

Minority Healthcare Services and COVID Era Access: How Do We Move Forward

Linda Martinez

Assistant Professor, Health Care Administration, California State University – Long Beach

Article Info

Received: June 11, 2021

Accepted: June 16, 2021

Published: June 24, 2021

***Corresponding author:** Linda Martinez, Assistant Professor, Health Care Administration, California State University – Long Beach.

Citation: Martinez L, "Minority Healthcare Services and COVID Era Access: How Do We Move Forward". International Journal of Epidemiology and Public Health Research, 1(3); DOI: <http://doi.org/03.2021/1.1013>.

Copyright: © 2021 Linda Martinez. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Abstract:

This research examines healthcare disparities, such as race and ethnicity, including sex, sexual identity, age, disability, socioeconomic status and even one's geographic location are factors that play both sensitive and difficult roles in the kind of care one obtains. This study is based on a simple meta-analysis following the "PRISMA" Preferred Reporting Items of Systematic Review and Meta-Analyses flowchart (Moher et al., 2015). The method resulted in searching articles that were published up to the end of May, 2021 through major electronic databases and established the criteria to determine whether the studies were eligible for this meta-analysis. The research uncovered major differences between minorities, including African Americans, Asian Americans, Hispanic Americans, Native American, Native Hawaiian or other Pacific Islanders and Native Alaskans. In general, the research shows that overall, when compared to their white counterparts, minorities suffer more chronic illnesses, more difficult access to healthcare, higher percentages of mental health issues, and often higher percentages of suicides.

Keywords: minorities; african americans; asian americans; hispanic americans; latin-x; native americans; pacific islander; native Alaskans; health disparities

Introduction:

A look at minority healthcare, performance and accessibility remains major concerns in the United States. During this study, the research and data pointed to different factors that affect quality health care among minorities or those at lower social economic status. The outcome of COVID-19 shed more light on how vulnerable minorities are treated in the land of the plenty. Based on the latest data, COVID-19 has affected 61.5 million individuals who tested positive and caused 1.435 million deaths and those numbers continue to rise (Vaughan, 2021). WHO (2020), warned about stress from the uncertain fear resulting from experiencing COVID-19. Also, longstanding health disparities affecting ethnic minorities in the U.S. have now shed more light on the healthcare problems in the country which have been made more visible as a result of the COVID-19 pandemic and data based on the recorded death records. New data has proven that minority groups are more likely than the Caucasian Americans to be affected with a higher prevalence of comorbidities that are associated with poor COVID-19 outcomes, such as type-2 diabetes, occupational risk and lack of access to health care, which all disproportionately affect minority ethnic groups and the risk of COVID-19 hospitalization across U.S. ICU admissions and death were greater for minorities, as seen in the news (WHO, 2020).

The COVID-19 pandemic has really exposed the healthcare inequalities in the U.S. and validated research and conversations in the country on racial and class disparities in morbidity, mortality rate and vaccination especially among African and Asian/Hispanic Americans. Therefore, the time is now to look into our healthcare system policies, and how the government funds and finances health care and to revisit the decades-long dismantling of the welfare systems that is known to have weakened the public health and exacerbated racial inequities (Shaefer & Edin, 2013). The essential workers in the country, while being treated as disposable are the reality that has deepened racial and gender inequities in the U.S., even though they have been publicly praised during the COVID-19 pandemic. It is now evident that African Americans, Asian Americans, Indigenous peoples, other minorities, such as Hispanics and women are highly over-



represented among the those who continue to work in high-risk jobs and among those who have lost their jobs and endure the highest rates of unemployment. It has been estimated that the pandemic affected more minority women than men, as they lost a total 5.4 million jobs, nearly one million more losses than men (Boesch & Phadke, 2021).

The median annual earnings for women working full-time was \$47,299 and in general, women experience a wider wage gap as a result of persisting gender, race, and ethnic biases; they are also disproportionately concentrated in jobs in the service and care sectors that are often considered essential, but poorly paid (Bleiweis, 2020). Indeed, the poorest suffer the most from COVID-19, conflict, and climate changes, halting COVID-19 and reversing its economic effects requires a combination of familiar and new approaches that would require governments to act decisively to expand financial support to vulnerable households and small businesses, by way of taking on debt needed to pay for the support (World Bank Group, 2020).

According to the CDC (2004), by 2050, racial/ethnic minorities will account for nearly 50% of the total U.S. population. If these populations continue to experience poor health status, the expected demographic changes will magnify the adverse impact of such disparities on public health in the United States. Despite recent progress, racial/ethnic disparities persist among the 10 leading health indicators identified in the 2010 national health objectives. Socioeconomic factors (e.g., education, employment, and poverty), lifestyle behaviors (e.g., physical activity, alcohol intake, and tobacco use), social environment (e.g., educational and economic opportunities and neighborhood and work conditions), and access to clinical preventive services (e.g., cancer screening and vaccination) contribute to racial/ethnic health disparities. Level of education has been correlated with the prevalence of certain health risks (e.g., obesity, lack of physical activity, and cigarette smoking). In addition, recent immigration might increase risks for chronic disease and injury among certain populations. Although some immigrants are highly educated and have high incomes, lack of familiarity with the U.S. health-care system, different cultural attitudes about the use of traditional and conventional medicine, and lack of fluency in English can pose barriers to obtaining appropriate health care. The elimination of racial/ethnic disparities in health status will also require important changes in the way health care is delivered and financed. Unequal access to care and unequal treatment of persons who receive care are key determinants of racial/ethnic disparities in health care and health status (CDC, 2004).

