Unveiling Health Equity in America:

Addressing the Impediments Preventing Access to Care for All

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Abstract

This paper explores the economic, social, legal, and political impediments preventing all Americans from achieving health equity and access to care. By examining the profit-centered nature of the healthcare industry, the systemic bias found within society, and the shortcomings in healthcare legislation and policy creation, this research cohort will identify the flaws present in the American healthcare system and explore possible solutions necessary to address these inequities. By examining the causes of healthcare worker burnout, the cost of prescription drugs, and healthcare administration costs, this paper lays out a framework that addresses the underlying economic and financial issues preventing health equity. Additionally, by discussing America's lack of healthcare literacy, the presence of food and pharmacy desserts, and the stigmas surrounding mental health, our researchers attempt to dismantle the social obstacles standing in the way of access to healthcare. Finally, focusing on government-sponsored healthcare initiatives and pharmaceutical industry activities, our group attempts to address the legal and political influences affecting Americans' health outcomes.

Keywords: health equity, healthcare, profit-based care, patient-based care, health literacy, food deserts, pharmacy deserts, mental health, Big Pharma, FDA, Affordable Care Act, Medicare, Medicaid

Introduction

Healthcare is a necessity for everyone - a matter of life or death. An overwhelming majority of Americans feel failed by the United States healthcare system due to extremely high treatment costs, confusing bills, frustrating insurance rates, and more. Despite trillions of dollars being poured into the country's health system, it fails to reach all those in need, creating an environment where various systemic impediments prevent Americans from gaining equitable access to care.

Prioritization of profit over patient care and treatment of healthcare as a luxury item creates economic issues. Socially, lack of healthcare prioritization, deprivation of necessary items (food, water, and space), and stigmatization of mental health disorders can disrupt healthcare progress. Governmental and legal systems also create issues; complex insurance policies, coverage gaps, and the influence of pharmaceuticals create a benefit for the minority over the majority.

In order to address the system inequities found in America's healthcare system, we must address the economic, social, and legal impediments that are causing inequitable health outcomes by creating a patient-centric health system, promoting health literacy, addressing racial biases, eliminating stigmas, and revisiting existing healthcare laws.

Economic Impediments

Providing quality care to patients should be the ultimate goal of the healthcare industry; however, the increasing commercialization of healthcare has introduced complex dynamics that can lead to an interrelated series of economic impediments that prevent Americans from

receiving equitable access to healthcare. This profit-driven approach to healthcare systems, which focuses on financial incentives and market forces, prioritizes revenue and shareholder returns compromises health equity and patient outcomes.

To reverse these troubling trends and create a system prioritizing positive patient outcomes, America must abandon its profit-centric approach to healthcare administration by returning to a patient-centric approach to care. By doing so, America's healthcare industry can return to one where the rate of healthcare worker burnout, administrative costs, and the price of drugs all decrease, thus leading to more positive health outcomes for all patients.

What is "Profit Based Care"?

Profit-based care is a healthcare system or approach that emphasizes financial gains and maximizing profits. In this, the delivery of healthcare services is often driven by market forces and the pursuit of financial success, which can sometimes overshadow patient-centered and worker-based care.

Affect on Patients

Profit-based care negatively affects patients and treatment by prioritizing financially lucrative interventions over necessary or beneficial ones. Cost-containment measures can lead to reduced staffing and rushed appointments, compromising individualized care and potentially resulting in errors. The focus on maximizing revenue can lead to shorter hospital stays, inadequate post-discharge care, and increased readmission rates. The cost of treatment may hinder the patient's ability to reach out to seek medical treatment in fear of non-affordable fixes.

In 2021, nearly 10% of all adults chose to postpone or skip necessary medical care due to the financial burden it imposed (Rakshit, 2023). These statistics highlight the negative impact of

profit-based care on patients. This delay or avoidance of care can seriously affect patients' health, potentially leading to worsened conditions, increased complications, and even avoidable hospitalizations.

Medical Nonadherence

A healthcare system that routinely prioritizes profits over patient outcomes has created an environment where increasing costs of and lack of access to medications severely jeopardizes the health of American citizens. Nearly half (47%) of Americans have chosen to avoid paying for prescription medications to be able to cover other necessary household expenses. (Montero et al., 2022). This voluntary avoidance of prescribed medical care is known as "nonadherence."

This election to forgo prescribed or necessary treatment due to the inability to cover the costs of medical expenses is debilitating and creates a cascading effect for those families affected. These high costs further prevent patients from receiving additional care and refilling prescriptions. This leads to serious health consequences later on. Consequently, poor adherence to medical treatment recommendations directly drives up mortality rates.

Affect on Healthcare Workers. In addition to having adverse effects on patients, profit-based care negatively affects healthcare workers by increasing productivity pressures, limiting autonomy and decision-making power due to financial reasons, offering inadequate compensation and job insecurity, and creating ethical conflicts. These factors contribute to burnout, stress, and decreased job satisfaction among healthcare workers.

Hospital earnings can have an effect on Healthcare workers for many reasons. It can put restraints on hiring staff, limit proper resources needed for specific treatments, cost-cutting for worker pay, unfair distribution of earnings, and rushed productivity, causing inefficiency. In an article by NBC News, they interviewed staff of HCA hospitals in which they had asked them

their concerns about some aspects of the hospital administration. The article states, “11 current and six former HCA employees in five states told NBC News they believe the company understated its hospitals as a practice, helping to keep earnings high but increasing the risks of adverse patient outcomes” (Morganson, 2023). The statement reveals a potential mistreatment of medical workers within HCA (Hospital Corporation of America) and highlights the negative impact on patient outcomes and healthcare workers. By allegedly understating hospitals, the company may engage in practices prioritizing financial gains over patient safety and quality care.

Why Health Care Worker Burnout is Important. Healthcare worker burnout has emerged as a critical issue within the healthcare industry, demanding urgent attention and consideration. As frontline heroes tirelessly battle the challenges presented, the toll on their mental, emotional, and physical well-being has become alarmingly evident. Burnout among healthcare professionals not only jeopardizes their health and job satisfaction but also poses a significant threat to the quality of patient care.

Health Worker Burnout Affects Patients. A study published in Health Affairs in September 2018 revealed that when healthcare providers experience burnout, the likelihood of adverse patient safety events doubles. The research also stated that providers who exhibited symptoms of depression due to burnout were associated with even higher risks to patient safety. Moreover, patients receiving care from burn-out providers were twice as likely to report experiencing low levels of provider professionalism and satisfaction with their healthcare experience (Heath, 2018). This demonstrates that healthcare worker burnout has a negative impact on patients. It doubles the odds of adverse patient safety events and increases the risk of patient dissatisfaction with provider professionalism and care encounters.

Decrease in Healthcare Workforce. Healthcare worker burnout has significantly contributed to the reduction in the workforce within the healthcare industry. As healthcare professionals experience chronic stress, overwhelming workloads, emotional exhaustion, and undesirable wages, they may become more susceptible to leaving their jobs or even the profession altogether.

According to a report from NEJM Catalyst in 2018, the issue of burnout among healthcare workers is prevalent in 83% of healthcare institutions. This problem is experienced by 78% of registered nurses, 64% of practice registered nurses, and 56% of clinical leaders. (Heath, 2018). These statistics underscore significant impact across various positions in the medical field.

There are many reasons why this burnout can cause decreased applicants in the work field. First, the loss of experienced and skilled healthcare workers reduces the overall capacity of the workforce, leading to staff shortages and increased workload for remaining personnel, which can exacerbate burnout among those who stay, creating a vicious cycle. Second, the cost and effort required to recruit and train new healthcare professionals to replace those who leave can strain healthcare organizations and the healthcare system. The decreased workforce and increased turnover rates hinder the ability to provide timely and quality care, potentially leading to longer wait times, compromised patient safety, and a diminished quality of healthcare services. Lastly, underpayment of medical care workers contributes to a decrease in the healthcare workforce. Undesirable wages may cause financial strain, job dissatisfaction, and professional attrition. The lack of competitive compensation packages also hinders attracting new talent to the field.

Impact of Business Operations and Administrative Policies

There are various reasons why healthcare costs in the United States are at an all-time high. America indeed has access to some of the best medical technology available and cutting-edge pharmaceutical research and development; however, despite those apparent benefits, America's healthcare costs are still overinflated because of bloated administrative costs.

Bloated Administration Costs. Healthcare administration contributes significantly to rising healthcare costs, as between 15% and 30% of all healthcare spending funds these costs. Unfortunately, the costs associated with US healthcare administration are neither expected nor commonplace in other healthcare markets. The second-largest spender, Germany, only spends about $306 per capita on healthcare administration compared to a whopping $1055 per capita cost in the United States. (Keating et al., 2022).

Compared to Canada, the U.S. has 44% more administrative staff, with U.S. physicians spending more time dealing with administrators than their Canadian peers. There are 2.2 million administrative staff workers in the United States per physician, with 12% of health insurance premiums going towards paying health administrators. (Cutler & Ly, 2011).

There are two significant reasons for these inflated costs. The first is due to inefficiencies in the healthcare system that require extra time and money for administrative staff to address. The second comes with the time-consuming process of dealing with insurance.

Administration Inefficiencies. Every hospital system has a different administrative interface and method of handling medical records and payments. Even though electronic record keeping is universal across all hospitals, these systems are not required to interface. While sufficient technological infrastructure allows our healthcare system to close this interface gap, underlying philosophical issues are at play. Many providers actively avoid electronic interchange because keeping records locally limits patients' mobility, decreasing the chances a

patient will switch doctors, thus creating a pseudo-monopoly for healthcare providers (Cutler, 2020).

