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An Analysis of Income and Healthcare Disparities Across Minority Populations by Incorporating Community Resource Collaboration in Public Policy

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AN ANALYSIS OF INCOME AND HEALTHCARE DISPARITIES ACROSS MINORITY POPULATIONS BY INCORPORATING COMMUNITY RESOURCE COLLABORATION IN PUBLIC POLICY

A Thesis

by

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ABSTRACT

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There is widespread literature on the connection between public policy, resource allocation, and income and health inequalities among minority communities. While various services are created to help communities, the distribution and allocation of these services remain elusive, without any collaboration towards a common objective among public policy leaders. This paper investigates the disparities in the access to healthcare within Florida, a state selected because of its documented problems with healthcare access. This thesis research analyzes the income and health inequalities in minority populations in Florida by integrating community resource collaboration into public policy. The study used secondary data from public health sources within the state. Key socioeconomic factors that affect healthcare access were examined using mixed methods approach. The study's findings reveal that healthcare insurance, work status, language, income, education, and race are barriers to healthcare in Florida. The study also recommends various solutions, including access to high-quality education and spending-based programs.

Keywords: Income, healthcare, Florida, disparities

DEDICATION

This paper is dedicated to the department of Public Affairs & Security Studies at The University of Texas Rio Grande Valley, Texas.

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CHAPTER I

INTRODUCTION

Overview

The relationship between public policy, resource allocation, and income and health disparities is well-cited within the current literature (Balakrishnan et al., 2017; Christy et al., 2017). Yet, while diverse services have been developed and implemented to improve the conditions leading to these disparities, there remains a division as to how the services are defined and allocated. Public policy leaders are then left to focus on individual missions within each available sector and organization rather than promoting collaboration towards the common goal. Health policy in Florida—a state selected for analysis because of its documented (Florida Department of Health, 2022a, 2022b) problems with healthcare access for minorities remains unspecified relating to minority health initiatives. On July 1, 2021, House Bill CS/HB 183 required that the Office of Minority Health and Health Equity develop statewide implementation of policies and programs to address these disparities. However, specification is not evident in the language, leaving the assigned role of health liaison without designation. Furthermore, as factors contributing to these disparities are not directly identified in the legislation, efforts to address minority health needs remain limited.

Some of the key socioeconomic factors that contribute to disparities in healthcare and healthcare outcomes include education, life skills, and healthcare access (Christy et al., 2017). Given the significance of collaboration on improvements to meet the needs of the most relating

to the provision of education, life skills, and healthcare access to reduce the health disparities among the minority populations in the state of Florida. Florida is not only a destination for retirees, but also has strong representation by various Latino groups and other minority populations (Mallet & Pinto-Coelho, 2018). In Florida, Hispanics and Latinos comprise 26% of the population while Black American comprise 17% (U.S. Census Bureau, 2021). Florida ranks 48th among U.S. states in access to healthcare (Common Wealth Fund, 2021). Disparities in healthcare access based on race and ethnicity are 3% higher in Florida than the national average, suggesting a disparity in healthcare outcomes and access to healthcare for racial and ethnic minorities in Florida (Common Wealth Fund, 2021).

Definition of Terms

Collaboration: The coordination of activities and negotiation of terms by two or more groups with diverse interests. (Butcher & Gilchrist, 2020).

Community resources: The assets within a community that are available to meet the identified needs of the population. (Cu et al., 2021).

Health disparities: The preventable differences in the total burden of injury, disease, violence, and opportunity to have optimal health. (Christy et al., 2017).

Health literacy: Having relevant knowledge related to health issues, self-care, and care-seeking (Christy et al., 2017).

Healthcare barriers: Any factor (such as lack of income) that limit the capacity or opportunity for an individual or family to receive or pay for healthcare. (Chauhan et al., 2020).

Healthcare: The provision of treatment for disease, injury, or impairment. (Purnell et al., 2016).

Income: The total consistent net revenue generated by an individual or family. (Purnell et al., 2016).

Minority populations: Any group that has less than 50% representation in a population based on a specific recognized characteristic such as race or ethnicity. (Shepherd et al., 2018).

Policy initiatives: Plans of actions for facilitating specific changes or accomplishing specific goals. (Thornton et al., 2017).

Public policy: The set of policy initiatives established in a jurisdiction such as a single U.S. state. (Thornton et al., 2017).

Skill: The capacities to attain viable employment. (Lenihan et al., 2019).

Socioeconomic factors: Lifestyle components and determinants of financial viability and the recognized social standing in a community or group. (Christy et al., 2017).

Research Questions and Objectives

The research study will be driven by the following research questions:

RQ1: What are the key barriers to access to adequate healthcare among minority communities in Florida?

HI_0: Socioeconomic factors significantly contribute to barriers in accessing adequate healthcare among minority communities in Florida.

HI_A: Socioeconomic factors do not significantly contribute to barriers in accessing adequate healthcare among minority communities in Florida.

RQ2: What key policy initiatives have been developed to improve access to healthcare among minority communities in Florida?

The primary objectives of this study are as follows:

To determine whether education, skill, and income levels significantly impact healthcare access among the minority populations in the state of Florida.

To survey current practices and initiatives addressing the health disparities and healthcare barriers among the minority populations in the state of Florida.

To establish clear recommendations as to how to inform public policy on the collaboration of services to promote healthcare access equality by addressing education, skills development, and health literacy (see definition above).

Statement of the Problem

The problem that the current study aims to address is the clear disparities in the access to healthcare in Florida, a state selected for analysis because of its documented (Florida Department of Health, 2022a, 2022b) problems with healthcare access for minorities. Given the overrepresentation of the elderly in Florida, the state has very high Medicare costs per resident (Common Wealth Fund, 2021). With such a high number of elderly residents in Florida, the state has not maintained sufficient funding for healthcare including Medicare (Common Wealth Fund, 2021). For minorities in the state, worsened healthcare outcomes may be contributed to by Florida's lack of responsiveness to the high healthcare costs within the state. Currently, minority populations face greater barriers in the access to healthcare in the state. The existing public policy has not sufficiently addressed such barriers. Instead, such a policy has had broad goals for improving healthcare access in Florida with limited results.

Some examples of barriers to healthcare access are as follows. Low education can mean that people are unaware of the need to seek healthcare for specific ailments (Cu et al., 2021). Low life skills can mean that people do not know how to manage their health care in a manner that prompts them to seek treatment (Christy et al., 2017). Finally, low access to healthcare

means that people cannot visit emergency rooms or other treatment settings, whether because of the lack of insurance, no ability to pay out of pocket, or similar factors (Florida Health., 2021).

In the past few decades, Florida has not passed significant legislation to address any of the individual barriers of healthcare access (see the methodology section for a discussion of these barriers, which are treated as independent variables, and for healthcare access, which is treated as the dependent variable) that are particularly impactful for minorities in the state (Phillips, 2020; Phillips, 2021; Phillips, 2022). Increasing health disparities among minorities in Florida is partially caused by decreased access to healthcare for such minorities within the state (Melix et al., 2020). In response, Florida has launched initiatives such as (a) Closing the Gap Grant, (b) Minority Health Liaisons, and (c) Body and Soul Toolkit.

Under this topic of inquiry, the researcher will investigate the relationships between minority status, income, education, and healthcare access disparities. Florida ranks 44th among U.S. states in income disparity as a contributor to worsened healthcare outcomes (Common Wealth Fund, 2021). The poverty rate in Florida is 9.2% for Whites, 19.8% for Blacks, and 15.7% for Hispanics (Kaiser Family Foundation, 2021). The distribution of Medicaid is lowest among Blacks in Florida with less than 25% of Black Floridians on Medicaid (Kaiser Family Foundation, 2021). Ethnic and racial minorities in Florida have a significantly higher infant mortality weight and lower birth weight (Florida Health, 2021). Meanwhile, white Floridians are more than 10% more likely to have active health insurance than racial minorities in Florida (Kaiser Family Foundation, 2021). White Floridians are more than 70% more likely to receive a college education compared to Black Floridians (Kaiser Family Foundation, 2021). White Floridians are 60% more likely to receive a college education compared to Hispanic Floridians (Kaiser Family Foundation, 2021). The level of education may help explain as much

as 10% of the low rate of health insurance among Black and Hispanic Floridians (Kaiser Family Foundation, 2021). Each potential source of barriers of healthcare access will be analyzed independently and all sources collectively analyzed to identify potential patterns between the various factors that are limiting the access of minorities to healthcare in Florida. The goal is to establish an improved understanding of such relationships in order to inform public policy on how to best address the identified barriers of healthcare access most impacting minorities communities in Florida. The potential for collaboration will be identified to establish evidence-based solutions.

