AMERICAN HEALTHCARE

A Comprehensive Investigation of Poverty's Role in Systematic Health Inequity

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Abstract

Background: Researchers have determined that a correlation exists between poverty and poor health. Specific groups such as racial minorities, especially African Americans, Hispanics, and Native Americans, the elderly, the young, the impoverished, and women are noted vulnerable populations within the American healthcare system because they experience poor health at high rates, when compared to the remaining population. This study sought to determine whether African Americans, Hispanics, and Native Americans experience poor health as a result of their marginal position within society or due to their commonly impoverished statuses.

Methods: Data from the National Health Interview Survey, for the year 2009, were used. Survey data were taken from 88,446 individuals from all 50 states and the District of Columbia via computer-assisted and face-to-face interviews.

Results: Cross-tabulations examining the relationship between an individual's annual income and health status showed that an impoverished status makes one vulnerable to poor health and a lack of health coverage. In addition, each vulnerable population experienced poverty at higher rates when compared to their less vulnerable counterpart, men, for women, and white Americans, for all other groups studied.

Conclusions: Ultimately, the poverty experienced by women, racial and ethnic minorities, and other poor individuals, was the primary source of their unequal health outcomes within the American healthcare system. These findings support previous findings that poverty is directly correlated with poor health. In addition, they suggest that in order to confront the issue of health reform, we must first address the issue of economic stratification within America.

Of all forms of inequality, injustice in health is the most shocking and the most inhumane.

(Martin Luther King, Jr., quoted in Patel & Rushefsky 2008: 278)

Introduction

"Since the days of Hippocrates, health inequities and the role of social and environmental factors in the determination of marked differences in health status have been well recognized" (Casas-Zamora & Ibrahim 2004: 2055). Along with this, research and discussions highlighting particular vulnerable groups within the American population have become increasingly important. In other words, specific groups have been labeled as vulnerable pertaining to their access to "fair" health care because researchers have found them to be consistently marginalized within both the greater American society and the American health care system. "'Fairness' is often utilized by public health organizations, especially in the establishment of new public health rules, programs or policies to promote health outcomes for specific groups or populations" (Jennings 2009: 4). Doresa A. Jennings suggests that instead of using the term fair, we should use "distributive justice" as the term defining this inequity (Jennings 2009: 4). "Distributive justice deals with what is 'fair' or 'right' with respect to the allocation of goods in a society which, for our intents and purposes, would be health care" (Jennings 2009: 4). Specifically, racial minorities, especially African Americans, Hispanics, and Native Americans, the elderly, the young, the impoverished, and women are noted as groups vulnerable because they fail to receive fair chances at being healthy citizens, in comparison to the remaining population.

In essence, Jennings suggests that in order to tackle the problems associated with health disparities, we must agree on the terms which define the dilemma. Therefore, without a general consensus on the terms involved, we cannot develop a "confidence" with respect to analysis of

the disparities at hand. Due to this, she defines health inequity as “a situation in which, regardless of individual behavior, an individual would not have access to positive health outcomes than can be reasonably expected given their situation” (Hoskins 2002: 4).

This paper is an investigation highlighting the contributions of socioeconomic status and corresponding class to the marginalization of African Americans, Hispanics, Native Americans (American Indians & Alaskan Natives), and women within the American healthcare system. The specific research question is: Do these groups experience healthcare inequity due to their marginal positions within American society or due to their commonly impoverished statuses? My corresponding hypothesis is: The poverty experienced by women, racial and ethnic minorities, and other poor individuals, is the primary source of their unequal health outcomes within the American health care system.

Fundamentally, the common thread between the specific vulnerable groups, with respect to healthcare in America, is poverty. “In general, the poor have more difficulty obtaining medical care than the rest of the population. This is the case even though, on average, low-income persons use more medical care than higher-income persons because they are in poorer health” (Wolfe 1994: 260). Moreover, most measures of health status indicate an inverse relationship to income, therefore, the growth of poverty and income inequality has significant health implications (Davis 2000:311).

Importantly, the vulnerable populations to be investigated are more likely to be impoverished due to their marginalization within American society; consequently, this general marginalization factors into their opportunities for good health outcomes. Authors Patel and Rushefsky provide the historical context for this marginalization, highlighting the significance of

these groups' statuses when our union was created. They maintain: "The Declaration of Independence proudly proclaimed: 'We hold these truths to be self-evident, that all men are created equal.' However, this declaration of equality presumably did not apply to slaves nor to women" (Patel & Rushefsky 2008: 3). Therefore, the vulnerability of these groups becomes evident; indeed, it is not a new phenomenon. In fact, this vulnerability plays a significant role in the history of our country. Patel and Rushefsky assert that this marginalization, despite social change, still persists, and is now demonstrated in various aspects of American life. I share with them the common interest in investigating this marginalization by focusing on the injustice perpetuated by the American health care system.

In order to thoroughly understand the importance of this research a discussion of poverty and its role within American society is necessary. Along with this, in order to understand the importance of investigating these specific populations, it is important to understand the historical context for each group's marginalization within American society, their relationship to poverty within American society, and each group's specific experience within the American healthcare system.

