

Stigmatization and discrimination perceptions among the uninsured: “They treat you different. It’s a different type care...”

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Abstract

Previous research documents the existence of perceived insurance-based discrimination and begins to describe how this discrimination influences health behavior. This research focuses on describing the context surrounding uninsured individuals’ perceptions of stigmatizations and discrimination through interactions with health care providers and health systems. Six focus groups were conducted by trained moderators with fifty-two adult participants. Participants represented the chronically uninsured (without health insurance for three or more years). A narrative analysis approach was used to code and examine focus group transcripts in NVivo 10.1.0 software. Findings illustrate how the quality, context and characteristics of patient and provider interactions contributed to participants’ sense of stigmatizations and discrimination. Participants described clear examples of perceiving they were being ignored or made to wait longer than others to be seen or were rushed through their appointments because of health insurance status. They described ways in which they felt they were identified differently than other patients with health insurance and how these interactions contribute to a sense of disempowerment, stress, and a loss of control.

Keywords: Medically Uninsured; Discrimination; Healthcare Disparities; Insurance Coverage

1. Background

Discrimination in healthcare has been the subject of numerous studies over the past several years. The landmark Institute of Medicine (IOM) 2003 report, *Unequal Treatment*, found that racial disparities exist in the quality of healthcare received, citing racism as a factor in these disparities. In their extensive literature review on racial disparities, authors make note that, in studies where insurance status was not controlled, it often emerges as a key predictor of quality of care. They summarize, “More such studies are needed to assess the relative contribution of access-related factors (e.g., insurance status)...to determine the extent of disparities in care” and reference an early 2001 IOM study that found that “insurance status, perhaps more than any other demographic or economic factor, determines the timeliness and quality of healthcare, if it is received at all” (LaVeist, Rolley, & Diala, 2003).

Thorburn and De Marco provide compelling reasons for focusing on insurance-based discrimination in healthcare (Thorburn & De Marco, 2010). First, any form of discrimination in healthcare has been shown to potentially affect health outcomes. Past studies have linked discrimination to delayed care and not following doctors’ advice (Blanchard & Lurie, 2004), as well as not receiving some preventive health services (Trivedi & Avanian, 2006) and decreased quality of care (Ayanian, Weissman, Chasan-Taber, & Epstein, 1999).

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Insurance-based discrimination in particular was found to be associated with fewer breastfeeding support actions and with a lower likelihood of a provider discussing birth control options after delivery in a study following pregnant women through childbirth (Thorburn & De Marco, 2010). Focusing on insurance-based discrimination is also unique in that insurance status is a modifiable characteristic, unlike race, ethnicity, or language, and recommendations for mitigating discrimination can be made to insurance policies and programs, as well as healthcare organizations (Thorburn & De Marco, 2010).

Racial/ethnic discrimination is among the more commonly researched forms of healthcare discrimination (Blanchard & Lurie, 2004; Crawley, Ahn, & Winkleby, 2008; Lillie-Blanton, Brodie, Rowland, Altman, & McIntosh, 2000; Gee, Ryan, Laflamme, & Holt, 2006; Bachhuber, Tschannerl, Lechuga, & Anderson, 2014; Bird & Bogart, 2001), although other forms studied include language and socio-economic status-based discrimination (LaVeist, Rolley, & Diala, 2003; Bird & Bogart, 2001; Simons, Groffen, & Bosma, 2013). A slightly less-commonly studied form of healthcare discrimination is insurance-based discrimination, although in the California Health Interview Survey, insurance-based discrimination was most commonly experienced (Trivedi & Avanian, 2006). In a study of Oregon mothers, insurance-based discrimination was the second highest reported form of discrimination (8.19%), surpassed only minimally by age-based discrimination (8.44%) (De Marco, Thorburn, & Zhao, 2008).