Significance of the Study

The current study is intended to identify the potential impact of a broad range of factors on those barriers that limit the access to healthcare by minorities in Florida. Prior research has identified a number of potential factors contributing to such barriers. Melix et al. (2020) found major income disparities within predominantly minority communities in Florida. Given the high population density in such communities, access to healthcare was found to be limited in part by the combination of high prices and low income. Chauhan et al. (2020) and Vickers et al. (2017) identified cultural factors that may be limiting the access of minorities to healthcare in Florida, while Hazelkorn and Gibson (2019) demonstrated how language barriers may also deter minorities from receiving healthcare. Rosano et al. (2017) further found that low levels of education have restricted access to healthcare for many Floridians, especially in predominantly minority communities. Each factor individually contributes to barriers to accessing healthcare among minorities in Florida. However, addressing the broader issue of minorities having undesired healthcare outcomes because of the increased barriers to healthcare access must be addressed by addressing these factors collectively and through collaborative models that utilize

and coordinate various resources (Oviawe et al., 2017).The current study is significant within the field of public policy as the overutilization of emergency health services and the loss of productivity and dependency on public funds have a significant impact on the state of Florida's ability to meet the needs of the population. Collaboration approaches are widely identified within the field of public policy inquiries. Yet, collaboration is more often identified with independent services rather than a collective collaborative approach to address primary disparities within a targeted population. Although current aims in the legislation to address these disparities have focused on developing a health liaison, identifying factors associated with healthcare disparities will better specify the policies and programs that must be implemented statewide. By identifying the impacts of those factors on barriers to accessing healthcare for minorities in Florida and assessing the existing public policy efforts to address such barriers, an improved understanding can be developed for where the current public policy emphasis should be directed. It is not enough for public policy to broadly aim at increasing access to healthcare in predominantly minority communities. Such public policy should be informed by research at the nexus of those factors most impacting barriers of healthcare access for minorities in Florida and what steps can be taken to address each barrier through collaboration.

Overview of the Literature

Florida remains in the bottom three among U.S. states in access to healthcare (Common Wealth Fund, 2021). In addition, Florida ranks among the worst states in income disparities and rate of uninsured in the U.S. (Common Wealth Fund, 2021). According to Melix et al. (2020), income disparities are highly recognized among minority populations in the state of Florida. Many communities are densely populated with minorities in Florida. The researchers further note that health service distribution in these communities have been assessed through social

determinants of health to identify potential barriers and causal relationships. Within these relationships, minority status barriers, including language barriers and citizen status, are noted to significantly affect both health and income status (Melix et al., 2020). Cox and Kim (2018) explained that, as Florida has an increasing population of elderly minority individuals with low income and poor access to healthcare services, these conditions will have negative implications on the state's response efforts, increasing the cost of recovery in response to natural disasters.

However, despite the evidence that indicates improvements in these areas would reduce overall costs and improve quality of life in the community, the services available remain widely fragmented, creating greater disparities across the state. According to Butcher and Gilchrist (2020), while the term collaboration has become frequently cited in the literature relating to public policy, the application across government, public, and private sector services remains largely absent in practice. Vickers et al. (2017) noted that the challenge has been found in the lack of discussion as to how each organization serves not only its core mission but also the greater shared goals of service coordination. In other words, aligning the public-school sector with services intended to provide life skills to non-English speaking adults has yet to be achieved in the realm of public policy collaboration. Instead, what has occurred has been a competition for resources and a non-uniform approach to negotiating the context of the needs in the population (Hazelkorn & Gibson, 2019).

Within the discussion of the public's needs, Lenihan et al. (2019) explained that public policy efforts must address the investment in human capital as a means to reduce the costs associated with disparities in income and health. According to the researchers, such disparities have significant negative implications for the financial sustainability of all systems within the population that support the well-being and earnings opportunities. However, defining and

assessing the skills affecting these disparities necessitates collaboration and communication across community services to inform and be informed by public policy (Oviawe et al. 2017). In this sense, collaboration is defined as "a joint activity by two or more organizations intended to create public value by working together rather than separately. It is a governance strategy used to achieve direction, control, and coordination of individuals and organizations with varying degrees of autonomy to advance or pursue joint objectives" (Imperial et al., 2018, p. 1). Yet, according to Vangen (2017), coordinating these efforts can be complicated by the competing goals and organization based operational definitions assigned to the concepts within the shared goals.

Yet, the identification of these agencies or organizations must involve, not only shared goals, but also common factors. For instance, Goethe and Colina (2018) explained that minorities are less likely to pursue and attain a higher education level, especially in STEM careers that are higher wage earning, necessitating minority-specific education policies. Jones et al. (2019) emphasized the need for economic policies to address the income disparities in the minority communities, explaining that the conditions negatively affect all aspects of minority experiences. Assari (2018) brings these policy needs together by asserting that the relationship between education and income has implications for subjective health, beginning the discussion for collaborative approaches to addressing healthcare disparities in minority populations.

Foutz et al. (2017) explained that a significant concern among minority populations in the practice of postponing care due to a lack of healthcare coverage. Although the Affordable Care Act (ACA) has increased the number of adults who have healthcare coverage, Foutz et al. (2017) noted that among the populations that are least likely to attain health insurance are racial and ethnic minorities. As costs were indicated as a primary reason for not having coverage and a

significant portion of the uninsured being identified based on their immigration status, it becomes increasingly evident that there is a relationship between minority status, healthcare coverage, and income status.

Nagelhout et al. (2019) found that such relationships have significant implications for minority health as many factors affect the attainment of healthcare and health behaviors. More specifically, the researchers examined the relationship between social networks, income, and influences on health. They found that minorities in complex living conditions with a low income have a less dominant social network for promoting healthy behaviors, including seeking medical care. As preventative healthcare is a significant factor in saving health-related costs and improving overall health, social networks are essential to the health of this vulnerable population.

Similarly, there is evidence that education levels may serve as barriers to access to healthcare (Stepanikova & Oates, 2017). Education levels may affect the individual's access to health care based on their race. Often, racial minorities with health insurance coverage experience racial discrimination based on educational levels but seem to focus on the opposite opinions of education because of race (Stepanikova & Oates, 2017). Rosano et al. (2017) found significant variations in educational attainment among immigrants who face challenges in accessing healthcare due to multiple components aligned through current policies. A primary barrier relating to a low level of education is a lack of information being made available to the patients (Rosano et al., 2017). Research shows that low education levels and poor health literacy contribute to the barriers to healthcare access though there may be complex relationships between the three.

Research shows that cultural and social factors may also play essential roles in the income and healthcare disparities across Florida, contributing to additional barriers to healthcare access (Vickers et al., 2017). Vickers et al. (2017) identified specific challenges found in the lack of discussion on how each organization serves its core mission and the more critical shared goals of service coordination. For example, aligning the public-school sector with services intended to provide life skills to non-English speaking adults has yet to be achieved in public policy collaboration. Instead, the competition for resources and a non-uniform approach to negotiating the population's context have not been addressed (Hazelkorn & Gibson, 2019). To address cultural, social, and language barriers impacting healthcare access, the Floridian government must first identify such barriers and then create interventions to address them. There may be room for private organizations to provide unique services, such as bilingual health services, to those most in need of additional healthcare access. Butcher and Gilchrist (2020) identified potential pathways to relieve the existing healthcare inequities in Florida, specifically related to the state's income and racial gaps. The researchers propose a collaboration model that will connect those populations most vulnerable to adverse health outcomes to healthcare services through targeted input and associated interventions (Butcher & Gilchrist, 2020). Collaboration in this context has frequently become popular in the literature on public policy and how governments can address the identified income and racial gaps in healthcare access and coverage (Butcher & Gilchrist, 2020). Through targeted collaboration, interventions can be developed that are particularly suited to serve the unique needs of minority communities across Florida. Federal efforts would contribute further to the capacities of Floridian healthcare organizations to meet such diverse needs (Butcher & Gilchrist, 2020).

