

Healthcare and Healthcare Disparities Within the United States

Samantha Mayadunna

Department of Psychology, Wagner College

PS441 and PS400

Dr. Nolan and Dr. England

Table of Contents

	page
ABSTRACT	3
 CHAPTER	
1 HISTORICAL FACTORS IN HEALTHCARE DISPARITIES HISTORY OF ATTEMPTS TO MAKE UNIVERSAL HEALTHCARE (INCLUDING MENTAL HEALTH) WITHIN THE UNITED STATES.....	4
The Push for Universal Healthcare	5
Attitudes and the Misunderstandings Surrounding Mental Health	10
Funding for Mental Healthcare.....	13
2 HEALTH DISPARITIES: THE REASON SOUTH ASIANS STRUGGLE WITH CARE OR TREATMENT OF HEALTH WITHIN THE UNITED STATES OF AMERICA.....	16
Immigration and Mental Health	18
Causes and Effects of Health Disparities.....	20
3 SOUTH ASIAN MIGRANT HEALTH: COMBATTING HEALTH DISPARITIES....	24
Possible Solutions for Health Disparities.....	25
4 REFLECTION.....	30
LIST OF REFERENCES.....	33

Abstract

This paper focuses on healthcare and health disparities within the United States. By reviewing the history of healthcare, this research attempts to gain an understanding of how the current U.S. healthcare system— which is ridden with various health disparities for U.S. minority populations and is the only industrialized country lacking a universal healthcare system—developed (Sen, 2015). In an attempt to address the many current disparities within the U.S. healthcare system, the problems causing such disparities and possible solutions will also be addressed. Lastly, all of the information discussed will be tied together to create a comprehensive thesis, advocating for the overall improvement of the U.S. healthcare system, specifically for mental healthcare.

Keywords: Universal healthcare, health disparities, South Asians, mental illnesses, mental healthcare

Chapter One: Historical Factors in Healthcare Disparities: History of Attempts to Make Universal Healthcare(including Mental healthcare) Within the United States

Ensuring all individuals within a society have access to healthcare (including mental healthcare), is vital for the maintenance of their health and wellness. Many industrialized countries such as Japan, China, and most of the countries in Europe, have taken initiative toward reforming their healthcare systems by implementing universal healthcare (Sen, 2015; Jones & Kantarjian, 2019). Universal healthcare systems refer to national healthcare systems which enable all individuals to have access to quality healthcare treatments and services (Bloom et al., 2018). The implementation of a universal healthcare system can also be beneficial financially, as it prevents financial hardship (individual or familial) by reducing the costs of healthcare (Sen, 2015; Bloom et al., 2018,).

Unfortunately, the United States of America is still the only industrialized country that has yet to develop a universal healthcare system (Sen, 2015). To better understand why the United States lacks a universal healthcare system, specifically for mental healthcare, this paper will review the history of attempts to establish universal healthcare within the United States, as well as the challenges faced throughout the process (Sen, 2015).

Based on the past research reviewed within this study, this current paper argues that lobbying against the establishment of universal healthcare by politicians and organizations with legislative influence, negative attitudes surrounding mental health, the misunderstanding of

mental illnesses, and poor funding by Congress for mental healthcare have all resulted in the current lack of universal healthcare within the United States.

The Push for Universal Healthcare

The push for a universal healthcare system within the United States began during the early 1900s. However, during this time, many opposed the idea of healthcare reform and prohibited the implementation of universal healthcare within the United States. This current paper will focus on three of the most significant changes within the U.S. healthcare system over time while also discussing the challenges experienced.

Although many individuals have pushed for universal healthcare, one of the first individuals to begin the pursuit of a plan establishing a U.S. universal healthcare system was the 32nd president of the United States, Franklin Delano Roosevelt (commonly referred to as F.D.R) (Buck, 2017). By 1933, when FDR first took office, the United States was still amidst the Great Depression—during which the stock market crashed, causing poverty to sweep the nation (Buck, 2017). In an attempt to help bring the country out of the Great Depression, F.D.R worked to establish various relief efforts (Buck, 2017). Specifically, F.D.R coined the term “New Deal” through which he pushed for a series of programs and services which focused on relief, reform, and reconstruction of the United States (Mukherjee, 2009). One of the most significant programs authorized under the New Deal was the Social Security Act of 1935 (Hansan, 2012). Through the enforcement of the Social Security bill, Roosevelt had initially planned to include disability, retirement, old-age, and federally sponsored health insurance (universal healthcare) (Buck, 2017).

Unfortunately, FDR was unable to include universal healthcare within the Social Security bill as many were not in favor of reforming healthcare at the time (Buck, 2017). More specifically, the Grand Old Party (Republican party) and private medical lobbies such as American Health Association created the false yet widely accepted beliefs of comprehensive healthcare being a part of F.D.R's attempt at social conspiracy and government overreach (Buck, 2017). Therefore, F.D.R believed that the addition of universal healthcare to the Social Security bill would be too controversial and ruin the prospects of the other programs (Zelizer, 2015). In addition to receiving pushback, F.D.R also chose to refrain from including universal healthcare within the Social Security bill due to matters of expediency as he believed that manually documenting worker benefits for the entire country would be too daunting (Buck, 2017). By removing universal healthcare from the Social Security bill, FDR chose to help workers receive the other benefits (disability, retirement, and old-age), as fast as possible through a piecemeal approach while hoping to enact universal healthcare later on (Buck, 2017). FDR did re-attempt to continue working on expanding health security programs again in 1945, but he was unable to complete his attempt as he passed away three months later (Buck, 2017).

F.D.R was not the only former U.S. president to engage in healthcare reform, as many others pushed for the idea of establishing universal health insurance. Specifically, following F.D.R, his successor Harry Truman—the 33rd president of the United States—was also driven toward healthcare reform as he proposed the Fair Deal program in 1949 (Buck, 2017). Through this program, Truman's goal was to expand, extend, and improve the Social Security program (Buck,2017). The Fair Deal emphasized enforcing policies that were not included within the New Deal, such as increasing the minimum wage, granting all Americans equal rights, and enabling health insurance for all (Zelizer, 2015). In 1945, Truman introduced bills proposing a

national health program to Congress (Buck, 2017). Within Truman's proposal, five major goals were outlined, (1) addressing the lack of trained health professionals in every community, (2) growing public health services, (3) increasing the funding for medical research and education, and (4) reducing the cost of individual medical care, and (5) increasing attention to the loss of income when individuals experience severe illness. Implementing this proposal would have been a major turning point in the U.S. healthcare system as healthcare would have improved in regards to quality, accessibility, and affordability.