In a study conducted with a group of ethnically diverse patients, 12% cited insurance-based discrimination as influencing the quality of the medical encounter (Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005). Studies have focused on discrimination based on both insurance type and insurance status (whether or not one holds any form of insurance). In a study focusing on insurance type, Gatchell found that women insured by Medicaid were more likely to report insurance-based discrimination than women holding employer-based coverage (Gatchell, 2006). In a more recent study (2013), participants reported experiencing "lower-quality care" as a result of not holding private insurance (Salm Ward, Mazul, Ngui, Bridgewater, & Harley, 2013). As with most factors affecting healthcare, discrimination is often multi-faceted, and recent studies have shown the interrelation between multiple forms of discrimination, including the interplay between racial and insurance-based discrimination (Bachhuber, Tschannerl, Lechuga, & Anderson, 2014). As an example, a 2008 study found that the uninsured were 2.39 times more likely to perceive racial or ethnic bias when receiving care (Stepanikova & Cook, 2008).

In a study at the provider-level, nurse practitioner students were found to hold many misconceptions about uninsured users of a free clinic. They mistakenly believed most users to be homeless, women with children, or minorities. Rather, they found that most patients were "...in their 40's and 50's, Caucasian, between jobs, and either low income or choosing not to pay for insurance premiums." In addition, they held some beliefs that could lead to discriminatory actions, including believing uninsured patients at free clinics were "drug-seekers" or demanding entitlement to care (Rasmor, Kooienga, Brown, & Probst, 2014).

While many studies have examined factors predictive of an individual perceiving insurance-based discrimination and medical consequences of discrimination in healthcare settings, few have examined *how* this discrimination is experienced, including the context that contribute to these experiences being perceived as discriminatory. Nápoles-Springer, et al. described how participants perceived it as discriminatory when providers' first line of questioning was related to insurance status (Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005). Furthermore, participants perceived insurance-based discrimination in their limited access to specialty care, inadequate explanations, and longer wait times, among others. Another study, focusing on African-American women, demonstrated perceptions of discrimination when presenting public medical assistance cards, noting they felt staff immediately viewed them as "lower class." They also reported perceptions of longer wait times, attributed to a combination of race and insurance-status (Salm Ward, Mazul, Ngui, Bridgewater, & Harley, 2013). Yet another study, focusing on perspectives of lung cancer, described how African-American participants believed insurance-status and socioeconomic factors to affect treatment access, although they did not refer to this as "discrimination" in the same way they spoke of racial discrimination (Lathan, Waldman, Browning, Gagne, & Emmons, 2015).

Rather than attempting to describe patient characteristics that influence likelihood to experience insurance-based discrimination, the purpose of this study is to describe *how* the chronically uninsured experience health care and what within these experiences contribute to a sense of insurance-based discrimination.

This includes the setting and context surrounding discriminatory experiences, including factors at the provider and organizational levels that contribute to perceptions of discrimination. It also begins to describe how insurance-based discrimination affects health behavior, and provides recommendations for improvement at provider and organizational levels.

2.0 Methods

The findings reported in this manuscript are part of a larger mixed methods study to examine the geographical distribution, health status, and access to healthcare of chronically uninsured individuals in South Carolina, in the Southeastern region of the United States. The state opted out of the Medicaid expansion associated with the Affordable Care Act. The goal of the larger project is to provide new empirical evidence for the discussion and development of cost-effective strategies to expand access to healthcare for the economically disadvantaged population in light of the Affordable Care Act. The purpose of the focus group component of the study is to learn about the healthcare experiences of the chronically uninsured and particularly to determine how these experiences inform beliefs and subsequent attempts to access healthcare and/or health insurance. Focus groups were conducted in the first year of implementation of the Affordable Care Act. Institutional IRB approval was obtained prior to the study.

2.1 Recruitment

Focus group participants were recruited through a community engagement process by partnering with churches, free clinics and community centers. Researchers partnered with six organizations in four different regions of the state. Project staff worked with key partners at each organization to distribute flyers and identify potential participants. The flyers and a screening script were used to introduce potential participants to the project and ensure that those invited to participate had been uninsured for at least 3 years. Interested participants signed-up for a focus groups session that was held within a 2-3 week period of recruitment activities. Reminder calls to those on the sign-up list were made a day or two prior to the focus group session.

