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Association Between Access to Healthcare Providers, Health Insurance, Income, Employment Status, and ACA Provision Based on Black Non-Hispanic and White Non- Hispanic

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
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Abstract

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MA/MS, Capella University, 2012

BS, Saint Louis University, 2007

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Healthcare Administration

Walden University

August 2024

Abstract

Despite significant advancements in healthcare delivery and policy reforms, disparities in access to healthcare services persist among different racial and ethnic groups in the United States. The impact of the Affordable Care Act (ACA) on these disparities remains debated. The purpose of this quantitative study was to utilize a secondary dataset from the Health and Medical Care Archive (HMCA) to examine the association between access to healthcare providers (dependent variable) and health insurance, income, employment status, and ACA provision (independent variables), based on Black non-Hispanic and White non-Hispanic between 2017 and 2020. The research questions investigated whether the ACA affected the healthcare access gap between these groups after accounting for health insurance, income, and employment status. Using Andersen's model of healthcare utilization and a sample of 89, a chi-square analysis and ordinal logistic regression were performed. The study found a significant relationship between ACA provision and access to healthcare services, and between health insurance coverage and access. No association was found between employment status or race/ethnicity and access to healthcare; however, income level was a key factor, with higher income levels correlating with better access. These findings suggest that while the ACA has improved healthcare access, income disparities remain significant barriers. This indicates a need for targeted efforts to address economic inequalities in healthcare access. The study contributes to positive social change by informing the development and refinement of healthcare policies aimed at reducing disparities in healthcare access.

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Dedication

This study is dedicated to all individuals who have faced barriers in accessing healthcare services due to their race, ethnicity, income, or employment status. It is for those who have been marginalized within the healthcare system and for the families who have struggled to obtain the care they need and deserve. This work is also dedicated to the healthcare professionals, policymakers, and advocates who tirelessly work towards creating a more equitable and accessible healthcare system for all, regardless of their background or socioeconomic status. May this study contribute to the ongoing efforts to dismantle disparities and inspire continued progress toward healthcare equity.

Acknowledgments

This study's completion would not have been possible without the support and encouragement of several individuals. I would like to extend my heartfelt gratitude to the faculty members who have guided me through the process of this research. Their insights and feedback have been invaluable in shaping this study. I am also deeply thankful to my family and friends, whose unwavering support and belief in my abilities have kept me motivated during challenging times. Their patience and understanding have been a constant source of strength. This acknowledgment is a small gesture to express my appreciation for their significant contributions to my academic journey and the successful completion of this study.

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Section 1: Introduction

U.S. adults who identify as Black non-Hispanic are challenged with health insurance costs, with finding a healthcare provider who accepts them as patients and accepts their health insurance, and with getting an appointment with selected physicians (VanGarde et al., 2018). According to Himmelstein et al. (2022), cost barriers discourage many U.S. residents from seeking medical care, and many who obtain it experience financial hardship. That said, it was also noted that little was known about the association between medical debt and social determinants of health (SDOH). Himmelstein et al. explored the prevalence of, and risk factors associated with, medical debt and the association of medical debt with subsequent changes in the key SDOH of food and housing security. Their study showed that acquiring medical debt between 2017 and 2019 was a risk factor associated with worsening SDOH. Himmelstein et al.'s study was important to my study because it revealed a wide range of possible disparities in the United States healthcare system. It also clarified how this issue is damaging, especially among the population in my study: Black non-Hispanic in the United States.

VanGarde et al. (2018) stated that several studies have documented the increase in young adults' insurance coverage because of the Patient Protection and Affordable Care Act (ACA); these studies demonstrated the impact of the ACA on young adults' insurance coverage, at times touching on covariates affecting insurance uptake, but did not focus on racial and ethnic disparities in access to insurance because of social economic status. Williams and Sahel (2022) added that lack of insurance is detrimental to health and the type of insurance coverage plays a significant role in vision outcomes and

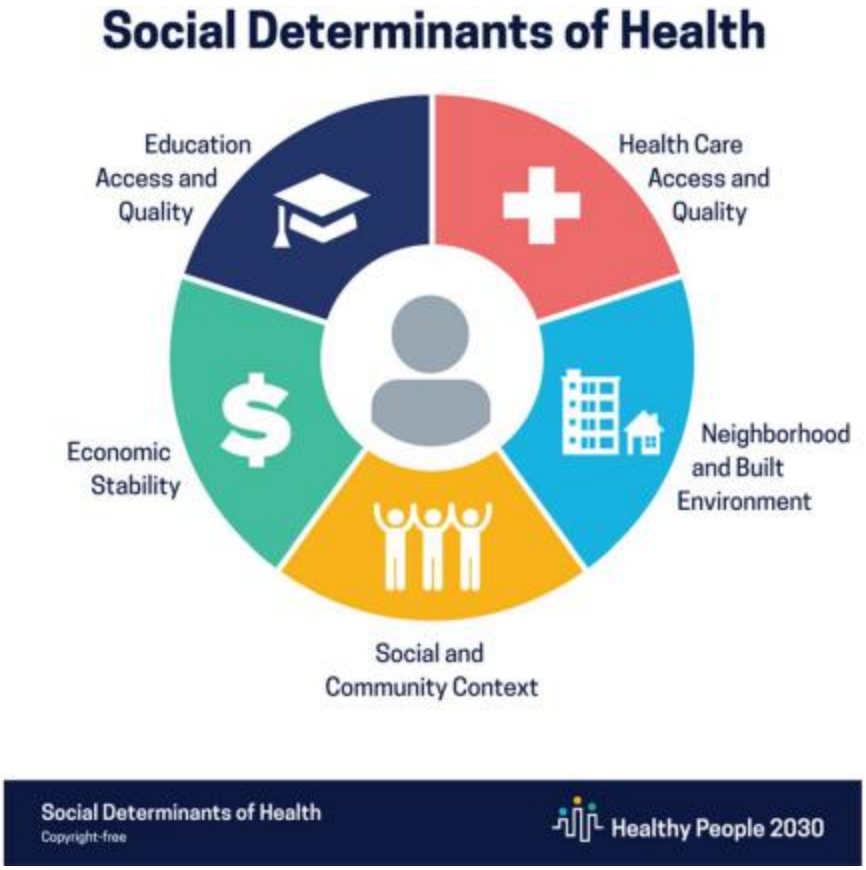
access to eye care. The authors further emphasized how Medicaid insurance, which is a government program that is generally available to low-income Americans, is associated with poorer outcomes and less access to care than private plans or Medicare. Finally, O'Loughlin et al. (2019) highlighted that historically, communities with African American majorities, regardless of whether they are urban, suburban, or rural, have been underserved regarding medical and behavioral health services.

The current research examined whether the barrier to healthcare provider access among Blacks who identify as non-Hispanic is due to race or ethnicity or lack of healthcare coverage, income, and employment status; the dependent variable in this study is access to healthcare provider. The independent variables are health insurance, income, employment status and ACA provision. These variables were used to summarize the socioeconomic status of the population in my study. Other potential confounding variables are cost, education, marital status, housing type, citizenship, home ownership, internet access, and socioeconomic status above/below the federal poverty level. The study clarified the misconception of why Black non-Hispanics lack access to healthcare providers outside of their race and ethnicity. Some researchers highlight the lack of healthcare utilization among the population of interest because of lack of education. The limitation of this study is I used secondary quantitative data; hence, I did not have control over how the data were collected. Since it is a survey, I could not be sure how honest the participants were in their responses. One or more of the data collection files have special restrictions, and restricted data files are not available for direct download from the website.

According to Williams and Sahel (2022), SDOH encompass the quality of an individual's social and physical environment and its effect on health outcomes; hence, disparities in these social and environmental factors have a significant role in vision health disparities and inequity in eye care. As reflected in Figure 1, the five SDOH include (a) education access and quality, (b) healthcare access and quality, (c) economic stability, (d) neighborhood and built environment, and (e) social and community context.

Figure 1

Social Determinants of Health



Note. From "Addressing Social Determinants of Vision Health," by A. M. William and J.-A. Sahel, 2022, *Ophthalmology and Therapy*, *11*, p. 1372 (https://doi.org/10.1007/s40123-022-00531-w).

As highlighted by Lipton et al. (2019), before the ACA, one in three young adults between 19 to 25 years of age were uninsured with substantial racial and ethnic disparities in coverage. This study analyzed the separate and cumulative changes in racial and ethnic disparities in coverage and access to healthcare among young adults after the implementation of the ACA in 2010, the dependent coverage provision, and the 2014 Medicaid and Marketplace expansions. Lipton et al. found that the dependent coverage provision linked with similar gains across racial and ethnic groups, but the 2014 expansion was associated with larger gains in coverage among Hispanics and Blacks relative to Whites. After the 2014 expansion coverage between Hispanics and Blacks increased by 11.0 and 10.1 percentage points respectively, compared with only a 5.6-point increase among Whites. This shows that the ACA provision helps improve access to healthcare among this population and increases in coverage were larger in Medicaid expansion states compared with the non-expansion states for most Racial and Ethnic groups.

According to Lee et al. (2021), there have been some studies that examine the ACA's impact using the National Academy of Medicine (NAM) approach. One of the studies estimated the changes in disparities by controlling only the age and gender while another study estimated NAM models by controlling for healthcare need variables (age, gender, general health status) and marital status among adults with serious psychological distress. Despite the benefits of the ACA, the study highlighted existing gaps in the literature regarding the ACA's impact on Racial and Ethnic disparities. Some studies that controlled for other economic factors found mixed results regarding disparities. While

few studies estimated the effects of Medicaid expansion on unmet healthcare needs due to cost and physician visits, access to specific types of care, such as specialist and mental health were not distinguished. According to the study, since uninsured patients are likely to be referred to diagnosis/therapeutic services, an increase in insured rates due to the Medicaid expansion is expected to increase referrals to specialist doctors. It has become obvious that more work needs to be done regarding access to healthcare services among the population in my study. As stated by Lee et al., "After the ACA Medicaid expansion, most access outcomes improve for disadvantaged groups, but also for others, with the result that disparities were not significantly reduced."

Study Background

According to Li et al. (2021), access to healthcare is defined as the timely utilization of appropriate health services to attain the best health outcome; barriers to healthcare access, such as lack of availability, high cost, lack of insurance coverage, and language barriers, can greatly affect individual health status. Further subsequent research by Dean et al. (2020) stated that in comparing men who reported difficulty in paying medical bills by race and ethnicity, a greater percentage of African American (18.32%) and Hispanic men (19.67) reported difficulties versus White men (15.16%). In addition, Li et al. stated that U.S. adults with intellectual and developmental disabilities (IDD) have poor health and face barriers such as long waits for appointments. Whether barriers differ by race and ethnicity or if race and ethnicity is the determinant of access to healthcare services has not yet been examined. Also, whether the ability to pay for healthcare, health insurance, cost, income, and employment status could be a contributing

factor to access to healthcare provider has not yet been examined among United States adults who identify as Black non-Hispanic between 2017 and 2020.

Problem Statement

The situation or issue that prompted me to search the literature is, as discussed by Li et al. (2021), barriers to healthcare access can greatly affect one's health status. People who identify as Black non-Hispanic are more likely to be uninsured due to health insurance costs which may result in limited or no access to healthcare services and are disproportionately experiencing financial strain due to healthcare expenditures. This problem anchored a lack of utilization of healthcare providers due to health insurance, employment status, and income. Crowley et al. (2020) stated that among the wealthy industrialized countries that have achieved universal health coverage, the United States' existing healthcare system is inefficient, unaffordable, unsustainable, and inaccessible to many. Taylor et al. (2019) stated that research available on racial and ethnic differences in the use of the healthcare system by patients with diabetes suggests that disparities exist. In one study using self-reported data from a nationally representative sample of 984 adults with diabetes, researchers found that non-Hispanic Blacks with diabetes have fewer primary care visits and fewer prescription refills when compared to non-Hispanic Whites. Another study examining emergency department use among 8596 patients in a diabetes management program in Louisiana found that Whites with Type 2 diabetes had 19% lower odds of non-urgent emergency department visits compared to Blacks. In a representative sample of 3003 older adults with diabetes in California, researchers using self-reported data found that non-Hispanic Blacks had nearly four times higher odds of

emergency department visits for diabetes and half times the odds of seeing a doctor in the previous 12 months compared to non-Hispanic Whites. Improving glycosylated hemoglobin (HbA1c) values has been associated with lower healthcare utilization and costs for patients with diabetes in the US and international studies that did not examine differences by race. Additional research using clinical databases can determine the impact of improved glycemic control on observed racial and ethnic disparities in the use of healthcare.

According to Dickman et al. (2022), racial inequalities in care have persisted for six decades and widened in recent years, suggesting the persistence and even fortification of structural racism in healthcare access. In Tien et al.'s (2023) study, it was highlighted that racial and ethnic disparities in access to cardiac procedural care were present; hence there is a continuing need for initiatives to reduce racial and ethnic disparities in healthcare.

As a result, the existing research is inadequate. Previous research has shown that the ACA has improved access to healthcare providers among people in the United States. However, there are also indications that certain groups of people may not experience the benefits of ACA equally. It is currently unclear to us as a nation the association of health insurance, income, employment status, and ACA provision of Blacks who identify as non-Hispanic, a gap in the literature regarding the impact of citizenship, education, and other demographic factors on access to healthcare services.

Research Questions and Hypotheses

The research questions for my study are as follows:

RQ1: Is there an association between health insurance, income, employment status, and access to healthcare providers in the United States among adults who identify as Black non-Hispanic and White non-Hispanics between 2017 and 2020?

$H_0$1: There is no statistically significant association between health insurance, income, employment status, and access to healthcare providers in the United States among adults who identify as Black non-Hispanic and White non-Hispanics between 2017 and 2020.

$H_1$1: There is a statistically significant association between health insurance, income, employment status, and access to healthcare providers in the United States among adults who identify as Black non-Hispanic and White non-Hispanics between 2017 and 2020.

RQ2: Is there an association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020?

$H_0$2: There is no statistically significant association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020.

$H_1$2: There is a statistically significant association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020.

Purpose of the Study

The purpose of this quantitative correlational study is to examine the association between access to healthcare providers, health insurance, income, employment status, and ACA provision based on Black non-Hispanic and White non-Hispanic. According to Li et al. (2021), barriers to healthcare access can greatly affect one's health status. People who identify as Black non-Hispanic are more likely to be uninsured due to health insurance costs which result in limited or no access to healthcare services and are disproportionately experiencing financial strain due to healthcare expenditures. According to Aggarwal et al. (2022), U.S. adults who identify as Black non-Hispanic are challenged with health insurance costs, have trouble finding a healthcare provider who accepts them as patients and accepts their health insurance, and have trouble getting an appointment with selected physicians. The question now is whether this problem of access to healthcare providers or access to healthcare services among this population would persist if health insurance, employment that provides adequate health insurance, adequate income, cost, education, and employment status were present. In this study, I sought to determine whether there could be an association between health insurance, income, employment status, ACA provision, and access to healthcare providers of adults in the United States who identify as Black non-Hispanic and White non-Hispanic between 2017 and 2020. I also sought to determine whether there is an association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020. There is one dependent variable which is

access to healthcare providers and four independent variables which are health insurance, income, employment status, and ACA provision. The data are from the Urban Institute; the Institute launched the Health Reform Monitoring Survey (HRMS), a survey of the non-elderly population, to explore the value of cutting-edge, internet-based survey methods to monitor the ACA before data from federal government surveys are available. Topics covered by the 19th round of the survey (first quarter of 2020) include self-reported health status, health insurance, access to healthcare, trust in the healthcare system, use of public benefits, material hardship, and the COVID-19 pandemic. Additional information collected by the survey includes age, gender, sexual orientation, marital status, education, race, and ethnicity. The information collected was used to measure access to healthcare providers. Questions assessing access to healthcare providers were adapted from the HRMS (first quarter 2020). The variable for my study would be measured as follows: Access to healthcare provider (DV) would be measured using nominal with logistic regression, income (IV) using ordinal with logistic regression, employment status (IV) will be nominal using ordinal regression, ACA provision (IV) will be nominal using ordinal regression and health insurance (IV) will be measured using ordinal and ordinal regression.