Insurance Bureaucracy. One of the most cited administrative hurdles in the healthcare industry is the bureaucracy implemented by insurance carriers. Credentialing and billing are the two most time-consuming elements of the provider-insurance relationship. As part of an insurance system, physicians must document their credentials, which takes a lot of time for the administrative staff to review (Cutler & Ly, 2011). Additionally, the billing function within the insurance industry is even more labor-intensive. Administrators must see what services the patient can have, how much of the patient's deductible has been met, if the patient has paid their premium, if the doctor is in the network, and much more.

On top of that, insurance tends to deny many claims. Physicians have to fill out prior authorizations that often get denied because more documentation is needed, or the company feels the patient can take this treatment in a different manner that is much cheaper for the company (Cutler & Ly, 2011).

Although many of these claims eventually get approved, the time, money, and energy spent fighting for approval of claims and prior authorizations is a lot. (Cutler & Ly, 2011). The administrative costs associated with handling the paperwork of denying and approving these claims and prior authorizations continue to add up. These costs need to be covered by someone. So, in a profit-centered healthcare system, they get passed along to the consumer.

Solving the Problem

Patient-based care prioritizes the individual needs and values of patients. It involves communication and shared decision-making between healthcare workers and patients. This approach recognizes the variety of backgrounds and experiences of patients and aims to deliver

respectful and compassionate care. The goal is to improve patient satisfaction and health outcomes by considering the physical and emotional aspects of a patient's well-being. Patient-based care puts patients at the center of the healthcare experience, promoting their active participation and involvement in care decisions.

A Move to Patient-based Care

Valuing patient-based care over profit-based care positively impacts patients and healthcare workers by focusing on individual needs and preferences, leading to better treatment adherence and satisfaction. Patient-based care reduces healthcare distress and promotes appropriate access to quality care.

Through this lens, healthcare workers may experience increased job satisfaction as they build meaningful connections with patients and witness the positive impact of their work. Patient-based care fosters a non-toxic work environment and reduces burnout among healthcare teams. This shift creates a healthcare system that prioritizes patient and worker well-being, improves the healthcare experience, and enhances professional fulfillment.

Improve Training. A simple initiative to action for creating this patient-centered system is to reevaluate our medical care workers' training by focusing on patient-based care principles. We can teach our healthcare worker trainees the true value of patient-based care to help implement them into their everyday practices.

Holistic Approach. Another initiative we can take is to empower healthcare teams to develop a more holistic approach to patient's emotional, physical, and social needs. By listening to patients, doctors may find personal connection as an easier path during treatment sessions.

Feedback Loop. Lastly, we can create stronger feedback mechanisms for our patients, meaning we create a program where patients can give direct feedback on their experiences. This will help create a guide for healthcare workers to know what they are doing right and what they could improve to improve the next patient visit.

Through these fundamental initiatives, we can cultivate a healthcare system that revolves around patient care. This transformative approach showcases commitment to patients' needs and sets the stage for patients and healthcare workers to thrive.

Regulating Efficiency

One way the US can move away from a profit-centric system is to reduce its health administration costs through complete standardization. By having each healthcare provider work independently of one another, America fosters an inefficient system that hampers proper patient care and inflates health administration costs unnecessarily. Instead, each healthcare system needs to work together to figure out a standardized process for submitting electronic records, handling payments, and managing prior authorizations and claims. There have been several proposals to make this happen.

Streamlining Claims Requests. The creation of a "centralized claims clearinghouse would standardize the electronic transmission of billing information to reduce the costs of operating disparate systems across providers and payers" (Keating et al*.,* 2022*)*. To accomplish this, the federal government would set up two entities.

The first agency would set the operational standards needed to facilitate the secure electronic transmission of records and payments that healthcare systems would need to follow. At the same time, a second agency would serve as an independent body that would process all claims from insurance, hospitals, physicians, providers, and other third-party healthcare players.

If Congress were to create this central clearinghouse, we could save nearly $300 million (or roughly $0.06 per claim) in annual administrative costs (Keating et al*., 2022)*. While that is only a savings of 0.02%-0.04% in administrative expenses, it is a step in the right direction.

Reimagining "Prior Authorizations." Another cost-saving proposal is to digitize the process associated with prior authorizations completely. Currently, prior authorizations are handled by phone and fax. According to a survey of around 1000 physicians, 91% of physicians reported prior authorizations delaying care, with many practices completing thirty-three prior authorizations per week. It is no surprise that "88% of physicians believe that the prior authorization burden has increased in the past five years and is a major contributing factor associated with physician burnout (M. Cutler, 2020).

Further complicating matters is that when these claims are denied (often for clerical issues), physicians have to fill out the prior authorizations again just to get a treatment approved for a patient. A digital platform would help alleviate these issues because it would make the authorization transaction more streamlined. The ultimate functionality would see healthcare providers have to respond to prior authorizations within 20 seconds and send their decision on the authorization within two business days (American Medical Association & American Medical Association, 2020).

Many people also advocate for reducing the need for prior authorizations in certain instances where common medications, diagnostics, or treatments are used for patients with chronic conditions (M Cutler, 2020). Implementing this authorization exception could reduce redundant administrative tasks, thus reducing administrative costs.

Another suggestion would be to create a "gold-card" system where healthcare providers with a history of providing appropriate, cost-effective care would gain priority approvals or

waivers of approvals altogether as a benefit for being a conscientious provider (M Cutler, 2020). This paper also suggests that these benefits should extend practices with a decision criterion for treatments, and practices should attach a price for completing prior authorizations (M Cutler, 2020).

Credentialing Standardization. The final framework proposal is the standardization of resources. For example, each health insurance plan has its directories to inform constituents about in-network practices. Healthcare providers assume a significant administrative burden by having multiple directories to reference. In addition, inaccuracy is a recurring issue. "[The] CAQH [Council for Affordable Quality Healthcare] estimates that the maintenance of directories costs US physician practices up to $2.76 billion annually." (Keating et al., 2022). However, having just one director for all health providers to use will "save more than $1.1 billion per year" (Keating et al., 2022).

Federal Intervention. These solutions mentioned above can mitigate the problem of rising health administration costs; however, the federal government needs to play a significant role in making it a reality. However, they have been reluctant to do so. "The federal government sees its role as providing insurance to people—Medicare and Medicaid in particular—but not looking out for the system as a whole. That thinking will need to change if progress is to be made" (Cutler, 2020). Hence, the real major step to achieve this goal is to bring support and convince the federal government and major companies that there are real financial benefits to these institutions as well by having a healthcare system that has a more efficient method of health administration.

A Step in the Right Direction

It is unclear what effects these proposals will have on our healthcare system as they have yet to be correctly implemented. However, by fostering an environment that focuses on patient-centric values, we will move toward a healthcare system that places a premium on patient care, reduces healthcare provider burnout, reduces the financial burdens patients endure, and minimizes administrative costs by eliminating waste and redundancy. Implementing these initiatives will be a step in the right direction towards reforming a healthcare system to meet the needs of patients and their providers.

Social Impediments

Addressing the economic impediments preventing equitable access to healthcare should undoubtedly be a priority; however, it is only one of several obstacles standing in the way of access to care for all. Many of the obstacles creating inequitable health outcomes in America are due to the societal barriers that deny people full access to healthcare. These social impediments can be ascribed to prejudices that are both consciously and unconsciously held against patients.

Inequities in healthcare are also brought on by environmental and logistical barriers in our communities. Specifically, multiple impediments hinder American healthcare, making it difficult for patients to navigate the system. The lack of healthcare prioritization, food and pharmacy deserts, and stigmas surrounding mental health challenges are all social obstacles to achieving equitable healthcare. We can truly achieve health equity in America once we address these issues brought on by systemic biases.

America's Lack of Healthcare Prioritization

In the ever-changing, bustling country that is the United States, prioritizing healthcare is critical; however, more than 97% of individuals in America aren't considered to be living a healthy lifestyle (Citroner, 2020). In fact, despite being considered a "well-developed" country,

America places 35th in a ranking of healthy nations (Miller, 2019). While a direct root of the problem correlates to the American Healthcare system, the structure of American Society also contributes to declining health in America. From work-life balance to health literacy, America is far behind in healthcare promotion and prioritization compared to other developed countries. This article identifies the problems with the American approach to healthcare and how that can be changed.

The Doctor Dilemma

Whenever an individual feels ill, they are met with the question of whether or not they want to visit the doctor; however, when the need for medical care is not dire, many choose to opt out of routine checkups. Individuals who delay their medical care are more likely to have poorer overall health than individuals who do not delay their medical care. Furthermore, individuals who delay their medical care are more likely to have present underlying conditions, stating that "delays in medical care may increase morbidity and mortality risk among those with underlying, preventable, and treatable medical conditions" (Gertz, 2022). Underlying conditions among the patients interviewed in the study included asthma, cancer, chronic disease, diabetes, and immunosuppressive conditions.

Individuals with limited financial resources or lack insurance coverage may view scheduled doctor visits as a burden. Since the cost of healthcare may be too high, individuals may stall out on seeking medical aid for as long as they can manage. For lower-income or uninsured individuals, avoiding preliminary doctor's appointments can be an option to save money for a short while; however, if the patient visits the doctor or a hospital in a worsened state, the resulting bills are likely to be much higher than the ones resulting from an earlier visit. Although a profit-based healthcare system has made it difficult for lower-income individuals to

seek the care they need, in the end, preventative healthcare is less expensive than restorative care. For example, if a patient is experiencing symptoms of a health condition and can receive care quickly, the resulting cost will be much less than the care needed for worsened and dire conditions. This is why it is essential for an individual to recognize when they need to go to the doctor.

