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Research Article

Disparities in Health Care Services and Economic Inequality among Minorities: Health Equity and Health Care Risk Management

Henry O'Lawrence[1], Martinez L[2*]

[1]*College of Health and Human Services, USA*
[2]*California State University, Long Beach, CA, USA*

Corresponding Author: Linda Martinez, Coordinator of Marketing, Ethics and Diversity Classes Health Care Administration, USA, E-mail: Linda.Martinez@csulb.edu

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Abstract

This research draws upon several areas of current research relating to risk factors in public health services and their effect on minority populations in the U.S. Most minorities today are affected with at least one non-communicable disease and most often, their behaviors trigger health risks, coupled with the inequity that leads to lack of access to quality health. When considering risk factors, it is suggested that modifiable behaviors such as tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol, all increase the risk of non-communicable diseases (NCDs). The research design relied on both secondary sources and qualitative data. Secondary data included publicly available data on social, economic and health status characteristics of minorities. Documentary data includes the articulating the interpretation, then the reflecting (also reflective) of the interpretation of the empirical material, and finally, the generating of theory as a multidimensional typology. After extensive analysis of the current research, the researchers concluded that the nation needs to be prepared for another global pandemic and start working on prevention measures that would work if used early and foster success in controlling the outcome. A rapid risk prevention strategy will help those disenfranchised (the unemployed and uninsured), create predictability, economic security and wellness.

Keywords

Health Care Disparities; Minorities; Lower Socioeconomic; Racial Disparities; Uninsured; Inequity; Health Care Reform; Equity; Risk Management

Introduction

This research draws upon several areas of current research relating to risk factors in public health services and their effect on minority populations in the U.S. The study of healthcare inequality and access to quality care among minority populations in the U.S. is a major aspect of health services that comprises the area of risk management which primarily is the part of behavioral health that involves risks specific to the services provided. A root cause or patient injury and health care risk management are also related to litigation that continues to be the breakdown in written and verbal communication between providers and patients; as is often the case in other types of health care delivery. According to the World Health Organization (WHO, 2019), the well-being of an individual is encompassed in the realization of their abilities, coping with normal stresses of life, productive work, and contribution to their community. Behavioral health also helps us to define mental health; since mental health (in terms of cultural differences, subjective assessments, and competing professional theories) is the level of an individual's psychological well-being or an absence of mental illness. Mental health is the state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment, which includes an individual's ability to enjoy life and to create a balance between life activities and efforts to achieve psychological resilience (WHO, 2019).

Most minorities today are affected with at least one non-communicable disease and most often, their behaviors trigger health risks, coupled with the inequity that leads to lack of access to quality health. When considering risk factors, it is suggested that modifiable behaviors, such as tobacco use, physical inactivity, unhealthy diet and the harmful use of alcohol, all increase the risk of non-communicable diseases (NCDs). This also includes metabolic risk factors that are regularly seen among the minority populations that increase the risk of NCDs such as:

- Raised blood pressure
- Overweight/obesity
- Hyperglycemia (high blood glucose levels), and
- Hyperlipidemia (high levels of fact in the blood)

Health equity is significantly linked to poverty. Poverty for obvious reasons is significantly linked with NCDs and

predicted to impede poverty reduction initiatives in low-income communities by increasing household costs that are associated with health care. As indicated, vulnerable and socially disadvantaged people get sicker from being exposed to harmful products, such as tobacco, unhealthy dietary practices and having limited access to health services (WHO, 2019).

The disproportionate effects of COVID-19 among ethnic minority populations have really widened realizations of the persistence of issues related to racism, police brutality, disproportionate effects of COVID-19 among ethnic minority populations and social health inequities in the United States. Therefore, there is a need to evaluate how medical institutions constrain or enable the critique of power structure and whether individuals working within the system evaluate their own privileges, practices and pedagogy to advance social justice [23]. Most essential workers are associated with minorities with minimum wage and below middleclass Americans that cannot afford to miss work, but are being forced to stay home due to the COVID-19 pandemic. These people cannot afford their medical bills and very often are afraid to even go for medical checkup; those with insurance nearly always end up having high-deductible plans and cannot cope with the medical bills debt that is sometimes outrageous [6]. behavioral health and clinical risk control must be integrated with the organization's quality improvement and patient safety initiatives, so that when monitoring activities are indicated to assure quality care and treatment, the organization may delegate such monitoring to its quality improvement program. Similarly, when the risk identification process recognizes opportunities for improved patient care and safety, referrals to the appropriate committees, departments, and individuals should be among the risk control techniques applied. Risk management issues related to behavioral health risks must be identified, controlled and monitored just as in any area of services. Suicide or homicide attempts are good examples, and all reporting activities should be documented in the patient's clinical record. The protocols for clinical monitoring are straight forward and there must be ongoing monitoring of the effectiveness of the facility's policies and procedures to identify patients at risk for suicide or homicide. Attempted and completed suicide or homicide must be reported to the following:

- Facility risk management department
- Facility administration
- Facility legal department or attorney
- Any person identified by the patient as a potential violence or homicide victim
- Patient's physician
- Patient's family or representative
- Law enforcement, when applicable
- State Department of Mental Health
- State Department of Health
- Professional licensing board, if applicable
- Facilities professional liabilities insurance broker and carrier

A confidential investigation and analysis of any suspected event should be carried out immediately. The investigation should include whether or not the organization's protocols, policies and procedures regarding the identification of patients at risk for suicide or homicide were properly carried out and a detailed plan of correction must be developed and implemented to prevent any future recurrence. Behavioral health risk programs need constant evaluation and must be adapted to meet changing needs and circumstances. Any incidents must be investigated, analyzed, and used as learning experiences, with sufficient risk control techniques implemented to prevent future similar incidents. Success can be measured in part by a facility's ability to learn from its own mistakes, and from the mistakes of others, and to proactively adjust the risk control program in response to those lessons learned [6].

Behavioral health professionals understand the importance of privacy and confidentiality; and have always understood their obligation to protect client privacy and confidentiality and to be familiar with widely recognized exceptions (for example, when mandatory reporting laws concerning abuse and neglect require disclosure of information without client consent, or when laws or court orders require disclosure without client consent during legal proceedings) [15].

Purpose of the Study

The purpose of this study is to provide an understanding of health care risk factors among the minority groups, the problems associated with income, their health behavior, including lack of access to quality healthcare. The majority of minorities fall under the category of low-income households, whereby they have low financial literacy and are unfamiliar with concepts like inflation. Most of the time, they have low expectations due to extent to which the low wage is being concentrated within a few low-wage sectors of the economy, versus the pandemic affecting low-wage workers in a number of sectors across the economy. According to Dalton [11], for each month from March 2020 to January 2021, at least 20% of the decline in employment among the lowest wage establishments was due to with-in-industry changes. Another important finding is that even for those who remained employed during the pandemic, the probability of becoming part-time for economic reasons increased, especially for low-wage workers.

Conceptual Framework

During the past few years, the distributions of income and wealth in the U.S. have changed in such a way that the economic environment, mostly lower-middle-class people has become much worse, and forcing poor minorities in the country to become victims of major health issues, most recently with the COVID-19 pandemic. Latest research suggested that the COVID-19 pandemic plunged the U.S. economy into recession in early 2020 and has fundamen-

tally affected the labor market [11], as of February 2021, COVID-19 was responsible for more than 450,000 deaths in the United States and the unemployment rate rose from 3.5% February 2020 to 14.7% in April 2020 before falling to 6.3% in January 2021. A new inclusive health systems framework is needed to balance disparities among people in the country; that would strengthen health systems in an effort to move towards universal health coverage and to achieve sustainable development goals to ensure health and wellbeing for all.

The conventional wisdom has long been that a growing gap between the rich and the poor is a bad thing and by providing a level of equity and providing opportunities for more income would decrease the inequity. Using income levels to measure the well-being of individual families may be helpful to determine how the lowest-paid workers are being disproportionately affected with the pandemic Also, changes in government spending patterns may help in distributions of income and wealth which may provide less costs to lower income families and tangible economics will lower the costs on universal health coverage for all Americans. It is significant to review income inequality by examining changes in the income-tax structure that significantly shifted real after-tax purchasing power in favor of those atop the socioeconomic ladder, compared to those below middle class, where their net worth remained virtually unchanged; and the real growth in wealth came predominantly at the top. These are the people that can afford health insurance or have access to quality health care and so on. Indeed, distributions of income and wealth are concentrated at the top 1% and those in the middle class and below lost ground [11].