Theoretical and/or Conceptual Framework

The theory grounding this study is Andersen's model of healthcare utilization. (Dean et al., 2020). This model delineated predisposing, enabling, and need characteristics as predictors of healthcare utilization (Dean et al., 2020). Predisposing characteristics are the demographic or biological factors that indicate the likelihood of

needing services. Enabling characteristics are the resources or means that must be available to use healthcare services. Need characteristics are people's perceived and professionally evaluated health status and their need for medical care. The logical connections between the framework presented and my study approach include Dean et al. (2020). Theoretical work assessed the relationship between the confidence level in understanding health insurance terms and the difficulty in paying medical bills among American men. Further subsequent research application by Dean et al. stated that in comparing men who reported difficulty in paying medical bills by race and ethnicity, a greater percentage of African American (18.32%) and Hispanic men (19.67) reported difficulties versus White men (15.16%).

The dependent variable in this study is access to healthcare providers, and the independent variables are health insurance, income, employment status, and ACA provision. According to Roddam et al. (2019), variations in access to healthcare are known to contribute to differences in life expectancy, morbidity, and health quality of life across population subgroups.

The United States needs to know whether race and ethnicity is the root cause of barriers to healthcare provider access and access to healthcare services of United States adults who identify as Black non-Hispanic between 2017 and 2020 or if all contributing factors to access such as health insurance, income, cost, and employment status. If the independent variables are controlled, would the barriers to healthcare providers among this population exist? William and Sahel (2022) highlighted that healthcare access (insurance and medical cost) is one of the five core domains of SDOH. Therefore,

adequate health insurance, education, employment, and stable income would prevent barriers to healthcare access.

Nature of the Study

According to Holahan and Karpman (2020), the Health and Medical Care Archive (HMCA) is the data archive of the Robert Wood Johnson Foundation (RWJF). This foundation is the largest philanthropy devoted exclusively to health and healthcare in the United States and it is operated by the Inter-university Consortium for Political and Social Research (ICPSR) at the University of Michigan. The ICPSR receives funding from RWJF. HMCA preserves and disseminates data collected by selected research projects funded by RWJF and facilitates secondary analyses of the data. The data collection in HMCA primarily includes large-scale surveys of the American public about public health, attitudes towards health reform, and access to medical care; surveys of healthcare professionals and organizations, public health professionals, and nurses; evaluations of innovative programs for the delivery of healthcare, and many other topics and populations of interest. The institution's goal is to build a culture of health by increasing the understanding of health and healthcare and the factors that contribute to health in the United States through secondary analysis of RWJF-supported data collections (Holahan & Karpman, 2020).

Literature Search Strategy

Different search terms were added to retrieve the most relevant articles from the set of articles related to my topic. Recent scholarly (peer-reviewed) articles and empirical literature were searched using the EBSCO database from Walden University Library.

Different search terms were used to get the result needed. I kept a logbook of those research terms, and the results were narrowed down as needed to meet the needs of my study. The literature used comprises sources published within 5 years of the time my prospectus was submitted in 2022; however, more recent literature was added as I continued to work on my proposal and addressed the feedback received from my chair, and I ended using literature from 2018 to 2023. Examples of the searches that were made are noted in Table 1:

Table 1

Research Strategy

Database	Search terms	Results	Notes
EBSCO	Healthcare barriers, social determinants of health, health insurance, United States	7	The results are diverse; health barriers and social determinants of health were paired together to narrow the results.

Literature Review Related to Key Variables and Concepts

A total of 22 articles were reviewed; it was not originally planned to review 22 articles; however, as I found out that I had enough articles that were closely related and align with my study variables, the review process stopped and for my record, I counted the number of articles that were reviewed, and it was 22. The articles used align more with my study variables.

According to VanGarde et al. (2018), the impact of the 2010 ACA was examined to see how this legislation affected insurance coverage and access to healthcare for ages

19-25; this group/population refers to as young adults, with a focus on racial and ethnic disparities. The increase in coverage for this population was significant and the cost-related barriers to accessing healthcare were also reduced significantly. Despite this positive outcome, racial and ethnic disparities in healthcare access and coverage were still a continuous issue. For this reason, the nation needs policies that will not depend on parental insurance to further reduce or solve the issue of disparities in the U.S. healthcare system. About my study, factors such as employment, income, education, and health status are contributing factors to healthcare access. The study further pointed out the importance of racial and ethnic mitigation with statistical data and references in support of the author's findings. The research topic was tailored around the implication of the ACA on health insurance, access to healthcare, and the potential disparities in coverage based on health status, race and ethnicity. Limitations of their analysis were noted as a lack of geographic identifiers in the data. For this reason, further research must be carried out to explore ACA and its impact.

On average, insurance rates among young adults increased by 6.12 percentage points after ACA implementation ($p<.001$). All racial groups experienced an increase in coverage. However, the impact varied by race and ethnicity and was largest for Whites. In addition, young adults had a 2.61 percentage point ($p<.001$) decrease in experiencing barriers to healthcare because of cost issues after the ACA with variation by race and ethnicity. The objective of this article was to examine the impact of the ACA's 2010 parental insurance coverage extension to young adults aged 19 to 25 years on health insurance and access to care, including racial and ethnic disparities. The ACA's

expansion had a significant positive effect on young adults acquiring Health insurance and reducing cost-related barriers to accessing healthcare. However, racial and ethnic disparities in coverage and access persist. This research is important to my study because I further explored the disparities in racial and ethnic disparities in the United States healthcare systems despite the major healthcare reform that was signed into law in the 2010 ACA.

Statistical analysis was used to examine the impact of ACA on insurance coverage, and access to healthcare for young adults using a quantitative method. The author began with the hypothesis of how the ACA impacted insurance coverage and access to care for young adults including possible disparities in coverage and access based on race and ethnicity and health status. The method in the study was further described as employing a multivariable differences-in-differences approach; this was used to compare changes in insurance and access to healthcare among the population of interest. A linear probability model was used to measure the significance of change in the result and standard errors were adjusted for clustering and stratification in the behavioral risk factors surveillance system.

The main result found from the study was that the ACA expansion had a significant positive effect on young adults acquiring Health insurance and reducing related healthcare costs for this group. According to the authors, the insurance rate among young adults increased by 6.12 percentage points following the implementation of ACA and an increase in coverage of all racial and ethnic groups was evident. Despite the impressive outcomes, the impact of ACA still varied by race and ethnicity and was

largest for Whites. A recorded decrease in young adults experiencing barriers by 2.61 percentage points.

The author pointed out some gaps and limitations of the study as follows: lack of geographic identifiers in the data; exploring state heterogeneity was prevented, observed contribution of covariates to variation in the study outcome was consistent with other previous research. Therefore, a need for further research was recommended to examine the impact of the 2014 ACA implementations. The racial and ethnic disparities in access to insurance care were not the focus of the study. The authors stated the importance of understanding Racial and Ethnic disparities in the United States healthcare system to be addressed by future policies.

Finally, the study also shows that Hispanics have lower rates of Health insurance compared to non-Hispanic Blacks and non-Hispanic Whites. It is currently unclear what impact the ACA has had on Racial and Ethnic disparities in Health insurance and cost preventing healthcare service utilization among this population (Young Adults). It was highlighted that the increase in insurance among non-Hispanic Blacks was smaller and there was no significant improvement in access to physician visits.

According to Luque et al. (2018), cultural factors participants demonstrated determination to access care but reported that their primary healthcare access barriers included the high cost of services, lack of health insurance, family and work responsibilities, and language barriers. This study explored uninsured Latino immigrant women's access to healthcare and alternative treatment strategies in coastal South Carolina. The findings in this study that stood out were that none of the participants had

health insurance at the time of the interview, but four participants reported they had sought health insurance in the last three years and 10 participants did not have a regular medical provider. According to the American College of Physicians (2019), the current U.S. healthcare system is inefficient, unaffordable, and inaccessible. Thus, there is a need for major changes to have a better healthcare outcome for the citizens. The American College of Physicians recommended that the United States should transition to universal healthcare coverage; in addition, to a single-payer or public choice model. Per the recommendation, which model chosen should ensure that all essential healthcare services for a diverse population.

Factors such as lack of insurance, high cost, language difficulties, and work/life balance issues are some of the barriers faced by uninsured Latino immigrant women in accessing healthcare in South Carolina. Sociocultural factors that are related to preventive healthcare for popular chronic diseases affecting this population were explored. The main healthcare access barriers highlighted were high cost, lack of health insurance, language barriers, family, and work responsibilities. Anti-immigrant political climate and work schedules among this population embodied transportation crisis, socioeconomic status, and anxiety. The population is connected to their social network, such as families, friends, and supporting one another in navigating life challenges. According to Luque et al. (2018), Latino immigrant women in South Carolina treated healthcare as the last result when traditional remedies or over-the-counter treatment fails.

The study topic was tailored around access to healthcare for uninsured Latino immigrant women in South Carolina, coping mechanisms and positive health behavior

employed by the population were discussed, cultural factors and alternative healthcare strategies were used by this group according to the authors. The author begins with the hypothesis of understanding the barriers and facilitators to healthcare access for an uninsured population of Latino immigrant women in South Carolina. Cultural factors that influence the healthcare-seeking behaviors of the population were investigated. The study participants had average age of 40, mostly married, unemployed, and from Mexico with low income and limited education. As recorded, none of the participants had Health insurance during the survey even though many of them reported having chronic health conditions.

The interviews among this group were conducted to protect confidentiality and differentiate interview participants. Some gaps and limitation were highlighted in the study such as lack of direct inquiry into the population of interest immigration status, specific reason and rationale for population relocation was not addressed and the state level policies was not directly addressed.

According to William and Sahel (2022), healthcare access (insurance and medical costs) is one of the five core domains of SDOH. Their study explored how disparities in visual impairments and eye care utilization are affected by each of the five core domains of SDOH. The article stressed the importance of the environment as a contributing factor to health and concluded that as patients are treated, the environment in which they live/belong cannot be ignored. The study also found that poorer living conditions also increase the risk of hospitalization. This finding and others would back up my study as

Black non-Hispanics are more likely to experience poor living conditions compared to White non-Hispanics.

SDOH and their impact was discussed relating to health and vision and health and eye care disparities. Five core domains of the SDOH and actionable strategies were outlined for ophthalmologists to address social needs. To reduce vision health disparities, the study highlights the importance of addressing SDOH. The following are the five core determinants of health that were discussed in this article: economic stability, education, healthcare access, neighborhood environment, and social context. The study recommended ways in which ophthalmologists can address social needs related to vision by promoting awareness of social needs. Social risks in patients must be identified, examine the social risk associations with relevant health outcomes. The authors mentioned several issues related to eye care. The disparities between Medicaid enrollees, commercial health insurance, and access to medical care for individuals with vision impairment or glaucoma care were highlighted.

Lack of health insurance could result in a negative impact on outcomes; insurance coverage plays a major role in vision outcomes and access to eye care. Poorer outcomes are associated with Medicaid insurance and less access to healthcare compared to private plans or Medicare. Social and community context were discussed particularly the Black race association with visual impairment and disparities in eye care utilization among beneficiaries of Medicare with glaucoma. The gap in health insurance and its impact on access to eye care has been studied; according to the author poorer outcomes and less care have been linked to Medicaid insurance with lots of self-reported visual impairment

decrease in the chance of a successful scheduling ophthalmology appointment compared to adults with private insurance coverage. Medical cost has been cited as a barrier to eye care; the research further indicated that medical costs disproportionately affect individuals with the greatest need.

Several efforts have been made to address these disparities that are found and improve access to eye care. For example, previous studies have investigated the impact of SDOH on Medicare ocular hospitalizations and adherence to diabetic retinopathy examination that aims to understand and mitigate barriers to care associated with this social determinant, racial and socioeconomic differences in eye care utilization among Medicare beneficiaries with glaucoma has also been explores focusing more on disparities in access to eye care and potential interventions that can be used to address these disparities.

It was highlighted that lack of insurance is detrimental to health and the type of Health insurance plays a major role in vision outcomes and access to eye care. The study found that SDOH that include economic stability education, healthcare access, neighborhood environment, and social context are factors that are associated with disparities in vision health and access to eye care health services.

This study is significant and needed because it sheds some more light on the significant impact of SDOH on vision health and eye care disparities.

According to Verlenden et al. (2021), healthcare access and utilization of young adults with disabilities in the United States were examined. A higher record indicated that young adults with disabilities have higher healthcare needs and lower satisfaction with

care compared to those young adults without disabilities. This population is likely to use hospital emergency room services for routine care, delayed care, or forgo healthcare services due to cost. The population is prone to having financial worries about the need for intervention to address access healthcare barriers and improve the transition for young adult with disabilities.

Findings in the study show that young adults with disabilities were more likely to visit emergency rooms with a record of 39.2% compared to young adults without disabilities with a record of 19.5%. A significant number of young adults delayed medical care due to cost (19.1 % vs 8.9%) and unmet medical needs (21% vs 10.2%). There is a provision of the usual source of care to young adults with disabilities when they are sick (82.2% vs 75%). This population also uses emergency rooms as their commonly used place of care. They often have had preventive care visits and emergency room visits within the last 12 months compared to young adults without disabilities. The study pointed out that this population was less likely to have dental visits. Medication prescriptions are more likely among this group in the past 12 months in addition to a usual place of care. Despite these provisions for this population, they are three times as likely to identify the emergency room as their commonplace of healthcare services compared to young adults without disabilities. These findings indicate a potential barrier to receiving needed healthcare services and care satisfaction and disparities in healthcare access among this population.

Several recommendations were highlighted within the study for healthcare access improvement and quality for this population: transition from pediatric to adult healthcare

which includes comprehensive healthcare coverage through the transition period, a usual source of primary healthcare provider, continuity of care, having access to a usual healthcare source, preventive healthcare visit, having health insurance. This will help to avoid gaps in care and promote the health of young adults with disabilities. The sample in this study was collected using data from 2014 to 2018 National Health Interview Survey. The topic was framed around the importance of healthcare access and utilization among young adults with disabilities during their transition from pediatric to adult healthcare. The study also pointed out the need for intervention to reduce the use of emergency rooms for routine care. Delays in healthcare services due to cost and other barriers need to be addressed. The article is described as a secondary data analysis with an understanding of the hypothesis in the study to understand healthcare access among young adults with disabilities from pediatric to adult healthcare in the United States.