2.2 Data collection

Six focus groups were held, one per recruitment site, with a total sample of 52 participants, 12 males and 40 females. Four focus groups were conducted in English, and two were with Spanish speaking individuals. A detailed description of participant demographics is provided in Table 1 and in the results section below.

Focus groups were conducted by two trained, experienced moderators. A note taker was present for each focus group, and each group discussion was audio-recorded and then transcribed by a professional transcription service. The moderators used a semi-structured discussion guide to elicit descriptions of participants' experiences and the experiences of those close to them. The focus group guide was developed by research team members with qualitative, disparity focused, participatory research experience and with input from community partners. The guide included 20 questions. Focus group questions queried participants about factors that contribute to not having health insurance, experiences in seeking health insurance in the past and through the new Affordable Care Act marketplace, health status and health needs, experiences in seeking healthcare, and support for meeting their healthcare needs and the needs of others in their community without health insurance. We used a variety of probes to stimulate discussion among participants about specific events and experiences that shape their opinions, perceptions and beliefs about the effects of being uninsured on these experiences. It is important to note that we did not include any questions or probes specifically asking about stigmatizing or discriminatory experiences. Each focus group discussion lasted between 1 to 2 hours. At the conclusion of each discussion the participants received a small honorarium.

2.3 Data analysis

Focus group transcripts were reviewed by each moderator to address missing and/or misinterpreted text (related to factors such as low volume and difficult accents). Data analysis was completed by a three-member team. Two members of this team were also the focus group moderators. The team used an inductive narrative approach to data analysis (Thomas, 2006; Kidd & MB, 2000; Thorn, 2000). Researchers began with an analysis of two randomly selected transcripts to create a codebook.

The codebook was then expanded as the research team coded all six transcripts. Following a process detailed by Miles and Huberman (Miles & Huberman, 1994) the three-member analysis team divided the coding duties so that each transcript was coded by two independent coders.

The team met during the coding process to address consensus, update the coding structure and revisit any previously coded text that needed to be reviewed again based on these updates. This process yielded 96.4% agreement in coding. Codes were applied to the transcripts using NVIVO 10.1.0 software. Themes emerged during a subsequent review and analysis of code based queries using the NVIVO software. A narrative structure emphasizing participants' perceptions, opinions, beliefs, and the experiences that shaped those perceptions was used to guide the review process. As new themes emerged, the narrative was expanded.

While this analysis focused on discrimination, it was not the only topic that the participants discussed. As a thematic category, discrimination appeared in 8 out of 27 codes. Participants also discussed positive experiences, described their reasons for seeking health insurance and health services and their understanding of the importance of health promoting behaviors.

3. Results

Table 1 provides the demographics of participants in the six focus groups.

Table 1: Focus Group Demographics (N=52)

| | N | % |
|---------------------------------------|---------|-------|
| Race/Ethnicity | | |
| • Non-Hispanic White | 17 | 32.6 |
| • African American | 24 | 46.1 |
| • Hispanic | 11 | 21.1 |
| • Other | 0 | 0 |
| Age (Range, yrs.) | (20-64) | ----- |
| Sex | | |
| • Male | 12 | 23.1% |
| • Female | 40 | 76.9% |
| Years without insurance (Range, yrs.) | (3-25) | ---- |

The age range was between 20-68 years of age. A majority (24, 46.1%) were African American, and a majority were women (40, 77%). Fifty-two (100%) participants had been without insurance for three or more years. The number of years of not being insured ranged from 3-25.

Across all six focus groups an overarching theme emerged of stigmatization and discrimination or feelings of being "made to feel lesser" because of a lack of health insurance. Participants' discrimination experiences centered around three main themes: (1) experiences with healthcare organizations; (2) interpersonal interactions with healthcare providers; and (3) loss of control. Coded text for each theme was present across all six focus groups.

3.1 Experience with healthcare organizations

In all six discussions participants described experiences of perceived stigmatization and institutional discrimination. They recounted stories of being denied care, feeling as if they were an "outcast", feeling as if they are made to wait longer to be seen and paradoxically being "kicked-out" of care earlier because of not having health insurance. Participants described trying to access care at various healthcare organizations and feeling dismissed. As one participant described:

"The treatment is very different if you don't have health insurance. The difference in treatment, they don't even want to talk to you once you say you don't have health insurance".