The Importance of Health Literacy

The Center for Disease Control, commonly known as the CDC, defines personal health literacy as "the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others." Health literacy is critical and affects health conditions and diseases as well as health status and outcomes (CDC, 2023). However, when met with less severe symptoms, many Americans opt out of visiting the doctor because they do not understand the consequences of doing so. This lack of health literacy can have adverse effects down the line.

Decreased health literacy causes many Americans to spend more money than they need to on healthcare. In comparison, increased literacy would mean that individuals could recognize symptoms of illness quicker and get diagnosed and treated fast, thus improving their health outcomes and saving money. Over 1 million unnecessary hospital visits are made annually, resulting in $25 billion of unnecessary expenses because of patients' lack of health literacy (UnitedHealth Group, 2020). This lack of education on the part of patients prevents them from reporting symptoms to their doctors, thus making the ultimate diagnoses much harder when they eventually seek medical treatment.

Poor Work-Life Balance Equals Poor Health

One of the greatest effects on an individual's overall health is the work-life balance (an individual's balance between personal and professional activities). A good balance would ensure proper division between the two without jeopardizing one another. Work-life balance may be defined differently between different occupations; for example, some workers do not have a consistent schedule. It is essential to acknowledge that the organization of work-life differs from individual to individual because establishing a work-life balance depends on a variety of factors, making work-life balance an individual matter. However, regarding the variation between occupations, the general basis for work-life balance still stands as an equilibrium in which one's work duties do not spill into one's personal life and schedule. Unfortunately, according to the Public Broadcasting Service, America ranks 29th among other well-developed countries in terms of work-life balance (Doerer, 2015). Poor work-life balance can lead to a variety of problems for an individual. For example, if one cannot practice a healthy work-life balance, the resulting issues can lead to a lack of rest when necessary. In particular, only 35% of Americans reported that their workplace encouraged taking breaks (American Psychological Association, 2023).

A poor work-life balance can also lead to sleep deprivation or a poor sleep schedule (Doerer, 2015). When an individual cannot establish a healthy sleep schedule due to work, the effects can manifest into health issues. The Mayo Clinic explains that cytokines needed for fighting stress and infection are produced during sleep, as well as antibodies (Olson, 2018). Thus, a poor work-life balance that leads to a lack of sleep can cause the deterioration of the immune system, which leaves the body open to foreign organisms-causing the human body to be more prone to illness. Overall, proper work-life balance is essential to regulating the human immune system and protecting against illness.

Paid Sick Leave vs. Unpaid Sick Leave

Sick workers often choose between taking leave or working while sick. Their decision is weighed by various conditions, including whether their leave is paid or not. In the United States, over 49 million Americans are left without paid sick leave (DeRigne, 2016). Moreover, the American Public Health Association states that around 40% of private sector workers in America do not have paid sick leave. In addition, this percentage is heavily made up of underprivileged workers who are paid hourly at low-wage jobs.

Furthermore, low-wage workers are likely to work longer hours, meaning they are more likely to experience poor health because of a low work-life balance. This indicates that although low-wage workers need paid sick leave the most, they are less likely to receive it. Compared to other developed countries—developed countries being countries with a rating of 0.8 or higher on the United Nations Human Development Index (Majaski, 2022)—the American Public Health Association explains the United States is the only one without paid sick leave (American Public Health Association, 2013).

Environmental Impacts on the Minority Population

Many social impediments that prevent individuals from gaining proper access to healthcare can be attributed to conscious and unconscious biases against individuals. There are also logistical and environmental impediments within our society that create healthcare inequities, preventing people from getting proper nutrition, medications, and the benefits of green space. These environmental issues can ultimately negatively affect a person's health and well-being. To tackle these issues, people must understand the source of these problems to devise and implement potential solutions.

What are the Environmental Impacts?

Society is made up of many infrastructures, both physical and social. Physical infrastructures include utilities like running water and electricity, transportation, and roads and bridges. Social infrastructures have services and policies such as public education and healthcare. This is necessary for individuals' well-being and allows a society to function (Abbott et al., 2023). However, not all areas have the adequate infrastructure they should, which can be a barrier in people's lives when it is hard to access certain facilities as simple as grocery stores, pharmacies, and green spaces.

Food Deserts. The National Research Council defines food deserts as neighborhoods and communities with limited access to healthy foods. Places that are food deserts do not have proper grocery stores that sell quality, nutritious food, so many people have to travel long distances to find one (K. Rogers, 2023). It is difficult to know the exact number of Americans living in a food desert because there are different definitions regarding what is considered a food desert; however, it is estimated that 11-27% of the U.S. population lives in areas of poverty and far from supermarkets (Kim, 2022). Regardless of the exact figure, far too many Americans do not have access to healthy and nutritious food, which causes many health-related issues.

Urban areas and rural locations have a high risk of becoming food deserts. For an urban area to be considered a food desert, at least 33% of the population has to live more than one mile from the nearest major grocery store and more than ten miles in a rural area (Marengo, 2020). The main reason in urban areas is because of unreliable public transportation. Public transportation may have issues such as inaccurate arrival times, crowds, or just the cost, which can prevent people from making the journey to the grocery store. In rural areas, the small population often cannot support proper grocery stores. The food in such stores may have higher prices because of this, which many might avoid (National Research Council, 2009).

With all these obstacles, cooking a healthy meal for dinner may not be an option for many families, which can impact people's health immensely. Good nutrition helps children grow and develop properly. It reduces the risk of them getting chronic diseases like obesity, heart disease, diabetes, and certain cancers later. For adults, a good diet helps them live longer and also reduces the risk of chronic diseases. Even for those who have chronic diseases, eating well can prevent further complications. Poor nutrition can also affect mental health. It can impact the brain by impairing reaction time and decision-making and lead to fatigue, stress, and depression (Centers for Disease Control and Prevention, 2022).

Lack of nutritious food is just one obstacle preventing people in certain communities from achieving health equity. People can also suffer from a lack of access to pharmaceuticals. This creates a situation that makes it very difficult for them to tend to otherwise treatable conditions, thus turning minor conditions into life-threatening medical situations.

Pharmacy Deserts. Areas where pharmacies are challenging to access are known as pharmacy deserts. Typically, they are classified as neighborhoods with a distance of one mile or more to the nearest pharmacy. In low-income neighborhoods with at least a hundred households with no vehicle, the concept is redefined to include a distance of half a mile or more. Over 40% of counties in the U.S. are considered pharmacy deserts, with most people driving fifteen minutes or more to reach the nearest pharmacy (Pisikian, 2022). Like food deserts, the high prices of drugs or no transportation methods to even get to a pharmacy prevent many from receiving the necessary medicines, putting people’s health at risk.

Pharmacies are important when it comes to protecting public health. They provide access to medicines and preventative/emergency care such as vaccines, contraception, and naloxone-an opioid overdose antidote. The closure of pharmacies could prevent people from getting such

essential items. Dima Qato, a NAM Pharmacy Fellow, has researched the impact the lack of access to pharmacies has on health outcomes. She and her colleagues found that people who get their prescriptions filled at a pharmacy that then closes are more likely to discontinue their medication (Frueh, 2020). This is huge because if people stop taking their medication for a possibly treatable condition, it could lead to a more severe condition that requires hospitalization, which could have been prevented.

The lack of commercial establishments is not the only environmental issue creating societal impediments to equitable health care. In some instances, purposeful planning is to blame. Urban planning that results in a lack of open, green spaces can also be seen as an obstacle when Americans try to access healthy outcomes.

Lack of Green Spaces. Green space is land that is partially or entirely covered with vegetation, such as grass, trees, and shrubs. Examples of green spaces that may be familiar include parks and community gardens. Areas to walk in neighborhoods, parks, and other areas draw people outside and are a good way for people to interact with one another. Green spaces are known to provide many health benefits, like taking walks for exercise (United States Environmental Protection Agency, 2023). Urban areas with bustling cities are not popular spots for many green spaces, so people may not reap the same benefits as those close to such areas, potentially leading to more negative health effects.

Dr. Eugenia South, a public researcher at the University of Pennsylvania, says a lack of green spaces is associated with a higher risk for heart disease, depression, and overall mortality. The lack of these places has both physical and mental effects on health. As aforementioned, green spaces draw people outside and potentially motivate them to be physically active, which cannot be seen in areas that lack green spaces. A lack of exercise increases the risk of chronic

health conditions. South's research also demonstrates a correlation between a lack of green spaces and depression, as seen in a study done in a neighborhood in Philadelphia. This neighborhood did not have many green spaces, so many vacant lots were made into gardens. After the study, people reported fewer depression symptoms after the change compared to before (S. Rogers, 2019). From this, one can see that a touch of green can go a long way in improving a person's overall health.

Disproportionate Effects on Minority Populations

Studies have shown that food deserts, pharmacy deserts, and lack of green spaces correlate with income and race, meaning these three areas are more commonly found in poorer minority neighborhoods; because of this, low-income and minority groups are subject to more negative health outcomes.

A former public health nurse, Kelly Bower, has studied the link between poverty and food availability since the mid-1990s. Through her job working for housing programs that served uninsured women recovering from substance abuse, she found that many African-American women suffered from cardiovascular disease, diabetes, obesity, and hypertension while they were only in their early 30s. These women also lived in unsafe neighborhoods without supermarkets or greenspaces and relied on public transportation (Brooks, 2014).