Finally, the study highlights limitations and implications; the limitation includes heterogeneity, and potential biases in proxy responses. This study is important because it brought up more in-depth reasons why disparities in healthcare access and utilization need to be addressed.

The authors stated that young adults with disabilities experience barriers to healthcare access and are at risk of not receiving needed services as they transition from the pediatric to the adult health system. The study examined patterns of healthcare utilization for young adults with disability barriers to receipt of care. The authors found that among adults with a disability, 19.1% reported having had to delay medical care due to cost, and 11.9% reported not receiving medical care due to cost significantly more than

young adults without disability (8.9% and 6.0% respectively). My study will look more into disparities among the Black non-Hispanic compared to White non-Hispanics as a contribution to previous studies. I believe all these studies could spark policy change in the United States healthcare system.

According to Markt et al. (2018), the association between race and ethnicity and cervical cancer survival was investigated, and potential mediating factors (insurance and treatment). The study highlighted five main findings from the study:

1. Increased risk of cervical cancer-specific mortality among non-Hispanic Black women compared to non-Hispanic White women, with a hazard ratio of 1.23 (95% CI:08-1.39)
2. Hispanic women had a decreased risk of dying from cervical cancer compared to non-Hispanic White women with a hazard ratio of 0.82 (95% CI: 0.72-0.93)
3. The mortality rate due to cervical cancer among non-Hispanic Black women compared to non-Hispanic White women was mediated by their insurance status (18.6%) and treatment (47.2 %)
4. Due to disparities in treatment, non-Hispanic Black women were more likely to receive radiation and less likely to receive surgery for early-stage disease.
5. The key strategy to improving treatment in all women suggested by the study is to enhance existing insurance coverage and to ensure equal and adequate treatment for all women.

The authors also pointed out that efforts to limit Health insurance may exacerbate disparities in outcomes.

Socioeconomic and clinical factors were addressed to reduce racial disparities; disparities in insurance coverage and access to timely treatment were highlighted to play a significant role in mediating disparities in cervical cancer outcomes among different racial and ethnic groups. The potential impact of ACA-dependent coverage expansion to increase early diagnosis was discussed. In addition, the study pointed out the impact of race and ethnicity on survival rate and access to appropriate care for cervical cancer.

Cervical cancer outcomes remain poor among disadvantaged populations, including ethnic minorities, low-income, and underinsured women. This study aimed to evaluate the mechanisms that underlie the observed association between race and ethnicity and cervical cancer survival. One of the research findings in this study is that non-Hispanic Black women had an increased risk of cervical cancer-specific mortality (HR:1.23, 95% CI, 1.08-1.39) and Hispanic women a decreased risk of dying from their diseases (HR:.82, 95% CI, 0.72- 0.93) compared with a non-Hispanic White. In this population-based study, they found that some of the excess cervical cancer-specific mortality for non-Hispanic Black women is mediated by factors such as insurance status and treatment. These findings suggest that enhancing existing insurance coverage and ensuring equal and adequate treatment in all women may be a key strategy for improving cervical outcomes. The research is important for my study because it is important for the researcher to continue exploring the issue of Access and cost-related healthcare barriers among Black and White non-Hispanic US adults to reduce the mortality rate among this population.

According to Ogbonnaya et al. (2020), African immigrants in the United States are the least-studied immigrant group, despite the research and policy efforts to address health disparities within immigrant communities. African immigrants make up about 5% of the U.S. population, which represents a 41% increase from the year 2000. More than 36% of Africans arrive from West Africa followed by 29% and 17% from Eastern and Northern Africa respectively. The research question in this study was designed to examine the extant information about African immigrant healthcare, experiences, and needs in the U.S., to develop lines of inquiry using a knowledge gap that was identified. Despite the researcher's contribution to this study, as a future healthcare administrator, it is important to understand the root causes of the identified barriers. Culture, religion, and spirituality were identified as intertwined key contributors to the healthcare experiences of African immigrants. In addition, the lack of culturally competent healthcare, distrust, and complexity of the U.S. health systems, and the exorbitant cost of care were identified as major healthcare barriers. Barriers to healthcare access include lack of culturally competent providers, challenges navigating the healthcare system, cost of care, providers that are biased and hostile in their attitudes, and forever loss of trust in the United States healthcare system. The cultural and spiritual beliefs understanding of African immigrant about their health is critically important. This study highlights the need for further studies on the topic to improve the healthcare experience of this population further and continuously. Apart from the language barrier of the population, the accents that come with spoken English are also seen as a barrier. More of the complications of this population that contributed to these barriers are oversimplification of the population

barriers to care, understanding of their unique needs, and putting all Black race in the same basket when it comes to healthcare needs. Because of the growing population of this group in the United States, researchers must pay close attention to health disparities to be able to have justifiable reasons for a policy that will reduce or eradicate disparities in the United States healthcare system. I hope that my study will contribute to the previous studies in the United States healthcare system and give healthcare provider and policymakers more information to guide their decision-making concerning this population. The study is also important to me as an African living in the United States.

According to Dickman et al. (2022), the study investigated racial disparities in healthcare use between Black and White individuals in the United States. Multiple surveys were conducted and analyzed which covers many decades. The author found persisting disparities that even widened in recent years. This shows the presence of structural racism in the United States healthcare system the few suggestions by the authors which increasing the number of Black health professional, investing in Black-serving health facilities, and implementing of universal health coverage to eradicate the inequalities that is evident is the healthcare systems. The study analyzed data from 154,859 Black and 446,944 White individuals surveyed from 1963-2019. Racial disparities in outpatient visits and attenuated total expenditures among older adults and working-age adults with private coverage. This suggests the importance of reducing financial barriers and equalizing fees for patients of different racial and ethnic groups. It is evidence that factors other than insurance coverage are causes of the disparities because disparities remained in the healthcare system even when analyzing individuals

with private insurance or Medicaid coverage. Other factors such as copayments, deductibles, structural racism, household wealth, residential and occupational segregation, and psychosocial factors are contributing factors to racial disparities in healthcare usage.

In the study racial disparities in healthcare use were found and measured as visits, rates, or total healthcare expenditures; these two narrowed after the implementation of Medicaid and Medicare but widened subsequently. The hurdle highlighted as the higher hurdle for privately insured Black individuals is co-payment and deductibles. The group's mean family income is 27% lower than the privately insured White group. Other factors such as non-payment-related factors that are associated with structural racism may also contribute to racial disparities in healthcare usage. Psychological factors were also pointed out such factors as differences in cultural norms and Black patients' beliefs about healthcare systems may reduce healthcare utilization among this group. The findings in this study suggest policy changes in the United States healthcare system with emphasis on financial barriers structural racism, and psychosocial factors. Six decades of racial disparities in healthcare have persisted between Black and non-Hispanic. This is a proven record of persistence and fortification of structural racism in healthcare.

Hernandez and Sparks (2020) highlighted the importance of addressing disparities in access to healthcare that is based on minoritized identities in context of ACA. The study recommended policies that specifically address the barriers faced by individuals with minoritized identities, to ensure equitable access to healthcare for individuals in line with the ACA goals. Another report by Berchick et al. (2019) provided detailed

information on Health insurance in the United States in 2018. This study could shine light on understanding of disparities in Health insurance by income level and employment status consisted of 316, 503 individuals with 52.6% being female and a mean age of 37.0 years. Two types of healthcare metrics were used: Count of visits and inpatient days, and total ambulatory and inpatient use. The number of ambulatory medical visits were collected in all the survey years.

Black people receive less healthcare than White people on long-term trends in these disparities, which provides historical context for interpreting contemporary inequalities, is lacking. The financial barrier may disproportionately reduce Black people's use of care. A much greater percentage of Black than White people in the U.S. are uninsured, and more Black adults report skipping needed care because of cost. The study was conducted to assess trends in Black-White disparities in healthcare use since 1963. The researcher found out through the study that White peoples' overall healthcare use (measured as expenditures by or on behalf of individuals) exceeded that of Blacks every year. This study is crucial because every person has one life to live, which means that it is important that every life has the right resources to sustain their health or meet their healthcare needs. In as much as every human being has the same blood that passes through his or her veins, all human beings should have equal rights to the same healthcare services regardless of their race, socioeconomic status, and much more.

According to Tien et al. (2023), there must be a continued effort to reduce racial and ethnic disparities in healthcare. The study that was conducted was the evaluation of the COVID-19 pandemic, and whether altered it altered the racial and ethnic composition

of a patient receiving cardiac procedural care. It was found that racial and ethnic disparities in access to cardiac procedures were present throughout all study periods. The reason why this research is important in my study is that the finding in this study reinforces the continuing need for initiatives to reduce racial and ethnic disparities in healthcare.

Goddard and Smith (2001) highlighted the pursuit healthcare access equity services in the United Kingdom. It further explores the extent of the present of inequities in access to different healthcare services and pointed out the methodological challenges in exploring utilization patterns and identifying the root causes of inequities in accessing various healthcare services. This study calls for further research and well-designed research studies to understand inequities and come up with a solution to this issue. The study emphasized on four main finding regarding the equity of access to United Kingdom healthcare access which are as follows:

1. Inequities are commonly found among socio groups in accessing some types of healthcare services.
2. The magnitude and nature of inequity in accessing healthcare services is evident, extensive, but for the most part inadequate, which makes it very difficult for researchers to draw a meaningful and firm conclusion about the issue.
3. Utilization rate is mostly used as a proxy to measure access, and knowing the quality of research varies widely across the board.

4. The lack of clear theoretical framework within previous and much research conducted has a significant impact on the firm conclusion of the study been drawn from the extensive literature review being undertaken regarding this subject of access to healthcare in the United Kingdom.

The study elaborated on some contributing factors to the inequities to healthcare access among socioeconomic groups. Factors such as differences in risk factors. For example, smoking, co-morbidities, and characteristics of patient which could vary from patient to patient at what point would individually seek care and treatment needed. Biases are present among the healthcare providers, variation in the quality of care and differences in individual cost of care to accessing different health services. It was also noted that variation in the availability and awareness of healthcare services among different social-economic group could also play a role in creating inequities in accessing healthcare services. These challenges make stand as a barrier to properly addressing the inequities effectively among this population. The lack of clear evidence and complexity of this issue makes it very difficult for policymakers to effectively craft strategies to address this problem. The study stated that the absence of research evidence in the matter does not equate to lack of or existence of potential severe inequities that is often caused by the intrinsic difficulty monitoring and distributing of services between this group of people.

The study used a review of existing literature and empirical evidence on equity of access among different socioeconomic groups. Utilization rate was used as a proxy measure of access to healthcare services.

According to Himmelstein et al. (2022), the study explored the prevalence and risk factors that exist in having medical debt in the United States and their association with SDOH. It is recorded that medical debts are a common situation even among those individuals that are insured, and this creates the worst SDOH. Medical debt could happen due to loss of insurance coverage and changes in health status. The study showed that financial distress could be alleviated by addressing medical debts and improving housing and food security. Some of the risk factors for accumulating medical debt in the United States include lower income, change in health status (worsening health), uninsured, hospitalization, high deductible, private plan, food, or housing insecurity. The study highlights a greater chance of women accumulating medical debts than men and non-Hispanic Black adults had recorded the highest incidence of medical debts. The suggested solution for addressing medical indebtedness and improving health courage in the United States is to implement universal healthcare coverage to eradicate the burden that comes with out-of-pocket costs, upgrading financial assistance in clinics and hospitals, forbearance in collecting debts and expanding Medicaid coverage.

Approximately 18.1% of households carried medical debt, low- and middle-income individuals have similar rates of 15.3% medical debt with 10.5% of individuals with private insurance. The study found that non-Hispanic Black adults had the highest incidence of medical debt at 16.5%, and non-Hispanic White adults at 10.3%. Data from the Census Bureau's 2018, 2019, and 2020 survey of income and program participation (SIPP) were used to assess the characteristics of adult's national medical debts, health-related insurance and the risk factors that come with such debts, including how medical

debts associates with food and housing insecurity. The following are characteristics of the population of interest: 51.6% were female, 16.8% were Hispanic, 6.0% were non-Hispanic, 6.0% were non-Hispanic Asian, 11.9% were non-Hispanic Black, 62.6% were non-Hispanic White and 2.18% were other non- Hispanic races and ethnicities. Most of the sample had private coverage and 11.2% had below poverty level family income.

Cost barriers discourage many U.S. residents from seeking medical care and many who obtain it experience financial hardship. That said it was also noted in the journal that little was known about the association between medical debt and SDOH. This study explores the prevalence of, and risk factors associated with, medical debt, and the association of medical debt with subsequent changes in the key SDOH of food and housing security. The study showed that acquiring medical debt between 2017 and 2019 was a risk factor associated with worsening SDOHs. This study is important to my study because it gives me a wide range of possible disparities in the United States healthcare system. It also clarifies my understanding of how this issue is damaging, especially among the population in my study.

According to Lee et al. (2021), the impact of ACA was examined on Health insurance and access to healthcare services among young adults 19 to 25 years of age. The study focused on racial and ethnic disparities and found that while ACA reduced cost-related barriers and increased insurance coverage for this population (young adults), the persistent racial and ethnic disparities in coverage still exist; hence policies that are not dependent on parental insurance could increase access and reduce disparities in care among this group. The author's topic was framed by discussing the gaps in the literature

about the ACA on racial and ethnic disparities in access to care. The need to study Medicaid expansion on access to healthcare among racial ethnic subgroups and the need for controlling economic factors to understand disparities was highlighted.

The quasi-experiment design was used; the hypothesis tested the impact of ACA on Medicaid expansion as it relates to racial and ethnic disparities in access to care. The findings from the study indicated that the gap between non-White and Whites remained unchanged even with Medicaid expansion despite the recorded significant gains in insurance coverage for all racial groups. The uninsured rate was reduced because of Medicaid expansion and an increase in Medicaid coverage. A more favorable impact on potential access associated with Medicaid expansion than healthcare utilization which comes with potential access including financial barriers.

According to Baumgartner et al. (2018), the article is a retrospective study that uses American Community Survey public microdata sample (ACS PUMS) and Behavioral Risk Factor Surveillance System (BRFSS) from 2013 to 2018. This data was used to analyze the impact of the ACA on racial and ethnic disparities and access to care and insurance coverage. The findings from the study show that ACA coverage has reduced racial and ethnic health access disparities significantly between 2013 and 2018, however, the progress has significantly stopped since 2016. During this period the Black uninsured rate dropped almost 10 points and White coverage narrowed 4.1 points. Coverage for Hispanics improved by 15.3 points and Hispanic-White disparity decreased by 9.4 points. Racial differences related to cost are also narrowed. That said, even though progress was seen throughout the United States, individuals that live in expansion States

experienced greater access to care and less racial disparities compared to individuals that live in non-expansion States (Baumgartner et al., 2018)

In addition, Black adults in expansion States are reporting better access or access as good as White in non-expansion States plus higher insurance coverage rates. It is also noted that despite the positive impact of ACA, 46% of Black adults live in the remaining non-expansion States, and Hispanics continue to face disparities and challenges. The study specifically focused on the gap in Health insurance by employment status, income level, and health insurance.

