BHA-FPX4020 Assessment 3: Data Collection and Analysis

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Program Name or Degree Name (e.g., Bachelor of Science in Psychology), University

COURSE XXX: Title of Course

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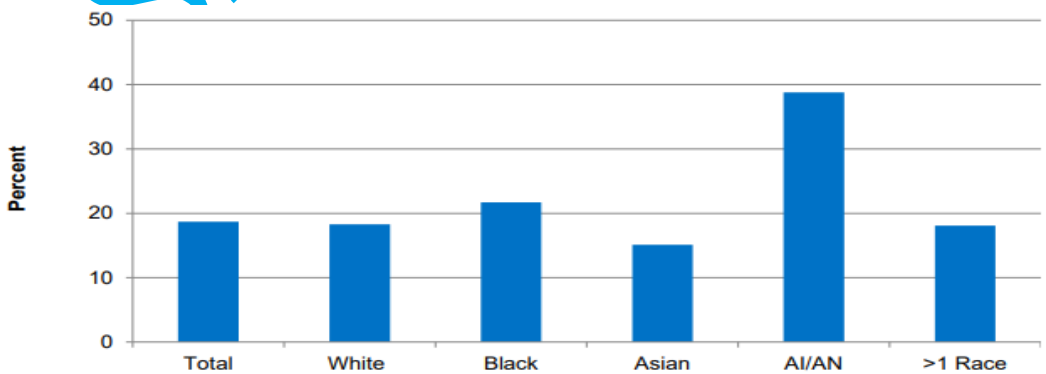
Data Collection and Analysis

Health disparities in the US pose a challenge by compromising the ability to provide timely, affordable, and quality care. According to the Agency for Healthcare Research and Quality (AHRQ) (2021), healthcare disparities entail differences between population groups that determine how they access, experience, and receive healthcare services. When elaborating on the problem of widening health inequalities, it is essential to incorporate the role of social determinants of health (SDOH) into the discussion. In this sense, synergies between ethnic, socioeconomic, environmental, and locational factors contribute to inequalities regarding access to care, care coordination, perceptions of patient safety, and care affordability. As a country of demographic and socioeconomic diversities, the US needs to understand the interactions between health disparities. Therefore, data collection and analysis emerge as a profound strategy for enhancing knowledge and inspiring evidence-based practice for addressing health inequalities. As a result, this assessment presents data regarding various health inequalities while proposing evidence-based strategies for addressing health disparities.

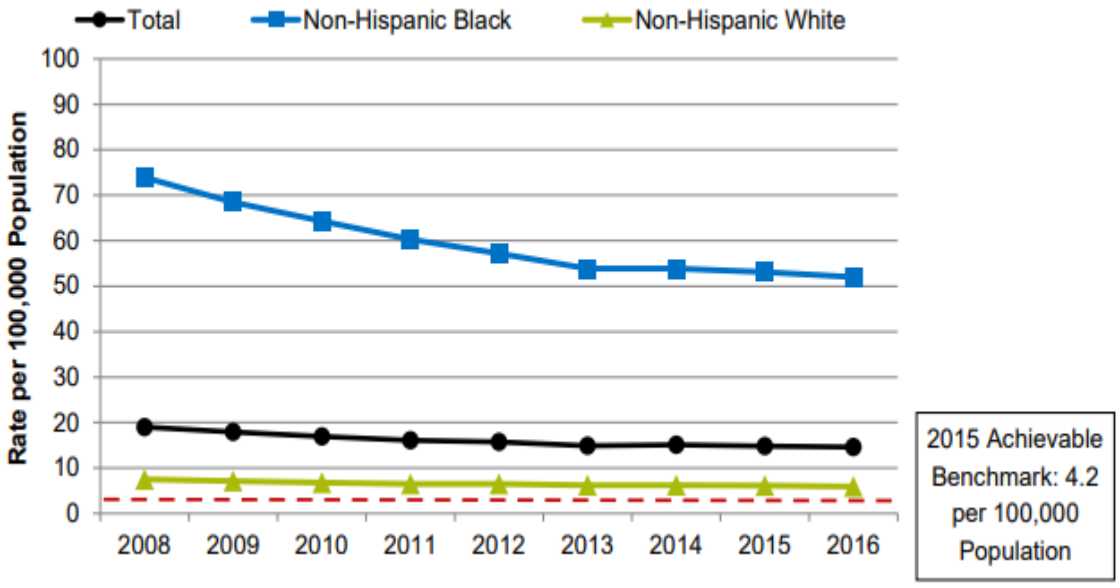
Data Presentation

Figure 1: People under age 65 with any period of uninsurance during the year, by race, 2017