Areas classified as food deserts tend to have more convenience stores that sell more high-caloric foods with no nutritional value (K. Rogers, 2023). That is why people tend to have poor diets high in sugar, sodium, and unhealthy fats, which can lead to various chronic health conditions: similar to what Bower states in her time as a nurse (Marengo, 2020). In addition, only 26.7% of white neighborhoods, compared to 38.5% and 39.5% of Black and Hispanic/Latino neighborhoods, respectively, are pharmacy deserts (Nelson, 2021). Even if those

women had public transportation, it would be hard to make the long journey very often to get the medicines they need from a pharmacy or even find a green space. Without access to nutritious food, pharmacies, and green spaces, making healthy lifestyle choices in such environments is difficult.

What is behind all this?

The reasons why there are food deserts, pharmacy deserts, and a lack of green spaces come down to one simple factor: money. Supermarkets and grocery stores avoid opening in low-income minority neighborhoods because they fear losing money, making the area a food desert. This is known as supermarket redlining (Kim, 2022). Another reason could be supply and demand. People may not be educated on healthy food choices and opt for unhealthier, cheaper foods, which maintains the demand for these foods (K. Rogers, 2023).

Similarly, pharmacy deserts often form because they have closed down in these neighborhoods because they do not make enough profit. It is difficult to remain open in areas that have a high Medicaid population, as they get low reimbursement for filling Medicaid prescriptions. That is why pharmacies move to more profitable locations (Pisikian, 2022). As for green spaces, there is substantial evidence that the lack of access to green spaces is because of systemic racism. While looking at cities with a history of a majority black population, such as Memphis, Tennessee, and Baton Rouge, Louisiana, 5% and 3%, respectively, of the land consists of parks compared to the national median of 15% (Shukla, 2020). That is a drastic percentage, and people may not care or look over spending money to construct or maintain green spaces in such areas.

In the United States, stigmas surrounding mental illness continue to exist, preventing people from accessing the care they require. These stigmas delay the deployment of

comprehensive medical services and perpetuate age inequities in mental health assistance. Different age groups face varying levels of stigma and barriers when seeking mental health care: younger individuals might encounter skepticism or dismissiveness from adults who may perceive their mental health concerns as just a phase. At the same time, older adults might face ageism, attributing their struggles solely to aging. Consequently, people directly affected by mental illnesses carry the bulk of these profoundly ingrained stereotypes. Stigmas surrounding mental illness create health inequities, hindering access to comprehensive medical services and perpetuating disparities. To eliminate these issues, dispelling the common misconceptions surrounding mental health and creating a more welcoming and helpful atmosphere for people of all ages dealing with mental health issues is necessary. By addressing the specific needs and experiences of individuals across all age groups, the United States can work towards a society where everyone can access the care they require and ultimately reduce health inequities. It is vital to eliminate these problems by eradicating widespread misconceptions about mental health and by fostering an environment that is more hospitable and supportive for individuals of all ages struggling with mental health challenges. The United States can work toward a society where everyone can obtain the care they need and, ultimately, lessen health inequities by addressing the unique needs and experiences of people across all age groups.

Mental illness stigmas hinder healthcare access

The widespread stigma associated with mental illness has severe and far-reaching effects on individuals, healthcare systems, and society. These stigmas create hurdles that hinder people from seeking the care they require, resulting in delays in getting appropriate treatment and assistance. Furthermore, these stereotypes lead to the underdevelopment of comprehensive mental health care services, leaving many without the necessary resources and assistance. Age

discrepancies exacerbate the negative impacts of these stigmas, making it even more critical to address and eradicate these deeply embedded prejudices in our culture.

Extensive research has shown that stigma contributes to worsening symptoms and reduces the likelihood of individuals seeking and receiving necessary treatment for any medical issues. Self-stigma, the negative attitudes, including internalized shame, that people with mental illness have about their condition, has been linked to negative consequences on recovery for those diagnosed with severe mental illnesses, including reduced hope, lower self-esteem, increased psychiatric symptoms, difficulties in social relationships, and a diminished likelihood of staying with treatment (Psychiatry.Org, 2020). Moreover, the pervasive nature of stigma has broader implications that go beyond the level of the individual, affecting different facets of society and mental health.

The stigma connected with mental health difficulties has a detrimental impact on charitable fundraising efforts for mental health organizations as well. In particular, potential donors may be less likely to donate due to the stigma attached to these issues. Furthermore, there could not be as many resources available for mental health services and support, making it even harder for those seeking treatment.

This underfunding of mental health research, compared to other health disorders, is a significant source of worry. Because of the stigma associated with mental diseases, there is a lack of public awareness and understanding, resulting in less public and private investment in research activities. This difference in funding impedes scientific progress in understanding mental health issues and limits the development of novel therapies and interventions that could enhance the lives of persons suffering from mental illnesses.

This detrimental cycle perpetuates reluctance to seek help, social isolation, limited work and social activities opportunities, and inadequate mental health coverage by insurance. In light of these realities, it becomes crucial to address and combat mental health stigma to break free from its harmful grip and promote the well-being and inclusion of all individuals seeking mental healthcare. A constant sense of helplessness, social isolation, a lack of empathy, limited employment and social possibilities, bullying, and poor insurance coverage are all reinforced by this negative cycle (Mayo Clinic, 2017). Given these facts, it is imperative to address and combat mental health stigma to free the mentally ill from its damaging hold and advance the inclusion and well-being of all people seeking mental healthcare.

Mental illness stigma hinders the development of medical services

The widespread stigmas associated with mental illness have serious ramifications, including the underdevelopment of medical services to meet mental health requirements, perpetuating a severe gap in care and support for people suffering from mental disorders. Governments are responsible for taking action to combat the damaging stigmas associated with mental illness; however, over 40% of nations do not currently have a mental health policy in place to properly care for individuals in need care. Furthermore, over 30% lack mental health programs, including 25% of nations that lack mental health laws altogether (WHO, 2011). These are indeed troubling numbers.

The severity of the burden on communities worldwide due to mental health issues contrasts sharply with this negligence. The response to this critical issue falls short, with over 33% of countries allocating less than 1% of their total health budgets to mental health and an additional 33% spending just 1% on mental health services. Insufficient access to essential medicines further exacerbates the problem, with about 25% of countries lacking the most

commonly prescribed drugs for treating schizophrenia, depression, and epilepsy at the primary health care level. The dearth of mental health professionals is alarming, with only one psychiatrist per 100,000 people in more than half the countries globally and 40% of countries having less than one hospital bed reserved for mental disorders per 10,000 people (WHO, 2011).

These statistics highlight the urgent need for governments to prioritize mental health and combat the stigmas that hinder the development of comprehensive medical services, ultimately perpetuating a significant gap in care and support for those suffering from mental disorders. Governments must prioritize mental health and fight the stigmas that prevent the creation of comprehensive medical services, eventually limiting the sizable gap in care and assistance for persons with mental illnesses.

Overcoming Stigmas at the Workplace

Unfortunately, these effects of inadequate mental health services do not exist in a vacuum. They affect those who suffer from mental health issues wherever they go, including at work.

Stigma Surrounding ADHD in the Office. Often, people who suffer from ADHD lack the accommodations necessary to succeed in an office setting. This is frequently due to the ongoing stigma associated with this condition. Employees with ADHD may struggle with disorganization, planning, and time management issues, frequently forcing them to submit their work at the last minute. When assignments are sent later than expected, it can cause problems in teams since other members must rush to do their tasks. By failing to skillfully manage and accommodate ADHD symptoms to overcome potential barriers within teams, an employer is failing the company, its staff members, and most importantly, the team member who suffers from ADHD.

Mental Health Support Across Different Ages

Age differences intensify the adverse effects of stigmas associated with mental illness, making it even more urgent to address and eradicate these ingrained prejudices in our culture. The stigma around mental diseases can substantially impact the elderly's capacity to receive correct treatment and support as they age, similar to how stigma prevents those with ADHD from making necessary adjustments in their employment settings. Unfortunately, the absence of sufficient treatment alternatives or accommodations for older people with mental health disorders might be ascribed to society's inability to comprehensively address mental health concerns.

As a result, the elderly may confront difficulties in their daily lives, feel lonely, and have difficulty receiving adequate medical treatment. To improve the well-being of elderly people with mental diseases, fostering community understanding and compassion and creating a culture that recognizes and caters to their needs throughout their lives is critical.

Overcoming Social Impediments

Like the economic impediments we examined previously, the social factors that are preventing Americans from receiving access to care must be addressed if true health equity is to be achieved. Therefore, there must be a coordinated, multifaceted approach that redefines attitudes, expectations, and social and environmental constructs that are currently obstacles to progress in the healthcare industry.

Changing Our Approach to Healthcare

Although completely changing the healthcare system may be a long and difficult process, some steps can be taken to reduce the societal impact of declining healthcare. These steps include increasing health literacy and changing work-life conditions in American workplaces.

Increase Health Literacy. For one, it is important to increase health literacy by teaching adults and children when to be concerned about their health and when to visit a healthcare professional. Improving health literacy may include changing health education curricula in schools to recognize symptoms of illness and teach children to know when to visit the doctor. As for adults, health education can be integrated into regular doctor visits to educate individuals about their health and what warning signs their doctors are focused on. This could change the current state of America's healthcare by increasing the number of early diagnoses and treatments, which is important in benefitting the prognosis of debilitating diseases and conditions.

Americans taking better control of their health could completely change the outlook for healthcare and greatly improve America's overall health. A great example of this concept in practice is Healthy People 2030, a national plan focusing on increasing preventative care for Americans to improve public health. The plan, which began in 2010, has various objectives to increase healthcare across multiple age groups and monitors the status of these goals on their website (effectively reporting the status of healthcare in America.)

Reduce Toxic Workplaces. In addition to education, it is important to reduce toxic workplace standards that negatively impact work-life balance for workers. As a nation with a relatively poor work-life balance, it is important to change workplace standards to improve the nation's health. This can be done by encouraging workers to take breaks and decreasing the interference of work duties when an individual is not in the office.

