# Health is Wealth: An Exploration of the Disparities in Healthcare Access and Quality between Black people and their white Counterparts

Spelman College®

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Healthcare Equity Disparities| United States of America

## Introduction

acism has impacted access to healthcare in the United States for millennials. id you know that African Americans generally have a greater likelihood of ffering diseases including heart disease, stroke, cancer, asthma, and diabetes mpared to their white counterparts? When compared to white people, frican Americans have a twofold higher risk of dying from heart disease etween the ages of 18 and 49 and a fifty percent higher risk of having high ood pressure between the ages of 35 and 64. This is not a singular result of ology or genetics, but rather a combination of the systems and structural rriers that impede people from low-income groups and minority communities om making choices that will allow them to lead fulfilling, healthy lives. Despite e fact that access to health care is supposed to be a "constitutional right" that plies to everyone, regardless of race, economic background, political opinions, social standing, it often seems more like a privilege for those who fall within a rticular racial or social group. Research shows a positive association between come and health – such that the wealthier a person is, the healthier they are kely to be. Further, your zip code can determine not only how well you live, t how long you live. Although gaps in healthcare access have been mphasized, much of the research exploring these inequities focuses on national regional trends and does not provide detailed information about particular mmunities.Based on their income, educational levels, and geographical cation we will examine and compare the healthcare quality experienced by ose who identify as black versus those who identify as white in this study.

## Methods

Data was obtained through the National Healthcare Quality and Disparities Reports (NHQDR). Researchers used regression analysis to examine the relationship between two or more variables. Demographic variables included age (over 65) and self-reported race/ethnicity (white single race, African American single race, and other). Socioeconomic variables included household income relative to federal poverty guidelines and educational status. Insurance coverage was categorized as uninsured at any time in the last year, insured public or private. Other variables included individual health status (outstanding/thorough, decent, or poor) and access to healthcare.NHQDR serves as an interactive variable select tool that assesses a statistically significant relationship between the quantitative data collected for overall healthcare quality depending on socioeconomic status, access to healthcare, and demographic variables organized in a bivariate table. This descriptive analysis allowed us to observe whether a relationship exists between the variables.

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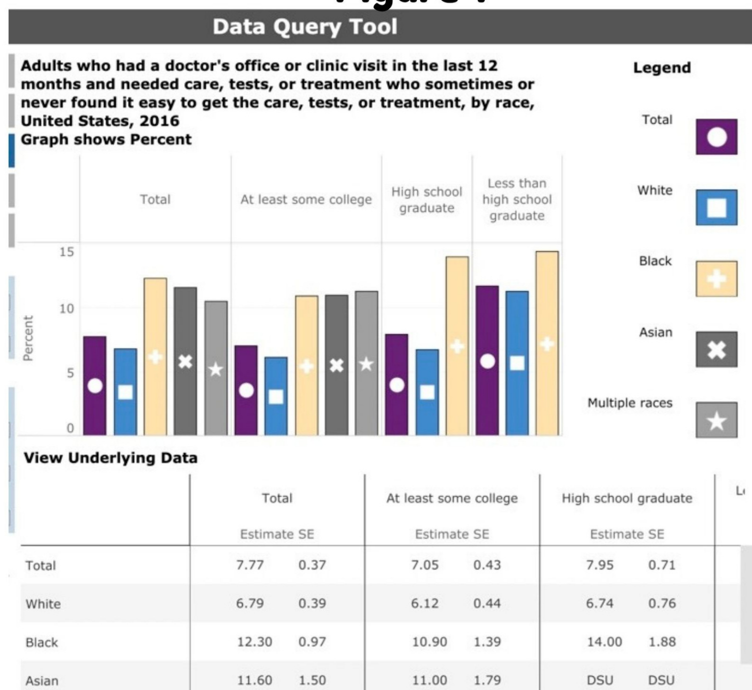
## Results

Race and education levels of participants in the study who were 65 years of age or older in the United States and had any private insurance are summarized in Table 1. Figure 1 shows data from 2016 for Americans who reported having had trouble getting medical care, treatments, or testing, broken down by race and educational level. Regardless of their education degree, those who identified as Black and Asian seemed to have greater values than white people. Participants who identified as white and had at least some college experience reported an average value of 7.05 when claiming to have difficulty obtaining treatment/tests and general healthcare, while participants who identified as black and had the same educational background reported a higher value of 10.90. Asians suffer the same dilemma. Additionally, Table 3 above highlights the health inequalities Black, White, and other Americans faced in 2019 while attempting to receive a prescription for medicine. According to race and employment status, the table clearly illustrates people's difficulties while attempting to acquire prescription medication. When employed (4.75, SE = 0.54) or unemployed (10.0, SE = 1.21), participants who identified as black had the highest numbers. Their employed white counterparts reported a value of 4.29 and SE = 0.26), and those not employed reported a value of 8.70, SE = 0.60. We notice a significant disparity in values between employment status and racial demographics