Lenihan et al. (2019) suggested that collaborative public policy efforts are most appropriate to address the investment in human capital to reduce the costs associated with disparities in income and health outcomes. Lenihan et al. (2019) found that the health disparities faced by individuals of low socioeconomic status may further contribute to financial hardships. Poor health outcomes have clear negative implications for the financial sustainability of individuals. This contributes to a cycle of poverty and poor health outcomes. In addition, poverty contributes to diminished access to health assessments and care. Such diminished access, then, contributes to worsened health outcomes, contributing further to continued poverty. The cycle continues, making it difficult for impoverished families to access healthcare (Lenihan et al., 2019). Public policy is needed to assist families in breaking free from this cycle. Such public policy may reflect increased access to healthcare services and financial assistance for families who cannot afford their medical bills and who may otherwise be without health insurance. Defining and assessing the skills affecting these disparities necessitates collaboration and communication across community services to inform and be informed by public policy (Oviawe et al., 2017). Collaboration in this context refers to those activities that reflect organizations and the public working together to generate strategies, coordinate resources, and advance measures to address recognized problems in the community. However, according to Vangen (2017), coordinating these efforts can be complicated by the competing goals and organization-based operational definitions assigned to the concepts within the shared goals. Various agencies and organizations will play a role in collaborative efforts to address the healthcare disparities plaguing minority communities, particularly in Florida. Identifying these agencies or organizations must involve shared goals and common factors. For instance, Goethe and Colina (2018) explained that minorities are less likely to pursue and attain a higher education level,

especially in STEM careers that are higher wage-earning, necessitating minority-specific education policies. The roles of race, education, and income create a complicated nexus that influences access to healthcare. Determining the best ways to address the various sources of health disparities across Florida requires collaboration between the public and organizations.

Methods

Due to the multiplicity of influences under investigation as having implications on the conditions of health disparities among the minority populations in the state of Florida, a secondary data analysis method has been determined as the most appropriate for the current study. According to Martins et al. (2018), this will allow the researcher to identify statistical data relating to the health disparities among the target population while also identifying current practices and utilization of available services to address the identified influences. Data will be collected through the Florida Department of Health which gathers data from various health organizations across the state to generate statistics on healthcare outcomes, demographics, and various other relevant factors. Demographic, income, and education levels will be identified among measurements of health outcomes, program utilization, and healthcare coverage. In addition, the implementation of House Bill CS/HB 183 will be assessed through the DOH documents required in the context of the bill. Exploring these findings through the context of collaboration theories will help the researcher to identify best practices and potentials for collaboration.

Chapter Summary

Chapter One has provided the preliminary details of the current study and justification through an overview of the available literature, including an identification of important barriers to healthcare. Chapter Two will provide a more detailed literature review as to the known

implications of education, skills development, and health literacy on health disparities among the minority populations in the state of Florida. Chapter Three will provide the details as to how the data is selected and analyzed to address the identified research questions. Chapter Four will detail the findings of this inquiry. Finally, Chapter Five will provide the responses to the research questions as well as recommendations for practice and continued research.

CHAPTER II

LITERATURE REVIEW

Introduction

The current chapter features a review of the current research on the nexus of income and health disparities across minority populations with a particular focus on Florida. There are various factors that influence the relationship between income and healthcare disparities. Most of such factors influence the access to healthcare in Florida. In general, low-income families are less likely to have access to healthcare because of a lack of health insurance and the belief that they will be unable to afford health insurance. As this review will demonstrate, language and cultural barriers, too, play significant roles in the diminution of access to healthcare among certain populations (Shepherd et al., 2018). Healthcare and help-seeking avoidance is also more common in minority populations because of the difficulties of patients finding cultural matches when considering whether to seek care (Chauhan et al., 2020). Further reluctance to seek care is present among minority populations because of distrust of medical professionals given the history of discrimination against minorities in the U.S. and the use of minority groups for experimentation. Cultural, social, and psychological factors may exacerbate the relationship between poverty and health outcomes in Florida. Given that there are high income disparities across Florida and concentrations of ethnic and racial minorities in impoverished communities in the state (Melix et al., 2020), increasing healthcare access to such populations is often viewed as a reasonable public policy goal. Nevertheless, discrimination within the political and healthcare

structures across Florida may continue to contribute to health gaps between populations in the state. The current chapter also covers the relationships between income, education, and health outcomes for different populations in the U.S. and in Florida specifically. In addition to the literature reviewed in this chapter providing a conceptual framework for understanding the issues to be investigated in future chapters, the current chapter identifies the existing gaps in the current state of research on this topic.

Minority Status and Barriers to Healthcare

A significant factor relating to the current inquiry is the relationship between minority status and barriers to healthcare. According to Alvidrez et al. (2019), the National Institute on Minority Health and Health Disparities (NIMHD) research framework identifies the complexities associated with minority status, including multiple domains and levels of influence. The authors further noted that determinants of health are considered through the socioecological model, identifying the policies ranging from immigration laws to environmental protection as contributing factors to minority health. Furthermore, Alvidrez et al. (2019) explained that contributors influence access to healthcare from the individual to macro levels, demonstrating the need to identify the policies that are most affecting the health outcomes and access to healthcare within this vulnerable population. Most significantly, this framework provides an understanding of how policies that might otherwise be dismissed in healthcare accessibility will lead to a more comprehensive approach to improving these outcomes.

Shepherd et al. (2018) explained that one such factor could be identified through the interpretation of healthcare safety policies that are not specifically developed or applied to meet the individual, intra-, and inter-ethnic variations. For instance, there is a lack of consistency as to how practitioners communicate information with ethnic minorities either due to bias or language

barriers (Shepherd et al., 2018). The researchers pointed out that physicians will give different information regarding pain medicines such as Tylenol to white patients compared to patients of color. These differences are embedded into practice, raising questions about the policies and regulations that determine the presentation of critical information and how this affects the trust relationship in a healthcare environment. According to Shepherd et al. (2018), Such safety concerns negatively affect health outcomes for ethnic minorities across healthcare platforms.

Chauhan et al. (2020) added to the discussion the considerations for cultural matching, or the ability to receive healthcare services from an individual from the same cultural background. When such a provider is not available, then the perception of the healthcare services was notably lower among ethnic minorities. However, Chauhan et al. (2020) further added that self-reports of racism were minimal among the participants in the study except for Native Americans, who reported more frequent occurrences. However, this was countered by a higher number of participants who reported having received poor treatment due to their cultural background, which could indicate variations in defining racism that do not include the context of culture (Chauhan et al., 2020). In other words, ethnic minorities recognize that they receive poorer treatment because of their cultural differences but do not equate this to the concepts of racism.

Cox and Kim (2018) found that Florida has an increasing population of minority elders with low income and poor access to healthcare services. Much of Florida's healthcare structures are intended to provide adequate access to care for the elderly. However, the discrepancies in the access of care for minority elderly patients suggest that such structures may be particularly suited for white Floridians rather than all Floridians. Such conditions have had negative implications on the state's response efforts to the care of minority elders in Florida (Cox & Kim, 2018).

The distrust of medical professionals in Florida is particularly high among minority elderly patients (Melix et al., 2020). The natural disasters that have impacted Florida in the past decade have also exposed the lack of equitable healthcare for the minority elderly patients (Cox & Kim, 2018). The state has also failed to adequately assess the access of healthcare between racial and ethnic groups within the state, which makes it particularly difficult for researchers to identify the primary causes of the inequitable health care received by minority populations in the state (Cox & Kim, 2018).