Mandate Paid Sick Leave. Americans should advocate for required sick leave, a cause that would provide relief to millions of Americans. Required sick leave would create an environment for workers to feel comfortable missing work while feeling ill. In the long-term, this would prevent the rapid spread of infectious diseases such as what was experienced with the

recent COVID-19 pandemic. While a concerted effort involving government regulation and private-industry compliance would be required to make this a reality, it can potentially improve American efforts to achieve health equity.

Eliminating "Deserts" Through Policy & Action

It is essential that local policymakers look for better options to support businesses in low-income areas so that infrastructures like supermarkets and pharmacies can thrive (Brooks, 2014). However, communities should not rely on government intervention alone.

Community Response to Food Deserts. While that policy discussion takes place, communities can support the elimination of food deserts by creating other healthier food sources. Establishing farmers' markets, providing healthier food options in schools, creating community gardens, and ordering food from online supermarkets are all great options (K. Rogers, 2023). One can even ask their healthcare provider about what to eat and where to find it (Brooks, 2014). By taking these actions locally, individuals can make them in a much shorter timeframe than policy and legislation may allow.

Addressing Pharmacy Shortages. More pharmacy mail-order and delivery options can prevent patients from traveling long distances or at least less frequently (Pisikian, 2022). Mail-order options are usually less expensive since they operate through one's health plan to get medications directly from the manufacturer at a lesser cost than traditional prescriptions. They also come in larger quantities (90-day supply), so getting refills takes less time and work.

Many online options also offer service 24/7 through their website or telephone, so one can ask any questions they might have without making the trip to the pharmacy (Miecznikowski & Skoler, 2022). Having medications delivered directly makes mail-order options in pharmacies much more convenient for many so they can get the treatment they need.

Creating Green Spaces. Increased green spaces can lessen health inequalities. They can lessen health disparities between races by providing equal health benefits (from green spaces) regardless of geographic location. These areas are sparse in urban areas, so building mini-parks, planting sidewalks, and even rooftop gardens can help squeeze in some green among the large buildings (Biasotti, 2021). However, advocates should learn what works best for their community before doing this.

According to The Greening of Detroit, a nonprofit organization, seeing what plants are common to the area and planning out where to plant can improve the commitment to the project. In addition, they engaged with a local youth employment program to maintain these green spaces and teach residents the importance of green spaces as it relates to health starting at a young age (Cartier, 2021). Overall, fixing these foundational issues can help improve people's health quality and pave the way for potential solutions further up the line.

A Wide-Ranging Approach to Limiting Mental Health Stigmas

Mental health disorders require a broad approach to addressing health inequalities. However, tackling the issue from multiple angles significantly decreases the chances of underrepresented individuals slipping through the cracks.

Improved Media Representation. One crucial step is fighting for fair and responsible media representations of mental illness. We can create standards for media that combat stereotypes and support realistic portrayals by working with mental health professionals and activists. These standards will be crucial in influencing public opinion and lowering the stigma associated with mental health disorders.

Heighten Public Awareness. Additionally, it is essential to raise public awareness and educate people about mental health. By implementing mental health education programs in

schools, running public awareness campaigns, and using social media, we can dispel myths and advance compassion in society by fostering empathy and understanding.

Improving Mental Health Care. Perhaps the most critical component of tackling health inequalities is ensuring everyone has access to high-quality mental health care.

Provide Financial Aid. To accomplish this, the United States may eliminate financial obstacles by promoting legislation that broadens mental health coverage in public and commercial health insurance plans and increases financing for mental health care. Access to care can be improved, particularly in rural or isolated areas, by building telemedicine platforms and expanding mental health services in underserved areas.

Better Training. The United States should create training programs for mental health professionals, seek out professionals from various backgrounds, and work with community-based groups to jointly design and execute sensitive services to provide culturally competent care to varied populations.

Interdisciplinary Policy Formation. Cooperation between mental health groups, healthcare professionals, legislators, and community leaders is imperative to create comprehensive policies that cater to the particular requirements of various communities. We can emphasize mental health equity and inclusion in healthcare reform conversations, effectively allocate resources, and better understand mental health inequities through coalitions, advocacy activities, and data-driven approaches.

Together, U.S. society can fight to develop a healthcare system that supports everyone's mental health and is more inclusive and egalitarian, regardless of their circumstances or background. Together, the U.S. can work to create an inclusive, egalitarian healthcare system that promotes everyone's mental health.

Contact-based Interventions. Large-scale contact-based interventions with service users as a core component and ongoing funding and participation can be leveraged to minimize the stigma encountered by persons with mental illnesses due to society's ignorance and fear. (Lancet, 2016).

Furthermore, contact interventions mediated through educational settings, which may be integrated into national curricula for personal and social education, could help children and young people. The ultimate purpose of society should be to demystify mental illness and cultivate acceptance of it, as well as other health disorders. However, the stigma cannot be eradicated until healthcare systems address the substandard care those with mental health disorders receive.

Collective Action

To develop a more inclusive and compassionate society, the U.S. must challenge myths, raise awareness, and provide a supportive atmosphere for people of all ages struggling to achieve health equity. The United States can change attitudes toward healthcare, improve societal infrastructures, break down barriers, and pave the path for a more compassionate and fair future by taking collective action and addressing social health inequalities.

Legal & Political Impediments

Economic and social impediments are complex issues with generations worth of bias that must be addressed and undone. The legal and political arenas are areas in which America could influence healthcare outcomes for the better. However, after years of attempting to implement policy and legislation to address health equity issues, the American government comes up short, even when it appears that it is making progress. Whether it is fixing existing legislation, creating

new state-sponsored healthcare initiatives, or holding the healthcare industry accountable, American policymakers and legislators must do a better job protecting their citizenry from inequitable health outcomes.

America's Health Insurance System

Throughout U.S. history, America's healthcare system has been subjected to constant change as it evolved from a simple system of home remedies to a complex and scientific system. These changes, of course, impact the insurance system, as the first insurance was the foundation of what we have today. As the healthcare insurance system expanded, issues began to surface as there are still large amounts of people who are uninsured mainly due to the rising U.S. healthcare cost. To address these issues, new healthcare reforms were introduced. Medicaid, Medicare, and the Patient Protection and Affordable Care Act (PPACA) are examples of legislation developed to help ease the burden Americans experience when seeking access to healthcare. Despite the intention behind the legislation and the general benefits these laws created, the application of these programs left many gaps in equitable access to healthcare for Americans. In order to close these equity gaps, we, as a society, must examine the concept of healthcare insurance, its availability, and its effects on the public when it is not readily available, as well as uncover the legal and political impediments preventing the healthcare insurance system in the U.S. from meeting the needs of the people.

A Brief History of Health Insurance

Health insurance was introduced in the 1930s during the Great Depression when the actual cost of obtaining healthcare was relatively low as medical technology was not as advanced as it is today. The early versions of health insurance did not include physicians, as many refused

to be a part of this system. Today, it is a big business with "an estimated 138,682 licensed health insurance agents working in the U.S." (Lichtenstein, 2023).

Modern Health Insurance. Health insurance is a plan or policy made between an individual and their insurance company/insurer that is a form of protection to help decrease the cost of medical events that might occur unexpectedly. It is there whenever an individual needs it, as accidents or instances when they need insurance cannot be predicted. Individuals who purchase a plan receive medical coverage as outlined in the plan. When an individual has insurance, they usually will pay a monthly rate (premium), copayments (other out-of-pocket fees), or have to meet deductibles every year before the effects of insurance coverage occur. Health insurance costs vary depending on the plan and individual, as many factors can affect their health insurance costs.

Why is it Important? There are many reasons to have health insurance, as it is critical to living a productive, secure, and healthy life. Health insurance is often associated "with [lowering] death rates, better health outcomes, and improved productivity" ("The Importance of Health Coverage," 2019).

Additionally, coverage "reduces individuals' and families' financial burden and risk by reducing annual out-of-pocket spending and essentially eliminating catastrophic expenditures" ("The Importance of Health Coverage," 2019). People with medical needs, such as chronic illness diagnoses, enrolled in health insurance plans saw a significant improvement in their financial health. Accessing and possessing affordable health insurance benefits all Americans; however, more than 28 million individuals in the US still lack coverage, putting their physical, mental, and financial health at risk.

Government-sponsored Healthcare. On July 30, 1965, President Lyndon B. Johnson signed the Medicare and Medicaid Act, also known as the Social Security Amendments of 1965, into law. It established Medicare, "a health insurance program for the elderly, and Medicaid, a health insurance program for people with limited income" ("Medicare and Medicaid Act," 2022). With the enactment of Medicaid and Medicare, many gaps in health insurance, such as health care for elderly and low-income families, were addressed.

What is Medicare? Medicare is a federally facilitated health insurance program for Americans 65 or older and some younger people with disabilities or diseases. ("What Exactly Are Medicaid and Medicare?," 2021). Medicare covers those who "have received at least 24 months of Social Security disability benefits or a disability pension from the Railroad Retirement Board (RRB)…[and/or] have amyotrophic lateral sclerosis (Lou Gehrig's disease)" ("What Exactly Are Medicaid and Medicare?" 2021).

On the other hand, Medicare does not cover every healthcare need. Without additional insurance or being included in a low-income bracket, an individual will probably still pay some premiums, deductibles, and copays.

Services, such as dental and vision, are also not covered, and each coverage will depend on one's plan. Before turning 65, most people have insurance through their employer or an individual health insurance policy. When one turns 65, they can use Medicare as their only insurance option or in combination with another insurance.