### Figure 1




| | Total | | At least some college | | High school graduate | |
|---|---|---|---|---|---|---|
| | Estimate | SE | Estimate | SE | Estimate | SE |
| Total | 7.77 | 0.37 | 7.05 | 0.43 | 7.95 | 0.71 |
| White | 6.79 | 0.39 | 6.12 | 0.44 | 6.74 | 0.76 |
| Black | 12.30 | 0.97 | 10.90 | 1.39 | 14.00 | 1.88 |
| Asian | 11.60 | 1.50 | 11.00 | 1.79 | DSU | DSU |

## Table 2/Table 3

**Table 1: Insurance Coverage in 65+ Individuals by Education Level**

| | Total (Estimate SE) | Some college (Estimate, SE) | High school graduate (Estimate, SE) | Less than high school (Estimate, SE) |
|---|---|---|---|---|
| Total | 40.90, 0.70 | 45.60, 0.80 | 42.60, 1.20 | 23.60, 1.60 |
| White | 44.60, 0.80 | 48.20, 0.90 | 45.30, 1.40 | 28.60, 2.10 |
| Black | 28.20, 1.70 | 34.00, 2.90 | 29.20, 3.40 | 18.50, 3.00 |
| Others | 23.90, 2.70 | 30.80, 3.80 | 28.50, 6.60 | DSU, DSU |

**Table 3: Difficulty in Access to Prescribed Medicine depending on Race and Employment Stat**

| People who were unable to get or delayed in getting needed prescription medicines | Total (Estimate SE) | Employed (Estimate SE) | Not employed (Estimate SE) |
|---|---|---|---|
| Total | 4.12, 0.15 | 4.25, 0.22 | 8.41, 0.49 |
| White | 4.17, 0.17 | 4.29, 0.26 | 8.70, 0.60 |
| Black | 4.65, 0.40 | 4.75, 0.54 | 10.00, 1.21 |
| Others | 1.48, 0.35 | DSU, DSU | DSU, DSU |

## Discussion & Conclusions

To achieve health equity, there is still a lot of work to be done to enhance access to and the standard of treatment. While previous efforts to minimize health care inequalities have had significant flaws, this study advances our understanding of the underlying knowledge and translation barriers. These findings alleviate any skepticism regarding th existence of health disparities between blacks and whites under similar conditions. The findings supported what was predicted, namely that there are large gaps in healthcar access that require attention. We must enhance and advance analytical techniques that maximize the potential for inferring causal relationships from observational research an facilitate a deeper understanding of the root causes of health disparities. In order to address and ideally resolve health inequalities, future research should also look at local components that improve preconception care and support for women, as well as formal and unofficial rules impacting health care systems. Collaboration between academics, providers, and policy makers is essential to overcoming implementation barriers, observing how policies affect marginalized communities, and advocating for financing

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# An Exploration Of The Relationship Between Cannabis Use And Opioid Use On Mental Health Among Hispanic Men And Women

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## Introduction

An estimated **26 to 36** million people are abusing opioids around the world, with almost **115 people dying** every day.

Cannabis has the ability to treat non-chronic pain which can help reduce opioid dependence.
- Tetrahydrocannabinol (THC) is the main component in cannabis that aids in pain relief
- THC impacts cognitive functions and pose threat to individuals' mental well-being

The present study explores associations that exist between cannabis and opioid use on mental health among **Hispanic adults** who participated in the 2019 by the SAMHSA NSDUH.

### Research Question: What is the relationship between mental illness and participant demographic factors among Hispanic adults who use opioids or marijuana?

## Data Analysis

Frequencies provided for drug use category, age, and education level

Bivariate analysis comparing the two-level status of suicidal ideation in the past year to the various levels of each of the three demographic variables

Chi-square statistic used to test significant association between the variables.

## Results

- 1,454 participants co-currently using illicit drugs and experiencing mental illness.
- **A significant relationship between suicidal ideation, age, and gender**
  - More young adults aged 18-25 and women reported having suicidal ideation compared to those 50 and older and men.
- Most opioid and marijuana users reported having MDD in the past year; however, this relationship was not significant.