American Healthcare, Poverty, and Inequality

"The existence of health care disparities in the United States is unquestionable" (Patel & Rushefsky 2008: 279). These disparities result from varying degrees of inequality demonstrated within our social order. Following this, research has determined that there exists a correlation between poor individuals and poor health. "In general, the richer people are, the longer they will live. The reasons are intuitive: Money can buy adequate food, clean water, and good health care" (Guterman 2007: 105). With this, it becomes evident that economic advantages provide

individuals with the access to more resources which, in turn, contributes to their access to resources and opportunities; this is reflected in an examination of their overall outcome. These advantages, in consequence, compound in a positive manner for those who start off with more in the beginning, yet also, compound negatively for the "have-nots."

In the past, poverty in America had a different face. Throughout the 15th through the 18th centuries, the conditions of poverty were similar. There was a great amount of poverty, at times reaching rates of over 50%; however, this poverty was "episodic," and representative of the fluctuations experienced by the population such as poor harvests, epidemics, wars, taxation policies, etc., rather than a reflection on the definite economic stratification within American society (Eldersveld 2007: 16). In addition, the poverty was handled communally, with churches, charities, the local wealthy, and families contributing in order to alleviate the woes resulting from poverty (Eldersveld 2007: 16). Over time, the responsibility of eradicating poverty became more than a simple communal effort; the people began to place a level of responsibility on the government, hence, the commencement of social welfare. Individuals came to the understanding that "the poor were citizens worthy of support, and that poor relief should not be organized on the assumption that some poor were worthy and some unworthy" (Eldersveld 2007: 17). Separate from its communal past, in the 19th century, big business and wealthy 'captains of industry,' altered the face of poverty (Eldersveld 2007: 20). In other words, the economic force of industry and capitalism influenced the nation's experience of poverty.

In the present, we, as a society, understand that poverty is a social issue that is complex, and a composition of various problems, and must be treated accordingly if we wish to properly examine the issue with intent to relieve any strain. Due to this, it becomes evident that when discussing the role of poverty within American society, the issue can, and should, be examined

from a variety of lenses. In *Poverty and the Underclass,* William Kelso, presents four theories that have been used to explain this persistence: structural theory, exchange theory, control theory, and conflict theory. For this research study, the exchange and conflict theories provide crucial insight in addressing the correlation between poor health and poverty, as these theories demonstrate the significant role that economic capital plays.

Exchange theory argues that "in the reciprocal relationships created by the division of labor, individuals must constantly bargain with one another over how the benefits of society will be divided" (Kelso 1994: 38). More specifically, exchange theorists blame the impoverished status of an individual on their lack of motivation to acquire the knowledge or skills necessary in order to raise their economic status because this knowledge or these skills would provide them with the opportunity to acquire a higher quality of employment. This model works from the assumption: " individuals will try to maximize their future rewards by choosing among the options open to them. The more generous the payoffs from a particular course of action, the more individuals will be pulled in that direction," (Kelso 1994: 38). Essentially, the exchange theory asserts that impoverished individuals lack the desire, initiative, or motivation that is required in order for them to raise their economic status. Significantly, this assertion presumes that the acquisition of particular knowledge and skills, or human capital, will consequently provide the individual with opportunities and access to more economic capital. This presumption is problematic because it fails to acknowledge inequalities within our society which inhibit individuals from having equal access prior to their acquisition of the human capital that would allow them to increase their standard of living economically.

In American society, we have a capitalist economy; this inevitably leads to conflict. Conflict theory is derived from Marx's assertion that "capitalist society depends on the

exploitation of the working class by the captains of industry" (Kelso 1994: 41). This theory highlights the systematic nature of poverty, as it suggests that those who are in control of the means of production within a society are the people in control of the wages of the working class. Therefore, conflict theorists would blame the persistence of poverty on the "captains of industry," or the capitalist class who fails to rightfully compensate the working class for its labor, while using their labor in order to make themselves increasingly wealthier. In addition, poverty is perpetuated as a result of the false consciousness experienced by individuals within the lower classes. Specifically, "as individuals come to think of themselves as consumers rather than members of an exploited class, they tend to accept the nature of society as a given and thus become immune to calls for radical change" (Kelso 1994: 41). Ultimately, from a conflict theory perspective, poverty will continue to persist as long as the laboring class continues to allow themselves to be exploited by the capitalist class. This particular analysis implies that the economic system utilized by a society determines how that particular society experiences poverty. Ultimately, economic stratification has implications for other types of inequality within a given society. Specifically, inequality exists within the American healthcare system.

"The American ideal of equality confronts the reality of inequality that persists in American democracy" (Patel & Rushefsky 2008: 3). John Rawls challenges the current model of democracy calling for "democratic equality" to be incorporated into the American social system in order to create a "just and fair society" (Ornstein 2007: 141-2). He argues that in a society practicing democratic equality there must be "consideration for the common public good. In short, in a just society, 'everyone as a citizen should gain from its policies'" (Ornstein 2007: 142). In essence, a democratic society would be one in which these gains would not be primarily in favor of the rich, such that the least advantaged groups get minimal benefits and there is

increasing inequality (Ornstein 2007: 142). Ultimately, in order to thoroughly investigate the disparities experienced within our society, we must give special attention to the inequality experienced within America, especially if we wish to understand specialized problems such as disparity within the healthcare system.