Regrettably, like FDR, many who worked towards the establishment of universal healthcare experienced major pushback from politicians, organizations, and many individuals in society. By 1946, Truman came to understand why F.D.R had chosen to refrain from successfully implementing a universal healthcare system, specifically due to controversy (Zelizer, 2015). For Truman, political parties had a great effect on his inability to engage in healthcare reform. Before 1946, Congress was controlled by Democrats, during which Truman's proposal for the national health program was meant to become a part of the Social Security expansion (Harry S. Truman Library & Museum). Unfortunately, by 1946, Congress became Republican-led, and any progress in establishing Truman's bill was immediately shut down for a variety of reasons (Buck, 2017). First, some argued that implementing such a bill would cause a high increase in taxes, which was unfavorable for many individuals in society (Harry S. Truman Library & Museum). Also, such proposals regarding expanding healthcare were viewed as attempts at socialized medicine, which was, and remains to be, a highly controversial topic within the United States (Mahler, 1953). According to Mahler (1953), during the 20th century, there were two opinions regarding socialized medicine. One side of the debate believed that a socialized medicine program would be a fundamental step toward the expansion and

improvement of medical care within the United States Whereas the other side of the debate felt strong opposition to any federal interest or intervention regarding the medical problems of the nation (Mahler, 1953). Moreover, Truman's attempt at establishing universal healthcare was also denied due to being bolstered by the Cold War fears of Communism (Buck, 2017). More specifically, post World War I, a substantial number of individuals became involved in a frenzy of rooting out any Communism-related ideologies in American society (Goldfield 1993 & Achter 2022). This was especially because of the rise of McCarthyism in the 1950s when U.S. senator Joseph McCarthy engaged in a series of investigations and hearings in an effort to expose alleged communists infiltrating the U.S. government (Goldfield 1993 & Achter 2022). This anti-Communist hysteria negatively impacted Truman's National Health Insurance (NHI), proposal as many important organizations such as the American Medical Association (AMA), and the National Physician's Committee—which was a front committee for the AMA, played into these fears (Goldfeild, 1993). Both the AMA and Physicians Committee engaged in efforts against the NHI proposal (Goldfield, 1993). With the support of Congress, the AMA conducted the most expensive lobbying effort during that time and the Physicians Committee created a position paper opposing the NHI proposal (Zelizer, 2015). All of these efforts were successful as by 1950, Truman's NHI proposal was dead (Zelizer, 2015). Truman considered the failure of the NHI proposal as the greatest failure of his presidency (Harry S. Truman Library & Museum).

As this current research discussed, up until the late 1950s, national healthcare was regarded as a losing cause (Zelizer, 2015). Yet, despite the past failed attempts for developing a universal healthcare system in the United States, by 1957, the congressman and New Deal liberal Aime Ford advocated for a smaller national health insurance program that would cover medical costs for Americans over the age of sixty-five (Zelizer, 2015). The 65 and older U.S. population

was specifically targeted because (1) many of these individuals required twice as much medical care than their younger counterparts, and (2) most could not afford the high costs of hospitalization (Zelizer, 2015). This proposal, soon named Medicare, was intended to be executed under the new Social Security administration and many democrats, including John F Kennedy, were in support of Medicare (Cohen, 1985). Kennedy's program for older adults included Medicare and was the basis of the Kennedy-Johnson Administration which supported Medicare from 1960 until 1965 (Zelizer, 2015). Similar to others who advocated for national health insurance programs in the past, Kennedy also received pushback from the AMA under the claim of socialized medicine (Zelizer, 2015). To further increase opposition to Medicare, the AMA created a political action committee that offered to provide campaign support to candidates opposing the bill (Zelizer, 2015). Furthermore, the AMA's women auxiliary created Operation Coffee Cup through which the wives of doctors would host the dangers of socialized medicine, attempting to stop more Americans from supporting Medicare.

Following Kennedy, Lyndon B. Johnson, the 36th president of the United States, played a significant role in the establishment of Medicare and Medicaid (Cohen, 1985). Johnson became president in 1963, during which he was determined to pass Medicare by convincing Congress to pass a series of bills constituting a second New Deal (Zelizer, 2015). To do so, Johnson enlisted Wilbur Cohen, one of the leading figures within the Social Security Administration to work alongside Wilbur Millis—the Arkansas Democrat in the house of Representatives who was against Medicare—to come up with a proposal for Medicare that would be accepted by the Ways and Means Committee (which had jurisdiction over major programs such as Social Security and other revenue related matters taxations and tariffs) (Zelizer, 2015). Together, Cohen and Mills were able to draft the “three-layer cake” which included utilizing Social Security taxes to pay for

hospital insurance, covering physicians' costs through a voluntary program, and Medicaid (Cohen, 1985). This bill satisfied most as general tax money and premiums covered doctors' bills satisfying Republicans, and since the voluntary part of the program included private physicians, the AMA could not accuse this bill as part of socialized medicine (Zelizer, 2015). The Ways and Means Committee approved the bill on March 23rd, 1965, shortly followed by the official signing of Medicare by President Johnson on July 30th, 1965 (Zelizer, 2015).

Following the signing of Medicare and Medicaid, over the next five decades, there was no further progress towards establishing universal health care in the U.S. until the Affordable Care Act (ACA) was passed in 2010 by the 44th U.S. president, Barack Obama (Obama, 2016). Obama recognized the uninsured rate in the U.S had not significantly decreased by the 21st century, especially since by 2008, more than one in seven Americans lacked health insurance coverage (Obama, 2016). The purpose of the A.C.A was to improve the high cost of care, access to health insurance and services, and the quality and efficiency of healthcare (Shaw et al., 2014). The A.C.A was successful in temporarily reducing the number of uninsured by 20 million by 2016 (Tolbert & Orgera, 2020). However, the number of uninsured increased again by 2019, emphasizing the inadequate development of the U.S. healthcare system within the United States.

