (2010) under President Obama's Administration was a key piece of legislation, tackling this issue. This government policy aims "to make health insurance more affordable for those with little or no coverage" (Adams, Clark, & Delorme, 2014). Nonprofits have also attempted to relieve citizens without health coverage. For instance, Planned Parenthood provides free or low-cost health services for men and women.

The second major micro-problem feeding healthcare inequity is inconsistent quality of care. The possible problems for inconsistent quality of care are: socio-economic status, race/ethnicity, gender, and citizenship, medical providers' level of skill, religious background, sexual orientation, and medical history. Although there are many possible micro-problems related to inconsistent quality of care, only some of them are plausible. According to Schneider, Leape, Weissman, Piana, Gatsonis, and Epstein (2001), African Americans receive a lower quality of care and more limited access to pertinent surgeries than their white counterparts. The Harvard Gazette further explains this inconsistency, stating that disparities in health services affect minorities more than whites because, on average, more minorities make up the nation's poor (Powell, 2017). The Kaiser Family Foundation performed a study that found adult Latino non-citizens were exponentially less insured than native citizens (70% of adult Latino noncitizens compared to 34% of Latino citizens), and that individuals whose first language was not English lacked the ability to communicate effectively with their physicians, which led to poor quality of care (Ku & Waidmann, 2003).

Analysis of the current plausible problems with inconsistent health care services shows that all these problems are actionable. In hospitals and healthcare facilities, signs, posters, and brochures are often converted into multiple languages. Similar to how individuals can request

translators at certain public establishments, some health entities take a similar approach to breaking down barriers in service delivery. Unfortunately, some problems involving inconsistent quality of care are linked to prejudices and these are harder to overcome, but institutions, private and public, have begun addressing these issues. The government has passed a number of anti-discrimination laws, and nonprofits, such as the NAACP, encourage equity and equality.

The third micro-problem leading to healthcare inequity is varying accessibility. The possible problems of varying accessibility are: geographic location, socioeconomic status (SES), disability, transportation, citizenship, and culture. However, some problems are better supported with research and theories than others, specifically geographic location, SES, and citizenship. For example, Ricketts (2002) states, "Rural residents are, on average, poorer, older, and, for those under age 65, less likely to be insured than persons living in urban areas" (p. 155). Another plausible problem, "people of lower SES have limited access to health care due to cost and coverage" (Arpey, Gaglioti, & Rosenbaum, 2017, p. 169). Correlated with SES, minorities experience higher rates of poverty than whites. The Agency of Healthcare Research and Quality (2010) reports, "In 2008, the percentage of people with a specific source of ongoing care was significantly lower for poor people than for high-income people (77.5% compared with 92.1%)" (p. 3). Lastly, The Kaiser Family Foundation explains how citizenship status determines whether a person will have insurance coverage through their employment or if the individual is eligible for government-provided healthcare (Ku & Waidmann, 2003). Typically, the absence of insurance decreases an individual's likelihood of seeking medical attention.

After analyzing the plausible micro-problems associated with varying accessibility, geographic location and SES are actionable. Geographic location is an actionable solution given that there are a number of nonprofits that provide health care services to citizens in rural areas:

Families USA, Kaiser Program on Medicaid and Uninsured, and many others. The issue of SES is actionable because it can be addressed using methods similar to those used for people without insurance.

Out of the many actionable problems mentioned for each major micro-problem, SALGBA, as an association, does not address any of these problems. SALGBA is not a service-delivery agency, and they also do not advocate for specific policies. Nevertheless, the agency provides a platform for its members to share their healthcare concerns and interests.

CONSEQUENCES

The National Academies of Sciences, Engineering, and Medicine (2017) reports two key explanatory concepts for consequences of health inequity: 1) structural inequities and 2) social determinants of health.