Importantly, democratic equality highlights the importance of equality of opportunity within American society. Equality of opportunity is a situation in which the least advantaged groups feel they have some chance to succeed (Ornstein 2007: 142). If the least advantaged groups do not have this feeling, "they will grow frustrated and cynical and retreat from the larger society, forming a subculture of their own and rejecting the values of the larger society, possibly engaging in criminal and deviant behavior and affecting everyone in the larger society except the very wealthy, who can insulate themselves or create barriers" (Ornstein 2007: 142). In addition, it is important to understand, in a democratic society, equality can be considered as a basic right that each citizen is entitled to. Therefore, in order to rectify inequality of opportunity and inequality of outcome, we must strive to incorporate democratic equality into our existing social system. This extends into the inequality of outcome experienced by the vulnerable populations within this research endeavor. Due to their inequality of opportunity, women, African Americans, Hispanics/Latinos, and Native Americans now experience inequality of outcome with respect to their personal health.

Women

Gender serves as a "ubiquitous system of oppression" (Ratcliff 2002: 7). This oppression pervades throughout the history of our nation, as women have been historically treated as second-class citizens "often seen as no more than property, subject to the will of their fathers and

then their husbands" (Patel & Rushefsky 2008: 161). This oppression is not absent or missing from the health and science community. Consequently, "the organization of society influences women's health, health research, and health care" (Ratcliff 2002: 7). Language and practice of oppression are definitely present within American healthcare. This is why "statements made to rationalize the exclusion of women from medical research (men are the norm; women are the other); the words used to justify hysterectomies ('women have outlived their ovaries'); or the concern with women as vectors and vessels, not as victims, of AIDS," exist (Ratcliff 2002: 7). These actions and beliefs persist and highlight our culture which promotes views of women as "less valuable than men, and useful primarily as reproductive vessels" (Ratcliff 2002: 7).

In addition to this, "poverty, the lack of power, racial discrimination, the gendered division of labor, and the devaluing of women all affect women's health" (Ratcliff 2002: 7). In fact, in 2004, the poverty rate for women was higher than men in all racial and ethnic groups (Patel & Rushefsky 2008: 164). Importantly, "poverty impacts women's health disproportionately by exposing women to a myriad of hazards in the home, in the neighborhood, in the work setting, and in life" (Ratcliff 2002: 48). For example, "if a poor woman has a job, her workplace is more likely than middle-class workplaces to be characterized by toxic exposures, high levels of stress, and other unsafe conditions, while at the same time her job is less likely to offer any economic security, pension benefits, or health insurance" (Ratcliff 2002: 49).

This is precisely why research highlighting the marginalization of women within the greater American society is important; it provides us with the understanding of the disparities they experience within specific realms of society. Crucial to this understanding is the notion that their marginalization within one realm is not independent from their marginalization within another; the realms influence each other. This mutual dependence and interaction only serves to

perpetuate the marginalization of women. Therefore, if women are more vulnerable to poverty in comparison to men, then they should be more vulnerable to poor health as well.

African Americans

"African Americans have experienced a unique history as a minority population in the United States, and this experience has profoundly affected their socioeconomic and health status" (Yehieli & Grey 2005: 33). Along with this, this group is the only major ethnic group that was forced to migrate to the Western Hemisphere, and therefore, it is evident that historically African Americans have been considered as second-class citizens (Yehieli & Grey 2005: 33). In fact, at one point in American history, African Americans were not viewed as citizens at all, but solely as property.

During slavery, the health of African Americans was in the hands of their masters. As a result, the quality of medical care received by slaves was often poor (Loue 1999: 89). During Reconstruction, African Americans experienced high mortality rates as a result of poor housing and poor sanitation (Loue 1999: 90). During this era, health conditions for African Americans were so bad that New York Life's and Equitable's actuaries predicted that blacks would be extinct by the year 2000 (Loue 1999: 90). During the 20th century, African Americans migrated north and into urban residences, however, this did not relieve them of their health disparities. In fact, it was during this time period that the notorious Tuskegee Experiment, a study conducted by the United States Public Health Service in order to examine the prevalence of syphilis among blacks and possible mechanisms for treatment was conducted (Loue 1999: 91). This unethical research endeavor exposed the vulnerable position of African Americans in American society, as this study serves as a "'symbol of their mistreatment by the medical establishment, a metaphor

for deceit, conspiracy, malpractice, and neglect, if not outright racial genocide'" (Loue 1999: 92). This dark history has serious implications for both the health status and economic standing of this population.

In general, cost is the greatest barrier to health care for African Americans in the United States" (Yehieli & Grey 2005:36). Along with this, "the gap in income between African Americans and the rest of the population has essentially remained the same since the 1960s , and 30 percent of African Americans lived below the poverty level in 1990" (Patel & Rushefsky 2008: 30). As a consequence of their impoverished status within American society, many have come to understand the health status of African Americans as a function of their marginal position in the U.S. health care system and a direct result of poverty and discrimination (Patel & Rushefsky 2008:30).

Hispanics/Latinos

"Hispanics face significant barriers to health care use, including the highest chance of being uninsured despite their great participation in the labor force" (Cafferty & Engstom 2002: 195). Money, language, and transportation are usually cited as the primary barriers to health care for Latinos (Yehieli & Grey 2005: 82). However, money and transportation can be combined into one category since lack of economic capital greatly influences one's access to adequate transportation. Along with this, Hispanics, as a group, have not shared equally in the economic wealth of the U.S. population (Patel & Rushefsky 2008: 75). Specifically, in 2005, 22% of Hispanics lived in poverty compared to 8% of whites; also, Hispanics earn the least out of all the workers within the U.S. labor force (Patel & Rushefsky 2008: 75). These high poverty rates and

low wages have serious implications on the group's access to and health outcomes within the American healthcare system.

