Inequity in Health-Care Access

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In this paper, I argue that the lack of access to health-care widens health disparities. According to Gulliford et al. (2002), the concept of equitable access to health-care involves the aspects of availability, affordability, accommodation of services, and quality of the provided service. A joint biannual report by the World Health Organization and the World Bank (2023) reveals that over half the global population lack complete access to key health services. In fact, since 2015, universal health coverage has seen a steady decline. As a result, over a billion people across the world are pushed into poverty because of out-of-pocket spending on health-care. Although health-care has come a long way in the past few decades, the lack of sufficient coverage means that medical services are less accessible to certain communities than others. These findings are concerning as it not only highlights the underlying issue of inequity but may also answer the question as to why some communities have not prospered in years. As such, this paper explores how limited access to health-care plagues under-served communities and results in increasing health as well as socioeconomic disparities.

I support my position on the importance of health-care access with the following three arguments. First, limited health-care access results in higher disease and mortality rates among certain communities. Riley (2012) argues that lower rates of health insurance coverage among marginalized sectors of a country advances illness before diagnosis, leading to poorer health outcomes within such communities. Second, I argue that economic and social well-being may deteriorate in the absence of a competent health-care system. Buck and Jabbal (2014) point out that a poverty-health cycle is created when poorer communities are further aggravated financially, leading to greater medical needs but inadequate health-care resources. Finally, I argue that lack of access to health-care limits health literacy. For instance, immigrants without local language proficiency tend to have poor health literacy,

which causes poorer health outcomes because of the inability to communicate and interpret effectively (Pandey et al., 2021).

I also consider three alternative views to my position. First, some may argue that equal access to health-care cannot help marginalized communities because of their socioeconomic circumstances (Fried, 2010). Second, many claim that lifestyle and genetics are the primary causes of health disparities as they increase the prevalence of certain diseases within a community (Fernandez, 2021). Finally, critics argue that complete access to a medical system may be redundant because of the practice of alternative medicine (Bishop, 2007). While these claims have some merit, they may not be considering the full picture. For example, although certain forms of Complementary and Alternative Medicinal (CAM) treatments appear to be effective, the majority remain biologically untested (Sheppard, 2015). As such, it would be unsafe to use these CAM remedies as alternatives to biomedicine.

This paper is important because it investigates an array of questions regarding accessibility to health-care. These questions include “What are the consequences of reduced medical access on marginalized communities,” “Why are certain groups unable to escape the effects of health inequity,” and “Why is lack of accessibility the true issue behind rising health disparities.” By exploring these questions, the goal of the paper is to draw the attention of concerned authorities and health-care providers to the injustice faced by disadvantaged communities who are unable to access health necessities.

How Limited Health-Care Access Widens Health Disparities

The lack of sufficient access to a medical system is an impediment to health equity. The consequences of reduced health-care access include an increase in disease rates, which further contributes to higher mortality rates within a community. Another consequence of the lack of equitable medical access is the formation of a poverty-health cycle, where poor health hinders socioeconomic development and vice-versa. In addition, limited access to health-care

can diminish health literacy rates within communities that face economic, language, or medical barriers.

Increases Disease Rates

Limited access to a medical system increases the prospect of diseases, disabilities, or mortality. For instance, Budu et al. (2021) conducted a study to determine the factors affecting health-care seeking behavior for child-illnesses in Chad. Among the mothers surveyed for the study, it was found that those families facing financial difficulties or transportation barriers to a medical center were less likely to seek treatment for their children. The authors also found that mothers with lower media exposure had decreased health awareness, which further decreased the probability to seek child health-care. These findings highlight the consequences of limited medical support since some of the most common causes of child mortality globally are untreated preventable diseases, including pneumonia, malaria, and diarrhea ("Child Mortality," 2022). In another study conducted in the United States, Marcondes et al. (2021) notes that Hispanics were less likely to be insured in comparison to the majority population because of limited health-care accessibility. As such, Hispanics with diabetes also had a lower probability of receiving adequate guideline-directed medical care such as annual eye exams, blood pressure, and cholesterol checks. Considering that lack of health-care insurance can increase the chances of mortality by about 40%, such reduced access to medical services is a concern to the health of minority communities (Wilper et al., 2009).