There is a clear need for improvements in the broad access to healthcare in Florida or more specific access to healthcare in minority communities, especially those with major elderly representation. A focus on such areas may reduce overall costs for healthcare in the state and may improve the quality of life in the community and specifically within communities that are predominantly ethnic and racial minorities. Currently, the healthcare services available to minorities in Florida remain largely fragmented and fail to address the diverse needs of such minority populations. After all, the bulk of research in healthcare and the medical industry more broadly has featured the overrepresentation of whites and the underrepresentation of minorities (Wasserman et al., 2019).

The result has been a healthcare structure and health assessments and treatments that are not particularly suited for minority communities (Wasserman et al., 2019). It is imperative, then, for Florida and the U.S. more broadly to focus research efforts on racial and ethnic minority populations. The existing structures are contributing to greater disparities across the state of Florida. Without a direct response to such disparities, the various gaps that have arisen will continue to spread (Wasserman et al., 2019). As mentioned above, distrust for healthcare organizations among minority populations has driven the divides in access to care further. Such

distrust has also decreased the participation of many minority groups in medical research, bolstering the existing structures that limit the capacities of healthcare to cater specifically to such minority groups (Wasserman et al., 2019). In Florida, new initiatives such as (a) Closing the Gap Grant, (b) Minority Health Liaisons, and (c) Body and Soul Toolkit are intended to address this issue (Florida Department of Health 2022a, 2022b).

Income Status and Barriers to Healthcare

Melix et al. (2020) found that income disparities within communities are prevalent in Florida. Minority communities in Florida are much more likely to be impoverished than predominantly white communities. Many communities within Florida are densely populated with high levels of poverty and strong representation of minorities (Melix et al., 2020). A major issue plaguing much of Florida is health service disparities. Most notably, health service distribution in Floridian communities has been assessed to be heavily unequal based on social determinants of health based on perceived barriers and causal relationships (Melix et al., 2020).

There is clear evidence that minority communities tend to have worse access to healthcare services either because of the high costs of such services or limited availability of such services within their communities. Minority status barriers also play contributing roles in limiting the access of minorities to healthcare services in Florida (Melix et al., 2020). For example, language barriers and citizen status have been found to significantly affect both health and income status (Melix et al., 2020). In addition, many minorities in Florida distrust healthcare professionals, contributing to additional barriers to access healthcare in the state (Melix et al., 2020). The evidence is clear that Florida has major problems in ensuring the state's minority populations have sufficient and equitable access to health care.

Foutz et al. (2017) explained that a significant concern among minority populations in the practice of postponing care due to a lack of healthcare coverage. Although the Affordable Care Act (ACA) has increased the number of adults who have healthcare coverage, Foutz et al. (2017) noted that among the populations that are least likely to attain health insurance are racial and ethnic minorities. The researchers further explained that 45% of those who do not have healthcare insurance stated that the costs were the primary reason they did not have coverage. Furthermore, "under current law, nearly half (47%) of the remaining uninsured are outside the reach of the ACA either because their state did not expand Medicaid, they are subject to immigrant eligibility restrictions, or their income makes them ineligible for financial assistance" (Foutz et al., 2017, p. 1). As costs were indicated as a primary reason for not having coverage and a significant portion of the uninsured being identified based on their immigration status, it becomes increasingly evident that there is a relationship between minority status, healthcare coverage, and income status.

Nagelhout et al. (2019) continued to explain that these relationships have significant implications for minority health as many factors affect the attainment of healthcare and health behaviors. More specifically, the researchers examined the relationship between social networks, income, and influences on health. They found that minorities in complex living conditions with a low income have a less dominant social network for promoting healthy behaviors, including seeking medical care. As preventative healthcare is a significant factor in saving health-related costs and improving overall health, social networks are essential to the health of this vulnerable population. Furthermore, within the context of multi-problem households, additional influences such as domestic violence, education levels, and income were considered, further substantiating

the assertion that multiple policies must be considered concerning the barriers to healthcare among minority populations.

Education Levels and Barriers to Healthcare

As earlier noted by Chauhan et al. (2020), perceived or actual discrimination in healthcare can significantly hinder healthcare-seeking behaviors among minorities. Stepanikova and Oates (2017) pointed out that another significant area of bias that occurs in the healthcare environment is related to the educational levels of the patients. The researchers explained that education levels have different effects on the individual's care based on their race. The researchers stated that "across racial groups, respondents who reported foregone medical care due to cost had a higher risk of perceived racial discrimination. Health insurance contributed to less perceived racial discrimination and more perceived privilege only among whites" (Stepanikova & Oates, 2017, p. 1). Interestingly, these findings demonstrated that even racial minorities with health insurance coverage experience racial discrimination based on educational levels but seem to focus on the opposite opinions of education based on whiteness.

On the other hand, Rosano et al. (2017) acknowledged the significant variations in educational attainment among immigrants who face challenges in accessing healthcare due to multiple components aligned through current policies. The researchers explained that a primary barrier relating to a low level of education is a lack of information being made available to the patients. Rosano et al. (2017) continued to explain that, because of this lack of information, "migrants encounter legal, financial, cultural, and geographical barriers to healthcare access including absence of health insurance coverage, linguistic and cultural problems, and lack of access to information (affecting the poorly educated and those with a poor health literacy) (p. 1). However, it is important to note that the authors differentiated between low education levels and

poor health literacy while maintaining that the relationship between the two cannot be dismissed when identifying or addressing barriers to healthcare among this population. While both Rosano et al. (2017) and Chauhan et al. (2020) recognized the relationship between discrimination and education, Rosano et al. (2017) noted the significance of discrimination in multiple areas that lead to the disparities in healthcare. The need for collaboration across multiple policy implications is further supported within the literature.

Cultural, Social, and Language Barriers to Healthcare

Cultural and social factors play clear roles in the income and healthcare disparities across Florida (Vickers et al., 2017). Vickers et al. (2017) identified specific challenges that had been found in the lack of discussion as to how each organization serves its core mission and the greater shared goals of service coordination. Aligning the public-school sector with services intended to provide life skills to non-English speaking adults has yet to be achieved in public policy collaboration. Rather, the competition for resources and a non-uniform approach to negotiating the context of the needs of the population (Hazelkorn & Gibson, 2019). To address cultural, social, and language barriers that are impacting access to healthcare, the Floridian government must first identify such barriers and then create interventions to address them. There may be room for private organizations to provide unique services, such as bilingual health services, to those populations most in-need of additional healthcare access.

Collaboration Models for Addressing Healthcare Disparities

Butcher and Gilchrist (2020) have identified a potential pathway to remedy the existing healthcare inequities in Florida, specifically as they relate to the income and racial gaps in the state. The researchers propose a collaboration model that will connect those populations most vulnerable to negative health outcomes to healthcare services through targeted input and

associated interventions (Butcher & Gilchrist, 2020). Collaboration in this context has become frequently popular in the literature relating to public policy and the ways in which governments can address the identified income and racial gaps in healthcare access and coverage (Butcher & Gilchrist, 2020). Through targeted collaboration, interventions can be developed that are particularly suited to serve the unique needs of minority communities across Florida. Federal efforts would contribute further to the capacities of Floridian healthcare organizations to meet such diverse needs (Butcher & Gilchrist, 2020).

Lenihan et al. (2019) suggested that collaborative public policy efforts are most appropriate to address the investment in human capital to reduce the costs associated with disparities in income and health outcomes. Lenihan et al. (2019) found that the health disparities faced by individuals of low socioeconomic status may further contribute to financial hardships. In fact, poor health outcomes have clear negative implications for the financial sustainability of individuals. This contributes to a cycle of poverty and poor health outcomes. Poverty contributes to diminished access to health assessments and care. Such diminished access, then, contributes to worsened health outcomes which can contribute further to continued poverty. The cycle continues, making it difficult for impoverished families to gain access to healthcare (Lenihan et al., 2019). Public policy is needed to assist families in breaking free from this cycle. Such public policy may reflect increased access to healthcare services, but also financial assistance for families who are unable to afford their medical bills and who may otherwise be without health insurance.