Since 1985, the U.S. Department of Health and Human Services has coordinated several initiatives to reduce or eliminate racial/ethnic health disparities, such as the Executive Order on Increasing Participation of Asian Americans and Pacific Islanders in Federal Programs. According to a survey of workplace stress by Harris Interactive and the American Psychological Association (2011), 36% of workers were exposed to daily stress during their workday, and 49% of workers emphasized that low salaries significantly affected their stress levels in the workplace. The study also pointed out that 43% of workers had increased stress because of few opportunities for growth and advancement in the workforce, 43% reported high expectations from supervisors, 40% reported unrealistic job requirements, and 39% reported

overwork. In addition to the trends mentioned previously, other key trends have been identified within the industry due to the COVID-19 pandemic, physician shortages, newly available technology, and inflation. The first decline in revenue this cycle was caused by the recent COVID-19 pandemic, while new technology and inflation have limited the growth of profitability in the industry. Also, the current shortage of physicians in the United States has become a major concern within the healthcare industry as a whole and will have significant impact on the primary care industry since it represents most patients' first contact when seeking health care services (Miller, 2020).

Uninsured and underinsured individuals have an increased risk for poor health outcomes and therefore, a lower health-related quality of life in which an individual's socioeconomic status is known to be a major risk factor that can negatively affect several health-related quality of life domains including physical, psychological, and social functioning (Wippold, Nmezi, Williams, Butler & Hodge, 2020). According to the findings published in Kaiser Family Foundation (KFF), Tolbert, et.al. (2020) report, about 28.9 million nonelderly individuals were uninsured, and among the groups that are insured, there is a pattern with the people of color making up this population. It was discovered that people of color make up 43.1% of the people that account for more than half of the total uninsured population. Along with this, Hispanic, Black, American Indian/Alaskan Native, Native Hawaiians, and other Pacific Islander people are more than likely to have higher uninsured rates than their White counterparts.

Griffin et al. (2010) discussed that job satisfaction, job stress, and job involvement were more vigorous predictors of burnout than the personality-related indicators, including gender, ethnicity, age, educational attainment levels, tenure, job position, and supervisory status. From these aspects, workers, who are working under less developed administrative policy and workforce management in their workplace, easily suffer stressful conditions beyond their personalities and job positions. Obviously, burnout resulting from stress affects workers' behaviors in their work and life. In the article introduced by the National Institute of Mental Health Information Resource Center (2019), it is addressed that the most common depression, called major depression, disrupts one's working productivity, sleep condition, concentration capacity, eating habits, and satisfaction of life. When people suffer depression, they often experience multiple conditions simultaneously. As a result, when workers encounter burnouts caused by stress in their workplace, turnover and absenteeism occur.

There are several factors that hinder access to healthcare for minorities, but most are associated with social, cultural, financial, and environmental aspects of the life they live. Even though, the current system and policy on health care may not be favorable to them, increases in health insurance coverage has even made it more difficult for these group to get out of poverty status as, about 27.4 million non-elderly individuals were without coverage in 2017 (Moore, 2019). Out-of-pocket costs often create a financial obstacle to accessibility and result in financial difficulty. Co-payments are not really a useful tool for rationing health care, rather it decreases all use of medical services, especially amongst patients with chronic diseases, as well as the poor. Urgent regulations are needed that will authorize the healthcare insurance



system to contract private facilities with acute inpatient capability to ensure that these treatments are delivered without co-payments (Thomson, Habicht, & Evetovits, 2020).

Furthermore, another factor consistent in research findings was the needs which play a role in health care inequality, which is the issue of healthcare access. The issue of relying so heavily on private health insurance affects the accessibility of individuals trying to afford the high costs of health care. According to Amadeo (2021), prior to the Affordable Care Act, about 20% of Americans had little or no health insurance and as result, almost 45,000 of them died each year due to in-affordability of the higher cost of health care. And between 2011 and 2013, 38% of those in households making less than \$22,500 a year reported they have poor or fair health while 12% in households making more than \$47,700 a year reported being in poor to fair health (Amadeo, 2021).

Purpose of the Study

Healthcare disparities, such as race and ethnicity, including sex, sexual identity, age, disability, socioeconomic status and even one's geographic location are factors that play both sensitive and difficult roles in the kind of care one obtains. Health disparity is defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (Office of Disease Prevention and Health Promotion, n.d., para. 5).

However, it is significant to understand that access to healthcare, and ability for minorities in this country to have health insurance are some of the most basic tenets, even though obtaining insurance does not ensure access to quality treatment for minorities in the U.S. Many of these health disparities are especially driven by social and economic inequalities, including factors like economic stability, education, physical environment, education, food, community, safety, and the health care system. These factors whether combined or viewed individually have an impact to one's health and well-being, affecting their life expectancy and mortality. Although disparities can occur all throughout one's life, it is of importance to focus on populations concerning people of color, low-income communities, women, children, older adults, individuals with special care needs, and those living in rural areas. Health disparities have a hand in the differences among populations in the prevalence and development of such health conditions and diseases.