Medicare: Pros. There are many positive sides to Medicare. Medicare provides coverage to many aging Americans and younger Americans with disabilities. The cost of having Medicare is also low as those who qualify pay only a small, out-of-pocket amount every month. In 2021, the standard premium is $148.50 per month. Additionally, Medicare allows Americans to have

greater access to prescriptions. Furthermore, many pharmaceutical companies began to invest in developing drugs specifically for seniors after seeing the potential in the Medicare market.

Medicare: Cons. With Medicare, large amounts of money must be used to ensure these benefits. In 2020, around $858.5 billion was used for Medicare, and it is estimated that it might increase over $1 trillion. This would result in increased taxes, as some Medicare funds come from payroll taxes. The current Medicare tax rate is 2.9%, split between employers and employees. An extra 0.9% is added to those who make more than $200,000. This meant that much money must come from each paycheck to sustain Medicare.

What is Medicaid? Medicaid is "a federal program administered by state governments, helps provide health coverage to eligible Americans with limited incomes" ("What Exactly Are Medicaid and Medicare?" 2021). States can determine eligibility, set payment rates, and decide what Medicaid covers outside mandatory eligibility groups, such as low-income families. Additionally, they must decide what certain services are covered through their plan, as there are some federal standards that every plan must meet. They must cover "inpatient and outpatient hospital services, home healthcare for eligible individuals, nursing facility services for individuals over age 21, lab and X-ray services, and federally qualified health center (FQHC) services and ambulatory services" ("What Exactly Are Medicaid and Medicare?," 2021).

Medicaid: Pros. Having Medicaid allows many to receive affordable healthcare since, in the past, many could not afford healthcare insurance due to their income. With Medicaid, those with lower incomes can now afford healthcare; in some situations, coverage is offered free. Medicaid offers many mandatory benefits, including but not limited to patient hospital services, outpatient hospital services, nursing facility services, physician services, laboratory and x-ray services, certified pediatric and family nurse practitioner services, and transportation to medical

care. Many of these mandatory benefits are essential for overall health and wellness for individuals and families, such as physician visits, as these prioritize health.

Medicaid: Cons. Unfortunately, there are also drawbacks, as limited healthcare provider options exist for those with Medicaid. Many providers do not accept Medicaid as "reimbursement rates are…lower than what many medical providers are accustomed to billing" (Martin, 2023). There are coverage limitations as sometimes Medicaid will not consider the procedure or service, which results in patients having to forgo the treatment or pay out-of-pocket.

Furthermore, Medicaid only provides coverage to certain groups of people that meet their specific requirements. This then led to the Affordable Care Act, also known as Obamacare, which aimed to provide affordable and basic health coverage to all Americans. The ACA allowed the expansion of Medicaid to address issues like the "coverage gaps" many uninsured faced. Those with "coverage gaps" do not qualify for Medicaid but do not earn enough to have insurance, resulting in a difficult situation. This issue was present when Medicaid was enacted, but the ACA aimed to fix this issue.

The Patient Protection and Affordable Care Act (PPACA or ACA). The Affordable Care Act (ACA), also known as Obamacare, was signed into law in 2010 in hopes of providing "affordable health insurance coverage for all Americans…[and] protect consumers from insurance company tactics that might drive up patient costs or restrict care" (Roland, 2019). It looked to expand the theoretical benefits of Medicare and Medicaid to every American.

Affordable Care Act Pros. On the positive side, the ACA made health care more affordable by providing insurance coverage to those who are currently uninsured. The law allows those uninsured to receive a copayment or coinsurance rate that allows them to partially pay the full price of a physician visit, hospital stay, or prescription drug. This way, people who struggle

with the total cost of a medical visit will receive assistance for their medical bills, allowing them to get the care they need.

Additionally, in 2014, people with preexisting health conditions could no longer be denied coverage based on preexisting health conditions. In the past, individuals suffering from chronic or debilitating medical conditions were often prevented from obtaining coverage. However, with the ACA, these individuals could receive the medical care they need as insurance companies cannot limit benefits for their condition or refuse to cover treatment for their pre-existing condition.

Prescription drugs cost less, as the ACA aimed to make prescription drugs more affordable for everyone. Before the ACA, many people, particularly senior citizens, could not afford all their medications. However, according to the Centers for Medicare and Medicaid Services press release in 2017, over $26.8 billion was saved by Medicare beneficiaries for prescription drugs under Obamacare. With the ACA enacted, the number of prescription and generic drugs covered by the ACA is growing every year. This will assist those who need these medications but have financial difficulties as it helps pay for prescription drugs and medications.

Through the ACA, a specific program, the Pregnancy Assistance Fund Program (PAF), was also started lasting ten years from 2009 to 2019. This program aimed to benefit those who were either expectant or parenting individuals by having a $25 million per year competitive grant program for states.

The Office of Population Affairs, which was in charge of this program, funded 32 states, and the funds were used to “establish, maintain, or operate expectant and parenting student services in high schools, community service centers, and/or institutions of higher education, improve services for pregnant women who are victims of domestic violence, [as well as] increase

public awareness and education concerning the services available" ("About the Pregnancy Assistance Fund Program," 2019).

Through this program, around 110,000 expectant and parenting families and individuals could receive various services that assist them. Through data analysis, participants in this program encountered many positive outcomes, such as "reductions in dropping out of high school, improvements in high school graduation, acceptance into institutions of higher education, and reductions in subsequent unintended pregnancies" ("About the Pregnancy Assistance Fund Program," 2019). Despite the positive outcomes, the ACA has been highly controversial, as many object to the increase in tax and higher insurance premiums needed to be paid to support Obamacare.

Affordable Care Act Cons. The ACA went a long way in providing access to health insurance for many Americans, but there are still significant issues with its practical application. With the ACA, America has seen an across-the-board increase in policy premiums and the amount one pays for health insurance every month. Insurance companies providing a more comprehensive range of benefits and covering people with preexisting conditions have caused premiums to rise for everyone, including those who received health insurance benefits under traditional channels (employer-sponsored policies).

Additionally, taxes are increasing due to the ACA. Tax increase mainly affects those with higher income as their taxes are increased to cover the costs associated with these expanded benefits. Furthermore, several new taxes were passed to help pay for the ACA. In order to raise revenue, the ACA created many new taxes on health insurers, pharmaceutical companies, and manufacturers of medical devices, including new taxes on medical devices and pharmaceutical sales. Over ten years, it is estimated that taxes will rise by $813 billion due to the ACA.

Coverage Expansion

Despite the recent advancements in health insurance policy, many Americans still found themselves with a "coverage gap" in health insurance coverage. These individuals earn too much to qualify for Medicaid but not enough for Marketplace premium tax credits available to individuals through the ACA. ("Questions and Answers on the Premium Tax Credit," 2022). This gap made both programs, ACA and Medicare, essentially useless to a large portion of the American population.

The Affordable Care Act's Medicaid expansion, a plan adopted by 40 states and Washington, D.C., allowed Medicaid coverage to expand to nearly all adults with "incomes up to 138% of the Federal Poverty Level ($20,120 for an individual in 2023)" ("Status of State Medicaid Expansion Decisions," 2023). Due to Medicaid expansion, more than two million people, mainly from underserved communities, gained coverage. This proved to be a huge step towards reducing the uninsured as this expansion allows many more people to gain coverage, especially those who struggle with "coverage gaps."

Many U.S. Residents Remain Uninsured

Despite the legislation of insurance coverage opportunities such as Medicaid, Medicare, the ACA, and the Medicare expansion plan, many Americans remain uninsured. Before the enactment of Medicare and Medicaid, more than 34 million people (about 13 percent of the population) remained uninsured. Unexpectedly, the numbers grew over the next ten years. In 2006, 47 million Americans (15.8 percent of the population) were uninsured, while in 2010, this number rose to around 16 percent of the entire population.

The number of uninsured nonelderly individuals dropped from 46.5 million in 2010 to 26.7 million in 2016. Most of the coverage gains "were larger among nonelderly Hispanics,

Asians, low-income individuals, and those in working families" (Tolbert et al., 2023). Although there have been significant improvements in America's effort to reduce the number of uninsured individuals, as of 2021, 27.5 million people remain without health care coverage. This number is still too many.

Wealth Disparities Create a "Coverage Gap." One of many reasons people remain uninsured is that there continue to be "families who made too much money to qualify for Medicaid but not enough money to purchase health insurance" (Lichtenstein, 2023). Those individuals would then fall into the aforementioned "coverage gap," which puts them in a difficult situation as they cannot receive benefits from Medicaid or other health insurance.

Reduction in Employment-related Insurance Benefits.

One of the reasons many individuals find themselves in this coverage gap is that while gainfully employed, they do not have access to coverage because not all employers offer health insurance coverage.

In 2021, around 64.4% of uninsured workers were either working for an employer that did not offer health benefits or for an employer that offered coverage at a high cost. Some remain in states that did not expand Medicaid as it varies across states.

Implications of being Uninsured. Individuals without insurance coverage have worse access to care than insured people. Studies repeatedly demonstrate that "uninsured people are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases" (Tolbert et al., 2023). In 2021, nearly half of the nonelderly uninsured individuals had not seen a doctor or health care professional in the past 12 months, while only 18.2% with private insurance and 13.1% with public coverage had gone without medical treatment in that year, as seen in the figure above.

For nonelderly adults without coverage aid, around 21% of them said that they went without necessary care in the past year because of the cost. In comparison, only 5% of individuals with private coverage and 6.1% with public coverage faced this problem. Uninsured face many barriers to healthcare due to the lack of coverage.