Defining and assessing the skills affecting these disparities necessitates collaboration and communication across community services to inform and be informed by public policy (Oviawe et al., 2017). Collaboration in this context refers to those activities that reflect organizations and

the public working together to generate strategies, coordinate resources, and advance measures to address recognized problems in the community. However, according to Vangen (2017), coordinating these efforts can be complicated by the competing goals and organization based operational definitions assigned to the concepts within the shared goals.

Various agencies and organizations will play a role in collaborative efforts to address the identified healthcare disparities plaguing minority communities in particular in Florida. The identification of these agencies or organizations must involve shared goals and common factors. For instance, Goethe and Colina (2018) explained that minorities are less likely to pursue and attain a higher education level, especially in STEM careers that are higher wage-earning, necessitating minority-specific education policies. The role of race, education, and income create a complicated nexus that influences access to healthcare. Determining the best ways to address the various sources of health disparities across Florida will itself require collaboration between the public and organizations.

Collaborative solutions should also reflect various economic and financial components. Economic growth in communities with high levels of poverty and poor access to healthcare can assist in improving access. Jones et al. (2019) identified the need for economic policies to address the income disparities in the minority communities, explaining that the conditions negatively affect all aspects of minority experiences. In particular, increased access to investment in communities that are predominantly minorities in Florida may help diminish those barriers impeding healthcare services.

Finally, collaborative solutions should reflect aspects of all of the recognized factors for diminished access to healthcare among the impoverished. Assari (2018) brings these policy needs together by asserting that the relationship between education and income has implications

for subjective health, beginning the discussion for collaborative approaches to addressing healthcare disparities in minority populations. Such collaborative approaches should be driven by the recognized needs of the community. These should reflect economic, educational, and other relevant factors that may influence the access to healthcare among those populations with the least access to healthcare in Florida.

Conclusion

The current chapter featured a review of the current research on the nexus of income and health disparities across minority populations with a particular focus on Florida. The discussion indicated that low-income families are less likely to have access to healthcare because of a lack of health insurance and the belief that they will be unable to afford health insurance. Language and cultural barriers also appeared to play significant roles in the diminution of access to healthcare among certain populations (Shepherd et al., 2018). Healthcare and help-seeking avoidance is also more common in minority populations because of the difficulties of patients finding cultural matches when considering whether to seek care (Chauhan et al., 2020). A method of testing these previous findings and theoretical expectations is described and defended in the next chapter.

CHAPTER III

METHODOLOGY

Introduction

This thesis used mixed methods data analysis to examine the income and healthcare disparities across minority populations in Florida. A diverse range of influences were investigated, as they all had significant implications on the conditions of health disparities within this population. Data were obtained from secondary sources. This is data that has been gathered by other researchers for different purposes; by using this existing data, researchers who may be limited in resources and/or time can still undertake studies, offering an alternative option (Johnston, 2014). In fact, this secondary data offers an empirical exercise, applying the same basic research principles as those studies that gather primary data, with a systematic research process being undertaken for the process of inquiry (Johnston, 2014).

An important consideration for this paper is what exactly "adequate healthcare" means. According to Article 25 of the Declaration of Human Rights (UDHR), everyone has the right to a standard of living adequate for the health and well-being of themselves and their families, which includes housing, clothing, food, and medical care (Human Rights Center, 2003). Furthermore, this article explains how states must act to guarantee all citizens have an adequate standard of living, as these services – including health care – represent vital aspects of a standard of living that is adequate for a person's ongoing health and well-being (Human Rights Center, 2003).

According to the Office of the High Commissioner for Human Rights (OHCHR, 2000), in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), the right to adequate health pertains to all people enjoying the highest attainable standard of physical and mental health. In fact, health is a fundamental human right that is indispensable for other human rights to be exercised, taking into consideration the person's biological and socio-economic preconditions as well as the available resources within the States when defining this "highest attainable standard of health" (OHCHR, 2000; World Health Organization [WHO], 2017). Nonetheless, this right to health refers to the right to enjoy numerous goods, services, facilities, and conditions that are needed for people to realize the highest attainable standard of health (OHCHR, 2000).

Research Questions and Hypotheses

When conducting research, the research method includes how researchers gather, analyze, and interpret the data (Creswell, 2009). Utilizing the secondary data analysis method, procedural and evaluative steps were followed, beginning first with developing the research questions; this enables both theoretical knowledge and conceptual skills to be applied to existing data, with the goal of answering these research questions (Johnston, 2014).

RQ1: What are the key barriers to access to adequate healthcare among minority communities in Florida?

HI_0: Socioeconomic factors significantly contribute to barriers in accessing adequate healthcare among minority communities in Florida.

HI_A: Socioeconomic factors do not significantly contribute to barriers in accessing adequate healthcare among minority communities in Florida.

RQ2: What key policy initiatives have been developed to improve access to healthcare among minority communities in Florida?

RQ1 is quantitative and is therefore associated with null and alternative hypotheses, as recommended by Creswell (2009). RQ2 is qualitative. The combination of quantitative and qualitative questions addresses the identified need to (a) determine whether socioeconomic factors significantly contribute to barriers in accessing adequate healthcare among minority communities in Florida (the quantitative objective); and (b) explore what is being done to improve access to healthcare among minority communities in Florida (the qualitative objective).

Data Collection

According to Creswell (2009), most research starts with an investigation to learn what is already known about a topic as well as what gaps in existing literature may exist. Data may already exist that can be employed to address the research questions (Johnston, 2014). Martins et al. (2018) recommends the use of governmental sources for finding secondary data, but only if these agencies are trustworthy and transparent. Additionally, private entities and agencies can be excellent sources of information, along with data acquired in private international projects (Martins et al., 2018). Another option is web scraping, which refers to an automated process where data is extracted from websites (Virgilito & Polidoro, 2017). Finally, many online journals accept researchers' uploaded databases along with supplementary materials, with many journals requiring authors to share these databases in an effort to promote transparency and trustworthiness (Martins et al., 2018).

In this study, all data were collected through the Florida Department of Health (FDOH), which gathers information from various health organizations across the state, using this data to

generate statistics on healthcare outcomes, demographics, and various other relevant factors. The variables of the study are as follows:

Dependent variable: Access to healthcare. This variable is at the continuous level of measurement and represents the number of times a person accessed inpatient or outpatient care in 2021.

Independent variable #1: Race. This variable is at the nominal level of measurement and was defined as 1 = white, 0 = minority.

Independent variable #2: Insurance. This variable is also at the nominal level of measurement and was coded as 1 = insured, 0 = uninsured.

Independent variable #3: Language. This variable is at the nominal level of measurement and was defined as 1 = English, 0 = any language other than English.

Independent variable #4: Work status. This variable is at the nominal level of measurement and was defined as 1 = employed full-time, 0 = not employed full-time. This variable was also taken as a proxy measurement of skill, data for which were not available in the dataset.

Independent variable #5: Education. This variable is at the nominal level of measurement and was defined as 1 = held a college degree, 0 = did not hold a college degree. This variable was also taken as a proxy measurement of skill, data for which were not available in the dataset.

Independent variable #6: Income. This variable is at the ordinal level of measurement and was defined as 1 = over $30,000 a year, 0 = $30,000 or below a year.

Data Evaluation

For managing this primary data, the secondary analyst researcher must acquire all documentation of the protocols and processes that were used by the primary researchers, which

should include the questionnaires, coding materials, and any publications related to the data (Boslaugh, 2007; Stewart & Kamins, 1993). The secondary researcher must also have access to the raw dataset, so they can perform new analyses (Boslaugh, 2007; Stewart & Kamins, 1993). Furthermore, it is important that the data that is gathered and analyzed helps develop the research's theory, answering the research questions; this includes determining if the assumptions from this data meet the research's intended conclusions (Martins et al., 2018). There should also be multiple sources of information, as this can strengthen the secondary researcher's confidence in their findings; for example, two or more sources may or may not arrive at the same conclusion, enabling researchers to compare the sources (Johnston, 2014).