The population studied consisted of approximately 1.8 million adults aged 19 to 64 from the American community public use microdata sample (ACC PUMS) and 270,000 adults aged 18 to 64 from the Behavioral Risk Factor Surveillance System (BRFSS). The access metrics used in the study were uninsured rate, lack of care because of cost in the past 12 months and having a usual source of care. The metrics were calculated both nationally and at the state level, stratified by race and ethnicity and annual rates for individuals living in both Medicaid expansion states and non-expansion states.

According to Neelankavil et al. (2023), this study investigated the impact of the COVID-19 pandemic on racial and ethnic disparities in access to cardiac procedural care. The authors highlighted that Black and /or African American and Latino and/or Hispanic patients was more likely to live in areas with lower economic status. The statistical analysis with one-way Analysis of variance/Chi-Square test was used to compare the groups. According to the authors, a total of 1,330 patients with 283 patients undergoing

transcatheter aortic valve replacement (TAVR) 455 patients undergoing coronary artery bypass graft (CABG) and 592 undergoing atrial fibrillation (AF) ablation were included in the study. Access metrics used in the study include procedural incidence rates adjusted to the country population as cases per 1,000,000 persons for patients undergoing TAVR, CABG, or AF ablation.

Definitions

For a better understanding of the study, the following terms are defined in the context of this study:

Access to healthcare Provider (dependent variable): Access to healthcare providers is an individual's ability to obtain medical care and services from healthcare professionals. For example, doctors, nurses, specialists, and other healthcare practitioners. This includes factors such as the availability of healthcare services, the availability of healthcare facilities in an individual's community, the ability to schedule appointments with healthcare providers, and the affordability of medical services. Access to healthcare providers is an integral part of healthcare delivery and can impact an individual's overall health and well-being. (Berchick, et.al., (2019).

African American: American of African (especially Black African) descent (Merriam-Webster, 2014).

Affordable Care Act (independent variable): The ACA is popularly known as Obamacare; it includes various provisions that are aimed at expanding health insurance coverage, improving healthcare access, and healthcare cost reduction. (ICPSR, 2020)

Dependent variable (DV) is defined as the variable that the equation solves for, it could also be referred to as the outcome or response of interest. (Royal College of Ophthalmologists, 2022)

Economic stability: Availability of resources to people to provide a stable healthy lifestyle. (Williams and Sahel, 2022).

Education access and quality: "Education access and quality include key issues such as educational attainment in general and language and literacy. These factors can influence how people prepare for and respond to an emergency." (CDC.gov, n.d.)

Employment status (independent variable): This is the individual's current position in the labor market to show whether they are employed, unemployed, or not in the labor force. The status of employment shows the number of people in the country who are currently working, looking for employment, or not actively participating in the workforce. In the context of this research, employment status is an independent variable. It captures the following: information about an individual's current work status. (ICPSR, 2020)

Health insurance (independent variable): Health insurance is defined as the system designed to provide coverage for medical and surgical expenses incurred by the insured. This coverage helps people pay for healthcare services including but not limited to doctor's visits, hospital stays, prescription medication, and preventive care. Various sources provide health insurance such as employer-sponsored plans, government programs such as Medicaid and Tricare, marketplace plans, and other private insurance options. (ICPSR, 2020)

Healthcare providers (independent variable): This is an organization or individual that is involved in rendering medical services or care to patients. This group comprises doctors, nurses, hospitals, clinics, and other health professionals or medical facilities that provide healthcare services (Bzovsky et al., 2022).

Income (independent variable) This is the money or earnings received from employment, investment, or other sources. Earnings can include wages, salaries, bonuses, dividends, interest, and rental income. The level of income could determine financial well-being and ability to meet their needs and expenses. In the context of the data used for my study, the levels of income are categorized based on different percentages of the federal poverty level. (ICPSR, 2020)

Independent variable (IV) is used to explain the values of the dependent variable; sometimes, it could be referred to as the explanatory variable or predictor. Royal College of Ophthalmologists (2022).

ICPSR: Inter-university Consortium for Political and Social Research, an association of institutions and organizations concerned with academic research, leadership, and training for social scientists with a mission to advance and expand social and behavioral research; the body is acting as a global leader in data stewardship, that provides rich data resources and responsive educational opportunities for the present and generations to come. (ICPSR, n.d.).

Neighborhood and build environment: Neighborhood and built environment includes key issues such as quality of housing, access to transportation, and neighborhood

crime and violence. These issues can make it difficult or impossible for people to prepare for and respond to an emergency to the best of their abilities (CDC.gov, n.d.)

Social and community context: Refers to settings in which people live and work, and it includes relationships between people, as well as the connections between people and institutions social, religious, cultural, and occupational. (Network for Public Health, n.d.).

Social determinants of health (SDOH): This is a mutable societal system, their components, and the social resources and hazards for health that societal systems control and distribute, allocate and withhold, and that, in turn, cause health consequences, including changes in the demographic distributions and trends of health. (Journal of Public Health Research, 2021.).

Assumptions

An assumption was made that being a Black non-Hispanic individual with health insurance, income, and employment does not guarantee timely access to healthcare providers or healthcare services. Using already collected public data, I assumed that all participants might not give an honest answer or might answer the survey question honestly. As a Black non-Hispanic with all the factors needed to receive healthcare services does not guarantee the same quality care compared to the White population. I assumed that since the data were collected in 2020, COVID-19 might have interfered with the answers given by the participant which could interfere with the data collection. Lastly, I assumed that since the dataset I would be analyzing is a public dataset, the issue of confidentiality with institutional review board (IRB) approval would not be an issue.

Scope and Delimitations

The U.S. government plays a vital role in my study; Congress has the power to pass a bill to address or not to address the gap highlighted in this study. The affected population is the United States adults who identify as Black non-Hispanic. If the population in my study has health insurance, income, affordable Health insurance cost, and employment, then barriers to access to the healthcare provider could be reduced or eradicated. Since the study is focusing on the United States adults who identify as Black non-Hispanic, this study will contribute to the knowledge of the benefit and impact of filling the gap that is present in this study.

My reason for my study is the importance of good health because in my opinion health is wealth and without health, there is no gathering of wealth. Secondary data analysis of previous studies was used in this study. A complete literature review was carried out and adequate journals that align with the variables were chosen.

Limitation

The limitation of this study is that the study used secondary data which is quantitative; hence I do not have control over how the data was collected. Since it is a survey, I am not sure how honest is the responses of the participants.

Significance

The study will contribute to the body of knowledge on the association of health insurance, income, employment status, and access to healthcare providers. This will help clear the misconception that United States adults who identify as Black non-Hispanic lack access to healthcare providers even with adequate health insurance, income, and

employment due to their race and ethnicity because the society has yet to see a study that was done on this. The study may help understand the gravity of Black non-Hispanics' access to healthcare providers. It may also help understand the possible challenges access poses to this population. It may contribute knowledge to make accurate decisions to have a policy in place that will possibly improve access to healthcare providers among this population.

Summary and Conclusions

The study was conducted using secondary data from a previous study; the population of focus was adults in the United States who identified as Black non-Hispanic between 2017 and 2020. Twenty-two articles were pulled from the database using EBSCO of which fifteen articles were found to relate to the variables used in my study. It employed quantitative research and utilized the one-point time Cross-Sectional Study. Statistical tools will be used to answer and prove the probes are dependent and independent variables. Different statistical scales of measurement will be used: ordinal, nominal, and ratio. The findings of my study will be summarized, using this chapter's problem statement, to examine the association between access to healthcare providers, health insurance, income, employment status, and ACA provision based on Black non-Hispanic and White non-Hispanic.

The findings during the literature review stood out and supported that the gap highlighted that was found by the previous researcher needs to be addressed. The following are some of the findings:

As highlighted by Luque et al. (2018), cultural factors participants demonstrated determination to access care but reported that their primary healthcare access barriers included the high cost of services, lack of health insurance, family and work responsibilities, and language barriers. This study explored uninsured Latino immigrant women's access to healthcare and alternative treatment strategies in coastal South Carolina. What was found: Of the many findings from this study, the one that stood out to me about my proposed study is that none of the participants had Health insurance at the time of the interview, but four participants reported they had sought Health insurance in the last three years and 10 participants did not have regular medical provider. All citizens must have access to medical providers or healthcare; failure to see healthcare for all citizens could cost a nation dearly. Health is wealth and without good health, there is no gathering of wealth. In addition, this study is crucial because a healthy nation is a wealthy nation.

According to William and Sahel (2022), healthcare access (insurance, and medical costs) is one of the five core domains of SDOH. The study carried out in this research journal is about how disparities in visual impairments and eye care utilization are affected by each of the five core domains of SDOH. The article stressed the importance of the environment as a contributing factor to health and concluded that as patients are treated, the environment in which they live/belong cannot be ignored. The study also found that poorer living conditions also increase the risk of hospitalization. This finding and others would back my study as the Black non-Hispanics are more likely to experience poor living conditions compared to the White non-Hispanics.

Section 2: Research Design and Data Collection

The purpose of this quantitative correlational study is to examine the association between access to healthcare providers, health insurance, income, employment status, and ACA provision based on Black non-Hispanic and White non-Hispanic. Barriers to healthcare access can affect one's health status (Li et al., 2021). People who identify as Black non-Hispanic are more likely to be uninsured due to Health insurance costs which result in limited or no access to healthcare services and are disproportionately experiencing financial strain due to healthcare expenditures (Aggarwal et al., 2022). This becomes a social problem that needs the nation's attention.

Research Design and Rationale

The current study is a correlational research design. I conducted a secondary data analysis of an existing dataset. This design has a connection with my research question because I identified and measured access to healthcare providers (dependent variable), health insurance (independent variable), income (independent variable), employment status (independent variable), and ACA provision (IV) without manipulating them. Because correlation does not equal causation, the research design has limitations. My study addressed two research questions. First, is there an association between health insurance (independent variable), income (independent variable) employment status (independent variable), and access to healthcare providers (dependent variable) among United States adults who identify as Black non-Hispanic, and White Hispanic between 2017 and 2020? Secondly, is there an association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after

controlling for health insurance, income, and employment status between 2017 and 2020? I ran regressions to present the status of access to healthcare providers among Black and White non-Hispanic United States adults. Bivariate correlations, linear regression, and independent t-tests were used to look at relationships and mean differences in access to healthcare providers (dependent variable) income (independent variable) employment status (independent variable).

Methodology

The research design for my study is a quantitative study; the data and studies used by previous researchers were used in this study. A cross-sectional study was conducted to answer the research questions and explore the hypothesis for this study. For my planned research design, my dataset comes from the HMCA. This is a data archive of the RWJF, the largest philanthropy devoted exclusively to health and healthcare in the United States. Operated by the ICPSR at the University of Michigan with funding from RWJF, HMCA preserves and disseminates data collected by selected research projects funded by RWJF and facilitates secondary analyses of the data. The dataset is public and was pulled from the ICPSR website (https://www.icpsr.umich.edu/web/HMCA/studies/38110).

Population

As illustrated in Figure 2, the population in my study is United States adults who identified as Black non-Hispanic between 2017 and 2020. Based on secondary data from previous researchers. I conducted a quantitative study using secondary data and datasets from the HMCA, this is a data archive of the RWJF, the largest philanthropy devoted exclusively to health and healthcare in the United States. Operated by the ICPSR at the

University of Michigan with funding from RWJF, HMCA preserves and disseminates data collected by selected research projects funded by RWJF and facilitates secondary analyses of the data.

Figure 2

Race/Ethnicity

PPETHM: Race / ethnicity

Value	Label	Unweighted Frequency	%
1	White, Non-Hispanic	5638	62.4 %
2	Black, Non-Hispanic	1004	11.1 %
3	Other, Non-Hispanic	416	4.6 %
4	Hispanic	1667	18.5 %
5	2+ Races, Non-Hispanic	307	3.4 %
	Total	**9,032**	**100%**

The study looked at Black, non-Hispanic, and White non-Hispanic and other, non-Hispanic; with a population of 1004, 5638,1667, and 416 respectively.

Sampling and Sampling Procedures Used to Collect Data

The secondary data used in this study were originally collected using the following sampling procedures. For each reform monitoring survey (HRMS) round, a stratified random sample of adults ages 18-64 was drawn from the knowledge panel, a probability-based, nationally representative sample internet panel maintained by Ipsos. Approximately 55,000 adults in this panel include households with and without internet access. The panel members were recruited from an address-based sample frame derived from the U.S. Postal Service delivery sequence file, which covers 97% of U.S. households. The 2020 reform monitoring survey includes 9,032 nonelderly adults, including oversamples of low- and moderate-income adults by race and ethnicity and an

oversample of adults ages 18 to 29 years old. The population is divided into strata and a random sample is taken from each subgroup.

Data Collection Procedure

The HRMS is a survey for the nonelderly population launched by the Urban Institutes to investigate the value of cutting-edge, internet-based survey methods to be used in monitoring the ACA while awaiting date from the government surveys. The following topics were used in the 19th round of the survey to collect data includes self-reported health status, health insurance, access to healthcare, trust in healthcare systems, use of public benefits, material hardship, and the COVID-19 pandemic. Additional information was also collected which includes age, gender, sexual orientation, marital status, education, race and ethnicity, U.S. citizenship, housing type, home ownership, internet access, income, and employment status. This round is important because of its ability to capture data at a specific point in time, providing valuable insights into health, social, and financial challenges faced by respondents at a specific period covered by the survey.