Significant of Study and Major Problems

Definitely, there is a need to correct the wealth distribution in the country, as the wealth gap among the upper-income families and the middle and lower-income families is growing significantly. According to Pew Research Center [7], lower-income families net worth increased only from $12,300 in 1983 to $20,600 in 2001 (about 67% increase), middle-income families increased from $102,000 in 1983 to $144,600 in 2001. The gains for both lower and middle-income families were outdistanced by upper-income families, whose median wealth increased by 85% over the same period, from $344,100 in 1983 to $636.00 in 2001.As of 2016, upper-income families had 7.4 times as much wealth as middle-income families and 75 times as much wealth as lower-income families; an indication that the wealthy are getting richer and the poor are getting poorer. So, the wealth gap between the richer and poorer families have more than doubled from 1989 to 2016; as in 1986, the richest 5% of families had 114 times as much wealth as families in the second quartile, about $2.3 million compared with $20,300. As a result of this and by 2016, this ratio had increased to 248, a much sharper rise than the widening gap in income [19].

For many industries, employment decline has been challenging and the income uncertainty has certainly decreased confidence in the economy growth, as most of the industries affected by the pandemic heavily relied on employment in-person interactions with the customers or engaging with human factors for productivity, as a way of having confidence in guaranteed income. So, the growing health concerns and finding ways to maintain the customer base in a safe way has become problematic for such industries to gain a competitive level and regain a higher productivity [12]. The percentage of people living from paycheck to paycheck has risen since the COVID-19 pandemic and the decline in employment has risen significantly as of December 2020; the current rate of unemployment is 6.7% [15]. About 85% of the global population is homing to low-income and high-risk populations which will continue to be in danger or a threat to equitable allocation of resources if strategies from national procurement fail, and could lead to inadequate supply to all populations. Vaccine hesitancy also continues to make the news, as some populations especially minorities are refusing or delaying acceptance of COVID-19 vaccines; this is mostly found in all socioeconomic, religious, and ethnic groups [25].

Research Methodology

The research design relied on secondary data sources that included publicly available data on social, economic and health status characteristics of minorities. Documentary data includes the articulating and the interpretation, then the reflecting (also reflective) of the interpretation of the empirical material, and finally, the generating of theory as a multidimensional typology. The findings in this research rely on a reexamination of published research within the last five years, especially during this COVID-19 period. Given the extensive literature review and analysis on health services for the minority, a deductive approach was pursued in the analysis of the findings [2, 10].

Major findings presented in the research mirror those within the frameworks investigated and correlated with the current public discussions concerning disparities in health care services and economic inequality, lack of access to care, failure to take mental health issues seriously, and the systemic racism that has indeed underpinned everything else currently going on in the country. Exclusion criteria in this study included publications that were not from this country and not published within the last two years. Disparities among social groups continue to be significantly persistent and many Americans continue to be affected by experiencing poorer health than people in other developed countries; this exposure of findings is needed for people to understand and find ways to tackle the problems.

Findings and Discussions

As was predicted from the start of the pandemic, the lowest-paid workers would be disproportionately affected. After analyzing the Bureau of Labor Statistics' (BLS) Quarterly Census of Employment and Wages and Occupational Employment Statistics data [13], The researchers found that low-paid occupations were heavily represented and high-paid occupations lightly represented in the industry sectors most susceptible to employment losses during the pandemic. Using data from BLS's Current Population Sur-

vey (CPS), the median hourly wage of workers in highly exposed sectors was $15.00, compared to $ 21.50 for workers in other sectors. However [11], a larger share of workers in highly exposed sectors worked part-time hours in 2019.

Health insurance, medical services, drugs and medical supplies, pose major risk factors for minorities and these four major areas, especially health insurance, provide access to healthcare in order to minimize the risk of catastrophic financial losses due to medical expenses by more evenly distributing healthcare spending [8]. It is evident that minorities do not have the luxury of having access to quality health care services, and most minority groups do not have insurance, whereas health insurance is the major measure of healthcare expenditures that accounted for almost 68.7% of total healthcare spending in 2018. Hispanics/Latinos and Blacks/African Americans spent less on healthcare than the Caucasian population in all the abovementioned categories. All groups increased their spending on healthcare gradually over the 2004–18 period, however spending by Whites and all others has increased more rapidly since 2014. Health insurance is a resource that provides access to healthcare for most of the households and accounts for more than two-thirds of healthcare costs per household. The spending on health insurance premiums by race and ethnicity also correspond with the total healthcare spending, whereas Hispanics or Latinos, or Blacks or African Americans spent less on health insurance, compared with the Caucasian and all other groups [8].