"Since the 1960s, a number of key public policies have helped to open doors of opportunity for Hispanics and other minorities who were historically cut off from avenues of educational, occupational, and political mobility" (Camarillo & Bonilla 2001: 123). Nevertheless, the historical marginalization of Hispanics within American society weighs heavily on their contemporary reality (Camarillo & Bonilla 2001: 124), even in discussions concerning healthcare. Importantly, Hispanics are currently the largest minority population in the United States, and the Census Bureau predicts that Hispanics will account for 25% of the population by 2050 (Yehieli & Grey 2005: 77). This means that efforts must be made to minimize disparities experienced by this group within both the American economy and healthcare system. As this group continues to grow, the inequality experienced by the population will prove undeniable and become increasingly visible, rendering social injustice within the American healthcare system irrefutable.

Native Americans

"Native Americans—American Indians and Alaska Natives—have historically had poorer health than the U.S. general population, as evidenced by their higher incidence of certain medical conditions and their shorter average life spans" (Indian Health Service 2005: 1). Along with this, Native Americans have experienced difficulty with regards to access to medical care (Yehieli & Grey 2005: 113). In addition, this population has consistently been one of the poorest groups in America (Rhoades 2000:51). Consequently, difficulty with regards to access to medical care can be viewed as a direct result of their commonly impoverished status because if

they have “limited financial means to purchase services,” they cannot receive adequate care unless they are “provided free or low-cost [health care] by organizations operated by Indian Health Services (IHS) or individual tribes” (Yehieli & Grey 2005: 113). In fact, the establishment of the IHS was due to the poverty experienced by Native American populations. The IHS is a special agency of the federal government that was designed specifically to provide health care access to this specific vulnerable population. Yet, despite the institutionalization of health care for Native Americans, they still remain vulnerable in terms of their access to healthcare within America because an impoverished status “places Native people at extreme risk because it limits access to prevention materials, good health care, and proper medical treatment,” which all alleviate the strains of poor health (Vernon 2001: 6).The correlation between health insurance and economic well-being may provide some explanation for this problem (Rhoades 2000: 54).

Importantly, the notion that health care is adequate enough to eliminate the disparity in health status between populations is problematic because it fails to recognize the factors that contribute to the poor health of individuals in the first place (Rhoades 2000:81). For example, this notion ignores the impoverished status of individuals that leads to both their poor health status and lack of access to health care. In theory, access to health care alone should increase the health status of individuals; however, the conditions which caused the individual to be sick in the first place must be addressed. This is precisely why an investigation of poverty’s role in the relative heath status of Native Americans, and other similarly marginalized groups, in comparison to the general American population, is necessary. This examination can shed further light on the marginalization of Native Americans within our health care system. In other words, are the members of this population unhealthy because they are poor or are they disadvantaged in

gaining access to good healthcare due to their minority status and the discrimination and inequality that they face?

Methodological Approach & Results

In this investigation, data from the National Health Interview Survey, for the year 2009, were used. This data collection is a national initiative taken by U.S. Department of Health and Human Services, Center for Disease Control, and National Center for Health Statistics in order to obtain information about the amount and distribution of illness, its effects in terms of disability and chronic impairments, and kinds of health services people receive (NHIS 2009). Survey data were taken from 88,446 individuals from all 50 states and the District of Columbia. In addition, the data were collected via computer-assisted personal interview and face-to-face interview. Importantly, the NHIS used a stratified multistage probability design. Blacks, Hispanics, and Asians were oversampled in order to gain a more precise estimation of health characteristics in these growing minority populations (NHIS 2009).

Statistical analysis

The data were analyzed using variables reporting sex, annual income, health status, and current health insurance or coverage. A series of correlations and cross-tabulations were used in order test the relationships between specific variables. In addition, analysis was primarily bivariate, with sex, race, and ethnicity serving as layers in order to test the relationships between variables within particular populations. Specifically, annual earnings served as the independent variable while reported health status and health insurance, or lack of health insurance, were the dependent variables.

Women

The results in Table 1 show that women of lower economic statuses, as measured by annual earnings, reported their health statuses as fair or poor at higher rates, when compared to women from higher income strata. In addition, the results show that women are most likely to report their health status as very good, with a response rate of 66% (Table 1). When women were compared to men, it was determined that while 48% of women reported their annual earnings as between $1 and $24,999, only 33% of men reported similarly (Tables 1). Along with this, the results demonstrated sex-based inequality as men are less likely to report their health status as fair or poor (Tables 1).