Previous public use files contained indicators for insured and uninsured status based on the Urban Institute's coverage editing process. These variables are not included in the 2020 public use file because of a change in the editing process for respondents who reported having Health insurance but did not report a specific coverage type and who did not enroll in a health plan through the Marketplace. Because of this change, estimates using the updated coverage status indicators in 2020 would not be directly comparable to estimates using the indicators from the public use files for the previous rounds of the

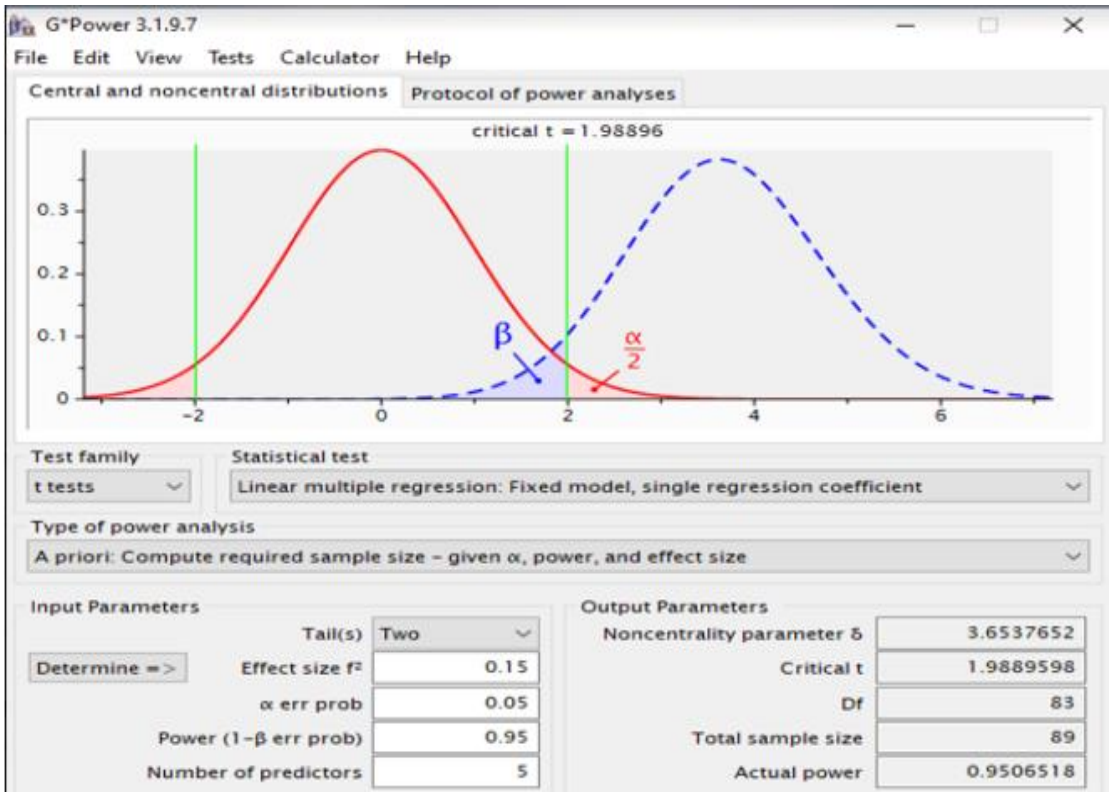
survey. The public-use and restricted-use data files are the same except for the variable PPREG4. The variables include original survey questions, household demographic profile data, and constructed variables which can be used to link panel members who participated in multiple rounds.

Power Analysis

Power analysis is used to determine the sample size used in a study; it gives the ability to detect an effect if present in a sample. This will help the researcher to reduce the chances of Type II errors. The G*Power tool could be thought of as a measure of sensitivity. That said, it means that the more power that is present, the more likely I can detect an effect if it is present. To determine the sample size in my study the G-power tool was used. Figure 3 shows the “Test Family” used in the calculation is the *t* test. The statistical test is a "fixed model, single regression coefficient" and a "two tail test" with an effect size of .15, an Alpha of .05, and a number of predictors is 5. This result shows the number of participants required to detect an effect size stated as a percentage of the power is 0.95. The total sample size required for power is at least 89 people with an actual power of 0.9506518. In the dataset, I have more than the 89 that are required.

Figure 3

G-Power



Note. Citation for G-Power Calculation size: https://www.statisticssolutions.com/how-to-determine-sample-size-from-gpower/

Instrumentation and Operationalization of Constructs

Figures 4 and 5 describe variables and indicate frequencies concerning current employment status and income.

Figure 4

Current Employment Status (PPWORK)

Value	Label	Unweighted Frequency	%
1	Working - as a paid employee	5843	64.7 %
2	Working - self-employed	804	8.9 %
3	Not working - on temporary layoff from a job	38	0.4 %
4	Not working - looking for work	475	5.3 %
5	Not working - retired	671	7.4 %
6	Not working - disabled	569	6.3 %
7	Not working - other	632	7.0 %
	Total	**9,032**	**100%**

Figure 5

Household Income (PPINCIMP)

Value	Label	Unweighted Frequency	%
1	Less than $5,000	382	4.2 %
2	$5,000 to $7,499	136	1.5 %
3	$7,500 to $9,999	121	1.3 %
4	$10,000 to $12,499	237	2.6 %
5	$12,500 to $14,999	257	2.8 %
6	$15,000 to $19,999	351	3.9 %
7	$20,000 to $24,999	491	5.4 %
8	$25,000 to $29,999	516	5.7 %
9	$30,000 to $34,999	456	5.0 %
10	$35,000 to $39,999	466	5.2 %
11	$40,000 to $49,999	606	6.7 %
12	$50,000 to $59,999	645	7.1 %
13	$60,000 to $74,999	753	8.3 %
14	$75,000 to $84,999	504	5.6 %
15	$85,000 to $99,999	520	5.8 %
16	$100,000 to $124,999	819	9.1 %
17	$125,000 to $149,999	449	5.0 %
18	$150,000 to $174,999	485	5.4 %
19	$175,000 to $199,999	325	3.6 %
20	$200,000 to $249,999	251	2.8 %
21	$250,000 or more	262	2.9 %
	Total	**9,032**	**100%**

According to Holahan and Karpman (2020), Q7_F was excluded by the principal investigator for disclosure risk; the previously used public files contained indicators for both insured and uninsured status that were based on the Urban Institute's coverage editing process. The variables are not part of the 2020 public use file due to changes in the editing process for the respondents who reported having Health insurance but did not report a specific coverage type and who did not enroll in a health plan through the marketplace. Because of this change, estimates using the updated coverage status indicators in 2020 would not be directly comparable to estimates using the indicators from the public use files for the previous rounds of the survey. It was mentioned that the public-use and restricted-use files were the same except for PPREG4 (Region 4: based on state of residence). The valid data for this variable has been set to missing in the public-use version of the data set. Data, labels, and open-ended responses were the same between the public-use and restricted-use versions. Demographic variables were provided by the Knowledge Panel.

To gain access to the dataset and download it from the HMCA website (https://www.icpsr.umich.edu/web/HMCA/studies/38110), user login was required. To download the dataset, the user must agree to "Terms of Use". The ICPSR adheres to the principle of CoreTrustSeal core trustworthy data repositories requirements. The requirement in part requires that the data consumer comply with access regulations and applicable licenses.

Certain variables were restricted from general dissemination for confidentiality reasons. In this case, users who are interested in obtaining the restricted data must

complete a restricted data use agreement with the ICPSR stating the reason for their request and obtain IRB approval or notice of exemption for their research.

Users interested in obtaining the restricted data must complete a restricted data use agreement with ICPSR, specify the reasons for the request, and obtain IRB approval or notice of exemption for their research. The researcher applies for access to the restricted data via the ICPSR restricted data contract portal which can be accessed on the study home page. The data file for my study is available for public use; hence there was no permission required other than agreeing to the terms of use.

The Urban Institutes launched the HRMS; the survey was used for a non-elderly population, which was used to explore the value of cutting-edge, Internet-based survey methods to monitor the ACA before the data from the federal government became available. In this survey, topics covered by the 19th round of the survey include self-reported health status, health insurance, access to healthcare, trust in the healthcare system, use of public benefits, material hardship, and the COVID-19 pandemic. Additional information collected by the survey included age, gender, sexual orientation, marital status, education, race and ethnicity, U.S. citizenship, housing type, home ownership, internet access, income, and employment status. The scales of measurement that were used for my study were nominal, ordinal, and scale. I used SPSS for the statistical analysis of my study.

The variables will be measured (see Table 2) by adding all the values of the respondent answers and using the range from lowest to highest range using the SPSS.

Table 2

Scale of Measurement

Variable names	Type of variable	Measure	Analysis	Dataset questionnaire
Access to Healthcare Providers	Dependent	Nominal	Logistic regression	Q6_A, Q6_B, Q6_C & Q6_D
Income	Independent	Ordinal	Ordinal regression	PPINCIMP: House Income
Employment Status	Independent	Nominal	Ordinal regression	PPWORK: Current employment status
Health Insurance	Independent	Ordinal	Ordinal regression	Q10I, Q16C, Q10H, Q10, Q7_A,
ACA Provision	Independent	Nominal	Ordinal regression	Q8C, Q8E, Q8H

Access to Healthcare Provider (DV)

Access to a healthcare provider is identified as nominal variable because the number assigned is arbitrary and does not represent levels. As reflected in Figures 6–9, I used the following questions to examine access to healthcare provider (DV):

1. Trouble finding healthcare provider (see Figure 6). Question 6A: Did you have trouble finding a doctor or other healthcare provider who would see you?
2. Trouble with finding a physician who accepts you as a patient (see Figure 7). Question 6B: Were you told by a doctor's office or clinic that they would not accept you as a new patient?
3. Trouble with finding a physician who accepts your insurance (see Figure 8). Question 6C: Were you told by a doctor's office or clinic that they do not accept your healthcare coverage?

4. Trouble getting an appointment with a selected physician (see Figure 9).

   Question 6D: Did you have trouble getting an appointment at a doctor's office or clinic as soon as you thought you needed one?

Figure 6

Question 6A: *Trouble Finding Healthcare Provider*

Value	Label	Unweighted Frequency	%
1	Yes	770	8.5 %
2	No	6999	77.5 %
3	Did not need care	1247	13.8 %
	Missing Data		
-1	Refused	16	0.2 %
	Total	**9,032**	**100%**

Figure 7

Question 6B: *Trouble Finding a Physician who Accepts you as a Patient*

Value	Label	Unweighted Frequency	%
1	Yes	935	10.4 %
2	No	6693	74.1 %
3	Did not need care	1377	15.2 %
	Missing Data		
-1	Refused	27	0.3 %
	Total	**9,032**	**100%**

Figure 8

Question 6C: *Trouble Finding a Physician who Accepts Your Insurance*

Value	Label	Unweighted Frequency	%
1	Yes	1003	11.1 %
2	No	6278	69.5 %
3	Did not need care	1077	11.9 %
	Missing Data		
-1	Refused	26	0.3 %
.	-	648	7.2 %
	Total	**9,032**	**100%**

Figure 9

Question 6D:Trouble Getting an Appointment With a Selected Physician

Value	Label	Unweighted Frequency	%
1	Yes	1371	15.2 %
2	No	6252	69.2 %
3	Did not need care	1382	15.3 %
	Missing Data		
-1	Refused	27	0.3 %
	Total	**9,032**	**100%**

Health Insurance (Independent Variable)

Health insurance is identified as a nominal variable because the number assigned is also arbitrary and does not represent levels. I used the following questions to examine health insurance (independent variable):

1. Question 10 (see Figure 10): Thinking about your health insurance over the past 12 months, how many months were you insured since March/April 2019?

2. Question 16C (see Figure 11): Thinking about the past 12 months, did any of your family members go without Health insurance at any time since March/April 2019?
3. Question 10I (see Figure 12): Are all the other people in your family currently covered by health insurance or a health coverage plan?
4. Q10H (see Figure 13): Does your current health insurance plan cover all the other people in your family?

Figure 10

Question 10: Health Insurance Coverage in Past 12 Months (Self)

Value	Label	Unweighted Frequency	%
1	I was insured all 12 months	7578	83.9 %
2	I was insured 6 to 11 months	377	4.2 %
3	I was insured 1 to 5 months	258	2.9 %
4	I did not have health insurance at all over the past 12 months	778	8.6 %
	Missing Data		
-1	Refused	41	0.5 %
	Total	**9,032**	**100%**

Figure 11

Question 16C: Health Insurance Coverage in Past 12 Months (Family Members)

Value	Label	Unweighted Frequency	%
1	Yes, someone in my family has been uninsured	294	3.3 %
2	No, no one in my family has been uninsured	4693	52.0 %
	Missing Data		
-1	Refused	15	0.2 %
.	-	4030	44.6 %
	Total	**9,032**	**100%**

Figure 12

Question 101: Current Health Insurance Coverage (Family Members)

Value	Label	Unweighted Frequency	%
1	Yes	1730	19.2 %
2	No	348	3.9 %
	Missing Data		
-1	Refused	7	0.1 %
.	-	6947	76.9 %
	Total	**9,032**	**100%**

Figure 13

Question10H: Current Health Insurance Plan (Family Member Coverage)

Value	Label	Unweighted Frequency	%
1	Yes, covers everyone in family	3551	39.3 %
2	No, does not cover everyone in family	2071	22.9 %
	Missing Data		
-1	Refused	14	0.2 %
.	-	3396	37.6 %
	Total	**9,032**	**100%**

Income (Independent variable)

I used PPINCIMP: Income to examine income in this study. The income variable is identified as ordinal because the dollar amount represents increasing levels of income (see Figures 14 and 15).

Figure 14

Income

PPINCIMP

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	103	10.3	10.3	10.3
	2	30	3.0	3.0	13.2
	3	21	2.1	2.1	15.3
	4	51	5.1	5.1	20.4
	5	34	3.4	3.4	23.8
	6	58	5.8	5.8	29.6
	7	66	6.6	6.6	36.2
	8	73	7.3	7.3	43.4
	9	63	6.3	6.3	49.7
	10	61	6.1	6.1	55.8
	11	76	7.6	7.6	63.3
	12	73	7.3	7.3	70.6
	13	58	5.8	5.8	76.4
	14	46	4.6	4.6	81.0
	15	42	4.2	4.2	85.2
	16	65	6.5	6.5	91.6
	17	27	2.7	2.7	94.3
	18	22	2.2	2.2	96.5
	19	20	2.0	2.0	98.5
	20	6	.6	.6	99.1
	21	9	.9	.9	100.0
	Total	1004	100.0	100.0	

Figure 15

Income

PPINCIMP: Household income

Value	Label	Unweighted Frequency	%
1	Less than $5,000	382	4.2 %
2	$5,000 to $7,499	136	1.5 %
3	$7,500 to $9,999	121	1.3 %
4	$10,000 to $12,499	237	2.6 %
5	$12,500 to $14,999	257	2.8 %
6	$15,000 to $19,999	351	3.9 %
7	$20,000 to $24,999	491	5.4 %
8	$25,000 to $29,999	516	5.7 %
9	$30,000 to $34,999	456	5.0 %
10	$35,000 to $39,999	466	5.2 %
11	$40,000 to $49,999	606	6.7 %
12	$50,000 to $59,999	645	7.1 %
13	$60,000 to $74,999	753	8.3 %
14	$75,000 to $84,999	504	5.6 %
15	$85,000 to $99,999	520	5.8 %
16	$100,000 to $124,999	819	9.1 %
17	$125,000 to $149,999	449	5.0 %
18	$150,000 to $174,999	485	5.4 %
19	$175,000 to $199,999	325	3.6 %
20	$200,000 to $249,999	251	2.8 %
21	$250,000 or more	262	2.9 %
	Total	**9,032**	**100%**

Based upon 9,032 valid cases out of 9,032 total cases.

Employment Status (Independent Variable)

I used PPwork and Q7_A to examine employment status (see Figure 16). Employment Status is identified as a nominal variable because the number assigned is arbitrary and does not represent levels.

Figure 16

Employment Status

Value	Label	Unweighted Frequency	%
1	Working - as a paid employee	5843	64.7 %
2	Working - self-employed	804	8.9 %
3	Not working - on temporary layoff from a job	38	0.4 %
4	Not working - looking for work	475	5.3 %
5	Not working - retired	671	7.4 %
6	Not working - disabled	569	6.3 %
7	Not working - other	632	7.0 %
	Total	**9,032**	**100%**

ACA Provision

The following questions were used to examine ACA provisions.