Another participant described her sister's experience:

"It was my sister who needed medicine for pain. Her friend had the same thing and had health insurance. Even though they were trying to get her out of there quickly, they were still checking on her. My sister was there all day, and no one checked on her."

Participants described being limited to free clinics and the emergency room for their care. Some participants described how they were very grateful for these services but they also recognized that the services available through these clinics were limited. Thus they were less able to fully participate in healthcare services, and were made to feel "lesser" due to a lack of autonomy in terms of provider/healthcare organization choice and the extent of treatment options available to them. They shared stories about family and friends being treated through a free clinic but not being able to access mental health or dental health services because they were not available at these centers. Participants also expressed an understanding that generally they could not be denied care at the emergency room. However, they also discussed how this was not desirable because it is a very expensive and inconvenient/time consuming way to receive care.

Participants also discussed experiences in which they were not denied services, but they were certain they were treated differently by the organization because of their lack of health insurance. They shared numerous stories of being ignored while waiting for care, being made to wait longer for care than others with health insurance and being released from care sooner than others with health insurance. For example one participant described his niece's experience as follows:

"It is also a fact they try and get you out of the hospital as fast as they can without health insurance. They sent my niece home after 2 weeks, but her stomach (incision) was still open."

They also shared stories of being "looked down on" by staff for not having health insurance. For example, one participant described the different experiences she had during her three different pregnancies. She had health insurance for the first pregnancy and described it as a very caring experience.

"Even our first trip to the bathroom after birth of the baby, the nurse was there with me and walked me to the bathroom. After the second two pregnancies, I had to go myself; there was no one there to help me. The first thing they wanted to know, do you have health insurance?"

A different participant summed it up as:

"Yea, they treat you different. It is a different type of care, a different type of concern, and but we all human, so I think we should get the same care regardless, but it is what it is. People judge you according to your insurance."

3.2 Interpersonal interactions with healthcare providers

As mentioned above, participants had several stories expressing their gratitude for services that are available. Additionally, participants in each of the six focus groups had stories of positive interactions with healthcare providers that expressed empathy, caring and treated them with respect. However, the participants had as many or more stories of being rushed through care and being made to feel like treating them was a hassle because of their lack of insurance. They described how it felt like healthcare providers just stopped listening to them once the provider found out they did not have health insurance. They also shared stories of being misdiagnosed and sent home without any follow-up care. One participant described her friend's experience as follows:

"The doctor sent her home, she still doesn't feel good and tried to go back to the doctor and that is when her appendix burst. This was three months after the birth of her baby. She end up in a situation where she was septic and they had to keep the incision open. She did get to stay in the hospital longer because she had a fever. But, they were waiting for her fever to end so they could push her out the door".

Another participant described her frustration and how her doctor made her feel ignored:

"You ain't looked at me, touched me, nothing -but you say I can go work with these bad feet I got?!"

Participants in five of the six focus group discussions shared stories of how difficult it is to get seen by a specialist. They most frequently shared stories about needing or wanting dental care and how difficult it is to access dental care without insurance.

However, they also shared stories of how they felt as if their healthcare provider just didn't help them with getting access to a specialist. They recognized that the primary obstacle was cost. However, as one participant stated:

"If it were available, I would pay for it, because we have to pay at (center). But, getting help from a specialist or getting blood drawn we can't do. We are not asking for anything free. We are just asking for help."

3.3 Loss of control

Participants in all six focus group discussions described how their experiences contributed to a feeling of disempowerment. Some participants described how high medical costs contributed to a spiraling financial difficulty which leads to "discouragement" and "stress" One participant described it as:

"If you don't have insurance, you talk about stress. I mean, there no level. It goes beyond the roof because how do you get treated? How do I get treated?"