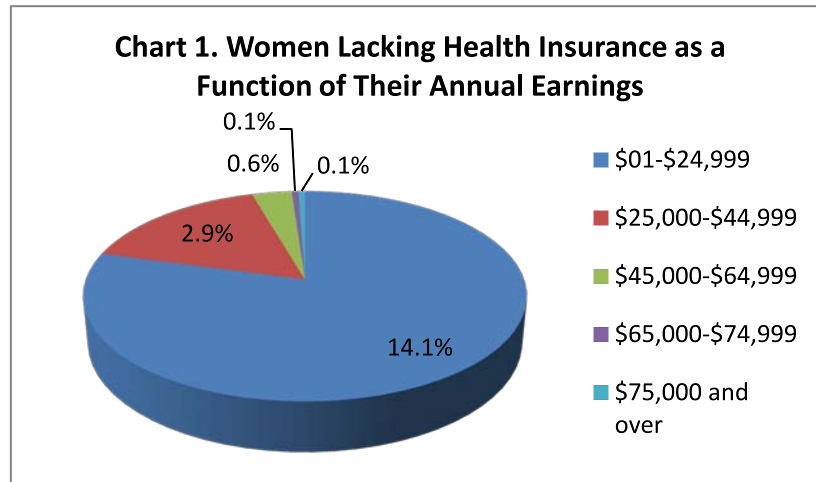
Table 1. Reported Health Status by Gender as a Function of Annual Earnings

		Very Good		*Good*		*Fair/Poor*		*Total*	
		M	W	M	W	M	W	M	W
Annual Earnings	$01-$24,000	20.1%	29.1%	9.5%	14.3%	3.4%	5.1%	33.0%	48.5%
	$25,000-$44,999	18.1%	18.8%	7.2%	7.2%	1.9%	1.7%	27.2%	27.7%
	$45,000-$64,999	12.3%	9.8%	4.7%	2.9%	0.8%	0.5%	17.8%	13.3%
	$65,000-$74,999	3.7%	2.4%	1.0%	0.7%	0.2%	0.1%	5.0%	3.3%
	$75,000 and over	13.6%	5.9%	2.9%	1.2%	0.5%	0.2%	17.0%	7.3%
	Total	67.9%	66.0%	25.4%	26.4%	6.8%	7.6%	100.0%	100.0%

p=0.000 N= 33,121

In the tests examining the relationship between an individual's annual earnings and their health coverage, the results showed that women having income levels between $1 and $24,999 were most likely to mention a lack of health coverage, at a rate of 14% (Chart 1). Moreover, women within this economic stratum disproportionately account for 80% of women who lack health coverage (Appendix). Along with this, women of higher economic strata ($45,000 and over) report a lack of health coverage at a rate of 1%, which is significantly lower than the impoverished stratum (Chart 1). Contrary to what was predicted by theorists, 24% of men

mentioned that they did not have health coverage, while only 18% of women replied in the same manner (Appendix).



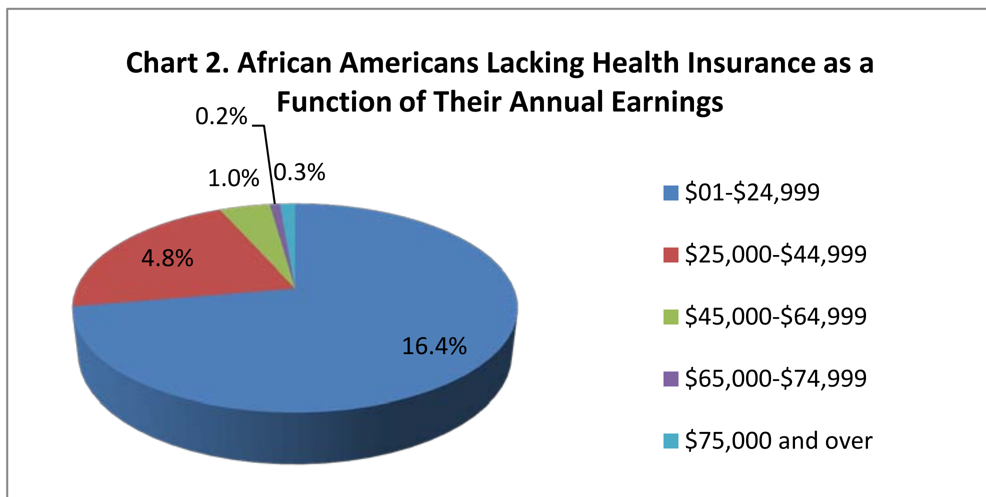
African Americans

The results in Table 2 show that blacks of lower economic statuses, as measured by annual earnings, reported their health statuses as fair or poor at higher rates, when compared to blacks from higher income strata. In addition, the results show that blacks are most likely to report their health status as very good, with a response rate of 59% (Table 2). When blacks were compared to whites, it was determined that while 45% of blacks reported their annual earnings as between $1 and $24,999, only 40% of whites reported similarly (Tables 2). Along with this, the results demonstrated race-based inequality as whites are less likely to report their health status as fair or poor when compared with blacks (Tables 2).

Table 2. Reported Health Status of Whites and African-Americans as a Function of Annual Earnings									
		Very Good		*Good*		*Fair/Poor*		*Total*	
		W	AA	W	AA	W	AA	W	AA
Annual Earnings	$01-$24,000	24.7%	24.4%	11.3%	14.6%	3.9%	6.0%	39.8%	45.0%
	$25,000-$44,999	18.8%	18.1%	6.8%	9.3%	1.6%	3.0%	27.1%	30.5%
	$45,000-$64,999	11.4%	9.5%	3.7%	4.4%	0.7%	0.8%	15.7%	14.7%
	$65,000-$74,999	3.3%	1.8%	0.9%	0.8%	0.1%	0.2%	4.4%	2.9%
	$75,000 and over	10.5%	5.1%	2.1%	1.6%	0.3%	0.2%	13.0%	6.9%
	Total	68.7%	59.0%	24.7%	30.7%	6.6%	10.2%	100.0%	100.0%

` p=0.000 N=30,531

In the tests examining the relationship between an individual's annual earnings and their health coverage, the results showed that blacks having income levels between $1 and $24,999 were most likely to mention a lack of health coverage, at a rate of 16% (Chart 2). Moreover, individuals within this economic stratum disproportionately account for 72% of blacks who lack health coverage (Appendix). Along with this, blacks of higher economic strata ($45,000 and over) report a lack of health coverage at a rate of 2%, which is significantly lower than the impoverished stratum (Chart 2). In addition, when comparisons were made across groups, 23% of blacks mentioned that they did not have health coverage, and 21% of whites responded similarly (Appendix).