Therefore, the purpose of this research is to explore the problems minorities face concerning infectious diseases, lack of access to quality healthcare, income inequity and the impact of the most recent infectious disease of COVID-19. It is of importance to address the social factors that affect one's fair distribution of quality health care. There are social, environmental, economic, and cultural determinants of health that play a role in health inequalities. This includes such things like the conditions in which people live including access to food, safe water, and housing; the quality of schools, workplaces, and neighborhoods" (Baciu et al., 2017).

The impact of these components is drastic, especially to those in the lower income bracket. There are nine social determinants that

influence an individual's health outcomes; this includes education, income and wealth, employment, health systems and services, housing, the physical environment, transportation, the social environment, and public safety. These social determinants result in the differences that create the unfair advantage and risk that results in poor health outcomes as established by this report.

Problems

Health-care expenses have risen to the top of the public's priority list of health-care concerns (Kirzinger, Munana, Wu, & Brodie, 2019). Insurance premiums are also at the top of a list of living costs that people are concerned about. Health-care costs have risen steadily over the last three decades, which is perhaps unsurprising. Last year, the typical American family spent nearly \$5,000 on healthcare services per individual. As per the Bureau of Labor Statistics Consumer Expenditures Survey (2019), this represents a 101% increase from the nearly \$2,500 per individual expenditures in 1984. Leonhardt (2019) reported that annual employer benefits report from Kaiser Family Foundation indicated that, people who depend on company insurance coverage spend an average of \$1,242 on out-of-pocket expenses. In 2019, the average price for a single individual was about \$7,188, with employers footing a much larger portion of the bill (Leonhardt, 2019).

The population of the United States was projected to be 323 million people in 2019. The majority of those people had private health insurance or were enrolled in a government-sponsored health-care program. In 2019, 30 million people (9.2% of the population) were uninsured in the United States (Congressional Research Services, 2021). From 2008 to 2013, the uninsured rate remained relatively unchanged, falling 6 percentage points to 8.6% in 2016. According to a new report, about 41 percent of Americans have medical bill problems or have troubles paying off their debts (The Commonwealth Fund, n.d.). There are several issues with obtaining and affording necessary medical treatment. About two-thirds of adults in the United States below 65, or 116 million individuals, have medical expense problems or debts, have avoided necessary care due to costs, have been uninsured for a longer period or have been underinsured—that is, their policy did not provide adequate protection against high medical expenses.

Conceptual Framework

Several studies and the statistics they provided allowed the researchers to understand that many health inequalities initially stem from an individual's household income. Those from low-income households tend to have poorer health than those who come from high income households. This holds the appearance that individual's earning more income have better access to health care. Health disparities are influenced by many social, economic, and environmental factors. Such factors influence and amplify the differences observed in health outcomes. According to Meyer et al., (2013), disparities have persisted for approximately 80% of the *Healthy People 2010 objectives* and have increased for an additional 13% of the objectives and identifying and resolving the issue of disparities is crucial in achieving an equal health experience for all. The issue of health inequalities gives rise to many issues that were not resolved beforehand and health



inequalities impact people of color and other marginalized groups.

Research Method

This study is based on a simple meta-analysis following the “PRISMA” Preferred Reporting Items of Systematic Review and Meta-Analyses flowchart (Moher et al., 2015). The method resulted in searching articles that were published up to the end of May 2021 through major electronic databases and established the criteria to determine whether the studies were eligible for this meta-analysis. First, the study must examine the association between any components of social economic factors among minorities and second, the study had to focus on non-communicable diseases among minorities.

The initial search resulted in 200 hits after duplicates were removed by way of searching for studies in the gray literature to increase the comprehensiveness of the meta-analysis. All abstracts were screened, and 50 articles were selected for text reading while a number of these articles were excluded because they did not meet one or more of the inclusion criteria. About 4 studies did not examine the topic of interest or use appropriate measures to assess the minority health. After further reading, screening the titles and abstracts, 30 studies were eligible for this research and all 30 studies had the full-text available for download. The results presented under the finding and discussion below represent the overall purpose of this study.

Findings and Discussion

Several findings are consistent to the U.S. department of health and human services, centers for disease control and prevention, morbidity and mortality report. Other research findings are related to health care inequality among minorities. Data also suggests that racial and ethnic minority populations disproportionately bear a burden of illness and death from COVID-19, as black/African American individuals accounted for 19.8% of confirmed cases (with known race/ethnicity) despite making up 13.4% of the U.S. population, while Hispanic individuals accounted for 31.1% of confirmed cases, but represented 18.5% of the U.S. population in 2020. Therefore, racial and ethnic minorities are at greater risk for exposure to and adverse outcomes from COVID-19 due to social determinants of health and living and working conditions. A greater prevalence of underlying health conditions also put racial and ethnic minorities at higher risk for severe illness and death from COVID-19. Persistent disparities in access to healthcare pose challenges for racial and ethnic minority populations receiving COVID-19 services. Another analysis of COVID-19 data shows that 59% of the COVID-NET catchment population are white residents, 18% are black, and 14% are Hispanic; and among those hospitalized within that same population, approximately 45% are white, 33% are black, and 8% are Hispanic, suggesting black populations might be disproportionately affected by COVID-19. All data reported in this study are consistent with state data and public reporting (U.S. Department of Health and Human Services Office of Minority Health, 2020).