Data Analysis

Analysis of variance (ANOVA) is a statistical model in which the mean of a continuously distributed variable (such as the number of times someone visits a hospital) as modeled as an outcome of membership in qualitatively defined groups (such as high or low education groups, high- or low-income groups, insured and uninsured people, English speakers and non-English speakers, etc.) (Kremelberg, 2010). In an ANOVA, the outcome variable is Y, and, if the ANOVA model is staged as an ordinary least squares (OLS) model with dummy variables, the general form of the model is:

$$Y = \beta 0 + X_1 + \ldots X_n + \varepsilon$$

In this model, each X term represents levels of an independent variable (such as high or low education groups, high- or low-income groups, insured and uninsured people, English speakers and non-English speakers, etc.), $\beta 0$ is the x-intercept, and ε is the error term (Kremelberg, 2010). The x terms are, for dummy variables, transformed into β values. A β value depends on how a dummy variable is coded (Kremelberg, 2010). If, for instance, there is a

dummy variable for education, a coding scheme could be 0 = low education, 1 = high education, and, therefore, β education would be the contributing of high education to the y variable in an OLS-based ANOVA. If β education were 2.5, then, in the model described here, someone who has high education would have 25 more hospital visits than someone who had low education.

Data analysis for RQ1 was conducted on the basis of an OLS-based ANOVA taking the following equation form:

$$Y \text{ access to healthcare} = \beta 0 + \beta 1 \text{ race} + \beta 2 \text{ insurance} + \beta 3 \text{ language} +$$

$$B4 \text{ work status} + \beta 5 \text{ education} + \beta 6 \text{ income} + \varepsilon$$

The OLS regression statistical analysis for RQ1 was conducted using Stata / BE 17.0 software. RQ2 was analyzed by means of qualitative analysis of the program data relevant to improving minority access to healthcare in the state of Florida.

Strengths and Limitations

There are many benefits to using a secondary data analysis and research methodology for this study. For example, according to Martins et al. (2018), there is an abundance of theory-driven research where secondary data is an excellent shortcut for collecting information, with this becoming a much easier endeavor, as there are numerous database sharing resources available online. This makes it possible for secondary researchers to find appropriate matches between their own research needs and existing databases (Martins et al., 2018). Furthermore, secondary database analysis may offer a new avenue for phenomenon-driven research, as it is quite likely there are findings within these primary datasets that have not been identified yet, reflecting novel ideas for future theory development (Martins et al., 2018). Within this research methodology, secondary researchers can draw new conclusions by manipulating variables, with these findings perhaps not being possible during the primary data collection; this is especially

true when there is strong theoretical grounding, with primary researchers employing proper documentation to guarantee transparency and reproducibility (Martins et al., 2018).

As Smith (2008) explains, secondary analysis has many advantages, including its convenience and cost-effectiveness, since the secondary researcher does not need to allocate financial resources to gathering data. Researchers can employ high quality larger databases when good secondary data is available, especially when the information is collected by agencies or well-funded studies; this is because they may have larger sample sizes, with significant breadth of research (Johnston, 2014). When there are larger samples, there is greater representation for the target population, enabling greater validity as the findings are more generalizable (Smith, 2008; Smith et al., 2011). Therefore, secondary researchers are provided with more opportunities to access this type of data, giving even those novice researchers the change to build capacity

for empirical research (Johnston, 2014). Finally, by using existing data, research can be accelerated, as the data collection and measurement development – which take up a great deal of time in research studies – have already been completed (Doolan & Froelicher, 2009). Unfortunately, there are also some limitations with using this research methodology. As Boslaugh (2007) exclaims, this data was gathered for some other purpose, meaning that it may be challenging to use this information to examine new research questions and produce new knowledge. Issues can arise, such as the secondary researcher being unable to find the specific data they want for their study; the information may be based on a different geographic region of interest or on a different population of interest (Boslaugh, 2007; Doolan & Froelicher, 2009). Another limitation of employing secondary data is that the secondary researcher was not a part of gathering this data, so they are unaware of how it was undertaken; this means they do not know if the information was collected appropriately or if there were any issues that arose like low

response rates or participant misunderstandings regarding the survey questions (Johnston, 2014). Therefore, secondary researchers must critically evaluate this information, examining the documentation from the primary researchers, including technical reports and publications (Boslaugh, 2007).

Ethical Considerations

Confidential Information pertains to individually identifiable information, which may include medical and demographic information that either discloses the participant's identity or is easily identified based upon the data; additionally, this confidential information may also offer a reasonable basis for which the identify of a participant or data subject may be determined (FDOH, n.d.). Examples of this confidential information include cause of death in all death and fetal death records, along with parentage, marital status, and medical information that are included in all fetal death records; therefore, this data can only be used for health research purposes that have been approved by the FDOH (n.d.).

Therefore, the information that was examined for this study did contain personal information, such as names, dates of birth, social security numbers, latitude/longitude, etc. As the FDOH (n.d.) explains, meaningful vital records data can be released, although the department's goal is to protect individual privacy and confidentiality. This is because these vital statistics data – both medical and personal information – may identify individual respondents, so it is considered confidential under Florida Statute 382.025 (3) (d) (FDOH, n.d.). For researchers and other external applicants, they must complete a Vital Statistics Data Use Agreement, which applies to whether the data are confidential or non-confidential as well as if it is a one-time request or ongoing project; the primary custodian refers to the individual that is provided with

access to this information, so they are responsible for guaranteeing they adhere to the FDOH data confidentiality and security policies (FDOH, n.d.).

There are also criteria for researchers that require them to first obtain a Florida IRB review, as federal regulations protect both the privacy and rights of human subjects who are involved – either directly or indirectly – in research studies (FDOH, n.d.). The US Department of Health and Human Services (HHS) issued regulations (45 CFR part 46) that apply to protecting human subjects in research, which include any living people whom the researcher wishes to gather information about, whether through interacting with them or collecting identifiable private information (FDOH, n.d.). These regulations ascertain whether an activity meets the criteria for research, as this pertains to a systematic investigation that is meant to generate or contribute to generalizable knowledge, with research development, testing, and evaluation (FDOH, n.d.). Therefore, these criteria for IRB review and approval include: 1) the project involves human subjects, with the purpose being to undertake an investigation or research that contributes to generalizable knowledge; 2) the activity involves procuring identifiable data regarding living individuals who are contacted for research purposes; or 3) the project deals with decedents, while also involving contact with their family (FDOH, n.d.). If any one of these criteria are met, then IRB approval is required (FDOH, n.d.).

Summary

This chapter contained a description and defense of the methods used to answer the research questions of the study. For RQ1, a quantitative approach based on OLS regression was defended. For RQ2, a qualitative approach based on content analysis was defended. The findings of the study, generated by means of the methods described in Chapter 3, are presented in Chapter 4.

CHAPTER IV

RESULTS

Introduction

The purpose of this chapter is to present the results of the study. The results have been presented separately for each of the research questions of the study.

RQ1 Results

Data were collected from 5,000 individuals for whom records existed in the database identified in Chapter 3. Table 1 below presents the descriptive statistics of the sample, with the following characteristics:

- 2,864 subjects were minorities, and 2,136 were white
- 3,159 subjects were uninsured, and 1,841 were insured
- 2,754 did not speak English as a first language, and 2,246 spoke English as a first language
- 2,985 were employed full-time, and 2,015 were not employed full-time
- 2,886 had no college degree, and 2,114 had a college degree
- 3,161 had a below average income, and 1,839 had an average or above average income

In the table below, Freq. indicates the frequency of each category, Percent indicates the percentage contribution of each category to the total, and Cum. Represents combined totals of percentages.