Attitudes and the Misunderstandings Surrounding Mental Health

Attitudes Surrounding Mental Health

Within Western society, the lack of progress towards developing universal mental healthcare has been impacted by the continued public attitudes of rejection and avoidance surrounding mental health patients, as well as the misunderstanding of mental illnesses (Rabkin, 1974). Beginning with the modern era, those who were deemed as mad or insane were institutionalized, leading to an increase in mortification and condemnation, but a decrease in the

accreditation of individuals with mental illnesses (Fabgera, 1991). Such attitudes followed into the 20th century as during the 1950s, mental health professionals struggled with identifying mental illnesses through the model of illness which was prevalent amongst healthcare professionals after World War II and used to identify other medical illnesses (Rabkin, 1974). This inability to diagnose patients further increased the lack of public endorsement of mental health ideology (Rabkin, 1974). To help better understand mental illnesses and reduce the negative attitudes surrounding mental illnesses, the first and second editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I and DSM-II) were established post World War II (APA). The DSM-I and DSM-II both contained a glossary of the diagnostic categories and descriptions of mental illnesses which were the first to be clinically used (American Psychiatric Association, n.d.). Yet despite this establishment, there still lacked a widespread acceptance and proper understanding of mental illnesses (American Psychiatric Association, n.d.). A contributing factor to the poor acceptance of mental health was the improper forms of treatment which isolated the mentally ill away from the rest of society (Rabkin, 1974). As a means of improving treatment, by 1963, President John F Kennedy advocated for a new era in mental health services (Breakey, 1996). Specifically, through the passage of the Community Mental Health Centers Construction Act, Kennedy worked towards the implementation of community mental health centers which enabled those who were mentally ill— but did not require confinement within hospitals— to become deinstitutionalized and return to their communities while still having access to treatment services (Breakey, 1996). Later on, during the 1970s, mental health reform continued to increase as psychiatry was established as a primary care specialty since psychiatrists were often the only physicians who evaluated patients with serious mental illnesses (Druss, 2002). However, anti-psychiatry attitudes remained throughout the

1960s and 1970s, as people regarded psychiatry as repressive and coercive, and overall more damaging than beneficial for patients (Rössler, 2016). Many also continued to claim mental illnesses as a myth (Rössler, 2016). Furthermore, the negative attitudes associated with mental illnesses and mental services remain to be a present-day issue (Rössler, 2016)

Misunderstandings of Mental Illnesses

Understanding how to adequately treat mental illnesses was a challenge that persisted into the late 1900s. During the 1980s, the DSM-III was published and included explicit diagnostic criteria and a complex diagnostic assessment system (American Psychiatric Association, n.d.). However, the DSM-III was found to have many inconsistencies, resulting in unclear diagnostic criteria which required the publication of the revised DSM-III-R in 1987 (American Psychiatric Association, n.d.). Moreover, the atmosphere of treatment centers, and the overall care for and management of patients, during and post institutionalization were still in question (Sartorius, 1983). Many felt that those employed in mental institutions were not benefitting the development of psychiatry or patient care, nor were they able to meet the needs of patients beyond symptom relief, or post deinstitutionalization (Sartorius, 1983; Anthony, 1993). More specifically, individuals with mental illnesses were recognized to be experiencing significant functional limitations, disabilities, and handicaps. However, professionals were unable to help most of these patients due to the little understanding surrounding treatment measures (Anthony, 1993). As an attempt to improve treatment methods, the most comprehensive mental health system of the 1980s—the Community Support System (CSS)—was implemented by the National Institute of Mental Health (NIMH) (Anthony, 1993). The CSS defined how services should be provided for individuals with long-term psychiatric disabilities,

and attempted to lay the foundation for the new vision of mental health service delivery within the 1990s (Anthony, 1993). Furthermore, by 1994, the DSM-IV was published as a more comprehensive research-based medical model (American Psychiatric Association, n.d.). By 2013, the DSM-5 was published, followed by the publication of the DSM-5-TR in 2022 (Shorter, 2013). Despite the various developments within the U.S. mental healthcare system, by the early 21st century, based on a public health perspective, many mental illnesses remained undiagnosed and undertreated (Druss, 2002). This is because, although the establishment of such medical models (the DSM) has evolved from a collection of statistical information, defining mental disorders has been a challenge since the information can not be easily validated and is constantly evolving (Shorter, 2013). Therefore, debates over what can and cannot be considered a mental illness within the current DSM-5-TR are likely to continue to be present as new research continues to be discovered (Shorter, 2013).

Funding for Mental Healthcare

Mental healthcare has continued to receive less funding than medical healthcare from Congress due to the combination of negative attitudes surrounding mental health, misunderstanding of mental illnesses, and the lack of integration between medical healthcare and mental healthcare (Smoyak, 2000). Beginning in the 19th century (the 1840s-1860s), as previously mentioned, most of society—including Congress—chose to ignore mental illnesses as they were surrounded by attitudes of rejection and avoidance (Rabkin, 1974). One of the first movements for establishing state hospitals for mental illness was started by a former teacher, Dorothea Dix (Breaky, 1996). Dix had to spend years advocating for public mental health systems since taxpayers and decision-makers did not believe that the mentally ill deserved better treatment, therefore disfavoring the idea of providing funding for mental healthcare. Many

viewed treatment methods as too subjective and felt that there was not enough existing information surrounding mental illnesses (Breaky, 1996). Although the government eventually provided funding for the development of hospitals, it was not enough to maintain the quality of treatment due to the high demands of staffing, equipment, and extended facilities (Breaky, 1996).

Concerning the misunderstanding of mental illnesses, during the 1940s-1950s, funding for mental healthcare was sparse since third-party insurers were designated the role of providing funding for medical care (Marmor & Gill, 1989). These insurers delegated funding by utilizing the medical model of illness post World War II (Marmor & Gill, 1989). However, because mental illnesses could not be identified through the medical model, mental healthcare received insufficient funding—in comparison to medical healthcare—from third-party insurers (Marmor & Gill, 1989). Fortunately, by 1946, Congress passed the National Mental Health Act (NIMH), which included two major goals regarding funding for mental health services (Smoyak, 2000). The first was concerning providing individual fellowships and institutional grants for the training of mental health personnel, and the awarding of grants to states for two reasons. (1) For assisting in the establishment of clinics and treatment centers, and (2) for the funding demonstration projects addressing the diagnosis, treatment, and prevention of neuropsychiatric disorders (Smoyak, 2000). However, the NIMH did not include the usage of federal funds for institutional care and treatment which could have potentially been useful in the progression toward establishing universal mental healthcare within the U.S. (Smoyak, 2000).

Regarding the integration of mental healthcare with medical healthcare, during the early 1980s, the “Linkage” was a proposed program as a way to encourage mental health programs to integrate with other health and social agencies (Breaky, 1996). However, poor organizational

relationships with general hospitals, as well as the growing emphasis placed on social models of mental illness over the medical models of mental illness, and limited financial resources made the integration between medical and mental health challenging (Druss, 2002). Moreover, during the 1990s, the increasing costs for mental health services caused the growth of mental health “carve-outs”, which provided mental health insurance benefits and treatments separate from medical care, further delaying the integration of mental healthcare with medical healthcare (Druss, 2002). More progress towards integration did occur during the 1990s however, as new grants benefitted the growth of treatment for mental disorders within federally qualified health centers (Druss, 2002).