Uninsured individuals are likelier than those insured to lack confidence in their ability to afford medical costs and significant medical expenses or emergencies. 75% of uninsured nonelderly adults say they are very or somewhat worried about paying medical bills if they get sick or have an accident, while only 45.9% of adults with Medicaid/other public insurance and 44.3% of privately insured adults are concerned about being able to afford health-related issues. Because of their lack of coverage, the uninsured are "more likely to face negative consequences due to medical bills, such as using up savings, having difficulty paying for necessities, borrowing money, or having medical bills sent to collections resulting in medical debt" (Tolbert et al., 2023).

Big Pharma's Effect on Healthcare Policy

With the United States spending 4.3 trillion dollars on healthcare, it is understandable to wonder where the money is going (Peter G. Peterson Foundation, 2023). In searching for an answer, one simply needs to look at the relationship between the pharmaceutical industry, the government, and the agencies responsible for health.

Divergence from the "Ideal" Market

The principle of neoclassical economics is simple. In an ideal market, production and pricing are based on three main factors: consumer demand, costs of production, and competition (Heled et al., 2020). This creates an efficient market with power checks, preventing any variable from becoming too powerful. For example, prices must be raised at a reasonable rate so that

goods and products will reflect their actual value, allowing the provider to make a profit and continue manufacturing a good that the consumer desires; however, with the healthcare market, this is different.

Healthcare is in the unknown, yet pricey. It is difficult to predict when one will need healthcare, but when needed, it can cost thousands of dollars, so insurance is necessary. This causes a considerable divergence from the neoclassical market as patients are not "informed consumers." All they know is that this product can save their life. So, the free, educated choice is replaced with necessity, preventing regulation through checks and balances (Krugman, 2009).

Additionally, healthcare is not like typical consumer products. There are no deals, no coupons, and no sales. What is being sold and bought is health (Krugman, 2009). In a utopia, ethics would be enough to stop exploitation; however, in a pragmatic setting, regulation is a requirement and expected from the government. However, regulation, due to lobbying and special interest groups, is failing at managing quality and supporting pharmaceutical companies.

Influencing Policy

Lobbying. Lobbying is a long-accepted political mechanism that allows private entities to influence public policy. Some find it a necessary and effective part of our political process, while others find it an underhanded way to manipulate policy formation. Regardless of which perspective one subscribes to, it is hard to argue that the pharmaceutical industry uses lobbying often and effectively.

From 1999 to 2018, the pharmaceutical and health product industry accounted for the highest percentage (7.3%) of money spent on lobbying Congress and federal agencies (Wouters, 2020). This money is intended to benefit the pharmaceutical industry - and to influence public

policy in their favor. This connection between the pharmaceutical industry's lobbying and political involvement is undeniable.

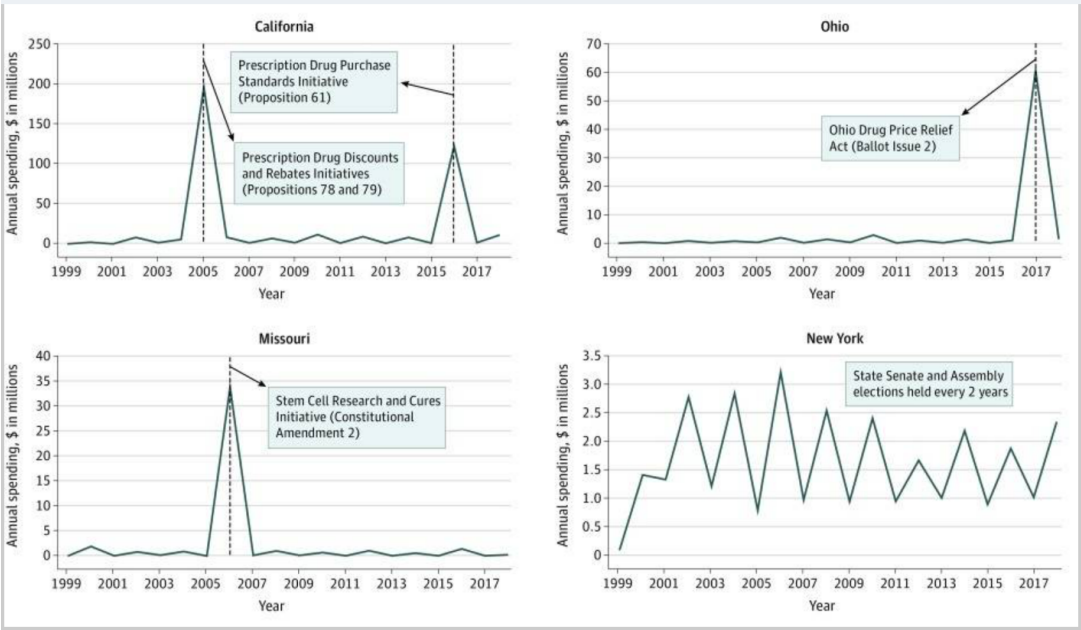
Campaign Influence. In addition to lobbying, pharmaceutical companies use two other key tactics to influence policy and public opinion: public relations and campaign spending (Citizens for Ethics, 2018). Campaign spending differs from lobbying in that it is intended to influence and support a government official and their legislative work.

Federal Campaign Finance. The 2016 federal elections focused on healthcare and drug pricing as 67% of voters indicated healthcare law and policy is "very important" to their vote, with 51% believing prescription drug pricing to be critical. These statistics indicate people wanted change and regulation to the unpredictable drug pricing (Kirzinger et al., 2016).

During these elections, over $16 million was "donated" to 399 members of the House of Representatives (Open Secrets, n.d.). From 1999-2018, the pharmaceutical and health product industry donated over $400 million to federal election campaigns, political action committees, and similar politically affiliated organizations (Wouters, 2020). As both Republicans and Democrats considered drug pricing a priority in this election, support was generally equal between the two. While it is neither illegal nor unethical for companies to make political donations, the timing of these donations is not coincidental.

State Elections. This influence is also seen at the state level - following state legislative measures in the pharmaceutical industry. For example, "contributions in California followed cyclical patterns, reflecting the timing of legislative elections. Of the $74 million donated in Ohio, $61 million (82.4%) was spent in 2017, the year of a ballot measure to lower prescription drug costs, which was voted down. Of the $43 million donated in Missouri, $34 million (79.1%)

was spent in 2006, the year of a ballot measure on the legality of stem cell research, which was passed (Wouters, 2020).



Source: (Wouters, 2020)

Impact on Policy. The timing and size of these donations indicate how lobbying and campaign contributions, though legal, are being used to influence major decisions. This ability to influence the government goes further than campaigns or public opinion. Governments become stuck between following public needs or focusing on pharmaceutical interests. Any legislature or measures they attempt to take can be counteracted by donations and lobbying influence (Wouters, 2020). This can start to affect public health through agencies, as well.

Pressure on the Food and Drug Administration

The Food and Drug Administration is the American government's chief pharmaceutical regulatory agency tasked with assuring the safety and security of drug manufacture and sale. However, despite its important role, it is not insulated against all influence, including that from both outside and inside the bureaucratic infrastructure.

The Case of DSUVIA. Amid the opioid crisis in 2018, the Food and Drug Administration (FDA) approved DSUVIA, a sublingual form of sufentanil, a synthetic analog to fentanyl, created by AcelRX Pharmaceuticals. DSUVIA is ten times as potent as fentanyl, which, along with other opioids, was responsible for 72,000 American deaths in 2017 (Eck, 2018). Four United States senators pleaded for the FDA not to approve DSUVIA (United States Senate, 2018); however, their pleas were unheeded.

The FDA Commissioner responded, "There are very tight restrictions being placed on the distribution and use of this product. We have learned much from the harmful impact that other oral opioid products can have in the context of the opioid crisis…The FDA will continue to carefully monitor the implementation of the REMS associated with Dsuvi…" (Food and Drug Administration, 2018).

The strict FDA guidelines for this drug and its potential for wounded soldiers on the battlefield seemed to placate many. However, investigations into DSUVIA funding and approval show a more significant problem.

AcelRX's DSUVIA research and development was funded heavily by the Department of Defense. "On May 11, 2015, the Company entered into an award contract (referred to as the DoD Contract) supported by the Clinical and Rehabilitative Medicine Research Program, or CRMRP, of the United States Army Medical Research and Materiel Command, or the USAMRMC, within the U.S. Department of Defense, or the DoD, in which the DoD agreed to provide up to $17.0 million to the Company in order to support the development of DSUVIA…" (*Acrx20171231_10k.htm*, n.d.). This connection between the DoD and the drug manufacturer clearly opens up an opportunity for skepticism when evaluating the independence of the FDA's review process.

DSUVIA also skipped the Drug Safety and Risk Management Advisory Committee's review, which is standard for drugs with the harmful potential DSUVIA had. Dr. Raeford Brown, chair of one of the FDA's advisory committees and an anesthesiology professor at the University of Kentucky, said, "I predict that we will encounter diversion, abuse, and death within the early months of its availability on the market" (Goodnough, 2018). However, despite all the backlash and insufficient evidence, DSUVIA was approved.

The FBI also took an interest in DSUVIA, claiming it was likely that DSUVIA would exacerbate the opioid crisis. In an intelligence bulletin, the FBI stated, "because of its potency, DSUVIA likely will cause deaths at a rate surpassing that associated with fentanyl, increasing the overall opioid-related death rate in the near term" (Correa, 2020).

Despite its originally stated military applications, AcelRx began to target civilian markets and hospitals. Although DSUVIA misuse has been relatively low, the COVID-19 pandemic has made it necessary for hospitals to stock more drugs to help incubate patients. This application could increase DSUVIA use in the coming years, escalating the risk of abuse and overdose as well (Correa, 2020).