Table 1

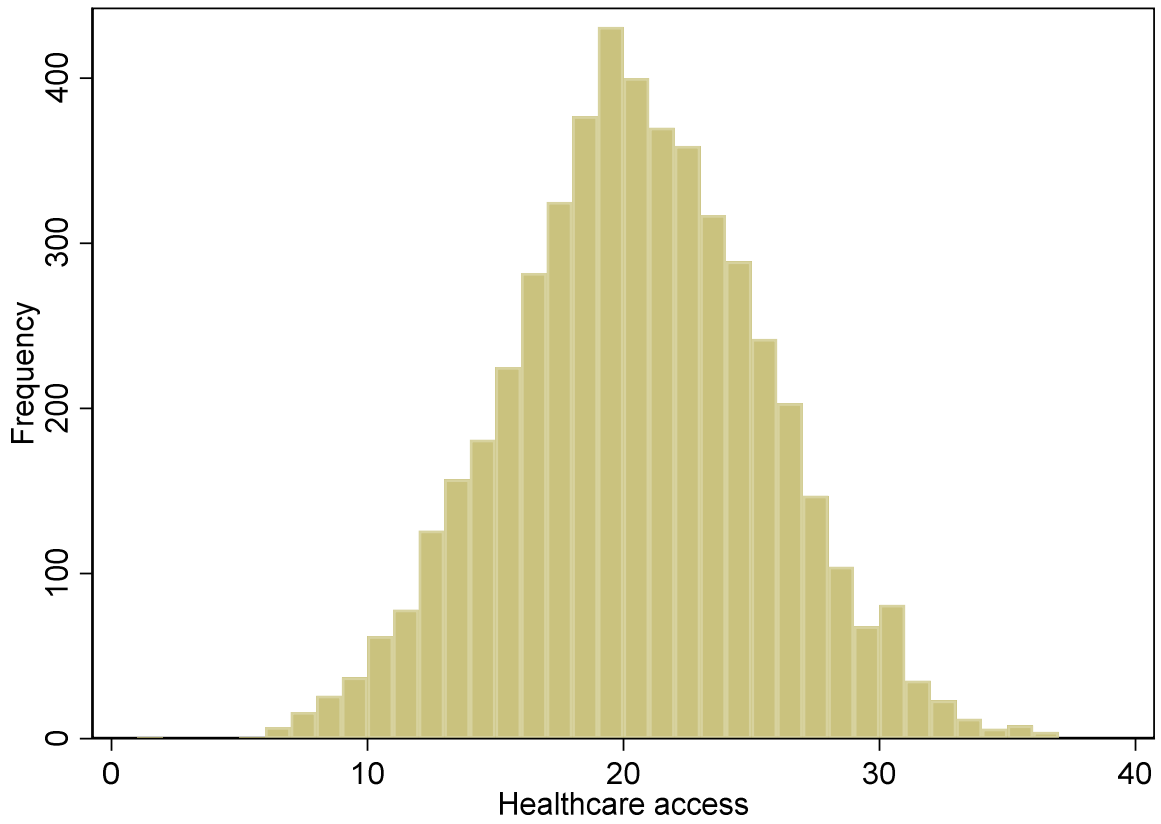
Descriptive Statistics of Sample

	Freq.	Percent	Cum.
Race			
Minority	2,864	57.28	57.28
White	2,136	42.72	100.00
Total	5,000	100.00	
Insurance			
Uninsured	3,159	63.18	63.18
Insured	1,841	36.82	100.00
Total	5,000	100.00	
Language			
Not English	2,754	55.08	55.08
English	2,246	44.92	100.00
Total	5,000	100.00	
Employment			
Full-time	2,985	59.70	59.70
Not full-time	2,015	40.30	100.00
Total	5,000	100.00	
Education			
No College Degree	2,886	57.72	57.72
College Degree	2,114	42.28	100.00
Total	5,000	100.00	
Income			
Below Average Income	3,161	63.22	63.22
Average/above average income	1,839	36.78	100.00
Total	5,000	100.00	

Next, data were collected on healthcare access. The mean number of healthcare visits in the sample was 20.02 (*SD* = 5.03), with a range from 1 to 37. Figure 1 below is the histogram of healthcare access, demonstrating a highly standard distribution. A histogram is a graphic that portrays the distribution of a continuously measured variable (*x* access, which is healthcare access in Figure 1 below) in terms of the frequency (*y* axis), meaning how many times each *x* value is observed in a sample (Kremelberg, 2010).

Figure 1

Histogram of healthcare access



Next, the OLS regression model of the study was fit. Table 2 contains the results. The regression was statistically significant, $F(6, 4{,}993 = 281.07)$, $p < .001$. The coefficient of determination was 0.2525, meaning that 25.25% of variation in healthcare access was related to variation in race, insurance status, language, work status, education, and income. In particular, in terms of how the coefficients affect the model outcome,

- White people had 0.94 more annual healthcare access events than non-white people
- Insured people had 2.34 more annual healthcare access events than uninsured people
- Native English speakers had 0.69 more annual healthcare access events than non-native English speakers
- Full-time workers had 1.59 more annual healthcare access events than non-full-time workers
- People with college degrees had 1.53 more annual healthcare access events than people without college degrees
- People of average or above average income had 2.28 more annual healthcare access events than people of below average income

Table 2

Regression Results, RQ1

Source	SS	Df	MS
Model	31919.44	6	5319.91
Residual	94504.56	4,993	18.93
Total	1264.99	4,999	25.29

Number of obs = 5,000

F (6, 4993) = 281.07

Prob>F = 0.00

R-squared = 0.25

Adj R-squared = 0.25

Root MSE

AC	Coefficient	Std. Err.	T	P> |t|	95% Conf. Interval
Race					
White	0.94	0.13	7.41	0.00	0.69 - 1.19
Insurance					
Insured	2.34	0.13	17.84	0.00	2.09 - 2.60
Language					
English	0.69	0.123	5.46	0.00	0.44 – 0.94
Employment					
Not Full Time	1.59	0.13	12.24	0.00	1.33 – 1.84
Education					
College Degree	1.53	0.13	12.08	0.00	1.28 – 1.78
Income					
Average/above average income	2.28	0.13	17.17	0.00	2.02 – 2.54
Cons	16.25	0.12	139.27	0.00	16.03 – 16.48

RQ2 Results

The second research question of the study was as follows: What key policy initiatives have been developed to improve access to healthcare among minority communities in Florida? There are several such policies that have been enacted by the Florida Department of Health. Below, key policy initiatives have been described.

Closing the Gap Grant

The first policy that is being enacted in Florida is the Closing the Gap Grant. The Closing the Gap Grant has been described as follows:

> The Closing the Gap Grant program is administered by the OMHHE [Office of Minority Health and Health Equity], and these grants are utilized to stimulate the development of community and neighborhood-based organizations to improve disparate health outcomes of racial and ethnic populations and promote disease prevention activities. As part of the Closing the Gap Grant program, Hebni Nutrition Consultants, Inc. introduced the "Fresh Stop" mobile farmers' market bus in Central Florida. "Fresh Stop" was introduced in 2014 with the goal of reducing diabetes risk in areas that are considered food deserts due to a lack of fresh nutritional and affordable food options. In addition to offering fresh produce, the "Fresh Stop" also provides healthy cooking and wellness lessons. More than half of residents in Eatonville that attended the wellness lessons had lost weight and reduced their risk of diabetes. (Florida Department of Health, 2022a, p. 1).

The Closing the Gap Grant program addresses healthcare access more in terms of prevention than in terms of treatment. The idea behind the Closing the Gap grant program is that, by reducing the risks of diabetes and obesity through appropriate lifestyle changes that are

facilitated by policies related to fresh food availability and subsidization, minorities will not have to subsequently rely on access to healthcare facilities. In this respect, the Closing the Gap grant program is part of public policies related to fresh food as a basis for health, especially for minorities.