In addition to individual socioeconomic factors, poor health-care quality is a primary contributor to poor health outcomes. In fact, as reported in "Delivering Quality Health Services" (2018), around 10% of all hospitalized patients in low or middle-income countries and approximately seven percent of hospitalized patients in high-income countries are prone to be exposed to an infection during their stay. As a result, around 15% of all hospital

expense in high-income countries is a direct cause of medical negligence. Further, it was found that health-care workers in certain low and middle-income African countries frequently ignore clinical guidelines and tend to make inaccurate diagnoses in at least one-fourth of their total working time. For example, although malaria kills around 63,000 to 96,000 Tanzanians annually, the medical staff in the country do not complete even a quarter of the checklist essential for patients demonstrating common symptoms of the disease (Das et al., 2008). Thus, a large number of health-care systems are ill-equipped to deal with their patients and often contribute to the disease and death toll.

Deteriorates Socioeconomic Well-being

Limited medical access can be detrimental to socioeconomic development and well-being. However, this cause-effect relationship may well be cyclic in nature. That is, poverty can limit access to health-care, which can further aggravate social and economic standing. For instance, a study by Chung et al. (2020) suggests that the primary forces behind the "poverty-health vicious cycle" in the health-care system in Hong Kong, an economically prosperous region, is the extreme income inequality. The survey conducted revealed that it was more difficult for the poor to afford to maintain their health in any way. In fact, illnesses remain the major cause of financial burden on such communities. Even so, the authors note that Hong Kong's dual-track health-care system means that the poor would have to resort to the cheaper yet less efficient system, further contributing to the cycle. Another study by Wang et al. (2022) points out that poor women are less likely to access prenatal care because of poverty, reduced accessibility, or literacy. As a result, such women experience worse birth outcomes, and their children tend to be less healthy. These families face higher medical costs because of their poorer health status, which in turn hinders socioeconomic well-being.

This cycle of poor income and poor health can negatively impact social and professional life in many ways. First, a vulnerable health status can significantly decrease

productivity in the workplace, thereby incurring high costs caused by health-related productivity loss (Goetzel et al., 2004; Loeppke et al., 2009; Schultz & Edington, 2007). Second, ill-health limits motivation and the ability to learn, which contributes to lower educational attainment (Basch, 2011). Finally, people with a lower socioeconomic status tend to have poorer social relationships, which can impact their mental health and other health behaviors (Li et al., 2020). Therefore, the poverty-health cycle, caused by gaps in health equity, can impact several other aspects of life including work, education, and social relations.

Limits Health Literacy

Inequity in access to health-care can decrease health literacy levels. In particular, lower socioeconomic status, which is related to poorer health and lower levels of education, is associated with low health literacy rates (Garcia-Codina et al., 2019; Stormacq et al., 2019). In most countries, such groups that are at an economic disadvantage are the minority or the refugee communities. Immigrant populations also face the challenge of poor health literacy caused by cultural and language barriers (Al Shamsi et al., 2020). For instance, within the United States, non-English and non-native English speakers are more likely to be unaware of the risk factors of several diseases including cardiovascular diseases and hypertension (Langellier et al., 2012). Further, limited health literacy is more common among older people because of the loss of cognitive ability with aging, although they constitute the age group that require greater medical attention for chronic conditions (Fleary & Ettienne, 2019; Shahid et al., 2022).

Owing to these financial, language, or health barriers, low health literacy can be a direct cause of poor health within certain communities. According to King et al. (2010), patients who are not health literate may have difficulty reading and interpreting essential health information given to them during a check-up. Considering that much of the health

literature, including treatment and medication instructions, require good comprehension skills, health illiteracy may adversely impact patient self-care as well as patient tendency to adhere to treatment plans. However, most patients often find it embarrassing to admit that they are unable to read or understand the information. As a result, a communication gap forms between the patients and their doctors, which may increase the risk of hospitalization or revisits to the emergency department, thereby increasing medical costs. Thus, poor health literacy, which is seen in certain medically vulnerable communities, can further increase the possibility of ill-health and financial burden.