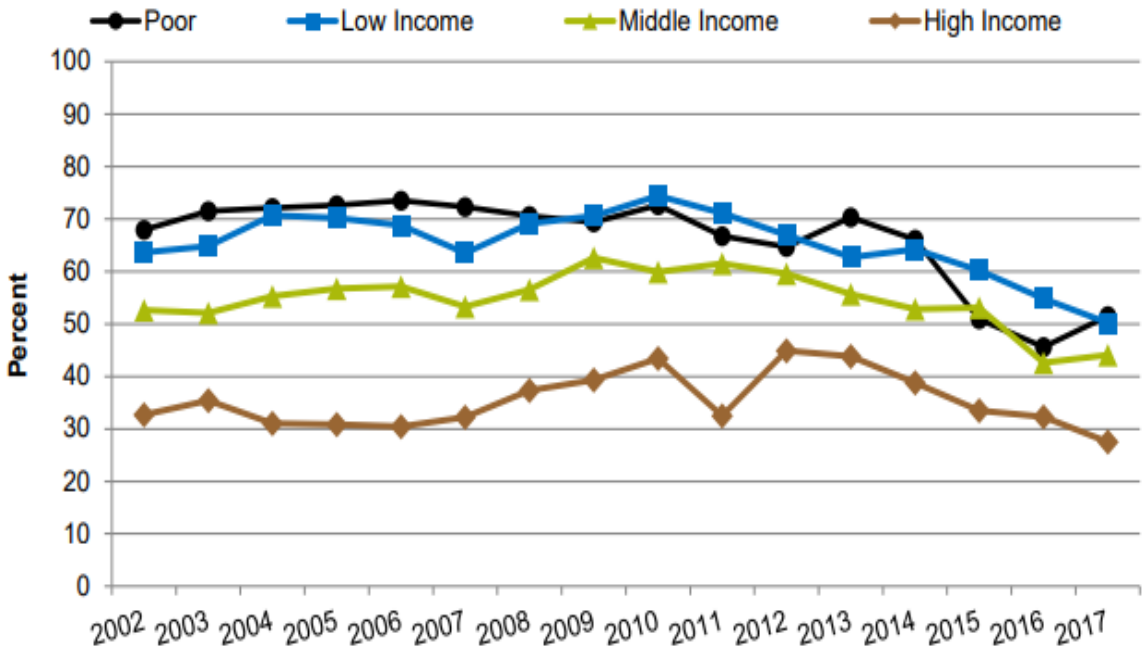
Key: AI/AN = American Indian or Alaska Native.
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2017.

Figure 2: New HIV cases per 100,000 population aged 13 and over, 2008-2016



Source: Agency for Healthcare Research and Quality (AHRQ)

Figure 3: People unable to get or delayed in accessing medical care due to financial or insurance reasons, 2002-2017



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2017.
Note: For this measure. lower rates are better.

Figure 4: Effects of Medicaid Expansion on States' Healthcare Expenditures

State	Year	Within Medicaid savings ($ millions)	Savings as % of state spending on traditional Medicaid	Savings as % of expected state expansion costs in 2020
Michigan	FY2022	47	1%	10%
Montana	FY2021	28.5	7%	46%
Ohio	FY2021	36	1%	7%
Virginia	FY2020	221.4	2%	85%
Arkansas	FY2017	112	8%	60%
New Jersey	FY2017	152	3%	50%
Colorado	CY2015	149.9	5%	85%
Kentucky	FY2015	33.3	2%	10%
Oregon	CY2015	137.5	7%	60%
Washington	FY2015	250.5	7%	85%

Data: Sources and assumptions are detailed in Appendix C.

Source: The Commonwealth Fund

Quantitative and Qualitative Analysis of Data

As noted earlier, health disparities influence how people access, experience, and receive healthcare services. In the United States, health inequalities manifest via various domains, including access to person-centered care, patient safety, healthy living, effective treatment, care coordination, and care affordability (Agency for Healthcare Research and Quality, 2021). In this sense, national and state health organizations set achievable benchmarks based on concepts from each domain. For example, organizations emphasize adverse drug events in patients with anticoagulants, urinary tract infections, and medication safety when establishing patient safety benchmarks. These sub-themes enable healthcare institutions to compare their performance with top-performing institutions.

Since health inequalities are diverse and beyond one measure of quality, it is essential to focus on areas that demonstrate widening gaps within the social determinants of health (SDOH). In this sense, analyzing quantitative and qualitative data from national healthcare organizations

such as the Agency for Healthcare Research and Quality (AHRQ) is essential to identify priority areas that demonstrate significant inequalities. The first graph represents quantitative data regarding the problem of uninsured people under the age of 65 years. The graph makes it possible to identify disparities in access to insurance coverage among people of different ethnic backgrounds, including White, Black Americans, Asian Americans, American Indians or Alaska Natives (AI/AN), and people of more than one race.

The graph indicates that in 2017, (AI/ANs) under age 65 were twice as likely to lack insurance as whites (38.8% compared with 18.3%). Also, Black Americans were more likely than Whites to have a period of uninsurance in 2017 (21.7% compared with 18.3%). While health disparities hamper access to insurance coverage for ethnic groups, this data from the Agency for Healthcare Research and Quality (AHRQ) can inform recommendations for addressing health inequalities within the national insurance models.