Minority Health Liaisons

According to the Florida Department of Health, "Minority Health and Health Equity Liaisons have been designated in each county as a part of the efforts to achieve the highest level of health for all people" (Florida Department of Health, 2022b, p. 1). A minority health and health equity liaison is, according to the Florida Legislature, responsible to:

> Develop and promote synergistic initiatives between programs, including, but not limited to, programs related to maternal and child health and human immunodeficiency virus and acquired immune deficiency syndrome, to mitigate health disparities for racial and ethnic minority populations in this state. Promote evaluations of demonstration projects and disseminate the evaluation findings to enhance the success and sustainability of policies, programs, and practices that increase health equity in this state. Promote the use of community health workers to improve the cultural competency of services and build individual and community self-sufficiency. Promote the development of programs that improve access to health care services for individuals with limited proficiency in the English language, including individuals with disabilities. (Florida Legislature, 2022, p. 1).

The Minority Health Liaison program is somewhat different from the two other policies discussed as part of the answer to RQ2, that is, the Body and Soul Toolkit and the Closing the

Gap Grant program. Unlike those two other programs, the Minority Health Liaison program facilitates actual healthcare access, whereas the other two programs focus on prevention.

Body and Soul Toolkit

According to the Florida Department of Health

> Body and Soul is a wellness program developed for African American churches. The program encourages church members to eat a diet rich in fruits and vegetables every day for better health. Churches that embrace Body and Soul help their members take care of their bodies as well as their spirits. The church is one of the most powerful elements to African American culture, and clergy leaders are key influencers to their congregations. (Florida Department of Health, 2022c, p. 1).

Thus, Body and Soul is a policy that, like the Closing the Gap Grant program, is designed to prevent subsequent need for healthcare interventions more so than increasing access to actually existing healthcare resources.

Summary of Findings

The following findings emerged from the study.

RQ1 Findings

A number of statistically significant findings emerged from the analysis for RQ1.

- White people had 0.94 more annual healthcare access events than non-white people. This means that not being white is a barrier to healthcare access.
- Insured people had 2.34 more annual healthcare access events than uninsured people. This means that being uninsured is a barrier to healthcare access.
- Native English speakers had 0.69 more annual healthcare access events than non-native English speakers. This means that not speaking English is a barrier to healthcare access.

- Full-time workers had 1.59 more annual healthcare access events than non-full-time workers. This means that not working is a barrier to healthcare access.
- People with college degrees had 1.53 more annual healthcare access events than people without college degrees. This means that not having high education is a barrier to healthcare access.
- People of average or above average income had 2.28 more annual healthcare access events than people of below average income. This means that having lower income is a barrier to healthcare access.

RQ2 Findings

The results for RQ2 included a recognition of the following programs designed to improve the healthcare access of minority Floridians:

- Closing the Gap Grant: A program / policy that is focused on promoting healthy eating as a means of reducing obesity, diabetes, and cardiovascular health disease among minorities in Florida.
- Minority Health Liaisons: A program / policy designed to improve minority access to healthcare resources, information, and prevention measures through the use of dedicated advocates.
- Body and Soul Toolkit: A program / policy that is focused on promoting health eating as a means of reducing obesity, diabetes, and cardiovascular health disease among African-Americans in Florida.

Conclusion

The objective of this chapter was to present the results of the study. The results were presented separately for each of the research questions of the study: (1) What are the key barriers

to access to adequate healthcare among minority communities in Florida? (2) What key policy initiatives have been developed to improve access to healthcare among minority communities in Florida? Race, insurance status, language, education, income, and work status were all identified as barriers to healthcare access. Three initiatives (Closing the Gap, Body and Soul, and Minority Health Liaisons) were identified as key policy initiatives.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Conclusion

Health and income disparities in the US have significantly increased in the previous years. There is a robust literature that connects income disparity to health disparities and thus, as the gap between the poor and the rich widens, so does the gap in their health. Although a wide gap has been noted in the connection between allocation of resources, policy, and health inequalities, different services have not been created and employed to rectify the circumstances resulting in the disparities. Besides Florida being one of the three bottom states in the US regarding healthcare access, it also ranks among the worst states in the rate of uninsured and cases of income disparities. The current study explores the best practices for applying collaborative efforts across the private, public, and government agencies concerning establishing healthcare access, life skills, and education to minimize the health disparities among Florida's minority populations. Specifically, the study aimed to note the main barriers to access to adequate healthcare among Florida's minority communities and the key initiatives created to advance health care access among the same communities.

Using mixed methods analysis, the study notes that race, insurance status, language, education, income, and work status are the key barriers to access to adequate healthcare among Florida's minority communities:

- White people had 0.94 more annual healthcare access events than non-white people. This means that not being white is a barrier to healthcare access.
- Insured people had 2.34 more annual healthcare access events than uninsured people. This means that being uninsured is a barrier to healthcare access.
- Native English speakers had 0.69 more annual healthcare access events than non-native English speakers. This means that not speaking English is a barrier to healthcare access.
- Full-time workers had 1.59 more annual healthcare access events than non-full-time workers. This means that not working is a barrier to healthcare access.
- People with college degrees had 1.53 more annual healthcare access events than people without college degrees. This means that not having high education is a barrier to healthcare access.
- People of average or above average income had 2.28 more annual healthcare access events than people of below average income. This means that having lower income is a barrier to healthcare access.

Minorities often face significant obstacles in their quest to access quality healthcare, and the study reinforces this reality. The study also notes that closing the Gap Grant, Minority Health Liaisons, and Body and Soul Toolkit are the programs created to advance healthcare access among the minorities in Florida.

Recommendations

The means that Florida can use to avert income and health disparities involves improving access to high-quality education such as parental support programs and childhood education. A good education can dramatically improve equality in both income and healthcare (Popham & Iannelli, 2021; Raghupathi & Raghupathi, 2020). Direct governmental investment in

opportunities for the disadvantaged is a means that income disparities can be overcome (Bourguignon, 2018). The government should be able to create chances for the poor people to generate effective and satisfactory income for a long time. Regarding Purnell et al. (2016) and Thornton et al. (2017) studies, addressing disparities should involve creating contemporary policies that promote collaboration among various stakeholders such as community-based organizations, government, businesses, and providers. The various stakeholders will prompt looking at the disparities from several angles and develop a comprehensive approach that addresses the various aspects driving disparities.

According to Mode et al. (2016), solving the income disparity should partly involve the development of a spending-based program of reparations that would offer a huge economic stimulus to the whole economy and instantly infuse the required funds in communities and households that have encountered lasting underinvestment. Heavy and progressive wealth taxation is another way to reduce income disparities since it minimizes the highly concentrated wealth possessed by wealthy individuals (Purnell et al., 2016; Williamson, 2020). The immense revenue amounts raised from the taxation should be devoted to programs that would increase economic equality. A raised and more effective income tax on the higher part of the revenue scale can assist in raising the required funds.

The collaborative model proposed by Butcher and Gilchrist (2020) should also be utilized in solving health disparities. The model connects the most vulnerable populations that avert health outcomes to healthcare services through associated interventions and targeted input. Through targeted collaboration, the diverse needs of the Florida minority community can be met using interventions specifically created to serve the distinct needs.

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APPENDIX

APPENDIX

Table 3

Suggested Data Model for Future Research

Comparison Pair #	Minority with Healthcare Access	Minority without Healthcare Access
1	1a: Health insurance, race, income, gender, education level, other socioeconomic and demographic variables	1b: Health insurance, race, income, gender, education level, other socioeconomic and demographic variables
2	2a: Health insurance, race, income, gender, education level, other socioeconomic and demographic variables	2b: Health insurance, race, income, gender, education level, other socioeconomic and demographic variables
3	3a: Health insurance, race, income, gender, education level, other socioeconomic and demographic variables	3b: Health insurance, race, income, gender, education level, other socioeconomic and demographic variables
…*n*	*n*a*:* Health insurance, race, income, gender, education level, other socioeconomic and demographic variables	*n*b: Health insurance, race, income, gender, education level, other socioeconomic and demographic variables

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