1. Question 8C: Is your current coverage a Health insurance plan through the marketplace? (see Figure 17)
2. Question 8E: Is your health insurance plan through the marketplace a private health insurance plan? (see Figure 18)
3. Question 8H: Is your current coverage a health insurance plan through a state or government sponsored program? (see Figure 19)

Figure 17

Question 8C: ACA Provision

Value	Label	Unweighted Frequency	%
1	Yes, I am enrolled in a health insurance plan through the marketplace	1345	14.9 %
2	No, I am not enrolled in a health insurance plan through the marketplace	6769	74.9 %
	Missing Data		
-1	Refused	59	0.7 %
.	-	859	9.5 %
	Total	**9,032**	**100%**

Figure 18

Question 8E: Private Plan

Value	Label	Unweighted Frequency	%
1	Yes, it is a private plan	577	6.4 %
2	No, it is not a private plan	427	4.7 %
3	Don't know	335	3.7 %
	Missing Data		
-1	Refused	6	0.1 %
.	-	7687	85.1 %

Figure 19

Question 8H: Plan Sponsored by State or Government

Value	Label	Unweighted Frequency	%
1	Yes, I am enrolled in a health insurance plan through one of those programs	873	9.7 %
2	No, I am not enrolled in a health insurance plan through one of those programs	1356	15.0 %
	Missing Data		
-1	Refused	19	0.2 %
.	-	6784	75.1 %
	Total	**9,032**	**100%**

I added values of the questions and arrive at the total value for each participant's answers; I am looking for a range between 3 to 6.

Threats to Validity

The generalizability of my study to other populations and settings could be envisioned; I believe that the findings in this study could be generalized to outside populations away from my study. I think that my study passed the common test of external validity such as participant characteristics, settings, and timing. The population in the study could represent a larger population. The timing of the survey does not show that significant changes could alter the findings. That said due to COVID-19 during this period, participant answers to the survey question could be impacted. This is a secondary data set that was used for this study; hence the setting is not known. By controlling the same independent variable, I would arrive at the same conclusion for other populations.

Regarding internal validity: the study has one dependent variable (Access to Healthcare Provider) and four independent variables (Health insurance, Income, Employment Status, and ACA provision. In this study, the relationship between the dependent variable and independent can be established. The following internal threats could potentially impact the reliability and accuracy of the findings of the study in the HRMS, United States, First Quarter of 2020; factors such as history, maturation, testing, instrumentation, statistical regression, experimental mortality, and selection-maturation interaction. Researchers likely adopted many methodological strategies to mitigate internal threats. For the threat of history, it is likely that the researcher carefully controlled external changes or occurrences that could impact the outcome of the study

being measured. The natural changes in participants over time, which is referred to as Maturation; this threat may have been solved through careful selection of statistical techniques and representative samples to take care or account for any of these changes that could impact the outcome. The measurement tools and procedure used might post an internal threat of testing and instrumentation; this threat is said to have arisen from the measurement tools and procedures that are used in the study; this threat may have been reduced by validated survey instrument and a well-scrutinized data collection protocol. Extreme scores that could regress towards the mean upon retesting which is known as statistical regression threat are another internal threat that the researcher could have managed through appropriate statistical analyses and result in interpretations. Losing participants from the study is another possible internal threat known as experimental mortality may have been controlled by adopting strategies to minimize attrition and by conducting sensitivity analyses to analyze the impact of the participant dropout from the study. The interaction of selection bias and natural changes over time known as selection maturation is another possible internal threat that could be addressed by the researcher through careful sampling techniques and statistical controls to factors in the confounding variables. To ensure the reliability and validity of the findings in the study, researchers might have explored a combination of methodological approaches that include study design, statistical analyses, and robust data collection methods. ICPSR (n.d.)

Ethical Procedures

Since secondary data will be used in my study, the issue of confidentiality of the population is not a concern; however, the ethical procedures in this study are to maintain

the integrity of the data and to make sure that the data in the survey study remain the same data that will be used for the analysis of the study without altering any part of the data collected through the survey. The IRB approval was granted to ensure the integrity of the data collected and to verify that the privacy of all participants is protected where applicable. That said, I do not see any risk or issue of participant rights or privacy being violated in my study due to the nature of the study.

Summary

The summary section presents the conclusion that was derived from the conduct of the study. The purpose of this quantitative correlational study is to examine the association between access to healthcare providers, health insurance, income, employment status, and ACA-provision based on Black non-Hispanic and White non-Hispanic. Between 2017 and 2020. I shall be using correlational design to find the relationship between the dependent variable and independent variables in my study. As earlier mentioned, and what was realized during the in-depth literature review, it understands Blacks are marginalized in the United States; however, my study will be addressing the issue within the healthcare section. To be specific and to avoid any misconception, the gap highlighted in my study is intended to see the challenges facing the population in my study when they need access to healthcare providers or healthcare services after controlling all factors that contribute to access to healthcare providers or healthcare services like health insurance, cost, Income, and employment status would the issues persist. The current study is correlational research design. I conducted a secondary data analysis of an existing dataset. This design has a connection with my research

question because I identified and measured access to healthcare providers (dependent variable), health insurance (independent variable), income (independent variable), employment status (independent variable), and ACA provision (independent variable) without manipulating them. I ran regressions to present the status of access to healthcare providers among Black and White non-Hispanic United States adults. Bivariate correlations, linear regression, and independent t-tests was used to look at relationships and mean differences in access to healthcare providers (dependent variable) income (independent variable) employment status (independent variable).

G-power, which is used to determine the sample size used in a study shows the number of participants required to detect an effect size stated as a percentage of the power is 0.95. The total sample size required for power is at least 89 people with an actual power of 0.9506518. In the dataset, I have more than 89 that are required which means I have more than the requirement.

The theory grounding this study is Andersen's model of healthcare utilization. (Dean et al., 2020). This model delineated predisposing, enabling, and need characteristics as predictors of healthcare utilization (Dean et al., 2020). I strongly believe that this theory aligns with my study because this model delineated predisposing, enabling, and need characteristics as predictors of health utilization.

Section three of my proposal writing will dig deeper into the study using statistical tests to explore the relationship, test the significance of the hypothesis, and present the findings from the study.

Section 3: Presentation of the Results and Findings

Introduction

The problem (gap) addressed in this study is that it is currently unclear whether there is the association of health insurance, income, employment status, ACA provision of Blacks who identify as non-Hispanic. There is a gap in the literature regarding the impact of citizenship, education, and other demographic factors on access to healthcare services.

Purpose of the Study

This quantitative correlational study examined the association between health insurance, income, employment status, ACA provision, and access to healthcare providers, based on Black non-Hispanic and White non-Hispanic. The independent variables are health insurance, income, employment status, and ACA provision. The dependent variable is access to healthcare providers.

Research Questions and Hypotheses

RQ1: Is there an association between health insurance, income, employment status, and access to healthcare providers in the United States among adults who identify as Black non-Hispanic and White non-Hispanics between 2017 and 2020? This question is answered with bivariate analyses.

$H_0$1: There is no statistically significant association between health insurance, income, employment status, and access to healthcare providers in the United States among adults who identify as Black non-Hispanic and White non-Hispanics between 2017 and 2020.

$H_1$1: There is a statistically significant association between health insurance, income, employment status, and access to healthcare providers in the United States among adults who identify as Black non-Hispanic and White non-Hispanics between 2017 and 2020

RQ2: Is there an association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020? This question is answered by multivariate analysis.

$H_0$2: There is no statistically significant association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020.

$H_1$2: There is a statistically significant association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020.

Section 3 Organization Preview

In this section, I summarize the data collection of the secondary data set and present the results of the findings. The dependent variable, access to a healthcare provider, is identified as a nominal variable because the number assigned is arbitrary and does not represent levels. As reflected in Section 2, I used the following questions to examine access to a healthcare provider:

1. Trouble finding a healthcare provider. (Q6_A)
2. Trouble with finding a physician who accepts you as a patient. (Q6_B)
3. Trouble with finding a physician who accepts your insurance. (Q6_C)
4. Trouble getting an appointment with a selected physician. (Question 6D)

The scales of measurement that were used for my study are nominal, ordinal, and categorical using SPSS for the statistical analysis of my study. The variables were measured by adding all the values of the respondent answers and using the range from lowest to highest range using the SPSS.

Data Collection of Secondary Data Set

The data used in this study were collected from the HMCA. According to Holahan and Karpman (2020), the HMCA is the data archive of the RWJF. This foundation is the largest philanthropy devoted exclusively to health and healthcare in the United States and it is operated by the ICPSR at the University of Michigan. Since the data used is secondary data that has already been collected for some other purpose. The time spent searching for the secondary day was 3.5 hours, spread out over 2 days.

The limitation of this study is that the study used secondary quantitative data; hence, I did not have control over how the data were collected. Since it is a survey, I am not sure how honest is the responses of the participants. That said, there is no form of incompatibility of the data collected for this study.

The dependent variable in the study, access to healthcare providers, was measured in five demographics: Finding a doctor, acceptance as a new patient, accepting insurance, Race /Ethnicity, and trouble getting an appointment.

The “test family” used in the calculation is the “T-Test.” The statistical test is a "Fixed Model, Single Regression Coefficient" and a "Two Tail Test" with an effect size of .15, an Alpha of 0.05, and some predictors is 5. This result shows the number of participants required to detect an effect size stated as a percentage of the power is 0.95. The total sample size required for power is at least 89 people with an actual power of 0.9506518. In the dataset, I have more than 89 required, which means I have more than the requirement. Selective sampling is used in the study as a good representation of the entire population.

The baseline descriptive and demographic characteristics of the sample in this study include a focus on U.S. adults who identified as Black non-Hispanic and White non-Hispanic, among others, between 2017 and 2020. The population was distributed as follows: Hispanic accounted for 1004 participants, White non-Hispanic accounted for 5638 participants and other non-Hispanic accounted for 1667 participants with the additional category that was not specified in the data which accounted for 416 participants. The diverse samples allow for a comprehensive analysis of access to healthcare providers among different racial and ethnic groups in the context of health insurance, income, and employment status, within the specified timeframe.

The sample is representative of the populations of interest as it was drawn from a stratified random sample of adults ages 18–64 from the knowledge panel, a probability-based, nationally representative sample internet panel maintained by Ipsos. The panel includes approximately 55,000 adults, covering households with and without internet access, and was recruited from an address-based sample frame derived from the U.S.

Postal Service delivery sequence file, which covers 97% of U.S. households. The 2020 reform monitoring survey included 9,032 nonelderly adults, with oversamples of low- and moderate-income adults by race and ethnicity. and an oversample of low- and moderate-income adults ages 18–29 years old, ensuring a good representation of the entire population.

The results of basic univariate analyses indicated significant variations in access to healthcare providers based on income, employment status, and health insurance coverage. For instance, higher income levels were associated with increased access to healthcare providers, suggesting income is a critical determinant of health access. Similarly, individuals who were employed had better access. Similarly, individuals who were employed had better access to healthcare services compared to those who were unemployed. Health Insurance coverage also played a significant role, with insured individual coverage also playing a significant role, with insured individuals reporting fewer difficulties in finding doctors, being accepted as new patients, and having their insurance accepted by healthcare providers. These findings justify the inclusion of income, employment status, and health insurance coverage as covariates in the model to adequately control for their effects on access to healthcare.

Results

Statistical Methods

Frequency and percentage statistics were performed to describe the demographic and clinical characteristics of the sample. For the first research question, chi-square analyses were performed in a bivariate fashion to compare the primary independent

variable (White, Non-Hispanics versus Black, Non-Hispanics) and other binary, categorical variables of interest (ACA provision, health insurance coverage, employment status) on the different levels of access to healthcare. Cross-tabulation tables were reported and interpreted for the chi-square analyses. A Spearman correlation (r_s) was performed to test the association between income and access to healthcare.

For the second research question, ordinal logistic regression was performed to adjust the relationship between race/ethnicity status and access to healthcare using ACA provision, health insurance coverage, employment status, and income. Adjusted odds ratios (AOR) with 95% confidence intervals were reported and interpreted for the model, along with the associated p-values for each model parameter. Statistical significance was assumed at an alpha value of .05 and all analyses were performed using IBM SPSS Statistics (Version 29).

Statistical Results

The demographic characteristics of the sample are presented in Table 3. The sample primarily did not have the ACA provision (n = 5210, 85.9%), did have health insurance coverage (n = 5720, 91.9%), were employed (n = 4628, 74.1%), were White, Non-Hispanic (n = 5313, 85.1%), made between $0-100,000 ($n$ = 4187, 57.0%), and had had a high level of access to healthcare (n = 3934, 63.0%). For the bivariate comparisons (see Table 4), there were statistically significant associations between having the ACA provision and access to healthcare, $\chi^2(4) = 38.76$, $p < .001$, having health insurance coverage and access to healthcare, $\chi^2(4) = 141.49$, $p < .001$, and between income and access, $r_s = 0.11$, $p < .001$. There were no significant associations between employment

and access, $\chi^2(4) = 3.08$, $p = .54$, nor between race/ethnicity and access, $\chi^2(4) = 1.63$, $p = .80$.

Table 3

Demographics for Independent and Dependent Variables

Variable/Level	Frequency (%)
ACA Provision	
No	5210 (85.9%)
Yes	858 (14.1%)
Health Insurance Coverage	
No	501 (8.1%)
Yes	5720 (91.9%)
Employment	
Not working	1614 (25.9%)
Working	4628 (74.1%)
Race/Ethnicity	
White, Non-Hispanic	5313 (85.1%)
Black, Non-Hispanic	929 (14.9%)
Income	
$0-50,000	2455 (29.3%)
$50,000-100,000	1732 (27.7%)
$100,000-200,000	1651 (26.4%)
$200,000+	404 (6.5%)
Access (ordinal level variable)	
0	874 (14.0%)
1	257 (4.1%)
2	361 (5.8%)
3	816 (13.1%)
4	3934 (63.0%)

Table 4

Bivariate Comparisons With Access to Healthcare

Variable/Level	Access Level 0	Access Level 1	Access Level 2	Access Level 3	Access Level 4	*p* value
ACA Provision (Yes)	146 (17.6%)	56 (22.8%)	67 (19.1%)	103 (12.9%)	486 (12.6%)	< .001
Health Insurance Coverage (Yes)	721 (82.8%)	219 (85.5%)	330 (91.4%)	758 (93.2%)	3692 (94.2%)	< .001
Employment (Working)	635 (72.7%)	184 (71.6%)	262 (72.6%)	607 (74.4%)	2940 (74.7%)	.54
Race/Ethnicity (Black, Non-Hispanic)	134 (15.3%)	37 (14.4%)	59 (16.3%)	128 (15.7%)	571 (14.5%)	.80

Note. There was a statistically significant positive correlation between income level and access, $r_s = 0.11$, $p < .001$.

The following tables are results associated with Table 4; hence the results for the SPSS tables are all presented in Table 4.

Crosstab

			ACAProvision		
			No	Yes	Total
Access	0	Count	682	146	828
		% within Access	82.4%	17.6%	100.0%
	1	Count	190	56	246
		% within Access	77.2%	22.8%	100.0%
	2	Count	283	67	350
		% within Access	80.9%	19.1%	100.0%
	3	Count	696	103	799
		% within Access	87.1%	12.9%	100.0%
	4	Count	3359	486	3845
		% within Access	87.4%	12.6%	100.0%
Total		Count	5210	858	6068
		% within Access	85.9%	14.1%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	38.762[a]	4	<0.001
Likelihood Ratio	35.935	4	<0.001
Linear-by-Linear Association	27.333	1	<0.001
N of Valid Cases	6068		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 34.78.