Structural Inequities

Structural inequalities are mechanisms that divide power and resources along lines of people's individual and group identities. The consequences discussed in our model collectively called structural inequalities are lower life expectancy and unfavorable birth outcomes. The quality of neighborhoods that adults and children live in plays a significant role in their health trajectory. Because neighborhoods are often divided by race and class lines, there is often inequity in access to resource rich neighborhoods that have quality and affordable health services (National Academies of Sciences, Engineering, and Medicine, 2017). Structural inequities, as mentioned above, lead to "preventable differences in health metrics such as life expectancy, with research indicating that one's zip code is more important to health than one's genetic code" (National Academies of Sciences, Engineering, and Medicine, 2017, p. 101; RWJF, 2009). Also, structural

inequities affect birth outcomes, such as the difference in birth weight and infant mortality rate, not associated to biological differences amongst African American women; these differences are seen even when researchers account for difference in socioeconomic status among these women (National Academies of Sciences, Engineering, and Medicine, 2017).

Social Determinants of Health

Social determinants of health are the economic and social conditions surrounding groups and individuals that affect their overall health (National Academies of Sciences, Engineering, and Medicine, 2017). The consequences discussed in our model collectively called structural inequalities are poor social environment, poor physical environment, violence, and mortality and morbidity. Societal factors such as, "exposure to violence, hazardous conditions, and residential instability" can affect how people respond to others and their surroundings (National Academies of Sciences, Engineering, and Medicine, 2017, p. 153; Diez Roux & Mair, 2010). Changes in physical environment can limit accessibility to the following: transportation, healthy homes, good schools, healthy food venues, social networks, transportation options, and recreational areas (National Academies of Sciences, Engineering, and Medicine, 2017; CDC, 2013) "Violence rates can lead to population loss, decreased property values and investments in the built environment, increased health care costs, and the disruption of the provision of social services" (National Academies of Sciences, Engineering, and Medicine, 2017, p. 156; Massetti & Vivolo, 2010; Velez, Lyons, & Boursaw, 2012). Differences in death rates exist among the most- and least-educated Americans; the most-educated are experiencing a decline in death rates while those that are least-educated are experiencing an increase in death rates (National Academies of Sciences, Engineering, and Medicine, 2017; Jemal, Ward, Anderson, Murray, & Thun, 2008).

Definition and Identification of Confounding, Spurious, Intervening Variables

The causes and consequences of health inequity are classified as confounding, spurious, and/or intervening variables. Confounding variables have an influence on the dependent variable along with the independent variable; in other words, confounding variables may be causing the effect on the dependent variable and not necessarily or partially by the independent variable (Bright, 2019a). Variables that have an influence on both the independent and dependent variables and entirely accounts for their relationship are called spurious variables; there is an association between the independent and the dependent variable only because the spurious variable is causing both the independent and the dependent variable to happen (Bright, 2019a). An intervening variable happens between the independent and dependent variable; it is understood to be "caused by the independent variable and is itself a cause of the dependent variable" (Bright, 2019a). Table 1 in Appendix C identifies the causes and consequences of health inequity by type of variable(s).

CONCLUSION

In our study, those that were male, a part of a minority group, less educated, and earned less faced more inequities in healthcare. Despite having coverage, Americans with healthcare also faced inequities and hardships because insurers do not always pay full medical bills, and recipients may have to take out loans to finance them. Healthcare is becoming increasingly more expensive, is not accessible to everyone, and is difficult to evaluate in terms of quality. Despite policies such as the Affordable Health Care Act, the current political climate in the United States is split on whether or not healthcare should be provided to all citizens. While other developed nations provide universal healthcare, or socialized medicine, the United States only guarantees healthcare to specific individuals in the population, while encouraging the rest of the population to seek

insurance through the private market. Our causal path model seeks to visualize the hierarchy nature of variables that factor into healthcare inequity, and the consequences that arise from it. High costs, inconsistency in quality of care, and varying accessibility to health care services are the main micro problems that factor into health care inequities. Structural inequities and unfavorable social determinants of health are consequences of inequities in health care provision.