In helping States protect the vulnerable populations affected, as of August 2020, the CDC has awarded over \$872 million from the Coronavirus Preparedness and Response Supplemental

Appropriations Act and then another \$631 million from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to state and local jurisdictions to support contact tracing, surveillance and testing, all of which are fundamental to protecting vulnerable populations, particularly as communities take steps to reopen. CDC has awarded \$10.25 billion to states to increase testing in 64 state and local jurisdictions from the Paycheck Protection Program and Health Care Enhancement Act. In addition, CDC has awarded over \$206.4 million to tribal nations, consortia, and organizations for responding to COVID-19 across tribal communities. In order to serve the minority populations better, another funding was provided for supporting hospitals that serve low-income communities and the federal office of rural health policy in Health Resources and Services Administration (HRSA) received \$150 million to assist hospitals funded through the small rural hospital improvement program to support capacity building in small hospital to help provide services to fight COVID-19. Because of the importance of these rural communities, HHS further allocated over \$11 billion from the Provider Relief Fund to support rural providers. Health and Human Services (HHS) also targeted an additional \$2 billion from the Provider Relief Fund to hospitals based on their Medicare and Medicaid disproportionate share and uncompensated care payments and who provided care for 100 or more COVID-19 patients through April 10, 2020 (U.S. Department of Health and Human Services Office of Minority Health, 2020).

The issue of relying so heavily on private health insurance affects the accessibility of individuals in trying to afford the high costs of health care. According to Amadeo (2021), prior to the Affordable Care Act, about 20% of Americans had little or no health insurance and as result, almost 45,000 of them died each year due to in-affordability of the higher cost of health care.

And between 2011 and 2013, 38% of those in households making less than \$22,500 a year reported they have poor or fair health, while 12% in households making more than \$47,700 a year reported being in poor to fair health (Amadeo, 2021).

Another report by Carratala & Maxwell (2020) break down the most persistent inequities facing African Americans or Black Americans, Hispanic Americans or Latinx American, Asian Americans, Native Hawaiian or other Pacific Islander Americans, and American Indians or Alaska Natives. Other areas of finding in Carratala & Maxwell (2020) are listed below:

Black or African Americans (See Table 1) “A person having origins in any of the Black racial groups of Africa” (U.S. Census Bureau, n.d., para. 3).

Health Coverage (Carratala & Maxwell, 2020)

- In 2020, 10.6% of African Americans were uninsured compared with 5.9% of non-Hispanic whites.
- 89.4% of African Americans had health care coverage in 2020 compared with 93.7% white non-Hispanic Americans.
- 41/1% of African Americans had government health insurance in 2017.
- 12.1% of African Americans under the age of 65 reported having no health insurance coverage. (Carratala & Maxwell, 2020, paras. 3-5).



Chronic health conditions

- 13.8% of African Americans reported having fair or poor health compared with 8.3% of non-Hispanic whites.
- Eighty percent of African American women are overweight or obese compared to 64.8% of non-Hispanic white women.
- In 2017, 12.6% of African American children had asthma compared with 7.7% of non-Hispanic white children. Forty-two percent of African American adults over age 20 suffer from hypertension compared with 28.7% of non-Hispanic white adults.

(Carratala & Maxwell, 2020, paras. 6-8).

Mental health

- In 2018, 8.7% of African American adults received mental health services compared with 18.6% of non-Hispanic white adults.
- 6.2% of African American adults received prescription medication for mental health services compared with 15.3% of non-Hispanic white adults.
- In 2018, 3.8% of African American adults reported serious psychological distress.

(Carratala & Maxwell, 2020, paras. 9-11).

Leading causes of death

- The leading causes of death among African Americans are heart disease, cancer, and accidents.
- African Americans have the highest mortality rate for all cancers combined compared with any other racial and ethnic group.
- There are 11 infant deaths per 1,000 live births among Black Americans. This is almost twice the national average of 5.8 infant deaths per 1,000 live births.
- 11.4 per 100,000 African American men and 2.8 per 100,000 of African American women die by suicide.

(Carratala & Maxwell, 2020, paras. 12-15).

	Health Coverage		Chronic health conditions		Mental health	
	AA	White	AA	White	AA	White
No Health Coverage	10.6%	5.9%				
Fair/Poor Health			13.8%	8.3%		
Obesity			80%	64.8%		
Asthma			12.6%	7.7%		
Hypertension			42%	28.7%		
Mental Services					8.7%	18.6%
Prescriptions					6.2%	15.3%
Psych Distress					3.8%	N/A

Note: Data obtained from Carratala and Maxwell (2020). Retrieved from

Table 1: African Americans Health Disparities Compared to Non-Hispanic Whites

<https://www.americanprogress.org/issues/race/reports/2020/05/0>

7/484742/health-disparities-race-ethnicity/
Hispanic Americans or Latinx Americans (Carratala & Maxwell, 2020) (See Table 2)

The federal government defines Hispanic or Latino “as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race” (U.S. Census Bureau, n.d., para. 1).