**Figure 1. Demographic Characteristics of Participants, N=1,454**

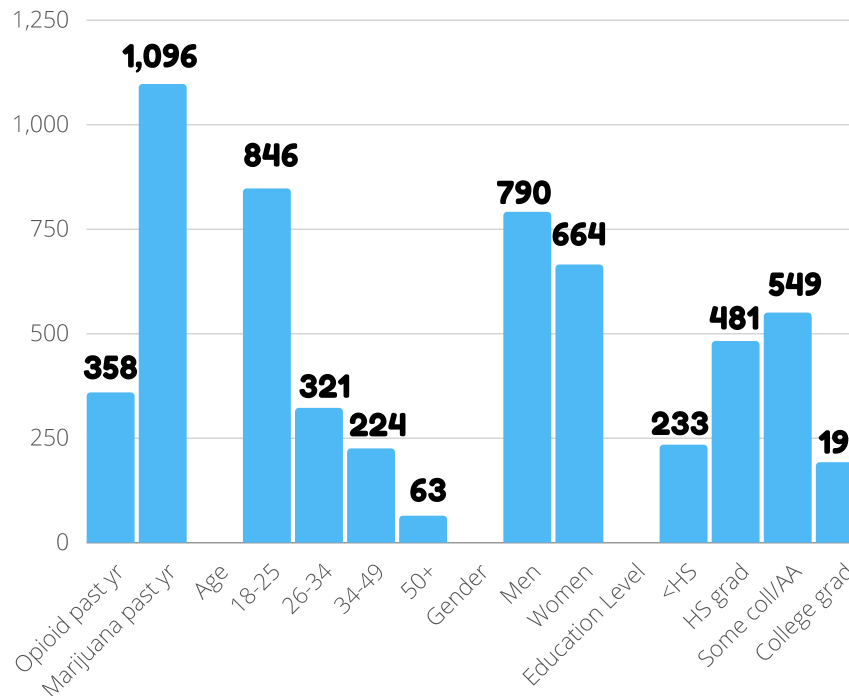
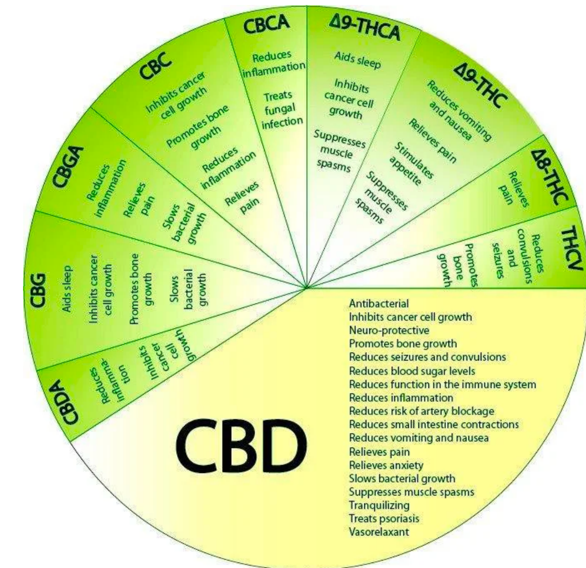



**Figure 2. Medicinal Reason for Marijuana use**




## Discussion & Conclusions

The "Quarter-Life Crisis" can be especially challenging for first-generation Americans, who are experiencing the barriers that could exists with creating a new life in the United States.

Future research should examine the barriers that exists between men, especially Hispanic men, seeking treatment for depressive disorders.

The study did not identify which form of pain management has greater impact, but future studies should examine use of CBD and THC as coping mechanisms for depression (see Figure 2).

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# The Impact of COVID-19 on Mental Health, Behavioral Health, and Access to Health Among Participants in the Mentoring in Medicine Network

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## Introduction

January 2020, life as we once knew it was altered without an end in sight. An overwhelming period of self-reflection, isolation, anxiety, and fear was born; the COVID-19 pandemic. Various global studies have led to the discovery of the negative impact of the COVID-19 pandemic on mental health. By defining all factors assessed when discussing mental health, going into depth on demographic stressors and the implications of behavioral studies in mental health, highlighting the various demographic and socioeconomic differences of 88 participants, and discussing how a lack in access to mental health care contributes to mental health issues, the statistics observed in the study can be used to assess the impact of the pandemic in a population of people with a significant gap between mental health and care received.