Within the early 21st century, adults with mental illnesses (depending on the disorder), were commonly viewed as less capable of making both financial and treatment-related decisions in comparison to other individuals within society (Pescosolido et al., 1999). Later on, in the 21st century, more progress was made towards establishing universal mental healthcare as the understanding and attitudes regarding mental health improved (Druss, 2002). Specifically, the funding for the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 was a monumental turning point in mental healthcare (Druss, 2002). MHPAEA helped reduce the financial burden for patients by barring differential coverage limits such as higher cost-sharing, hospitalization or separate visit maximums, and the unequal application of techniques for managing care (Druss, 2002). Parity was extended to insurance plans regardless of whether they offered coverage for behavioral health conditions, although most plans did offer coverage (Druss, 2002). Additionally, more advances included the “Decade of the Brain” during the 1990s when Mental Illness Awareness Week was established alongside an increase in national recognition for brain research and public education (Walthall, 2020). As the U.S. continues to

increase initiatives for funding while also decreasing the negative attitudes and the misunderstanding surrounding mental illness, universal mental healthcare could be a possibility in the future of U.S. healthcare.

In sum, the absence of a universal mental healthcare system within the U.S. has been affected by the lobbying against universal healthcare by politicians and organizations with legislative influence, continued negative attitudes, and misunderstanding of the reality and severity of mental illnesses. Moreover, as a result of the misunderstanding of mental illnesses in combination with negative attitudes, the allocation of funding by Congress for mental health treatments, in comparison to medical health, has suffered and resulted in a delay in the establishment of universal healthcare within the U.S.

Chapter Two: Health Disparities: The Reasons South Asians Struggle With Care or Treatment of Health Within The United States of America

For a society to be successful, the health and wellness of its individuals need to be efficiently maintained. Unfortunately, although there have been various advancements in health throughout time, not all countries—such as the United States of America, have progressed so that all of its people have been benefited equally-- regarding health and wellness (Benson & Koroshetz, 2022). Kronenfeld (2020) supports this by stating that to this day, there are many marginalized groups of individuals within the U.S who not only have poorer experiences with health but are also in substandard states of physical and mental health. Such individuals include people of color, women, LGBTQ members, and the lower-working class (Kronenfeld, 2020). In comparison, individuals who are considered to be more privileged such as white people, males, heterosexuals, and those in higher socioeconomic standing are less likely to have such negative experiences with their health and wellness (Kronenfeld, 2020). This is specifically due to what is

known as health disparities. Health disparities refer to differences within health shaped by policies and are often experienced by disadvantaged social groups as mentioned above including racial or ethnic minorities, the poor, and women (Bravemen, 2006). Historically, health disparities (including within mental health) have been understood to persist because of various demographic and socioeconomic factors, as mentioned above. Bravemen (2006) states that to eliminate such disparities, many societies work toward implementing health equity, which can establish equal opportunities of health for all. As previously mentioned, this has yet to occur within the U.S as health disparities remain to be a current issue and became especially notable during the pandemic. Shannon et al. (2022) affirms this as they convey disproportionate statistics resulting from the outbreak of coronavirus including mortality rates between marginalized groups and those more privileged therefore attesting the existence of health disparities within the U.S. to be a present-day concern (Shannon et al., 2022).

Although addressing the issue of health disparities is beneficial for all of the populations affected by them, this paper will solely focus on one marginalized group in particular, the South Asian population within the U.S. –referring to individuals from Sri Lanka, India, Pakistan, and Bangladesh (Mukherjea et al., 2017). South Asian health—especially mental health, has historically suffered as immigrants within the United States (Katz et al., 1997). Beliefs regarding health and mental health (including stigmas), hailing from different types of cultures (collectivist vs. individualist), or negative associations with health due to past experiences may be contributing factors (Smith et al., 2021). Additionally, as South Asians within the U.S. remain underserved, they are also understudied, therefore making this topic an important subject of research as there is a clear need for more information on South Asian health (Ali et al., 2020). As made evident by Kronenfeld (2020), health disparities are a topic for serious concern

as they place marginalized individuals—including South Asians, at a major disadvantage in regard to access, treatment, and overall experience with health and mental health. As this paper is intersectional review, the goal is to address the different positions held amongst individuals within the U.S healthcare system—the disadvantaged and the privileged, to understand the differing experiences between such differing positions. More specifically, as it reviews South Asians and how health disparities affect their mental health, the main factors of focus include immigration and mental health, and the causes and effects of health disparities (which will be understood by focusing on affordability or accessibility, racialization, and experiences with treatment).

Immigration and Mental Health

Although research has been done on the intersection between immigration and mental health, there is little information surrounding how immigration has affected the mental health of the South Asian population within the United States. The experience of migrating to a new country is likely to come with challenges, including possibly harming mental health. For example, culture conflicts and assimilation are two specific challenges which may arise. Assimilation refers to the adjustments made by minority groups to adapt to the majority groups within a society, whereas culture conflicts can arise amidst assimilation to said society (Rath, 2000). Karasz et al. (2019) discusses acculturative stress, which results from immigrant attempts to incorporate the traits of their new country's culture with that of their own. This form of stress not only aids the deterioration of mental health but it is also one that all immigrants are susceptible to regardless of age or generation. The authors found that acculturative stress can affect all generations including first generation (also referred to as 1.5) children as well as foreign-born parents. Adjusting to a new culture can further act as a burden on mental health as

the issues which cause stress to does not necessarily only arise amongst interactions with fellow foreigners. Specifically, inter-generational conflicts within immigrant homes have been found to have a negative impact on mental health and be associated with higher levels of depression (Karasz et al., 2019). Additionally, Karasz et al. (2019) also mention that for women who lived in more traditional households, eating disorders were also more prevalent. Therefore, affirming that immigrating to a new country can have a negative impact on both physical and mental health as these women may struggle with eating due to challenges with culture conflicts and assimilation. For example, these eating disorders may arise due to feeling as though their cultural foods are outside of the cultural norms within their new societies, increasing their feelings of being an outsider. Moreover, the prevalence of eating disorders may also be caused by struggles with body image brought on by assimilation as these women may have an increased desire of wanting to look like the majority of women within their society. In general, migration has the possible effect of interacting with other social factors including unemployment or poverty, which can also lead to negative impacts on mental health (Karasz et al., 2019). Based on the information provided, immigration plays a role in acting as a detriment on mental health due to assimilation, culture conflicts, and socioeconomic challenges.