Alternative Views on the Impact of Medical Access on Health Disparities

Many believe that limited access to health-care does not significantly contribute to health disparities. For example, critics argue that increased medical access cannot help marginalized communities because of their socioeconomic status. In addition, some believe that lifestyle and genetics, rather than accessibility, are the primary contributors to health inequity. Others argue that alternative medicine can fill the void left by reduced biomedicinal access. While these arguments hold some strength, their potential limitations need to be examined.

Inescapable Socioeconomic Circumstances

Critics argue that poor socioeconomic status nullifies the benefits of equal or improved health-care access. More specifically, equality in health-care access cannot reduce health disparities as disadvantaged communities are unable to escape the poverty cycle. In fact, some believe that the concept of equal access to health-care is an anomaly because of the persistence of economic inequality between communities (Fried, 2010). Others claim that improved medical access can increase the burden of paying taxes on both health-care consumers and providers, which will only aggravate the socioeconomic standing of consumers who struggle financially (Gutmann, 1981). Further, the Commonwealth Fund

(2023) reports that 30% of all Americans with employer insurance coverage still had medical, dental, or other health-care debt, which lead to a delay or complete avoidance in getting medical help for subsequent health-related issues. Among these citizens, those with lower incomes, under 400% of the Federal Poverty Level, incurred greater medical debt than those with higher incomes. Considering these findings, many suggest that having improved access to health-care, such as insurance coverage, does not sufficiently help poorer communities.

Although these arguments hold validity, they fail to consider an important point. While equality is certainly a difficult concept to achieve in health-care access, health equity can remove several inadequacies, if not all, in the medical services received by the poor. As Spalluto et al. (2022) points out, health equity can be achieved by tailoring the health system in a community so as to provide its residents their most important health needs. Such changes may include the provision of Unconscious Bias training to health-care workers in communities that face systemic discrimination. The authors note that another implemented strategy to address inequity is the existence of public and private society fundings to improve health equity and associated research. For instance, the Genentech Health Equity Innovation Fund, launched in 2019, actively funds ideas and projects that aim to eliminate health disparities caused by racial and ethnic discrimination. As a result, projects under this fund have been able to increase Black representation in clinical trials (Lydgate, 2023). Some of these funded projects have also made active efforts to diversify the nursing workforce (Bangert, 2023). Therefore, efforts to achieve health equity have made a significant impact on the health services received by marginalized communities, despite their financial standing.

Lifestyle and Genetics

Many claim that lifestyle, race, and genetics are the driving forces of health disparities. One study showed that minority groups like Hispanics are more vulnerable to certain non-communicable diseases because of genetic variations and lifestyle factors like

poor diet or sedentary behaviors (Fernandez, 2021). In another study conducted by Hunt et al. (2013), it was found that 5% of clinicians acknowledged that they are quicker to diagnose hypertension in African Americans as they are considered vulnerable to the medical condition because of their genetic composition. In fact, 86% of clinicians were taught to prescribe distinct medications for African Americans to manage hypertension. In addition, Ashana et al. (2022) argues that physicians avoid Advanced Care Planning (ACP) with patients who belong to a certain ethnic minority because of their end-of-life preferences. These studies suggest that physician approach is impacted by the ethnicity of their patients, which may lead to disparities in health outcomes between ethnic and racial groups.

While lifestyle and genetics do increase the prospect of diseases, the major contributor to health disparities is still accessibility. Gray et al. (2019) conducted a study to identify the existence of any significant differences in the way rural and urban cancer survivors react to the Reach Out to Enhance Wellness (RENEW) intervention program. RENEW is a home-based diet and exercise strategy to improve the physical health conditions of older cancer survivors. After a thorough analysis of the effects of the RENEW trial, it was found that rural cancer survivors had lower physical strength as well as reduced consumption of farm-produce, such as fruits and vegetables, compared to their urban counterparts. The author also notes that urban participants were more likely to show consistent growth throughout their RENEW trial because of better access to healthy groceries. Similarly, several other studies have shown that people living in rural areas were less likely to be healthy, physically or mentally, because of reduced accessibility to health-care (Jones et al., 2019; Nielsen et al., 2017; Weaver et al., 2013). Therefore, the fact that there is a significant difference between health outcomes in rural and urban areas suggests that health illiteracy and limited access to competent medical service is the primary issue at hand.