Another participant described her lack of control as follows:

"... You feel like you have control. Right now, I have control, but I don't have control because if I go to the emergency room then I get this big bill. They can't deny me, you know, but then if I can't pay you when I get there, I can't pay this now. Really? You sending me a bill? So, I mean, I'm not saying I'm not responsible, but it's just the fact that it's a lot. They charge a lot. So, having the insurance just makes it more comfortable..."

Participants also described how healthcare costs associated with being uninsured or underinsured contributed to stressful situations.

".....the cost were more than \$500,000 and my sister had to keep moving around, because the charges keep following her."

Participants also described actions they would take in an effort to regain some control in their health and healthcare options. For example, they discussed how they made decisions about where, from within their limited choices, they would go for treatment.

"...go to (Hospital A) because they don't take your tax money like (Hospital B) will."

"...you don't go to that emergency room. You try to go to (Hospital C). You go like 17 miles down the road or either you go to (Hospital D) because you go you the emergency room in (Hospital E), you gonna be there like 14 or 15 hours."

They also described many self-care behaviors that were used in lieu of seeking healthcare.

"You just get over-the-counter medicine"

"Or find a drug dealer on the corner. He can give you what you need."

"We try to self-diagnose and self-treat. What do you do if you can't pay?"

"When I tried to self-diagnose it ended up being my gall bladder. I ended up having to have surgery."

This sense of loss of control was most adamantly discussed in the two focus groups with Spanish speaking participants. They discussed their inability to fight anything or advocate for themselves because of their immigration status and or perceptions about them among the larger community. They expressed that it seemed like no matter the situation "it is always our fault". They discussed fear of going to jail if they advocate for themselves. They also discussed frustration at not being able to apply for health insurance because of immigration status. Lastly, they also provided stories of different treatment for their children based on having Medicaid, which was also linked to immigration status and they described how this created tension in their families.

4. Discussion

Study participants shared many stories illustrating how their healthcare experiences made them feel they were treated differently. Furthermore, they described how they perceived this difference to be stigmatizing and/or discriminating because it was based on their lack of insurance. Their experiences were similar to uninsured patient experiences reported in other studies (Thorburn & De Marco, 2010; Nápoles-Springer, Santoyo, Houston, Pérez-Stable, & Stewart, 2005; Salm Ward, Mazul, Ngui, Bridgewater, & Harley, 2013). It is entirely possible that a person without the disadvantage of being uninsured may have very similar interactions and interpret them very differently.

It is important to note that all of the study participants' stories recount their interpretation of an event or action and how it made them feel. Thus, all of the findings are grounded in their perceptions.

4.1 Experience with healthcare organizations.

SalmWard et al(2013) described how low-income African American women report "learning to go last" in prenatal care settings. In their qualitative focus group study of 31 African American women in Oregon, themes of discrimination based on insurance status or income emerged in every discussion. Participants described unfavorable reactions when they produced medical assistance cards, being made to feel "lower class" compared to the reception they would witness by those who presented a private health insurance card. SalmWard reported that "some discussion threads seemed to blur the lines between insurance or income status and race, attributing negative treatment to insurance or insurance status, but mentioning race in their description of the experience." (Salm Ward, Mazul, Ngui, Bridgewater, & Harley, 2013) Unlike SalmWard's study, the current study did not include prompts mentioning race, and instead all prompts were asked within the context of being uninsured. However, it is difficult to detangle discrimination based on insurance status from discrimination based on other factors (gender, race/ethnicity, age, health issue, etc.).

Threads of race, insurance status and income were comingled, perhaps because the three are so closely tied, (and potentially more so in the South). Demarco, et al described the perceptions of discrimination during prenatal care as primarily due to insurance-based discrimination rather than race(De Marco, Thorburn, & Zhao, 2008).

4.2 Interpersonal interactions with healthcare providers.

Participants in this study perceived that they were treated differently by providers based on their insurance status. Johnson, et al described the treatment as "being othered", whereas Meyers, et al determined that physicians *do* incorporate their patients' insurance status into their clinical decision making and acknowledge they frequently alter their clinical management as a result (Meyers, et al., 2006; Johnson, et al., 2004). Participants also discussed experiences where they were not denied services but were certain they were treated differently by the organization because of their lack of health insurance. They shared stories of being ignored while waiting for care, being made to wait longer for care than others with health insurance and being released from care sooner than others with health insurance. This is interesting given the fact that while health insurance is seen as a "gold ticket" to gain access to the healthcare system, the lack of health insurance may indeed causes one to be released sooner.