Cultural beliefs also have a large impact on South Asian mental health, specifically about seeking treatment. Social stigma relating to mental health, for example, is an especially significant factor as research has found that South Asians heavily base their reluctance to seek care on social stigma (Karasz et al., 2019). Karasz et al. (2019) include the example of a group of South Asian caretakers who purposely chose not to consult healthcare professionals for the treatment of their elder relatives because of the underlying reason of social stigma associated with mental health. A cause for experiencing social stigma may be due to the differences in types

of cultures as mentioned earlier. Specifically, South Asian communities follow a collectivist culture, meaning that there is a large emphasis on conformity, family cohesion, and cooperation (Karasz et al., 2019). Additionally, collectivists often place the priorities of the group above those of the individual. Therefore, individuals are less likely to seek out care—especially for themselves if the ultimate purpose for doing so relates to a self-benefit rather than for their community (Karasz et al., 2019). Karasz et al. (2019) suggest that another reason for choosing not to seek care could be that they do not want to stray from cooperating or conforming with their culture. However, this can be an issue for South Asians who have immigrated to places such as America where a more individualist culture is the norm rather than a collectivist. Furthermore, immigration can come with various challenges as mentioned earlier, and some of those challenges may include shifts in family dynamics which can therefore alter the maintenance of a collectivist culture after immigrating. The disruption of this norm can therefore also lead to additional negative effects on the mental health for these individuals (Karasz et al., 2019).

Causes and Effects of Health Disparities

Affordability or Accessibility

As previously noted, a common challenge for those who immigrate to the United States is dealing with financial difficulties which can arise from a mixture of the other challenges such as lack of literacy, proper assimilation, or even poor mental health statuses (Karasz et al., 2019). Unfortunately, within the United States, individuals coming from lower socioeconomic backgrounds are more likely to experience health disparities (Kronenfeld, 2020). Therefore, as South Asians not only identify as people of color—who are already susceptible to health disparities, the addition of financial burdens makes their likelihood of experiencing health

disparities even more so. Concerning socioeconomic status, one of the most prominent challenges regarding health disparities is being able to access or afford proper care. In fact, according to Tauler et al. (2018), within the United States, psychiatric conditions—which are recognized as causes of significant disability, cost over \$300 billion annually. Still, the majority of the people who require care—regardless of how prevalent their conditions may be, lack access to effective and high-quality care (Tauler et al., 2018). According to the authors, this is caused by increased rates of uninsured individuals amongst racial-ethnic minority groups (Tauler et al., 2018). This is a cause for concern as health insurance within the United States has become nearly essential as its per capita health care costs are the highest globally, and it continues to increase—alongside the number of uninsured people within the country (Hoffman & Paradise, 2008). Hoffman and Paradise (2008) affirm this as statistics prove that by 2006, the amount of uninsured people within the country increased by over one million annually on average. More specifically, by 2006, the amount of people lacking coverage surpassed 46 million (Hoffman & Paradise, 2008). Additionally, lack of insurance is also concerning because whether an individual is insured or not is often reflective of their overall health. Specifically, people with lower income ---and consequentially poor or lack of health insurance, are more susceptible to having poor or just fair health in comparison to those with higher income. This was especially noted during recent spread of Covid-19 as research found that nearly 18.2 million racial and ethnic minority groups --who were also considered to be more at-risk individuals of severe Covid-19 symptoms, lacked health insurance and therefore experienced worse health outcomes during the pandemic (Parolin & Lee, 2022). Parolin and Lee (2022) explain that this is partly because most people who lack adequate health insurance are also generally less likely to seek out healthcare services especially for seeming minor health issues or preventative care, in comparison to insured

individuals. This is a serious problem as people should be able to access care as soon as they need it rather than having to wait until their conditions worsen.

Racialization

Racialization and experiences of discrimination are also leading factors in health disparities. Due to racial inequality, people of color are statistically more likely to show poorer states of health in comparison to their white counterparts (Kronenfeld, 2020). The study of racialization focuses on immigrants of color, racial minorities, their offspring, and their experiences with healthcare. According to these theorists, individuals who identify within the groups listed prior have been found to have different experiences due to having to face discrimination and racism towards their cultures, attitudes, and bodies—not only within the healthcare system, but also within everyday life. (Kronenfeld, 2020). These different experiences then shape their assimilation outcomes and racial statuses which have a significant effect on their social positioning. Therefore, according to this theory, racial health disparities are a result of racialization and racial hierarchy within society (Kronenfeld, 2020). This especially pertains to South Asians, as discrimination is found to be a significant factor in South Asian's experiences of migration related stress (Karasz et al., 2019). In fact, such experiences with racial discrimination are associated with shaping the self-reported health statuses amongst Asian (East and South) Americans. Results from this data supports the understanding that racial discrimination significantly affects South Asian self-reported health statuses. In fact, as various forms of discrimination increase—including overt, covert and structural, the probability of reporting better health decreases (Gee et al., 2009). More specifically, overt discrimination refers to acts of racial bias including hate crimes whereas Gee et al. (2009) describe overt discrimination as the inclusion of implicit attitudes, and structural discrimination as acts of

segregation, racial ideologies, and institutional policies. However, Gee et al. (2009) note that acts of overt discrimination are less prevalent and detrimental than the more mundane actions experienced through covert and structural discrimination. According to the authors, institutionalized discrimination--stemming from structural discrimination, is likely to be one of the more fundamental causes of health disparities. Research supports this as for most Asians, many experiences with mental health including mental health outcomes and utilizing mental health treatment and preventative services were all reported to be negatively associated with discrimination (Gee et al., 2009).

Experience With Treatment

Treatment of mental health and health, in general, may also be negatively affected by health disparities for South Asians. As immigrants living in both the United States and United Kingdom, research has found that the most prevalent mental health disorder within South Asian communities is depression (Karasz et al., 2019). According to the authors, various factors such as social isolation, poor physical health, financial difficulties, perceptions of illness, older age, literacy, and gender roles contribute to this statistic (Karasz et al., 2019). Unfortunately, part of the reason why depression remains prevalent in South Asian communities is because of improper treatment. As mentioned by Karasz et al. (2019), South Asian patients who have sought out primary care when presenting with psychological difficulties often leave such appointments untreated and undiagnosed. This is often due to the unfortunate encouragement from some psychologists or physicians who persuade such patients into believing that their symptoms are effects of somatization, rather than the actual illness itself (depression) (Karasz et al., 2019). This is not only an issue in regard to treatment but also for fighting stigma in relation to health disparities. As mentioned earlier, many South Asians do not seek out treatment for their mental

health due to disparities. Therefore, continuation of poor experiences in healthcare settings is likely to increase stigma and decrease the number of South Asians actively seeking treatment, which then poses the possibility of deeper detriment to their overall health and wellbeing (Jaspal & Lopes, 2021).