Another ideal measure of health disparities is the prevalence of new HIV cases among people aged 13 and above. In Figure 2, the Agency for Healthcare Research and Quality (AHRQ) (2021) indicates the inequalities regarding new HIV cases in 2016. The graph indicates that non-Hispanic Blacks reported 52.0 new HIV cases per 100000 population for people aged 13 and above compared with 5.9 per 100000 cases for non-Hispanic Whites. Although these numbers did not match the 2015 national achievable benchmark of 4.2 cases per 100000 population, they signify underlying conditions that create imbalances in the quality of life across the two groups. Therefore, the data shed light on areas where the federal and state governments should improve to reduce health inequalities.

Apart from the prevalence of new HIV cases and the number of uninsured people across populations, income issues are essential determinants of health disparities. In Figure 3, it is

evident that poor and low-income people grapple with the problem of delayed care compared to middle-and-high-income people. The graph indicates that 51.5% of the poor faced the challenge of delayed care in 2017 due to financial or insurance reasons. Although the income disparities narrowed from 2002 to 2017, poor and low-income people endure delayed care due to financial or insurance reasons. Therefore, national and state governments can use such data to initiate programs to reduce income inequality.

Evidence-Based Recommendations

Healthcare organizations in the US operate to promote care quality, timeliness, equality, and affordability. However, the prevailing health disparities affect how people access, experience, and receive healthcare services. In the current healthcare systems, external evidence significantly influences organizations' practices and informs clinical decisions. While health inequalities rely massively on discrepancies within the social determinants of health (SDOH), it is vital to implement recommendations from reputable sources to address these disparities. These recommendations include:

Medicaid Expansion

The United States lacks a universal insurance model for providing health coverage to vulnerable groups. The absence of universal public insurance coverage exacerbates the problem of uninsured people, leading to expensive insurance premiums and complex health reimbursement models. According to Radley et al. (2021), nearly 30 million Americans are still uninsured and are disproportionately people of color. Although the Affordable Care Act (ACA) 2010 required states to expand Medicaid, the revised eligibility criteria exclude poor and low-income people. As a result, they are ineligible for Medicaid coverage, leading to multiple

ramifications, including limited access to quality care, the problem of delayed care due to financial or insurance issues, and compromised quality of life.

Although Medicaid expansion is an ideal strategy for addressing income-related health disparities, it is essential to establish its cost-benefit analysis to ensure its economic plausibility. Since Medicaid is a federal insurance policy, its expansion can alter national healthcare expenditures. However, states are more likely to save the cost of healthcare outside Medicaid services. Ward (2020) argues that Medicaid expansion reduces states' spending in various areas, including mental health and substance abuse treatment, corrections, and uncompensated care. The qualitative data in Figure 4 present savings estimates from traditional Medicaid and Medicaid expansion for selected states in different fiscal years. It is vivid that expanding Medicaid addresses disparities in access to quality care, care affordability, coordination, and patient safety.

Developing Community-Based Programs and Policies for Ensuring Health Equality

Medicaid expansion cannot singlehandedly address the prevailing health inequalities. Instead, health organizations and governmental agencies should embrace interdisciplinary collaboration to support community-based initiatives tackling health inequalities. According to Gomez et al. (2020), these localized programs should focus on various social determinants of health, including education, housing, healthcare justice, and literacy. Also, they should compromise sub-themes such as attending to root causes of health inequalities and disparities, addressing issues that affect susceptible groups, promoting equal opportunities for all people to guarantee improved quality of life, and fair distribution of socioeconomic resources to promote healthy living.

Eliminating Structural Racism in Healthcare Organizations

Organizational cultures are consistent with patient safety, coordination, and patient-centered care. According to Lavizzo-Mourey et al. (2021), racial and ethnic disparities in healthcare organizations exist and are disproportionate to minority groups such as Black Americans and Asian Americans. Such inequalities result in adverse health effects by compromising the tenets of patient-centered care, patient safety, and positive medical outcomes. As a result, addressing the underlying organizational barriers to equal healthcare service delivery is a profound strategy for tackling health discrepancies at the organizational level.

Conclusion

Undoubtedly, health inequalities and disparities cut across various domains, including access to person-centered care, patient safety, coordination, affordability, and effective treatment. Since the US grapples with social determinants of health discrepancies, it is essential to incorporate evidence-based strategies from quantitative and qualitative data regarding measures of health inequalities. Figures 1, 2, and 3 present insights on various health discrepancies prevailing among ethnic and socioeconomic groups. Therefore, national and state governments should use such data to formulate policies and programs addressing health disparities. Evidence-based recommendations are Medicaid expansion, implementing community-based interventions to ensure equality, and eliminating structural racism in healthcare settings.

References

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