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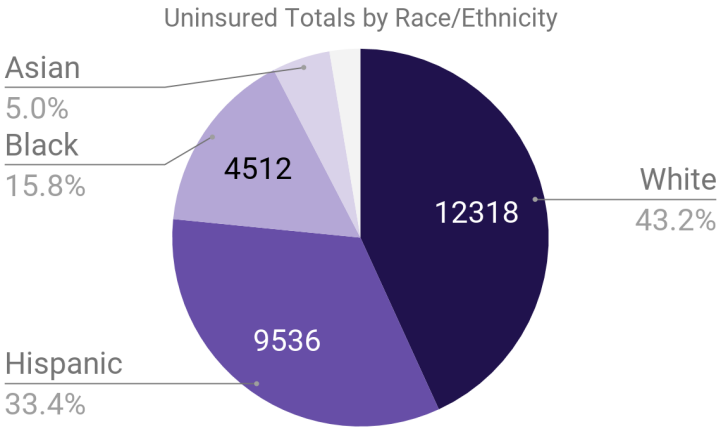
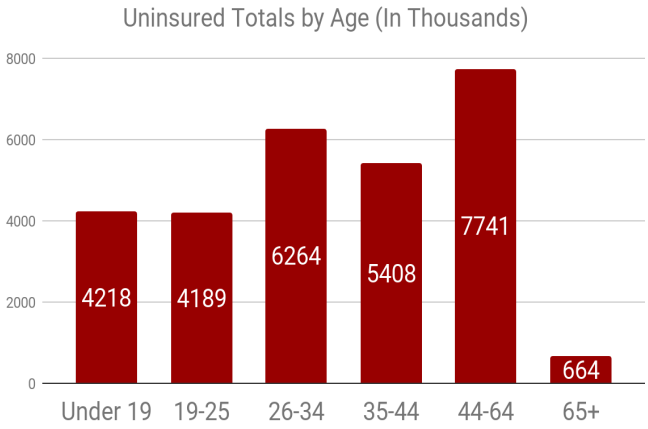
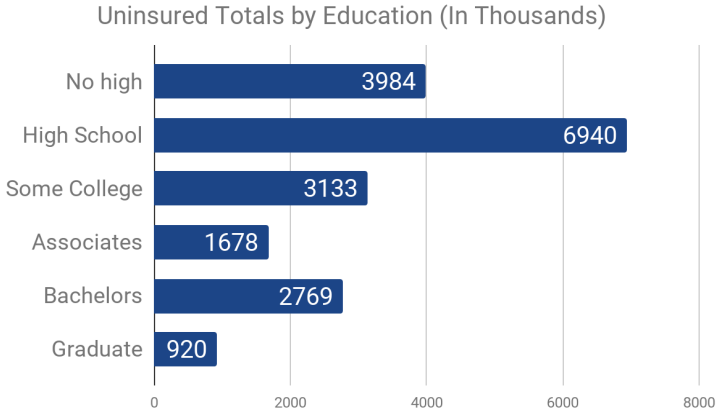
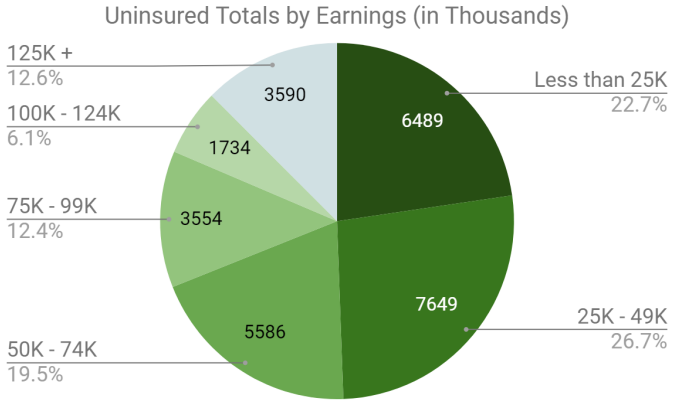
APPENDIX A