Overall, research shows that South Asians are at greater risk for poorer health and mental health due to health disparities. Moreover, factors such as socioeconomic status, racialization, social stigma, and poor treatment have a significant impact on the overall health experience for these individuals. Preexisting mental health challenges may be related to living in the United States, however, due to the challenges which arise from health disparities, it is likely that improving their health will also be a challenge. This is an important issue that must be prioritized in future research. Therefore, in order to help prevent and eliminate health disparities to achieve the long-term goal of bettering the health of South Asians, more research needs to be done within these populations.

Chapter Three: South Asian Migrant Health: Combating Health Disparities

Within the (U.S.), a rapidly growing population is the South Asian population (Mukherjea et al., 2017). Unfortunately, for many of these individuals their states of health—especially mental health—are often substandard because of health disparities (Ali et al., 2020). More specifically, as a result of health disparities, problems such as lack of access to healthcare (including mental healthcare), language barriers prohibiting proper treatment, and lack of research regarding South Asian mental health—persist within the U.S. (Mukherjea et al., 2017). These problems continue to harm South Asians as they create a detriment to their overall health and wellness.

As health disparities pose a clear problem for those affected concerning accessing care and effective treatment, the purpose of this chapter is to address the possible solutions for eliminating health disparities in the U.S.-based South Asian community. With that said, to progress the process of eliminating health disparities, this paper addresses three possible solutions pertaining to three problems arising from health disparities within the U.S. South Asian community. Areas of focus include solutions regarding improving the U.S. healthcare system in relation to funding, methods for preventing or decreasing the language barriers in health care, and finally, increasing research on South Asians and mental health. Overall, by utilizing these solutions— and as a result reducing or eliminating the problem of health disparities— the health and wellness of South Asians will likely improve significantly.

Possible Solutions for Health Disparities

Healthcare

In order to establish a society where all of its individuals have positive experiences with and equal access to healthcare, the services for such care must be affordable. Unfortunately, within the U.S., the current healthcare system is in fact the most expensive system globally, making it difficult for all Americans to be covered for healthcare—especially for those more affected by disparities such as South Asians (Jones & Kantarjian, 2019). The high cost of care is a problem within the U.S. healthcare system as it enables insurance disparities and therefore limits many individuals from accessing mental health treatment due to the inability of affording mental health care. Researchers note that (1), a quarter of the U.S. population does not have proper access to mental health care, and (2), one out of every four Americans has a mental disorder yet two-thirds of that population lack treatment (Safran et al., 2011). Additionally, because patients with mental health illnesses are twice as likely to be referred to a specialist than

most chronic conditions, many of those individuals are unable to be successfully treated as most coverage plans do not extend to specialist care (Katon & Unützer, 2013). Research finds that only 60% of individuals referred to a specialist follow through with the referral (Katon & Unützer, 2013). The affordability of plans for coverage within the current U.S. healthcare system requires modifications so that individuals can have better access to care.

Unlike the U.S., most major industrialized countries—such as China, Japan, Germany, and France—provide their citizens with universal health care programs as they recognize access to proper health care as a human right (Jones & Kantarjian, 2019). With that said, for the current state of the U.S. healthcare system to progress towards resolving health disparities for South Asians and their mental health, the optimal change would be to follow other nations and establish a universal healthcare system—one which includes coverage of mental health care for all. To establish such a system for universal care, a legislation-based solution of dedicating more funding toward medical services would be tremendously beneficial to the U.S. healthcare system. Specifically, by providing more funding, health care coverage can be further expanded and allocated to various forms of medical care—including mental health specialties (Jones & Kantarjian, 2019). This expansion can allow more individuals to completely fulfill their treatment plans rather than halting treatment due to a lack of affordability (Katon & Unützer, 2013). Moreover, increasing funding can also benefit individuals by reversing the perverse market incentives which are currently active within the U.S. healthcare system such as high-costing drugs, out-of-product expenses, and high deductibles (Jones & Kantarjian, 2019). Furthermore, an increase in funding would also benefit the U.S. healthcare system through important improvements such as coordination of care through better staffing which can decrease burnout for healthcare workers, more access to services for prevention and early detection of

mental illnesses, and the reduction of financial costs (total costs for care and individual spending) (Jones & Kantarjian, 2019). Overall, increasing funding for healthcare would benefit not only the South Asian population, but all groups facing healthcare disparities as more funding could potentially increase opportunities for better health services.

Language Barriers

In addition to affordability, cultural barriers within health care—specifically pertaining to language barriers relating to mental health—are also common problems experienced through health disparities. As previously mentioned by Safran et al. (2011), accessibility to mental health services is a severe problem for many individuals. Language barriers in particular act as a prominent challenge for many minority individuals—including South Asians—when attempting to access healthcare. Research shows that for families who have limited English proficiency (LEP), the experience of barriers when accessing physical and behavioral health care is increased in comparison to those who are non-LEP (Herbst et al., 2015). Moreover, language and immigration status are also some of the most prevalent causes of health disparities within the U.S. healthcare system as both factors are associated with an increased risk of behavioral, developmental, or social delays (Herbst et al., 2015). This barrier through language is an important problem to address—and resolve—as it continues to contribute to health disparities pertaining not only to access but also to quality and equity.

Similar to resolving the problem of funding for healthcare, a solution for language barriers requires a change to be implemented through legislation. More specifically, through the enactment of increasing employment of more health care professionals who are proficient in languages other than English. According to Herbst et al. (2015), the continued issue of language barriers within healthcare is due to the shortage of healthcare professionals able to communicate

in languages other than English. This can have a serious impact on patient care as research shows that patients who are LEP experience overall poorer communication with their healthcare providers and greater dissatisfaction due to poorer understanding of their treatment plans and diagnoses (Herbst et al., 2015). Consequently, LEP patients are more frequently associated with health disparities relating to shorter amounts of time spent with their health care providers and experience less sensitivity from their provider concerning family values and customs (Herbst et al., 2015). Therefore, by choosing to hire more multilingual individuals, more LEP patients would have the ability to more effectively communicate with their providers and as a result, also experience a better sense of overall care.