Health inequities usually referred to as health disparities, have become major research topics and areas of concern to both political organizations and educational institutions. The current event is forcing people to reflect on so many areas of injustice in the country and people are realizing how complex it really is. We are now seeing the multi-factorial construct, differential access to medical care, treatment modalities, and disparate outcomes among various racial and ethnic groups have been validated in numerous studies; and most importantly, the cost and access to the healthcare system, primary care physicians, and preventive health services plays the subtle role of bias in creating and/or exacerbating health disparities and is well documented in the literature that is being generated. As a singular human race occupying this planet, we have an ethical obligation to work as one group and find ways to eradicate the major pandemic we face – racism. A recent publication by the U.S. Centers for Disease Control and Prevention (CDC) identified specific groups at higher risk for severe illness, such as older adults living in long term care facilities, those with a BMI of forty or higher, and immunosuppressed individuals, including people with HIV/AIDS. However, most risk models have not incorporated clinical, Sociodemographic, and environmental variables, which may be predictive of community spread within the U.S [7, 22].

As with other infectious diseases, predictors of COVID-19 infections may include employment status, education level, income, and housing conditions, which could influence the ability to seek care, adhere to treatment, and practice physical distancing measures. Thus, effective strategies for predicting risk factors for community transmission should include both clinical and social factors. The latter factors in particular remain understudied, especially among communities of lower socioeconomic status. Emerging data already show that minority communities and/or low socioeconomic status are experiencing disproportionate rates of serious illness if infected, due to pre-existing economic and health inequities (p. 2).

Race and ethnicity are major predictors of risk. Higher risk of infection among African Americans, indigenous, and other people of color are reported to be associated with other Sociodemographic and environmental characteristics found to be significant; and African Americans and Latinos are more likely to live in communities with poor air quality, work in jobs that cannot telecommute, and lack access to healthcare, which may increase the risk of infection and contribute to racial disparities in mortality. Additionally, chronic conditions such as obesity, stroke, and diabetes, and premature death also affect African Americans and Latinos disproportionately compared to whites. Minority communities are more likely to experience lower socioeconomic status, and be employed as essential workers. For other vulnerable groups, lack of personal transportation is a barrier to healthcare access and social distancing which further exacerbates infection risk. Minorities also experience more structural barriers to social distancing measures and are more vulnerable to severe illnesses [21, 22].

The researchers concluded that the nation needs to be prepared for another global pandemic and start working on prevention measures that would work if used early and foster success in controlling the outcome. A rapid risk prevention strategy will help those disenfranchised (the unemployed and uninsured); create predictability, economic security and wellness. Doing so would help develop favorable public movements for social justice and economic equality that will lead to more responsive government policy and sociopolitical systems that are more attuned to diversity, equity, and inclusion.

Notable findings and discussions reported in different research indicated that about 78% of pediatric coronavirus deaths occur in Black, Hispanic or indigenous populations, while COVID-19 related gene expression is higher in Black patients [14]. Also, during the COVID-19 pandemic, African American and Latina women had been the most affected due to layoffs and lack of child care support that drove women out of the workforce entirely. The number, as of February 2021, for women in the labor force participation rate was 55.5%, approximately the same rate as was recorded in April 1987 and minority women working in low-wage occupations has been the most impacted [17]. Now, there is a sweeping societal change predicted that will make life worse for most people as greater inequality, rising authoritarianism and rampant misinformation take hold in the wake of the COVID-19 outbreak; this is in reference to what life will be like in 2025 in the wake of the outbreak of the global pandemic and other crises that took place in 2020; among the outcomes predicted is a higher

level of economic inequality [1].

Indeed, patient safety is important and needs to be incorporated in on how to reduce health disparities among minority populations since equity issues in patient safety have been understudied and there has been an inability to create principles for successfully advancing health equity, as aligned with the culture and toolkit of the safety field. According to Chin [9], achieving equitable patient safety is realistic and necessary to create important opportunities for people to receive the care needed as the patient safety field needs to move quickly to maximizing the health of diverse individuals and individual organizations must commit to the mission of maximizing the health of diverse individuals and minority populations. These actions will help improve individual and population health, improve health and healthcare equity, examine safety criteria and systems for bias, develop validated patient safety equity performance measures; promote and nurture the moral movement for equity in patient safety [9].