Charts



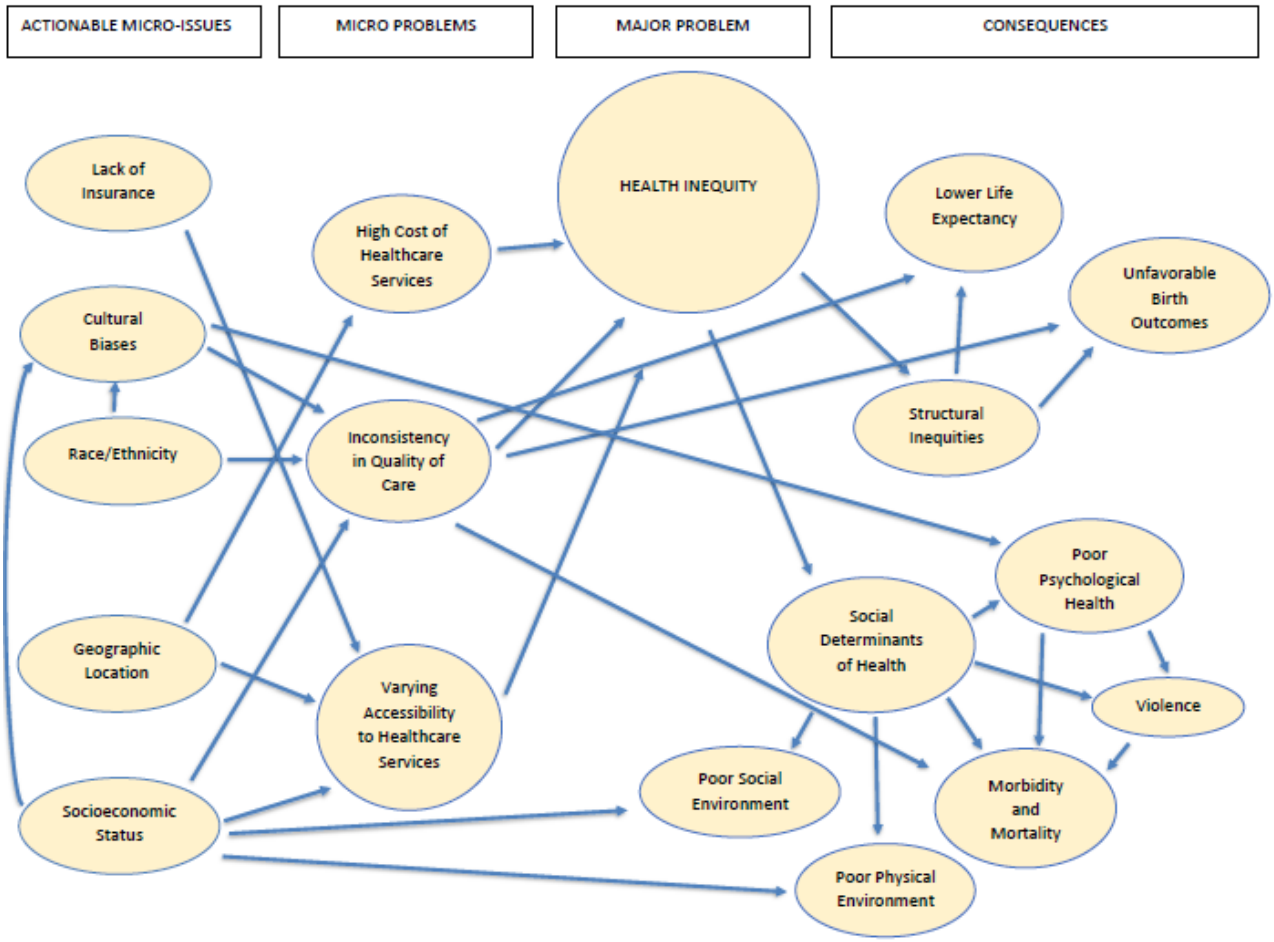






APPENDIX B

Causal Path Model



APPENDIX C

Table 1

Classification of Causes and Consequences of Health Inequity by Confounding, Spurious, and/or Intervening Variables

Causes and Consequences			
Variables	Confounding	Spurious	Intervening
Race	✔		
Ethnicity	✔		
Gender	✔		
Class	✔		
Sexual orientation	✔		
Gender expression	✔		
Power		✔	✔
Socioeconomic status	✔	✔	
Geography	✔	✔	
Disability	✔	✔	
Immigration status	✔	✔	
Racism			✔
Xenophobia			✔
Homophobia			✔
Policies cultivating inequities	✔	✔	
Life expectancy	✔		
Social environment	✔		
Housing	✔		
Employment	✔		
Public safety	✔		
Physical environment	✔		
Income and wealth	✔		
Health systems and services		✔	✔
Transportation	✔		✔
Education	✔	✔	