Research

As previously mentioned, the South Asian population within the United States continues to grow rapidly (Ali et al., 2021). Unfortunately, South Asians remain underserved and extremely understudied as there is a severe lack of research regarding South Asian health, especially mental health within the United States (Mukherjea et al., 2018). Mukherjea et al. (2018) confirm that a leading cause of the lack of research on South Asian mental health is the lack of participation by most South Asians in research studies. Many South Asians report reasons such as mistrust, demand for time, legal status, stigma, and lack of access to information, as to why they choose not to participate in research (Mukherjea et al., 2018). These reasons are often characterized by various concerns about providing informed consent, lacking financial resources and/ or time, language barriers (especially for LEP individuals), and fear of judgment from family members or surrounding community members (Mukherjea et al., 2018). Moreover, South Asians must be encouraged to engage in more research since understanding and addressing the

disparities faced by South Asians in the U.S. can be difficult with the limited amount of information that currently exists. (Mukherjea et al., 2018).

To be able to reduce and eliminate preventable disparities amongst South Asians within the U.S., the simple solution would be to create more opportunities for research amongst this population. However, as Mukherjea et al. (2018) assert, South Asians require more encouragement. Therefore, a possible solution would be to increase the amount of South Asian research representatives within such studies as it can reduce common negative associations between research and South Asians such as mistrust and stigma. Mukherjea et al. (2018) state that for the South Asians who do participate in research, the facilitators are often individuals of cultural congruence, meaning they are individuals representing potential participants– in this case referring to South Asians. This is beneficial as it creates a sense of familiarity between researchers and participants, decreases challenges of language barriers, and also decreases community or family-related altruism (Mukherjea et al., 2018). Furthermore, lower perception of risks and increases in the likelihood of convenience for study times and locations are also seen in culturally congruent relationships between researchers and participants (Mukherjea et al., 2018). Moreover, implementing such a change within South Asian mental health research would increase opportunities for identifying and establishing methods for the implementation, development, and evaluation of the health interventions targeting the South Asian community (Ali et al., 2021).

Overall, with the implementation of the solutions suggested within this research (universal healthcare, multilingual healthcare workers, and culturally congruent researchers), the health and wellness of South Asians will likely improve significantly. Specifically, these changes will enable South Asians to have better access to health care, lower chances of experiencing

language barriers, and also have an increased amount of data regarding the U.S. South Asian community and mental health– which can be used for specifically tailored and targeted interventions for South Asian health disparities. Furthermore, although the population of focus within this research is migrant South Asians within the U.S., the solutions proposed are likely applicable to other U.S. based minority groups experiencing similar challenges with health disparities.

Chapter Four: Reflection

Throughout my thesis paper, each chapter focused on topics pertaining to healthcare within the United States(including mental healthcare). More specifically, chapter one focused on the history of healthcare, chapter two discussed health disparities within the South Asian population, and chapter three addressed the problems within the healthcare system that cause health disparities as well as the possible solutions for such problems. By reviewing the history of healthcare in chapter one, I was able to gain a better understanding of the development of the U.S. healthcare system, and how it came to become the current state that it is today. Based on my research, I found that the lobbying against the establishment of universal healthcare by politicians and organizations with legislative influence, negative attitudes surrounding mental health, the misunderstanding of mental illnesses, and poor funding by congress for mental healthcare (as a result of the negative attitudes and misunderstanding of mental health), have all resulted in the current lack of universal healthcare within the United States. Following this, chapter two focused on one of the major consequences of lacking a universal healthcare system, the result of health disparities. As later discussed in chapter three, universal healthcare has the benefit of establishing health equity, which can be seen through increasing the quality and access to healthcare for all populations (Bravemen, 2006). However, because the United States has yet

Chapter 4 redacted to remove personal reflections and any identifying information.

References

- Ali, S. H., DiClemente, R. J., & Parekh, N. (2021). Changing the landscape of South Asian migrant health research by advancing second-generation immigrant health needs. *Translational Behavioral Medicine, 11*(6), 1295–1297. <https://doi.org/10.1093/tbm/ibaa084>
- American Psychiatric Association. *DSM History*.
<https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm>
- Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11.
<https://doi.org/10.1037/h0095655>
- Benson, R. T., & Koroshetz, W. J. (2022). Health disparities: research that matters. *Stroke, 53*(3), 663–669. <https://doi.org/10.1161/STROKEAHA.121.035087>
- Bloom, D. E., Khoury, A., & Subbaraman, R. (2018). The promise and peril of universal health care. *Science (Washington DC), 361*(6404).
- Braveman, P. (2006). *Health disparities and health equity: Concepts and measurement*.
<https://doi.org/10.1146/annurev.publhealth.27.021405.102103>
- Breakey, W. R. (Ed.). (1996). *Integrated mental health services: Modern community psychiatry*. Oxford University Press, USA.
- Buck, S. (2017). Universal healthcare was almost part of the original Social Security act of 1935. *Timeline*. <https://timeline.com/social-security-universal-health-care-efe875bbda93>
- Cohen, W. J. (1985). Reflections on the enactment of Medicare and Medicaid. *Health Care Financing Review, Suppl*, 3–11.

- Druss, B. G., & Goldman, H. H. (2018). Integrating health and mental health services: A past and future history. *The American Journal of Psychiatry*, *175* (12), 1199–1204.
- Fabrega, H. (1991). The culture and history of psychiatric stigma in early modern and modern Western societies: A review of recent literature. *Comprehensive Psychiatry*, *32*(2), 97–119.
[https://doi.org/10.1016/0010-440X\(91\)90002-T](https://doi.org/10.1016/0010-440X(91)90002-T)
- Gee G.C., Ro A, Shariff-Marco S, Chae D, Gee, G. C., Ro, A., Shariff-Marco, S., & Chae, D. (2009). Racial discrimination and health among Asian Americans: Evidence, assessment, and directions for future research. *Epidemiologic Reviews*, *31*, 130–151. <https://doi.org/10.1093/epirev/mxp009>
- Goldfield, N. (1993). Truman and the medical profession: replay or lesson for the nineties. *Physician Executive*, *19*(2), 3–9.
- Giritli-Nygren, K., & Olofsson, A. (2014). Intersectional approaches in health-risk research: A critical review. *Sociology Compass*, *8*(9), 1112–1126. <https://doi.org/10.1111/soc4.12176>
- Hansan, J.E. (2012). The New Deal: Part II. <https://socialwelfare.library.vcu.edu/eras/great-depression/the-new-deal-part-ii/>
- Harry S. Truman Library & Museum. *The Challenge of National Healthcare*.
<https://www.trumanlibrary.gov/education/presidential-inquiries/challenge-national-healthcare>
- Hermer, L. (2005). Alan Derickson, Health Security for All: Dreams of Universal Health Care in America. *Politics and the Life Sciences*, *1*, 89. [https://doi.org/10.2990/1471-5457\(2005\)24\[89:ADHSFA\]2.0.CO;2](https://doi.org/10.2990/1471-5457(2005)24[89:ADHSFA]2.0.CO;2)
- Herbst, R. B., Margolis, K. L., Millar, A. M., Muther, E. F., & Talmi, A. (2016). Lost in translation: Identifying behavioral health disparities in pediatric primary care. *Journal of Pediatric Psychology*, *41*(4), 481–491. <https://doi.org/10.1093/jpepsy/jsv079>