Health coverage

- In 2017, 16.1% of Hispanics were uninsured compared with 5.9% of non-Hispanic whites.
- 83.9% of Hispanics had health care coverage in 2017 compared with 93.7% white non-Hispanic Americans.
 - 39.5% of Hispanics had government health insurance coverage in 2017.
- 20.1% of Hispanics under the age of 65 reported having no health insurance coverage.
- In 2017, 7.7% of Hispanic children were uninsured compared with 4.1% of non-Hispanic white, 4.0% of non-Hispanic Black, and 3.8% of non-Hispanic Asian children.

(Carratala & Maxwell, 2020, paras. 17-20).

Chronic health conditions

- 10% of Hispanics reported having fair or poor health compared with 8.3% of non-Hispanic whites.
- 21.5% of Hispanic adults over age 20 have been diagnosed with diabetes compared with 13% of white adults over age 20.
- Approximately 25% of Hispanics have high blood pressure.
- Hispanic women are 40% more likely to have cervical cancer and 20% more likely to die from cervical cancer than non-Hispanic white women.

(Carratala & Maxwell, 2020, paras. 21-24).

Mental health

- In 2018, 8.8% of Hispanic adults received mental health services compared with 18.6% of non-Hispanic white adults.
- 6.8% of Hispanic adults received prescription medication for mental health services compared with 15.3% of non-Hispanic white adults.
- In 2018, 4.6% of Hispanic adults reported serious psychological distress.

(Carratala & Maxwell, 2020, paras. 25-28).

Leading causes of death

- The leading causes of death among Hispanics are cancer, heart disease, and accidents.
- The life expectancy for Hispanics, 81.9 years, is longer than that of non-Hispanic whites.
- In 2017, the infant mortality rate for Puerto Ricans was 40% higher than for non-Hispanic whites.
- There are 5.1 infant deaths per 1,000 live births among Hispanic and Latinx Americans.
- In 2017, the number of suicide attempts by adolescent Hispanic females was 40% higher than that of adolescent non-Hispanic white females.

(Carratala & Maxwell, 2020, paras. 29-32).



	Health Coverage		Chronic health conditions		Mental health	
	H/L	White	H/L	White	H/L	White
No Health Coverage	16.1%	5.9%				
Fair/Poor Health			10%	8.3%		
Diabetes			21.5%	13%		
Hypertension			25%	28.7%		
Cervical Cancer			40% more likely	N/A		
Mental Services					8.8%	18.6%
Prescriptions					6.2%	15.3%
Psych Distress					4.6%	N/A

Note: Data obtained from Carratala and Maxwell (2020). Retrieved from

Table 2: Hispanic/Latinx Americans Health Disparities Compared to Non-Hispanic Whites

<https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/>

Asian Americans (Carratala & Maxwell, 2020) (See Table 3)

“An Asian American person is an American with origins in any of the original peoples of East Asia, Southeast Asia, or the Indian subcontinent, including but not limited to China, Korea, India, and Pakistan” (U.S. Census Bureau, 2020, para. 5).

Health coverage

- In 2017, 7.3% of Asian Americans were uninsured compared with 5.9% of non-Hispanic whites.
- 92.7% of Asian Americans had health care coverage in 2017. 29.6% of Asian Americans had government health insurance coverage in 2017.

(Carratala & Maxwell, 2020, paras. 34-36).

Chronic health conditions

- In 2017, tuberculosis was 35 times more common in Asian Americans than among non-Hispanic whites.
- Although Asian Americans have overall lower cancer rates than non-Hispanic whites, they have nearly twice the incidence of liver and inflammatory bowel disease cancer.
- Asian Americans are twice as likely to develop chronic hepatitis B as non-Hispanic whites and are eight times more likely to die from hepatitis B than non-Hispanic whites.
- Asian Americans are 40% more likely to be diagnosed with diabetes than non-Hispanic white Americans. They are also 80% more likely to be diagnosed with end-stage renal disease.

(Carratala & Maxwell, 2020, paras. 37-40).

Mental health

- In 2018, 2.1% of Asian American adults reported serious psychological distress. In 2018, 6.3% of Asian American adults received mental health services compared with 18.6% of non-Hispanic white adults.
- 3.6% of Asian American adults received prescription medications for mental health services compared with 15.4% of non-Hispanic white adults.

(Carratala & Maxwell, 2020, paras. 41-43).

Leading causes of death

- The leading causes of death for Asian Americans include cancer, stroke, heart disease, accidents, and diabetes.
- There are 3.8 infant deaths per 1,000 live births in this population.
- In 2017, suicide was the leading cause of death for Asian Americans ages 15 to 24.

(Carratala & Maxwell, 2020, paras. 44-46).