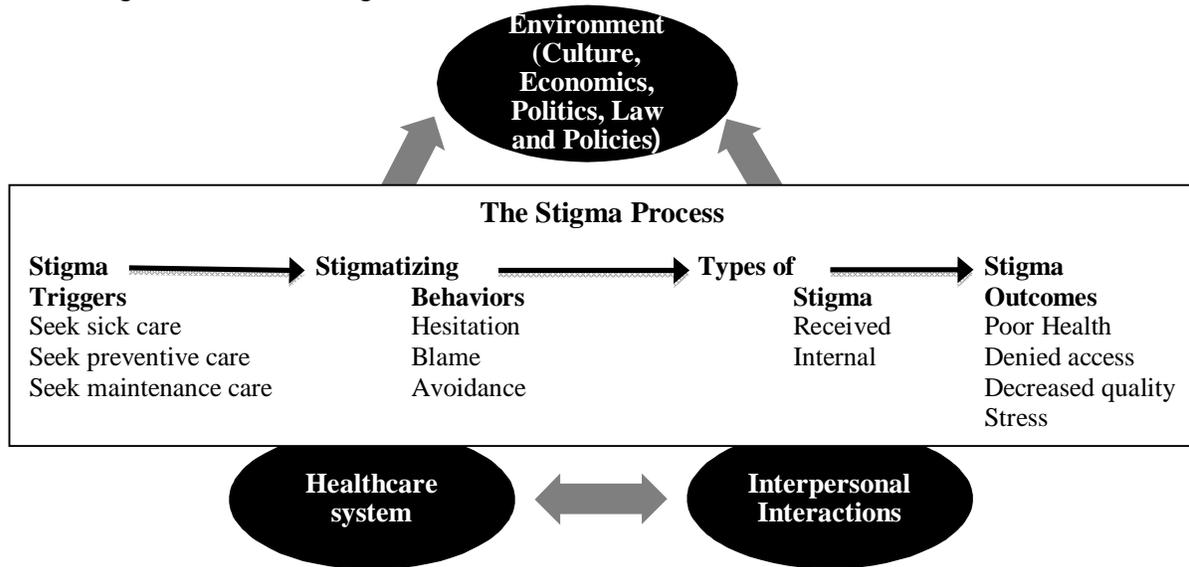
4.3 Loss of control.

Participants cited the close association between lack of insurance and stress, and lack of insurance and financial burden. When participants or a family member became ill, they described the dual burden of stress due to illness and due to impending medical charges. Participants described specific actions that they took following incidents of perceived discrimination in an effort to regain some control in their health and healthcare options. There was also a prevalent fear that "they" (hospital or clinic) would obtain their tax information and possibly garnish wages or turn them into the IRS for not having health insurance. They spoke of avoiding returning to places where they had outstanding charges and in one case, moving residences to evade the charges.

There were a variety of examples where participants described "self care" actions of themselves or family members when they felt a lack of access to healthcare services. These included self-diagnosing and treating, using over-the-counter medications, or in one group, going to a "drug dealer on the street". Many cited changes in behavior such as self-treatment of diabetes or pain management. This is consistent with a study of 167 African Americans with chronic illness. Becker et al. found that uninsured patients were significantly more likely to engage in self-care without physician influence than insured patients(Becker, Gates, & Newsom, 2004).

A disease-based conceptual model of discrimination and stigma may serve as a useful starting point for conceptualizing insurance-based discrimination. An adaptation of the model developed regarding HIV/AIDS stigma by Holzmer et al 2007 could help to show the process of stigmatization and discrimination that occurs among uninsured patients(Holzemer, et al., 2007). The adapted model below is based upon findings from this focus group study.