Alternative Medicine

Some argue that alternative medicine may reduce the need for full access to a biomedical system. Such claims hold that effective Complementary and Alternative Medicinal (CAM) remedies offer patients what conventional medicine cannot, including better treatment plans, tolerance to medication, and value for money (Booth, 2015). In fact, around 36% of all adults were found to have used some form of CAM between 1997 and 2007 (Tais, 2014). Tangkiatkumjai et al. (2020) argues that CAM is primarily used among adults because of the expected benefits of alternative medicine, the expected safety of CAM, affordability, and discontentment with biomedicine. The author found that the increase in CAM usage among Asian populations can be attributed to ease of access as well as adherence to traditional practices. Furthermore, Ventola (2010) claims that patients may turn to alternative medicine as they believe certain conventional doctors prescribe drugs unduly without explaining the benefits or risks of the treatment methods used. As such, CAM appears to be less authoritarian and paternalistic to such patients, thereby providing the impression of autonomy.

Although there exist effective and safe CAM remedies, several alternative medicinal treatments are untested and unregulated. As Angell and Kassirer (1998) point out, the primary difference between conventional medicine and CAM is that several CAM advocates do not even acknowledge the importance of scientific testing. However, they claim that such alternative treatments are safer and more effective solely because they are nature-based treatments. The authors assert that conventional medicine undergoes rigorous testing before being made available for human use today, while most herbal remedies are not subjected to the Food and Drug Administration's testing programs. Furthermore, most physicians are poorly informed and trained in CAM treatments like homeopathy, naturopathy, or herbal medicine (Stubbe, 2018). As such, only few physicians regularly ask their patients about the intake of herbal supplements, while several other patients are unwilling to disclose

information regarding CAM intake ("Most Doctors Not Knowledgable About Herbals," 2010). This communication gap can be cause for concern since certain herbal supplements may biologically interact and interfere with any drugs prescribed to the patient (Davis et al., 2012). Thus, alternative medicine cannot yet replace the growing need for biomedicinal access because of the lack of clinical trials in and poor knowledge of CAM.

Conclusion

Understanding the causes and consequences of rising health disparities is critical to employ possible solutions that can ensure health equity for all communities. In this paper, I argued that insufficient or lack of access to health-care increases health disparities. One possible way in which limited medical access contributes to health inequity is by increasing disease and mortality rates. In addition, lack of health-care access can push people into a poverty-health cycle, where poor socioeconomic status and limited health-care access play cause-and-effect or vice-versa. As such, the possibility of achievement of equity is perpetually hindered. Further, low health literacy can contribute to poor health outcomes, specifically within communities facing economic, language, or health barriers.

Despite the evident consequences of limited medical access, alternative perspectives regarding the impacts of health-care access exist. First, some argue that equal access to health-care cannot reduce the effects of health inequity on certain communities because of their poor socioeconomic circumstances. While this claim holds some validity, it is important to acknowledge that attempts on the health-care system to achieve health equity is a step toward fulfilling the needs of the people. Second, many believe that lifestyle or genetics are the primary causes of widening health disparities between communities. Although lifestyle and genetics do contribute to health inequity, evidence shows that lack of access is still the major issue. Finally, some claim that alternative medicinal treatments can be used in place of

biomedicine to reduce health inequity. However, studies suggest that alternative medicine cannot yet be used as a substitute as there is little research or clinical trials done.

The severe consequences of health disparities on marginalized communities are a testament to the injustice imposed by the current health-care system. Wealth inequity or the availability of alternative means of treatment cannot serve as excuses for limited medical access. However, further research into alternative medicine is required so that people can benefit from multiple clinically tested and safe treatment methods. Moreover, for the sake of fairness and equity, we must compel governments, other concerned authorities, and health-care providers to tailor the current system in order to incorporate people from all sectors into a more efficient health-care network.

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