Hispanics/Latinos

The results in Table 3 show that Hispanics of lower economic statuses, as measured by annual earnings, reported their health statuses as fair or poor at higher rates, when compared to Hispanics from higher income strata. In fact, Hispanics having incomes of $45,000 and over reported their health status as fair or poor at a rate of 1% (Table 3). In addition, the results show that Hispanics are most likely to report their health status as very good, with a response rate of 61% (Table 3). When Hispanics were compared to whites, it was determined that while 54% of Hispanics reported their annual earnings as between $1 and $24,999, only 40% of whites reported similarly (Tables 3). Along with this, the results demonstrated race or ethnic-based inequality as whites are less likely to report their health status as fair or poor (Tables 3).

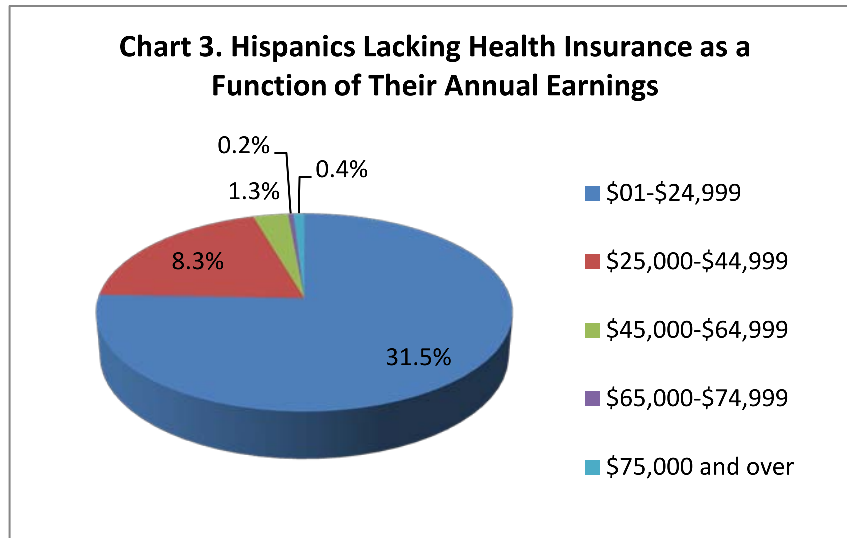
Table 3. Reported Health Status of Whites and Hispanics as a Function of Annual Earning

		Very Good		*Good*		*Fair/Poor*		*Total*	
		W	H	W	H	W	H	W	H
Annual Earnings	$01-$24,000	24.7%	30.8%	11.3%	18.3%	3.9%	6.5%	39.8%	55.6%
	$25,000-$44,999	18.8%	18.0%	6.8%	7.8%	1.6%	1.7%	27.1%	27.5%
	$45,000-$64,999	11.4%	6.6%	3.7%	2.7%	0.7%	0.7%	15.7%	10.0%
	$65,000-$74,999	3.3%	1.9%	0.9%	0.5%	0.1%	0.2%	4.4%	2.6%
	$75,000 and over	10.5%	3.3%	2.1%	0.9%	0.3%	0.2%	13.0%	4.3%
	Total	68.7%	60.6%	24.7%	30.1%	6.6%	9.2%	100.0%	100.0%

p=0.000 N=32,932

In the tests examining the relationship between an individual's annual earnings and their health coverage, the results showed that Hispanics having income levels between $1 and $24,999 were most likely to mention a lack of health coverage, at a stark rate of 32% (Chart 3). Moreover, Hispanics within this economic stratum disproportionately account for 76% of Hispanics who lack health coverage (Appendix). Along with this, Hispanics of higher economic

strata ($45,000 and over) report a lack of health coverage at a rate of only 2%, which is significantly lower than the impoverished stratum (Chart 3). As expected, 36% of Hispanics mentioned that they did not have health coverage, while only 21% of whites replied in the same manner (Appendix).