	Health Coverage		Chronic health conditions		Mental health	
	H/L	White	H/L	White	H/L	White
No Health Coverage	7.3%	5.9%				
Tuberculosis			35% more common	N/A		
Liver/Colon Cancer			21.5%	N/A		
Hepatitis			Twice as likely	N/A		
Diabetes			40% more likely	N/A		
End Stage Renal Disease			80% more likely			
Mental Services					6.3%	18.6%
Prescriptions					3.6%	15.3%
Psych Distress					2.1%	N/A

Note: Data obtained from Carratala and Maxwell (2020). Retrieved from

Table 3: Asian Americans Health Disparities Compared to Non-Hispanic Whites

<https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/>

Native Hawaiian or other Pacific Islander Americans (Carratala & Maxwell, 2020) (See Table 4)

“A Native Hawaiian person is any individual with total or partial ancestry from the indigenous or Aboriginal people of the Hawaiian Islands. A Pacific Islander is an individual with origins in any of the original peoples of Polynesia, Melanesia, or Micronesia, including and not limited to Guam, Samoa, Fiji, Palau, Tokelau, and the Marshall Islands” (U.S. Census Bureau, 2020, para. 6).

Health coverage

- In 2017, 8.3% of Native Hawaiians and Pacific Islanders were uninsured compared with 5.9 percent of non-Hispanic whites.
- 66.9% of Native Hawaiians and Pacific Islanders had private health insurance in 2017 compared with 75.4% of white Americans.
- 33.5% of Native Hawaiians and Pacific Islanders had government health insurance in 2017.

(Carratala & Maxwell, 2020, paras. 48-50).

Chronic health conditions

- Native Hawaiians and Pacific Islanders have higher rates of smoking, alcohol consumption, and obesity in comparison to other populations.
- The incidence rate of tuberculosis for Native Hawaiians



and Pacific Islanders is higher than in any other population.

- In 2014, Native Hawaiians and Pacific Islanders were 10% more likely to have diagnosed coronary heart disease than non-Hispanic whites.
- In 2016, Native Hawaiians and Pacific Islanders were 80% more likely to be obese compared with non-Hispanic whites.

(Carratala & Maxwell, 2020, paras. 51-54).

Mental health

- In 2018, 6.9% of Native Hawaiian and Pacific Islander adults reported a major depressive episode in the past year.
- In 2018, 21.1% of Native Hawaiian and Pacific Islander adults reported some form of mental illness.
- 10.9 percent of Native Hawaiian and Pacific Islander adults received mental health services in 2018 compared with 18.6% of non-Hispanic white adults.
- 6.3% of Native Hawaiian and Pacific Islander adults received prescription medication for mental health services in 2018 compared with 15.4% of non-Hispanic white adults.

(Carratala & Maxwell, 2020, paras. 55-58).

Leading causes of death

- From 2013 to 2015, Native Hawaiians had the highest mortality rate for all types of cancer in the state.
- The leading causes of death for Native Hawaiians and Pacific Islanders include cancer, heart disease, accidents, stroke, and diabetes.
- There are 7.6 infant deaths per 1,000 living births in this population.

(Carratala & Maxwell, 2020, paras. 59-61).

	Health Coverage		Chronic health conditions		Mental health	
	H/L	White	H/L	White	H/L	White
No Health Coverage	8.3 %	5.9 %				
Smoking/Alcohol Consumption			Higher Rates	N/A		
Tuberculosis			Higher any Population	N/A		
Hypertension			10% more likely	N/A		
Obesity			80% more likely	N/A		
Mental Services					10.9 %	18.6 %
Prescriptions					6.3 %	15.3 %
Psych Distress					6.9 %	N/A

Note: Data obtained from Carratala and Maxwell (2020). Retrieved from

Table 4: Native Hawaiian/Pacific Islander Americans Health Disparities Compared to Non-Hispanic Whites <https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/>

American Indians and Alaska Natives (Carratala & Maxwell, 2020) (See Table 5)

“A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment” (U.S. Census Bureau, 2020, para. 4).

Health coverage

- In 2017, 14.9% of American Indians and Alaska Natives were uninsured compared with 5.9% of non-Hispanic whites.

(Carratala & Maxwell, 2020, para. 63).

Chronic health conditions

- 17.4% of American Indians and Alaska Natives reported having fair or poor health compared with 8.3% of non-Hispanic whites.
- American Indians and Alaska Natives have a rate of HIV infection twice as high as that of non-Hispanic whites.
- In 2017, American Indian and Alaska Native adults were almost three times more likely to have diabetes than non-Hispanic white adults. They were also 2.5 times more likely to die from diabetes.
- American Indian and Alaska Native adolescents are 30% more likely than non-Hispanic white adolescents to be obese.
- American Indian and Alaska Native youth and adults have the highest rates of cigarette smoking among all racial and ethnic groups in the United States.

(Carratala & Maxwell, 2020, paras. 64-68).

Mental health

- In 2018, 4.5% of American Indian and Alaska Native adults reported serious psychological distress.
- In 2018, 14.1% of American Indian and Alaska Native adults received mental health services compared with 18.6% of non-Hispanic white adults.
- 11.6% of American Indian and Alaska Native adults received prescription medication for mental health services compared with 15.4% of non-Hispanic white adults.