Figure 1: Model of Stigmatization and Discrimination Process for the Uninsured



Participants described a stigmatization and discrimination process that begins as they initiate care as one of the first questions they are asked: “Do you have insurance?” As they described, this process could occur when seeking preventive, sick, or maintenance care. They most frequently talked about the process in the context of emergency room care or hospital care. However, it was not limited to just these settings. Participants described two types of perceived stigma, received and internalized. The definitions are presented in Table 2. The components, and associated examples, of each type of stigma are developed from the experiences described by study participants. Received stigma consists of any type of stigmatization resulting from being uninsured and are associated with the experience with healthcare organization and interpersonal interactions with healthcare providers themes. Internal stigma, as illustrated in the loss of control theme, includes thoughts and actions based on personal perceptions and care options. Stress was the most frequently discussed consequence of this process. However, other research has clearly shown how the triggers are associated with healthcare access and quality and consequently poor out comes(LaVeist, Rolley, & Diala, 2003; Blanchard & Lurie, 2004; Trivedi & Avanian, 2006).

Table 2: Types of Stigma and Definition

| Type | Definition |
|------------------------|--|
| Received Stigma | All types of stigmatizing and discriminating behavior towards uninsured patients |
| Negating care | Denying care or limited access to desired or needed care |
| Neglecting | Offering or giving less care than expected or made to wait longer than expected for appointment or wait longer for care or rushed through care |
| Avoiding | Ignoring questions or request |
| Internal Stigma | Thoughts and behaviors stemming from stigmatizing or discriminating behavior toward uninsured patients |
| Perception of self | Feel as though they are looked down up or ignored |
| Care Withdrawal | Feeling discouraged and hopeless about access care |
| Stress | Feeling heighted stress related to care options and interactions |
| Control Actions | Any action to try and regain control over health status and access to care |

This adaptation to the stigmatization model adheres to earlier models by Holzerman et al and important concepts of including both a process and structural elements (Holzemer, et al., 2007; Parker & Aggleton, 2003). As noted by Holzerman et al, these processes are not likely to change unless the structural elements are addressed (Holzemer, et al., 2007). There is less known about healthcare organizational factors and clinical staff factors that may influence these stigma processes.

This study had several limitations. While data from this formative research cannot be generalized to other populations, this study population is a fairly representative cross section of the chronically uninsured in the southeastern state where the study was conducted. It is important to remember that all of the participants were uninsured. A next phase of the study may be to explore of similar experiences are described among the insured. Because of the exploratory nature of this study, focus groups were not stratified by type of healthcare organization, type of healthcare received or geographic location. These factors may contribute to different experiences in discrimination, but the findings were remarkably similar across all six groups. The use of focus groups in this study allowed researchers to probe specific examples of discrimination and how such treatment affects seeking of healthcare services and health behaviors.

Another possible limitation of the study was that both men and women were included in these groups. Since the primary inclusion criteria was being chronically uninsured (3 or more years) and there were so few men, researchers did not separate the groups. However, it is possible that some participants may have felt more comfortable to express themselves about specific healthcare experiences in single-gender groups. One male participant approached a moderator after the focus groups to quietly tell them about experiences of uninsured HIV-positive males in the community. Perhaps something that might have been probed further in single-gender group.

Overall, our findings suggest that men and women perceived discrimination based on insurance status within healthcare organization and from providers and that feeling of helplessness and loss of control continued after the encounter. These feelings of loss of control led participants to delay seeking healthcare services or to learn to go without services completely. Our findings highlight the need for better healthcare services for the chronically uninsured and for recognition by organizations and providers that even the subtlest communications can be perceived as discriminatory. Ultimately, providers and organizations must know their patient communities; understand these perceptions and work to create more equitable healthcare experiences. Promising efforts in other areas have included training staff in cultural competency, hiring polices to ensure organizational staff are more reflective of patient demographics, cross disciplinary training, and tolerance training for staff (Anderson, Scrimshaw, & Fullilove, 2003). Further research is needed to better understand how the underinsured perceive their healthcare experiences and how healthcare workers perceive their interactions and structural environment as well as to establish objective measurement of discrimination so that organizations can monitor progress towards providing more equitable care.

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