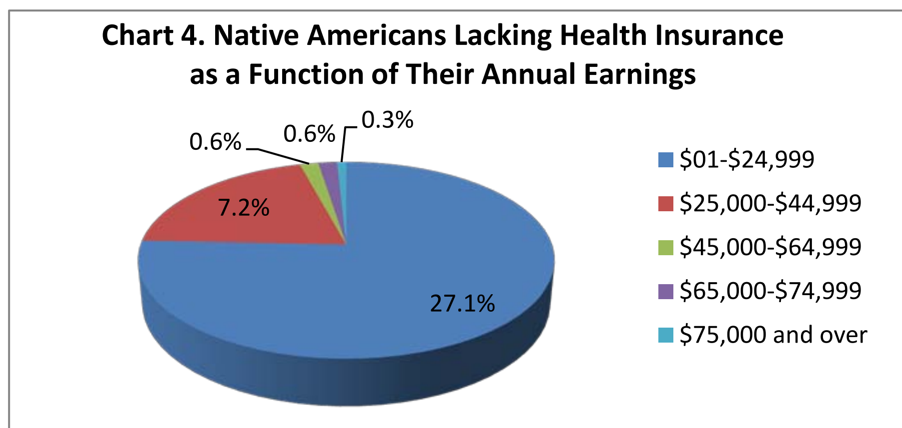
Native Americans

The results presented in Table 4 show that Native Americans of lower economic statuses, as measured by annual earnings, reported their health statuses as fair or poor at higher rates, when compared to Natives from higher income strata. When Native Americans were compared to whites, it was determined that while 56% of this population reported their annual earnings as between $1 and $24,999, solely 40% of whites reported similarly (Tables 4). Along with this, the results demonstrated a degree of inequality as whites are less likely to report their health status as fair or poor (Tables 4).

Table 4. Reported Health Status of Whites and Native Americans as a Function of Annual Earnings									
		Very Good		*Good*		*Fair/Poor*		*Total*	
		W	NA	W	NA	W	NA	W	NA
Annual Earnings	$01-$24,000	24.7%	27.4%	11.3%	17.5%	3.9%	9.0%	39.8%	53.9%
	$25,000-$44,999	18.8%	14.4%	6.8%	8.4%	1.6%	3.3%	27.1%	26.2%
	$45,000-$64,999	11.4%	6.6%	3.7%	3.0%	0.7%	0.6%	15.7%	10.2%
	$65,000-$74,999	3.3%	3.0%	0.9%	0.6%	0.1%	0.0%	4.4%	3.6%
	$75,000 and over	10.5%	3.9%	2.1%	1.8%	0.3%	0.3%	13.0%	6.0%
	Total	68.7%	55.4%	24.7%	31.3%	6.6%	13.2%	100.0%	100.0%

p=0.592 N=25,993

In the tests examining the relationship between an individual's annual earnings and their health coverage, the results showed that Natives with income levels between $1 and $24,999 were most likely to mention a lack of health coverage, at the highest rate of all groups: 32% (Chart 4). Moreover, Native Americans within this economic stratum disproportionately account for 76% of Natives who lack health coverage (Appendix). Along with this, Native Americans of higher economic strata ($45,000 and over) report a lack of health coverage at a rate of 2%, which is significantly lower than the impoverished stratum (Chart 4). Alarmingly, but as predicted by theory, 42% of Natives mentioned that they did not have health coverage, while only 21% of whites responded similarly (Appendix).



Discussion

Importantly, the results represented in the data support the hypothesis. The poverty experienced by women, racial and ethnic minorities, and other poor individuals, is the primary source of their unequal health outcomes within the American health care system. This can be understood by examining the trends observed within each group. In an intragroup analysis of the relationship between the annual earnings and variables denoting health outcome, one can clearly see that economic capital is the primary source of the disparity. For example, when examining women the trend shows that the higher one's annual earnings are, the better one's reported health status and the greater the likelihood that the woman will have health coverage. This finding is consistent throughout all of the vulnerable populations. In addition, it is consistent throughout *all* populations studied, including men and whites. Due to this observation, I determine that the impoverished status of an individual primarily leads to their vulnerability to negative health outcomes, regardless of the individual's gender or race/ethnic group. In conclusion, these trends suggest that the health status of an individual and their access to healthcare coverage is associated with their access to economic resources. This lack of economic capital, in turn, influences their health outcomes and opportunities.

Although the results support the hypothesis, it is important to give proper examination to other disparities the results brought to light. Importantly, the results showed that each vulnerable population experiences poverty at higher rates when compared to their less vulnerable counterpart, men, for women, and white Americans, for all other groups. For example, 56% of Native Americans reported their annual earnings between $01 and $24,999, while only 40% of white individuals responded in the same manner. These findings are significant because they

maintain and support the notion that inequality, with respect to acquisition of economic resources, does exist, and may influence the corresponding health statuses of each group.

Despite the insight gained through this research study, there are some limitations to this study. Specifically, the under-sampling of Native Americans limits the results of the study. In future investigations, the NHIS should over-sample this population as they did with African Americans, Hispanics, and Asians. Over-sampling will help researchers accurately assess relationships that exist between Native Americans and the American healthcare system. In addition, future studies should seek to examine other variables, besides socioeconomic status, that denote poverty and assess their relationship to healthcare access and outcomes. Importantly, a similar study that highlights the intersections of gender, class, and race/ethnicity would contribute to the existing body of literature because there is an understanding that compounded gender, race/ethnicity, and socioeconomic or class status has profound implications on one's access to and healthcare outcome. Specifically, women of color's experiences within the American healthcare system are different from white women, as their race or ethnicity and gender status cause them to be even more susceptible to poverty. A research endeavor highlighting this would provide additional understanding in the intersection of these multiple statuses, and the implications the intersection has on the individuals' experience within the American healthcare system.