Additional Examples of Influence. Similar cases have been increasing. For nearly 40 years, pharmaceutical drug approval and regulation processes have become increasingly complex and interconnected. "The FDA has increasingly accepted less data and more surrogate measures and has shortened its review times" (Darrow et al., 2020). Other studies have found that the FDA has been listening to less and less evidence and advisors. Though the FDA does not require advisor support to approve a product, it has often been one of the FDA's most vital points: showing they put science above all else (Lurie & Wolfe, 1998).

Lower Standards & Speedier Approvals

19 of the 53 professionals responsible for reviewing and approving drug applications said that half of the new drugs they reviewed in the past three years should not have been approved but approved (Lurie & Wolfe, 1998). Additionally, when asked how they would compare the current standards of FDA review for safety and efficacy to those in existence prior to 1995, 17 Medical Officers described the current standards as "lower" or "much lower," while 13 described them as "about the same." Only six described them as "higher." None described the standards as "much higher" (Lurie & Wolfe, 1998).

Conclusions from the Public Citizen study found that "Inappropriate pressure from Congress, the drug companies, and senior FDA employees create an atmosphere in which the likelihood of drug approval is maximized. The pressure takes the form of inappropriate phone calls, pressure to withhold data or personal opinions unfavorable to a drug from FDA Advisory Committees, and pressure from supervisors to change their opinion in the direction of approving the drug" (Lurie & Wolfe, 1998). Legislation passed by Congress puts immense pressure on the FDA.

According to Sydney Lupkin of NPR, "Faster approval was the goal of many legislative and regulatory changes starting in the 1980s. For instance, in 1983, Congress passed the Orphan Drug Act to encourage drugmakers to develop rare disease treatments that otherwise might not be profitable. The FDA allowed approval for these drugs based on smaller trials with more flexible evidence standards, and it offered more time on the market for the medicines without generic competition" (Lupkin, 2019).

Pharmaceutical influence on Congress certainly has an influence on such legislature, pressuring the FDA for faster results. However, the failing quality of the product review and approval process creates more problems than solutions. According to the New York Times, "Dr.

Resha Ramachandran, co-director of the Yale Collaboration for Research Integrity and Transparency, said that doctors were not trained to sift through F.D.A. records to scrutinize the quality of the studies that led to approvals. Nor do many recognize the pressure the drug industry exerts on the F.D.A. to meet approval decision deadlines" (Jewett, 2022).

Solving Legal & Political Impediments

Addressing disparities in healthcare equity is necessary to improve the nation's overall health and prosperity. The federal government "identified health equity as a priority and has since launched initiatives to address disparities…[and] alongside the federal government, states, local communities, private organizations, and providers have engaged in efforts to reduce health disparities" (Ndugga & Artiga, 2023). Thus, many steps and actions must be taken.

Closing the "Gaps"

A possible step toward achieving more equitable health outcomes would be expanding Medicaid to other states. This will benefit those in "coverage gaps" as it would further increase eligibility for coverage among the remaining uninsured for all groups. States, such as Wyoming, Kansas, Texas, Wisconsin, Tennessee, Mississippi, Alabama, Georgia, South Carolina, and Florida, did not allow the expansion of Medicaid, which puts over 2.1 million people in the "coverage gap," contributing to the number of uninsured.

One main obstacle for these states to expand Medicaid is that many Republican lawmakers at the state level argue "that the Medicaid expansion is an overstep of the federal government, criticizing the amount of spending the government is doing rather than letting private insurers navigate the market themselves" (Neukam, 2023). However, these states should be reminded of the importance of allowing low-income individuals suffering from "coverage gaps" to receive insurance to ensure healthy individuals throughout America. Without action

from the governmental level, not much can be done for all individuals falling into “coverage gaps.” Allowing private insurers to navigate the market themselves will not ensure that those currently uninsured will be assisted with coverage and receive the healthcare that they deserve.

Medicaid Enrollment Education

It is essential to increase coverage to narrow disparities by enrolling people eligible for Medicaid coverage; these opportunities would further increase if additional states adopted Medicaid expansion. As of today, “The American Rescue Plan Act of 2021 encourages non-expansion states to take up the expansion by providing an additional temporary fiscal incentive for states to newly implement the ACA Medicaid expansion” (Rudowitz et al., 2021).

Since most uninsured people are eligible for Medicaid coverage, outreach, and enrollment efforts could increase coverage and reduce coverage disparities. Luckily, this step is already in action as the Biden Administration "increased funding for Navigators for the 2022 Open Enrollment Period to assist with outreach and enrollment efforts, contributing to record levels of Marketplace enrollment in 2022, and has made an additional investment of $98.9 million in Navigator funding for the 2023 Open Enrollment Period" (Artiga et al., 2023). When preventing people from receiving coverage losses and closing remaining gaps in coverage, which could be achieved through Medicaid expansion, long-standing health disparities are being addressed.

Balancing Private and Public Interests with Regard to Big Pharma

While it is clear that there is a delicate balance that needs to be stuck when it comes to managing the relationship between Big Pharma and the government, it is important to note that there is no “bad guy” in this scenario. Painting the pharmaceutical companies as a villain and calling for an industry upheaval is not the answer. In 2020, the pharmaceutical industry had a 538,000

workplace population with an average salary of $110,000 (Data USA, 2023). It is not reasonable to expect such pharma companies not to find any way they can to make a profit: it is an industry that provides dinner to hundreds of thousands of people and has created so many advancements.

The answer is not to limit pharmaceutical companies and keep them contained through more policies. What needs to be focused on is using policy efficiently so pharmaceutical companies do not have to use "legal loopholes" to keep themselves in business, make a profit, and provide jobs. Policy needs to support the pharmaceutical industry and maintain public health at the same time.

The proposed solution is a simple yet necessary one. Before creating more laws or acts that can be exploited again, looking at existing legislation to determine its efficacy is essential. For example, there are provisions related to affordable drug pricing and commercialization of drugs in the legislature already, but they are underutilized (Heled et al., 2020). If there are already laws to fix current issues, it is essential to ask why they are already not working.

Public policy experts are trained and educated to be able to find these issues. They, however, also remain underutilized. They are resources that must be implemented so they can delve into public policy and determine which aspects can be changed - and how. For example, the Center for Health Policy at Brookings discusses changes to be made in public policy - and the steps to be taken to get there. A seminal report published by Brookings ("Bending the Curve"), which focused on high healthcare costs and issued recommendations to fix this, has influenced high-level policymakers and stakeholders in their reform work (Brookings, n.d.). Other organizations, including the Kaiser Family Foundation (KFF) and the Economic Policy Institute, have recently influenced healthcare public policy.

While these solutions cannot be easily or quickly done, federal and state policymakers have several options to help millions of people keep or gain coverage, increasing opportunities for everyone to live the healthiest life possible, no matter who we are, where we live, or how much money we make; the core of health equity. Focusing on facts over fallacies and prioritizing policies over politics, the government's mission for secure public health will be achieved.

Policy Recommendation Summation

These suggessted measures aim to mitigate, control, and, in the long term, significantly reduce health inequity.

Patient-based Care

By prioritizing patient-based care, we can improve patient satisfaction and health outcomes - improving patient's healthcare and treatment as a whole. Healthcare workers may also experience less burnout as they have increased job satisfaction through building meaningful connections with their patients. Achieving patient-centric care can be done by improving worker's training, following a holistic or more comprehensive approach, and allowing for easier and more feedback.

Another possible way to move from profit-centric care to patient-focused care is industry standardization. Universal processes for electronic records, handling payments, and managing claims should significantly improve the industry and reduce expenses, alleviating the burden placed on healthcare officials.

Improve Health Literacy & Infrastructure

From a social perspective, steps can be taken to prioritize healthcare, mitigate inequality in necessary resources, and prevent social stigmatization of mental health. Social issues can be greatly reduced by increasing health literacy. Adding to or developing a health education

curriculum can help educate a new generation, as well as adults and older persons. Reducing toxic workplaces and mandating paid sick leave can help people prioritize their own healthcare and accept help when they need it. In the long term, this can prevent serious health effects.

Food desserts and pharmacy shortages can be stopped through community action or local policy. Education of nutrition, establishment of healthy food options, and online orders can help improve community resources and information. Green spaces have a significant impact on a person's health.

Mental health stigmas can be greatly reduced or even removed entirely with improved media representation and heightened public awareness. These actions can have a great impact on social health in the present and long-term future.

Revisit Existing Policy

Legal and political measures can be long-lasting and extremely beneficial if implemented in a correct manner. Expansion of Medicaid and removing coverage gaps can help ensure better care for all. Governmental actions are necessary to be able to solve the issue of coverage gaps. Increasing education about Medicare and Medicaid can help individuals know if they are eligible - significantly decreasing the possibility of financial strain they may have in relation to their healthcare.

Additionally, analyzing existing policies to determine what is effective and what is ineffective can create better policies in the future. Federal and state lawmakers often have tremendous power in what their policies are capable of. This power should be implemented towards managing public - and private - interests and to ensure that the focus remains on facts. If these measures are taken into practice, health inequality may not become such a significant issue in upcoming years.

Conclusion

Overall, there are many economic, social, and political impediments in the American healthcare system that affect patients' ability to gain access to care. By creating a healthcare system that focuses more on profits than patients, American society suffers from healthcare worker burnout, high drug prices, and bloated administrative costs. By failing to prioritize healthcare prioritization and perpetuating biases and stigmas, society further complicates the issue. Even our existing healthcare policy fails to create a system in which health equity is an achievable goal because existing social programs and legislation are insufficient or inadequate. If America is ever going to provide equitable access to healthcare for all, it must work to address and eliminate not one, but all of these impediments.

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