Risk factors in public health services and their effect on minorities in the U.S. remain to be labor market effects with declines in employment due to COVID-19 in the areas, such as services like construction and transportation, leisure and hospitality, warehousing, and other services that greatly has both short-term and long-term effects of implications for future employment among minorities. Most are ordered to stay home and several other mandates for businesses to close and leading to the collapse of major business sectors [12]. With this, about 25% of unemployment claims can be explained by the implementation of stay-at-home orders [3]. About 30% decline in online job postings across the United States during the pandemic [18] and workers in the bottom quintile of wages make up over half of the employment in industries particularly exposed to the virus [13] also, 42% of recent layoffs result in permanent job loss [4].

Conclusion

Several findings suggested that due to COVID-19, the U.S. economy plunged to recession in early 2020 due to COVID-19 and affected the labor market [11] reported that as of February 2021, unemployment rate rose from 3.5% in February 2020 to 14.7% in April before falling to 6.3% in January 2021. The Bureau of Labor Statistic current population survey (CPS) found that median hourly wage of workers in highly exposed sectors was $15.00 compared to $21.50 for workers in other sectors in 2019 while a larger share of workers in highly exposed sectors worked part-time hours in 2019 [5], findings using Home base work records reported that as of mid-April, the number of hours worked by workers with a wage below $15 an hour was about 75% below the level in late January, while the hours of workers with wage above $15 was about 60% below the January level. By June, the hours of all workers in their sample had recovered to about 50% to 60% of the January level. The Opportunity Insights Economic Tracker indicated that employment bottomed out in the third week of April, at which time the employment level for workers with annual earnings below $27,000 was 37.4% below the level in January. For workers earning between $27,000 and $60,000, this figure was 23.3%, and it was 13.7% for workers earning more than $60,000. By the third week in August, the employment level of workers in the lowest earnings group was still 17.5% below the January level. In contrast, the employment of workers in the middle earnings group was 5.4% below the January level and the employment of high wage workers had nearly recovered completely, as it was only 1% below its level in January [11].

Significant efforts are needed to eradicate health disparities among minority groups with intervention projects that will include ensuring cultural competence among health care providers and improving health literacy among health workers, physicians, government policy and reviews of the health care system in America. Without intervention, existing racial and ethnic health disparities among minority older adults are likely to be exacerbated, as racial and ethnic minorities will comprise 42% of older adults. The pressing need to address these health disparities is perhaps most evident in Alzheimer disease (AD), which increases in prevalence with age and is disproportionately more prevalent among African American and Hispanic/Latino individuals [24]. The relevance of the Affordable Care Act (ACA) is also significant to provide quality healthcare to the uninsured, especially families that fall below the poverty line and middle-class individuals, as health care remains unaffordable for many minorities in the lower income bracket. As reported, the average premium for a mid-level plan for a 40-year-old, who doesn't qualify for a subsidy has climbed to $462 a month in 2020 from $273 in 2014, additionally the law has not addressed soaring prescription drug costs and staggering deductibles [16].

The Affordable Care Act should not become a financial burden; however, not everyone in the lower income bracket benefitted or was even aware of what it means for themselves and their family. The recent 2018 National Health Interview Survey and the National Healthcare Quality and Disparities Report indicated that minorities rate their health status as fair or poor more often than White individuals, and minorities receive worse care than White patients for about 40% of 250 quality measures. In an increasingly diverse nation, including African Americans, Hispanics, Asians, Native Americans, Alaska Natives, Native Hawaiians, Pacific Islanders, and White individuals, health disparities among racial and ethnic groups are prevalent, pervasive, and persistent [20, 21].

In conclusion, ethnic minority populations experience disparity in the quality and safety of the health care they receive due to a range of socio-cultural and economic factors and there is a dearth of evidence pointing to the nature and rate of patient safety and risk management events occurring at alarming rates amongst ethnic minority consumers. Developing relevant intervention approaches to enhance the safety of their care and developing healthcare risk management protocols to prevent NCDs are so significant in 2021 century and completely necessary in order for us to be competitive in the global economy. Patient safety and risk management have grown tremendously, but un-

fortunately, there are insufficient resources dedicated to its practical application in the context of risk to the patient, provider, unit and system levels.

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