Conclusion

Ultimately, the findings support previous findings that poverty is directly correlated with poor health. These findings suggest that in order to eradicate some of the disparity experienced by women, African Americans, Hispanics, and Native Americans with respect to health care, we

must develop health care reform that addresses the fact that they are poor. In addition, general economic reform is required in an effort to minimize poverty and the economic stratification that results from capitalism in American society. However, this health care reform proves to be a difficult task to accomplish, especially because about 84-85 percent of individuals of the population have insurance (Patel & Rushefsky 2008 280). Therefore, only a small percentage of our population feels the effects of a lack of health insurance, so only the few who lack and a few others care. In addition, reform poses difficulties as the proportion of minorities and types of minorities vary by state, therefore federal policy impositions may be rejected by various states for valid reasons (Patel & Rushefsky 2008: 280). The list of difficulties is endless; yet, in the end, we must create some solution to the problem of discrepancies experienced within our health care system as the issue of rights is brought up. Problematically, in the United States, there is no right to health care, unlike other Western, industrialized countries (Patel & Rushefsky 2008: 280). The question remains is this fair, but also is it the responsibility of American society to ensure that it is indeed fair?

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APPENDIX

Correlation Tables

Variables	1	2	3	4	5	6
1. Sex	1.000					
2. Annual Earnings	-0.196**	1.000				
3. Reported Health Status	0.032**	-0.148**	1.000			
4. Lack of Health Insurance	0.041**	0.302**	-0.055**	1.000		
5. Physician Visits Within a Year	-0.064**	0.005	-0.286**	-0.083**	1.000	
6. Obesity/Weight Problem	-0.087	a	0.065	-0.141*	0.056	1.000

Variables	1	2	3	4	5	6
1. Race	1.000					
2. Annual Earnings	0.019**	1.000				
3. Reported Health Status	-0.004	-0.148**	1.000			
4. Lack of Health Insurance	0.000	0.302**	-0.055**	1.000		
5. Physician Visits Within a Year	0.032**	0.005	-0.286**	-0.083**	1.000	
6. Obesity/Weight Problem	0.390**	a	0.065	-0.141*	0.056	1.000

Variables	1	2	3	4	5	6
1. Ethnicity	1.000					
2. Annual Earnings	0.189**	1.000				
3. Reported Health Status	-0.020	-0.148	1.000			
4. Lack of Health Insurance	0.230	0.302	-0.055	1.000		
5. Physician Visits Within a Year	-0.056	0.005	-0.286	-0.083	1.000	
6. Obesity/Weight Problem	0.026	a	0.065	-0.141	0.056	1.000

a. Cannot be computed because at least one of the variables is constant.

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed.)

Table 1a. Healthcare Coverage by Gender as a Function of Annual Earnings							
		No		*Yes*		*Total*	
		M	W	M	W	M	W
Annual Earnings	$01-$24,000	15.2%	14.1%	17.7%	34.3%	32.9%	48.4%
	$25,000-$44,999	6.6%	2.9%	20.6%	24.8%	27.2%	27.7%
	$45,000-$64,999	1.5%	0.6%	16.3%	12.7%	17.8%	13.3%
	$65,000-$74,999	0.3%	0.1%	4.7%	3.2%	5.0%	3.3%
p=0.000 N=33,053	$75,000 and over	0.6%	0.1%	16.5%	7.2%	17.0%	7.3%
	Total	24.1%	17.7%	75.9%	82.3%	100.0%	100.0%

Table 2a. Healthcare Coverage of Whites and African-Americans as a Function of Their Annual Earnings							
		No		*Yes*		*Total*	
		W	AA	W	AA	W	AA
Annual Earnings	$01-$24,000	14.4%	16.4%	25.3%	28.6%	39.8%	45.1%
	$25,000-$44,999	4.7%	4.8%	22.4%	25.6%	27.1%	30.4%
	$45,000-$64,999	1.1%	1.0%	14.7%	13.7%	15.7%	14.7%
	$65,000-$74,999	0.2%	0.2%	4.2%	2.7%	4.4%	2.9%
p=0.000 N=30,472	$75,000 and over	0.3%	0.3%	12.6%	6.6%	13.0%	7.0%
	Total	20.7%	22.9%	79.3%	77.1%	100.0%	100.0%

Table 3a. Healthcare Coverage of Whites and Native Americans as a Function of Their Annual Earnings							
		No		*Yes*		*Total*	
		W	NA	W	NA	W	NA
Annual Earnings	$01-$24,000	14.4%	27.1%	25.3%	26.8%	39.8%	53.9%
	$25,000-$44,999	4.7%	7.2%	22.4%	19.0%	27.1%	26.2%
	$45,000-$64,999	1.1%	0.6%	14.7%	9.6%	15.7%	10.2%
	$65,000-$74,999	0.2%	0.6%	4.2%	3.0%	4.4%	3.6%
p=0.000 N=25,945	$75,000 and over	0.3%	0.3%	12.6%	5.7%	13.0%	6.0%
	Total	20.7%	35.8%	79.3%	64.2%	100.0%	100.0%

Table 4a. Healthcare Coverage of Whites and Hispanics as a Function of Their Annual Earnings							
		No		*Yes*		*Total*	
		W	H	W	H	W	H
Annual Earnings	$01-$24,000	14.4%	31.5%	25.3%	24.1%	39.8%	55.6%
	$25,000-$44,999	4.7%	8.3%	22.4%	19.2%	27.1%	27.5%
	$45,000-$64,999	1.1%	1.3%	14.7%	8.7%	15.7%	10.0%
	$65,000-$74,999	0.2%	0.2%	4.2%	2.4%	4.4%	2.6%
p=0.000 N=32,853	$75,000 and over	0.3%	0.4%	12.6%	4.0%	13.0%	4.3%
	Total	20.7%	41.7%	79.3%	58.3%	100.0%	100.0%