Crosstab

			HealthInsuranceCoverage No	HealthInsuranceCoverage Yes	Total
Access	0	Count	150	721	871
		% within Access	17.2%	82.8%	100.0%
	1	Count	37	219	256
		% within Access	14.5%	85.5%	100.0%
	2	Count	31	330	361
		% within Access	8.6%	91.4%	100.0%
	3	Count	55	758	813
		% within Access	6.8%	93.2%	100.0%
	4	Count	228	3692	3920
		% within Access	5.8%	94.2%	100.0%
Total		Count	501	5720	6221
		% within Access	8.1%	91.9%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	141.486[a]	4	<0.001
Likelihood Ratio	119.394	4	<0.001
Linear-by-Linear Association	134.894	1	<0.001
N of Valid Cases	6221		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 20.62.

Crosstab

			Employment		
			Not working	Working	Total
Access	0	Count	239	635	874
		% within Access	27.3%	72.7%	100.0%
	1	Count	73	184	257
		% within Access	28.4%	71.6%	100.0%
	2	Count	99	262	361
		% within Access	27.4%	72.6%	100.0%
	3	Count	209	607	816
		% within Access	25.6%	74.4%	100.0%
	4	Count	994	2940	3934
		% within Access	25.3%	74.7%	100.0%
Total		Count	1614	4628	6242
		% within Access	25.9%	74.1%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.082[a]	4	0.544
Likelihood Ratio	3.050	4	0.549
Linear-by-Linear Association	2.600	1	0.107
N of Valid Cases	6242		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 66.45.

Crosstab

			RaceEthnicity		
			White, NH	Black, NH	Total
Access	0	Count	740	134	874
		% within Access	84.7%	15.3%	100.0%
	1	Count	220	37	257
		% within Access	85.6%	14.4%	100.0%
	2	Count	302	59	361
		% within Access	83.7%	16.3%	100.0%
	3	Count	688	128	816
		% within Access	84.3%	15.7%	100.0%
	4	Count	3363	571	3934
		% within Access	85.5%	14.5%	100.0%
Total		Count	5313	929	6242
		% within Access	85.1%	14.9%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	1.632[a]	4	0.803
Likelihood Ratio	1.613	4	0.807
Linear-by-Linear Association	0.506	1	0.477
N of Valid Cases	6242		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 38.25.

Correlations

			Income	Access
Spearman's rho	Income	Correlation Coefficient	1.000	0.109**
		Sig. (2-tailed)	.	<0.001
		N	6642	6242
	Access	Correlation Coefficient	0.109**	1.000
		Sig. (2-tailed)	<0.001	.
		N	6242	6242

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

For the ordinal logistic regression model, the independent variables were entered into the model in a simultaneous fashion to predict the ordinal level outcome of access to

healthcare. When controlling for other variables, having the ACA provision led to a significant decrease in the odds of having access to healthcare, AOR = 0.81, 95% CI [0.70, 0.94], $p = .005$. Those who had health insurance coverage had a significant increase in the odds of having access to healthcare, AOR = 2.34, 95% CI [1.93, 2.84], $p < .001$, when controlling for other factors. Increasing income also yielded statistically significant increases in odds for access to healthcare ($50,000-$100,000 – AOR = 1.32, 95% CI [1.16, 1.51]; $100,000-$200,000 – AOR = 1.54, 95% CI [1.34, 1.77]; $200,000 – AOR 1.63, 95% CI [1.30, 2.05]), $p < .001$ for all and when controlling for other variables. There were no associations between employment and access, $p = .38$, nor between race/ethnicity and access, $p = .11$, when controlling for the other variables in the model. The findings for the ordinal logistic regression are presented in Table 5.

Table 5

Ordinal Logistic Regression Predicting for Access to Healthcare

Variable	AOR (95% CI)	*P* value
ACA Provision	0.81 (0.70 – 0.94)	.005
Health Insurance Coverage	2.34 (1.93 – 2.84)	< .001
Employment	0.94 (0.84 – 1.07)	.38
Race/Ethnicity	1.13 (0.97 – 1.31)	.11
Income		
$50,000–100,000	1.32 (1.16 – 1.51)	< .001
$100,000–200,000	1.54 (1.34 – 1.77)	< .001
$200,000+	1.63 (1.30 – 2.05)	< .001

In the SPSS created, the beta estimates were exponentiated, and the 95% confidence intervals to get the adjusted odds ratio presented in Table 5 above.

Parameter Estimates

		Estimate	Sig.	95% Confidence interval Lower bound	Upper bound
Location	[ACAProvisionOrdLog=.00]	-0.207	0.005	-0.351	-0.062
	[ACAProvisionOrdLog=1.00]	0[a]	.	.	.
	[InsuranceOrdLog=.00]	0.852	<0.001	0.659	1.045
	[InsuranceOrdLog=1.00]	0[a]	.	.	.
	[EmployOrdLog=.00]	-0.055	0.377	-0.177	0.067
	[EmployOrdLog=1.00]	0[a]	.	.	.
	[IncomeOrdLog=1.00]	0.489	<0.001	0.260	0.718
	[IncomeOrdLog=2.00]	0.432	<0.001	0.293	0.571
	[IncomeOrdLog=3.00]	0.278	<0.001	0.147	0.409
	[IncomeOrdLog=4.00]	0[a]	.	.	.
	[RaceEthOrdLog=.00]	0.122	0.107	-0.026	0.270
	[RaceEthOrdLog=1.00]	0[a]	.	.	.

Research Question 1

Is there an association between health insurance, income, and employment status with access to healthcare providers in the United States among adults who identify as Black non-Hispanic (BNH) and White non-Hispanics (WNH) between 2017 and 2020?

Data Analysis. Chi-square analysis was used to compare categorical variables (race/ethnicity, ACA provision, health insurance coverage, and employment status) on their level of access to care. A Spearman correlation was used to test the association between the ordinal level variable of income and the level of access to care.

Results. For the bivariate comparisons, there were statistically significant associations between having the ACA provision and access to healthcare, $\chi^2(4) = 38.76$, $p < .001$, having health insurance coverage and access to healthcare, $\chi^2(4) = 141.49$, $p < .001$, and between income and access, $r_s = 0.11$, $p < .001$. There were no significant

associations between employment and access, $\chi^2(4) = 3.08$, $p = .54$, nor between race/ethnicity and access, $\chi^2(4) = 1.63$, $p = .80$. See Table 2 for the frequency and percentage statistics associated with these findings.

Interpretation. In order to answer the research question, a series of chi-square analyses were performed to test the associated hypotheses. In a bivariate fashion, it was found that the ACA provision was used to a lesser extent by those with more access to care. This finding makes sense because people with access to care 1) have health insurance, and 2) have higher income. People with health insurance and higher income typically do not need the ACA provision to access care. Similarly, those with insurance coverage had more access to care. People with private and/or public insurance have better access to healthcare because their needed services are reimbursable and they typically can get referred to primary care physicians (PCP), specialists, and they can more easily obtain needed medications through their insurance. Interestingly, employment status had no effect on access to care. Typically, those that are employed receive some sort of benefits such as health insurance coverage due to their respective employment. Unemployed people typically have more barriers (income, rural living, lack of insurance) in regards to access of care. Race/ethnicity had no effect on access to care. Again, the lack of statistical significance here is surprising because of the well-established barriers of minority-status people (lower income, lesser access to care, higher unemployment rates, etc.) versus Caucasian people. Higher income levels led to higher levels of access to care. This was not a surprising finding. Those with more money tend to be employed, have health

insurance, and are Caucasian. With more money, more health insurance, and fewer barriers to care, it makes sense that higher income leads to higher access to care.

Research Question 2

Is there an association between the provision of ACA and the healthcare access gap among Black and White non-Hispanics in the United States after controlling for health insurance, income, and employment status between 2017 and 2020?

Data Analysis. Ordinal logistic regression was used to answer this research question.

Results. When controlling for other variables, those with the ACA provision had lesser odds of access to care (AOR = 0.81, 95% CI 0.70 – 0.94, $p = 0.005$), those with health insurance coverage had higher odds of access to care (AOR 2.34, 95% CI 1.93 – 2.84, $p < 0.001$), and increasing income levels led to increased access to care ($50,000-$100,000 – AOR 1.32, 95% CI 1.16 – 1.51, $p < 0.001$; $100,000 - $200,000 – AOR 1.54, 95% CI 1.34 – 1.77, $p < 0.001$; $200,000+ - AOR 1.63, 95% CI 1.30 – 2.05, $p < 0.001$). When controlling for other parameters, there were no associations between employment and access to care ($p = 0.38$), nor race/ethnicity and access ($p = 0.11$).

Interpretation. Multivariate analysis allows for the controlling of potential confounding variables when looking at the relationship between the primary independent variable and the primary dependent variable. In order to answer the second research question, an ordinal logistic regression was performed to control for ACA provision, health insurance coverage, employment status, and income when looking at the relationship between race/ethnicity and access to care. According to the results, the ACA

provision leads to lesser access to care, when controlling for other variables. This is a similar finding to the bivariate analyses and provides further evidence, in a multivariate sense, that the provision is associated with lesser access to care. And similarly to Research Question 1, health insurance coverage and increasing income levels increase access to care. These associations show that having health insurance and earning more income lead to increased access to care, when controlling for other extraneous factors. And, in line with the analyses for Research Question 1, employment status and race/ethnicity still do not affect access to care, when controlling for the other variables. The continuity and consistency of the bivariate and multivariate findings provide significant evidence for health insurance coverage and higher income leading to more access to care, while the ACA provision detracts from access, and that employment status and race/ethnicity do not play significant roles when predicting for access to care.

Discussion

The findings from this study indicate a statistically significant association between access to healthcare providers and health insurance, income, and employment status among adults in the United States. Individuals with health insurance, higher incomes, and those who are employed report better access to healthcare providers. These results underscore the importance of socioeconomic factors in healthcare access and suggest potential areas for policy intervention to improve healthcare accessibility. American Psychological Association (2020).

Summary

Implications for Professional Practice and Social Change

The findings of this study have important implications for professional practice and policies aimed at improving healthcare access. Specifically, they underscore the need for continued efforts to expand health insurance coverage, address income inequalities, and support policy provisions like the ACA that have been shown to improve access to healthcare services. Additionally, while this study did not find direct evidence of racial and ethnic disparities in access to healthcare providers, it highlights the importance of ongoing research and policy efforts to address potential disparities and ensure equitable healthcare access for all individuals, regardless of race, ethnicity, or socioeconomic status.

From the insight for the analysis, we transition from empirical findings to the practical implications and possible avenues for fostering positive social change. The unveiled significant association between the ACA provision, health insurance coverage, and access to healthcare services, and factoring in the crucial role of income level, and access to healthcare services, lay an important foundation for actionable strategies that are designed to enhance healthcare accessibility. The absence of a link between employment status or race/ethnicity and healthcare access underscores the complexity of healthcare disparities and the need for multifaceted interventions. Moving into Section 4, we will dig into how these findings can inform professional practice, guide policy changes/formulation, and contribute to the broader goal of achieving equitable healthcare access for all, irrespective of socioeconomic status or demographic background.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The findings from the comprehensive study on the association between health insurance, income, employment status, the ACA provision, and access to healthcare providers among Black non-Hispanic and White non-Hispanic adults in the United States provide critical insights into the dynamics of healthcare access and utilization. These insights have significant implications for professional practice within the healthcare industry, policy formulation, and the broader agenda of promoting social change toward health equity. This section is designed to bridge the gap between empirical evidence and actionable strategies that can be employed by healthcare professionals, policymakers, and community leaders to address the identified disparities in healthcare access and outcomes.

The study's findings underscore the critical role of health insurance and the ACA in improving access to healthcare services, highlighting income as a significant determinant of healthcare access. In addition, the absence of a direct correlation between employment status or race/ethnicity and access to healthcare services suggests a significant interplay of factors influencing healthcare accessibility. The uncovered complexity calls for a multifaceted approach to healthcare reform and policy development, aiming not only to address the surface-level disparities but also to tackle the underlying SDOH that perpetuate inequities.

In examining the application of these findings to professional practice, it is important to consider the implications at large for social change. The goal is to promote a

healthcare system that is not only accessible and equitable but also responsive to the diverse needs of all population segments. By leveraging the additional insights gained from this study, stakeholders across the healthcare ecosystem can contribute to the creation of a more inclusive and equitable healthcare landscape, ultimately driving positive social change and improving health outcomes for marginalized communities.

In this study, I explored the association between health insurance, income, employment status, the ACA provision, and access to healthcare providers among Black non-Hispanic and White non-Hispanic adults in the United States from 2017 to 2020. Utilizing a quantitative research design and secondary data analysis from the HRMS, this aim of this study was to address disparities in healthcare access. Grounded in Andersen's model of healthcare utilization, the research was conducted to understand the dynamics influencing healthcare access and to contribute to efforts aimed at reducing racial and ethnic disparities in healthcare, particularly in the context of the ACA's impact. The purpose was to inform policy and practice by identifying key factors that affect access to healthcare services, thereby supporting targeted interventions to improve healthcare equity across different racial and ethnic groups.

The study investigated the association between health insurance, income, employment status, the ACA provision, and access to healthcare providers among Black non-Hispanic and White non-Hispanic adults in the United States from 2017 to 2020. Utilizing a quantitative research design and secondary data analysis from the HRMS, key findings include:

- Health Insurance and Access to Healthcare: Individuals with health insurance coverage were significantly more likely to have access to healthcare services compared to those without coverage, highlighting the critical role of health insurance in facilitating healthcare access.
- Income Level: Income level emerged as a significant factor influencing access to healthcare services, with higher income levels associated with better access. This underscores the socioeconomic barriers to healthcare access.
- ACA Provision: There was a significant association between the ACA provision and improved access to healthcare services, indicating the positive impact of policy interventions on healthcare accessibility.
- Employment Status: The study found no significant association between employment status and access to healthcare providers, suggesting that employment alone does not guarantee better access to healthcare services.
- Race/Ethnicity: No significant relationship was found between race/ethnicity and access to healthcare services within the scope of this study, indicating that health insurance, income, and ACA provisions play a more defining role in healthcare access than racial or ethnic background.
- SDOH: The study also highlighted the importance of addressing SDOH, such as medical debt, housing, and food security, to alleviate financial distress and improve healthcare access.

These findings suggest that while the ACA has had a positive impact on healthcare access, significant disparities remain, influenced by factors like income and

health insurance coverage. The study underscores the need for continued efforts to address these disparities and improve healthcare access for all individuals, regardless of socioeconomic status or racial/ethnic background.

The findings of this study both extend and confirm existing knowledge within the discipline, as discussed in the peer-reviewed literature outlined in Section 1. For instance, the significant relationship between the ACA provision and access to healthcare services aligns with previous research that has highlighted the ACA's positive impact on increasing healthcare access for various populations. This extends the discipline's understanding by reinforcing the ACA's role in mitigating access disparities, particularly among Black non-Hispanic and White non-Hispanic adults in the United States.

