In the United States, there exist several “at risk” populations of people who must navigate through many challenges and hurdles to obtain even the most basic of health care services. Institutions such as community health centers, public hospitals, and other not-for-profit health care organizations play a big role in providing health care to the most vulnerable populations in our country. Shi & Singh (2014) provide various terms that are used to describe vulnerable populations, such as underserved populations, medically underserved, medically disadvantaged, underprivileged, and American underclasses. By definition, vulnerable populations are those that are at greater risk for poor health status and health care access (Shi & Stevens, 2005). Numerous efforts have been made to characterize vulnerable populations by disease, age groups, and even demographics (Aday, 2001). No matter how vulnerable populations are classified, they almost always include racial and ethnic minorities, low socioeconomic status populations, and the uninsured (Shi & Stevens, 2005).

There are many initiatives that exist and attempt to bridge the gap between vulnerable populations and their access to health care. In fact, reducing and eliminating disparities in health care is a primary goal for the United States in Healthy People 2020. As racial and ethnic minorities constitute a growing percentage of the U.S. population, overcoming persistent health and health care disparities that affect certain ethnic and minority groups will benefit the entire society (Centers for Disease Control and Prevention, 2014). As the U.S. population becomes more diverse, it will be imperative that cultural competency be a goal of health care organizations to reduce disparities. Cultural competency can be defined as the ability of health care providers to function effectively in the context of cultural differences. Studies have shown that when cultural competency is an included strategy, the quality of health care received by racial and ethnic minority groups is improved (Jackson & Gracia, 2014).

Of course, it is not just racial and ethnic minority groups that face disparities in health care. Other at-risk populations include children, women, the homeless, the uninsured, the chronically ill and disabled, and those suffering from mental health illness. For example, homeless adults and children have a high prevalence of untreated acute and chronic medical conditions and face many barriers to accessing health care, such as financial barriers (Shi & Singh, 2014). Interestingly, research on low socioeconomic status populations (e.g., the homeless) has been overshadowed by racial- and ethnic-related disparities resulting in them being referred to as the “ignored determinant” of health in the United States (Diggs, 2012). This has resulted in those with the greatest health care needs not having them adequately met.
for this population, often because of cost (Shi & Stevens, 2005). The Affordable Care Act specifically targets the at-risk population by attempting to improve access and financial protection (Kristof, Berenson, Shih, & Riley, 2011).

Unlike other countries in the world, the United States does not offer universal health care or equal access to health care. The ability to pay determines access to health care in the United States, and if one cannot afford to pay for health care nor qualify for means-tested programs such as Medicaid, health care needs are unmet. There has been progress in alleviating health care disparities in United States, but more can be done. It is important that community-based initiatives be established to reduce disparities, and that ultimately feeds into the national goal to eliminate unequal access to quality health care and build stronger communities (Diggs, 2012). Reducing health disparities among all communities is a tremendous challenge for the United States; however, through effective policy and community engagement, progress can be made.

References