(Carratala & Maxwell, 2020, paras. 69-71).

Leading causes of death

- The leading causes of death among American Indians and Alaska Natives are heart disease, cancer, and accidents.
- In 2018, chronic liver disease was the fourth-leading cause of death for American Indians and Alaskan natives.
- Lung cancer is the leading cause of cancer-related deaths among American Indians and Alaska natives.
- There are 9.2 infant deaths for every 1,000 living births in this population. In 2017, suicide was the second-leading cause of death among American Indian and Alaska Natives ages 10 to 34.



(Carratala & Maxwell, 2020, paras. 72-76).

	Health Coverage		Chronic health conditions		Mental health	
	H/L	White	H/L	White	H/L	White
No Health Coverage	14.9 %	5.9%				
Fair/Poor Health HIV Diabetes Obesity Smoking			17.4% Twice as likely Three times more likely 30% Highest of all ethnicities	8.3% N/A		
Mental Services Prescriptions Psych Distress					14.1% 11.6% 4.5%	18.6% 15.3% N/A

Note: Data obtained from Carratala and Maxwell (2020). Retrieved from

Table 5: American Indians/Alaska Natives Americans Health Disparities Compared to Non-Hispanic Whites

<https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/>

According to Bleiweis (2020) women consistently earn less than men, and the gap is wider for most women of color. Gender wage gap is more significant for most minority women looking at comparing 2018 median earnings of full-time, year-round workers by race, ethnicity and gender. While White men earned \$1.00, White women median earnings is was 79 cents, Black 62 cents, Hispanic or Latino 54 cents, Asian 90 cents and American Indian and Alaska Native was 57 cents. This gender wage gap is calculated by finding the ratio of women’s and men’s median earnings for full-time, year-round workers and then taking the difference. The figure also revealed that women of all races earned on average, 82 cents for every \$1 earned by men of all races, which translates to a calculation of the ratio of median annual earnings for women working full time, year-round to those of their male counterparts that translates to a gender wage gap of 18 cents. The gender wage gap refers to the difference in earnings between women and men (Bleiweis, 2020).

While women’s and men’s earnings may shift slightly each year with each new batch of Census Bureau data, the gender wage gap will not close anytime soon without a concerted action. Efforts to close the wage gap must address the varying drivers of it, as well as the multitude of biases that hold for women, particularly women of color. Therefore, to close the gender wage gap, women need updated comprehensive equal pay legislation, such as the Paycheck Fairness Act, that will strengthen existing protections

and further combat discriminatory practices must be review again for amendment.

It is also very important to note that many of these factors can be directly and indirectly influenced by discrimination based on gender and race or ethnicity. Gender-based pay discrimination has been illegal since 1963 but is still a frequent, widespread practice—particularly for women of color (U.S. Equal Employment Opportunity Commission, The Equal Pay Act of 1963). It can thrive especially in workplaces that discourage open discussion of wages and where employees fear retaliation. Beyond explicit decisions to pay women less than men, employers may discriminate in pay when they rely on prior salary history in hiring and compensation decisions; this can enable pay decisions that could have been influenced by discrimination to follow women from job to job. The gender wage gap is not only complex and nuanced, but it is also very challenging. Without updated and comprehensive equal pay reform, the gender wage gap has only closed by 4 cents in more than a decade. At the current pace, women are not estimated to reach pay parity with men until 2059 (Center for American Progress, 2009).

Conclusion

This study summarized all findings that reported the same results after validating consistency in data information reported researching improving COVID-19 data collection and reporting by race and ethnicity. The collection and reporting of race and ethnicity data are essential to address targeted needs of racial and ethnic communities impacted by COVID-19. In addition, reliable and timely data to identify the populations that are most vulnerable to COVID-19 or any infectious disease is critical. As of August 11, 2020, CDC has received a total of 3,822,986 case reports. Among these case reports, 60% contain race data, 50% contain ethnicity data, and 48% contain race and ethnicity data. Overall, from April 2 to August 11, there was an improvement in completeness of race and ethnicity in the case reports, from 21% to 60% for race and from 18% to 50% for ethnicity. Additionally, on June 4, 2020, HHS issued new guidance under the CARES Act that specifies laboratories must report additional demographic data, including patient race and ethnicity, to state and local health departments for all COVID-19 test results beginning in August 2020. Under this new guidance, we expect to gain critical information about people who test positive for COVID-19, including data on race and ethnicity. In addition, CDC reports and advises on the disproportionate impact of COVID-19 among racial and ethnic minority groups in the following ways.

Barriers to reducing COVID-19 disparities among racial and ethnic minority individuals are associated with a number of potential contributing factors, including lack of knowledge about COVID-19, lack of availability of healthcare services in the community, inability to pay for services, and lack of culturally and linguistically appropriate services (including language access services and culturally competent and/or bilingual providers). A recent study found that persons living in communities with higher proportion of racial and ethnic minority populations were more



likely to have more than 20 minutes travel time to a COVID-19 testing site (RaderB, et al. 2020).