Moreover, the confirmation that health insurance coverage is crucial for accessing healthcare services supports existing literature that underscores the importance of insurance in facilitating healthcare utilization. This finding is consistent with prior studies that have identified health insurance as a key enabling factor in accessing healthcare services, thereby confirming and reinforcing the established knowledge base.

However, the lack of a significant association between employment status or race/ethnicity and access to healthcare services presents a nuanced extension of the discipline. While previous studies have often highlighted race and employment as critical determinants of healthcare access, this study suggests that within the context of the ACA provision, these factors may not directly influence healthcare access as significantly as health insurance and income levels do. This finding disconfirms some aspects of the existing literature that emphasize the direct impact of employment and race on healthcare

access, suggesting a more complex interplay of factors influenced by policy interventions like the ACA.

Additionally, the identification of income level as a key factor influencing access to healthcare services extends knowledge by highlighting the persistent socioeconomic barriers to healthcare access, even in the context of policy interventions designed to mitigate these barriers. This finding aligns with the broader literature that recognizes socioeconomic status as a critical determinant of health and healthcare access, further emphasizing the need for multifaceted approaches to address healthcare disparities.

In summary, the study's findings both confirm and extend existing knowledge by reinforcing the importance of health insurance and policy interventions like the ACA in improving healthcare access, while also challenging and refining the understanding of the roles of employment status and race/ethnicity within this context. This contributes to a more nuanced understanding of the factors influencing healthcare access and underscores the complexity of addressing healthcare disparities in a diverse society.

Interpretation of the Findings

The findings of this study are analyzed and interpreted within the context of Andersen's model of healthcare utilization, which delineates predisposing, enabling, and need characteristics as predictors of healthcare utilization. According to this theoretical framework, predisposing characteristics (such as demographic factors), enabling characteristics (such as resources or means like health insurance and income), and need characteristics (such as perceived and professionally evaluated health status) are integral

in understanding healthcare utilization patterns. The study findings can be interpreted in the context of Andersen's model as follows:

- Health Insurance as an Enabling Characteristic: The significant relationship between health insurance coverage and access to healthcare services found in this study aligns with Andersen's model, emphasizing health insurance as a crucial enabling resource. This finding confirms that having health insurance significantly enhances individuals' ability to access healthcare services, consistent with the model's assertion that enabling resources are vital for healthcare utilization.
- Income Level and Healthcare Access: The study's identification of income level as a key factor influencing access to healthcare services further supports Andersen's model by highlighting income as another enabling characteristic. Higher-income levels correlate with increased access to healthcare services, underscoring the socioeconomic barriers to healthcare access and the importance of enabling resources in healthcare utilization.
- Impact of the ACA: The association between the ACA provision and improved access to healthcare services demonstrates the role of policy interventions as enabling factors that can significantly influence healthcare utilization. This aligns with Andersen's model by illustrating how policy-level changes can modify the enabling characteristics, thereby improving access to healthcare services.

- Employment Status and Race/Ethnicity: The lack of a significant association between employment status or race/ethnicity and access to healthcare services in this study suggests a more complex interplay of factors beyond the predisposing characteristics outlined in Andersen's model. This finding indicates that within the context of the ACA and current healthcare policies, enabling characteristics such as health insurance and income might play a more significant role in healthcare access than predisposing characteristics like employment status or race/ethnicity.

In interpreting these findings within the context of Andersen's model, it is clear that enabling characteristics (health insurance and income) play a critical role in healthcare access and utilization. This interpretation does not exceed the data, findings, or scope of the study but rather aligns with the theoretical framework (Dean et al., 2020) by highlighting the importance of resources and policy interventions in facilitating healthcare access. The study reinforces the relevance of Andersen's model in understanding healthcare utilization patterns and the critical role of enabling characteristics in this process.

Limitations of the Study

The study's use of a secondary data set introduces several limitations to the generalizability, trustworthiness, validity, and reliability of its findings. First, since the data was collected for purposes other than this study, there is a limitation in how the data aligns with the specific research questions and hypotheses being investigated. The inability to control the data collection process means that the researcher cannot guarantee

the accuracy or honesty of the participants' responses, which could affect the study's validity. Furthermore, the study's reliance on quantitative data from a survey limits the depth of understanding regarding participants' experiences and perceptions, potentially affecting the richness and trustworthiness of the findings.

Another limitation is related to the internal validity of the study. While the relationship between the dependent variable (access to a healthcare provider) and the independent variables (health insurance, income, employment status, and ACA provision) can be established, the secondary data set may contain internal threats such as history, maturation, testing, instrumentation, statistical regression, experimental mortality, and selection-maturation interaction, which could impact the reliability and accuracy of the findings. Although methodological strategies likely were adopted to mitigate these threats, the inherent nature of using secondary data means that these strategies may not fully address all potential validity and reliability concerns (Holahan & Karpman, 2020). Moreover, the generalizability of the study's findings is limited by the specific context and population from which the secondary data were collected. The data set's focus on a particular period and demographic (U.S. adults who identify as Black non-Hispanic) means that the findings may not apply to other populations or contexts without further research

In summary, while secondary data analysis offers valuable insights, the limitations regarding generalizability, trustworthiness, validity, and reliability were carefully considered. These limitations stem from the nature of secondary data analysis,

including the lack of control over data collection and the potential for internal validity threats that could affect the study's findings

Recommendations

Based on the strengths and limitations of the current study, as well as the literature reviewed in Section 1, the following recommendations for further research are proposed:

- Explore Qualitative Dimensions: Given the quantitative nature of the current study, future research could benefit from incorporating qualitative methods to gain deeper insights into the experiences and perceptions of United States adults who identify as Black non-Hispanic regarding access to healthcare providers. Qualitative interviews or focus groups could uncover nuanced barriers and facilitators to healthcare access not captured through quantitative measures.
- Longitudinal Studies: The current study provides a snapshot based on secondary data analysis. Longitudinal research could track changes over time in healthcare access among the target population, especially in response to policy changes or economic fluctuations. This would allow for a better understanding of the dynamics of healthcare access and the long-term effects of the ACA provision.
- Comparative Studies: To address the limitations related to generalizability, future studies could compare healthcare access between different racial and ethnic groups or between different socioeconomic statuses within the Black

non-Hispanic population. This would help to delineate the specific impact of race, ethnicity, and socioeconomic status on healthcare access, providing a more comprehensive understanding of the barriers and facilitators.

- Impact of Cultural Factors: Given the findings from the literature review about the importance of cultural factors in healthcare access, further research could specifically investigate how cultural beliefs, practices, and language barriers impact healthcare access for Black non-Hispanic adults. This could inform culturally sensitive interventions to improve access.
- Policy Analysis Studies: Considering the significant relationship found between the ACA provision and access to healthcare services, future research could conduct detailed policy analysis to identify which aspects of the ACA or other health policies are most effective in improving access for the target population. This could also include evaluating the impact of state-level variations in ACA implementation.
- Examine the Role of Digital Health Technologies: With the increasing role of technology in healthcare, future studies could explore how digital health technologies (e.g., telehealth) are influencing access to healthcare services for Black non-Hispanic adults. This could include barriers to technology access and the potential for digital solutions to overcome traditional barriers to healthcare access.

These recommendations are grounded in the strengths and limitations of the current study and the literature reviewed, ensuring they do not exceed the study

boundaries. They aim to address gaps in the current research and contribute to a more nuanced understanding of healthcare access among United States adults who identify as Black non-Hispanic.

Implication for Professional Practice and Social Change

Professional Practice

The following are recommendations for professional practice based on the findings of this study:

- Enhance Cultural Competency: Healthcare providers should receive training to enhance their cultural competency, enabling them to better understand and address the unique healthcare needs and barriers faced by diverse populations, including Black non-Hispanic adults and African immigrants. This includes understanding cultural and spiritual beliefs about health, as well as language and communication barriers (Dickman et al., 2022).
- Improve Access to Insurance and Affordable Care: Professionals within the healthcare system should advocate for policies and practices that improve access to health insurance and make healthcare services more affordable. This includes supporting the implementation of healthcare policies that are inclusive of all citizens, regardless of their employment status, income level, or citizenship.
- Address SDOH: Healthcare professionals, including ophthalmologists, should be aware of and address the SDOH that affect access to care and health outcomes. This involves identifying social risks in patients and examining the

associations with health outcomes, as well as promoting awareness of these needs within the healthcare community.

- Transition Support for Young Adults with Disabilities: Healthcare providers should develop and implement strategies to support the transition from pediatric to adult healthcare for young adults with disabilities. This includes ensuring comprehensive healthcare coverage during the transition period, establishing a usual source of primary healthcare, and promoting continuity of care to avoid gaps and improve health outcomes.
- Policy Advocacy: Healthcare professionals should engage in policy advocacy to support the expansion of healthcare access and quality. This includes advocating for policies that address the barriers to healthcare access identified in the study, such as high costs, lack of insurance, and language barriers, and that promote universal healthcare coverage or a public choice model.
- Research and Education: Encourage ongoing research into the barriers to healthcare access and the effectiveness of interventions designed to overcome these barriers. Healthcare professionals should also seek to educate themselves and their peers on the findings of such research to continually improve practice.

By implementing these recommendations, healthcare professionals can contribute to reducing disparities in healthcare access and improving the health outcomes of diverse populations.

The methodological implications of this study highlight the importance of utilizing Anderson's model of healthcare utilization as a guiding framework for examining the association between access to healthcare providers, health insurance, income, employment status, and the ACA provision. This approach underscores the relevance of considering a broad range of factors, including policy elements like the ACA, in understanding healthcare access disparities. Future research could benefit from incorporating mixed methods to capture both quantitative and qualitative dimensions of healthcare access, thus providing a more comprehensive understanding of the barriers and facilitators to healthcare utilization among different populations.

Theoretically, this study contributes to the body of knowledge on SDOH by empirically examining how specific factors such as income level and health insurance coverage impact access to healthcare services. The findings support the notion that economic stability and insurance coverage are critical components of healthcare access, aligning with the core domains of SDOH as identified by William and Sahel (2022). This reinforces the need for theoretical models of health disparities to integrate these determinants in explaining and addressing disparities in healthcare access.

Empirically, the study's findings regarding the significant relationship between the ACA provision and improved access to healthcare services for young adults, including those from various racial and ethnic backgrounds, provide evidence of the ACA's impact on reducing some barriers to healthcare access. However, the persistence of racial and ethnic disparities in coverage and access even after the ACA's

implementation suggests that further empirical research is needed to explore and address the underlying causes of these disparities.

Positive Social Change

The potential impact for positive social change at the individual, family, organizational, and societal/policy levels is significant. At the individual and family levels, improved access to healthcare services can lead to better health outcomes, reducing the burden of medical costs and enhancing the quality of life. At the organizational level, healthcare providers and insurers can use these findings to tailor services and policies that address the specific needs of underserved populations, thereby improving healthcare delivery and satisfaction. At the societal and policy levels, the study's findings can inform the development and refinement of healthcare policies aimed at reducing disparities in healthcare access. By highlighting the effectiveness of the ACA in improving access for young adults and identifying areas where disparities persist, policymakers can be guided in making evidence-based decisions to further enhance healthcare access and equity.

In conclusion, this study underscores the importance of continued efforts to address healthcare access disparities through comprehensive policy measures, targeted interventions, and ongoing research to ensure that all individuals, regardless of income, insurance status, or racial/ethnic background, have equitable access to healthcare services.

The potential impact for positive social change stemming from the study's findings can be observed across multiple levels, including individual, family, organizational, and societal/policy:

1. Individual Level: Improved access to healthcare services as a result of the ACA provision can lead to better health outcomes for individuals. This is particularly significant for those with higher healthcare needs, such as young adults with disabilities, who may experience enhanced satisfaction with care and reduced reliance on emergency services for routine needs.
2. Family Level: Families may experience less financial strain and anxiety related to healthcare costs and access. Better healthcare access can reduce the burden of medical expenses on families, particularly those in lower income brackets, thereby improving their overall well-being and economic stability.
3. Organizational Level: Healthcare organizations and providers can use the insights from this study to tailor services more effectively to meet the needs of diverse populations. This includes addressing the SDOH that impact access to care, such as economic stability and the built environment, thereby improving patient care and satisfaction.
4. Societal/Policy Level: The findings highlight the importance of healthcare policies like the ACA in improving access to healthcare services. Policymakers can use this evidence to advocate for further reforms that address remaining barriers to access, such as high costs, lack of insurance, and language barriers. This could lead to more equitable healthcare access across

different racial, ethnic, and socioeconomic groups, contributing to a healthier and more productive society.

In conclusion, the study's implications for positive social change are profound, offering a roadmap for improving healthcare access and outcomes at various levels of society. By addressing the identified barriers and leveraging the ACA's provisions, there is potential for significant advancements in public health and equity.

The study's findings have significant implications for social change across various levels, directly aligning with the observed relationships between the ACA provision, health insurance coverage, and access to healthcare services. While no association was found between employment status or race/ethnicity and access to healthcare, income level emerged as a critical factor influencing access, suggesting that higher income levels correlate with increased odds of having better access to healthcare services.

1. Individual Level: Individuals, particularly those from lower-income brackets, stand to benefit from policies like the ACA that aim to improve access to healthcare services. This can lead to better health outcomes and a reduction in the financial burden associated with healthcare costs.
2. Family Level: Families may experience reduced financial stress and improved overall well-being as a result of enhanced access to healthcare services. This is particularly relevant for families navigating the challenges of securing healthcare for members with varying needs.

3. Organizational Level: Healthcare organizations can leverage these findings to tailor their services more effectively, addressing the needs of diverse populations. This includes recognizing the importance of economic stability and insurance coverage in facilitating access to healthcare.
4. Societal/Policy Level: At the societal and policy levels, the study underscores the importance of healthcare policies like the ACA in improving access to healthcare services. Policymakers can use this evidence to advocate for further reforms that address remaining barriers to access, thereby contributing to a more equitable healthcare system.

In conclusion, the study's implications for social change emphasize the need for continued efforts to address disparities in healthcare access through comprehensive policy measures and targeted interventions. By focusing on the factors that significantly impact access to healthcare, such as income level and insurance coverage, there is potential for substantial positive social change, enhancing the well-being of individuals and families while informing organizational practices and policy development.

Conclusion

This comprehensive study underscores the critical role of the ACA in enhancing access to healthcare services among Black non-Hispanic and White non-Hispanic adults in the United States, with a particular focus on the period between 2017 and 2020. By leveraging Andersen's model of healthcare utilization and analyzing data from the HRMS, the research illuminates the significant impact of health insurance coverage in facilitating access to healthcare. Key findings reveal that while health insurance coverage

markedly increases the likelihood of accessing healthcare services, income level emerges as a pivotal factor influencing healthcare access. Notably, the study highlights that the ACA provision has successfully improved access to healthcare services, showcasing the policy's effectiveness in reducing barriers to healthcare access. However, the absence of a significant relationship between employment status and access to healthcare providers points to the nuanced complexities within the healthcare access landscape. This study calls attention to the ongoing need for targeted policies and interventions to address the multifaceted barriers to healthcare access, aiming to bridge the gap and ensure equitable healthcare for all, regardless of race, ethnicity, or socioeconomic status.

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