- Hoffman, C., & Paradise, J. (2008). Health insurance and access to health care in the United States. *Annals of the New York Academy of Sciences*, 1136, 149–160.
<https://doi.org/10.1196/annals.1425.007>
- Jaspal, R., & Lopes, B. (2021). Discrimination and mental health outcomes in British Black and South Asian people during the COVID-19 outbreak in the UK. *Mental Health, Religion & Culture*, 24(1), 80–96. <https://doi.org/10.1080/13674676.2020.1871328>
- Jennie, J., & Kronenfeld. (2020). *Race, Ethnicity, Gender and Other Social Characteristics As Factors in Health and Health Care Disparities*. Emerald Publishing Limited.
- Jones, G., & Kantarjian, H. (2019). The many roads to universal health care in the USA. *The Lancet Oncology*, 20(10), e601–e605. [https://doi.org/10.1016/S1470-2045\(19\)30517-0](https://doi.org/10.1016/S1470-2045(19)30517-0)
- Karasz, A., Gany, F., Escobar, J., Flores, C., ... Diwan, S. (2019). Mental health and stress among South Asians. *Journal of Immigrant and Minority Health*, 21(Suppl 1), 7–14.
- Katon, W. J., & Unützer, J. (2013). Health reform and the Affordable Care Act: The importance of mental health treatment to achieving the triple aim. *Journal of Psychosomatic Research*, 74(6), 533–537. <https://doi.org/10.1016/j.jpsychores.2013.04.005>
- Katz, S. J., Kessler, R. C., Frank, R. G., Leaf, P., & Lin, E. (1997). Mental health care use, morbidity, and socioeconomic status in the United States and Ontario. *Inquiry*, 34(1), 38–49.
<https://www.jstor.org/stable/29772668>
- Lee-Tauler, S. Y., Eun, J., Corbett, D., & Collins, P. Y. (2018). A systematic review of interventions to improve initiation of mental health care among racial-ethnic minority groups. *Psychiatric Services*, 69(6), 628–647 <https://doi.org/10.1176/appi.ps.201700382>
- Mahler, I. (1953). Attitudes toward Socialized Medicine. *Journal of Social Psychology*, 38(2),

273–282. <https://doi.org/10.1080/00224545.1953.9711461>

- Marmor, T. R., & Gill, K. (1990). The political and economic context of mental health care in the United States. In I. M. Marks & R. A. Scott (Eds.), *Mental health care delivery: Innovations, impediments and implementation*, 137–153. Cambridge University Press.
- Mukherjee, A. (2009). "The "New Deal" for healthcare: reforms, risks, choices and outcomes", *International Journal of Pharmaceutical and Healthcare Marketing*, Vol. 3 No. 3. <https://doi.org/10.1108/ijphm.2009.32403caa.001>
- National Alliance of Mental Illness. (2020). *The evolution of the Mental Health Movement*. <https://nami.org/Blogs/NAMI-Blog/June-2020/The-Evolution-of-the-Mental-Health-Movement>
- Obama, B. (2016). United States healthcare reform: progress to date and next steps. *JAMA*, 316(5), 525–532.
- Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: A systematic literature review. *Administration and Policy in Mental Health and Mental Health Services Research*, 40(5), 384–399. <https://doi.org/10.1007/s10488-012-0430-z>
- Parolin, Z., & Lee, E. K. (2022). The role of poverty and racial discrimination in exacerbating the health consequences of COVID-19. *The Lancet Regional Health - Americas*, 7. <https://doi.org/10.1016/j.lana.2021.100178>
- Rath, J. (2000, June). Editorial: Assimilation of immigrants in Amsterdam and New York: A case for international comparative study. *Netherlands Journal of Social Sciences*, 36(2), 117–125.
- Rabkin, J. (1974). Public attitudes toward mental illness: A review of the literature. *Schizophrenia Bulletin*, 1(10), 9–33. <https://doi.org/10.1093/schbul/1.10.9>
- Rössler, W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO Reports*, 17(9), 1250–1253.

- Safran, M. A., Mays Jr, R. A., Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., McDuffie, K. Y., & Trachtenberg, A. (2009). Mental health disparities. *American Journal of Public Health*, 99(11), 1962–1966. <https://doi.org/10.2105/AJPH.2009.167346>
- Sartorius, N. (1983). Mental health in the early 1980s: some perspectives. *Bulletin of the World Health Organization*, 61(1), 1–6.
- Shannon, J., Abraham, A., Bagwell Adams, G., & Hauer, M. (2022). Racial disparities for COVID19 mortality in Georgia: spatial analysis by age based on excess deaths. *Social Science & Medicine*, 292. <https://doi.org/10.1016/j.socscimed.2021.114549>
- Shaw, F. E., Asomugha, C. N., Conway, P. H., & Rein, A. S. (2014). The Patient Protection and Affordable Care Act: opportunities for prevention and public health. *The Lancet*, 384(9937), 75–82. doi:10.1016/S0140-6736(14)60259-2
- Smith, J., Sulek, R., Abdullahi, I., Green, C. C., Bent, C. A., Dissanayake, C., & Hudry, K. (2021). Comparison of mental health, well-being and parenting sense of competency among Australian and South-East Asian parents of autistic children accessing early intervention in Australia. *Autism: The International Journal of Research and Practice*, 25(6), 1784–1796. <http://dx.doi.org/10.1177/13623613211010006>
- Shorter, E. (2013). The history of DSM. In *Making the DSM-5* (pp. 3-19). Springer, New York, NY.
- Smoyak, S. A. (2000). The history, economics, and financing of mental health care. Part 2: The 20th century. *Journal of Psychosocial Nursing and Mental Health Services*, 38(10), 26–37.
- Subica, A. M., & Link, B. G. (2022). Cultural trauma as a fundamental cause of health disparities. *Social Science & Medicine*, 292, 114574. <https://doi.org/10.1016/j.socscimed.2021.114574>
- Tolbert, J., Orgera, K., Singer, N., & Damico, A. (2019). Key facts about the uninsured population. *Kaiser Family Foundation*.

<https://doi.org/10.1016/j.socscimed.2021.114574>

Zelizer, J. (2015). How Medicare Was Made. *The New Yorker*. <https://www.newyorker.com/news/news-desk/medicare-made>