The difference in travel time may limit access to and utilization of testing services for those who have limited access to transportation and those who live in areas with fewer public transit services and schedules. Other factors that may affect access to and utilization of testing services include lack of healthcare insurance, concern about the costs or co-pays, occupational factors, such as not being able to take time off of work, lack of paid leave, and distrust of the government and healthcare systems. Strategies to address barriers to reducing disparities include improving the development and dissemination of culturally and linguistically appropriate messaging and information about COVID-19 testing and healthcare services; working with community partners to support outreach, education and linkages to services; using data to identify socially vulnerable/high-need areas in which to place COVID-19 testing sites; continuing to increase the capacity of IHS facilities and health centers to provide COVID-19 testing and healthcare services; disseminating CMS information about Medicare and Medicaid coverage of COVID-19 testing and services; and promoting cultural competency training and workforce diversity programs. Addressing these barriers are important for the COVID-19 response and to address disparities more broadly is imperative (Berchick, et al. 2019; Institute of Medicine, 2002; Economic Policy Institute, 2020; & Institute of Medicine, 2003).

References

- Agency for Healthcare Research and Quality. (2020). *2019 National Healthcare Quality and Disparities Report*.
- Amadeo, K. (2021). How health care inequality increases costs for everyone. *The Balance*. <https://www.thebalance.com/health-care-inequality-facts-types-effect-solution-4174842>
- Ames, H. (2020, October 16). How long does coronavirus last in the body, air, and in food? *Medical News Today*.
- Baciu, A., Negussie, Y., & Geller, A. (2017). *The root causes of health inequity - Communities in Action: Pathways to health equity*. National Academies Press, 3 (The Root Causes of Health Inequity).
- Barnett, J. C., & Upton, R. D. *Current Population Reports, P60-267(RV), Health Insurance Coverage in the United States: 2018*. U.S. Government Printing Office.
- Brown, A. (n.d.). *Health Disparities in the United States Models and Mechanisms of Public Health*. Lumen Learning.
- Bleiweis, R. (2020). Quick facts about the gender wage gap.
- Boesch, D. & Phadke, S. (2021). When women lose all the jobs: Essential actions for a gender-equitable recovery. *Center for American Progress*.
- Carratala, S. & Maxwell, C. (2020). Health disparities by race and ethnicity.
- CDC (2004). Health disparities experienced by racial/ethnic minority populations.
- Center for American Progress (2009). Wage gap by the numbers.
- Congressional Research Services. (2021). U.S. Health Care Coverage and Spending. 1-3.
- Economic Policy Institute. (2020). *Black workers face two of the most lethal preexisting conditions for coronavirus—racism and economic inequality*.
- Equal Employment Opportunity Commission, “The Equal Pay Act of 1963,”
- Institute of Medicine (2020) Committee on the Consequences of Uninsurance. *Care without coverage: Too little, too late*. National Academies Press (US).
- Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. The National Academies Press.
- Kirzinger, A., Munana, C., Wu, B., & Brodie, M. (2019, June 11). *Data note: Americans’ challenges with health care costs*.
- Leonhardt, M. (2019, October 9). *Americans now spend twice as much on health care as they did in the 1980s*. Retrieved from CNBC:
- Meyer, P., Yoon, P., & Kaufmann, R. (2013). Introduction: CDC health disparities and inequalities report — United States. *Morbidity and Mortality*
- Moher, D., Shamseer, L., Clarke, M., Ghersi, D., Liberati, A., Petticrew, M. Shekelle, P., & Stewart, L.A. & PRISMA-P Group. (2015). Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Systematic reviews*, 4, Article 1.
- Moore, R. (2019, November 6). *4 Ways to improve access to healthcare*. Retrieved from Athena Health
- Office of Disease Prevention and Health Promotion. (n.d.). *Disparities | Healthy People 2020*. Healthy People.
- Paycheck Fairness Act, H.R. 7, 116th Cong., 1st sess. (2019).
- Rader, B. Astley, C.M., Therese K, et al. (2020). Geographic access to United States SARS-CoV-2 testing sites highlights healthcare disparities and may bias transmission estimates. *Journal of Travel Medicine*.
- Shaefer, H.L. & Edin, K. (2013). Rising extreme poverty in the United States and the response of federal means-tested transfer programs.
- Stasha, S. (2021, February 14). *27+ Affordable Care Act statistics and facts | Policy Advice*. Policy Advice.
- The Commonwealth Fund. (n.d.). *Survey: 79 million Americans have problems with medical bills or debt*
- Thomson, S., Habicht, T., & Evetovits, T. (2020, April 27). *How are countries removing financial barriers to accessing health services in the context of COVID-19?* Retrieved from Cross-Country Analysis:
- Tolbert, J., Orgera, K., & Damico, A. (2020, November 13). *Key Facts about the uninsured population*. KFF.
- U.S. Census Bureau (n.d.). Hispanic or Latin Origin.
- U.S. Census Bureau (2020). About.
- U.S. Department of Health and Human Services office of Minority Health (2020). 2020 update on the action plan to reduce racial and ethnic health disparities. Retrieved from.
- Vaughan, A. (2021). Global vaccine inequality. *New Scientist*.
- World Bank Group (2020). Poverty and shared prosperity 2020. Reversals of fortune.