## Methods

Participants completed the July 2022- September 2022 survey, "New Post-Covid Mental Health Survey" consisting of 21 questions regarding demographic information, mental health, behavioral health, and access to care. Demographic questions included age, income, number of individuals in the household, gender, race, and ethnicity. Mental health questions assessed work problems, daily motivation, feelings of disappointment, self-esteem, suicidal ideations, increased suicidal ideations, and decreased interest in activities. Behavioral health questions assessed increased substance abuse (alcohol, marijuana, cocaine, and heroin), changes in interpersonal/familial relationships, dietary and sleep changes also contributed to the research. Access to healthcare questions included mental health diagnosis, time of diagnosis, and access to facilities. Participants polled whether or not they strongly agree, agree, are neutral, disagree, or strongly disagree with each statement being made.

## Results

Results from the study demonstrate important intersections between demographic information, mental health, behavioral health, and access to care. The data used in the study was collected from 88 participants in the Mentoring in Medicine network who were at least 18 years old. The results show the prevalence of mental health issues based on demographic health, access to care, changes in emotional and behavioral health. The data resulted in a clear distinction between mental health illness and diagnosis, the external factors contributing to access to care, and the relevance of demographic information pertaining to mental health.

**Figure 2: Participants Access to Mental Healthcare (With and Without Mental Health Diagnosis)**

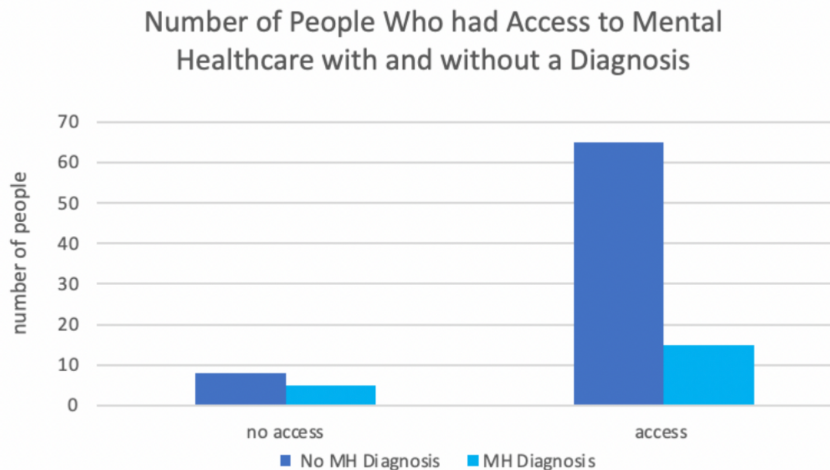
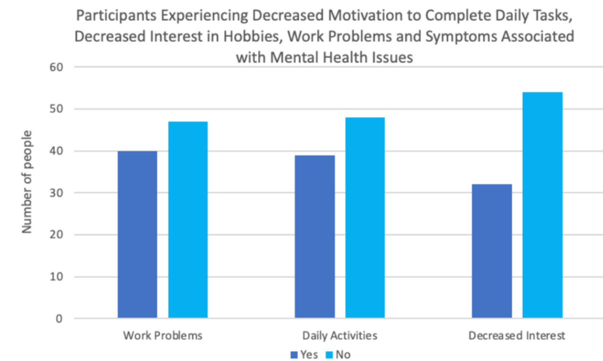



**Figure 3: Participants Experiencing Decreased Motivation to Complete Daily Tasks, Decreased Interest in Hobbies, Work Problems and Symptoms Associated with Mental Health Issues During the COVID- 19 Pandemic**




## Discussion & Conclusion

When compared, Figures 3 and 1 indicate the gap between mental health issues and care received. Almost half of the participants (45.6%) admitted to having problems doing daily activities due to emotional issues such as feeling depressed, sad, or anxious; however, 76.9% of participants had never been diagnosed with a mental health illness, 68.3% of which had no difficulty accessing care. An interesting conversation can be made, transcending race, income, and other factors that impact mental health. Using these statistics regarding increased prevalence of common mental illness markers means that the COVID-19 pandemic in itself can be analyzed as a contributor to mental health issues. A hypothesis can be made about the severity of the pandemic and its implications on all aspects of peoples livelihood such as work, joy, interpersonal relationships, and the self. In conclusion, the impact of the COVID-19 pandemic on mental health is visible in some magnitude in this diverse population of individuals. The impact of the pandemic on mental health managed to transcend demographic factors that statistically set participants apart.

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